Derbyshire Healthcare NHS Foundation Trust

PUBLIC BOARD MEETING
TUESDAY, 3 JUNE 2025 TO COMMENCE AT 9.30AM
CONFERENCE ROOMS A&B, RESEARCH & DEVELOPMENT CENTRE, KINGSWAY, DERBY, DE22 3LZ

	TIME	AGENDA	LED BY
1.	9:30	Chair's welcome, opening remarks, apologies and declarations of interest 1.1 Trust Vision and Values 1.2 Register of Interests 2025/26 1.3 Annual review of 2024/25 Declarations of Interest	Selina Ullah
PATIENT STORY			
2.	9.35	Patient Story *"Making information easier to understand in Neurodevelopmental services"*	Tumi Banda
STANDING ITEMS			
3.	10.00	Minutes of the Board of Directors meeting held on 4 March 2025	Selina Ullah
4.		Action Matrix and Matters Arising	
5.		Questions from members of the public	
6.	10.05	Chair's update	Selina Ullah
7.	10.15	Chief Executive's update	Mark Powell
OPERATIONAL PERFORMANCE			
8.	10.25	Integrated Performance report to include Operations, Finance, People and Quality	Vikki Ashton Taylor/ James Sabin/Rebecca Oakley/Tumi Banda
9.	10.50	Year-end Financial Position – 2024/25	James Sabin
11.00am BREAK			
10.	11.10	Making Room for Dignity progress	Andy Harrison
11.	11.20	Trust Strategy progress update	Vikki Ashton Taylor
STRATEGIC PLANNING AND CORPORATE GOVERNANCE			
12.	11.30	<u>2025/26 Plan</u> 12.1 Planning update – 2025/26 12.2 Medium Term Financial Plan (MTFP)	James Sabin
13.	11.40	Corporate Governance report, including 11.1 Board Committee Terms of Reference 11.2 Audit and Risk Committee Year-end report 11.3 Trust Sealings 11.4 Continuation of Services Condition 7 – Provider Licence	Justine Fitzjohn
14.	11.45	Board Assurance Framework update	Justine Fitzjohn
QUALITY GOVERNANCE			
15.	11.50	Transformation and Continuous Improvement (bi-annual)	Vikki Ashton Taylor
16.	12.00	Intensive and Assertive Community Mental Health Treatment – Independent Homicide Review - Nottingham	Tumi Banda
BOARD COMMITTEE ASSURANCE			
17.	12.10	Board Committee Assurance Summaries	Committee Chairs

REPORTS FOR NOTING ON ASSURANCE AT BOARD COMMITTEES			
18.	12.25	People and Culture Committee 18.1 Annual Modern Slavery Statement for approval 18.2 Annual Gender Pay Gap report for approval 18.3 Annual Medical Appraisal and Revalidation Quality and Safeguarding Committee 18.4 Learning from Deaths/Mortality annual report for approval 18.5 SEND Annual report for approval	Ralph Knibbs Lynn Andrews
CLOSING BUSINESS			
19.	12.30	Consideration of any items affecting the Board Assurance Framework (BAF)	Selina Ullah
20.		Meeting effectiveness	
FOR INFORMATION			
Summary of Council of Governors meeting held 4 March 2025 Glossary of NHS Acronyms Forward Plan 2025/26			

Questions applicable to the agenda, and at the Chair's discretion, can be sent by email to the Board Secretariat dhcft.boardsecretariat@nhs.net up to 48 hours prior to the meeting for a response by the Board. The Chair may, under the Foundation Trust's Constitution, request members of the public to withdraw for the Board to conduct remaining business in confidence as special reasons apply or because of information which could reveal the identities of an individual or commercial bodies.

The next meeting will be held on 22 July 2025 at 9.30am in Conference Rooms A and B, Centre for Research and Development, Kingsway. Arrangements will be notified on the Trust website seven days in advance of the meeting.

Users of the Trust's services and members of the public are welcome to observe meetings of the Board. Participation in meetings is at the Chair's discretion.

Strategy on a page

NHS
Derbyshire Healthcare
NHS Foundation Trust

Our strategic priorities

Our vision

We make a positive difference in everything we do

Patient focus

Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.

Caring

We provide safe care and support people to achieve their goals.

Inclusive

We respect and include everyone in all we do.

Partnerships

We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.

WE MAKE A POSITIVE DIFFERENCE • IN EVERYTHING WE DO •

Ambitious

We offer high quality services, and we commit to ongoing improvement.

Belonging

We come together to create a culture that is welcoming, open and trusting.

People

We will attract, involve and retain staff creating a positive culture and sense of belonging.

Collaborative

We work together to achieve the best outcomes for our people and communities.

Productive

We will improve our productivity and design and deliver services that are financially sustainable.

Our values

Find out more

derbyshirehealthcareft.nhs.uk/about-us/strategy

Our vision, values and strategic priorities are central to everything we do. They are the 'thread' that ties together all our work, explaining how we can best serve the people of Derby and Derbyshire and support each other. How does your role form part of that thread?

DECLARATION OF INTERESTS REGISTER 2025/26		
NAME	**INTEREST DISCLOSED**	**TYPE**
Selina Ullah Trust Chair	• Director/Trustee, Manchester Central Library Development Trust • Non-Executive Director, General Pharmaceutical Council • Non-Executive Director, Locala Community Partnerships CIC • Non-Executive Director, Accent Housing Group • Director, Muslim Women's Council • Trustee and Board member of NHS Providers representing Mental Health Providers	(e) (e) (e) (e) (e) (e)
Tony Edwards Deputy Trust Chair	• Independent Member of Governing Council, University of Derby	(a)
Deborah Good Non-Executive Director	• Trustee of Artcore – Derby • Director of Craftcore Derby	(e) (e)
Andrew Harkness Non-Executive Director	• Spouse, Nicola Harkness, works at Staffordshire and Stoke-on-Trent Integrated Care Board	(e)
Ashiedu Joel *(until 31-Jul-2024)* Non-Executive Director	• Director, Ashioma Consults Ltd • Director, Peter Joel & Associates Ltd • Director, The Bridge East Midlands • Director, Together Leicester • Lay Member, University of Sheffield Governing Council • Fellow, Society for Leadership Fellows Windsor Castle • Elected Member, Leicester City Council • School of Business and Law Advisory Board Member, De Montfort University • Independent Chair, Derby and Derbyshire Drug and Alcohol Strategic Partnership • Justice of the Peace, Leicester, Leicestershire and Rutland Magistracy	(a) (a) (a) (a) (a) (a) (a) (a) (e) (e)
Ralph Knibbs Senior Independent Director	• Trustee of the charity called Star* Scheme	(d)
Geoff Lewins Non-Executive Director	• Director, Arkwright Society Ltd • Director, Cromford Mill Limited (wholly owned trading subsidiary of Arkwright Society)	(a) (a)
Mark Powell Chief Executive	• Treasurer, Derby Athletic Club	(d) (e)
Vikki Ashton Taylor Deputy Chief Executive and Chief Delivery Officer	• Magistrate, covering mainly Derbyshire and Nottinghamshire Courts	(e)
James Sabin Director of Finance	• Spouse works at Sheffield Health & Social Care NHS Foundation Trust as Head of Capital and Therapeutic Environments	(e)
All other members of the Board of Directors have submitted a nil return, meaning they have no interests to declare.		

(a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those dormant companies).
(b) Ownership or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
(c) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.
(d) A position of authority in a charity or voluntary organisation in the field of health and social care.
(e) Any connection with a voluntary or other organisation contracting for National Health Services or hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or any other body which could be seen to influence decisions you take in your NHS role (see conflict of interest policy -loyalty interests).

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 June 2025

Annual Review of Declarations of Interest

Purpose of Report

This report provides the Trust Board with the year-end 2024/25 Register of Directors' interests. This register will be published in the Annual Report for 2024/25. The register is updated with each new interest declared/removed and the revised version is then reported to each Public Board.

Executive Summary

- It is a requirement that the Chair and current Board members who regularly attend the Board should declare any conflict of interest that may arise in the course of conducting NHS business. Directorship and other significant interests held by NHS Board members should be declared on appointment and kept up to date
- The Chair and Board members should declare any business interest, position of authority in a charity or voluntary body in the field of health and social care, and any connection with a voluntary or other body contracting for NHS services
- For this reason each Director should make a continual declaration of any interests they have to the Board Secretary as they arise
- To ensure openness and transparency during Trust business, the Register is included at the next meeting in the papers that are considered by the Board of Directors at each meeting.

Strategic Considerations	
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X

Risks and Assurances

- Directors are asked to disclose to the meeting any changes to the Register of Directors' Interests during the course of the year
- When declaring an interest, each Board member has affirmed their agreement to comply with the NHS Codes of Conduct and Accountability, and the Seven Principles of Public Life (Nolan), and to state whether there is any relevant audit information of which the Trust's Auditors are unaware.

Consultation

None.

Governance or Legal Issues

The disclosure and statements referenced within this report are subject to the NHS Code of Conduct and Accountability and Licence Conditions of the Trust.

Public Sector Equality Duty & Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

There is no impact to those with protected characteristics arising from this report.

Recommendations

The Board of Directors is requested to approve and record the declarations of interest as disclosed. These are recorded in the Register of Interests which is accessible to the public at the Trust Head Office and will be listed in the Trust's Annual Report for 2024/25.

Report presented by: **Selina Ullah**
Trust Chair

Report prepared by: **Jo Bradbury**
Corporate Governance Officer

DECLARATION OF INTERESTS REGISTER 2024/25		
NAME	**INTEREST DISCLOSED**	**TYPE**
Selina Ullah Trust Chair	• Director/Trustee, Manchester Central Library Development Trust • Non-Executive Director, General Pharmaceutical Council • Non-Executive Director, Locala Community Partnerships CIC • Non-Executive Director, Accent Housing Group • Director, Muslim Women's Council • Trustee and Board member of NHS Providers representing Mental Health Providers	(e) (e) (e) (e) (e) (e)
Tony Edwards Deputy Trust Chair	• Independent Member of Governing Council, University of Derby	(a)
Deborah Good Non-Executive Director	• Trustee of Artcore, Derby • Director of Craftcore, Derby Limited	(e) (e)
Andrew Harkness Non-Executive Director	• Spouse, Nicola Harkness, works at Staffordshire and Stoke-on-Trent Integrated Care Board	(e)
Ashiedu Joel *(until 31-Jul-2024)* Non-Executive Director	• Director, Ashioma Consults Ltd • Director, Peter Joel & Associates Ltd • Director, The Bridge East Midlands • Director, Together Leicester • Lay Member, University of Sheffield Governing Council • Fellow, Society for Leadership Fellows Windsor Castle • Elected Member, Leicester City Council • School of Business and Law Advisory Board Member, De Montfort University • Independent Chair, Derby and Derbyshire Drug and Alcohol Strategic Partnership • Justice of the Peace, Leicester, Leicestershire and Rutland Magistracy	(a) (a) (a) (a) (a) (a) (a) (a) (e) (e)
Ralph Knibbs Senior Independent Director	• Trustee of the charity called Star* Scheme	(d)
Geoff Lewins Non-Executive Director	• Director, Arkwright Society Ltd • Director, Cromford Mill Limited (wholly owned trading subsidiary of Arkwright Society)	(a) (a)
Mark Powell Chief Executive	• Treasurer, Derby Athletic Club	(d) (e)
Vikki Ashton Taylor Deputy Chief Executive and Chief Delivery Officer	• Magistrate, covering mainly Derbyshire and Nottinghamshire Courts	(e)
Arun Chidambaram Medical Director	• Clinical Director, NHSE Midlands Mental Health – 6 January 2025-31 March 2025	(e)
James Sabin Director of Finance	• Spouse works at Sheffield Health & Social Care NHS Foundation Trust as Head of Capital and Therapeutic Environments	(e)
All other members of the Board of Directors have submitted a nil return, meaning they have no interests to declare.		

(a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those dormant companies).
(b) Ownership or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
(c) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.
(d) A position of authority in a charity or voluntary organisation in the field of health and social care.
(e) Any connection with a voluntary or other organisation contracting for National Health Services or hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or any other body which could be seen to influence decisions you take in your NHS role (see conflict of interest policy -loyalty interests).

Derbyshire Healthcare NHS Foundation Trust

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

Held in Conference Rooms A and B
Research and Development Centre, Kingsway, Derby DE22 3LZ

Tuesday 4 March 2025

MEETING HELD IN PUBLIC

Commenced: 09.30am Closed:12.37pm

PRESENT	Selina Ullah	Trust Chair
	Tony Edwards	Deputy Trust Chair
	Ralph Knibbs	Senior Independent Director
	Lynn Andrews	Non-Executive Director
	Andrew Harkness	Non-Executive Director
	Geoff Lewins	Non-Executive Director
	Mark Powell	Chief Executive
	Tumi Banda	Director of Nursing, Allied Health Professions (AHPs), Quality and Patient Experience
	Dr Arun Chidambaram	Medical Director
	Justine Fitzjohn	Director of Corporate Affairs and Trust Secretary
	Rebecca Oakley	Director of People, Organisational Development and Inclusion
	James Sabin	Director of Finance
IN ATTENDANCE	Anna Shaw	Associate Director of Communications and Engagement
DHCFT2025/016	Richard	Guest for Patient Story
DHCFT2025/016	Joe Thompson	Assistant Director of Clinical and Professional Practice
DHCFT2025/028	Tamera Howard	Freedom to Speak Up Guardian
DHCFT2025/024	Tamsin Hooton	Programme Director, Joined Up Care Derbyshire Provider Collaborative
	Jo Bradbury	Corporate Governance Officer
APOLOGIES	Deborah Good	Non-Executive Director
	Vikki Ashton Taylor	Deputy Chief Executive and Chief Delivery Officer
OBSERVERS	Sue Ryan	Lead Governor
	Dave Allen	Public Governor - Chesterfield
	Fiona Birkbeck	Public Governor – High Peak and Derbyshire Dales

DHCFT/ 2025/015	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** Trust Chair, Selina Ullah, welcomed Board members, colleagues, governors and observers to the meeting. It was noted that Tamsin Hooton, Programme Director, Joined Up Care Derbyshire Provider Collaborative was in attendance and would be presenting agenda item DHCFT/2025/024, an update on Joined Up Care Derbyshire. Apologies were as listed. One declaration of interest was made by Arun Chidambaram, Medical Director, as he had accepted the position of Clinical Director with NHSE Midlands Mental Health until

	31 March 2025. Arun advised the declaration was more of a conflict of interest for NHSE than for the Trust.
DHCFT/ 2025/016	**PATIENT STORY – MY JOURNEY FROM SERVICE USER TO RECOVERY** The Board welcomed Richard to the meeting, to share his experience of the Trust's Living Well services in Derby (Derby Wellbeing). Richard spoke about a point in his life when, despite abstinence from drugs and alcohol, he suffered with low mood and negative overthinking. He was keen to feel better, get his life together and secure employment and this had prompted a self-referral to Derby Wellbeing. It was noted that the flexibility offered by the service had supported Richard's individual needs, building confidence and an understanding of his condition. In particular, Richard explained how the offer of support in non-clinical spaces and the therapeutic benefit of time spent outdoors contributed to his recovery and desire to get back into running. The value of receiving advice from those with lived experience of mental health conditions was highlighted and Richard was delighted to be working with the Trust to support the training of Junior Doctors from an Expert by Experience perspective. The Board voiced their thanks to Richard for the heartfelt and emotional account. Referring to the points raised, Lynn Andrews, Non-Executive Director, commented on the positive benefits achieved through peer support and the need to raise awareness of Trust services. Mark Powell, Chief Executive, echoed this and expressed his gratitude for the time Richard had given to Junior Doctors. He asked for his consent to discuss further opportunities for improvement. Richard thanked the Board for listening and for making him feel comfortable. The clear and articulate account was praised by Selina and she wished Richard well with running, bird watching and nature endeavours. **RESOLVED: The Board of Directors was appreciative of Richard's presentation, which had highlighted the importance of peer support, flexibility and the need to raise awareness of Trust services.**
DHCFT/ 2025/017	**MINUTES OF THE PREVIOUS BOARD OF DIRECTORS MEETING** The draft minutes of the previous meeting held on 14 January 2025 were accepted as a correct record of the meeting.
DHCFT/ 2025/018	**ACTION MATRIX AND MATTERS ARISING** The Board reviewed and closed the completed actions. No actions remained outstanding. There were no matters arising.
DHCFT/ 2025/019	**QUESTIONS FROM MEMBERS OF THE PUBLIC** No questions had been received.
DHCFT/ 2025/020	**CHAIR'S UPDATE** Selina provided the Board with her reflections on activity since the previous Board meeting on 14 January 2025 and drew attention to the below points: She had been on several visits to Trust services, including the Finance team, Adult Crisis team and colleagues in the Mental Health Act (MHA) office had these had provided detailed insight.

	Selina reflected on the level of dedication and support provided by these teams to support Trust services and service users. It was noted that: • the Finance team does not just focus on money, they support the development of Trust services and work closely with Service Managers and other team members • the Mental Health Act team performs essential activity, ensuring compliance with the MHA and helping patients' rights to be observed • the Adult Crisis team carries a level of risk in their role of supporting families and patients to stay in the community and also effectively manage demand from families wanting their loved ones in Trust Inpatient services. On behalf of the Trust, Selina thanked the family of Barry Whitehead for their kind donation to the Trust's Dementia Rapid Response team. Barry's grandson, Jack, had raised money to donate to the team in his memory, by completing a half marathon. Speaking about a recent Board Development Session that had taken place at the Pakistan Centre, Selina reminded the Board that Trust actions and decisions impact the community. This had been the first time a session had been held in the community during her tenure and it had heightened engagement and highlighted the need to listen to what will work for people, along with the need to address health inequalities. Ralph Knibbs, Senior Independent Director, acknowledged the Trust's responsibility to promote its services within those communities. Geoff Lewins, Non-Executive Director, agreed, stating the necessity to balance available services with community need. Finally, Selina welcomed new members of the Council of Governors, following the elections that took place at the start of the year. Lynn was keen to give recognition to Dr Karny Jawahar, the Trust's Guardian of Safe Working Hours, following his attendance at a recent Employment Tribunal. She reflected that he had given evidence for two hours and had spoken very well of Trust services in a professional and positive way. Selina agreed the Trust has fantastic staff and colleagues and it is important to acknowledge this. It was noted that Amanda Pritchard, CEO, NHS England, had resigned and Sir James Mackey had taken on the interim role. Selina confirmed that the focus remains on finance, recovery and delivery. The challenge for systems to respond successfully was emphasised. **RESOLVED: The Board of Directors noted the content of this report.**
DHCFT/ 2025/021	**<u>CHIEF EXECUTIVE'S UPDATE</u>** The report provided an update on current local issues and national policy developments, with detail drawn from a variety of sources, including Trust internal communications, local meetings and information published by NHS England (NHSE), NHS Providers, the NHS Confederation and the Care Quality Commission (CQC). It was noted that the NHSE Planning Guidance had now been released and Mark was disappointed at the de-prioritisation of some services related to Mental Health, Learning Disabilities, Autism and Children. He drew attention to the neighbourhood health approach, which was an exciting step forward to improve access to care. Explaining that the shift aligns with how the Trust works already, Mark stated it will provide further impetus and intent with the new Strategy, and the recent community engagement forms part of that. The significant financial challenges were highlighted, along with the improvement plan for next year upwards of 5%, in addition to the 5% this year. Mark declared that appropriate governance is vital to balance and deliver good quality care. He added that the key focus will be on delivery and that the Trust is very engaged with system partners to achieve this.

	Mark was delighted to announce the official opening of the Bluebell Ward, providing older adults with a dedicated unit. It was noted that the Derwent and Carsington Units should be opened by the end of March. The hard work that had taken place to achieve this was recognised. Referring to the published CQC report, Mark highlighted the significant progress at the Radbourne and Hartington Units, which had resulted in the improved assurance rating of 'Good' for inpatient services. It was noted that last month, the Derby and Derbyshire Integrated Care Board (ICB) had confirmed the new provider of Talking Therapy services as Vita Health. As part of this transition, the Trust would need to close its waiting list in readiness for the transition on 1 July 2025. Mark advised that engagement between the new provider and staff had commenced in the last few weeks. Vikki Ashton Taylor, Deputy Chief Executive and Chief Delivery Officer and Louise Braham, Consultant Clinical Psychologist and Multi-Disciplinary Team Development Lead, had been pursuing an agreement around the waiting list for new referrals and Mark pointed out the significant risk around this. He stressed the need to protect patients and staff, adding that there are 7-8k referrals into the service each month. He recognised the necessity to work through the logistics ethically, ensuring the right environment for Trust staff in which to work. It was noted that due to staff looking for other roles, there was significantly less capacity to provide high volume service. Tony Edwards, Deputy Chair, observed that decisions and choices would be increasingly difficult in the coming year and require a balance of acceptance, whilst accomplishing the best for the community. He added that due to the strict financial envelope, the priorities are not necessarily those the Trust would have chosen. Mark agreed that there are organisational and system choices and it is important to ensure the framework is fair and equitable. Lynn stated the safety of patients could reflect on the Trust and there must be absolute confidence that its values are applied. It was agreed that the shift from hospital to community requires partnership working and constant review of the new Strategy. Finally, Mark recognised achievements by a number of people and services, in particular he stated that the Finance and Perinatal teams continue to deliver good, quality services. **RESOLVED: The Board of Directors noted the report.**
DHCFT/ 2025/022	**<u>INTEGRATED PERFORMANCE REPORT (IPR)</u>** The IPR provided an update on Trust performance at the end of January 2025, focusing on key finance, performance and workforce measures. Executive Directors drew attention to the following areas and responded to questions: **Finance** James Sabin, Director of Finance, reported the year to date position is a deficit of £5.4m and the forecast position remains in line with the plan submission of £6.4m deficit. In order to deliver this planned deficit, he pointed out the key risks to be managed, which included: • Adult Acute out of area expenditure • Observations • Non-recruitment of vacancies

It was noted that the forecast assumes full delivery of a 65% recurrent cost improvement programme (CIP) and that a new capital allocation of £1m had been received and incorporated.

James had no concerns around debts and whilst cash was above plan, he expected this to reduce by the end of March, as a result of the additional capital expenditure for the Making Room for Dignity (MRfD) programme.

Tony echoed James' overview and recognised the good progress in terms of recurrent efficiencies, although he stressed that there is more to be done. Mark agreed and stated the Trust CIPs are significantly ahead of other providers. However, he added that proportionately, next year the Trust would be worse off financially.

James gave a summary of what it means to be regularly in deficit. It was noted that reduction in cash due to the MRfD programme has also impacted the material deficit. The need to demonstrate control of the deficit was emphasised, along with a hiatus on capital investment.

Quality

A reduction in complaints was reported, along with an increase in compliments and it was noted that the quick resolution process is expected to stabilise with ongoing monitoring and reporting.

Tumi Banda, Director of Nursing, AHPs, Quality and Patient Experience, drew attention to the challenges around those patients clinically ready for discharge due to the lack of available housing, funding and social care, which also impacts on the Trust's ability to reduce the length of stay metric.

The progress around reducing restrictive practices, including seclusions and prone restraints was welcomed. Tumi gave recognition to the Radbourne staff who worked extremely well with challenging patient behaviours. He was pleased to report the volume of medication incidents remained low.

Reflecting on the Care Planning algorithm that was not being picked up, Geoff asked how this gap could be closed. In response, Tumi explained that the team is currently running two systems, to ensure the Care Plans are there. He added it was not possible to transfer the data between systems and SystmOne records just 72%. Therefore, it is necessary to run audits alongside.

Mark agreed this is the right way to evidence care plans in the interim, however, he stated the goal is for them all to go through SystmOne. Lynn also concurred and was pleased the ongoing challenge had been raised at Board. She added that the issue had been scrutinised by the Quality and Safeguarding Committee, who had been able to receive assurance through the audits.

Operations

Arun reported an increasing number of people receiving dementia diagnoses and it was noted that the NHS Derby and Derbyshire ICB has the third highest diagnosis rate in the region. The improvements around the Child and Adolescent Mental Health services waiting list were highlighted, along with their high activity levels for patient contact. In addition, Arun advised that the Community Perinatal services continued to see increasing numbers of people.

The key challenges were noted and included inappropriate out of area placements and inpatient bed occupancy levels.

Due to demand continuing to outstrip capacity, the waiting times for autistic spectrum disorder (ASD) assessment and Community Paediatrics remained significantly high. However, the number of completed adult ASD assessments had exceeded the contracted target by 260%.

	Mark commended the progress and pointed out that the Trust fairs very well in relation to national measures. **People** Rebecca Oakley, Director of People, Organisational Development and Inclusion, informed that annual turnover had improved and there had been a focus on exit interview data, which had pinpointed themes and trends. She added that Stay Surveys, undertaken at three, six and nine months, are becoming embedded as part of a retention programme. It was noted that staff absence had increased during the winter months and in response, Wellbeing summits continue to run. Following an audit of clinical and management supervision processes, Rebecca confirmed work continues on the recommendations and overall compliance is seeing an incremental improvement. It was noted that awareness around the 'how to' and the 'reasons for' recording had been low. Lynn asked if the Trust's Health and Wellbeing offer is shared during return to work interviews and if anything further can be done to encourage these interviews to take place. Rebecca accepted that the current system needs to be improved and that benefits of the return to work conversation could be better promoted. **RESOLVED: The Board of Directors:** **1. Accepted significant assurance on current performance across the areas presented on the basis that there is a generally sound system of control designed to meet the system's objectives, however, some weakness in the design or inconsistent application of controls puts the achievement of particular objectives at risk** **2. Agreed that this report incorporates the key elements of assurance to the Trust Board that would otherwise have come from Finance and Performance Committee and People and Culture Committee reporting** **3. Determined that no further assurance is required.**
DHCFT/ 2025/023	**<u>STRATEGIC PLAN – 2025-2028</u>** The Plan outlined how the actions in the new Trust Strategy would be achieved over the next three years and was a result of ongoing engagement with colleagues. **RESOLVED: The Board of Directors approved the final draft Strategic Plan 2025-2028.**
DHCFT/ 2025/024	**<u>JOINED UP CARE DERBYSHIRE (JUCD) PROVIDER COLLABORATVE – GOVERNANCE ARRANGMENTS, WORK PROGRAMME AND MEMORANDUM OF UNDERSTANDING (MOU)</u>** Tamsin Hooton, Programme Director, Joined Up Care Derbyshire (JUCD) Provider Collaborative, presented several documents, some of which were for approval and support, and some for information and assurance. It was noted that the specific intent of the papers was to: • update the Board on changes to the ways of working and meeting arrangements for the provider collaborative, and seek approval of the revised Terms of Reference and the Partnership Document for the Collaborative • update the Board on the priorities and 2024/25 work programme for the Collaborative, appraising the Board on the potential impacts and consequences of shared working and securing Board support for the direction of travel particularly in relation to enabling services • seek Board approval to the risk and gain share agreement (Memorandum of Understanding) for the Provider Collaborative.

	Tony asked if there was additional detail to help decisions on where best to collaborate. He observed that the Board needs to assess the benefits to ensure confidence. In response, Tamsin advised there is a robust approach at a granular level, which includes review of each function; multiple functions in the same model; opportunities; similarities; benchmarking and continuous improvement. Geoff pointed out some narrative within the Memorandum of Understanding, *"Each partner will contribute to the team costs in line with the agreed recharging schedule on an annual basis"* and asked about the levels of costs as these were not in the charging schedule. Tamsin apologised for the omission and advised that each scheme is different and based on share of income. Mark acknowledged the regular engagement between the Trust and JUCD and confirmed his awareness of the costs schedule. He also referred to the new Strategy Plan and the substantial focus on partnerships. He added that governance around provider collaboratives is built into this plan. It was noted that the new National Oversight Framework is awaited and that a new NHS operating model will set out the responsibilities of NHSE, ICBs and Provider Collaboratives, all of which need to be built into Trust governance. In summary, Mark stated the rationale for the NHS Provider Collaborative is to encourage Derbyshire organisations to work together and remain streamlined. **RESOLVED: The Board of Directors:** **1. Noted the update on the provider collaborative's development, working arrangements and work programme, and supported the commitment to collaborative working and shared services that is envisaged, with particular note to the enabling services work** **2. Approved the Partnership document and Terms of Reference for the Provider Collaboration Board** **3. Approved the Memorandum of Understanding and risk and gain share agreements, agreeing that minor future amendments to this may be made with the agreement of the Provider Collaboration Board.**
DHCFT/ 2025/025	**<u>BOARD ASSURANCE FRAMEWORK (BAF) UPDATE – ISSUE 4, VERSION 4.3</u>** Justine reported that the majority of changes were highlighted at the last update and were to align with the new strategic objectives. In order to minimise volume, it was noted that future submissions will include the tracked changes version only. She added that the next review will record the change of arrangements for the Improving Access to Psychological Therapies (IAPT) service and the risks to the Trust. Discussion focused on the best use of the BAF to manage Trust risks and how it can be shaped to complement the new strategy. Further analysis of the BAF against the new strategy was suggested with further input from Board colleagues to ensure it is fully reflective of the risks the Trust's faces to delivering its Strategy. **RESOLVED: The Board of Directors:** **1. Approved this final issue of the BAF for 2024/25 and the assurance the paper provided of the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives** **2. Agreed to receive updates in line with the forward plan for the Trust Board.**
DHCFT/ 2025/026	**<u>APPROVAL OF REVISED TRUST CONSTITUTION</u>**

	Justine presented the proposed revisions to the Trust's Constitution following a review. She gave thanks to the small working group for their support and challenge, adding that the majority of changes were based on statutory or code of governance changes. **RESOLVED: The Board of Directors agreed the proposed changes to the Constitution.**
DHCFT/ 2025/027	**<u>NHS STAFF SURVEY 2024 – NATIONAL RESULTS</u>** The analysis provided a comprehensive assessment of the Trust's current position in comparison to other NHS trusts in the same benchmarking group, identifying key trends, strengths, and areas requiring improvement. It was noted that the national staff survey results remained under embargo and that these will be published by NHSE on 13 March. However, the Board of Directors discussed ways to act upon the feedback received through the most recent survey, to make meaningful changes in response to Trust staff. Rebecca acknowledged that 36% of the workforce had not taken part in the 2024 survey, however, response rates have increased year on year. Tony pointed out that the data indicated the reason for low engagement is that 'nothing happens' and he suggested that when things do change, the Staff Survey should be given credit. He expressed frustration at the delay in the results being shared. **RESOLVED: The Board of Directors received the National 2024 Staff Survey results and noted that a full discussion will take place at the People and Culture Committee in March.**
DHCFT/ 2025/028	**<u>FREEDOM TO SPEAK UP GUARDIAN (FTSU) REPORT (SIX-MONTHLY)</u>** Tam Howard, Freedom to Speak Up Guardian, presented the half yearly report which reflected trends in data over the last six months and steps being taken to support a speaking up culture. It was noted that patient safety concerns and reports around bullying and harassment remain relatively low. Emerging or ongoing themes included an increase in the number of queries received around inclusion/discrimination and worker wellbeing and safety. The effort required in relation to inclusion and racism was emphasised and Tam reflected on the inconsistency resulting from the turnover of Trust Equality, Diversity and Inclusion Leads. In terms of the increase in FTSU referrals, the impact of the changes to the IAPT staff was acknowledged as well as the impact of raised awareness for FTSU which should be viewed as a positive with more people speaking up rather than more issues. It was noted that the People and Culture Committee takes direction from Tam in relation to focus areas and learning. Selina highlighted that the Board is cognisant on inclusion challenges, improvements to which forms a key part of the Trust Strategy. Mark observed that many of the concerns raised related to Human Resources (HR)as opposed to Patient Safety concerns, which had been the original driving focus of FTSU. The Board noted that FTSU data was triangulated alongside other areas such as staff survey results. It was agreed that it was important to ensure HR support is in place for any people-related concerns. Mark added he would like to see the Personal Accountability Charter included with the triangulation. **RESOLVED: The Board of Directors:** **1. Supported the current mechanisms and activities in place for raising awareness of the FTSU agenda**

	2. Determined the report sufficiently assures the Board of the FTSU agenda at the Trust and that FTSU processes promote a culture of open and honest communication to support staff to speak up.
DHCFT/ 2025/029	**BOARD COMMITTEE ASSURANCE SUMMARIES** The Board Assurance summaries from recent meetings of the Trust Board Committees were accepted as a clear representation of the priorities that were discussed and will be taken forward in forthcoming meetings. The following points were brought to the attention of the Board by Committee Chairs: Audit and Risk Committee: Geoff Lewins, Committee Chair advised that significant assurance had been accepted on the efforts to improve compliance against risk management processes but he was still concerned that risk owners were not reviewing overdue risks and actions. People and Culture Committee: limited assurance had been received for the MRfD programme. This was due to the significant number of 'hard-to-recruit' and 'national workforce shortage' posts required and on the development of and progress with the service and cultural transformation and implementation. However, Ralph Knibbs, Committee Chair acknowledged the complementary, joined up scrutiny of the programme by the People and Culture, Quality and Safeguarding and Finance and Performance Committees. Finance and Performance Committee: Following the meeting held on 3 March, Tony Edwards, Committee Chair gave a verbal update. The focus on MRfD finances was noted, along with an interesting update on the delivery of the Information Management, Technology and Records (IMT&R) and the wider Digital Strategy from Arun. Tony gave recognition to Maria Riley, Assistant Director of Transformation, for the progress made in relation to the Transformation and Continuous Improvement framework and associated delivery plan. The Committee was concerned about the uncertainty of future funding for the City Alcohol Care team, which had been flagged as part of the portfolio of service-related contracts and foresight of potential risks to income. Quality and Safeguarding Committee: Lynn Andrews, Committee Chair, reflected on the volume of agenda items covered by the Committee. Subsequent to a Regulation 28 notice, an audit of admissions and handover had been undertaken and significant assurance accepted that an effective process is in place to keep patients safe.
DHCFT/ 2025/030	**REPORT FOR NOTING ON ASSURANCE AT BOARD COMMITTEE** **Quality and Safeguarding Committee** Learning from Deaths/Mortality Report The Board received the report regarding learning from deaths, covering the period 1 October 2024 to 31 December 2024. **RESOLVED: The Board of Directors accepted the Mortality Report with limited assurance from the Quality and Safeguarding Committee and agreed for the report to be published on the Trust's website as per national guidance.**
DHCFT/ 2025/031	**CONSIDERATION OF ANY ITEMS AFFECTING THE BOARD ASSURANCE FRAMEWORK (BAF)** The Board considered if any changes were needed to the BAF following its discussions and agreed to include the risks associated with the IAPT transfer to the new provider.
DHCFT/ 2025/032	**MEETING EFFECTIVENESS**

	Observers at the meeting had been stuck by the focus and good balance around culture and finance, along with the pertinent questions raised by the Non-Executive Directors. Sue Ryan, Lead Governor, had been inspired by the patient story. However, she had struggled to hear some people. The conversation around community engagement was welcomed by Anna Shaw, Associate Director of Communications and Engagement. It was noted that Deborah Good, Non-Executive Director, is unwell at the present time and Selina extended best wishes to her on behalf of the Board.
The next meeting to be held in public session will be held in person on 3 June at 9.30am in Conference Rooms A and B, Centre for Research and Development, Kingsway, Derby.	

ACTION MATRIX - BOARD OF DIRECTORS - JUNE 2025							
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
14-Jan-2025	DHCFT/2025/008	Integrated Performance Report (IPR) Operations	Tumi Banda	Investigation of a more formal process for exiting services, to ensure a positive patient/employee experience and that they are waiting well.	07-May-2025	On 07-May, the Quality and Safeguarding Committee received significant assurance from the paper explaining the Quality and Equality Impact Assessment (QEIA) process. Should the Trust need to exit a service, a QEIA is completed to identify all related risks and impacts for staff and service users. Responsibility for mitigating these risks is allocated to the appropriate risk handler.	Green

Key:	**Action Overdue**	RED		**0**	**0%**
	Action Ongoing/Update Required	AMBER		**0**	**0%**
	Resolved	GREEN		**1**	**100%**
	Agenda item for future meeting	YELLOW		**0**	**0%**
				1	**100%**

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 June 2025

Trust Chair's update

Purpose of Report

This report is intended to provide the Board with the Trust Chair's reflections on activity with and for the Trust since the previous Board meeting on 4 March 2025. The structure of this report reflects the role that I have as Trust Chair.

Our Trust and Staff

1. I start my report with my meeting with staff side representatives on 11 March. It is a time of uncertainty in the NHS and it is important that there is ongoing communications with staff-side representatives. We had a productive meeting about the Trust. We discussed developments within the Trust, the need for greater efficiencies and the approaches we are taking to address some of the challenges the Trust and the system is facing regarding the expectations of provider trusts and the Integrated Care Board (ICB) announced by the Secretary of State.
2. On 14 March we held a memorial service for colleagues, Simon Stansfield, Joanne Roberts and Deborah Matthews who sadly passed away. It was a moving affair and provided an opportunity to remember and pay tribute to Simon, Joanne and Deborah with their family, friends and colleagues. Colleagues spoke of their warmth and support to colleagues and their dedication to their work and their patients.
3. On 14 April I had an introductory meeting with Shaminder Kaur, the new Head of Equality, Diversity and Inclusion. Shaminder brings a wealth of experience from Network Rail and the NHS. We discussed the journey the Trust is on and the need for pace.
4. On 22 April I undertook a number of service visits, including a visit to Derwent Unit, the Hartington Unit, Blue Bell Ward at the Walton Hospital and the Crisis and Liaison teams based at the Hartington Unit. My thanks to Michelle Hague, Area Service Manager, who showed me around the new Derwent Unit and Nicola Owen, Ward Manager, who showed me around the Bluebell Ward, the newly refurbished and relocated Older Adults Ward from the Hartington Unit. It was satisfying to see the finished Derwent Unit with patients and staff in it and fully operational. Although I had seen the Derwent at various stage of the build, it was very impressive to see it completed. I was pleased to see the excitement and enthusiasm of everyone at the Derwent Unit and the Bluebell Ward. The Crisis team spoke about the challenges in supporting patients out of Chesterfield Royal's Accident and Emergency Department and the wards to community care. The Adult Crisis team spoke at length of the high level of acuity and the high level of risk that they carry in managing patients in the community as well as supporting the families and carers of patients. My thanks to Louise Peers, Independent Prescriber/Lead Nurse, and Amy Harcombe, Specialist Nurse Practitioner, for their time and to all of the services for their openness, commitment and enthusiasm to do their best for our patients.
5. I was pleased to show my fellow provider chairs, Mahmud Nawaz, Trust Chair of Chesterfield Royal, and Ian Litchfield, Acting Chair at University Hospitals of Derby and Burton, around the Derwent Unit. They were very impressed with the quality of the environment and the clear pride that was evident amongst staff and patients. They spoke of the quality of care that they are now able to provide and the positive experience of patients including access to outdoor space.

6. On 23 May, we held the official opening of the Bluebell Ward. Elizabeth Fothergill, HM Lord-Lieutenant of Derbyshire, opened the unit as the King's representative. The event was well attended with staff from Bluebell Ward, system partners, Governors and Non-Executive Directors (NEDs).

7. I continue to join the live engagement events being hosted via MS Teams. These meetings are very useful to me in terms of understanding how staff are feeling and engaged with the Trust. I am pleased to note that several NNEDs also join these calls.

Council of Governors

8. Our Governors have the key responsibilities of holding the Board to account, connecting the Trust with our communities, and bringing intelligence about how Derbyshire residents are experiencing our services. I have met with our Governors, including some of our newly appointed Governors, on a virtual coffee session on 17 March. It was an informal meeting and a way to better get to know each other and understand some of the issues that are of interest and of concern.

9. The Council's Governance Committee met on 15 April, chaired by Marie Hickman, Library and Knowledge Manager. The agenda included mainly governance matters including the draft Governor and Membership section of the Annual report 2024/25, the Quality Account and the draft Governor Statement, Governor Declarations of Interest annual update.

10. On 16 April, the recruitment panel met to shortlist for the NED role and shortlisted six strong candidates. The recruitment panel met on 12 May to interview the shortlisted candidates for forthcoming vacancies arising from the end of Geoff Lewins' term of extended one-year appointment and that of Tony Edwards, first term of appointment. My thanks to Susan Ryan, Lead Governor and Staff Governor; Fiona Rushbrook, Governor; Brian Edwards, Governor and Khawran Kaur, Senior OT Manager and Recruitment Inclusion Guardian and Nigel Smith, Non-Executive Director, ICB; for their involvement and input in the full recruitment process.

11. I met with our staff Governors on 11 March and 22 May, who shared the issues they had picked up from colleagues. This included the move to the new facilities, the proposed operating model and the 50% reduction in ICB costs and corporate staffing levels in provider trusts announced by the Department of Health and Social Care. We acknowledged the anxiety staff were feeling about their future and discussed ways to further communicate with staff.

12. An Extraordinary Nominations and Remunerations Committee was held on 14 May to receive the recommendation for appointment to the NED roles from the recruitment panel.

13. On 12 May, the Nominations and Remunerations Committee met to receive the appraisals of myself and the NEDs - Geoff Lewins, Lynn Andrews, Tony Edwards and Ralph Knibbs and the objectives agreed with Andrew Harkness. The purpose of this meeting is to gain assurance that the process outlined and agreed by the Council of Governors, had been followed accordingly. The appraisal process for Deborah Good will be concluded when she returns from sickness absence. The Committee also received my annual review of Board composition of skills and time commitment and membership of committees.

14. On 22 May, the Council of Governors met to approve the appointment of Chioma Akpom as NED and Chair of the Audit and Risk Committee, she will replace Geoff Lewins when his term comes to an end in November. Chioma brings a wealth of experience in audit from the banking sector. The appointment of the other NED who will be replacing Tony Edwards will be made at the Council of Governors later today.

15. I met with Susan Ryan, Lead Governor and Hazel Parkyn, Deputy Lead Governor, on 10 March and 22 May as part of our monthly update meetings. The purpose of these meetings with the Lead Governors is to ensure that we are open and transparent around the challenges and issues that the Trust is dealing with. We discussed the changes taking place in the system, the new NHS operating guidance and the Trust's new proposed operating model. Denise Baxendale, Membership and Involvement Manager, was also in attendance. Regular meetings between the Lead Governors and Chair are an important way of building a relationship and understanding of the working of both governing bodies.

16. I had the opportunity to meet face to face with governors in Chesterfield on 23 May. We discussed wider learning from incidents in the NHS and behavioural change.

17. The Council of Governors and Trust Board will meet jointly for a development session on 22 July, following the Public Board meeting. The next formal Council of Governors meeting will then be on 23 September.

Board of Directors

18. I met with Ralph Knibbs on 10 March, Senior Independent Director (SID), for my annual appraisal. This is a robust process with 360-degree feedback sought from NEDs, Executives, Governors, external colleagues and other internal colleagues. A report on the process and outcome of the appraisal is collated by the SID and presented to the Council's Nominations and Remunerations Committee on 25 April and then Council of Governors.

19. In March and April I undertook the annual appraisals of the NEDs and agreed with them, their objectives for 2025/26. NED appraisals follow a similar process to the Chair appraisal with 360-degree feedback, a review of the objectives set for the last 12 months, the setting of new objectives for the next 12 months and identifying any development needs. The Governor Nominations and Remunerations Committee agrees the framework for the appraisal process and provides assurance to the Council of Governors that the process has been duly followed and effective.

20. On 17 March the Remuneration and Appointments Committee met to review the status of mandatory training for the Board, Board development, annual review of composition of the Board and to review several year-end processes, including the Fit and Proper Persons Test compliance report, ahead of the publication of the Annual Report and Accounts. The Committee also reviewed its effectiveness and its Terms of Reference.

21. On 17 March, an Extra-ordinary meeting of the Finance and Performance Committee took place to understand the position with the Trust's financial likely year end position as well as the financial plan for 2025/26.

22. At the Audit and Risk Committee on 24 April, the Committee undertook the annual review of Board composition and the Committees' year-end effectiveness reports and terms of reference, with some minor changes in line with recent policy guidance.

23. The Board held a Development Session on 30 April to understand the potential opportunities and ambition of the Trust in becoming a more digitally enabled organisation. This session was facilitated by NHS Providers and provided the space to have dedicated time to focus on how the trust can continue on its journey to improve and innovate.

24. On 23 April I undertook Mark Powell's annual appraisal and agreed with him, his objectives for 2025/26. Thereby completing all the appraisals that I am responsible for, with the exception of one of the NEDs who is currently on sickness absence leave.

25. There were a number of Confidential Board meetings in March and April, including an Extra-ordinary Confidential Board meeting on 15 April to consider matters related to the financial plan and the Trust operational delivery plan and to approve the final sign-off of the 2025/26 plan submission to NHS England.

26. I have also continued to meet with NEDs individually on a quarterly basis.

System Collaboration and Working

27. On 10 March, the Provider Collaboration Board met, followed by my one to one with Kathy McLean, ICB Chair, on 12 March.

28. I met with my fellow provider chairs on 23 April at Chesterfield Royal. Mahmud Nawaz, the Trust Chair, showed us around the Portland Ward a 22-bedded intermediate ward. We spoke to the senior staff who work on the ward and the impact it has made in the management of flow and discharge of patients. We also visited their award winning, Wellbeing Hub. We spoke of the opportunity for Derbyshire Healthcare staff to also have access to the facilities. I was also able to show the provider chairs around our Derwent Unit as it is on the site of the Chesterfield Royal Hospital.

29. Mark Powell and I continue to have our four-way meetings with Kathy McLean, ICB Chair and Chris Clayton, CEO, Joined up Care Derbyshire. We discussed system issues and responses and our continued efforts to improve the care and experience of people with mental health and learning disabilities and the progress we are making in our transformation of services and financial position.

30. I have continued to meet regularly with various Trust chairs of the East Midlands Alliance of Mental Health Trusts, which has been a very useful source of sharing best practice and peer advice.

Regulators, NHS Providers and NHS Confederation and others

31. As a trustee of the NHS Provider, I attended Board meetings held on 5 March, 14 March and 7 May. The NHS has been in considerable turmoil since the announcement of the abolition of NHS England, the 50% reduction to budgets of Integrated Care Boards and the stipulated 50% reduction in Corporate services 2019-2025 growth expected from provider trusts. NHS Providers as the represented body for provider trusts has been busy to understand the likely impact on the delivery of services, workforce and safety in order to advocate on behalf of providers. NHS Providers has also been considering the impact of these financial cuts on its business plan, the priorities for the year ahead and approval off the financial plans for 2025/26.

32. I attend fortnightly briefings from NHSE for the Midlands region, which has been essential to understand the progress of the management of some considerable system challenges, including plans for recovery, financial plans and performance.

33. I have also joined, when possible, the weekly calls established for Chairs of Mental Health Trusts, hosted by the NHS Confederation Mental Health Network, in collaboration with the Good Governance Institute, where support and guidance on the Board through the pandemic has been a theme, as well as the focus on recovery and stabilisation of services.

Strategic Considerations	
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X

Risks and Assurances

- The Board can take assurance that the Trust level of engagement and Influence is high in the health and social care economy
- Feedback from staff and other stakeholders is being reported into the Board.

Consultation

This report has not been to other groups or committees.

Governance or Legal Issues

Covered as part of the individual items.

Public Sector Equality Duty & Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

This report reflects a wide range of activities across the Trust, and consideration relating to ensuring inclusion is embedded in operational work of the Trust. The specific services visited provide support to those with protected characteristics by the nature of their work. I have supported the work of the Trust in promoting an inclusive culture and an inclusive Board. I have instigated a Board development programme on inclusion which will assist in developing the Board's understanding and response to the inclusion challenges faced by many of our staff.

With respect to our work with Governors - we work actively to encourage a wide range of nominees to our governor elections and strive that our Council of Governors is representative of the communities they serve. We also provide support to any current or prospective Governors to enable them to carry out their role to address any specific needs they may have. This includes providing transport for those who may not be able to access public transport due to physical needs, accommodating communication requirements and providing support workers at meetings.

Demonstrating inclusive leadership at Board level

As a Board member I have ensured that I am visible in my support and leadership on all matters relating to diversity and inclusion. I attend meetings to join in the debates and conversation and to challenge where appropriate, and also to learn more about the challenges of staff from groups who are likely to be, or seem to be, disadvantaged. I ensure that the NEDs are also engaged and involved in supporting inclusive leadership within the Trust.

New recruitment for Board members has proactively sought to appoint people from protected characteristics, thereby trying to ensure that we have a Board that is representative of the communities we serve.

Recommendations

The Board of Directors is requested to consider the content of this report, and to ask for any clarification or further information.

Report prepared and presented by: **Selina Ullah**
Trust Chair

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 June 2025

Chief Executive's Report

Purpose of report

This report provides an update on current local issues and national policy developments since the last Board meeting. The detail within the report is drawn from a variety of sources, including Trust internal communications, local meetings and information published by NHS England, NHS Providers, the NHS Confederation and Care Quality Commission (CQC).

The report is intended to be used by the Board of Directors to inform and support strategic discussion. The Board should note that the report reflects a wider view of the Trust's operating environment and serves to horizon scan for risks and opportunities that may affect the organisation.

Executive summary

National context

Working together in 2025/26 to lay the foundations for reform

Since the Board of Directors' last meeting there has been a significant number of changes proposed to the way the NHS is going to operate in the future. These include significant changes to NHS England (NHSE) and Integrated Care Boards (ICBs).

A letter from NHS England's transitional Chief Executive, Jim Mackey, sent to all Providers and ICB CEOs in April, titled 'Working together in 2025/26 to lay the foundations for reform', provided further detail. It included an update on 2025/26 planning, next steps on reducing corporate costs, and planned work on the financial regime and NHS operating model. Of relevance to Derbyshire Healthcare is the reduction in corporate costs of £1.6m that are expected to be delivered by the end of the calendar year.

In addition, the Model Integrated Care Board – Blueprint has also been published, with an expectation that changes to ICBs are delivered by the end of the calendar year.

The significant changes highlight the immense financial and operational pressures facing the NHS and will have an impact on how we work as a Trust and across Derbyshire with our partners. Stabilising the NHS in the short term and prioritising patient care will be essential, finding the balance between recovery and reform.

Mental Health, Learning Disability and Autism in the NHS Standard Contract 2025/26

2025/26 NHS Standard Contract has been published, requiring Providers to deliver critical elements of mental health care including:

- Achieving NICE concordance for Early Intervention in Psychosis (EIP) services
- Reducing out of area placements
- Physical health monitoring and referrals of people on anti-psychotic medication
- Discharge
- Patient and Carer Race Equality Framework (PCREF)
- Urgent access to mental health care
- National Quality Requirements on: Discharge; EIP services; NHS Talking Therapies; and children and young people's eating disorder services.

New best practice guidance in suicide safety published

NHS England has published Staying safe from suicide: best practice guidance for safety assessment, formulation and management. This new 'wrap around' suicide prevention guidance will help clinicians provide more personalised care for patients struggling with suicidal feelings. The guidance will help providers move away from the previous risk stratification used to predict a person's risk of taking their own life, replacing it with a far more personal approach.

Launch of the Dementia 100 Toolkit

This offers a set of 100 criteria which health systems can measure their current performance against to evaluate and enhance services.

Updated guidance on urgent and emergency care mental health data quality

The urgent and emergency mental health care pathways: guidance for improving data quality in the mental health services data set (MHSDS) has been updated for the first time since 2021. It includes key updates on NHS111 Mental Health Data Collection, capturing patient feedback to drive service improvements and Call Referral Best Practice.

Regional and local context

Making Room for Dignity programme

We are now entering the final stage of the programme, with many of the Trust's new and refurbished facilities due to open in the coming weeks.

The Derwent Unit, based on the Chesterfield Royal Hospital site, opened on 20 March. This is a new 54-bed adult acute unit, with single en-suite bedrooms offered across three wards – Sycamore, Oak and Willow. We have received a wealth of positive feedback from patients, carers and colleagues about the improvements these new facilities have made to people's experience of our services.

At the point this report was being prepared, the initial two wards at the Carsington Unit (Dove and Robin Wards) were scheduled to open towards the end of May, alongside Audrey House, the new Enhanced Care Unit. Wren Ward at the Carsington Unit is due to open in June, together with Kingfisher House, the new Psychiatric Intensive Care Unit (PICU). The new services will support people in being able to access care locally, reducing the need for patients having to be cared for out of Derbyshire.

Once our new and refurbished units are open and operational on the Kingsway Hospital site in Derby, the refurbishment of the existing Radbourne Unit will recommence. The remaining two wards will occupy the recently vacated clinical space to minimise any impact of the work taking place.

I look forward to seeing people start to benefit from the new, purpose-built environments. Together with improving people's privacy and dignity, the new model of care provides a focus on personalised, therapeutic interventions, with an increase in our sensory approach and trauma informed care.

Formal opening of Bluebell Ward

On Friday, 23 May, we will welcome Elizabeth Fothergill, HM Lord Lieutenant for Derbyshire, to formally open the new Bluebell Ward in Chesterfield.

Bluebell Ward, at Walton Hospital in Chesterfield, is the new home for our older adult inpatient mental health service for northern Derbyshire. The refurbished ward opened on 7 January 2025 and provides 12 beds for older adults with functional mental health needs.

Care Quality Commission (CQC)

The Trust has recently had a focused CQC inspection across the Older Adults Wards. The inspection was over two weeks starting on 28 April 2025 until 14 May 2025.

All the wards were reviewed, with CQC speaking to staff, patients, carers and requested supporting information which has been provided.

Feedback has been positive, and issues highlighted have been addressed during the inspection. There were no safety concerns raised on any of the wards. Initial feedback was provided to the Trust on 16 May, which identified lots of good practice. The CQC anticipates that a draft report will be shared with the Trust in four weeks' time for factual accuracy, after which the report will be published.

Partnership with University of Derby

In recent months, several meetings have taken place between the Trust and the University of Derby to explore opportunities for closer working. We already have a strong relationship with the university after hosting placements for their nursing and occupational therapy students for many years and, more recently, benefiting from the wellbeing workshops delivered by the university's Work Health Hub team.

We have now formalised a closer working relationship with the university through the signing of a strategic partnership that will enable us to share learning and further develop skills and expertise across both organisations. We believe this will benefit university students and our health professionals and patients, and is in line with our Trust Strategy, where one of our four priorities is 'partnership'.

Through the partnership agreement, we will guide the university on how their courses for nurses, medics and allied health professionals can give real-world benefits to their students – recognising that this will benefit the NHS too, and the people we care for, because it will mean those students are equipped to be the best possible practitioners when they qualify.

The university will, in turn, help us to develop a bespoke upskilling programme for international doctors who are qualified in psychiatry in their country of origin, so they can understand the local context they will be working in here in the NHS and can increase their cultural competence. This programme will supplement and support their progress to consultant psychiatrist roles.

In addition, we will also learn from the university through the application of cutting-edge research in a number of areas – such as workforce wellbeing, the application of Artificial Intelligence (AI) and the use of data to understand the needs of our communities. These are issues that will be crucial to the success of the NHS in the years ahead.

System-wide transformation

Discussions at the Mental Health, Learning Disability and Autism Delivery Board have agreed the system-wide use of the Mental Health Services Assessment (MEN-Sat) Tool, which offers a system-level, self-critical assessment that brings together all aspects of urgent and emergency mental health pathways, including crisis and crisis alternative services.

All partners have agreed for Derbyshire to start using the tool, which helps position our system across 12 key domains including access and waits, strategy and sustainability, workforce, evidence-based practice, pathways, environment, involvement and participation, productivity, outcomes, data quality, culture, and digital and informatics.

The tool collects the views of all system partners and professionals, to identify and gain a shared understanding of where things are working well, to challenge where they are not, and identify how these can be improved, all with the aim of providing a better service to service users. The aim is for MEN-Sat to work as an improvement tool, that provides an initial baseline for longer term improvement activities. It offers a joined-up perspective of how things are working across Derbyshire.

In a session on 1 May, colleagues started to collate responses to a series of questions on the participation and involvement domain.

This included rich conversations on our collective participation and involvement work, and a shared scoring of our implementation, impact and evidence to date. Three virtual workshops and a face-to-face summit will take place over the next six weeks to complete the tool, following this initial introductory session. The Mental Health Improvement Advisors will also undertake a series of site visits (both in the day and out of hours) to observe how pathways are working locally. A feedback session has been scheduled for the end of June, with a report being shared later this summer.

Staff engagement

I have continued to get out and about to see our colleagues and service users at the following sites:

- A Board visit to the Day Service and Participation (CAMHS) teams at Temple House on 1 April
- Spent a morning with the Paediatric Occupational Therapy Team at Ilkeston Health Centre on 7 May
- Visit to the Derwent Unit, Chesterfield on 19 May
- Regular engagement has been undertaken to involve and inform staff of the national and local changes currently taking place across the NHS
- I have been undertaking the performance appraisals for the Executive Directors during the past few weeks and agreeing their objectives for the next 12 months.

NHS Talking Therapies

Vita Health Group are the new lead provider for Talking Therapies for a three-year period, starting on 1 July 2025. Vita will have a sub-contracting arrangement with Everyturn, who are current providers of Talking Therapies services across Derbyshire. Focused work is underway to ensure a smooth transition of staff and services, including a transfer plan for people who are receiving services as well as those on the waiting list. Similarly to other local providers, Derbyshire Healthcare NHS Foundation has now closed the waiting lists ahead of this transfer taking place.

As the service transitions to a new provider, I would like to personally thank and acknowledge the dedication and professionalism of colleagues who have worked in DHcFT's Talking Mental Health service for many years.

MP visits

At the end of February, I met with Jonathan Davies, MP for Mid-Derbyshire, for a tour of the Carsington Unit at Kingsway, Derby. He was delighted to see this new facility for the people of Derbyshire.

In May I started a new series of online engagement sessions with local MPs, providing the opportunity for regular and ongoing engagement with local MPs.

Recent achievements:

- The Trust has been shortlisted in three categories at this year's HSJ (Health Service Journal) Digital Awards - Digital Organisation of the Year, Generating Impact in Population Health through Digital and Driving Prevention and Early Intervention through Digital. The awards recognise, on a national scale, NHS Trusts who show dedication to pioneering digital solutions that are shaping the future of healthcare across the UK. Being shortlisted for not one, but three esteemed awards highlights our Trust's commitment to digital innovations that significantly enhance patient care
- Congratulations to Anthony Newman, support worker at Kedleston Low Secure Unit, who was presented with a Chief Nursing Officer Award in April for demonstrating outstanding care and commitment to their work. Only awarded to individuals who exemplify the highest standards of care, Anthony was nominated for his involvement in reducing restrictive practices to keep the Kedleston Unit a safe and therapeutic setting

- The Mental Health Liaison Team, based at the Royal Derby Hospital, has been shortlisted in the 'Outreach Category' in the National Dementia Care Award for their innovative approach to improve health outcomes for dementia patients. The awards celebrate outstanding practice in dementia services and recognise a commitment to deliver outcome focused, person centred care for people living with dementia. During the Covid-19 pandemic, the suspension of specialist diagnostic services led to a drop in dementia diagnosis rates in the community which resulted in an increase of requests for memory assessments for people presenting in crisis who required placement at discharge. The Mental Health Liaison Team responded by ensuring high-quality memory assessments and new referral pathways were in place, which ultimately contributed to a more efficient and effective way of diagnosing dementia
- Congratulations to recent DEED award winners:
    - Brighton Makombe, Registered Nurse from Ward 34 at the Radbourne Unit, was the April DEED winner. Brighton was recognised for demonstrating qualities of leadership, compassion and dedication. He has made students feel welcomed and valued, taking time to provide orientation in the ward environment, explain procedures and ensure people feel comfortable asking questions. Thank you and congratulations to Brighton!
    - Michelle Hague and colleagues at the Derwent Unit (including others who supported the service's recent move) were March's collective DEED winners. Michelle and the teams were nominated for working tirelessly to prepare the new Derwent Unit so it was ready to open, supporting patients in their new environment and for the professionalism shown over recent weeks as the move was underway. Congratulations to Michelle and everyone else who was involved.

Raising awareness

Over recent months the Trust has supported awareness raising for a range of different events including Stress Awareness Month, Maternal Mental Health Awareness Week, Neurodiversity Celebration Week and Down's Syndrome Day. We also celebrated the role and contribution of our colleagues on International Nurses Day and World Social Work Day.

We have continued to promote our services, including support now available across the East Midlands with problem gambling and the 30 Days Dry challenge run by Derby Drinkwise.

Following on from a recent Board session with colleagues from Community Action Derby (CAD), I have held a further meeting with Kim and Ejaz to discuss options on how we can better work together, to support the delivery of the Partnerships priority in the Trust Strategy. I am hopeful that I will be able to provide more details on this in future reports.

Trust activity

Our **Work Your Way** employment service successfully supported **58 people** open to community mental health services into **permanent work in roles of their choice**

NHS
Derbyshire Healthcare
NHS Foundation Trust

The East Midlands **Gambling Harms** Service received **204 self referrals** from people concerned about their gambling habits.

The Derbyshire Healthcare **website** was visited by **57,000 people** on **103,000 separate occasions**

89 service users, carers and staff members of all ages were involved in **research** studies

February to April 2025

IN NUMBERS

Derbyshire Healthcare received **457 compliments** from service users, carers, families and students

84 pregnant women or new mothers referred themselves to our **perinatal mental health services**

209 DEED (Delivering Excellence Every Day) nominations, **celebrating staff, teams and services**, were received

The Strategic Health Facilitation team in our **Integrated Adult Neurodevelopmental Service** supported **1637 people with a learning disability** to get an **annual health check** from their GP

Strategic Considerations	
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X

Risks and Assurances

Our strategic thinking includes an assessment of the national issues that will impact on the organisation and the community that we serve.

Feedback from staff, people who use our services and members of the public is being reported into the Board.

Consultation

The report has not been to any other group or committee though content has been discussed in various Executive and system meetings.

Governance or Legal Issues

This report describes emerging issues that may become a legal or contractual requirement for the Trust and potentially impact on our regulatory licences.

Public Sector Equality Duty & Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

This document is a mixture of a strategic scan of key policy changes nationally and changes in the Derbyshire Health and Social Care environment that could have an impact on our Trust. The report also covers updates to the Board on my engagement with colleagues in the Trust and the reporting of internal actions and feedback I have received relating to the strategy delivery.

As such, implementation of national policy in our Trust would include a repeat Equality Impact Assessment, even though this will have been completed nationally.

Recommendations

The Board of Directors is requested to scrutinise the report and seek further assurance around any key issues raised.

Report presented and prepared by: **Mark Powell**
Chief Executive Officer

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 June 2025

Integrated Performance Report

Purpose of Report

The purpose of this report is to provide the Board of Directors with an update of how the Trust was performing up to the end of April 2025 regarding the key operational, quality and people measures, and at financial year end regarding the finance measures.

Executive Summary

The report provides the Trust Board with information that demonstrates performance against a suite of key operational targets and measures. The aim of which is to provide the Board with a greater level of assurance on actions being taken to address areas of underperformance. Recovery action plans have been devised and are summarised in the main body of this report. Performance against the relevant NHS national long term plan priority areas is also included.

Operational Performance

This chapter has been developed to provide a greater level of assurance to the Board on actions being taken to address areas of underperformance. The chapter includes performance against the relevant NHS national long-term plan priority areas.

Most challenging areas

The areas found most challenging persist, as follows:

- Waiting times for adult autistic spectrum disorder (ASD) assessment – there has been an ongoing high level of demand, with over 1,200 referrals received in 2024/25
- Community Paediatric waiting times and numbers waiting remain significantly high owing to ongoing pathway issues and high levels of demand, with the average waiting time doubling in 24 months to over 60 weeks. Capacity has also reduced through the loss of five of the team, including three experienced consultants. Mitigation measures to address the vacancies arising will form part of the service transformation programme, through a review of roles, skill mix, and service specification. Request for Locum cover has been approved
- Inappropriate out of area placements, and high levels of inpatient bed occupancy remain a challenge. A comprehensive recovery action plan is summarised in the main body of the report, with actions being implemented to address patient flow issues across the pathway in both inpatients and the community, in order to reduce the need for admissions, reduce length of stay of admissions, and thereby free up bed capacity within the Trust. As a result of these actions there has been a significant reduction in inappropriate out of area placements from a high of 28 at the end of January 2025 to just five at the end of March 2025. March also saw the opening of the Derwent Unit in Chesterfield, a 54 bedded inpatient unit to replace the dormitory style wards at the Hartington unit. Each patient has their own en-suite bedroom and control over their environment, with the ability to adjust the lighting and temperature to suit their needs. The new facility also provides greater access to outdoor and green spaces, with exercise areas and outdoor sensory spaces accessed directly from the wards. The building is purpose-built, offering a range of usable spaces to aid patient recovery. It will play a major part in the provision of trauma-informed and sensory-informed care to patients, in a therapeutic environment, supporting reduced length of stay.

Most improved areas

- The number of completed adult ASD assessments per month has remained extremely high within existing resources, and the full year contracted activity target for 2024/25 was exceeded by over 300%
- The Child and Adolescent Mental Health service (CAMHS) triage and assessment team continues to manage the waiting lists very effectively, with numbers waiting and average waiting times both sustained at a reasonable and manageable levels.

Areas of success

- NHS Talking Therapies 18-week and six-week referral to treatment, three-day follow-up of discharged inpatients, and the data quality maturity index standards have all been consistently achieved
- The individual placement and support service, Work Your Way, is continuing to be extremely productive. Recruitment has continued in line with approved funding and from May 2025 the service will be fully staffed in line with NHS long term plan targets
- The rate of dementia diagnosis remains high – third highest in the region and 11th highest in the country
- Community Perinatal services continue to see increasing numbers of people, flexing to meet the ongoing high level of demand, and performing third highest in the region against the national access standard
- Adult Community Mental Health services continue to exceed their target activity level for patient contacts, sitting second highest in the region for transformed services.

Regional comparison

In the most recently published data (January 2025) NHS Derby and Derbyshire Integrated Care Board (ICB) continues to perform favourably against the majority of long-term plan targets to which the Trust contributes, when compared with other ICBs in the region: dementia diagnosis, children and young people contacts, Adult Community Mental Health contacts and Perinatal access. Inappropriate out of area placements remain challenging, with the number of inappropriate bed days at the highest level in the region.

Finance

At the end of the financial year, the unadjusted outturn was a deficit of £25.3m.

However, taking into account the following technical adjustments, the adjusted financial position was breakeven against an adjusted plan of £6.4m deficit:

- Impairments, where the value of a building has been reduced by £24m which related to the Making Room for Dignity programme, the plan included impairments of £35m
- Peppercorn rent costs accounted for within the position but adjusted back out of the position
- Public Finance Initiative (PFI) adjustment related to the International Financial Reporting Standards (IFRS) 16 accounting change.

Efficiencies

The plan includes an efficiency requirement of £12.5m with a higher proportion phased from quarter 2. The plan assumes that 71% of savings are delivered recurrently.

At the end of the financial year the required savings have been delivered in full.

Agency

Agency expenditure for the financial year totals £5.1m which is below plan by £1.2m. This includes £1.2m of additional costs to support a patient with complex needs (which ceased at the beginning of September). Excluding this additional support, agency expenditure would be below plan by £2.4m.

Business as usual agency expenditure (excluding the support to the patient with complex needs and zonal observations) has been reducing from August 2024.

The two highest areas of agency usage continue to relate to consultants and nursing staff.

The agency expenditure as a proportion of total pay for March has significantly reduced during the year to 2.1%. NHSE use of resources includes an action to improve workforce productivity and reduce agency spend to a maximum of 3.2% of the total pay bill across 2024/25.

Out of Area Placements

The plan for out of area expenditure is based on a reducing trajectory from twenty-two to zero beds by the end of the financial year. In addition to this the plan also included a further six block beds for part of the financial year.

During 2024/25, £10.5m has been spent on out of area placements, which is £5.7m above plan. Expenditure increased in the period November to February but has seen a reduction in March.

Capital Expenditure

At the end of the financial year, we were £3.7m above plan against the system capital allocation which is due to the residual Making Room for Dignity cost pressure after the original business as usual schemes have been scaled back to help provide some mitigation, agreed by the system.

The centrally-funded schemes are out-turning to the agreed additional funding, but the plan remains as the original submission.

Cash

Cash at the end of March is at £19.1m (£24.3m last month) which is on plan.

People

Annual Appraisals

Appraisal compliance continues to remain high at 89% against a target of 90%. Compared to the previous month, compliance has increased by 1.81%. Low compliance continues to remain a particular challenge within Corporate services and efforts continue to address both appraisals that are out of date and those coming up for renewal.

Annual Turnover

Overall turnover continues to remain in line with national and regional comparators and has remained below the Trust's 12% upper tolerance for the last ten months.

Compulsory Training

Overall, the 85% target has been achieved for the last 24 months. Operational services are currently 92% compliant (an increase of 2% since the last reporting period) and Corporate services are at 90% (an increase of 3% since the last reporting period).

Staff Absence

The annual sickness absence rate is running at 5.93%; a reduction of 0.08% compared to the previous reporting period. Anxiety, stress or depression related illness remains the highest reason for sickness absence, followed by other musculoskeletal problems and cold, cough, flu – influenza.

Proportion of Posts Filled.

At the end of April, 88% of funded posts overall were filled with contracted staff. At the start of the financial year, new investment is released which creates brand new vacancies, initially reducing the percentage of funded posts filled. This year will see a staged adjustment to

vacancies throughout the year, as service developments and cost improvement programmes are delivered.

Bank and Agency Staff

Agency usage has reduced significantly over recent months and continues to fall following a temporary increase in agency usage due to a requirement for increased clinical observations. The Authorisation Panel to oversee agency requests across the Trust continues to remain in place.

Supervision

Compliance continues to remain a challenge in both clinical supervision at 81% and management supervision at 85%. Efforts continue to work with Teams with low compliance and rates are expected to increase over the next month.

Quality

Patient Experience

- **Compliments**: Currently above the mean of 140; however, under-recording persists. Heads of Nursing are addressing barriers and monitoring via Clinical Reference Groups
- **Complaints**: “Quick resolution” complaints declined due to backlog; “Closer look” complaints remain stable. Thematic reviews are ongoing for trend analysis and assurance.

Discharge Readiness

- **Clinically Ready for Discharge (CRD)** cases show common cause variation, with delays due mainly to housing and social care issues. Multi-agency meetings and a new 72-hour admission review are expected to address discharge delays.

Care Plan Approach (CPA)

- **CPA Compliance** has improved to 86%, aiming for 95% by August 2025. Action plans, digital guides, and weekly crosschecks are supporting improvement.

Medication Safety

- **Medication incidents** have decreased (mean from 90 to 80); most are low harm and relate to storage. Ongoing work includes incident reviews, competency training, and improvement plans across Divisions.

Serious Incidents

- Moderate/catastrophic harm incidents rose until March, then declined. Increases linked to self-harm and medical issues in Adult and Older People’s services. Substance misuse deaths reflect national trends and are being addressed through joint initiatives.

Restrictive Practices

- **Prone Restraint** incidents remain below threshold; peaks linked to a few unwell individuals
- **Physical Restraints** are above the margin (45), driven by self-harm interventions. Training compliance is improving via revised induction processes
- **Seclusion episodes** peaked in March due to new unit opening but are now below threshold.

Falls

- Falls remain above the Trust margin, influenced by higher ward occupancy and frailty. Most incidents caused no harm. Prevention measures include care planning, bed sensors, and regular review meetings.

Staffing – CHPPD

Care Hours per Patient Day are below national averages: 9.95 hours v national 15.2. This includes lower figures for both registered Nurses (4.08 v 5.1) and Support Workers (5.56 v 9.5), indicating staffing challenges.

Strategic Considerations	
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X

Risks and Assurances

This report should be considered in relation to the relevant risks in the Board Assurance Framework (BAF). The content provides assurance across several BAF risks related to workforce, operational performance and regulatory compliance. The use of run charts provides the Board with a more detailed view of performance over time as it enables the differentiation between common cause and special cause variation.

Consultation

Versions of this report have been considered in various other forums, such as Board Development and Executive Leadership Team.

Governance or Legal Issues

Information supplied in this paper is consistent with the Trust's responsibility to deliver all relevant parts of the Oversight Framework and the provision of regulatory compliance returns.

Public Sector Equality Duty & Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

- This report reflects performance related to all of the Trust's service portfolio. Therefore, any decisions that are taken as a result of the information provided in this report is likely to affect members of those populations with protected characteristics in the REGARDS groups

- Any specific action will need to be relevant to each service and considered accordingly, so for example, as parts of the report relate specifically to access to Trust services; we will need to ensure that any changes or agreed improvements take account of the evidence that shows variable access to services from different population groups.

Recommendations

The Board of Directors is requested to:

1. Confirm the level of assurance obtained on current performance across the areas presented. The recommended level is significant assurance: there is a generally sound system of control designed to meet the system's objectives, however, some weakness in the design or inconsistent application of controls puts the achievement of particular objectives at risk (see appendix 2)
2. Formally agree that this report incorporates the key elements of assurance to the Trust Board that would otherwise have come from Finance and Performance Committee and People and Culture Committee reporting
3. Determine whether further assurance is required.

Report presented by: **Vikki Ashton Taylor**
Deputy Chief Executive and Chief Delivery Officer

James Sabin
Director of Finance

Rebecca Oakley
Director of People, Organisational Development and Inclusion

Tumi Banda
Director of Nursing, Allied Health Professionals, Quality and Patient Experience

Report prepared by: **Peter Henson**
Head of Performance & Delivery

Rachel Leyland
Deputy Director of Finance

Liam Carrier
Assistant Director of Workforce Transformation

Joseph Thompson
Assistant Director of Clinical Professional Practice

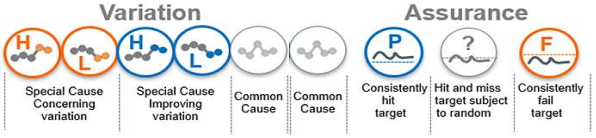
Performance Summary	
Areas of Improvement	**Areas of Challenge**
Operations	
• High level of adult ASD assessments completed • Psychological services waiting times continue to reduce and the number of people waiting has dropped significantly • CAMHS waiting times managed effectively • Inappropriate out of area placements have reduced.	• Adult ASD assessment waiting times remain high • Community paediatric waiting times continue to prove challenging • NHS Talking Therapies waiting times from first to second treatment • Inpatient bed occupancy levels remain high.
Finance	
• The financial position has been managed and an adjusted position of breakeven has been delivered • Agency expenditure continued to reduce in the second half of the financial year • The efficiency requirement has been delivered in full.	• Adult acute out of area expenditure is significantly higher than planned • Capital expenditure was above plan but supported by the Derbyshire system • Long-term plans to progress back to financial sustainability and balance.
People	
• Compulsory and role specific training • Annual turnover • Annual appraisals.	• Staff absence • Bank staff use • Agency staff use • Supervision.
Quality	
• **Complaint Handling**: Quick resolution complaints are expected to stabilise with ongoing monitoring and reporting • **Medication Safety**: Incidents remain below the mean, with improved guidelines, training, and monitoring • **Seclusion and Prone Restraints**: Both have decreased and remained within acceptable limits, with further reductions expected through targeted interventions • **Falls Prevention**: Most falls were minor or insignificant, and additional intervention is planned to enhance fall prevention efforts.	• **Staffing and Care Hours Per Patient Day (CHPPD)**: CHPPD remain below national averages, indicating workforce constraints • **Physical Restraints**: Despite a downward trend, incidents remain above the Trust margin, primarily due to self-harm interventions • **Delayed Discharges/Clinically Ready for Discharge (CRFD)**: Persistent challenges in housing, funding, and social care placements continue to impact patient flow • **Care Programme Approach (CPA) Compliance**: Compliance rates remain below target but are improving with ongoing training and digital support required to improve documentation.

Assurance Summary

A. Operations

	Metric Name	Performance	Assurance	Latest Value	Target	Lower process limit	Upper process limit	Mean
1a	Waiting list - adult CMHT - average wait to be seen			5	4	7	9	8
1b	Waiting list - older adult CMHT - average wait to be seen			1	4	1	2	1
2a	Waiting list - adult CMHT SPOA - number waiting			734		686	930	808
2b	Waiting list - older people CMHT SPOA - number waiting			53		20	118	69
2c	Older people mental health 4 week referral to treatment			93%		11%	95%	53%
2d	Adult mental health 4 week referral to treatment			94%		0%	95%	47%
2e	Waiting list - ASD assessment - average wait to be seen			61		62	71	67
2f	Waiting list - ASD assessment - number waiting at month end			1,585		2001	2313	2157
2g	ASD assessments			85	26	27	83	55
3a	Waiting list - psychology - average wait to be seen			21		10	47	29
3b	Waiting list - psychology - number waiting at month end			525		622	777	699
4a	Waiting list - CAMHS - average wait to be seen			10		12	19	16
4b	Waiting list - CAMHS - number waiting at month end			265		293	437	365
5a	Waiting list - community paediatrics - average wait to be seen			52		34	40	37
5b	Waiting list - community paediatrics - no. waiting at month end			2,655		2520	2863	2692
B1	3 day follow-up			89%	80%	79%	96%	88%
D1	Community Mental Health Access (2 plus contacts)			12,395	11,899	10756	11576	11166
E1	Children & Young People Mental Health Access (1 plus contact)			3,415		3120	3302	3211
E4	Children & Young People Eating Disorder Waiting Time - Routine			100%	95%			
E5	Children & Young People Eating Disorder Waiting Time - Urgent			100%	95%			
G3	Early intervention 14 day referral to treatment - complete			92%	60%	61%	106%	83%
G3	Early intervention 14 day referral to treatment - incomplete			71%	60%	48%	122%	85%
H0	IAPT 6 week referral to treatment			91%	75%	57%	75%	66%
H1	IAPT 18 week referral to treatment			99%	95%	98%	101%	99%
H2	IAPT 1st to 2nd Treatment over 90 Days			60%	10%	16%	40%	28%
H7	IAPT patients completing treatment who move to recovery			45%	50%	43%	59%	51%
I1	Individual Placement and Support Access			485	343	147	490	319
K2	Average patients out of area per day - adult acute			26	0	1	23	12
K2	Patients placed out of area - adult acute			37	0	4	35	19
K2	Average patients out of area per day - PICU			15	0	13	23	18
K2	Patients placed out of area - PICU			23	0	21	36	28
L1	Perinatal Rolling 12 Months Access			11.4%	10%	7%	8%	7%
L2	Perinatal Access Year to Date			805	1,070	274	831	553
N4	Data quality maturity index			98%	95%	98%	98%	98%

Key to symbols[1]:



Blue dots indicate special cause variation, better than expected.

Orange dots indicate special cause variation, worse than expected.

[1]The rating symbols were designed by NHS Improvement

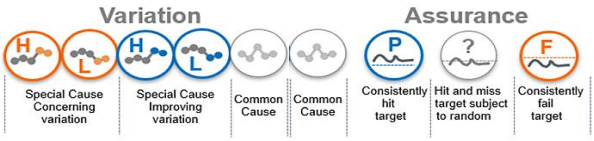
B. People

	Metric Name	Variation	Assurance	Latest Value	Target	Lower process limit	Upper process limit	Mean
1	Annual appraisals			89%	90%	83%	89%	86%
2	Annual turnover			11%	8-12%	11%	12%	12%
3	Compulsory training			93%	85%	90%	92%	91%
4	Staff absence			5%	5%	5%	7%	6%
5	Clinical supervision			84%	95%	80%	85%	82%
6	Management supervision			81%	95%	77%	84%	80%
7	Filled posts			88%	100%	87%	94%	90%
8	Bank staff use			4%	5%	4%	7%	6%

C. Quality

	Metric Name	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	No. of compliments received			153	119	70	203	137
2	No. of formal complaints received ("quick resolution")			3		0	37	19
3	No. of formal complaints received ("closer look")			17		2	30	16
4	Proportion of patients clinically ready for discharge			11%	4%	7%	14%	10%
5	Proportion of patients on CPA >12 months who have had their care plan reviewed			80%	95%	63%	72%	68%
6	Patients who have their employment status recorded as "in employment"			12%		12%	13%	12%
7	Patients who have their accommodation status recorded as "settled"			48%		40%	47%	43%
8	Number of medication incidents			66		47	112	80
9	No. of incidents of moderate to catastrophic actual harm			79	48	36	87	61
10	No. of incidents requiring Duty of Candour			0	1	0	3	1
11	No. of incidents involving prone restraint			7	12	0	24	11
12	No. of incidents involving physical restraint			49	46	22	136	79
13	No. of new episodes of patients held in seclusion			13	14	2	31	16
14	No. of falls on inpatient wards			38	30	7	62	35

Key to symbols[1]:



Blue dots indicate special cause variation, better than expected.

Orange dots indicate special cause variation, worse than expected.

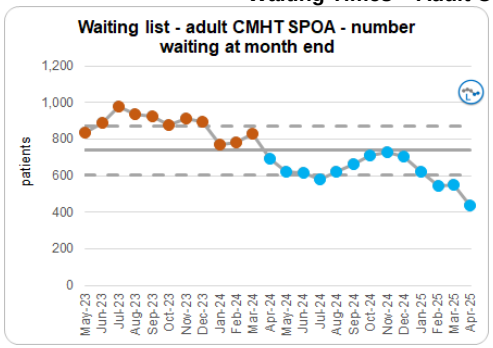
[1]The rating symbols were designed by NHS Improvement

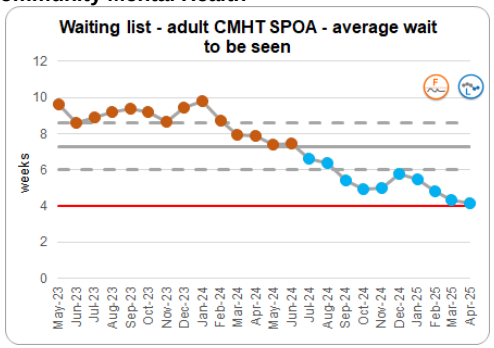
Derbyshire Healthcare
NHS Foundation Trust

Operations

Operational Performance

Waiting Times – Adult Community Mental Health



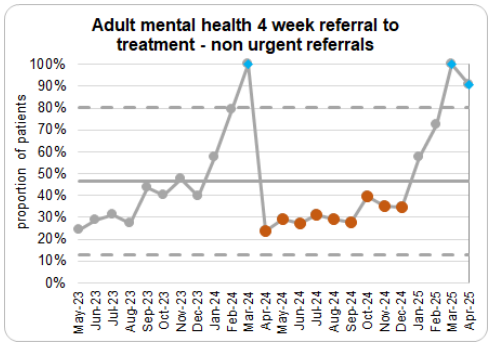


SPOA = single point of access – the route for external referrals into the services

Summary
Although services are seeing an increase in referrals, the average wait to be seen continues to reduce and is currently just over 4 weeks.

Over the last financial year the number of referrals received by the single points of access (SPOA) has exceeded the number of discharges from the community teams by 38%. This can be attributed to the increasing referrals into SPOA since the mobilisation of Living Well. Onward referrals from SPOA for intervention/treatment into different parts of the Living Well service, both short and long-term offers have outweighed the number of discharges from these parts of the pathway. If this increase in referrals for both assessment and intervention continues, and remains higher than the number of monthly discharges, there is a high risk that waiting lists will increase and that people will not get timely access to services when they require it owing to limited flow.

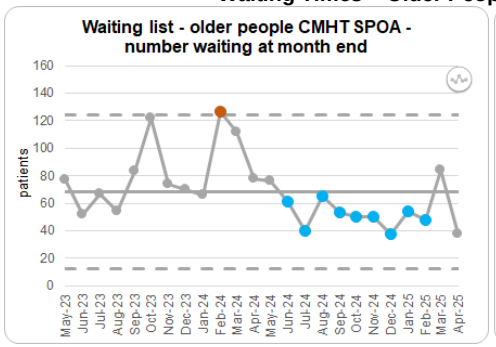
Actions to support flow
All sites have now mobilised Phase One of the Living Well CMHF Transformation. Proactive work continues through a focus on productivity, to address data quality issues, increasing flow through the service and creating capacity to be more responsive and reduce waiting times for people trying to access the services. Employee wellbeing measures are being implemented as a priority within the division.

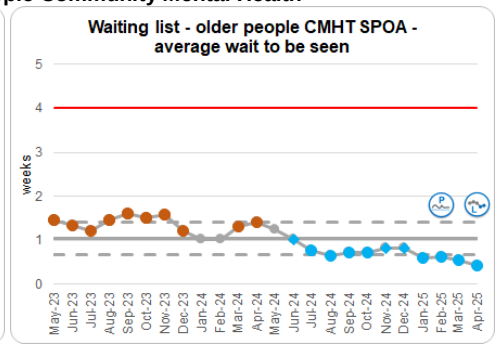


The plan is positively impacting on waiting times and this can be seen in the consistently below average wait times over the last 9 months, which is a statistically significant reduction.

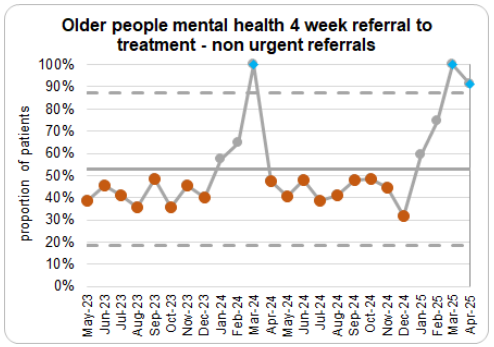
4 week referral to treatment
Currently 4 week referral to treatment is an internal measure based on referral to 2nd contact. The data does not show patients who are currently waiting for their 2nd contact.

Waiting Times – Older People Community Mental Health





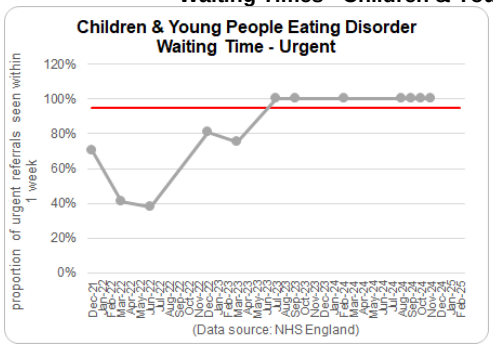
SPOA = single point of access – the route for external referrals into the services

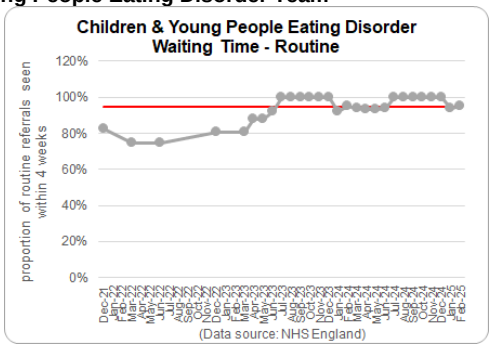


Summary
Wait time reduction in MAS and CMHT has been maintained through proactive monitoring and triaging. We continue to have a focus on productivity and review of processes. Bolsover CMHT remains a hotspot due to ongoing complex ER issues and sickness.

Next steps
Both the functional and organic pathways are under review to establish any potential transformational opportunities. Transformation of MAS and day services underway to improve patient experience and increase productivity. Continued engagement with primary care to support smooth and appropriate referral.

Waiting Times - Children & Young People Eating Disorder Team





Summary
Data indicate that the Trust's Children & Young People (C&YP) Eating Disorder Service generally continues to achieve around 100% for both standards. The Division also internally monitors the C&YP Eating Disorder Service waits from 1st to 2nd contact (days):

Days	Qtr1	Qtr2	Qtr3	Qtr4	
2023/24	11	4	4	8	
2024/25	2	3	4	2	
2025/26	0				

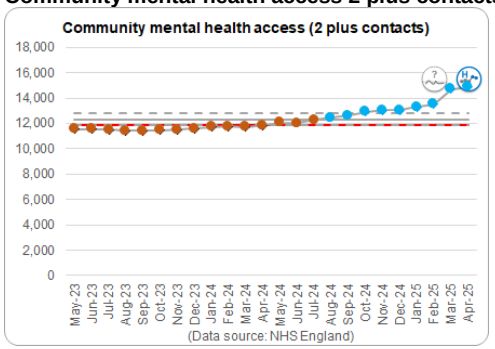
Operational Performance

https://livingwellderbyshire.org.uk/

Mental Health services that are available in the community to support people with mental ill health are changing and improving. In alignment with the Community Mental Health Framework, mental health services are transforming to reach a wider cohort of people, including those who have traditionally fallen between the gaps of primary and secondary care, as well as those people with a severe mental illness. Health services, social care and the voluntary, community and social enterprise (VCSE) sector are working in partnership to deliver new integrated ways of working that are modernising community mental health services for adults and older adults, considering the particular needs of each local area. In Derbyshire, this is called the Living Well Derbyshire programme. In Derby, it is called the Derby Wellbeing programme.

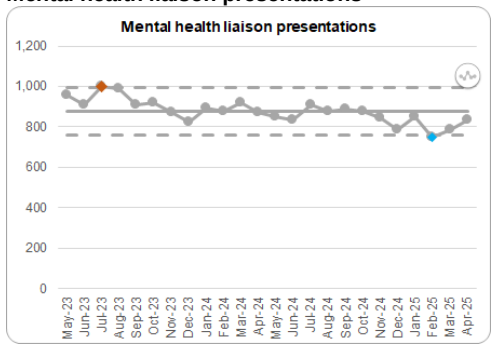
Community Mental Health Framework/Living Well Programme
DHCFT is a partner in the programme alongside the voluntary, community or social enterprise sector and the local authorities. Go live of the Living Well sites concluded its final locality in March 2024, at this stage of the mobilisation, all teams are established and receiving referrals from Primary Care and self-re-introduction only. We can already see positive impact in terms of case load sizes (long term caseloads reducing whilst short term caseloads have increased). In addition, there are early indications of reducing referrals to MH Liaison Teams which frees up capacity to provide greater support to complex cases in the community and therefore to reduce presentations at A&E.

Community mental health access 2 plus contacts (NHS long term plan target)



Summary
For financial year 2024/25 NHSE have published data up to February 2025, which demonstrate that year to date the target level of activity has been sustained each month. Internal data for March and April 2025 indicate that the target level of activity has also been achieved in both months.

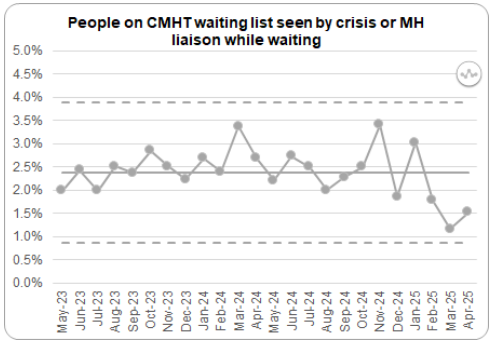
Mental health liaison presentations



Summary
One aim of living well is to free up capacity within secondary care mental health community teams to be able to provide support to more acutely unwell patients in the community. This approach should result in fewer presentations at acute trust emergency departments and support admission avoidance.

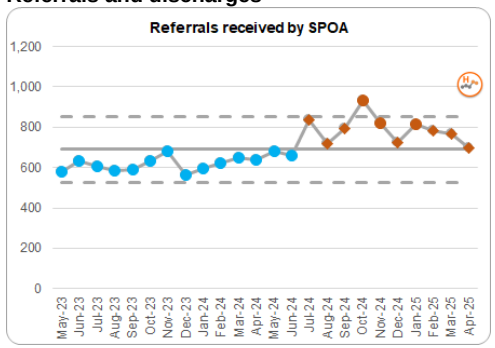
The data indicate a continued overall improvement since Living Well mobilisation.

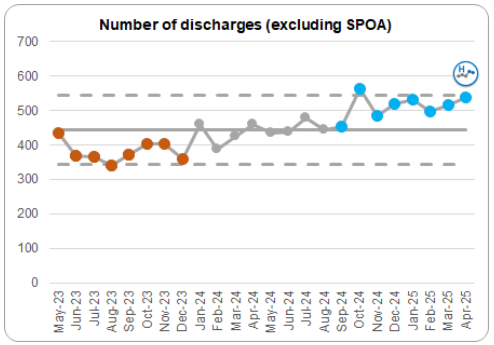
People on the community mental health team waiting list who have been seen by crisis services or mental health liaison while waiting



Summary
People who are waiting to be seen by community mental health teams should be seen sooner, therefore we would be expect the number of people needing to access crisis services whilst waiting for community mental health services to decrease, reducing demand on secondary services. We are now seeing a reduction, in addition there is a specific piece of work through the enabler MaST (Management and Supervision Tool) to review those patients in high escalation on CMHT caseloads to increase activity to prevent them from further health escalation/deterioration.

Referrals and discharges





Summary
The volume of referrals received has been steadily increasing and significantly high for the last 9 months. This is attributed to the Living Well mobilisation. The volume of discharges has also been increasing over time since December 23, but at a lower level.

Operational Performance

https://livingwellderbyshire.org.uk/

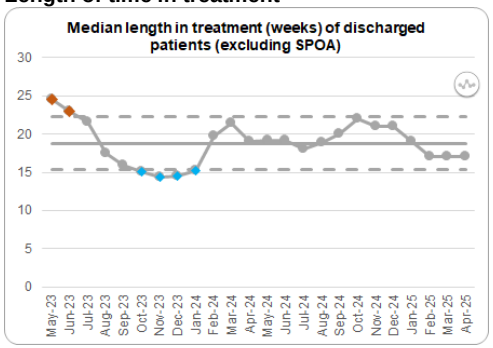
Caseload sizes

Over time it would be expected to see long term offer caseloads reducing, and short-term offer caseloads increasing. The data demonstrate that this continues to be the case. The columns below give the proportion of caseload that was long term offer in each team each month:

STO & LTO caseloads	Proportion of caseload that is long term offer													
Team	Oct-23	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	Movement
CHESTERFIELD	96%	75%	72%	79%	73%	75%	75%	73%	72%	74%	71%	68%	68%	67%	
HIGH PEAK	71%	54%	54%	53%	53%	54%	49%	46%	47%	46%	45%	47%	51%	51%	
AMBER VALLEY	98%	87%	89%	87%	84%	84%	69%	64%	66%	61%	61%	57%	55%	56%	
EREWASH	100%	91%	89%	90%	88%	89%	79%	75%	75%	73%	73%	71%	70%	69%	
SOUTH DERBYSHIRE	100%	91%	86%	83%	77%	78%	70%	67%	66%	64%	64%	64%	61%	63%	
DERBY CITY B	72%	57%	58%	66%	60%	65%	63%	67%	69%	66%	65%	66%	66%	65%	
DERBY CITY C	74%	61%	60%	67%	58%	60%	59%	63%	68%	67%	66%	65%	64%	63%	
Grand Total	**88.5%**	**74.7%**	**73.9%**	**77.2%**	**72.7%**	**74.3%**	**68.0%**	**66.7%**	**67.6%**	**65.5%**	**64.6%**	**63.2%**	**62.4%**	**62.2%**	

NB Bolsover, Killamarsh, North & South Dales are excluded from this table, as those teams only hold long term offer caseloads and so will always be 100%. Their short-term offer caseloads are held elsewhere.

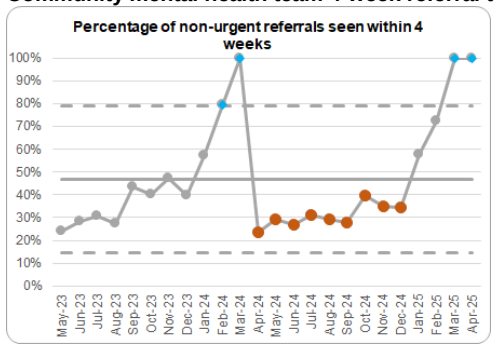
Length of time in treatment



Summary

Discharges would be expected to increase and length in treatment to reduce, owing to the short-term offer throughput offering a 12-week service. The flow of people through the service would ensure there is capacity to support people in a timely manner. To date the length of time has varied. Work continues with localities to develop community connections for people to continue to be supported through voluntary groups and through developing pathways to the long term offer. Work also continues to embed the Living Well Practice so that staff are supporting people to reintroduce themselves to the service should they wish to access services again following discharge.

Community mental health team 4-week referral to treatment

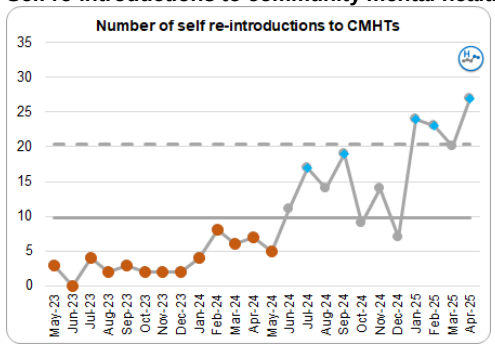


Summary

NB 4-week referral to treatment performance is based on referral to second contact of patients who had their 2nd contact in the month. The data does not show patients who are still waiting for their second contact.

A significant piece of work is taking place to correct multiple patient contacts that have been recorded incorrectly on SystmOne. This work can be seen to be having a positive impact on reported waiting times from January 2025.

Self re-introductions to community mental health services



Summary

The Living Well Service enables people to readily access services up to 2 years following discharge from a previous spell of treatment. The number of self re-introductions would be expected to increase over time, through the provision of easier access to services, and is also expected to reduce demand on primary care. The ability to self-reintroduce has been established during phase 2 of the Living Well transformation. The data indicates an increase in self-referrals on an upward trajectory.

Operational Performance

Adult Neurodevelopmental Division (ND)

Service Delivery/Flow

- The Short-Term Intervention Team (STIT) funding has formally been extended until September 2025.
- New system-wide Discharge Delivery Group has been established to oversee the work in relation to patient discharges, with a focus on the proposed 17 ICB/Secure discharges throughout 25/26.
- New 25/26 inpatient trajectory has been submitted to NHSE- target of 27 proposed.

Transforming care programme	Target	Actual April 25	Status
Number of adults in ICB commissioned inpatient care with LD/ LD&A	22	10	
Number of adults in secure inpatient care with LD/ LD&A		11	
Number of adults in ICB commissioned inpatient care with ASC	11	4	
Number of adults in secure inpatient care with ASC		9	
Number of CYP in specialised/ secure inpatient care	3	4	
CTR - Post admission Adult	75%	100%	
CTR - Post admission CYP	75%	100%	
CTR – 6 month follow up - ICB Commissioned	75%	100%	
CTR - 12 month follow up - Secure Inpatient	75%	95%	
CTR - 12 month follow up – CYP	75%	100%	

ND Delivery Plan (Previously known as Road Map)

Key priority areas have been proposed for the 2025-2028 ND delivery plan. Agreement and formation of workstreams to be decided. Priority areas include care and accommodation, strategic partnership working and training and development.

Integration

EPR migration- all DCHS employees have now migrated to the DHcFT EPR system. The ND service now operates under 1 EPR system.

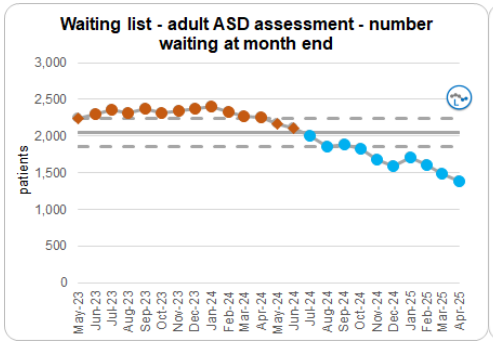
Major Service Change- Exec leads and SRO have been identified for both Short Breaks and Inpatient major service change. Project plan and options appraisal being worked up.

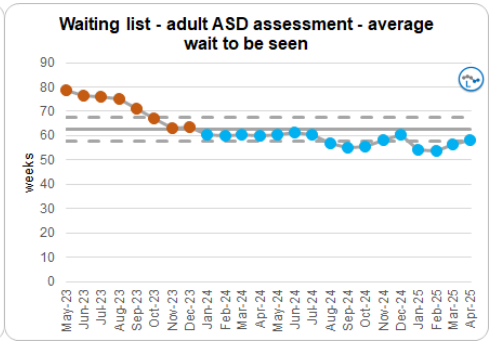
Risks

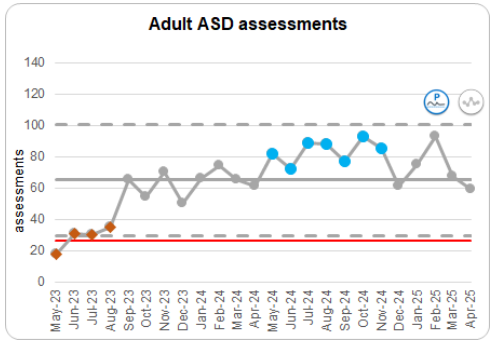
ND Patient Assurance Team**:** Recovery action plan in place and continued progress with infrastructure and processes. Vacancies imminent which need resolving to continue to drive progress.

Training and Risk Screen Compliance**:** Work continues in relation to data cleansing around risk screens and safety plan reporting. Working group addressing this with ND Head of People is leading this. To be reviewed in Operational & Clinical Operational Assurance Team (COAT) meetings monthly.

Adult Neurodevelopmental Division (ND)







Adult Diagnostic Service

The number of completed assessments per month has remained high and the full year contracted target for 2024/24 was exceeded by over 300%.

The number of people waiting continues to reduce significantly.

Continued discussions with the ICB are taking place regarding extending the Autism diagnostic service (16 year +) following on from the closure of Sheffield diagnostic service.

Success

- Recent visit from NHSE was well received with positive feedback on service delivery and models of care.
- Recent progress on being able to roll out patient survey will improve ND opportunities to capture patient experience.
- Copilot being trialled by some individuals and in progress of securing Heidi-App trial to improve productivity.

Challenges

- Staff Wellbeing- Transformation/change fatigue across ND given the continual changes the integration is bringing on top of trust-wide demands. Staff survey reflecting this. Work with DPL to support this work.
- Significant ongoing demand for the adult ASD assessment service, with 265 referrals received in January 2025 alone, and 1,264 referrals received over the full financial year.

Operational Performance

Psychology & Psychological Therapies

The Division has maintained its excellent reputation in the region for being a fantastic place for psychologists to work and remains the employer of choice in the region. The Division currently have 9.43% vacancy, with a head count of 199 (166.7 WTE) staff excluding TMHD.

Trainee, research and external facing roles: We continue to support our employed trainees to provide the future workforce for DHCFT. Staff contribute to professional teaching on the DClinPsy course as well as psychotherapy and CBT trainings. One staff member continues to be funded by Manchester University for a PhD. Senior staff have a number of external facing national roles in different arenas (including within the BPS, specialist collaboratives or boards etc) all with the focus of raising the profile of psychology in DHCFT.

Talking Mental Health Derbyshire (TMHD): TMHD remain focused on completing all treatments started and completing as many assessments from the waiting list as possible before the end of contract. The team are currently testing data to support the move to Vita Health. A project plan is in place to support smooth transition for the first of June 25. There is a support plan in place and a number of engagement sessions have been delivered to date.

Flow: The psychology teams continue to work to support the development of formulations for those with EUPD presentations within the inpatient areas. The EUPD pathway teams are also supporting with trying to maintain those in the community with a specific focus to avoid hospital admissions. The STEPS pilot will start in May, which is a more intensive support programme for those with relational needs.

Safety and quality: Friends and Family Test, where reported, continues to show excellent feedback. In the last 12 months:

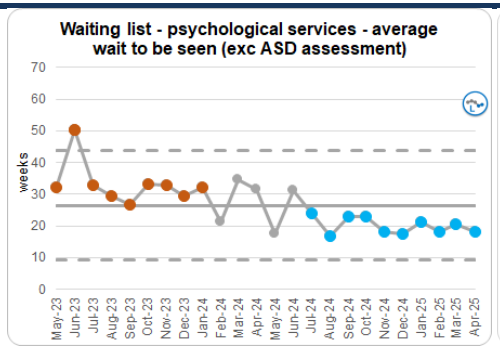
- Adults of working age psychology received 35 returns showing 83% positive feedback. The less positive feedback was owing to waiting times.
- Cognitive behavioural therapy & psychodynamic therapy received 3 responses and 100% were positive
- NHS Talking Therapies received 1,251 responses and 99% were positive.
- Learning disability psychology received 2 responses which were both positive.

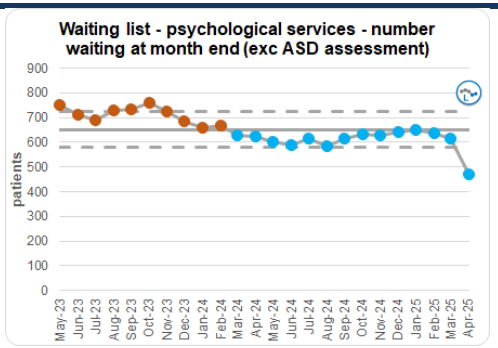
We are working to increase the volume of friends and family completed feedback.

Trust wide staff wellbeing: Wellbeing remains a priority for all teams. Divisional staff receive continued requests to support individuals and teams which remains challenging. There remains a lack of appropriate psychological support for staff internally and across the system, but psychologists are delivering reflective practice where they can.

Increasing psychological awareness: Bite size psychological teaching sessions continue to have good attendance. Psychologists will be leading the upcoming MDT work; and trying to support broader understanding of psychological safety within teams.

New projects: DP&PT staff are engaging with and supporting a number of projects across the trust and system including work in developing 24/7 neighbourhood scheme and looking at models for intensive community working; developing a pathway for people who need support for emotional and relational behaviours.





Waiting lists and referrals: Overall, there continues to be a sustained reduction in the number of people waiting for psychological input to around 20 weeks. Waiting lists continue to pose a challenge to staff in finding new ways to be able to psychologically support the people who use our services. The other pressure point remains ASD assessment where the average wait is 58 weeks (April 2025).

ASD and ADHD services: The Trust are currently continuing discussions with the ICB to provide an ADHD service and to extend the ASD assessment service to meet the needs of the population. Even with all the improvements made by the ASD team, referrals / need still outweighs supply in Derbyshire. Whilst all agree that there is a need for ADHD services within Derbyshire, and a clear specification for delivery has been developed by the ICB, as yet there is no agreement or funding for such a service. This is impacting people of Derbyshire who without a diagnosis cannot get the right support.

Key performance indicators: Managerial supervision stands at 90% currently, and clinical supervision 91%. Annual appraisal completion stands at 90%. Mandatory training is exceeding target at 95%. Return to work interviews (RTWI) remain low at 66% for April, but this is a further improvement from last month. We have an action plan in place to increase the RTWI as well as focus on care planning – where we are currently at 80%. Sickness in the division remains much lower than the trust average of 5.8%, with April reported as 1.8%.

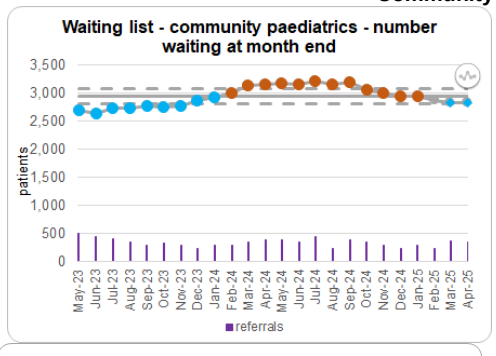
Productivity: Patient facing productivity remains a focus for all teams. However, the need for accurate and timely data remains so as to support this endeavour. Digitising psychological tests and assessments will support this longer term.

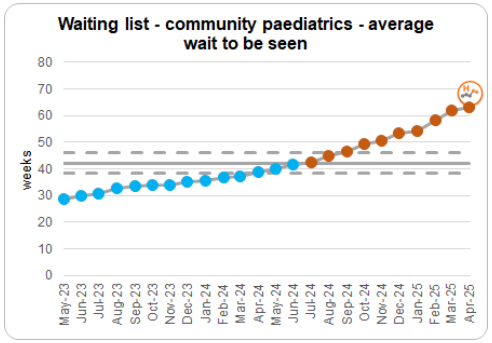
Finance and efficiencies: The DP&PT has planned the full CIP for 25/26. The plan is being reviewed by executives (nursing and medical) and we will deliver on this accordingly.

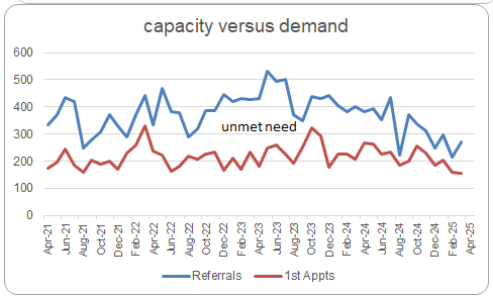
New ideas / work: Our LD teams have developed a drop-in session; and have developed a single referral form (move toward trusted assessor model). The forensic team have developed a pathway for those with emotional /relational difficulties who offend; we have a member of staff writing guidelines for the ACP addressing risk and safety in dissociative practice.

Operational Performance

Community Paediatrics







Summary

At the end of April 2025 there were 2,839 children waiting to be seen, with average wait of 63 weeks. Whilst referrals continue to rise, the positive impact of the internal review of processes, job plans etc. which enabled increasing the number of assessments by 34% has continued into the current financial year to date. However, demand continues to outstrip capacity by 38%. Over the next 3 months there are likely to be over 300 patients in the Community Health Services Data Set who have been waiting over 104 weeks to be seen. The service has lost 5 of the community paediatrician team through retirement and/or voluntary resignation. This includes the loss of 3 experienced consultants, including the clinical director, which will have a significant impact on service delivery.

Internal factors

Ongoing difficulty in discharging children under NICE guidance and shared care agreements in relation to medication for ADHD – specialist nursing team caseloads continue to expand causing problems with flow from the community paediatrics service. Recruitment and retention of medical staff: recruitment to mitigate expected turnover in the next quarter period.

External factors contributing to increased demand on Community Paediatricians

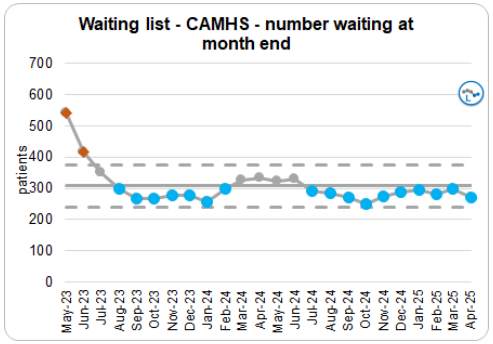
- Significant increase and enduring demand for ASD/ADHD specialist assessment. Demand for ASD and ADHD assessments is linked to an increase in SEND in schools, school pressures, cost of living crisis and reduced community support.
- Ongoing increased volume of referrals to community paediatricians owing to developmental delay, which has persisted since the pandemic.
- Increased complexity of children & young people's presenting needs post the pandemic, resulting in longer appointments, which reduces capacity to see more patients.
- Ongoing ADHD supply issues continue to impact on demand and management of cases needing to be expedited.
- Recruitment takes time and although this process has started the existing workforce has had to absorb the caseloads of Dr's leaving or left resulting in fewer new clinic appointment slots.

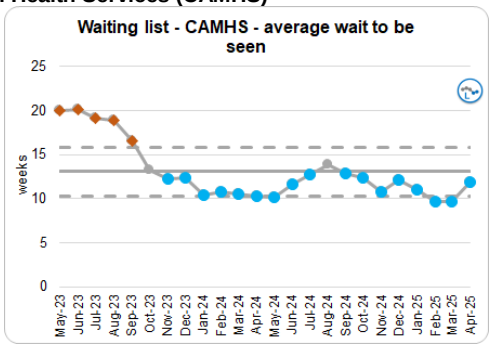
Actions

- Recovery action plan is in place. Transformation work for the CYP neurodevelopmental pathway is ongoing. Ongoing triage review of long waiters, with a system decision made to focus on education/schools in order to reduce referrals by offering advice, support and signposting as needed.
- Mitigation measures to address the vacancies arising will form part of the service transformation programme, through a review of roles, skill mix, and service specification. Request for Locum cover has been approved.
- Posts are live on Trac / NHS jobs. Included are 2 x medical posts, 1 x NMP and 1 x band 6 nurse.
- Review of service offer around priority needs and clinical risks.
- Review of the use of AI for referral management: 2 options being considered.

Waiting times for community paediatrics are likely to continue to rise. The ongoing challenge is to reduce the growth and speed at which this takes place.

Child & Adolescent Mental Health Services (CAMHS)





Summary

At the end of April 2025, 272 children & young people were waiting to be seen and the average wait time was just under 12 weeks. The average wait is now more accurately reflected in the data following adjustments to recording. Priority referrals continue to be seen within 4-6 weeks and routine assessments up to 20 weeks, however this is still a significant improvement from where we were in 2022.

Actions

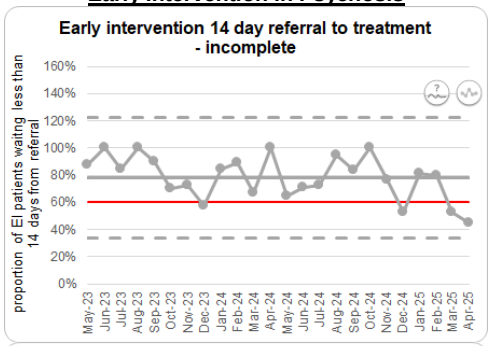
- The triage and assessment team are continuing to positively impact on external waiting times and are adhering to the Trust waiting well policy. Owing to the efficiency of the Triage and Assessment Team, it is necessary to limit and control the rate of assessments so that the teams further down the pathway do not become overwhelmed. It was planned to increase from 4 to 6 in January. However, owing to absences and vacancy, it has been increased to 8 per week which is maintaining a steady enough flow into the pathway and maintaining the average wait at around 16 weeks.
- CAMHS Assessment Team clinicians continue to support with the quantitative behaviour clinic assessments to help reduce wait times. The team also continues to support with CAMHS ASD assessments, at the rate of 1-2 assessments per clinician per week. This results in young people, who were solely waiting for an ASD assessment potentially being discharged from service at a much faster rate than had they been waiting for the CAMHS specialist assessment team.
- Assessment Service Leads are closely monitoring the impact of the closure of national gender services, as referrals start to be sent through. As yet, there has not been a significant impact. A significant number of those referred in were already known to services/open to services, so the time spent triaging was minimal. The assessment of all CYP on the wait list for the gender clinics that have been closed was a mandated requirement from NHSE to mitigate the risks of having unknown CYP on their wait lists. The ongoing commissioning of gender services has not been resolved.
- Capacity within the assessing team is diverted for internal triage/reviews of long waiters when necessary.

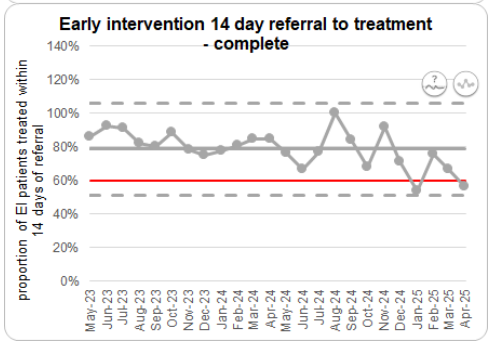
Recovery timescales:

Average wait is below 18 weeks however a national standard of 4 weeks was proposed by NHS England. If mandated, this would require new investment as outlined in the business case above.

Operational Performance

Early Intervention in Psychosis



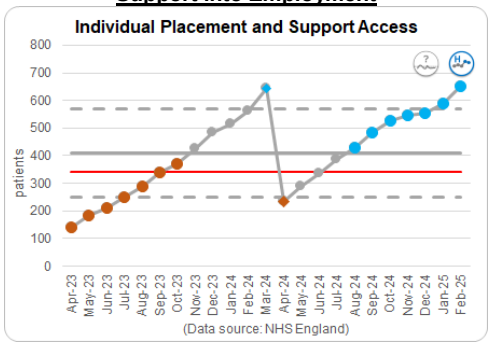


Summary
Up until recently patients with early onset psychosis have received very timely access to the treatment they need, but for the last few months this has become more challenging.

The key issues facing the service
There is a risk assessment in place for both the EI North and EI City & South teams owing to significant staffing pressures as a result of maternity leaves, vacancies, and sickness absence, resulting in caseloads above the agreed standard and challenges in meeting the 14-day access target. The risk assessment is regularly reviewed by the Service Manager, Clinical Lead and Area Service Manager to ensure actions are in place to mitigate against the risk where possible.

Actions being undertaken
Proactive recruitment and use of bank staff where possible, is in place to minimise any staffing gaps to remain above target. Robust caseload management and improving interface with the Living Well Long-Term Offer Teams to support flow.

Support into Employment



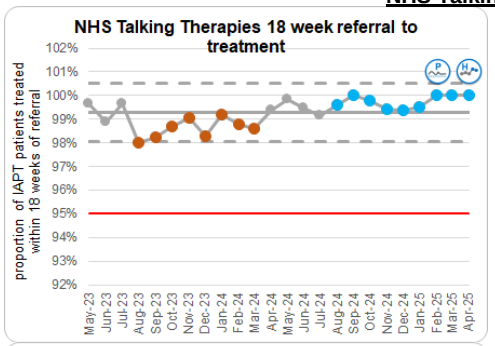
Summary
Work Your Way is a team of employment specialists and peer support workers helping people using community mental health services in Derbyshire to find work and stay in work. The team is continuing to be extremely productive.

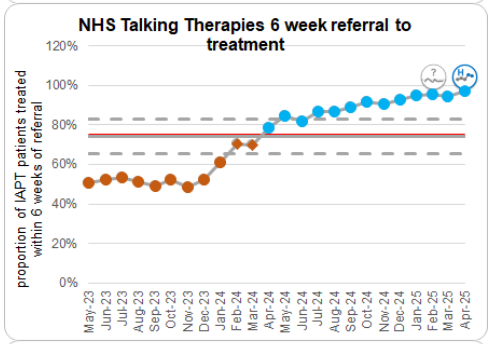
Recruitment has continued in line with approved funding and from May 2025 the service will be fully staffed in line with NHS long term plan targets. There has already been an upturn in referrals as a result, and waiting lists are reducing in certain areas.

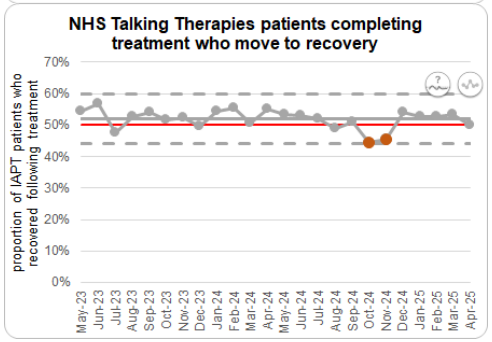
Some innovative ideas have come from the team including how to identify employers with whom there has been a positive experience. The intention is to create an internal list to discuss with to clients and work with for future job outcomes, if it is in line with the client's choice.

IPS Grow has confirmed that there will be 2 reviews of the service undertaken this year. The North team is scheduled for 26 and 27 May, and the East Team is scheduled for review on the 16 and 17 September. There will also be 3 guided self-assessments in between to ensure the quality of the service remains high.

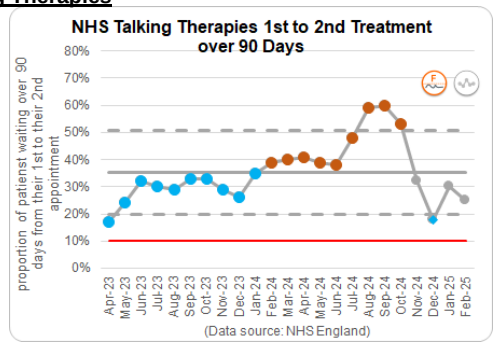
NHS Talking Therapies







Summary
- 18-week referral to treatment performance and 6 6-week wait for referral to assessment/ 1st treatment entered continue to exceed target.
- Recovery rate and reliable improvement rate are both above target for April 25 and for the full year 2024/25.
- Friends & family test feedback has remained overwhelmingly positive since inception of the services, with over 16,000 people reporting a positive experience (98%).



Summary
1st to 2nd treatment over 90 days has continued to remain low compared to Aug and Sep 2024. Given the uncertainty of the current situation for the service it is remarkable that the outcome measures have remained high. In April the service completed over 20% more treatments than the ICB target.

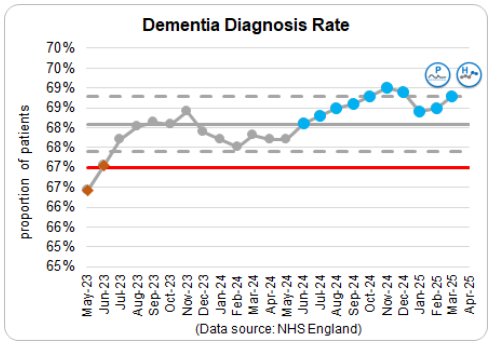
Actions
- Quarter 1 of 2025/26 is the final quarter for Talking Mental Health Derbyshire before handover to a new provider on 1 July 2025.
- Activity with 3 of the 4 sub-contractors was retained into quarter 1.
- The service closed to referrals and ceased new treatments as of 4 April 2025 in order to stabilise waiting lists and to attempt not to hand over anyone in treatment.
- The service lost, and continues to lose, clinician and non-clinical staff into the new financial year with none being replaced. The sub-contractors have also reduced staffing down to minimal numbers in preparation for contract end.
- Work on a project to close on 30 June 2025 continues in order to ensure an orderly exit and to facilitate continuing service post closure.

Regional Comparison February 2025
People completing a course of treatment

Organisation Name	Measure Value STR	LTP Trajectory STR	LTP Trajectory Percentag..
NHS DERBY AND DERBYSHIRE ICB	1,290	988	131%
NHS NOTTINGHAM AND NOTTINGHAMSHIRE ICB	1,400	1158	121%
NHS SHROPSHIRE, TELFORD AND WREKIN ICB	500	454	110%
NHS LINCOLNSHIRE ICB	745	684	109%
NHS STAFFORDSHIRE AND STOKE-ON-TRENT ICB	1,125	1064	106%
NHS BIRMINGHAM AND SOLIHULL ICB	1,505	1490	101%
NHS NORTHAMPTONSHIRE ICB	590	643	92%
NHS COVENTRY AND WARWICKSHIRE ICB	780	865	90%
NHS BLACK COUNTRY ICB	980	1271	77%
NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	730	976	75%
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICB	365	682	54%

Operational Performance

Dementia Diagnosis Rate



Summary

There has been a national drive to increase the proportion of people estimated to have dementia, who have a coded diagnosis of dementia. The target for Derby & Derbyshire has been achieved since June 2023 and steadily increasing for the last 7 months to the latest high of 68.8% (Mar 25). NB this is national data, and the April 2025 position is yet to be published by NHSE.

Regional Comparison February 2025

Dementia diagnosis rate

Organisation Name	Measure Value STR
NHS STAFFORDSHIRE AND STOKE-ON-TRENT ICB	72.9%
NHS NOTTINGHAM AND NOTTINGHAMSHIRE ICB	70.1%
NHS DERBY AND DERBYSHIRE ICB	68.5%
NHS LINCOLNSHIRE ICB	68.2%
NHS NORTHAMPTONSHIRE ICB	66.5%
NHS BLACK COUNTRY ICB	65.4%
NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	64.5%
NHS BIRMINGHAM AND SOLIHULL ICB	62.6%
NHS SHROPSHIRE, TELFORD AND WREKIN ICB	62.5%
NHS COVENTRY AND WARWICKSHIRE ICB	58.6%
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICB	54.9%

NHS Derby & Derbyshire ICB has the 3rd highest diagnosis rate in the region, with performance exceeding the long-term plan trajectory target.

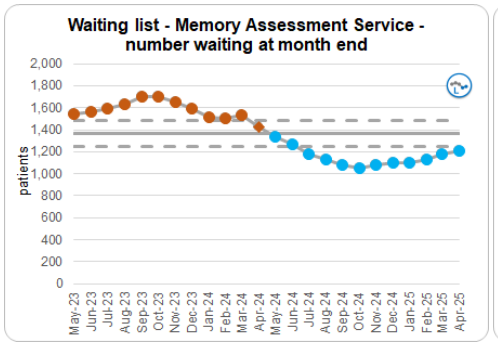
Dementia Diagnosis Benchmarking Data

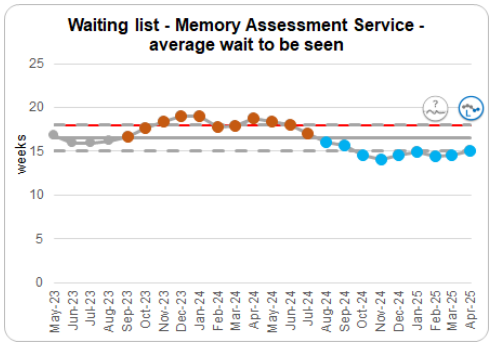
Org type	Org code	Diagnosis rate
ICB	QF7	75.3
ICB	QOP	74.4
ICB	QWE	73.5
ICB	QNC	73
ICB	QUY	70.3
ICB	QWO	70.2
ICB	QKK	70.1
ICB	QT1	70.1
ICB	QHG	69.3
ICB	QHM	68.9
ICB	QJ2	68.8
ICB	QE1	68.4
ICB	QJM	68.2
ICB	QH8	67.7
ICB	QYG	67.6
ICB	QXU	67.5
ICB	QMJ	67.2
ICB	QNQ	67.1
ICB	QPM	66.6
ICB	QUA	65.9
ICB	QR1	65.3
ICB	QM7	65.2
ICB	QRV	64.9
ICB	QK1	64.5
ICB	QRL	63.6
ICB	QOC	62.9
ICB	QHL	62.6
ICB	QNX	62.5
ICB	QMM	62.1
ICB	QU9	62
ICB	QT6	61.8
ICB	QOQ	61.7
ICB	QMF	61.6
ICB	QOX	61.6
ICB	QKS	60.9
ICB	QUE	60.6
ICB	QJG	60
ICB	QWU	59
ICB	QJK	58.9
ICB	QVV	58.2
ICB	QGH	55.3
ICB	QSL	54.8

Primary Care Dementia Data - NHS England Digital

The diagnosis rate in Derby & Derbyshire continues to compare very favourably with other areas nationally.

Dementia Diagnosis Waiting Times





Summary

At the end of April 2025 there were 1,207 people on the waiting list, with an average wait of 15 weeks, which includes people currently waiting as well as those who were assessed in month. Waiting times for initial assessment remain at approximately 24 weeks. Some progress has been made on assessment to diagnosis which is currently 8 weeks across the county.

Reasons for underperformance

- There continues to be an extremely high demand for the service which exceeds capacity.
- The situation in unlikely to improve as the prevalence of dementia is predicted to increase significantly by the end of the decade.

Action plan

- Resource to be maximised within the service (inclusive of the medical workforce). The Flow Coordinator is tasked with moving resource / clinic types to ensure all clinical capacity is used and that there is a flow of assessment to diagnosis.
- A complex case clinic has been introduced utilising the skillset of the new SAS doctor.
- Reducing the DNA rate. There are still a number of cancellations, but the service are working to rebook people into suitable slots. A cancellation list is held and pull people are seen in the clinics where there are DNA's.
- Dementia assessment pathway work remains ongoing, with further engagement with Primary Care underway. Weekly emails to staff with individual performance data to ensure individual accountability for service provision.
- Regular monitoring of wait times and data cleansing.
- Complex case/under 55 pathway review completed.
- The intellectual disability pathway & MDM has been reinstated.
- QI pilot is being planned around a 'one stop MCI clinic'.

By when we will have recovered the position

Quality improvement actions to optimise performance within the current service offer and financial envelope have been fully implemented. Any further developments will be minor and classified as business as usual.

Operational Performance

Summary
From April 24 NHS England changed to measuring the number of out of area placements at month end, at ICB level only. From internal data, at the end of March 2025 there were 5 inappropriate out of area adult acute patients and 16 inappropriate out of area PICU patients. NB these figures exclude placements where continuity of care principles have been put in place, which are classed as appropriate placements.

Reasons for underperformance
There is an ongoing high level of demand for acute and PICU beds. Adult acute wards continue to operate at around 100% capacity, however, leave beds are utilised where safe to do so.

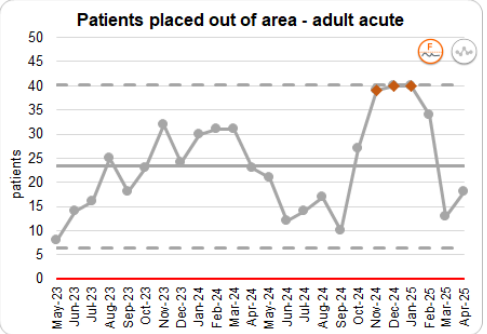
The level of acuity remains persistently high, resulting in the need for PICU beds and represented by the increase in adult acute admissions under the Mental Health Act, which account for 70% of all admissions. The level of acuity may also result in people taking longer to recover.

There are no PICU beds in Derbyshire at this time and therefore all patients placed in PICU are placed in out of area beds.

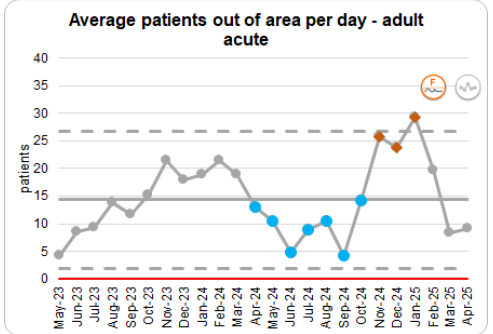
There is a need to ensure the number of inpatients who are clinically ready for discharge are kept to a minimum.

Regional comparison February 2025
Inappropriate out of area placement bed days

Organisation Name	Measure Value STR
NHS DERBY AND DERBYSHIRE ICB	1,505
NHS BIRMINGHAM AND SOLIHULL ICB	1,245
NHS NOTTINGHAM AND NOTTINGHAMSHIRE ICB	600
NHS NORTHAMPTONSHIRE ICB	470
NHS STAFFORDSHIRE AND STOKE-ON-TRENT ICB	430
NHS COVENTRY AND WARWICKSHIRE ICB	415
NHS BLACK COUNTRY ICB	390
NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	370
NHS LINCOLNSHIRE ICB	325
NHS SHROPSHIRE, TELFORD AND WREKIN ICB	245
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICB	150

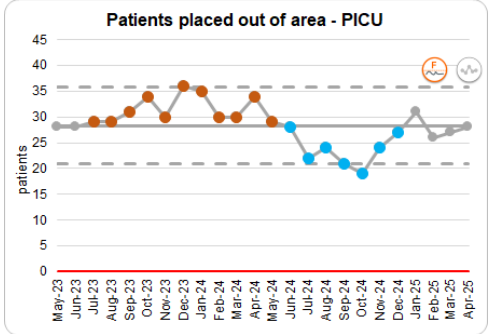


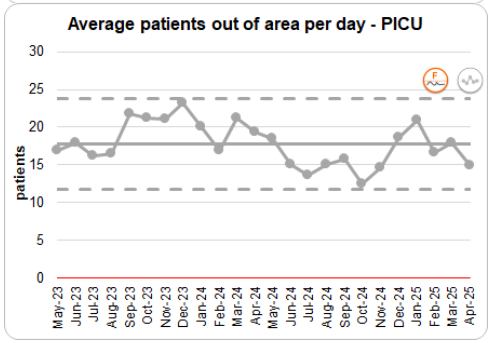
Recovery action plan
- A comprehensive recovery action plan has been developed and is being implemented.
- Step down beds to help with discharge flow and crisis house beds are being utilised to help avoid admissions where safe to do so.
- The crisis teams continue to work with higher than usual caseloads to avoid admissions to hospital wherever possible and appropriate.
- The Trust Strategic Integrated Flow Lead and Medical Lead for Clinical Transformation continue to support the improved flow of patients into and out of hospital.
- Changes to the learning disability & autism patient pathway to improve assessment and decision making have been implemented which have helped to manage this to ensure community alternatives are explored prior to admission.
- A twice weekly mini-MADE and MADE event is in place to ensure reduction in CRFD and able to escalate to Super-MADE where required.
- Gatekeeping has been implemented to provide a multi-agency response to the admission challenges.
- Implementation of community based Clozaril initiation, avoiding the need for admission to hospital.
- Enhanced impact of the emotional regulation pathway to support prevention of admission to hospital and/or facilitate early discharge.
- Derbyshire Mental Health Response Vehicle implemented in October 2024. This consists of one vehicle staffed by a paramedic and a mental health nurse.



Recovery action plan (cont.)
- The establishment of MAST in CMHTs ensuring focused input to those of greatest need and at greatest risk of admission.
- Development and implementation of criteria led discharge guidance.
- Challenge and confirm process incorporated into review of out of area patients.
- Challenge and confirm process incorporated into reviews for patients with LOS over 60 days.
- Daily dashboard generated providing breakdown of performance daily.
- Weekly multidisciplinary review of key performance data on the ward dashboard
- Estimated discharge date established during admission process and discharge planning to start at point of admission.
- Derbyshire ICB have set a target of maximum delayed discharge being 24 hours. At the moment the average delayed discharge is 65 days with between 20 and 30 patients identified as “delayed discharge” at any one time.
- Creating capacity to repatriate PICU patients when appropriate to do so and a reduction in requirement for psychiatric intensive care.

By when we will have recovered the position
- End of quarter 2, 2025/26.





Summary
The Mental Health Flow Escalation Meeting oversees the progress of the action plan on a fortnightly basis.

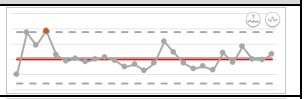
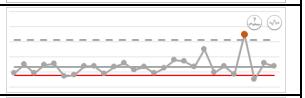
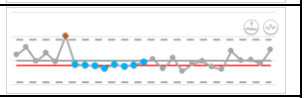
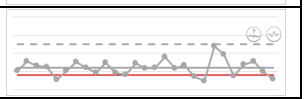
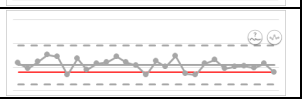
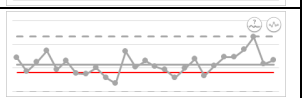
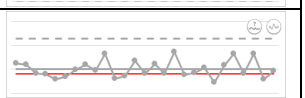
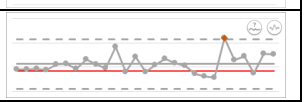
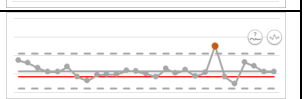
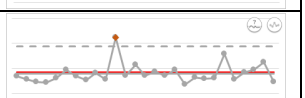
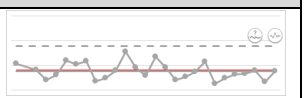
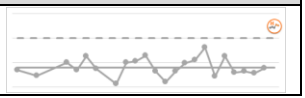
The admission rate to out of area beds continues to reduce with a significant reduction in March.

The average number of patients in out of area beds also continues to reduce with a notable reduction in March.

This improved flow is also positively impacting patients in PICU as there has been a reduction in the number of patients placed in PICU during the month.

Operational Performance

Occupancy & length of stay (days)

Clinical area	Beds	Bed occupancy Nov-24	Average duration of stay to date of current patients		Average length of stay Apr-25 discharged		Change versus previous month discharged		Change over time – mean length of stay of discharged inpatients
Adult Acute			Mean	Median	Mean	Median	Mean	Median	
Morton/ Willow	18	100%	46	39	47	29	↗	↘	
Pleasley/ Sycamore	18	105%	56	41	70	59	↘	↗	
Tansley/ Oak	18	103%	86	45	73	48	↗	↗	
Ward 33	20	99%	71	41	30	26	↘	↘	
Ward 34	20	102%	52	27	39	34	↘	↘	
Ward 35	20	110%	95	48	66	33	↗	↘	
Ward 36	21	104%	70	34	46	35	↗	↗	
Older People									
Bluebell	12	101%	78	47	157	96	↗	↗	
Cubley Female	18	75%	50	32	152	146	↘	↗	
Cubley Male	18	94%	92	81	110	110	↘	↘	
Tissington	18	96%	83	60	47	49	↘	↘	
Perinatal									
The Beeches	6	63%	25	13	38	30	↗	↗	
Rehabilitation									
Cherry Tree Close	23	83%	372	362	n/a	n/a	n/a	n/a	

Explanatory note: where occupancy is over 100% this means that patients are on periods of trial home leave and their beds are being used for new admissions while they are at home. Leave beds used are predominantly safe planned leave, so leave would normally be extended, where safe to do so, to prevent 2 patients being in one bed. Patients are encouraged to not spend too much time in their room, so even if a patient was to return, there would be the day to look at where beds could be shifted around. It is a constant daily challenge for the Bed Management Team, who do a sterling job. NB low secure have been removed from the table as the number of discharges is very infrequent.

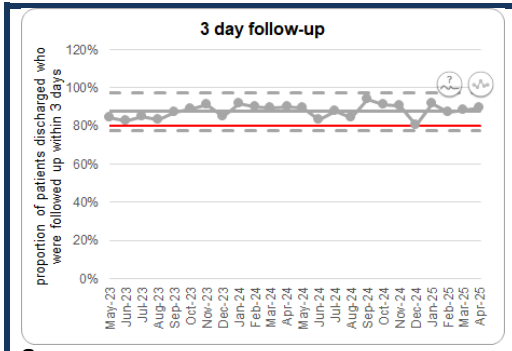
Research based on Erlang's queuing theory suggests that with the size of our bed base there should be a maximum occupancy of 85% in order to have readily available beds to enable management of acutely ill patients to occur in a safe and appropriate setting, and in order to protect both patients and staff from untoward incidents arising from busyness. https://www.priory.com/psychiatry/psychiatric_beds.htm

ICB national length of stay reduction target 2025/26
This is the mean of patients discharged in the previous 3 months, based on NHS Derby & Derbyshire ICB GP-registered patients, for those aged 18 and over discharged from adult acute, older adult acute and psychiatric intensive care unit (PICU) beds.
Latest NHSE published data - February 2025 position:

- **Trust = 67 days**
- **ICB = 71 days**

The Trust's target is to reduce to 55 days by financial year end March 2026.

Operational Performance

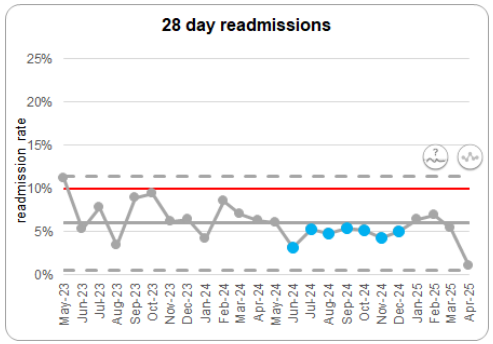


Summary

Patients are followed up in the days immediately following discharge from mental health inpatient wards to provide support and to ensure their wellbeing during the period when they are potentially at their most vulnerable. The national standard for follow-up has been exceeded throughout the 24-month data period.

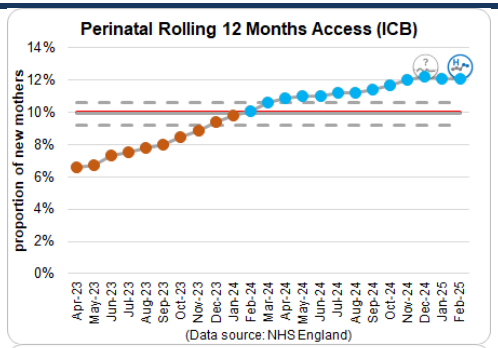
Actions

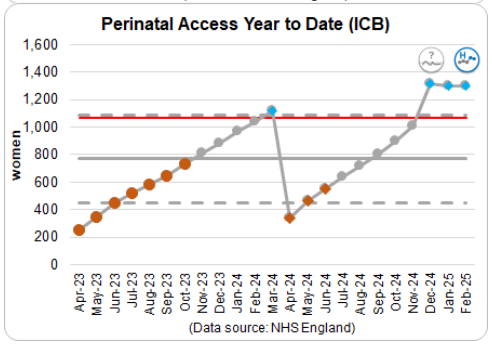
- Ongoing regular audit of follow-ups to ensure improved accuracy of reporting.
- Ongoing completion of breach reports for any follow-ups that were not achieved to enable learning of any lessons from breaches.



Summary

The rate of patients readmitted within 28 days of discharge from inpatient wards has remained within common cause variation throughout the reporting period and below the 10% contractual target for the vast majority of the time.





Summary

The service continues to exceed the 10% access target: rolling access rate is currently 12.1%. The service is now fully recruited to and has specialist assessor roles in place. Accepting self-referrals and developing an outreach workstream is improving inclusive, parity of access. There is a consistently high demonstrable demand for the service. The service is currently refining clinical pathways to ensure that wait times are managed effectively. Completion of assessments within the maternal mental health service (MMHS) and psychology are lower than initially projected owing to length of stay on caseload and workforce challenges.

Actions needed to maintain target

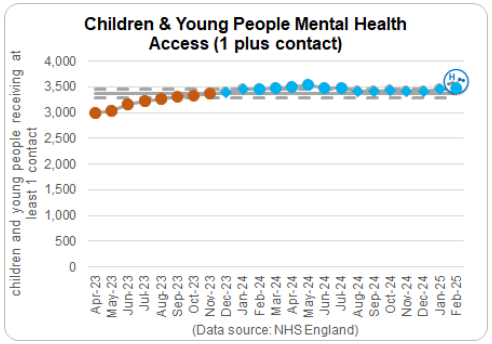
- Ensure that referrals meet inclusion thresholds to meet demand
- Service to continue strategic direction to address health inequalities and potential barriers to access.
- Waiting list to continue to be monitored by RAP and monthly exception report
- Service to refine clinical pathways
- MMHS and psychology team to increase capacity to assess and manage wait times for the service.

Regional comparison February 2025

Perinatal access – rolling 12 months

Organisation Name	Measure Value STR	LTP Trajectory STR	LTP Trajectory Percentag..
NHS SHROPSHIRE, TELFORD AND WREKIN ICB	810	501	162%
NHS DERBY AND DERBYSHIRE ICB	1,330	1111	120%
NHS NORTHAMPTONSHIRE ICB	990	905	109%
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICB	795	781	102%
NHS COVENTRY AND WARWICKSHIRE ICB	1,050	1045	100%
NHS BIRMINGHAM AND SOLIHULL ICB	1,945	1953	100%
NHS LINCOLNSHIRE ICB	725	742	98%
NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	1,215	1259	97%
NHS NOTTINGHAM AND NOTTINGHAMSHIRE ICB	1,245	1298	96%
NHS BLACK COUNTRY ICB	1,500	1585	94%
NHS STAFFORDSHIRE AND STOKE-ON-TRENT ICB	1,120	1215	92%

NHS Derby & Derbyshire ICB was the 2nd highest performing in the region, achieving 120% against the long-term plan trajectory.



Summary

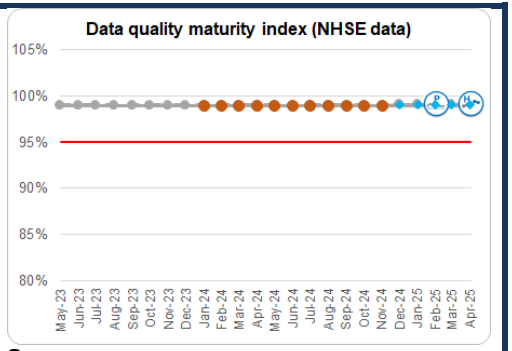
Performance has remained significantly high since December 2023.

Regional comparison February 2025

C&YP access 1 plus contact

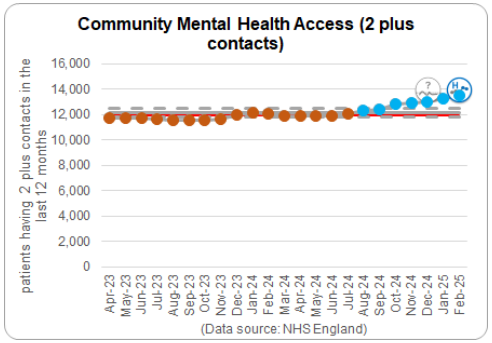
Organisation Name	Measure Value STR	LTP Trajectory STR	LTP Trajectory Percentag..
NHS NOTTINGHAM AND NOTTINGHAMSHIRE ICB	20,630	16124	128%
NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	17,870	14553	123%
NHS NORTHAMPTONSHIRE ICB	10,260	9600	107%
NHS DERBY AND DERBYSHIRE ICB	14,715	14463	102%
NHS COVENTRY AND WARWICKSHIRE ICB	12,985	12972	100%
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICB	11,555	11865	97%
NHS STAFFORDSHIRE AND STOKE-ON-TRENT ICB	15,300	17273	89%
NHS BLACK COUNTRY ICB	17,715	20240	88%
NHS BIRMINGHAM AND SOLIHULL ICB	19,545	24834	79%
NHS SHROPSHIRE, TELFORD AND WREKIN ICB	6,470	8341	78%
NHS LINCOLNSHIRE ICB	9,250	11829	78%

NHS Derby & Derbyshire ICB was the 4th highest performing in the region, achieving 102% against the long term plan trajectory.



Summary

The level of data quality is consistently higher than the required standard. Work is in progress to correct many incorrectly recorded patient contacts which are impacting on reported waiting times.



Summary

NHSE have published data for the current financial year 2024/25 up to January 25, which demonstrate that the target level activity has been achieved, and this high level has sustained for months.

Regional comparison February 2025

Community mental health 2 plus contacts

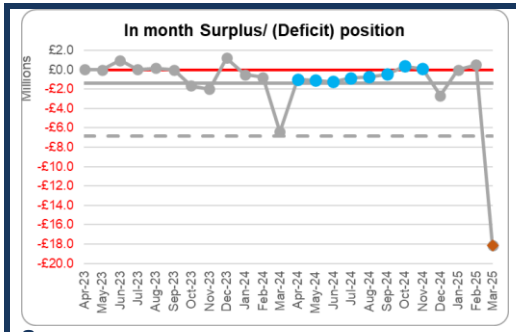
Organisation Name	Measure Value STR	LTP Trajectory STR	LTP Trajectory Percentag..
NHS BIRMINGHAM AND SOLIHULL ICB	25,235	10486	241%
NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	14,695	6935	212%
NHS NOTTINGHAM AND NOTTINGHAMSHIRE ICB	15,675	8138	193%
NHS DERBY AND DERBYSHIRE ICB	13,850	7463	186%
NHS BLACK COUNTRY ICB	15,200	8722	174%
NHS NORTHAMPTONSHIRE ICB	8,445	5026	168%
NHS STAFFORDSHIRE AND STOKE-ON-TRENT ICB	11,860	7970	149%
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICB	8,010	5361	149%
NHS LINCOLNSHIRE ICB	7,675	5509	139%
NHS SHROPSHIRE, TELFORD AND WREKIN ICB	4,345	3459	126%
NHS COVENTRY AND WARWICKSHIRE ICB	8,165	6499	126%

NHS Derby & Derbyshire ICB was the 4th highest performing in the region, achieving 186% against the long term plan trajectory.

NHS
Derbyshire Healthcare
NHS Foundation Trust

Finance

Financial Performance

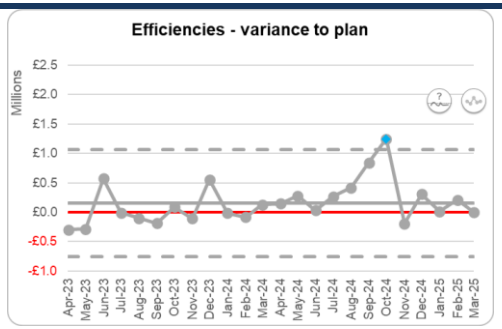


Summary

At the end of the financial year, the unadjusted outturn was a deficit of £25.3m.

However, taking into account the following technical adjustments, the adjusted financial position was breakeven against an adjusted plan of £6.4m deficit:

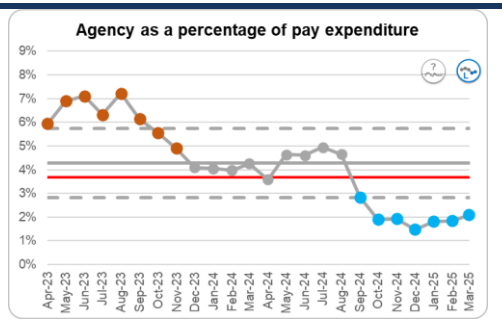
- Impairments, where the value of a building has been reduced by £24m which related to the Making Room for Dignity programme, the plan included impairments of £35m
- Peppercorn rent costs accounted for within the position but adjusted back out of the position
- Public Finance Initiative (PFI) adjustment related to the International Financial Reporting Standards (IFRS) 16 accounting change



Summary

The plan included an efficiency requirement of £12.5m with a proportion phased from quarter 2. The plan assumes 71% of the savings are delivered recurrently.

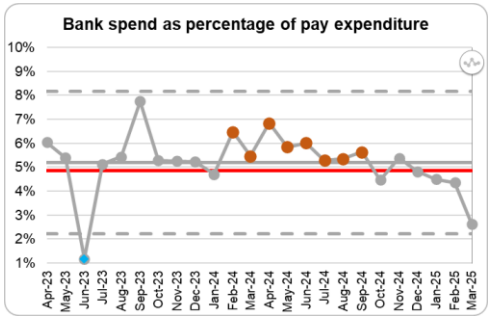
At the end of the financial year, the efficiency requirement was delivered in full.



Summary

Agency expenditure at the end of the financial year totalled £5.1m which is below plan by £1.2m. This includes £1.2m of additional costs to support a patient with complex needs (ceased at the beginning of September). Excluding that cost the agency expenditure would be below plan by £2.4m.
The agency expenditure as a proportion of total pay for March is 2.1%.

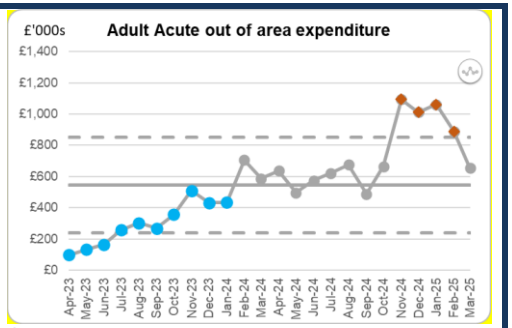
There has been a significant reduction in agency expenditure since July, with December being the lowest for the financial year.
The two highest areas of agency usage continue to relate to consultants and nursing staff.



Summary

Bank expenditure totalled £8.6m, which was within plan. The bank expenditure as a proportion of total pay for March is 2.6%.

Some of the additional staff on the wards in relation to CQC actions are through bank use, where the plan was set against agency.

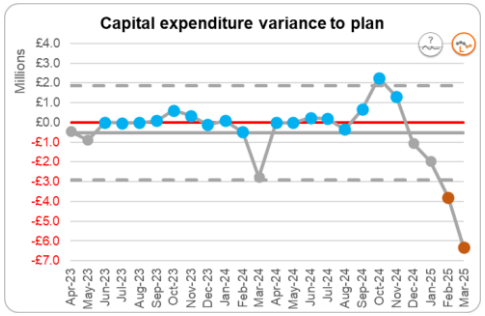


Summary

The plan for out of area expenditure is based on a reducing trajectory from twenty-two to zero beds by the end of the financial year. In addition to this the plan also included a further 6 block beds for part of the financial year.

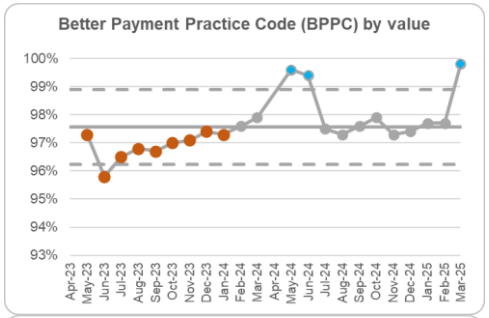
At the end of the financial year £10.5m has been spent on Adult Acute out of area placements, which was £5.7m above the plan.

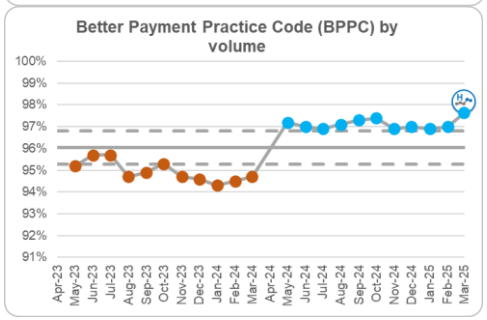
Financial Performance



Summary
Capital expenditure against the system capital allocation at the end of the financial year was above plan by £3.7m. This reflects the additional costs in relation to the Making Room for Dignity (MR4D) programme, of which some costs have been mitigated from pausing existing planned schemes.

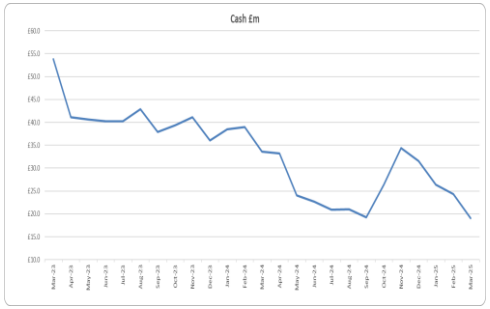
The centrally funded schemes out turned to the agreed allocation.





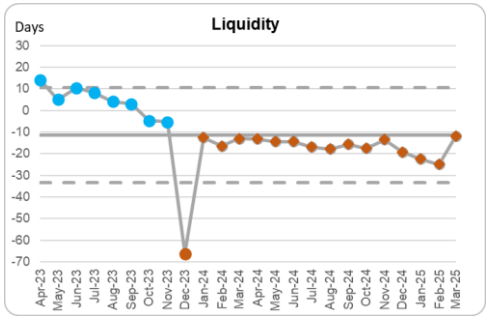
Summary
The Better Payment Practice Code (BPPC) sets a target for 95% of all invoices to be paid within 30 days. BPPC is measured across both invoice value and volume of invoices.

At the end of March, both the value and volume of invoices exceeded the target at 97.9% and 97.1% respectively.



Summary
Cash at the end of March was at £19.1m (£24.3m last month) which was on plan.

The cash increase in November was due to the timing of the VAT rebate on the MR4D programme.

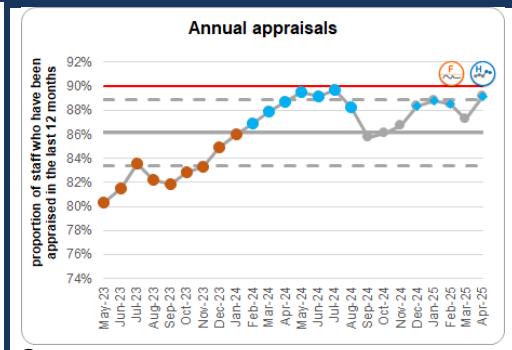


Summary
The chart above shows the liquidity levels over the last two years. Liquidity levels were high in 2021/22, however in 2022/23 the liquidity reduced due to the timing of cash receipts related to the centrally funded capital scheme for the MR4D programme. The Public Dividend Capital (PDC) drawdown requests caught up in January 2024 which increased the level back up. Drawdown requests are transacted monthly which has stabilised liquidity levels during 2024/25.

Derbyshire Healthcare
NHS Foundation Trust

People

People Performance

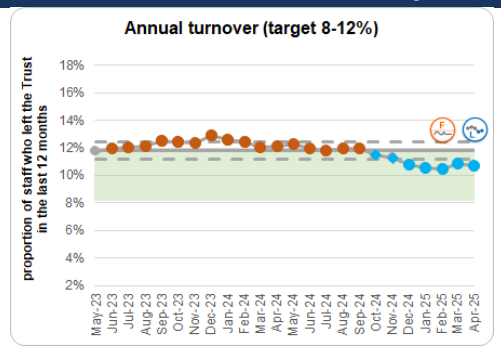


Summary

Overall, performance remains slightly below target. Operational Services are currently just above 90% and Corporate Services at 84%, against the target of 90%.

Actions

- Work has been undertaken to understand why there are challenges within corporate services to achieve full compliance. As a result, a shortened version of the appraisal is being developed for estates and facilities and team appraisals are being considered to support the division.
- A new IT function is now operating to automatically notify and send calendar reminders to both appraiser and appraisee
- Targeted emails from the DOP and CEO are being sent to managers where compliance remains consistently below target.
- Appraisal data is being used with other key people performance metrics to identify hotspot areas and bespoke targeted OD work is being commissioned.

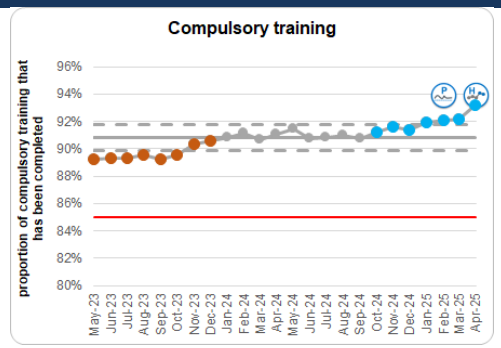


Summary

Overall turnover has been on target for the last 11 months and remains in line with national and regional comparators.

Actions

- The review of staff benefits to support engagement and retention has been completed. One of the key components of the review was the Trusts salary sacrifice schemes. The scheme was re-launched in August 2024 and is proving extremely popular with our colleagues.
- The Trust continues to run a vacancy control panel to monitor all recruitment activity.
- Stay surveys are now becoming embedded in a retention programme at 3,6 and 9 months to ensure managers and colleagues are supported to address any early concerns and to support retention.



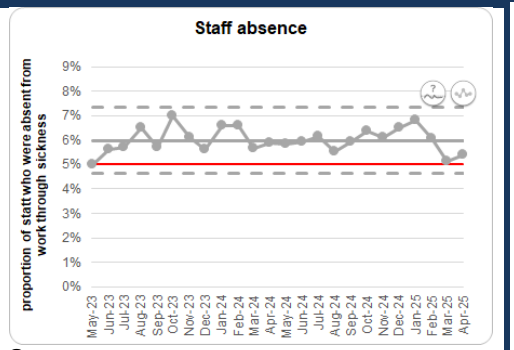
Summary

Overall, the 85% compliance target has been achieved for the last 24 months. Operational Services are currently 94% compliant and Corporate Services are 90%.

Actions

The following actions remain in place to support achievement of compliance:

- A review and monitoring of all 'did not attend' (DNA's) occurrences is regularly fed back to ensure all employees re-book in a timely manner.
- A targeted campaign of prioritising compulsory training elements that have been out of date the longest has been undertaken.
- The Training and Education Group continue to oversee and review training compliance, changes and challenges.



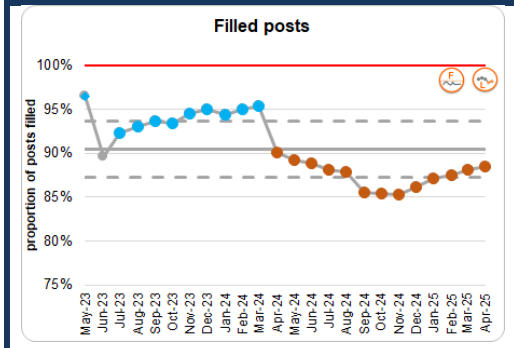
Summary

The monthly sickness absence rate in April was 5.4%, consisting of 2.59% short term absence and 2.81% long term absence. Anxiety, stress or depression related illness remains the highest reason for sickness absence, followed by other musculoskeletal problems and Cold, Cough, Flu – Influenza.

Actions:

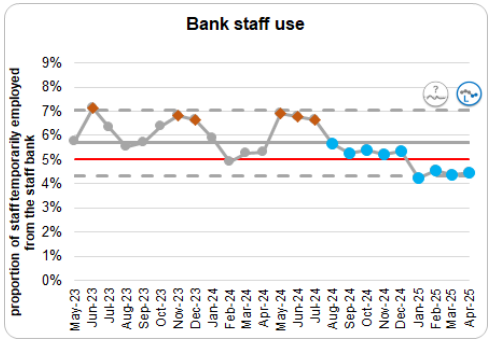
- A review continues to take place with a view to ensure early intervention takes place at an earlier stage.
- All long-term absences are reviewed each month with the Director of People, Organisational Development & Inclusion and the Employee Relations to ensure a supportive and robust approach continues to be taken to managing all absences.

People Performance

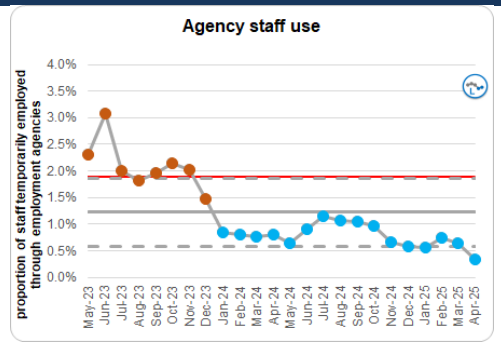


Summary
At the end of April 2025, 88% of posts overall were filled. At the start of the financial year, new investment is released which creates brand new vacancies. This year will see a staged adjustment to vacancies throughout the year as service developments and cost improvement programmes are delivered.

Actions
- Work continues towards planning and recruiting into the Trust's key transformation project 'Making Room for Dignity' programme.

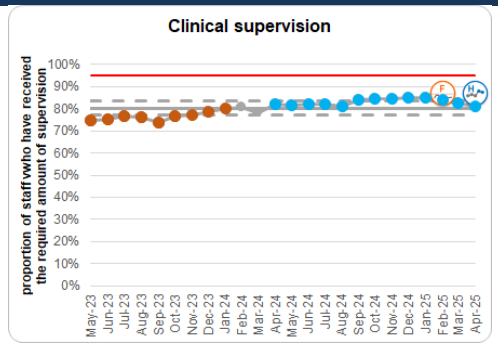


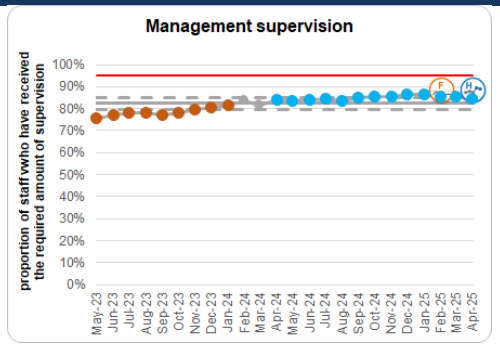
Summary
The proportion of staff employed from the bank ranges from 4-7% per month. Bank staff are predominantly working on inpatient wards. Reasons for temporary staffing include cover for vacancies, sickness and for increased levels of observations.



Summary
Agency usage has reduced significantly over recent months and continues to fall following a temporary increase in agency usage due to a requirement for increased clinical observations.

Actions
The actions previously identified below, continue to remain in place and operate as business as usual.
- Weekly Authorisation Panel continues to oversee agency requests across the Trust.
- All admin and clerical agency usage remains eliminated.
- Clear protocols are in place to cover the circumstances where the various levels of agency workforce (including Thornbury) relate to enhanced, safer and emergency staffing levels.
- Ongoing actions are taking place to support the reduction in medical agency, these include creative recruitment campaigns, alternative workforce roles where appropriate and continued increase of availability of temporary staffing through the Trust's medical bank function.
- Work continues with the NHSE National Price Cap Compliance programme, which aims to deliver agency supply at price cap or below.





Summary
Overall compliance is 84% management supervision and 81% for clinical supervision.

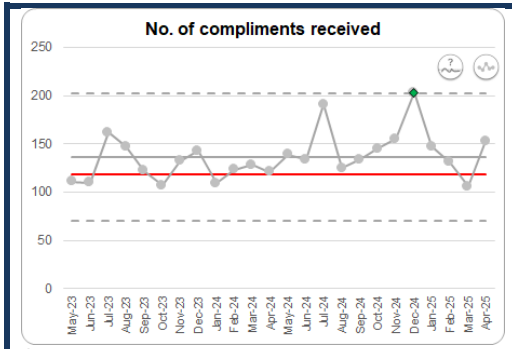
Actions
Following an audit of supervision processes, the Trust is now following up on the recommendations which should help towards achieving its target for both clinical and non-clinical supervision. In addition, efforts continue to work with Teams with low compliance and rates are expected to increase over the coming month.

The audit recommendations include:
- the Supervision Policy and consider whether a full review/refresh is required based on the findings in this report and the responses to the survey of Trust staff
- arrangements for documenting and recording supervision to ensure these are clearly outlined within the policy and ensure these responsibilities and communicated and compliance is monitored
- training arrangements for supervisors
- governance arrangements in place to monitor supervision compliance to ensure forums are in receipt of sufficiently detailed reports to oversee and scrutinise performance of all types of supervision
- the actions in place to improve supervision and the performance reporting in place to ensure these are consistent across Operational and Corporate Services
- reporting across the Trust covers all areas of supervision required as outlined within the Trust's policy. minimal supervision expectations and how these are allocated throughout the year and update reporting to reflect this requirement to assess compliance.

Derbyshire Healthcare
NHS Foundation Trust

Quality

Quality Performance

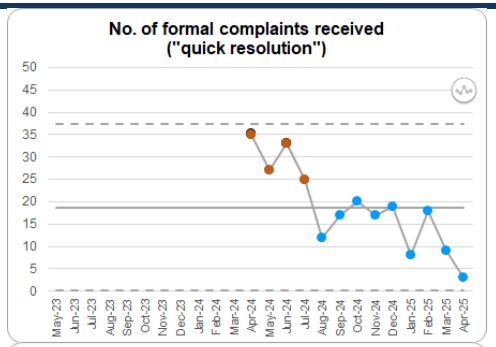


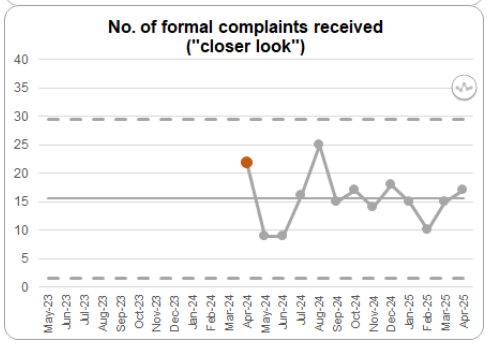
Summary
The number of compliments recorded between January and April 2025 is following a pattern of common variation and is currently above the Mean of 140 compliments recorded.

Actions
The Head of Nursing/Practice team continue to monitor this data via the quarterly patient and carer experience report and have identified actions to improve the gathering of compliments.

However, it is noted that all services would benefit from improving the recording of compliments as it is clear from looking at trust provision such as the delivering everyday excellence (DEED) awards that compliments received are not accurately recorded.

The Heads of Nursing/Practice will attend their Divisional Clinical Reference Group (CRG) to explore the barriers of getting feedback from services and the progress will continue to be monitored.

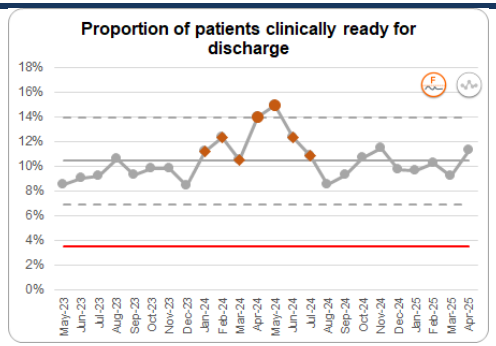




Summary
The number of complaints Identified as “quick resolution” (QR) has been on a downward trajectory since February 2025. This is due to a backlog of QR complaints waiting to be logged on the system and will likely increase over the next 3 months.

The complaints categorised as “closer look”, which involve a Trust commissioned investigation, have followed a pattern of common cause variation and will continue to be monitored by the Patient Experience Team.

Actions
The Patient Experience Team Log and monitor complaints and where specific themes are identified, these are passed on to the HoN/P Team and explored in a quarterly thematic analysis Patient and Carer Experience Committee report which is sent to both the Patient and Carer operational group and the Trust Quality and Safeguarding Committee for assurance.

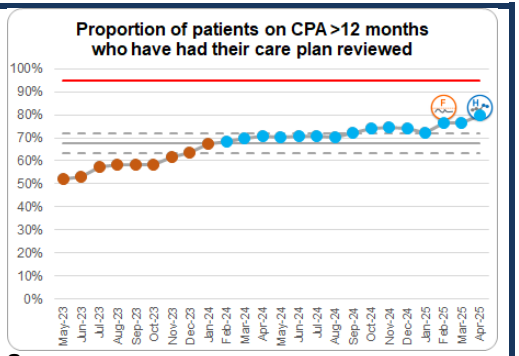


Summary
The proportion of service users meeting the criteria of Clinically Ready for Discharge (CRD) has followed a pattern of common cause variation between January and April 2025.

The most common reason for patients meeting the criteria for CRD continues to be a lack of available, appropriate housing, establishing funding, and availability of social care placements.

Escalation processes and partnership support

- Twice weekly Multi agency Discharge event (MADE) meetings with ICB, DHcFT Directors, the Head of Social Care, Continuing Health (funding panel members) and Housing take place to discuss any barriers to discharge and support resolution.
- In addition to MADE, a 72 hour admission review meeting is being introduced from July 2025 as a vehicle to support early engagement with the persons family/ carers and teams in involved in post discharge support. The 72 hour admission review meeting will also identify any potential barriers to discharge and enable escalations to support discharge to take place as early as possible. This is expected to reduce delays in discharge and reduce the number of patients who become clinically ready for discharge whilst an exit plan is being secured.

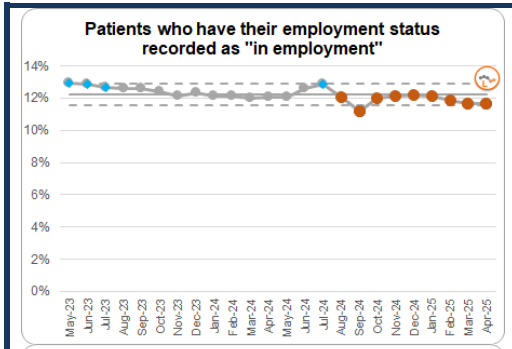


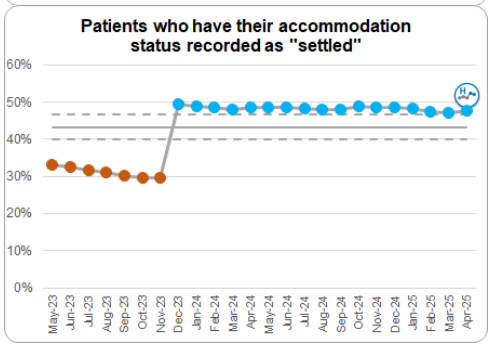
Summary
The current percentage of patients who have had their care plan reviewed and have been on CPA for over 12 months is 86%. The trust target is 95% compliance however compliance continues to improve month on month with a 12% improvement between since January 2025. It is expected that CPA compliance will reach the 95% target by the next report in August 2025.

Actions

- The Trust services with compliance lower than 85% have identified action plans to improve care plan, risk screen and CPA compliance and weekly quality performance “crosscheck” meetings was established in the working age adult community division In April 2025 and will be commenced in the Older People’s services in May 2025.
- The Trust Digital Practice team sent out “quick user guides” to services and offer drop-in sessions to support staff in inputting information correctly.

Quality Performance



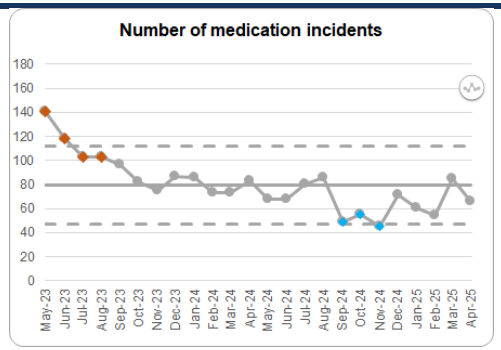


Summary

Patients open to the Trust in settled accommodation has remained static at 49% between August and November 2024 and the number of patients open to employment has continued to remain between 11 and 13 percent since August 2022. This measure continues to be monitored by individual services.

Actions

- A report has been developed which informs teams if there are gaps in the current Data Quality Maturity Index information recorded on referral and Ward and Service Managers have been asked to review this report weekly and action any gaps identified. This is monitored via monthly service specific operational meetings and employment support will be included in the Community mental health team quality improvement plan.

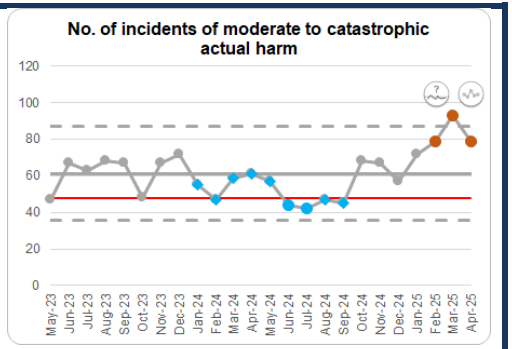


Summary

The number of medication incidents between January and April 2025 have followed a pattern of common variation and the mean has reduced from 90 to 80 due to a sustained reduction in incidents. The number of incidents is expected to continue in this pattern, and it should be noted that the medication incidents reported are largely of low-level harm with the largest proportion of storage incidents related to temperature monitoring and excursions.

Actions

- The Trust Pharmacy team have introduced a monthly medicine incident group to review trends and themes to support lessons learnt
- To improve medicine temperature monitoring a task and finish group including Heads of Nursing, pharmacy and clinical leads started in January 2024 has continued and is expected to reduce the number of incidents recorded following its conclusion. The scrutiny provided by this group is likely impacting on incidents not going over 90 since January 2025 and each division has been asked to develop a improvement plan to address area that require improvement.
- The Trust Pharmacy team are developing a Medicine Competency Assessment for staff administering medicines with a focus on the continuing trends identified in Datix including potting up medicines, ensuring prescriptions are robustly checked prior to each administration and importance of second check for injectable medicines. This is expected to sustain the trend of no major or catastrophic incidents since January 2025 and will further support the reduction of administration related incidents.
- The number of medication incidents is reviewed via the monthly medication management subgroup and is reported on within the quarterly thematic “Feedback Intelligence Group” (FIG) report by the Heads of Nursing/Practice and is included in the Serious Incidents Bi-monthly report. Any actions identified are reviewed via the medicines management subgroup and the Serious Incidents Bi-monthly report is taken quarterly to the Quality & Safety Committee (QSC) for assurance.



Summary

This data demonstrates the number of DATIX incidents recorded as moderate or catastrophic harm. The number of incidents increased between January and March 2025 but is on a reducing trajectory between March on April 2025.

Analysis suggests that this is due to an increase in the number of incidents reported by staff in the Adult Acute and Older People's services.

In the Adult acute service there is a sustained increase of incidences recorded as “self-harm” and in Older People Services, an increase in the number of “medical issues” reported.

An increase in the number of deaths reported in Substance misuse services has been noted which is consistent with the with the national picture.

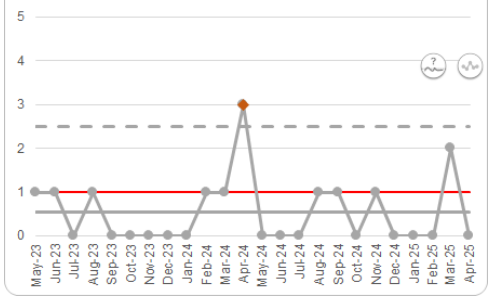
The Substance Misuse service are working in partnership with Drugs and Alcohol Related Deaths (DARD) Steering Group with the aim of improving prevention and education and working closely with CMHTs in developing effective interventions and support systems for service users with Co-occurring Mental Health and Alcohol/Drug Use Conditions.

This will be reviewed further and discussed with the patient safety team in relation to any themes or patterns and any learning fed back to teams via the divisional “learning the lessons meetings”

This will be monitored by the Patient Safety team and the Heads of Nursing/Practice.

Quality Performance

No. of incidents requiring Duty of Candour



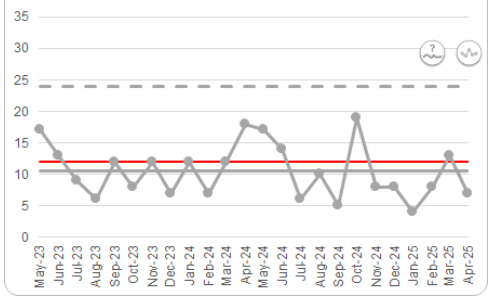
Summary
Two incidents between January and April 2025 required duty of candour disclosure.

The Trust Family Liaison Office has created information leaflets and standing operating procedures to support staff in completing Duty of Candour communications. Furthermore, these are reviewed twice weekly within serious incident groups.

The Trust Family Liaison Office has created information leaflets and standard operating procedures to support staff in completing duty of candour communications. Furthermore, these are reviewed twice weekly within serious incident groups.

Action
Training around accurately reporting DoC continues within clinical teams and the Family Liaison Officer with support from the patient safety team review each DoC incident as they occur and request support from the HoN team as required.

No. of incidents involving prone restraint

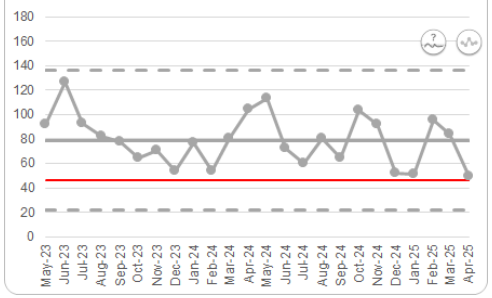


Summary
Incidents of prone restraint have continued within common cause variation between August and November 2024 and are currently below the Trust margin of 12 incidents.

The increase between January and March 2025 was attributed to a small number of unwell individuals who required multiple interventions and numbers have reduced in line with the recovery of these individuals

Action
This data is monitored via the monthly Reducing Restrictive Practise group and is presented for assurance to the Trust Mental Health Act committee and Quality and Safeguarding committee.

No. of incidents involving physical restraint

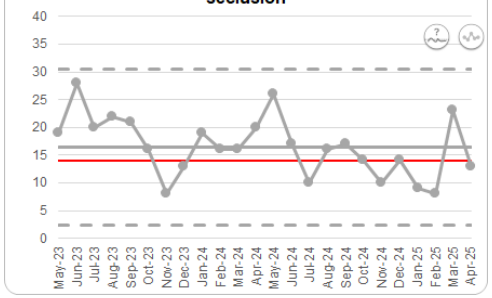


Summary
Physical restraints have continued to follow a pattern of common cause variation between January and April 2025 and continue above the Trust margin of 45 incidents. The highest peak between January and February 2025 is attributed to an increase in self-harm incidents in a small number of patients and a correlating increase in staff intervention required to prevent individuals from harming themselves.

Action
The Trust Positive and Safe Support team continues to offer supplementary training sessions to improve training availability for staff and compliance with positive and safe training continues to improve and is currently at 82% for teamwork and 77% for breakaway training. Compliance is likely to stay at this level due to a high number of staff being recruited who require the training related to the making room for dignity programme. However, from April 2025, a new induction booking process for new staff is in place and when these staff are in post and trained, it is expected that compliance will improve further.

Any staff who do not have a training enrolment date are emailed weekly and a weekly report is sent to Ward Managers and General Managers outlying any staff who require training or have not attended. This is monitored via the Training and Education Committee.

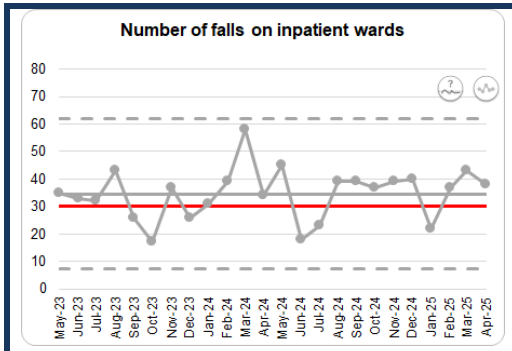
No. of new episodes of patients held in seclusion



Summary
The number of new episodes of patients held in seclusion increased between February and March 2025 but reduced in April 2024 to below the threshold of 14 episodes. This continues to follow a pattern of common cause variation. The increase in February 2025 could be related to the Derwent unit opening in March 2025 now having access to a seclusion suite when there was no access to a does it designated seclusion suite in the Hartington unit. This will be monitored via the Reducing Restrictive Practice group.

Action
- Episodes of seclusion will continue to be monitored via the monthly Reducing Restrictive Practice group.

Quality Performance



Summary

The number of falls recorded have continued above the Trust margin of 25 falls and have followed a pattern of common cause variation.

The number of falls recorded are attributed to higher than average occupancy of the Older Adult wards over the past 3 months and a sustained increase in frail patients who have high levels of physical care needs. An increase of patients with winter viruses/Infections requiring antibiotics between February and March 2025 was noted at the regional Falls Meeting and was attributed to a regional increase in falls. The highest number of falls are attributed to repeated incidents ascribed to a small group of patients with challenging conditions.

It should be noted that 93% of the falls recorded over this period were categorised as minor or insignificant meaning that no harm came to the individuals involved.

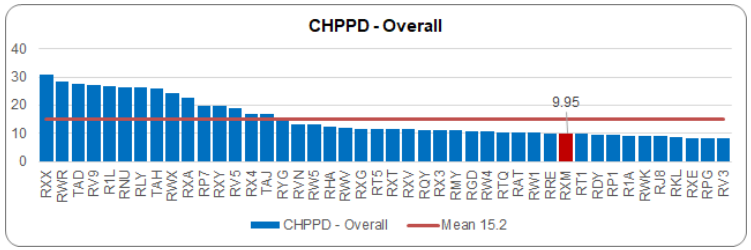
Actions

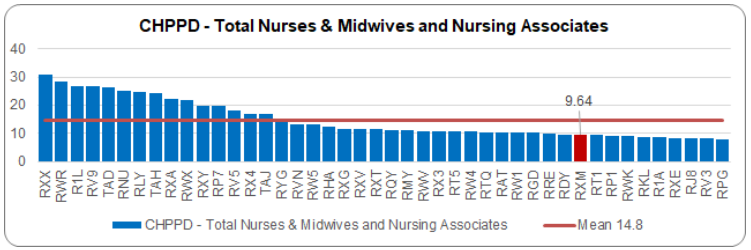
- The patients identified as high risk of falling are discussed in the biweekly falls prevention meeting and have fall prevention care plans in place
- Bed sensors are in place for those individuals deemed at the highest risk of falling
- The number of falls reported is monitored via the Falls Lead Occupational Therapist, Head of Nursing and Clinical Matron and learning from the bi-weekly falls prevention meeting is reviewed in the monthly Divisional COAT meeting.

Care Hours per Patient Day (CHPPD)

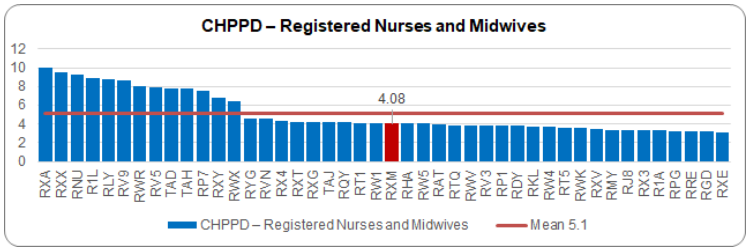
CHPPD is rolling data updated monthly, to show staffing levels in relation to patient numbers on an inpatient ward. Every month, the hours worked during day shifts and night shifts by registered nurses and midwives and by healthcare assistants are added together. Each day, the number of patients occupying beds at midnight is recorded. These figures are added up for the whole month and divided by the number of days in the month to calculate a daily average. Then the figure for total hours worked is divided by the daily average number of patients to produce the rate of care hours per patient day.

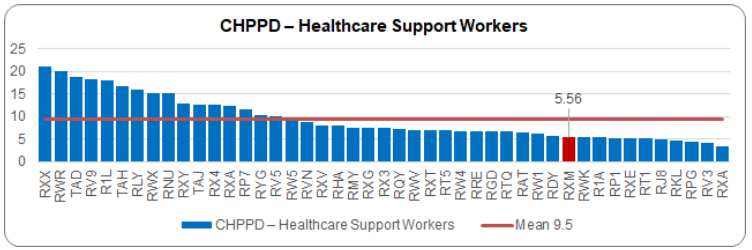
The charts below indicate that the Trust's CHPPD overall achieved 9.95 hours, which was well below average when benchmarked against other mental health trusts in the country (15.2). For total nurses and nursing associates the Trust achieved 9.64 hours against the national average of 14.8 hours:





For registered nurses the Trust achieved 4.08 hours against the national average of 5.1 hours. For healthcare support workers the Trust achieved 5.56 hours against the national average of 9.5 hours:



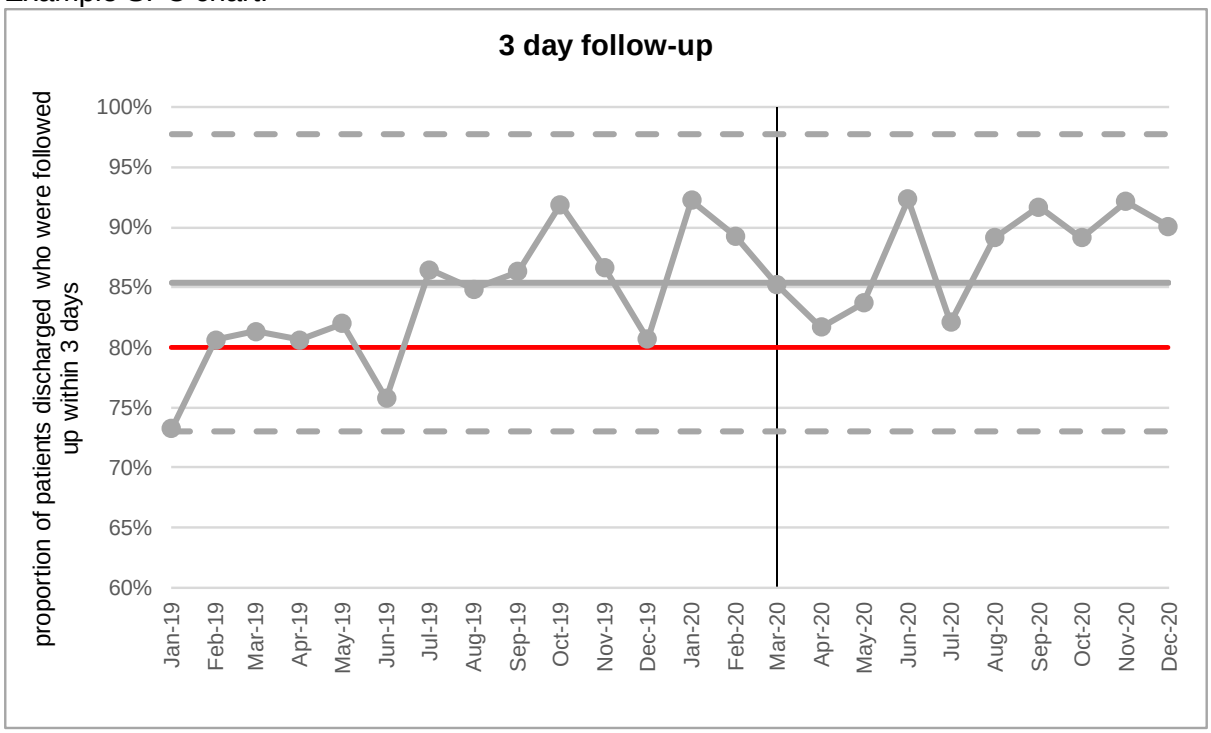


https://www.england.nhs.uk/publication/care-hours-per-patient-day-chppd-data/

Appendix 1

Statistical Process Control Chart (SPC) Guidance

Example SPC chart:



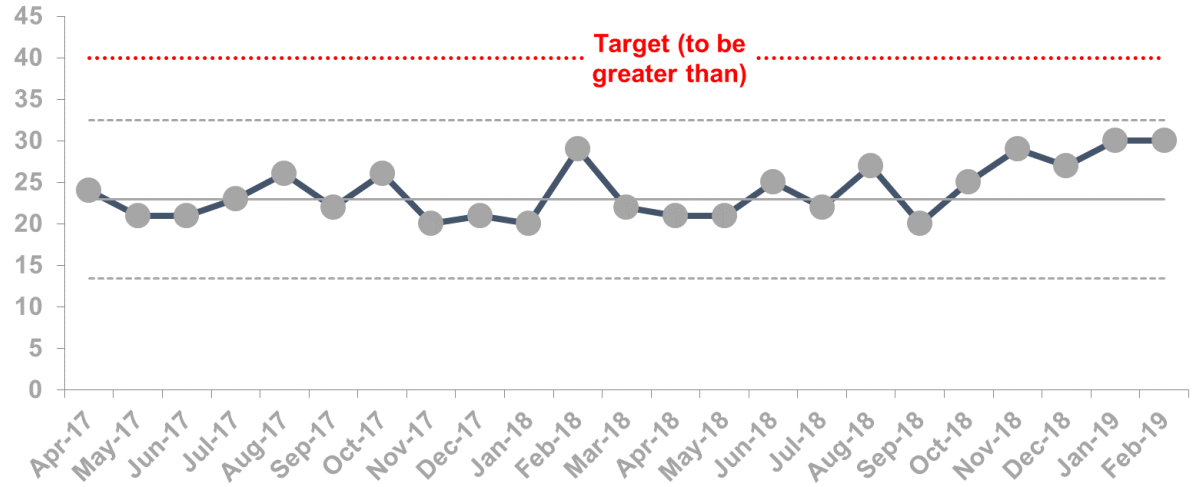
- The red line is the target
- The grey dots are the actual performance each month. They are coloured grey as performance each month is normal in this example
- The solid grey line is the average (mean) of all the grey dots
- The grey dotted lines are called process limits, or control limits.

Very simply, any grey dots sitting between the upper and lower grey dotted lines is normal performance for the process and is known as “common cause variation”.

The closer the two grey dotted lines are together, the less variation there is and therefore the more tightly controlled is the process.

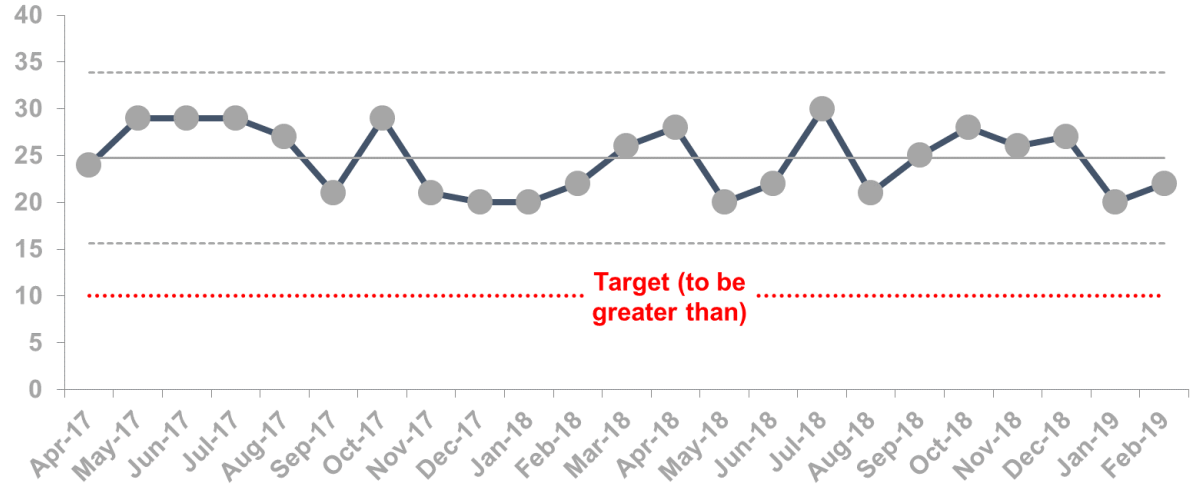
Things to look out for:

1. A process that is not working:



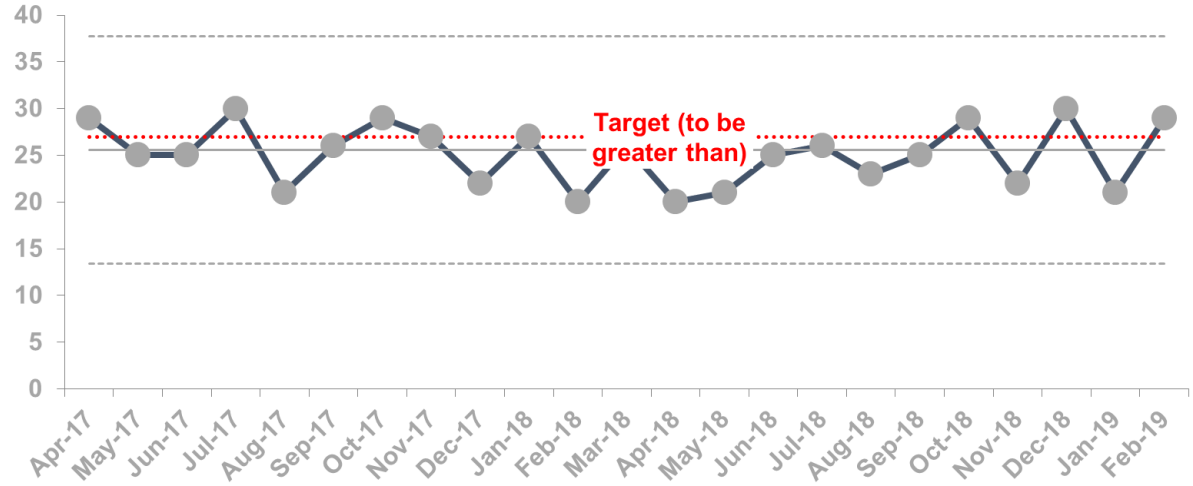
In this example the target is higher than the upper dotted grey line. This means that the target will never be achieved. To achieve the target, we need to change how we do things.

2. A capable process:



The lower grey dotted line is above the target line. This gives assurance that the target will consistently be achieved, and that the system is effective.

3. An unreliable system:

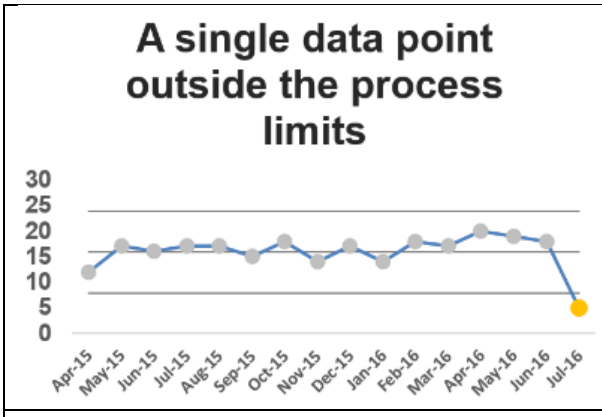
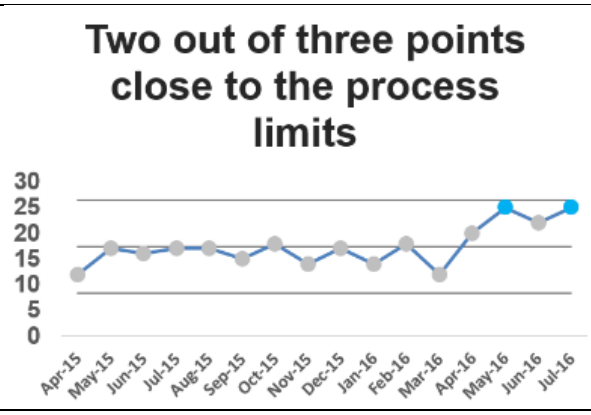
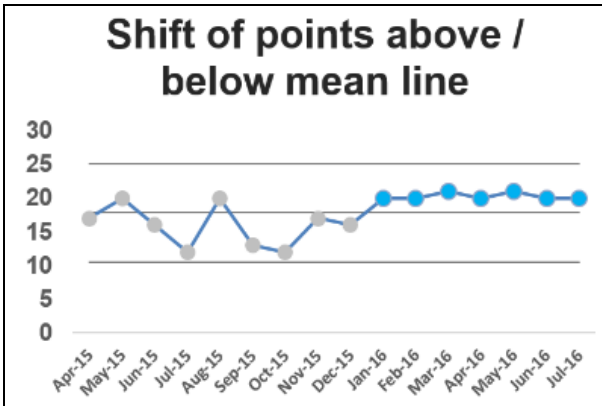
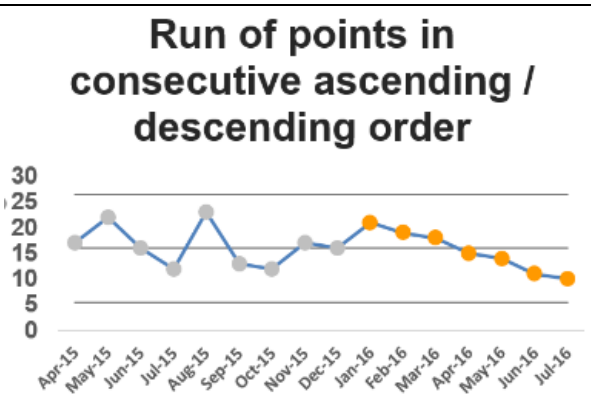


In this example, the target line sits between the two grey dotted lines. As it is normal for the grey dots to fall anywhere between the two dotted grey lines, this means that it is entirely random as to whether or not the target will be achieved. So, this system is unreliable and needs to be redesigned if the target is to be consistently achieved.

4. Unusual patterns in the data

If there is anything unusual in the data, the grey dots will change colour. Orange means it is unusually worse than expected and blue means it is unusually better than expected. These unusual patterns should be looked into to establish why it is happening.

There are four scenarios where this can happen:

<table>
<tr>
<td> 
</td>
<td> 
</td>
</tr>
<tr>
<td>In this example the July 2016 perfomance is significantly lower than expected and falls beneath the lower grey dotted line.</td>
<td>Two out of three points close to one of the grey dotted lines is statistically significant, in this case they are blue, indicating better than expected performance.</td>
</tr>
<tr>
<td> 
</td>
<td> 
</td>
</tr>
<tr>
<td>A run of seven points above or below the average line is significant. In this example it might indicate that an improvement was made to the process in Jan 2016 that has proven to be effective.</td>
<td>A run of seven points in consecutive ascending or descending order is significant. In this example things are getting worse over time.</td>
</tr>
</table>

Frequently seen in the NHS:

"**Spuddling**" - to make a lot of fuss about trivial things, as if they were important.
Spuddling leads to tampering and tampering nearly always increases variation.

Sometimes the first and most important thing we need to react to is the degree of variation in a process.

(Adapted from guidance kindly provided by Karen Hayllar, NHS England)

Appendix 2

Assurance Ratings

- **Full Assurance** can be provided that the system of internal control has been effectively designed to meet the system's objectives, and controls are consistently applied in all areas reviewed
- **Significant Assurance** can be provided that there is a generally sound system of control designed to meet the system's objectives. However, some weakness in the design or inconsistent application of controls put the achievement of particular objectives at risk
- **Limited Assurance** can be provided as weaknesses in the design or inconsistent application of controls put the achievement of the system's objectives at risk in the areas reviewed
- **No Assurance** can be provided as weaknesses in control, or consistent non-compliance with key controls, could result [have resulted] in failure to achieve the system's objectives in the areas reviewed.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 June 2025

Year-end Financial Position – 2024/25

Purpose of Report

This paper provides an update on the financial position for 2024/25.

Executive Summary

The overall financial outturn for 2024/25 was a deficit of £25.3m against a planned deficit of £42.0m. After technical adjustments the outturn position is breakeven against a deficit plan of £6.4m.

	Plan £'000s	Actual £'000s
Surplus / (deficit) for the period	**(42,032)**	**(25,280)**
Add back all I&E impairments / (reversals)	35,200	23,998
Surplus / (deficit) before impairments and transfers	**(6,832)**	**(1,282)**
Retain impact of DEL I&E (impairments) / reversals	(200)	(139)
Remove capital donations / grants / peppercorn lease I&E impact	0	(1,063)
Remove PFI revenue costs on an IFRS 16 basis	6,467	7,973
Add back PFI revenue costs on a UK GAAP basis	(5,819)	(5,488)
Adjusted financial performance surplus / (deficit)	**(6,384)**	**1**

The previous month's forecast was a reduced deficit of £2.9m which was driven by internal mitigations from non-recurrent benefits of £2.1m and additional non-recurrent income of £1.4m from the ICB.

A further allocation of non-recurrent income from the ICB was made in March bringing the previous forecast deficit of £2.9m to breakeven. All internal mitigations and income is non-recurrent in nature and therefore the underlying deficit of £6.4m remains going into 2025/26.

The £12.5m efficiency programme did deliver in full.

Agency continues to remain at lower levels.

Draft annual accounts were submitted on 25 April and are subject to audit review with final accounts due on 30 June.

Strategic Considerations	
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X

Risks and Assurances

The key risks relate to the Board Assurance Framework Risk on delivery of the financial plan which is currently at Extreme.

Consultation

- The financial position is discussed and signed off internally and reported to the Derbyshire system and NHSE
- A detailed finance report is provided to the Finance and Performance Committee.

Governance or Legal Issues

- Satisfactory financial and operational performance underpins many aspects of statutory, regulatory, and legal compliance for foundation trusts
- Failure to deliver the Trust financial plan to a material extent would likely have regulatory consequences.

Public Sector Equality Duty & Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

Cost improvement planning and any other transformation schemes all need to involve an appropriate quality and equality impact assessment in order to mitigate any risks that are identified in the schemes or actions being proposed such as identifying barriers, increasing the opportunities for positive outcomes for all groups, and fostering opportunities to bring different communities together.

Recommendations

The Board of Directors is requested to note the financial position for 2024/25.

Report presented by: **James Sabin**
Director of Finance

Report prepared by: **Rachel Leyland**
Deputy Director of Finance

2024/25 Outturn

At the end of March, the unadjusted financial position before technical adjustments was a deficit of £25.3m against a deficit plan of £42.0m.

	Plan £'000s	Actual £'000s
Surplus / (deficit) for the period	**(42,032)**	**(25,280)**
Add back all I&E impairments / (reversals)	35,200	23,998
Surplus / (deficit) before impairments and transfers	**(6,832)**	**(1,282)**
Retain impact of DEL I&E (impairments) / reversals	(200)	(139)
Remove capital donations / grants / peppercorn lease I&E impact	0	(1,063)
Remove PFI revenue costs on an IFRS 16 basis	6,467	7,973
Add back PFI revenue costs on a UK GAAP basis	(5,819)	(5,488)
Adjusted financial performance surplus / (deficit)	**(6,384)**	**1**

The following technical adjustments have been taken into account when reporting the adjusted financial position of breakeven against the deficit plan of £6.4m:

- Impairments, where the value of a building has been reduced by £24m which related to the Making Room for Dignity programme, the plan included impairments of £35m
- Peppercorn rent costs accounted for within the position but adjusted back out of the position
- Public Finance Initiative (PFI) adjustment related to the International Financial Reporting Standards (IFRS) 16 accounting change.

The forecast at month 11 was a deficit of £2.9m, due to £2.1m of required internal mitigations and £1.4m of cash backed income from the Integrated Care Board (ICB). However, in month 12, the ICB allocated another £2.9m of cash backed income which brought us to the breakeven position.

It is important to note that the £2.1m of internal mitigations are all non-recurrent, along with the £4.3m of additional income from the ICB, therefore the underlying deficit remains.

Temporary Staffing

At the end of March, agency expenditure was £5.1m, which was below plan by £1.2m. The main area of agency expenditure was on Consultants at £2.8m, £1.1m on qualified nursing and £1.1m on unqualified nursing. There has been a reduction on agency expenditure throughout the financial year and is significantly lower than the expenditure in previous years.

Agency spend by NHSI Staff Group
Mar-25

	% of spend	2024-25 Actual	2023-24 Actual	Change
Consultants, agency	55%	£2,808,986	£3,629,170	-£820,184
Career/staff grades, agency	0%	£0	£26,754	-£26,754
Trainee grades, agency	0%	£0	£35,697	-£35,697
Qualified nursing, midwifery and health visiting staff, agency	22%	£1,110,010	£2,994,326	-£1,884,316
Support to nursing staff	22%	£1,112,541	£1,958,436	-£845,895
Qualified scientific, therapeutic and technical staff, agency	0%	£0	£60,850	-£60,850
Managers and infrastructure support, agency	1%	£57,702	£119,333	-£61,631
Support to clinical staff, excluding support to nursing staff, agency	0%	£0	£0	£0
	100%	**£5,089,240**	**£8,824,567**	**-£3,735,327**
Contingency		£0	£0	£0
		£5,089,240	**£8,824,567**	**-£3,735,327**
2024-25 Plan		**£6,282,970**		
Expenditure below plan		**-£1,193,731**		
Expenditure % below plan		**-19.0%**		

Bank staff expenditure totalled £8.6m in 2024/25 which was within plan, a slight underspend of £35k. The main area of bank usage relates to the in-patient wards.

Efficiencies

At the end of the financial year the efficiency programme of £12.5m has been delivered in full, with 51% delivered recurrently:

Efficiency Savings	Plan 31/03/2025 YTD £'000	Actual 31/03/2025 YTD £'000	Variance 31/03/2025 YTD £'000
Recurrent			
Pay - Recurrent	7,482	5,625	(1,857)
Non-pay - Recurrent	1,335	676	(659)
Income - Recurrent	100	65	(35)
Total recurrent efficiencies	**8,917**	**6,366**	**(2,551)**
Non recurrent			
Pay - Non-recurrent	3,363	4,817	1,454
Non-pay - Non-recurrent	260	1,189	929
Income - Non-recurrent	0	168	168
Total non-recurrent efficiencies	**3,623**	**6,174**	**2,551**
Total Efficiencies	**12,540**	**12,540**	**0**

Adult Acute out of area

During 2024/25, £10.5m has been spent on out of area placements, which is £5.7m above plan. Expenditure increased in the period November to February but has seen a reduction in March.

Capital

At the end of the financial year, we were £3.7m above plan against the system capital allocation which is due to the residual Making Room for Dignity cost pressure after the original business as usual schemes have been scaled back to help provide some mitigation, agreed by the system.

The centrally funded schemes are out turning to the agreed additional funding, but the plan remains as the original submission.

Capital Scheme Desc	Full Year Plan 31/03/2025 Year ending £'000	Actual Outturn 31/03/2025 Year ending £'000	Variance 31/03/2025 Year ending £'000
Self Funded schemes			
IT Equipment	550	152	398
Anti-Ligature works	25	25	0
Backlog maintenance	490	506	(16)
Kingsway car parking	100	0	100
Cherry Tree Close Extention	500	9	491
Urgent Estate requests	150	124	26
Fire compartmentation works	400	0	400
Energy Management	75	0	75
Property Environment	75	0	75
Estate Staffing	240	255	(15)
MRFD - Bluebell Wards Additonal Costs		1,550	**(1,550)**
MRFD - Ashbourne Centre Kitchen Costs		500	**(500)**
MRFD - Audrey House Additional Costs		312	**(312)**
MRFD - AAU Additional Costs		2,822	**(2,822)**
Total CDEL (befroe IFRS16)	**2,605**	**6,255**	**(3,650)**
Centrally funded schemes PDC			
MR4D Radbourne Unit	4,780	4,780	**0**
MRFD - Bluebell Additional funding		510	**(510)**
MR4D PICU		760	**(760)**
Perinatal allocation (national funding)	0	27	**(27)**
Backlog Maintenance - Significant and high risk (CIR)	0	200	**(200)**
Backlog Maintenance - Significant and high risk (CIR)	0	400	**(400)**
Backlog Maintenance - Significant and high risk (CIR)	0	80	**(80)**
New Build - Multiple areas/ Other		393	**(393)**
Total central funding	**4,780**	**7,150**	**(2,370)**
Total capital plan submitted	**7,385**	**13,405**	**(6,020)**
Operating Leases			
CHP	193	179	14
External Providers - rent increases	500	538	(38)
Corbar view lease	300	0	300
Total Leases	**993**	**717**	**276**
PFI Capital - Lifecycle - residual Interest	819	343	476
Total Capital	**9,197**	**14,465**	**(5,268)**

Derbyshire Healthcare
NHS Foundation Trust

Making Room for Dignity

Update to Trust Board – 3 June 2025

Andy Harrison,
Senior Responsible Owner, Acute Care Capital Programme

Making Room for Dignity Programme

Derbyshire Healthcare NHS Foundation Trust

- ❑ **Bluebell Ward** – 12-bed older adult facility, Chesterfield
- ❑ **Derwent Unit** – 54-bed adult acute unit, Chesterfield
- ❑ **Carsington Unit** – 54-bed adult acute unit, Derby
- ❑ **Audrey House** – 8-bed female Enhanced Care Unit, Derby
- ❑ **Kingfisher House** – 14-bed male PICU, Kingsway – Derby
- ❑ **Radbourne Unit** – 2x 17-bed adult acute unit, Derby

Making Room for Dignity Programme

Derbyshire Healthcare
NHS Foundation Trust

- **Bluebell Ward – Chesterfield**
  - 12 single-room, en-suite accommodation
  - providing functional mental health care for older adults
  - Opened 7 January 2025
- with therapeutic areas
- and garden space

Making Room for Dignity Programme

Derbyshire Healthcare
NHS Foundation Trust

❑ Derwent Unit – Chesterfield Royal Hospital

- ❑ 54 single-room, en-suite accommodation
- ❑ providing working age adult acute care
- ❑ **Opened 20 March 2025**
- ❑ with therapeutic & physical activity space
- ❑ and access to garden space

Making Room for Dignity Programme

Derbyshire Healthcare
NHS Foundation Trust

- **Carsington Unit – Kingsway, Derby**
  - 54 single-room, en-suite accommodation
  - providing working age adult acute care
  - due to open 28 May 2025
  - with therapeutic & physical activity space
  - and access to garden space

Making Room for Dignity Programme

Derbyshire Healthcare
NHS Foundation Trust

❑ Audrey House – Kingsway, Derby

- ❑ 8-bed single-room, en-suite accommodation
- ❑ providing enhanced care for female working age adults
- ❑ due to open Summer 2025
- ❑ with therapeutic and physical activity spaces
- ❑ and access to garden / outside spaces

Making Room for Dignity Programme

Derbyshire Healthcare
NHS Foundation Trust

❑ Kingfisher House – Kingsway, Derby

- ❑ 14-bed single-room, en-suite accommodation
- ❑ providing psychiatric intensive care for male working age adults
- ❑ Completion May 2025 - Opening June 2025
- ❑ with therapeutic and physical activity spaces
- ❑ and access to garden / outside spaces

Making Room for Dignity Programme

Derbyshire Healthcare
NHS Foundation Trust

- **Radbourne Unit – Derby Royal Hospital**
  - Two 17- bed single-room, en-suite accommodation
  - providing acute care for female working age adults
  - with therapeutic and physical activity spaces
  - and access to garden / outside spaces
  - Completion of 1st ward expected summer 2026
  - Completion of 2nd ward expected summer 2027

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 June 2025

Trust Strategy Progress Update

Purpose of Report

To present a progress update on the arrangements to enact and oversee delivery of Trust strategy.

Executive Summary

The new Trust Strategy was launched in October 2024 and action over subsequent months was focused on development of an associated Strategic Plan to enact the ambitions described within this.

The Strategic Plan for 2025-28 was approved by the Board on 4 March 2025.

Action has since been progressed to map the assurance section of the plan to the Trust governance framework and committee work schedules, ensuring completeness of assurance across all priorities to relevant oversight forum. A series of related changes are being enacted across the governance framework, including the institution of a new Strategic Portfolio Oversight Group.

The Strategic Portfolio Oversight Group has been established to oversee assurance that all aspects of the Strategic Plan are on track for implementation according to agreed timescales, and to oversee the development and delivery of a portfolio of transformation that is aligned to deliver organisational strategic intent. The newly established Group will meet for the first time in June 2025.

Content of the Strategic Plan has been mapped to Executive Director objectives with subsequent cascade being enacted through teams and personal development plans across the organisation via the appraisal process.

A number of detailed delivery plans are referenced as deliverables in the first quarters of the Strategic Plan roadmap, for example the Quality Delivery Plan and Digital Delivery Plan. A timeline has been developed for production of all associated delivery plans and action has been progressed to develop and consult on the content of these with approvals scheduled aligned to the agreed roadmap.

Aligned to the establishment of the Strategic Portfolio Oversight Group a formal progress report on delivery of the agreed priorities and roadmap set out within the Strategic Plan will be produced at the end of each quarter. The quarter one progress report will be compiled in July 2025.

Alongside internal engagement work to establish robust cascade of plan content, action has been delivered to engage system partners, and a focus on this will be maintained throughout the lifecycle of the plan. For example, the key aspects of the Strategic Plan which will be delivered through partnership were presented to the Joined Up Care Derbyshire Primary and Community Care Delivery Board in April 2025.

Strategic Considerations	
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X

Risks and Assurances

- The Strategic Plan has been established as the roadmap to enact Trust strategy
- The source and forum for assurance is defined for each priority
- Risks to delivery will be managed via the Board Assurance Framework
- An update on progress in delivery of the Strategic Plan will be reported quarterly.

Consultation

The Strategic Plan has been developed through engagement and consultation through two board development sessions, the staff conference, and the leadership forum.

Governance or Legal Issues

The new Trust Strategy was approved by the Board in October 2024.

Public Sector Equality Duty & Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

The Trust's strategy embeds its commitment to Equality, Diversity and Inclusion. This is reflected throughout the Strategic Plan, with specific reference within the delivery content at People section 2.

Recommendations

The Board of Directors is requested to note the update on the arrangements to enact and oversee delivery of Trust strategy.

Report presented by: **Vikki Ashton Taylor**
Deputy Chieve Executive and Chief Delivery Officer

Report prepared by: **Maria Riley**
Assistant Director of Transformation

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 June 2025

2025/26 Planning update

Purpose of Report

The report provides an update on the final financial plan which was resubmitted at the end of April.

Executive Summary

The financial and workforce plans were submitted at the end of March. All organisations were requested to resubmit their plans at the end of April.

The main changes to the financial plan were around capital and efficiencies. The workforce plan was also changed to reflect the development of the efficiency plans.

The March and April submission included a breakeven revenue plan following the allocation of additional income from the Integrated Care Board.

The capital plan was updated to reflect the status of some of the bids against some national funding.

The efficiency plan was updated to reflect the progress in the development of the schemes. The March submission contained £4.0m of unidentified savings, however the full programme has now been identified.

The workforce plan changed to also reflect the development of the efficiency schemes.

Strategic Considerations	
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X

Risks and Assurances

- The extent to which our efficiency plan and approach are successfully developed and implemented, will directly result in the likelihood of us achieving our agreed financial plan
- Managing temporary staffing expenditure within the set planning levels
- Managing out of area expenditure in line with the reducing trajectory.

Consultation

Throughout the planning process updates have been provided to Executive Leadership Team, Finance and Performance Committee and Confidential Trust Board.

Governance or Legal Issues

Links to financial plan and wider operational planning guidance.

Public Sector Equality Duty & Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

- All CIPs will need to go through a full QEIA process to ensure the Trust is content with the wider impact of any changes
- The above also applies to any decommissioning or changes to service provider.

Recommendations

The Board of Directors is requested to note the resubmission of the 2025/26 plan.

Report presented by: **James Sabin**
Director of Finance

Report prepared by: **Rachel Leyland**
Deputy Director of Finance

2025/26 Plan

The financial plan was submitted at the end of March with a resubmission at the end of April.

The table below shows the income and expenditure position before and after technical adjustments for 2025/26:

Statement of comprehensive income	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan
	30/04/2025	31/05/2025	30/06/2025	31/07/2025	31/08/2025	30/09/2025	31/10/2025	30/11/2025	31/12/2025	31/01/2026	28/02/2026	31/03/2026	31/03/2026
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Year Ending
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Operating income from patient care activities	19,486	19,486	19,486	19,496	19,496	19,534	19,534	19,534	19,534	19,534	19,533	19,525	**234,181**
Other operating income	1,064	1,073	1,064	750	750	726	735	726	735	718	688	715	**9,745**
Employee expenses	(15,806)	(15,807)	(15,807)	(15,486)	(15,486)	(15,250)	(15,225)	(15,225)	(14,926)	(15,910)	(14,906)	(14,856)	**(184,688)**
Operating expenses excluding employee expenses	(4,814)	(4,875)	(4,375)	(4,509)	(4,509)	(4,023)	(4,472)	(4,468)	(3,983)	(4,392)	(4,387)	(8,100)	**(56,908)**
OPERATING SURPLUS/(DEFICIT)	**(70)**	**(123)**	**369**	**251**	**251**	**988**	**572**	**568**	**1,361**	**(50)**	**928**	**(2,715)**	**2,330**
FINANCE COSTS													
Finance income	50	50	50	50	50	50	50	50	50	50	50	50	**601**
Finance expense	(313)	(263)	(263)	(263)	(263)	(263)	(263)	(263)	(264)	(264)	(262)	(265)	**(3,209)**
PDC dividend expense	(453)	(453)	(453)	(453)	(453)	(453)	(453)	(453)	(453)	(453)	(453)	(453)	**(5,433)**
NET FINANCE COSTS	**(716)**	**(666)**	**(666)**	**(666)**	**(666)**	**(666)**	**(666)**	**(666)**	**(667)**	**(667)**	**(665)**	**(668)**	**(8,041)**
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(785)**	**(788)**	**(296)**	**(415)**	**(415)**	**322**	**(93)**	**(98)**	**694**	**(717)**	**263**	**(3,383)**	**(5,711)**
Technical Adjustments													
Add back all I&E impairments/(reversals)	0	0	0	0	0	0	0	0	0	0	0	4,200	**4,200**
Surplus/(deficit) before impairments and transfers	**(785)**	**(788)**	**(296)**	**(415)**	**(415)**	**322**	**(93)**	**(98)**	**694**	**(717)**	**263**	**817**	**(1,511)**
Retain impact of DEL I&E (impairments)/reversals	0	0	0	0	0	0	0	0	0	0	0	(200)	(200)
Remove PFI revenue costs on an IFRS 16 basis	545	545	545	545	545	545	545	545	546	546	544	526	**6,521**
Add back PFI revenue costs on a UK GAAP basis	(403)	(403)	(402)	(402)	(402)	(402)	(403)	(402)	(404)	(404)	(402)	(382)	**(4,810)**
Adjusted financial performance surplus/(deficit)	**(643)**	**(646)**	**(153)**	**(272)**	**(272)**	**465**	**49**	**45**	**836**	**(575)**	**405**	**761**	**0**

The table below shows the movement from the 2024/25 deficit plan of £6.4m to the final plan submission at the end of April, which was a breakeven plan following the allocation of non-recurrent income from the Integrated Care Board:

	£'000s
2024/25 Deficit	**(6,384)**
NR CIP added back	(2,010)
NR planning allocation in 2024/25	(1,500)
Other adjustments	(691)
MTFP submitted 24/01/2025	**(10,585)**
Inflation	(6,478)
Recurrent Efficiencies	6,714
Non Recurrent Efficiencies	4,476
Investments	0
Disinvestments	0
Other budget setting changes	(899)
Draft deficit plan 11/02/2025	**(6,772)**
Depreciation Funding removed	(229)
Convergence	(548)
Draft deficit plan 19/02/2025	**(7,548)**
Depreciation funding added in	229
Convergence impact on Depreciation	(41)
Draft deficit plan 21/02/2025	**(7,361)**
NR income made recurrent	1,500
roundings	61
Draft deficit plan 25/02/2025	**(5,800)**
Additional Income - Depreciation	3,357
Additional income - share of mitigation	750
Additional Income - share of surplus	1,693
Breakeven plan 27/03/2025	**0**

Efficiencies

At the time of the March submission there was an unidentified gap in the programme of £4.1m, which has now reduced to zero in the resubmission at the end of April. The recurrent schemes total £12.1m which equates to 82%.

The tables below are an extract from the Financial Plan template and shows the current status of the efficiency programme as at 25 April 2025 ahead of the resubmission which is due 30 April.

Efficiency Savings Planned for 2025/26	Plan 30/04/2025 Month 1 £'000	Plan 31/05/2025 Month 2 £'000	Plan 30/06/2025 Month 3 £'000	Plan 31/07/2025 Month 4 £'000	Plan 31/08/2025 Month 5 £'000	Plan 30/09/2025 Month 6 £'000	Plan 31/10/2025 Month 7 £'000	Plan 30/11/2025 Month 8 £'000	Plan 31/12/2025 Month 9 £'000	Plan 31/01/2026 Month 10 £'000	Plan 28/02/2026 Month 11 £'000	Plan 31/03/2026 Month 12 £'000	Plan 31/03/2026 Year Ending £'000
Recurrent													
Pay - Recurrent	477	524	526	776	801	800	1,100	1,099	1,101	1,150	9,303	0	**8,354**
Non-pay - Recurrent	399	219	221	216	178	176	181	105	101	103	2,708	0	**1,899**
Income - Recurrent	8	8	8	8	8	8	9	9	9	9	100	0	**84**
Total recurrent efficiencies	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Non recurrent													
Pay - Non-recurrent	13	14	13	13	14	14	14	14	14	14	163	0	**137**
Non-pay - Non-recurrent	518	51	50	539	48	47	536	47	46	535	2,477	0	**2,417**
Income - Non-recurrent	0	2	4	4	4	4	4	4	4	4	34	0	**34**
Total non-recurrent efficiencies	**477**	**524**	**526**	**776**	**801**	**800**	**1,100**	**1,099**	**1,101**	**1,150**	**9,303**	**0**	**8,354**

Efficiency Plan Risk	Pay Plan 31/03/2026 Year Ending £'000	Non Pay Plan 31/03/2026 Year Ending £'000	Income Plan 31/03/2026 Year Ending £'000	Plan 31/03/2026 Year Ending £'000
High Risk	5,293	2,276	34	**7,603**
Medium risk	0	2,371	0	**2,371**
Low Risk	4,173	538	100	**4,811**
Total Efficiencies	**9,466**	**5,185**	**134**	**14,785**

Efficiency Plan Status	Pay Plan 31/03/2026 Year Ending £'000	Non Pay Plan 31/03/2026 Year Ending £'000	Income Plan 31/03/2026 Year Ending £'000	Plan 31/03/2026 Year Ending £'000
Fully Developed	5,236	2,623	100	**7,959**
Plans in Progress	4,230	2,286	0	**6,516**
Opportunity	0	276	34	**310**
Unidentified	0	0	0	**0**
Total Efficiencies	**9,466**	**5,185**	**134**	**14,785**

Project	Type of Expenditure / Income	Recurrent or Non Recurrent	Status	Efficiency Programme Area	Risk Rating													
Desc	Desc	Desc	Plan	Desc	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan
31/03/2026	31/03/2026	31/03/2026	31/03/2026	31/03/2026	31/03/2026	30/04/2025	31/05/2025	30/06/2025	31/07/2025	31/08/2025	30/09/2025	31/10/2025	30/11/2025	31/12/2025	31/01/2026	28/02/2026	31/03/2026	31/03/2026
Year Ending	Year Ending	Year Ending	Year Ending	Year Ending	Year Ending	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Year Ending
						£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Agency reduction	Pay	Recurrent	Fully Developed	Pay - Agency - reduce the reliance on agency	Low	107	108	108	108	108	108	108	108	108	108	108	108	**1,295**
Bank reduction	Pay	Recurrent	Fully Developed	Pay - E-Rostering / E-Job Planning	Low	37	37	37	37	37	38	38	38	38	38	38	38	**451**
Improve Flow	Non-Pay	Recurrent	Plans In Progress	Non-Pay - Clinical Service re-design	High	341	352	341	161	161	156	119	116	119	46	42	46	**2,000**
Childrens	Pay	Recurrent	Fully Developed	Pay - Establishment reviews	Low	20	20	20	20	20	20	20	20	20	20	20	19	**239**
Estates	Non-Pay	Recurrent	Fully Developed	Non-Pay - Estates and Premises transformation	Low	6	6	6	7	7	7	7	7	7	7	7	7	**81**
Estates	Non-Pay	Non-Recurrent	Fully Developed	Non-Pay - Estates and Premises transformation	Low	16	16	16	16	17	17	17	17	17	17	17	17	**200**
Finance	Pay	Recurrent	Fully Developed	Pay - Corporate services transformation	Low	2	1	2	1	2	1	2	1	2	1	2	1	**18**
Finance	Pay	Non-Recurrent	Fully Developed	Pay - Corporate services transformation	Low	1	2	1	2	1	1	1	1					**10**
IM&T	Non-Pay	Recurrent	Fully Developed	Non-Pay - Procurement (excl drugs) - non-clinical directly achieved	Low	1	1	1	1	1	1	1	1	1	1	1	1	**12**
Pharmacy	Non-Pay	Recurrent	Fully Developed	Non-Pay - Medicines efficiencies	Medium	14	14	14	14	14	14	14	14	14	14	14	13	**167**
Procurement	Non-Pay	Recurrent	Plans In Progress	Non-Pay - Procurement (excl drugs) - non-clinical directly achieved	Medium	29	29	29	20	21	20	18	18	18	15	15	14	**246**
Admin Review	Pay	Recurrent	Plans In Progress	Pay - Establishment reviews	High	0	0	0	22	22	22	22	22	22	22	23	23	**200**
Taxi usage	Non-Pay	Recurrent	Plans In Progress	Non-Pay - Fleet optimisation	Low	3	3	3	3	3	3	3	3	4	4	4	4	**40**
MAR scheme	Pay	Recurrent	Fully Developed	Pay - Establishment reviews	Low	29	29	29	29	29	29	29	29	29	29	30	30	**350**
New Operating Model	Pay	Recurrent	Plans In Progress	Pay - Clinical Service re-design	High						250	250	250	550	550	550	600	**3,000**
Forensic and Rehab	Income	Recurrent	Fully Developed	Income - Non-Patient Care	Low	8	8	8	8	8	8	8	8	9	9	9	9	**100**
People and Inclusion	Non-Pay	Recurrent	Fully Developed	Non-Pay - Procurement (excl drugs) - non-clinical directly achieved	Low	0	0	0	8	9	9	9	9	9	9	9	9	**80**
Non Recurrent	Non-Pay	Non-Recurrent	Fully Developed	Non-Pay - Corporate services transformation	Medium			490			490			489			489	**1,958**
Digital	Pay	Recurrent	Plans In Progress	Pay - Digital transformation	High							25	25	25	25	25	25	**150**
Clinical Services - Vacancies	Pay	Recurrent	Fully Developed	Pay - Establishment reviews	High	152	151	144	170	171	169	166	165	164	164	163	164	**1,943**
Clinical Serv Management	Pay	Recurrent	Fully Developed	Pay - Establishment reviews	Low	10	10	10	10	10	10	11	11	11	11	11	11	**126**
Adult Care Community	Pay	Recurrent	Plans In Progress	Pay - Establishment reviews	Low	27	27	27	27	27	27	28	28	28	28	28	28	**330**
Older Peoples Care	Pay	Recurrent	Plans In Progress	Pay - Establishment reviews	Low	18	18	18	18	18	20	20	20	20	20	20	20	**230**
Older Peoples Care	Pay	Non-Recurrent	Plans In Progress	Pay - Establishment reviews	Low	5	5	5	5	5	5	5	5	6	6	6	6	**64**
Neuro Developmental	Pay	Recurrent	Plans In Progress	Pay - Establishment reviews	Low	16	16	17	17	17	17	17	17	17	17	17	17	**202**
Neuro Developmental	Pay	Non-Recurrent	Plans In Progress	Pay - Establishment reviews	Low	4	4	4	4	4	4	5	5	5	5	5	5	**54**
Psychology	Pay	Recurrent	Fully Developed	Pay - Establishment reviews	Low	45	45	46	46	46	46	46	46	46	46	46	46	**550**
Corporate	Non-Pay	Recurrent	Fully Developed	Non-Pay - Procurement (excl drugs) - non-clinical directly achieved	Low								1	1	1	1	1	**5**
Corporate	Pay	Non-Recurrent	Fully Developed	Pay - Corporate services transformation	Low	2	3	3	3	3	3	3	3	3	3	3	3	**35**
Delivery Strat Perf Trans	Pay	Recurrent	Fully Developed	Pay - Corporate services transformation	Low	12	12	12	12	12	12	12	12	12	12	12	12	**144**
Delivery Strat Perf Trans	Non-Pay	Recurrent	Fully Developed	Non-Pay - Digital transformation	Low	3	3	3	3	3	4	4	4	4	4	4	4	**43**
Delivery Strat Perf Trans	Non-Pay	Non-Recurrent	Fully Developed	Non-Pay - Digital transformation	Low	3	3	3	3	3	4	4	4	4	4	4	4	**43**
Pharmacy Team	Pay	Recurrent	Fully Developed	Pay - Establishment reviews	Low			7	7	7	7	7	8	8	8	8	8	**75**
Pharmacy Team	Non-Pay	Recurrent	Fully Developed	Non-Pay - Digital transformation	Low									1	1	1	1	**4**
Chief Exec inc Comms	Non-Pay	Recurrent	Fully Developed	Non-Pay - Procurement (excl drugs) - non-clinical directly achieved	Low	2	2	2	2	2	2	3	3	3	3	3	3	**30**
Trustwide scheme	Non-Pay	Non-Recurrent	Opportunity	Non-Pay - Procurement (excl drugs) - non-clinical directly achieved	High	11	11	9	32	30	28	27	26	26	26	25	25	**276**
Research and Development	Income	Non-Recurrent	Opportunity	Income - Non-Patient Care	High				2	4	4	4	4	4	4	4	4	**34**
						924	**936**	**1,415**	**818**	**822**	**1,556**	**1,053**	**1,049**	**1,844**	**1,278**	**1,275**	**1,815**	**14,785**

Capital Plan

As part of the planning process, system bids were submitted to various regional capital pots. Due to the current status of those bids this has required changes to the system CDEL allocations and therefore Provider capital plans. The main change in our capital plan relates to the unsuccessful bid against the MH out of area allocation of £2.2m. This has therefore been removed from our plan, but linked to this the ICB has received confirmation of two capital allocations in relation to the MRfD business cases of £6.6m and £5.2m.

Previous Capital Plan

£'000s	2025/26 Plan	CDEL	MHOOA Capital pot	PDC	Other
MR4D - RU	8,440	6,201	2,239		
Fire Compartmental works	400	400			
Estates Staffing	240	240			
Leases	600	600			
IT Kit	772	772			
Backlog	1,500	1,500			
Anti-ligature works	25	25			
Urgent CQC/H&S	200	200			
The Beeches - Air conditioning	50	50			
Hartington Unit – works to retained space	100	100			
Medical Equipment rolling programme	50	50			
EV charging - Infrastructure upgrades	50	50			
EV charging - charging points - estate roll out	50	50			
PFI	876				876
Total	**13,353**	**10,238**	**2,239**	**-**	**876**

Plan adjustments					
BAU reductions	- 4,361	- 4,361			
Add in PDC	5,210			5,210	
Add in PDC	6,600			6,600	
Remove Bid	- 2,239		- 2,239		
Revised total	**18,563**	**5,877**	**-**	**11,810**	**876**
Total changes	**5,210**	**- 4,361**	**- 2,239**	**11,810**	**-**

Revised Capital Plan

£'000s	2025/26 Plan	CDEL	MHOOA Capital pot	PDC	Other
MR4D - RU	13,650	1,840	-	11,810	
Fire Compartmental works	400	400			
Estates Staffing	240	240			
Leases	600	600			
IT Kit	772	772			
Backlog	1,500	1,500			
Anti-ligature works	25	25			
Urgent CQC/H&S	200	200			
The Beeches - Air conditioning	50	50			
Hartington Unit – works to retained space	100	100			
Medical Equipment rolling programme	50	50			
EV charging - Infrastructure upgrades	50	50			
EV charging - charging points - estate roll out	50	50			
PFI	876				876
Total	**18,563**	**5,877**	**-**	**11,810**	**876**

Temporary Staffing

The tables below show the planned expenditure for bank and agency before and after efficiencies.

Comparing expenditure levels from quarter 4 of 2024/25 prorated to the plan for 2025/26, both bank and agency CIP can be delivered, and costs should remain within the reduced budgets.

Bank

	2025/26 Base Budget £'000s	CIP £'000s	2025/26 Revised budgets £000's	204/25 Q4 x4
Registered nursing, midwifery and health visiting staff	3,060	(153)	2,907	2,634
Healthcare scientists and scientific, therapeutic and technical staff			-	97
Support to clinical staff	4,335	(242)	4,093	3,062
Consultants	689	(34)	655	208
Career/staff grades			-	
NHS infrastructure support	446	(22)	424	448
Total	**8,530**	**(451)**	**8,079**	**6,449**
				1,629

Agency

	2025/26 Base Budget £'000s	CIP £'000s	2025/26 Revised budgets £000's	204/25 Q4 x4
Consultants, agency	2,748	(623)	2,125	2,344
Qualified nursing, midwifery and health visiting staff, agency	980	(333)	647	440
Support to nursing staff	983	(339)	644	359
Managers and infrastructure support, agency				110
Total	**4,711**	**(1,295)**	**3,416**	**3,252**
				164

Workforce Plan

The table below is an extract from the workforce plan. The changes in the workforce plan will reflect the full year investment in the MRfD programme, along with reductions in relation to pay related efficiencies:

Annual Workforce Plan 2025/26	Expected Sign	Baseline		Plan	
		Staff in post outturn	Establishment	Staff in post outturn	Establishment
		Year End (31-Mar-25)		Year End (31-Mar-26)	
		Total WTE	Total WTE	Total WTE	Total WTE
Total Workforce (WTE)		3,238.11	3,362.42	3,221.34	3,271.82
Total Substantive		3,070.89	3,362.42	3,065.08	3,271.82
Total Bank		146.08		142.56	
Total Agency		21.14		13.70	
Total Substantive	+	**3,070.89**	**3,362.42**	**3,065.08**	**3,271.82**
Medical & Dental	+	192.65	208.35	190.92	212.21
Registered Nursing, Midwifery & Health Visiting Staff	+	1,179.56	1,222.34	1,235.44	1,135.87
Reg/ Qual Scientific, Therapeutic and Technical Staff	+	455.17	490.44	453.61	468.32
of which Allied Health Professionals	+	236.41	243.01	234.01	259.73
of which Other S, T & T	+	218.76	247.43	219.60	208.59
of which Healthcare Scientists	+	0.00	0.00	0.00	0.00
Clinical Support	+	532.43	656.08	579.31	738.28
Infrastructure	+	711.08	785.21	605.80	717.14
Other Staff	+	0.00	0.00	0.00	0.00

Mental Health and Learning Disability Care performance targets

The table below shows the performance objectives included in the operational plan:

Area	Objective	Performance 31 March 2025	2025-26 Plan Ambition
Mental Health and Learning Disability Care	Improve patient flow and reduce the need for inappropriate out of area placements	37 JUCD Total: 5 - DHcFT Adult Acute 32 – ICB PICU (no DHcFT facilities at 31-03-25)	Reduction to 5 inappropriate OOA by 31 March 2026: • 2 Female PICU – no DHcFT facility • 3 Adult Acute – staff or other exception
	Deliver the 10 high impact actions for mental health discharge and reduce average length of stay In acute mental health beds	58.8 Days - DHcFT Combined Metric	10% reduction in LoS and combined DHcFT metric of 55 Days by 31 March 2026: • Adult Acute 47.2 Days by 31 March 2026 • Older Adults 85.2 Days by 31 March 2026 • PICU Male 55 Days by 31 March 2026
	Increase the number of CYP accessing services to achieve the national ambition for 345,000 additional CYP aged 0-25 compared to 2019)	174,600 ICB (Annual) 41,460 DHcFT Contribution (Annual)	Maintain access at 2024-25 levels: • 174,600 ICB contacts by 31 March 2026 • 41,460 DHcFT contact contribution by 31 March 2026
	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, delivering a minimum 10% reduction	34 Adult Placements 3 CYP Placements	20% reduction by 31 March 2026: • 27 Adult Placements • 3 CYP Placements

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 June 2025

Medium Term Financial Plan (MTFP) – Process and Timeline

Purpose of Report

To provide an update on the requirement for a Medium-Term Financial Plan (MTFP) for both the Organisation and the Derbyshire system.

Executive Summary

The expectation is that each Joined Up Care Derbyshire (JUCD) sovereign organisation would produce a MTFP, ratified by its Board, jointly under the leadership of the ICB system teams, to be consolidated into a system-wide plan.

The MTFP would be a rolling current year plus a three-year plan.

The underlying 'LIVE' plan is based on the known and agreed system position only (Baseline position rolled forward with full year effect (FYE) efficiencies, FYE Investments, known national impacts including debt repayment and convergence and agreed system decisions). Scenario plans will then deviate from the 'LIVE' plan to include assumptions for inflation, and future decision making including efficiency forecasts.

The proposed timeline is as follows:

- 23 April: ICB Executive approval of process
- 2 May: NHS System Executive approval
- May 2025: Governance sign-off across all organisations
- End of June 2025: Initial MTFP approved (status quo based on known decisions only)
- Quarterly: Regular updates to maintain relevance.

The paper that was presented to System Executives is included as an annex.

Strategic Considerations	
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X

Risks and Assurances

The key risks relate to the Board Assurance Framework Risk on delivery of the financial plan which is currently at Extreme.

Consultation

The attached paper has been through the Derbyshire System Executive Group and has been supported.

Governance or Legal Issues

- MTFPs developed individually by each organisation and collated by Joined Up Care Derbyshire
- Overseen by the Planning Sub-Group and Chief Finance Officers, reported into the Executive System Planning Group and Financial Sustainability Board
- Requires full governance sign-off from each organisation
- Iterative updates to ensure alignment with evolving operational decisions.

Public Sector Equality Duty & Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

Cost improvement planning and any other transformation schemes included in the medium term financial plan, will all need to involve an appropriate quality and equality impact assessment, in order to mitigate any risks that are identified in the schemes or actions being proposed, such as identifying barriers, increasing the opportunities for positive outcomes for all groups and fostering opportunities to bring different communities together.

Recommendations

The Board of Directors is requested to sign off the process and timelines for the production of the Medium-Term Financial plan.

Report presented by: **James Sabin**
Director of Finance

Report prepared by: **Rachel Leyland**
Deputy Director of Finance

NHS
Derby and Derbyshire
Integrated Care Board

EXECUTIVE TEAM MEETING

23 April 2025

Report Title	Medium Term Financial Plan (MTFP) – Process and Timeline							
Author	Craig West – Associate Director of Finance (System Planning)							
Sponsor (Executive Director)	Bill Shields – Chief Finance Officer							
Presenter	Bill Shields – Chief Finance Officer							
Paper purpose	Decision	☒	Discussion	☒	Assurance	☐	Information	☐

Presented at ICB Delivery Group	**Yes**	☐	**No**	☐

Recommendations

The Executive Team is recommended to:

- Approve the Development of a system wide Medium-Term Financial Plan (MTFP)
- Approve the proposed process and timeline for development of the plan.

Report Summary

This paper highlights the need for a Medium-Term Financial Plan (MTFP) to align financial resources with Joined Up Care Derbyshire's (JUCD) strategic and system-wide priorities. Currently, JUCD operates without a fully developed and governed MTFP. Having a MTFP in place gives demonstrates good governance and provides opportunity for:

- Longer term decision-making based on impact analysis
- Greater resource alignment (particularly relevant to delivering the Darzi report priorities)
- Stable cash flow especially for providers
- Greater board accountability of plans
- Greater opportunity to deliver investment and transformational change.

Therefore, it is proposed to develop a combined JUCD MTFP alongside workforce and performance. To do so, each JUCD sovereign organisation would produce a MTFP, ratified by its Board, jointly under the leadership of the ICB system teams, to be consolidated into a system-wide plan. The MTFP would be a rolling current + three-year plan. The underlying 'LIVE' plan is based on known and agreed system position only (Baseline position rolled forward with full year effect (FYE) efficiencies, FYE Investments, known national impacts including debt repayment and convergence and agreed system decisions). Scenario plans will then deviate from the 'LIVE' plan to include assumptions for inflation, and future decision making including efficiency forecasts. A naming convention will be maintained to ensure that any version of the MTFP being presented in a meeting is clear including understanding of the governance of the current LIVE plan.

Maintaining the MTFP, including organisational Board oversight, will support annual planning with an agreed and understood underlying position being clear to system Execs earlier in the planning process. This should enable joint decision making which affords the system financial stability.

Process and Governance

- MTFPs developed individually by each organisation, collated by JUCD Finance
- Overseen by the Planning Sub-Group and Chief Finance Officers, reported into the Executive System Planning Group and Financial Sustainability Board
- Requires full governance sign-off from each organisation
- Iterative updates to ensure alignment with evolving operational decisions.

Considerations

The MTFP will need to maintain an alignment to workforce, quality, operations and transformation. The MTFP is not a standalone process and will need to be produced in collaboration across planning leads.

Timeline

- **23 April**: ICB Executive approval of process
- **2 May**: NHS System Executive approval
- **May 2025**: Governance sign-off across all organisations
- **End of June 2025**: Initial MTFP approved (status quo based on known decisions only)
- **Quarterly**: Regular updates to maintain relevance.

Financial impact on the ICB or wider Integrated Care System
****To be completed by Finance ONLY****

Yes ☐	No☐	N/A☒

Details/Findings	**Has this been signed off by a finance team member?**
n/a – this is to develop a medium term financial plan based on what we know now and is not to approve further expenditure	*Craig West – Associate Director of Finance* *Jen Leah – Operational Director of Finance*

Staffing Resource Implications

Please confirm that HR advice has been sought if there are any 'people' implications within this report: n/a	☐ Yes, HR advice has been sought

QIPP delivery ie; how the contents/proposals impact on QIPP Delivery

No impact on QIPP delivery but will support the transaction and impact of QIPP delivery across the system and medium term

Identification of Key Risks

N/A.

Proposed Next Seps/Referred to

NHS System Executive sign off on 2 May 2025.

Medium Term Financial Plan (MTFP) – Process and Timeline

This paper outlines the importance of implementing a Medium-Term Financial Plan (MTFP) as a strategic tool to align financial resources with organisational & system priorities. Without such a plan, the system risks misalignment between objectives and funding and an inability to respond proactively to emerging challenges and opportunities.

Having a MTFP in place gives demonstrates good governance and provides opportunity for:

- **Longer term decision-making based on impact analysis**: without an MTFP in place, there may become an overreliance on annual budgets/planning. This could result in reactive decision-making and overlook long-term opportunities. With an MTFP in place, options appraisal for potential decisions can take a longer term system view leading to better health outcomes
- **Greater resource alignment**: (particularly relevant to delivering the Darzi report priorities); Aligning financial resources with strategic initiatives will support funding priorities and minimise inefficiencies. This is particularly important as we operationalise the three priorities from the Darzi report
- **Stable cash flow especially for providers**: Taking a longer term view of financial forecasting will help the system plan for liquidity issues which is particularly important for our Acute providers at present. This will reduce the overall cost of finance to the system by minimising the need for borrowing
- **Greater board accountability of plans**: The MTFP is a baseline and benchmark over the medium-term making evaluation of financial performance better and driving greater financial discipline. For example, the 'push-pull' felt as part of annual financial planning, where non-recurrent efficiencies are unwound and annual efficiency plans re-provide for similar performance, will be more transparent and minimised
- **Greater opportunity to deliver investment and transformational change**. Forward planning will allow the system and individual organisations agility to capitalise on opportunities.

As a result, the proposal is to develop an MTFP for JUCD covering all 6 Organisations. The purpose of the MTFP will be to:

- **Strategic Alignment:** Ensures financial planning supports long-term strategic objectives by reflecting the impact of strategic and operational decisions
- **Resource Optimisation:** Helps prioritize spending and allocate resources effectively across Organisations and the system
- **Risk Management:** Identifies financial risks in advance and develops mitigation strategies
- **Performance Monitoring:** Establishes financial benchmarks and performance indicators to track progress
- **Stakeholder Confidence:** Enhances transparency and credibility with regulators and partners by demonstrating foresight and financial discipline
- **Scenario Planning:** Provides flexibility to test various “what-if” scenarios to understand the financial impact of different decisions or external factors.

Whilst there is not necessarily a requirement to develop a medium-term workforce or operational plan, it is really important that this isn’t a finance plan in isolation. The plan will be produced in collaboration with colleagues across the system and any operational decision is reflected in the MTFP.

Process

Each organisation will be required to develop their own MTFP which will then be collated by the JUCD finance team to create one MTFP for the system. There will be a template that starts from current year and bridges to an underlying position and ultimately to a plan figure for each of the next three years. The plan will be maintained as a current + three- year plan.

The baseline that is developed will be based on 'what we know now' and will build in estimates for inflation, convergence, efficiencies based on previously received guidance or past trends to ensure its as robust as possible.

To ensure there is a shared understanding of the MTFP throughout the year, the MTFP will be updated on a regular basis to create an iterative process which will then be used to support annual planning (with the Year 1 position being the expected annual plan for each organisation and any deviation being transparent and explained within the system).

Once baselines are established any decisions made will be layered on to ensure version control is maintained. A key outcome of this will be that each organisations board will already be sighted and signed up to their own Organisation plan as we head into 2026/27 (and subsequent planning rounds).

Governance

The responsibility for completing the MTFP will be through the System Financial Planning Sub-Group (a sub-group of the System Operational Directors of Finance group). Outputs will go through a confirm and challenge within the Operational Directors of Finance group to ensure alignment and that it accurately reflects the impact of operational decisions and transformation. It will be overseen by the Chief Finance Officer's and reported into the Executive System Planning group, ICB Executives/Directors planning group and Financial Sustainability Board.

To ensure robustness and system sign up, the process and timeline will be required to go through all Organisations governance. The first part of this will be an iteration of this report going to the System Executive meeting on 2 May to ensure system buy-in and agreement on 'this is what we want to do, and this is how we will do it'. It is also imperative that regular updates are taken through the same governance process for each Organisation.

Timeline

- 23 April – ICB Executives to approve process and timeline
- 2 May – NHS System Executives to approve process and timeline
- May 25 – All Organisations to have taken process and timeline through internal governance
- End of June 2025 – 'Status Quo' MTFP developed and approved for both Organisations and system
- Ongoing – continued review and update to the iterative MTFP with regular updates through internal and system governance.

Please see appendix 1 for an indicative timeline

Recommendations

The ICB Executive team is asked to:

- Approve the Development of a system Medium-Term Financial Plan
- Approve the process and timeline for development of the plan.

Appendix 1 – Proposed Indicative Timeline

JUCD Planning Timeline

2026/27 MTFP → 2026/27 MTFP → 2026/27 MTFP → 2026/27 Plan

	Quarter 1 **2026/27 MTFP**	Quarter 2 **2026/27 MTFP**	Quarter 3 **2026/27 MTFP**	Quarter 4 **2026/27 Plan**
Activities	List of activities	List of activities	List of activities	List of activities
	Sign off Contracts from 2025/26 – 8th May	Review impact of efficiencies and workforce on run-rate	Review and overlay impact of efficiencies and workforce on run-	Refresh MTFP based on CUF and income growth rates from planning
	Lessons Learnt	Review impact of efficiency delivery on MTFP	Joint meeting with Workforce to review run rates	Understanding implications of CUF and growth assumptions
	Create and share Draft 'Status Quo' 2026/27 MTFP	Refresh 'Status Quo' 2026/27 MTFP, with focus on run rates	Review impact of efficiency delivery on MTFP	Headline Submission to NHSE
	Review and update Planning Principles	Joint meeting with Workforce to review run rates	Summarise and share 2025/26 planning guidance	Submit 2026/27 Plan
	Deps F2F Meeting to ensure no push out and pull back in UDLs	Highlight impact of run rates on 'Status Quo' MTFP for 2026/27	Review impact of Planning Guidance	Complete Working Papers and Templates for Planning Submission
Governance	CFO's meeting	CFO's meeting	CFO's meeting	CFO's meeting
	Exec Sign-off of 'Status Quo' Plans	Exec Sign-off of updates to Plan	Exec Sign-off of updates to Plan	Exec Sign-off of updates to Plan
	NHS System Executives	NHS System Executives	NHS System Executives	NHS System Executives
	Financial Sustainability Board	Financial Sustainability Board	Financial Sustainability Board	Financial Sustainability Board

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors -3 June 2025

Corporate Governance Report

Purpose of Report

To note the assurance on Board Committee year end reporting, to approve the revised suite of Terms of Reference (ToRs) for Board Committees, to receive the Trust sealings report and to approve a regulatory self -declaration on continuity of services.

Executive Summary

Assurance is provided from the Audit and Risk Committee (ARC) on the year-end governance reporting from Board Committees. ToRs were revised during the year-end effectiveness reviews, and these are attached for the Board's approval (Appendix 1). There are only minor changes proposed, mainly to ensure consistency across the Committees. Of note this year has been:

- Reiteration that non-quorate meetings may go ahead unless the chair decides not to proceed. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting
- All Board Committees, with the exception of the ARC, participated in an MS Forms effectiveness survey which invited members (and other core attendees, where appropriate) to deliver feedback on the meetings held over the year and how the Committee could be improved, including identifying any training or support needs. The Healthcare Financial Management Association (HFMA Audit Committee checklists in paper form were used for ARC.

The year-end report for the ARC is also presented (Appendix 2) and summarises how the Committee has discharged its remit during 2024/25.

The Trust Sealings register is attached (Appendix 3) for information.

The Board is asked to approve the 2024/25 Continuation of Services Condition 7 – availability of resources self-declaration for signature of the Chair and Chief Executive (Appendix 4).

Strategic Considerations	
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X

Risks and Assurances

The Trust has complied with national guidance and statutory duties. Each Committee or Committee Chair has been assured through their review that the Committees are working effectively and meeting the requirements of the Terms of Reference (ToR) as required by the Corporate Governance Framework.

Consultation

The year-end governance reports and ToR have been through the individual Board Committees during the March/April meeting cycle and reported to the Audit and Risk Committee at its April meeting.

Governance or Legal Issues

The year-end governance reports are in line with governance best practice. The HMFA NHS Audit Committee Handbook advises that an Audit Committee, in line with best practice in other sectors, should prepare a report to the Board that sets out how the Committee has met its ToR. One of the general roles of the Board under the scheme of delegation is to agree the ToRs for Committees of the Board. It is an NHS requirement for the Board to approve the Continuation of Services Condition 7 declaration. The requirement to report on the use of the Trust seal is set out in the Trust's Standing Orders.

Public Sector Equality Duty and Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

There is no direct impact on those with protected characteristics arising from other aspects this report. However, governance of the Trust includes broad consideration of equality and diversity issues for example as a key part of Board Committee business. Each Board Committee has a specific objective around equality which is now built into ToR.

Recommendations

The Board of Director is requested to:

1. Approve the suite of ToR for Board Committees (Appendix 1)
2. Note the assurance received by the Audit and Risk Committee that all Board Committees have effectively carried out their role and responsibilities as defined by their Terms of Reference during 2024/25 and receive the year-end report of the Audit and Risk Committee (Appendix 2)
3. Note the Trust seal report (Appendix 3)
4. Approve the Continuation of Services Condition 7 self-declaration (Appendix 4).

Report presented by: **Justine Fitzjohn**
Director of Corporate Affairs and Trust Secretary

Report prepared by: **Jo Bradbury**
Corporate Governance Officer

1. Year-end governance reporting from Board Committees and approval of Terms of Reference (ToR)

At its meeting on 24 April 2025, the Audit and Risk Committee received the year-end effectiveness summaries for all of the Board Committees as well as their Terms of Reference (ToR).

All Board Committees have reviewed their activity during the past year and sought confirmation from their members that they had fulfilled the key duties under their ToR and were operating effectively in providing assurance to the Trust Board. Board Assurance Summaries of Committee business are reported to the Board throughout the year, including any escalations.

The Audit and Risk Committee received assurance from the summary reports and effectiveness surveys, that the Committees have effectively carried out their role and responsibilities during 2024/25. All the Board Committees have developed a full future year's forward plan.

The suite of ToR is included as Appendix 1.

The year-end report for the Audit and Risk Committee is also presented to the Board at Appendix 2. This summarises how the Committee has discharged its remit during 2024/25.

Recommendation:

The Board of Directors is requested to:

- approve the suite of ToR for the Board Committees and note the assurance received by the Audit and Risk Committee that all Board Committees have effectively carried out their role and responsibilities as defined by their ToR during 2024/25
- receive the year-end report for the Audit and Risk Committee.

2. Register of Trust Sealings

The six-monthly update on the authorised use of the Trust Seal since the last report to the Board on 5 November 2024 is attached for information at Appendix 3.

Recommendation:

The Board of Directors is requested to note the contents of the report.

3. 2024/25 Continuation of Services Condition 7 – availability of resources

The Trust holds a provider licence which forms part of NHS England (NHSE) oversight arrangements for NHS providers. The NHS provider licence was updated in April 2023. Trusts and Foundation Trusts are no longer required to self-certify under all conditions, however providers who have a service designated as a Commissioner Requested Service are required to self-certify under condition CoS7; Continuity of services - Availability of Resources.

The Board must self-certify assess against one of three statements (a), (b) or (c) and explain the reasons / main factors considered when selecting the chosen statement.

a) After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate

b) After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services

c) In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

It is recommended that statement (a) is made to align with the going concern assessment which had been approved by the Audit and Risk Committee and will be reported within the Trust's 2024/25 Annual Report. Other sources of assurance/evidence to support this statement are listed in Appendix 4.

The certificate will need to be signed on behalf of the Board and published on the Trust's website.

Recommendation:

The Board of Directors is asked to approve the 2024/25 Continuation of Services Condition 7 – availability of resources for signature of the Chair and Chief Executive.

Appendix 1

Remuneration and Appointments Committee Terms of Reference

Purpose

The Committee is responsible for identifying and appointing candidates to fill Director positions on the Board of Directors including the Chief Executive, voting and non-voting Executive Directors and overseeing their annual appraisals. The Committee is also responsible for establishing and keeping under review a remuneration policy in respect of Executive Directors and to advise upon and oversee contractual arrangements for Executive Directors.

1. Authority

1.1 The Remuneration and Appointments Committee (the Committee) is constituted as a standing Committee of the Trust's Board of Directors (the Board). Its constitution and terms of reference shall be as set out below, subject to amendment at future Board meetings.

1.2 The Committee is authorised by the Board to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Committee.

1.3 The Committee is authorised by the Board to obtain external legal or other independent professional advice. The Committee is authorised by the Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

1.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

1.5 As a Committee of the Board, the Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's strategic objectives which fall within the Committee's remit.

1.6 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

1.7 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The Committee will ensure consideration has been given to equality impact related risks.

1.8 To actively consider the equality impact and evidence relating to all items of Committee business as part of the Committee's contribution to equality, diversity and inclusion.

1.9 As a designated policy ratification group, (see 'Policy on Policy Documents) the Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. This includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template. All policy documents are allocated a policy ratification group as they are published on Focus.

2. Membership

2.1 The membership of the Committee shall consist of:

- Trust Chair
- All Non-Executive Directors.

2.2 The Trust Chair will chair the Committee.

2.3 When appointing or removing the Chief Executive, the Committee shall be the committee described in Schedule 7, 17(3) of the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 (the Act) (that is all the Non-Executive Directors). When appointing or removing the other Executive Directors the Committee shall be the committee described in Schedule 7, 17(4) of the Act (that is the Trust Chair, the Chief Executive and the Non-Executive Directors).

3. Attendance

3.1 Meetings of the Committee may be attended in an advisory capacity by:

- Chief Executive
- Director of People, Organisational Development and Inclusion
- Director of Corporate Affairs and Trust Secretary
- Corporate Governance Officer
- Any other person who has been invited to attend the meeting by the Committee so as to assist in deliberations.

3.2 Members of the Committee must attend at least 80% of all meetings each financial year but should aim to attend all scheduled meetings.

4. Quorum

4.1 A quorum shall be three members. Non-quorate meetings may go ahead unless the chair decides not to proceed. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

4.2 Meetings may be held face-to-face or virtually by conference call, suitable electronic means or via a hybrid combination, so long as those present can hear each other and contribute simultaneously.

~~4.3 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Board meeting as an urgent item.~~

5. Frequency of Meetings

Meetings shall be held quarterly or as required.

6. Duties and Responsibilities

These terms of reference are based in part, on best practice as set out in the Code of Governance[1] and have been drafted referring to the provision in the code. The code states as two of its principles that:

[1] Code of governance for NHS provider trusts. ~~This comes into effect from 1 April 2023 and replaces the 2014 Code of Governance~~

"There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding his or her own remuneration."

"Appointments to the Board of Directors should follow a formal, rigorous and transparent procedure, and an effective succession plan should be maintained for Board and senior management. Appointments should be made solely in the public interest, with decisions based on integrity, merit, openness and fairness. Both appointments and succession plans should be based on merit and objective criteria and, within this context, should promote diversity of gender, social and ethnic backgrounds, disability, and cognitive and personal strengths, Directors of NHS foundation trusts must be "fit and proper" to meet the requirements of the general conditions of the provider licence"

To be responsible for identifying and appointing candidates to fill all the Executive Director positions on the Board and for determining their remuneration and other conditions of service. The exception being that both the appointment and removal of the company secretary should be a matter for the whole board.

The Committee will ensure that when matters of concern are raised during Committee business these are dealt with openly and transparently and scrutinised as appropriate. When issues arise the Committee will undertake to challenge robustly and fairly in order to develop a culture of continuous improvement, openness and honesty.

To consider the Board Assurance Framework and high level risks, in particular as they relate to the remit of the Committee; and to comply with any request from the Audit and Risk Committee for assurance in relation to the Board Assurance Framework and the Risk Register including deep dives of risks as appropriate.

These Terms of Reference are intended to ensure that the Trust's procedure for the appointment of the Chief Executive and other Directors (excluding Non-Executive Directors) to the Board reflect these principles.

6.1 Appointments (and removal) Role

6.1.1 To be responsible for identifying and appointing candidates to fill all the Executive Director positions on the Board, including the Chief Executive, voting and non-voting Directors. Non-Executive Directors are appointed through the Nominations and Remuneration Committee of the Council of Governors. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from a relevant ICB, and the Foundation Trust should engage with NHS England to agree the approach.

6.1.2 Regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the board evaluation process as appropriate, and make recommendations to the board, and nomination committee of the Council of Governors, as applicable, with regard to any changes.

6.1.3 Give full consideration to and make plans for succession planning for the Chief Executive and other Executive Board Director roles taking into account the future challenges, risks and opportunities facing the trust and the skills and expertise required ~~needed~~ on the Board to meet them.~~in the future.~~

6.1.4 To advise upon and oversee contractual arrangements for Executive Directors, including but not limited to termination payments.

6.1.5 Ensure that a proposed Executive Director's other significant commitments (if applicable) are disclosed before appointment and approve requests from individual Executive Directors to take on external appointments, including, but not limited to, additional paid employment, non-executive directorships, or trusteeships that any changes to their commitments are reported to the Board as they arise. Full-time

Executive Directors should not take on more than one non-executive directorship of another Trust or organisation of comparable size and complexity, and not the chairship of such an organisation.

6.1.6 Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.

6.1.7 Consider any matter relating to the continuation in office of any Executive Director including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract.

6.1.8 Ensure that contractual terms on termination, and any payments made, are fair to the individual, and the NHS, aligned with the interests of the patients, that failure is not rewarded and that the duty to mitigate loss is fully recognised, in line with national guidance where appropriate.

6.1.9 ~~The Committee will~~ Ensure all Executive Director appointments meet the Fit and Proper Persons Test (FPPT) on commencement and will oversee ongoing compliance. ~~with the Fit and Proper Person requirements of Directors.~~

6.1.10 Oversee the annual appraisal process for the Executive Directors, monitoring and evaluating the performance of the Chief Executive and Executive Directors against objectives for the previous year and noting forward objectives.

6.2 Remuneration Role

6.2.1 Establish and keep under review a remuneration policy in respect of Executive Directors.

6.2.2 Consult the Chief Executive about proposals relating to the remuneration of the other Executive Directors.

6.2.3 In accordance with all relevant laws, regulations and Trust policies, decide and keep under review the terms and conditions of office of the Trust's Executive Directors (voting and non-voting) on locally determined pay in accordance with all relevant Foundation Trust policies, including:

- salary, including any performance-related pay or bonus
- provisions for other benefits, including pensions and cars
- allowances.

6.2.4 In adhering to all relevant laws, regulations and Trust policies:

- establish levels of remuneration which are sufficient to attract, retain and motivate Executive Directors of the quality and with the skills and experience required to lead the Trust successfully and collaborate effectively with system partners, without paying more than is necessary for this purpose, and at a level which is affordable for the Trust
- use national guidance and market benchmarking analysis in the annual determination of remuneration of Executive Directors (both voting and non-voting) on locally determined pay, while ensuring that increases are not made where Trust or individual performance do not justify them.
- any performance-related elements of Executive Directors' remuneration should be transparent, stretching and designed to promote the long-term sustainability of the NHS foundation trust. They should also take as a baseline for performance any required competencies specified in the job description for the post.

- the Committee should take care to recognise and manage conflicts of interest when receiving views from Executive Directors or consulting the Chief Executive about its proposals

6.2.5 Monitor and assess the output of the evaluation of the performance of individual Executive Directors and consider this output when reviewing changes to remuneration levels.

7. Minutes and Reporting

7.1 The minutes of all meetings of the Committee shall be formally recorded. These will be held confidentially by the Director of Corporate Affairs and Trust Secretary on behalf of the Trust Chair.

7.2 The Committee shall ensure that Board emoluments (total monies paid to Board members) are accurately reported in the required format in the Trust's annual report.

7.3 The Committee will report annually to the Audit and Risk Committee describing how the Committee has fulfilled its terms of reference and give details of any significant issues and how they have been addressed.

7.4 The Committee will conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

7.5 Agendas and papers will be distributed in accordance with deadlines agreed with the Committee Chair. Ideally, this should be no less than three working days although flexibility will be maintained for extra-ordinary circumstances.

8. Terms of Reference Review

8.1 The Terms of Reference shall be subject to review at least annually.

Approved by Remuneration and Appointments Committee	17 March 2025
Approved by Audit and Risk Committee	24 April 2025
Approved by Board of Directors	3 June 2025

Finance and Performance Committee Terms of Reference

Purpose

The prime purpose of the Committee is to gain assurance on all aspects of financial and operational performance, on behalf of the Board. The Committee also oversees and approves business developments as well as considering progress with commercial and contractual matters. The Committee is responsible for agreeing terms of reference and annual work programmes for its supporting sub-committees. It also receives agreed assurance and escalation reports as defined in the forward plan for the Committee.

1. Authority

1.1 The Committee oversees and approves business developments as well as considering progress with commercial and contractual matters.

The Committee may refer specific issues to the Board, Audit and Risk Committee and other Committees and make recommendations as appropriate. Matters formally delegated to the Finance and Performance Committee by the Board of Directors are:

- Continuous Improvement including CIP (Cost Improvement Programme) plan reporting
- Contractual compliance performance reporting, including procurement
- Treasury Management – to approve policy, procedures, controls and monitoring of policy implementation
- Working Capital Facility – to approve (if applicable)
- Estate strategy delivery oversight including assurance on performance of the estates and facilities management function, on maintenance programmes and on statutory and regulatory compliance – twice yearly updates
- Indicative 5-year capital plan – approval
- National Cost Collection: process - sign-off
- Emergency Preparedness, Resilience and Response (EPPR)
- Health and Safety Compliance Report.

1.2 Aside from those specific matters listed, the Committee otherwise gains assurance on matters through reports and exceptions provided to it.

1.3 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

1.4 The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

1.5 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion, and belief, gender, and sexual orientation. The Finance and Performance Committee will ensure consideration has been given to equality impact related risks.

1.6 The Committee will actively consider the equality impact and evidence relating to all items of Committee business as part of the Committee's contribution to equality, diversity, and inclusion.

1.7 As a designated policy ratification group, (see 'Policy on Policy Documents) the Finance and Performance Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. This includes monitoring that the style, content, and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template. All policy documents are allocated a policy ratification group as they are published on Focus.

1.8 As a Committee of the Board, the Finance and Performance Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's strategic objectives which fall within the Committee's remit.

1.9 To receive assurance in relation to the fulfilment of the financial and performance aspects of the Trust's roles and responsibilities as Lead Provider of the East Midlands Perinatal Mental Health Provider Collaborative during the development and subsequent implementation of the provider collaborative, including the effective operation of Northamptonshire Healthcare Commissioning Hub support.

1.10 To receive assurance in relation to the fulfilment of the financial and performance aspects of the Trust role in all collaborative and alliances where it is a partner and incorporates the Trusts role within the following:

- Adult Forensic Secure Provider Collaborative – Impact
- CAMHS Provider Collaborative
- Adult Eating Disorders
- Gambling Harm
- OP Courage.

2. Membership

2.1 The membership of the Committee shall comprise:

Non-Executive Directors x three (one will be appointed as the Chair)
Director of Finance
Deputy Chief Executive and Chief Delivery Officer
Director of People, Organisational Development and Inclusion

Standing attendees comprise of:
Clinical Operational Managing Director leads
Deputy Director of Finance

2.2 If the Chair is not present, one of the Non-Executive Directors will chair the meeting.

2.3 The Trust Chair will appoint the Chair of the Committee.

2.4 Executive Director members should aim to attend all scheduled meetings with fully briefed deputies attending no more than one third of meetings on an exception basis.

2.5 The Trust Board has delegated authority to any Non-Executive Director of the Trust to act as nominated deputy in the absence of any Non-Executive and this attendance will count towards the quorum.

3. Attendance

3.1 Other staff may be required to attend at the invitation of the Committee.

3.2 Members of the Committee must attend at least 80% of all meetings each financial year but should aim to attend all scheduled meetings.

3.3 The Chief Executive Officer reserves the right to attend any meeting.

4. Quorum

4.1 A quorum shall be three members, including at least one Executive Director and two Non-Executive Directors; noting that as a minimum the executive attendance must include either the Director of Finance (supported by a Managing Director – or their deputies acting as their direct representatives) in the absence of the Deputy Chief Executive and Chief Delivery Officer or the Deputy Chief Executive and Chief Delivery Officer (supported by the Deputy Director of Finance in the absence of the Director of Finance). Non-quorate meetings may go ahead unless the chair decides not to proceed. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

4.2 Meetings may be held face-to-face or virtually by conference call, suitable electronic means or via a hybrid combination, so long as those present can hear each other and contribute simultaneously.

~~4.3 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Trust Board meeting as an urgent item.~~

5. Frequency

5.1 Meetings should be held bi-monthly with additional meetings if required.

6. Duties and Responsibilities

6.1 To monitor the development and delivery of financial and operational aspects of the Trust strategy through:

- Detailed oversight of current and future financial performance including financial risks
- Detailed oversight of current and future operational performance.

6.2 To monitor delivery of the continuous improvement programme including CIP.

6.3 To oversee progress on contractual negotiations of an income and expenditure basis.

6.4 To receive reports on business and commercial matters.

6.5 To consider outline business cases and proposals and to approve or make recommendations to Board accordingly.

6.6 To receive reports or referrals from committees and other meetings, relevant to the work of this Committee.

6.7 The agenda for the Committee will be informed by a forward plan of regular items but will also receive reports on relevant issues requiring additional scrutiny and assurance pertaining to actual and anticipated performance and/or when required by Trust Board or Audit and Risk Committee.

6.8 To consider the Board Assurance Framework and high-level risks, in particular as they relate to the remit of the Committee; and to comply with any request from the Audit and Risk Committee

for assurance in relation to the Board Assurance Framework and the Risk Register including deep dives of risks as appropriate.

6.9 To conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

6.10 To ensure that when matters of concern are raised during Committee business these are dealt with openly and transparently and scrutinised as appropriate. When issues arise, the Committee will undertake to challenge robustly and fairly to develop a culture of continuous improvement, openness, and honesty.

7. Minutes and Reporting

7.1 The minutes of all meetings of the Committee shall be formally recorded and made available to the Board of Directors.

7.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed.

7.3 The Committee will report annually to the Audit and Risk Committee describing how the Committee has fulfilled its Terms of Reference and give details of any significant issues and how they have been addressed.

7.4 The Committee will conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

7.5 Agendas and papers will be distributed in accordance with deadlines agreed with the Committee Chair. Ideally, this should be no less than three working days, although flexibility will be maintained for extra-ordinary circumstances.

8. Terms of Reference Review

8.1 The Terms of Reference shall be subject to review at least annually.

Approved by Finance and Performance Committee	3 March 2025
Approved by Audit and Risk Committee	24 April 2025
Approved by Board of Directors	3 June 2025

Quality and Safeguarding Committee Terms of Reference

Purpose

The prime purpose of the Committee is to enable the Board to obtain assurance that high standards of care are provided by the Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to promote safety and excellence in patient care, identify, prioritise and manage risk arising from clinical care, ensure the effective and efficient use of resources through evidence-based clinical practice; and protect the health and safety of Trust employees. The Quality and Safeguarding Committee is responsible for agreeing Terms of Reference and annual work programmes for its supporting sub-committees. It also receives agreed assurance and escalation reports as defined in the forward plan for the Committee.

The Committee is also responsible for setting the Safeguarding Quality Strategy, to provide quality governance and gain assurance on all aspects of the safeguarding agenda. The Committee's purpose is to provide assurance to the Trust Board that the organisation is effectively discharging and fulfilling its statutory responsibility for safeguarding to ensure better outcomes for children and vulnerable adults.

1. Authority

1.1 The Board of Directors has approved the establishment of a Quality and Safeguarding Committee as a Committee of the Board in accordance with standing orders.

1.2 As a Committee of the Board, the Quality and Safeguarding Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's strategic objectives which fall within the Committee's remit.

1.3 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

1.4 The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

1.5 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The Quality Committee will ensure consideration has been given to equality impact related risks.

1.6 The Committee has an objective to actively consider the equality impact and evidence relating to all items of Committee business as part of the Committee's contribution to equality, diversity and inclusion.

1.7 As a designated policy ratification group, (see 'Policy on Policy Documents) the Quality and Safeguarding Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. This includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template. All policy documents are allocated a policy ratification group as they are published on Focus.

1.8 To receive assurance in relation to the fulfilment of the quality aspects of the Trust's roles and responsibilities as Lead Provider of the East Midlands Perinatal Mental Health Provider Collaborative during the development and subsequent implementation of the provider

collaborative, including the effective operation of Northamptonshire Healthcare Commissioning Hub support.

2. Membership

2.1 The membership of the Committee shall comprise:

- Non-Executive Directors x three (one will be appointed as the Chair)
- Director of Nursing, Allied Health Professionals, Quality and Patient Experience or a nominated deputy
- Medical Director or a nominated deputy
- ~~Deputy Chief Executive and Chief Delivery Officer or a nominated deputy.~~

2.2 The Trust Chair will appoint the Chair of the Committee.

3. Attendance

3.1 Attendees for specific agenda items at the request of the Committee:

- Deputy Chief Executive and Chief Delivery Officer or a nominated deputy.
- Deputy Director of Nursing and Quality Governance
- Lead professional for Patient Safety
- Chief Pharmacist
- Research and Clinical Audit Manager
- Risk and Assurance Manager
- Assistant Director of Clinical Professional Practice
- Assistant Director of Legal, Governance and Mental Health Legislation
- Health and Safety Manager
- Safeguarding Children Lead
- Safeguarding Adults Lead
- Chairs or Deputy Chairs of the Clinical Operational Assurance Team (COATs) will be required to attend specific agenda items at the request of the Committee.

3.2 The following may also attend:

- Chief Executive Officer
- Trust Chair
- Director of Finance
- Director of People, Organisational Development and Inclusion
- ~~Deputy Chief Executive and Chief Delivery Officer~~
- Director of Corporate Affairs and Trust Secretary

Any other attendees will be invited upon request.

3.3 If the Committee Chair is not present, the meeting shall be chaired by another Non-Executive Director.

3.4 The Trust Board has delegated authority to any Non-Executive Director of the Trust to act as nominated deputy in the absence of any Non-Executive and this attendance will count towards the quorum.

3.5 Members of the Committee must attend at least 80% of all meetings each financial year but should aim to attend all scheduled meetings.

3.6 Executive Director members should aim to attend all scheduled meetings with fully briefed deputies to attend no more than one third of meetings on an exception basis.

3.7 The Committee's Executive Lead (Director of Nursing, Allied Health Professionals, Quality and Patient Experience) must be in attendance, or the Medical Director will act as the Committee's Executive Lead.

3.8 Nominated deputies for Executive members will contribute to attendance figures but will not contribute to quorum.

3.9 Other staff may be co-opted to attend meetings as considered appropriate by the Committee on an ad hoc basis.

4. Quorum

4.1 A quorum shall be three members, including at least one Executive Director and two Non-Executive Directors. Non-quorate meetings may go ahead unless the chair decides not to proceed. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

4.2 Meetings may be held face-to-face or virtually by conference call, suitable electronic means or via a hybrid combination, so long as those present can hear each other and contribute simultaneously.

~~4.3 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Board of Directors meeting as an urgent item.~~

5. Frequency

5.1 Meetings shall be held ten times a year on a monthly basis except during January and August.

6. Duties and Responsibilities

In respect of general governance arrangements:

6.1 To ensure that all statutory elements of operational risk and quality governance are adhered to within the Trust including the requirements of regulators, NHS England and the Care Quality Commission (regulations).

6.2 To provide a clear link with the Trust's Strategy and Quality framework when agreeing quality governance priorities and monitor scrutinise these areas to provide assurance and inform the Board on the strategic direction for Quality and monitor the performance of the clinical services.

6.3 To provide direction to the quality governance activities of the Trust's services and divisions. This will include setting strategy, delegating activities and monitoring clinical performance against this strategy or quality priorities.

6.4 To scrutinise, gain assurance and approve the Trust's Quality Governance Annual Reports before submission to the Board.

6.5 To have final sign off of the Trust Quality Account.

6.6 To approve the Terms of Reference and membership of its reporting sub-committees, the primary reporting committee will be the Executive-chaired quality sub-group known as the Trust Quality Operational Group (TQOG) which is established to provide assurance to the Quality and Safeguarding Committee and Trust Board with regards to the quality and safety of patient care delivered by the Trust. The Group will establish a framework to continuously monitor compliance with standards and improve the quality of care.

6.7 To scrutinise the work of the TQOG and receive assurance from the Chair of the group on quality performance issues and mitigating actions to ensure safe and effective services.

6.8 To agree to refer specific issues to the Board and other Board Committees where required and make recommendations as appropriate.

6.9 To receive and approve the annual Clinical Audit Programme consistent with the audit needs of the Trust and consistent with the Quality priorities.

6.10 To have oversight and gain assurance on the Trust's policies and procedures with respect to the use of clinical data and patient identifiable information to ensure that this is in accordance with all relevant legislation and guidance including the Caldicott Guidelines and the Data Protection Act 1998.

6.11 To make recommendations to the Audit and Risk Committee concerning the annual Internal Audit plan, to the extent that it applies to matters within these terms of reference; and to comply with any request from the Audit and Risk Committee for assurance in relation to the Board Assurance Framework and the Risk Register.

6.12 To have overview, responsibility and gain assurance for all regulations and standards as described by the Care Quality Commission as part of our responsibilities under the Care Quality Commission (Registration) Regulations 2009 and Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as amended.

6.13 To promote within the Trust a culture of open and honest reporting of any situation, including Duty of Candour, that may threaten the quality of patient care in accordance with the Trust's policy on Freedom to Speak Up and monitoring the implementation of that policy. This will include an approach that enables an open patient safety culture and gain assurance on its implementation.

6.14 To ensure that when matters of concern are raised during Committee business, these are dealt with openly and transparently and scrutinised as appropriate. When issues arise, the Committee will undertake to challenge robustly and fairly, in order to develop a culture of continuous improvement, openness and honesty.

6.15 To oversee the system within the Trust for obtaining and maintaining any licences relevant to clinical activity in the Trust, such as those which relate to clinical electronic systems in operation within the services of the Trust.

6.16 To ensure that risks to patients are minimised through the application of a comprehensive risk management system including clinical risk registers, monitoring and learning from deaths and associated monitoring.

6.17 To oversee the process and gain assurance within the Trust to ensure that appropriate action is taken in response to adverse clinical incidents, mortality, complaints and litigation and those examples of good practice are disseminated within the Trust and beyond if appropriate.

6.18 To ensure a clear link with the Mental Health Act Committee on aspects of quality governance that are cross cutting clinical standards across the Mental Health Act or Mental Capacity Act legislation that impacts upon clinical standards.

6.19 To maintain a forward plan of regular agenda items as identified by the scheme of delegation.

6.20 To ensure a clear link and be assured with the Commissioners Quality Assurance Group, and that escalated clinical concerns, gaps in commissioning and patient safety concerns are discussed and monitored through the joint commissioner and provider risk and issues log.

6.21 To gain assurance and monitor the work of the Trust-wide groups which report to the Quality and Safeguarding Committee, currently the Serious Incident Requiring Investigation (SIRI) group, the Physical Health Care Committee, Drugs and Therapeutics Committee, Patient Experience group and any short term named task and finish groups established to design or develop Trust Clinical Strategy.

6.22 To co-operate with and assist the work of other Trust-wide groups which report or scrutinise the work of the Quality and Safeguarding Committee, eg governors' Governance Committee or the Council of Governors.

6.23 To receive assurance on how the Trust has developed and planned for all clinical service re-design with sign-off of any associated clinical safety plans to mitigate any significant or material changes in service, which have been designed and developed by the Clinical Operational Assurance teams.

6.24 To conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

6.25 To oversee the development of an annual review of performance of the Committee against key areas of delegated authority and provide a check that all areas of governance and responsibility have been monitored.

6.26 To consider the Board Assurance Framework and high-level risks, in particular as they relate to the remit of the Committee; and to comply with any request from the Audit and Risk Committee for assurance in relation to the Board Assurance Framework and the Risk Register, including deep dives of risks as appropriate.

6.27 To set the Safeguarding Quality Strategy, to provide quality governance and gain assurance to all aspects of the safeguarding agenda and lead the assurance process on behalf of the Trust for the following areas:

6.27.1 **Children Act** has a statutory duty of care towards children (Children Acts 1989 and 2004) at risk of harm who are resident in Derby city and Derbyshire in the Trust's care. The Committee will ensure that safeguards are in place that not only protect and promote the welfare of vulnerable children, but that have a significant impact on children's health and well-being.

6.27.2 **The Care Act (2014)** safeguarding adults at risk of abuse or neglect (Section 42 and named other relevant NHS legislation and NHS Safeguarding Adults policy and procedures.

6.27.3 **The Health and Care Act (2022)** which establishes a framework that supports collaboration and partnership-working to integrate services for patients. The Committee will ensure measures are in place to maintain oversight of quality and safety, specifically in relation to the duty to facilitate the sharing of information relevant to child safeguarding arrangements.

6.27.4 **Counter Terrorism and Security Act 2015** places a duty on specified authorities (identified in full in Schedule 6 to the Act) to have due regard to the need to prevent people from being drawn into terrorism through the Prevent duty. The Prevent duty requires all specified authorities to ensure that there are mechanisms in place to enable health staff to understand the risk of radicalisation and how to seek appropriate advice and support.

6.27.5 **The Mental Health Act (1983) amended 2007** the Committee will ensure that measures are in place to maintain oversight of compliance with the requirements of the Mental Health Act code of practice (2015).

6.27.6 **Mental Capacity Act 2005** the Committee will ensure that measures are in place to maintain oversight of compliance with the requirements of the Mental Capacity Act code of practice (updated 2020)**,** including the deprivation of liberty safeguards (DOLS).

6.27.7 **A formal link to the area Safeguarding Children and Adults Boards** and provide systems leadership to our wider geographical and community safeguarding responsibilities and be the conduit for linking the community Safeguarding Board

strategies with the Trust strategy.

6.27.8 **Promote a proactive and preventative approach** to safeguarding through our Flourishing Families agenda.

6.27.9 Ultimately provide assurance to the Trust Board that the organisation is effectively discharging and fulfilling its statutory responsibility for safeguarding to ensure better outcomes for children and vulnerable adults.

6.27.10 Ensure the Trust workforce is appropriately trained in safeguarding children and adults to their appropriate level depending on their role and responsibility.

6.27.11 To determine strategic and operational development that will enable the Trust to integrate best practice in safeguarding across the Trust. The Committee has a responsibility to improve and develop safeguarding practices consistent with national and local legislation, guidance and standards in safeguarding children and vulnerable people.

6.27.12 To ensure that the Trust embeds Think Family principles within all aspects of care and service developments to enable 'Flourishing Families'.

6.27.13 To provide rigorous and transparent assessment of performance and effectiveness and quality of practice for Safeguarding of Children and Family and Vulnerable Adults services within the Trust.

6.27.14 To advise the Trust Board of national and local standards and Derby and Derbyshire Safeguarding Board arrangements.

6.27.15 The Committee will oversee Serious Case Reviews, Independent Learning Reviews, Domestic Homicide Reviews and all safeguarding major incidents and will advise service level directors and operational managers of recommendations, lessons learnt and compliance requirements.

6.27.16 The Committee will oversee and assure itself that all Safeguarding Boards for Children and Adults are appropriately represented and feedback from Boards to the Trust Board is in place.

6.27.17 The Committee will oversee and assure itself on the 'Prevent and Channel: Supporting Individuals Vulnerable to Recruitment by Violent Extremists' agenda. Establish or use existing mechanisms for understanding the risk of radicalisation. Communicate and promote the importance of the Prevent duty, as outlined in the Counter Terrorism and Security Act (2015) and ensure staff implement the duty effectively.

6.27.18 The Committee will oversee and assure itself on the Multi-Agency Public Protection Arrangements (MAPPA) with relevant agencies including the police. These processes ensure that the requirements for offenders in the community needs are met and duties to public safety are met fully.

6.27.19 The Committee will oversee and assure itself on the Multi-Agency Risk Assessment Conference (MARAC) agenda, that the Trust is discharging its duty. The MARAC aims to share information to increase the safety, health and wellbeing of victims/survivors - adults and their children; improve agency accountability; and improve support for staff involved in high-risk domestic abuse cases.

6.27.20 Have authority in setting the quality standards, defining and monitoring of clinical practice in safeguarding children and vulnerable adult people through delegated duties to the Safeguarding Operational group.

6.28 Safeguarding Adults Key Responsibilities:

6.28.1 Schedule 2 of the Care Act (2014) that geographical links to the Safeguarding Adults Boards must have a clear, agreed understanding of the roles, responsibilities, authority and accountability of its member agencies. Therefore, the Trust should annually:

- Review suitable governance arrangements an effective infrastructure and adequate resources
- Deliver operational and strategic requirements
- Provide links to other boards and partnerships
- Provide links to other boards and partnerships
- Provide a person-centred, outcome focused safeguarding policy and procedures
- Ensure that there is awareness training for all health and social care staff and police who work directly with people with care and support needs
- Ensure that there is a specialist training for all practitioners who have direct responsibilities for safeguarding work
- Develop and publish a Trust strategy specifying each service area's responsibilities
- Link with the wider community to inform its work and learn of the work of the Board
- Sign off the Safeguarding Adult Annual reports, detailing what the Trust and its members have achieved, including how they have contributed to the Board's objectives and what has been learned from and acted upon from the findings of Safeguarding Adults Reviews and Case Reviews and other Domestic Homicide reviews and associated audits
- Arrange for the quality assurance of the effectiveness of safeguarding work.

6.29 Safeguarding Children Key Responsibilities:

- Scrutinise the Safeguarding Children Annual report, oversight of the Section 11 audit work and assurance that the Trust discharges its duty responsibly in line with national requirements
- Review suitable governance arrangements an effective infrastructure, adequate resources
- Deliver operational and strategic requirements
- Provide links to other boards and partnerships
- Provide a child centred, outcome focused safeguarding policy and procedures
- Ensure that there is training for all health and social care staff and police who work directly with people with care and support needs
- Develop and publish a Trust strategy specifying each service area's responsibilities
- Sign off the Children and Looked After Children Annual Reports, detailing what the Trust and its members have achieved, including how they have contributed to the Board's objectives and what has been learned from and acted upon from the findings of Safeguarding Serious Case Reviews.

7. Minutes and Reporting

7.1 The minutes of all meetings of the Committee shall be formally recorded and made available to the Board of Directors.

7.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed.

7.3 The Committee will report annually to the Audit and Risk Committee describing how the Committee has fulfilled its Terms of Reference and give details of any significant issues and how they have been addressed.

7.4 Agendas and papers will be distributed in accordance with deadlines agreed with the Committee Chair. Ideally, this should be no less than three working days, although flexibility will be maintained for extra-ordinary circumstances.

8. Terms of Reference Review

8.1 The Terms of Reference shall be subject to review at least annually.

Approved by Quality and Safeguarding Committee	3 April 2025
Approved by Audit and Risk Committee	24 April 2025
Approved by Trust Board	3 June 2025

People and Culture Committee Terms of Reference

Purpose

The Committee supports the organisation to achieve a well-led, values driven and inclusive positive culture. The Committee is to provide assurance to the Board that the appropriate structures, processes and systems are in place to ensure an effective capable workforce to meet the Trust's current and future needs including workforce engagement and development.

1. Authority

1.1 The People and Culture Committee is constituted as a standing committee of the Foundation Trust's Board of Directors. Its constitution and Terms of Reference shall be as set out below, subject to amendment at future Board of Directors meetings. The People and Culture Committee shall not have executive powers in addition to those delegated in these terms of reference.

1.2 The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice and to secure the attendance of both internal and external officers with relevant experiences and expertise it if considers this necessary.

1.3 To consider the Board Assurance Framework and high-level risks, in particular as they relate to the remit of the Committee; and to comply with any request from the Audit and Risk Committee for assurance in relation to the Board Assurance Framework and the Risk Register including deep dives of risks as appropriate.

1.4 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

1.5 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The People and Culture Committee will ensure consideration has been given to equality impact related risks.

1.6 The Committee has an objective to actively consider the equality impact and evidence relating to all items of Committee business as part of the Committee's contribution to equality, diversity and inclusion.

1.7 As a Committee of the Board, the People and Culture Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's strategic objectives which fall within the Committee's remit, this includes the delivery and implementation of the Trust's People Strategy.

2. Membership

2.1 The membership of the Committee will comprise:

- Non-Executive Directors x three (one will be appointed as the Chair)
- Director of People, Organisational Development and Inclusion
- Director of Nursing, Allied Health Professionals, Quality and Patient Experience
- Deputy Chief Executive and Chief Delivery Officer.

The Deputy Director of Nursing and Quality Governance and Managing Directors are to attend meetings as nominated deputies if the Director of Nursing, Allied Health Professionals and Patient Experience or Deputy Chief Executive and Chief Delivery Officer are unable to attend.

In attendance as core attendees:

- Deputy Director of People, Organisational Development and Inclusion
- Other team leaders may be invited to attend to present on specific agenda items or when relevant at the discretion of the Chair and Director of People, Organisational Development and Inclusion.

2.2 Executive Director members should aim to attend all scheduled meetings with fully briefed deputies to attend no more than one third of meetings on an exception basis.

3. Attendance

3.1 Only members of the Committee have the right to attend and vote at Committee meetings. The Committee may require other officers of the Trust, and other individuals to attend all or any part of its meetings as and when is necessary.

3.2 The Chief Executive Officer reserves the right to attend any meeting.

3.3 The Trust Chair will appoint the Chair of the Committee.

3.4 Members of the Committee must attend at least 80% of all meetings each financial year but should aim to attend all scheduled meetings.

3.5 The Trust Board has delegated authority to any Non-Executive Director of the Trust to act as nominated deputy in the absence of any Non-Executive and this attendance will count towards the quorum.

4. Quorum

4.1 A quorum shall be three (not less than two Non-Executive Directors and one Executive Director). Non-quorate meetings may go ahead unless the chair decides not to proceed. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

4.2 Meetings may be held face-to-face or virtually by conference call, suitable electronic means or via a hybrid combination, so long as those present can hear each other and contribute simultaneously.

~~4.3 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Trust Board meeting as an urgent item.~~

5. Frequency

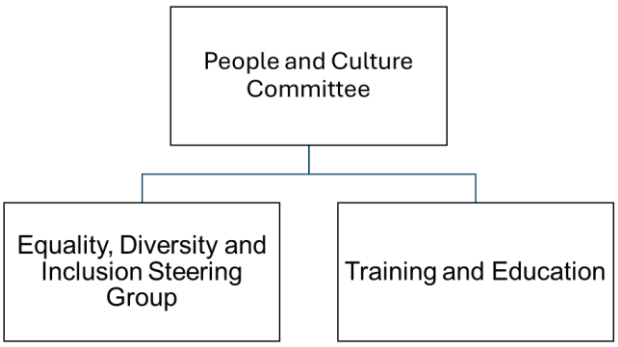
5.1 The Committee will meet on a bi-monthly basis with additional meetings being called when necessary.

6. Duties and Responsibilities

6.1 The Committee will support the organisation to achieve a well led, values driven positive culture. The Committee is to provide assurance to the Board that the appropriate structures, processes and systems are in place to ensure an effective capable workforce to meet the Trust's current and future needs.

6.2 The Committee will monitor the implementation of the People Plan~~Strategy~~ and report progress to the Board by exception.

6.3 A number of supporting groups/forums will be accountable to the People and Culture Committee whilst not exhaustive; it is anticipated that the following groups will have a direct or indirect relationship and will be agreed within the Committee:



6.4 The Committee will oversee and monitor workforce performance.

6.5 The Committee reviews and monitors the Workforce metrics and Board Assurance Framework and ensures the Board is kept informed of any significant workforce risks.

6.6 The Committee considers the Board Assurance Framework and high-level risks, in particular as they relate to the remit of the Committee; and complies with any request from the Audit and Risk Committee for assurance in relation to the Board Assurance Framework and the Risk Register including deep dives of risks as appropriate.

6.7 The Committee is to be assured that mechanisms are in place to review and monitor the effectiveness and capability of the workforce across the whole Trust and that appropriate actions are taken to address issues of poor performance and bring about continuous quality improvement.

6.8 The Committee is to be assured that the Trust identifies lessons for improvement and implements these in all relevant areas.

6.9 The Committee is to be assured that national standards, guidance and best practice are systematically reviewed and embedded within the Trust.

6.10 The Committee is to be assured that the views of staff and appropriate others are systematically and effectively engaged in organisational development activities.

6.11 The Committee is committed to ensuring that when matters of concern are raised during Committee business these are dealt with openly and transparently and scrutinised as appropriate. When issues arise, the Committee will undertake to challenge robustly and fairly in order to develop a culture of continuous improvement, openness and honest.

6.12 The Committee will oversee the leadership, training and education framework and monitor progress.

6.13 The Committee will oversee staff health and wellbeing including Trust and Divisional level health and wellbeing initiatives and health and wellbeing support aligned to staff absence

6.13 The Committee will monitor the implementation of agreed action plans in relation to organisational interventions and measure the effectiveness of change.

6.14 The Committee will review its effectiveness by self-assessment on an annual basis and at the end of each meeting. The annual review will be presented to the Audit and Risk Committee.

7. Minutes and Reporting

7.1 The minutes of all meetings of the Committee shall be formally recorded and made available to the Board of Directors.

7.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed.

7.3 The Committee will report annually to the Audit and Risk Committee describing how the Committee has fulfilled its Terms of Reference and give details of any significant issues and how they have been addressed.

7.4 The Committee will conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

7.5 Agendas and papers will be distributed in accordance with deadlines agreed with the Committee Chair. Ideally, this should be no less than three working days, although flexibility will be maintained for extra-ordinary circumstances.

8. Terms of Reference Review

8.1 The Terms of Reference shall be subject to review at least annually.

Approved by People and Culture Committee	25 March 2025
Approved by Audit and Risk Committee	24 April 2025
Approved by Trust Board	3 June 2025

Mental Health Act Committee Terms of Reference

Purpose

The Committee monitors and obtains assurance on behalf of the Hospital Managers and the Trust as the detaining authority that the safeguards of the Mental Health Act are appropriately applied. It also monitors related statute and guidance and reviews the reports following Mental Health Act inspections by the Care Quality Commission.

1. Authority

1.1 The Board of Directors has approved the establishment of a Mental Health Act Committee as a Committee of the Board. The purpose of the Committee is to obtain assurance, on behalf of the "Hospital Managers" and the Trust as the detaining authority, that the safeguards and provisions of the Mental Health Act are appropriately applied; to take account of the provisions of related statute and guidance, such as Mental Capacity Act, Deprivation of Liberty Safeguards (DOLS) and Human Rights Act.

1.2 The Committee will exercise its responsibilities by fulfilling a scrutiny and monitoring role from receipt of regular activity data and inspection reports from an Operational Group; by obtaining assurance that best practice is deployed across the Trust.

1.3 As a Committee of the Board, the Mental Health Act Committee has an important role to provide assurance on the progress and risks arising relating to the delivery of the Trust's Strategic objectives which fall within the Committee's remit. It will consider any exceptions or risks escalating these to the Trust Board or referring to the Executive Leadership Team as necessary.

1.4 The Committee is authorised by the Board of Directors to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

1.5 The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

1.6 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The Mental Health Act Committee will ensure consideration has been given to equality impact related risks.

1.7 The Committee will actively consider the equality impact and evidence relating to all items of Committee business as part of the Committee's contribution to equality, diversity and inclusion.

1.8 As a designated policy ratification group, (see 'Policy on Policy Documents) the Mental Health Act Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. These include policies in relation to the Mental Health Act and Code of Practice requirements, and the duties of Associate Hospital Managers, including the protocols for the hearing of appeals and reviews. It also includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template. All policy documents are allocated a policy ratification group as they are published on Focus.

1.9 An operational subgroup will meet approximately one month before the full Committee to prepare assurances and highlight exceptions.

2. Membership

2.1 The membership of the Committee shall comprise:

- Non-Executive Directors x three (one will be appointed as Chair of the Committee)
- Medical Director or ~~a nominated Deputy~~ Director of Nursing, AHPs, Quality and Patient Experience
- Director of Corporate Affairs and Trust Secretary.

2.2 The Trust Chair will appoint the Chair of the Committee.

2.3 If the Committee Chair is not present, the meeting shall be chaired by another Non-Executive Director.

3. Attendance

3.1 Additional attendees shall comprise:

- Assistant Director of Legal, Governance and Mental Health Legislation
- Mental Health Act Manager
- Representative of Associate Hospital Managers
- Director of Nursing, Allied Health Professionals and Patient Experience, when required (refer to quorum at 4.1 below)
- Other senior management/professional leads may be invited at the discretion of the Committee Chair.

3.2 The Chief Executive Officer reserves the right to attend any meeting.

3.3 Members of the Committee must attend at least 80% of all meetings each financial year but should aim to attend all scheduled meetings.

3.4 The Trust Board has delegated authority to any Non-Executive Director of the Trust to act as nominated deputy in the absence of any Non-Executive and this attendance will count towards the quorum.

4. Quorum

4.1 A quorum shall be a minimum of three members including at least two Non-Executive Directors and one Executive Director. If the Medical Director is unable to attend the Director of Nursing, Allied Health Professionals and Patient Experience will be required to attend instead in order to meet the quorum requirements. Non-quorate meetings may go ahead unless the chair decides not to proceed. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

4.2 Meetings may be held face-to-face or virtually by conference call, suitable electronic means or via a hybrid combination, so long as those present can hear each other and contribute simultaneously.

~~4.3 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Trust Board meeting as an urgent item.~~

5. Frequency

5.1 Meetings will be held quarterly.

6. Duties and Responsibilities

6.1 To receive compliance and assurance reports from the Operational Group regarding the number of patients subject to detention under each section of the Mental Health Act for the previous quarter as part of a rolling twelve-month review to identify any variation or trends (including diversity data) and provide interpretation of data including an outline of actions arising as appropriate.

6.2 To consider matters of recommended good practice, and in particular the requirements of the Code of Practice (Revised): Mental Health Act (1983) and its Code of Practice as amended and approve policy changes to receive assurance on the steps taken to implement and embed recommended good practice relating to the requirements of the Mental Health Act, Mental Capacity Act and related legislation.

6.3 To receive assurance reports and scrutinise, as required, other activity reports from the Operational Group, eg the use of seclusion, noting any exceptions and escalating concerns as necessary.

6.4 To receive assurance reports relating to the Care Quality Commission Inspection Reports and the implementation of the management response as defined by the Operational Group, providing scrutiny and challenge and noting exceptions and risks escalated by the operational group. With regard to Section 136, to oversee and receive assurance on the use of this section through the multi-agency Section 136 sub-committee.

6.5 To oversee the implications of related legislation, principally the Mental Capacity Act, (including Deprivation of Liberty), Human Rights Act guidance and other related legislation as appropriate, receiving assurance on impact, risk and effective implementation throughout the Trust.

6.6 To oversee that training needs are satisfactorily met to ensure compliance with legislative and best practice requirements, through assurance reporting and in general help promote awareness of the requirements of the Mental Health Act, Mental Capacity Act and associated legislation.

6.7 When receiving information on Mental Health Act activity and reports, the Committee will pay due regard to the Trust's Equality and Diversity Agenda.

6.8 To ensure that when matters of concern are raised during Committee business these are dealt with openly and transparently and scrutinised as appropriate. When issues arise, the Committee will undertake to challenge robustly and fairly in order to develop a culture of continuous improvement, openness and honesty.

6.9 To consider the Board Assurance Framework and high-level risks, in particular as they relate to the remit of the Committee; and to comply with any request from the Audit and Risk Committee for assurance in relation to the Board Assurance Framework and the Risk Register including deep dives of risks as appropriate.

6.10 To conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

6.11 To maintain a forward plan of regular agenda items to encompass the role and remit of the Committee as outlined in the Terms of Reference.

6.12 To oversee the development of an annual review of performance of the Committee against key areas as outlined within the Terms of Reference and confirm that all areas of governance and responsibility have been monitored.

6.13 Receive feedback from Associate Hospital Mangers and review any performance issues arising from mental health tribunals.

7. Minutes and Reporting

7.1 The minutes of all meetings of the Committee shall be formally recorded and made available to the Board of Directors.

7.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed.

7.3 The Committee will report annually to the Audit and Risk Committee describing how the Committee has fulfilled its Terms of Reference and give details of any significant issues and how they have been addressed.

7.4 Agendas and papers will be distributed in accordance with deadlines agreed with the Committee Chair. Ideally, this should be no less than three working days, although flexibility will be maintained for extra-ordinary circumstances.

8. Terms of Reference Review

8.1 The Terms of Reference shall be subject to review at least annually.

Approved by Mental Health Act Committee	21 March 2025
Approved by Audit and Risk Committee	24 April 2025
Approved by Trust Board	3 June 2025

Appendix 2

Board Committee Meeting Year-End Review 2024/25

Audit and Risk Committee

1. Purpose

The Audit and Risk Committee is the principal Committee for seeking independent assurance on the general effectiveness of the Trust's internal control and risk management systems and for reviewing the structures and processes for identifying and managing key risks. It is responsible for reviewing the adequacy of all risk and control related statements prior to approval by the Board of Directors and for seeking assurances on these controls. In discharging its responsibilities, the Committee takes independent advice from the Internal Auditor or seeks any other legal or professional advice as required to discharge its responsibilities.

It achieves this by:

- Ensuring there is an effective internal audit function that provides appropriate independent assurance to the Committee, the Chief Executive and the Board of Directors
- Reviewing the work and findings of the Trust's External Auditor
- Reviewing the findings of other significant assurance functions, both internally and externally
- Reviewing the work of other committees within the organisation
- Requesting and reviewing reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control
- Reviewing and by delegated authority, approving the annual report and financial statements
- Ensuring that the systems for financial reporting to the Board, including those around budgetary control, are subject to review in order to be sure that they are complete and accurate.

Throughout the year, the Committee considers external audit reports, internal audit reports, and counter-fraud progress reports. All audit outcomes are overseen by monitoring the delivery of internal and external audit report recommendations.

The Committee considers the Board Assurance Framework, Annual Report and Annual Governance Statement and progress with internal and external audit plans. It also receives updates on losses and compensation payments, exit payments, conflicts of interest, tenders and waivers, debtors and clinical audit. The Committee also considers governance and compliance documents as well as oversight of the Trust's commercial insurances.

The Committee assesses the effectiveness of the external audit process by undertaking a self-assessment each year and by meeting with auditors in private. Auditors attend every meeting of the Committee, and the Trust's compliance with the audit plan approved by the Committee is monitored.

2. Authority

The Audit and Risk Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's strategic objectives. This includes identification, review and scrutiny of all relevant risks on the Board Assurance Framework (BAF) and reviewing of BAF management and reporting prior to formal reporting to the Trust Board. The Committee is authorised by the Board of Directors to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice. The Committee is also authorised by the Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

The Committee did not identify the need to seek external legal advice or other independent professional advice during the year.

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The Audit and Risk Committee will ensure consideration has been given to equality impact related risks. The equality impact of all reports to the Committee is considered via the prompt on the report cover sheet template.

As a designated policy ratification group, (see Policy on Policy document) the Audit and Risk Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. This includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template.

In 2024/25 the Committee approved the following:

- Corporate Governance Framework – May 2024
- Counter Fraud and Bribery Policy and Procedures – October 2024.

The Committee agreed a revised set of Standing Financial Instructions (SFIs) during the annual review of SFIs at its July meeting.

3. Membership of Audit and Risk Committee

The Audit and Risk Committee comprises independent Non-Executive Directors. The Committee members in 2024/25 are listed below:

Name	**Title**
Geoff Lewins	Committee Chair, Non-Executive Director
Deborah Good	Non-Executive Director
Andrew Harkness (from Jan-2025)	Non-Executive Director
Ashiedu Joel (until Jul-2024)	Non-Executive Director

4. Attendance

An attendance log reflects attendance by members of the Committee, as well as the Director of Corporate Affairs and Trust Secretary and Director of Finance who are required to attend routine meetings of the Committee to support the Chair and Committee members. The Director of Corporate Affairs and Trust Secretary is the nominated Lead Executive for the Committee. Other Executive Directors have attended by invitation to consider areas of risk or operation that are their responsibility.

The Chief Executive as Accountable Officer attends the annual sign of meeting at which the Annual Report and Accounts including the Annual Governance Statement were considered, as well as the opinion of the Head of Internal Audit which supports the conclusion within the Annual Governance Statement. The Trust Chair also attended the meeting to consider and approve the Annual Report and Accounts. The Lead Governor is invited to attend the meeting to observe the final approval of the Annual Report and Accounts, where they cannot attend the Committee Chair offers a follow up meeting.

The External Auditor was represented at all meetings. Internal Auditors attended all meetings of the Committee. A representative of the Counter Fraud Service attended the meetings when counter fraud reporting was scheduled. Both the Internal and External Auditors had the opportunity to meet with the Audit and Risk Committee Chair in private (without Executives present) prior to Committee meetings.

5. Access

The Head of Internal Audit, representatives of External Audit and Counter Fraud Specialist have a right of direct access to the Chair of the Committee and are aware of the channels through which this can be achieved. In practice, this has been undertaken through the private meetings held prior to each Committee meeting.

6. Frequency of Meetings

The Committee met six times throughout the year: 25 April 2024, 23 May 2024, 19 June 2024, 25 July 2024, 10 October 2024 and 23 January 2025 discharging its responsibilities as set out in the Terms of Reference.

7. Required frequency of attendance by members

According to the Committee's Terms of Reference, members should attend at least 80% of all meetings each financial year but should aim to attend all scheduled meetings. In 2024/25, the majority of members achieved in excess of 80% attendance at the meetings of the Committee. All meetings have been quorate (although for one meeting another Non-Executive Director attended to ensure quoracy). Below is the 2024/25 attendance log:

Audit & Risk Committee - 2024/25									
Attendance Record	**25-Apr-2024**	**23-May-2024**	**19-Jun-2024**	**25-Jul-2024**	**10-Oct-2024**	**23-Jan-2025**	**Number of meetings attended**	**Total number of meetings eligible to attend**	**%**
MEMBERS									
Geoff Lewins	1	1	1	1	1	1	6	6	100%
Deborah Good	1	1	0	1	1	1	5	6	83%
Andrew Harkness						1	1	1	100%
Ashiedu Joel	1	1	1	0			3	4	75%
Ralph Knibbs					1		1	1	100%
EXECUTIVE ATTENDEES									
Justine Fitzjohn	1	1	1	1	1	1	6	6	100%
James Sabin	1	1	1	1	1	1	6	6	100%

8. Duties and Responsibilities

The Audit and Risk Committee has an annual plan of scheduled agenda topics, along with a range of specific issues which are subject to review. A rolling programme of actions is maintained and monitored. The following subheadings, shown in italics, are copied from the Duties and Responsibilities section of the Terms of Reference of the Audit and Risk Committee (attached). The commentary underneath each subheading is drawn from a review by the Director of Corporate Affairs and Trust Secretary of the minutes of all meetings and other relevant information.

The Committee's duties and responsibilities can be categorised as follows:

9. Integrated governance, risk management and internal control

9.1 To review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities, clinical and non-clinical, that supports the achievement of the Trust's objectives.

The Committee has a forward plan that maps out the periodic review of governance, risk and controls, internally and externally (via the audit plan and programmes).

The management of risk underpins the achievement of the Trust's Strategy and related objectives. The Trust's approach to Risk Management is set out in the Risk Management Strategy 2023-2025 which comprehensively brings together the Trust's risk management approach. The Committee received an annual summary of progress against the Risk Management Strategy in October 2024.

It was agreed that annual updates will continue to be received in order to measure progress against the Risk Management Strategy. The Committee accepted the inclusion of the system-based risk impacting on and mitigated by multiple system organisations as a stand-alone risk that is now included in the BAF report for scrutiny but presented apart from risks specific to the Trust's strategic objectives. This was changed with the launch of the new Strategy in November 2024 and is now included in the Partnerships BAF risk.

The Committee receives quarterly Operational Risk Management reports.

9.2 To consider the Board Assurance Framework and high-level risks, and to comply with any request for assurance in relation to the Board Assurance Framework and the Risk Register including deep dives of risks as appropriate.

The Committee has reviewed the format and content of the Board Assurance Framework three times during 2024/25 and has challenged the adequacy of the assurances that have been received. The BAF includes risks and mitigations developed in line with the objectives which support delivery of the Trust Strategy.

The Committee was assured that the Board Assurance Framework process was reviewed, scrutinised and updated in seeking to identify and mitigate risks to achieving the Trust's strategic objectives. There was one deep dive (finance) in January 2025.

9.3 In particular to review the adequacy and effectiveness of:

- ***all risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances.***

The Annual Governance Statement was subject to scrutiny and challenge by the Audit and Risk Committee to ensure it met the requirements as set out for the report. The Committee was assured that the report was balanced and fair.

- ***the underlying assurance processes that indicate the degree of achievement of the Trust's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.***

- ***arrangements for the effective management of clinical and corporate risk to underpin the delivery of the Trust's principal objectives***.

The Committee has a process for receiving 'Deep Dives' which provides assurance over controls and gaps in assurance with a focus on action plans to manage risks. This approach informs and supports the overall review of the BAF prior to regular submission to the Trust Board.
All high and extreme clinical and corporate risks are identified and linked to the BAF risks as part of routine reporting. A six-monthly report links corporate/operational risks to BAF risks.

- ***arrangements in place for preventing and countering fraud, bribery and corruption and managing security in compliance with the related NHS Counter Fraud Authority standards.***

The Trust's Counter Fraud Service was provided by 360 Assurance to the year end. Plans were designed to provide counter-fraud, bribery and corruption work across generic areas of activity in compliance with the latest guidance and standards.

The counter fraud annual report includes the NHS Counter Fraud Authority Functional Return. 360 Assurance assured the Committee that the Trust's counter fraud, bribery and corruption arrangements are embedded. There is a strong anti-fraud, bribery and corruption culture within the Trust and the counter fraud service delivered by 360 Assurance is efficient.

The Committee receives progress reports against delivery of the work plan including compliance against the comprehensive fraud risk assessment. This assessment is also recorded and managed in line with the organisation's risk management policy and included on the appropriate risk registers.

The Committee's Executive Lead and Director of Corporate Affairs and Trust Secretary has an additional role as the Trust's Counter Champion.

- ***The Committee shall maintain an oversight of the Trust's general material control and risk management systems, including processes and responsibilities, the production and issue of any risk and control-related disclosure statements. The key record to guide the Committee's work will be the Board Assurance Framework (BAF).***

The BAF is a 'live' document and as such is regularly reviewed and updated. The Committee is responsible for reviewing the BAF to assure itself that the BAF appropriately addresses objectives and risks and also to ensure that newly arising risks are identified. The Committee has confirmed that it is satisfied that the BAF shows a clear mapping across all risks identified by the Board of Directors and that good engagement has taken place with the Executive Directors in managing the overarching Risk Register.

9.4 As part of its integrated approach, the Committee will ensure appropriate information flows, to the Committee from executive management and from and between other Board Committees, in relation to the Trust's overall internal control and risk management position.

The Audit and Risk Committee secures its oversight on assurance of effectiveness of other committees via each Committee's year-end report. Annual Effectiveness Reports relating to 2023/24 were received by the Committee in April 2024. For 2024/25 they are planned for review by the Committee in April 2025. Ongoing oversight was secured from the Committee assurance summaries presented to the Trust Board. There have been escalations between Board Committees during the year.

9.5 To monitor corporate governance (eg compliance with terms of the licence, constitution, codes of conduct, standing orders, standing financial instructions, maintenance of registers of interests).

The Corporate Governance Framework was presented to the Committee at its May 2024 meeting. The Waiver of Standing Financial Instructions Register reports are received by the Committee every six months. An annual review of Standing Financial Instructions (SFIs) is built into the Forward Plan.

An external assessment under the Well Led Framework was undertaken in 2023 by the Office of Modern Governance. The assessment of the Trust's governance arrangements was a positive one. During the course of the review the Office of Modern Governance indicated they observed many elements of good or leading-edge leadership and governance practice. This was balanced by the highlighting of areas where a sharpening or subtle refocusing of the Trust approach will accelerate the journey of improvement the Trust is on. These areas were reflected in the recommendations and have been built into the action plan, delivery of which is being monitored by the Audit and Risk Committee.

9.6 To develop and use an effective assurance framework to guide the Committee's work. This will include utilising and reviewing the work of the internal audit, external audit and other assurance functions as well as reports and assurances sought from directors and managers and other investigatory outcomes so as fulfil its functions in connection with these Terms of Reference.

See items 9.2-9.3 above.

10. Internal audit

10.1 To review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation.

The Trust takes a risk-based approach to developing the internal audit. The Committee has received assurance that sufficient work has been undertaken for the Head of Internal Audit opinion.

10.2 To oversee on an on-going basis the effective operation of internal audit in respect of:

- ***Adequate resourcing***
- ***Co-ordination with external audit***
- ***Meeting the Public Sector Internal Audit Standards***
- ***Providing adequate independent assurances***
- ***Having appropriate standing within the Trust***
- ***Reviewing and approving the internal audit plan ensuring that this meets the internal audit needs of the organisation.***

The Committee has a standing item on its agenda to receive a progress report from the Internal Auditors. The internal audit programme was regularly reviewed in year to ensure that it continued to meet the internal audit needs of the organisation.

10.3 To consider the major findings of internal audit investigations and management's response and their implications and monitor progress on the implementation of recommendations.

Much of the work of the Committee is supported by the programme of work for internal audit services, provided by 360 Assurance. Services have been within an agreed work plan, prepared in consultation with the Executive Leadership Team and approved by the Committee, which seeks to ensure that reviews focus on areas of risk identified by the Trust.

The Internal Auditors progress report lists the outcomes of the completed reviews. Any Limited Assurance report is presented in full to the Committee, the Executive Director Lead is invited to attend the meeting to set out the management response and approach towards the agreed actions. Compliance against actions is monitored through the 'Pentana' system and reported in the Internal Audit Progress Report.

10.4 To consider the provision of the internal audit service, the cost of the audit.

360 Assurance's contract was renewed via direct award and commenced on 1 December 2022-31 March 2026 with a further two year optional extension.

10.5 To monitor the effectiveness of internal audit and to conduct an annual review of the internal audit function.

Reviewed as part of the annual report presented to the Committee, 360 Assurance issues client satisfaction questionnaires.

11. External audit

11.1 To make a recommendation to the Council of Governors in respect of the appointment, re-appointment and removal of an external auditor and related fees as applicable. To the extent that the recommendation is not adopted by the Council of Governors, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

Mazars (now Forvis Mazars) were appointed on 1 September 2020 under a three-year contract (with a two-year renewal option) performing the external audit of the Trust from 2020/21 onwards.

The Council of Governors approved the award for the two years in 2023 and the current contract is due to expire at the end of August 2025. The Committee will be assisting the Council of Governors to ensure that a contract is in place before the expiry of the current contract.

11.2 To discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy.

Regular reporting to the Committee by the External Auditor as a standing agenda item encompasses updates on the nature and scope of the annual audit to be undertaken.

11.3 To assess the External Auditor's work and fees each year and based on this assessment, to make the recommendation above to the Council of Governors with respect to the re-appointment or removal of the Auditor. This assessment should include the review and monitoring of the External Auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.

A report is presented annually to the Council of Governors on the work of the External Auditors. A positive response was received from the Trust on the annual client satisfaction survey performed issued by Forvis Mazars.

11.4 To oversee the conduct of a market testing exercise for the appointment of an auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors with respect to the appointment of the Auditor.

See 11.1 and 11.2

11.5 To review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations.

Implementation of recommendations has been overseen as part of reporting to the Committee on internal and external audit review recommendations.

11.6 To develop and implement a policy on the engagement of the External Auditor to supply non-audit services.

This policy is in place with the External Auditors.

11.7 To consider the provision of the external audit service, the cost of the audit and any questions of resignation and dismissal of the auditors.

See items above (11.2, 11.3 11.4) relating to the provision of the External Audit service.

12. Annual accounts review

12.1 To approve the Annual Report and Accounts and Annual Governance Statement on behalf of the Trust Board. In doing so the Committee will determine their completeness, objectivity, integrity and accuracy.

In preparation for approval of the Annual Report and Accounts, the Committee reviewed the relevant disclosure statements, in particular the Annual Governance Statement, together with the Head of Internal Audit Opinion, External Audit Opinion and considered that the Annual Governance Statement was consistent with its views on the Trust's systems of internal control.

12.2 To review all accounting and reporting systems for reporting to the Board of Directors, including in respect of budgetary control.

The Committee agreed the draft accounting policies for annual accounts 2024/25 in January 2025.

13. Speaking Up

To review the adequacy of the Trust's arrangements by which Trust staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.

The Committee receives updates on the implementation of the Freedom to Speak Up (FTSU) Policy within the Trust twice a year, in October and April. The reports enable the Committee to review the robustness of policy and procedures.

The Committee agreed significant assurance in 2024/25 with the adequacy of the Trust's arrangements by which Trust staff may, in confidence, speak up about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.

14. Standing orders, standing financial instructions and standards of business conduct

14.1 To review on behalf of the Board of Directors the operation of, and proposed changes to, the standing orders and standing financial instructions, the constitution, codes of conduct and standards of business conduct; including maintenance of registers.

Apart from SFI, this requirement is covered by the Corporate Governance Framework which is reported and approved by the Committee. The Framework is comprehensively reviewed every three years but elements of it are revised more frequently, for example the annual review and approval of Committee Terms of Reference.

14.2 To examine the circumstances of any significant departure from the requirements of any of the foregoing, and whether those departures relate to a failing, an overruling or a suspension.

No significant issues were reported during the 2024/25 year. Reports of waiving of the Standing Financial Instructions and Standing Orders (where these have occurred) have been routinely reported to the Committee.

14.3 To review the scheme of delegation.

This forms part of the Corporate Governance Framework of the Trust and is reviewed periodically.

Other

14.4 To review performance indicators relevant to the remit of the Committee.

Through reporting from the auditors, the Audit and Risk Committee remained appraised of the Trust's performance in financial indicators as benchmarked against other mental health foundation trusts and the wider NHS.

14.5 To examine any other matter referred to the Committee by the Board of Directors and to initiate investigation as determined by the Committee.

No actions have been referred to the Committee by the Board of Directors during the year.

14.6 To consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health sector and professional bodies with responsibilities that relate to staff performance and functions.

Direct oversight of regulatory reviews carried out during the year, such as those undertaken by the CQC, have remained within the remit of the Trust Board itself, with assurance for CQC reporting through the Quality and Safeguarding Committee.

14.7 To review the work of all other Trust committees in connection with the Committee's assurance function.

See 9.4 above.

14.8 The Committee may also request specific reports from individual functions within the Trust (for example, clinical audit).

Reports have been requested during the year including on-going updates on salary overpayments and processes for the supervision of staff. The Committee also received assurance on the overall 2023/24 Clinical Audit programme, its fitness for purpose and its delivery; and provided an initial view of the Clinical Audit Programme for 2024/25.

14.9 The Committee may refer specific issues to the Board, Finance and Performance Committee and other Committees and make recommendations as appropriate.

At the conclusion of every meeting the Committee discussed and agreed any necessary referrals to other Committees. These are noted on the assurance summary of the meeting presented to the Public Board meeting. Referrals are noted on the Committee's actions matrix and archived once evidence and assurance has been received that these are complete.

14.10 The Committee will receive assurance reports on Information Governance arrangements, particularly in respect to compliance with the Information Governance Toolkit and legislative compliance including the Data Protection Act and General Data Protection Regulation (GDPR).

An update on Data Security and Protection including cyber security and compliance with the Data Security and Protection Toolkit was received in May 2024 in line with the revised national reporting timetable. Significant assurance was confirmed. Reporting will continue on bi- annual basis.

14.11 Audit and Risk Committee has a specific responsibility for overseeing the management of conflicts of interest and evaluating the Trust's response to implementing the Trust's Conflict of Interest Policy. The Committee is specifically cited in the national guidance in respect of consideration of any breaches.

The Committee receives updates on compliance against the Conflicts of Interest Policy twice a year. This also includes reporting on gifts, hospitality, sponsorship and secondary employment in line with the Policy.

15. Feedback from Audit Committee Handbook survey

The Director of Corporate Affairs and Trust Secretary and Committee Chair have completed Checklist 1 from the HFMA Audit Committee handbook and this year, Members (and regular attendees) have also been invited to complete the Checklist 2 questionnaire individually. This questionnaire covers Committee processes and effectiveness. The significant majority of responses were either 'strongly agree' or 'agree' in terms of positive response. Examples of positive comments are:

- the Committee is a place where robust challenge and open discussion is welcomed
- papers are clear, well understood and often have general understanding on consensus.

An area for improvement is connectivity and sharing information with/and from other Board Committees in support of the Audit Committee's work.

16. Objectives

These are now embedded in the terms of reference and assessed as part of the year-end effectiveness report which will be prepared for the Committee in April 2025.

The key objectives are:

- **To ensure the internal audit programme is effectively implemented and reports signed off in a timely manner.**

Measured by adherence to agreed timelines for internal audit processes as reported through internal audit plan progress reports as standing item at all Committee meetings.

- **To promote best practice across all Board Committees, building upon embedded practice and seeking continuous improvement.**

Evaluated through end of year reports and ongoing discussion at Board Committee chairs meetings during the year. Best practice across all Board Committees is a core item of business at the Board Committee Chairs meetings.

- **Ensure continued engagement/governor involvement in external audit and related Committee matters.**

See 4. The Lead Governor is invited to observe the year end account sign off meeting. The Annual Report and Accounts and report from the External Auditors is reported to the Council of Governors in September every year. Approval of the External Audit Contract is a duty of the Council of Governors, which is assisted by the Audit and Risk Committee.

- **To further embed oversight of risk within the Board Committee structure.**

The Committee has led focus on the BAF, including Deep Dives on any Extreme rated BAF risks where required, to drive Board and Committee business to focus work on the successful delivery of the Trust's strategic objectives.

This is measured through the year-end review of Committees (April annually) to confirm embeddedness of established process in this area. Assurance summaries from Committees to the Board operated well during the year to date in their role to provide the Board with assurance on key areas of Committee business and also to escalate risk issues.

- **To ensure that robust governance processes are in place, including oversight of effective implementation of any revised governance structure arising from Trust strategy review.**

Evidenced through implementation of the framework of established activity in internal audit, external audit, assurance reporting on risk management and other internal/external reports which have given assurance to allow sign off of annual report and accounts including the Annual Governance Statement.

The Annual Governance Statement brings together all the detail on systems, controls and processes. A draft will be presented to the Committee in April 2025. The Committee has received staged reporting on the Head of Internal Audit Opinion.

The Committee also oversees the Well Led Review action plan, which at the end of 2024/25 only had one action outstanding.

- **To identify training needs of Audit and Risk Committee members and deliver appropriate training/support to enable members to be effective in their Committee role.**

The Committee Chair has attended networking events relating to their roles during the year and he also attends the JUCD Audit Committee Chairs group. Additional training and support is provided to the newest members of the Committee. The latest HMFA Audit Committee Handbook has been circulated to the Committee. Internal and External Audit circulate regular briefing relevant to the audit environment.

- **To review results from the annual Committee effectiveness report and develop actions (not covered by above) for delivery by the Committee to agreed timeframes.**

See 10 above.

- **To clarify and implement effective reporting and oversight of Data Quality**

The Committee has continued to seek periodic assurance from the IM&T lead that data continues to follow the rules of validation. An update report is presented every six months.

- **To actively consider the equality impact and evidence relating to all items of Committee business as part of the Committee's contribution to equality, diversity and inclusion.**

Although the Committee has not undertaken a specific review in 2024/25, report authors continue to complete the equality, diversity and inclusion section of the front sheets.

- **To ensure any gaps in assurance identified in the internal audit programme are adequately covered via alternative methods such as self-effectiveness or external review.**

This will be evaluated as part of the response to the 2024/25 Head of Internal Audit Opinion and will be considered as part of approval of the 2025/26 Internal Audit Plan.

17. Freedom to Speak Up

The Audit and Risk Committee is committed to the principles of Speaking Up and actively shaping the speaking up culture. To this end the Committee has considered in carrying out this review, that it has robustly challenged itself to improve patient safety, develop a culture of continuous improvement, openness and honesty. This can be specifically evidenced through the update reports on Freedom to Speak Up received by the Committee.

18. Ongoing Assurance – Governance Best Practice

The Committee has embedded the principles of the good governance best practice and continues to follow the process contained in its annual forward planning and review of effectiveness.

19. Minutes and Reporting

19.1 The minutes of all meetings of the Committee shall be formally recorded and made available to the Board of Directors.

Each meeting is formally recorded and available to all Board members.

19.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed. This will include details of any evidence of potentially ultra vires, otherwise unlawful or improper transactions, acts, omissions or practices or any other important matters. To the extent that such matters arise, the Chair of the Committee shall present details to a meeting of the Board of Directors in addition to the assurance summary.

An assurance summary is reported to the public meeting of the Board of Directors after each meeting, which summarises discussions, details assurance and actions required, as well as decisions made and identification of any key risks. Items for escalation to the Board or for referral to other Board Committees are also contained within the assurance summary.

19.3 The Committee will report annually to the Board of Directors and the Council of Governors in respect of its work in support of the annual governance statement (AGS) specifically commenting on:

- ***The assurance framework and its fitness for purpose***
- ***The effectiveness of risk management within the Trust***
- ***The integration of and adherence to governance arrangements***
- ***The appropriateness if the evidence that shows the organisation is fulfilling its regulatory requirements relating to its existence as a functioning business***
- ***The robustness of the processes behind the quality accounts; and***
- ***Any pertinent matters in respect of which the Committee has been engaged.***

The Board of Directors receives regular updates on the progress of compiling the AGS as part of the Board Committee Assurance Reports. The Committee has delegated authority from the Board to sign off the Annual Report and Accounts including the AGS Report and the sign off meeting is attended by the Chair and Chief Executive. The Committee Chair presented a summary of the Committee's Annual Report for 2023/24 to the Council of Governors in September 2024. The Trust's Annual Report and Accounts for 2023/24 were presented to the Council of Governors by Forvis Mazars, the Trust's External Auditors, in September 2024.

19.4 The Committee's annual report should also describe how the Committee has fulfilled its Terms of Reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed. The Trust's annual report shall include a section describing the work of the Committee in discharging its responsibilities.

This report outlines how the Committee has addressed all elements of its Terms of Reference during the year. The work of the Committee is included within the Annual Report. The Board takes significant assurance regarding the contents of the Annual Report and Accounts for the as overseen by the Committee.

19.5 The Committee will conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

The Committee reflected upon its effectiveness at the end of each meeting, the appropriateness of papers and received suggestions for improvement. Overall, members have been satisfied with the way the Committee operates and have commented on good level of debate, challenge and participation of members and attendees and chairing effectiveness. Papers have continued to improve with well-structured recommendations, contributing to holding Executive Directors to account. The Committee has continued to receive good levels of assurance and has been responsive to demand and priorities.

Board Committee Chairs discussed Committee effectiveness at their meetings held in year and were assured of key elements of governance, consistency and intelligence sharing across Committees.

20. Administrative Support

The Director of Corporate Affairs and Trust Secretary discharged her duties in support of the Audit and Risk Committee throughout the year.

21. Review of Terms of Reference

The Terms of Reference will be reviewed in April 2025 as part of the end of year reporting process and are appended to this report for further review.

22. Conclusion

The Audit and Risk Committee has continued to be a well-functioning effective Board Committee throughout 2024/25 and has provided appropriate assurance to the Board.

Audit and Risk Committee Terms of Reference

Purpose

This is the principal Committee for seeking independent assurance on the general effectiveness of the Trust's internal control and risk management systems and for reviewing the structures and processes for identifying and managing key risks. It is responsible for reviewing the adequacy of all risk and control related statements prior to approval by the Board and for seeking assurances on these controls. In discharging its responsibilities, the Committee takes independent advice from the Internal Auditor or seeks any other legal or professional advice as required to discharge its responsibilities.

1. Authority

1.1 The Audit and Risk Committee (the Committee) is constituted as a Committee of the Trust's Board of Directors. Its constitution and Terms of Reference are set out below and are subject to amendment at future Board of Directors meetings. The Committee shall not have executive powers in addition to those delegated in these Terms of Reference.

1.2 As a Committee of the Board, the Audit and Risk Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's strategic objectives which fall within the Committee's remit. This includes identification, review and scrutiny of all relevant risks on the Board Assurance Framework.

1.3 The Committee is authorised by the Board of Directors to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

1.4 The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

1.5 The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. The Act protects against discrimination on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. The Audit and Risk Committee will ensure consideration has been given to equality impact related risks.

1.6 The Committee will actively consider the equality impact and evidence relating to all items of Committee business as part of the Committee's contribution to equality, diversity and inclusion.

1.7 As a designated policy ratification group, (see 'Policy on Policy' document) the Audit and Risk Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. This includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template. All policy documents are allocated a policy ratification group as they are published on Connect.

2. Membership

2.1 The Committee shall be composed of at least three independent Non-Executive Directors, at least one of whom should have recent and relevant financial experience.

2.2 One of the members shall be appointed Chair of the Committee by the Board of Directors.

2.3 The Trust Chair shall not be a member of the Committee (but may attend by invitation as appropriate).

2.4 Members of the Committee must attend at least 80% of all meetings each financial year but should aim to attend all scheduled meetings.

3. Attendance

3.1 Only members of the Committee have the right to attend meetings, but the Director of Finance and Director of Corporate Affairs and Trust Secretary shall generally be invited to attend routine meetings of the Committee. Other Executive Directors and/or staff and executives shall be invited to attend those meetings in which the Committee will consider areas of risk or operation that are their responsibility and will be expected to attend as requested.

3.2 The Chief Executive, as Accountable Officer, may be invited to attend meetings and should discuss at least annually with the Committee the process for assurance that supports the governance statement. They should attend when the Committee considers the Annual Governance Statement and the annual report and accounts.

3.3 The External Auditor or their representative should normally attend meetings.

3.4 The Head of Internal Audit or their representative should also attend routine meetings.

3.5 A representative of the local Counter Fraud Service will attend at least two meetings of the Committee per year.

3.6 A governor representative may be invited to attend meetings of the Committee as an observer when the Committee considers the Annual Governance Statement and the Annual Report and Accounts.

3.7 The Director of Corporate Affairs and Trust Secretary shall be the secretary to the Committee and will provide appropriate support and advice to the Chair and the Committee members.

3.8 At least once per year the Committee Chair should meet privately with the external and Internal Auditors.

Access

3.9 The Head of Internal Audit or their representatives, representatives of External Audit and Counter Fraud Specialist have a right of direct access to the Chair of the Committee.

4. Quorum

4.1 A quorum shall be two Non-Executive Directors. Non-quorate meetings may go ahead unless the chair decides not to proceed. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

4.2 Meetings may be held face-to-face or virtually by conference call, suitable electronic means or via a hybrid combination, so long as those present can hear each other and contribute simultaneously.

~~4.3 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Trust Board meeting as an urgent item.~~

5. Frequency of meetings

5.1 Meetings shall be held at least four times per year, the total number of meetings being determined by the assurance required by the Committee to discharge its responsibilities. The Board of Directors, Chief Executive, External Auditors or Head of Internal Audit may request an additional meeting if they consider that one is necessary.

6. Duties and Responsibilities

6.1 The Committee's duties and responsibilities can be categorised as follows:

Integrated governance, risk management and internal control

6.2 To review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities, clinical and non-clinical, that supports the achievement of the Trust's objectives.

6.3 To consider the Board Assurance Framework and high-level risks, including Deep Dives of risks as appropriate.

6.4 In particular to review the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances

- the underlying assurance processes that indicate the degree of achievement of the Trust's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

- arrangements for the effective management of clinical and corporate risk to underpin the delivery of the Trust's strategic objectives

- arrangements in place for preventing and countering fraud, bribery and corruption and managing security in compliance with the related NHS Protect Standards

- The Committee shall maintain an oversight of the Trust's general material control and risk management systems, including processes and responsibilities, the production and issue of any risk and control-related disclosure statements. The key record to guide the Committee's work will be the Board Assurance Framework (BAF).

6.5 As part of its integrated approach, the Committee will ensure appropriate information flows, to the Committee from executive management and from and between other Board Committees, in relation to the Trust's overall internal control and risk management position.

6.6 To monitor corporate governance (eg compliance with terms of the licence, constitution, codes of conduct, standing orders, standing financial instructions, maintenance of registers of interests and adequacy of commercial insurance cover).

6.7 To develop and use an effective assurance framework to guide the Committee's work. This will include utilising and reviewing the work of the internal audit, external audit and other assurance functions as well as reports and assurances sought from directors and managers and other investigatory outcomes so as fulfil its functions in connection with these Terms of Reference.

Internal audit

6.8 To review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation.

6.9 To oversee on an ongoing basis the effective operation of internal audit in respect of:

- Adequate resourcing
- Co-ordination with external audit
- Meeting the Public Sector Internal Audit Standards
- Providing adequate independent assurances
- Having appropriate standing within the Trust

- Reviewing and approving the internal audit plan ensuring that this meets the internal audit needs of the organisation.

6.10 To consider the major findings of internal audit investigations and management's response and their implications and monitor progress on the implementation of recommendations.

6.11 To consider the provision of the internal audit service and the cost of the audit.

6.12 To monitor the effectiveness of internal audit and to conduct an annual review of the internal audit function.

External audit

6.13 To make a recommendation to the Council of Governors in respect of the appointment, re-appointment and removal of an External Auditor and related fees as applicable. To the extent that the recommendation is not adopted by the Council of Governors, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

6.14 To discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy.

6.15 To assess the External Auditor's work and fees each year and based on this assessment, to make the recommendation above to the Council of Governors with respect to the re-appointment or removal of the Auditor. This assessment should include the review and monitoring of the External Auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.

6.16 To oversee the conduct of a market testing exercise for the appointment of an auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors with respect to the appointment of the Auditor.

6.17 To review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations.

6.18 To develop and implement a policy on the engagement of the External Auditor to supply non-audit services.

6.19 To consider the provision of the external audit service, the cost of the audit and any questions of resignation and dismissal of the auditors.

Annual accounts review

6.20 To approve the Annual Report and Accounts and Annual Governance Statement on behalf of the Trust Board. In doing so the Committee will determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

- The meaning and significance of the figures, notes and significant changes
- Changes in, and compliance with the accounting policies, practices and estimation techniques
- Areas where judgment has been exercised
- Explanation of estimates or provisions having material effect
- Explanations for significant variances
- The schedule of losses and special payments
- Significant adjustments in the preparation of the financial statements and any unadjusted statements
- Any reservations and disagreements between the External Auditors and management which have not been satisfactorily resolved
- Compliance with the Annual Reporting Manual requirements for the content of the annual

report as published by NHS England.

6.21 To review all accounting and reporting systems for reporting to the Board of Directors, including in respect of budgetary control.

Freedom to Speak Up (Raising Concerns including Protected Disclosures)

6.22 To review the adequacy of the Trust's arrangements by which Trust staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.

Standing orders, standing financial instructions and standards of business conduct

6.23 To review on behalf of the Board of Directors the operation of, and proposed changes to, the standing orders and standing financial instructions, the constitution, codes of conduct and standards of business conduct; including maintenance of registers.

6.24 To examine the circumstances of any significant departure from the requirements of any of the foregoing, and whether those departures relate to a failing, an overruling or a suspension.

6.25 To review the scheme of delegation.

Other

6.26 To review performance indicators relevant to the remit of the Committee.

6.27 To examine any other matter referred to the Committee by the Board of Directors and to initiate investigation as determined by the Committee.

6.28 To consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health sector and professional bodies with responsibilities that relate to staff performance and functions.

6.29 To review the work of all other Trust committees in connection with the Committee's assurance function.

6.30 The Committee may also request specific reports from individual functions within the Trust (for example, clinical audit).

6.31 The Committee may refer specific issues to the Board, Finance and Performance Committee and other Committees and make recommendations as appropriate.

6.32 The Committee will receive assurance reports on Data Security and Protection arrangements, particularly in respect to compliance with the Data Security and Protection Toolkit and legislative compliance including the Data Protection Act and General Data Protection Regulations.

6.33 Audit and Risk Committee has a specific responsibility for overseeing the management of conflicts of interest and evaluating the Trust's response to implementing the Trust's Conflict of Interest Policy. The Committee is specifically cited in the national guidance in respect of consideration of any breaches.

6.34 Responsibility for the oversight of data quality assurance.

6.35 The Committee is committed to ensuring that when matters of concern are raised during Committee business these are dealt with openly and transparently and scrutinised as appropriate. When issues arise, the Committee will undertake to challenge robustly and fairly in order to develop a culture of continuous improvement, openness and honesty.

7. Minutes and Reporting

7.1 The minutes of all meetings of the Committee shall be formally recorded and made available to the Board of Directors.

7.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed. This will include details of any evidence of potentially *ultra vires*, otherwise unlawful or improper transactions, acts, omissions or practices or any other important matters. To the extent that such matters arise, the Chair of the Committee shall present details to a meeting of the Board of Directors in addition to the assurance summary.

7.3 The Committee will report annually to the Board of Directors and the Council of Governors in respect of its work in support of the Annual Governance Statement, specifically commenting on:

- The assurance framework and its fitness for purpose
- The effectiveness of risk management within the Trust
- The integration of and adherence to governance arrangements
- The appropriateness of the evidence that shows the organisation is fulfilling its regulatory requirements relating to its existence as a functioning business
- The robustness of the processes behind the quality accounts
- Any pertinent matters in respect of which the Committee has been engaged.

7.4 The Committee's annual report should also describe how the Committee has fulfilled its Terms of Reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed. The Trust's annual report shall include a section describing the work of the Committee in discharging its responsibilities.

7.5 The Committee will conduct a self-effectiveness review of the performance of the Committee at the close of every meeting.

8. Administrative Support

8.1 The Committee shall be supported by the Director of Corporate Affairs and Trust Secretary whose duties in this regard include, but are not limited to:

- Agreement of the agenda with the Chair of the Committee and attendees
- Agendas and papers will be distributed in accordance with deadlines agreed with the Committee Chair. Ideally, this should be no less than three working days, although flexibility will be maintained for extra-ordinary circumstances
- Ensuring that those required to attend are invited to the meeting in good time
- Ensuring that the minutes are taken and keeping a record of matters arising and issues to be carried forward
- Manage the forward plan of the Committee's work
- Arranging meetings for the Chair with directors and advisers as necessary
- Advising the Committee as appropriate on pertinent issues/areas of interest/policy developments
- Enabling training and development of Committee members as appropriate
- Reviewing every decision to suspend the standing orders.

9. Review of Terms of Reference

The Terms of Reference of the Committee shall be reviewed at least annually.

Approved by Audit and Risk Committee	24 April 2025
Approved by the Board of Directors	3 June 2025

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 June 2025

Trust Sealings

Purpose of Report

This report provides the Trust Board with a six-month update of the authorised use of the Trust Seal since the last report to the Board on 5 November 2024.

Executive Summary

The Trust's Standing Financial Instructions (point 8.16) were revised in September 2024 to allow a more practical process for the signing of contracts, as the size of the organisation's contract values have grown. The authorised signatory limits reflect the delegated expenditure limits in section 3.2.2i.

Prior to the most recent change, all contracts over £500,000 were required to be sealed and these are the ones listed below. Going forward only deeds and contracts relating to the disposal, acquisition or leasing of land or property need to be executed under the Common Seal of the Trust.

In accordance with the Standing Orders of the Board (section 12 point 6) a report of all sealing shall be made to the Trust Board twice a year. The report will contain details of the seal number, the description of the document and date of sealing. The register will be retained by the Trust Secretary.

A report on use of the seal was last made to the Board on 5 November 2024. Since the last report, the Trust Seal was used as follows (where the contract value for these transactions exceeded £500,000 or where the nature of the transaction required a seal, ordinarily property transactions such as deeds or leases):

- DHCFT/126 (29 November 2024) Agreement for lease of land at Chesterfield Royal Hospital and lease for same between 1) Derbyshire Support and Facilities Services Ltd, 2) Derbyshire Healthcare NHS Foundation Trust and 3) Chesterfield Royal Hospital NHS Foundation Trust.
- DHCFT/127 (13 December 2024) Subcontractor's Collateral Warranty between 1) Freeman Mills Partnership Ltd, 2) Derbyshire Healthcare NHS Foundation Trust and 3) Stepnell Ltd relating to Bluebell Ward Refurbishment at Walton Hospital Chesterfield.
- DHCFT/128 (13 December 2024) Subcontractor's Collateral Warranty between 1) DICE Consulting Engineers Ltd, 2) Derbyshire Healthcare NHS Foundation Trust and 3) Stepnell Ltd relating to Bluebell Ward Refurbishment at Walton Hospital Chesterfield.
- DHCFT/129 (13 December 2024) Subcontractor's Collateral Warranty between 1) MB Glass Supplies Ltd, 2) Derbyshire Healthcare NHS Foundation Trust and 3) Stepnell Ltd relating to Bluebell Ward Refurbishment at Walton Hospital Chesterfield.
- DHCFT/130 (13 December 2024) Subcontractor's Collateral Warranty between 1) Highcross Building Services Ltd, 2) Derbyshire Healthcare NHS Foundation Trust and 3) Stepnell Ltd relating to Bluebell Ward Refurbishment at Walton Hospital Chesterfield.
- DHCFT/131 (13 December 2024) Subcontractor's Collateral Warranty between 1) CTD Architects, 2) Derbyshire Healthcare NHS Foundation Trust and 3) Stepnell Ltd relating to Bluebell Ward Refurbishment at Walton Hospital Chesterfield.
- DHCFT/132 (27 March 2025) Agreement to lease for land at Chesterfield Royal Hospital NHS Foundation Trust.
- DHCFT/133 (27 March 2025) Agreement to lease for land at Chesterfield Royal Hospital NHS Foundation Trust FT.

- DHCFT/134 (6 May 2025) Lease relating to the former Oakwood Children's Centre, Derby.

Strategic Considerations	
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X

Risks and Assurances

Use of the Trust Seal has been undertaken in accordance with the Standing Financial Instructions and Standing Orders of the Board of Directors.

Consultation

N/A.

Governance or Legal Issues

The affixing of the seal is consistent with the Board's responsibilities outlined within the Standing Financial Instructions and Standing Orders of the Board of Directors.

Public Sector Equality Duty and Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

There is no direct impact on those with protected characteristics arising from this report.

Recommendations

The Board of Directors is requested to note the authorised use of the Trust Seal since the last report to the Board on 5 November 2024 and receive full assurance that this has been undertaken in accordance with the Standing Financial Instructions and Standing Orders of the Board of Directors.

Report presented by: **Justine Fitzjohn**
Director of Corporate Affairs and Trust Secretary

Report prepared by: **Jo Bradbury**
Corporate Governance Officer

Emma Warrilow
Personal Assistant

Continuation of Services Condition 7 – availability of resources – 2024/25

Declaration:

After making enquiries, the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months (2024/25).

Rationale for above declaration:

Primary evidence is contained in the Going Concern assessment which has been considered by the Audit and Risk Committee. This assessment is based solely on the anticipated future provision of our services in the public sector in line with current guidance. This decision will be reviewed each year in order to ensure that accounts are prepared on an appropriate basis given prevailing circumstances at the time. The Trust's financial management arrangements, overseen by Finance and Performance Committee. This is described in full along with mitigating actions in the Board Assurance Framework.

Selina Ulla
Trust Chair

Mark Powell
Chief Executive

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 June 2025

Board Assurance Framework (BAF) update
Issue 1 2025/26

Purpose of Report

To meet the requirement for boards to produce an Assurance Framework. This report details the current BAF, Issue 1, version 1.3 for 2025/26.

Executive Summary

Director Leads, Deputy Directors, Directors of Operations, Operational Leads and Trust Senior Managers have reviewed the risks to the Trust's strategic objectives for 2025/26 and provided comprehensive updates for the new issue of the BAF.

All risks included in the final version of the 2024/25 BAF have been carried forward to the 2025/26 version.

Each Director has undertaken a thorough review of the risks, root causes and key gaps in control and actions to close those gaps to ensure that:

- The key controls and internal assurances of those controls still correct
- Any of the measures under the new objectives have been added to the controls, assurances, or to the narrative against the actions
- Action deadline dates and review dates (shown in brackets) have been reviewed based on the targets for 2025/26
- Progress updates against actions is current and concise.

Summary of Updates

Patient Focused – Our services will deliver safe and high-quality care

Risk 1A: There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board

Key gap in control – Implementation of revised priority actions for 'High Quality Patient Focused Care' which support the Trust strategy and patient outcomes and guidance and standards for quality care:

All actions completed in 2024/25 except for two. The Director of Nursing, AHPs, Quality and Patient Experience (DoN) has set a new review date to review outstanding actions in quarter 2 (expected completion is quarter 3).

Key gap in control – Gap in operating standards and clinical risks for acute and community mental health services:

New action and measure identified. New review date set by the DoN rather than a deadline based on the new services and environments being established.

Key gap in control – Implementation of new quality priorities.

Gaps closed as all actions completed in 2024/25.

Key gap in control – Clinical improvement in the current use and transformation of Care Programme Approach (CPA), to support safe community practice:

New review date set rather than deadline as a new measure is added.

A new key gap in control was identified in the last quarter.Risks associated with the loss of Talking Mental Health services to an independent provider following a procurement process undertaken by the ICB. Actions to close the gap and measures have been added by the Chief Delivery Officer (CDO). Three have definite deadlines for expected completion and a review date has been set for one as this is to monitor impact on other Trust waiting lists and this can only be reviewed after the transfer to the new provider.

Risk 1B: There is a risk that the Trust does not deliver key regulatory and strategic requirements related to dormitory eradication and PICU and that the Trust estate more generally is not maintained sufficiently well to comply with regulatory and legislative requirements

Additional root causes and possible impact and assurances have been added. The Director of Finance (DoF) has been added as a joint Risk Owner (with the CDO) and both have provided comprehensive updates. Expected completion dates/review dates for updated actions and newly identified measures have been added for expectations for 2025/26 onwards, including the projected opening timeline for Carsington Unit and Audrey House.

One action has been closed as the Older Adult service relocation has been completed with Bluebell Ward opening.

Risk 1C: There is a risk that the Trust's increasing dependence on digital technology for the delivery of care and operations increases the Trust's exposure to the impact of a major outage

The Medical Director (MD) has been added as joint Risk Owner as the director responsible for the Data Security and Protection workstream. The CDO has reviewed progress on the action, the status remains the same.

Risk 1D: There is a risk that the organisation is in breach of essential standards for privacy and dignity in its acute bedded care facility as it has not fully completed its dormitory eradication programme. This may result in regulatory action if mitigation to improve safety does not occur

The CDO has reviewed progress on the action and updated the current status.

People - Derbyshire Healthcare is a great place to work

The Director of People and Inclusion (DPOI) has reviewed all actions to close key gaps in control. RAG status has been added to the last three key gaps in control for Risk 2A and the last of Risk 2B (added in the last issue) as the status of associated actions has been reviewed and updates provided.

Productive - Our services will be productive, demonstrate best value for our population and be cost effective

The current risk rating has improved, going from extreme to moderate, and action RAG ratings are improved to reflect the position at the start of the fiscal year and the updates provided against the 2025/26 measures.

The previous completion dates were set for progress to made throughout 2024/25 and with the rollover into 2025/26 new review dates have been set to measure progress against the updated actions.

Partnerships - Our organisation will identify new ways of working, through new collaborative approaches

All risks and actions to close key gaps in control have been reviewed and updates have been provided by the CDO where the status has progressed.

Operational Risks

The linked operational risks (high/extreme, Trust-wide) have been updated in Issue 1 of the BAF report by the Risk and Assurance Manager – Updates are taken from the progress summaries recorded in Datix by the Risk Handlers.

Risk 22790: Prescribing Valproate: Failure to comply with MHRA patient safety regulations

Pharmacy have completed all of their actions. The outstanding medical action plan has been raised at the Medicines Management Committee and Medical Senate and escalated to the MD.

Risk 23372: Risk to patient and staff safety due to parking issues - Kingsway Site

This has been removed from the BAF report as the Risk Hander has re-assessed the current rating as moderate.

BAF Reporting Cycle/Format

All changes/updates to this issue of the BAF, compared with Issue 4 2024/25, are indicated in blue. All text that has been stricken through will be removed from the next issue (Issue 2 2025/26).

The **Issue 1 cycle** is:

ELT for **review**: Version 1.1	8 April 2025
ARC for **approval**: Version 1.2	24 April 2025
Board for **review and approval**: Version 1.3	3 June 2025

Board committees also receive extracts from the current version of the BAF report to review the risks they are responsible for. All updates received from the Board committees are incorporated to the 'live' version of the BAF.

Strategic Considerations	
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X

Risks and Assurances

This paper details the current Board Assurance risks and provides assurance on the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives.

Consultation

- Executive Directors
- Deputy Directors
- Directors of Operations
- Operational Leads
- Managing Directors
- General Managers
- Operational Risk Handlers

Formal Reviews

- Executive Leadership Team, Issue 1.1: 8 April 2025
- Audit and Risk Committee, Issue 1.2: 24 April 2025
- Audit and Risk Committee, Issue 1.2 with ops risk update: 20 May 2025 (virtual)

Governance or Legal Issues

Governance or legal implications relating to individual risks are referred to in the BAF itself, where relevant.

Public Sector Equality Duty & Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

Specific elements within each BAF risk and associated actions are addressed by the relevant lead director in taking forward.

Recommendations

The Trust Board is requested to:

1. Seek assurance from the Medical Director that the medical action plan to manage the linked operational risk 22790 sets out the timelines for delivery against the actions
2. Review and approve Issue 1 of the BAF for 2025/26 and the assurance the paper provides of the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives
3. Agree to receive updates in line with the forward plan for the Trust Board.

Report presented by: **Justine Fitzjohn**
Director of Corporate Affairs and Trust Secretary

Report prepared by: **Kel Sims**
Risk and Assurance Manager

Board Assurance Framework 2025/26 – Issue 1.3 Board June 2025

Ref	Risk	Director Lead	Risk Rating	Responsible Committee
Patient Focused - Our services will deliver safe and high-quality care				
25-26 1A	There is a risk that the Trust will fail to provide standards for safety, and effectiveness as required by our patients, regulators, partners and our Board, There is also a risk of poor patient experience and outcomes	Director of Nursing, AHPs and Patient Experience (DON) / Medical Director (MD)	**HIGH**	Quality and Safeguarding Committee
25-26 1B	There is a risk that the Trust does not deliver key regulatory and strategic requirements related to dormitory eradication and Psychiatric Intensive Care Unit (PICU) and that the Trust estate more generally is not maintained sufficiently well to comply with regulatory and legislative requirements	Chief Delivery Officer (CDO) / Director of Finance (DOF)	**HIGH**	Finance and Performance Committee
25-26 1C	There is a risk that the Trusts increasing dependence on digital technology for the delivery of care and operations increases the Trusts exposure to the impact of a major outage	Chief Delivery Officer (CDO) / Medical Director (MD)	**MODERATE**	Finance and Performance Committee
25-26 1D	There is a risk that the organisation is in breach of essential standards for privacy and dignity in its acute bedded care facility as it has not fully completed its dormitory eradication programme. This may result in regulatory action if mitigation to improve safety does not occur	Director of Nursing, AHPs and Patient Experience (DON) / Chief Delivery Officer (CDO)	**MODERATE**	Quality and Safeguarding Committee
People - Derbyshire Healthcare is a great place to work				
25-26 2A	There is a risk that we are unable to create the right culture with high levels of staff morale	Director of People, Organisational Development and Inclusion (DPOI)	**HIGH**	People and Culture Committee
25-26 2B	There is a risk that we do not have an adequate supply of a diverse workforce with the right people with the right skills to support and deliver safe high-quality care	Director of People, Organisational Development and Inclusion (DPOI)	**HIGH**	People and Culture Committee
Productive - Our services will be productive, demonstrate best value for our population and be cost effective				
25-26 3A	There is a risk that the Trust fails to deliver its revenue and capital financial plans for 2025/26 caused by factors including non-delivery of Cost Improvement Programme (CIP) targets and increased cost pressures not mitigated resulting in a threat to our financial sustainability and delivery of our statutory financial duties	Director of Finance (DOF)	~~**EXTREME**~~ **MODERATE**	Finance and Performance Committee

Partnerships - Our organisation will identify new ways of working, through new collaborative approaches				
25-26 4A	There is a risk that the effects of both nationally and locally driven changes to roles and responsibilities within the Integrated Care Board (ICB), and with its partners may impact negatively on the cohesiveness of the Derbyshire health and care system	Chief Delivery Officer (CDO)	**MODERATE**	Trust Board
25-26 4B	There is a risk of reputational damage if the Trust is not viewed as a strong partner both within the Derby and Derbyshire Integrated Care System (ICS) and more broadly within the East Midlands Mental Health Provider Alliance	Chief Delivery Officer (CDO)	**MODERATE**	Trust Board
25-26 4C	There is a risk to safe, effective clinical care across Derbyshire impacting upon patients, due to not achieving national standards and variation of clinical practice and service commissioning in the Learning Disability (LD) Transforming Care Partnership	Chief Delivery Officer (CDO)	**HIGH**	Trust Board

Board Assurance Framework 2025/26 – Issue 1.3 Board June 2025

Patient Focused - Our services will deliver safe and high-quality care

There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board

Impact: May lead to avoidable harm including increased morbidity and mortality; delays in recovery; and longer episodes of treatment; affecting patients, their family members, staff or the public

Root causes:

a) Workforce supply and lack of capacity to deliver effective care across hotspot areas, increasing risks in the clinical and medical workforce

~~a)~~b) Loss of Talking Mental Health Derby (TMHD) as a Trust delivered service and challenge to clear links with primary and secondary and specialist care. Growth of waiting list during transition period leading to management of greater risk

~~b)~~c) Risk of substantial increase in clinical demand in some services

~~c)~~d) Intermittent lack of compliance with Care Quality Commission (CQC) standards~~, specifically the safety domain~~

~~d)~~e) National Oversight Framework (NOF) Level 3 ~~quality issues~~ - Financial position and out of area placements and continued monitoring of quality standards in acute services

~~e)~~f) Lack of embedded outcome measures at service level

~~f)~~g) Lack of compliance with physical healthcare monitoring in primary and secondary care, not at the required level for reductions in mortality

~~g)~~h) Restoration and recovery of access standards in autism and memory assessment services

~~h)~~i) Lack of appropriate environment to support high quality care, i.e. single gender dormitories and PICU leading to out of area (OOA) bed use for PICU

~~i)~~j) Local NHS Trusts will offer Recruitment and Retention Premium to Consultant Psychiatrists in specialist services and other clinical staff due to competitive practices that destabilises Trust clinical services and leads to a deterioration in waiting time and potentially in safety

~~j)~~k) Data quality could be adversely affected due to the ~~need to embed the new~~ Electronic Patient Record (EPR) and its application

~~k)~~l) Health inequalities across Derbyshire. Initial insights show gaps in access to service, case load and worsening patient outcomes for our patients

~~l)~~m) Sustained pressure in the crisis and acute care pathway with bed occupancy over 85% and increased waiting time for patients to access bedded care from the community

~~m)~~n) Gaps in Advocacy for Children who are under 18

~~n)~~o) Capacity to learn from other organisations in their ability to maintain adequate mortality, serious incidents and learning reviews to respond to improve practice and to also comply with the coroner's formal requirements

p) Lack of systematic capture of patient experience and feedback in our services

~~o)~~q) Lack of learning from patient or carer feedback from complaints and concerns due to delayed investigations and responses

~~p)~~r) Safety and learning culture, learning from internal incidents, complaints and other sources of feedback is not developing and needs to be further embedded

BAF Ref: 25-26 1A	**Director Lead**: Tumi Banda (DON) / Dr Arun Chidambaram (MD)	**Responsible Committee**: Quality and Safeguarding Committee

Key Controls

Initial Risk Rating			Current Risk Rating			Target Risk Rating			Risk Appetite		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Quality governance structures, teams and processes to identify quality related issues; mandatory training; Duty of Candour processes; clinical audits and research; health and safety audits; risk assessments; physical health care screening and monitoring; monitoring and effective responses to infection and control guidance, EQUAL unannounced visits to services and anonymised bright ideas service improvement ideas. Feedback intelligence from independent advocacy, Director visits in and out of hours and Board visits

Detective – Quality dashboard reporting; Board visits virtual clinical service contact visits; incident, complaints and risk investigation; clinical audit; Fire Safety Regulations (FSR) compliance checks; mortality review process; physical health care monitoring clinics pilots; safety check log; Head of Nursing and Matron compliance visits, reviewed model of announced and unannounced visits to service throughout the 24-hour period

Directive – Trust Strategy; Physical Health Care Strategy; Joint Child Adult and Family Safeguarding Strategy~~Safeguarding Strategy~~; Patient and Carer Experience Strategy; Patient Safety Incident Response Plan (PSIRP)~~Suicide Reduction Strategy~~; clinical strategies; policies and procedures available via Trust intranet; Central Alerting System (CAS) alerts; Risk Management Strategy; clinical sub committees of the Quality and Safeguarding Committee (QSC); ~~Continuous Improvement Plan – Confirmed launch date is 01.04.25~~

Assurances on controls – Internal	Assurances on controls – External
Trust quality and performance dashboards Scrutiny of Quality Account by committees Programme of physical healthcare and other clinical audits and associated plans Infection Control Board Assurance Framework reported to NHS England Positive and Safe self-assessment Head of Nursing and Matron compliance visits Board visits and out of hours visits ~~CQC action plan in place (April 2024)~~ Fundamental standards of care Clinical audits Incident reporting and monitoring systems through Datix Quality and safeguarding workplan Trust risk registers and scrutiny of the Risk Management Strategy by Board committees	National enquiry into suicide and homicide NHS Litigation Authority (NHSLA) scorecard demonstrating low levels of claims Safety Thermometer identifies positive position against national benchmark ~~Mental Health Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards~~ CQC comprehensive review 2020 Trust is rated Good Trust fully compliant with National Quality Board Learning from Deaths guidance ~~Relationship Meetings~~Engagement meetings with CQC taking place Patient Safety Incident Response Framework (PSIRF) implementation CQC inspection for acute and PICU December ~~(April~~ 2024~~)~~ Regular NOF Level 3 meetings with NHS England (NHSE) and Integrated Care Board (ICB) ICB local review to ensure there are clear policies in place to meet the needs of people in Derbyshire with severe mental health illness ~~NHSE guidance on intensive and assertive community mental health treatment~~ ~~Lord Darzi report and anticipated 10 year plan for the NHS~~ Adult and Children Safeguarding Boards (Derby City and Derbyshire County) ICB Quality System Group for Integrated Care System (ICS) quality system monitoring

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Summary of progress	Action rating
Implementation of revised priority actions for 'High Quality Patient Focused Care' which support the	To ensure adherence with guidance and standards of care, to measure improvements in patient outcomes	Compliance with suite of metrics and reporting schedule detailed in quality dashboard	~~31.03.25~~ (30.06.25)	Quality Surveillance Dashboard revision is in progress ~~revised~~	AMBER

Trust strategy and patient outcomes and guidance and standards for quality care	To develop and implement a Quality Plan and a Continuous Improvement Plan To develop an improved learning culture within the Trust [ACTIONS OWNER: DON]	Internal reporting against self-assessment CQC inspection and assessment as a measurement tool Fundamental standards of care Patient and carer feedback Compliance with statutory and regulatory requirements, such as infection prevention control, safer staffing, patient safety incident rates and Health and Safety legislation		~~(programme of ward visits which are assessed against the CQC's single assessment framework)~~ A CQC/Fundamental Standards Trust Oversight Group has been established. This is now business as usual for quality assurance ~~, which scrutinises progress of actions arising from regulatory inspections and Mental Health Act visits and provides sign-off of completed actions~~ CQC Executive Oversight Group in place. Now complete and the objective to improve quality of care in acute services has been achieved. The service is now rated good ~~— Fortnightly scrutiny of actions and updates reviewed~~ Divisional Performance Reviews (DPRs) now embedded. We are now using the scorecard report with a data informed approach in the DPRs A new Trust Strategy has been launched which sets out a clear direction for patient focussed improvements	

				New Quality Plan to be completed by July 2025 ~~and Continuous Improvement Plans are planned for development in 2025~~	
Gap in operating standards and clinical risks for acute and community mental health services	Improve the assessment interventions and risk management of patients requiring enhanced input or assertive outreach services Compile outcome measures for acute and community services and create relevant dashboards for the services to inform areas for improvement Improvement of both inpatient and community care settings – Environments need to be improved [ACTIONS OWNER: DON] Set out improvement plans to achieve Royal College of Psychiatrists (RCP) accreditation across services [ACTION OWNERS: MD/DON/CDO] Implement Community Mental Health Framework (CMHF) [ACTION OWNER: CDO]	Improve working with carers and families Improving risk assessment and care planning for patients in community settings Deliver the assertive outreach pathway to support patients with complex care needs Improvement in operating standards compliance to be overseen by Quality and Safeguarding Committee Implemented Acute Inpatient Mental Health Service Accreditation (RCP Standards) reported in Divisional ~~Achievement~~ Performance Reviews and Quality Account Implemented Mental Health Community Framework to Quality and Safeguarding Committee	~~31.03.25~~ (31.12.25) ~~31.03.25~~	Increased performance management scrutiny and unannounced site visits undertaken with compliance checks Monitoring Fundamental Standards of Care and the quality measures through the Quality Dashboard Internal Trust programme Board in place to strengthen contribution and involvement in system-wide programme and delivery ~~Mobilisation underway in High Peak, Derby City, Chesterfield and North-East Derbyshire System Programme Team now established~~ ~~Final stage of mobilisation now completed in Amber Valley, Erewash, South Derbyshire and Derbyshire Dales~~ Living Well transformation mobilisation completed March 2025	AMBER

				Viability of the model may be at risk due to possibility of the social worker component not being funded by the ICB The funding has now been agreed for 2025/26 for social care and the voluntary sector to support the CMHF. The programme team supporting the delivery has been reduced and is committed for a further two years to support transformation Dashboard has been generated for inpatient acute services. DON leads a fortnightly forum around achieving compliance CQC have reinspected acute inpatients areas and adjusted the rating to good	
~~Implementation of new quality priorities for:~~ ~~- Sexual safety~~ ~~- Implementing CQUINS and Clinical outcome measures~~ ~~- Recovering services – equally well~~ ~~- New Trust strategy and priorities~~	~~Develop and implement an improvement plan to enable all quality priorities to be implemented~~ ~~[ACTION OWNER: DON]~~	~~Compliance with suite of metrics and reporting schedule~~	~~31.03.25~~	~~The Trust has developed a sexual safety plan and has signed up to the sexual safety charter~~ ~~Sexual safety – Improvement work (dashboard, preceptorship training and protocols) commenced. Sexual safety on professional~~	~~GREEN~~ ~~BLUE~~

- ~~Dormitory eradication programme~~				~~standards video launched with new training~~ ~~Dormitory eradication programme in construction: Making Room for Dignity is making progress with the units planned for opening between February and June 2025~~ ~~The Trust is participating in the Culture of Care Collaborative~~ ~~Implementation of the Models of Care is progressing well~~	
Learning from independent and national forums on current issues affecting patient safety outcomes and experience	Participate in collaborative local and regional forums to gather learning Revisit all assurances and scrutinise practice, gathering intelligence and implement an improvement plan to enable all services to provide the highest standard of care which would be expected [ACTIONS OWNERS: DON/MD]	Ensuring that staff are aware of how to raise concerns and speak up Implement the Accountability Framework Strengthen out of hours, weekends and night announced and unannounced visits. To promote access to multiple managers, relationships, so colleagues feel empowered to report any concerns Professional leads are in place and supported by Employee Relations to ensure that registered professional staff are aware of the requirements to practice in line with their professional codes	~~(31.03.25)~~ (30.09.25)	Options for staff to have conversations about care delivery and raise concerns available include Trust-wide and divisional engagements, Freedom to Speak Up, Schwartz Rounds Improvements in engagement of temporary staff identified Increased visibility of senior staff through Board visits and out of hours visits Robust oversight of patient safety incidents, concerns, complaints, and compliments with scrutiny from independent partners, e.g. Healthwatch	AMBER

		Uphold safeguarding standards including PIPOT Timely investigation and response to concerns and complaints		and experts by experience being core members of Patient and Carer Experience Committee External partnership working including Healthwatch and advocacy services within safeguarding and secure services. The Trust provides assurance and participates in external reviews alongside the ICB and Adult Safeguarding Board Trust-wide Learning, Culture and Safety Group established, providing oversight of teams/services with repeating patterns for improvements to be made Four wards are currently actively participating in Culture of Care quality collaborative	
Clinical improvement in the current use and transformation of Care Programme Approach (CPA), to support safe community practice	Identify the Trust's preferred alternative model to replace CPA Establish transition plan which includes communications and training strategy and clear timeline for go live of the new system and detailing when use of CPA will cease Implement an improvement plan to enable all services to provide the highest standard of care	Review of changes to national policy to replace CPA Safe and effective practice is in place Improve patient safety risk assessment, care planning and CPA review compliance in community services	~~31.03.25~~ (30.09.25)	Ongoing oversight of CPA continues with focus on care planning and risk assessment ~~Planning discussion has taken place in relation to the transition from CPA to the preferred alternative model, Dialogue Plus~~	AMBER

	[ACTIONS OWNERS: DON/MD]			CPA training continues at present until alternative identified Further review of this action to take place over quarter 1 and quarter 2 – This is part of the transformation plan for moving away from CPA	
Review of the new Major Conditions Strategy and Suicide Prevention Strategy for England: To be considered as Trust Clinical Plan developed	Scrutinise new policy direction and develop new plans Routinely review incidents for learning in suicide prevention including cluster analysis and benchmarking [ACTIONS OWNERS: DON/MD]	Adjust strategy and policy to meet requirements Undertake a cluster analysis of in-patient and acute care pathway deaths	~~(31.03.25)~~ (30.06.25)	Review of new strategy for Major Conditions and Suicide Prevention PSIRF priorities ~~for 2024/25~~ focusing on prevention and oversight, linked to new strategies Trust Clinical Plan in development	AMBER
Review of Patient Carer Race and Equality Framework (PCREF) and develop implementation plan	Revisit new policy direction and develop new plans [ACTION OWNER: MD]	Review framework and develop implementation plan	~~(31.03.25)~~ (30.06.25)	New Patient and Carer Strategy has gone through QSG and will be launched in line with the wider Trust Strategy EDI lead is in position for PCREF ~~will be responsible for workforce elements of PCREF - Recruitment process underway~~ Central oversight and resource to be identified	AMBER
Risks associated with the loss of Talking Mental Health services to an independent provider following a procurement process undertaken by the ICB. Risks include managing patients on the	Liaise with ICB and Vita Heath Group Review patients on waiting list Escalate risks and the size of the waiting list with the ICB	Working with ICB to close waiting list Joint transition planning with new provider for those on the waiting list	30.06.25 30.06.25	Contract awarded to new provider January 2025 Transition meetings commenced with new provider and with ICB	AMBER

growing waiting list, the impact on staff and a potential for increased referrals to secondary mental health services in the future	Utilise all mutual aid Regular staff engagement ongoing [ACTIONS OWNER: VT]	Expectation that staff will transition to new provider under TUPE arrangement Monitor for any impact on other Trust waiting lists post-transfer to the new provider	30.06.25 (30.09.25)	Ongoing engagement with staff to support during the transition	

Related operational high/extreme risks on the Corporate Risk Register:

ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating
22790	Corporate Services – Pharmacy	Prescribing Valproate: Failure to comply with MHRA patient safety regulations	24.05.23: ePMA now deployed to all services in the Trust which will help with our understanding of valproate use and can be incorporated into planning. Reporting will need to be constructed as part of the optimisation of ePMA 13.11.24: Agreed at Medicines Management Committee (MMC) that risk remains high and has been escalated from MMC to QSC. Some prescribers have yet to act in female cases of child bearing potential highlighted to them by pharmacy colleagues several months ago 30.01.25: Await specific medical profession action plan from consultant colleagues. Other elements of the trust-wide action plan have been progressed as far as possible 02.04.25: Dr Walker has volunteered to lead the Psychiatrist response and a plan is now awaited. To review at next MMC (May)	28.02.22	02.06.25	HIGH
23251	Forensic and Mental Health Rehabilitation Services	Risk to public due to management of Section 37/41	01.08.24: Following a recent Section 37/41 audit it has highlighted that clinical documentation is not of the standard and completion that is felt to effectively support and manage this group of patients - Risks posed to members of the public 18.11.24: Audit highlighted concerns around the clinical documentation and management of 37/41's in local CMHTs – Continue to look at hybrid working within CMHTs 21.03.25: MPAC appointed and increase in capacity within CMHT which supports review and allocation. Ongoing work with CMHT and audit of clinical documentation	02.10.24	30.06.25	HIGH

Patient Focused - Our services will deliver safe and high-quality care

There is a risk that the Trust does not deliver key regulatory and strategic requirements related to dormitory eradication and PICU and that the Trust estate more generally is not maintained sufficiently well to comply with regulatory and legislative requirements

Impact:
Low quality care environment specifically related to dormitory wards
Crowded staff environment
Patient safety and dignity risks associated with dormitory in-patient bedded care
Non-compliance with statutory care environments
Non-compliance with statutory health and safety requirements
Final ward refurbishment at risk on affordability grounds
Completion of the full Dormitory eradication programme has been delayed until 2026/27

Root causes:

a. Long term under investment in NHS capital projects and estate
b. Limited opportunity for Trust large scale capital investment
c. Increasing expectations in care and working environments as national capital strategy and surrounding legislative and regulatory requirements evolve
d. National capital funding restrictions for business-as-usual capital programme for Trusts and Integrated Care Systems
~~d.~~e. Cost creep in the development has added pressure to the Making Room for Dignity programme and the ability to complete the Radbourne Unit refurbishments. Whilst funding is secured in relation to the first ward, issues with the foundations are driving up costs and delaying the completion of the programme

BAF Ref: 25-26 1B	**Director Lead**: Vikki Ashton Taylor (CDO) / James Sabin (DOF)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Appetite**		
High	Likelihood 4	Impact 4	High	Likelihood 3	Impact 5	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Routine environmental assessments for statutory health and safety requirements; environmental risk assessments reported through Datix; Infection, Prevention Control (IPC) risk assessments
Detective – Reporting progress against Premises Assurance Model (PAM) to the Executive Leadership Team (ELT); Dormitory Eradication Board reports into Trust Board
Directive – Capital Action Team (CAT) role in scrutiny of capital projects; IPC policy and procedure; Continuous Improvement Plan – Confirmed launch date is 01.04.25; Estates Plan – In development

Assurances on controls – Internal	Assurances on controls – External
IPC risk assessments Health and safety audits Premises Assurance Model System (PAMS) reporting Making Room for Dignity Programme Committee structure and working groups	Mental Health Capital Expenditure bidding process External authorised reports for statutory health and safety requirements Estates and facilities management internal audit Regional reporting and NHSE oversight Gateway review process

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Lack of adherence to emerging national guidance and policy requiring the elimination of mixed sex wards and dormitory style inpatient facilities	Deliver two new adult acute 54-bed units with ~~a~~ single room en-suite with additional staffing and new model of care [ACTION OWNER: CDO]	Delivery of approved business cases Completion of the units CQC approval and sign off Successful transition and opening of the units	~~31.03.25~~ 31.03.26	Two new build adult acute unit FBCs nationally approved September 2022, funded by £80m national PDC and £18.6m CDEL. ICS supported and approved revenue funding ~~Delay in national approval and redesign of foundations. Planned to go live February/March 2025~~ Derwent Unit opened in March 2025 ~~Carsington unit due to open March 2025~~Carsington Unit opening delayed due to necessary ensuite shower remediation ~~The Acute Plus ward (Audrey House) and PICU will follow early in 2025/26 – Expected completion date updated~~	AMBER

	~~Older Adult service relocation to refurbished ward with single room en-suite and gender segregation, with additional staffing and new model of care, by September 2024 to eradicate dormitories in Northern Derbyshire and avoid the 12-bed service being isolated in otherwise vacated wards~~ ~~National PDC capital funding approval [ACTIONS OWNER: CDO]~~	~~Delivery of approved business case~~ ~~Completion of the build~~ ~~CQC approval~~ ~~Successful transition and opening of the unit~~	~~31.01.25~~	~~Older Adult service relocation FBC and revenue funding approved by ICS. National PDC capital funding approved by NHSE~~ ~~Scheme re-tendered due to affordability, refurbishment started on site December 2023. Bluebell Ward opened as planned in January 2025~~	~~GREEN~~ BLUE
	Radbourne Unit dormitory eradication refurbishment to provide two 17-bed wards with single room en-suite, with additional staffing and new model of care, to complete dormitory eradication in Southern Derbyshire. Service users continue to receive care in non-compliant wards until this refurbishment is completed National PDC capital funding approval [ACTIONS OWNER: CDO]	Delivery of approved business case Completion of the units CQC approval and sign off Successful transition and opening of the units	~~31.12.25~~ 31.03.27	FBC and revenue funding approved by ICS. National PDC capital funding approved by NHSE Radbourne Ward 32 refurb commenced but then paused due to patient safety and noise issues. ~~Will reconvene in April 2025 and be concluded in March 2026 November 2023. Due to go live autumn 2025~~Recommencement of refurbishment delayed due to remediation work needed at Carsington Unit Ward 35 refurb scheduled ~~January 2025 – for mid-2026, subject to funding live summer 2026~~ Radbourne Unit will progress with one ward due for completion in 2025/26 and one in 2026/27 – Expected completion date updated	RED
Lack of an accessible Derbyshire wide Psychiatric Intensive Care Unit (PICU)	Delivery of local PICU arrangements (new build and associated projects	Agreed programme of work with capital funding to support it	31.05.25	FBC approved by ICS	AMBER

	taking into account gender considerations) National PDC capital funding approval [ACTIONS OWNER: CDO]	Approved business case CQC sign off Successful opening and transition of out of area PICU male patients		PICU fully funded by national and Trust capital ~~– Expected to be operational April/May 2025~~ The Derbyshire Male PICU practical completion delayed due to necessary ensuite shower remediation.~~is due to open in May 2025~~ Audrey House Enhanced Care Unit delayed opening due to building control certification – Expected opening May 2025.~~The female HDU will open in April/May 2025~~	

Related operational high/extreme risks on the Corporate Risk Register: None

Patient Focused - Our services will deliver safe and high-quality care

There is a risk that the Trust's increasing dependence on digital technology for the delivery of care and operations increases the Trust's exposure to the impact of a major outage

Impact: This could lead to the disruption in the provision of services with risk to patient safety

Root causes:

a. Increasing reliance on a single electronic patient record
b. Increasing use of video software for the direct provision of care and operational purposes
c. Increased staff home working
d. Increasing electronic collaboration across health and social care partners
e. Increasing global instability and risk from state supported cyber attacks
f. Increase in locally developed system solutions to support DHCFT and partner operations and performance, i.e., flu vaccination, health risk assessments

BAF Ref: 25-26 1C	**Director Lead**: Vikki Ashton Taylor (CDO) / Dr Arun Chidambaram (MD)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Appetite**		
Moderate	Likelihood 3	Impact 4	Moderate	Likelihood 3	Impact 4	Moderate	Likelihood 2	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Trust utilises NHS provided solutions as widely as possible, i.e., Office 365, NHS Mail to ensure compliance with mandated requirements. Use of the secure Health and Social Care Network (HSCN) specified by NHS Digital. Staff training on data security and protection. Regular all staff communications regarding safe ways of working and phishing emails. Contract with NHS Arden and Greater East Midlands Commissioning Support Unit provides information governance and security services, includes review of risks and addressing of vulnerabilities. Subscription with NHS Digital Care Certification Programme highlights cyber vulnerabilities and monitors Trust's compliance against them
Detective – Cyber essentials framework: NHS Digital encourage all organisations to comply. Advanced Threat Protection (ATP) monitors every server and device to highlight threats and software vulnerabilities
Directive – Compliance with NHS Digital requirements. Monthly rigor review meeting with NHS Arden and Greater East Midlands Commissioning Support Unit. Security and Protection Policies and Procedures. Business continuity policy and procedure; Digital Plan – In development

Board Assurance Framework 2025/26 – Issue 1.3 Board June 2025

Assurances on controls – Internal	Assurances on controls – External
IM&T Strategy delivery update to F&P – Annual Embedded programme of software and hardware upgrades Live testing of business continuity plans Digital Plan – In development	Templar Cyber Organisational Readiness Report (CORS) Annual external cyber review by Dynac (vulnerability scan) Data Security and Protection (DSP) annual review by Internal Audit Compliance with DSP Toolkit; high levels of training compliance

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Business continuity plans reflect changes to service delivery such as increased phone and video contacts	All services to review business continuity plans to ensure they take account of the increased use of phone and video contacts for care provision and also use of video conferencing for operational delivery [ACTION OWNER: CDO]	Reporting to the Divisional Performance Reviews (DPRs)	~~(31.03.25)~~ (30.06.25)	Business continuity training for Trust Leads started March 2024. Revised business continuity policy was ratified April 2024. Wider business continuity work (e.g. audit) took place in Quarter 2 as part of the EPRR Core Standards Recovery Action Plan – This is on track and expecting to be substantially compliant in the regional assessment	GREEN

Related operational high/extreme risks on the Corporate Risk Register: None

Board Assurance Framework 2025/26 – Issue 1.3 Board June 2025

Patient Focused - Our services will deliver safe and high-quality care

There is a risk that the organisation is in breach of essential standards for privacy and dignity in its acute bedded care facility as it has not fully completed its dormitory eradication programme. This may result in regulatory action if mitigation to improve safety does not occur

Impact: May adversely impact on regulatory requirements to provide safe and quality care. Patients' dignity and privacy may be impacted. Enforcement regulatory notices may issued against the Trust that may impact on Trust reputation and restrictions to capital could be applied.

Root causes:

a) There was commitment across mental health services to eradicate dormitories by 2022 – Although the Trust has active plans for Making Room for Dignity with a fully funded programme, with the building and infrastructure commencing, the Trust has not delivered in the set timeframes
b) Infrastructure does not comply with current standards
c) Outdated approach of delivering mental health care in dormitories does not comply with current guidance
d) Dormitories compromise patient privacy and dignity due to the dormitory layout
e) Dormitories do not comply with Infection, Prevention and Control (IPC) guidance
f) Dormitories could compromise Health and Safety regulations and increase risks, e.g. fire safety
g) Dormitories are not therapeutic spaces to provide mental health care in

BAF Ref: 25-26 1D	**Director Lead**: Tumi Banda (DON) / Vikki Ashton Taylor (CDO)	**Responsible Committee**: Quality and Safeguarding Committee

Key Controls

Initial risk rating			**Current risk rating**			**Target risk rating**			**Risk appetite**		
Moderate	Likelihood 3	Impact 4	Moderate	Likelihood 3	Impact 4	Moderate	Moderate 3	High 4	Accepted	Tolerated	Not Accepted

Preventative – Screening of each admission considering safety, care and infection control needs supported by the infection control team, health and safety audits; risk assessments; physical health care screening and monitoring; Maintaining environments and cleaning, Director and senior leader visits. Board visits. Quality governance structures, teams and processes to identify quality related issues. EQUAL unannounced visits to services and anonymised bright ideas service improvement ideas

Detective – Quality dashboard reporting; Board visits virtual clinical service contact visits; incident, complaints, and risk investigation; Fire Safety Regulations (FSR) compliance checks; mortality review process; physical health care monitoring clinics pilots; safety check log; Head of Nursing and Matron compliance visits, reviewed model of announced and unannounced visits to service throughout the 24 hour period, cleaning schedules and maintenance logs. Compliance to Delivering Same Sex Accommodation requirements

Directive – Trust Strategy; Physical Health Care Strategy; Safeguarding Strategy; Suicide Reduction Strategy; clinical strategies; policies and procedures available via Trust intranet; Central Alerting System (CAS) alerts; Risk Management Strategy; clinical sub committees of the Quality and Safeguarding Committee, Making Room for Dignity programme (MRfD)~~; Continuous Improvement Plan – Confirmed launch date is 01.04.25~~

Board Assurance Framework 2025/26 – Issue 1.3 Board June 2025

Assurances on controls – Internal	Assurances on controls – External
Trust quality and performance dashboards Bed Management processes Scrutiny of Quality Account by committees Programme of physical healthcare and other clinical audits Infection Control Board Assurance Framework reported to NHSE Positive and Safe self-assessment Head of Nursing/Matron compliance visits Cleaning and maintenance schedules IPC training Level 1 and 2 Trust targets of 85% compliance minimum Continuous Improvement Plan – Confirmed launch date is 01.04.25	Delivery of Same Sex Accommodation Guidance Safety Thermometer identifies positive position against national benchmark Mental Health Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards CQC comprehensive review 2020 Trust is rated Good Estates and Facilities Management internal audit CQC inspection (April 2024) Patient Safety Incident Response Framework (PSIRF) implementation Monitoring of IPC standards compliance and reporting – ICS IPC Team

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Inpatients care is delivered in wards with dormitories, that compromise on patient dignity, privacy and effective IPC practice	Implement bed management process that ensure that admissions are screened to comply to gender, safety and IPC requirements Ensure that the environments are routinely check by clinicians, estates, and domestic staff Infection Prevention and Control monitoring, and training compliance Effective monitoring of the clinical environments by clinical, estates and domestic staff Monitor delivery of same sex guidance through Quality and Safeguarding Committee [ACTIONS OWNERS: DON/CDO]	Monitor and report breaches of same sex admission Monitoring of maintenance and cleaning schedules Head of Nursing and Matron environmental walkabouts Infection and Prevention and Control reports and monitoring of infections – To comply with the Infection Control Handbook and complete the required level of auditing Provision of other rooms for privacy and confidentiality across the estate	~~31.03.25~~ (30.06.25)	Level 1 and level 2 IPC training are above compliance target and there is improved governance and monitoring Fully funded programme of work in place – Making Room for Dignity programme is progressing Amended gatekeeping and purposeful admission process was launched in April 2024. This is having a positive impact on robust bed management processes A risk management summit has been organised to review the risk register to streamline required risk assessments and update in-line with the move to the new inpatient units	AMBER

Related operational high/extreme risks on the Corporate Risk Register: None

People - Derbyshire Healthcare is a great place to work

There is a risk that we are unable to create the right culture with high levels of staff morale

Impact: This could impact on the wellbeing and motivation of our people as well as the quality and effectiveness of the services we provide. This could also impact on our ability to recruit as well as maintain staff, with a potential negative impact on the broader reputation of Derbyshire Healthcare

Root causes:

a) The growth of and increasing complexity of demand on our services and therefore our workforce
b) Lack of consistency and expectations of managers and leaders
c) Lack of strategic development pathway for leaders
d) The number of leadership layers we have
e) Lack of accountability across the leadership levels
f) The volatile work environments where staff can be exposed to harm and trauma
g) The need to develop cultural competence and confidence that is needed to value and create a sense of belonging for people of all backgrounds, ethnicities and with lived experience
Employee Relations service sits outside of the trust in a shared joint venture which impacts on quality of service and accountability of responsiveness

BAF Ref: 25-26 2A	**Director Lead**: Rebecca Oakley (DPOI)	**Responsible Committee**: People and Culture Committee

Key Controls

Initial risk rating			**Current risk rating**			**Target risk rating**			**Risk appetite**		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 3	Accepted	Tolerated	Not Accepted

Preventative – Freedom to Speak Up Guardian (FTSUG) self-assessment and six monthly reports; actions taken from staff survey results, people performance reviews and actions, training and education meeting, Equality, Diversion and Inclusion (EDI) steering group, staff networks, health and wellbeing network
Detective – National staff survey, Quarterly Pulse Checks, FTSUG log and escalations; staff network engagement; WRES, WDES, wellbeing champion network, executive led engagement sessions; non-executive, executive and deputy visits to teams
Directive – Joined Up Care Derbyshire (JUCD) People Strategy, National People Plan; strategic people priorities

Assurances on controls – Internal	Assurances on controls – External
National staff survey and reporting into board, ELT and divisions Quarterly pulse check and action planning process Exit interview analysis and reporting	Benchmarking in mental health Trusts and at system level Staff survey analysis and reporting

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Lack of planned leadership development growth, stretch programmes and opportunities including coaching and mentoring	Leadership section of the People Plan to align to organisational leadership needs Review and development of Trust leadership offer and impact [ACTIONS OWNER: DPOI]	Percentage of leaders with development plan as part of objectives Percentage of employees accessing leadership development programmes	~~(31.03.25)~~ (30.06.25)	Third cohort of Aspiring-2-Be leadership course launched Leadership Strategic Approach finalised and signed off at ELT and PCC in June 2024 Senior leadership programme agreed and dates being finalised Leadership forum now embedded and running regularly Senior triumvirate leadership programme commissioned and will commence post operating model consultation for all relevant posts	AMBER
Lack of progress across EDI including staff networks and reporting (WRES/WDES/gender pay gap)	Staff networks have an embedded operating framework through which to maximise the impact of staff networks Clear measurable EDI plan that includes all national reporting and Trust level actions Support to bi-monthly network Chairs meetings through DPI, Head of EDI and EDI Manager [ACTIONS OWNER: DPOI]	Clarify on role and function of staff network chairs and objectives for each network – Reviewed twice a year Annual updates by network Chairs of engagement undertaken to be included in annual reports Year on year change WRES/WDES, staff surveys and lived experience of staff through staff networks	~~(31.03.25)~~ (30.06.25)	Framework, including clear actions to progress and signed off at PCC Head of EDI commencing in post 31.03.25 2024 Gender Pay Gap report indicates improvements in reducing the gender pay gap	AMBER

Lack of ownership and embedded models of care and cultures across MRfD workforce resulting in retention and turnover challenges and inconsistency of approach across MRfD programme	Review of all commissioned and in house owned programmes both clinical and non-clinical to be clear of the 'ask' and the 'why' Clear framework to ensure alignment across all programmes Comprehensive plan of delivery and outcome measures [ACTIONS OWNER: DPOI]	Delivery against plan including attendance on programmes Staff survey measures Bespoke MRfD surveys to measure awareness and impact of programmes	~~(01.04.25)~~ (30.06.25)	Revised programme board and workstreams to ensure alignment and learning from gateway review Progress on measures is phasing to the opening of the new wards Bluebell ward commencing organisational development culture programme in May 2025, Derwent wards will be 12 weeks post opening (end of June 2025)	RED
Not yet embedded the Trust personal accountability framework and inconsistent support for Employee Relations (ER) informal and formal cases	Fully embed Trust personal accountability framework across all teams and individuals to have ownership of their own behaviours Development and delivery of ER training for managers on cases and investigations Establish new ER services in Trust (currently in a shared service) [ACTIONS OWNER: DPOI]	Reduction in length of cases Reduction in formal cases Attendance at training by managers on cases and investigations Establishment of new ER in-house team	(30.06.25)	~~Progress under review – Updates to follow in next BAF issue~~ ER service currently transitioning out of DCHS Joint Venture into DHCFT – Completion expected 01.06.25 Capsticks case manager training commenced and ongoing roll out Case investigator training currently being rolled out to support	~~TBC~~ RED
Inconsistent approach to flexible working impacting on staff morale	Develop and embed a clear approach to flexible working that supports service delivery and staff Develop a clear and consistent way of recording and reviewing flexible working that supports both managers and staff [ACTIONS OWNER: DPOI]	Ability to record and track number of flexible working arrangements in place Staff engagement measures via staff survey and pulse check	(30.06.25)	Progress under review – Updates to follow in next BAF issue	~~TBC~~ RED

Lack of robust absence management policy and processes that support both managers and staff	Review and relaunch a new absence management policy Review support provided to managers to review and move forward long term sickness absence cases Review Occupational Health access, support and usage to ensure maximising service and being used to [ACTIONS OWNER: DPOI]	Reduction in absence management across both long and short term absences Reduction in Occupational Health DNAs	(30.06.25)	~~Progress under review – Updates to follow in next BAF issue~~ Absence plan developed and presented to PCC Oversight working group established Notice given to Goodshape (external absence management system) to enable in-house absence management to be developed	~~TBC~~ RED

Related operational high/extreme risks on the Corporate Risk Register: None

People - Derbyshire Healthcare is a great place to work

There is a risk that we do not have an adequate supply of a diverse workforce with the right of people with the right skills to support and deliver safe high-quality care

Impact: May lead to reduced staffing levels and skill gaps which impact on safe staffing levels and addressing health inequalities in patient facing services and the ability of our supporting and corporate teams to support front line services

Root causes:

a. There are occupational shortages nationally which mean that the supply of some professions create long term vacancies and a lack of workforce planning in solutions to fill the gaps
b.
c. Pressures on workforce development and Continued Professional Development (CPD) funding may risk ability to develop skills and expertise
d. Disproportionate growth in senior leadership posts in correlation with frontline clinical posts
e. Lack of triangulation of workforce and finance data
National and regional Recruitment Retention Premium (RRP) applications to hard to recruit posts impacting on Trust recruitment and retention

BAF Ref: 25-26 2B	**Director Lead**: Rebecca Oakley (DPOI)	**Responsible Committee**: People and Culture Committee

Key Controls

Initial risk rating			**Current risk rating**			**Target risk rating**			**Risk appetite**		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Alliance, system and national Human Resources forums for sharing best practice and risk mitigation, website, workforce plan
Detective – People Performance Report in TLT, ELT and PCC; Bank Improvement Group; Combined Delivery Group with multi-disciplinary team (MDT) input; Medical Staffing Group, Sustainability Meeting; FTSU culture; exit interview process stay interview process
Directive –JUCD Careers Team; JUCD and People and Inclusion meeting; recruitment policy and procedure; TRAC recruitment system; safe staffing plans

Assurances on controls – Internal	Assurances on controls – External
People Performance Report at ELT and PCC People Dashboard in PCC PCC forward plan and deep dive plan Workforce plan Embedded recruitment and retention scheme	Healthcare Support Workers (HCSW) submissions System operational planning process Safe staffing report Regular NOF Level 3 meetings with NHSE and ICB (in relation to Making Room for Dignity (MRfD) recruitment)

Board Assurance Framework 2025/26 – Issue 1.3 Board June 2025

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
An integrated workforce plan and planning process that feeds into pipeline plans and ensures we have the right people in the right place with the right skills	Develop a Trust Workforce Plan linking demand and capacity, workforce redesign to ensure a fully funded workforce Develop vacancy rate data and breakdown variances in vacancy data [ACTIONS OWNER: DPOI]	Vacancy rates Time taken to fill vacant posts Transformational posts, e.g. apprenticeships all identified Reduction in agency costs	~~(31.03.25)~~ (30.06.25)	Work commenced to map apprenticeship plan and resources required Agency reduction plan in place and having impact Agency summit took place October and November 2024 to focus on medical and acute agency spend (highest areas) Executive-led vacancy control meeting takes place every week for approval of all vacancies and workforce expenditure increases, i.e., job evaluation	AMBER
We do not have an effective and embedded succession talent management processes	Develop a Talent Management Strategy Pilot career conversations for senior leaders and roll out career conversations for all colleagues Work as a system to develop system-wide approach to talent management and align where best for the Trusts [ACTIONS OWNER: DPOI]	Career conversations taking place Internal appointments/promotions Turnover rate Key staff survey measures	~~(31.03.25)~~ (30.06.25)	Talent Strategy finalised Talent programme relaunched following learning from previous pilot with clear engagement timescales and expectations Talent and succession planning part of every Executive Director objectives	RED
Onboarding and retention process and planning needs to be embedded (this includes MRfD and challenges on retention of high numbers of newly qualified nurses)	Understand the key retention issues for posts/teams/professions with the highest turnover Ensure ‘stay conversations’ form part of regular 1:1s Develop NHS retention framework for nursing	Improvements to turnover Staff survey engagement scores	~~(31.03.25)~~ (30.06.25)	Additional posts added to the preceptorship team to support retention of high numbers of newly qualified staff Stay Surveys launched at months 3, 6 and 12	~~RED~~ AMBER

	[ACTIONS OWNER: DPOI]				
Lack of inclusive recruitment practices and actions to consider the needs of people from different backgrounds, to support our commitment to embedding an inclusive culture	All chairs of recruitment panels have undergone inclusive chairs recruitment training Data driven recruitment practices [ACTIONS OWNER: DPOI]	WRES and WDES data shows year on year improvement, staff survey and lived experience of staff Increase the proportion of applications from ethnic minority groups, increase likelihood of shortlisting and reduce disparity in all areas	~~(31.03.25)~~ (30.06.25)	Inclusive recruitment for chairs training commenced	RED
Effectiveness of recruitment policy, practice and processes	Review and develop existing recruitment Key Performance Indicators (KPIs) to ensure fit for purpose Where appropriate move away from TRAC to advertise jobs and use fast track processes, e.g. Indeed/MSforms Develop cohort recruitment for key posts Improve the multidisciplinary working (HR, communications and recruiting managers) to enable better planned and executed campaigns [ACTIONS OWNER: DPOI]	Time to recruit Number of applicants applying and successfully shortlisted Campaign impact and reach Financial savings through cohort recruitment	~~(31.03.25)~~ (30.06.25)	Trust Strategic Recruitment and Retention Lead appointed Successful recruitment events in place including attendance at universities A range of recruitment methods are deployed to ensure we attract a diverse range of applicants On track with MRfD recruitment posts and plans in place for hard to recruit posts	AMBER
Agency and bank usage control measures and reduction	Ensure bank and agency usage is controlled by clear processes and measures with accountability at team level on spend Agency off framework usage is managed with clear expectations Plan in place to reduce and align to agency price cap for all posts Bank staff are recognised and rewarded appropriately [ACTIONS OWNER: DPOI]	Agency and bank usage reduction Agency off framework nil return Agency price cap achieved Bank usage is appropriate and available to support where needed	(30.06.25)	~~Progress under review – Updates to follow in next BAF issue~~ Ongoing weekly agency approval in place for approval of all agency requests	~~TBC~~ AMBER

Related operational high/extreme risks on the Corporate Risk Register: None

Productive - Our services will be productive, demonstrate best value for our population and be cost effective

There is a risk that the Trust fails to deliver its revenue and capital financial plans for 2025/26 caused by factors including non-delivery of Cost Improvement Programme (CIP) targets and increased cost pressures not mitigated resulting in a threat to our financial sustainability and delivery of our statutory financial duties

Impact: The Trust becomes financially unsustainable. The Trust's National Oversight Framework rating has deteriorated and this could lead to a lack of organisational direct control in the longer term via increased regional and national intervention. Corrective action is needed and progress towards financial balance is required. Whilst our planned deficit has reduced in 2024/25 it is still a long way to breakeven. In addition, we have an ambitious CIP requirement in excess of 5% (approaching 6% due to cost pressures)

Root causes:

a) Financial detriment (revenue, cash and/or capital) resulting from large capital development programme, in particular dormitory eradication and associated capital schemes
b) Organisational financial detriment created by commissioning decisions or wider 'system-first' decisions including enactment of risk-sharing agreement in partnership arrangements or changes in NHS financial arrangements. System financial position resulting in required additional financial savings to support the System position from Mental Health funds
b) Non-delivery of expected financial benefits from transformational activities
c) Non-delivery of required levels of efficiency improvement
d) Lack of sufficient cash and working capital
e) Loss due to material fraud or criminal activity
f) Unexpected income loss or non-receipt of expected transformation income (e.g. long-term plan (LTP) and Mental Health Investment Standard (MHIS) without removal of associated costs
g) Costs to deliver services exceed programmes the Trust financial resources available
h) Lack of cultural shift/behaviours to return to financial cost control regime. Areas of non-compliance with Standing Financial Instructions (SFIs) and financial duties. Ineffective grip and control measures to control inappropriate spending
i) Inability to reduce temporary staffing expenditure
j) Inability to reduce inappropriate out of area placements and effectively manage flow
k) Inability to manage increasing demand and acuity in our inpatient settings
~~k)~~l) k)l) Trust reluctance to remove costs in line with non-recurring income removal due to wider system impact (financial and Equality Impact Assessment concerns)

BAF Ref: 25-26 3A	**Director Lead**: James Sabin (DOF)	**Responsible Committee**: Finance and Performance Committee

Board Assurance Framework 2025/26 – Issue 1.3 Board June 2025

Key Controls											
Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Appetite**		
Moderate	Likelihood	Impact	~~Extreme~~ Moderate	Likelihood	Impact	Moderate	Likelihood	Impact	Accepted	Tolerated	Not Accepted

Preventative – Operating plan and financial plan agreed for ~~24/25~~2025/26 in line with ICB requirement. Integrated Care ~~System~~ Board (~~ICS~~ICB) signed off and fully support the dormitory eradication programme and are supporting this through to completion as a pre-commitment. Devoted and adequate team for Programme delivery. High quality business cases. Regular meetings with NHSE on programme progress. Meaningful stakeholder engagement (internal and external). Robust cash flow forecasting and delivery. Multi-disciplinary development of financial plans for new of work. System sign-off and appropriate governance arrangements for new programmes of work: Budget training, segregation of duties, management of commissioning risk through system engagement and leadership, mandatory counter fraud training and annual counter fraud work programme: Enhanced cash management and forecasting aligned to large capital and transformational programmes

Detective – Risk logs and programme-reporting (capital/transformation) informs ongoing financial risk assessment: Audits (internal, external and in-house); scrutiny of financial delivery, bank reconciliations; continuous improvement including cost improvement planning (CIP) and efficiency / QI delivery; contract performance, local counter fraud scrutiny

Directive – Business plans and templates set out clear financial plans and assumptions: Standing financial instructions; CIP Monitoring, Performance management reviews, Treasury management procedures, budget control, delegated limits, recruitment approval processes; business case approval process; invest to save/Quality Improvement methodology and protocol and Plan Do Study Act. Risk and gain share agreements; new strengthened governance processes around the Making Room for Dignity Capital Programme

Assurances on controls – Internal	Assurances on controls – External
Operational plan; financial planning including CIP planning, processes and delivery monitoring	Monthly reporting into ICB and NHSE, in addition to Trust internal reporting
CIP programme group established to strengthen oversight. Further work and governance changes planned to drive the transformational plans and monitor progress	All CIP plans and progress reporting into the EPMO for shared system oversight across the ICB
Vacancy control process in place with Executive oversight	NHSE feedback throughout progress of dormitory eradication
Performance management processes in place and being refreshed to add to assurance levels. Now also established and in place for 2025/26 for corporate functions	Programme and business cases in programme
Dormitory eradication and PICU programme monitoring and reporting	Systems Finance and Estates Committee/System Project Management Office/system DOF meetings
Appropriate monitoring and reporting of financial delivery – Trust overall and programme-specific ~~including 'Use of Resources' reporting updates~~	Internal Audits – Financial integrity and key financial systems audits
Assurance levels gained at Finance and Performance Committee (F&P)	External Audits – Strong record of high-quality statutory reporting with unqualified opinion
Delivery of Counter fraud and audit work programme with completed and embedded actions for all recommendations	National Fraud Initiative – No areas of concern
Independent assurance via internal auditors including HFMA checklist, external auditors and counter fraud specialist that the figures reported are valid and systems and processes for financial governance are adequate	Local counter fraud work – Referrals show good counter fraud awareness and reporting in Trust and no material losses have been incurred. Use of risk-based activity in new counter fraud standards
	Information Toolkit rating – Evidencing strong cyber risk management
	Programme Director, Senior Responsible Officer completed NHS Better Business Case Training
	Regular NOF Level 3 meetings with NHSE and ICB

New governance process in place for the Making Room for Dignity programme and action plan in place in relation to the gateway review findings	

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Trust cash and capital risks related to national funded acute capital programme: - Inflation cost risk - Risk-share - Cashflow timings and variability - Guaranteed Maximum Price exceeds national funding envelope (due to hyperinflation and other factors) Increased cost pressure now aligned to final refurbishment project	Risk share arrangements with PSCP Programme approach and engagement with all stakeholders. Close involvement with NHSE Discussions ongoing with ICB and NHSE around the Making Room for Dignity cost pressure. Although initial ask was supported, the cost pressure has grown materially in relation to the adult acute units, We are also not in a position to meet the conditions as now the pressure has grown and we will not have a Guaranteed Maximum Price (GMP) for Radbourne Until late Quarter 4 Further discussions are ongoing with NHSE Also progressing another VAT claim to part fund final stage [ACTIONS OWNER: DOF]	Cash and capital reporting as part of finance reporting into F&P and Board forecasting evidence of plan delivery and/or indicates areas of required management action New governance process will report formally into ELT and F&P then upwards to Board	~~31.03.25~~ (30.06.25)	Regular oversight of capital and cash position. Reporting to Trust Programme meetings and Committees on risks and mitigations Hyper-inflation cost risk is reducing We have reached a deal with IHP (building contractor) and concluded the cost of the adult acute units. Further risks are mitigated Any minor contract variations are now customer driven and cosmetic Significant cost pressures on Radbourne Unit Refurb. Options being revisited in light of growing pressure. ~~Kier reconvenes work in April 2025.~~Kier recommencement of refurbishment delayed, incurring additional delay costs, due to necessary remediation work at Carsington Unit The decision and affordability question of the second ward will be worked up in quarter 1 aligned to receipt of the GMP ~~Additional funding earmarked from national team is insufficient. Options and review needs to conclude in Quarter 4 to enable reinstatement of original plans with Kier in April 2025 or to move to a plan B~~	~~RED~~ AMBER

				VAT rebate continues to flow to Trust. Still ongoing and reducing current/ongoing payments – Resolved for the North and ongoing for the South. Resolution anticipated in quarter 1	
System capital programme funding shortfall for self-funded Trust capital programme System Capital Departmental Expenditure Limit (CDEL) inadequacy for system capital requirements	Access any new national funding streams (e.g. digital or cyber) in year to maximise system capital plan in order to redirect CDEL capital for this cost pressure and other needed schemes [ACTION OWNER: DOF]	There remains a risk we will overcommit our CDEL allocation in 2024/25 (likely by £4M) Ward 35 decision is a key risk later this year and would have wider impact on the strategic objective to eradicate all dorms Although national funding has been confirmed, it is now known this is not sufficient, we will have an issue to address with the ICB To proceed at risk (affordability, cashflow and CDEL breach concerns) or pause/stop/abandon which would not deliver dormitory eradication and reduce bed capacity. Alternative more cost effective options to be explored but overall pressure remains	~~31.03.25~~ (30.06.25)	The system is managing the overspend on dormitories in 2024/25. We are expecting to live within our collective CDEL System capital plan has been submitted as part of planning process. We have also fed in the 10 year capital plan as part of a wider ICB system-~~-~~wide return A detailed system plan has been developed for 2025/26 and is not a considered a cause for concern. The Radbourne Unit development is supported as a pre-commitment Risk remains in relation to the Making Room for Dignity cost pressure and discussions with ICB and NHSE remain ongoing. The GMP will not be known until ~~late~~ quarter ~~2~~3	~~RED~~ AMBER
Additional revenue related to new builds, refurbishments and PICU not fully funded by system Some partners moving away from business case assumptions and previous agreements	Close partnership working with ICB and system partners. ~~National funding for PDC revenue costs included in allocations for 2023/24 plan~~ Early recruitment to staffing built into revenue plan of the Trust and funded by the system (both income and expenditure in the plan) as part of operating plan for 2024/25. Full year	Monitoring and reporting of income allocations and expenditure in year Transparent reporting of position shared with ICB to reduce challenge and ensure joint understanding and support	~~31.03.25~~ (31.05.25)	MHLDA DB agreed to oversee revenue delivery contained within programme spend Capital delay has led to reduced revenue risk and slippage Supporting non-recurrent revenue costs associated with dormitories and wider system	AMBER

Re-costing service provision, increasing Service Level Agreements	effect of funding passed over for 2025/26 contract [ACTIONS OWNER: DOF]				
Insufficient substantive staffing into vacancies and temporary staffing costs for bank and agency staff do not reduce	Additional management action and oversight Agency progress monitored and strengthened links to CIP oversight group Direct engagement solution being implemented re medics Agency actions and controls are working and costs continue to reduce [ACTIONS OWNER: DPOI/DOF]	Enhanced bank and agency costs reported as part of wider financial and workforce reporting Continued workforce strategies progressed to reduce agency and increase bank reducing risk Continued reduced run rates evidence in spend Continued reduction in breaches in rates and framework providers	~~31.03.25~~ (30.06.25)	Reports to ELT and F&P outlining current areas of pressure and required actions to be taken in year in order to remain on plan ~~Funding contribution agreed with Eating Disorder Provider Collaborative for exceptional agency costs re 2023/24. Discussions ongoing re 2025/26 costs. Transfer of patient was concluded in September and no-longer a concern~~	AMBER
Non-delivery of required recurrent cost reduction and improved efficiency and Quality Improvement	Compilation and delivery of planned Trust efficiencies and quality improvements to deliver ~~2024/25~~2025/26 plan including recurrent long term cost reductions to return to breakeven Planning for ~~2024/25~~2025/26 has led to a recent ask for directorates to develop plans of between 3-5% in addition to various transformation plans. In total the Trust is chasing a reduction in costs of approaching 6%. ~~4% cost improvement in addition to various transformation schemes~~ CIP governance and reporting processes strengthened. Close links to wider work re agency reduction, effective rostering and vacancy control [ACTIONS OWNERS: DOF/DPOI]	Efficiency and QI reporting to executives and F&P	~~31.03.25)~~ (30.06.25)	CIP gap continues to reduce. The percentage which has been identified recurrently continues to increase Executive vacancy panel established in December 2023 Performance meetings are in place for clinical directorates and plans are being put in place in future for corporate areas Performance related additional controls are being developed to help close the CIP gap and ensure mitigation is in place Risk reducing due to continued progress ~~Out of area risk, rather than CIP risk is now the primary factor in our plan delivery~~	AMBER

Financial cost pressures created both internally and by system first decisions leading to the requirement for mitigations to close both the internal gap and the system financial gap	Additional 'stretch' management action required to reduce other cost and mitigate impact to achieve overall financial position Long list of unpalatable options drawn up and supported in principle by Board for further review. These are for consideration post planning nationally due to potential to impact patients and core Trust NHS offer. Need to develop these into costed and prioritised plans with clarity of patient and wider staff impact [ACTIONS OWNER: DOF/MD/DON/cdo]		~~31.03.25~~ (30.06.25)	The financial position for Derbyshire is a risk to the statutory duties for DHCFT to manage its financial position Financial plan for ~~2024/25~~2025/26 is almost concluded but we need to continue to work on reducing the deficit as part of our longer term financial sustainability All new investments to follow governance processes with business cases via ELT, F&P and Board where appropriate and will require wider system support Further system grip and control and investigation and intervention processes maybe added	RED

Related operational high/extreme risks on the Corporate Risk Register: None

Board Assurance Framework 2025/26 – Issue 1.3 Board June 2025

Partnerships - Our organisation will identify new ways of working, through new collaborative approaches

Principal risk: There is a risk that the effects of both nationally and locally driven changes to roles and responsibilities within the Integrated Care Board (ICB), and with its partners may impact negatively on the cohesiveness of the Derbyshire health and care system
Impact: Quality of services and patient experience may deteriorate. Financial position of the Derbyshire Health and Care system worsens; working relationships across the system deteriorates; loss of confidence from regulators in the Derbyshire system

Root causes:

a) Senior management relationships across organisations and organisational expectations of role and responsibilities
b) Creation of mental health, learning disability and autism provider collaborative may destabilise some of the established relationships in place across Derbyshire
c) Creation of system level governance structures, for example Provider Collaborative Leadership Board, may impact on provider Foundation Trust governance arrangements and decision-making processes
d) Staff impacted by change, may lead to increased staff turnover in teams supporting the delivery of the Mental Health Long-Term Plan and subsequent loss of organisational memory
e) The Trust taking on additional lead-provider responsibilities at an ICS or regional level could impact on the quality, performance and financial risks faced by the organisation

BAF Ref: 25-26 4A	**Director Lead**: Vikki Ashton Taylor (CDO)	**Responsible Committee**: Trust Board

Key Controls

Initial Risk Rating			Current Risk Rating			Target Risk Rating			Risk Appetite		
High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 3	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Governance structures in place at a system and Delivery Board level. Ongoing close communication with NHSE, mental health and learning disability teams at a regional and national level. Assumed NHSE led appointment process to new ICS Board positions
Detective – Continuing engagement in all Joined up Care Derbyshire governance from DHCFT representatives. Due diligence processes undertaken prior to accepting any lead provider responsibilities
Directive – Mental Health, Learning Disability and Autism System Delivery Board to engage widely across membership on the development of any provider collaborative with agreed plans and processes. Gateway process run by NHSE prior to agreement to establish the Trust as lead-provider in any regional collaborative

Assurances on controls – Internal	**Assurances on controls – External**
Regular reporting of position to Board by CEO Regular ELT updates and discussions NED Board members on JUCD committees and Board Board agreement required prior to undertaking of lead-provider responsibilities	Mental Health and Learning Disability assurance meetings with NHSE and ICB Gateway process run by NHSE prior to agreement to establish a Trust as lead-provider in regional collaboratives Representation on system-wide governance groups

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Increased governance at ICB and system level may create delays to decision making and cause increased governance burden	Keep Trust structures under continuous review against the wider governance landscape, including the provider collaboratives and alliance arrangements – This in turn may lead to a formal change of DHCFT governance arrangements Continue to influence within the system to ensure Lean and safe decision making and governance arrangements [ACTIONS OWNERS: CEO/DCA]	Board level assurance that the Trust's corporate governance systems are compatible with the new ways of working that would allow both Trust and system objectives to be achieved Board level assurance that the Trust's risks have been fully articulated and understood within the wider integrated care system	~~(31.03.25)~~ (30.06.25)	We have implemented a new divisional performance review process, underpinned by balanced scorecards. To ensure operational performance delivery of MHLDA constitutional standards that DHCFT is a lead or main provider Derbyshire Provider Collaborative Leadership Board have an agreed work programme as approved by ICB The Trust is an active member of and provides regular assurance to system-wide governance groups, e.g. their quality and safety group Memorandums of understanding and alliance agreements are in place where appropriate, i.e. LD Alliance Trust's risks reported to the ICB monthly for cross-reference with other providers for the ICB BAF	AMBER

Related operational high/extreme risks on the Corporate Risk Register: None

Board Assurance Framework 2025/26 – Issue 1.3 Board June 2025

Partnerships - Our organisation will identify new ways of working, through new collaborative approaches

There is a risk of reputational damage if the Trust is not viewed as a strong partner both within the Derby and Derbyshire Integrated Care System (ICS) and more broadly within the East Midlands Mental Health Provider Alliance

Impact:
May have detrimental impact on patient experience and quality of care provided for people accessing services.

Root causes:

a) Silo working within the organisation
b) Not actively engaging enough as part of a broader multi-agency partnership at Place and community level
c) Increasing national expectations in provider collaboration and multi-disciplinary delivery model at Place level

BAF Ref: 25-26 4B	**Director Lead**: Vikki Ashton Taylor (DSPT)	**Responsible Committee**: Trust Board

Key Controls

Initial risk rating			Current risk rating			Target risk rating			Risk appetite		
High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 3	Moderate	Likelihood 3	Impact 3	Accepted	Tolerated	Not Accepted

Preventative – Active membership in each Local Place Alliance; Active participation in Integrated Place Executive; Meaningful stakeholder engagement (internal and external); Multi-disciplinary and cross organisational development and implementation of services
Detective – Quality Improvement (QI) delivery; Contract performance; Continuing engagement in all Joined up Care Derbyshire governance from DHCFT representatives
Directive – Integrated Care Strategy; Joint Forward Plan (JFP); Trust Strategy

Assurances on controls – Internal	Assurances on controls – External
Appointment to Managing Director roles Regular TLT and ELT updates and discussions NED Board members on JUCD committees Developing collaborative plans with system partners to recognise and mitigate gaps within the system for ADHD and ASD diagnostics	Monthly Mental Health and Learning Disability assurance meetings with NHSE Monthly reporting by County and City Places to JUCD Place Executive Patient surveys conducted by Healthwatch CEO on ICB Board and Integrated Care Partnership (ICP) Regular NOF Level 3 meetings with NHSE and ICB

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Some core constitutional targets not being met and risk to making progress, at pace and scale, resulting in some patients being cared for outside of Derby and Derbyshire	New internal performance improvement group Recovery action plans for areas where Trust constitutional standards are not being met Improvement plan for joint autism service (with system partners) [ACTIONS OWNERS: CDO]	Improvement in performance in constitutional standards Recovery action plans in place in all required areas Feedback from social care on awareness of the Autism Strategy and reduction in autism waiting times	~~(31.03.25)~~ (30.06.25)	In-year progress delivering recovery action plans: Performance improvement in dementia diagnosis and perinatal access has resulted in DHCFT now delivering the core constitutional targets in this area and others Ongoing work to reduce inappropriate Out of Area Placements, underpinned by a Recovery Action Plan continues including a twice weekly Multi-Agency Discharge Event, roll out of home treatment service, and piloting weekend working for community mental health teams. New build facilities including a local PICU, will support improved patient flow and improved quality of care as the above will enable patients to be treated locally Flow improvement plan is impacting and out of area bed numbers and acute length of stay are reducing Performance reviews are in place for all divisions to monitor performance	RED
System partners report that DHCFT is inward looking and not easy to work with	To build stronger working relations and build stronger integrated ways of working and be more accessible, both	Increased delivery of integrated services	~~(31.03.25)~~ (30.06.25)	Active membership of Derby City PLACE Board, PLACE County Partnership Board, and	GREEN

	from an organisational and service perspective To deliver more integrated care [ACTIONS OWNER: CDO]			the integrated PLACE executive Senior management representation named for all PLACE Alliance groups. Collaborative development of community mental health 24/7 pilot alongside general practice partners Twice weekly mini MADE and MADE events take place every week. This is helping to develop our working relationship with social care and ICB colleagues whilst focusing on reducing length of stay and Clinically Ready For Discharge numbers	
Police partners report they do not always feel supported by mental health services and are under pressure to respond to mental health crisis	To reduce inpatient absent and missing cases To support Police with education and training where appropriate To streamline process and timeline for 136 suite admissions and handover [ACTIONS OWNER: CDO]	Reduction in inpatient absent and missing cases Training sessions offered to Police partners: • Police mental health awareness training sessions • Suicide prevention work • Joint working with Trust safeguarding teams • Collaborative response to Right care Right Person (RCRP) Increased handovers completed within one hour	~~(31.03.25)~~ (30.06.25)	Police are a formal member of the MHLDA DB Mental Health Response Vehicle (MHRV) to be implemented during 2024/25, to jointly provide a Trust and Police response to mental ill health calls Crisis café have opened in Buxton, Ripley and Swadlincote – This reduces demand on Police call-outs Trust is a member of the RCRP implementation executive group covering the Derbyshire system	AMBER

Patient and carers groups report that they would like to see more progress in service user and carer involvement and moving from engagement to decision making	Peer support strategy and objectives for EQUAL and the Mental Health Engagement Group [ACTION OWNERS: DON/MD]	Peer support strategy Co-production in Patient and Carer Race Equality Framework (PCREF) requirements	~~(31.03.25)~~ (30.06.25)	EQUAL group established to support service user and carer engagement and informs future service improvements across the East Midlands Perinatal Mental Health Provider Collaborative DON has worked with the Patient and Carers Committee, EQUAL and the Carers Engagement Group to review their terms of reference and linkages to strengthen the cross-working of the groups	AMBER

Related operational high/extreme risks on the Corporate Risk Register: None

Partnerships - Our organisation will identify new ways of working, through new collaborative approaches

There is a risk to safe, effective clinical care across Derbyshire impacting upon patients, due to not achieving national standards and variation of clinical practice and service commissioning in the Learning Disability (LD) Transforming Care Partnership

Impact: Poor partnership and system working could impact on the experience and quality of care provided for people with a ND disorder in Derbyshire

Root causes:

a) The community Intensive Support Team and Learning Disability models have non-standardised operating models and require more capacity
b) Currently the delivery and commissioning partnership in Derbyshire have not met national standards or local ambitions for more robust community-based offers, working across the geography and in an integrated way with partners including social care and the voluntary sector
c) The collective vision for Learning Disability services across Derbyshire and the formal outcome to achieve repatriation to Derbyshire has not been effective with some people remaining in outsourced areas of England for extended and significant periods of time
d) Health inequalities across our Derbyshire footprint – Initial insights continue to show gaps in access to service, case load and worsening patient outcomes. Mitigations need to be built alongside DCHS and the ICB
e)

BAF Ref: 25-26 4C	**Director Lead**: Vikki Ashton Taylor (CDO)	**Responsible Committee**: Quality and Safeguarding Committee – DHCFT Quality and Performance Committee – Derbyshire ICS Mental Health, LD and Autism Board in terms of system operational delivery

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Appetite**		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 3	Accepted	Tolerated	Not Accepted

Preventative – Health and safety audits; risk assessments; investment in estates development; workforce plan covering recruitment and retention. Mental Health Act Code of Practice
Detective – CQC inspection reports; Board visits virtual clinical service contact visits; incident, complaints and risk investigations; safety check log; Head of Nursing and Matron compliance visits
Directive – Trust Strategy; Physical Health Care Strategy; Safeguarding Strategy; Trust Policy Dashboard

Assurances on controls – Internal	**Assurances on controls – External**
Regional and national escalation process – Internal preparation	Advisory support provided by DHCFT to the system on bedded care standards for Learning Disability in-patient services Involvement of Local Government Association to deliver a peer review Involvement of external consultants

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Summary of progress on action	Action rating
The community Intensive Support Team and Learning Disability models require improvement	Review all models of support offered by the Intensive Support Team (IST) [ACTION OWNERS: CDO/DON/MD]	Outcome of review – Improved models of support	~~(31.03.25)~~ (30.06.25)	ICB have presented to both providers on how to ensure community offers are enhanced further through the review of pathway offers where resource is disproportionately allocated Ongoing discussions to commit more resources to community pathways The Trust is working alongside DCHS and has established an integrated service provision for neurodevelopmental services across both organisations The integrated model continues with a governance structure aligned	AMBER
Improvements are required in rapidly returning patients who access Learning Disabilities and Autism (LD&A) services to local care to enable them to live in the least restrictive manner, as close to home as possible	Continue to work on developed delivery improvement plan, owned by system partners. This includes new cohort stratification– Key action to implement embed approach to ensure focussed system action on existing inpatients who are placed inappropriately and out of area [ACTION OWNER: CDO]	Improvement plans developed and implemented resulting in a stabilised service and positive outcomes for patients Enhancing and reviewing Listening and Engagement Active Partnerships (LEAP) procedures Improvement plans in admission avoidance, crisis alternatives to admission, including	~~(31.03.25)~~ (30.06.25)	Derbyshire is no-longer in national escalation regarding performance with inpatient services after demonstrating improvement against plans New Dynamic Support Pathway (DSP) launched following cross-agency redesign work	AMBER

		improvement in the use of Dynamic Support Registers as a means of admission avoidance Reduction in delayed discharges in units across the country resulting in NHSE escalations		Cross-system delivery plan continues to be monitored through Neurodevelopmental Delivery group Board – Includes action plan in response to inflow, flow and outflow as discussed with NHSE and ICB leaders The Trust with the ICB continues to meet with NHSE on a quarterly basis to monitor performance and transformation, focussing on those patients with a long length of stay and who are Clinically Ready for Discharge	

Related operational high/extreme risks on the Corporate Risk Register:

ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating
23314	Corporate Services – IM&T	Interpretation of data submitted within NHSE datasets risks erroneous views on the Trust	30.10.24: NHSE interpret and analyse data submitted within mandated NHSE submissions. This analysis is not fed back to the Trust to allow them to validate and comment on before being published to the wider NHSE community, ICBs and others. This may also include historical analysis where the Trust has no way of rectifying any issues that might be raised. With this there is a risk that external organisations to the Trust are forming views on the Trust based on erroneous information 06.02.25: Risk still resides and will remain so until NHSE, regional sections of NHSE and ICB's communicate and coordinate methodologies prior to publishing analysis	30.10.24	06.05.25	HIGH

Board Assurance Framework 2025/26 – Issue 1.3 Board June 2025

Risk Rating
The full Risk Matrix is included in the Trust's Risk Management Strategy

Risk Assessment Matrix					
Risk Score = Consequence Rating X Likelihood Rating					
	CONSEQUENCE				
LIKELIHOOD	INSIGNIFICANT 1	MINOR 2	MODERATE 3	MAJOR 4	CATASTROPHIC 5
RARE 1	1	2	3	4	5
UNLIKEY 2	2	4	6	8	10
POSSIBLE 3	3	6	9	12	15
LIKELY 4	4	8	12	16	20
ALMOST CERTAIN 5	5	10	15	20	25

RISK RATING	RISK APPETITE
Very Low	Accepted
Low	
Moderate	Tolerated
High	Not Accepted
Extreme	

Actions Against Gaps in Key Controls - Expected completion dates to be included or next review dates to be shown in brackets	Action Rating
Action **completed**	Blue
Action **on track** to completion within proposed timeframe	Green
Action **implemented in part** with potential risks to meeting proposed timeframe	Amber
Action **not completed** to original or formally agreed revised timeframe. Revised plan of action required	Red

Action Owners

CEO	Chief Executive Officer
DOF	Director of Finance
MD	Medical Director
CDO	Deputy Chief Executive / Chief Delivery Officer
DON	Director of Nursing, AHPs and Patient Experience
DPOI	Director of People, Organisational Development and Inclusion
DCA	Director of Corporate Affairs and Trust Secretary

Definitions

Preventative	A control that limits the possibility of an undesirable outcome
Directive	A control designed to cause or encourage a desirable event to occur
Detective	A control that identifies errors after the event

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 June 2025

Transformation and Continuous Improvement Framework

Purpose of Report

To provide the Board with an update on progress with development of the Transformation and Continuous Improvement Framework and associated delivery plan.

Executive Summary

Best practice for management of complex and interrelated transformational activities is to use a standard project and programme management framework, supported by a Programme Management Office (PMO).

Aligned to development of the NHS approach to continuous improvement it is evidence based that:

- If we … adopt quality improvement as the primary method for addressing challenges
- We will … create optimum conditions for continuous improvement and high performance
- So that … we can provide high quality health and care services that meet the evolving needs of our population.

Whilst continuous improvement practice should be embedded locally in every-day ways of working, the implementation of a standardised approach to generating, testing and evaluating ideas from frontline teams supports organisational understanding of the improvement activity ongoing, learning from success and failure, and the spread and adoption of improvement solutions that could scale as transformational change.

This enclosed document outlines the framework agreed for implementation by Derbyshire Healthcare NHS FT to establish a standardised and best practice approach across all continuous improvement and transformation activities.

A detailed plan is in delivery for the development of continuous improvement and transformation arrangements at DHcFT aligned to the framework, with the key components of this consisting:

- A comprehensive review and evaluation of the current transformation portfolio aligned to the Strategic Plan 2025-28 and 2025/26 planning round, with decisions identified on any areas of misalignment or new opportunities for developing the portfolio
- Design and development of programme plans across the transformation portfolio for 2025/26 and beyond
- Refresh of the PMO manual and all project/ programme management standard documentation
- Alignment of PMO arrangements across the current portfolio with framework and documentation standards
- Alignment of governance arrangements across all project and programme with framework standards
- Development of the continuous improvement approach in alignment with the NHS IMPACT framework
- Development of reporting and assurance on delivery of the transformation and continuous improvement portfolio
- Development of the arrangements that underpin successful delivery of transformation and continuous improvement: establishing co-production as default; effective application of data, information and intelligence and actively harnessing technology and innovation.

A ‘live’ and holistic view will be maintained as appendices to the framework document of the current portfolio and associated governance. These have been drafted and will be presented to the inaugural Strategic Portfolio Oversight Group in June 2025. As set out within the Strategy update under separate cover, this group has been established to oversee assurance that all aspects of the Strategic Plan are on track for implementation according to agreed timescales, and to oversee the development and delivery of a portfolio of transformation that is aligned to deliver organisational strategic intent.

To inform the continuous improvement components of the delivery plan, a refresh has been completed of the baseline self-assessment against the NHS IMPACT framework. Analysis of this exercise has been applied to inform a development plan that is aligned to broader change of the organisational operating model with the draft transformation and continuous improvement framework delivery plan to be considered via the Strategic Portfolio Oversight Group.

Strategic Considerations	
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X

Risks and Assurances

The framework sets out the proposed approach for management of risk and assurance over delivery of transformational and continuous improvement activities at DHcFT.

Consultation

The framework has been developed in consultation with relevant stakeholders across the trust and has been discussed and approved via the Trust Leadership Team and Executive Leadership Team.

Governance or Legal Issues

The framework sets out the proposed governance arrangements associated with transformational and continuous improvement activities at DHcFT.

Public Sector Equality Duty & Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

The contents of the framework are expected to have a neutral impact on those with protected characteristics.

Recommendations

The Board of Directors is requested to:

1. Note the development of the Transformation and Improvement Framework, and associated delivery plan
2. Support implementation of the approach and arrangements described.

Report presented by: **Vikki Ashton Taylor**
Deputy Chief Executive and Chief Delivery Officer

Report prepared by: **Maria Riley**
Assistant Director of Transformation

Derbyshire Healthcare
NHS Foundation Trust

Transformation and Continuous Improvement Framework

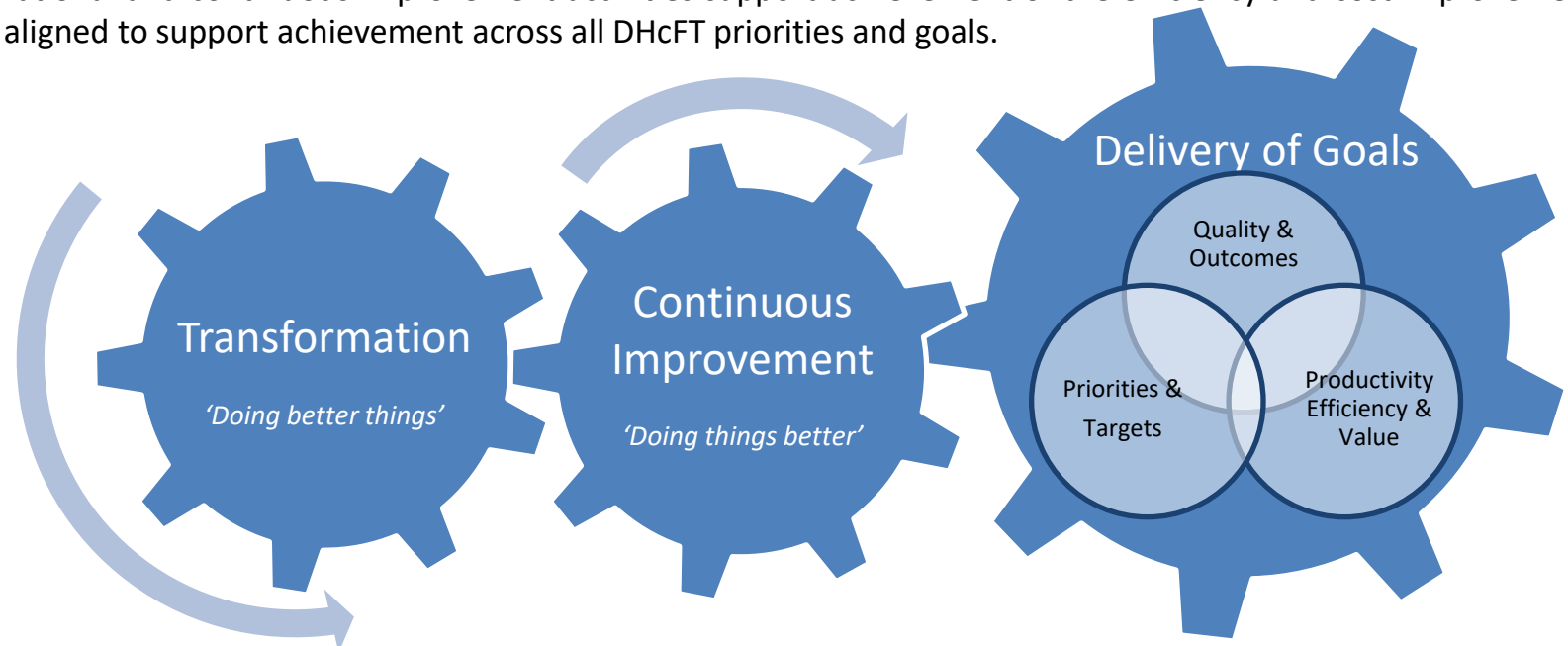
Contents

1. Purpose

- Best practice for management of complex and interrelated transformational activities is to use a standard project and programme management framework, supported by a Programme Management Office (PMO).
- Aligned to development of the NHS approach to continuous improvement it is evidence based that:
  - ✓ If we… adopt quality improvement as the primary method for addressing challenges.
  - ✓ We will…create optimum conditions for continuous improvement and high performance.
  - ✓ So that…we can provide high quality health and care services that meet the evolving needs of our population.
- Whilst continuous improvement practice should be embedded locally in every day ways of working, the implementation of a standardised approach to generating, testing and evaluating ideas from frontline teams supports organisational understanding of the improvement activity ongoing, learning from success and failure, and the spread and adoption of improvement solutions that could scale as transformational change.
- This document outlines the framework implemented by Derbyshire Healthcare NHS FT (DHcFT) to a standardised and best practice approach across all continuous improvement and transformation activities.

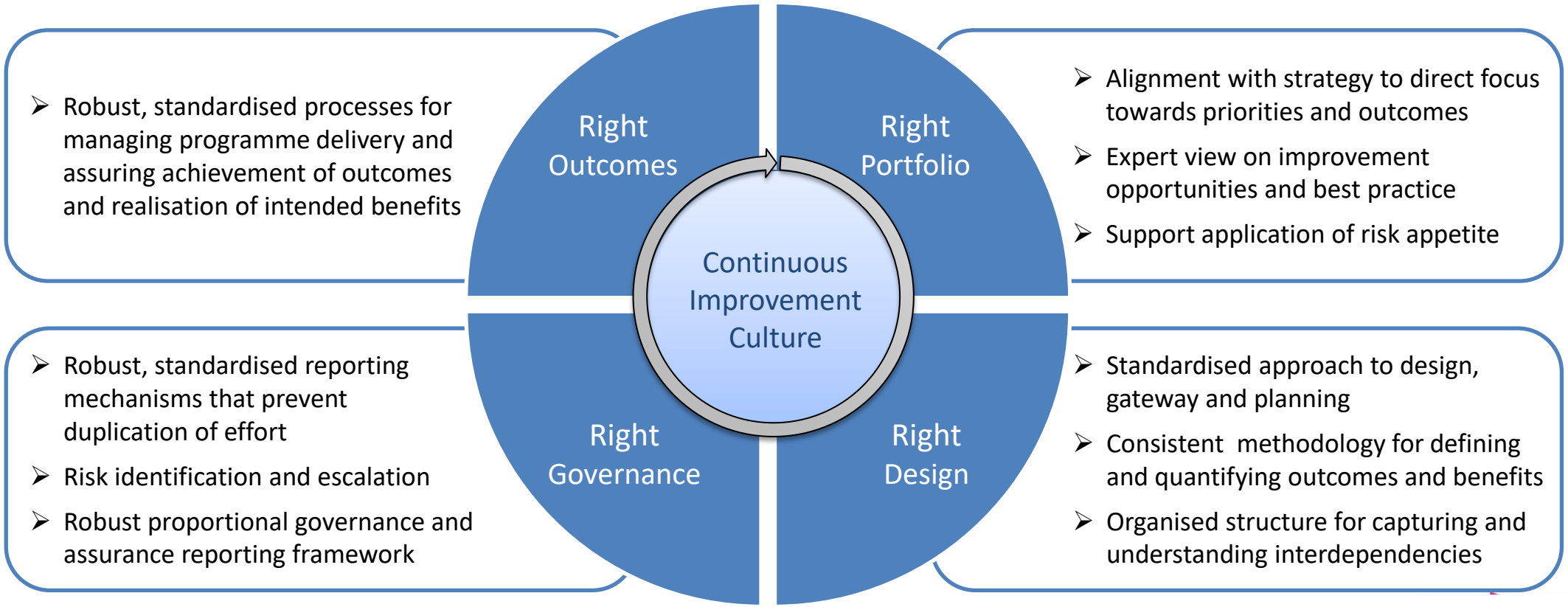
2. Definition

- Transformation and continuous improvement are related concepts and share similar goals – to make an organisation better – but they are applied under different situational drivers for change. Continuous improvement seeks to make incremental changes to a base state, whilst transformation seeks to change the base state itself.
- Transformation and continuous improvement are not mutually exclusive. Continuous improvement principles should be applied to drive transformational change and provides the enabling cultural conditions for successful transformational change. A set of transformations over time can also technically be thought of as continuous improvement in a larger, more holistic sense.
- Aligned to national best practice the definitions applied by DHcFT are:
  - Transformation: 'Doing better things' through a deliberate planned process to change how care and services are delivered and achieve planned and substantial measurable improvement.
  - Continuous improvement: 'Doing things better' through consistent, incremental improvement of processes, practices and systems by every person, every day, in all that they do, gradually leading to significant measurable improvement over time.
- Whilst transformational and continuous improvement activities support achievement of the efficiency and cost improvement programme, the portfolio is more broadly aligned to support achievement across all DHcFT priorities and goals.



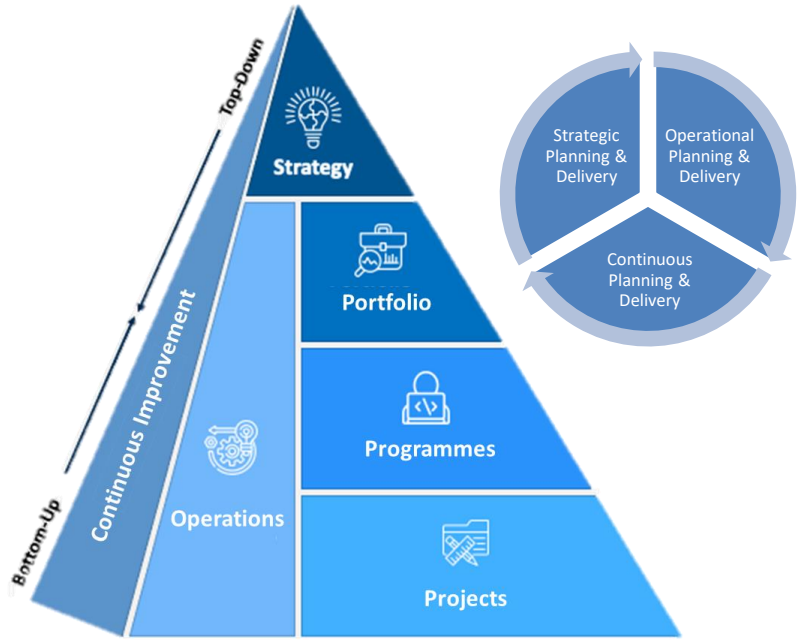
3. Transformation Framework

- The framework for transformation at DHcFT has been designed in alignment with best practice to establish the right portfolio, design, governance and outcomes. The framework is underpinned by the continuous improvement culture which provides the enabling conditions, leadership behaviours, and organisational capability for successful transformational change.
- DHcFT are a partner in transformational activity that is being designed and delivered with local and regional partners. This framework is applied to all activities and where appropriate assurance is secured that project and programme arrangements led by partners adhere to DHcFT standards.



3.1.1 Transformation: Portfolio

- Strategic alignment of the transformation portfolio connects the objectives and deliverables of each project and programme to organisational long term goals. At DHcFT this is enacted through alignment of the strategic and transformation planning and delivery framework, and through the robust approach to benefits realisation described in further detail at following section 3.1.6.
- At each strategic planning round a comprehensive review and evaluation of the current transformation portfolio is undertaken with outcomes mapped to the strategic plan and goals, and decisions identified on any areas of misalignment or new opportunities for developing the portfolio.
- On an annual basis, aligned to the NHS operational planning process, the strategic mapping outputs will be refreshed with the existing transformation portfolio remapped to national, regional and local strategy, operational planning guidance, and current improvement priorities. Decisions will be identified on development of, or commitment to the current transformation portfolio.
- Alignment of the oversight and governance arrangements for delivery of organisational strategy and the transformation portfolio further supports connection of objectives with long term strategic goals.



- Outside of the strategic and operational planning process, a dynamic approach will be maintained to development of the transformation portfolio, aligned to the continuous improvement framework. Arrangements for maintaining an expert view on national and international best practice and benchmarking, new intelligence, improvement and innovation opportunities will be maintained, with decisions identified on the potential to further develop the transformation portfolio.
- Strategic alignment of all new transformation projects and programmes will be further supported through the robust processes for design and development of projects and programmes as described in following section 3.1.3.
- The risk appetite defined by the Board sets the optimal position in pursuit of its strategy and vision and is significant tool within the development of the transformation portfolio. At DHcFT alignment of projects and programmes with risk appetite is embedded within the design stage. This alignment will ensure adherence to the risk appetite framework across the transformation portfolio and the level of innovation pursued.
- A 'live' and holistic view will be maintained as appendices to this document of the current portfolio and the associated governance.

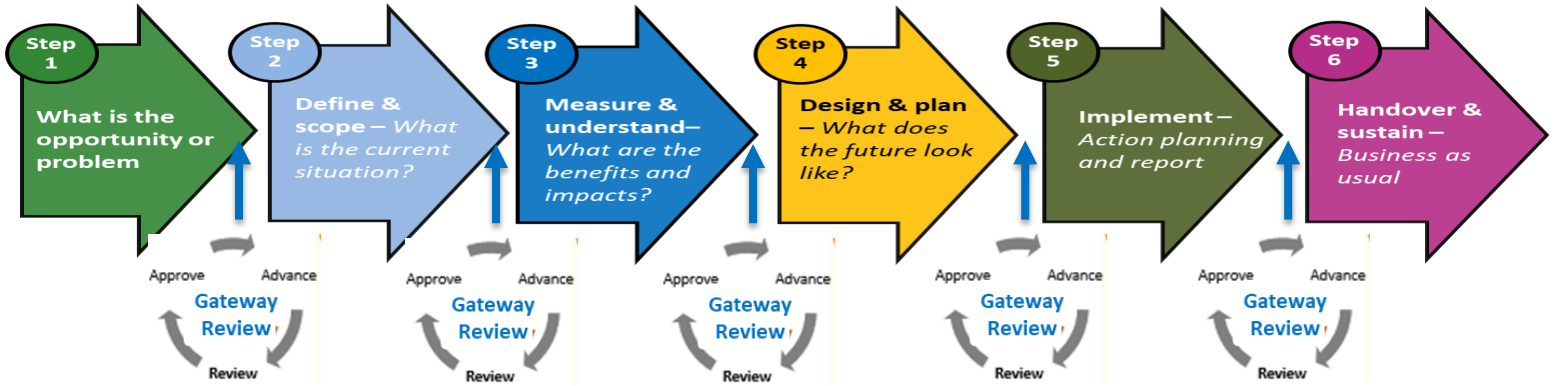
3.1.2 Transformation: Design Management

- The successful design and delivery of transformational plans, and realisation of intended outcomes and benefits, is underpinned by effective project and programme management arrangements. The DHcFT approach to project and programme management is based upon recognised methodologies such as Managing Successful Programme (MSP) and PRINCE2.
- The DHcFT Programme Management Office (PMO) team fulfils a number of key functions that include:
  - ✓ Supporting alignment of focus on strategic outcomes.
  - ✓ Establishing and overseeing project management processes and standards.
  - ✓ Applying best practice improvement tools and techniques.
  - ✓ Overseeing good project and programme governance.
  - ✓ Supporting the identification, measurement and assurance on realisation of outcomes and benefits.
  - ✓ Offering education and coaching to develop project management skills and capability.
  - ✓ Supporting evaluation and adoption of learning from success and failure.
  - ✓ Stimulating and acting as a catalyst for innovation.
  - ✓ Supporting the application of the trust business case process and development of robust proposals.

- The DHcFT PMO work collaboratively with other 'expert' teams across the trust to ensure that all projects and programmes are effectively supported and serviced across the initial design and delivery phases, through to post project evaluation. Expertise from DHcFT teams may be required across specialisms including data and analytics, digital and ICT, finance, people and workforce, estates, engagement and involvement, communications and procurement.
- A PMO Manual is in place that further describes the role and responsibilities of the PMO and other teams, along with the programme management processes and standards that are implemented at DHcFT.
- DHcFT are a partner in transformational activity that is being designed and delivered with local and regional partners. For all activities where DHcFT does not lead PMO arrangements, a relationship with the partner PMO is established with assurance secured that any alternative arrangements adhere to DHcFT standards, and reporting mechanisms formalised to ensure robust PMO arrangements are maintained.

3.1.3 Transformation: Design Process

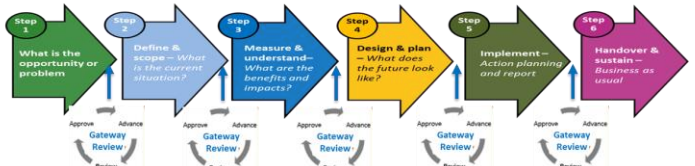
- A DHcFT PMO Manual is in place that describes the programme management processes and standards that are implemented at DHcFT.
- The Joined Up Care Derbyshire (JUCD) system uses a digital ePMO solution to capture and manage delivery of projects and programmes. All DHcFT projects and programmes will be captured and managed through the ePMO and the DHcFT PMO Manual clarifies the interface between the JUCD standardised processes, and where arrangements are tailored, for example to align with DHcFT internal governance arrangements.
- All fundamental documentation such as the Project Initiation Documentation (PID) are completed and organised electronically within the ePMO. A detailed ePMO Quality Manual has been established which is applied by all JUCD organisations, including DHcFT. The manual steps through each project management stage in detail with step by step guides for each of the ePMO templates and tools.
- A six step process is applied to all transformation project and programme improvement activities aligned to agreed DHcFT methodology and the JUCD ePMO.



- A robust gateway process is in place with oversight and governance between each stage. The gateway process is underpinned by a detailed compliance checklist with controls overseen by the DHcFT PMO team.
- DHcFT are a partner in transformational activity that is being designed and delivered with local and regional partners. For all projects and programmes where DHcFT does not lead PMO arrangements, assurance is sought that arrangements align with DHcFT standards, and the interface with the internal PMO assurance and reporting and assurance framework is formally documented by the DHcFT PMO team.

3.1.4 Transformation: Governance

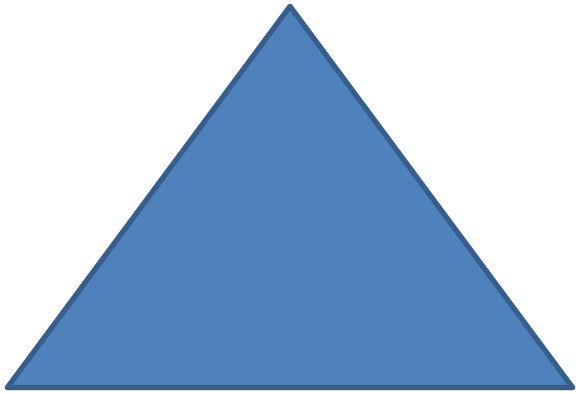
- At DHcFT all projects and programmes are overseen by a project or programme board. The prime purpose of each board is to drive the project/ programme forward and deliver the intended outcomes and benefits. Members of the board provide resource and specific commitment to support the Senior Responsible Officer (SRO) who is accountable for the successful delivery of the programme.
- The project/ programme board fulfils a number of key functions over the lifecycle of the project/ programme aligned to the processes described at the prior section 3.1.3, which includes:
  - ✓ Evaluating the potential project/ programme at high level prior to committing energy and resources to define it fully, considering the strategic fit, vision, costs, duration, risks, and providing a high level business case for the project/ programme.
  - ✓ Using the information in the Project/ Programme Brief to develop the scenarios and options that the trust should consider, and then define and plan the chosen option in sufficient detail to prove viability and to enable launch.
  - ✓ Overseeing the development and approval of the benefits map and associated reporting
  - ✓ Overseeing robust project/ programme delivery activities including progress against the programme plan, that deliverables enable required changes and those in turn deliver the benefits sought, continual stakeholder engagement, risk and issue management, benefits and business case management.
  - ✓ Closure of the programme so as to ensure changes can be sustained when the programme team is disbanded, including reviewing performance of the project/ programme, identification and application of lessons learned, planning for and ownership of any post project/ programme benefits management activities.
- The project/ programme board is serviced by robust and standardised reporting that supports effective discussions and informed decision making. Aligned to the DHcFT PMO standards, documentation is updated and presented to each board meeting that includes the delivery plan, risk register progress highlight and benefits reporting.
- In alignment with the governance framework documented at the following section 7, project/programme boards are accountable through the Strategic Portfolio Oversight Board to the Executive Leadership Team, and Finance and Performance Committee.



3.1.5 Transformation: Leadership

- DHcFT project and programme leadership teams form “triumvirates” with senior responsible officers, project leads and clinical leads identified for each project and working in partnership. Large scale programmes will also have an appointed Executive Lead.
- The leadership team is supported by the Programme Management Office, and a wider project management team with appropriate skills and expertise depending on the size, scale and focus of the project or programme.
- The DHcFT PMO offer education and coaching to support the development of project management capacity and capability. An evaluation will be completed at the inception of each project or programme to ensure that the right people, with the right skills and expertise are assigned to support successful delivery.

Senior Responsible Officer
A lead Senior Responsible Officer (SRO) is ultimately accountable for delivery of the project or programme of work. The SRO will support the project/ programme lead and clinical lead in resolving issues and risks, managing stakeholders and holding the wider project team to account.

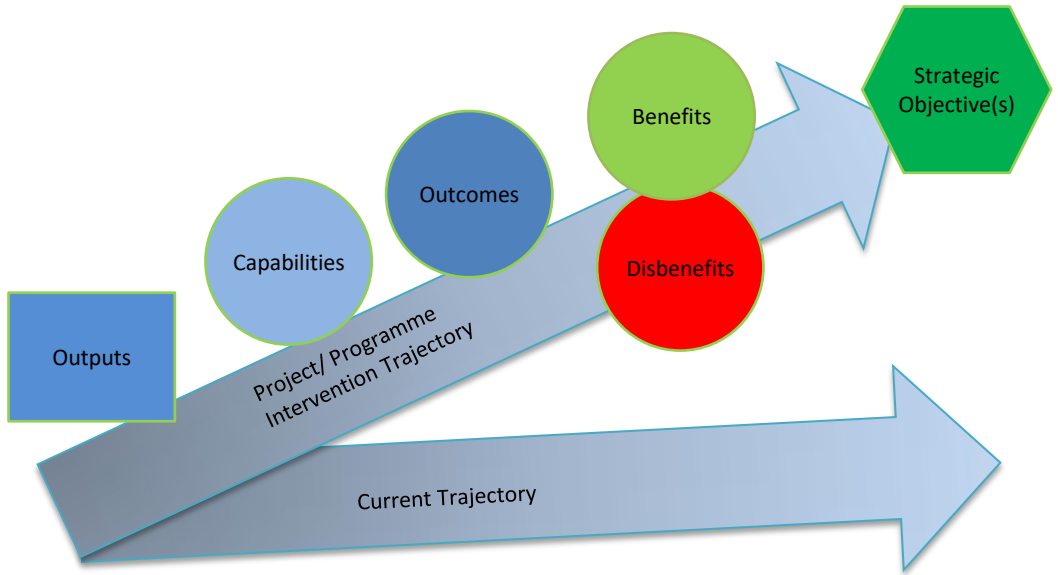


Clinical or Professional Lead
The clinical lead is responsible for leading the clinical design, galvanising clinical input from colleagues within the multi-disciplinary team and championing the project as a “figure head”.

Project/ Programme Lead
The project/ programme lead is responsible for delivery of the project benefits, overseeing project management and supporting the SRO and clinical lead in driving delivery. Project Leads can be anyone who takes responsibility for leading the project, regardless of their usual role and responsibilities.

3.1.6 Transformation: Outcomes and Benefits

- In collaboration with 'expert' partners that include the business intelligence and finance teams, the DHcFT PMO oversee application of consistent methodology for defining and quantifying outcomes and benefits and monitoring delivery and realisation of benefits.
- Aligned to national best practice a benefits map is established for all projects and programmes which sets out:
  - ✓ Outputs: The expected deliverables of a project / programme.
  - ✓ Capabilities: The means or the ability to produce outcomes or 'enablers'.
  - ✓ Outcomes: The results obtained through the use of a project / programme output i.e. the results of actions taken, work completed or change made.
  - ✓ Benefits and dis-benefits: The value perceived or realised by those experiencing the outcomes of the change.
  - ✓ Strategic objectives: Organisational long term goals.
  - ✓ Dependencies between outputs, outcomes and benefits/dis-benefits.



- The benefits map is produced during the design phase (Step 3) and formally approved by the SRO and project/ programme board.
- Reporting mechanisms are also established during the design phase that offers oversight and monitoring of all intended deliverables as set out within the map. Reporting on outcomes and benefits is regularly presented to the project/ programme board once the realisation stage is reached, with analysis of achievement aligned to the monthly project/ programme highlight report.
- Progress on benefits realisation is monitored throughout the lifecycle from the opportunity phase pre business case through to final benefits achievement which may be a number of years post implementation.

4. Continuous Improvement Framework

- NHS IMPACT (Improving Patient Care Together) was launched in 2023 as the new, single, shared NHS improvement approach, recognising that by creating the right conditions for continuous improvement and high performance, systems and organisations can respond to today's challenges, deliver better care for patients and give better outcomes for communities.
- DHcFT is committed to implementation of a systematic approach to continuous improvement aligned to the five components defined by NHS IMPACT:

1. Building a shared purpose and vision
2. Investing in people and culture
3. Developing leadership behaviours
4. Building improvement capability and capacity
5. Embedding improvement into management systems and processes

- The continuous improvement framework will be holistically and consistently applied to create the conditions in which continuous improvement is the "go to" method for DHcFT people and teams in tackling clinical, operational and financial challenges.
- Our overarching ambition in development of our arrangements at DHcFT is to establish the capability, capacity and the right leadership behaviours to enable staff to solve the problems that matter to them, their patients and their populations.
- DHcFT has completed a maturity self assessment against the NHS IMPACT framework and established a detailed action plan for development of its arrangements across all domains. Progress against this action plan is being overseen by the Executive Leadership Team on a quarterly basis and the assessment will be refreshed and benchmarked against peers on an annual basis.

4.1.1Continuous Improvement: Aim

- The diagram below sets out the aim of the continuous improvement framework at DHcFT, and how we will deliver success across each of the five components set out within the NHS IMPACT framework.

To mainstream continuous improvement across DHcFT to achieve enhanced patient outcomes, increased operational efficiency and overall excellence in healthcare delivery

Building a shared purpose and vision

Our workforce, trainees and learners understand the direction and strategy of the organisation / system, enabling an ongoing focus on quality, responsive and continued learning.

- Shared vision and purpose established with strategy embedded in ways of working and brought to life
- Priorities role modelled and aligned with improvement work at local level
- Celebration and learning events established practice to recognise and share improvements widely
- Patients, carers, staff and public have a voice which influences the strategic improvement agenda

Investing in people and culture

Clear and supported ways of working, through which all staff are encouraged to lead improvements.

- Established and constantly nurtured culture consistent with improvement
- Our people describe what matters most and how this translates into their local improvement priorities
- A coaching style of leadership embedded as the default approach throughout the organisation
- People and teams are systematically engaged in co-produced improvement activity as part of their day-to-day work

Developing leadership behaviours for improvement

A focus on instilling behaviours that enable improvement throughout organisations and systems, role-modelled consistently by our Boards and Executives.

- Board focus on constancy of purpose which is visibly linked to future planning at a system level
- Clear framework and expectations embedded for leadership and management values and behaviours
- Board and wider system establish a multi-year journey with improvement at its core
- Leaders at all levels act as champions of the improvement and management methods and remove barriers
- All levels of leaders and managers undertake regular learning and engage with external 'go and see' visits

Building improvement capability and capacity

All our people (workforce, trainees and learners) have access to improvement training and support, whether embedded within the organisation/system or via a partner collaboration.

- Systematic approach to improvement embedded with induction and training provided to every member of staff
- Learning from improvement activity is driving continuous improvement and there is a common language in use
- Demonstrable impact and sustained improvement from problem solving and organisational focus on data
- People with lived experience and stakeholders embedded in teams and an integral part of the capability
- Cascade of huddles embedded for all teams from executive to frontline teams

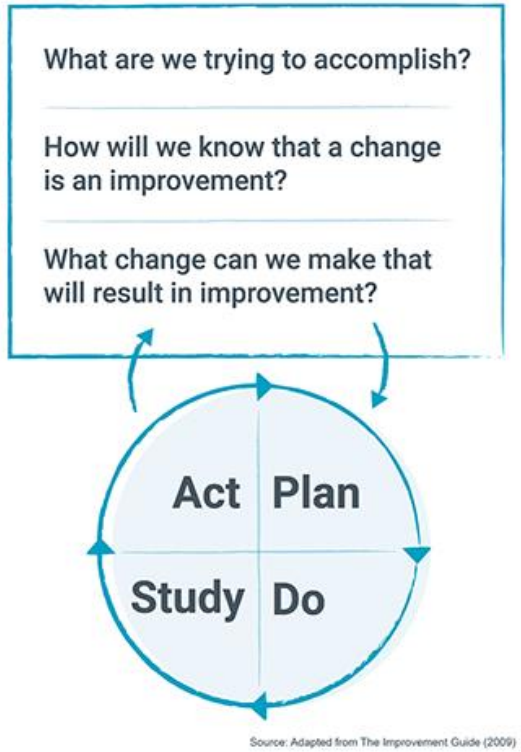
Embedding improvement into management systems and processes

Embedding approaches to assurance, improvement and planning that co-ordinate activities to meet patient, policy and regulatory requirements through improved operational excellence.

- Management system embedded that aligns the strategy, vision and purpose from Board to frontline level
- Planning and and performance management processes give good visibility of status and progress against goals
- All teams use the management method to understand, run and improve each aspect of our organisation
- Systems embedded to identify and monitor early warning signs and risks, with clear processes to respond to these
- Continuous improvement is integrated in all that we do and we constantly strive for excellence

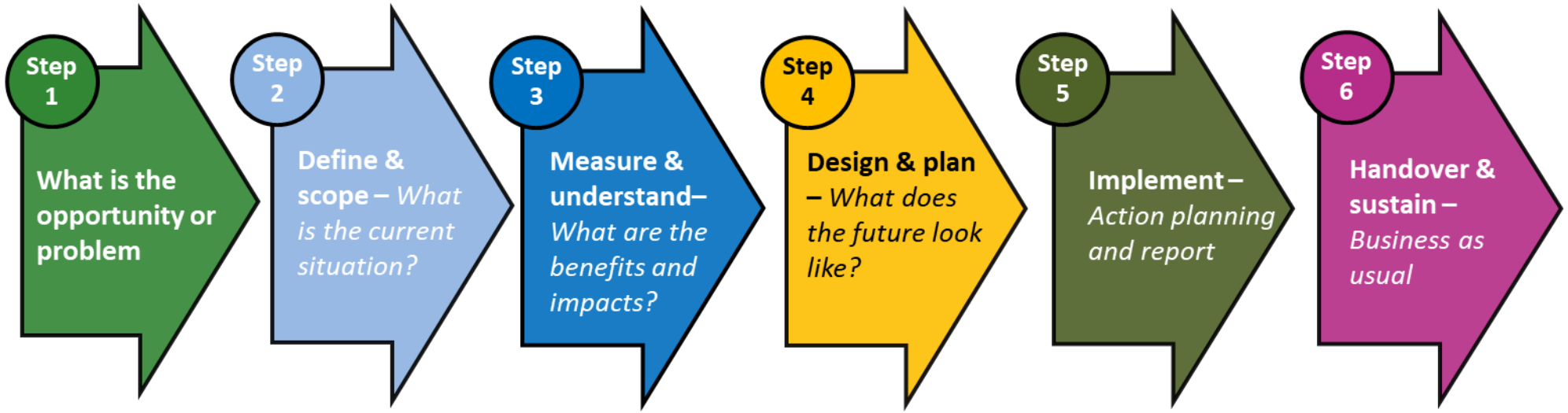
4.1.2 Continuous Improvement: Methodology

- DHcFT apply the Institute for Health Improvement 'Model for Improvement' as a framework for designing and developing improvement solutions.
- The model is based on three fundamental questions:
  1. What are we trying to accomplish?
  2. How will we know that a change is an improvement?
  3. What changes can we make that will result in improvement?
- The Plan-Do-Study-Act (PDSA) cycle is applied to test and adapt changes to ensure they result in the desired improvement.
- Answering the model's three questions is an iterative process — the team moves back and forth between them as changes in thinking in one question or learning from PDSA cycles results in changes in thinking in another.
- Where appropriate, alternative, more advanced approaches may be adopted at DHcFT, supported by the continuous improvement team. The use of more advanced approaches might be useful in circumstances such as there being a need for service design, application of lean principles for reduction of waste, or process/ value stream mapping. Complementary methodologies, techniques and tools will be applied in combination to form an effective approach depending on the improvement aim.



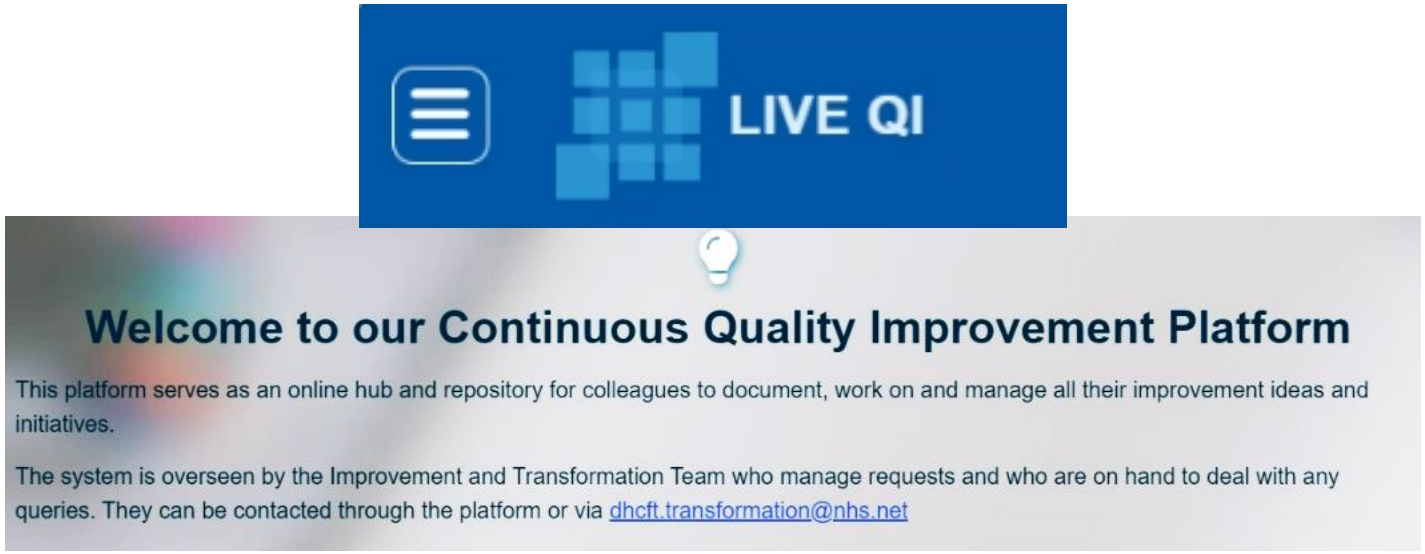
4.1.3 Continuous Improvement: Process

- A six step process is applied to continuous improvement activities at DHcFT aligned to the Model for Improvement and agreed improvement methodology. Whilst this is aligned to the process for planned transformational activities as described at section 4, there are light touch arrangements for documentation and 'check in' points along the improvement design and delivery journey rather than the structured oversight and PMO governance in place for transformational activities.



4.1.4 Continuous Improvement: Management

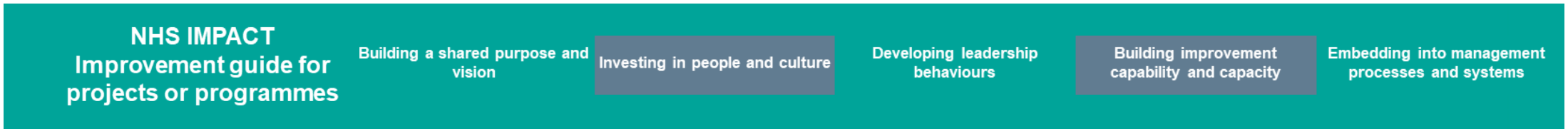
- Continuous improvement activities are captured on the DHcFT internally designed 'LiveQI' platform.
- Live QI has been designed to support users with each step of the improvement process and includes:
  - ✓ Forms to support documentation of ideas and the subsequent development and testing of solutions.
  - ✓ Support with measures and benefits.
  - ✓ Improvement tools and templates.
  - ✓ Opportunities to request support.
- The platform is used as a management tool to track, analyse and support the measurement and evaluation of outcomes. Reporting functionality enables sharing and learning from both success and failure, and the spread and adoption of solutions.



4.1.5 Continuous Improvement: Programmes

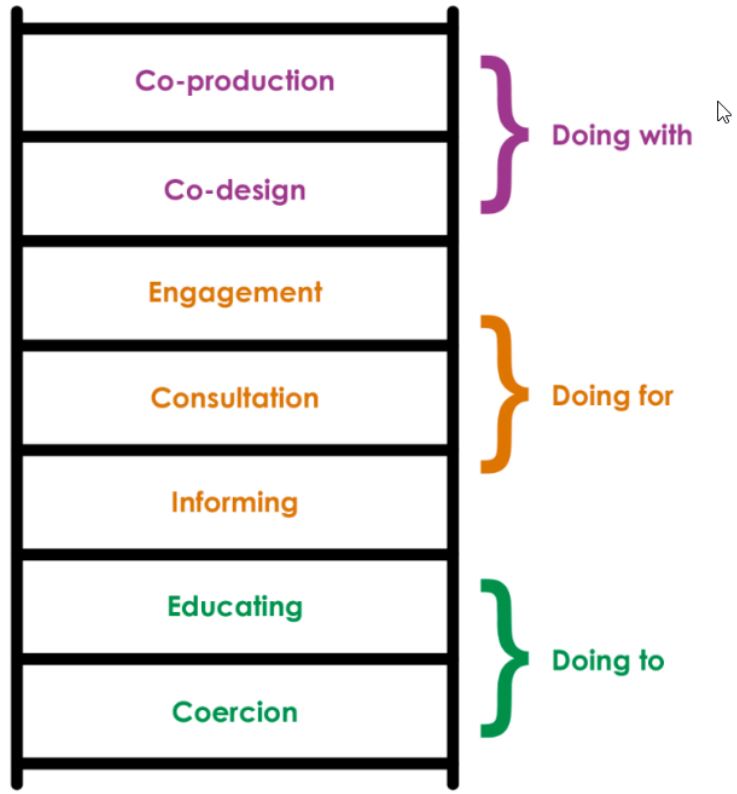
- DHcFT is committed continuous improvement being our 'go to' approach for tackling complex clinical, operational and financial challenges.
- For all large scale and transformational project and programmes the NHS IMPACT improvement guide is used to self assess whether best practice is being applied in adopting improvement as a method for design and delivery. The guide assesses 5 core components of large-scale design: aim; content theory; execution theory, measurement and learning; communication and storytelling.
- The self assessment is completed by the project/ programme lead, through an inclusive process, involving a range of stakeholders to support a robust self-assessment that takes diverse perspectives into consideration, especially when considering how well the features are embedded.
- The improvement guide offers a snapshot of the maturity position at a point in time and is first completed at the design stage to assess whether activities or approaches are in line with the best practice in large-scale design for improvement. The self-assessment is reviewed and updated throughout the lifecycle of the project/ programme with consideration of update at each gateway stage.
- Outcomes of each assessment are formally considered by the project/ programme board with learning and actions developed as appropriate.
- Aligned to the gateway checklist and process described at prior section 3.2.3, the assessment process is overseen by the DHcFT PMO.

NHS IMPACT
Improving Patient Care Together



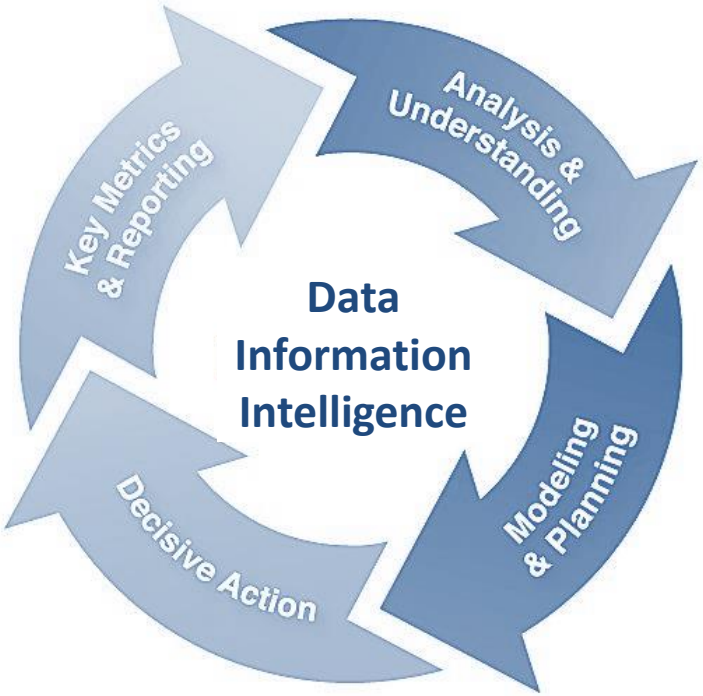
5.1 Fundamental Principles: Co-production

- Aligned to the NHS IMPACT framework co-production is at the heart of the DHcFT transformation and continuous improvement framework as the default approach in improving experiences of care.
- DHcFT is committed to involving people who use health and care services, carers and communities in equal partnership; and routinely engaging groups of people at the earliest stages of design, development and evaluation.
- At DHcFT a co-productive approach to planning and delivery of all transformation and continuous improvement provides an opportunity for people with lived experiences to be part of our projects and programmes from inception to completion. In doing so we will establish a portfolio shaped by patients, for patients.
- A detailed work plan is under design for development of the DHcFT approach to co-production, which will incorporate advancement of arrangements across transformational and continuous improvement activities.



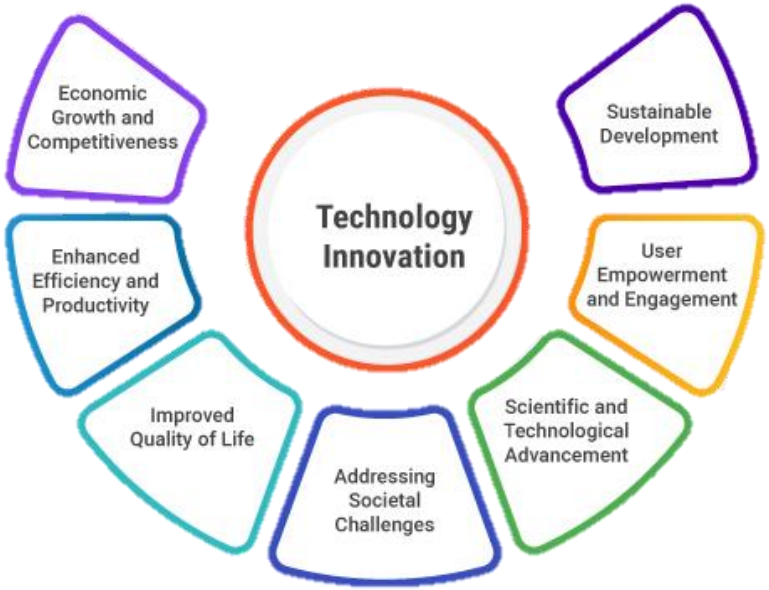
5.2 Fundamental Principles: Data & Intelligence

- High quality and timely data, information and intelligence are fundamental to the successful operation of the DHcFT transformation and continuous improvement framework.
- Data, information and intelligence are applied to inform the diagnosis of problems, identification of opportunities, and design and development of both the strategic transformation portfolio, and local continuous improvement activities at DHcFT.
- Data, information and intelligence are also fundamental to the tracking of intended outcomes and benefits across the planned transformation portfolio, and critical at local level across continuous improvement activities, in developing an improvement hypothesis, measuring the change, and demonstrating whether the change has led to improvement.
- At DHcFT the Performance and Delivery team act as an active partner across all transformation and continuous improvement activities, providing systematic input into design and decision-making and routinely equipping teams with data, information and intelligence that drives and delivers successful transformation and improvement.
- DHcFT also work in active collaboration with partners In JUCD, regionally and nationally in the development and application of population health data and the translation of this into new models that seek to improve care and tackle health inequalities.



5.3 Fundamental Principles: Technology & Innovation

- Technology and innovation offer significant opportunities to transform health and care, and are critical enablers of change.
- DHcFT is committed to harnessing opportunities to innovate and adopt new technologies across the transformation portfolio, and within local continuous improvement activities, and we do so by:
  - ✓ Nurturing a culture of innovation that facilitates creativity, experimentation, where our people feel at ease to suggest and test new ideas, and where failures are celebrated as an opportunity for learning .
  - ✓ Investing time and resources in innovation and supporting development of innovative thinking and solutions, recognising that this investment will support long term financial sustainability.
  - ✓ Aligning technology and innovation with our vision and strategy and with the voice of people who use health and care services, carers and communities.
  - ✓ Actively scanning for, pursuing and embracing new technologies, innovative products and services, and maintaining connections with the external forum for developing and spreading innovation.
  - ✓ Recognising and understanding our success and failure, learning from this, and striving to apply this in forward innovation.
- DHcFT proactively connect and collaborate internally with research and externally with organisations including Health Innovation East Midlands and broader industry to discover, test and spread technology and innovation.
- Strategic delivery plans describe how DHcFT will harness technology and innovation over the course of the current strategic planning cycle.



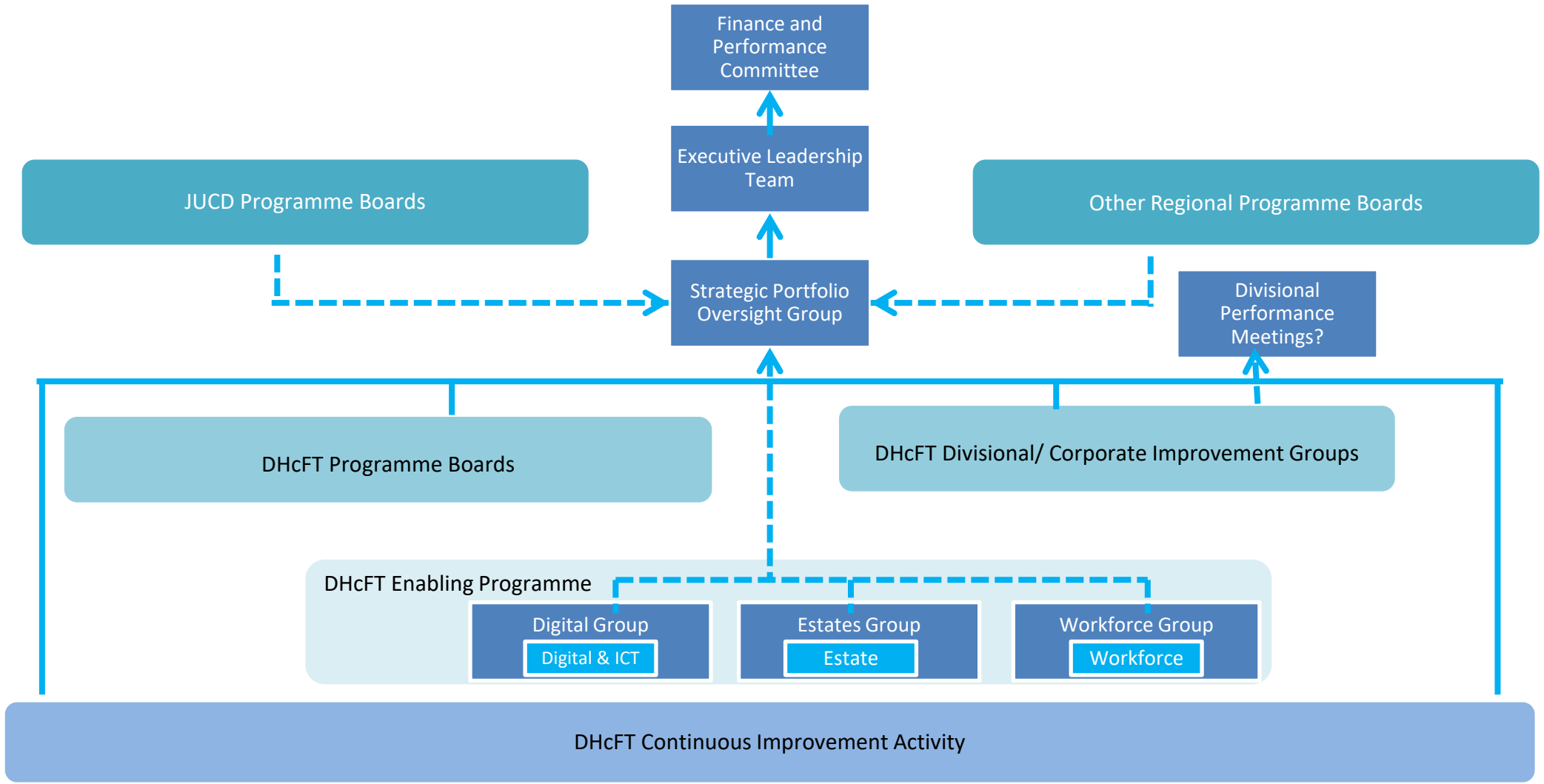
6. Reporting and Assurance

- A quarterly report is produced through the Programme Management Office on transformation and continuous improvement activity. This is structured over three core sections, offering assurance over PMO processes, delivery of the transformation portfolio, and development of the continuous improvement approach.

Section 1:	**PMO Assurance**	
	1.1	PMO Processes
	1.2	PMO Reporting
	1.3	Current Portfolio
Section 2:	**Programme Status Report**	
	2.1	Summary Programme Status
	2.2	Summary Programme Risk
	2.3	Detailed Programme Status Reports
Section 3:	**Improvement Approach**	
	3.1	Sharing and Celebrating Success
	3.2	Improvement Education
	3.3	Improvement Community
	3.4	Learning and Ambition
	3.5	NHS IMPACT Action Plan

7. Governance

- Delivery of organisational strategy, and the holistic transformation and continuous improvement portfolio is overseen through an integrated governance model with the Strategic Portfolio Oversight Group meeting on a quarterly basis.



8. Development Plan

- A detailed plan has been established for the development of continuous improvement and transformation arrangements at DHcFT.
- The key components of this consist:
  - A comprehensive review and evaluation of the current transformation portfolio aligned to the launch of the new trust strategy and 2025-26 planning round, with decisions identified on any areas of misalignment or new opportunities for developing the portfolio.
  - Design and development of programme plans across the transformation portfolio for 2025-26 and beyond.
  - Review and refresh of the PMO manual and all project/ programme management standard documentation.
  - Review of PMO arrangements across the current portfolio to verify compliance with this framework and documentation standards.
  - Review of governance arrangements across all project and programme boards to verify compliance with expected standards.
  - Development of the continuous improvement framework in alignment with the NHS IMPACT action plan.
  - Development of reporting and assurance on delivery of the transformation and continuous improvement portfolio.
  - Development of the arrangements that underpin successful delivery of transformation and continuous improvement: establishing co-production as default; effective application of data, information and intelligence and actively harnessing technology and innovation.

Appendix 1: Current Portfolio

- Placeholder for portfolio on a page view that is to be presented to Strategic Portfolio Oversight Group.

Appendix 2: Governance of Current Portfolio

- Placeholder for governance associated with Appendix 1.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 June 2025

Intensive and Assertive Community Mental Health Treatment Independent Homicide Review - Nottingham

Purpose of Report

To provide the Board of Directors with a progress report into meeting the recommendations from the independent review and The Care Quality Commission (CQC) Section 48 review of Nottinghamshire Healthcare NHS Foundation Trust

Executive Summary

Following the publication of the Independent Mental Health Homicide Review into the tragedies in Nottingham all Integrated Care boards (ICBs) and Mental Health trusts have been asked to produce an action plan in relation to the findings from the review.

DHcFT has formed a multi-disciplinary working group to focus on the key areas identified. All Trust Divisions are represented. The work of this group builds on, and runs alongside, other workstreams relating to Care Quality Commission (CQC) action plans and the Community Mental Health Maturity Index Action Plan.

Divisions have submitted information on their current status and have identified areas where improvements are needed.

A table is provided in the main report with an overview of the current status and identified actions.

Work is ongoing, with some Divisions awaiting finalisation of their action plans. The group has links with the regional programme managers for Community Mental Health at NHS England. They will provide feedback on the work of the group and also updates on regional and national progress.

Strategic Considerations	
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X

Risks and Assurances

Risks identified are supported by an action plan under review by the chairs of the Group with escalation as required.

Consultation

This paper has been through the Quality and Safeguarding Committee and has been reviewed by members of the Executive Leadership Team.

Governance or Legal Issues

The work is being carried out in line with direction from NHS England to all ICBs and Mental Health trusts.

Public Sector Equality Duty & Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

Access to services and health inequalities consideration.

Recommendations

The Board of Directors is requested to note the work undertaken to date in ensuring the recommendations from the independent review are being addressed.

Report presented by: **Tumi Banda**
Director of Nursing, AHPs, Quality and Patient Experience

Report prepared by: **Dr Wendy Brown**
Consultant Psychiatrist

Toby Marandure
Head of Nursing

Update from DHcFT working group on actions from the Independent Mental Health Homicide Review into the tragedies in Nottingham

Background

The Board is asked to discuss the action plan and progress in taking forward to improve the intensive and assertive community treatment for people with mental illness as set out by NHSE in February 2025.

On 5 February 2025, all Integrated Care Board's (ICBs) and Mental Health trusts received a letter from the National Director for Mental Health, Learning Disability and Autism and the Medical Director for Mental Health and Neurodiversity from NHS England. In this letter, it is stated that Mr Valdo Calocane, a patient experiencing serious mental illness, was failed by mental health services, which had devastating consequences.

Whilst acknowledging the work already undertaken by services, the letter sets out the next steps. It asks services to review local actions plans with particular attention to:

1) Personalised assessment of risk across community and inpatient teams
2) Joint discharge planning arrangements between the person, their family, the inpatient and community team (alongside other involved agencies)
3) Multi-agency working and information sharing
4) Working closely with families
5) Eliminating out of area placements in line with ICB three-year plans.

In February 2025, NHS England published an Independent Mental Health Homicide Investigation. This was into the events in June 2023 in Nottingham when three people lost their lives.

In 2024, the Care Quality Commission published "Learning from the Nottinghamshire Healthcare Section 48 reviews" in two main parts. The Section 48 review of Nottinghamshire Healthcare NHS Foundation Trust was commissioned by the Secretary of State for Health and Social Care in response to the conviction of Valdo Calocane. The review aimed to assess patient safety, quality of care, and systemic issues within the Trust's mental health services, with a particular focus on the care provided to Valdo Calocane.

Part 1 (Published March 2024):

- Assessed patient safety and quality of care at Nottinghamshire Healthcare NHS Foundation Trust
- Focused on demand for services, access to care, quality of care, staffing, and leadership
- Included a review of progress at Rampton Hospital since the last inspection in July 2023
- Identified significant failings in the Trust's ability to manage service demand, staffing, and leadership, prompting the Trust to begin addressing these risks through an Improvement Plan.

Part 2 (Published August 2024):

- Provided a rapid review of evidence related to the care of Valdo Calocane
- Further examined systemic issues in community mental health care, particularly in care co-ordination, medication management, and discharge planning
- Benchmarked the Trust's services against findings from the reviews.

Learning and Response to the reviews, Part 1 and 2 the Trust has taken learning from the two reviews and work with partners to implement the actions as follows:

- Following the reviews, the Trust completed the Integrated Care Boards (ICB) Review Outcome Template and the ICB Maturity Index Self-Assessment Tool. These tools are designed to ensure that recommended actions are embedded within senior governance structures at both the Trust and ICB levels
- The ICB Review Outcome Template is mandatory and was submitted by 30 September 2024. These processes support structured evaluation and readiness for providing effective Assertive Outreach (AO) and Intensive Community Support, aligning with NHS operational planning guidance for 2024/25.

Workshops and collaborative sessions were held to address key learning areas such as care co-ordination (identifying gaps in how patients with complex needs are managed across services), medication management (reviewing monitoring medication in the community), discharge planning (planning and supporting safe transitions from inpatient to community care), management of non-engagement (emphasizing the need for assertive approaches to patients who disengage from services), listening to families (stressing the importance of incorporating family input into care decisions) and risk assessment (underlining the need for robust and ongoing risk assessments, especially for high-risk individuals).

A summary of the risks and mitigations associated with this work is presented in the table below. The organisational risk is captured in the Board Assurance Framework under Risk 1, *"There is a risk that the Trust will fail to provide standards for safety, and effectiveness as required by our patients, regulators, partners and our Board, there is also a risk of poor patient experience and outcomes*".

Area	Mitigation	Risks
Identification of AO patients	Management and Supervision Tool (MaST) is being used to identify AO case and these are then allocated to the AO worker/AO waiting list. AO standard operating procedure in place. AO worker funding is ringfenced.	Some AO workers continue to have high caseloads numbers and mixed caseloads. It is anticipated that numbers will increase as identification methods become more robust.
Risk management	Daily safety huddles to identify increasing risk. Forensic CMHT supervision and social supervision as needed.	Training specific to AO workers needed. Documentation quality need to be improved on the electronic record systems.
Carer involvement	Carer dashboard is being used by AO workers and CMHT staff.	Increased awareness across all teams of the carer dashboard.
Care plans/risk assessments	Quality Dashboards, clinical audits, Fundamental standards of care review, crosscheck meetings, managerial supervision and caseload management. Clarification of the care standards to community staff.	Access to psychological interventions difficult. Quality of care plans can be variable. Care Programme Approach (CPA) compliance is below the expected targets. Care plan and Risk management documentation standard is variable. Care plan and risk management require improvement in involving carers
Discharge processes	Policies amended to ensure that non engagement is not a reason for discharge. Clinical supervision to ensure discharge decisions are multidisciplinary and include inpatient and community teams.	Challenges to co-produce discharge planning with both the person and their families.
Flow	Step up and step-down processes according to need.	Consistency of AO review meetings across teams. Capacity for consultants to do home visits. Robust caseload management required for stepping treatment up or down.

The Trust and Integrated Care Board (ICB) are aligning self-assessment findings with current improvement programmes and developing targeted action plans to drive quality enhancement. Between March and April 2025, the Adults of Working Age Community Mental Health Teams (CMHT) conducted Fundamental of Care Standards visits across 10 teams, interviewing 50 staff and reviewing 164 patient records from various service pathways in the Adult CMHTs. These visits were tailored to incorporate learning from the Section 48 Independent enquiry into Nottinghamshire Healthcare and were mapped to the Care Quality Commission's (CQC) 10 Fundamental Standards of Care.

The ongoing Fundamental of Care Standards reviews will provide assurance to the Adult CMHT Community Operational and Assurance Team (COAT), with findings reported to the Quality and Safeguarding Committee.

In March and April 2025, Fundamental Standard Reviews were completed in line with the highlighted areas in the independent review and Care Quality Commission (CQC) Single Assessment Framework. All the community teams are being supported with areas of improvement identified. Quality visits will continue across all services to ensure sustained improvement and readiness for future CQC inspections. Additionally, the standards will be monitored through weekly cross-check meetings in Adult CMHTs, Inpatients and as a standing agenda item at Clinical Reference Group meetings, with oversight provided by COAT and feedback delivered to Performance Review Meetings and the Trust Leadership Team. The Fundamental of Care visits are scheduled to be repeated in three months to ensure continuous improvement and effective implementation of action plans.

In January 2025, a paper was presented to the DHcFT Executive Leadership Team (ELT) to provide an overview of the current Assertive Outreach (AO) Offer in the Trust and an options appraisal for a future model of Assertive Outreach. Feedback provided from ELT was that the favoured model would be a stand-alone AO team. The future model came from a specific request from NHSE, this was an ask but not a promise to fund.

The investment required is £3m recurrent and £1.6m non-recurrent.

Delivery of the action plan and progress

DHcFT has set up a working group to focus on these actions detailed by NHSE in February 2025. The group is multi-disciplinary, with representation from across all the Trust's Divisions. The group is chaired by a Consultant Psychiatrist and Head of Nursing.

The group is aware that a significant amount of work is already underway in DHcFT, working closely with the system partners, which relates to the findings of the independent report. The group aims to work with the key leads of this work to avoid any unnecessary duplication and ensure collation of information. The work of this group should therefore be considered alongside work undertaken by DHcFT as part of CQC action plans and prior work on the Community Mental Health Maturity Index Action Plan.

The working group will continue to identify, and address identified gaps in each of the key areas of the action plan. The group will continue to meet monthly. Input from NHS England Community Mental Health Programme Managers is planned to provide support to the group. There will be updates provided from the regional/national teams every six months. It is envisaged that the action plans will be monitored via Divisional governance structures in due course. The Trust is engaged in the consultation by NHSE to deliver the Personalised Care Framework to replace the CPA. This framework will also focus on working with families and it is due to be published by end of summer 2025 and the Trust will adopt the framework with a programme transformation programme to transition from CPA.

Please note that point 5) above (Eliminating Out of area Placements in line with ICB three-year plans) forms part the ongoing work of a separate group within DHCFT and is not within the scope of this working group. However the has been progress made to reduce out area placement with various initiatives put in place. The trust finished the year 2024/25 March 31st with 4 Out of area placements. There is fortnightly Flow Escalation meeting chaired by Chief Executive that has been focusing on delivery of rapid acceleration of the 10 High Impact Actions for Discharge.

Below is a summary table capturing an overview of the work so far.

Next steps from NHSE letter	Recommendation from report	Current situation	Identified gaps/risks	Actions needed/timeframe
PERSONALISED ASSESSMENT OF RISK	The recommendation was a National Recommendation for NHS England. However, there is overlap with the care planning recommendation below.	Services complete the risk assessment and care plans as per Trust policy and are monitored through regular audit. Improvement plans are in place for areas where audit standards are not met. Specialist risk assessments are used in some areas of the Trust, eg Forensic and Rehabilitation settings. We currently have an electronic system to pro-actively identify patients at risk.	Substance Misuse Services work from a different module of the electronic patient record. Information, eg risk assessments do not necessarily follow the patient when they become involved in another part of the service. All staff do however have read only access to the substance misuse module. There is no Trust/System or Nationwide database to record those patients with section 117 entitlement*. This would help to pro-actively support those patients with severe and enduring mental illness and also identify those who may be at risk.	Promotion of co-production and exploration of the use of Advance Choice Documents/Advance statements. September 2025 to align with Move Away from CPA. We will roll out our Safety Planning Training which is aligned to Personalised Assessment of Risk before end of 2025, as this will enable clinical practice to move away from risk stratification in an evidence-based way.

Next steps from NHSE letter	Recommendation from report	Current situation	Identified gaps/risks	Actions needed/timeframe
JOINT DISCHARGE PLANNING ARRANGEMENTS between the person, their family, the inpatient and community team (alongside other involved agencies)	The Trust must have processes in place to assure themselves that people who use mental health services, their families, carers and/or support network co-produce care plans. Individuals who use services should be involved in their own personal safety planning arrangements including scenario planning.	CPA** and core care standard principles are in place. This is the framework through which safe discharge planning takes place.	Improvement in processes for pro-actively identifying patients with substance misuse and informing and involving substance misuse services when patients are discharged from inpatient care. Current situation is not consistent. Nationally there is a move away from CPA however, CPA is still in place within DHcFT.	Under review by working group. Action plan to be developed in conjunction with divisional representatives. September 2025 to align with NHSE guidance of Move Away from CPA. Reinforcing message that CPA is still in place within DHcFT is necessary. The Trust will implement the Personalised Care Framework when published by NHSE by end of summer 2025.

Next steps from NHSE letter	Recommendation from report	Current situation	Identified gaps/risks	Actions needed/timeframe
MULTI AGENCY WORKING AND DECISION MAKING	The Trust should develop inter-operable systems and processes to enable sharing of necessary clinical and risk-related patient data across clinical care settings. This should include sharing and increasing the visibility of information across primary and secondary care (NHS & independent providers). The purpose of this is to enable shared decision making and risk management with up-to-date information whilst remaining mindful of a person's privacy when identifying necessary information to share. The Trust, the Integrated Care Board and system partners (for example the Police) should review and evidence the effectiveness and reliability of communication processes across all system partners relevant to mental health care, treatment and risk management.	CPA and core care standard principles are in place. This framework allows for the regular review of the care plan with all involved agencies. This is monitored through care planning audits.	Lack of timely process for staff to obtain risk information from police/safeguarding. Staff request information sharing protocol to be developed.	Review how best to share intelligence with system partners i.e. police, Housing associations, without the breach of patients' privacy and confidently. September 2025, this will with be in line with other pieces of work, ie Right Care Right Person.

Next steps from NHSE letter	Recommendation from report	Current situation	Identified gaps/risks	Actions needed/timeframe
WORKING CLOSELY WITH FAMILIES	The Trust should define what positive family engagement looks like. The offer should be developed with people with lived experience – including people who use services, their families, carers or support network, and be informed by all available information. The Trust should then develop processes, in line with national guidance (ie the Triangle of Care and the Patient and carer race equality framework), to support effective family engagement. The new processes should inform decisions on care, treatment and the management of both safety and risks.	Carer involvement leads actively involved in working group. DHcFT is a Triangle of care level two organisation. Teams complete self-assessment. Triangle of care training is compulsory for all staff. The carer dashboard is available on the EPR. Services have staff who are carer champions.	Carer leads are developing guidance for staff about information sharing with families/carer's when there are risk concern's and patient consent to share information is an issue.	Flow- chart to clearly show when to share information with families where consent is not given. September 2025, this will align with the work from CPA, Care Standards and Carer Co-ordinator. Use of PROMs like Dialog plus will help us embed meaningful involvement from families – May 2026.

* Section 117 entitlement – this refers to a section of the Mental Health Act relating to aftercare for individuals who have been detained under specific sections of the Mental Health Act. It mandates the NHS and social care to provide free after care to these individuals. The aim is to support individuals to remain well and prevent readmissions to hospital.

**CPA is the Care Programme Approach. This is a framework used to co-ordinate and deliver care for individuals with complex needs. It involves development and review of a care plan.

Board Committee Assurance Summary Reports to Trust Board – 3 June 2025

The following summaries cover the meetings that have been held since the last public Board meeting held on 4 March 2025 and are received for information.

- Finance and Performance Committee 3 March, 17 March (Extra-ordinary) and 6 May
- Quality and Safeguarding Committee 11 March, 3 April and 7 May
- Mental Health Act Committee 21 March
- People and Culture Committee 25 March, 24 April (Extra-ordinary), 1 May and 23 May (Extra-ordinary)
- Audit and Risk Committee 24 April and 22 May.

Key:

	Full Assurance received during the meeting with the accompanying report
	Significant assurance received during the meeting with the accompanying report
	Limited assurance received during the meeting with the accompanying report
	No Assurance received during the meeting with the accompanying report
	items shared **for information** to advise the committee on progress and next steps

Finance and Performance Committee – key assurance levels for items – 3 March 2025	
	Making Room for Dignity Programme (MRfD) update The Finance and Performance Committee receive regular updates on the MRfD Programme, including latest progress, key risks and cost pressures. It was reported that Bluebell Ward had been successfully opened on 7 January and had been well received by everyone. Practical completion details for the Units were noted, along with full sign-off of the building control regulations for both Derwent and Carsington Units. The residual cost pressure of £5.8m remain for the programme. All additional works are being agreed through the programme governance structure. Questions were raised about the cost pressure and additional income secured from NHSE. **Limited assurance** was agreed due to cost pressures and slippage.
	Delivery of IM&T Strategy and Wider Digital Strategy The Committee noted progress in line with the plan set out in the Clinical Digital Strategy. Questions focussed on the evidence to support the Trust being an exemplar. Whilst the role of the Clinical Digital Board was highlighted, challenges were raised in relation to Directorate feedback from performance reviews. Development areas were acknowledged, along with planned mitigations. The need to support people with this technological advancement and digital innovation impact was highlighted. **Limited assurance** was agreed.
	Financial Performance – Month 10 Finance Report A £5.4m deficit was reported, which was £400k better than plan at Month 10. Delivery of the £6.4m deficit plan for the year was on target, whilst managing pressures due to high vacancy levels, out of area and continued overspend on the inpatient staffing. The ICB was aware of the MRfD slippage. Mitigations are underway to close the c£10 million system gap. From a Trust perspective the risk of non-achievement was reported as low due to good progress throughout the year.

	From a Cost Improvement Programme (CIP) perspective, the Trust has had one of its best years. **Significant assurance** was given against delivery of the financial plan.
	Operational and Financial Planning The paper highlighted the high-level System planning to date and the scale of the financial challenge heading into 2025/26. It was acknowledged that refining the profiling and updating the workforce modelling to reflect CIP plans remains the focus. **Significant assurance** was given on the planning progress.
	Continuous Improvement The Committee was supportive of the work underway and progress made. The consistency, alignment and good engagement was acknowledged. **Significant assurance** was given on the progress.
	Operational Performance The report focused on key performance measures and national priority indicators up to the end of January 2025. Clarity around ASD and ADHD capacity and investment was the main concern. Early Intervention Services issues were queried and linked to staffing pressures. The key initiatives in relation to improving flow are around the 24/7 Urgent Mental Health Hub and the 24-hour Neighbourhood Hub were discussed. It was acknowledged that CAMHS were managing growing demand well under resource pressure. **Significant assurance** was given on the overall progress within the report.
	City Alcohol Care team It was noted that non-recurrent funding will cease 31 March 2025, and the service would close if funding cannot be secured. Staff in the team are to be redeployed within the Trust and UHDB. The Committee accepted **significant assurance** regarding what is required. The Committee accepted **limited assurance** in relation to the adverse impact on the wider system.
	System Update: ICB Finance Committee/System Directors of Finance Consideration was given to the scale of the challenge to achieve the £45m deficit plan the System has committed to.
	Contracts update The ICB contract was now being processed. The Committee noted that several contracts are at decommissioning stage and therefore, the Trust will need to consider the impact.
	Finance and Performance Committee's annual Effectiveness report and annual review of Terms of Reference (ToR) The Committee reviewed the year-end report on its activity and effectiveness and confirmed that it had fulfilled its ToR during 2024/25. Analysis of the online evaluation process reflected positively. Key themes included timeliness of the papers, recognising that some are occasionally late due to national planning timelines. It was noted that reports should be succinct and focus on assurance with more consideration given to Equality, Diversity and Inclusion. Executive Summaries were generally good. Revisions to the ToR were accepted by the Committee. **Significant assurance** was given on the process and effectiveness of the Committee.

	Board Assurance Framework (BAF) 2024/25 Risks Overview Updates to reflect the new Strategy were noted.
	Escalations to Board or other Committees: None **Items added to the Board Assurance Framework:** Routine refresh led by lead Executive. **Next scheduled meeting:** 17 March 2025.
Committee Chair: Tony Edwards	**Executive Lead: James Sabin, Director of Finance**

Extra-ordinary Finance and Performance Committee – key assurance levels for items – 17 March 2025	
	Operational Plan 2025/26 update The Committee covered the following: 1. Operational Plan 2025/26 update: • a planned £5.8m deficit for the 2025/26 financial year was confirmed • challenges faced by other provider trusts in meeting financial plan targets were highlighted • Discussions included the impact of NHS England's recent changes, the need for cost management, and the importance of realistic planning • concerns raised about the system's ability to meet financial targets and the potential risks. 2. Cost Improvement Programmes (CIP): • various CIP schemes were discussed, with £4m still unidentified • the focus was on managing costs, particularly in acute trusts and improving the out-of-area position in Mental Health • the transformational projects were presented to help us meet CIP targets. 3. System Meetings and Funding: • recent system meetings in Derbyshire aimed at closing financial gaps and managing risks • discussions on the ICB's surplus and its potential use to support trusts • the need for additional assurance statements in line with planning guidance highlighted. 4. Income Generation: • plans to set up a new business development unit to explore income opportunities • an external report identified significant commercial opportunities.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework:** None. **Next scheduled meeting:** 6 May 2025.
Committee Chair: Tony Edwards	**Executive Lead: James Sabin, Director of Finance**

Finance and Performance Committee – key assurance levels for items – 6 May 2025	
	Making Room for Dignity Programme (MRfD) update The successful opening of Derwent was reported and staff and service user feedback was very positive. The remediation works at Carsington were running slightly ahead of schedule. The timeline for PICU had been agreed along with early access. Building Control visit to Audrey House was scheduled. Costs associated with the delay were being collated, alongside discussions to recover these.

	Limited assurance was agreed.
	Assurance on delivery of Estate Plan The refreshed Estates delivery plan was shared. A six-facet survey to update the condition of estates and also a decarbonisation survey to support future Estates planning and ensure eligibility for future funding aligned to NHS net zero/sustainability targets had been commissioned. Discussion topics included population health, inequalities, rural service challenges and the new Adept programme, which will help drive future need via clinical activity and demand planning. The Committee accepted **significant assurance** on the plan. **Limited assurance** was received on the ability to deliver against the Estates plans.
	Sustainability Strategy incorporating Green Plan The Committee noted the bi-annual item which would include the NHSE requirement to submit an updated green plan by July 2025. **Significant assurance** was given on the progress.
	Financial Performance – Month 12 Finance Report The Trust finished the year with a £1 surplus. The forecast at Month 11 was a £2.9m deficit, which had already improved by £3.5m due to additional non-recurrent income and other monies through the ICB. A further non-recurrent income allocation of £2.9m was allocated to get to zero. It was noted that all organisations in the system finished at breakeven at the end of the year. Trust accounts would reflect a material deficit of £25m for the year, with the underlying deficit remaining in terms of the £6.4m plan. Going into 2025/26, the same challenges were highlighted. The Trust had delivered the CIP in full, which was £12.5m. There were overspends across out of area. The accounts were under audit until mid-June. There were no concerns from a cash perspective and no material debts of concern. The Trust had delivered on the Capital Departmental Expenditure Limit as a collective system. **Significant assurance** was given on the year end outcome, noting the future challenges.
	Operational and Financial Planning The planned submission was completed by the end of March, with a resubmission on 30 April to show progress on efficiency plans. It was noted that additional work is needed to close the gap fully.
	National Cost Collection Submission – pre submission report The Committee approved the costing plan and supporting information provided to ensure that it meets the expected requirements noted in the Approved Costing Guidance. **Significant assurance** was noted.
	Operational Performance Report Service improvements over the last 12 months were noted. Key areas were ASD and ADHD, where the Trust was commissioned to deliver 24 assessments per month. As this did not meet demand, funding had been offered to deliver increased autism assessments, along with an ADHD service. There had been a significant reduction of inappropriate out of area placements over the last quarter. **Limited assurance** was received on the report as a whole.
	Exception report on Operational Contracting and Developments The Committee was informed of Derby City Council's intention to go out to tender for two services currently provided by the Trust. In addition, the 0–19 universal services contract was to be redesigned to fit a reduced contract value. One to one consultation had commenced with the remaining Talking Mental Health Therapies staff following the Trust's decision not to re-tender for the contract.

	The Trust had been awarded £300k capital monies funding to establish an Urgent Care Hub, the aim of which was to avoid attendance at Emergency Departments. Transformation work would be required as staffing costs were not included in the funding. **Limited assurance** was agreed based on the impact of the changes.
	System updates: ICB Finance Committee/System Directors of Finance Updates have been included with the system year-end financial position and the overall system 2024/25 plan resubmission.
	Health and Safety Report The risks associated with medical devices were noted. The Committee was pleased that this is now being progressed and resources identified. **Significant assurance** was agreed.
	Business Continuity Report The Committee recognised the substantial progress made on the policy and business continuity plans. **Significant assurance** was agreed.
	Board Assurance Framework (BAF) 2025/26 risks overview (and forward plan of deep dives consideration) It was noted that BAF updates reflected the roll forward into the new year. The main risks updated were 1b and 1c in relation to Dormitory Eradication and Digital Technology. **Significant assurance** was agreed on the BAF process.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework:** None. **Next scheduled meeting:** 8 July 2025.
Committee Chair: Tony Edwards	**Executive Lead: James Sabin, Director of Finance**

Quality and Safeguarding Committee – key assurance levels for items – 11 March 2025	
	Action Matrix and Matters Arising An update was given on venous thrombo-embolism (VTE) assessments in respect of the Trust's processes for recording and electronic prescribing. SystmOne is not currently configured to ensure VTE assessment completion prior to medications being prescribed with a plan in place to ensure medical staff training is completed within 6 months to reach improvement compliance.
	Director of Nursing Update The Committee received an updates on the Independent Review into Valdo Calocane, which had highlighted the need for better risk assessments, decision-making and carer involvement. To ensure that known risks were actively addressed and communicated, a systematic approach to risk assessments and formulating care plans was being discussed with the Integrated Care Board (ICB). Mitigations included the roll out of safety planning training, which had been co-produced with service users.
	Fundamental Standards of Care Report The fundamental standards of care visit schedule was presented along with changes to the Clinical Matron role to emphasise the focus on quality, safety, and patient experience. The Director of Nursing is looking nationally to learn from other organisations regarding Fundamental Standards and Matron responsibilities.

	The Committee agreed **significant assurance**.
	Guardian of Safe Working Hours Report Exception reporting showed the need for better time management and prioritisation among doctors, to ensure they do not work excessive hours. The Committee understood the anxiety and concerns of doctors about raising concerns and that it was important to help them speak up. The Committee was **significantly assured** that that the duties and requirements as set out in the 2016 Resident Doctor contract were being met.
	Risk Report The risk report showed an increased number of risk reviews which had been due to the overlap of new and existing wards. The number of risks is suggestive of a low risk appetite. Therefore, the risk register needed to be cleansed to ensure risks related to the environment accurately reflect current conditions. **Limited assurance** was accepted regarding the risk management and reporting strategy as the volume needed to be reduced.
	Sexual Safety and Trauma (Sexual Safety Charter) In compliance with the Sexual Safety Charter, additional information and workshops on sexual safety were being arranged. The numbers were similar over quarters 1 and 2 and were being investigated. A trauma video had been designed and is now part of Positive and Safe training to raise awareness. **Significant assurance** on compliance with the Charter was agreed.
	Getting it Right First Time (GIRFT) The service is up and running and the challenges and successes of keeping people out of hospital was reported, along with the need for better understanding of the rehabilitation offer. It was noted that there was no intention to join the service up with Assertive Outreach and work was ongoing with Inpatient services to review flow, establishing what had brought service users into hospital. Issues with social and environmental factors had been identified. It was advised that the service originally supported Adults of Working Age with long-term psychotic conditions, however there was a real need to help Older Adults.
	National Institute for Health and Care Excellence (NICE) Guidance Compliance Detailed assurance on implementation of all NICE guidelines remained a gap in control on the Trust's BAF. However, the Trust's full compliance in relation to tobacco was highlighted. The NICE Steering Group was to be re-instated, which would provide assurance around compliance. The Committee noted that the CQC would use the code of practice to scrutinise restraints and restrictive practices. **Limited assurance** was accepted around the Trust's integration of NICE into usual practice, with plans to take forward.
	Patent Experience report (quarterly) The report provided the Committee with **limited assurance** on the complaints process due to the significant delays in responses in some of the cases, however improvements were being made. Whilst the challenges were acknowledged, the Chair pointed out the impact the delays and backlog would be having on patients receiving quality and compassionate care and suggested a stronger focus in the BAF. Despite the new process, the number of complaints had worsened and escalation to the Board was suggested. A comprehensive plan to improve the patient experience feedback system was in development, including setting realistic performance targets for service lines, measuring replies as a percentage of expected responses and ensuring timely complaint resolutions.

	Care Planning/Person-Centred Care Teams that were under-performing in completing care plans were to be targeted. The management and supervision tool (MAST) did not provide effective staff management reporting so the supplier had been asked for additional enhancements to the system. It was agreed to provide a focussed summary report to show the areas doing well and what impactful actions had been taken to reach compliance and the areas doing less well, outlining the key actions being taken to improve Care Planning compliance. **Limited assurance** was accepted from the report.
	Patient and Carers Race Equality Framework (PCREF) The Trust was committed to addressing inequalities in service delivery and a deep dive will be undertaken to identify commonalities; consider where the gaps are, what actions were needed and which groups of people were most affected. Work could then begin to consider the relative levels of access, experience and outcomes for these patient groups.
	East Midlands Alliance (EMA) Provider Collaborative (quarterly) The Committee noted the significant improvements in the Children and Adolescent Mental Health service (CAMHS) and the potential reduction of 20 beds due to better community care. An update on commissioning for Adult Eating Disorder services was advised. **Significant assurance** was received on the quality and safety of services provided.
	Review of Quality and Safeguarding Board Assurance Framework (BAF) Risks Following alignment of the BAF with the new strategy, it was advised that the next step was to ensure the focus areas in terms of quality were reflected explicitly. It was agreed to include clear measurable actions to close the gaps in assurance and to focus on triangulation when looking at the impact.
	Policy Review The Committee approved the outlined changes to the Tobacco Dependence, Intervention and Support Policy, which introduced significant revisions to align with the latest clinical guidelines, legislative changes and organisational priorities.
	Escalations to Board or other Committees: It was agreed that the need for escalation of the Patient Experience issues regarding the delays in complaints handling had not yet been reached and that the Making Room for Dignity programme would provide the catalyst to implement changes and improvements should be demonstrated within the next quarter. **Items added to the Board Assurance Framework:** None. **Next scheduled meeting:** 3 April 2025.
Committee Chair: Lynn Andrews	**Executive Lead: Tumi Banda, Director of Nursing, AHPs, Quality and Patient Experience**

Quality and Safeguarding Committee – key assurance levels for items – 3 April 2025	
	Director of Nursing update The following points were highlighted: Medical Devices: a repairs budget was now in pace as well as Service Level Agreements for servicing. Care Quality Commission (CQC) Mental Health Act (MHA) Visit: Informal positive feedback had been received following a visit to Older Adults Inpatient wards. The formal report was awaited.

	Safer Staffing: Matrons now had a clear responsibility for safer staffing and rosters were reviewed daily with Ward Managers, along with weekly reporting to Area Service Managers for second sign-off. Recovering Quality of Life (ReQoL) *a patient-reported outcome measure to rate progress at the start and end of intervention*: The differing views on the efficacy of ReQoL were shared and consideration was being given as to how the measure might benefit inpatient areas.
	Fundamental Standards of Care report An Acute Inpatient Action Plan allocated actions for each ward following the CQC inspections. Understanding of the single assessment framework was ongoing but good progress was being picked up on Fundamental Standards of Care visits and the focus now was on the outcomes of inpatient and undertaking community fundamental standard visits. The Committee accepted **limited assurance** as the programme is incomplete.
	Making Room for Dignity (MRfD) Programme The Derwent Unit had been successfully opened on 20 March, with all service users relocated without incident. The Carsington Unit was awaiting sign off of the final works. Audrey House was awaiting formal Building Control sign off and practical completion dates were outlined for Kingfisher House, Psychiatric Intensive Care Unit. The Derwent Unit had opened as smoke free and it was acknowledged that there may be challenges to manage. **Significant assurance** was received on the robust processes to ensure the required standards, that all issues are being addressed and patients are not moved until safe to do so.
	Intensive and Assertive Community Mental Health Treatment An update was provided regarding the work being undertaken by Derby and Derbyshire Integrated Care Board (ICB) working group which Derbyshire Healthcare Trust is part of. The ICB assessments had identified 10 subgroups to improve support for Assertive Outreach cases in Derby and Derbyshire. Housing and homelessness remained significant challenges and the Trust was looking to work with the Housing Association Charitable Trust to address the disproportionate impact on outreach. The Committee noted that many patients would come via the Right Care Right Person (RCRP) pathway and a strategy for robust psychological support for staff and service users was being developed. In addition, an Intensive and Assertive Outreach Standard Operating Procedure had been shared widely. A separate working group would focus on cases with substance misuse problems. **Significant assurance** was received for the update on Intensive and Assertive Community Mental Health Treatment.
	Draft Quality Account 2024/25 The Committee acknowledged the draft report and contributed with suggested amendments. It was appreciated that the document is a work in progress and members were enthusiastic to see the final version in May.
	Quality Dashboard The Committee consider the progress made regarding key clinical performance indicators across the Trust between December 2024 and February 2025. Patient Safety: a significant reduction in seclusions was reported, along with substantial investment to train people in the model of care, the culture of care and how to use seclusion. It was stressed that patients are being supported with care plans, additional one to one care and observations to mitigate increased self-harm incidents. Incidents of absconsion had continued to reduce and sexual safety incidents remained low. Responsive Care: it was noted that quick resolution and closer look formal complaints remained within or below the mean and a further metric was suggested to monitor response times.

	Effective and Caring: a focus on patients clinically ready for discharge had been intensive and included a fortnightly meeting to review flow and length of stay. The ambition to achieve a 40 day length of stay average on all inpatient wards was highlighted. Well Led: the close attention being given to risk assessments was welcomed. The Committee received **limited assurance** on progress towards clinical performance targets.
	Right Care Right Person (RCRP) report The Committee noted progress and updates in relation to the implementation and delivery of RCRP across Derbyshire. It was reported that the police would continue to respond where warranted and when they had a legal duty to do so, including: • where there is a real and immediate risk to life or serious harm • where a crime or potential crime is involved. The shift to a system approach had resulted in strong collaborative working arrangements. Changes included a need for Trust colleagues to search for missing people, which would likely be a combined approach, based on case by case, whilst ensuring safe staffing on the wards, however, ideally a preventative approach would be the aim. **Sufficient assurance** against the changes made in support of reducing Absent and Missing Inpatients was received.
	Care Planning/Person-Centred Care It was noted that challenges remained with SystmOne recording and utilisation of the management and supervision tool (MaST). The differences between a Care Plan and a Care Programme Approach (CPA) was explained. Reflecting on the multi-disciplinary team approach, the Committee recognised the challenges with recording as clinicians see patients at different times and it can be difficult getting together to conclude a CPA. The current focus to enhance accountability was stressed. The report provided a level of **limited assurance**, due to the services which have not yet achieved the target compliance level.
	Quality and Safeguarding Committee annual Effectiveness report and annual review of Terms of Reference (ToR) The Committee considered the year-end report on its activity and effectiveness and confirmed that it had fulfilled its ToR during 2024/25. Analysis of the online evaluation process demonstrated that the Committee was generally effective and dedicated. It was suggested that more succinct and promptly submitted papers would add value. It was agreed to accept the ToR, however, a potential review of the minimum expected attendance levels was to be considered.
	Quality and Equality Impact Assessment (QEIA) Assurance (quarterly) – verbal update Submitted QEIAs are reviewed fortnightly for Cost Improvement Plans (CIPs) to ensure the protection of service delivery for patients and their families. Where there are suggestions to reduce clinical posts, there was robust challenge. It was confirmed that information from the assessments also went through the weekly Vacancy Control Panel to facilitate discussion and ensure decisions taken did not compromise clinical quality and safety.
	Policy Review The Committee reviewed and ratified the Consent to Examination and Treatment Admission Policy and Procedures.
	Escalations to Board or other Committees: It was agreed to monitor progress over the next two months thereupon determining if official escalation regarding Care Plans and Care Planning

	Programme was required. It was suggested an explanation of Care Plans and the Care Programme Approach to be presented to the Council of Governors. **Items added to the Board Assurance Framework:** None. **Next scheduled meeting:** 7 May 2025.
Committee Chair: Lynn Andrews	**Executive Lead: Tumi Banda, Director of Nursing, AHPs, Quality and Patient Experience**

Quality and Safeguarding Committee – key assurance levels for items – 7 May 2025	
	Director of Nursing Update The following points were highlighted: • overview of NHSE's consultation on a new framework to replace the Care Programme Approach (CPA) which will focus on 10 principles • implementation of a smoke-free trust was progressing. Temporary signs were in place and a smoking cessation group was actively supporting patients. Early indication shows that staff response had been positive and patients had adjusted well to the changes.
	Fundamental Standards of Care Report The Committee received an overarching summary of the Trust's preparedness for regulatory inspection and compliance and the various contributing workstreams. All inpatient teams were working to the action plan from the CQC's report on the Radbourne Unit, with improvements seen in ratings and engagement. The focus on compliance against the standards within community services and teams is now being supported with governance training and weekly cross-checks. **Limited assurance** was agreed on the basis that fundamental standards of care partially met in the review conducted in the report.
	Infection Prevention and Control (IPC) update An update on actions following the annual report was provided. There had been no adverse incidents and IPC audits were compliant. The Trust was implementing the NHS England IPC audit framework and would be training matrons to lead on infection control audits. **Limited assurance** was agreed on the basis that spot checks were still flagging issues outside of the audits.
	Ligature Risk Reduction report The Committee noted progress made over the past six months on ligature risk reduction across Inpatient and Community services within the Trust. It was noted that the programme was aligned with Mental Health Learning Disabilities (MHLD)/Care Quality Commission (CQC) guidance and was overseen monthly by the Ligature Risk Reduction Group. The key highlights included significant progress in assessment completion, policy revision, staff training and system development. Assurance was sought on the new ligature risk assessments system which had recently been moved out of the Trust's Datix system. **Limited assurance** was agreed as training compliance and socialisation of the revised approach is ongoing.
	Patient Safety Annual Report This report outlined areas of improvement, plans and achievements the for the 2024/25 financial year. This included the thematic areas of focus, which included risk management, communication and teamwork, managing complex cases and promoting openness in incident reporting. The learning the lessons group was being embedded to ensure accountability and learning.

	Limited assurance was accepted due to the backlog in investigations.
	Quality Account Final Draft The final draft of the Trust's Quality Account was approved, subject to the inclusion of stakeholder comments, including the Integrated Care Board.
	Special Education Needs and Disabilities (SEND) annual report The SEND annual report paper outlined some of the significant improvements made in terms of the Trust's self-assessment. Challenges remained in relation to staff training and an improvement plan was in place. Risks remain as a system and ensuring all partners pull together for patient needs and benefits. It was recommended that performance measures should be included in the report. **Limited assurance** was agreed in some areas of the report due to the new nature of the requirements.
	Independent Mental Health Homicide Review – Nottingham (Intensive and Assertive Community Health Treatment) Learning from the review emphasised the need for assurance on learning and risk mitigation, including understanding risks, implementing plans and ensuring governance. Following the directive from the National Director for Mental Health that all Trusts had to review their processes and respond by June 2025, the Committee received a paper that outlined progress made including an evaluation of the Trust's Outreach team. The Committee discussed whether the risks identified from the review were captured appropriately in the Board Assurance Framework and suggested that narrative be added around strengthening the engagement with families. A report on the Trust's review would be presented to the Trust Board which would provide assurance on the Trust's understanding and learning and its plans to mitigate key risks. Additional evidence would need to verify plans had been implemented and were working. The Committee agreed **Limited assurance** based on the format of the report and the requirement for additional information in the version that is presented to the Board.
	Clinical Audit – annual report on Effectiveness and Clinical Audit Plan The 2024/25 Clinical Audit Programme and the initial plan for 2025/26 were presented. Following the process redesign, the updated policy is now called 'Clinical Audit Based Quality Improvement' (QI) policy, which aligned more explicitly with QI methodology. The Committee understood the reasons for offering limited assurance, however, they were keen to recognise the progress made. The approach, rigour, ambition and format was praised, particularly the Executive Summary. In order to maximise and standardise the impact of the audits, it was noted that the Research and Development Operational Group (RDOG) had representation from key leads and the output from clinical audit also went to the Resident Doctor Forum. The Trust had embedded researchers who were involved with the RDOG and these people understood audit and QI principles, along with the academic rigour of research methodology. **Limited assurance** was accepted due to inconsistent application of otherwise sound design controls.
	Care Planning/Person-Centred Care and Divisional Improvement Plans The report provided an outline of the improvement plans in place to improve compliance and monitor quality. Intensive scrutiny had been implemented within Community teams including: • Weekly cross-check of care plans/CPA • Fundamental Standards of Care cross-checks • Reiteration of compliance standards and recording obligations • Focussed support • Emphasis on Psychology teams • Triangulation within Performance Reviews.

	Limited assurance was agreed as improvements were not yet sustained.
	Board Visits – Themes and Findings Good feedback had been evidenced in the Board visits, in terms of sharing learning on complaints and incidents and QI projects. Themes on challenges had been on estate repairs, hot desking and sickness and absence levels. The visits allow visibility of the Board and an opportunity for staff to raise concerns. With the appointment of the Compliance and Governance Manager, opportunity to review the process for the next session now presents itself. **Limited assurance** was agreed as more visits need to be arranged and completed and the process requires further improvement.
	Learning from Deaths/Mortality annual report The Committee received information for the period 1 April 2024 to 31 March 2025. The key learning focused on four areas: risk assessment and management; communication and team work, supporting staff with complex case management and developing a culture of openness. The Mortality Group has now integrated with the Learning the Lessons Oversight Committee who will hold oversight of the learning being embedded. **Limited assurance** was agreed**.**
	Quality and Equality Impact Assessment (QEIA) The process for evaluating impact on service delivery, quality and patient experience for all projects managed within the Trust transformation programmes was presented. All projects in the programme are required to have an authorised Project Initiation Document (PID) or equivalent, and a Quality and Equality Impact Assessment (QEIA). **Significant assurance** was agreed for the process.
	Review of Quality and Safeguarding Committee Board Assurance Framework (BAF) Risks The Committee reviewed the BAF, noting updates, the need to align with the four Ps and the focus on improving governance and ensuring risks were mitigated.
	Policy Review The following were approved: • Child Visiting to Mental Health Inpatient, Residential Areas and Community Policy and Procedure • Standard Operating Procedure (SOP) for Admission to Kingfisher House - Psychiatric Intensive Care Unit (PICU).
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework:** None. **Next scheduled meeting:** 4 June 2025.
Committee Chair: Lynn Andrews	**Executive Lead: Tumi Banda, Director of Nursing, AHPs, Quality and Patient Experience**

Mental Health Act (MHA) Committee - key assurance levels for items – 21 March 2025	
	MHA Operational Group The Committee receives the notes and action matrix of the above Group, for information. Due to the delays to some of the progress in areas such as training, Limited Assurance was given.

MHA Managers Report

The MHA Quarterly Report covering MHA Office activity from 1 October to 31 December was considered. Points of note included:

- Compliance data on the reading of rights had deteriorated due to a change in process. The change had been made to improve patient experience and ensure patients are read their rights earlier so they understand all their rights and all restrictions
- Data on holding powers was flagged and staff are being encouraged to complete the paperwork correctly and in a timely manner.

Significant assurance was agreed on the improvements identified in the report and **limited assurance** was agreed on the reading of rights, but it was hoped that this would be improved when the e-system was embedded

Mental Health Act Committee year-end Effectiveness report and Annual Review of Terms of Reference

The Committee discussed the Mental Health Act year-end effectiveness report, it was agreed to clarify the Committee's role around restrictive practices to avoid duplication with other Committees. Overall, the Committee had worked to its Terms of Reference and been effective during 2024/2025.

Training Report

The Committee received a revised report format for training compliance for Safeguarding Adults Level 1, Level 2, and Level 3 MHA, Mental Capacity (MCA) and Deprivation of Liberties (DoLs).

Limited assurance on the basis that there are a number of areas not meeting the training targets and the Committee wanted to see improvements in the format of the report.

Report on the use of Section 135/136 Suites

The report showed that the delays in securing use of out of area beds contributed to delays in transferring patients from Section 136 suites. The Committee wanted to see improvements in custody outcomes and healthcare checks as well as improved data alignment. On this basis **Limited assurance** was agreed.

Restrictive Practice Quality Report

There had been reductions in physical restraint incidents and seclusion. The Committee was pleased to see that prone restraint numbers are continuing to decrease and that training on alternative injection sites is continuing. The locked doors policy is now in place following positive feedback on the pilot. Reductions were expected on the newly opened Derwent as there is more space and patients have their own bedroom and bathroom.

The issues with the Brigid App were discussed, including the Wi-Fi connectivity, device buffering and staff accountability. It was confirmed that the new units will have better Wi-Fi connectivity, and that staff have been retrained on the system. The Committee agreed that, whilst improvements should continue to be pursued, the Brigid App was fit for purpose and the focus needs to be on improved adherence to working practice. A review of process is scheduled for six months' time.

Limited assurance was agreed as the Committee required evidence of sustained improvements in Restrictive Practice and use or Brigid App once both new units were open.

Policy Review

The Committee approved the following policies:

- The Mental Health Act Hospital Managers Scheme of Delegation
- Section 17 leave
- Section 4 Policies.

Escalations to Board or other Committees: None

Items added to the Board Assurance Framework: None

	Next scheduled meeting: 12 June 2025
Committee Chair: Deborah Good (Geoff Lewins providing temporary cover)	**Executive Lead: Arun Chidambaram, Medical Director**

People and Culture Committee – key assurance levels agreed – 25 March 2025	
	People and Inclusion Assurance Dashboard The Committee reviewed current performance. The main points were: Mandatory Training: It was highlighted that training compliance remained positive, with a slight drop in two areas. A proposal to increase the target from 85% to 95% was agreed for mandatory training. However, for role-specific training, it was suggested that a phased trajectory would be more achievable. Staff Turnover, Vacancies and Recruitment: It was noted that the Vacancy Control Panel (VCP) met each week to review posts and that the majority are approved, especially those within the NMC profession. Bank Usage: The need to strengthen governance around bank usage, particularly for admin roles, was reported. It was noted that fill rates and requests would be a focus over the next quarter, in line with the national requirement to reduce bank expenditure. Freedom to Speak Up (FTSU): Consideration was given to reported incidents of racial abuse and it was stressed that if an individual has capacity and they are abusive, there must be zero tolerance. A review of Trust policies was suggested. **Significant assurance** was accepted on progress shown for mandatory training, staff turnover, vacancies and recruitment, bank usage and Freedom to Speak Up.
	Attendance and Absence In order to reduce costs and improve data accuracy, an absence management delivery plan was outlined, which would introduce a 'Reducing Absence Oversight Group' and transition away from 'GoodShape' to an in-house solution by August. Employee Relations (ER): Transition of the team from Derbyshire Community Health Services NHS FT (DCHS) to the Trust was expected by 1 June. Clinical Supervision and Annual Appraisals: A proposal to increase compliance levels to 95% was considered. It was agreed a plan would be devised, to include a realistic trajectory for improvement through achievement of incremental targets and how this would be implemented. **Limited assurance** was accepted on attendance and absence, Employee Relations, clinical supervision and annual appraisals.
	Making Room for Dignity (MRfD) The programme was on track to meet safer staffing levels for registered Nurses, however, turnover remained a challenge, with attrition to community and external posts. It was noted that a 'stay survey' issued at three, six and 12 months' service had been introduced, in addition to the organisational development culture training at 12 weeks' service. It was reported that there were 25% more BME colleagues employed in the MRfD programme and slightly fewer colleagues recorded with a disability, compared to the Trust as a whole. The model of care training had been paused due to the opening of the new units and more sessions would be scheduled once staff are settled in the Derwent Unit. The Committee received **limited assurance** on the actions and progress being taken to mitigate the risk of significant numbers of 'hard-to-recruit' and 'national workforce shortage' posts required. **Limited assurance** was also received on the development of, and progress with, the service and cultural transformation work, and implementation**.**

	Year-end Effectiveness report and review of Terms of Reference (ToR) The Committee considered the year-end report on its activity and effectiveness and confirmed that it had fulfilled its Terms of Reference during 2024/25. An online evaluation process, completed by Committee members, had elicited positive feedback that meetings had been well chaired, with structured agendas and well informed reports. The minor revisions to the ToR were agreed.
	Assurance on Contracted Services The Committee noted the strong governance and regular performance reviews for the Occupational Health (OH) and Payroll services, contracted out to University Hospitals of Derby and Burton NHS FT (UHDB). It was advised that the services contracted through the Joint Venture (JV) with DCHS were moving to a Service Level Agreement (SLA) in order to strengthen governance. The Committee received **significant assurance** on the contracts held with UHDB for payroll and occupational health. **Limited assurance** was accepted around the governance and performance of JV services.
	Modern Slavery Statement The Committee approved the Trust's annual Modern Slavery Statement for submission to the Board, noting there were no significant changes.
	System updates The presentation included national, system and Trust updates. It was noted that Deloitte had been commissioned for an 'enabling services' review and the new Head of EDI was to commence on 31 March.
	Talking Mental Health – Learning update The very complex situation for the organisation and staff involved, following the Trust's decision not to bid for the Talking Mental Health service and the subsequent exit process, was summarised. The feedback provided to date and the learning the Trust had taken from this was noted along with the commitment to continue learning from the process to inform future situations. A number of engagement sessions had been set up, along with communication hub on the intranet with a frequently asked questions section and colleagues would be guaranteed interviews for suitable Trust vacancies.
	Deep Dive – Exit Interviews and Leaver Narratives It was noted that response rates for exit questionnaires varied across service areas, with Psychology and Older People's services achieving the highest completion rate. The information was based on the traditional ESR reasons for leaving, the employee's own words and also the Staff Survey, highlighting that the key theme was work pressure. The Committee noted the plans in place to use the triangulated data at Divisional Review meetings as part of the follow up Staff Survey Organisational Development programme. **Significant assurance** was received that the Trust had effective processes and **limited assurance** on the types of data and how it was to be used.
	Talent Management and Succession Planning To assist succession planning, each Director was reviewing how cover would be provided in exceptional circumstances and Training Needs Analyses had been shared for the relevant teams. It was agreed that on completion of Phase One, there would be a period of reflection to consider the operating model with a report back in July.

	Equality, Diversity and Inclusion (EDI) report – Gender, Ethnicity and Disability Pay Gap It was noted that the gender pay gap was moving in the right direction, reducing from 11.53% in 2023 to 7.81% in 2024. The process for starting salary on appointment was explained. It was confirmed that all appointees commenced at the bottom point, unless they are able to evidence relevant and recognisable service.
	2024 National Staff Survey – Full Benchmarking The data showed that the Trust's results compared favourably against 50 other trusts within the same category. It was reported that a robust strategic, engagement plan would be implemented immediately up until September.
	Board Assurance Framework (BAF) – key risks identified: It was emphasised that the BAF would be revised to align with the new strategy and delivery plans, ensuring that all risks were appropriately categorised and linked to strategic objectives. Additional clarity around the Personal Accountability Framework would be included with links to Employee Relations, culture, appraisals, development. and how embedment would be measured.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework:** None. **Next scheduled meeting:** 1 May 2025.
Committee Chair: Ralph Knibbs	**Executive Lead: Rebecca Oakley, Director of People, Organisational Development and Inclusion**

People and Culture Committee – key assurance levels agreed – 1 May 2025	
	People and Inclusion Assurance Dashboard The Committee reviewed current performance. The main points were: Mandatory Training: Good compliance rates were being maintained. Staff Turnover: It was noted that benchmarking against other trusts showed the Trust's position currently sat just under 11%. Bank Usage: Whilst the reduction in sickness absence was welcomed, attention was drawn to increased bank and agency usage, influenced by the volume of annual leave. **Significant assurance** was accepted on the progress shown for mandatory training, staff turnover, vacancies and recruitment, bank usage and FTSU.
	Annual Appraisals and Clinical Supervision: Plans to improve compliance included detailed reports, performance reviews, monitoring individual accountability and a further deep dive in Corporate areas. The Committee accepted **limited assurance** for attendance and absence, clinical supervision and annual appraisals.
	People Heat Map and Triangulation The Committee was presented with a data-informed plan, developed in response to workforce challenges identified through the NHS Staff Survey, and a new reporting tool, the 'People Heat Map'. This was a diagnostic tool that would identify areas needing attention by flagging areas with three or more key performance indicators (KPI) below target. The tool and triangulation approach, which would be useful in helping to triangulate with other measures, such as clinical quality and financial concerns, was approved by the Committee.

	Making Room for Dignity (MRfD) Programme update Successful recruitment of staff for the north and south was highlighted. The Model of Care training had been delivered to 97% of the current staff at the Radbourne Unit, with Ward 35 achieving 100% within this total; the Hartington Unit was slightly lower at 85%. It was noted that settling-in time was needed and a recovery plan was in place. The Committee received **limited assurance** on the recruitment and cultural transformation work.
	System Developments – verbal update The potential merger of Derbyshire and Nottinghamshire Integrated Care Boards (ICBs) were discussed, along with the impact these changes may have on the Trust.
	Annual Medical Appraisal and Revalidation – 2024/25 Attention was drawn to the progress in compliance levels (90%) for timely completion of appraisals, compared to the previous year. In relation to the non-compliance of some doctors, it was noted that the clinical directors provide contextual information, ensuring a comprehensive assessment of individuals' fitness to practice. The five-yearly 360 review process was discussed, which included reflection on complaints, compliments and engagement with the job plan. The paper provided a **significant level** of assurance.
	Deep Dive - Recruitment The main points were noted as: • Gaps in Band 5 Nurses, mainly around the Making Room for Dignity programme. A fast track process had resulted in 80 offers • Ward Managers were to take a lead with some campaigns, with an Assessment Centre approach • Cohort recruitment was to be used for volume campaigns • 12 Consultant vacancies had been filled with international candidates, expected to start around June • Changes to visa requirements were expected to impact on healthcare recruitment. The Committee acknowledged that high attrition was influenced by the current volume of Nursing opportunities nationally. It was suggested that focus around the onboarding process and improved engagement between the initial offer and commencement would be beneficial. Improvement opportunities were discussed. Receiving **limited assurance**, the Committee agreed that good processes were in place, however, finesse was required, as the desired response had not yet been achieved.
	Internal Audit Actions – Staff Health and Wellbeing The Committee was pleased to note that the four actions due by the end of April had been completed and the Health and Wellbeing Lead was supporting with the remaining actions.
	Equality, Diversity and Inclusion (EDI) High Level Plan 2025-26 – Objectives and Priorities It was reported that whilst progress had been made, EDI was not fully embedded. Plans to address this were to: • Develop an organisational EDI Plan • Establish an EDI Governance Structure • Define and Refine EDI Ambitions and Objectives The importance of co-producing the Race Equality Action Plan and creating safe spaces for colleagues to discuss EDI issues was highlighted.
	Review of People and Culture Committee Board Assurance Framework (BAF) It was noted that a performance dashboard was in development to support analysis of the Medical appraisal and job planning.

	Following some debate, the Committee agreed all the rag ratings should be reviewed to ensure accuracy.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework:** None. **Next scheduled meeting:** 3 July 2025.
Committee Chair: Ralph Knibbs	**Executive Lead: Rebecca Oakley, Director of People, Organisational Development and Inclusion**

Extra-ordinary People and Culture Committees – 24 April 2025 and 23 May 2025	
	Proposed Operating Model These two Extra-ordinary meetings were held to update the Committee on the business case, consultation and engagement on the proposed new operating model.
Committee Chair: Ralph Knibbs	**Executive Lead: Rebecca Oakley, Director of People, Organisational Development and Inclusion**

Audit and Risk Committee – key assurance levels agreed – 24 April 2025	
	Board Assurance Framework (BAF) The Committee was presented with the first issue for the new financial year. A key change had been the removal of the system-wide risk, which had now been incorporated in the expanded Partnership section. All sections had been reviewed by Director leads. Another update on the Making Room for Dignity programme would be sent to the Committee in advance of a revised version going to the Trust Board. Concern was expressed over the length of time taken to close an operational risk on valproate prescribing and assurance was sought on a resolution. **Significant assurance** was agreed on the process of review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives.
	Operational Risk Management The Committee reviewed the quarterly update on Datix compliance and risk management. Improvements were noted across all divisions, with overdue risk reviews decreasing and streamlining of duplicated risk assessments underway. **Significant assurance** was noted on the efforts to drive the risk management process and the escalation to address non-compliance but **limited assurance** was obtained from the report due to the continued presence of overdue risk reviews on high and extreme risks.
	Annual Governance Statement (AGS) The first draft of the AGS was received, a further version would be submitted to the May meeting.
	Annual Report and Accounts The Committee received first drafts of the Annual Report and Annual Accounts. It was agreed that the financial narrative needed to clearly articulate the year end position, explaining the adjustment for the technical deficit against the final breakeven position. Members were asked to submit comments within two weeks.

	Going Concern assessment Evidence was presented that the Trust's accounts should be prepared on a going concern basis, following definitions in the guidance. The following statement was agreed. • *The Directors have a reasonable expectation that the services provided by the NHS Foundation Trust will continue to be provided by the public sector for the foreseeable future, and for this reason, they have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.*
	Salary overpayments update The Committee received an update on the slightly improved position and the actions implemented in relation to the management and prevention of salary overpayments. **Limited assurance** was agreed on the impact of the actions already taken and an update on progress was planned in six months' time.
	Freedom to Speak Up (FTSU) report The FTSU Guardian report presented the six-monthly report along with an update on the NHS England/NHS Improvement FTSU Reflection and Planning Tool. The FTSU had been informed about future service changes, allowing planning for potential increased activity and having the information to signpost staff to. The paper provided **significant assurance** to the Committee that the Trust has adequate arrangements in place for speaking up and summarises the work that is being conducted under the FTSU policy framework within the Trust for the period reported.
	Year-end effectiveness report The Committee considered the year-end report on its activity and effectiveness for 2024/25, comparing the work of the Committee to its Terms of Reference (ToR). Checklists 1 and 2 from the HMFA NHS Audit Committee Handbook had been followed and feedback overall had been positive. **Significant assurance** was agreed that the Committee had discharged its duties and minor changes to its ToRs were agreed.
	Board Committees year-end effectiveness reports and annual review of Terms of Reference The Committee considered the year-end effectiveness reports from the Board Committees concerning their activity and effectiveness for 2024//25, comparing their work to their Terms of Reference (ToRs). Feedback had been positive, with some learning points which had been acted upon. Discussion took place on the appropriateness of the 80% attendance target for all Board committee meetings. **Significant assurance** was agreed that all the Board Committees have effectively carried out their role and responsibilities as defined by their ToRs during 2024/25. A summary report on this year-end process would be submitted to the next Trust Board.
	Interim Head of Internal Audit Opinion (HoIAO) and Progress Report The Internal Auditor (360 Assurance) report identified progress made in relation to completion of work from the Trust's 2024/25 Internal Audit Plan. The Interim Head of Internal Audit Opinion (HoIAO) would be finalised once all reports were issued. Compliance against the completion of audit actions had improved and compared well with other organisations. There needed to be an improvement from the Trust's side in response times for agreeing audit terms of reference and final reports. The draft 2025/26 Internal Audit Plan was presented, noting that phasing needed to be finalised.
	Counter Fraud, Bribery and Corruption Progress Report The Committee received an update on Counter Fraud Plan activity and the current position in compliance with, and submission of, the Trust's Counter Fraud Functional Standard Return. The

	Trust had scored green on twelve out of thirteen standards, with one scoring an amber. This had been on compliance of conflict of interests returns and an improvement plan had been put in place.
	External Audit Progress Report The External Auditor, Forvis Mazars, presented the external Audit Strategy Memorandum, confirming members of the audit team and the approach.
	Escalations to Board or other Committees: No specific issues. **Items added to the Board Assurance Framework**: None. **Next scheduled meeting:** 22 May 2025.
Committee Chair: Geoff Lewins	**Executive Leads: Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary and James Sabin, Director of Finance**

Audit and Risk Committee – key assurance levels agreed – 22 May 2025	
	Annual Governance Statement (AGS) The final draft of the AGS was received, the only outstanding area was the Head of Internal Audit Opinion. The AGS would be incorporated into the master Annual Report and Accounts document for sign off on 18 June 2025. The Committee asked for minor changes.
	Progress Update on Annual Report and Accounts The Committee was provided with the latest version of the Annual Report and Accounts, including. the summary of the changes between versions. Testing on the accounts continues.
	Data Security and Protection (DS&P) Report The latest progress on 2024/25 Data Security and Protection (DS&P) toolkit was noted. This included the work of the DS&P Committee, DS&P risk and incident management and Information Commissioner's Office (ICO) concerns. DS&P training was at 98% compliance and there is a robust plan to support staff that have not undertaken the training to complete it. The Committee was assured by the responses to the Data Security breaches and the learning from them. All audit recommendations from the 2023/24 audit had been completed. The Committee congratulated the team for their achievements and noted the **substantial assurance** and high confidence from our internal auditors in this work.
	Standing Financial Instructions (SFI) Breaches – annual report The Committee received the annual report on the use of waivers and received **significant assurance** that use has been appropriate and **significant assurance** on the process followed to approve and record waivers.
	Internal Audit Progress Report The Internal Auditor (360 Assurance) report identified progress made in relation to completion of work from the Trust's 2024/25 Internal Audit Plan. The final 2025/26 Internal Audit Plan was approved.
	Counter Fraud, Bribery and Corruption Annual Report The Committee noted the key messages and progress made, with another positive year of compliance against the functional standards. Two additional days had been approved in year for reactive audits.

	External Audit Progress Report The External Auditor, Forvis Mazars, presented a report setting out progress in delivering their responsibilities as the Trust's external auditors for the 2024/25 financial year. An issue was flagged about potential additional national requirements that could delay the submission of the laying of the annual report and accounts to Parliament but this would not affect the submission to NHS England.
	Escalations to Board or other Committees: None specified. **Items added to the Board Assurance Framework**: None. **Next scheduled meeting:** 18 June 2025 (sign off meeting).
Committee Chair: Geoff Lewins	**Executive Lead: Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary and James Sabin, Director of Finance**

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 June 2025

Modern Slavery Statement

Purpose of Report

To present the Trust's Annual Modern Slavery Statement for 2024/25 for approval.

Executive Summary

The Trust's Annual Modern Slavery Statement for 2024/25 is attached. This statement was considered and supported by the People and Culture Committee on 25 March who assessed whether the Trust has met the criteria for the preceding financial year.

The statement has been reviewed by the Head of Strategic Procurement and Tendering, the Assistant Director, Safeguarding Adults, the Strategic Recruitment Lead and the Head of Equality, Diversity and Inclusion.

The Board is requested to approve the Statement to be uploaded to the Trust's website, replacing the previous version.

Strategic Considerations	
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	

Risks and Assurances

The Board receives assurance that the Trust is discharging its statutory duties regarding the modern slavery statement through the statement which it approves on an annual basis.

Consultation

- People and Culture Committee 25 March 2025
- Board of Directors 3 June 2025.

Governance or Legal Issues

The Trust has to publish an annual statement setting out the steps they take to prevent modern slavery in their business and their supply chains. This is a requirement under Section 54 (Transparency in Supply Chains) of the Modern Slavery Act 2015. The statement must be updated every year and published on the Trust website within six months of the financial year end.

Public Sector Equality Duty and Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

The Trust commits to the design and implementation of services, policies and measures that meet the diverse needs of services, the population and workforce, ensuring that none are placed at a disadvantage over others.

The Trust has to publish an annual statement setting out the steps they take to prevent modern slavery in their business and their supply chains. This is a requirement under Section 54 (Transparency in Supply Chains) of the Modern Slavery Act 2015. The Statement must be updated every year and published on the Trust website within six months of the financial year end.

Recommendations

The Board of Directors is requested to approve the revised Modern Slavery Statement for publishing on the Trust's website, replacing the previous version.

Report presented by: **Ralph Knibbs**
Chair, People and Culture Committee and Senior Independent Director

Report prepared by: **Justine Fitzjohn**
Director of Corporate Affairs and Trust Secretary

MODERN SLAVERY STATEMENT – 2024/25

INTRODUCTION

This Statement is made pursuant to section 54 of the Modern Slavery Act 2015 and sets out the steps that Derbyshire Healthcare NHS Foundation Trust (the Trust) has taken, and is continuing to take, to make sure that modern slavery or human trafficking is not taking place within our business or supply chain.

Modern slavery encompasses slavery, servitude, human trafficking and forced labour. The Trust has a zero-tolerance approach to any form of modern slavery. We are committed to acting ethically and with integrity and transparency in all business dealings and to put effective systems and controls in place to safeguard against any form of modern slavery taking place within our business or our supply chain.

AIM OF THIS STATEMENT

The aim of this statement is to demonstrate that the Trust follows good practice, and all reasonable steps are taken to prevent slavery and human trafficking.

All members of staff have a personal responsibility for the successful prevention of slavery and human trafficking, with the Procurement Department taking the lead responsibility for compliance in the supply chain.

ABOUT THE ORGANISATION

The Trust is a provider of mental health, learning disability and children's services across the city of Derby and wider county of Derbyshire. We provide a variety of inpatient and community-based services throughout the county. We also provide specialist services across the county including substance misuse and eating disorders services.

Successful partnership working is essential to the delivery of many of our services. The Trust works in close collaboration with our commissioners and fellow providers of local healthcare services, together with local authority colleagues at Derby City Council and Derbyshire County Council, and voluntary and community sector organisations. Derbyshire Healthcare is an active partner in Joined Up Care Derbyshire, an Integrated Care System of health and care organisations working collectively to address challenges and improve the level of joined up working within the local health and care economy.

The Trust provides services to a diverse population, including areas of wealth alongside significant deprivation. The Trust's catchment area includes both city and rural populations, with over 70 different languages being spoken.

We became a Foundation Trust in 2011 and we employ over 2,400 staff based in over 60 locations across the whole of Derbyshire. Across the county and the city, we serve a combined population of approximately one million people.

OUR POLICIES ON SLAVERY AND HUMAN TRAFFICKING

The Trust is aware of its responsibilities towards patients, service users, employees and the local community and expects all suppliers to the Trust to adhere to the same ethical principles. The Trust is committed to ensuring that there is no modern slavery or human trafficking in our supply chains or in any part of our business. Our internal policies replicate our commitment to acting ethically and with integrity in all our business relationships.

Currently all awarded suppliers sign up to our terms and conditions of contract which contain a provision around Good Industry Practice to ensure each supplier's commitment to anti-slavery and human trafficking in their supply chains; and that they conduct their businesses in a manner that is consistent with the Trust's anti-slavery policy.

The Trust policies, procedures, governance and legal arrangements are robust, ensuring that proper checks and due diligence are applied in employment procedures to ensure compliance with this legislation. We also conform to the NHS employment check standards within our workforce recruitment and selection practices. This strategic approach incorporates analysis of the Trust's supply chains and its partners to assess risk exposure and management on modern slavery.

If required, the information may also be provided in other languages.

We operate a number of internal policies to ensure that we are conducting business in an ethical and transparent manner. These include the following:

Recruitment and Selection policy and procedure: We operate a robust recruitment policy including conducting eligibility to work in UK checks for all directly employed staff. Other checks include checks of identity, evidence of qualifications, health clearance, employment history and Disclosure Barring Service criminal records check for roles that meet the requirements. External agencies are sourced through the NHS Improvement nationally approved frameworks and are audited to provide assurance that pre-employment clearance has been obtained for agency staff to safeguard against human trafficking or individuals being forced to work against their will.

Equal Opportunities: We have a range of controls to protect staff from poor treatment and/or exploitation which comply with all respective laws and regulations. These include provision of fair pay rates, fair terms and conditions of employment, and access to training and development opportunities.

Safeguarding Policies: We adhere to the principles inherent within both our Safeguarding Children and Adults policies and procedures. These provide clear guidance so that our employees are aware as to how to raise safeguarding concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain.

Freedom to Speak Up Policy: We operate a Speak Up policy so that all employees know that they can raise concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain, without fear of reprisals.

Standards of Business Conduct (within Standing Orders): This policy explains the manner in which we behave as an organisation and how we expect our employees and suppliers to act.

WORKING WITH SUPPLIERS

The Procurement Team ensures that due diligence is undertaken for all new and ongoing suppliers of goods and services to the organisation and their associated Supply Chains by sourcing through the following compliant routes:

1. Competitive Procurement Act 2023 (Public Contract Regulations) procurements tendered in compliance with UK guidance which require suppliers to confirm they comply with the Modern Slavery Act. To support their response bidders are also required to state:

    a. *the organisation's structure, its business and its supply chains*
    b. *its policies in relation to slavery and human trafficking*
    c. *its due diligence processes in relation to slavery and human trafficking in its business and supply chains*
    d. *the parts of its business and supply chains where there* is *a risk of slavery and human trafficking taking place, and the* steps *it* has *taken to* assess *and manage that risk*
    e. *its effectiveness in ensuring that slavery and human trafficking* is *not taking place in its business or supply chains, measured against such performance indicators as it considers appropriate*
    f. *the training and capacity building about slavery and human trafficking available to its staff.*

2. Procurement through compliant national government frameworks. The Trust purchases large amounts of products from third party distributors such as NHS Supply Chain and utilises framework agreements from national framework providers such as Crown Commercial Services (CCS) which include specific questions around the Modern Slavery in their procurement documentation and any breaches of labour laws which result in disqualification of unsuitable organisations.

3. All contracts and associated purchase orders are raised on the NHS Standard Terms and Conditions which suppliers are mandated to comply with. These conditions state:

    10.1.28 it shall: (i) comply with all relevant Law and Guidance and shall use Good Industry Practice to ensure that there is no slavery or human trafficking in its supply chains; and (ii) notify the Authority immediately if it becomes aware of any actual or suspected incidents of slavery or human trafficking in its supply chains

    10.1.29 it shall at all times conduct its business in a manner that is consistent with any anti-slavery Policy of the Authority and shall provide to the Authority any reports or other information that the Authority may request as evidence of the Supplier's compliance with this Clause 10.1.29 and/or as may be requested or otherwise required by the Authority in accordance with its anti-slavery Policy.

TRAINING

Advice and training about Modern Slavery and human trafficking is available to staff through our mandatory Safeguarding Children and Adults training programmes, our Safeguarding policies and procedures, and our Safeguarding Leads. It is also discussed at our compulsory staff induction training.

Awareness is also raised through information sharing on the Trust intranet and our public website.

Advice and training about Modern Slavery and human trafficking is available to staff through our Safeguarding Children and Adults training programme. The Trust is committed to and follow the Derbyshire and Derby Safeguarding Adults Policy and Procedures and the Derby and Derbyshire Safeguarding Children Partnership Procedures.

OUR PERFORMANCE INDICATORS

We will know the effectiveness of the steps that we are taking to ensure that slavery and/or human trafficking is not taking place within our business or supply chain if:

- No reports are received from our staff, the public, or law enforcement agencies to indicate that modern slavery practices have been identified.

BOARD OF DIRECTORS' APPROVAL

The Board of Directors has considered and approved this statement and will continue to support the requirements of the legislation.

This statement is made pursuant to Section 54(1) of the Modern Slavery Act 2015 and constitutes our organisation's modern slavery and human trafficking statement for the current financial year.

Signed on behalf of the Board of Directors:

Selina Ullah
Trust Chair

Mark Powell
Chief Executive

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 June 2025

Equality, Diversity and Inclusion report
Gender, Ethnicity and Disability Pay Gap

Purpose of Report

This report provides the Board of Directors with the annual pay gap reports for gender, ethnicity and disability. As part of the Equality Act 2010, the Trust is required to publish the gender pay gap report on the government portal. The Trust has chosen to publish an ethnicity and disability pay gap report in line with the work on the equality, diversity and inclusion agenda and the national aspiration.

Executive Summary

The attached paper provides the Board with the data on each of the three pay gaps. The information is broken down into figures showing the pay gap and the bonus pay gap. The gender pay gap provides additional information as required by the legislation. The report shows we have a median gender pay gap of 7.81%, a median ethnicity pay gap of 2.56% and there is no median disability pay gap. The report also provides a number of actions that the Trust is committed to working on over the next 12 months to reduce the pay gap. Some of these actions are also in line with our Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) action plans.

Strategic Considerations	
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X

Risks and Assurances

- The gender pay gap has reduced from 11.53% to 7.81% from 2023 to 2024. However, there are actions that the Trust needs to take to continue to reduce the gap
- The Trust needs to continue to work on encouraging staff members to share their personal disability data via ESR. This will enable the Trust to continue to assess and work on actions required.

Consultation

Staff-side colleagues

People and Culture Committee, 25 March 2025

Governance or Legal Issues

This report allows us to comply with the Equality Act 2010 with regard to reporting the gender pay gap. It also supports our obligations with regard to the public sector equality duty.

Public Sector Equality Duty & Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

This report provides the data on each of the pay gaps for gender, ethnicity and disability. There are actions that the Trust will take to address the gaps where they exist. This is supported by our actions on the WRES and WDES reports. The action plan will support the Trust to assess and address any associated risks.

Recommendations

The Board of Directors is requested to note the information on the three pay gaps and the associated actions that the People, Organisational Development and Inclusion team are committed to delivering.

Report presented by: **Ralph Knibbs**
Chair, People and Culture Committee and Senior independent Director

Report prepared by: **Alex Dougall**
Strategic Recruitment Lead

NHS
Derbyshire Healthcare
NHS Foundation Trust

Gender, Ethnicity and Disability Pay Gaps Report

2024/25 (data extract as of 31 March 2024)

Background

The gender pay gap reflects inequalities and discrimination in the labour market that mostly affect women. Women earn significantly less than men over their entire careers for complex, often interrelated reasons. These include but not limited to:

- differences in caring responsibilities
- more women in low skilled and low paid work
- outright discrimination[1]

NHS organisations are covered by the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 which came into force on 31 March 2017. These regulations underpin the Public Sector Equality Duty and require Employers with 250 employees and over need to publish the following information annually for all employees who are employed under a contract of employment, a contract of apprenticeship or a contract personally to do work.

This will include those under Agenda for Change terms and conditions, medical staff and very senior managers. All calculations are made relating to the pay period in which the snapshot day falls.

What is the gender pay gap?

- The gender pay gap is the difference between the average earnings of men and women, expressed relative to men's earnings
- The mean pay gap is the difference between average hourly earnings of men and women
- The median pay gap is the difference between the midpoints in the ranges of hourly earnings for men and women.

Reporting requirements

There are six calculations an organisation is required to publish, which are listed in the table below:

Table 1: Gender Pay Gap reporting requirements	
Mean gender pay gap.	The difference between the average of men's and women's hourly pay.
Median gender pay gap.	The difference between the midpoints in the ranges of men's and women's pay. All salaries in the sample are lined up separately for men and women in order from lowest to highest, and the middle salary is used. The figure is the difference of these two middle points.
Mean bonus gender pay gap.	The difference between the mean bonus payments made to relevant male employees and that paid to relevant female employees. For DHCFT this refers to local and national clinical excellence awards.
Median bonus gender pay gap.	The difference between the median bonus payments made to relevant male employees and that paid to relevant female employees. For DHCFT this refers to local and national clinical excellence awards.
Proportion of males and females receiving a bonus.	The proportions of relevant male and female employees who were paid a bonus payment. For DHCFT this refers to local and national clinical excellence awards.
Proportion of males and females in each quartile band.	The proportions of male and female relevant employees in the lower, lower middle, upper middle and upper quartile pay bands.

[1] Close the gender pay gap | The Fawcett Society

What employers need to publish:

- The information outlined above will need to be published within one year of the date for the 2024 snapshot (publishing deadline of 30 March 2025 for data as of 31 March 2024)
- The information must be published on a website that is accessible to employees and the public free of charge
- The information should remain on the website for a period of at least three years beginning with the date of publication
- In addition, employers have the option to provide narrative that will help people to understand why a gender pay gap is present and what the organisation intends to do to close it.

Gender Pay Gap

The median pay gap indicates that for every £1.00 a man makes, a woman makes £0.92 pence.

The mean pay gap indicates that for every £1.00 a man makes, a woman makes £0.84 pence.

Gender	Average Hourly Rate	Median Hourly Rate
Male	£22.91	£19.63
Female	£19.35	£18.10
Difference	£3.55	£1.53
Pay Gap %	**15.51%**	**7.81%**

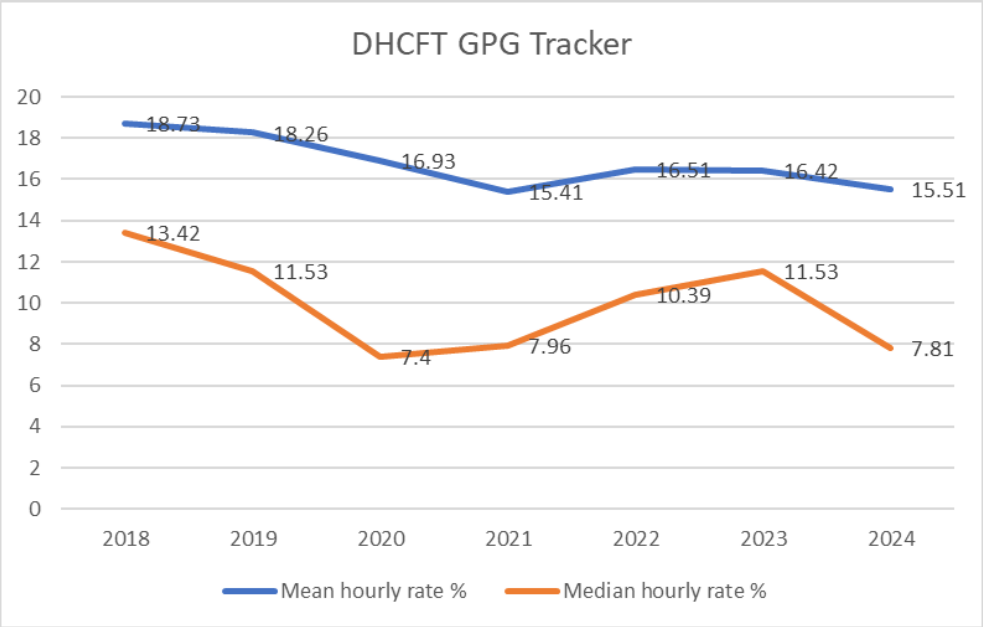
Gender Pay Gap

	31 March 2023		31 March 2024		Variation	
Gender	Average Mean Hourly Rate	Median Hourly Rate	Average Mean Hourly Rate	Median Hourly Rate	Average Mean Hourly Rate	Median Hourly Rate
Male	£21.94	£19.48	£22.91	£19.63	£0.96	£0.15
Female	£18.34	£17.24	£19.35	£18.10	£1.01	£0.86
Difference	£3.60	£2.25	£3.55	£1.53	-£0.05	-£0.71
Pay Gap %	**16.42%**	**11.53%**	**15.51%**	**7.81%**	-0.91%	-3.72%

The median pay gap has decreased to 7.81% in 2024 from 11.53% in 2023. The mean pay gap has reduced slightly from 16.42% in 2023 to 15.51%. There is a £3.55 mean pay gap between men and women and a £1.53 median pay gap which shows the importance of trying to ensure proportionate representation of gender across the Trust.

It is positive that the median pay gap has decreased for the first time in the last three years. It is worth noting that although both the median and mean can change depending on fluctuations in the workforce. The mean can be influenced by high and low salaries as this is the average hourly rate of pay.

As the organisation is made up of 79.21% females, there is high percentage of women in the lower quartiles where pay is lower and outliers in high pay can impact on this mean. The median is a good judge of distribution of pay so it is positive that this has decreased in the past 12 months. The median is not impacted by high salary outliers.



Quartiles

The table below highlights the proportion of women across the organisation and this distribution has a direct impact on the gender pay gap. By creating a more equal distribution this is likely to reduce the gender pay gap.

Since 2023 the number of males and females has increased across all quartiles, demonstrating the growth of the organisation as a whole. The proportion of men has increased in the lower quartile since 2023. The proportion of women in the upper quartile has slightly increased from 71.02% in 2023 to 71.91%, In order to improve the gap more work must be done to ensure women progress through the pay bands- and to continue to attract males into roles where they are underrepresented in the lower quartile.

31 March 2023				
Quartile	Female	Male	Female %	Male %
1	684	114	85.71	14.29
2	599	156	79.34	20.66
3	698	157	81.64	18.36
4	571	233	71.02	28.98

31 March 2024				
Quartile	Female	Male	Female %	Male %
1	716	131	84.53	15.47
2	699	165	80.90	19.10
3	700	158	81.59	18.41
4	617	241	71.91	28.09

Variation	
Female %	Male %
-1.18	1.18
1.57	-1.57
-0.05	0.05
0.89	**-0.89**

The following table highlights that although the percentage of women in the upper quartile has increased proportionally in comparison to the workforce composition women are underrepresented in this quartile and overrepresented in the lower quartile.

	Proportion of females and males in each quartile over a period of four years							
	Women				Men			
Quartile	2021	2022	2023	2024	2021	2022	2023	2024
Q1 (lowest)	83.75 % 608	84.35% 636	85.71% 684	84.53% 716	16.25% 118	15.65% 118	14.29% 114	15.47% 131
Q2 (lower middle quartile)	80.84 % 557	79.89% 580	79.34% 599	80.90% 699	19.16% 132	20.11% 146	20.66% 156	19.10% 165
Q3 (upper middle quartile)	79.54 % 618	81.86% 650	81.64% 698	81.59% 700	20.46% 159	18.14% 144	18.36% 157	18.41% 158
Q4 (highest)	71.21 % 522	71.94% 546	71.02% 571	71.91% 617	28.79% 211	28.06% 213	28.98% 233	28.09% 241

Bonus Gap

There are currently two types of bonus payments at Derbyshire Healthcare, the clinical excellence and long service awards. The variation of the bonus pay gaps can depend on who is eligible for each award and is not linked to previous years payments.

The bonus pay gap mean was 78.54% and median 33.33%. The table shows a variation due to the clinical excellence awards and long service awards. The Trust has worked on reducing the gap by applying these awards consistently now. The gaps, in the main, are caused by legacy payments.

Gender	Total Avgerage Bonus Pay	Total Median Bonus Pay
Male	£3,553.28	£300.00
Female	£762.58	£200.00
Difference	£2,790.70	£100.00
Pay Gap %	**78.54%**	**33.33%**

Gender Pay Gap Bonus

31 March 2023

Gender	Average Mean Bonus Pay	Median Bonus Pay
Male	£8,318.55	£6,996.75
Female	£2,584.76	£300.00
Difference	£5,733.79	£6,696.75
Pay Gap %	**68.93%**	**95.71%**

31 March 2024

Gender	Average Mean Bonus Pay	Median Bonus Pay
Male	£3,553.28	£300.00
Female	£762.58	£200.00
Difference	£2,790.70	£100.00
Pay Gap %	**78.54%**	**33.33%**

Variation

Average Mean Bonus Pay	Median Bonus Pay
-£4,765.27	-£6,696.75
-£1,822.18	-£100.00
-£2,943.09	-£6,596.75
9.61%	-62.38%

The bonus pay gap was mainly due to the clinical excellence awards and this can be associated with some large outlier payments to males based on honouring historic entitlements which increase this gap. During Covid in 2020, the **Clinical Excellence Awards** started being divided equally between eligible consultants at DHcFT, the existing gap is mainly due to a number of consultants receiving the award based on the historical process.

Clinical Excellence Awards

31 March 2023		
Gender	Average Mean Bonus Pay	Median Bonus Pay
Male	£11,816.59	£6,996.75
Female	£7,876.27	£6,996.75
Difference	£3,940.32	£0.00
Pay Gap %	33.35%	0.00%

31 March 2024		
Gender	Average Mean Bonus Pay	Median Bonus Pay
Male	£8,770.57	£3,546.03
Female	£4,433.84	£3,546.03
Difference	£4,336.74	£0.00
Pay Gap %	49.45%	0.00%

Variation	
Average Mean Bonus Pay	Median Bonus Pay
-£3,046.02	-£3,450.72
-£3,442.43	-£3,450.72
£396.42	£0.00
16.10%	0.00%

The bonus gap for long service awards is 0.41% and there is no median gap so this indicates that the scheme is administered consistently.

Long Service Awards

31 March 2023		
Gender	Average Mean Bonus Pay	Median Bonus Pay
Male	£246.15	£200.00
Female	£242.62	£200.00
Difference	£3.53	£0.00
Pay Gap %	1.43%	0.00%

31 March 2024		
Gender	Average Mean Bonus Pay	Median Bonus Pay
Male	£242.00	£200.00
Female	£241.00	£200.00
Difference	£1.00	£0.00
Pay Gap %	0.41%	0.00%

Variation	
Average Mean Bonus Pay	Median Bonus Pay
-£4.15	£0.00
-£1.62	£0.00
-£2.53	£0.00
-1.02%	0.00%

We will continue to monitor bonus payments and how these are paid to ensure fairness particularly in our clinical excellence awards which tends to cause the bigger gap.

DHcFT overall mean and median bonus gap based on hourly rates of pay				
	DHcFT 2021	**DHcFT 2022**	**DHcFT 2023**	**DHcFT 2024**
Mean bonus gender pay gap	89.54%	87.62%	68.93%	78.54%
Median bonus gender pay gap	88.93%	50.00%	95.71%	33.33%
NB bonuses paid relate to clinical excellence awards (including long service?) which are for applicable consultants only rather than all employees (even though the calculation includes all staff)				

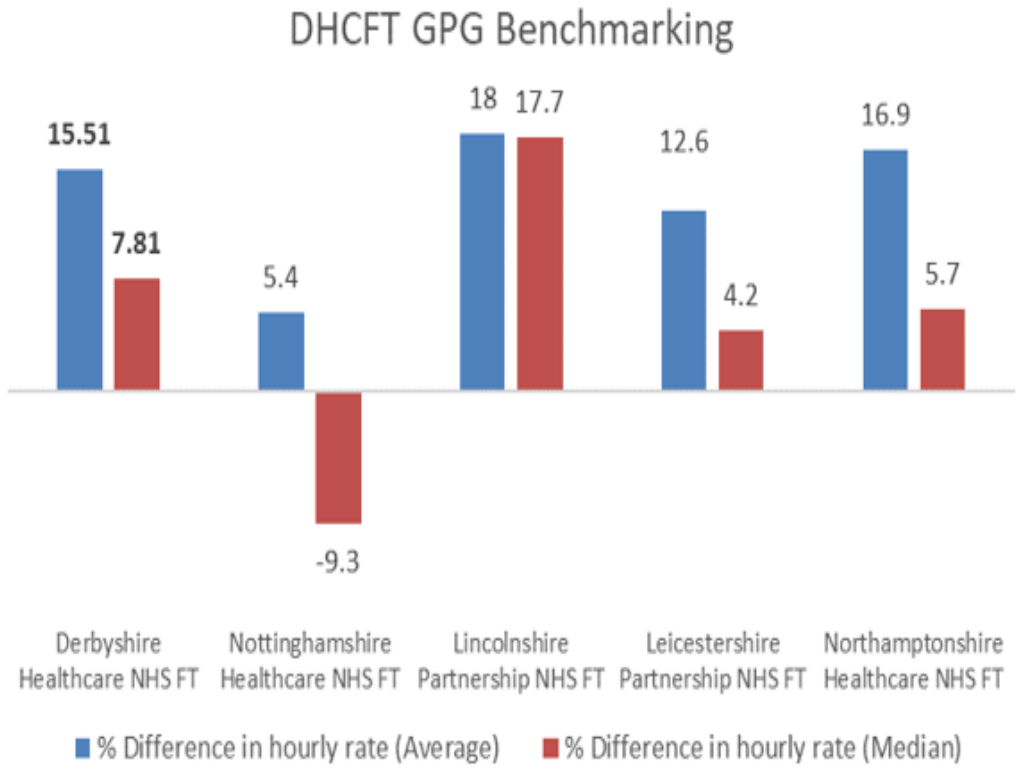
Competitor Benchmarking

The following table shows the Trust compares compared to similar NHS provider Trusts from data published in 2023 as at the time of publishing 2024 data is unavailable.

Benchmarking (latest available benchmarking data 31 March 2023):

Employer	% Difference in hourly rate (Average)	% Difference in hourly rate (Median)	% Women in lower pay quartile	% Women in lower middle pay quartile	% Women in upper middle pay quartile	% Women in top pay quartile	% Who received bonus pay (Women)	% Who received bonus pay (Men)	% Difference in bonus pay (Mean)	% Difference in bonus pay (Median)
Derbyshire Healthcare NHS FT	**15.51**	**7.81**	84.53	80.90	81.59	71.91	8.53	12.23	78.54	33.33
Nottinghamshire Healthcare NHS FT	**5.40**	**-9.30**	76.50	66.70	76.40	78.90	28.40	32.50	14.40	33.30
Lincolnshire Partnership NHS FT	**18.00**	**17.70**	14.00	19.00	18.00	28.00	0.20	2.80	18.00	17.70
Leicestershire Partnership NHS FT	**12.60**	**4.20**	84.70	82.20	85.20	75.40	0.90	3.80	53.80	0.00
Northamptonshire Healthcare NHS FT	**16.90**	**5.70**	89.30	83.10	87.30	77.10	25.40	34.80	42.90	39.40

Source: *GOV.UK*



Ethnicity & Disability Pay Gap Reporting

In line with the aspirations of the NHS nationally, the Trust has compiled the below ethnicity and disability pay gap reporting, as part of the organisation's approach to improve inclusion and tackle inequality in the workplace.

With more year-on-year data, the Trust will be in a better position to explore the ethnicity and disability pay gap trends and subsequently address it through impactful interventions.

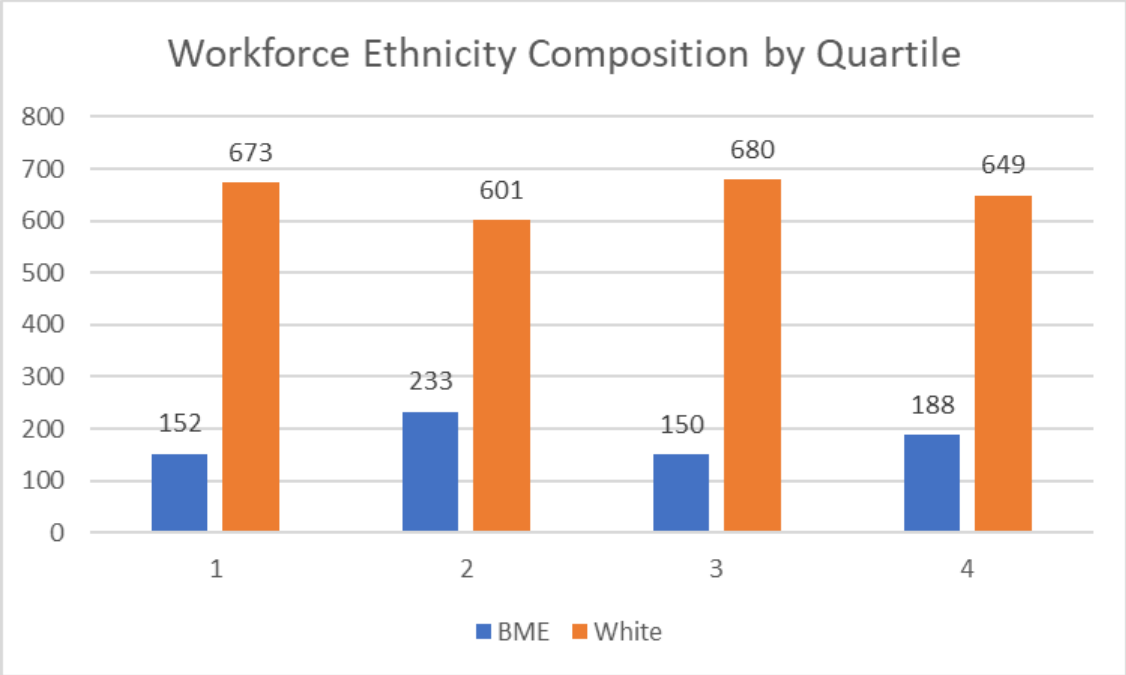
Ethnicity Pay Gap

Our data at a glance

Median pay gap 2.56%: For every £1.00 a white colleague makes, a BME colleague makes £0.97 pence.

Mean pay gap -9.04%: For every £1.00 a white colleague makes, a BME colleague makes £1.09 pence.

The Trust workforce consists of 2,603 staff (77.3%) (as last year) from White background, and 723 (21.7%) from BME background. This is an increase of 2.2% from 2023. The breakdown will fluctuate throughout the year due to staff starters and leavers. Subsequently, all our quartiles are predominantly White colleagues. The highest concentration of colleagues from BME background remains in the lower middle quartile.



The overall picture indicates that BME staff across the Trust on average earn more than White colleagues as the mean pay gap is 9.04% in favour of BME staff. However, further analysis of this indicates that the medical workforce contributes to this where rates of pay are higher than other roles. When removing the medical workforce, the mean pay gap is 5.52% and the median is 5.47%in favour of white employees. This shows the importance of undertaking more detailed analysis across the Trust and between professional groupings.

Ethnicity	Average Hourly Rate	Median Hourly Rate
White	£19.70	£18.30
BME	£21.48	£17.84
Difference	-£1.78	£0.47
Pay Gap %	-9.04%	2.56%

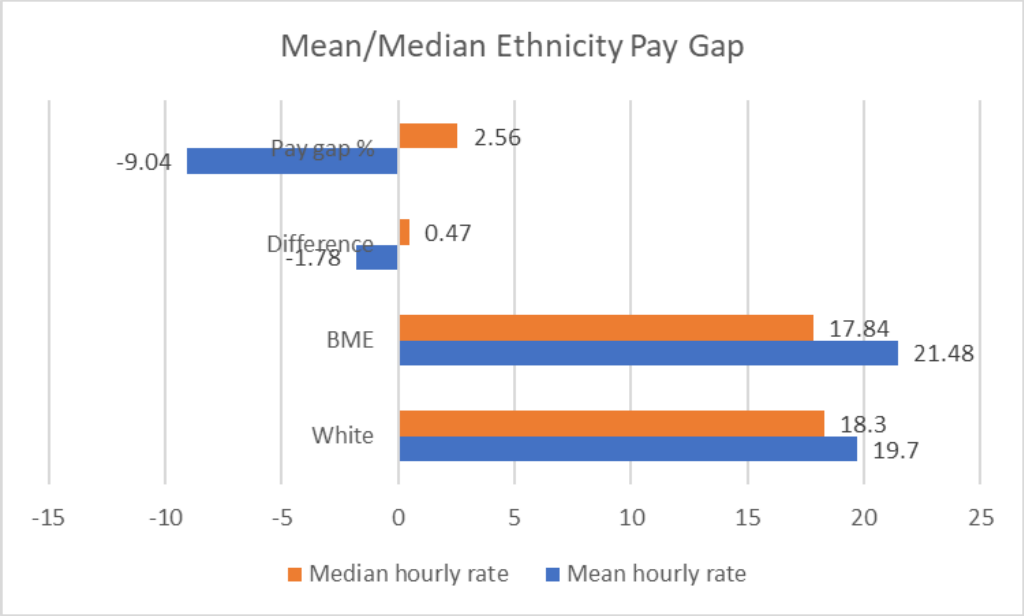


Table 3 below shows DHcFT's overall mean and median ethnicity pay gap and bonus gap based on hourly rates of pay over a period of three years. These have stayed relatively consistent over the past three years.

Table 3: DHcFT Overall mean and median ethnicity pay gap based on hourly rates of pay over a three-year period			
	DHcFT 2022	**DHcFT 2023**	**DHcFT 2024**
Mean hourly rate pay gap	-10.94%	-9.44%	-9.04%
Median hourly rate pay gap	6.53%	**3.30%**	**2.56%**
NB bonuses paid relate to clinical excellence awards which are for applicable consultants only rather than all employees (even though the calculation includes all staff)			

Proportion of white and BME colleagues in each quartile over a period of 2 years				
Quartile	**2023**	**2024**	**2023**	**2024**
Q1 (lowest)	18.77% 143	18.42% 152	81.23% 619	81.58% 673
Q2 (lower middle quartile)	29.42% 213	27.94% 233	70.58% 511	72.06% 601
Q3 (upper middle quartile)	14.15% 116	18.07% 150	85.85% 704	81.93% 680
Q4 (highest)	22.12% 175	22.46% 188	77.88% 616	77.54% 649

Disability Pay Gap results

This is the second year DHcFT is reporting on the Disability pay gap in line with the NHS national aspiration. As per our Workforce Disability Equality Standards report, the Trust employs 334 members of staff that have declared they have a disability which equates to 11.6% (up from **8.9%%** in 2023) of the overall workforce.

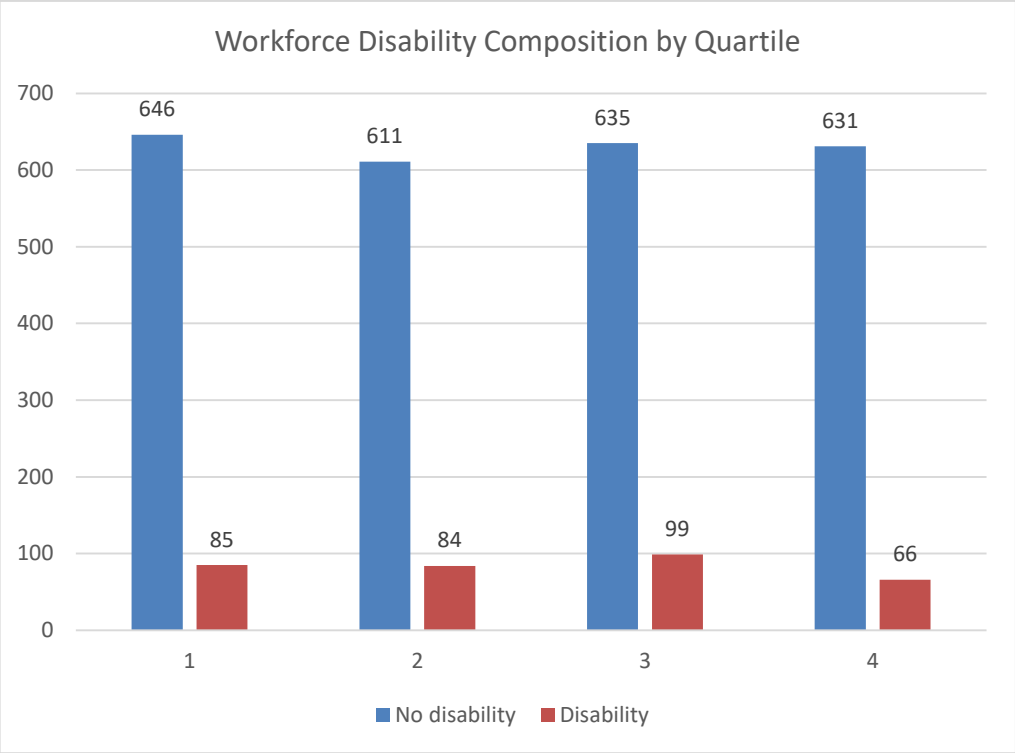
It is crucial to note that this figure might not be representative of the actual number of colleagues who have a disability since it depends on the declaration rates.

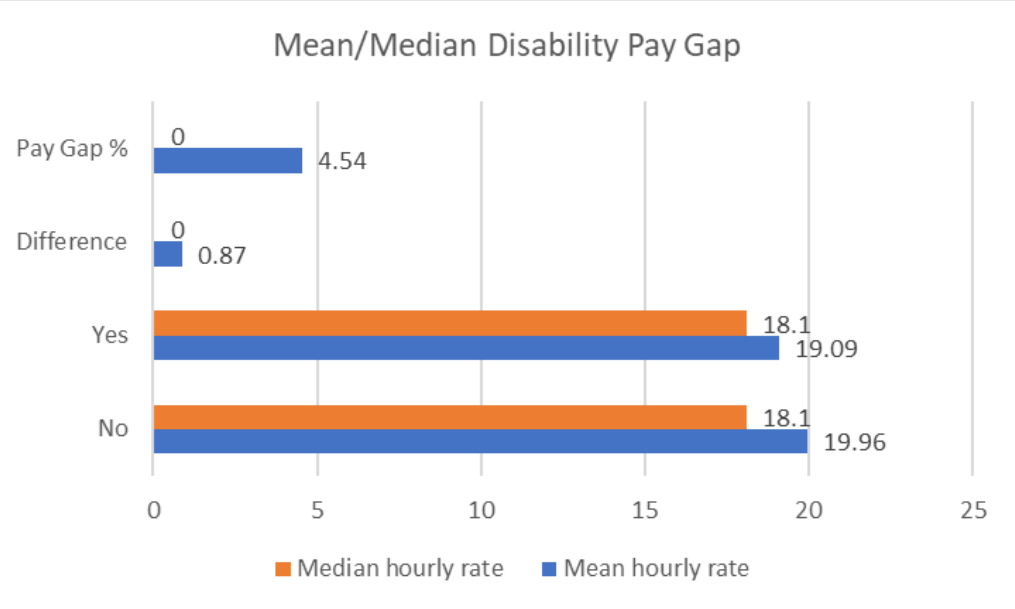
As per the below data, the trust does not have a median hourly rate gap between staff who declared a disability and those who stated they do not have a disability. However, the mean hourly rate shows a gap of 4.54% in pay between colleagues who declared a disability and those who did not. The mean though can be impacted by any outliers in pay. It is positive there is no median pay gap. However, more work will be done to encourage staff to disclose their diversity information.

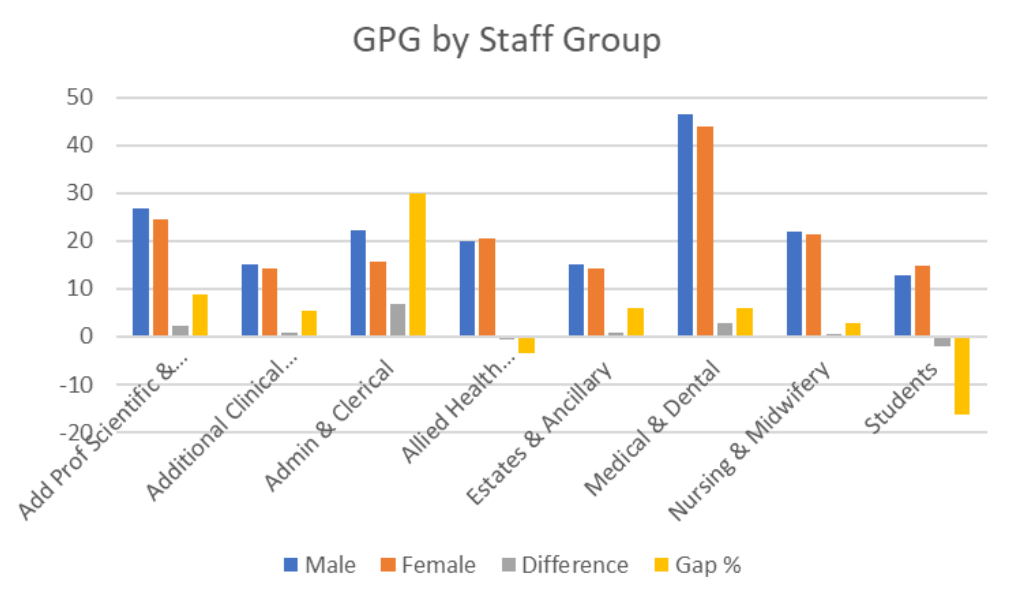
The table below shows distribution of colleagues who stated that they have a disability and those who stated that they do not across the four quartiles.

Disability	Average Hourly Rate	Median Hourly Rate
No	£19.96	£18.10
Yes	£19.09	£18.10
Difference	£0.87	£0.00
Pay Gap %	4.54%	0.00%

Quartile	No	Yes	No %	Yes %	Totals
1	646	85	88.37	11.63	731
2	611	84	87.91	12.09	695
3	635	99	86.51	13.49	734
4	631	66	90.53	9.47	697


Workforce Disability Composition by Quartile
700
600
500
400
300
200
100
0
646
85
611
84
635
99
631
66
1
2
3
4
No disability
Disability


Mean/Median Disability Pay Gap
Pay Gap %
0
4.54
Difference
0
0.87
Yes
18.1
19.09
No
18.1
19.96
0
5
10
15
20
25
Median hourly rate
Mean hourly rate


GPG by Staff Group
50
40
30
20
10
0
-10
-20
Add Prof Scientific &...
Additional Clinical...
Admin & Clerical
Allied Health...
Estates & Ancillary
Medical & Dental
Nursing & Midwifery
Students
Male
Female
Difference
Gap %

Actions to address the pay gap:

The gender pay gap exists due to a number of factors, some of which are driven by societal and cultural structures that puts women at a disadvantage. These can create bias in organisational structures and systems.

Some of the measures the trust is committing to over the next 12 months:

- Monitor the proportion of men and women who start above the bottom of the pay band and review actions required which may include developing further guidance for recruiting managers on starting salaries
- Encourage employees to complete their diversity information as this will give the Trust a more meaningful data to work with and take actions against
- Roll out more widely chairs of recruitment training to encourage inclusive recruitment decisions
- Analyse in more detail gender pay gaps across staff types and where barriers are in progression. Once this work is complete, review the actions that are required to support progression in the organisation
- Update the flexible working policy to ensure each request is considered fairly including encouraging job share and part time working in more senior roles. Implement an electronic solution through ESR to monitor flexible working requests and whether there are any barriers to these at a senior level
- Support staff networks to reach their full potential
- Work with our communities and partners to try and attract and diverse range of applicants into our roles
- Update and relaunch the Recruitment Inclusion Guardian process
- Review diversity of recruitment panels across the trust where there are barriers to women's and under-represented groups progression
- Review the Trust development offer to ensure it supports the progression of women and under-represented groups across the Trust
- Continue to monitor effectiveness of the Trust Sexual Safety Charter through the newly established Sexual Safety Working Group
- Identify and support staff with carer responsibilities
- Support the relaunched women's network and work in partnership to address any issues
- Encourage men to apply for roles where they are under-represented
- A commitment to understand and analyse intersectionality to identify any pay gap issues through the EDI steering group.

We know that sustained improvements will take time but have confidence in the targeted actions being applied. Our WRES and WDES actions will also support our development in these areas.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 June 2025

Annual Medical Appraisal and Revalidation– 2024/25

Purpose of Report:

To provide the Board of Directors with an update on medical appraisal and revalidation activity within the Trust during the 2024/25 medical appraisal cycle.

Executive Summary:

The purpose of medical revalidation and appraisal is to support and develop our medical workforce through reflection on clinical practice whilst complying with GMC frameworks to protect patients.

As at 31 March 2025, 121 doctors had a connection with the Trust for appraisal. Of these:

- 121 doctors have completed their appraisal within the required time
- 12 doctors have not completed an appraisal during this time frame
- All doctors without an appraisal have been contacted by the medical appraisal lead and have a plan in place to support them to improve their compliance with appraisal.

The Trust has embedded the electronic platform L2P for medical appraisal. Using L2P allows greater transparency of the appraisal data for individual doctors as well as for the Trust Revalidation team. It provides a much easier platform for carrying out appraisals than the previous system. Built-in automatic reminders around time frames have helped to improve compliance with appraisal submission dates.

In September 2024, Dr Chidambaram, RO, wrote to all doctors eligible for appraisal to set out expectations and consequences of non-compliance with appraisal. There has been an improvement in compliance rates of appraisal over the past 12 months, with 90% of doctors completing their appraisal on time in the 2024/25 cycle v 61% in the 2023/24 cycle. However, many doctors continue to submit appraisal information very close to the deadline, putting significant pressure on the appraisal team to ensure deadlines are met.

The Responsible Officer Advisory Group (ROAG) is now established within the Trust. The medical appraisal lead reports into this group to provide regular updates on appraisal data and can seek advice to identify early and support any doctors who are not on track to complete their appraisal in a timely manner.

The Responsible Officer has regular meetings with the Employment Liaison Advisor from GMC to seek advice regarding non-engagement with appraisals and escalate concerns. Whilst the appraisal process triangulates all information relating to practice in a single framework, those processes, for example, learning from a complaint or patient safety investigation, independently operate and will be responded to, irrespective of the doctor's appraisal completion in a particular year.

Strategic Considerations	
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X

Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	

Risks and Assurances

The move to L2P has highlighted more clearly a small number of doctors who are significantly behind with their appraisals. This situation is being closely monitored by the appraisal lead and the doctors are being actively supported to take action to bring themselves in line with requirements.

Consultation

People and Culture Committee, 1 May 2025.

Governance or Legal Issues

N/A.

Public Sector Equality Duty & Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

The above has been considered but no impact has been identified.

Recommendations

The Board of Directors is requested to note the contents of this report, which offers a significant level of assurance as there is a sound system; process, governance and assurance to meet the Trust objectives. However, inconsistent application arises in terms of the engagement of a small number of individual clinicians.

Report presented by: **Ralph Knibbs**
Chair, People and Culture Committee and Senior Independent Director

Report prepared by: **Wendy Brown**
Medical Appraisal Lead

Classification: Official

Publication reference: PR1844

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.2 Feb 2023

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A–G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020 but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (eg consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The Board can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.
2.

Action from last year: The DHcFT Responsible Officer will continue to discharge the role and responsibilities on behalf of the medical staff and will provide appropriate support to the Medical Appraisal Lead

Comments: Dr Chidambaram is the DHcFT Responsible Officer.

Action for next year: To continue.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes

Action from last year: Continue to embed the use of L2P across the medical body.

Comments: DHcFT has embedded the L2P electronic platform into its processes for appraisal. All doctors eligible for appraisal have access and receive an induction to the process from the appraisal lead. L2P is now the only platform used for medical appraisal.

Externally delivered high quality training was provided in June 2022 for new and existing appraisers. Further training is scheduled for November 2025. This has led to new appraisers joining the existing cohort. Appraiser support is provided through informal network discussions and one to one support from the appraisal lead where needed.

Action for next year: Training for new and existing appraisers is scheduled for November 2025.

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: To continue to use current systems to maintain accurate information.

Comments: The medical appraisal lead ensures an accurate record is kept on the electronic system L2P. This happens through liaison with medical staffing colleagues and the workforce information team to highlight new starters and leavers to the Trust. This information is cross refenced with the GMC connect site which lists those medical practitioners with a prescribed connection to DHcFT.
Action for next year: To continue to use current systems to maintain accurate information.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: The policy will continue to be reviewed in line with DHcFT timeframes.
Comments: The medical appraisal policy was reviewed in 2023 and is available for staff on the DHcFT Intranet.
Action for next year: The policy will continue to be reviewed in line with DHcFT timeframes. It is due for review in September 2026.

6. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: Consideration to be given to peer review during future appraisal cycles.
Comments: The DHcFT Medical Appraisal Lead has established regular contact with the Medical Appraisal Lead in a neighbouring trust (Nottinghamshire). Quarterly meetings take place with a focus on national updates, comparison of local (anonymised) data and sharing of best practice.
Action for next year: To continue with and develop this link.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: To continue with current arrangements as detailed below.
Comments: Locums and short-term placement doctors are contacted by the medical appraisal lead and arrangements put in place for their appraisal as required. Agency

locums may carry out their appraisal through their agency or can do this through DHcFT. All medical staff have access to CPD, appraisal, revalidation, and governance.

Action for next year: To continue with this arrangement.

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1]

Action from last year: An electronic appraisal system will allow automated prompts and reminders to be sent to doctors to improve appraisal completion timeframes.

Comments: Quality of appraisals continues to be good and appraisals are carried out to a high standard. Completion of appraisals within required timeframes is an ongoing challenge. The move to L2P provides greater transparency about individual doctors appraisal status and allows targeted support to those doctors who are not in line with standards.

Action for next year: to continue to support all doctors to complete their appraisal in line with GMC standards with focused support for those who are not meeting required timescales.

8. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: To continue to improve compliance with appraisal timeframes.

Comments: Systems have been developed in DHcFT to formalise the escalation process when doctors are falling behind with appraisal. Involvement of operational managers and Clinical Directors forms part of this process and an individual meeting with the RO may take place. Escalation is co-ordinated through the Responsible Officer Advisory Group (ROAG) which meets bi-monthly. The Responsible Officer has regular meetings with the Employment Liaison Advisor from GMC to seek advice regarding non-engagement with appraisals and escalate concerns. Whilst the appraisal process triangulates all

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

information relating to practice in a single framework, those processes, for example, learning from a complaint or patient safety investigation, independently operate and will be responded to, irrespective of the doctor's appraisal completion in a particular year.
In September 2024 all doctors eligible for appraisal were sent a letter from the Responsible Officer clearly outlining the expectations for appraisal, requirements for revalidation and potential consequences of not complying with the process.
At the end of the 2024/25 appraisal cycle (31 March 2025) four doctors remained significantly out of date with their appraisal (more than five years of no appraisals). All were working at Consultant Level within DHcFT. Since this time one has retired. Escalation processes are in place for the other three doctors.
Action for next year: To continue to improve compliance with appraisal timeframes through the above processes.

9. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: The Policy will be reviewed according to DHcFT timeframes.
Comments: The Medical Appraisal Policy was reviewed in 2023 with minor amendments. It is available to all staff via the Trust intranet.
Action for next year: The Policy will be reviewed according to DHcFT timeframes – next review September 2026.

10. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: To continue to maintain adequately trained appraisers through training new appraisers in order to account for retirements and resignations.
Comments: DHcFT has maintained appropriate numbers of appraisers. New doctors have joined the existing cohort following appropriate training. Further training is planned for November 2025.
Action for next year: To continue to maintain adequately trained appraisers through training new appraisers in order to account for retirements and resignations.

11. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review

and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: We will continue to seek opportunities for feedback and peer review within the appraiser group as well as periodic refresher training.
Comments: Medical appraisers receive support through informal group and individual discussion with peers and the appraisal lead.
Action for next year: Further appraisal training planned in November 2025. This is for existing and new appraisers.

12. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: A quality assurance audit to be carried out.
Comments: All annual appraisals are reviewed by the medical appraisal lead once they are submitted. Any issues raised by the appraiser or picked up by the appraisal lead at this stage will lead to further amendments by the doctor before the appraisal is signed off. Prior to revalidation, the appraisal lead and RO review all appraisals for that revalidation cycle for the individual doctor. Standards are measured against GMC requirements for revalidation. Any further information required will then be requested prior to revalidation.
Action for next year: To continue with this quality assurance process.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation: Derbyshire Healthcare NHS Foundation Trust	
Total number of doctors with a prescribed connection as at 31 March 2025	121
Total number of appraisals undertaken between 1 April 2024 and 31 March 2025	109
Total number of appraisals not undertaken between 1 April 2024 and 31 March 2025	12
Total number of agreed exceptions	8

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: To continue with regular liaison meetings.
Comments: The Responsible Officer has regular, documented meetings with the GMC 89Employment Liaison Officer. Fitness to practice issues and thresholds of referral are discussed and noted.
Action for next year: To continue with regular liaison meetings.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: To continue with high levels of compliance in this area.
Comments: All revalidation recommendations have been made within appropriate timeframes.
Action for next year: To continue with high levels of compliance in this area.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: To look further at the use of data to inform individual doctors practice and comparison amongst groups of doctors.
Comments: Quality Improvement activity is undertaken across services and by individuals to look at their own practice. Feedback is given about complaints and serious incidents. There is a drive within DHcFT to make data accessible to clinicians to support improved care and outcomes for example reviewing prescribing data.
Action for next year: To look further at the use of data to inform individual doctors practice and comparison amongst groups of doctors.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: To continue with and develop the approach below.
Comments: Individual doctors and the Appraisal Lead are able to link in with the Patient Experience team for details of any complaints or serious incidents involving them.
Action for next year: To continue with and develop the approach above.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: To continue and develop the approach below.
Comments: Processes are in place involving the Patient Experience team to review concerns. The RO is in regular contact with the GMC Liaison Officer to discuss any concerns. The Medical Disciplinary Policy has been extensively revised and ratified by the People and Culture Committee.
Action for next year: To continue and develop this approach.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: Formal disciplinary matters are reported to People and Culture Committee along with other professions. This report has narrative on numbers, type (conduct and capability) and breakdown of protected characteristics.
Comments: We will continue to work with Deputy Director of Human Resources, who is now engaged with the governance of Responsible Officer Advisory Group and is familiar with the practice of medical disciplinary policy.
Action for next year:

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: Continue with the plan to liaise with other ROs and stakeholders. Comments: Responsible Officer Advisory Group workflow will continue to support effective communication. Action for next year:

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Comments: Employee relations workstream is now being brought back in house and currently we are in transition. Maintaining High Professional Standards policy (medical disciplinary policy is not familiar for operational colleagues). Action for next year: Continue to work with Deputy Director of HR in educating non-medical colleagues about disciplinary policy for medics.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: Pre-employment checks are completed by Medical HR team focussing on registration, qualifications, DBS checks. Section 12 status and Approved Clinician Status was included as part of pre-employment check. We have access to the national database for Section 12 status and Approved Clinician status. Comments: Continue with current practice. This year we have done international recruitment and adhered to GMC guidelines for sponsor of international candidates. Action for next year:

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- **General review of actions since last Board report**

Medical appraisal within DHcFT has been the subject of significant focus over the past few years. Investment into the electronic platform L2P has allowed greater transparency on individual doctors appraisal status as well as streamlining and simplifying the overall process both for the individual doctor and the appraisal team.

- **Actions still outstanding**

Many actions in this report are ongoing and build on the previous year's work. There has been significant progress in raising the profile of appraisal and revalidation through the efforts of the RO supported by the appraisal team.

- **Current Issues**

At the end of the 2024/25 appraisal cycle (31 March 2025) four doctors remained significantly out of date with their appraisal (more than five years of no appraisals). All were working at Consultant Level within DHcFT. Since this time, one has retired. Escalation processes are in place for the other three doctors.

- **New Actions:**

Appraisal training to be delivered in November 2025.

Overall conclusion:

There has been significant progress in raising the profile of appraisal and revalidation through the efforts of the RO supported by the appraisal team. Continued work is necessary to ensure this progress is evidenced in our data.

Section 7 – Statement of Compliance:

The Board has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body
Chief Executive

Official name of designated body: _

Name: _ Signed: _

Role: _

Date: _

NHS England
Skipton House
80 London Road
London
SE1 6LH

This publication can be made available in a number of other formats on request.

Publication reference: PR1844

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 June 2025

Learning from Deaths/Mortality - annual report

Purpose of Report

The 'National Guidance on Learning from Deaths' requires each trust to collect and publish specified information on a quarterly basis. This report covers the period 1 April 2024 to 31 March 2025. The Board of Directors is requested to accept this report as assurance of the Trust's approach and agree for the report to be published on the Trust's website as per national guidance.

Executive Summary

The Trust received 2,182 death notifications of patients who had been in contact with our services in the last year. There is very little variation between male and female deaths; 1,145 male deaths were reported, compared to 1,035 females.

There have been 22 Learning Disability deaths in the reporting timeframe, two of which relate to patients with a diagnosis of autism.

The Trust commissioned 24 Learning Responses surrounding deaths through Case Record Review, of these four have been completed with no problems in care identified. There were three Patient Safety Incident Investigations commissioned, two are ongoing and one was completed with no problems in care identified. Learning emerging from Case Record Reviews and Patient Safety Incident Investigations (PSII) raises themes in relation to:

- Risk Management, comprehensive risk assessments being completed/reviewed to reflect needs, are individualised and holistic
- Communication and Teamwork, need to enhance communication between multi-disciplinary teams (MDTs) and the importance of open and transparent communication with patients and families
- Supporting staff with complex case management particularly around safeguarding, risk management and clinical decision-making in complex cases
- Patient Safety and Incident Reporting, developing a culture of openness, where incidents, near misses and concerns are reported, managed and responded to, to support the dissemination of learning.

The newly established Learning the Lessons Oversight Committee will hold oversight for actions resulting from Learning Responses, quality improvement plans, early learning and thematic analysis of incidents including deaths supported by subgroups within each service to improve ownership, accountability, joined up working.

Medical Examiner Officers have been established in all Acute trusts in England and their role will be extended to include deaths occurring in the community. The implementation of this process came into force on 9 September 2024. There have been system access issues impacting. The Patient Safety team will continue to meet regularly with the Medical Examiners to ensure the Trust maintains momentum in this area.

Good practice identified through case note reviews is fed back to clinicians involved as part of our appreciative learning.

A process has been implemented within the Electronic Patient Record, which aids staff in identifying deaths which meet the threshold for Datix reporting. This process fulfils stage one of the Learning from Deaths Guidance in that all deaths are considered for red flags.

Strategic Considerations	
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X

Risks and Assurances

This report provided limited assurance to the Quality and Safeguarding Committee that the Trust is following recommendations outlined in the National Guidance on Learning from Deaths.

Consultation

Medical Director
Quality and Safeguarding Committee, 7 May 2025.

Governance or Legal Issues

There are no legal issues arising from this report.

The Care Quality Commission Regulations - this report provides assurance as follows:

- Outcome 4 (Regulation 9) Care and welfare of people who use services
- Outcome 14 (Regulation 23) Supporting staff
- Outcome 16 (Regulation 10) Assessing and monitoring the quality of service provision
- Duty of Candour (Regulation 20).

Public Sector Equality Duty & Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

- During 1 April 2024 to 31 March 2025, there was very little variation between male and female deaths; 1,145 male deaths were reported, compared to 1,035 female deaths
- No unexpected trends were identified according to ethnic origin or religion.

Recommendations

The Board of Directors is requested to accept this Mortality Report with limited assurance of the Trust's approach and agree for the report to be published on the Trust's website as per national guidance.

Report presented by: **Lynn Andrews**
Chair, Quality and Safeguarding Committee and Non-Executive Director

Report prepared by: **Rachel Williams**
Lead Professional for Patient Safety

Louise Hamilton
Safer Care Co-ordinator

Davinia Connelly
Operational Patient Safety Manager

Learning from Deaths/Mortality - annual report

1. Background

In line with the Care Quality Commission's (CQC) recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a framework for NHS Trusts - 'National Guidance on Learning from Deaths'. The purpose of the framework is to introduce a more standardised approach to the way NHS trusts report, investigate, and learn from patient deaths, which should lead to better quality investigations and improved embedded learning. To date, the Trust has met all the required guidelines.

The report presents the data for 1 April 2024 to 31 March 2025.

2. Current Position and Progress

- Cause of death information is currently being sought through the Coroner offices in Chesterfield and Derby but only a very small number of cause of deaths have been made available. This will improve now that the Medical Examiners process of reviewing the Trust's non-coronial deaths is in place. The Trust continues to meet with the Medical Examiners on a regular basis
- Regular audits continue to be undertaken to ensure compliance with policy and procedure and any necessary amendments made. This has included auditing complaint data against names of deceased patients to ensure this meets the requirements specified in the National guidance. The last audit was completed 29 April 2025
- A process has been implemented within the Electronic Patient Record, which aids staff in identifying deaths which meet the threshold for Datix reporting. This process fulfils stage one of the Learning from Deaths in that all deaths are considered for red flags as identified under the national Learning from Deaths procedure. This is a significant improvement in process and will release capacity within the service to re-deploy into other priorities, such as actions and high-profile incident management. The plan will also allow for more joined up working with Corporate and Legal services ensuring better sharing of information and identification of priorities for both services
- The Mortality Case Record review panels were paused whilst processes around Mortality and Incidents were reviewed. Having completed amendments to the incident process and the inclusion of Mortality red flags it was agreed that the format and content of the Mortality Case Record Reviews panels required re-development. Works have commenced to re-design and better utilise the resource to provide a quality and assurance check to deaths closed to the incident review process at Incident Review Tool level. This has been discussed and agreed within the Executive Incident Review group chaired by the Trust Medical Director on 24 April 2025. The Trust Mortality Technical is currently working towards this revision with support from the Operational Patient Safety Manager (System)
- In line with changes being made to the assurance and oversight of learning post incident the Trust Mortality Committee has been replaced with the Learning the Lessons Oversight Committee. This committee will have oversight and governance responsibility for incidents which include Mortality red flags and be responsible for overseeing the dissemination of learning post incident. The committee will work with service line Learning the Lessons groups to develop and drive forward quality improvement programmes across the Trust.

3. Data Summary of all Deaths

Note that Inpatient and Learning Disability (LD) data is based upon whether the patient has an open Inpatient or LD referral at time of death.

The following table outlines information from 1 April 2024 to 31 March 2025:

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Deaths Per Month	186	169	176	171	153	179	200	180	208	221	173	166
LD Referral Deaths	4	2	3	0	0	0	1	2	2	4	2	2

Correct as at 10 April 2025

From 1 April 2024 to 31 March 2025, the Trust received 2,182 death notifications of patients who have been in contact with our services. Of these deaths, 1,145 patients were male, 1,035 female, 1,646 were white British and 40 Asian British. The youngest age was zero years, the oldest age recorded was 104. The Trust has reported 22 Learning Disability deaths in the reporting timeframe and two deaths of patients with a diagnosis of autism.

4. Review of Deaths

In line with national requirements, all deaths of a person who has been in contact with services in the six months prior to death are considered at Stage 1 Mortality review against Trust and national Mortality red flags. The table below details deaths which have been reported through the Trust Incident process as meeting a Trust or national Mortality red flag. These deaths are then subject to further scrutiny and consideration under the Operational Incident Review process for further Learning Response. Of these deaths:

- Two patients died on our wards receiving end of life care
- Two patients died following transfer to the acute hospital due to a deterioration in their physical health. One patient whilst on section 17 leave died unexpectedly
- Two patients died receiving end of life care at the acute hospital following transfer. One inpatient death (overdose in the community prior to admission) died following transfer to the acute hospital for further treatment
- One patient died on the ward due to a suspected suicide.

Figures are subject to change and impacted by issues such as data quality checks such as the rejection of Expected Deaths within community settings or Physical Health related Deaths under Substance Misuse services.

Incident Subcategory	Number of deaths
Suspected suicide - laceration	1
Suspected suicide - drowning	2
Suspected suicide - other	4
Death unexpected - accident	7
Suspected suicide - overdose	8
Suspected suicide - ligature	9
Death unexpected - alcohol use	14
Death unexpected - substance misuse	26
Expected - end of life pathway	27
Death unexpected - other	69
Death unexpected - medical condition/natural causes	96
Grand Total	**263**

Only deaths which meet the criteria below are reported through the Trust incident reporting system (Datix) and these are also reviewed using the process of the *Untoward Incident Reporting and Investigation Policy and Procedure.*

Any patient, open to services within the last six months, who has died and meets the following:

- Homicide – perpetrator or victim
- Domestic homicide - perpetrator or victim
- Suicide/self-inflicted death, or suspected suicide
- Death following overdose
- Death whilst an inpatient
- Death of an inpatient who died within 30 days of discharge from a DHcFT hospital.
- Death following an inpatient transfer to acute hospital.
- Death of patient on a Section of the Mental Health Act or Deprivation of Liberty Safeguards (DoLs) authorisation
- Death of patient following absconsion from an inpatient unit

- Death following a physical restraint
- Death of a patient with a learning disability
- Death of a patient where there has been a complaint by family/carer the Ombudsman or where staff have raised a significant concern about the quality-of-care provision
- Death of a child (this will also be subject to scrutiny by the Child Death Overview Panel)
- Death of a patient open to safeguarding procedures at the time of death, which could be related to the death
- Death of a patient with historical safeguarding concerns, which could be related to the death
- Death where a previous Coroners Regulation 28 has been issued
- Death of a staff member whilst on duty
- Death of a child under the age of 18 of a current or previous service user who has died in suspicious circumstances
- Where an external organisation has highlighted concerns following the death of a patient, whether they were open to the Trust at time of death or not
- Death of a patient with autism
- Death of a patient who had a diagnosis of psychosis within the last episode of care
- Death of a patient who had a diagnosis of an eating disorder within the last episode of care or within six months of discharge
- Death of a patient open to Crisis Home Resolution team or equivalent at the time of death.

5. Learning Responses for 2023/24 and 2024/25

The table below outlines the number of deaths that have been recorded through the Trust incident reporting system Datix and the learning response that has been commissioned. All deaths reported through the Datix system that meet the Trust 'red flag' will have an Incident Review Tool completed. This is then reviewed and a decision made as to whether a further Learning Response is required.

Financial Year	Datix	Case Record Review	Patient Safety Incident Investigation
2023/24	119 deaths	39	16
2024/25	141 deaths	23	3

Please note: 56 deaths are currently awaiting a decision.

6. Duty of Candour (DoC) for 2023/24 and 2024/25

During 2023/24 there were five deaths which met the criteria for DoC. There have been no deaths determined to be Duty of Candour for 2024/25. However, it should be noted there are Learning Responses for this period which remain active.

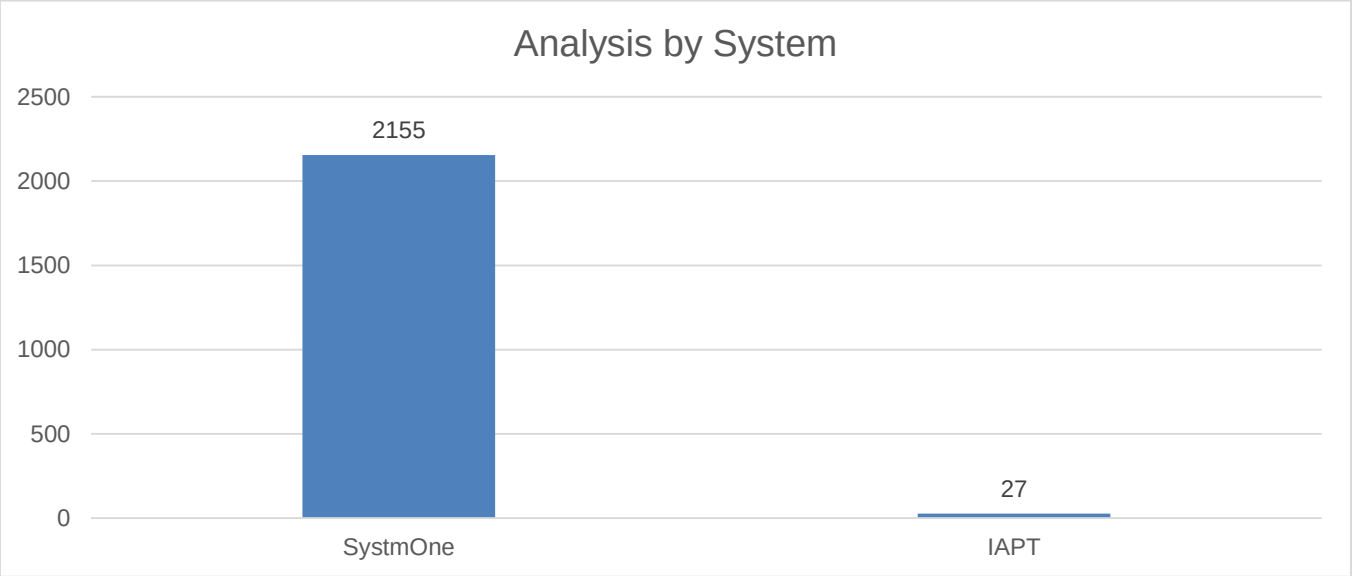
7. Learning from Deaths Procedure

The Trust has now completed a move in terms of its mortality process, a process has been implemented within the Electronic Patient Record which aids staff in identifying deaths which meet the threshold for Datix reporting. This process fulfils stage one of the Learning from Deaths in that all deaths are considered for red flags as identified under the national Learning from Deaths procedure. This is a significant improvement in process and will release some capacity within the service to re-deploy into other priorities such as actions and high-profile incident management. The plan will also allow for more joined up working with Corporate and Legal services, ensuring better sharing of information and identification of priorities for both services.

There is a process for weekly random audits of deaths against the red flags to provide assurance that the new process is working as intended.

8. Analysis of Data

8.1. Analysis per notification system since 1 April 2024 to 31 March 2025

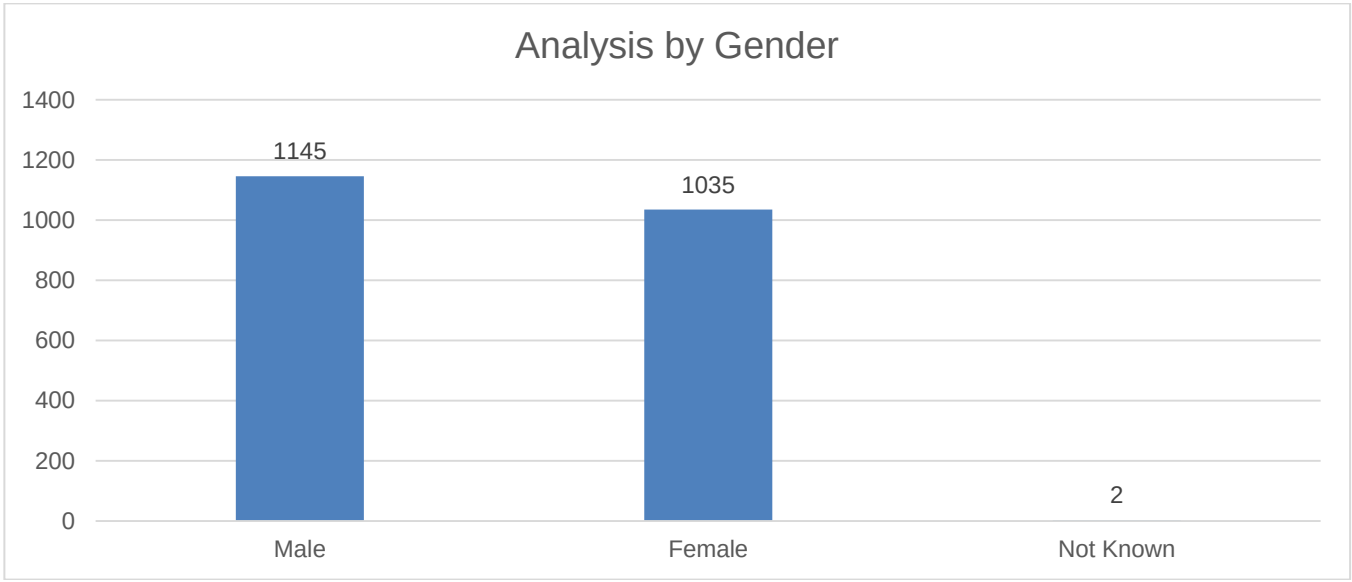


System	Number of Deaths
SystmOne	2,155
IAPT	27
Grand Total	**2,182**

The data above shows the total number of deaths reported by each notification system. The majority of death notifications were predominately pulled from SystmOne. This clinical record system is aligned to our largest population of patients and a population at greatest risk of death due to the proportion of older people in our care.

8.2. Analysis by Gender

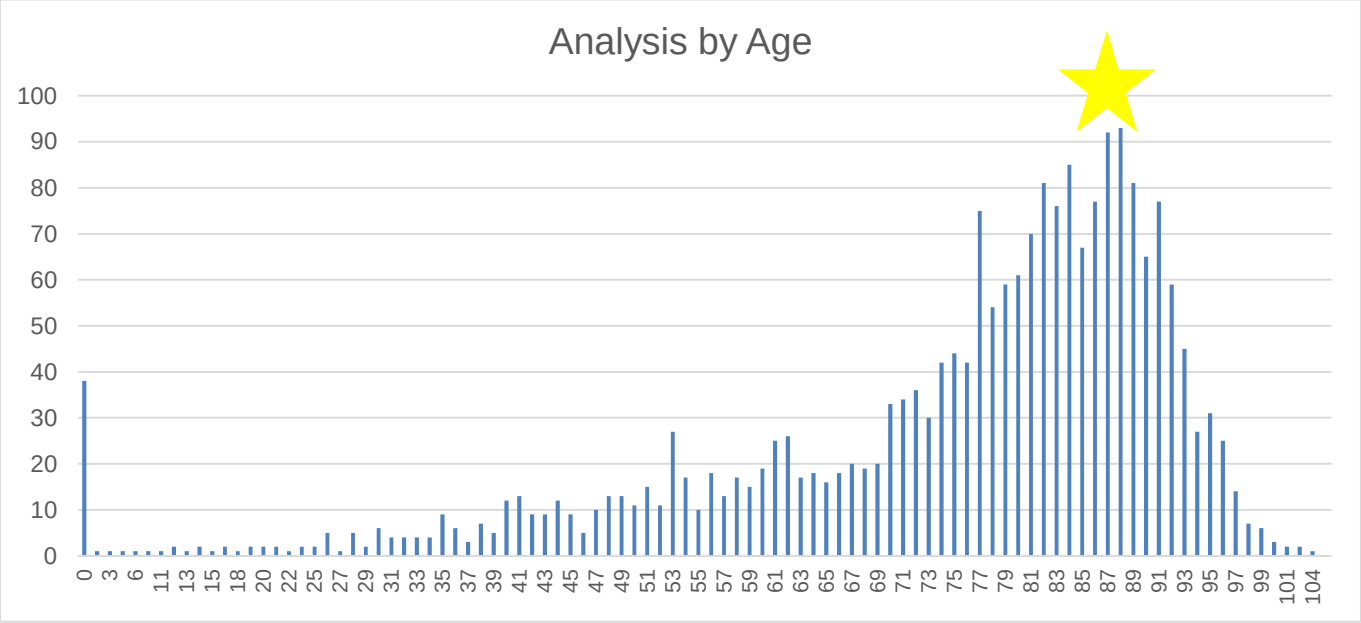
The data below shows the total number of deaths by gender 1 April 2024 to 31 March 2025. There is very little variation between male and female deaths; 1,035 female deaths were reported. compared to 1,145 males.



Gender	Number of Deaths
Male	1,145
Female	1,035
Not Known	2
Grand Total	**2,182**

8.3. Analysis by Age Group

The youngest age was classed as zero, and the oldest age was 104 years. Most deaths occurred within the 82 to 89 age groups (indicated by the star):



8.4. Learning Disability Deaths (LD)

The Trust reviews all deaths relating to patients diagnosed with a Learning Disability. The Trust also currently sends all Learning Disability deaths that have been reported through the Datix system to the LeDeR programme. Scoping is planned with operational services through their Learning the Lessons subgroups to consider the most appropriate management process for Learning Disability deaths moving forward.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
LD Deaths	4	2	3	0	0	0	1	2	2	4	2	2
Autism	0	0	0	1	0	0	0	0	0	0	0	1

Since 1 January 2022, the Trust has been required to report any death of a patient with autism. To date, fourteen patients have been referred.

During 1 April 2024 to 31 March 2025, the Trust has recorded 22 Learning Disability deaths. The Trust now receives a quarterly update from LeDeR which highlights national good practice and identified learning; this is shared in the Mortality monthly meeting.

8.5. Analysis by Ethnicity

White British is the highest recorded ethnicity group with 1,646 recorded deaths, 161 deaths had no recorded ethnicity assigned. The following chart outlines all ethnicity groups:

Ethnicity	Number of Deaths
White - British	1,646
Other Ethnic Groups - any other ethnic group	240
Not Known	139
White - any other White background	39
Asian or Asian British - Indian	23
Not stated	22
White - Irish	20
Black or Black British - Caribbean	15
Asian or Asian British - Pakistani	13
Black or Black British - African	8
Mixed - White and Black Caribbean	7
Asian or Asian British - any other Asian background	4
Mixed - any other mixed background	2
Mixed - White and Asian	2
Black or Black British - any other Black background	1
Mixed - White and Black African	1
Grand Total	**2,182**

8.6. Analysis by Religion

Christianity is the highest recorded religion group with 850 recorded deaths, 535 deaths had no recorded religion assigned. The chart below outlines all religion groups:

Religion	Number of Deaths
Christian	828
Not religious	626
(blank)	528
Church of England, follower of	52
Church of England	34
Christian, follower of religion	11
Christian religion	11
Methodist	10
Roman Catholic	10
Sikh	9
Catholic religion	8
Patient Religion Unknown	7
Muslim	7
Religion NOS	5
Atheist movement	4
Hindu	4
Buddhist	3
Jehovah's Witness	3
Islam	3

Agnostic movement	3
Catholic: non Roman Catholic	2
Rastafarian	1
Protestant	1
Anglican	1
Spiritualist	1
Atheist	1
Quaker	1
Nonconformist	1
Agnostic	1
Congregationalist	1
Church of Scotland, follower o	1
Follower of Church of Nazarene	1
Jewish	1
Baptist	1
Pagan	1
Grand Total	**2,182**

8.7. Analysis by Sexual Orientation

Heterosexual or straight is the highest recorded sexual orientation group with 1,448 recorded deaths, 725 have no recorded information available. The chart below outlines all sexual orientation groups:

Sexual Orientation	Number of Deaths
Heterosexual	1448
(blank)	615
Sexual orientation not given - patient refused	71
Sexual orientation unknown	19
Not stated (person asked but declined to provide a response about their sexual orientation)	12
Unknown	7
Bisexual	3
Female homosexual	2
Male homosexual	2
Lesbian or gay	1
Homosexual	1
Person declined to disclose	1
Grand Total	**2182**

8.8. Analysis by Disability

The table below details the top eight categories by disability. Gross motor disability was the highest recorded disability group with 430 recorded deaths:

Disability	Number of Deaths
Gross motor disability	430
Intellectual functioning disability	125
Emotional behaviour disability	73
Hearing disability	57
Disability Questionnaire - Behavioural and Emotional	37

Disability Questionnaire - Mobility and Gross Motor	20
Disability Questionnaire - Memory Adult	19
Disability Questionnaire - Progressive Conditions and Physical Health	14

There have been 983 deaths with a disability assigned and the remainder were blank or had no assigned disability.

9. Recommendations and Learning

Learning emerging from Learning Responses at Case Record Review or Patient Safety Incident Investigation level highlights improvements needed in relation to the following areas:

- Improving risk management to ensure that comprehensive risk assessments are completed and reviewed and that these accurately reflect the patient needs, particularly in complex/ high-risk patients and working to identify and mitigate risks early. This aligns to the development of the Trust Risk Assessment, Safety Planning and Suicide Prevention works which includes a training package and revised Suicide Prevention strategy with a Suicide Prevention lead now in place
- Ensuring that care plans are individualised and reflect the holistic needs of patients, including their psychological, emotional, and physical wellbeing
- Improving communication and teamwork, a re-occurring theme which identifies the need to enhance communication between multi-disciplinary teams (MDTs) and the importance of open and transparent communication with patients and families, particularly around critical decisions and care pathways. Promoting the importance of respecting patient preferences and involving patients and their families in care decisions
- Supporting staff with complex case management by identifying gaps in training and guidance, particularly related to safeguarding, risk management and clinical decision-making so they are equipped with the skills and knowledge they need to deal with complex cases
- Patient safety thread and Incident Reporting, to encourage a culture of openness where all incidents, near misses, and concerns are reported and acted upon. Ensuring that incidents are appropriately managed and responded too to support the dissemination of learning to reduce risk to patients.

The table below **Themes arising from Incident Learning Responses** provides more detail in relation to themes and improvement needs:

Improvement issue	Improvement plan
Transfer, Leave and Discharge.	**Transfer of the deteriorating patient** Transfer and return of patients between inpatient services for the Trust and Acute providers, including handover of information, and the way patients are conveyed. A quality improvement project has been undertaken between Derby Hospital and DHcFT to develop a transfer and handover proforma which is now in place. **Self-harm of patients whilst on leave from inpatient services and Section 17 leave arrangements** Issues in relation to leave arrangements for inpatient services including follow up. A further thematic review was completed on conclusion of a cluster of inpatient suspected suicide incidents. An action plan has been developed. This included a review of the pathway of communication and documentation (including risk assessments and care plan) between Crisis Resolution and Home Treatment/Community teams and Inpatient services when a patient is due to be on s17 leave/discharged. This will be reviewed within the Adult Acute Learning the Lessons Subgroup. A further four incidents for Inpatient services are scheduled to be included within an external thematic review commissioned by the Trust for 2025/26.
Suicide Prevention.	**Suicide Prevention training** The Trust has identified the need to re-establish Suicide Prevention training across services, this is being led by the Trust Medical Director and has been incorporated into the new Risk Assessment, Safety Planning training package under-development. A Trust Suicide Prevention Lead has now been appointed and this links into current training development as well as a review of the trust Suicide Prevention strategy.

Improvement issue	Improvement plan
Training and awareness of Emotionally Unstable Personality Disorder (EUPD).	Development of a training and awareness package for all services in relation to EUPD which is being led by the Trust Medical Director.
Multi-agency engagement following incidents.	It is known that patients are often known to multiple services both internally and externally. Works have been commissioned to consider agreements needed to enhance multi-agency working with partner agencies, when an incident investigation has been commissioned to improve shared learning and enhance family liaison and support.
Physical Health management within inpatient environments.	Quality improvement work in relation to improving physical healthcare management, observation, and care planning within Older People's services. A quality improvement programme will be developed with the Trust Physical Healthcare lead. Enhancement of wound care management and infection prevention and control investigation and follow up within inpatient services. Introduction of RESTORE2 into ILS training framework, including review of current ILS provision. Transition agreed to Level 2 and Level 3 resuscitation training and adoption of more recognition of Deteriorating Patient scenarios in training to aid clinicians (Bluebell Ward first adopter). Establish a Physical Health Reporting Working Group to establish the new system one reporting frameworks to improve reports for assurance. Introduction of RESTORE2 into ILS / Level 2 and level 3 training framework, including review of current ILS provision.
MDT process improvements within CMHTs.	Themes in relation to MDT processes within CMHTs and works are currently underway to review the EPR and recording documentation and MDT process to ensure this is fit for purpose and being adhered to.
Self-harm within inpatient environments, including management of contraband.	Adoption of the CQC/MHLD Nurse Directors forum guidance for ligature risk assessment processes. Risk assessment has new section on the risk assessment tool in the EPR. Quality Improvement programme in relation to self-harm via sharps of females within Inpatient services (local priority) - currently on hold. Improvement to environment – now using convex mirrors and zonal observations on female wards, changed ligature environment risk assessment. Improvement to therapeutic engagements. Improvement to risk assessment and management including observation levels - observation booklet in place. To continue commissioned working group to review handheld clinical devices and compliance with observations, including physical health observations. Ligature training package in place and is currently being rolled out including competency assessment. Green zone – within inpatient areas there is an area painted green which holds emergency equipment such as ligature knife, resuscitation equipment so is easily identifiable. Ligature Risk Reduction Working Group.
Dissemination of learning and service improvements following incidents, including	Work is underway to improve the way in which the Trust learns and improves from incidents. This will include a revision to the processes in place in relation to internal investigation recommendations, Case Record Review learning, Incident Review Tool learning and the revised Trust Mortality process. Develop pathway to offer clear governance processes.

Improvement issue	Improvement plan
assurance and governance.	Develop service line learning briefings specific to service learning. Trust-wide learning the lessons to share high-level responses and learning. Develop better ways for monitoring and reporting emerging themes. Joined up working between services. Improved monitoring of high-profile cases and joined up working between services involved. Development of more collaborative Learning Responses.
Application of red flags and flow of incidents resulting in death.	Improvement in the application and identification of red flags for reporting death. Revision of current red flags for relevance given changes both nationally and locally. Redesign the function of the 'Mortality' process within structures through the Learning the Lessons subgroups. Review the purpose and function of the Mortality Case Record Review panel and redesign this to one of audit and assurance.
Interface between Mental Health and Substance Misuse services.	Suspected Suicide of a patient who has a dual diagnosis of substance misuse and mental health but has been rejected by Community Mental Health services is an area which has been noted through Case Record Review. This has been selected as a new local priority for the Trust. Themes will feed into Learning the Lessons subgroups for both services to jointly develop an improvement plan.
Substance Misuse services and Adult Acute Inpatient environments.	Learning Responses for unexpected deaths post-discharge/whilst on leave have highlighted gaps around knowledge, support and process for the management and support of risk in relation to addiction and substance misuse. Currently several actions in place. Improvement plan to be developed and managed through the services Learning the Lessons subgroup.
Risk assessment, management and care planning.	This is an area which repeatedly shows need for improvement and the trust is currently finalising a Safety Planning training package which will consist of four modules and incorporate suicide prevention.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 June 2025

Special Education Needs and Disabilities (SEND) annual report

Purpose of Report

To meet the quality requirement in schedule from Derbyshire ICB to provide an annual report of SEND.

Executive Summary

The requirement from the ICB states that our current position and future plan of development in relate to SEND in the follow areas.

1. SEND self-assessment and action plan
2. Quality Assurance of health advice - audit
3. KPI performance- SEND Dashboard
4. Staff training
5. CYP/family's satisfaction, feedback & co-production
6. Governance- how does the SEND workstream fit within the organisation
7. Transition to adult services

This was a new requirement for 2022/23; therefore, this is the third annual report.

Strategic Considerations	
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X

Risks and Assurances

The Trust has limited assurance in some areas of the report due to the new nature of the requirements.

Consultation

All service lines within the Children's Division have been consulted and some limited involvement from Adult Learning Disability and Neurodevelopmental services. Feedback from children/young people and their families has been included.

Governance or Legal Issues

- Children and Families Act 2014
- Ofsted and CQC SEND inspection framework
- Quality and Safeguarding Committee, 7 May 2025.

Public Sector Equality Duty & Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation)) including risks, and say how these risks are to be managed.

Below is a summary of the equality-related impacts of the report:

The aim of the report is to improve access and outcomes for children with Special Educational Needs and Disabilities in Education and Health. No protected characteristics should be disadvantaged by this report, but it is limited under 25 years of age. This limit is set by legislation.

Recommendations

The Board of Directors is requested to:

1. Review and comment on the report
2. Accept limited assurance in some areas of the report due to the new nature of the requirements.

Report presented by: **Lynn Andrews**
Chair, Quality and Safeguarding Committee and Non-Executive Director

Report prepared by: **Susan Walker**
SEND Clinical Co-ordinator

Annual Report of SEND

Introduction

This is the third annual report for Derbyshire Healthcare NHS Foundation Trust (DHcFT) regarding Special Education Needs and Disability (SEND). The Children and Families Acts 2014 Section 3 first introduced significant responsibilities for health, social care and education to work closely together to improve outcomes for children and young people (0-25 years old) who have special education needs or disabilities.

These reforms where monitored through the first round of local area SEND inspections (joint CQC and Ofsted) up to 2022. The new Framework of SEND inspection has been in place now for two years. Derbyshire Local Area (Derbyshire County Council area) was inspected in September 2024 which found "widespread and/or systemic failings leading to significant concerns about the experiences and outcomes of children and young people with special educational needs and/or disabilities (SEND), which the local area partnership must address urgently" (Ofsted/ CQC 2024). Focus has been on how the local area can demonstrate it makes a positive impact on outcomes for this group of people. Derby City are expecting their inspection by the end of 2025.

In response to the new SEND inspection framework, the Integrated Care Board for Derbyshire (ICB) has updated some of its requirements as part of the quality assurance for services who see people up to the age of 25. This report has been completed to meet this requirement and will support the priority action plan in Derbyshire and planning for inspection in Derby City.

The requirements for this report are:

1. *SEND self-assessment and action plan*
2. *Quality Assurance of health advice - audit*
3. *KPI performance - SEND Dashboard*
4. *Staff training*
5. *CYP/family's satisfaction, feedback & co-production*
6. *Governance- how does the SEND workstream fit within the organisation*
7. *Transition to adult services*

SEND Self-assessment, Local offer and Action Plan

The Local Offer websites for both Derby City and Derbyshire have been audited to ensure that our services information is on the website and is up to date. Both areas local offer websites provide a brief description of the services and the appropriate link to the Trust website to ensure information is up to date. This was last audit by the SEND Clinical Co-ordinator in March 2025.

The SEND self-assessment for the last 5 years has been regularly completed by the Service leads and SEND Clinical Co-ordinator and has been updated April 2025. Please see Appendix A. This is reviewed by the Senior Leadership team in the Children's Division and updated of progress report are sent quarterly to the Children's COAT.

Significant progress has been made on this self -assessment, particularly around the access of information to be able to identify children and young people with an Education, Health and Care Plan (EHCP) and having clearly and reliable processes to meet our statutory responsibilities regarding the EHCP assessment process. We have a good relationship with the ICB and both Derby City and Derbyshire Councils' SEND departments and supporting initial assessment and those which are going the SEND extend tribunal appeals through our well establish SEND Single Point of Access (SPA).

To support the assurance of this the SEND oversight group has supported the work of the SEND Clinical Co-ordinator. A SEND Policy is now in place which would apply across the Trust to ensure we meet our responsibilities under the Children and Families Act 2014 and ensure that we support the "Local Areas" of Derbyshire and Derby City to be inspection ready. It also gives guidance to support services if there are disputes about what advice can be given and the escalation process if needed.

Planned Development

The terms of reference for the SEND oversight meeting are currently under review due to the change of governance structure for SEND and the trust's recognition that it covers all services which see up to 25 years old.

Quality Assurance of Health Advice- Audit

The quality schedule from the ICB and the Children and Families Act 2014 states that we must provide good quality health advice for Children and Young People who are receiving a service from the Trust within six weeks of request as part of the statutory assessment process for EHCP. An audit tool was developed in partnership with the ICB and other local health providers to meet the NHS standards for report. We have also completed random sample audits in each service and results have been fed back to services.

Service	Compliance in audit
Children's Occupational Therapy	98%
Children's Physiotherapy	100%
Community Paediatrician	100%
ADHD Nurses	100%
CAMHS	100%

Other services have not been randomly audited as they complete less than 10 reports per year.

Most services in the Trust are using the check list of NHS standards to have quality assurance by the clinical lead before every report is sent to the Local Authority. This is reflected in the results of the audit. These are very positive results. We are still getting the occasional abbreviation, but generally the reports are of a high standard, and we have received positive feedback from the ICB regarding the high quality.

There is a standard template for providing the advice which was introduced this year. Services have developed some standards phased for the provision that will offered which can be tailored to the individual. This was an area of development identified in the last SEND annual report. However, there has been concern raised since it's introduced about the amount of clinical time each report takes and alongside the increase in number of requests for Health EHC assessment advice (see Performance). The amount of time for report writing is impacting on the delivery of services.

Planned Development

The SEND Clinical Co-ordinator has had discussion with the DCO (SEND) to see if it is possible to combine standard clinic letters with the need to provide this advice. Health's legal responsibilities are to provide advice, but provided all the areas are covered there is no requirement to be presented in a particular format. It is the local authority's responsibly to write the EHCP from the information provided. Therefore, the plan is to look at developing clinic letters, initial with the Community Paediatrician which met the EHC quality audit plan. If this is successful in reducing administration time, to then roll out to other services. This will need to be audited to ensure that we continue to meet the quality standards for professional advice.

KPI Performance- SEND Dashboard

The only KPI we are currently being asked to report on is the compliance with the statutory six-week timescale for providing EHC health advice as part of the initial EHCP assessment.

Summary of KIP data across Derbyshire and Derby City

Letter Requests/ Number of Plans	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Letter1	67	82	84	98	27	34	66	46	42	0	0	10
Letter2	121	95	89	142	114	208	123	148	114	193	138	197
EHCP Draft	39	67	66	76	1	0	8	31	40	2	6	0
EHCP	74	117	45	99	62	40	28	32	32	13	45	19

Response Times (by Month of Response) for Children Open in Reporting Year	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
No. Letter 2 Responses with Preceding Letter 2	151	117	90	130	112	126	202	141	137	126	191	202
No. Letter 2 Responses within 42 Days	151	117	90	130	112	126	201	141	137	126	191	202
Letter 2 %	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	99.50%	100.00%	100.00%	100.00%	100.00%	100.00%
No. Letter 2s where Response Date Deadline Falls in Month (42 days after Letter 2 Request)	180	144	77	91	134	141	75	229	130	148	111	162
No. Letter 2s Due where Response Recorded and Within 42 Days	180	144	77	91	134	140	75	229	130	148	111	162
% Letter 2s Due where Response Recorded and Within 42 Days	100.00%	100.00%	100.00%	100.00%	100.00%	99.29%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

This compliance is a significant achievement, particularly as the demand for EHC health report has again grown by 13% this year, having increased by 41% the previous year and with the loss of the temporary support role of the SEND Process Co-ordinator in December. This will present a challenge in how the service will continue to maintain the compliance.

There have been significant challenges within these processes this year with Derbyshire County Council introducing a new electronic system Derbyshire EHC Hub (by IDOX). This system was introduced without going through Joined Up Derbyshire processes and initially presented challenges around data governance and training of staff. Therefore, the Trust, alongside all other health providers with the support of the DCO (SEND) have only agreed to use the system in a limited way to reduce the risks involved. We have a health working group for the system and have had intermittent engagement from Derbyshire County Council.

We have had recent improvement in communication with the appointment of a new Assistant Director, who has responsibility for oversee the EHCP processes.

We are now able to report and give a wide picture to evidence we meet SEND requirements. This includes the statutory requirement to notify the local authority of children under statutory school age who have or may have SEND (however it is not a formal KPI). The 0-19's service now notify the local authority when they refer an under 5 to a specialist service or receive correspondence to indicate they have a disability from a specialist service not within our organisation as part of the disability pathway in the 0-19 service. The Community Paediatricians also complete this notification if a child is diagnosed with a disability, their SystmOne template was not able to be record the notification read code. This has been updated, and we are able to provide data on the number of notifications we have completed.

Local Authority	Apr, 2024	May, 2024	Jun, 2024	Jul, 2024	Aug, 2024	Sep, 2024	Oct, 2024	Nov, 2024	Dec, 2024	Jan, 2025	Feb, 2025	Mar, 2025	YTD
Derby City Council	18	33	21	12	16	19	38	15	28	26	25	28	279
Derbyshire County Council	4	2	3	4	2	1	1	0	3	0	2	2	24
Total	22	35	24	16	18	20	39	15	31	26	27	30	303

The other request for data is for waiting times for children and young people who have SEND. There is significant difficulty in identifying this cohort of children and young people. We can identify children and young people who have an EHCP, but it is significantly more difficult to identify children and young people who have a special educational need without disability or those who have SEND but being supported at SEND support/ graduated response level. This is a national issue as the definition of SEND is that the health or social care need, needs to be having a significant impact on education which cannot be met through normal reasonable adjustments and it's not diagnosis led. Therefore, without education data of which children are considered to have SEND we are unable to identify accurately which children we should be reporting on. The ICB has now agreed that our stance is that we can only reliable identify those with an EHCP. The quality assurance schedule for the contract is now requiring all health providers to have a visible flag on the health record for those who are known to have an EHCP. Our Trust has this in place for a number of years.

Our data around statutory compliance for EHCP should be considered an area of strength as we are able to provide consistent good quality data to the ICB.

Planned Development

As we continue to develop our Neurodevelopmental pathway the SEND Footprint Assurance Group have requested a quarterly report on Care Education and Treatment Review (CETR) and the dynamic support register to be presented at this meeting.

The Trust alongside other health care providers and ICB will continue to work with Derbyshire County Council to improve the processes to embed the new Derbyshire EHC Hub (by IDOX). We are currently only using it for initial assessment in the SEND Single Point of Access (SPA) for the Trust. Derbyshire County Council would like for it to be also used for Annual reviews of EHCPs, which we do not have any data on and was an area of development identified in the SEND inspection particularly post 16.

The SEND inspection also requested data which shows the impact services around outcomes for young people with SEND. The SystmOne modules in the Children's Services have now got the ability to record Goal based outcomes. In CAMHS they are being used. However, the use of these is still in development as for a significant number of our children's services the goal can be to maintain skills and development instead of improvement, due to the degenerative nature of the conditions the children's and young people have. Therefore, we need to develop our understanding of what we are measuring.

Staff training

We have extended SEND training from just the Children's Division to all services which see those under 25 years old. SEND Basic Awareness was added to all staff's training passports who are in both clinical and service development roles in November 2024. We are using the recommended Council of Disabled Children's e- learning.

	meets requirement	
Division	**n**	**%**
383 Operational Services	**1085**	**68%**
383 Adult Care Acute	**256**	**59%**
Role specific	256	59%
383 Adult Care Community	**152**	**55%**
Role specific	152	55%
383 Children's Services	**324**	**85%**
Role specific	324	85%
383 Clinical Serv Management	**66**	**93%**
Role specific	66	93%
383 F+R and Specialist Services	**172**	**65%**
Role specific	172	65%
383 Neuro Developmental	**59**	**68%**
Role specific	59	68%
383 Older Peoples Care	**19**	**79%**
Role specific	19	79%
383 Psychology	**37**	**67%**
Role specific	37	67%
383 Corporate Services	**22**	**49%**
383 Med Education & CRD	**1**	**13%**
Role specific	1	13%
383 Ops Support	**3**	**100%**
Role specific	3	100%
383 People + Inclusion	**1**	**100%**
Role specific	1	100%
383 Clinical Quality Directorate	**10**	**50%**

Role specific	10	50%
383 Training	**6**	**60%**
Role specific	6	60%
383 Delivery, Strategy, Performance & Transformation	**1**	**50%**
Role specific	1	50%
383 Central (L3)		**0%**
Role specific		0%
Grand Total	**1107**	**67%**

However, there is other training available in Training passports which support the SEND and reasonable adjustments agenda. This across the whole of the Trust (all ages):

Course	Not completed	Completed	Total
The Oliver McGowan Mandatory Training on Learning Disability and Autism	380	2,281	2,661 - 85.72%

Training has also been delivered in response to an identified need to change practice to CAMHS, following concerns raised by the DCO (SEND) and local authorities. The identified area was although them were very good at writing high quality advice for formal EHCP requests for advice, they were less clear about what to do of when parents requested support letters of educational placements. Training has been delivered to all teams with CAMHS by the SEND Clinical Co-ordinator.

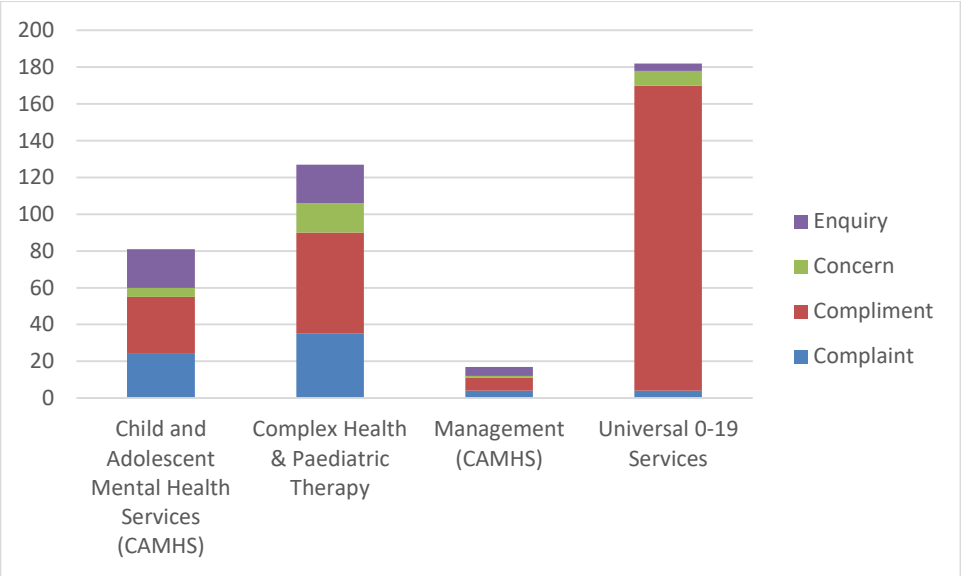
We have also looked to increase people's general awareness by adding SEND information as part of the safeguarding information sharing document which goes to all team meetings monthly across the trust in COAT and shared by the named nurses from the safeguarding unit.

Planned Development

The new SEND policy will need to be audited for us to have assurance we are compliant with our responsibilities. From this audit process any further training needs will be identified, and we aim to develop an action plan for this.

CYP/family's satisfaction, feedback & co-production

Within the Trust we have a range of methods to receive feedback and satisfaction. Datix is used to record compliments, concerns, and complaints. This system allows the monitoring of themes and that actions have been completed around areas of development identified.



One of the main themes from concerns and complaints is around waiting times for services, particularly for Neurodevelopmental assessments. The main issue is demand is outstripping capacity.

The current demand for assessments is approximately 300 new referrals per month (this has reduced by approximately 25% over the past 12 months), while our existing capacity allows us to see around 130 new cases per month (this has increased by approximately 20% over the past 12 months). Even in recognition of the improvements made to managing demand and increasing our productivity, this disparity between demand and capacity has contributed to the growing waiting list.

Our recovery plan focuses on a multi-faceted approach, addressing both the immediate backlog and the underlying system issues contributing to the increased demand and capacity constraints. Key areas of focus include:

- Addressing the Referral Pathway: We are undertaking a thorough review of the referral process, particularly focusing on areas where alternative support or information could be provided prior to formal assessment. This involves working with primary care providers, schools, and the Local Authority to ensure referrals are appropriate and that families have access to early intervention strategies
- Enhancing Internal Efficiency and Productivity: We continue to explore opportunities to optimize our current assessment processes and workflows to increase the number of children we can see each month. This has involved:
  - Reviewing staffing models and skill mix to ensure the most effective use of our workforce. We have increased the number of Non-Medical Prescribers and Band 4-6 in support of the ADHD pathway and a nurse post to support Doctors manage the increasing number of EHCP requests
  - Review of pathways in line with the service specification and priority groups
  - Implementing standardized tools (EHCP template) and protocols to improve efficiency without compromising quality
  - Exploring the use of digital technologies to streamline administrative tasks and improve communication with families
  - Providing further training and development to schools and ND hubs to support opportunities for earlier intervention

- Exploring Options for Increased Capacity: Alongside efficiency improvements, we will actively explore options to increase our overall assessment capacity. This includes:
  - Investigating the feasibility of recruiting additional clinical staff
  - Exploring partnerships with other organisations / providers to deliver assessments
  - Piloting innovative service delivery models, such as the early year pilot with Speech and Language Therapy targeting pre reception children (reduced time taken to be seen, reduced the number of specialist assessments and improved the patient journey and outcome).

We continue to work collaboratively with families, service users, and stakeholders to develop and implement this recovery plan. Regular monitoring of progress is via the ND oversight group, reporting through to COAT, DCC SEND Board and the CYP JUCD Board.

The friends and family test are operational across all services although its use and feedback is inconsistent across services.

Response to Friends and Family test April 2024-March 2025:

Count of Response	Column Labels					
Row Labels	**Very poor**	**Poor**	**Neither Good nor Poor**	**Good**	**Very Good**	**Grand Total**
CAMHS	26	18	26	49	57	180
CIC THERAPY&COMPLEX NEEDS	2	2	3	6	8	21
UNIVERSAL 0-19	5	4	7	29	53	100
Grand Total	**33**	**24**	**36**	**84**	**118**	**301**

This test also only provides a snapshot about how an individual feels around the appointment they have just had does not give a detailed outcome or feedback. For this reason, the Trust has developed an electronic patient survey.

The following teams in Children's are now involved with the electronic patient feedback initiative:

- CAMHS Triage and Assessment team
- CAMHS Crisis and Home Treatment team
- CAMHS ID
- CAMHS ED
- CAMHS Recovery team
- CAMHS Liaison team
- CAMHS Day service
- Derby and South Derbyshire Children's Therapist services
- Derby City Child and Family Community Paediatrics Unit
- Derby City Child and Family Specialist Nursing

The survey was conducted on a staged approach commencing March 2024. Since commencing we have collected 337 responses in the annual period.

The results are collated at different points of the CYP journey, this is currently at three months, six months and/or discharge, depending on the service and appointment times the services collect at different points, this will be developed in the future around service requirements once embedded. This function is via SystmOne, SMS or a QR code that has been added to letters in some teams and posters which are on display in clinical settings. Mainly we find the feedback is positive and supportive and where service change is underway the results often reflect this.

- Through the collection of data the themes of having to wait for long periods of time, having to see A&E doctors and suggestions of other places to assess young people in mental health crisis was noted. Work around this is being completed jointly with the CAMHS Crisis Team and Liaison to make sure that there are not unnecessary waits for young people, especially overnight in UHDB
- Ongoing work with UHDB to look at how they triage young people who come into the department and how we most effectively work together
- Ongoing work to develop Crisis Teams and professional awareness of Crisis Team so there are other options for young people beside A&E when urgent mental health assessments are needed
- Ongoing work in regard to flow of service to work on cutting down waiting times for young people who need CAMHS support
- Care Plans and Safety plans being sent out to the family by post following their 7/14 day follow up with the CAMHS Liaison team
- Development of the MCM questionnaire to capture the demographics of the young people attending A&E to get a better understanding of where more support is required to reduce the need for hospital attendance in order to access support given the community pathways that are now in place
- Development of a safety netting sheet that is being handed to all families who are assessed by the CAMHS Liaison Team with signposting to support services available if more support is needed
- In Liaison significant increase in reports of care plans and safety plans being completed and evidence of young person and parent involvement in these care documents with 5 out of 6 respondents feeling they received good self-help advise which is something that the team have been working on and continue to work on
- Parents felt involved in care plans – 100% respondents reflected this in the recent data for Liaison
- For the complex health services, the data received continues to show mixed information regarding feedback from service users. There continues to be request for need of ongoing ASD support
- Parental expectations appear to cause difficulty particularly if there have been waiting times
- Positive qualitative data evidenced regarding good child focussed care
- An increasing number of positive comments, overall responses are positive around communication personable experience. Evidence that families prefer consistency with staffing. Positive child friendly approach
- Transformation continues in services for the ADHD and ASD pathway
- CAMHS Triage and Assessment Team feedback was mainly positive with a theme of responses reflecting feeling comfortable in environment and with staff, felt listened to, explained everything, staff were compassionate and understanding, directed to correct services and treated as an equal.

Within the Trust there is a range of co-production activities. This includes:

Involvement of carers in particular projects such neurodevelopmental pathway transformation. Feedback from families has influenced the support being offered whiles they are waiting for assessment and the use of the ND Hubs.

Public Health Nursing teams and Derby City has been working really hard in embedding the offer for families who have children with SEND and also the preventative measures that can be put into place to support families before they hit crisis. The Family Hubs have a range of services based there including Health Visiting and some specialist health services, alongside early years support from Derby City Council. The family hubs have a regular parent carer panel where they discuss support needs and where the gaps/ improvements in service are needed. From these meetings the hub has had significant investment in parenting courses covering helping to manage children's behaviour, sleep and toileting support. There is an offer for support with children who struggle to eat a balanced diet.

There has been investment in specific support for children who's development is outside the normal range to support them to understand if a Single point of access (SPOA) referral would be beneficial and what the process is. Feedback from this group has had a low response rate but the response received have been positive.

Response from text survey following group December-March:

Question	Outcome	Number of responses
Did you find the group useful?	Yes	16
	No	2
Were you clear about the next steps and plan for your child?	Yes	16
	No	2

There was also some feedback to a member of staff who is involved with this group by text after follow-up appointment with Paediatrician, "I've had appointment today and I've got a diagnosis. They've diagnosed him with Autism. It's overwhelming but deep down I already knew it's been a hard and long journey, but you've helped me so much - thank you so much."

A significant project is being currently undertaken to understand about what would benefit young people who are being transitioned to adult learning disabilities health services. The Trust has held three events:

- In conjunction with the DCHS Quality Improvement team and Umbrella, a focus group was held for service users with a Learning Disability, to get their input on experiences of transition and ideas for improvement in transition
- In conjunction with the same teams above a carer group is booked in with Umbrella to get feedback from carers on transition
- In conjunction with the DCHS patient experience team a questionnaire was produced and sent out to health and social care partners to get input from carers (and where applicable individuals with a learning disability) on what works well in transition and what could be improved.

The outcomes of these events are still being evaluated, with the aim to improve our current transition processes.

Another project was around Adults with learning disability from ethnic minority backgrounds are members of two marginalised groups facing 'double discrimination'. Barriers faced by this population lead to poorer health outcomes.

According to Learning from Lives and Deaths - People with a Learning Disability and Autistic People (LeDeR), the median age at death for people with learning disability from ethnic minority backgrounds is 34 years compared to 62 years for people from a 'white' background with a learning disability, who died in the period between 2018 to 2021. The aim of this project is to raise staff awareness of ethnic minorities with a learning disability and address barriers to their engagement with learning disability services and recruitment into research.

Tailored training sessions were developed based on local service and population data, in the context of published literature on known inequalities. Seventy-three staff members within the Adult Neurodevelopmental service across Derbyshire Healthcare Foundation Trust (DHcFT) and Derbyshire Community Health Services (DCHS) attended the sessions.

Seven adults with a learning disability from ethnic minority backgrounds and six carers took part in face-to-face interviews or focus groups. They were asked about their experiences with healthcare, learning disability service, and perceived importance of research, as well as how to break down barriers to healthcare and research. The general themes include: 1) Increased awareness raising and outreach; 2) Longer appointment times if needed; 3) Accessible information format, eg video and information in different languages; 4) Cultural competence in the workforce. One contributor shared that healthcare felt more difficult once transitioned into Adult services, particularly mentioning that the Doctors spoke to her mum and not to her. She also identified other barriers to healthcare such as the lack of willingness for staff to understand the struggles she experiences related to her culture. Overall, patient and public contributors thanked us for the opportunity to share their views and recognised the importance of coproduction.

Action plans for improving service access and increasing research participation were created based on staff feedback, patient and public involvement interviews and focus groups. The service is currently in the process of implementing these actions.

This project is part of a wider workstream funded by the East Midlands Clinical Research Network, National Institute of Health Research (NIHR) – targeting under-served communities in research 2023/24 funding.

Employed Parent Carer Peer Support Workers in CAMHS provide weekly support groups as well as 1:1 support for any parent or carer with a child open to the CAMHS service including parents of children and young people who are on CAMHS waiting lists. When there is an employed Young Person Expert by Experience in post they lead a fortnightly "Our Peer Space" group which offers a social space where participation occurs organically and, again, is open to any young person open to CAMHS; these groups are supported by the Lundy model and incorporate occasional formal working groups run by the Young Person Expert by Experience which have historically been attended by a diverse mix of young people, and we hope that the same will be achieved once our new Young People Expert by Experiences have commenced in post. There are clear feedback loops into clinical and operational structures in relation to the work undertaken within these groups and the CAMHS Advisory Board (chaired by the Lead Young Person Expert by Experience (when in post) and attended by a diverse workforce (including managers) is an integral part of this process.

The participation team is also proud to have piloted voluntary roles for people with lived experience and was the first service within the Trust to implement this within their work. We are looking to further this over the upcoming months both for young people with lived experience and for parents of young people with lived experience.

The Young Person Expert by Experience also oversees the successful running of the Summer Programme which offers children and young people open to CAMHS a diverse range of social and creative activities over the long summer holidays – this includes adjustments being made to activities to ensure they are accessible to all the children and young people open to CAMHS.

In addition to facilitating specific spaces for parents and carers, all members of the participation team offer lived experience consultancy within all service developments across CAMHS and the wider network, representing the voice of children, young people and families. Some examples of this are; being on interview panels, completing audits of clinical environments from a lived experience perspective, working with the complaints team to improve communications between systems and diverse families, and sitting within the working groups which are focussed upon QNCC accreditation.

There is also have a formal voice through the Patient and Carer Experience Committee which feeds into the Quality Safety Committee and Trust Board.

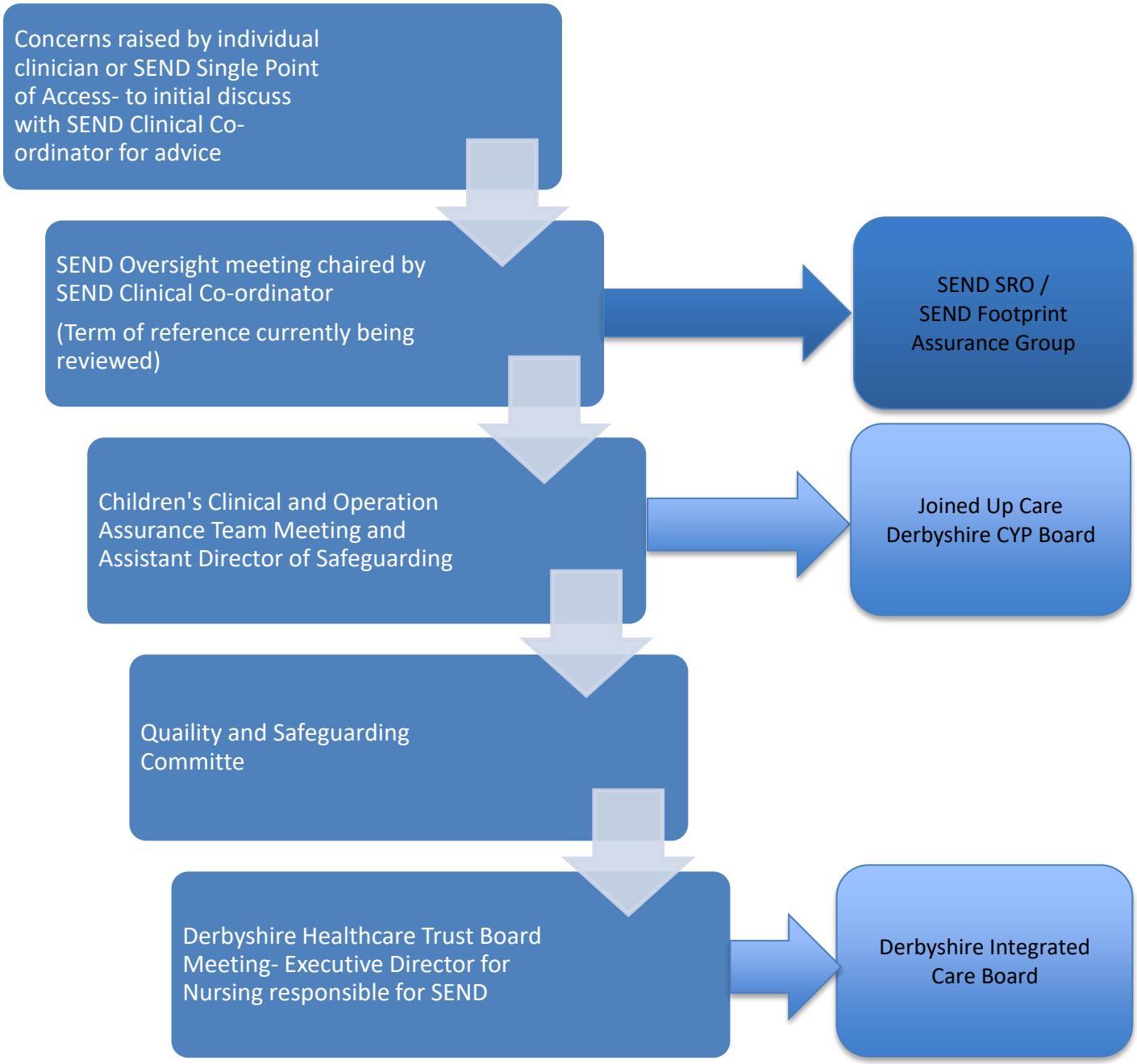
Planned development

The services will continue to receive feedback from the electronic patient survey. Themes from these surveys will continue be review by teams and the information will continue to be use as part of service development, this is then reported on in the Patient Experience Committee through the PEC report. The proposal is to develop a “you said we did” section for each service on the Trust website to complete the circle of feedback to the local area. This will be managed by an identified within clinician the team for each team/service.

The development of the neurodevelopmental pathway will be continued in a co-produced manner. Supporting families while waiting with the new ND hubs is work that will be continued which will hopefully support the themes from the concerns/ complaints around waiting times.

Governance- how does the SEND workstream fit within the organisation

Derbyshire Healthcare FT SEND Escalation Standard Operating Procedure



Transition to Adult services

We currently have a transition from CAMHS to adult mental health service policy. Most services have locally held standard operating procedures or processes for transition to the equivalent adult service where it exists normally in our partner health providers. We also have a young adult service cover, up to the age 25 for occupational therapy (physical health) and physiotherapy. However, this is not currently captured in an overarching policy. This was identified in the previous SEND report and work in this has been delayed. The Adult Neurodevelopmental service have appointed a Transitions Lead whose role is to scope the need and identify the support needing in transiting into these services. The SEND Clinical Co-ordinator is involved with to ICB lead Transition strategy who work is due to be completed soon. Therefore, both of this piece of work need to be completed before an overarching policy can be developed.

The numbers of young people who are needing to be transitioned from CAMHS to adult mental health services is low. The care co-ordinator can develop an individual plan with the young person and adult services to transition them across. Transition from Children's services to adult mental health services for those who need a continuation of their Attention Deficit Hyperactivity Disorder (ADHD) medication now works well and there is good communication between the services.

There does remain a significant issue though for those wishing to start ADHD medication or are not on a stable dose as our adult mental health teams are not commissioned to support this. The global shortage of ADHD medication has made this a more significant issue is impacting on more young people. The ADHD nurses and Community Paediatricians are working hard to get young people back onto medication safely as the supply chain becomes has become more stable. However, medication supply can still sudden become not available. this has created a significant back log of young people who need titrating back on to medication or those newly diagnosis starting medication. The introduction of the "right to choose" providers has given a pathway for those who have not managed to be started on medication due to the length of waiting lists before their 18th birthday.

We have developed a system which alerts clinicians if the young person they are working with is entitled to a learning disability annual health check, which is overdue. This is currently only operational in the Mental Health units of our SystmOne (not children's physical health services). Whereas the responsibility for health check remains with the GP, the aim of this is to encourage young people to start accessing their GP services to support the transition to primary care from specialist services.

<u>Planned development</u>

The most challenging areas around transition remain where there is no equivalent adult service. Clinicians work with the young person and family to find the best available support on an individual basis. Predominantly these are young people with an intellectual disability or neurodiversity which does not meet the criteria for specialist services. The use of being able see which young people with an intellectual disability are not accessing their health check, is an area we need to explore to see if this would benefit young people in our other services. There is further work needed to be done with universal services, predominately GP services in how we support accessing primary services having been supported by children's specialist services, building on the work done around annual health checks.

Summary and Future Plans and Developments

The previous SEND Inspection framework focused on quantitative measures around timeliness of EHCP and quality of contributes from professionals. This we have completed successfully and received some positive feedback from the DCO (SEND).

The new inspection framework is more focused on outcomes and the experience of young people and their families. As a health provider we are seen as responsive to adapting to develop processes which support the SEND agenda. However, there is still a significant amount of work to do in maintaining the compliance and quality for the EHCP processes due to increase demand. There is likely to be more focus in the next 12 months on developing data around annual reviews and our compliance with completing annual review reports as this was highlighted in the Derbyshire SEND inspection, particular for those post 16.

There will be more focus on waiting times for children with SEND as this was particularly highlighted in the Derbyshire SEND inspection report for Neurodevelopmental assessments and mental health.
Priorities for the next 12 months need to be:

- Improve training compliance of all staff on the principles of SEND
- Continue to transform initial EHCP process in Derbyshire and scope what evidence we need around annual reviews
- Focus on reducing wating times in keys services
- transition from Children's to Adult services
- Support Derbyshire with their Priority action plan for SEND
- Work with Derby City Council in preparation for their SEND inspection, which is likely to be towards the end of the calendar year.

Susan Walker SEND Clinical Co-ordinator

Appendix A - Self Assessment

DHcFT%20version%
20NHS%20Provider%

Derbyshire NHS Provider Service- SEND Self-Assessment

Derby and Derbyshire Integrated Care Board

- NHS Derby and Derbyshire Integrated Care Board (ICB) would like to obtain assurances from our NHS Health Providers that the services are meeting their statutory duties for Children & Young People with Special Educational Needs and Disabilities (SEND) relating to Part 3 of the Children's and Families Act 2014
- The SEND Self-Assessment is the quality assurance tool used to seek assurance for Schedule 4 of the Quality Schedule of the Derbyshire wide Quality Schedule Contract Quality Schedule
- The SEND Self-Assessment is based on the chapters of the SEND Code of Practice (2015) reflecting statutory duties, guidance and responsibilities
- This allows NHS services for both **children & adult services for young people 0-25yrs** to evidence their compliance with these requirements
- Completion and reporting against this should be annually and will be shared with the Designated Clinical Officer for SEND & NHS trust/organisations quality assurance/improvement governance and trust/organisation SEND Lead. The results form part of the trust's/organisation's annual SEND report.

Name of NHS Provider organisation: Derbyshire Healthcare NHS Foundation Trust
List Service (s) provided for Children and Young People 0-25yrs: 0-19s Integrated Public Health Service (Derby City only) CAMHS (Southern Derbyshire and Derby City) Physiotherapy (Southern Derbyshire and Derby City) Occupational Therapy (Southern Derbyshire and Derby City) Community Paediatricians (Southern Derbyshire and Derby City) ADHD Nurses (Southern Derbyshire and Derby City) Children's Continence (Derby City only) Eating Disorders (all ages Derbyshire wide post 18 years old) Perinatal Mental Health (Derbyshire Wide) Psychological services (post 16 Derbyshire wide) Alcohol and Drug service (Southern Derbyshire under 18s, whole Derbyshire post 18) Adult Mental Health Services, community, crisis and inpatient (whole Derbyshire) Forensic and Rehabilitation Services (whole of Derbyshire)
Completed by: SEND Clinical Co-ordinator with input from ASMs in Children's services
Date completed/quarter reporting: April 2025

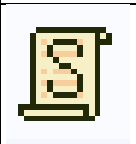
Self-Assessment Rating

The RAG rating system relates to how an organisation/service assesses itself and how it plans to make improvements

RED	No progress has been made in terms of actions therefore no impact of progress Arrangements need to be developed as soon as possible
AMBER	Some measures are in place, but others require review or improvement/ Some progress has been made in terms of actions.
YELLOW	Progress has been made in terms of actions and there is emerging impact of progress but still requires some further improvements
GREEN	The necessary arrangements are in place, up to date and meets the required minimum standard

Assessment Criteria				
1. Principals	**Useful resources**	**Y/N RAG rate**	**Documentary Evidence**	**Improvement Plan/Actions**
Staff have received training and are SEND aware?	 Health_Professional_Guide_to_the_Send_ *Council for disabled children- e-learning	Y	All services who see those under aged 25 years old have SEND awareness on their training passports. Current compliance is 68% for the Trust and 85% in Children's Division.	To increase compliance to 85% across the whole Trust
Staff understand their roles & responsibilities, statutory duties and policy in relation to the implementation of the reforms. (SEND code of practice).	 SEND_Code_of_Practice_January_2015.p	Y	Most staff have been training in this, see above. However, we still need to increase out compliance with training.	As above.
The process for providing health advice into EHCP needs assessment, is part of service induction process for new staff?		Y	SEND Single point of Access (SPA) System working well in Children's Services SEND co-ordinator is currently the link with requests for 18-25 year olds. There is a clear procedure of notification of a SEND Single Route of Redress logged with the ICB.	Training for SEND awareness is now added to all new starters in service who see under 25 year olds. CAMHS to add to our Induction training for new staff. All Complex health and Therapy services include report writing as part of local induction.
There are clear procedures in place for sharing information		Y	SEND Single point of Access (SPA) System working well in Children's Services.	All Children's services have a SOP of sharing of information.

between the LA and your service that all staff are familiar with?			SEND co-ordinator is currently the link with requests for 18-25 year olds. There is a clear procedure of notification of a SEND Single Route of Redress logged with the ICB.	Derbyshire has introduced their EHC hub system (IDOX) which means that we have had to review and update the SEND SPA procedures. This roll out has been chaotic with poor communication from Derbyshire to health providers. We are still finding areas we have no process for/or are unsure of. We are still waiting for formal processes for data breaches to be shared, but verbal have been assured there is a process. In Derby City is no current procedure for notifying and involving health for annual reviews. We are not aware of all children who have an EHCP as the information has not been shared from the Local Authority. Staff are individually contacted if the school is aware the service is involved. This is also true for Derbyshire LA until the introduction of the IDOX system in September 2024. However, staff have yet to be trained in the system. Health providers are currently not engaging with the EHC Hub (IDOX) for annual reviews. The data sharing policy between Derbyshire County Council and health providers is up to date.
2. Impartial Information, advice & support	**Useful resources**	**Y/N RAG rate**	**Documentary Evidence**	**Improvement Plan/Actions**
Staff are aware of, understand the remit of and sign-post parents/carers and settings to Independent Advice and support service (IASS) available for CYP and parents/carers for both City and County.	Derbyshire IASS factsheet Nov 2014.c Derby City-Factsheets for P	Y	0-19s services have this as part of their pathway and SEND template in SystmOne. Complex health and CAMHS staff are aware through training.	CAMHS have identified they would like to write an information document to share amongst all staff. Flowchart available within body of the policy.
3. Working Together across Education, health and care for joint outcomes	**Useful resources**	**Y/N RAG rate**	**Documentary Evidence**	**Improvement Plan/Actions**

• Providers have data on the numbers of CYP with EHCP's on their caseloads.		Y	The Trust is able to identify the numbers of children on each caseload where we have received a copy of the EHCP.	Escalation: A child living in Derbyshire should have a flag if they have an EHCP if issued before the introduction of the Derbyshire EHC Hub (IDOX). It is not clear if we are getting a copy if we have not submitted a report, eg a child is on a waiting list through the new system. In the city there is an outstanding backlog of children who we cannot identify as having an EHCP but has not been shared with us. These have been requested and it has been appropriately escalated. We are now receiving all newly issued EHCPs, but there remains a risk of not being able to identify those who have a current EHCP in place, but an updated plan has not been issued.
• There is a mechanism to identify CYP with SEND within individual case notes, eg question on case history re SEND.		Y	 severe learning disability child with SEN  ASD Diagnosis	We are unable to identify children on our caseload with SEND as we do not hold this information. We have some flags which can be added to the CYP record in added to an EHCP flag and any reasonable adjustments can be individually written on the front page of the record which will show across all units which we share with.
There is a mechanism to identify and report on the number of C&YP within the service with EHCPs.		Y	 The Trust is able to add a Flag on front page of System One if EHCP copy received. This is added by SPA and visible to all units in Children's Services. This flag can be removed if we are notified by the Local Authority that the plan has been ceased or the young person reaches the age of 25. Reports of number on caseloads can be run in SystmOne.	
The organisation/service has a named SEND link?		Y	The Trust has a SEND Clinical Co-ordinator post.	

The organisation/service contributes to the development of SEND reforms locally?		Y	Senior leadership will attend and contribute to operational, developmental and strategic forums. SEND Co-ordinator/Senior leaders will work closely with the DCO, liaise with community and acute services re improvement and innovation.	
Is there a representative who attends SEND governance meetings and communicates back to all services within the organisation for each LA?		Y	Assistant Director of Safeguarding is representing Trust at Derbyshire Performance and Assurance Board. SEND Clinical Co-ordinator attends Health footprint, ordinary available and local offer groups in Derbyshire. We have not been asked to attend any other meetings.	
4. Local Offer 0-25yrs	**Useful resources**	**Y/N RAG rate**	**Documentary Evidence**	**Improvement Plan/Actions**
Up to date information about the service is available on either/or Derby city and Derbyshire SEND Local Offer websites& the service knows how to update this, including eligibility criteria?	Derbyshire- http://localoffer.derbyshire.gov.uk/ Derby City- https://www.derby.gov.uk/education-and-learning/special-education-needs-disabilities/	Y	SEND Clinical Co-ordinator has audited both local offers and each has a brief outline of services and a link to the service web page on Trust website, except for 0-19s which is missing from Derby City Local offer.	To liaise with DCO (SEND) and Derby City to get 0-19's on Local offer.
Staff/ the service signposts the Local offer website to parents and CYP and is well publicised (COP).		Y	Standard for all Children's Services to have the Local offer details on the initial appointment letters.	
The service regularly updates its information on the LO website.		Y	Trust website is regularly update and this links to local offers.	
Staff are familiar with LO website and promote this with parents/carers/CYP.		Y	It is promoted on written information, website and in training updates. Recent training in CAMHS highlighted this.	
Staff are familiar with the SEN support and the Graduated		Y/N	The Trust has a SEND policy SEND_Policy_version_1.docx which outlines the responsibilities within the	We have recently started a monthly update of SEND which goes to all teams in the Trust which will include updated about the Graduated

Response provided by each LA in mainstream schools.			graduated response of health and how to support families. Graduated response is discussed in ad-hoc training, but more work in developing the confidence in this is needed.	response, however it will take time to build confidence that there is one within schools.
Staff are familiar with the Local Authority SEN support (eg HI team, specialist teachers, etc) and how schools and pupils access this?		N	This is known in some teams, but not consistently. It is also difficult to keep up to date as council services regularly transform.	We have recently started a monthly update of SEND which goes to all teams in the Trust, so any updates we receive from the councils can be included.
Staff know how to contribute to schools documentation to support children with SEN who do not have an EHCP?	 My SEND Learning Programme 2017.doc	N	Staff are familiar and happy in liaising with school around health needs but are not widely involved in contributing to SEN documentation, unless it is part of a TAF.	The responsibility for the documentation is the schools.
5. Early Identification	**Useful resources**	**Y/N RAG rate**	**Documentary Evidence**	**Improvement Plan/Actions**
Staff in each service are familiar with the duty to "**Notify "**the appropriate local authority if they identify a child under compulsory school age as having, or probably having, a disability or SEN".	 Notification power point - March 2020.p  **Health Notification - share all NHS trusts 2**  County EARLY YEARS referral & Not	Y	0-19's Public health review clinical letters and complete developmental reviews at 2 and 3.5years. If a child under 5 needs to be referred a specialist services they complete the notification and this is evidenced via reporting on SystmOne. Community Paediatrician will complete the notification if they make a diagnosis in an under 5, again reportable on SystmOne.	SPOA process is constantly reviewed with new pilot with SLT and updated, most recent document included above.  SPOA Referral Process.pdf
Waiting times for services are reported regularly to commissioners and action plans in place to address waiting times.		Y	Schedule 6 reporting. Waiting times are reported to commissioners. Action plans for long waiting times are in place, ND services, Mental Health.	
6. Schools/further education- chapters	**Useful resources**	**Y/N RAG rate**	**Documentary Evidence**	**Improvement Plan/Actions**

Staff know who to sign post parent/carers to in the school for support/ guidance If they have concerns regarding the support for pupils.	 Guide for 16- 25yrs & families how to resc  Routes to resolving SEND disagreements	Y	Highlighted in recent training & in the policy Routes for disagreements/complaints on SEND information on website.	Information is available on website. The escalation process is outline in the new SEND Policy. We need to increase staff awareness of the policy.
Parental/carer consent is obtained routinely to share clinical reports/ letters with schools/ colleges, SENCO's/ class teachers		Y	Consent to send information to local authority in regard to support possible SEND needs is made before notification is made. Consent is obtained before reports and letters are shared with schools and colleges. Not all health letters and reports are shared, only the ones which impact on education and the family have consented to be shared.	
Schools/ colleges are informed when pupils are discharged from service with rationale and guidance on re- referral.		Y	Schools and colleges are not informed in all cases, unless there is an identified EHCP. Then they would as part of an annual review. ALL discharge letters are copied to the families and GP with rationale and guidance on re-referral.	
Staff in each service are familiar with the SEN support and the Graduated Response provided by each LA in mainstream schools.		Y	SEND policy cover what we expect services to do as part of the Graduated response and the SEND standards for this.	We have a policy but no evidence of compliance
Staff in each service are aware that each school has a SENCO and a SEN register to record any additional support for children with SEN including those with and without an EHCP		Y	Services are aware but are often told by parents that school will not support additional needs without a diagnosis/EHCP.	We need to build confidence in the system that child will receive support without an EHCP.

7. EHC needs assessment and plans	Useful resources	Y/N RAG rate	Documentary Evidence	Improvement Plan/Actions
Does the organisation/Trust have a Single Point of Access (SPA) to manage EHCP requests for health advice?		Y	Special needs email: <dmh-tr.specialneedsmedicals@nhs.net>	
There is a SOP in place that outlines the service admin procedure for provision of health advice for EHCP?		Y	We have a SEND policy.	
Are staff familiar with Local Authority SEND team and-contact details/roles and responsibilities?		Y	Staff are aware of the SEND Co-ordinator role and would contact for initial advice/point of contact and request ongoing signposting/contact to SEND team as required.	
Staff are familiar with the information sharing SOP agreement between NHS organisations & LAs		Y	Staff are aware of data sharing.	
There are written guidelines for staff to follow that support the provision of high-quality advice for EHC plans?	See Royal colleges &CDC guidelines	Y	In the SEND Policy and check list for use by clinicians.	Generally the feedback from the local area for reports is good. However, there are some inconsistencies. These reports are regularly audit for quality against the ICBs recommended NHS EHC reports “check list”. Action: However, this is currently held locally and it would be best practice to be able to show this on the dashboard so there was Trust oversight.
The service has an agreed format or template for contribution to EHCP needs assessment which includes needs/ provision & outcomes?	Report template	Y	We have introduced the new Derbyshire ICB agreed EHCP template.	
Parents/ carers receive a copy of EHC advice sent to the LA.		Y	Part of report template.	
The service provides training for staff on how to write a report contributing to EHCP assessment including writing outcomes?		Y	Local services support report writing by junior staff by reviewing/supporting as part of the clinical lead role.	We have no formal training except what is available on the e-learning SEND awareness part 1 and 2. Support is provided by the SEND Clinical Co-Ordinator on request.

				Post 18 services have not been involved until recently.
There is a QA process in place to monitor the quality-of-service advice to EHCP assessment (eg use of proof-reading checklist and audit tool and outcomes of audit cycle are reported).	Proof reading checklist and audit tool 2021  Derbyshire footprint-Final SEND	Y	OT, Physio and CAMHS services reports are quality assured by Clinical Leads before being sent. A rolling quality audit for each service is being led by the SEND Clinical Co-ordinator.	
Managers know how to flag cases of need beyond Local Offer to ICB commissioners.	 Process -over above local offer provison ne	Y	SEND Clinical Co-ordinator and some service leads are aware.	This process is in the process of being publicised via the monthly Safeguarding and SEND information sharing document which goes to every team.
The service centrally monitors requests for advice and timeliness of responses.		Y	Schedule 6 LRR13L – SEND report.	
The service regularly reports on performance against 6-week target for advice for EHCP assessment to ICB.		Y	Schedule 6 LRR13L – SEND report.	
Draft plans are reviewed to ensure that the advice from the service has been accurately detailed in the plan.		Y/N	Drafts are shared when received, however it is very ad hoc if they are reviewed, partly due to the lack of confidence in the EHCP system that they amend the draft as we have been previously that health professional cannot comment on drafts.	The develop confident with Derby City and County that professional can comment on drafts and that the full two week consultation period is allowed before issuing final. This is part of the ongoing development with Derbyshire re EHC Hub (IDOX).
EHC plans are part of the patient record.		Y	All EHCP are added to SystmOne.	
There are service guidelines in place re the annual review process and contributing to ARs.		Y	In SEND Policy.	

Staff routinely – attend &/or submit information to EHCP Annual Reviews?	Levels of health contribution to EHCP . Draft 2- AR template- health staf	Y- in children's service N-in 18-25 services	Staff will write reports and attend if needed, if they are aware of the annual review and been given enough notice of review. However, this is on staff report in Children's services, not data. Derbyshire SEND inspection highlighted lack input in post 16.	Annual review template is on all SystmOne modules, but further training is need of adult services. There is no system in Derby City to ensure health is invited to annual reviews. The Derbyshire Hub (IDOX) will notify staff of an annual review but is currently not being using by health (with ICB agreement).
Staff are aware of Personal Health budgets and where to sign post families/carers CYP on the SEND local offer?	https://joinedupcarederbyshire.co.uk/your-services/personal-health-budget-phb/	Y	Key staff are aware of the process and staff would know which staff to ask.	
8. Voice of the Child/ young person and parents/carer	**Useful resources**	**Y/N RAG rate**	**Documentary Evidence**	**Improvement Plan/Actions**
The voice of the CYP and their family is evident in the EHCP assessment health advice.	Item 6 SEND Participation Best Pra parent_carer_partici pation_sharing_good	Y	It is a section on the EHC Health needs initial assessment template and audit shows that this is completed (see quality assurance audit data).	
Children, young people and their families are involved in setting and evaluating targets for intervention.		Y	Patient survey reports 100% felt involved with their care plan.	Outcome measures are now on all SystmOne modules. Services are developing local protocols in how often these are to be used. The aim is to be able to report on this.
The service/s have systems in place to routinely capture the satisfaction of children and young people with SEND and their families.	County-Participatio n self evaluation tool	Y	We have friend and family survey and the electronic patient survey, which has been operational for 12 months.	
The views of CYP with SEND who use the service are used to inform service Improvements.		Y	Participation. Focus groups. See SEND annual review for evidence.	

9. Preparing for Adulthood Ed, health and Social care, should support children and young people with special educational needs (SEN) or disabilities to prepare for adult life, and help them go on to achieve the best outcomes in employment, independent living, health and community participation.	**Useful resources**	**Y/N RAG rate**	**Documentary Evidence**	**Improvement Plan/Actions**
The Service/organisation has a transition policy.	 SEND-quick-guide-commissioning-transitior	Y/N	Transition policy only covers CAMHS Transfer_of_Young_People_Receiving_Services_From_Child_And_Adolescent_Mental_Health_Services_To_Adult_Mental_Health_Services_Policy.docx	Policy needs to cover all services. See SEND annual report for progress. The trust is involved with the Derbyshire Transition network. Most services have a local SOP for Transition.
There is a pathway/procedure to enable smooth transition from Children's to Adult services.	 transition-from-childrens-to-adults-service	Y	Clear pathways between all services which have a direct equivalent service.	
The service has clearly identified links with adult services to enable hand over post 18/19yrs.		Y		Regular meetings jointly CAMHS and h WAA services to improve the transfer of young people's care.
The service has a clear transfer process/procedure when CYP leave the service post 18/19yrs.		Y	All services can identify how the CYP needs will be met post leaving Children's services. CAMHS and Adults – can be some delay in transition due to in part commissioning in adult only from 18 years old. Can refer onto waiting list at 17.5 years but can by 19 by time accepting. However, there is not always a direct equivalent service. Team members know who they need to liaise with in the local area.	

Staff are familiar with & contribute to the PfA outcomes required in EHC plans from Y9 and Annual reviews.		Y	Training has been provided on this to Complex health and CAMHS service and part of the annual review template.	Children's services are familiar with this but adults services are less so. Therefore this awareness need further development.
Where an EHCP is in place, staff ensure that transition from your service is notified at the EHCP annual review process and shared with parents/carers from Y9.		Y	This is part of the standard annual review report template.	
10. CYP in specific circumstances	**Useful resources**	**Y/N RAG rate**	**Documentary Evidence**	**Improvement Plan/Actions**
LAC information from the health assessment & plan is routinely shared as part of an EHCP needs assessment & at annual review.		Y	LAC Initial & review health assessments are included as part of the health assessment and returned to the LA for EHCP request. LAC review health assessments are aimed to be just before the annual review of the EHCP, so they are shared, and used as part of the review.	
11. Resolving Disagreements	**Useful resources**	**Y/N RAG rate**	**Documentary Evidence**	**Improvement Plan/Actions**
Staff know how where to sign-post parent/ CYP if they have disputes or disagreements with school/college or the local authority.	Routes to resolving SEND disagreements SEND Guide- 4 qestions-Final guidan	Y	Process in place. Information on Trust website. The escalation process is in the SEND Policy.	
Staff are supported to contribute to and attend mediation within 30days when requested.		Y	SEND Co-ordinator links with staff. Staff are supported by their line manager/clinical lead.	
Information is available to parent/carers and CYP with SEND on how to make a complaint and access PALS.		Y	On website.	
Guidance and support is available and in place for		Y	SEND co-ordinator links with staff and informs clinicians.	

relevant staff to contribute to SEND tribunals if required.			Clinical leads in each service support clinicians.	

FORWARD PLAN - BOARD - 2025/26		03-Jun-2025	22-Jul-2025	23-Sep-2025	25-Nov-2025	27-Jan-2026	24-Mar-2026
	Deadline for Approved Papers	20-May-2025	10-Jul-2025	11-Sep-2025	13-Nov-2025	15-Jan-2026	12-Mar-2026
DoCA/TS	Declarations of Interest	X	X	X	X	X	X
DoN	Patient/Board Story	X	X	X	X	X	X
CHAIR	Minutes/Matters Arising/Action Matrix	X	X	X	X	X	X
CHAIR	Board review of meeting effectiveness	X	X	X	X	X	X
CHAIR	Board Forward Plan (for information)	X	X	X	X	X	X
CHAIR	Summary of Council of Governors meeting (for information)	X	X		X	X	
CHAIR	Chair's update	X	X	X	X	X	X
CEO	Chief Executive's update	X	X	X	X	X	X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE							
DCEO/CDO	Trust Strategy progress update	X			X		
DPODI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) *request for Board delegated authority for People and Culture Committee meeting Sep to approve the October submissions*			X			
DPODI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Strategic implications (retrospective sign-off on assurance at People and Culture Committee - Sep)				X		
MD	Patient and Carers Race Equality Framework *scheduling tbc*						
DoCA/TS	Receipt of Reports (on assurance from Audit and Risk Committee (ARC)):						
	Year-end Governance reporting from Board Committees and approval of Terms of Reference (ToRs) (ARC - Apr)	X					
DPODI	Receipt of Reports (on assurance from People and Culture Committee (PCC)):						
	Annual Approval of Modern Slavery Statement (PCC - Mar, to be published on Trust website on approval)	X					
	Staff Survey results (PCC - Mar)						X
	Annual Gender Pay Gap report for approval (PCC - May)	X					
	2025/26 Flu Campaign annual report (PCC - Jul)			X			
DoCA/TS	Continuation of Services Condition 7 - Provider Licence	X					
DoCA/TS	Trust Sealings (six-monthly - for information)	X			X		
DoCA/TS	Annual Review of Register of Interests	X					
DoCA/TS	Board Assurance Framework update	X		X	X		X
FTSUG	Freedom to Speak Up Guardian report (six-monthly)			X			X
CHAIR	Fit and Proper Person Declaration		X				
DoF/DCEO/CDO/ DPODI	2025/26 Plan	X					
Committee Chairs	Board Committee Assurance Summaries	X	X	X	X	X	X
OPERATIONAL PERFORMANCE							
DCEO/CDO/DON/ DOF/DPODI	Integrated Performance and Activity report (Operations, Finance, People and Quality)	X	X	X	X	X	X
DCEO/CDO	ICB Joint Forward Plan (ad hoc inclusion with CEO Update)						
DCEO/CDO	Emergency Preparedness, Resilience and Response (EPRR) Core Standards			X			
Prog Director	Making Room for Dignity progress	X	X				
DPODI	Receipt of Reports (on assurance from People and Culture Committee (PCC)):						
	Workforce Plan annual review (PCC - Jul)			X			
DoN/MD	Receipt of Reports (on assurance from Quality and Safeguarding Committee (QSC)):						
	Safer Staffing annual review (QSC - Jul)			X			
DoF	Year-end Position 2024/25	X					
QUALITY GOVERNANCE							
DoN	Fundamental Standards of Care report (CQC Domains)		X			X	
DoN/MD	Intensive and Assertive Outreach Treatment - Community Mental Health Action Plan update	X					
DoN	Outcome of patient stories (every two years, due Mar-2026)						
MD	Receipt of Reports (on assurance from People and Culture Committee (PCC)):						
	Annual Medical Appraisal and Revalidation (PCC - May)	X					
DoN	Receipt of Reports (on assurance from Quality and Safeguarding Committee (QSC)):						
	Guardian of Safe Working Hours report (QSC - quarterly)		AR		X	X	
	Annual Special Educational Needs and Disabilities (SEND) (QSC - May/Jun)	X					
	Quality Account (QSC - Jul)			X			
	Annual Looked After Children (QSC - Sep)				X		
	Infection Prevention and Control annual report and IPC BAF (QSC - Oct)				X		
	Annual Safeguarding Children and Adults at Risk (QSC - Sep)				X		
	Delivery of Same Sex Accommodation (QSC - Oct)				X		
MD	Learning from Deaths/Mortality report (QSC - quarterly)	AR			X	X	X
DCEO/CDO	Transformation and Continuous Improvement (bi-annual)	X			X		
POLICY REVIEW							
DoCA/TS	Fit and Proper Person Policy (31-Mar-2026)				X		
DoCA/TS	Policy for Engagement Between the Board of Directors and the Council of Governors (30-Nov-2025)				X		
DoF	Standing Financial Instructions Policy and Procedures (31-Oct-2025)			X			

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
A	
A&E	Accident & Emergency
ACCT	Assessment, Care in Custody & Teamwork
ACE	Adverse Childhood Experiences
AC/RC	Approved Clinician/Responsible Clinician
ADHD	Attention Deficit Hyperactivity Disorder
ADI-R	Autism Diagnostic Interview-Revised
ADOS	Autism Diagnostic Observation Schedule (assessment)
AED	Adult Eating Disorder
AED	Automated External Defibrillator
AfC	Agenda for Change
AHP	Allied Health Professional
AI	Artificial Intelligence
AIMS	Royal College of Psychiatrists Accreditation for Inpatient Mental Health Services Standards
ALB	Arms-length body such as NHS Improvement (NHSI) and NHS England (NHSE)
AMM	Annual Members' Meeting
AMHP	Approved Mental Health Professional
ANP	Advanced Nurse Practitioner
AO	Accountable Officer
AO	Assertive Outreach
AOVPN	AlwaysOn VPD (secure network access)
APC	Annual Physical Health
APOM	Activity Participation Outcome Measure
ASD	Autism Spectrum Disorder
ASM	Area Service Manager
ATR	Alcohol Treatment Requirement
ATU	Acute Treatment Unit
B	
BAF	Board Assurance Framework
BCF	Better Care Fund
BCO	Building Control Officer
BCP	Business Continuity Plan
BIA	Business Impact Analysis
BLS	Basic Life Support (ILS Immediate Life Support)
BMA	British Medical Association
BAME	Black, Asian and Minority Ethnic
BME	Black and Minority Ethnic group
BoD	Board of Directors
BPD	Borderline Personality Disorder
BPPC	Better Payment Practice Code
C	
CAMHS	Child and Adolescent Mental Health Services
CASSH	Care and Support Specialised Housing
CBT	Cognitive Behavioural Therapy
CBRN	Chemical, Biological, Radiological and Nuclear
CCG	Clinical Commissioning Group (defunct from 1 July 2022)
CCQI	College Centre for Quality Improvement
CCT	Community Care Team
CDEL	Capital Departmental Expenditure Limit

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
CD-LIN	Controlled Drug Local Intelligence Network
CDM	Construction Design and Management
CDMI	Clinical Digital Maturity Index
CE	Chief Executive
CEO	Chief Executive Officer
CER	Clinical Establishment Review
CESR	Certificate of Eligibility for Specialist Registration
CGA	Comprehensive Geriatric Assessment
CHANNEL	Confidential, voluntary, multi-agency safeguarding programme that provides early intervention to protect vulnerable children and adults who might be susceptible to being radicalised
CHPPD	Care Hours Per Patient Day
CIC	Children in Care
CIN	Children in Need
CIP	Cost Improvement Programme
CMDG	Contract Management Delivery Group
CMHF	Community Mental Health Framework
CMHT	Community Mental Health Team
CNST	Clinical Negligence Scheme for Trusts
COAT	Clinical Operational Assurance Team
COF	Commissioning Outcomes Framework
CoG	Council of Governors
COO	Chief Operating Officer
CP	Child Protection
CPA	Care Programme Approach
CPD	Continuing Professional Development
CPN	Community Psychiatric Nurse
CPR	Child Protection Register
CPRG	Clinical Professional Reference Group
CQC	Care Quality Commission
CQI	Clinical Quality Indicator
CQRG	Care Quality Review Group
CQUIN	Commissioning for Quality and Innovation
CRD	Clinically Ready for Discharge
CRG	Clinical Reference Group
CRH	Chesterfield Royal Hospital
CRHT	Crisis Resolution and Home Treatment
CROMS	Clinician Reported Outcome Measures
CRR	Case Record Reviews
CRS	(NHS) Care Records Service
CRS	Commissioner Requested Services
CSC	Commonwealth Scholarship Commission
CSDS	Community Services Data Set
CSF	Commissioner Sustainability Fund
CSPR	Child Safeguarding Practice Review
CTO	Community Treatment Order
CTR	Care and Treatment Review
CUF	Cost Uplift Factor
CYP	Children and Young People
D	
DAR	Divisional Assurance Review
DASP	Drug and Alcohol Strategic Partnership

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
DAT	Drug Action Team
Datix	Trust's electronic incident reporting system of an event that causes a loss, injury or a near miss to a patient, staff or others
DBS	Disclosure and Barring Service
DBT	Dialectical Behavioural Therapy
DfE	Department for Education
DCHS	Derbyshire Community Health Services NHS Foundation Trust
DDCCG	Derby and Derbyshire Clinical Commissioning Group
DEED	Delivering Excellence Every Day
DHCFT	Derbyshire Healthcare NHS Foundation Trust
DHR	Domestic Homicide Review
DISCO	Diagnostic Interview for Social and Communication Disorders (assessment)
DIT	Dynamic Interpersonal Therapy
DME	Director of Medical Education
DNA	Did Not Attend
DoC	Duty of Candour
DoF	Director of Finance
DoH	Department of Health
DoL	Deprivation of Liberty
DoLS	Deprivation of Liberty Safeguards
DoN	Director of Nursing
DPA	Data Protection Act
DPI	Director of People and Inclusion
DPR	Divisional Performance Review
DPS	Date Protection and Security
DQMI	Data Quality Maturity Index
DRR	Drug Rehabilitation Requirement
DRRT	Dementia Rapid Response Team
DSAB	Derby and Derbyshire Safeguarding Adult Board
DS&P	Data Security and Protection
DSCB	Derby and Derbyshire Safeguarding children Board
DSPT	Director of Strategy, Partnerships and Transformation
DTOC	Delayed Transfer of Care
DV	Domestic Violence
DVA	Derbyshire Voluntary Action (formerly North Derbyshire Voluntary Action)
DWP	Department for Work and Pensions
E	
EbE	Expert by Experience
ECT	Enhanced Care Team
ECT	Electroconvulsive Therapy
ECW	Enhanced Care Ward
ED	Emergency Department
EDS2	Equality Delivery System 2
EHA	Early Help Assessment
EHCP	Education, Health and Care Plan
EHIC	European Health Insurance Card
EHR	Electronic Health Record
EI	Early Intervention
EIA	Equality Impact Assessment
EIP	Early Intervention In Psychosis
EIS	Early Intervention Service
ELT	Executive Leadership Team

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
EMDR	Eye Movement Desensitising and Reprocessing Therapy
EMR	Electronic Medical Record
EPC	Energy Performance Certificate
EPMA	Electronic Prescribing and Medicine Administration
ePMO	Electronic Programme Management Office
EPR	Electronic Patient Record
EPRR	Emergency Preparedness, Resilience and Response
ERIC	Estates Return Information Collection
ESR	Electronic Staff Record
EUPD	Emotionally Unstable Personality Disorder
EWTD	European Working Time Directive
F	
FBC	Full Business Case
FFT	Friends and Family Test
FGM	Female Genital Mutilation
FOI	Freedom of Information
FOT	Forecast Out-Turn
FSR	Full Service Record
FT	Foundation Trust
FTE	Full-time Equivalent
FTN	Foundation Trust Network
FTSU	Freedom to Speak Up
FTSUG	Freedom to Speak Up Guardian
F&P	Finance and Performance
FYE	Full Year Effect or Financial Year End
5YFV	Five Year Forward View
G	
GAM	Group Accounting Manual
GDPR	General Data Protection Regulation
GGI	Good Governance Institute
GIRFT	Getting it Right First Time
GMC	General Medical Council
GMP	Guaranteed Maximum Price
GoSWH	Guardian of Safe Working Hours
GP	General Practitioner
GPFV	General Practice Forward View
H	
HACT	Housing Association Charitable Trust
HCA	Healthcare Assistant
HCP	Healthy Child Programme
H1	First half of a fiscal year (April through September)
H2	Second half of a fiscal year (October through the following March)
HEE	Health Education England
HES	Hospital Episode Statistics
HFMA	Healthcare Financial Management Association
HoNOS	Health of the Nation Outcome Scores
HoP	Head of Practice
HOPE(s)	The HOPE(s) model is an ambitious human rights-based approach to working with individuals in segregation, developed from research and clinical practice
HSCIC	Health and Social Care Information Centre
HSE	Health and Safety Executive

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
HSSC	Health and Safety Security Committee
HV	Health Visitor
HWB	Health and Wellbeing Board
I	
I&E	Income and Expenditure
IAPT	Improving Access to Psychological Therapies
Icare	Increase Confidence, Attract, Retain, Educate
ICB	Integrated Care Board
iCIMS	Internet Collaborative Information Management System
ICM	Insertable Cardiac Monitor
ICO	Information Commissioner's Office
ICS	Integrated Care System
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IDVAs	Independent Domestic Violence Advisors
IFRS	International Financial Reporting Standards
IG	Information Governance
ILS	Immediate Life Support (BLS – Basic Life Support)
IMST	Information Management Systems and Technology
IMT	Incident Management Team
IMT&R	Information Management, Technology and Records
INQUEST	
IPP	Imprisonment for Public Protection
IPR	Integrated Performance Report
IPS	Individual Placement and Support
IPT	Interpersonal Psychotherapy
IRHTT	In-reach Home Treatment Team
IRT	Incident Review Tool
J	
JCVI	Joint Committee on Vaccination and Immunisation
JDF	Junior Doctor Forum
JLNC	Joint Local Negotiating Committee
JNCC	Joint Negotiating Consultative Committee
JTAI	Joint Targeted Area Inspections
JUCB	Joined Up Care Board
JUCD	Joined Up Care Derbyshire
K	
KLOE	Key Lines of Enquiry (CQC)
KPI	Key Performance Indicator
KSF	Knowledge and Skills Framework
L	
LA	Local Authority
LAC	Looked After Children
LCFS	Local Counter Fraud Specialist
LA – CYPD	Local Authority – Children and Young People Divisions
LADO	Local Authority Designated Officer
LD	Learning Disabilities
LD/A	Learning Disability and Autism
LeDeR	Learning Disabilities Mortality Review
LFPSE	Learn from Patient Safety Events

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender and Queer or Questioning, Intersex, Asexual
LHP	Local Health Plan
LHRP	Local Health Resilience Partnership
LHWB	Local Health and Wellbeing Board
LNC	Local Negotiating Committee
LOS	Length of Stay
LPS	Liberty Protection Safeguards
LSU	Long-Term Service Use
LTP	Long Term Plan
LTS	Long Term Segregation
LWSTO	Living Well Short-Term Offer
M	
MADE	Multi-agency Discharge Event
MAPPA	Multi-agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference (meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors
MARS	Mutually Agreed Resignation Scheme
MAS	Memory Assessment Service
MASH	Multi-Agency Safeguarding Hub
MaST	Management and Supervision Tool
MAU	Medical Assessment Unit
MBU	Mother and Baby Unit
MCA	Mental Capacity Act
MCC	Medicine Clinical Committee
MD	Medical Director
MDA	Medical Device Alert
MDM	Multi-Disciplinary Meeting
MDR	Medical Device Regulation
MDSO	Medical Device Safety Officer
MDT	Multi-Disciplinary Team
M&E	Mechanical and Electrical
MFA	Multi-Factor Authentication
MFF	Market Forces Factor
MHA	Mental Health Act
MHAC	Mental Health Act Committee
MHIN	Mental Health Intelligence Network
MHIS	Mental Health Investment Standard
MHLDA	Mental Health, Learning Disabilities and Autism
MHLT	Mental Health Liaison Team
MHOST	Mental Health Optimal Staffing Tool
MHRA	Medical and Healthcare products Regulatory Agency
MHRT	Mental Health Review Tribunal
MHRV	Mental Health Response Vehicle
MHSDS	Mental Health Services Data Set
MMaSP	Medicine Management Safety and Practice
MMC	Medicines Management Committee
MoU	Memorandum of Understanding
MPAC	Multi-Professional Approved Clinician
MSC	Medical Staff Committee

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
MSK	Musculoskeletal (conditions)
MSP	Medicines Safety and Practice
MST	Multisystemic Therapy
MSU	Medium Secure Unit
MTFP	Medium Term Financial Plan
N	
NAI	Non-Accidental Injury
NCRS	National Cancer Registration Service
ND	Neuro-development
NED	Non-Executive Director
NETS	National Educational Training Survey
NHS	National Health Service
NHSCFA	NHS Counter Fraud Authority
NHSE	National Health Service England
NHSI	National Health Service Improvement
NHSEI	NHS England and NHS Improvement
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NIMS	National Incident Management System
NIVS	National Immunisation and Vaccination System
NPS	National Probation Service
NQB	National Quality Board
NR	Non-Recurrent
NROC	Non-Resident On-Call
O	
OBC	Outline Business Case
ODG	Operational Delivery Group
OOA	Outside of Area
OPMO	Older People's Mental Health Services
OP	Outpatient
OSC	Overview and Scrutiny Committee
OSCE	Objective Structured Clinical Examination
OT	Occupational Therapy
P	
PAB	Programme Assurance Board
PAG	Programme Advisory Group
PALS	Patient Advice and Liaison Service
PAM	Payment Activity Matrix
PARC	Psychosis and the reduction of cannabis (and other drugs)
PARIS	This is an electronic patient record system
PbR	Payment by Results
PCC	Police & Crime Commissioner
PCC	People and Culture Committee
PCLB	Provider Collaborative Leadership Board
PCN	Primary Care Networks
PCOG	Patient and Carer Operational Group
PCREF	Patient and Carers Race Equality Framework
PDC	Public Dividend Capital
PDF	Portable Document Format
PDSA	Plan, Do, Study, Act
PFI	Private Finance Initiative

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
PFF	Probation Feedback Form
PFR	Provider Finance Return
PHC	Public Health Commissioners
PHCIC	Physical Healthcare and Infection Control Committee
PHE	Public Health England
PHSCC	Population Health and Strategic Commissioning Committee
PHSMI	Physical Health Serious Mental Illness
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PiPoT	Persons in a Position of Trust
PJF	Professional Judgement Framework
PLACE	Patient-Led Assessments of the Care Environment
PLIC	Patient Level Information Costs
PMF	Performance Management Framework
PMH	Perinatal Mental Health
PMLD	Profound and Multiple Disability
PMO	Project Management Office
PODG	Programme Oversight and Delivery Group
PPE	Personal Protection Equipment
PPI	Patient and Public Involvement
PPN	Public Protection Notice
PPT	Partnership and Pathway Team
PQN	Perinatal Quality Network
PREM	Patient Reported Experience Measure
PROMS	Patient Reported Outcome Measures
PSF	Provider Sustainability Fund
PSII	Patient Safety Incident Investigations
PSIRF	Patient Safety Incident Review Framework
PSQG	Patient Safety and Quality Group
PYE	Part Year Effect
Q	
QAG	Quality Assurance Group
QASI	Quality Assurance Serious Incidents
Q&SC	Quality and Safeguarding Committee
QEIA	Quality and Equality Impact Assessment
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity Programme
QOF	Quality and Outcomes Framework
R	
RAID	Rapid Assessment, Interface and Discharge
RAP	Recovery Action Plan
RCGP	Royal College of General Practitioners
RCI	Reference Cost Index
RDOG	Research and Development Operational Group
REGARDS	Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation
ReQoL	Recovering Quality of Life
ROAG	Responsible Officer Advisory Group
ROM	Reported Outcome Measure
RRP	Recruitment Retention Proposal
RTT	Referral to Treatment

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
S	
s132	Section 132 of the Mental Health Act: As soon as a patient is detained under the Act the patient must be given their rights orally and in writing unless it is not practicable at that time. If this is the case, it must be documented in the patient's electronic care record
s136	Section 136 of the Mental Health Act: Police can use emergency powers if they think you have a mental disorder, you're in a public place and need immediate help. They can take you or keep you in a place of safety, where your mental health will be assessed.
SAAF	Safeguarding Adults Assurance Framework
SAR	Safeguarding Adult Review
SAS Doctor	Specialist, Associate Specialist and Specialty Doctor
SBARD	Situation, Background, Assessment, Recommendation and Decision (SBARD) tool
SBS	Shared Business Services
SCPHN	Specialist Community Public Health Nurse
SEIPS	Systems Engineering Initiative for Patient Safety
SEND	Special Educational Needs and Disabilities
SFI	Standing Financial Instructions
SI	Serious Incidents
SIG	Serious Incident Group
SID	Senior Independent Director
SIDS	Sudden Infant Death Syndrome
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement
SLaM	South London and Maudsley NHS Trust
SLR	Service Line Reporting
SMI	Severe Mental Illness
SNOMED CT	Systemised Nomenclature of Medicine – Clinical Terms
SOAD	Second Opinion Appointed Doctor
SOC	Strategic Options Case
SOF	Single Operating Framework
SOP	Standard Operating Procedure
SPOA or SPA	Single Point of Access
SPOE	Single Point of Entry
SPOR	Single Point of Referral
SSQD	Specialised Services Quality Dashboards
STEIS	Strategic Executive Information System
STF	Sustainability and Transformation Fund
STOMP/STAMP	Stopping The Over-Medication of children and young People with a learning disability, autism or both / Supporting Treatment and Appropriate Medication in Paediatrics
STP	Sustainability and Transformation Partnership
SUI	Serious (Untoward) Incident
SW	Social Worker
SystmOne	Electronic patient record system
T	
TAV	Team Around the Family
TARN	Trauma Audit and Research Network
TBT	Tobacco Dependence Team
TCP	Transforming Care Partnerships
TCS	Transforming Community Services
TDA	Trust Development Authority

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
TDT	Tobacco Dependence Team
TIC	Trauma Informed Care
TLT	Trust Leadership Team
TMAC	Trust Medical Advisory Committee (now Medical Senate)
TMT	Trust Management Team
TMTC	Trust Medical Training Committee
TOIL	Time Off In Lieu
TOOL	Trust Operational Oversight Leadership
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
U	
UHDB	University Hospitals of Derby and Burton
UEC	Urgent and Emergency Care
V	
VARM	Vulnerable Adult Risk Management
VCOD	Vaccination as a Condition of Deployment
VCP	Vacancy Control Panel
VdTMoCA	Vona du Toit Model of Creative Ability *(a practical guide for Acute Mental Health Occupational Therapy Practice)*
VFM	Value For Money
VO	Vertical Observatory
VTE	Venous Thromboembolism
W	
WAP	Wireless Application Protocol
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent
Y	
YTD	Year to Date

May 2025

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 3 June 2025

Report from the Council of Governors meeting

The Council of Governors has met once since the last report, on 14 January 2025. The meeting was conducted as a hybrid meeting.

Submitted Questions from Members of The Public

A question on Attend Anywhere was received from a Trust member. The response was formulated and emailed to the member after the meeting. There was a second question and the Chair confirmed that it is not appropriate to respond as it was regarding the physical health of our workforce.

Chief Executive's Update

The Chief Executives update focused on:

- NHS planning guidance 2025/26
- Making Room for Dignity programme
- Report from the Care Quality Commission (CQC)
- Talking Therapy services update.

Report From Governors' Nominations and Remuneration Committee

The Trust Chair presented an overview of the matters discussed at the last Governors Nominations and Remuneration Committee which focused on an outline of the appraisal process for the Trust Chair and Non-Executive Directors (NEDs), a proposal to reappoint Ralph Knibbs as Non-Executive Director and Senior Independent Director, and the recruitment plan for two NED appointments to the Trust Board.

Development of Annual Plan

The Director of Finance gave a presentation on the NHS planning round. The presentation set out a number of performance targets the Trust is required to deliver and the financial and workforce summaries and what that means in terms of activity.
The planning processes have changed over the last few years, but the statutory position is that the Trust must have due regard to the views of the governors on the plan.

Review of Trust Constitution

The Council of Governors approved the changes recommended by the working group led by the Director of Corporate Affairs and Trust Secretary.

Non-Executive Directors Report

The Non-Executive Director (NED) who Chairs the Finance and Performance Committee and is Deputy Chair presented his report which summarised his activities as a NED from March 2024. The report focused on the work of the Finance and Performance Committee.

Escalation item to the Council of Governors from the Governance Committee

The Deputy Chair, on behalf of the Trust's Director of Strategy, Partnerships and Transformation provided governors with assurance that an internal review of the utilisation of crisis beds is underway; and that the Trust is aware of Local Authority changes including removal of council discretionary grants and other reductions in voluntary funding and is working closely with other NHS providers and the Integrated Care Board (ICB) to understand them.

Verbal Summary of Integrated Performance Report (IPR)

Non-Executive Directors gave a verbal summary of the IPR focusing on key finance, performance, and workforce measures.

Governance Committee Report

A report of the Governance Committee meetings held on 4 December 2024 and 5 February 2025 was presented. The Committee agreed the process for the election of the Chair and Vice-Chair of the Committee.

Review Governor Engagement Action Plan

The Membership and Involvement Manager provided an update on the Governors Membership Engagement Action Plan (the Action Plan). The Action Plan was last reviewed by the Governance Committee on 5 February 2025. The Action Plan is aligned to the key objectives for members' engagement in the Membership Plan 2025-2028.

Governor Training, Awareness and Development Schedule for the Year

The Membership and Involvement Manager outlined training, development and awareness sessions that governors have received, and sessions that will be taking place during the year. Governors were also made aware of training delivered by external organisations that are available to them.

Update On Governor Elections

The Membership and Involvement Manager presented a summary report on the 2024/25 elections. Inductions have been completed for the new governors. There is still one vacancy for the seat in Bolsover and North East Derbyshire.

Deputy Lead Governor Elections

The Director of Corporate Affairs and Trust Secreatary outlined the process for electing a Deputy Lead Governor.

RECOMMENDATION

The Trust Board of Directors is asked to note the summary report from the Council of Governors meeting held on 4 March 2025.