Derbyshire Healthcare NHS Foundation Trust

Public Trust Board Meeting

22 July 2025

Conference Rooms A and B, Centre for Research and Development

Kingsway

Derby, DE22 3LZ

Derbyshire Healthcare NHS Foundation Trust - Public Trust Board Meeting - 22 July 2025

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Derbyshire Healthcare
NHS Foundation Trust

Public Board Meeting

Agenda

Date: Tuesday, 22 July 2025

Time: 9.30am

Location: Conference Rooms A&B, Research & Development Centre, Kingsway, Derby, DE22, 3LZ

Item	Time	Topic	Lead
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	Selina Ullah
2	9.35	Board Story – Children and Young People	Tumi Banda
3	10.00	Minutes of the Board of Directors meeting held on 3 June 2025	Selina Ullah
4		Action Matrix and Matters Arising	
5		Questions from members of the public	
6	10.05	Chair's update – verbal	Selina Ullah
7	10.15	Chief Executive's update	Mark Powell
8	10.25	Integrated Performance report, including Operations, Finance, People and Quality	Vikki Ashton Taylor/ Tumi Banda/Rebecca Oakley/James Sabin
BREAK 10.55am			
9	11.05	Corporate Cost Reduction (for retrospective approval)	James Sabin
10	11.15	Fit and Proper Persons Test Declarations	Justine Fitzjohn
11	11.20	Winter Plan – 2025/26	Vikki Ashton Taylor
12	11.30	Fundamental Standards of Care	Tumi Banda
13	11.40	Quality Delivery Plan (for ratification)	Tumi Banda
14	11.50	Board Committee Assurance Summaries	Committee Chairs
REPORTS FOR NOTING FOLLOWING ASSURANCE AT BOARD COMMITTEES			
15	12.15	<u>People and Culture Committee</u> 15.1 Flu Vaccination Plan – winter 2025/26 <u>Quality and Safeguarding Committee</u> 15.2 Guardian of Safe Working Hours annual report	Ralph Knibbs Lynn Andrews
16	12.20	Consideration of any items affecting the Board Assurance Framework (BAF)	Selina Ullah
17		Meeting effectiveness	

FOR INFORMATION
Summary of Council of Governors meeting held 3 June 2025 Glossary of NHS Acronyms Forward Plan 2025/26

Next meeting:

Date:	Time:	Location:
23 September 2025	9.30am	Conference Rooms A&B, Research and Development Centre, Kingsway, Derby, DE55 3LZ. Arrangements will be notified on the Trust website seven days in advance of the meeting.

In the event of an emergency, should you require assistance to evacuate the building (eg due to mobility, hearing, vision, or other needs), please let us know so we can put a Personal Emergency Evacuation Plan (PEEP) in place for you – thank you.

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.

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.

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.

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.

WE MAKE A POSITIVE DIFFERENCE • IN EVERYTHING WE DO •

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

Inclusive
We respect and include everyone in all 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.

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

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)
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).

v1.1 DRAFT MINUTES

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, 3 June 2025

MEETING HELD IN PUBLIC

Commenced: 09.30am Closed: 12.47pm

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
	Vikki Ashton Taylor	Deputy Chief Executive and Chief Delivery Officer
	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
DHCFT2025/002	Alyson Akers	Trainee ACP, ND services and guest for Board Story
DHCFT2025/002	Adam	Guest for Board Story
	Jo Bradbury	Corporate Governance Officer
APOLOGIES	Deborah Good	Non-Executive Director
	Mark Powell	Chief Executive
OBSERVERS	Dave Allen	Public Governor, Chesterfield
	Fiona Birkbeck	Public Governor, High Peak and Derbyshire Dales
	Christopher Williams	Governor, Erewash
	Sandra Austin	Equal Network Advisor
	Sabeeha (Sabs) Anisah	Health Protection Lead Nurse (RN)
	Sarah Barker	Senior Occupational Therapist
	Hannah Buckland	Governance and Compliance Manager

DHCFT/ 2025/033	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** Trust Chair, Selina Ullah, welcomed Board colleagues and observers to the meeting. Apologies were as stated. It was noted that in the absence of Mark Powell, Chief Executive, Vikki Ashton Taylor, Deputy Chief Executive and Chief Delivery Officer, would deputise.

	The Register of Directors' Interest for 2025/26 was noted with no declarations of interest with any of the day's agenda items.
DHCFT/ 2025/034	**ANNUAL REVIEW OF 2024/25 DECLARATIONS OF INTEREST** The report set out the year-end Register of Directors' interests that would be published in the Annual Report for 2024/25. To ensure openness and transparency during Trust business, the Register was updated with each new interest declared/removed and the revised version was then reported to each Public Board. **RESOLVED: The Board of Directors approved and recorded the declarations of interest as disclosed. These were recorded in the Register of Interests which was accessible to the public at the Trust Head Office and would be listed in the Trust's Annual Report for 2024/25.**
DHCFT/ 2025/035	**BOARD STORY - MAKING INFORMATION EASIER TO UNDERSTAND IN NEURODEVELOPMENTAL SERVICES** The Board welcomed Adam and Alyson to talk about a project completed in Neurodevelopmental services which looked to improve the accessibility of written patient information. Understanding health literacy and making communication reasonable adjustments are vital to ensure information produced by the Trust is meaningful, accessible and relevant. The project was focused on how Easy Read materials were created to ensure a consistent approach to developing letters and patient information that people with a learning disability (and wider literacy/accessibility requirements) could read, understand and remember. It was noted that Adam and Alyson would be raising awareness of the project amongst colleagues as it developed and everyone was asked to consider the needs of patients and communities when creating written information. To provide some context to showcase the Easy Read project, Alyson quoted some interesting statistics, which included: • The average reading age in the UK is around 9 years (National Literacy Trust, 2017) • Four out of 10 adults are unable to understand everyday communications, such as letters, information, reports and graphs • In England, 42% of working-age adult population are unable to understand and make use of everyday health information, rising to 61% when numeracy skills are also required for comprehension, eg understanding figures and graphs (Public Health England, 2015) • Research shows that 60% of young offenders, 60-80% of service users within mental health psychiatric outpatients, up to 90% of people with learning disabilities and 40-65% of children in Children and Adult Mental Health services (CAMHS), rising to 80% of those with emotional and behavioural difficulties, have speech, language and communication difficulties. This covers a number of patients within the Trust who require additional support with their communication. Some of the benefits of providing good quality health literacy and communication reasonable adjustments were highlighted and included the following: • Reduction in the number of non-attendances at healthcare appointments • Reduction in complaints • Increased compliance and engagement throughout patient journey • More informed and meaningful decision making • People feel better about their health experiences • They have better relationships with healthcare staff and are more confident in their care • The NHS should be aiming for Plain English for all (Health Literacy Toolkit, HEE 2023) • The NHS should also be making information more accessible to those who need it, as per the Accessible Information Standard, 2017 • Cost savings (£1b saved by improving health literacy, representing 1% of the NHS budget, Marie Curie study 2016).

	Commenting on his 13 years with the Trust, five of which had been on a voluntary basis, Adam shared that his favourite tasks were helping people create Easy Reads and supporting those with learning disabilities. He mentioned GP letters regarding annual health checks, which used long words and jargon and expressed sadness when people were unable to understand what was written. Adam explained the basics of Easy Read: • Pictures on the left – short sentences on the right • Someone to read with • Information that is easy to understand. Lynn Andrews, Non-Executive Director, remarked that the ambition was not purely sharing information, but helping patients with recall. Andrew Harkness, Non-Executive Director, agreed that Easy Read supports with understanding of communications and asked Adam for his recommendations for improvement. It was noted that wider training and raising awareness would be beneficial, with additional help from Speech and Language Therapy services who are able to support in clinical settings, and also in a strategic way by giving a clinical perspective on communication within the trust. Reflecting on the impactful statistics quoted, Vikki pointed out the Trust had a legal duty to ensure information was accessible to all and also it was the right thing to do. **RESOLVED: The Board of Directors was inspired by the presentation, which emphasised the importance of health literacy and communication reasonable adjustments and the need to raise awareness of this.** **Post-meeting note, it has been requested to share an Easy Read version of this minute, please see Appendix A for information.**
DHCFT/ 2025/036	**MINUTES OF THE PREVIOUS BOARD OF DIRECTORS MEETING** The draft minutes of the previous meeting held on 4 March 2025 were accepted as a correct record of the meeting.
DHCFT/ 2025/037	**ACTION MATRIX AND MATTERS ARISING** The Board reviewed and closed the completed action. It was noted there would be more detail on the Talking Therapies service within the Chief Executive's update.
DHCFT/ 2025/038	**QUESTIONS FROM MEMBERS OF THE PUBLIC** No questions had been received.
DHCFT/ 2025/039	**CHAIR'S UPDATE** Selina provided the Board with her reflections on activity since the previous Board meeting on 4 March 2025. The current level of uncertainty within the NHS was highlighted, along with the need for greater efficiencies and the approaches taken to address the challenges faced, regarding the expectations announced by the Secretary of State. This included managing increased demand with reduced funding and capacity. Selina reflected on her participation in conversations across the Joined Up Care Derbyshire system. It was noted that regular feedback was received from Trust governors, including how Trust colleagues are affected by the changes.

	Recent visits to Trust services included the Derwent Unit and Crisis and Liaison team and Selina praised the great care provided by colleagues, often whilst under great pressure. Selina gave an overview of the official opening of Bluebell Ward, which took place in May. She encouraged people to visit the outstanding environment, and stated that the facilities are so good, patients don't want to be discharged. Nicola Owen, Ward Manager, had commented that the new Unit had *'de-escalated a lot of stress, it was now more relaxed with a sense of team working'*. There had been a number of Nominations and Remunerations meetings, as recruitment of two new Non-Executives was underway, given that the terms of office for Tony Edwards and Geoff Lewins were coming to an end. Selina praised the l sharing and guidance from those Governors and colleagues that had been involved. It was noted that two very strong candidates had been selected. Following a visit to the Wellbeing Hub at Chesterfield Royal Hospital, it was confirmed that Trust staff were able to enjoy a discounted rate to use these facilities. **RESOLVED: The Board of Directors noted the content of the report and asked for clarification as required.**
DHCFT/ 2025/040	**<u>CHIEF EXECUTIVE'S UPDATE</u>** The report provided an update on current local issues and national policy and also reflected a wider view of the Trust's operating environment. In the absence of Mark Powell, Chief Executive, Vikki highlighted the following matters: The Care Quality Commission (CQC) had recently visited the Trust's Older Adult Acute Inpatient services and shared positive feedback which commended staff working in those areas. The formal report was awaited. Building on the already strong relationship with the University of Derby, it was noted that a strategic partnership had now been agreed which would be mutually beneficial in a number of areas. This included an upskilling programme for international doctors, service development and the use of technologies to support and understand the needs of the Trust's local communities. An update on Derbyshire's NHS Talking Therapies services was provided. Focused work was underway to ensure a smooth transition of staff, services, people receiving services and those on the waiting list, from the Trust to Vita Health Group, the new lead provider. It was noted that the Trust would cease provision of the service on 1 July. Sincere thanks and appreciation were extended to the staff working in those services, whose dedication and professionalism had been exemplary over many years. An observation from Tony Edwards, Deputy Trust Chair, questioned how a private organisation was able to provide the same level of service, whilst also subcontracting some of the work, whereas the Trust was unable to do the same with the financial envelope offered? In response, Vikki pointed out that other organisations may not have the infrastructure and national costs of the NHS. She added that Vita was partnering with Everyturn, which was a charity. It was noted that the Trust's model of care design was more expensive and this needed to be challenged, whilst remaining safe and effective. There was a requirement to be agile in order to compete for those services that go out to procurement. It was agreed that the Board needed a principle debate around income generation and the potential to have subsidiary organisations as an option when tendering. This would be discussed at the June Board Development Session. It was noted that in a TUPE situation, all terms and conditions of employment must be honoured, with the exception of the pension, which could change from day one.

	Arun Chidambaram, Medical Director, acknowledged consideration needed to be given to physical space, estate, digital implications, clinician engagement and the addition of value, effectively, transformation was required. **RESOLVED: The Board of Directors noted the report.**
DHCFT/ 2025/041	**<u>INTEGRATED PERFORMANCE REPORT (IPR)</u>** The IPR provided an update on key operational, quality and people measures up to the end of April 2025, and at financial year end regarding the finance measures. Executive Directors drew attention to the following areas and responded to questions: **Operational** Vikki was delighted to report that there was a number of Trust services achieving or exceeding national expectations on performance. By way of regional comparison, it was noted that dementia diagnosis, children and young people contacts, Adult Community Mental Health contacts and Perinatal access all performed favourably. In terms of service delivery, the waiting times for adult autism spectrum disorder (ASD) assessments remained a challenge, with over 1,200 referrals received in 2024/25. Completion of assessments had remained extremely high within existing resources. Vikki highlighted that the Trust expected to receive formal confirmation from the Integrated Care Board (ICB) to commission additional activity, along with a new service. It was noted that the number of inappropriate Out of Area placements had fluctuated, some of which was attributed to the Making Room for Dignity (MRfD) moving dates. Vikki was optimistic that a reduction would be evidenced now that some beds were open. Tony pointed out that the new facilities were so good, a challenge would be that people would not want to leave and he questioned if the readiness to leave assessment would change in light of this? Arun responded that there was no evidence of an increased length of stay and that faster recovery and discharge was anticipated. Geoff Lewins, Non-Executive Director, observed the need to review the Trust's clinical models, highlighting that the ASD team was over-performing by 300% due to increased referrals. He said the only solution was for increased capacity. Following on from this, Vikki gave an explanation of the Mental Health Services Assessment Tool (Men-Sat), which was a targeted support offer provided by NHS England's, Mental Health Improvement Support team. The offer included review of the Trust's community healthcare pathway to diagnose issues, working across all partners, such as voluntary organisations, social services and the police, to provide care to people in need and avoid escalation to Inpatient services. It was noted that this was a six month programme in the diagnostic phase, before agreeing key actions to facilitate change, such as reduced length of stay, improved expediency for clinical discharge and reduction of inappropriate out of area placements. It was noted that the specifics from the commissioners would confirm if the additional resources were for the new service or also to support existing services. **Finance** James Sabin, Director of Finance, reported that the Trust ended last year with a financial deficit. As a result of bringing the new inpatient facilities into use through the Making Room for Dignity programme, a valuation led to an impairment of £23.8m which was the main driver of a reported out-turn deficit of £25.2m (before adjusting for technical adjustments). It was noted that a number of required technical adjustments offset this deficit to return the Trust to its adjusted break-even position. From a performance perspective, the Trust delivered a break-even position against a £6.4m deficit plan.

It was highlighted that the cost improvement plan for 2024/25 was delivered in full, making higher than anticipated savings in some areas including through the reduced use of agency staffing. It was emphasised that it would be a challenge to achieve the financial balance in the current year. James advised that the Trust currently had a savings gap of £400k to identify from the overall target of £14.7m.

People

Rebecca Oakley, Director of People, Organisational Development and Inclusion, highlighted the introduction of an oversight group and reduction plan to manage staff absence and that there would be increased control of long-term absences.

The Trust had welcomed colleagues joining Derbyshire Healthcare to create an in-house Employee Relations (ER) team (moving away from the service being offered through the People Services joint venture). This change was in order to provide prompt resolution to any ER cases, supporting teams and colleagues compassionately. It was noted that those affected by organisational change would have access to fast-tracked support.

Due to a significant increase in non-attendance for mandatory training, Rebecca confirmed there was to be additional focus in this area, with similar scrutiny around appraisal and supervision compliance, including escalation to Executive Directors.

The improved processes to hold managers to account was praised by Tony.

Selina asked where the Trust sat in relation to the national annual turnover stability index and it was advised that turnover was stable at just over 10% and that Rebecca would revert with more detail. **Action**.

Post-meeting note, data on turnover received from the organisation benchmarking tool, February 2025. The Trust had the fourth highest stability index of all mental health and learning disability trusts:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/february-2025

Selina welcomed Vikki's proposal to review the format of the IPR in line with the new draft NHS Performance and Assessment Framework (NPAF). This would involve the IPR mirroring those changes to ensure the Board saw what the Trust was being held to account against nationally.

It was noted that a restyled IPR was being developed to demonstrate performance against the new NPAF.

Quality

Tumi Banda, Director of Nursing, AHPs, Quality and Patient Experience, reported a reduction in the number of formal complaints along with a positive increase in the risk assessments and care plan compliance.

Increased use of seclusion was noted, which had coincided with the opening of the Derwent Unit. It was emphasised that the new environment would provide the opportunity for better use of activities, along with de-escalation space.

In relation to care hours per patient day (CHPPD), a metric to ensure safe staffing, the Trust compared well with other organisations. Tumi explained that the guidance was for a minimum of two registered Nurses per shift and the CHPPD was based on patient need, whereas the safer staffing standard was based on maintenance of a safe environment. Lynn pointed out a correlation between the two, in that CHPPD did not capture all staff, it related to Nursing and Allied Health Professionals, at a particular point in the day, as per the national dashboard.

RESOLVED: The Board of Directors confirmed significant assurance on current performance across the areas presented, as there was 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.
DHCFT/ 2025/042	**YEAR-END FINANCIAL POSITION – 2024/25** James delivered an update on the financial position for 2024/25. It was noted that 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 was breakeven against a deficit plan of £6.4m. 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. It was reported that 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 was non-recurrent in nature and therefore the underlying deficit of £6.4m remained going into 2025/26. It was noted that the draft annual accounts were submitted on 25 April and were subject to audit review with final accounts due on 30 June. **RESOLVED: The Board of Directors noted the financial position for 2024/25.**
DHCFT/ 2025/043	**MAKING ROOM FOR DIGNITY PROGRAMME UPDATE** Andy Harrison, Senior Responsible Owner, gave a presentation on progress of the new units, which were designed to promote a therapeutic model of care to enhance recovery and reduce people's length of stay in Trust services. The new Acute units and Psychiatric Intensive Care Unit (PICU) would also provide additional capacity to support people within Derbyshire, thereby reducing the number of people being supported out of area. The current position with each of the construction projects was summarised: • Bluebell Ward – which offered 12 beds for older adults with functional mental health diagnoses, opened in January. An official opening of the new ward, which was located on the Walton Hospital site in Chesterfield, took place in May. Positive feedback had been shared by patients, carers and colleagues and the Board noted a recent benefits realisation report which confirmed the new environment had resulted in a reduction in the number of risks registered • Derwent Unit – the new 54-bedded acute inpatient unit opened in March on the Chesterfield Royal Hospital site • Carsington Unit - the new 54-bedded acute inpatient unit opened in May on the Kingsway Hospital site in Derby • Radbourne Unit – refurbishment was due to commence shortly. Two wards supporting male patients would remain at the site although internal moves had taken place to minimise potential disruption to patient facing services • Audrey House (Enhanced Care Unit) and Kingfisher House (Psychiatric Intensive Care Unit or PICU) were in the final stages of completion and expected to open to patients in the coming months. Interested in Andy's reflections, Ralph Knibbs, Senior Independent Director, asked him to identify one unintended, positive consequence from the experience, to which Andy replied that it had been possible to remove a magnitude of risks associated with clinical environments from the project Risk Register. On the reverse of that question, Selina asked what had been the greatest learning point in relation to what hadn't gone so well? Jokingly, Andy said he would have liked a crystal ball to foresee the hyper-inflation when writing the final business cases. In seriousness, the

	importance of checking and rechecking the plans during the design period, was stressed, along with the need for a clear understanding prior to building completion/readiness sign-off. James agreed it was essential to focus on the designs and he added that changes and pauses were the two aspects that costed the most. The Board congratulated Andy and the team for the excellent achievements and in particular, for the opening of the Carsington Unit. Lynn recognised the amount of challenge that had been presented and the professional manner in which these had been met. She reflected on the essential impact for staff and patients and emphasised that there any been no negative feedback in relation to moves. **RESOLVED: The Board of Directors noted the progress to date and congratulated the team on its delivery of the MRfD Programme.**
DHCFT/ 2025/044	**TRUST STRATEGY PROGRESS UPDATE** Vikki presented an update on the arrangements to enact and oversee delivery of Trust strategy. It was agreed that the IPR should be refreshed in order to reflect and identify achievement towards the Strategy. Andrew and Lynn requested improved governance and reporting at Board committees in addition to Board oversight. Tony recommended the relevant stakeholders met to align the four Ps of the Strategy to the assurance committees. In agreement with all comments, Vikki confirmed the new Strategic Portfolio Oversight Group would provide overall scrutiny along with committee assurance. **RESOLVED: The Board of Directors noted the update on the arrangements to enact and oversee delivery of Trust strategy.**
DHCFT/ 2025/045	**2025/26 PLAN** **Planning update** James provided an update on the final financial plan which was resubmitted at the end of April. The main changes to the financial plan were around capital and efficiencies. It was noted that changes in the workforce plan would reflect the full year investment in the MRfD programme, along with reductions in relation to pay related efficiencies. James highlighted that at the time of the March submission, there was an unidentified gap in the programme of £4.1m, which had now reduced to zero in the resubmission and the recurrent schemes totalled £12.1m which equated to 82%. Comparing expenditure levels from quarter 4 of 2024/25 pro-rata to the plan for 2025/26, it would be possible to deliver both bank and agency cost improvement programmes and costs should remain within the reduced budgets. Reflecting on the encouraging position, Geoff asked about opportunities for future progress. In response, James acknowledged the high volume of unmitigated risks across the system, which were transparently reported nationally. He pointed out that the Trust had been extremely fortunate to receive funding for the ASD service. Rebecca was keen to increase scrutiny around bank usage and mentioned that implantation of a 'spot rate' for those workers currently on the Agenda for Change scale may support as there would be no incremental changes.

	Referring to the national ask to reduce any increased corporate costs since 2019 by 50% by the end of quarter 3, James advised the current CIP plans were currently sufficient, however, this may change depending on how the guidance is formulated. **RESOLVED: The Board of Directors noted the resubmission of the 2025/26 plan.** **Medium Term Financial Plan (MTFP)** The Board of Directors was provided with an update on the requirement for an MTFP for the Trust and the Derbyshire system. It was noted that the underlying 'live' plan was based on the known and agreed system position and that the baseline point indicated the scale of challenge. James stated the plan was helpful for scenario modelling across the system. **RESOLVED: The Board of Directors signed-off the process and timelines for the production of the Medium-Term Financial plan.**
DHCFT/ 2025/046	**CORPORATE GOVERNANCE REPORT** Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary, asked the Board 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 the regulatory self-declaration on continuity of services. Recognition was extended to Lynn, who had supported with the development of an online process to measure Committee effectiveness. **RESOLVED: The Board of Directors:** **1. Approved the suite of ToR for Board Committees** **2. Noted the assurance received by the Audit and Risk Committee that all Board Committees had effectively carried out their role and responsibilities as defined by their Terms of Reference during 2024/25 and received the year-end report of the Audit and Risk Committee** **3. Noted the Trust seal report** **4. Approved the Continuation of Services Condition 7 self-declaration.**
DHCFT/ 2025/047	**BOARD ASSURANCE FRAMEWORK (BAF) UPDATE, ISSUE 1, VERSION 1.3, 2025/26** Justine presented the current issue of the BAF, highlighting the broader wording around the Trust Priorities, the four Ps. Attention was drawn to an issue around the prescribing of sodium valproate. Arun explained that an agreed plan had been discussed at the Medical Senate which would provide resolution. **RESOLVED: The Board of Directors:** **1. Received assurance from the Medical Director that the medical action plan to manage the linked operational risk 22790 (sodium valproate) set out the timelines for delivery against the actions** **2. Reviewed and approved Issue 1 of the BAF for 2025/26 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** **3. Agreed to receive updates in line with the forward plan for the Trust Board.**
DHCFT/ 2025/048	**TRANSFORMATION AND CONTINUOUS IMPROVEMENT (BI-ANNUAL)** The Board received an update on development of the Transformation and Continuous Improvement framework and associated delivery plan. Vikki highlighted that best practice was to use a standardised project management framework, supported by a Programme Management Office (PMO). She added that in order to begin

	delivery of the plan, a refresh of the baseline self-assessment against the NHS IMPACT framework had been completed. Commenting on the comprehensive and structured programme, Geoff asked what sat beneath? In response, Vikki acknowledged that more Quality Improvement trained people would be beneficial and that reorganisation in other areas had enhanced the team, increasing capacity. It was noted that all Divisions were targeted to identify a certain amount of improvements and their own project plans and that the PMO method had already been used successfully. Arun emphasised the positive impact of the programme, which included bringing teams together, strengthening relationships and improving patient experience. The psyomics platform was also mentioned and it was noted that liaison with other trusts had evidenced this digital health tool demonstrated a lot of potential to reduce waiting lists and would be considered further at Executive Leadership Team (ELT)/Trust Delivery Group. On behalf of the Board, Selina expressed thanks to Vikki and Maria Riley, Assistant Director of Transformation, for the good work. **RESOLVED: The Board of Directors:** **1. Noted the development of the Transformation and Improvement Framework, and associated delivery plan** **2. Supported implementation of the approach and arrangements described.**
DHCFT/ 2025/049	**INTENSIVE AND ASSERTIVE COMMUNITY MENTAL HEALTH TREATMENT – INDEPENDENT HOMICIDE REVIEW - NOTTINGHAM** The Board received a progress report on the Trust's plans to implement learning following the serious incident in Nottingham in June 2023 and the recommendations from the independent review and the Care Quality Commission (CQC) Section 48 review of Nottinghamshire Healthcare NHS Foundation Trust. It was noted that funding had not been identified to create a standalone Assertive Outreach team and risks were currently being mitigated within the current model of care. Lynn highlighted that assurance had been reviewed at the Quality and Safeguarding Committee and whilst good mitigations were in place, there was a lot of caseload management. Selina acknowledged the level of risk Trust Community teams were carrying. It was noted that alignment with some national and local initiatives had improved practice. Vikki pointed out that the ICB needed a report which set out the mitigation plan for those risks identified, including costs, resources and the investment required. **Action, Tumi to prepare a Board letter for the ICB**. **RESOLVED: The Board of Directors noted the work undertaken to date in ensuring the recommendations from the independent review were being addressed.**
DHCFT/ 2025/050	**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 to be taken forward in forthcoming meetings. The following points were brought to the attention of the Board by Committee Chairs: **Finance and Performance Committee:** There had been three meetings since the last Board meeting, all of which were documented in the papers. It was noted that the Estates Plan which had provided limited assurance, reflected a maintenance backlog. However, Committee Chair, Tony Edwards, advised this was relatively

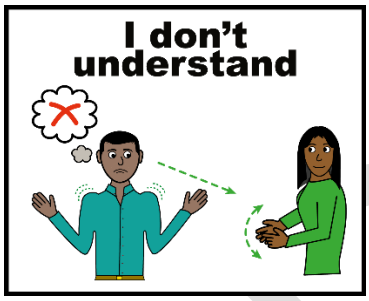
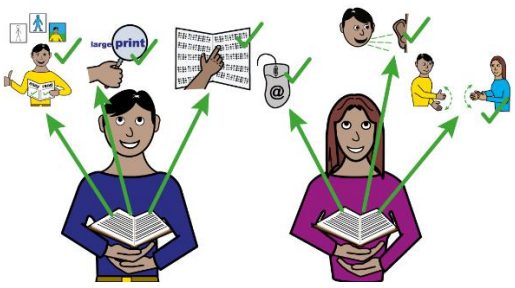
	small compared to other trusts. James advised that £18m had been set aside for expansion development to align existing estate with the new builds. **Quality and Safeguarding Committee:** Committee Chair, Lynn Andrews, confirmed that challenges within the Patient Safety team had now been resolved, and the backlog was being worked through. Justine asked if the high number of reports in May with an amber rating (limited assurance) was a cause for concern? Lynn confirmed that overall, significant progress was being made, however, the recommendations offered limited assurance in relation to the controls. **Mental Health Act Committee:** In relation to the level of amber rated reports, Geoff stated the Committee required improvement in a number of areas, including Restrictive Practice and use of the Brigid app to record observations. **People and Culture Committee:** Committee Chair, Ralph Knibbs, confirmed that MRfD was now a standard agenda item, focusing on induction and training. He remarked on the good collaboration between the Finance and Performance, People and Culture and Quality and Safeguarding Committee Chairs. The two Extra-ordinary meetings had been in consideration of the new operating model, consultation and ensuring people were treated with dignity and respect throughout the process. **Audit and Risk Committee:** The two meetings had generally been positive and progress had been made towards the accounts sign-off. Committee Chair, Geoff Lewins, highlighted the number of overdue risk reviews and was optimistic that a lot of operational risks would be removed with the move to the new facilities. **RESOLVED: The Board of Directors noted the Board Assurance Summaries.**
DHCFT/ 2025/051	**<u>REPORTS FOR NOTING ON ASSURANCE</u>** The following reports were received, in line with the Board's Forward Plan: **People and Culture Committee:** the following reports were received for information and noting having provided assurance to the People and Culture Committee on 25 March and 1 May. <u>Modern Slavery Statement</u> The 2024/25 annual statement was considered and supported by the People and Culture Committee as evidence that the Trust had met the criteria for the preceding financial year. The Board approved the Annual Modern Slavery Statement for sign-off by the Chair and Chief Executive and this would be uploaded to the Trust's website, replacing the previous version. <u>Gender, Ethnicity and Disability Pay Gap</u> The paper informed that the Trust had a median gender pay gap of 7.81%, a median ethnicity pay gap of 2.56% and there was no median disability pay gap. A number of actions were being worked on over the next 12 months to reduce the gaps. <u>Medical Appraisal and Revalidation</u> The Board of Directors noted the contents of the report, which offered a significant level of assurance as there is a sound system; process, governance and assurance to meet the Trust objectives. However, inconsistent application arose in terms of the engagement of a small number of individual clinicians. **Quality and Safeguarding Committee:** the following reports were received for information and noting having provided assurance to the Quality and Safeguarding Committee on 7 May. <u>Learning from Deaths/Mortality</u> The annual report provided limited assurance that the Trust was following recommendations outlined in the National Guidance on Learning from Deaths.

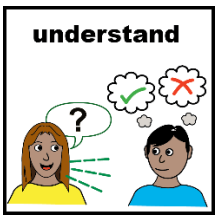
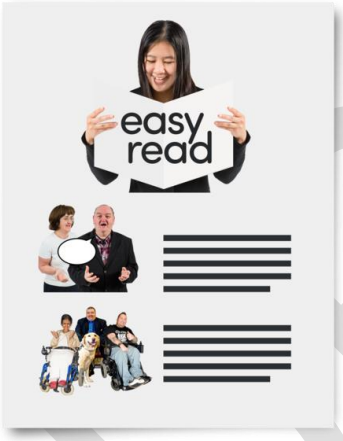
	Special Educational Needs and Disabilities (SEND) annual report The Board of Directors reviewed the report and accepted limited assurance due to the nature of new requirements and the need for more partnership working.
DHCFT/ 2025/052	**CONSIDERATION OF ANY ITEMS AFFECTING THE BOARD ASSURANCE FRAMEWORK (BAF)** No issues were identified for inclusion in the BAF.
DHCFT/ 2025/053	**MEETING EFFECTIVENESS** Observers at the meeting were asked for their thoughts and commented that whilst it had been difficult to follow the papers due to the volume, the insight into the Board workings had been enlightening. Dave Allen, Public Governor commented that the discussion on some items would be followed on at the Council of Governors meeting that afternoon. It was highlighted that attendance in person rather than virtually had ensured an improved experience. In particular, the co-production of patient letters was welcomed.
The next meeting to be held in public session will be held in person on 22 July 2025 at 9.30am in Conference Rooms A and B, Centre for Research and Development, Kingsway, Derby.	

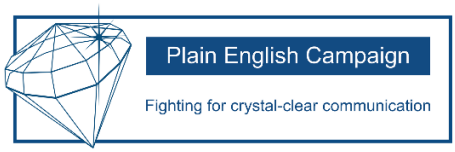
Appendix A

Board Story - 3 June 2025

Easy Read version

 	Alyson and Adam came to speak at the board meeting in June 2025 about their Easy Read project.
Health Literacy Derbyshire Healthcare NHS Foundation Trust	Alyson talked about health literacy. This means the NHS needs to make what we tell people easy enough to understand for everyone.
	Alyson said that lots of people across our services have communication difficulties – often staff don't realise.
	We need to know how and when to make communication reasonable adjustments.
	This means we have to change how we communicate to make sure people understand and can be involved.

	Adam talked about himself and how he communicates.
 	Adam likes to have Easy Read information to help him understand and remember things.
	Adam talked about the Easy Read project we did in Neurodevelopmental services. He said what Easy Read should look like • picture on the left • simple writing on the right • short sentences • no jargon or complicated words!
	We trained someone from every team in the ND service how to make Easy Read information.

 	Adam and Alyson said that they would like the trust to think about: • The Trust should be making everything we communicate in Plain English for everybody, staff need to know about health literacy • As well as this, lots of patients in lots of services will have communication difficulties • Staff need training to realise when people have communication difficulties and how to help.

ACTION MATRIX - BOARD OF DIRECTORS - JULY 2025

Date	Minute Ref	Item	Lead	Action	Completion Date	Current Position	
03-Jun-2025	DHCFT/2025/041	Integrated Performance Report (IPR) People	Rebecca Oakley, Director of People, Organisational Development and Inclusion	Share the Trust's position in the national annual turnover stability index.	10-Jun-2025	Turnover from organisation benchmarking tool, Feb-2025 - data received. The Trust has the fourth highest stability index of all mental health and learning disability trusts *https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/february-2025*	Green
03-Jun-2025	DHCFT/2025/049	Intensive and Assertive Community Mental Health Treatment - Independent Homicide Review - Nottingham	Tumi Banda, Director of Nursing, AHPs, Quality and Patient Experience	A report setting out the mitigation plan for the risks identified, including costs, resources and the investment required, to be submitted to the ICB.	19-Jun-2025	Letter drafted by Tumi and issued by Mark Powell on 19-Jun-2025 to Dean Howells at the ICB.	Green

Key:	**Action Overdue**	RED		**0**	**0%**
	Action Ongoing/Update Required	AMBER		**0**	**0%**
	Resolved	GREEN		**2**	**100%**
	Agenda item for future meeting	YELLOW		**0**	**0%**
				2	**100%**

Chief Executive's update

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

10 Year Health Plan

The government has now published the 10 Year Health Plan. The plan sets out how the government will reinvent the NHS through the three shifts we have been discussing over the last year:

- From hospital to community
- From analogue to digital
- From sickness to prevention

NHS Providers have shared a useful briefing document outlining the key policy announcements in the plan. There is also an open letter to staff from Jim Mackey, NHS Chief Executive, and Wes Streeting, the Secretary of State for Health and Social Care, which can be found on the NHS England website.

The changes outlined provide clarity over the future direction of travel and, in most instances, align with the Trust's strategy, supporting the work we currently have in place and in development. The plan is extensive and sets out significant changes that are expected to be delivered over the coming months and years.

Further detail regarding some delivery plans are expected to be published after the summer. In the meantime, we will need to fully digest the content of the plan and assess both the opportunities and challenges it presents to the delivery of the Trust's Strategy.

Changes to NHS Regulatory bodies

Last month the government announced further changes that will significantly alter the NHS regulatory landscape. The purpose of the changes described by the Department of Health and Social Care is to reduce complexity, improve accountability, and focus on patient-centred care. Currently, over 150 bodies are involved in assessing quality and issuing guidance across health and care settings, and the number has grown over the past decade, often resulting in overlapping responsibilities and uncoordinated recommendations that have placed additional burdens on NHS staff and organisations.

To address this, the government plans to abolish a significant number of organisations and bodies, including the National Guardian's Office (Freedom to Speak Up), Healthwatch England, Commissioning Support Units and Integrated Care Partnerships.

This move is intended to simplify the system, eliminate unnecessary bureaucracy and redirect resources to frontline services.

In early July, Dr Penny Dash published her report into the review of patient safety across the health and care landscape.She has made nine key recommendations aimed at streamlining oversight, improving accountability, and enhancing patient outcomes. All recommendations have been accepted and are summarised below:

1. revamp, revitalise and significantly enhance the role of the National Quality Board
2. continue to rebuild the Care Quality Commission with a clear remit and responsibility
3. continue the Health Services Safety Investigations Body's role as a centre of excellence for investigations and clarify the remit of any future investigations
4. transfer the hosting arrangement of the Patient Safety Commissioner to the Medicines and Healthcare products Regulatory Agency (MHRA), and broader patient safety work to a new directorate for patient experience within NHS England, transferring to the new proposed structure within DHSC
5. bring together the work of Local Healthwatch, and the engagement functions of integrated care boards (ICBs) and providers, to ensure patient and wider community input into the planning and design of services
6. streamline functions relating to staff voice
7. reinforce the responsibility for and accountability of commissioners and providers in the delivery and assurance of high-quality care
8. technology, data and analytics should be playing a far more significant role in supporting the quality of health and social care
9. there should be a national strategy for quality in adult social care, underpinned by clear evidence.

Model ICB 'blueprint'

Following on from my last update about the reallocation of functions within the NHS and how it is going to operate in the future, NHS England has shared a blueprint[1] which outlines the strategic direction for Integrated Care Boards (ICBs).

The blueprint creates an opportunity to reset the system, and the changes will see the ICB focus on the things that only they can do to improve the population's health, ensure access to consistently high quality services, and make best use of the local health budget; such as strategic commissioning, neighbourhood health, addressing health inequalities and service user involvement, in line with the 10 Year Health Plan.

To allow the ICB to focus on these things, some of their current responsibilities will transfer to the regional/national teams such as oversight of provider performance, Emergency Preparedness, Resilience, and Response (EPRR), and high-level strategic workforce planning. Some responsibilities will also transfer to providers, such as digital, medicines optimisation, and pathway and service development programmes.

Locally, the ICB clustering arrangement comprising Derby and Derbyshire, Lincolnshire, and Nottingham and Nottinghamshire ICBs has been announced. We should start to see what the other final arrangements for the new system, regionally and nationally arrangements will look like through the summer. There will of course be the requirement to understand what these changes mean for us practically and how we build on the relationships with our partners and colleagues during this next phase.

Urgent and Emergency Care Plan for 2025/26 and winter planning

Published last month, this plan requires all system partners to work collaboratively to improve the effectiveness of urgent and emergency care pathways. One of the seven priorities is 'reducing the number of patients who remain in an emergency department for longer than 24 hours while awaiting a mental health admission'.

[1] Model-ICB-Blueprint-02.05.2025.pdf

The expectations for winter planning have been set out. The submissions need to be made by August 2025 and there is a focus on board visibility and assurance that these expectations will be met. There is a separate report on today's agenda which sets out the key themes and the priority areas for system plans.

NHS Oversight Framework 2025/26

This new one year framework sets out how NHS England will assess ICBs and providers against a range of agreed metrics, promoting improvement while helping to identify organisations needing support. The framework will be reviewed in 2026/27 to incorporate work to implement the ICB operating model and to take account of the ambitions and priorities in the 10 Year Health Plan.

There is an expectation that every ICB and provider must deliver a balanced net system financial position and unless providers are delivering a surplus or breakeven position, their segmentation will be limited to no better than 3. Provider segmentation positions will be confirmed on 21 July.

The framework outlines the circumstances in which providers can obtain increased freedoms. It also describes how NHS England will determine whether a provider's performance falls below an acceptable standard and/or has governance concerns that may lead NHS England to use regulatory powers to step in and secure improvement. NHS England will not be segmenting ICBs in 2025/26, as this will be a year of significant change for these organisations.

Workforce race and disability equality standards data published

NHS England has published the annual Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) data reports. These reports continue to support trusts' work to achieve the goals of NHSE's 2023 equality, diversity and inclusion improvement plan.

The reports aim to:

- enable organisations to compare their performance with others in their region and those providing similar services, with the aim of encouraging improvement by learning and sharing good practice
- provide a national picture of WRES and WDES in practice, to colleagues, organisations and the public on the developments in the workforce race equality agenda.

NHS Providers summarises the data as showing steady but slow progress and highlight the need for the NHS to have a sustained focus on providing equal opportunities for career progression and promotion for staff from ethnic minority backgrounds. They also highlight worrying results showing staff with disabilities being more likely to experience bullying and harassment at work. Our WRES and WDES data was discussed by our People and Culture Committee in May and a summary of this is included in the People and Culture Committee report.

Regional and local context

Care Quality Commission (CQC) report into older adult inpatient services

On Friday 27 June, the Care Quality Commission (CQC) published their report into our Older Adult Inpatient services, following the inspection that took place this spring. This confirmed that the overall rating is rated good, with a good rating also being achieved across all domains. This is positive news, and an improvement on the previous ratings.

The report highlights several areas of good practice, including positive feedback on Trust colleagues and how they demonstrated a high level of care for the people they look after, and show kindness and respect. Our teams were also commended for helping people to maintain important relationships and stay connected with their communities and for the leadership shown across Older Adult services.

There are a small number of improvements highlighted, including effectively using IT tools to record observation checks and using evidence-based tools to track and monitor people's behaviour. We are committed to ensuring ongoing learning and further improvements across our Older Adult services.

Quality Account

The Trust's Quality Account 2024/24 is available on the Trust's website on this link. Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders.

Making Room for Dignity programme

Refurbishment work has now resumed at the Radbourne Unit, to create single ensuite bedrooms across two wards. Colleagues and patients on Ward 34 have relocated to the vacant Ward 35 to minimise the disruption and noise experienced by people who continue to use the unit.

Strategic partnership with the University of Derby

The Trust recently signed a Strategic Partnership Agreement with the University of Derby to develop a more joined-up approach to the teaching of students and a more research-based approach to the delivery of healthcare. The three-year agreement between the University of Derby and the Trust will also build on existing relationships to strengthen knowledge, exchange opportunities, further develop the skills and expertise of the healthcare workforce and offer students an optimal learning experience. In addition, it will enable both organisations to work together on broader opportunities across the city and county.

Local Government reform in Derbyshire

Councillor Alan Graves, Leader of Derbyshire County Council, has recently written to me to provide an update on the County Council's progress towards proposals for local government reform in Derbyshire, specifically the Government's programme of reorganisation to create new unitary councils across two-tier areas.

At its Full Council meeting on 9 July, a recommendation will be put forward to agree in principle to a preferred option of a two unitary authority model for the county area on a north/south configuration and approval will be sought to further develop proposals, including a detailed options appraisal and full business case. If the new preferred option is approved, a period of public consultation will follow to engage with residents, businesses and stakeholders, including the NHS, to seek views.

Provider collaboration

The Joined-Up Care Derbyshire Provider Collaborative has set out its high-level work programme for 2025/26. The content of the programme reflects the two main priorities for the collaborative:

- Integrated Clinical pathways which address financial and operational sustainability as well as improved outcomes
- Enabling Services: improving productivity and efficiency through shared working.

A review of enabling services has been conducted by Deloitte, demonstrating the benefits which could be gained through at scale working. The scope of this work has covered finance, digital and data, procurement, estates, people services and governance and legal. The next step will be to focus on those services with the greatest potential for achieving savings and with the lowest complexity of implementation.

At present, the work has focussed on the four NHS Foundation Trusts but there is a willingness to involve other partners in the work, including providers in neighbouring ICSs and ICBs, where this makes sense and does not delay progress.

Armed Forces Week

On 25 June, I had the privilege of opening an event recognising Armed Forces Week, on behalf of the Armed Forces Network that is run jointly between the Trust and Derbyshire Community Health Services (DCHS). Attendees heard from other speakers who shared details from Op NOVA, Op COURAGE and Op RESTORE – which each champion the physical and mental wellbeing of people in the armed forces.

It was also interesting to visit stalls and discuss how different partners can work together to support mental wellbeing and recovery principles and to hear more about some of the work and activities that are taking place locally.

Recent achievements

- The Trust was named the winner in two categories at the 2025 HSJ (Health Service Journal) Digital Awards in June, recognising the organisation's commitment to digital innovation and the transformative impact of digital technology on patient care and population health across Derbyshire. At a ceremony on 26 June, the Trust won the 'Digital Organisation of the Year' award in recognition of our successful rollout of a future-proof electronic patient record system. This achievement highlights our commitment to integrated, standardised, and transparent clinical systems that support consistent and safe patient care.
- Our School Nursing team received the 'Generating Impact in Population Health through Digital' award for transforming their approach to Health Needs Assessments using The Lancaster Model as a digital, evidence-based platform. This change has enabled the team to move from a reactive, safeguarding-focused service to a proactive, child-centred public health model. The digital insights gathered have already made a meaningful difference to the health and wellbeing of young people and their families across Derby City
- The Derby Psychiatry Teaching Unit – part of Derbyshire Healthcare NHS Foundation Trust – launched its Expert Patient Programme Toolkit at an event hosted by Lord Kamlesh Patel of Bradford at the House of Lords in early June. The milestone event marks the culmination of 17 years of pioneering work aimed at providing those who teach medical students with the resources they need to embed lived experience in their teaching. Developed by NHS professionals working in the education of medical students from the University of Nottingham, the toolkit represents the collective efforts of the faculty team and 60 expert patient teachers – believed to be the largest of its kind in the UK, and possibly the world
- The Division of Psychology and Psychological Therapies has been shortlisted for 'The Employer Award' category at the National Learning Disabilities and Autism Awards. This award celebrates organisations that go above and beyond to employ and support individuals with a learning disability or autism, creating inclusive workplaces where everyone can thrive
- Congratulations to Izzy Davies, Mental Health Practitioner in the South Dales Adult Community Mental Health team at St Oswald's Hospital, who was the DEED winner for May. Izzy was nominated for her devotion and commitment to her role as the wellbeing champion in the team. Her engaging sessions with the team reinforce the importance of being there for each other.

Staff engagement

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

- A coffee and conversation visit to our teams at Deepdale Business Park, in Bakewell in the High Peak on 5 June
- On 16 June I held a virtual engagement session for inductees who had joined the Trust in September, October, November and December, to hear about their experiences since joining our organisation

- A Board visit to the CAMHS and Breakout Substance Misuse Service on 1 July
- I visited the High Peak Living Well Community Mental Health Team (CMHT) Team at Corbar View in Buxton on 2 July.

Executive Directors have also been continuing with their visits around services at the following sites:

- Arun Chidambaram, Medical Director, visited The Beeches on a Board visit on 20 June
- Vikki Ashton Taylor, Deputy CEO and Chief Delivery Officer, visited the High Peak Crisis team in Chapel-en-le-Frith on 26 June and joined me on a visit to the Carsington Unit on 30 May
- Tumi Banda, Director of Nursing, AHPS, Quality and Patient Experience, visited the Derwent Unit in Chesterfield on 10 June
- Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary, joined a Board visit on 4 June to the IPS service at St Andrew's House, Derby
- James Sabin, Director of Finance, visited Kedleston Unit and Cherry Tree Close on 1 July.

Raising awareness

In June, the Trust supported awareness raising for a range of different events including Learning Disability Week, Pride Month, Volunteers Week, Carers Week, Men's Health Week, Estates and Facilities Day, Refugee Week, World Wellbeing Week and Armed Forces Week.

16 to 22 June was Learning Disabilities Week and the Trust highlighted the importance of free annual health checks for individuals with a learning disability.

As part of Men's Health Week, which took place from 9 to 15 June, David Mellors, ex-army veteran and current Peer Support Worker at the Trust, has shared his story. David, who has complex, post-traumatic stress disorder as a veteran, has received support from local charities, NHS therapists and the Trust's early intervention service to better navigate his mental health in a healthier way.

As we moved into July, we celebrated the NHS 77th birthday, with a NHS Big Tea event, which saw teams and units baking cakes to sell to raise money for our Trust's Charitable Funds. We also celebrated the birthday with a Park Run on Saturday 5 July, in which several staff took part to celebrate the day and raise funds for the Charitable Funds.

18 July is the start of South Asian Heritage Month, which will see the re-launch of our BME Staff Network. To celebrate the month, we will be sharing blogs from our South Asian colleagues, who will share details of their heritage and personal journeys.

Trust activity

March to June 2025

in numbers

NHS Derbyshire Healthcare NHS Foundation Trust

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

Our **Work Your Way** employment service successfully supported **81 people** open to community mental health services into **permanent work in roles of their choice.**

The East Midlands **Gambling Harms** Service received **162 self referrals** from people concerned about their gambling habits.

125 pregnant women or new mothers made a self referral to our **perinatal mental health services.**

Derbyshire Healthcare received **592 compliments** from service users, carers, families and students.

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

The Mental Health Helpline and Support Service spoke to **10,555 people** who needed help.

Between March and May 2025, our **Integrated Adult Neurodevelopmental Service** supported **1,247 people with a learning disability** to get an **annual health check** from their GP.

The Derbyshire Healthcare **website** was visited by **73,549 people** on **243,000 separate occasions.**

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

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 May 2025 regarding key operational, financial, quality and people measures.

Executive Summary

The Finance and Performance Committee ('the Committee') and Trust Board meetings are now synchronised to enable the Integrated Performance Report to be scrutinised by the Committee in advance of Trust Board.

The report provides the Trust Board with information that demonstrates performance against a suite of key operational targets and measures. The purpose of this 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.

Going forward, it is proposed to update the format and content of the report in line with the NHS England performance assessment framework measures proposed for this financial year once they have been finalised. A draft revised report format will be presented to the Board meeting for approval.

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 are as follows:

- **Adult autistic spectrum disorder assessment (ASD):** waiting times remain high at around 56 weeks, with demand far exceeding capacity. Negotiations continue with the Integrated Care Board (ICB) around a new model of service delivery, and discussions are progressing with a digital company and the transformation team to support the new service model
- **Community paediatrics:** waiting times continue to grow month on month owing to ongoing pathway issues and high levels of demand exceeding capacity by 380%. A recovery action plan is in place in order to reduce the speed of growth of the waiting list. It is likely that community paediatric waits would contribute towards the community 52 week waiting times measure proposed by NHS England in the draft performance assessment framework that was out for consultation until the end of May. The outcome of the consultation is pending
- **Early intervention in psychosis:** the target for referral to treatment within two weeks has not been achieved for the last few months. This has resulted from significant increase in referrals (36%), coupled with staffing issues owing to maternity leave, vacancies, and sickness. Proactive recruitment is underway, and use of bank staff where possible. The use of agency staff to try and increase compliance with the two week timeframe is also being considered
- **Inappropriate out of area adult acute placements:** there has been a reduction from a high of 28 back in January, to the current position of eight. 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.

The new adult acute inpatient units are now open in both Chesterfield and Derby. The purpose built buildings offer a range of usable spaces to aid patient recovery. They 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. Early indications suggest a reduction in length of stay on three of the wards recently, ranging from 20 to 32 days.

- The most recent Model Mental Health Trust benchmarking data (April 2025) indicate that the Trust's adult acute length of stay was three days longer than other mental health trusts in the region, and older adult acute length of stay was 29 days longer. The mental health helpline is reported as having the lowest proportion of calls received which are answered in the region. The percentage of calls answered in 60 seconds or less is below national average.

Most improved areas

- **Adult community mental health:** waiting list numbers and waiting times have reduced significantly. This is likely linked to the implementation of the living well model of care provision, which is having a positive impact on mental health liaison presentations, discharges, patient contacts, reduced long-term offer caseloads, and increased self-reintroduction to services
- **Transforming care programme:** all but one of the 10 targets for improving care for people with learning disabilities, autism or autistic spectrum conditions have been achieved, and the remaining target is close to being achieved
- **Adult ASD assessment**: the number of completed adult ASD assessments per month has remained extremely high, and the number of people waiting to be seen continues to reduce significantly, although it is acknowledged that the number waiting remains extremely high.

Areas of success

- **Dementia diagnosis:** the national target has been exceeded for the last two years, current placing at third highest in the region and 9th highest in the country
- **Children and young people mental health access:** performance has remained significantly high since December 2023
- **Three day follow-up:** patients are followed up in the days immediately following discharge from mental health inpatient wards in order 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
- **Community perinatal mental health service**: increasing numbers of women are being supported by the service, which now ranks second highest in the region against the national access standard.

Regional comparison

In the most recently published data 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, NHS Talking Therapies patients completing a course of treatment, adult community mental health contacts, and perinatal access.

Finance

At the end of May there is an overall deficit of £1.4m, which has been adjusted for the Public Finance Initiative (PFI) adjustment related to the International Financial Reporting Standards (IFRS) 16 accounting change, bringing the adjusted financial position to a deficit of £1.3m, which is on plan.

The forecast outturn remains in line with the breakeven plan, however there are several risks in delivering the financial plan:

- Delivery of efficiencies in full
- Adult Acute out of area placements
- Usage of bank and agency above planned levels
- Unfunded posts and other emerging cost pressures.

Efficiencies

The plan includes an efficiency requirement of £14.8m with the plan assuming 82% is delivered recurrently.

At the end of May efficiencies delivered to the plan of £1.86m. The forecast assumes the full efficiency plan is met in full.

Agency

Agency expenditure at the end of May is £0.5m, which equates to 1.5% of the total pay expenditure.

The two highest areas of agency usage continue to relate to consultants and nursing staff. However, medical agency expenditure has significantly reduced in May.

Adult Acute Out of Area Placements

The plan for out of area expenditure is based on a reducing trajectory from 32 to four beds by the end of the financial year. At the end of May expenditure was above plan by £1.4m. The forecast assumes an improving trajectory, with expenditure forecast to be above plan by £4.6m.

Capital Expenditure

At the end of May capital expenditure was below plan against both the system capital allocation and the national monies for the Making Room for Dignity programme. Capital expenditure is forecast to spend in full by the end of the financial year.

Cash

Cash at the end of May is at £17.6m which is higher than plan by £4.0m and forecast to be on plan at £25.4m by the end of the financial year.

People

Annual Appraisals

Appraisal compliance continues to remain high at 91% and has now surpassed the 90% Trust target. Compared to the previous month, compliance has increased by 1.37%. 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 94% compliant (an increase of 2% since the last reporting period) and Corporate services are at 91% (an increase of 1% since the last reporting period).

Staff Absence

The annual sickness absence rate is running at 5.89%, a reduction of 0.04% 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 Surgery. The absence oversight group has been formed. The group will focus on reviewing absence and other relevant data to inform the development of its delivery plan. A high-level overview has been produced with a focus on monitoring, policy, specific hot spot areas of focus, support for managers and support for our people. A Quality Improvement approach will be taken to focus on reducing sickness absence.

Proportion of Posts Filled

At the end of May, 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 remain low 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 82% and management supervision at 85%. Efforts continue to work with teams with low compliance and rates are expected to increase over the coming months.

Quality

Patient Experience

Compliments: Numbers fell below the expected threshold (140) in April and May. Underreporting is a concern, as informal feedback (eg DEED awards) suggests higher actual numbers. Actions include reinforcing recording processes via divisional meetings and CRG engagement.

Complaints:

- **Quick Resolution (QR):** Remain within acceptable limits, though an increase was seen due to resolution of backlog.
- **Closer Look (formal investigations):** Below mean and stable. Themes continue to be monitored and escalated through governance committees.

Discharge Readiness

- **Clinically Ready for Discharge (CRD):** Common variation pattern observed. Discharge delays are primarily due to housing, funding, and care placement barriers. Twice-weekly MADE meetings and a new 72-hour admission review (from July 2025) aim to reduce discharge delays through early intervention and escalation.

Care Plan Approach (CPA)

- **Current Compliance:** Steady at 86% against a 95% target, expected to be met by August 2025. Targeted improvement plans and weekly “crosscheck” meetings are underway. Digital support is being provided.

Medication Safety

- **Incidents:** Below mean of 80 and decreasing. Low harm incidents dominate, particularly in temperature monitoring. Ongoing task group, monthly incident reviews, competency assessments, and governance reporting continue to support safe practice.

Serious Incidents

- Moderate/Catastrophic Harm Incidents: Slight reduction but remain above threshold. Sustained high levels 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:** Below Trust margin (12 incidents); previous spike linked to repeated incidents involving small number of patients
- **Physical Restraint:** Above margin (45 incidents); reduction seen following peak in early 2025
- **Seclusion Episodes:** Remain above threshold (14), potentially influenced by new seclusion facility at Derwent Unit.

Falls

- Incidents: Still above margin but decreasing. Mostly minor/no harm. Linked to frailty, infection rates, and ward occupancy. Individual risk management plans, use of bed sensors, and biweekly reviews with shared learning in place to support reduction of numbers.

Staffing – Care Hours per Patient Day (CHPPD)

CHPPD are below national averages: 9.34 hours vs. national 11.5. This includes lower figures for both registered nurses (3.86 vs. 3.9) and support workers (5.22 vs. 7.5), 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

The report has been presented to the Finance & Performance Committee.

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. Determine whether further assurance is required.

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

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

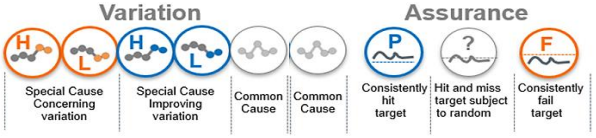
Performance Summary	
Areas of Improvement	**Areas of Challenge**
Operations	
• Adult community mental health waiting lists and associated living well metrics • Transforming care programme.	• Adult ASD assessment waiting times • Community paediatric waiting times • Early intervention in psychosis waiting times • Inappropriate out of area adult acute placements.
Finance	
• The financial position has been managed to plan at the end of May • Agency expenditure has reduced again in May and continues to be better than the plan • The efficiency target for the first two months has been delivered to plan • Capital expenditure was below plan but forecast to spend in full.	• Adult acute out of area expenditure is significantly higher than planned • Delivery of the efficiency programme in full for the full year with recurrent plans in place • 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 • **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)**: remain below national averages, indicating workforce constraints • **Restrictive Practices**: Incidents of physical remain above the Trust margin and Episodes of Seclusion have increased • **Delayed Discharges Clinically Ready for Discharge (CRFD)**: Persistent challenges in housing, funding, and social care placements continue to impact patient flow • **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			4	4	6	8	7
1b	Waiting list - older adult CMHT - average wait to be seen			1	4	1	1	1
2a	Waiting list - adult CMHT SPOA - number waiting			364		582	856	719
2b	Waiting list - older people CMHT SPOA - number waiting			51		13	121	67
2c	Older people mental health 4 week referral to treatment			97%		15%	93%	54%
2d	Adult mental health 4 week referral to treatment			100%		7%	90%	48%
2e	Waiting list - ASD assessment - average wait to be seen			56		57	67	62
2f	Waiting list - ASD assessment - number waiting at month end			1,399		1833	2202	2018
2g	ASD assessments			55	26	32	101	67
3a	Waiting list - psychology - average wait to be seen			27		9	43	26
3b	Waiting list - psychology - number waiting at month end			454		575	716	646
4a	Waiting list - CAMHS - average wait to be seen			12		10	16	13
4b	Waiting list - CAMHS - number waiting at month end			272		242	349	296
5a	Waiting list - community paediatrics - average wait to be seen			67		39	48	44
5b	Waiting list - community paediatrics - no. waiting at month end			2,857		2850	3131	2991
B1	3 day follow-up			89%	80%	78%	98%	88%
D1	Community Mental Health Access (2 plus contacts)			13,935	11,899	11846	12588	12217
E1	Children & Young People Mental Health Access (1 plus contact)			3,485		3288	3464	3376
E4	Children & Young People Eating Disorder Waiting Time - Routine			95%	95%			
E5	Children & Young People Eating Disorder Waiting Time - Urgent			n/a	95%			
G3	Early intervention 14 day referral to treatment - complete			47%	60%	49%	105%	77%
G3	Early intervention 14 day referral to treatment - incomplete			46%	60%	34%	119%	77%
H0	IAPT 6 week referral to treatment			97%	75%	67%	85%	76%
H1	IAPT 18 week referral to treatment			99%	95%	98%	100%	99%
H2	IAPT 1st to 2nd Treatment over 90 Days			22%	10%	20%	50%	35%
H7	IAPT patients completing treatment who move to recovery			49%	50%	44%	59%	52%
I1	Individual Placement and Support Access			715	343	263	585	424
K2	Average patients out of area per day - adult acute			13	0	2	27	15
K2	Patients placed out of area - adult acute			26	0	7	41	24
K2	Average patients out of area per day - PICU			12	0	11	23	17
K2	Patients placed out of area - PICU			19	0	19	36	28
L1	Perinatal Rolling 12 Months Access			12.2%	10%	9%	11%	10%
L2	Perinatal Access Year to Date			1,310	1,070	475	1078	777
N4	Data quality maturity index			99%	95%	99%	99%	99%

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

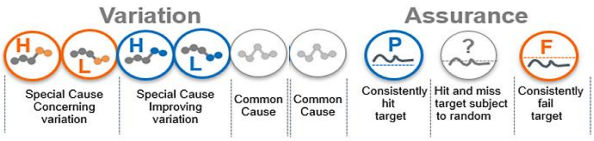
B. People

	Metric Name	Variation	Assurance	Latest Value	Target	Lower process limit	Upper process limit	Mean
1	Annual appraisals			91%	90%	84%	89%	87%
2	Annual turnover			11%	8-12%	11%	12%	12%
3	Compulsory training			94%	85%	90%	92%	91%
4	Staff absence			5%	5%	5%	7%	6%
5	Clinical supervision			85%	95%	80%	85%	83%
6	Management supervision			83%	95%	77%	84%	81%
7	Filled posts			89%	100%	88%	93%	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			110	119	72	207	139
2	No. of formal complaints received ("quick resolution")			8		0	36	18
3	No. of formal complaints received ("closer look")			9		1	30	15
4	Proportion of patients clinically ready for discharge			10%	4%	7%	14%	11%
5	Proportion of patients on CPA >12 months who have had their care plan reviewed			80%	95%	65%	73%	69%
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"			49%		40%	47%	44%
8	Number of medication incidents			63		45	109	77
9	No. of incidents of moderate to catastrophic actual harm			65	48	36	82	59
10	No. of incidents requiring Duty of Candour			3	1	0	3	1
11	No. of incidents involving prone restraint			6	12	0	23	10
12	No. of incidents involving physical restraint			64	46	23	133	78
13	No. of new episodes of patients held in seclusion			18	14	3	30	17
14	No. of falls on inpatient wards			39	30	8	64	36

Key to symbols[1]:



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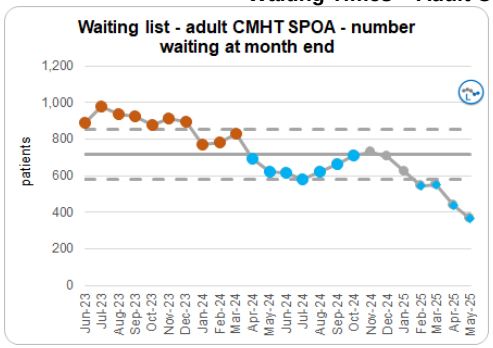
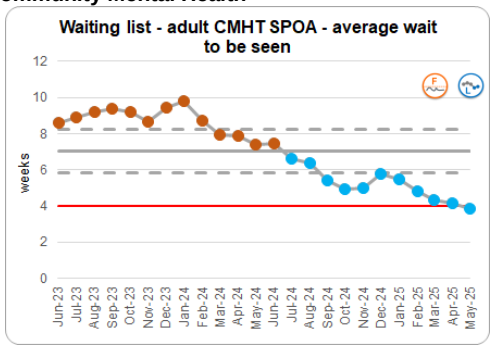
Derbyshire Healthcare
NHS Foundation Trust

Operations

Operational Performance

Waiting Times – Adult Community Mental Health



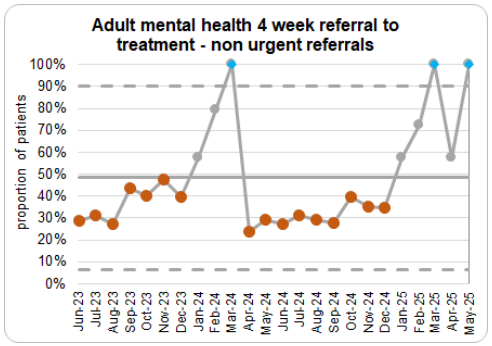


SPOA = single point of access – the route for external referrals into the services

Summary
The average wait to be seen continues to reduce and is currently under 4 weeks. The number of people waiting each month has more than halved.

Productivity has improved alongside an overall CMHT workforce reduction of 6%. Over the last 12 months (May 2024 to April 2025) the overall number of referrals into SPOA was less than the number of discharges by 125, which demonstrates flow through the Single Point of Access, despite an increase in referrals from the previous 12 months. Of concern, onward referrals from SPOA for intervention/treatment into different parts of the Living Well service, both short and long-term offers such as STO health, LTO community (excluding IPS and outpatients), have outweighed the number of discharges from these parts of the pathway with 574 more referrals than discharges between May 2024 and April 2025. If this pattern continues with higher number of referrals for intervention than discharges, there is a high risk that waiting lists will increase and people will not get timely access to the care, support and treatment when they require it, due to limited flow.

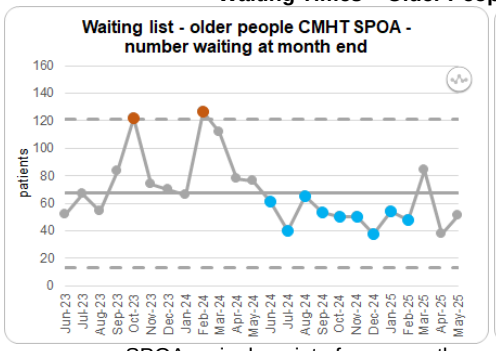
Actions to support flow
All sites have now mobilised Phase One of the Living Well CMHF Transformation. Proactive work continues through a focus on productivity, to address data quality issues, increasing flow through the service and creating capacity to be more responsive and reduce waiting times for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

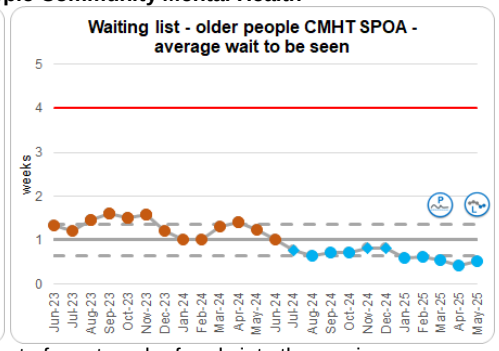


The plan is continuing to have a positive impact on waiting times and this can be seen in the consistently below average wait times over the last 11 months, which is a statistically significant reduction.

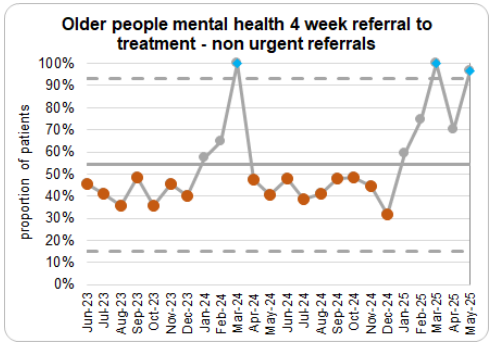
4 week referral to treatment
Currently 4 week referral to treatment is an internal measure based on referral to 2nd contact. The data does not show patients who are currently still waiting for their 2nd contact.

Waiting Times – Older People Community Mental Health





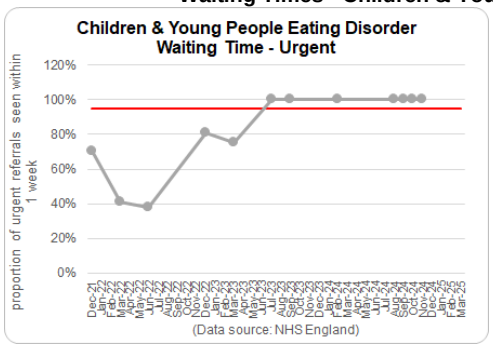
SPOA = single point of access – the route for external referrals into the services

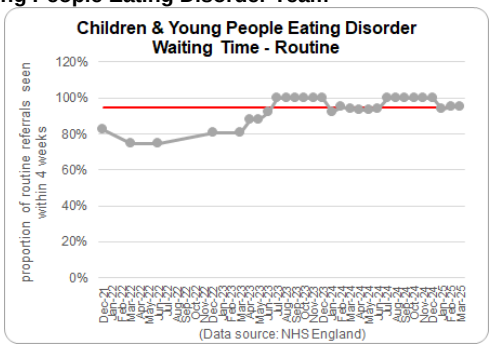


Summary
Wait times within the OA CMHT's have remained stable in some teams and reduced in other. Whilst the longest waits continue to be in the Bolsover area, this has reduced to 13 weeks, and there has been a resolution to the 2 complex ER issues, therefore further improvement should be noticed over coming months.

Next steps
The dementia assessment pathway work continues, inclusive of ongoing engagement with Primary Care. The next stage in the pathway review, is the transition from OA CMHT to Dementia Rapid Response Team (and vice versa). The functional assessment pathway work is now underway, with a focus currently on the graduation of patients from working age adult services into older adult services, alongside ensuring new referrals are accepted into the correct part of the pathway.

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. Very few urgent referrals have been received. 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	1				

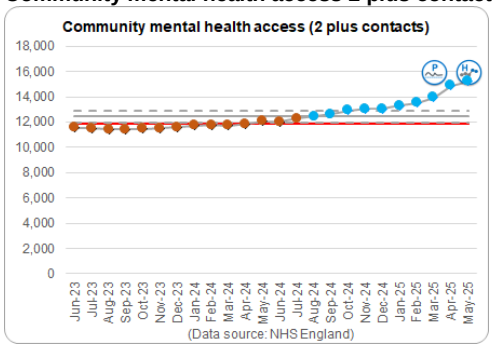
Operational Performance

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 needs of each local area. In Derbyshire, this is called the Living Well Derbyshire programme. In Derby, it is called the Derby Wellbeing programme.

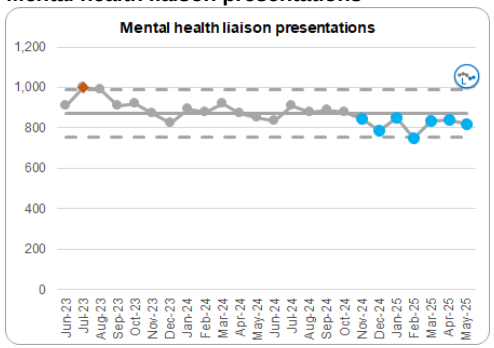
Community Mental Health Framework/Living Well Programme
DHCFT is a partner in the programme alongside the voluntary, community or social enterprise sector and the local authorities. Go live of the Living Well sites concluded its final locality in March 2024, at this stage of the mobilisation, all teams are established and receiving referrals from Primary Care and self-re-introduction only. There has been a 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 March 2025, which demonstrate that year to date the target level of activity has been sustained each month. Internal data for April and May 2025 indicate that the target level of activity has also been achieved in both months.

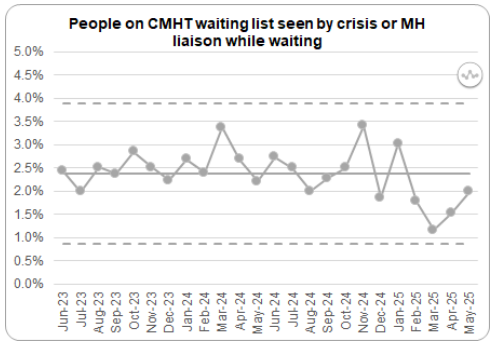
Mental health liaison presentations



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.

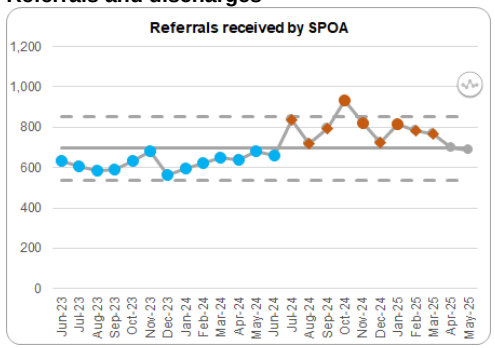
The data indicate a continued overall improvement since Living Well mobilisation.

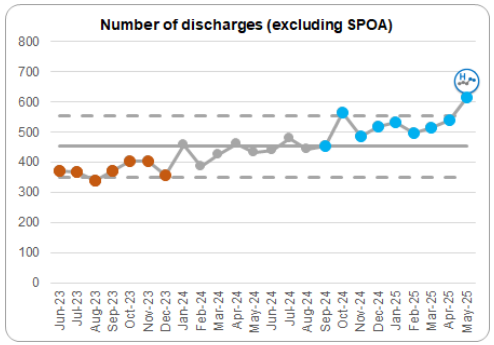
People on the community mental health team waiting list who have been seen by crisis services or mental health liaison while waiting



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. Overall this position has improved and is below average.

Referrals and discharges





Summary
The volume of referrals received has been steadily increasing and significantly high following the Living Well mobilisation, this number will increase again following expansion of pathways in Phase 2 of the transformation. The volume of discharges has also been increasing over time since December 23.

Operational Performance

https://livingwellderbyshire.org.uk/

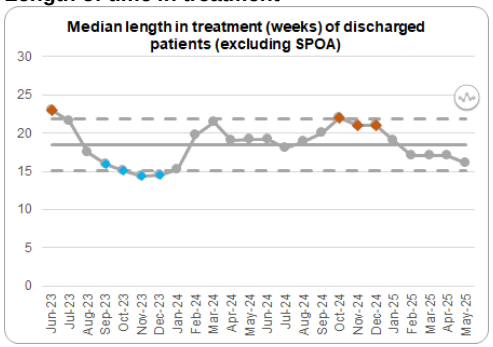
Caseload sizes

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	May-25	Movement
CHESTERFIELD	96%	75%	72%	79%	73%	75%	75%	73%	72%	74%	71%	68%	68%	67%	66%	
HIGH PEAK	71%	54%	54%	53%	53%	54%	49%	46%	47%	46%	45%	47%	51%	51%	49%	
AMBER VALLEY	98%	87%	89%	87%	84%	84%	69%	64%	66%	61%	61%	57%	55%	56%	54%	
EREWASH	100%	91%	89%	90%	88%	89%	79%	75%	75%	73%	73%	71%	70%	69%	66%	
SOUTH DERBYSHIRE	100%	91%	86%	83%	77%	78%	70%	67%	66%	64%	64%	64%	61%	63%	65%	
DERBY CITY B	72%	57%	58%	66%	60%	65%	63%	67%	69%	66%	65%	66%	66%	65%	66%	
DERBY CITY C	74%	61%	60%	67%	58%	60%	59%	63%	68%	67%	66%	65%	64%	63%	65%	
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%**	**61.9%**	

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.

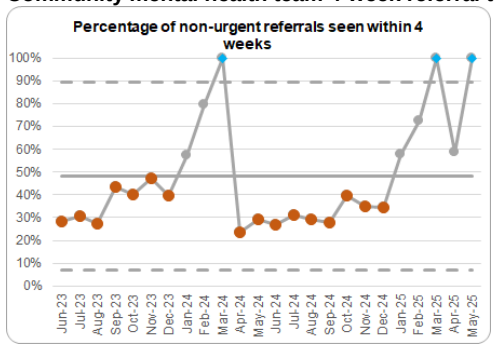
Length of time in treatment



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

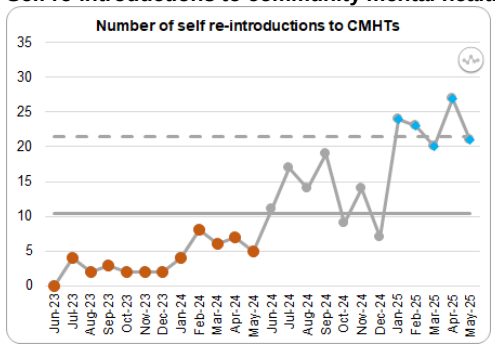


Summary

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 overall.

Operational Performance

Adult Neurodevelopmental Division (ND)

Service Delivery/Flow

- The Short-Term Intervention Team (STIT) funding needs further securing as due to end in 12 weeks.
- System-wide Discharge Delivery Group continues to ensure there is oversight in relation to patient discharges, some challenges being encountered in discharge planning for OOA patients
- Audit of CTR underway to capture successes and gaps in national process.

Transforming care programme	Target	Actual May 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	12	4	
Number of adults in secure inpatient care with ASC		8	
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%	100%	
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. Initial workstreams in care and accommodation, strategic partnership working and training and development are being formed with coproduction underpinning all areas.

Integration

Major Service Change- Exec leads and SRO have been identified for both Short Breaks and Inpatient major service change. Project Lead has been commissioned by DCHS with a timeline of 12 months to complete the service redesign project.

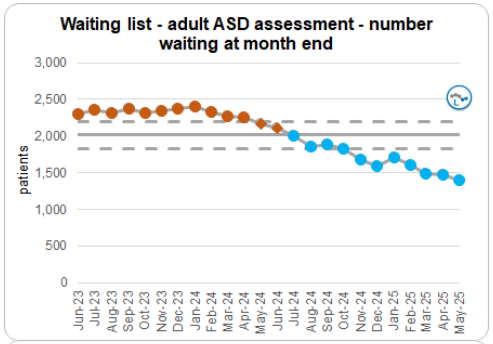
Risks

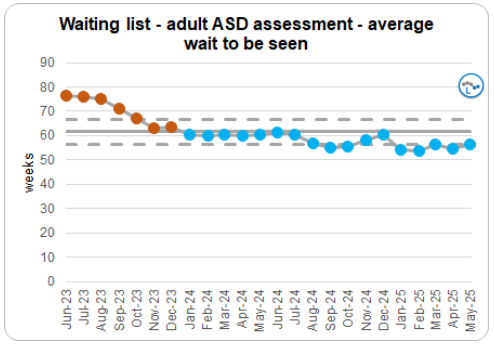
ND Patient Assurance Team: Recovery action plan in place and continued progress with infrastructure and processes. Vacancies stabilising.

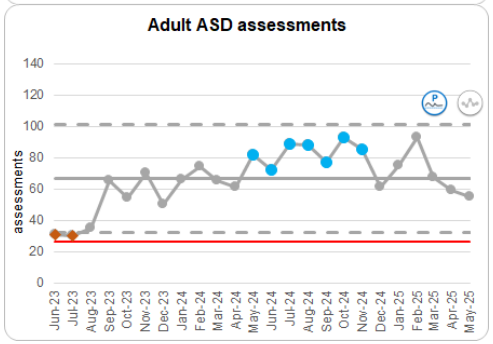
Speech & Language Therapy: continued risks in relation to staffing levels causing increased waits across dysphagia and communication. Mitigations in place including support from north teams.

ADHD/ASD: continued negotiations around new service delivery for 16+ with ICB. Discussion with digital company and transformation to support new service model.

Adult Neurodevelopmental Division (ND)







Success

- Successful Fundamental of Care standard visits across all sites which has provided a baseline and informed an action plan.
- Sustainable improvement in performance metrics due to weekly oversight meetings

Challenges

- Staff Wellbeing- Transformation/change fatigue across ND given the continual changes as well as new operational model proposal.

Operational Performance

Psychology & Psychological Therapies

Overall performance summary: 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 16.29% vacancy, which is an increase from May. There is a head count of approximately 165 WTE staff. The vacancies have risen due to keeping vacancies for the CIP and without those ear-marked for CIP our vacancy factor would be at 12%. Even with the restructure, CIPs and other challenges facing clinical staff the sickness level is still well below the trust average at 1.6%. Further the division has been shortlisted for the employer of the year through the National Learning Disability and Autism Awards. This highlights the Division's flexible response to employing persons who may be neurodiverse.

Trainee, research and external facing roles: We continue to support our 21 employed trainees across three years groups. We are getting prepared for the new cohort in October; recruitment is ongoing in partnership with the universities of Nottingham and Lincoln. Staff contribute to professional teaching on the DClinPsy course as well as psychotherapy and CBT trainings. We have two externally funded researchers contributing to our understanding of need.

Talking Mental Health Derbyshire (TMHD): TMHD will stop delivering on 30th June and the service will close. All TUPE transfers have been planned; data is ready to be moved to the new service and the TMHD service is managing the process of closure. This is a really sad time after 18 years of delivering a fantastic service for the people of Derbyshire. There will be a two-week hiatus in the delivery of talking therapies across Derbyshire as the new service delivered by a Vita Health / Everyturn partnership begins delivery from the 14th June.

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 started in May, and will hopefully support through provision of a more intensive support programme for those in the community. Local data and literature indicates that this is a further area for development.

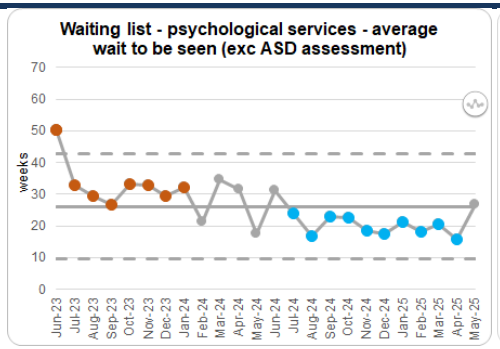
Safety and quality: Friends and Family Test, where reported, continues to show excellent feedback. In the last 12 months:

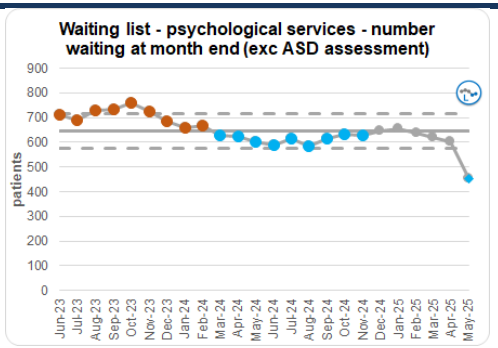
- Adults of working age psychology received 28 returns showing 82% positive feedback. The people giving less positive feedback did not give reasons for their evaluation.
- Cognitive behavioural therapy received 1 response which was positive
- NHS Talking Therapies received 1,157 responses and 99% were 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. The division has written the psychosocial response plan which is being shared and built on across the region.

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





Waiting lists and referrals: Overall, there has been a sustained reduction in the number of people waiting for psychological input to an average of around 20 weeks over the last 11 months. 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 (May 2025). Services continue to focus on the most efficient ways of moving through the waiting lists.

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.

Oter key performance indicators: Managerial supervision stands at 92% currently and clinical supervision stands at 93%. Annual appraisal completion has improved to 92%. Mandatory training is exceeding target at 94%. Return to work interviews (RTWI) have improved from a low of 67% for May to 85.7% this month.

Productivity: There is a push to make sure that the data is accurate, which at present it is not. There are a number of issues with system one in relation to how things are recorded to make sure the data pulled off the other end is accurate. Productivity remains a focus as the number of clinicians shrinks this year. There is the need to digitise psychological tools to enable more efficient delivery of care.

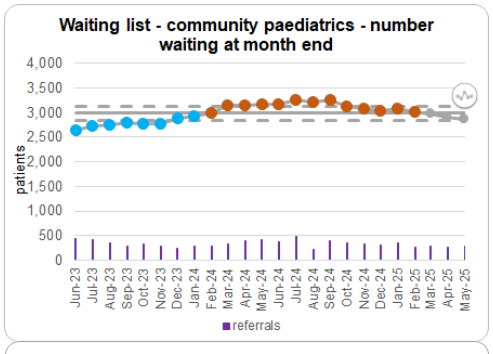
Finance and efficiencies: The DP&PT has planned the full CIP for 25/26. The plan has been partially reviewed by executives (nursing and medical) and we are waiting for further feedback. We will deliver accordingly. This will equate to the loss of 10 WTE clinical posts and all teams are working hard to try and mitigate this loss.

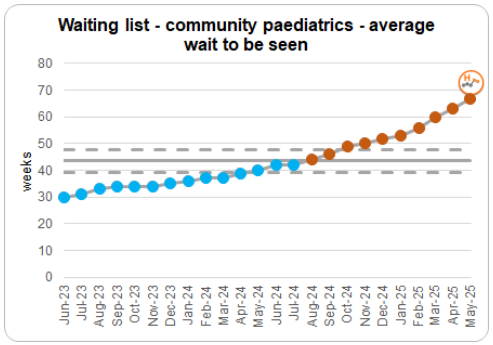
New ideas / work: All teams continue to build on the continuous improvement approach; and the CBT team is focussing on development of a service for OCD, which is a response to current need. The LD team have also lunched a compassion focussed therapy group to support its people. Population health is high on the agenda in relation to how we organise our services, with a focus on areas of deprivation.

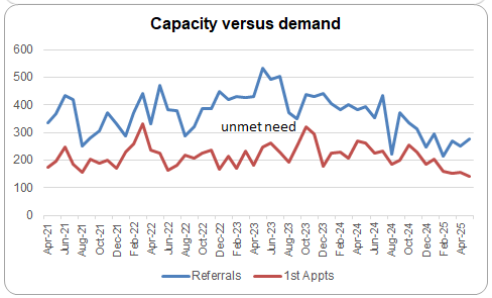
New projects: DP&PT staff are engaging with and continuing to support a number of projects across the trust and system including QI. We are launching a new recruitment campaign for specialist posts in our acute, LD and OA teams.

Operational Performance

Community Paediatrics







Summary

At the end of May 2025 there were 2,857 children waiting to be seen, with average wait of 67 weeks. We are still seeing on average 300 referrals into the service per month. Despite the internal review of processes which boosted assessments by 34% this financial year, demand exceeds capacity by 380%. In the next three months, over 300 patients in the Community Health Services Data Set will have waited more than 104 weeks to be seen. The recent loss of the medical workforce has had a significant impact on service delivery. Consequently, the existing medical staff have taken on the caseloads left by their colleagues, which will reduce the number of new assessment slots available and increase waiting times further.

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

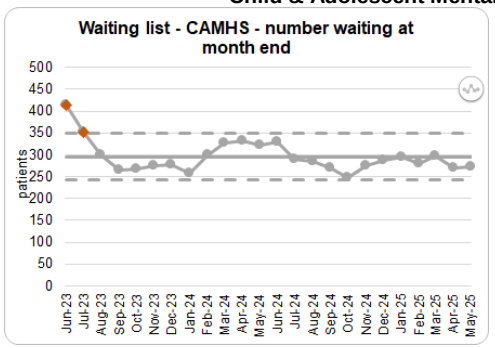
- Significant increase and enduring demand for ASD/ADHD specialist assessment. Demand for ASD and ADHD assessments is linked to an increase in SEND in schools, school pressures, cost of living crisis and reduced community support.
- Ongoing increased volume of referrals to community paediatricians owing 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.

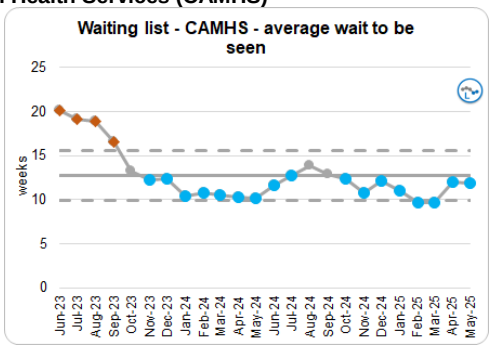
Actions

- 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.
- Review of service offer around priority needs and clinical risks.
- Successful recruitment of 2 x specialty doctors, 1 substantive and 1 x fixed term whilst we appoint a consultant. The consultant vacancy is awaiting Royal College of Psychiatrists approval and a panel to be set up, and we have 1 applicant shortlisted.
- Review of the use of AI for referral management:
- Following the success of the early years pilot there are considerations to extend this into the city area. All plans are being reviewed as a system approach including the local authority and education, alongside the community Hubs.

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 May 2025, 272 children & young people were waiting to be seen and the average wait time was 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

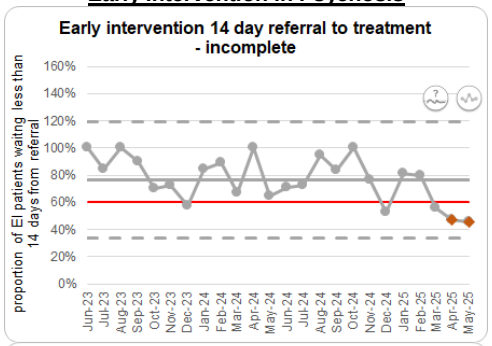
- The 'waiting times' business case, that was originally submitted to the ICB late in 2023, has now been approved, and recurrent funding of £986k has been secured. Slight adjustments are having to be made to the proposed workforce model (owing to the final amount not fully accounting for inflation and pay award increases) but nevertheless, close to £1m of recurrent investment will have a significant positive impact on the internal & external waiting times, and on general flow through the CAMHS service.
- All referrals sent through following the closure of the Tavistock have been processed, without causing any significant additional work. These have been onwardly referred through to paediatricians as per national guidance. Work is still being done as a system to shore up the local pathway.
- The assessment service has had to pull back on its offer of supporting with neurodevelopmental assessments and waiting well support to other areas in the service, owing to their own waiting times increasing.

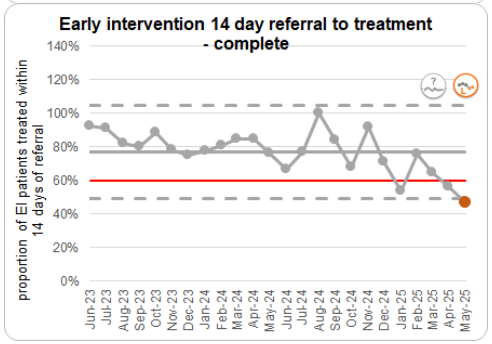
Recovery timescales:

The goal is to get wait times down to 4-6 weeks for assessments and treatments within 18-24 months.

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

Referral numbers have significantly increased from February this year, with a 36% increase in referrals from Feb – May this year compared with the same period last year. This directly correlates with the change from meeting the standard, to not meeting the standard.

There is a risk assessment in place for both EI 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. Reduced leadership is also impacting.

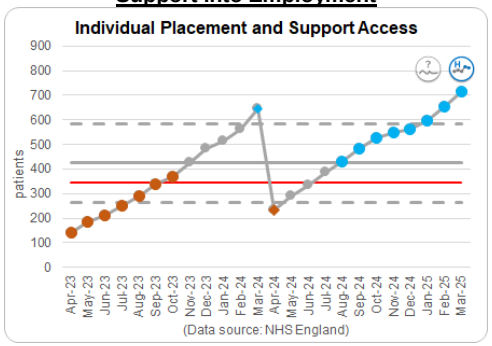
Actions being undertaken

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. Assessments being prioritised. The vacancy control panel has now approved substantive recruitment to the EI Service Manager position. The use of agency to try and increase compliance with the 2 week assessment timeframe is currently being considered.

Recovery timescales

Access target compliance is likely to fluctuate over the next few months. Recovery trajectory being developed with ambition to re-achieve target by Q3.

Support into Employment

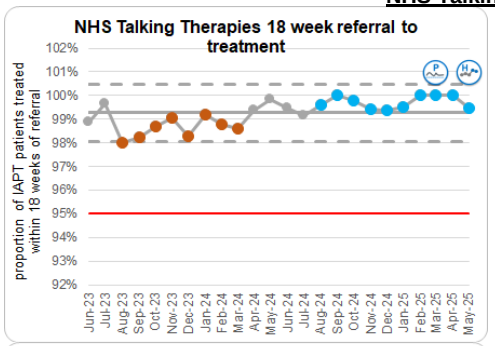


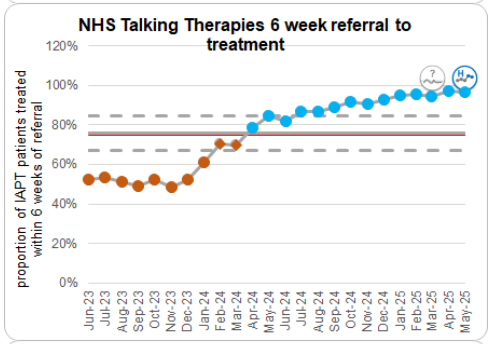
Summary

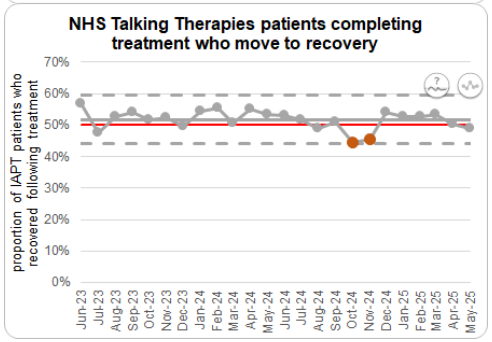
2025/26 has started well, with 204 referrals received engaging 100 people, and already 40 people have secured jobs. Owing to short term sickness and maternity leave there are small waiting lists in certain areas, however these are reducing as newer members of the team get up to speed.

The north team received a fidelity review on 26/27 May. This is a new team and so this was their first review. Initial draft results from the review scored the team at 108, which is a good score. The team will focus on any recommendations made. A fidelity review of the East Derbyshire IPS team is scheduled for September.

NHS Talking Therapies

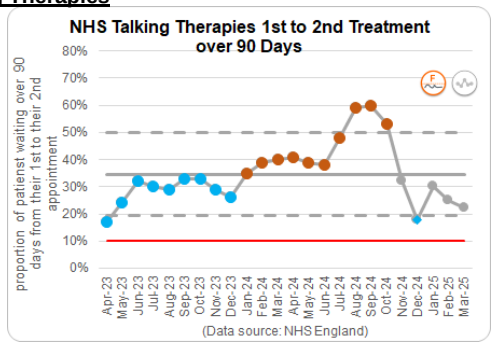






Summary

- 18-week referral to treatment performance and 6 6-week wait for referral to assessment/ 1st treatment entered continue to exceed target.
- Recovery rate is very slightly below target year to date by 0.1%, while reliable improvement rate is above target.
- 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 August to October 2024.

Actions

- Quarter 1 of 2025/26 is the final quarter for Talking Mental Health Derbyshire before handover to the new provider, Vita, on 1 July 2025.

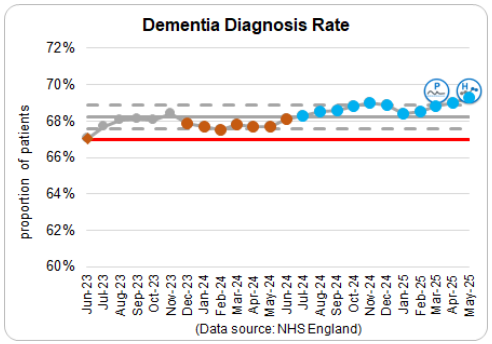
Regional Comparison March 2025

People completing a course of treatment

Organisation Name	Measure Value STR	Plan STR	Plan Percentage Achieved ..
NHS LINCOLNSHIRE ICB	810	560	145%
NHS NOTTINGHAM AND NOTTINGHAMSHIRE ICB	1,735	1282	135%
NHS SHROPSHIRE, TELFORD AND WREKIN ICB	560	504	111%
NHS DERBY AND DERBYSHIRE ICB	1,255	1170	107%
NHS COVENTRY AND WARWICKSHIRE ICB	750	729	103%
NHS STAFFORDSHIRE AND STOKE-ON-TRENT ICB	1,170	1156	101%
NHS BIRMINGHAM AND SOLIHULL ICB	1,520	1619	94%
NHS NORTHAMPTONSHIRE ICB	490	565	87%
HS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	705	1060	66%
NHS BLACK COUNTRY ICB	1,015	1788	57%
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICB	420	832	50%

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 11 months to the latest high of 69.3%.

Regional Comparison March 2025

Dementia diagnosis rate

Organisation Name	Measure Value STR	Standard STR
NHS STAFFORDSHIRE AND STOKE-ON-TRENT ICB	73.0%	66.7%
NHS NOTTINGHAM AND NOTTINGHAMSHIRE ICB	69.9%	66.7%
NHS DERBY AND DERBYSHIRE ICB	69.3%	66.7%
NHS LINCOLNSHIRE ICB	68.4%	66.7%
NHS NORTHAMPTONSHIRE ICB	66.3%	66.7%
NHS BLACK COUNTRY ICB	66.2%	66.7%
NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	64.6%	66.7%
NHS SHROPSHIRE, TELFORD AND WREKIN ICB	63.0%	66.7%
NHS BIRMINGHAM AND SOLIHULL ICB	62.7%	66.7%
NHS COVENTRY AND WARWICKSHIRE ICB	58.8%	66.7%
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICB	55.5%	66.7%

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

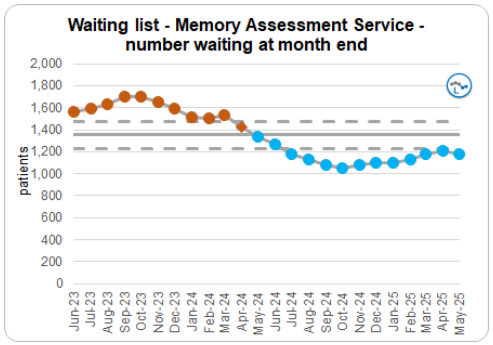
Dementia Diagnosis Benchmarking Data

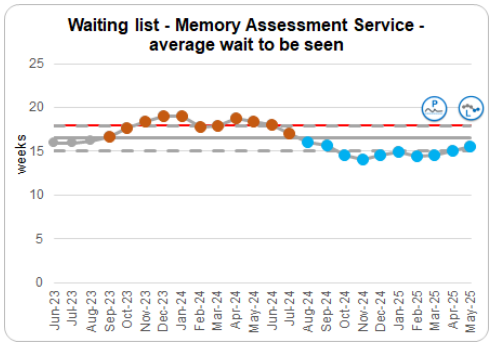
ORG TYPE	ORG CODE	DIAGNOSIS RATE
ICB	QF7	75.4
ICB	QOP	74.3
ICB	QWE	73.9
ICB	QNC	73
ICB	QKK	71
ICB	QUY	70.9
ICB	QWO	70.3
ICB	QT1	69.9
ICB	QJ2	69.3
ICB	QHG	69.2
ICB	QHM	68.9
ICB	QJM	68.4
ICB	QE1	68.2
ICB	QH8	67.9
ICB	QYG	67.6
ICB	QXU	67.5
ICB	QMJ	67.4
ICB	QNQ	67.1
ICB	QPM	66.3
ICB	QUA	66.2
ENGLAND	ENG	65.6
ICB	QM7	65.5
ICB	QRV	65.1
ICB	QK1	64.6
ICB	QOC	63
ICB	QRL	62.9
ICB	QR1	62.7
ICB	QHL	62.7
ICB	QMM	62.5
ICB	QNX	62.5
ICB	QMF	62.1
ICB	QU9	62
ICB	QT6	61.6
ICB	QKS	61.1
ICB	QUE	61
ICB	QOX	60.9
ICB	QOQ	60.4
ICB	QJG	60
ICB	QWU	58.8
ICB	QJK	58.7
ICB	QVV	57.7
ICB	QGH	55.5
ICB	QSL	55.5

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 May 2025 there were 1,179 people on the waiting list, with an average wait of almost 16 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 Mild Cognitive Impairment clinic'.
- A transformational programme to amalgamate MAS and Day Services South has commenced, with the aim of improving patient experience and creating some efficiencies
- The trust is participating in the Royal College of Psychiatrists' National Audit of Dementia service mapping audit.

By when we will have recovered the position

Continuous 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

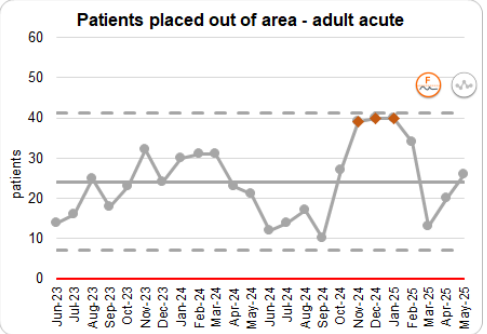
Summary
From April 24 NHS England changed to measuring the number of out of area placements at month end, at ICB level only. From internal data, at the end of May 2025 there were 15 inappropriate out of area adult acute patients and 12 inappropriate out of area PICU patients. NB these figures exclude 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 over 100% capacity, however, leave beds are utilised where safe to do so.

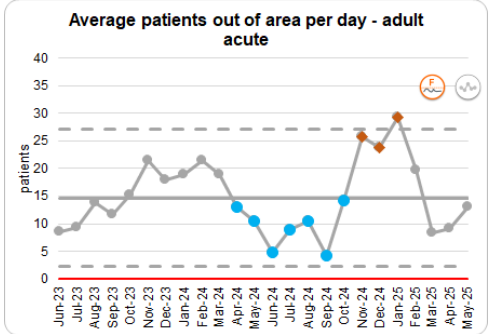
The level of acuity remains high, resulting in the need for PICU beds and represented by the increase in adult acute admissions under the Mental Health Act, which account for 70% of all admissions. The level of acuity may also result in people taking longer to recover.

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. Currently this averages between 20 and 30 at any one time. Derbyshire ICB have set a target of maximum delayed discharge being 24 hours. At the moment the average delayed discharge is 65 days.

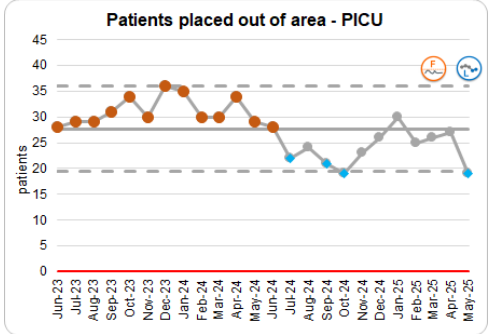


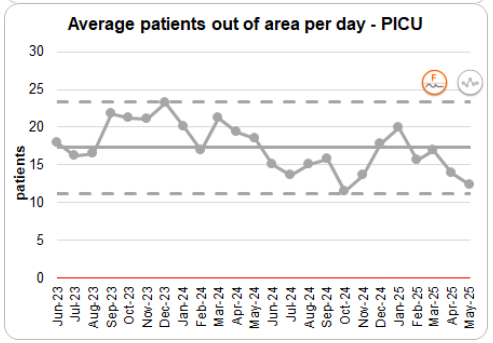
Recovery action plan
- A comprehensive recovery action plan has been developed and is being implemented.
- Step down beds to help with discharge flow and crisis house beds are being utilised to help avoid admissions where safe to do so.
- The crisis teams continue to work with higher than usual caseloads 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.
- 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.
- 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 available enabling wards to access performance data on a daily basis.
- 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.
- Creating capacity to repatriate PICU patients when appropriate to do so and a reduction in requirement for psychiatric intensive care.
- Improved pathway between PICU and Acute is helping to repatriate patients quicker and therefore contribute to the reduction in the number of patients in PICU beds over the last few months.

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





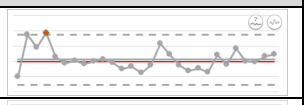
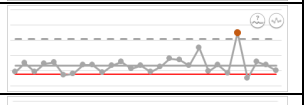
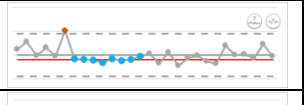
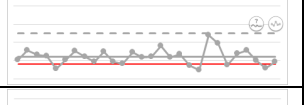
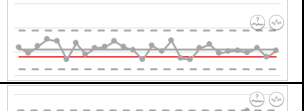
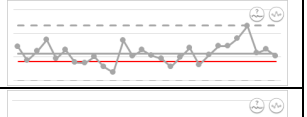
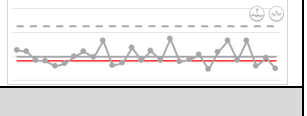
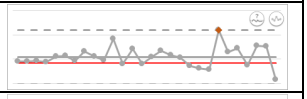
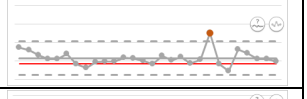
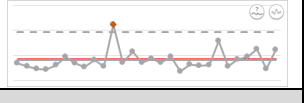
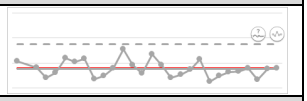
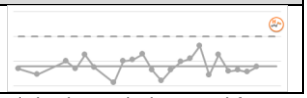
Summary
The Mental Health Flow Escalation Meeting oversees the progress of the action plan on a fortnightly basis.

The admission rate to out of area beds has continued to rise over the last 3 months. The uncertainty regarding the opening of the Derwent Unit and Carsington Unit has caused disruption to patient flow as beds were held as part of the preparation for move. Opening the wards at the Carsington Unit also facilitated an additional 13 beds that had not been available previously. In attempts to maximise the use of the additional capacity, a review of gender profile of beds has been completed which resulted in the temporary increase in female capacity to respond to the additional demand being encountered at this time.

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.

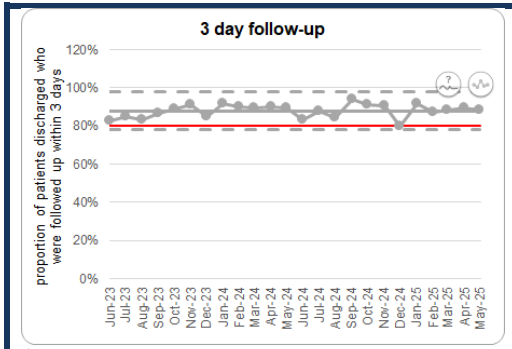
Operational Performance

Occupancy & length of stay (days)

Clinical area	Beds	Bed occupancy May 25	Average length of spell to date of current patients		Average length of spell of patients discharged in May 25		Change versus previous month discharged		Change over time – mean length of spell of discharged inpatients
Adult Acute			Mean	Median	Mean	Median	Mean	Median	
Morton/ Willow	20/ 18	105%	56	56	49	44	↗	↗	
Pleasley/ Sycamore	21/ 18	104%	65	44	50	43	↘	↘	
Tansley/ Oak	21/ 18	101%	75	23	48	29	↘	↘	
Ward 33/ Robin	20/ 18	98%	88	40	47	44	↗	↗	
Ward 34/ Ward 35	21/ 21	100%	52	41	52	55	↗	↗	
Ward 35/ Dove	20/ 18	97%	108	48	52	41	↘	↗	
Ward 36	21	98%	58	27	24	27	↘	↘	
Older People									
Bluebell	12	98%	70	46	43	47	↘	↘	
Cubley Female	18	89%	73	60	15	15	↘	↘	
Cubley Male	18	96%	101	84	96	107	↘	↘	
Tissington	18	99%	57	30	121	26	↗	↘	
Perinatal									
The Beeches	6	75%	20	20	40	37	↗	↗	
Rehabilitation									
Cherry Tree Close	23	89%	354	361	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.

Operational Performance

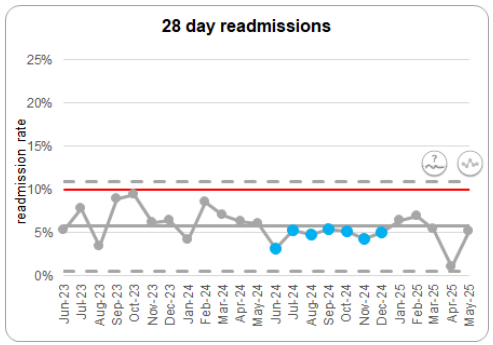


Summary

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.

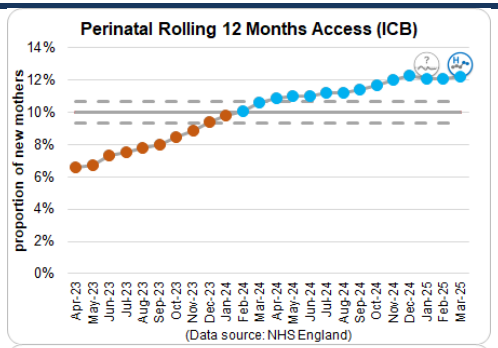
Actions

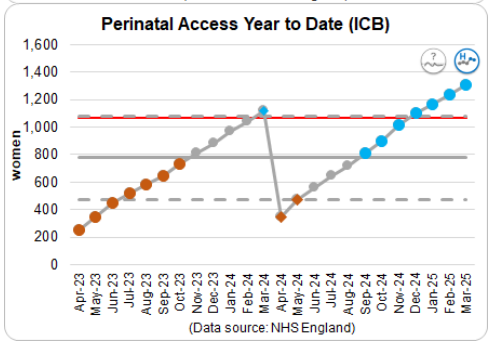
- Central monitoring of people awaiting follow-up to ensure no follow-ups are overlooked
- Ongoing regular audit of follow-ups to ensure improved accuracy of reporting.
- Ongoing completion of breach reports for any follow-ups that were not achieved to enable learning of any lessons from breaches.



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 throughout the 24 month period.





Summary

The service continues to exceed the 10% access target, and at the end of the financial year the rolling access rate was 12.2%. 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. To ensure that demand does not outstrip capacity the service has recently provided refresher training regrading robust triage and thresholds. High demand and some workforce challenges have contributed to wait times higher than local targets.

Actions needed to maintain target

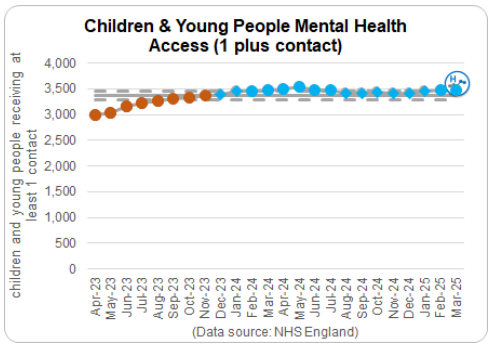
- Ensure that referrals meet inclusion thresholds, referral educational e-resource circulated to referrers
- Waiting list to continue to be monitored by RAP and monthly exception report and added to the divisional risk registers (perinatal and psychology)
- Service to refine clinical pathways based in recent clinical profile audit
- Mitigation plan to manage potential reduction in leadership capacity/oversight resulting from Trust restructure.

Regional comparison March 2025

Perinatal access – rolling 12 months

Organisation Name	Measure Value STR	LTP Trajectory STR	I Trajectory Percentag...
NHS SHROPSHIRE, TELFORD AND WREKIN ICB	855	501	171%
NHS DERBY AND DERBYSHIRE ICB	1,340	1111	121%
NHS COVENTRY AND WARWICKSHIRE ICB	1,100	1045	105%
NHS NORTHAMPTONSHIRE ICB	940	905	104%
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICB	790	781	101%
NHS BIRMINGHAM AND SOLIHULL ICB	1,965	1953	101%
NHS NOTTINGHAM AND NOTTINGHAMSHIRE ICB	1,255	1298	97%
NHS LINCOLNSHIRE ICB	720	742	97%
NHS STAFFORDSHIRE AND STOKE-ON-TRENT ICB	1,170	1215	96%
NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	1,200	1259	95%
NHS BLACK COUNTRY ICB	1,505	1585	95%

NHS Derby & Derbyshire ICB was the 2nd highest performing in the region, achieving 121% against the long-term plan trajectory.



Summary

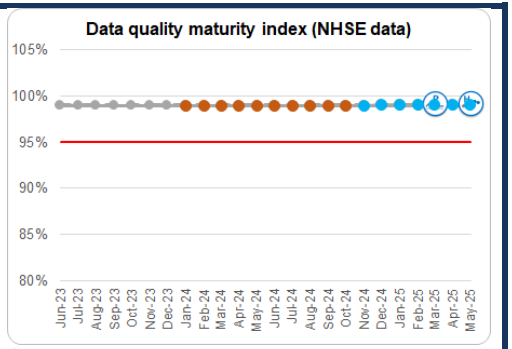
Performance has remained high since December 2023.

Regional comparison March 2025

C&YP access 1 plus contact

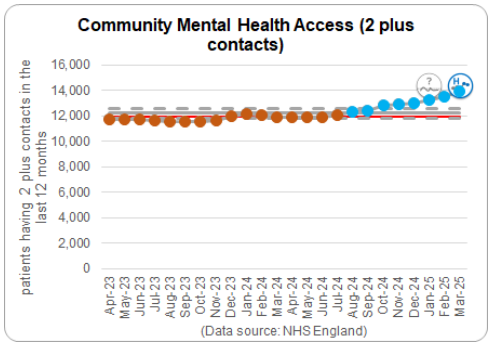
Organisation Name	Measure Value STR	LTP Trajectory STR	I Trajectory Percentag...
NHS NOTTINGHAM AND NOTTINGHAMSHIRE ICB	20,810	16124	129%
NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	18,745	14553	129%
NHS NORTHAMPTONSHIRE ICB	10,270	9600	107%
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICB	12,120	11865	102%
NHS COVENTRY AND WARWICKSHIRE ICB	13,160	12972	101%
NHS DERBY AND DERBYSHIRE ICB	14,430	14463	100%
NHS STAFFORDSHIRE AND STOKE-ON-TRENT ICB	15,675	17273	91%
NHS BLACK COUNTRY ICB	17,985	20240	89%
NHS LINCOLNSHIRE ICB	9,630	11829	81%
NHS BIRMINGHAM AND SOLIHULL ICB	20,230	24834	81%
NHS SHROPSHIRE, TELFORD AND WREKIN ICB	6,555	8341	79%

NHS Derby & Derbyshire ICB was the 6th highest performing in the region against plan, achieving 100% 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 hundreds of incorrectly recorded patient contacts which are impacting on reported waiting times.



Summary

NHSE have published data up to March 2025, which demonstrate that the target level activity has been achieved, and this high level has been sustained for 8 months.

Regional comparison March 2025

Community mental health 2 plus contacts

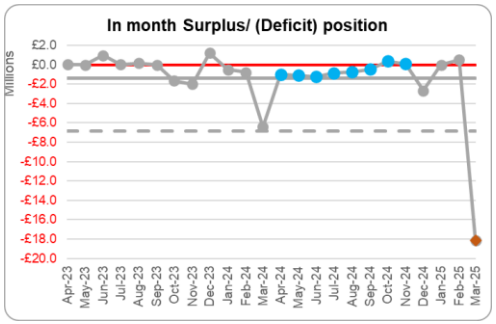
Organisation Name	Measure Value STR	LTP Trajectory STR	I Trajectory Percentag...
NHS BIRMINGHAM AND SOLIHULL ICB	25,340	10552	240%
NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	14,920	6979	214%
NHS NOTTINGHAM AND NOTTINGHAMSHIRE ICB	15,630	8189	191%
NHS DERBY AND DERBYSHIRE ICB	14,345	7510	191%
NHS BLACK COUNTRY ICB	15,325	8776	175%
NHS NORTHAMPTONSHIRE ICB	8,460	5057	167%
NHS STAFFORDSHIRE AND STOKE-ON-TRENT ICB	11,890	8020	148%
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICB	7,955	5395	147%
NHS LINCOLNSHIRE ICB	7,670	5543	138%
NHS SHROPSHIRE, TELFORD AND WREKIN ICB	4,440	3481	128%
NHS COVENTRY AND WARWICKSHIRE ICB	8,280	6540	127%

The Trust was the 4th highest performing in the region, achieving 191% against the long term plan trajectory.

NHS
Derbyshire Healthcare
NHS Foundation Trust

Finance

Financial Performance

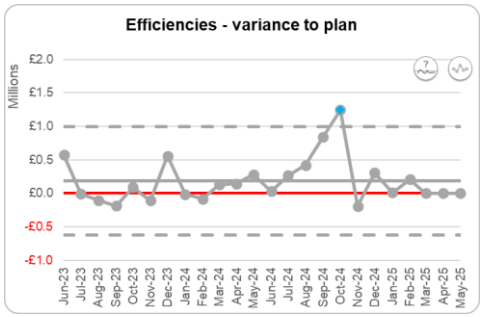


Summary
At the end of May, the year to date adjusted financial position is a deficit of £1.3m which is on plan.

The forecast assumes delivery of the breakeven plan. However, there are several risks that need to be managed in year:

- Delivery of efficiencies in full, in particular schemes related to savings on out of area placements and savings linked to the operational restructure through delays or changes resulting in lower level of savings in year.
- Adult acute out of area placements are currently above plan which has been impacted on from delays in the Making Room for Dignity programme.
- Temporary staffing usage
- Unfunded posts and services and the speed at which they are being addressed.

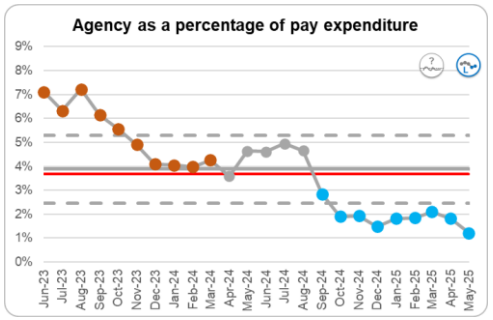
The Board Assurance Framework (BAF) risk *that the Trust fails to deliver its revenue and capital financial plans for 2025/26, is* rated as MODERATE due to the financial risks above.



Summary
The plan includes an efficiency requirement of £14.8m phased differently across the financial year.

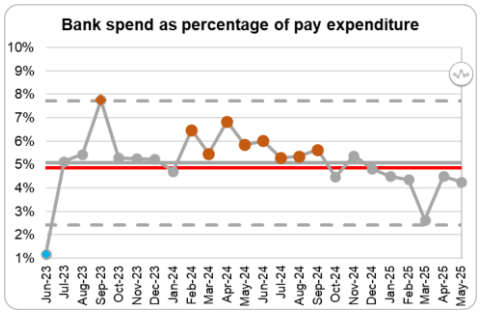
The plan assumes 82% of the savings are delivered recurrently.

At the end of May actual efficiencies delivered to the YTD plan of £1.86m.

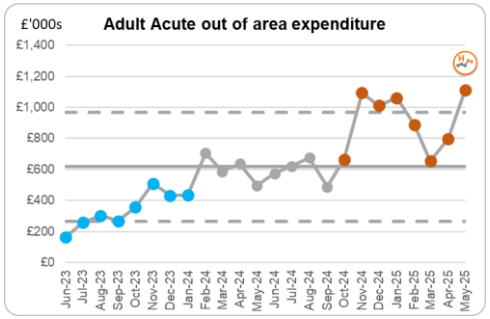


Summary
Agency expenditure at the end of May totalled £0.5m
The agency expenditure as a proportion of total pay for April is 1.8% and May is 1.2%.

There has been a significant reduction in agency expenditure since August with May being the lowest for the last two years.
The two highest areas of agency usage continue to relate to consultants and nursing staff.



Summary
Bank expenditure totalled £1.3m at the end of May, which was within plan. The bank expenditure as a proportion of total pay for May is 4.3%.

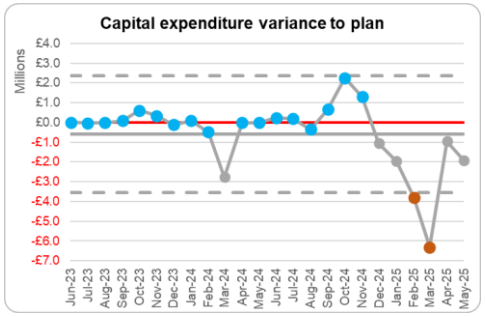


Summary
The plan for out of area expenditure is based on a reducing trajectory from thirty-two to four beds by the end of the financial year.

At the end of May Adult Acute out of area expenditure is above plan by £1.4m.

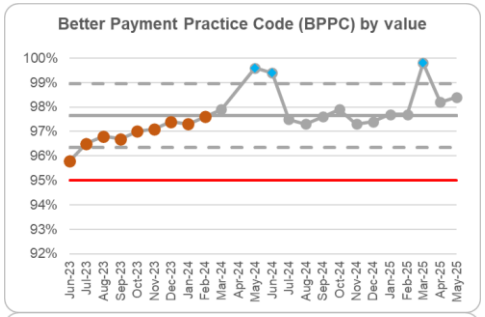
The current forecast assumes a reducing trajectory from July, which brings the forecast to £6.8m, which is over plan by £4.6m.

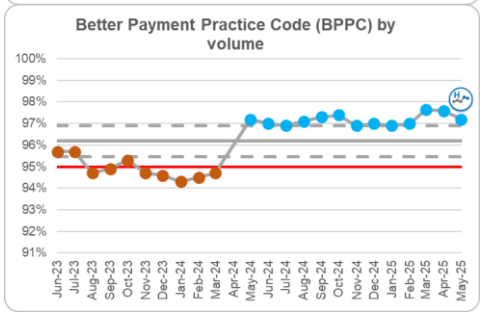
Financial Performance



Summary
Capital expenditure is below the system capital allocation and the national funding for the Making Room for Dignity programme at the end of May.

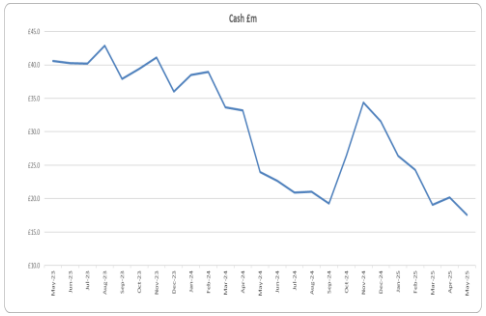
Capital expenditure is forecast to spend to the full plan by the end of the financial year.





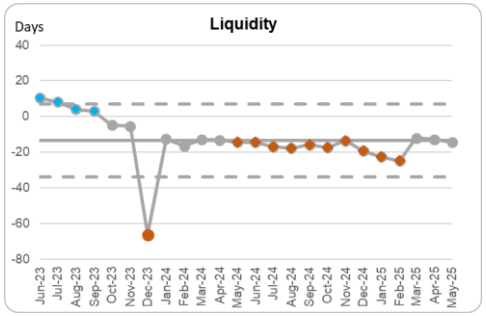
Summary
The Better Payment Practice Code (BPPC) sets a target for 95% of all invoices to be paid within 30 days. BPPC is measured across both invoice value and volume of invoices.

At the end of May, both the value and volume of invoices exceeded the target at 97.2% and 98.4% respectively.



Summary
Cash at the end of May was at £17.6m (£20.2m last month) which was higher than plan by £4.0m.

The cash increase in November was due to the timing of the VAT rebate on the Making Room for Dignity programme.



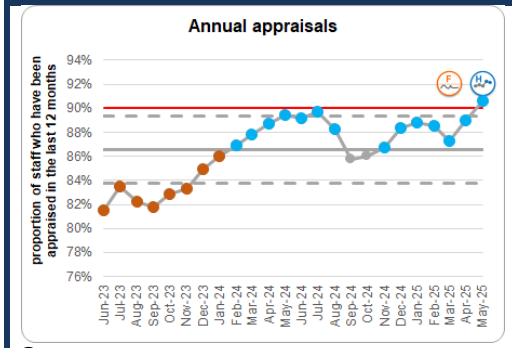
Summary
The chart above shows the liquidity levels over the last two years. Liquidity levels were high in 2021/22, however in 2022/23 the liquidity reduced due to the timing of cash receipts related to the centrally funded capital scheme for the Making Room for Dignity programme. The Public Dividend 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

Annual appraisals



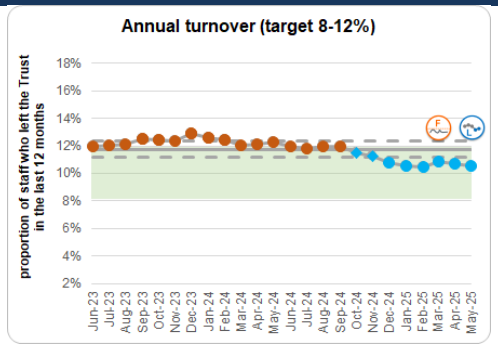
Summary

Performance at organisation level remains high at 91% and has now surpassed the 90% Trust target. Operational Services are currently at 92% and Corporate Services at 85%.

Actions

- Executive directors are receiving monthly compliance data and a breakdown of all outstanding appraisals.
- Appraisal data is being used with other key people performance metrics to identify hotspot areas and bespoke targeted OD work is being commissioned. It also forms part of the newly developed People Heatmap.
- The appraisal paperwork has been updated to include the personal accountability charter and encourages a conversation around demonstrating behaviours aligned to the charter and trust values.

Annual turnover (target 8-12%)



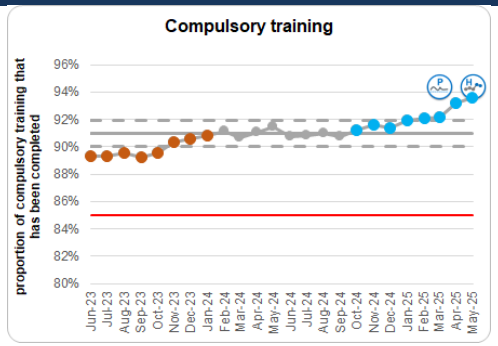
Summary

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

Actions

- 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.

Compulsory training



Summary

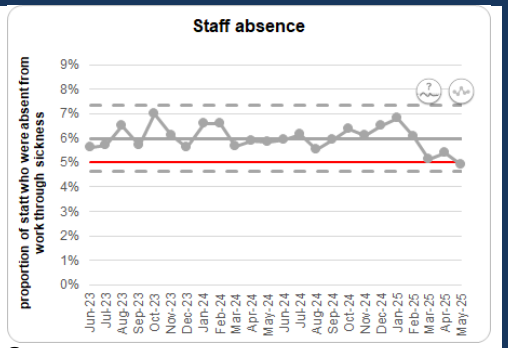
Overall, the 85% compliance target has been achieved for the last 24 months. Operational Services are currently 94% compliant and Corporate Services are 91%.

Actions

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

- 'Did not attend' (DNA's) continue to be a challenge and increased scrutiny over these is taking place through divisional performance reviews and the training and education group.
- The Training and Education Group continue to oversee and review training compliance, changes and challenges.

Staff absence



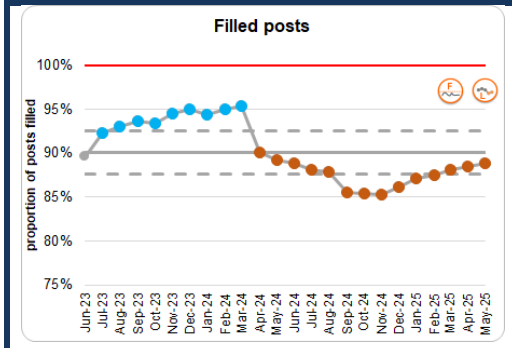
Summary

The monthly sickness absence rate in May was 4.93%, consisting of 2.60% short term absence and 2.33% long term absence. Anxiety, stress or depression related illness remains the highest reason for sickness absence, followed by other musculoskeletal problems and Surgery.

Actions:

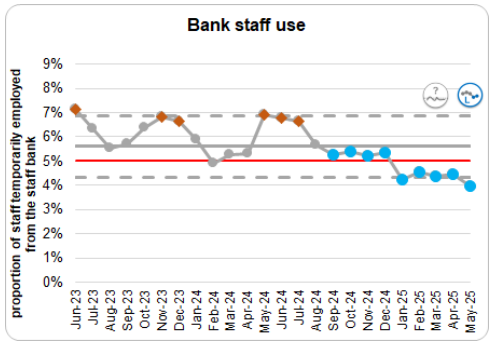
- An absence oversight group has been formed with the governance arrangements being developed to ensure the operations and clinical input is sought.
- A Quality Impact approach to absence will be taken by the group
- Robust reporting arrangements are being developed in readiness to exit GoodShape.

People Performance



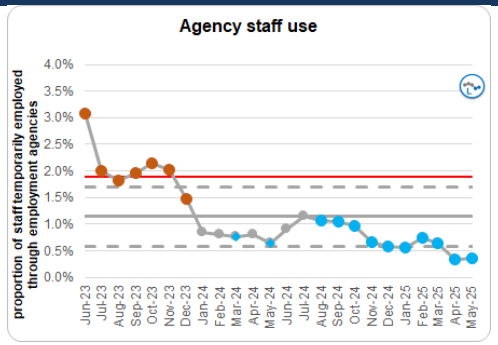
Summary

At the end of May 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.



Summary

The proportion of bank workers being used from the temporary staffing bank remains low. Bank workers predominantly work on inpatient wards to cover for vacancies, sickness and for increased levels of observations. Work continues to work towards the national target to see a reduction of 10% in bank usage by 31 March 2026.



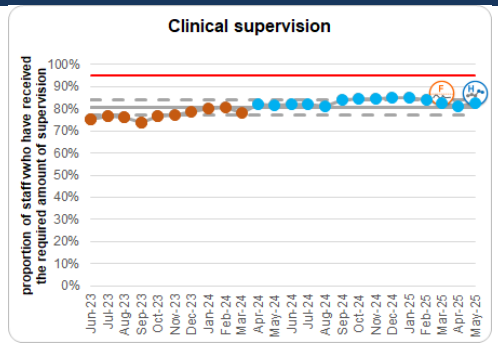
Summary

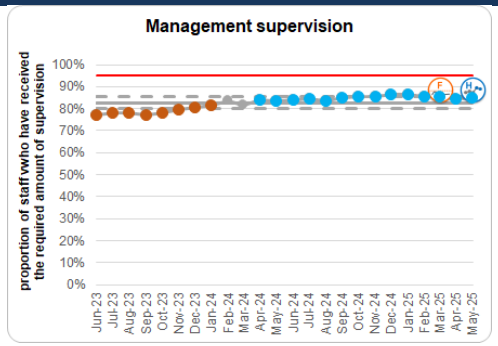
Agency usage has reduced significantly over recent months and continues to remain low. Work continues to reduce this further inline with the national target to see a reduction in spend of 30% by 31st Match 2026.

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.
- 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 85% management supervision and 82% for clinical supervision. Performance has been gradually improving incrementally for the last 14 months. Operational Services stand at 87% managerial and 84% clinical, and Corporate Services 76% management and 42% clinical.

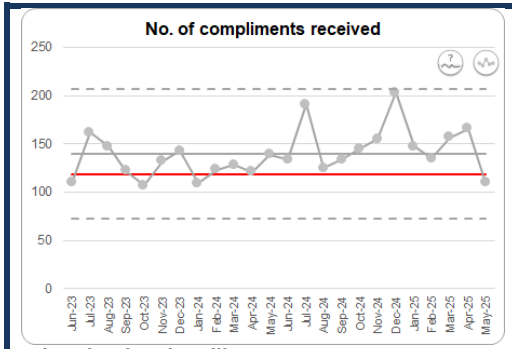
Actions

- Clinical Supervision training is available to staff and includes several eLearning modules depending on role. The training content has recently been reviewed and refreshed, relaunched from June 2025.
- Increased governance on non-compliance - this will now be reporting into the newly formed Trust Delivery Group and at performance review meetings.
- Ongoing data cleansing is taking place to ensure correct requirements i.e. corporate staff who do not require clinical supervision are removed from the data.
- Updating of the reporting system is currently with IT to align to the new policy.

Derbyshire Healthcare
NHS Foundation Trust

Quality

Quality Performance

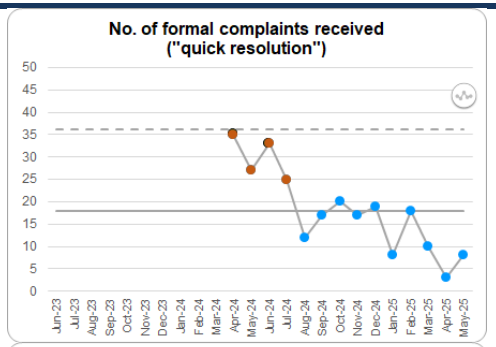


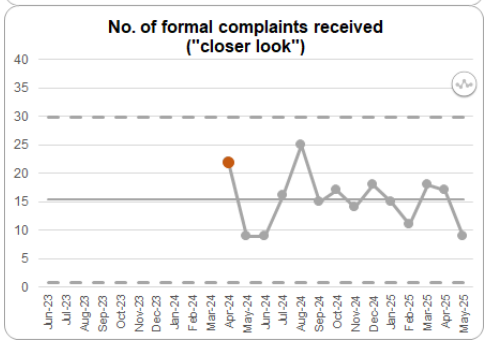
What the data is telling us:
The number of compliments recorded is following a pattern of common variation but fell below the threshold of 140 compliments April and May 2025.

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 continued to be 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 have attended their Divisional Clinical Reference Group (CRG) to explore the barriers of getting feedback from services and requested that all staff be reminded of the process of recording compliments via divisional team meetings. Progress will continue to be monitored.

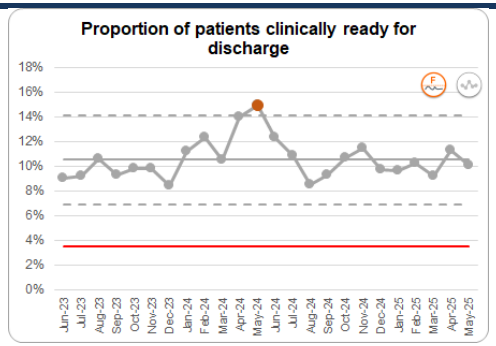




What the data is telling us:
The number of complaints identified as “quick resolution” (QR) are following a pattern of common variation and continue under the threshold of 17. The increase between April and May 2025 was expected due to a backlog of QR complaints waiting to be logged on the system and will likely continue to increase over the next 2 months.

The complaints categorised as “closer look”, which involve a Trust commissioned investigation, have followed a pattern of common cause variation and fell below the mean of 15 between April and May 2025 they 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.



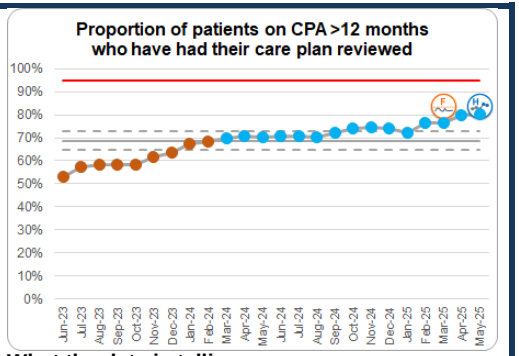
What the data is telling us:
The proportion of service users meeting the criteria of Clinically Ready for Discharge (CRD) has continued to follow a pattern of common cause variation between April and May 2025.

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.



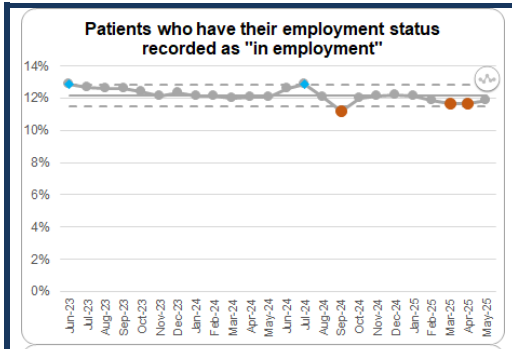
What the data is telling us:
The current percentage of patients who have had their care plan reviewed and have been on CPA for over 12 months has remained unchanged at 86%. The Trust target is 95% compliance. It was expected that CPA compliance will reach the 95% target by August 2025.

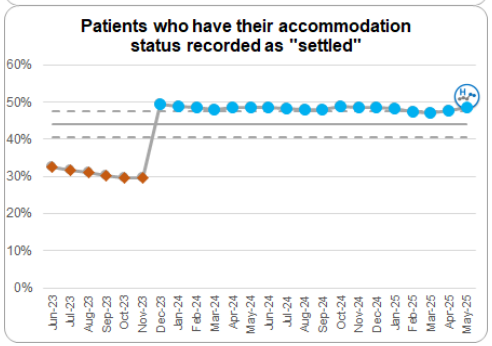
Actions

- 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 was commenced in the Older People’s services in June 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 based on feedback from the crosscheck meetings.

Quality Performance

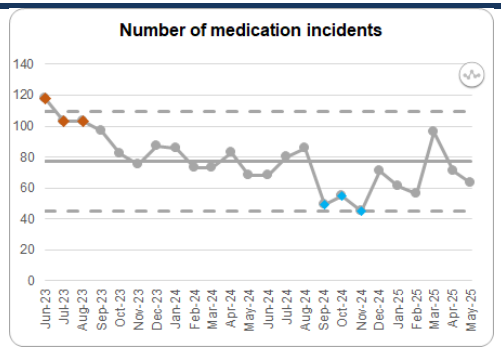




What the data is telling us:
Patients open to the Trust in settled accommodation has remained static at 49% between April and May and the number of patients open to employment has continued to remain between 11% and 13% since August 2022. This measure continues to be monitored by individual services.

Actions

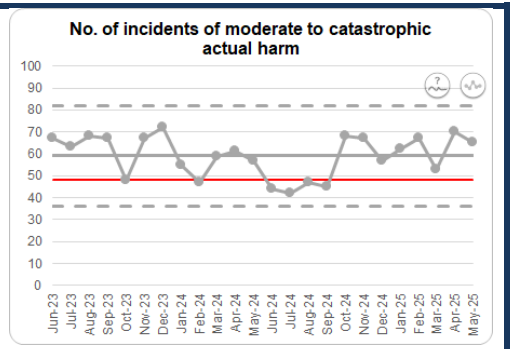
- A report has been developed which informs teams if there are gaps in the current Data Quality Maturity Index information recorded on referral and Ward and Service Managers have been asked to review this report weekly and action any gaps identified. This is monitored via monthly service specific operational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



What the data is telling us:
The number of medication incidents between April and May 2025 have continued to follow a pattern of common variation and continue below the mean of 80 which reduced from 90 in the last report 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 and these are being addressed via an ongoing task and finish group started in January 2025.

Actions

- The Trust Pharmacy team have introduced a monthly medicine incident group to review trends and themes to support lessons learnt
- 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.



What the data is telling us:
This data demonstrates the number of DATIX incidents recorded as moderate or catastrophic harm. The number of incidents reduced between April and May 2025 but is still over the trust threshold of 50.

Analysis suggests that the number of incidents reported is due to a sustained increase of incidences recorded as “self-harm” in the Acute Inpatient services and in Older People Services, a sustained number of “medical issues” reported.

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

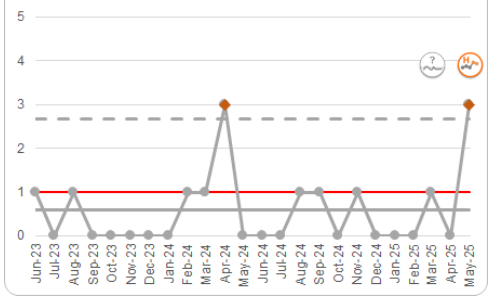
The Substance Misuse service are working in partnership with Drugs and Alcohol Related Deaths (DARD) Steering Group with the aim of improving prevention and education and working closely with CMHTs in developing effective interventions and support systems for service users with Co-occurring Mental Health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



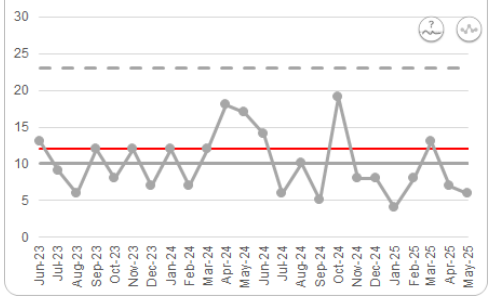
What the data is telling us:
3 incidents between April and May 2025 required duty of candour disclosure, however analysis of the data shows there was no pattern in relation to the division or type of incidents reported.

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



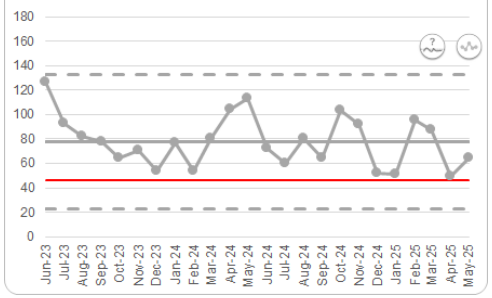
What the data is telling us:

Incidents of prone restraint have reduced between April and May 2025 and continue below the Trust margin of 12 incidents.

The increase between March and April 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

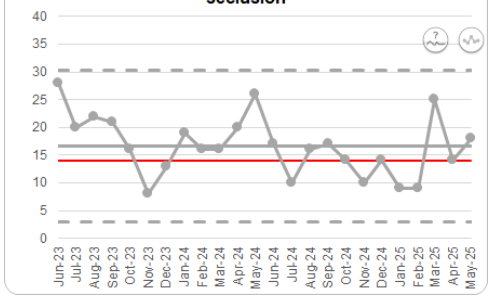


What the data is telling us:
Physical restraints have continued to follow a pattern of common cause variation between April and May 2025 and continue above the Trust margin of 45 incidents. The highest peak between January and February 2025 is attributed to an increase in self-harm incidents in a small number of patients and a correlating increase in staff intervention required to prevent individuals from harming themselves and this has reduced in line with the recovery of these individuals.

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 83% for teamwork and 70% for breakaway training. Compliance is likely to stay at this level over the next three months due to a high number of staff being recruited who require the training related to the making room for dignity programme. The breakaway compliance is also unlikely to increase quickly as staff from the crisis services have had the training added to their compliance from May 2025. .

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.

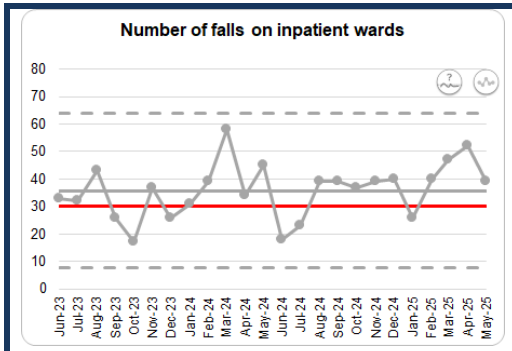
No. of new episodes of patients held in seclusion



What the data is telling us:
The number of new episodes of patients held in seclusion remained above the threshold of 14 episodes between April and May 2025 but continues to follow a pattern of continuous variation. The increase from February 2025 as previously reported, 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 designated seclusion suite in the Hartington unit. This will continued to 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



What the data is telling us:
The number of falls recorded have continued above the Trust margin of 25 falls but have reduced between April and May 2025.

The number of falls recorded is attributed to a sustained 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 has also continued between April and May 2025 as noted at the regional Falls Meeting and this has been 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 98% of the falls recorded over this period in the older people services were categorised as minor or insignificant meaning that no harm came to the individuals involved.

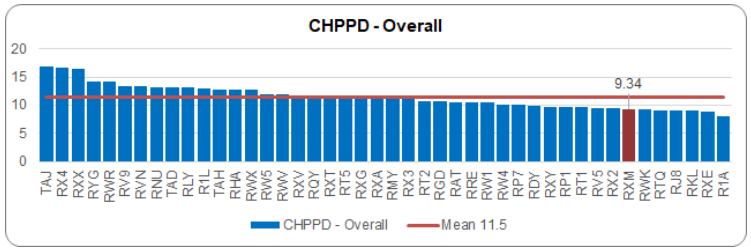
Actions

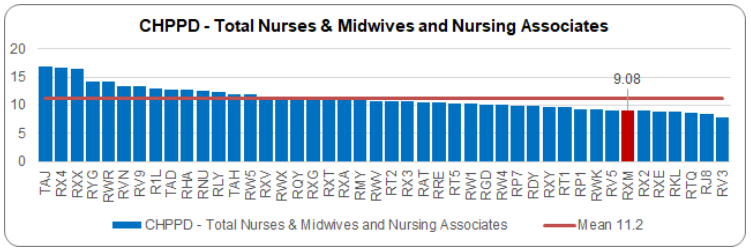
- The patients identified as high risk of falling are discussed in the biweekly falls prevention meeting and have fall prevention care plans in place
- Bed sensors are in place for those individuals deemed at the highest risk of falling
- The number of falls reported is monitored via the Falls Lead Occupational 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)

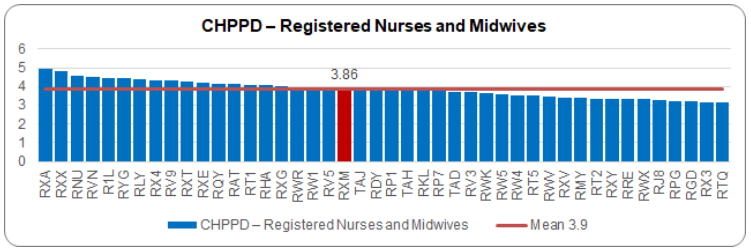
CHPPD is rolling data updated monthly, to show staffing levels in relation to patient numbers on an inpatient ward. Every month, the hours worked during day shifts and night shifts by registered nurses and midwives and by healthcare assistants are added together. Each day, the number of patients occupying 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. NHS England publish the figures for every provider each month online.

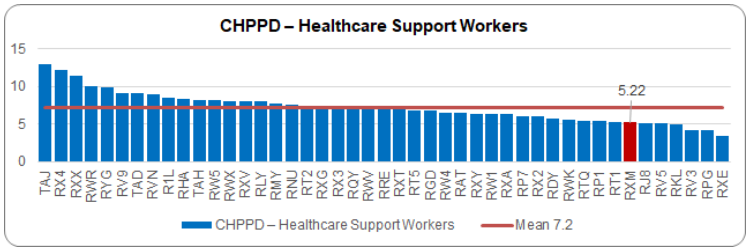
The charts below indicate that the Trust's CHPPD overall achieved 9.34 hours, which was well below average when benchmarked against other mental health trusts in the country (11.5). For total nurses and nursing associates the Trust achieved 9.08 hours against the national average of 11.2 hours:





For registered nurses the Trust achieved 3.86 hours against the national average of 3.9 hours. For healthcare support workers the Trust achieved 5.22 hours against the national average of 7.2 hours:



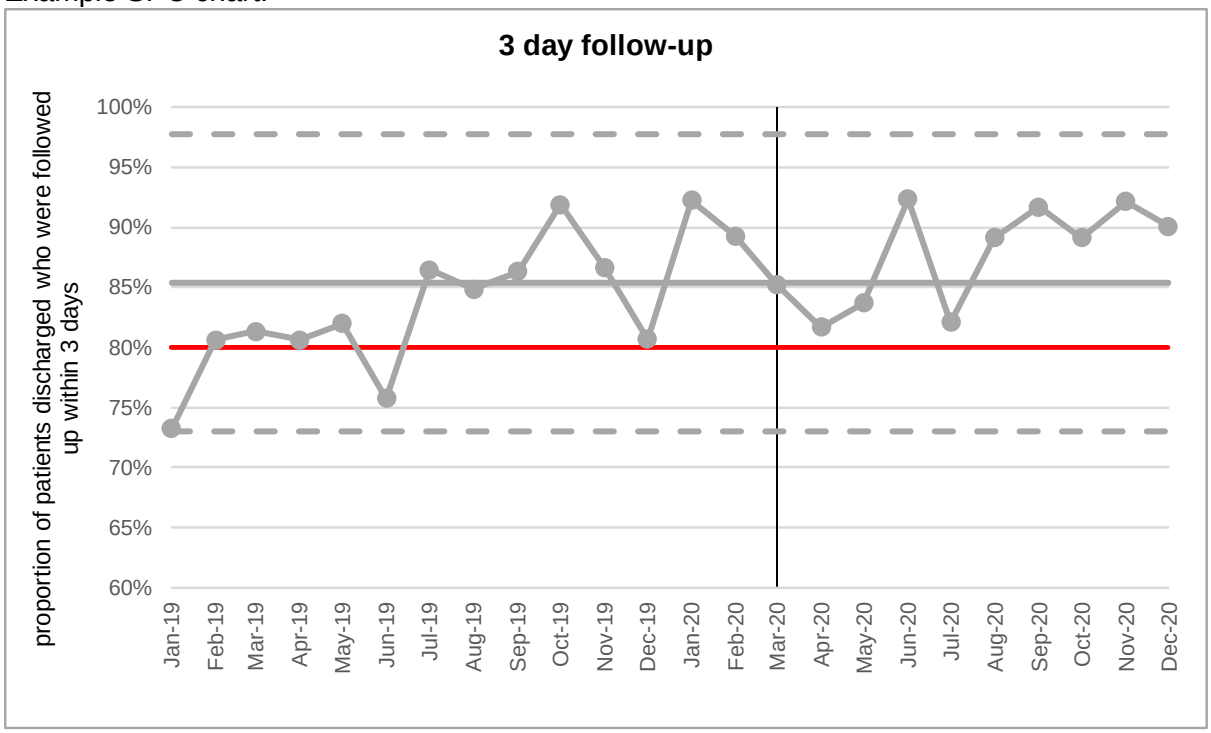


https://www.england.nhs.uk/publication/care-hours-per-patient-day-chppd-data/

Appendix 1

Statistical Process Control Chart (SPC) Guidance

Example SPC chart:



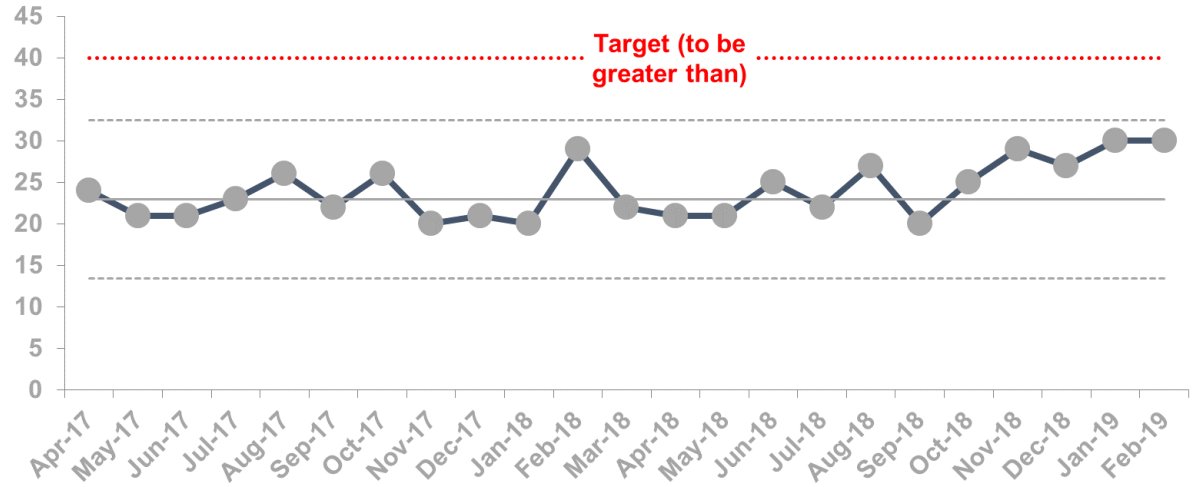
- The red line is the target
- The grey dots are the actual performance each month. They are coloured grey as performance each month is normal in this example
- The solid grey line is the average (mean) of all the grey dots
- The grey dotted lines are called process limits, or control limits.

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.

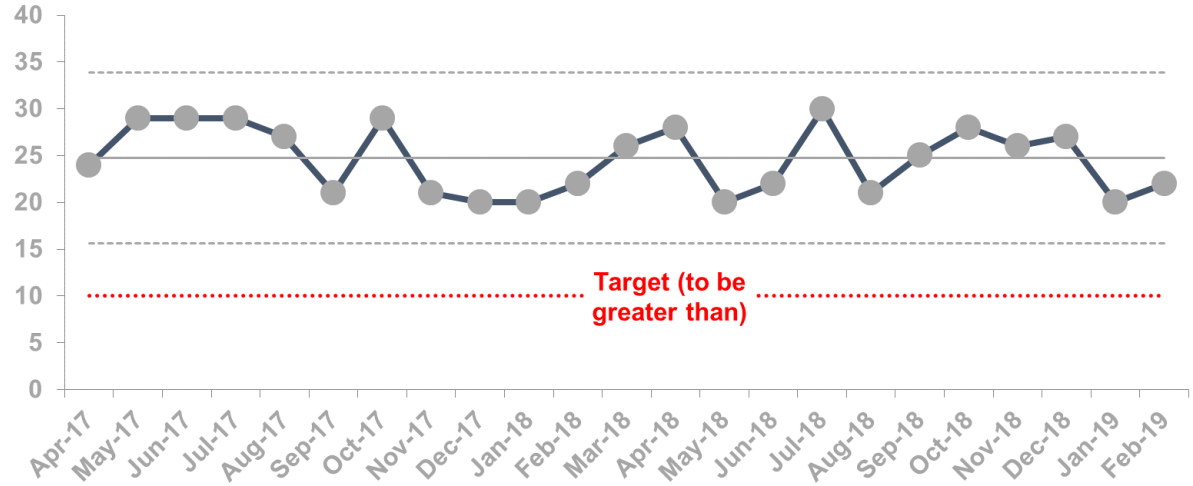
Things to look out for:

1. A process that is not working:



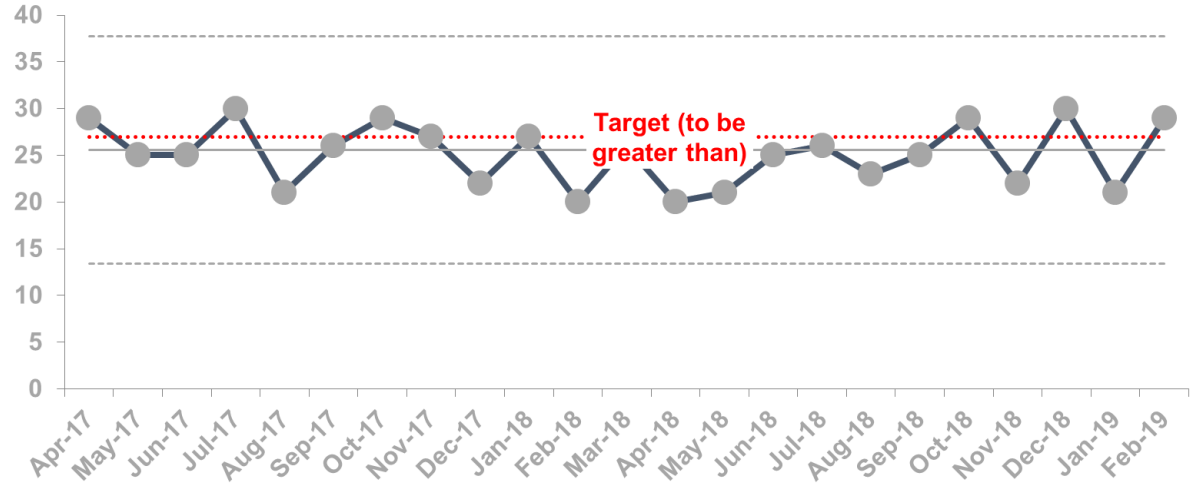
In this example the target is higher than the upper dotted grey line. This means that the target will never be achieved. To achieve the target, we need to change how we do things.

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:

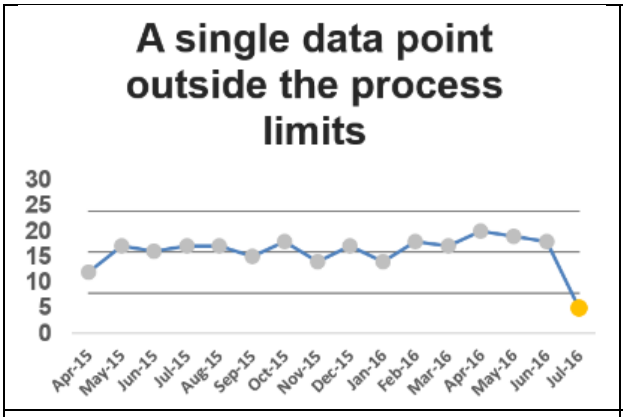
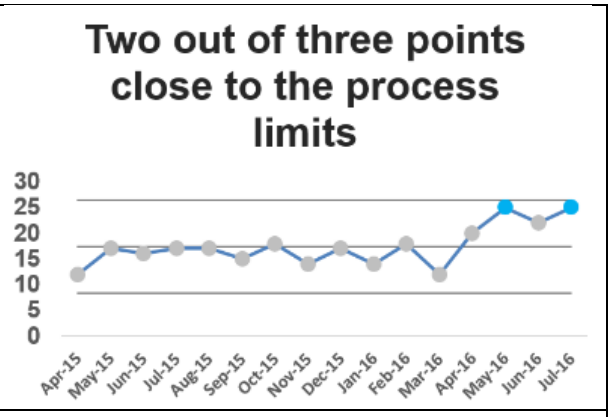
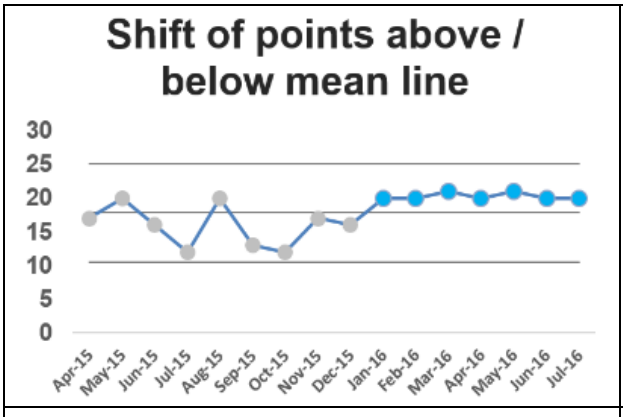
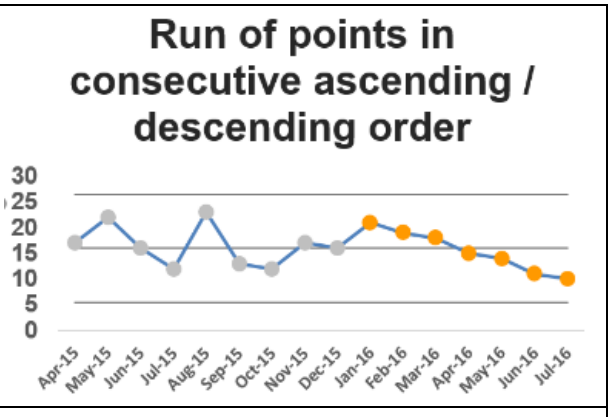


In this example, the target line sits between the two grey dotted lines. As it is normal for the grey dots to fall anywhere between the two dotted grey lines, this means that it is entirely random as to whether or not the target will be achieved. So, this system is unreliable and needs to be redesigned 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
Confidential Report to the Board of Directors – 22 July 2025

Corporate Cost Reduction Return
for discussion and retrospective approval

Purpose of Report
To retrospectively update the Board on the corporate cost reduction return.

Executive Summary

The Trust received a letter dated 16 April, which included analysis and a request to reduce corporate costs to the extent of 50% of the perceived growth between 2018/19 and 2023/24.

For Derbyshire Healthcare, the growth was identified as £3.2m (after adjusting for pay awards and inflation) and thus have been set a reduction target of £1.6m. The ask was to remove this cost and deliver in quarter 3 of 2025/26.

The letter and accompanying schedules have been shared organisation-wide and been part of various Chief Executive updates and communication newsletters.

The return was due for submission on 30 May, with the template finally being issued 19 May. Due to the timing of issue, this has had to come retrospectively.

This paper provides an update that we have a plan and continue to work on reducing corporate overheads.

This was already a key component of our new agreed strategy and one of the objectives under the Productivity strand.

We were already well on our way to identifying our Cost Improvement Programmes (CIP) for 2025/26. This was building on improved performance and delivery in 2024/25 in terms of identification, delivery and recurrency. This was in the pursuit of CIPs and efficiency being delivered in a way to best protect front line services.

We were already lined up to reset our corporate support to meet the new clinical directorate structures. This latest ask has just brought the need forward a little.

The detailed plans are all being fed via the system, electronic Programme Management Office and being reported as part of our efficiency monitoring and tracking.

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

The extent to which our CIP plan and approach are successfully developed and implemented, will directly result in the likelihood of us achieving our agreed financial plan once developed. At the same time, the plan needs to be reasonable and realistic.

Consultation

All changes follow due process and involve HR and union involvement. All CIP schemes go via formal Project Initiation Document (PID) processes and a full formal Quality and Equality Impact Assurance (QEIA) process.

Governance or Legal Issues

Links to delivery of the 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.

Recommendations

The Board is requested to:

1. Note the Trust corporate cost reduction submission
2. Retrospectively endorse/approve the submission
3. Agree for ongoing monitoring to continue via the Executive Leadership Team, Finance and Performance Committee and Board as routine financial oversight where necessary.

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

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

Rachel Leyland
Deputy Director of Finance

Working Towards Reducing Corporate Costs and Overheads to Protect Front Line Clinical Healthcare Services

Introduction

In the ever-evolving landscape of healthcare, maintaining the quality and accessibility of front-line clinical services is paramount. To achieve this, it is essential to adopt strategies that reduce corporate costs and overheads. By streamlining administrative processes, implementing cost-effective measures, and prioritising essential services, healthcare organisations can ensure that resources are allocated efficiently, thereby safeguarding the well-being of patients and frontline healthcare providers.

This is a key building block of our new agreed strategy agreed at Board and set for 2025-2028.

Strategic priorities – the four Ps

Our strategic priorities outline the high-level initiatives we will focus on in order to deliver the Trust vision. They will be a foundation for our decision making and resource allocation and form the basis of how we will measure performance and successful delivery of the Trust Strategy.

The priorities are all of equal focus and importance. Each will remain in place for the three years this Trust Strategy covers (winter 2024–spring 2028) and will have a set of key deliverables which set under each priority. These will be reviewed on an annual basis to monitor progress, completion and to identify any new deliverables that reflect the changing environment in which we work.

A number of key plans and documents will support delivery of the strategic priorities, as outlined on the subsequent pages. Where these documents are not in place, they will be developed during the life of this Trust Strategy:

- Patient focused
- People
- Productive
- Partnerships.

Underpinning the Productive element, we made a commitment to the following:

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

Strategic intent:

Our services will be productive, demonstrate best value for our population and be cost effective.

What success will look like:

- **To increase productivity through continuous improvement approaches**
- **Understanding of our cost base**
- Delivery of the agreed financial plan
- **Reduction in overhead costs**
- Increased proportion of money spent on community and care closer to home
- Our services access and use accurate and timely data to make improvements
- **Our services make use of digital technologies**
- Reduced NHS Carbon Footprint
- **More efficient and effective use of our buildings**
- Establish a business unit for income generation.

This priority is supported by the following enabling plans:

- Financial Sustainability Plan
- People Plan
- Sustainability Plan (incorporating the Green Plan)
- Estates Plan
- Digital Plan
- Continuous Improvement Plan
- Research and Development Plan.

Understanding Corporate Costs and Overheads

Corporate costs and overheads refer to the expenses incurred in the administrative and operational aspects of healthcare organisations. These include costs related to management, marketing, human resources, and other non-clinical services. While these functions are necessary for the smooth running of an organisation, they can sometimes divert resources away from direct patient care.

Identifying Areas for Cost Reduction

To effectively reduce corporate costs, it is crucial to identify areas where savings can be made without compromising the quality of care. Some of the key areas for cost reduction include:

- Streamlining Administrative Processes: Simplifying paperwork, reducing redundancy, and automating routine tasks can lead to significant savings
- Optimising Supply Chain Management: Implementing efficient procurement practices and negotiating better rates with suppliers can reduce costs
- Reducing Energy Consumption: Adopting green technologies and practices can lower utility bills and contribute to sustainability
- Implementing Telehealth Services: Offering remote consultations can reduce the need for physical infrastructure and associated overheads
- Consider collaboration and/or outsourcing Non-core Functions: Potentially collaborating or Contracting out services such as IT support and facility management could be more cost-effective.

As part of planning for 2025/26, we had already started on a journey to restructure our clinical directorates and our directorate leadership structures. This was working towards removing c80 management roles. The Corporate Directorates were planned to be reset to support the new structures as a phase 2 and planned later in 2025/26.

The national ask to reduce our corporate costs, has just fast tracked this need a little. This is now progressing alongside the other planned and ongoing restructures.

Baseline Data

The ask was for us to reduce our corporate overhead costs by c£1.6m. This is based on growth between 2018/19 and 2023/24 of an assumed c£3.2m.

There has been a lack of transparency of the adjustments made for inflation and pay awards, but we accept it is the ask and we move on.

Furthermore, we know that Mental Health (MH) trusts have incurred material pressures on pay award funding for years. The pay award calculations assume a c60% pay element. Most MH trusts are 70–80% in reality. As a result, we see growing costs and increased efficiency core asks built into financial plans for MH providers to ensure delivery and organisations remain on plan. This pain is already being felt on squeezing our corporate functions harder.

This adds to the pressure of a small provider when benchmarked against expected lower quartile metrics.

Having said that, we have made some good progress in the last two years. Our Cost Improvement Programme (CIP) performance improved drastically in 2024/25. This was not only in terms of quantum of delivery but recurrency.

We delivered CIPs in the corporate space of £0.6m in 2024/25 on a recurring basis.

We have outline plans drawn up for 2025/26 amounting to £1m.

£0.8m was already identified and in place at the start of the year. We have worked hard on closing the remaining £200k gap over the last few months.

These plans have all been developed with a full identified lead, Project Initiation Document (PIDs) being in place and have been via a formal Quality and Equality Impact Assurance (QEIA) process.

The template has been populated on this basis and has been included as Appendix A.

Whilst we have noted some challenges, we have not included any exemptions on the submission.

We continue to review corporate opportunities and trust wide initiatives and will continue to work on delivering our core strategy of reducing our corporate overhead. It is our intention to continue annual reviews across all areas.

Benchmarking Data

Legal (2023/24 cost opportunity to LQ – £0.22m)

Few opportunities exist within our legal function due to the small nature of the team. Costs do vary dramatically dependant on the level of ongoing legal issues, particularly driven by Employment Tribunal (ET) related costs.

However, we do continue to work with Derbyshire partners and are exploring potential opportunities for collaboration. We have recently brought the ET resource in-house to support better and more timely resolution.

No further material savings opportunity expected in 2025/26.

Procurement (2023/24 cost opportunity to LQ – £0)

This is an area identified as severely under-resourced. We had only 1.5 whole time equivalent operating for an organisation of £244m. This has seen a small-scale level of investment to ensure we remain complaint and drive better value for money (VfM). We are also continuing to work with partners and are looking at collaborative procurement where possible.

No further material savings expected in 2025/26 from the function's direct resources (team of three) but they are contributing to the wider efficiency challenge of the Trust and going to help drive better VfM Trust-wide.

Finance (2023/24 cost opportunity to LQ – £0.78m)

Historically delivered on the CIP requirement and Finance continues to work on identifying CIPs for 2025/26. All areas have been working to 6% CIP targets for some time, recognising the opportunity identified within the model hospital benchmarking data. This has been done without the need for a full restructure to date. We were keen to build on the positive staff survey results that shows us as the third best in the country from a Finance function perspective.
Any restructure would be following work being progressed across Joined Up Care Derbyshire and around collaborative shared services.

We already use the national SBS system and are looking to improve processes via automation and continue the move to paperless. We also plan to move to full 'no purchase order - no payment' for 2026/27.

Turnover remains modest but helps, as we are redesigning the offer to avoid replacing.

Human Resources (HR) (2023/24 cost opportunity to LQ – £1.31m)

Another area which benchmarks poorly but is multi-faceted - this has been driven in recent years by the unsuccessful nature of a HR joint venture, meaning more and more roles have been brought and added back in-house. Restructuring continues to ensure we have a responsive and supportive HR function. CIP targets have been identified, and plans are ongoing.

Governance (2023/24 cost opportunity to LQ – £2.77m)

This is the area where most opportunity exist under the model hospital benchmarking data. Some aspects are driven by being a foundation trust. Work is ongoing and underway to reduce our corporate costs in this area. We do have a few MH specific areas around the MH Act and various statutory requirements, but we recognise the opportunities. Work is continuing to look at opportunity and learn from benchmarking and best practise. A restructure is ongoing in relation to the Corporate Nursing and Medical leadership, alongside our operational restructure referenced above.

Information Management, Technology and Records (IMT&R) and Digital (2023/24 cost opportunity to LQ – £0.48m)

IMT&R is driving a lot of our ambition to improve the efficiency of our Corporate functions. We recognise we are a little bit behind in terms of bots, automation and the roll out of artificial intelligence.

Work is ongoing to identify saving opportunities and reduce costs where we can. Aspects are outsourced to Arden and Gem and are under contract. Therefore, opportunities are limited in terms of 2025/26.

Conclusion

In conclusion, working towards reducing Corporate costs and overheads is essential for the sustainability of healthcare organisations. This is aligned to our core Trust Strategy. By adopting strategic measures, healthcare providers can ensure that front-line clinical services are protected and continue to deliver high-quality care to patients. Balancing cost reduction with the prioritisation of patient care is key to achieving long-term success in the healthcare sector.

Overall, we believe we have a plan, are on track and aim to delivery on our core Operational and Finance plan, including delivery in full, whilst reducing our overheads and protecting front line services as much as possible.

We will look to work collaboratively with our partners to extract future opportunities.

Corporate services overview

erbyshire Healthcare NHS Foundation Trust (RXM) - Mental Health - Derby And Derbyshire ICS

FY 2023/24 costs and opportunities

	Digital & Technology		HR	Governance & Risk	Finance †	Procurement	Legal	Payroll	Total
	Transactional	Non-transactional							
Trust income (£m)									216
Trust FTE									2,759
Cost (£m)	3.54	0.43	3.52	4.04	1.93	0.24	0.44	0.14	14.28
Cost opportunity to national LQ (£m)	0.48	See note‡	1.31	2.77	0.78		0.22	0.00	5.57
Cost per £100m trust income (£m)	1.64	0.20	1.63	1.87	0.89	0.11	0.20	0.06	6.62
National lower quartile (£m)	1.42	0.51	1.02	0.59	0.53	0.15	0.10	0.06	
National quarter	2	1	4	4	4	1	3	2	
Quarter change from last year	–	–	–	–	–	–	–	–	

† Finance function total excludes 'Service Improvement / PMO team' sub-function.

‡ No cost opportunity is calculated for non-transactional Digital and Technology (D&T).

Costs over time

Year	Trust income (£m)	Trust FTE	Function cost (£m)							
			Digital & Technology		HR	Governance & Risk	Finance †	Procurement	Legal	Payroll
			Transactional	Non-transactional						
FY 23/24	215.90	2,759	3.54	0.43	3.52	4.04	1.93	0.24	0.44	0.14
FY 22/23	205.81	2,625	3.55	0.43	3.67	3.58	1.73	0.24	0.39	0.13
FY 21/22	182.89	2,469	3.43	0.42	2.87	3.03	1.47	0.22	0.29	0.13
FY 20/21	173.56	2,204	3.66	0.83	2.40	2.66	1.62	0.20	0.26	0.17
FY 18/19	148.64	2,205	2.97	0.77	1.92	2.10	1.39	0.17	0.23	0.13

Corporate Cost Reduction Return

Appendix B

Year	Planned Function reduction (£m)								Total	Other Corporate / Overhead functions	Revised total	Commentary
	Digital & Technology		HR	Governance & Risk	Finance	Procurement	Legal	Payroll				
	Transactional	Non-transactional										
18/19 Pay	0.9	0.6	0.1	2.0	1.1	0.2	0.1		**5.0**			
18/19 NP	2.1	0.1	1.8	0.1	0.3	0.0	0.2	0.1	**4.7**			
FY 18/19 inflation adjusted	3.2	0.9	2.0	2.6	1.7	0.2	0.2	0.1	**11.0**			
FY 23/24	3.5	0.4	3.5	4.0	1.9	0.2	0.4	0.1	**14.3**			
Proxy target reduction	(0.2)	0.3	(0.8)	(0.7)	(0.1)	(0.0)	(0.1)	(0.0)	**(1.6)**			Issued to us via national letter
Proposed exceptions	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**-**			
Proxy 26/27 Spending limit	**3.4**	**0.7**	**2.7**	**3.3**	**1.8**	**0.2**	**0.3**	**0.1**	**12.6**			Excludes pay award and inflation impact. Always larger percentage of pay cost in MH Trusts. National pay award assumptions flawed and penalises MH Trusts.
FY 23/24 actual	3.5	0.4	3.5	4.0	1.9	0.2	0.4	0.1	**14.3**			
Planned reductions	(0.2)		(0.2)	(0.0)	(0.0)	(0.0)			**(0.5)**	(0.1)	**(0.6)**	2024/25 CIP delivered recurrently as part of Trustwide initiatives. All progressed via PIDs and QEIA process.
FY 25/26 plan	**3.3**	**0.4**	**3.3**	**4.0**	**1.9**	**0.2**	**0.4**	**0.1**	**13.8**			Not adjusted for pay award and inflation
Further expected 25/26 reductions	**(0.3)**		**(0.2)**	**(0.1)**	**(0.1)**	**(0.0)**			**(0.7)**	(0.3)	**(1.0)**	2025/26 CIP plans. All developed and part of opening 25/26 plan. This includes full PIDs and QEIA processes.
Revised 25/26 plan	**3.1**	**0.4**	**3.1**	**3.9**	**1.8**	**0.2**	**0.4**	**0.1**	**13.1**			Not adjusted for pay award and inflation
Full year effect of 25/26 reductions									**0.0**		**0.0**	The above assumes FYE extraction and no delays rolling into 2026/27
Further reductions planned for 26/27	**(0.2)**	**0.0**	**(0.2)**	**(0.2)**	**(0.1)**	**(0.0)**	**0.0**	**0.0**	**(0.6)**		**(0.6)**	Assumed 5% target for 2026/27. Continued focus on areas identified as having opportunity based on corporate benchmarking and not being aligned to lower quartile.
Projected 26/27 corporate costs	**2.9**	**0.4**	**2.9**	**3.7**	**1.7**	**0.2**	**0.4**	**0.1**	**12.5**	**0.0**	**12.5**	Not adjusted for pay award and inflation
(Shortfall) to spending target	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	

Corporate Cost Reduction Programme Template

Derbyshire Healthcare NHS Foundation Trust

RXM

Year	Planned Function reduction (£m)								Total	Other Corporate / Overhead functions	Revised total	Commentary
	Digital & Technology		HR	Governance & Risk	Finance	Procurement	Legal	Payroll				
	Transactional	Non-transactional										
18/19 Pay	0.9	0.6	0.1	2.0	1.1	0.2	0.1		**5.0**			
18/19 NP	2.1	0.1	1.8	0.1	0.3	0.0	0.2	0.1	**4.7**			
FY 18/19 inflation adjusted	3.2	0.9	2.0	2.6	1.7	0.2	0.2	0.1	**11.0**			
FY 23/24	3.5	0.4	3.5	4.0	1.9	0.2	0.4	0.1	**14.3**			
Proxy target reduction	(0.2)	0.3	(0.8)	(0.7)	(0.1)	(0.0)	(0.1)	(0.0)	**(1.6)**			Issued to us via national letter
Proposed exceptions	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**-**			
Proxy 26/27 Spending limit	**3.4**	**0.7**	**2.7**	**3.3**	**1.8**	**0.2**	**0.3**	**0.1**	**12.6**			Excludes pay award and inflation impact. Always larger percentage of pay cost in MH Trusts. National pay award assumptions flawed and penalises MH Trusts.
FY 23/24 actual	3.5	0.4	3.5	4.0	1.9	0.2	0.4	0.1	**14.3**			
Planned reductions	(0.2)		(0.2)	(0.0)	(0.0)	(0.0)			**(0.5)**	(0.1)	**(0.6)**	2024/25 CIP delivered recurrently as part of Trustwide initiatives. All progressed via PIDs and QEIA process.
FY 25/26 plan	**3.3**	**0.4**	**3.3**	**4.0**	**1.9**	**0.2**	**0.4**	**0.1**	**13.8**			Not adjusted for pay award and inflation
Further expected 25/26 reductions	**(0.3)**		**(0.2)**	**(0.1)**	**(0.1)**	**(0.0)**			**(0.7)**	(0.3)	**(1.0)**	2025/26 CIP plans. All developed and part of opening 25/26 plan. This includes full PIDs and QEIA processes.
Revised 25/26 plan	**3.1**	**0.4**	**3.1**	**3.9**	**1.8**	**0.2**	**0.4**	**0.1**	**13.1**			Not adjusted for pay award and inflation
Full year effect of 25/26 reductions									**0.0**		**0.0**	The above assumes FYE extraction and no delays rolling into 2026/27
Further reductions planned for 26/27	**(0.2)**	**0.0**	**(0.2)**	**(0.2)**	**(0.1)**	**(0.0)**	**0.0**	**0.0**	**(0.6)**		**(0.6)**	Assumed 5% target for 2026/27. Continued focus on areas identified as having opportunity based on corporate benchmarking and not being aligned to lower quartile.
Projected 26/27 corporate costs	**2.9**	**0.4**	**2.9**	**3.7**	**1.7**	**0.2**	**0.4**	**0.1**	**12.5**	**0.0**	**12.5**	Not adjusted for pay award and inflation
(Shortfall) to spending target	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	

Proposed exceptions										**Commentary**	
Item 1									**0.0**	Had to invest in procurement. Was a team of only 1.5 WTE	
Item 2									**0.0**	Had to invest in sustainability lead 0.4 WTE	
Item 3									**0.0**	We have no central PMO function	
Item 4									**0.0**	We have no resources to lead CIPs outside of core finance	
Item 5									**0.0**	We have no resources to lead productivity	
Item 6									**0.0**	We hope to have further opportunities once the system corporate collaboration agenda progresses in 2026/27	
Item 7									**0.0**	Part of IMST is outsourced and under contract, Timing it is not possible to extract some costs at present.	
Item 8									**0.0**	Legal costs are sporadic and not always predictable or budgeted	
Item 9									**0.0**	GOV & Risk include MH Act requirements which are not possible to extract as legal duties	
Item 10									**0.0**		
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**		

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 22 July 202

Fit and Proper Persons Test - Chair's Annual Declaration

Purpose of Report

To inform the Board of the Board members compliance against the Fit and Proper Persons Test Framework.

Executive Summary

NHS England developed a Fit and Proper Person Test (FPPT) Framework in response to recommendations made by Tom Kark KC in his 2019 review of the FPPT. This also takes into account the requirements of the CQC in relation to Board Directors being fit and proper for their roles. It is confirmed that DHcFT Trust Board member references/pre employment checks (where relevant) and full FPPT, including the annual self-attestation have been completed and are satisfactory for each Trust Board member.

A summary of the checks is included at **Appendix 1.**

It is the responsibility of the Chair to discharge the requirement placed on the Trust to ensure that all Board Directors meet the fitness test and do not meet any of the 'unfit' criteria. Under the new Fit and Proper Persons Test Framework, the Chair is required to complete a review of the whole Board annually and submit a template confirming compliance to NHS England. This has been sent off by the 30 June deadline. The Chair's declaration covers 2024/25 and is included at **Appendix 2.**

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.	

Risks and Assurances

- The Board can receive assurance that due process has been followed in line with the Trust's Fit and Proper Persons Policy to ensure that all relevant post holders meet the fitness test and do not meet any of the 'unfit' criteria
- That comprehensive files have been established and maintained for each relevant post, evidencing compliance and that proactive processes have been set in place to monitor the filing system.

Consultation

This report has not been considered by other groups/committees. However, confirmation of Fit and Proper Person Test compliance for Non-Executive appointments is reviewed by the governor Nomination and Remuneration Committee, and confirmation of compliance with Fit and Proper Persons Test requirements have been overseen by the Remuneration and Appointments Committee for Executive Director appointments made in year.

Governance or Legal Issues

- It is a requirement of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that NHS bodies undertake a 'fit and proper person test'
- The regulations have been integrated into the CQC's registration requirements and falls within the remit of their regulatory inspection approach.

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.

Recommendation

The Board of Directors is requested to:

1. Receive full assurance from the Chair's declaration that that all Board Directors meet the fitness test and do not meet any of the 'unfit' criteria and that the Board is fit and proper
2. Note the compliance against the national Fit and Proper Persons Test (FPPT) Framework.

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

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

Appendix 1

Fit and Proper Person Checks introduced as part of FPPT framework.

1. All new appointments are subject to a full FPPT that includes:

1.1. Standard employment checks as per the Trust's Recruitment and Selection Procedure

1.2. References, using the board member reference template that cover a six-year continuous employment history

1.3. An enhanced DBS for a person who will be acting in a role that falls within the definition of a 'regulated activity'

1.4. Search of insolvency and bankruptcy register

1.5. Search of Companies House register to ensure that no board member is disqualified as a Director

1.6. Search of the Charity Commission's Register of Removed Trustees

1.7. Employment Tribunal Judgement check

1.8. Web/social media search

1.9. Satisfactory completion of the self-attestation form

2. For annual assurance, the FPPT includes:

2.1. Annual completion of the self-attestation form

2.2. Annual Declaration of Interest for Directors in post

2.3. DBS check at least every three years

3. All Board leavers:

3.1. Completed Board Member exit reference based on template to be kept on file, irrespective of whether a reference is requested from another NHS employer.

Requirement to hold certain FPPT data in the Electronic Staff Record (ESR)

New data fields in ESR will hold individual FPPT information for all Board Members. A privacy notice is issued to all Board Members.

Appendix 2 - NHS FPPT submission reporting template

NAME OF ORGANISATION	TYPE OF ORGANISATION *Select organisation*		NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:
Derbyshire Healthcare NHS Foundation Trust		Trust	Selina Ullah	2024/25
	X	Foundation Trust		
		ICB		

Part 1: FPPT outcome for board members including starters and leavers in period

Role**	Total Number Count	Confirmed as fit and proper?			Leavers only	
		Yes	No	How many Boad Members in the 'Yes' column have mitigations in place relating to identified breaches? *	Number of leavers	Number of Board Member References completed and retained
Chair/NED board members	8	8		n/a	1	1
Executive board members	9	9		n/a	2	2
Partner members (ICBs)	n/a					
Total	17	17			3	3

**** See 3.8 'Breaches to core elements of the FPPT (Regulation 5)' in the Framework.***

***** Do not enter names of board members.***

Have you used the Leadership Competency Framework as part of your FPPT assessments for individual board members?	Yes	

Part 2: FPPT reviews / inspections

Use this section to record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews, etc.

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
None – Chair submits annual declaration to the Board				

Part 3: Declarations

DECLARATION FOR DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST 2024/25				
For the SID/deputy chair to complete:				
FPPT for the chair (as board member)	Completed by: Senior Independent Director	Ralph Knibbs	**10 March 2025 (date of appraisal)**	Fit and proper? Yes

For the chair to complete:		
Have all board members been tested and concluded as being fit and proper?	**Yes**	**If 'no', provide detail:**
Are any issues arising from the FPPT being managed for any board member who is considered fit and proper?	**No**	**If 'yes', provide detail:**

As Chair of Derbyshire Healthcare NHS Foundation Trust, I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.	
Chair signature:	
Date signed:	**20 June 2025**
For the regional director to complete:	
Name:	
Signature:	
Date:	

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 22 July 2025

Winter Plan – 2025/26

Purpose of Report

The purpose of this report is to inform the board of the Trust's commitment and plans towards the Winter Plan for 2025/26.

Executive Summary

In support of planning, preparedness and assurance for Winter 2025/26 the Trust is working towards both a Trust-level and System-level Winter Plan.

There is a pre-empted expectation of a difficult winter, which will not only be impacted upon by seasonal pressures but will also require plans to work in conjunction with the structural transition of the wider NHS landscape.

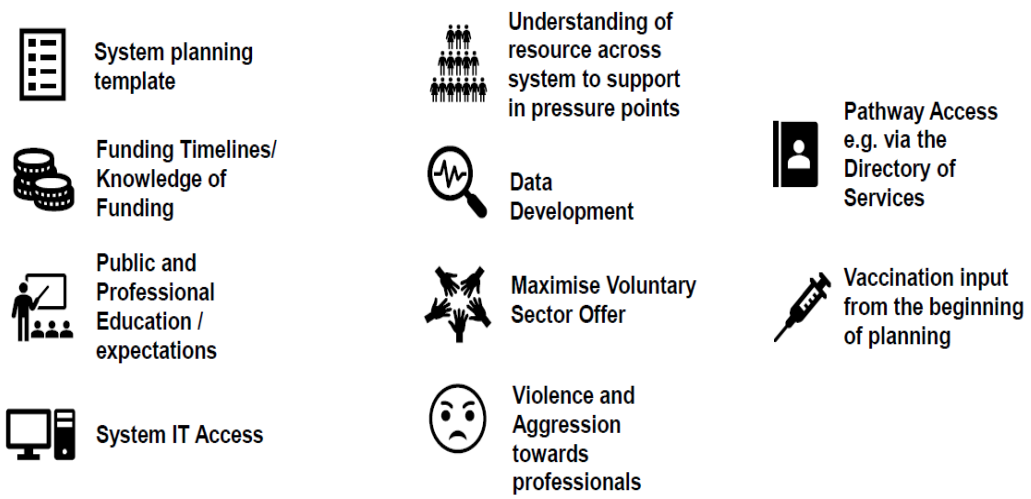
The early data from 2024/25 has underlined that flu and respiratory illness will again be major drivers of System pressure, with flu-related hospital admissions and bed days likely to reach significant levels. At the same time, we are preparing for the anticipated staffing pressures arising from industrial action, ongoing workforce challenges and higher baseline levels of demand.

The expectation of Boards/ICBs are to have clear oversight of four key areas outlined below:

- **Learning from 2024/25**

The Integrated Care Board (ICB) led a Joined Up Care Derbyshire (JUCD) Winter Wash Up Event in April 2025 to reflect on the System's Winter Plan for 2024/25 and to begin thinking about the Winter Plan for 2025/26.

Please see outlined below key findings from this event:



From a System-level review of the above, the agreed priorities for 2025/26 and in preparation for winter include:

The last two years have shown the peak of demand increases during summer months, school holidays and the new year period. There is work required to determine the most effective use of capacity against demand to include forward planning around discharges to reduce bed occupancy. There is a requirement to ensure that there are sufficient resources in place across the community pathways during peak demand periods to support admission avoidance and timely discharge.

- **Mitigating Wider System Change**

The Trust is implementing a new operating model, the organisation will maintain standards and manage risk across Urgent and Emergency Care (UEC) and elective care pathways by way of ensuring the transition of roles and responsibilities is carried out through careful planning and implementation. Associated transformation timelines and delivery will be aligned to the changes in structure with clear oversight via the senior leadership to ensure delivery is on track and any risks are identified and escalated to avoid impact.

The management and delivery of the Winter Plan will be monitored through the Trust Delivery Group.

The anticipated changes for ICBs and NHS England are being worked through at a national and cluster level. The responsibilities around leading the winter response will remain a priority so impact in this area is expected to be limited.

- **Leadership Capacity – Appointing a Designated Winter Director**

The Trust's designated Lead for Winter is Vikki Taylor Deputy Chief Executive Officer and Chief Delivery Officer, who will lead the Trust's operational and System-level engagement and commitment during the winter period; ensuring there are efficient and effective representation for System co-ordination, escalation and assurance throughout winter.

- **Assurance on Delivery Impact**

The ask of the Board is to confirm assurance that there are sufficient plans in place to mitigate the anticipated impacts of increased winter pressure, including surge and super-surge scenarios.

The initial governance route for ratification of the Winter Plan 2025/26 is outlined in the timeline below. The finalised version will be shared with this board in September to obtain full assurance against delivery.

Key Lines of Enquiry (KLoEs) specific to winter pressures and planning:

Flow

The Derbyshire Healthcare Foundation Trust Winter Plan indicates sufficient capacity to meet expected demand this winter through internal and out of area bed utilisation. Projected position is based on a demand increase of 4% this winter.

DHcFT current bed base is outlined in the table below.

Psychiatric Intensive Care Unit (PICU) beds and Enhanced Care Unit (ECU) beds (Audrey) are in development and are due to be opened within the financial year of 2025/26 – date is yet to be confirmed. However, expectation is that the beds will be open prior to winter (from October).

Totals by Site	Adult Acute	Older Adult Acute	Psychiatric Intensive Care	Rehabilitation	Specialist	Total
Chesterfield Royal	54	0	0	0	0	**54**
Walton Hospital	0	12	0	0	0	**12**
Chesterfield Total	**54**	**12**	**0**	**0**	**0**	**66**
Kingsway Hospital	62	54	14	23	20	**173**
Radbourne Unit	34	0	0	0	6	**40**
Derby Total	**96**	**54**	**14**	**23**	**26**	**213**
Grand Total	**150**	**66**	**14**	**23**	**26**	**279**

The Trust has eight additional surge beds available across the two wards at the Radbourne Unit which are currently being used. This additional capacity is available for peak periods of demand.

The Trust has access to additional capacity in Mill Lodge, Sherwood and step-down facilities, as well as out of area beds in those cases that are necessary. The plans are that Mill Lodge and Sherwood bed capacity will reduce alongside the opening of the specialist beds, ie PICU and the ECU.

The Trust having its own PICU and ECU beds will support improvements to flow, including length of stay benefits.

In additon to bed capacity, the Trust also has the following provisions in place:

- Mental Health Liaison teams reach into those patients in acute inpatient beds or emergency departments (EDs) whilst awaiting a mental health bed for assessment and advisory purposes

- The Crisis Resolution and Home Treatment team (CRHTT) offers intensive support within the home to effectively treat mental health problems and support the safety of our service users. The service provision is in place over a 24hour period
- In support of Crisis services, there are commissioned Crisis Alternative services which are aimed at reducing attendance at ED and inpatient admissions. This provision provides access to Voluntary, Community and Social Enterprise (VCSE) led Crisis beds providing up to seven-day stay, to include support plans and wrap around care
- Gatekeeping processes to determine the decision to admit or alternatives
- Multi-Agency Discharge Event (MADE) to include silver and gold escalation
- 72-hour reviews on all new patients to determine discharge plans including the expected date of discharge
- Safety Huddles across community teams to manage patients in the community.

Urgent Emergency Care (UEC)

The Trust have recently taken part in an urgent care mental health self assessment alongside system partners and led by NHSE Mental Health Improvement Support team (MHIST) which works in alignment with national guidance and best practice standards.

The UEC Men-SAT tool used as part of this assessment is designed to identify critical gaps within pathways, supporting commissioning efforts, including winter planning. It provides systems with tailored improvement plans aimed at enhancing mental healthcare delivery and reducing demand and delays in emergency. The findings will be utilised to drive system led task and finish groups to further enhance current service provision where needed.

In addition to the above, the Trust continue to have in place:

- Mental Health Liaison teams reach into those patients in acute inpatient beds or ED whilst awaiting a mental health bed for assessment and advisory purposes
- 136 suites in operation which has been increased from two to three suites since last winter and a back up suite at each site to support cases of damaged suites
- Crisis Resolution and Home Treatment team (CRHTT) offers intensive support within the home to effectively treat mental health problems and support the safety of our service users. The service provision is in place over a 24-hour period
- In support of Crisis services, there are commissioned Crisis 224 to Alternative services, which are aimed at reducing attendance at ED and inpatient admissions. This provision provides access to VCSE-led Crisis beds providing up to seven-day stay, to include support plans and wraparound care.

Learning from incidents/patient safety

In line with the Patient Safety Incident Response Framework (PSIRF), the Trust has an operational Serious Incident (SI) Group and an Executive SI Group which review all SI and PSIRF incidents and allocate actions and designated lead to act on recommendations to improve patient care. To supplement this each division has a learning lessons meeting to review serious incidents and PSIRF to identify any lessons learnt and actions for continuous improvement.

Care Quality Commission (CQC) Fundamental Standards are maintained

Compliance of CQC Fundamental Standards for UEC care is consistently maintained through standard practice to include collaboration with system partners, pathways and joint processes/protocols that reflect a right care from the right professional approach and ensures shared, professional, multi-agency decision making takes place to support efficiency and effectiveness towards both the immediate and continuity of care for the patient.

Infection Prevention and Control (IPC)

IPC policies supporting on-call arrangements can be stood up where specialist IPC cover is required, as well as cohorting and usage of isolation plans when required.

Vulnerable Inpatients are included in the plan for 2025/26 and there is a blended model of bookable appointments and dedicated peer vaccinations support in the plans for winter. Learning from the last campaign and wider system has been incorporated to include testing for respiratory illness, which would be implemented if indicated.

Workforce

To support the sustainbility of workforce over the winter period the Trust has an enhanced programme of wellbeing support and staff vaccination plans in place.

There are also timely recruitment processes in place for clinical roles and effective rostering to minimise reliance on agency, utilising available workforce, enabling an effective skill-mix.

Winter Plan Timeline

The draft Winter Plan currently remains work in progress across the System. The timeline for the plan to be finalised and ratified is outlined below:

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

There are no risks to identify at this stage.

Consultation

System level and Trust level consultation through the development of agreed priorities and planning.

Governance or Legal Issues

Trust governance route via Trust Delivery Group and system level governance route via Urgent Emergency Care and Mental Health Learning Disability & Autism Delivery Boards.

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 national and local initiative supports access to the most appropriate care for all; to include all protected characteristics as referenced above.

Recommendations

The Board of Directors is requested to:

1. Note the planning and timeline for finalising the Winter Plan 2025/26
2. Confirm the Board is assured of the planning and governance routes.

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

Report prepared by: **Lee Doyle**
Managing Director

Stephanie Harris
Strategic Transformation Programme Lead

Fundamental Standards of Care

Purpose of Report

To update the Board on the Fundamental Standards of Care and the performance against the set standards as set out in the Care Quality Commission (CQC) key line of enquiry.

Executive Summary

The Older Adults Inpatient team had an unannounced assessment, which took place between 28 April and 14 May 2025. The report was published on 2 July 2025, rating the service as 'Good' with an improvement in Safety from 'Required Improvement' to 'Good'.

There has been a review of the processes for medical devices and plans are in place to address the backlog, with oversight from the Health and Safety Group.

Safer staffing has been achieved in the Inpatient areas; the registered Nurses are within the set levels between 80% and 130%, the non-registered Nurses (Health Care Support Workers) are above the margins due to enhanced observations. There has been an improvement in reducing overstaffing within the wards with robust governance in place.

Inpatient units have successfully implemented the Smokefree Policy, the impact of which is being monitored.

In March and April 2025, Fundamental Standards of Care visits were conducted in all Community Mental Health teams to review the Section 48 issues raised in the Assertive Outreach team. Following completion of the visits, action plans are in place and being progressed.

The Board continues to have visibility in services. Board members have been conducting group or individual visits. Between 1 April and 30 June 2025, there were 41 visits by Board.

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.	

Risks and Assurances

- The Fundamental Standards of Care have been developed in line with single assessment framework
- Significant assurance that the Trust responded to the legal restrictions imposed by the CQC.

Consultation

- Operational CQC Group
- Quality and Safeguarding Committee.

Governance or Legal Issues

CQC regulated activity and regulation.

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:

Improving compliance with the fundamental standards will ensure a high standard of care for all patients including those who may have protected characteristics. Therefore, the areas covered by this report do not disproportionately affect any of the nine protected characteristics.

Recommendations

The Board of Directors is requested to accept limited assurance on the Fundamental Standards of Care Compliance, there is improved delivery of the standards in some areas whilst others require further improvement.

Report presented by: **Tumi Banda**
Director of Nursing, AHPs, Quality and Patient Experience

Report prepared by: **Libby Runcie**
Deputy Director of Nursing

CQC Updates

Older Adults Inpatient CQC Inspection

The unannounced assessment took place between 28 April and 14 May 2025. The areas visited were Bluebell Ward, Tissington House and Cubley Court. This was the first assessment for all three services using the Single Assessment Framework.

Alongside the inspection, there was a data request submitted, which covered all five Key Lines of Enquiry (Safe, Caring, Responsive, Effective and Well Led) for all three services.

The report was published on 2 July 2025. The service was rated 'Good' with an improvement in Safety from 'Required Improvement' to 'Good'. The overall Trust rating remains unchanged at 'Good'. The link to the report is provided below:
Derbyshire Healthcare NHS Foundation Trust HTML report for assessment AP11447 - Wards for older people with mental health problems - Care Quality Commission

Bluebell Ward had a Mental Health Act visit on 8 July 2025. Verbal feedback received has been positive and areas of concern have been addressed or have plans in place to address. The Trust awaits the report in about six weeks' time.

1. Safety

Medical devices

A new structure is now in place with an appointed Medical Devices Lead to have oversight of the servicing, maintenance and repair of the physical health equipment, with the support of the Medical Devices Asset Register Business Administration Apprentice.

All Trust staff have been informed of the new Medical Devices Helpdesk and where to record calls for equipment in need of repair or service via Focus (policy also on Focus).

The Medical Devices Sub-group will continue in August with representatives from the Trust and University Hospitals of Derby and Burton, as a sub-group of the Trust Health, Safety and Security Committee.

Personnel and financial resources have been provided to the Health and Safety team to address the issues with support from the care groups and support services.

There is a backlog of medical devices to be serviced. Progress against the backlog is being monitored by The Medical Devices Sub-group, that reports to the Health and Safety Group. The Quality and Safeguarding Committee has received limited assurance on medical devices and will continue to monitor the progress.

Trust-wide Suicide Prevention, Risk Assessment, and Safety Planning Training

Suicide Prevention, Risk Assessment, and Safety Planning Training, the first module went live in June 2025 and the remaining four modules are expected to be in place by September 2025.

Safer staffing

Safer staffing Fill Rate Data				
	Day		Night	
Month	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)	Average fill rate - Registered Nurses/Midwives (%)	Average fill rate - Non-registered Nurses/Midwives (care staff) (%)
Oct-24	94%	122%	83%	180%
Nov-24	101%	119%	87%	174%
Dec-24	116%	123%	95%	173%
Jan-25	114%	116%	97%	173%
Feb-25	106%	112%	93%	153%
Mar-25	109%	124%	96%	172%
Apr-25	110%	114%	93%	157%

All areas of deficit in the qualified workforce have a level of mitigation through the over-achieving of unqualified care staff levels. However, the considerable level of over-staffing in non-registered staff is also linked to more staff being required to facilitate the need for environmental zonal observations, which were in place for the female wards. Over-resourcing of care staff in these wards is over 500% in some cases at night. There has also been significant investment in over-staffing to safely prepare the move of wards in relation to the Making Room for Dignity (MRfD) programme. Once the ward moves are completed. the additional staffing will not be required.

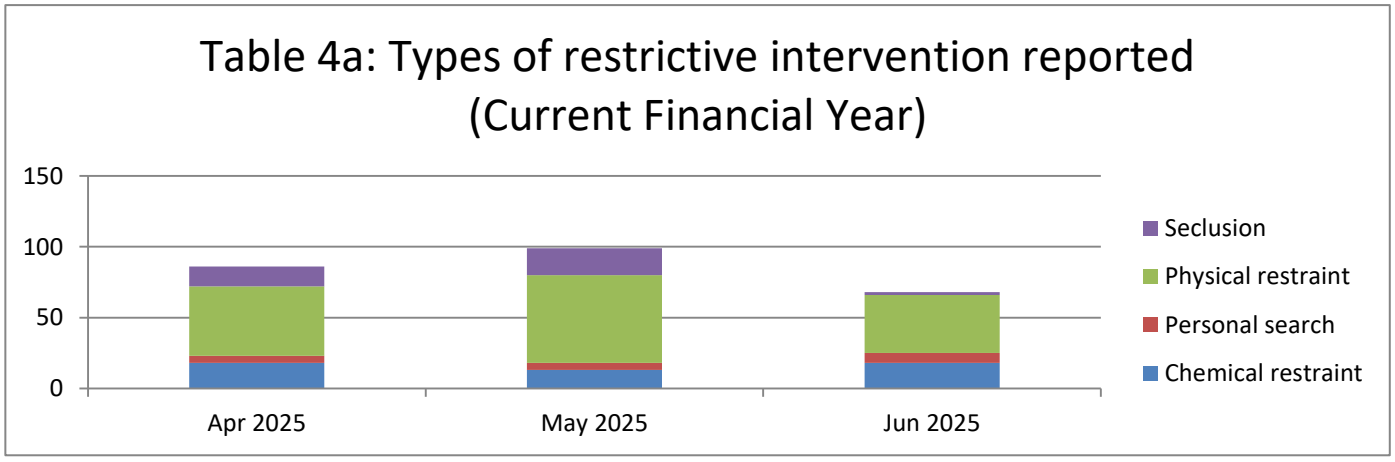
To mitigate and explore the over-resourcing of care staff, from March 2025, the Deputy Director of Nursing started a monthly Check and Challenge meeting to review effective use of e-rosters within Working Age Adult Inpatient services and the Clinical Matrons have taken over the final review, prior to submitting the rosters for finalisation. Therefore, following the move to the Derwent and Carsington Units in May and June 2025, respectively mitigating the need for extra staff to facilitate zonal observations, and the extra governance now in place, the percentage of overstaffing is expected to reduce over the next six months, while maintaining safe fill rates on all wards. There has been a continued reduction of agency use and this is monitored through the People and Culture Committee.

Use of Restrictive Interventions

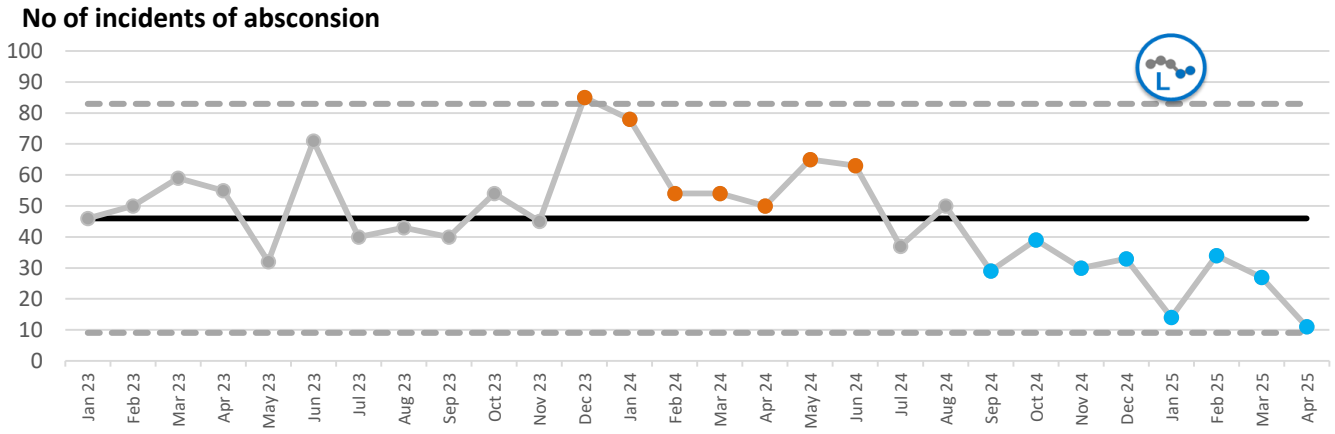
The Trust is committed to reducing the use of restrictive practices such as Physical Restraint, Rapid Tranquillisation, Searching, Seclusion, Segregation and Engagement Observations. Physical restraint to be the largest area of restrictive intervention reported on by the Trust.

Graph A, below, gives an overview of the types of restrictive intervention reported since the last report in February 2025 to 22 of June 2025:

Graph A



Graph B



Graph B (above) shows that there has the overall trend of reduction in the numbers of absconsion, various interventions are in place in the units to reduce absconsion.

The significant impact has been the Trust's approach to controlled access and locked doors in inpatient areas, which became usual practice in October 2024, following an evaluation of a pilot locking the ward doors and the front doors of the inpatient units being locked as part of the Right Care Right Person programme. With the opening of the Derwent and Carsington Units in April and June 2025, the ward doors and front doors of the units are locked as per the updated Trust Locked Door policy. This is monitored by the Reducing Restrictive Practice Group and service users are encouraged to give their feedback or raise any concerns around doors being locked as part of the blanket restriction element of the agenda for weekly Inpatient Community Meetings. As of yet no concerns have been raised.

2. Effective

Smoke-Free in Inpatient settings

All in-patient areas have successfully transitioned to smoke-free environments. This aligns with the Trust's commitment to providing a healthier environment for service users and staff. Signage is displayed around sites.

The Smoke-Free Policy has been updated and uploaded to the Trust's internal systems. This Policy outlines the roles and responsibilities for maintaining a smoke-free environment and provides clarity on the support available to service users. The Policy was approved by the Quality and Safeguarding Committee in March 2025.

The Tobacco Eradication Working Group is meeting regularly with key leads from across our sites. This group is essential for ensuring consistent implementation of the Smoke-Free Policy and addressing any issues that arise. The group tasks oversight of the delivery of the approach and provides governance support and direction to the clinical areas in accordance with the policy and strategy of the organisation.

There has been good, clear and consistent engagement from Clinical and Operational leads, which has been crucial for the successful implementation of the Smoke-Free Policy.

The consistent delivery of the approach is key to the success of the programme and the clinical teams are being supported to provide a clear and consistent message and response in support of our service users.

Datix incidents are being monitored, and any trends or issues of concern are being addressed directly with clinical areas and thematically through the Tobacco Eradication Working Group. It is too early to evaluate the impact of the change in approach.

Evidence based approach

Three guidelines have been updated since January 2025 that are relevant to the care provided by the Trust.

The updated guidelines have been shared with the relevant leaders and Divisions via the Head of Nursing for discussion and any required actions via the Divisional Clinical Reference Group or Physical Health Forum (in relation to Tobacco).

Title	Reference Number	Published	Last Updated
Tobacco: preventing uptake, promoting quitting and treating dependence.	NG209	30 November 2021	04 February 2025
Gambling-related harms: identification, assessment and management.	NG248	28 January 2025	28 January 2025
Digitally enabled therapies for adults with depression: early value assessment.	HTE8	16 May 2023	14 January 2025

3. Responsive

Safeguarding

The Trust had the Section 11 assessment Safeguarding Review with the Integrated Care Board (ICB) on 20 May 2025. The formal written report will be sent in the next few weeks. All standards were graded green, which meets required standards, apart from one section of standard 1, which covers the Trust safeguarding children accountability structure. This standard was graded amber, requires review. This is due to the Trust having no permanent Consultant Paediatrician as the Named Doctor for Safeguarding Children. There is medical cover in this role whilst attempts are being made to recruit to the role.

4. Caring

Culture of Care (CoC)

The Culture of Care programme (CoC) aims to improve the culture of Inpatient Mental Health wards for patients and staff so that they are safe, therapeutic and equitable places to be cared for and fulfilling places to work.

- Programme status CoC: all wards have fortnightly coaching sessions booked in with CoC Coach
- 30 change ideas have been identified by the wards taking part in the programme and have been imported onto the CoC national dashboard
- Derbyshire Healthcare is one of only three Trusts that have submitted benchmarking data and have a process to sustain this and provide monthly data on number of incidents of: Restrictive Practice (restraint; seclusion and rapid tranquilisation); sexual harm; the number of days since the last incident of absent without leave (AWOL) and the percentage of shifts filled by bank and agency staff
- Organisational level support sessions to be booked in for November by end of June 2025
- Executive coaching sessions are in place
- From July 2025, the Trust's Suicide Prevention Lead will be the Trust Lead in relation to Personalised Approaches to Risk (PAR) and will support embedding this approach across the organisation.

5. Well-Led

The Trust Strategy is now operational and the delivery plans are in various stages of development and delivery. The progress on the plans is being monitored in The Strategic Portfolio Oversight Group:

- Estates, Sustainability and Finance plans are in development and in draft
- People Plan is in final draft due to be ratified in September 2025
- Digital Plan was presented to Clinical Digital Board in July and the plan is progressing to the Finance and Performance Committee next
- Operational Plan has been signed off in April 2025 and is in delivery

- Communication Plan has been signed off and is in delivery
- The Clinical Plan is being developed and is in draft
- The Quality Delivery Plan has been consulted on and recommended to Board for ratification in July 2025
- Pharmacy Strategy has been signed off and is in delivery
- Suicide Prevention Strategy draft was presented to Quality and Safeguarding Committee in July 2025.

Board Visits

This report covers the period: 1 April to 30 June 2025. There were 41 visits by Board during this period, including group and individual visits:

Group Visits:

The areas visited were:

- Participation team and Triage/Assessment team, Children's services
- Paediatric Therapy
- Erewash Adults of Working Age CMHT
- Individual Placement Support team, Adults of Working Age
- In-reach and Liaison team, Neurodevelopmental services
- Bed Management team
- Perinatal Maternal Mental Health (Psychological services)
- Perinatal Community team.

The visits were conducted with a combination of Executive Directors, Non-Executive Directors and Governors. Work is underway to have a schedule for the visits well in advance and more visits are being arranged to have Board visibility in all of the services. There is a schedule of visits until September 2025. The visits have been well received in the organisation. The Clinical Directorate is to raise awareness on the revised approach of the Board visit, from a formal visit to an engagement approach.

Fundamental Standards of Care visits

In March and April 2025 Fundamental Standards of Care visits were conducted in all Community Mental Health teams to review the Section 48 issues raised in the Assertive Outreach team. On completion of the visits, action plans are in place and being progressed.

Since April 2025 the following visits have been completed:

- All 12 Community teams had Fundamental Standards of Care visits conducted. The reviews were aimed at the Assertive Outreach Review findings from the section 48 from Nottinghamshire Healthcare. Areas of improvement identified have action plans in place
- Five teams based at Brooklands, St Andrews, Dale Bank View, Ash Green and Rivermead had visits completed
- Forensic and Rehabilitation services have had three visits conducted in June 2025
- Derwent Unit had visits completed after the new wards opened.

There is a schedule in place to ensure that all services are reviewed. From June 2025 all the visits will include people with lived experience supported by EQUAL. Actions plans are reviewed and monitored in COAT meetings.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 22 July 2025

Quality Delivery Plan

Purpose of Report

To provide the final version of the Quality Delivery Plan to the Trust Board for ratification.

Executive Summary

Following engagement and reviewing feedback this latest iteration of the Quality Delivery Plan is for noting on progress and for final sign off by the Trust Board.

Key Changes:

- Shortened to a more succinct version
- Embedded throughout with patient stories
- Clearly captures the 'how we will deliver' the plan.

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 Quality Delivery Plan provides demonstrably evidences that engagement has taken place throughout the development of the Plan and that feedback has been listened to and acted on with this final iteration.

Consultation

- Carers forums and EQUAL
- Relevant stakeholders in the Trust
- Quality and Safeguarding Committee, 9 July 2025.

Governance or Legal Issues

None anticipated.

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:

None anticipated.

Recommendations

The Board of Directors is requested to ratify the final iteration of the Quality Delivery Plan.

Report presented by: **Tumi Banda**
Director of Nursing, AHPs, Quality and Patient Experience

Report prepared by: **Libby Runcie**
Deputy Director of Nursing, Quality and Patient Safety

NHS
Derbyshire Healthcare
NHS Foundation Trust

Quality Delivery Plan

2025-2028

Introduction

Derbyshire Healthcare
NHS Foundation Trust

I am proud to present the 2025-2028 Quality Delivery Plan. The new Trust Strategy is now in place, with patient focused being one of four Trust-wide strategic priorities. This plan outlines our approach to achieving the quality ambitions outlined under this priority, through three pillars of quality care – effectiveness, safety and experience.

The Quality Delivery Plan outlines how these three pillars will be delivered, underpinned by a clear set of principles and co-produced pledges. Digital developments and approaches will be central to our progress, as we aim to achieve a single, consistent approach to delivering quality –involving evidence-based care, benchmarking, learning from others, triangulating experience, safety and effective measures and more.

We are looking forward to various changes in legislation and developments, including the new 10-year Health Plan amongst other updates geared towards the delivery of better quality and safer services.

I am grateful to everyone that have contributed to this Quality Delivery Plan, and I look ahead with hope, excitement and commitment to delivering on it.

Tumi Banda
Director of Nursing, AHPs, Quality and Patient Experience

Patient stories are included throughout our plan, grounding us in our vision and commitment.

Quality Delivery Plan

NHS
Derbyshire Healthcare
NHS Foundation Trust

This summarises how we will meet the **patient focused** strategic priorities outlined in the Trust strategy

Three key pillars of quality care:

1. Effectiveness

Providing evidence-based care to improve patient outcomes.

2. Safety

Providing care that will not cause harm and is timely.

3. Experience

Providing an experience that is personalised, compassionate, respectful and dignified.

Our **patient focused** strategic priority (one of the Trust's 4Ps) is: **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.**

In the plan…

- There are **objectives** and **delivery measures** outlined for each of the three key pillars
- There are a series of **co-produced pledges** that underpin the plan, together with examples of real-life experiences from patients and staff
- **Digital** is seen as a key enabler of the plan.

The plan also sets out our **quality approach** with some principles and pledges.

Introduction

NHS
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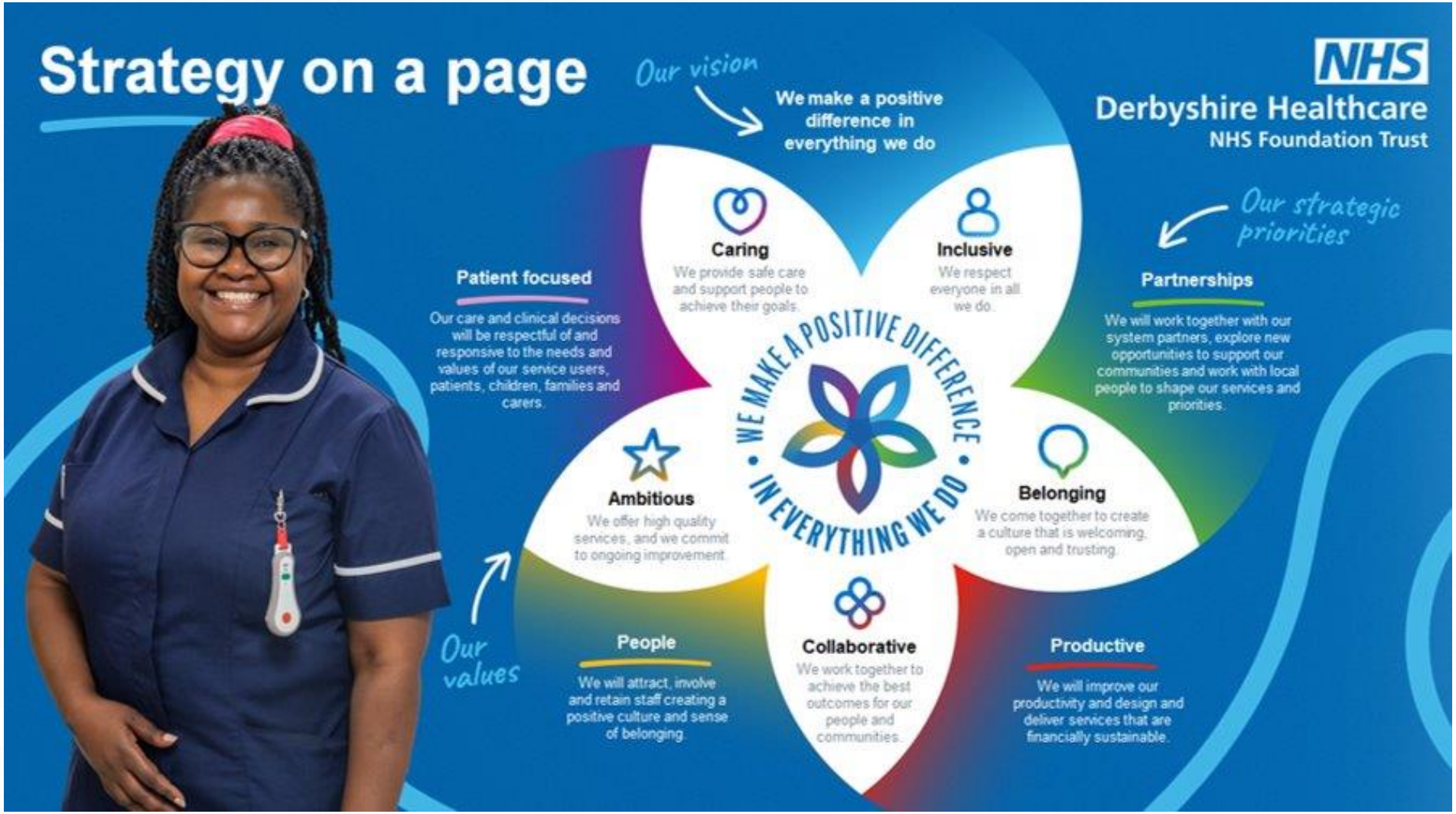
NHS Foundation Trust

The Trust launched its strategy for 2024-28 in November 2024 with four strategic priorities



Andrew

Derbyshire Healthcare
NHS Foundation Trust

Andrew is a 12-year-old boy, diagnosed with ASD by our paediatrician at 4, referred to the continence team and not attending school, parent struggling too as unable to work due to caring for him.
Support by clinician and GP commenced an intensive medication regime.

Within a month annual review of his EHCP completed incorporating his health care plan, he returned to school and has got his confidence back, mum has also been able to return to work fulltime.

Marvin

Derbyshire Healthcare
NHS Foundation Trust

Marvin spent 25 years addicted to crack cocaine and is finally clean thanks to the help from Derby Drug and Alcohol services (DDAR).

The Trust heard how Marvin was £80,000 in debt and still unable to give up gambling until DDARS intervened.

Purpose

NHS Derbyshire Healthcare NHS Foundation Trust

1. Patient focused

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.

NHS Derbyshire Healthcare NHS Foundation Trust

Priorities for delivery of success	Roadmap to delivery of success			Strategy into action metrics	Executive lead and forum for delivery management	Assurance source and forum
	2025-26	2026-27	2027-28			
1.1 Improve safety and effectiveness in line with our quality ambitions	Develop and implement Quality Delivery Plan, agree improvement ambitions and measures, and establish associated governance Monitor performance and implement action plans to address any identified improvement opportunities Implement national initiatives including Culture of Care inpatient quality improvement programme and Patient Carer Race and Equality Framework	Review ambitions and quality measures based on year 2 Quality Delivery Plan Monitor performance and implement action plans to address any identified improvement	Review ambitions and quality measures based on year 3 Quality Delivery Plan Monitor performance and implement action plans to address any identified improvement	Top quartile performance across all Delivery Plan measures by 2028 'Outstanding' CQC rating by 2028 Regulatory accreditation across all relevant services and standards	Director of Nursing Quality Delivery Group	Quality Report Quality and Safeguarding Committee
1.2 Improve experience for, and empower, service users patients and carers	Define and agree experience measures across all services Review and refine feedback mechanism s across all services Monitor feedback and implement plan to address any identified improvement aligned to transformation and continuous improvement portfolio Develop and agree framework for empowerment Design and launch education programme Develop and implement engagement through to co-production framework	Evaluate and refine measures across all services for year 2 Develop and establish a framework for feedback across all services Monitor feedback and implement action plans as required aligned to transformation and continuous improvement portfolio Implement framework for empowerment and evaluate progress Embed consistent and proactive approach to engagement through to co-production	Evaluate and refine measures across all services for year 3 Embed systems to obtain review and act on feedback across every service Establish digital dashboard reporting for feedback Monitor feedback and implement action plans as required aligned to transformation and continuous improvement portfolio Evaluate impact of and refresh empowerment and co-production framework	Top quartile performance across all agreed experience and empowerment measures	Director of Nursing Quality Delivery Group	Quality Report Quality and Safeguarding Committee
1.3 Develop effective quality governance systems and processes that facilitate shared learning and support a positive safety culture	Review, refresh and embed quality governance systems aligned to new Quality Delivery Plan Refine Learning Culture and Safety Group as a mechanism to develop and assure a positive safety culture Agree preferred model and design plan for transition from Care Programme Approach to support safe care co-ordination	Self assess quality governance systems, re-evaluate ambitions and implement update or refinement as appropriate Deliver transition from Care Programme Approach to agreed model support safe community practice	Self assess quality governance systems, re-evaluate ambitions and implement update or refinement as appropriate	Ward to board quality governance assurance to include the personal accountability charter Compliance with all national framework and standards	Director of Nursing Quality Delivery Group	Quality Report Quality and Safeguarding Committee
1.4 Improve access to our services and achieve all target wait times	Launch and deliver year 1 Clinical Services Delivery Plan with a focus on improving access and on understanding and addressing health inequalities Design framework for disproportionate allocation of resources based on needs of our population Agree and monitor achievement of target waiting times across all services with a year 1 priority focus on eradication of inappropriate out of area (OOA) placements through 'end to end' pathway optimisation	Deliver year 2 of Clinical Services Delivery Plan with a focus on improving experience and reducing racial inequalities aligned to PCREF Implement framework for disproportionate allocation of resources Evaluate access across services, define improvement ambitions and deliver year 2 plan	Deliver year 3 of Clinical Services Delivery Plan with a focus on improving outcomes aligned to the new model for safe community practice Evaluate and further develop framework for disproportionate allocation of resources Evaluate access across services, define improvement ambitions and deliver year 3 plan	Improved access for underserved communities by 2028 Shift in resource by 2028 Achievement of all waiting list standards Zero inappropriate OOA placements Reduction in ward length of stay	Medical Director Executive Leadership Team	Strategic Progress Report Board of Directors Integrated Performance Report Finance and Performance Committee
'Breakthrough' Continuous Improvement Priority: To promote timely, high quality and personalised care						

Pledges

Derbyshire Healthcare NHS Foundation Trust

1. We will ensure that our work is co-produced by Experts by Experience working for DHcFT. That communication is done in a clear, accessible, timely and compassionate manner. It will track patient experience from referral to discharge, ensuring we are improving patient and carer experiences.
2. Assessment of service standards will involve by Experts by Experience and carers. Treating patients closer to home and reducing wait times will improve patient experience.
3. Feedback will be used to improve patient and carer experience and increase involvement in care. Restrictive practice groups will include Experts by Experience to co-produce solutions. Communities of practice will improve communication.
4. This work will increase carer involvement, track patient and carer experience.
5. Involvement of patients and carers in establishing fundamental care standards will improve patient experience of services, increase co-production and carer involvement.
6. Patients and carers will be partners in care, co-producing their care documentation and involved in quality improvement projects. Involvement of carers and patients in quality visits will improve standards of care and patient experience.
7. Clear, accessible communication will ensure development of lived experience roles across services. Increased involvement of lived experience staff and volunteers to co-produce service development will support an improvement in patient pathway experiences.

Three key components of quality of care

Derbyshire Healthcare NHS Foundation Trust

What is quality care?

It is care that meets evidence-based standards to ensure it is effective, safe and provides as positive an experience as possible.

Quality care is delivered when all three components are present (Care Delivery Darzi, 2008)

- **Effectiveness** – quality care is care that is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes
- **Safety** – quality care is care that is delivered to avoid all avoidable harm and risks to the individual's safety
- **Experience** – quality care is care that looks to give the individual as positive an experience of receiving and recovering from the care as possible, including being treated according to what that individual wants or needs and with compassion, dignity and respect.

Charlotte

Derbyshire Healthcare
NHS Foundation Trust

Charlotte, aged 17, started attending CAMHS for support due to mood issues linked to her physical health medication.

Initially resistant to sharing personal experiences, she displayed significant emotional distress in sessions and struggled with trust.

Over time, Charlotte showed improvement, engaging more in therapy and expressing hopes of becoming a paramedic, indicating her potential for continued positive development.

Effectiveness

Derbyshire Healthcare NHS Foundation Trust

Our ambition: **Providing evidence-based care to improve patient outcomes**

Our objectives	Our measures of delivery
Implement a framework to replace Care Programme Approach. Develop and deliver a safer staffing approach in Crisis and Community Mental Health services.	Implement the Personalised Care Framework across the Mental Health, Learning Disability and Autism services, Inpatient and Community services. Move to Dialog plus and Advance Choice Document. Safe caseload management in the services. Reduction of wait times for intervention. Implement the MHOST and Safe Care modules in delivery of safer staffing in inpatient settings. Evidence robust and effective MDT working and multi-agency partnerships.
Monitor and provide assurance on the quality of care in the services. Create a culture of routine preparedness via rolling rota of Fundamentals Standards of Care visits.	Improve the compliance to Fundamental Standards of Care Framework. All services to work in line with the CQC Single Assessment Framework and improve the quality of the services. Use outcome measures for the services, using dashboards, individualised outcomes and performance outcomes. All clinical teams to be above 85% Trust-wide target for Fundamental Standards of Care. Develop service early warning signs trigger tool and application of 'what good looks' like matrix.
Patient pathways to have outcome measures to monitor effectiveness of care and interventions.	Demonstrate learning from all levels of incidents. All services will use Quality Dashboards. Improve care and pathways by continuous QI methodology (eg Models of Care, Culture of Care, MaST, falls reduction, medication management and reduction of length of stay).
Reduce the risk of physical health deterioration in severe mental illness (SMI). Prioritise physical health needs in Mental Health services	Focus on improving physical health monitoring and interventions for patients with SMI to prevent and manage comorbidities and reduce mortality rates. Increase physical healthcare offer from inpatient to community, including, availability, range of activity and increasing access. Map and signpost to appropriate Derbyshire services. Reporting on success through engagement data. All services and teams to have appropriate Physical Health Dashboard.

Pauline

Derbyshire Healthcare
NHS Foundation Trust

For patients like Pauline, one of the hardest things about being admitted to a mental health unit, was the noise.

However, that has since changed with the opening of the Trust's new Bluebell Ward in Chesterfield.

With single en-suite rooms and calm break-out spaces for patients, Bluebell Ward is one of six new or refurbished facilities in the Making Room for Dignity programme.

Safety

Derbyshire Healthcare
NHS Foundation Trust

Safety culture:

- **Insight:** to improve understanding of safety across the whole system by drawing intelligence from multiple sources of patient safety information.
- **Involvement:** to ensure that patients, staff and our partners have the skills and opportunities to improve patient safety.
- **Improvement:** to develop and support safety improvement programmes that prioritise the most important safety issues and employ consistent measurement and effective improvement methods.

Amelia

Derbyshire Healthcare
NHS Foundation Trust

"I had so much love around me, but this immense fear that myself and my baby were going to die."

In December 2024, new Mum Amelia was struggling from post-partum psychosis after the birth of her son.

Thankfully Amelia found help at The Beeches, a six-bed specialist mother and baby unit in Derby.

Safety

Derbyshire Healthcare NHS Foundation Trust

Our ambition: Providing care that will not cause harm and is timely

Our objectives	Our measures of delivery
The voice of the child and making safeguarding personal for adults is central to everything we do in a 'Think Family approach'. Improve principles for working with parents and carers that centre the importance of building positive, trusting and co-operative relationships to deliver tailored support to families.	Work within all our services to reduce sexual safety Incidents, Neglect, Domestic Violence and online harm for our patients. Align safeguarding policies and practice to Think Family and monitor through regular audits and audit compliance on training. Collaborate with our partners, strengthening that successful outcomes for children and adults depend on strong multi-agency partnership working across the whole system. Compliance to Section 11 and SAF standards. Increase feedback to support collaborative relationships between practitioners and, parents and carers, in order to understand the wishes and feelings of the child/adult and what is in their best interest remain central to decision-making.
Promote a culture of learning and continuous improvement. Learning from Incidents, and develop a positive safety culture and embedding the PSRIF approach We will foster and enhance relationships with key stakeholders. We will ensure that patients families and carers are included within the learning response process and will ask for feedback to continue to improve the service.	Timely review of incidents and share learning across services. Improve governance to reduce silo working with the Trust and learning from other organisations. We will continue to cross reference against complaints data for all deaths. improve the timeframe/responses for learning reviews. We will benchmark against the Trust Incident Reporting and Investigation Policy and Procedure and Learning from Deaths Policy and benchmark against other trusts. Engage internal and external stakeholders in changes in processes, including templates and guidance documents. Implement Patient Carer Race and Equality Framework . Share learning from Child Practice Learning Reviews, Domestic Homicide Reviews and Safeguarding Adult Reviews via bespoke training and if required, internal communications.
Ours patients to be treated and cared for as well as our staff to work for in settings that do not them cause harm.	Reduce incidents and harm from ligatures in clinical settings. Reduce racist attacks and abuse towards wards staff. Reduce violence and aggression in our clinical settings. Reduce incidents of self-harm and harm for patients within our services. Reduce DNA of appointments.
Work with patients, families, carers and partner organisations on prevention of suicides.	Patients to have co-produced and trauma-informed assessments, risk assessments and care plans. Patients to be supported in the appropriate care pathways with the right support and treatment. Enhance staff training and compliance on care planning, assessments and risk management to comply with Trust targets. Roll out of safety planning training.

Experience

Derbyshire Healthcare NHS Foundation Trust

Our ambition: Providing an experience that is personalised, compassionate, respectful and dignified

Our objectives	Our measures of delivery
Improve patient and carer experience and satisfaction with our services.	Improved community mental health survey. Inpatient survey results. Improved response rate and results from Family and Friend Test. Collect, feedback, compliments and surveys from all services.
Ensure services are safe and responsive to individual needs.	Have carers/family/patients involved in Fundamental Standards of Care and Quality visits. Reduced Out of Area placements and have care close to home. Reduced waiting times for patients in need of services. Reduced length of stay in inpatient wards.
Help develop services that support patients' dignity and independence.	Develop and deliver Community of practice model to build on this work. Reduced restrictive practice. Measure patient outcome using ReQoL Seek feedback from patients, carers and family.
Encourage staff to find new ways to deliver healthcare within the Triangle of Care.	Develop and deliver Community of practice model to build on this work. Improved Care Survey results. Improved performance and quality of delivery of the six standards of the Triangle of care in all the services.
Improve accountability to our patients, their families, carers and the public.	Have carers/family/patients involved in Fundamental Standards of Care and Quality visits. Reduce avoidable harm to patients embed a learning culture whereby a safety culture and lessons are learnt. Timely response to concerns and complaints within the set timeframes. Ensure there is learning from all sources of feedback from patients, carers and families.
Provide a person-centred service and improve quality.	15 steps challenge for all inpatient settings at least once a year. Quality visits with partners, service user representatives and patients. Increased co-produced projects of quality improvement. Improved co-production of care plans and risk plans that are personalised and trauma-informed.
Develop and implement governance and support systems for experts by experience and lived experience roles.	Develop consistent functions for lived experience roles across all services. Lived experience staff and volunteers have a role in quality monitoring , assurance service development and continuous quality improvement. Standards of supervision and support to be co-produced with people with lived experience.

Digital enablement of quality: Improving effectiveness, quality and safety

Derbyshire Healthcare NHS Foundation Trust

Our objectives

Improve data quality and strategic dashboard:
To review and rebuild on existing portfolio to improve safety and quality oversight, compliance and improvement.
Increase, improve and utilise AI opportunities.

Analogue to digital:
To review and identify manual processes and develop a step approach to digitalise and improve access and efficiency.
Rollout of communication annex - to improve patient experience and additional method to communicate with healthcare practitioners and co-production of care.
Attend Anywhere - virtual consultation /appointment platform.
Artificial intelligence pilots (Heidi Health) - AI assisted consultations, automative administrative and processes.

Improve digital literacy and analytical skills for the workforce:
To provide access, training, standard operating procedures (SOPs) assessment, devices and engagement sessions to improve competency, embed learning and staff users' experiences.

Improve digital inclusion, literacy and competency for patient and carers:
To work collaboratively with third sector and voluntary organisation in signposting, upskilling and providing access to digital literacy, infrastructure and platforms for patients and carers.

Improve integration and interoperability of systems:
Pathology systems – DHcFT uses two different pathology systems as these vary in the north and south of the county.
To maximise Sharing Care Records functionality - Derbyshire Shared Care Records (DSCR) Partnership working, patient safety and interoperability gains will be improved as sharing of patient information become increasingly part of everyday clinical practice across the Trust.
Maximise and realise the benefits of existing digital platforms, Apps.
Strengthen the digital governance process and standards.

Digital enablement of quality

Derbyshire Healthcare NHS Foundation Trust

Our actions	Drivers	Enablers	Trust outcome	Patient benefits
Maximise benefits from: EPR SystmOne and all other digital platform/Apps Maximise the benefits from IT Infrastructure.	Benefits realisation. System standardisation and optimisation. Clinical informatics. Cost reduction. Data quality. Activity output/clinical productivity.	Trust Staff. Patients and Carers. Clinical digital team. Informatics and IMT&R. Operational leads, Performance leads. Digital skills partners Operations Board. Digital forum and Board.	Standardise and optimise care. Maximise investment. Improve and drive clinical and data quality. Reduction in cost. Improved analytics. Improve staff satisfaction. Improve clinical and operational productivity. Robust oversight and surveillance.	Efficient and consistent care pathways. Co-designed/co-produced care. Access to shared data. Access to health information. Care at home. Efficient referrals. Reduced waiting times. Easy/flexible access to healthcare.
Identify, evaluate, Share and engage - Trust staff, stakeholders and systems partners.	Digital Governance structure and processes. Shared learning and benefits (forums, conferences, meeting across the systems). Cost savings. QI methodology and embedding of learning. Standardisation and optimisation of care. Reduce risks and incident.	Digital / ICB. Procurement. Finance. Trust staff. Applications support. Communications and Engagement team. Digital skills partners. CIO, CSO, CNIO, CCIO. Patient and Carers representative.	Less duplication. Shared benefits. Improved efficiencies. Improved quality and safety. Reduction in costs. Improved quality and outcomes. Digital skills development. Forward thinking and exemplar Trust- improve recruitment and retention.	Prioritised care. Data-informed care. Improved appointments, online consultations and interventions. Convenient and flexible access to healthcare. Reduction in DNAs. Improved clinical and operational productivity.

Claudia

Derbyshire Healthcare
NHS Foundation Trust

Living with an eating disorder is hard enough but the festive period can be an especially triggering time of year.

For 25-year-old Claudia, that nightmare was all too real, having spent last Christmas in the throes of anorexia nervosa mixed with anxiety and depression.

Just 12 months on and with thanks to the support from Derbyshire Eating Disorders Service, Claudia has found a route back to full time employment and self-sufficiency whilst fighting the ongoing battle with her eating disorder.

Staff stories

NHS
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NHS Foundation Trust

We will deliver - our quality approach

Derbyshire Healthcare NHS Foundation Trust

Quality Control is a process by which procedures and methods are established to review and standardize the reliability and quality of all factors involved in the production of products or services.

Quality Assurance is any systematic process of checking or auditing periodically to see if a product or service being developed is meeting specified requirements, targets, or goals.

Quality Improvement is the combined and unceasing efforts of everyone (e.g., healthcare professionals, patients and their families, researches, payers, planners, and educators) to make the changes that will lead to better patient outcomes (e.g., health), better system performance (e.g., care), and better professional development.

Our quality approach

Derbyshire Healthcare NHS Foundation Trust

We will…

- Deliver evidence-based care, to improve patient outcomes and foster recovery.
- Benchmark and learn from others.
- Have governance and oversight on the standard of care provided.
- Triangulate experience, safety and effective measures to seek assurance on quality.
- Have clear leadership structures with visible, accountable leaders and shared leadership in the triumvirate at all levels of the organisation.
- Listen, learn and seek ways to improve, through training, reflection, development, transformation and continuous improvement methodology.

Board Committee Assurance Summary Reports to Trust Board – 22 July 2025

The following summaries cover the meetings that have been held since the last public Board meeting held on 3 June 2025 and are received for information.

- Quality and Safeguarding Committee 4 June and 9 July
- Mental Health Act Committee 12 June
- Audit and Risk Committee 18 June
- People and Culture Committee 3 July
- Finance and Performance Committee 8 July

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

Quality and Safeguarding Committee – key assurance levels for items – 4 June 2025	
	Director of Nursing update The Committee received a summary of the CQC inspection on the Older Adult Inpatient wards between 28 April and 15 May. The immediate actions, positive outcome and progress made was welcomed, along with evidence of the shared learning impact from previous inspections. **Significant assurance** was agreed.
	Making Room for Dignity (MRfD) Programme **Significant assurance** was received on the mobilisation and operationalisation for the Derwent and Carsington Units, Audrey House Enhanced Care Unit and Kingfisher House Psychiatric Intensive Care Unit. The Committee received **limited assurance** on the plans to ensure all members of staff received the clinical Model of Care training and its impact on care.
	Medicines and Pharmacy Annual Report The Committee accepted **significant assurance** from the report and acknowledged the volume of positive information. The challenges to resolve the long-standing issues around sodium valproate prescribing were noted as were the current mitigations now in place. Non-quorate meetings and the plans to improve attendance were also noted.
	Safeguarding Children Assurance Report The continued good performance was noted, along with the Section 11 assessment conducted with the ICB. The ICB was aware and supportive of the risk around the vacancy for a Named Doctor for Safeguarding Children. The position for resources within Safeguarding to be reduced was acknowledged. The report provided the Committee with **significant assurance** around the activity, systems and controls within the Trust.

	Safeguarding Adults Assurance Report The report highlighted progress in Multi-agency Public Protection Arrangements involvement and the Committee noted improved processes for identifying and addressing sexual safety cases. The challenge to Safeguarding during a period of local and national change was understood. **Full assurance** was accepted around Safeguarding activity and reviews, and that statutory duties were being met.
	Guardian of Safe Working Hours (GoSWH) Annual Report An increase in exception reporting was highlighted which was attributed to specific events. The report outlined the implementation of exception reporting which was to be outlined by upcoming contractual changes as well as guidance from the British Medical Association and NHS Employers. It was noted that an automated process aimed to reduce the burden on supervisors and ensure doctors were compensated for their time. It was noted that the three year term of the GoSWH was due to end on 1 December. The Committee accepted **significant assurance**.
	Risk Report It was reported that a substantial number of risks had been closed, including many related to the MRfD programme. The Committee noted that a thorough review had combined many duplicate risks which were now allocated to more appropriate handlers who had the ability to influence resolution. **Significant assurance** was accepted regarding the risk management and reporting strategy.
	Physical Healthcare – Smoke-Free The Committee noted that compliance continued to be monitored and feedback gathered to evaluate the initiative, with oversight by the Tobacco Eradication Group. It was reported that funding had been allocated which would support smoking cessation.
	Clinical Research and Development (R&D) Annual Report and Plan 2024/25, including Annual Review of R&D Operational Group Effectiveness and Terms of Reference and the Revised R&D Strategic Plan 2023-2026 The report provided **significant assurance** and highlighted the extensive range of projects undertaken by the R&D team. It was agreed that future reports should include additional information around the resulting positive impacts. The Committee recommended the addition of more explicit links to the Trust Strategy and the four Ps. The revised R&D Strategic Plan (2023-2026) was ratified.
	Quality Dashboard A high number of aggression incidents were reported; however, support had been put in place and was demonstrating improvements. The Committee noted the downward trend in absconsions from inpatient areas and an improved response time for Complaints. A request was made to cross-reference Complaints to identify any relevant Duty of Candour incidents. **Limited assurance** was received on progress towards clinical performance targets.
	Quality Plan – Draft The Committee received an overview on progress and noted the plan included the definition of quality and how the Trust would deliver the strategic priorities. Improvements were suggested, which included the addition of an executive summary and refinement of the content to increase focus on the areas that would drive improvements in quality and safety.

	Care Planning/Person-Centred Care The continued improvement within Acute services was noted. However, concerns had been raised at the Council of Governors meeting on 3 June around the Care Programme Approach in the south. The Committee discussed the matter, the potential causes and resolutions and agreed progress was being supported by the additional oversight currently in place. The proposed level of **limited assurance** was accepted.
	East Midlands Alliance (EMA) Perinatal Mental Health Provider Collaborative There were no patient safety or quality concerns. It was noted that an ongoing issue with room temperature at the Beeches had now been mitigated. The Committee discussed the consistency of processes across the collaborative and noted this was a current area of focus. **Significant assurance** was received on the quality and safety of services provided.
	Policy Review The Committee ratified the below: • Policy and Procedure for Handling Patient Feedback: Concerns, Compliments, Complaints Quick Resolution and Complaints Closer Look • Absent and Missing Mental Health Patients Joint System Policy – Derbyshire. The 'Right Care Right Person System Agreement – Derbyshire' was approved in principle, pending Executive level discussions with all system partners.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework:** None. **Next scheduled meeting:** 9 July 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 – 9 July 2025	
	Director of Nursing – verbal update The following points were highlighted: 10 Year Health Plan: Tumi advised that the publication focused on quality of care addressing their plans for patient experience, governance, leadership and data quality. Implications included enhanced powers for the Care Quality Commission (CQC) and the risk of decommissioning services if quality is not appropriate. A more informative report to be presented at the next meeting. CQC Mental Health Act (MHA) Inspection: Bluebell ward had undergone a MHA CQC inspection. There were no significant patient safety concerns raised from the visit through the verbal feedback. It was noted that the CQC is advising the steps needed to achieve an 'outstanding' result. Dr Penny Dash Review: the significant review focused on patient safety across the health and care landscape, including changes to the organisations overseeing quality. A summary of the implications to be presented at the next meeting. It was confirmed that the proposed Trust Quality Plan was in line with the review findings.
	Fundamental Standards of Care It was noted that teams had been working on action plans to address areas with low scores in the Fundamental Standards of Care. The CQC had been receptive to evidence of good practices and had incorporated some of this in their reports. Competing priorities had challenged engagement with the Acute services with the recent focus on preparation for the new therapeutic environments. The importance of willing engagement and compassionate leadership was emphasised.

	The benefit from peer review and different clinicians undertaking the assessments was discussed and it was highlighted that this elicits alternative perspectives whilst adhering to a consistent approach. Understanding of the single-assessment framework had been supported by the CQC and this ensured alignment. The process for governance and monitoring of actions was explained, which included regular visits, feedback and sharing of good practice across the Trust. In addition, Tumi explained he has secured involvement of people with lived experience to support the Fundamental Standard visits moving forward. The Committee acknowledged the improved processes and level of control. **Limited assurance** was accepted on the findings and subsequent actions, seeking consistent application and outcomes to reach significant assurance.
	Physical Healthcare report – Medical Devices The Committee noted the legacy of poor organisation and the substantial challenges now faced by the Trust; which included a lack of effective servicing and maintenance for a number of years. The steps being taken to address the issue involved the development of policy, strategy, helpdesk response, administration support, a formal review of the existing contract and alignment of the centralised budget and unified financial management. The Committee recognised the ground work undertaken and that controls were now in place. Substantial work is required to ensure a comprehensive service and maintenance plan is in place moving forward. **Limited assurance** was accepted.
	Reducing Restrictive Intervention (bi-annual) Compliance with legal frameworks was highlighted, as were the ongoing challenges with observations and the efforts to improve training and post-incident debriefs. The sustained improvement around risk management and the continued reduction in absconsions was noted. There had been no disproportionate use of physical restraint. Work to improve the use of prone restraint and chemical restraint was ongoing. The Committee received **limited assurance**, acknowledging the progress made and emphasising the need to monitor seclusions due to the new suite.
	Safer Staffing annual report It was noted that staffing levels had been reviewed and adjusted and there had been a reduction in the use of bank and agency staff, without compromising quality of care. Tumi explained that following the training the organisation is now able to implement the Menal Health Optimisation Tool (MHOST) by September which will aid with establishment reviews enabling the professional judgement framework to be utilised alongside the mental health well-being assessment. **Limited assurance** was received.
	Quality Delivery Plan The Committee remarked positively on the Quality Plan which had received extensive input from Trust colleagues. Previous comments from committee members had been considered and included. Alignment with the Penny Dash review of patient safety across the health and care sector was confirmed. Feedback regarding the inclusion of triumvirate working, use of AI to triangulate patient experience feedback and a clearer objective for Patient & Carer Race Equality Framework (PCREF) were also considered. Subject to minor amendments, the plan was approved for submission to Board for ratification.
	Board Visits – Themes and Findings The Committee were encouraged by the progress since the appointment of the Compliance and Governance Manager. The Committee accepted **limited assurance** around the operational and governance challenges highlighted, which included feedback gaps and visit co-ordination issues.

	The recurring themes included ongoing issues with inputting data electronically, caseload management and internal waits. Suggestions to improve the process were offered by members of the Committee and would be incorporated as appropriate.
	Care Planning/People-Centred Care Improvements were highlighted, however, the desired targets had not been achieved. **Limited assurance** was accepted from the positive progress evidenced. It was reported that the Information Management, Technology and Records team was working to simplify the recording process. The Committee noted recent discussions within the Trust, regarding the data sources for monitoring compliance with the Care Planning and Care Programme Approach (CPA). It was emphasised that this was attributed to the data sources. Explanation clarified that the primary data source was SystmOne, the host system for all patient information; the use of the Management and Supervision Tool (MaST) was being piloted in some Community areas and that this system did not include all the data. The importance of following Trust policy for the completion of CPA was also emphasised. The Committee was assured that the data presented was accurate and showed an improving position. The Committee also heard that patient safety was not being compromised as a result of the data misunderstandings. Consideration was being given to the transition from CPA to the new Personalised Care Framework and how this would be supported. It was noted that the move would provide improved compliance data from all the current systems in use.
	Children and Young People, 0-19 Years service and Midwifery – Risks associated with amendments to system recording The Committee was informed of risks associated with the introduction of Badgernet and the Trust's services' inability to access and view necessary information. It was noted that the issue required discussion at the Trust Delivery Group for further action and considered escalation to ELT, whereupon assurance could be offered.
	Review of Quality and Safeguarding Committee Board Assurance Framework (BAF) A review of Risks 1A and 1D was undertaken and the risks around Section 48 working were highlighted, along with those risks that had been removed/adjusted. The Committee was satisfied that the BAF captured the appropriate actions/mitigations and level of risk connected with the meeting's business.
	Board Assurance Framework (BAF) – key risks identified: it was noted that the next version of the BAF will reflect alignment with the Quality Delivery Plan once ratified.
	Suicide Prevention Strategy – late paper This important document was introduced to the Committee and its alignment with national guidelines was highlighted. It was noted that content was built from Derbyshire patient safety learning and The Suicide Prevention Strategy for England 2023-28. The Trust Strategy had been updated and incorporated a systematic approach, understanding the high risk groups and the appropriate interventions. Following inclusion of feedback, the final version to be presented at the next meeting ahead of recommendation for Board in September 2025.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework:** None. **Next scheduled meeting:** 10 September 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 – 12 June 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 reading of rights, the timely reviews of Community Treatment Orders (CTOs) and training, Limited Assurance was given. The Group had also extended the Section 62 urgent treatment policy. This group now receives update from the Associate Hospital Managers and received information on the latest CQC Mental Health Act visits and legislative changes.
	MHA Managers Report The MHA Quarterly Report covering MHA Office activity from 1 January to 31 March was considered. Points of note included: • Compliance data on the reading of Section 132 rights was presented and the Committee made an escalation to the Trust Delivery Group due to the on-going low compliance. There were some factors for the lower compliance that included the impact of the recent ward moves and also the timescales for attempted reading had been reduced from two days to 24 hours of admission. The change to timescales had been made to improve patient experience and ensure patients are read their rights earlier so they understand all their rights and all restrictions. The Committee sought assurance that an improvement plan is in place • Data on holding powers was flagged and staff are being encouraged to complete the paperwork correctly and in a timely manner • A suggestion was made to embed the Community Treatment Order (CTO) reading of rights into an already existing process. A report will be submitted to the next meeting on the process to improve the low compliance with the explanation of rights on follow up (s132A) for Community Mental Health Teams (CMHTs) • Findings of an audit of use of s62 urgent treatment requests highlighted that requests for Second Opinion Appointed Doctor (SOADs) are routinely being requested later then desirable and this was being closely monitored • There had been one CQC Mental Health Act monitoring visit to Ward 34 during the quarter and the Committee received a summary of the feedback. An action plan has been produced and submitted to the CQC. **Limited assurance** was agreed due to the underperformance in a number of areas.
	Mental Health Act/Mental Capacity/Deprivation of Liberty (DoLs) training compliance The Committee noted an improved compliance as a result of a targeted approach, but it was still below the target. A stratified approach will be taken to improve performance further. **Limited assurance** on the basis that there are a number of areas not meeting the training targets.
	Mental Health Act – Training Needs Analysis There will be a three tiered approach to Mental Health Act training, including practical training for Consultants and Lead Nurses on the practicalities of completing paperwork and understanding Trust policies and processes and a generic category for those with lesser interaction with the Mental Health Act, providing them with a basic understanding of its function and importance. **Significant assurance** was accepted on the proposed way forward for the delivery of the tiered training.
	Mental Health Act Bill The Committee received an update on the Mental Health Act Bill, which is currently at the committee stage in the House of Commons. A working group will be set up to prepare for the changes, the potential impact on resources, and the importance of digitisation support the implementation of the changes.
	Section 12 Compliance An internal audit on Section 12 compliance provided significant assurance on the processes in place. The audit recommended documenting the processes in policy and creating a policy for monitoring

	Section 12 compliance. The recommendations have been implemented, and the policy is being developed.
	Policy Review The Committee approved the following policies: • The Mental Health Act Hospital Managers Scheme of Delegation and Overarching MHA Policy and Procedure The Committee received an update on the status of the protocol for conveyance of service receivers and the social supervisor policy. Both policies have been reviewed for accuracy and clinical appropriateness for use by Trust staff, noting that the policy was the responsibility of other partners and they had been asked to urgently review and send for approval.
	Escalations to Board or other Committees: None **Items added to the Board Assurance Framework:** None **Next scheduled meeting:** 11 September 2025

Committee Chair: Deborah Good (Geoff Lewins providing temporary cover)	**Executive Lead: Arun Chidambaram, Medical Director**

Audit and Risk Committee – key assurance levels agreed – 18 June 2025	
	This meeting was held to review and approve the Annual Report and Accounts 2024/25 under the delegated authority of the Board. The Committee agreed **significant assurance** on the processes undertaken to produce the document. A technical issue raised by external audit on their completion report would delay the formal signing, however, the Committee was able to approve the document. The final Head of Internal Audit Opinion and Annual Internal Audit Report was also presented with a **significant assurance** outturn.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework:** None. **Next scheduled meeting:** 24 July 2025.
Committee Chair: Geoff Lewins	**Executive Leads: Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary and James Sabin, Director of Finance**

People and Culture Committee – key assurance levels agreed – 3 July 2025	
	People and Inclusion Assurance Dashboard The Committee reviewed current performance. The main points were: Mandatory Training: high levels of did not attend were being escalated to the Managing Directors. Staff Turnover: it was noted that whilst annual turnover remained within the target parameters, there was a focus on retention for Allied Health Professionals and Healthcare Support Workers (HCSW). Attendance and Absence: the Committee welcomed the compliance (below 5%) and noted the substantial cost savings for the organisation, attributed to the move from GoodShape to the Trust's own system. Clinical Supervision: data quality was negatively affecting records and this was being addressed. **Significant assurance** was accepted on progress shown for Mandatory Training, Staff Turnover, Vacancies and Recruitment, Bank Usage and Freedom to Speak Up and **limited assurance** on Attendance and Absence, Clinical Supervision and Appraisals.

	Making Room for Dignity (MRfD) Programme update **Significant assurance** was accepted on mitigation of the risk of the significant numbers of 'hard-to-recruit' and 'national workforce shortage' posts required. All safe staffing levels had been met and challenges in relation to HCSW recruitment were being addressed. Improvements in the overall recruitment process were highlighted. The Committee discussed the Model of Care, Organisational Development and national Culture of Care programmes. It was noted that staff at the Bluebell Ward and Carsington Unit were on target for the relevant training compliance. However, the Derwent Unit staff were yet to be scheduled effectively. **Limited assurance** was received on the development and progress of the cultural transformation work and implementation.
	Medical Job Planning The Committee noted the Trust's response to the NHSE Improvement Plan, the Terms of Reference for the Job Planning Oversight Group and the associated action plan.
	System Developments – verbal update Following the enabling services review, it was noted that Deloitte would not be commissioned further. Consideration was being given to improved collaboration and models for each functional team.
	Deep Dive - Leadership Development The Committee received **significant assurance** that activity supported themes within the Leadership Strategy. The impressive programmes available to Trust colleagues were championed and it was noted that the NHS Leadership Competency Framework was awaited. Whilst the high level of recorded 'did not attend' was attributed to operational pressures, it was agreed that further analysis was required. **Limited assurance** was received in terms of triangulation; the right people on the right courses; addressing the gaps in leadership and connection with talent.
	Flu Vaccination Plan – 2025/26 In light of the lessons learned from previous campaigns and the challenges with cold chain vaccinations, the Committee noted changes to this year's delivery model. The overall ambition was to ensure suitable access for all those who wanted vaccination.
	Temporary Staffing Workforce (Bank) It was highlighted that the national ask was to reduce bank usage by 10% and agency spend by 30%. The main usage within the Trust was for Bank HCSWs and registered Nursing for inpatient areas. Emphasis was placed on roster accuracy to minimise the need for temporary staffing. The Committee noted that the Roster Efficiency Programme included Challenge and Confirm meetings for additional scrutiny.
	Deep Dive – Michelle Cox review The recommended actions from the review had been considered and aligned, where appropriate, in the development of the Trust's Race Equality Strategy. It was noted that a Race Equality Working Group and a Sexual Safety Group were to be created. The proposed Equality, Diversity and Inclusion Plan and priorities were approved.
	Staff Survey – Actions and Learning The Committee received an overview of the finalised Staff Survey action plans, developed across all Divisions.

	The Non-Executive Directors were pleased to see the 'you said, we did' information, which clearly evidenced that the Trust was listening.
	Review of Committee Board Assurance Framework (BAF) Risks The BAF had been updated to reflect the national and system provider changes connected to the financial position and was now alighted to the People Plan priority, as per the Trust Strategy.
	Board Assurance Framework (BAF) – key risks identified: None.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework:** None. **Next scheduled meeting:** 2 September 2025.

Committee Chair: Ralph Knibbs	**Executive Lead: Rebecca Oakley, Director of People, Organisational Development and Inclusion**

Finance ad Performance Committee – key assurance levels for items – 8 July 2025	
	Making Room for Dignity (MRfD) programme update Discussions and questions were raised around the next phase, the refurbishment of wards at the Radbourne Unit; Ward 32 and the affordability and cost pressure associated with Ward 35. In addition, the ongoing benefit realisation work and the discussions with the contractor It was recognised that many of the delays were outside of the Trust's control, however, the opening of the remaining units opening are key to the Out of Area (OoA) performance. A review of the ongoing governance post-benefit realisation was underway and it was acknowledged that this will soon be a single ward refurbishment project. **Limited assurance** was agreed for the update.
	Financial Performance – Month 3 Finance Report including Medium Term Financial Plan (MTFP) update It was reported that the Trust remained on plan at month 2, despite the cost pressure of OoA driven by delays in the Carsington Unit opening. The Committee noted that the Trust remained on track to deliver the agreed System financial plan. Performance towards Cost Improvement Programmes (CIPs) was positive, with a fully identified CIP plan. Agency and bank spend continues to reduce the national targets will be achieved. There were no concerns in relation to debts, cash or Better Payment Practise Code (BPPC). Whilst not being complacent, no major risks were flagged at present. The MTFP was also included for wider awareness and information. **Significant assurance** was agreed for the update.
	Contracts update An update was provided which highlighted some minor issues being worked through with the Integrated Care Board (ICB) with regards to signing main contracts. The Trust was ensuring that any agreements were aligned to the agreed financial plans of the system. Some minor issues needed to be work through post Talking Therapies service transfer. The Committee was pleased to note that some investment for ASD and ADHD could be secured. Contracting Governance was reported on and was to be strengthened, this included the establishment of a contract risk register and contract assurance meetings. This aimed to provide greater visibility of risks and improved decision-making. **Significant assurance** was agreed for the update.

	Training and Continuous Improvement An update was provided on the continuous improvement training, mentioning the establishment of the Strategic Portfolio Oversight Group (SPOG) and the focus on improvement across Divisions. The importance of integrating continuous improvement with digital transformation and other areas was highlighted. **Limited assurance** was received in light of the SPOG not yet being embedded.
	Operational Performance Recovery Action Plan for Out of Area Expenditure: The discussion focused on the recovery action plan to address out of area expenditure, including operational improvements and transformational changes. The importance of community transformation to manage patient flow was also acknowledged. Operational Improvements were highlighted and discussed, including the focus on reducing clinically ready for discharge patients and implementing a 72-hour post-admission review to start planning for discharge. There would be a need to ensure acute Medical colleagues supported the benefits of implementing changes, based on national best practice. Community Transformation would be important to manage patient flow, integrating teams to provide better support in the community and prevent unnecessary admissions. This would involve a significant change programme over the next six months. **Significant Assurance** was agreed for a number of areas in the report, with the exception of the risks around OoA which received **limited assurance**.
	Exception report on operational issues The majority of issues within the report were covered off in the earlier discussion but the added detail and context of the development and operational ongoing work outside the core IPR reporting was welcomed by the Committee and **significant assurance** was agreed on progress.
	Collaborations and Other Alliances The Committee noted updates on the alliances that mainly focused on progress in Perinatal services.
	System update: ICB Finance Committee/System Directors of Finance (DoFs) The discussion focused on the drive to discuss all issues and across the Derbyshire and Nottinghamshire System, recognising the clustering of Derbyshire and Nottinghamshire ICB Systems. It was expected that this would now include Lincolnshire. Meetings had commenced across the wider footprint for DoFs and Deputy DoFs forums alongside bringing finance and workforce colleagues together more. The Committee noted the changes to the operational leads across the System. Ongoing reviews of governance and questions around duplication remained under review but the Trust continues to engage and feed-back.
	Emergency Preparedness, Resilience and Response (EPRR) report An update was provided on emergency preparedness and business continuity, highlighting the progress made in embedding business continuity within local services and the ongoing work to address identified gaps. Discussions continued in relation to the upcoming 360 Assurance report and the anticipated compliance with core standards. **Significant assurance** was agreed for the update.
	Board Assurance Framework (BAF) 2025/26 Risks Overview Updates to the BAF were, in the main, noted and accepted. It was strongly felt that whilst the actions and mitigations may be complete in relation to the specifics of the cyber risk, it was felt very unwise to remove this cyber risk from the BAF all together. This was not supported for removal but

	suggested it should be reviewed and refreshed to align to the continuous risk all trusts face, in an ever increasing digital-dependant world.
	Escalations to Board or other Committees: The Committee talked at length about what support would be helpful to Operations. Whilst recognising the good work of Operations, the clinically ready for discharge challenge was multi-agency. As a result, it was agreed that all Executives and the wider Board could help pressure and seek support in this area to alleviate stress on OoA and flow. **Items added to the Board Assurance Framework:** It was agreed to rework the cyber risk so it was broader regarding the ongoing and ever present national risk, as the previous actions and mitigation have addressed some of the specifics of the previous risk. **Next scheduled meeting:** 9 September 2025.
Committee Chair: Tony Edwards	**Executive Lead: James Sabin, Director of Finance**

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 22 July 2025

Flu Vaccination Plan - winter 2025/26

Purpose of Report

To outline the Trust's approach to flu vaccination for winter 2025/26, building on the 2024/25 campaign and aligned with NHS England's winter planning guidance and ICB Midlands Key Lines of Enquiry.

Executive Summary

- Achieve a 5% increase in flu vaccination uptake over the 2018/19 baseline (1,138 vaccinated out of 2,276; ~50%)
- Deliver a blended model combining:
  - Community-accessible vaccination offers
  - Peer-supported vaccination for inpatient staff and patients
- 1,189 doses administered by the Trust
- ~500 staff accessed vaccines externally
- ImmForm recorded only 629 vaccinations, highlighting reporting tool limitations
- Ensure accurate reporting via ImmForm (UKHSA system used to order medical products and collect vaccine uptake data) aligned with ESR
- Estimated 2025/26 denominator: ~2,600 staff, based on revised Green Book definitions.

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.	

Risks and Assurances

- Capacity to deliver vaccination internally adjusted to reflect service withdrawal of Hospital Hub and HPU service.

Response: targeted peer vaccination in highest risk area (Inpatients). Community offer will reflect other provider models such as ICB and Social Care.

- Cold chain management and governance needs tight grip within a peer vaccinator model.

Response: managing peer vaccination amongst In-Patient areas where storage and monitoring procedures already exist should reduce risk of waste and loss.

- Uptake likely to be negatively influenced by Vaccine hesitancy, refusal, and apathy have increased since 2022, driven by:
  - NHS workforce dissatisfaction
  - Negative social media narratives
  - Reduced public understanding of vaccine effectiveness.

Response: Targeted communications, peer-led engagement and a focus on informed choice.

Consultation

- Chief Pharmacist
- Director of Nursing
- ELT
- People and Culture Committee, 3 July 2025.

Governance or Legal Issues

- The Health Protection Unit will not be delivering the programme this year
- The Trust will no longer partner with DCHS due to differing delivery models
- Internal delivery will be supported by trained peer vaccinators and a revised booking system.

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:

No impact related to individual characteristics are identified within the proposed approach.

Recommendations

The Board of Directors is requested to:

1. Note changes to delivery model
2. Recognise challenges to achieving proposed target
3. Feedback any comments.

Report presented by: **Ralph Knibbs**
Chair, People and Culture Committee

Report prepared by: **Richard Morrow**
Assistant Director of Public and Physical Healthcare

Flu Vaccination Plan – winter 2025/26

1. Introduction

This report outlines the Winter 2025/26 Vaccination Plan for the Trust Board of Directors. It builds upon the structure of the 2024/25 DHcFT Flu Campaign Plan and incorporates guidance from the NHS Winter Planning Letter 2025 and the ICB Midlands NHSE Key Lines of Enquiry. The plan targets a 5% increase in flu vaccination uptake over the 2018/19 baseline, and addresses delivery, reporting, and engagement strategies.

The Trust will not be operating the Hospital Hub which delivered the COVID vaccination programme up until spring/summer 2025 as the governance structure differs to seasonal flu vaccination and requires a dedicated staffing team rather than a peer vaccinator model. Trust staff will be directed to access Community assets, such as community pharmacies, if they are in the eligible cohorts, these have yet to be confirmed and differ from those included in the flu programme.

The Trust has purchased sufficient vaccines to achieve the anticipated cohort target of c1,500 staff. As per the 2024/25 campaign, the Trust has taken a pragmatic approach and ordered in line with anticipated uptake, to avoid potential waste and has purchased in line with the guidance in the Flu Letter – Appendix 1.

Cold chain and governance management have historically been challenging in peer delivery models, leading to waste and loss of vaccines. This complexity can be alleviated by using a peer vaccination model for inpatients, where existing processes can support the programme. Low-foot traffic in community bases and difficulties in finding enough vaccinators and clinic spaces suggest using local GPs and pharmacies, in line with ICB and social care staff models.

2. Historical and Projected Uptake

In 2018/19, 1,138 healthcare workers out of a denominator of 2,276 received the flu vaccine, representing approximately 50% uptake. For 2025/26, the denominator is estimated at 2,500–2,600 colleagues, based on the revised Green Book definition of those likely to have direct patient contact.

In 2024/25, the Trust administered 1,189 doses, with an estimated 500 additional staff accessing vaccines externally. However, due to limitations in national reporting tools, ImmForm ((UKHSA system used to order medical products and collect vaccine uptake data) recorded only 629 vaccinations, which does not reflect internal figures. Accurate reporting to ImmForm must be aligned with ESR data, and self-reported external vaccinations must be included, even if unverifiable.

The Trust will track uptake through an updated database as per previous years to support ImmForm submission and Trust oversight.

3. Delivery Model

The 2025/26 campaign will adopt a blended delivery model, combining community-accessible vaccination offers with a focused peer support programme for inpatient NHS staff and patients. This approach aims to maximise accessibility and engagement across all staff groups.

4. Reporting and Data Accuracy

The transition from the NHS Record a Vaccination Service (RAVS) to the NHS National Immunisation Management System (NIMS) has rendered previous Foundry-based reports inaccurate. The 2025/26 campaign will use ImmForm for national reporting, and Trust ESR records must be aligned to ensure accurate submissions. Staff who report receiving vaccines externally will be included in the data, although verification may not be possible.

5. Addressing Hesitancy and Engagement Challenges

Since 2022, increasing vaccination hesitancy, refusal, and apathy have posed significant challenges. These are multi-factorial, linked to dissatisfaction within the NHS, negative social media bias, and reduced public understanding of vaccination programmes and their effectiveness. The Trust will implement targeted communication and peer-led engagement strategies to address these issues.

6. Partnership Changes

The Trust will no longer pursue a partnership working approach with Derbyshire Community Health Services NHS FT, due to significant differences in programme resources and delivery methods. This decision supports a more tailored and internally managed vaccination strategy.

7. Health Protection Unit (HPU) Involvement

The HPU is unlikely to be delivering the vaccination programme this year, due to the absence of a recurrent funding stream. This change needs to be treated with sensitivity as key stakeholders are not aware of the changes. as the proposal works through the Quality and Equality Impact Assessment and transformation process. The Trust will ensure continuity of service through internal delivery mechanisms.

8. Conclusion

The Board has not yet received a confirmed delivery model for final sign-off. We welcome any comments or feedback on the proposed changes and the overall strategy.

8. Appendices

National flu immunisation programme 2025 to 2026 letter - GOV.UK

Guardian of Safe Working Hours (GoSWH) annual report (June 2025)

Purpose of Report

This annual report from the DHcFT Guardian of Safe Working Hours (GoSWH) provides data about the number of Resident Doctors in training in the Trust, full transition to the 2016 Resident Doctor contract and any issues arising therefrom. The report details arrangements made to ensure safe working within the new contract and arrangements in place to identify, quantify and remedy any risks to the organisation.

Executive Summary

The Board of Directors is requested to note:

1. Exception report numbers are almost double this year at 44 (23 and 24 in the previous two years respectively). That being said this must be considered within the context of 18 exception reports coming from two specific events and doctors
2. Processing of exception reports (specifically a suggested outcome from the GoSWH) occurs within seven days. There were delays with two specific scenarios, both of which required further investigation to reach an outcome
3. One formal work schedule review was carried out, resulting in payment to the doctor; time off in lieu (TOIL - unable to be taken as the doctor rotated out of the Trust), and Medical Education reviewed the training post, making necessary amendments
4. The current fines total at £3,213.16. The majority of this is earmarked for the resident doctor away day on 5 June
5. Locum shift expenditure totals £214,740. No agency spend. This is an increase on the previous year of £108,000.17
6. Vacancies are due to doctors working less than full time, or high specialty training posts being unfilled (can occur as the psychiatry school distributes these residents across Lincolnshire, Nottinghamshire and Derbyshire)
7. Following the end of industrial action in September 2024, junior doctors are now known as resident doctors. Medical Education colleagues, and the Resident Doctor Forum (RDF – formerly the Junior Doctor Forum) have transitioned to using these terms and encourage all staff within DHcFT to do so as well
8. The GoSWH chaired a task and finish group in response the NHS England project to Improve the Working Lives of Doctors in Training. This ran from September to December 2024. The GoSWH is still to draft the report and apologises to the Quality and Safeguarding Committee and the Board for the delay
9. The Making Room For Dignity project has had input from the RDF into the rest facilities available in both the Carsington and Derwent units. Hours monitoring has recently been completed for the resident doctor rotas as a baseline given valid concerns that the south rota will become particularly busy and likely need another doctor working overnight
10. 13 exception reports were from the same GP registrar, with a delay of over a month in submitting. Initially these were outcome for payment as the doctor had rotated out of the Trust. However, escalating through the Quality and Safeguarding Committee, declined to pay as the contractual 14 day limit had lapsed. The GoSWH initially waived the 14 day period when he came into post but has since reinstated. He had agreed to give training to supervisors on exception reporting following this scenario. However,

11. Exception reporting reform has recently been announced, and broadly this will change several contractual elements, the biggest of which is that hour breaches of two hours or less will be ‘automatically’ process for either payment or TOIL (residents’ choice) through the provider HR function. Further information and guidance is awaited from the BMA and NHS Employers on this, but the implementation date is set for September 2025
12. The GoSWH’s three year term is due to end on 1 December 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

This report from the DHcFT Guardian of Safe Working Hours provides data about the number of resident doctors in training in the Trust, full transition to the 2016 Resident Doctor contract and any issues arising therefrom. The report details arrangements made to ensure safe working within the new contract and arrangements in place to identify, quantify and remedy any risks to the organisation.

Consultation

The GOSWH has shared the previous quarterly and annual reports to the Quality and Safeguarding Committee with the Joint Local Negotiating Committee (JLNC), the Trust Medical Training Committee (TMTC), the Resident Doctor Forum (RDF) and its constituent resident doctors. Following presentation to the Quality and Safeguarding Committee, this report will be shared at the next RDF meeting, its constituent resident doctors, the TMTC and the JLNC.

Governance or Legal Issues

None.

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:

None.

Recommendations

The Board of Directors is requested to:

1. Note the contents of this report
2. Support the implementation of exception reporting reform as to be outlined by upcoming contractual changes, as well as guidance from the BMA and NHS Employers.

Report presented by:	**Lynn Andrews** **Chair, Quality and Safeguarding Committee**
Report presented and prepared by:	**Dr Kaanthan Jawahar** **Guardian of Safe Working Hours**

GUARDIAN OF SAFE WORKING ANNUAL REPORT (June 2025)

1. Resident doctor data

Extended information supplied from 21 February 2025 to 27 May 2025. Annual aggregated data is not presented as this would be difficult to interpret owing to variable rotation dates for resident doctors.

Numbers in post for resident doctors in training

Numbers of doctors in post WTE	North	South
FY1	3	5
FY2	3	5
GP ST	3.5 (headcount 4)	6.8 (headcount 7)
CT	9.8 (headcount 11)	11.8 (headcount 12)
HSTs	7.4 (headcount 8)	8.8 (headcount 9)
Paediatrics ST	0	2

Key

CT = Core training resident years 1-3
FY1/FY2 = Foundation year resident (years 1 and 2)
HST = Specialty training resident (ST) years 4-7
GP ST = General practice specialty registrar
Paediatrics ST = Paediatrics specialty training resident (year 4+)

2. Exception Reports

Aggregated data, covering the period **16 May 2024 to 29 May 2025**:

Location	No of exceptions raised	No of exceptions closed	No of exceptions outstanding
North	9	9	0
South	35	35	0
Total	**44**	**44**	**0**

Grade	No of exceptions raised	No of exceptions closed	No of exceptions outstanding
CT1-3	9	9	0
ST4-7	12	12	0
GP	19	19	0
Foundation	4	4	0
Total	**44**	**44**	**0**

Action taken

Location	Payment	TOIL	Not agreed	No action required
North	0	8	0	1
South	15	6	0	14
Total	**15**	**14**	**0**	**15**

Response time

Grade	48 hours	7 days	Longer than 7 days	Open
CT1-3	0	9	0	0
Foundation	0	4	0	0
ST4-7	0	12	0	0
GP	0	1	18	0

- The 18 exception reports that took >seven days to resolve required further investigation to come to a decision
    - 5 of the exception reports resulted in a work schedule review (see the next section)
    - The remaining 13 exception reports were from the same GP registrar doctor. These referred to exception reports detailing working beyond contracted hours in a CMHT setting. The doctor initially raised this with their clinical supervisor, and then their educational supervisor (external to the trust). The latter signposted them to the GOSWH for a discussion in confidence. Broadly, there were learning needs for the doctor around time management and prioritisation. The doctor was encouraged to submit the exception reports, however these were only submitted the day before they rotated out of the Trust following a delay of >one month. Initial review by the GoSWH and the relevant Deputy Director of Medical Education opted for payment (no opportunity to give TOIL), with an ask to the doctor's educational supervisor to look into the learning needs in more detail. Medical Staffing colleagues questioned this approach as the 14 day maximum contractual period for submitting exception reports had lapsed. This specific scenario was escalated to the Chair of the Quality and Safeguarding Committee, and to the Medical Director. As the 14 day period had lapsed, and the Trust had no opportunity to review the scenario before the doctor rotated, payment was not granted.

3. Work schedule reviews

- One work schedule review was carried out for a GP registrar following the submission of five exception reports. The Medical Education team reviewed the post and made amendments around supervision to prevent further issues with postholder needing to stay beyond their contracted hours to enact time critical tasks following weekly supervision. There have been no further issues with the post since.

4. Fines

- £2,252.24 levied in fines against the trust since the last annual report. These have all arisen through breaches of non-resident on call minimum rest requirements
- The current total of fines available for the JDF to spend is £3,213.16 through cost code G62762.

5. Locum/Bank Shifts covered (31 April 2024 to 27 March 2025)

	North	Cost	South	Cost
Locum/bank shifts covered	148	£89730	268	£125,010
Agency locum shifts covered	0	0	0	0

6. Agency Locum (31 April 2024 to 27 March 2025)

Nil.

7. Vacancies (21 February 2025 to 27 March 2025)

	North	South
CT1-CT3	1.2	0.2
ST4-7	4	0
GP registrars	0.5	0.6
Foundation	0	0

- For CT, GP registrars, and foundation residents, there are no headcount vacancies. The 'vacant' amounts above reflect residents working less than full time
- The four WTE vacancies for STs are true vacancies. Not all ST posts are filled at any given time, as this depends on where residents are placed within the Trent School of Psychiatry, which covers Nottingham and Lincoln in addition to DHcFT.

8. Qualitative information

- Exception report numbers are almost double this year at 44 (23 and 24 in the previous two years respectively). That being said this must be considered within the context of 18 exception reports coming from two specific events and doctors
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- Locum shift expenditure totals £214,740. No agency spend. This is an increase on the previous year of £108,000.17
- Vacancies are due to doctors working less than full time, or high specialty training posts being unfilled (can occur as the psychiatry school distributes these residents across Lincolnshire, Nottinghamshire and Derbyshire
- Following the end of industrial action in September 2024, junior doctors are now known as resident doctors. Medical Education colleagues, and the Resident Doctor Forum (RDF – formerly the Junior Doctor Forum) have transitioned to using these terms and encourage all staff within DHcFT to do so as well

- The GoSWH chaired a task and finish group in response the NHS England project to Improve the Working Lives of Doctors in Training. This ran from September to December 2024. The GoSWH is still to draft the report and apologises to the Quality and Safeguarding Committee and the Board for the delay
- The Making Room For Dignity project has had input from the RDF into the rest facilities available in both the Carsington and Derwent units. Hours monitoring has recently been completed for the resident doctor rotas as a baseline given valid concerns that the south rota will become particularly busy and likely need another doctor working overnight
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- Exception reporting reform has recently been announced, and broadly this will change several contractual elements, the biggest of which is that hour breaches of two hours or less will be ‘automatically’ process for either payment or TOIL (residents’ choice) through the provider HR function. Further information and guidance is awaited from the BMA and NHS Employers on this, but the implementation date is set for September 2025
- The GoSWH’s three year term is due to end on 1 December 2025.

9. Compliance of rotas

Current work schedules are compliant with the 2016 resident doctor contract.

10. Other concerns raised with the Guardian of Safe Working (GoSWH)

- One exception report was awarded TOIL, but the resident requested payment. The specific reason was for fearing detriment from the supervisor should they look to take TOIL. Efforts were made to engage this doctor to discuss their concerns in detail, and in confidence, however these were declined. This was escalated through Medical Education, and the directors of medical education (DMEs) sought to gain soft and discrete intelligence in this area. No actions appear to have been necessary
- The Foundation Programme Training Director raised concerns directly with the GoSWH on how a particular clinical supervisor was treating their foundation resident. From the information available, this appeared to be a repeating pattern. The specific case was escalated the relevant Deputy DME to take further action.

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 - annual					X	
DoCA/TS	Receipt of Reports (following assurance at 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 (following assurance at 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					
DPODI	Receipt of Reports (following assurance at People and Culture Committee (PCC)):						
	Workforce Plan annual review (PCC - Jul)			X			
DoN/MD	Receipt of Reports (following assurance at 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 (following assurance at People and Culture Committee (PCC)):						
	Medical Appraisal and Revalidation - annual report (PCC - May)	X					
DoN	Receipt of Reports (following assurance at Quality and Safeguarding Committee (QSC)):						
	Guardian of Safe Working Hours report (QSC - quarterly)		AR		X	X	
	Infection Prevention and Control annual report and IPC BAF (QSC - Oct)				X		
	Looked After Children - annual report (QSC - Sep)				X		
	Quality Account (QSC - Jul)			X			
	Quality Delivery Plan (QSC - Jul)		X				
	Delivery of Same Sex Accommodation (QSC - Oct)				X		
	Safeguarding Children and Adults at Risk - Annual report (QSC - Sep)				X		
	SEND - Annual Special Educational Needs and Disabilities (QSC - May/Jun)	X					
MD	Learning from Deaths/Mortality report (QSC - quarterly)	AR			X	X	X
DCEO/CDO	Transformation and Continuous Improvement (bi-annual)	X			X		
DCEO/CDO/MD/DoN	Winter Plan		X				
POLICY REVIEW							
DCEO/CDO	Emergency Preparedness, Resilience and Response (EPRR) Policy			X			
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			

KEY
ARC - Audit and Risk Committee
DCEO/CDO - Deputy Chief Executive and Chief Delivery Officr
DoCA/TS - Director of Corporate Affairs and Trust Secretary
DoF - Director of Finance
DoN - Director of Nursing, Allied Health Professionals, Quality and Patient Experience
DPODI - Director of People, Organisational Development and Inclusion
FTSUG - Freedom to Speak Up Guardian
MD - Medical Director
PCC - People and Culture Committee
QSC - Quality and Safeguarding Committee

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 programme
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
BILD	British Institute of Learning Disabilitites
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
CCT	Community Care Team
CDEL	Capital Departmental Expenditure Limit
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	

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
DAR	Divisional Assurance Review
DASP	Drug and Alcohol Strategic Partnership
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
EIS	Early Intervention Service
ELT	Executive Leadership Team
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
ETOC	Enhanced Therapeutic Observations and Care
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
FT ARM	Foundation Trust Annual Reporting Manual
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
HCHS	Hospital and Community Health Services (NHS)
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
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
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)
ImmForm	UKHSA ImmForm system – used to order medical products and collect vaccine uptake data
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
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
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
LTWP	Long Term Workforce Plan
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
MHRT	Mental Health Review Tribunal
MHRV	Mental Health Response Vehicle
MHSDS	Mental Health Services Data Set
MiCAD	Reporting system for medical device service and repair
MMaSP	Medicine Management Safety and Practice
MMC	Medicines Management Committee
MoU	Memorandum of Understanding
MPAC	Multi-Professional Approved Clinician
MSC	Medical Staff Committee
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 Immunisation Management System
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
PAR	Personalised Approaches to Risk
PARC	Psychosis and the reduction of cannabis (and other drugs)
PARIS	This is an electronic patient record system

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
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
PFF	Probation Feedback Form
PFR	Provider Finance Return
PHC	Public Health Commissioners
PHCIC	Physical Healthcare and Infection Control Committee
PHE	Public Health England
PHE	Physical Health Equipment
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
PSR	Provider Selection Regime
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
R	
RAID	Rapid Assessment, Interface and Discharge
RAP	Recovery Action Plan
RAVS	Record a Vaccination Service
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
RPOG	Restrictive Practice Oversight Group
RRN	Restraint Reduction Network
RRP	Recruitment Retention Proposal
RTT	Referral to Treatment
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
SoCI	Statement of Comprehensive Income
SOP	Standard Operating Procedure
SPOA or SPA	Single Point of Access
SPOE	Single Point of Entry

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
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
TDG	Trust Delivery Group
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

July 2025

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 22 July 2025

Report from the Council of Governors meeting

The Council of Governors has met once since the last report, on 3 June 2025. The meeting was conducted as a hybrid meeting.

Matters arising

Non-Executive Director and Chair of the Trust's Quality and Safeguarding Committee, confirmed that the Care Programme Approach system is being replaced by the Personalised Care Framework (PCF).

Chief Executive's Update

On behalf of the Chief Executive, the Director of Finance presented the update which focused on:

- The national context – including significant changes to NHS England and Integrated Care Boards (ICB)
- An update on the Trust's Making Room for Dignity programme
- The Care Quality Commission's (CQC) recent inspection across the Older Adults Wards
- The formalisation of a closer working relationship with the University of Derby
- 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
- An update on NHS Talking Therapies – including the transition of staff/service users to the new provider Vita Health Group.

Report from the Governors' Nominations and Remuneration Committee

The Trust Chair presented an overview of the matters discussed at the last Governors Nominations and Remuneration Committee on 12 May which covered the following business:

- The appraisals for the Trust Chair and Non-Executive Directors (NEDs)
- Proposal for the re-appointment of a NED and approval of a new Deputy Trust Chair
- Several year-end reports
- Update on the NED recruitment including recommendation to approve the appointment of the Finance and Performance Committee Chair NED.

The Council of Governors approved the:

- Chair's objectives as set out in the report
- Appointment of Lynn Andrews as the Trust's Deputy Chair from 1 August 2025
- Reappointment of Lynn Andrews, as Non-Executive Director for a further three year term, from
  11 January 2026
- Committee's Terms of Reference
- Proposal to appoint to the Chair of the Finance and Performance Committee NED role.

Council of Governors Annual Effectiveness Survey

The Council of Governors approved the recommendation that the survey is undertaken in September 2025.

Non-Executive Directors (NED's) Report

Two NEDs presented their reports which summarised their role and activities.

Staff Survey Results

The Human Resources and Organisational Development Project Lead presented the staff survey results which shows the current position of the Trust for the 2024 NHS staff survey.

Escalation item to the Council of Governors from the Governance Committee

Governors received responses to two holding to account questions to the NEDs regarding the government imposed cost reductions and the accumulation of cuts on the voluntary sector; and the impacts these may have on the services the Trust provides. Governors were assured by the responses given.

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 (including approval of governor statement for the Quality Account)

The Co-Chair of the Governance Committee presented a report of the meeting held on 15 April 2025.

The Council of Governors approved the:

- Governor statement for the Quality Account which was included in the report.

Review Governors Membership 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 15 April 2025. The Action Plan is aligned to the key objectives for members' engagement in the Membership Plan 2025-2028.

RECOMMENDATION

The Trust Board is asked to note the summary report from the Council of Governors meeting held on 3 June 2025.