Derbyshire Healthcare
NHS Foundation Trust

Public Trust Board Meeting

23 September 2025

Conference Rooms A and B, Centre for Research and Development, Kingsway

Meeting Book - Public Trust Board Meeting

Contents and Page Numbers

Derbyshire Healthcare
NHS Foundation Trust

Public Board Meeting

Agenda

Date: Tuesday, 23 September 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's Occupational Therapy service*	Tumi Banda
3	10.00	Minutes of the Board of Directors meeting held on 22 July 2025	Selina Ullah
4		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	Vikki Ashton Taylor (on behalf of Mark Powell)
Operational Performance			
8	10.25	Integrated Performance report, including Operations, Finance, People and Quality	Vikki Ashton Taylor/ Tumi Banda/Rebecca Oakley/James Sabin
9	10.50	09.1 Emergency Preparedness, Resilience and Response (EPRR) annual report and Core Standards 09.2 EPRR and Business Continuity Policy	Vikki Ashton Taylor
Break 11.00am			
10	11.10	Mental Health Services Assessment Tool (Men-SAT)	Vikki Ashton Taylor
Quality Governance			
11	11.20	Winter Plan – 2025/26 and Board Assurance Statement for sign-off	Vikki Ashton Taylor
Strategic Planning and Corporate Governance			
12	11.30	Strategic Plan – 2025-2028 – progress update	Vikki Ashton Taylor
13	11.40	Board Assurance Framework (BAF) update	Justine Fitzjohn
14	11.45	Freedom to Speak Up Guardian report (six-monthly)	Tam Howard
15	11.55	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports and action plans - request for Board delegated authority for the People and Culture Committee to approve the October submissions	Ralph Knibbs
16	12.00	Board Committee Assurance Summaries	Committee Chairs

Report for Noting following Assurance at Board Committees			
17	12.20	Quality and Safeguarding Committee: Safer Staffing annual review	Lynn Andrews
Policy Review			
18	12.25	Standing Financial Instructions (SFIs) Policy and Procedures	James Sabin
Closing Business			
19	12.30	Consideration of any items affecting the Board Assurance Framework (BAF)	Selina Ullah
20		Meeting effectiveness	

FOR INFORMATION
Forward Plan - 2025/26 Glossary of NHS Acronyms

Next meeting:

Date:	**Time:**	**Location:**
25 November 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

Derbyshire Healthcare
NHS Foundation Trust

We make a positive difference in everything we do

Our vision

Our strategic priorities

Patient focus

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

Caring

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

Inclusive

We respect and include everyone in all we do.

Partnerships

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

Ambitious

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

WE MAKE A POSITIVE DIFFERENCE • IN EVERYTHING WE DO •

Belonging

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

People

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

Collaborative

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

Productive

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

Our values

Find out more

derbyshirehealthcareft.nhs.uk/about-us/strategy

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

DECLARATION OF INTERESTS REGISTER 2025/26		
NAME	**INTEREST DISCLOSED**	**TYPE**
Selina Ullah Trust Chair	• Director/Trustee, Manchester Central Library Development Trust • Non-Executive Director, General Pharmaceutical Council • Non-Executive Director, Locala Community Partnerships CIC • Non-Executive Director, Accent Housing Group • Director, Muslim Women's Council • Trustee and Board member of NHS Providers representing Mental Health Providers	(e) (e) (e) (e) (e) (e)
Tony Edwards *until 31-Jul-2025* 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)
Jo Hanley *from 4-Aug-2025* Non-Executive Director	• Non-Executive Director, Dudley NHS Foundation Trust • Remediation Unit Director, Post Office Limited	(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).

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, 22 July 2025

MEETING HELD IN PUBLIC

Commenced: 09.30am Closed: 12.10pm

PRESENT	Tony Edwards	Deputy Trust Chair
	Lynn Andrews	Non-Executive Director
	Deborah Good	Non-Executive Director
	Andrew Harkness	Non-Executive Director
	Geoff Lewins	Non-Executive Director
	Mark Powell	Chief Executive
	Vikki Ashton Taylor	Deputy Chief Executive and Chief Delivery Officer
	Tumi Banda	Director of Nursing, Allied Health Professions, 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	Richard Eaton	Head of Communications
DHCFT2025/055	Joseph Thompson	Assistant Director of Clinical and Professional Practice
DHCFT2025/055	Kelly Thompson	Named Nurse Children in Care/Clinical Lead
	Jo Bradbury	Corporate Governance Officer
APOLOGIES	Selina Ullah	Trust Chair
	Ralph Knibbs	Senior Independent Director
OBSERVERS	Sandra Austin	Equal Network Advisor
	Sue Ryan	Lead Governor and Public Governor, Amber Valley
	Dave Allen	Public Governor, Chesterfield
	Fiona Birkbeck	Public Governor, High Peak and Derbyshire Dales
	Christopher Williams	Public Governor, Erewash

DHCFT/ 2025/054	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** In the absence of Trust Chair, Selina Ullah, the meeting was chaired by Tony Edwards, Deputy Chair, who welcomed everyone to the meeting. Apologies were as stated. The Register of Directors' Interests for 2025/26 was noted with no declarations of interest raised with any of today's agenda items.
DHCFT/ 2025/055	**BOARD STORY – CHILDREN IN CARE** Joe Thompson, Assistant Director of Clinical and Professional Practice, introduced the Board Story, which was to be presented by Kelly Thompson, Named Nurse Children in Care/Clinical

	Lead, who would talk about a young person in care and their experience of trying to access specialist health services. Summarising the Children in Care Team, Kelly advised it included Doctors, School Nurses and Health Visitors. The team was responsible for undertaking statutory health assessments for children in care and adoption, as well as providing health advice and education to these young people and their carers, living in Derby and within a 20-mile radius of the city. Kelly explained how, when a child or young person is placed outside the Derby city area, then moves back into Derby, this can impact on where they are placed on waiting lists for certain health services. The team had improved the co-ordination of Mental Health and Sexual Health services for the children they support, ensuring they were given priority access. However, there were still issues at times regarding Community Paediatrics and Neurodevelopmental services. The Board noted the example of an eight-year-old child who was living outside the Derby city area and had been waiting to see a local Paediatrician and a Clinical Psychologist for a number of months about behavioural issues relating to past trauma, and about their sensitivity to light and loud noises. Upon moving back into Derby, the young person and their carer were told that they would have to join the start of the queue to see a Clinical Psychologist, meaning the waiting time might be very long. The Children in Care team were able to intervene on this person's behalf and work with the Neurodevelopmental Pathway team to back-date the referral. As a result, the young person had their clinical psychology appointment earlier this year, where they were diagnosed as having autism spectrum disorder (ASD). On behalf of the team, Kelly wanted to request that all children in care received this kind of priority access to Community Paediatric and Neurodevelopmental services. The impact waiting lists had on children and the inability for the Trust to achieve what it would like to, was acknowledged by Tony. The powerful story highlighted the vulnerabilities of children in care compared to other children. Arun Chidambaram, Medical Director, remarked that the presentation brought to life the need for work to continue as part of the Health Inequalities action plan. Mark Powell, Chief Executive, stated the Trust needed to find a way to prioritise children in care. He made a commitment on behalf of the Board to achieve this. **RESOLVED: The Board of Directors was greatly inspired by Kelly's presentation and committed to improving access to Community Paediatric and Neurodevelopmental services.**
DHCFT/ 2025/056	**MINUTES OF THE PREVIOUS BOARD OF DIRECTORS MEETING** The minutes of the last meeting held on 3 June 2025 were accepted as a correct record of the meeting, subject to the following amendment, requested by Geoff Lewins, Non-Executive Director: *'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'.* To be amended to: *'Geoff Lewins, Non-Executive Director observed the need to review the Trust's clinical models. As an example, the ASD team was delivering 300% more assessments having reviewed and improved their processes.'* **Post-meeting note, wording amended.** Attention was drawn to the Easy Read version of the Board Story, appended to the minutes.
DHCFT/ 2025/057	**ACTION MATRIX AND MATTERS ARISING**

	The Board reviewed and closed the completed actions. No actions remained outstanding. There were no matters arising.
DHCFT/ 2025/058	**QUESTIONS FROM MEMBERS OF THE PUBLIC** No questions had been received.
DHCFT/ 2025/059	**CHAIR'S UPDATE – VERBAL** Tony remarked at the unmitigated circumstances within which the Trust was operating at the present time. The ongoing hard work undertaken by Selina to represent the Trust was acknowledged. **RESOLVED: The Board of Directors noted the verbal update.**
DHCFT/ 2025/060	**CHIEF EXECUTIVE'S UPDATE** The report covered current local issues and national policy developments and also reflected a wider view of the Trust's operating environment. Mark stressed the significant level of change within the NHS at the present time. Encouraging colleagues to read the full or summarised version, attention was drawn to the 10 Year Health Plan, which was aligned to three shifts, from: • hospital to community • analogue to digital • sickness to prevention. It was noted that the Trust Strategy was aligned to the 10 Year Plan and this needed to continue, albeit with some nuances. The publication of Dr Penny Dash's review of patient safety was mentioned, which proposed significant changes to NHS regulatory bodies and the ambition to streamline some of those organisations. Reference to the Model Integrated Care Board (ICB) 'blueprint' shared by NHS England, was highlighted, which outlined the intent to cluster the Derby and Derbyshire ICB with Nottinghamshire and Lincolnshire, Mark explained this would have a direct and indirect impact, with a number of functions placed elsewhere, including with local providers. Mark acknowledged the refreshed NHS Oversight Framework for 2025/26, which would assess ICBs and providers against a range of metrics. He explained how work was already underway to cross-reference the Framework to ensure alignment with the Trust Strategy. Mark also reflected on news closer to home, including the publication of an inspection report by the Care Quality Commission (CQC) which announced that the Trust's Older Adult Acute Inpatient services were now rated 'good' overall and 'good' across all the CQC's key domains. He stated the achievement was testament to the hard work of staff on those wards. The signing of a new strategic partnership with the University of Derby was welcomed. It was noted this would develop a more joined-up approach to the teaching of students and a more research-based approach to the delivery of healthcare. In conclusion, Mark advised that refurbishment work had now resumed at the Trust's Radbourne Unit as part of the Making Room for Dignity (MRfD) programme. He was delighted to announce that Kingfisher House, the Psychiatric Intensive Care Unit was opening that day, with a phased transition to accommodate Out of Area (OoA) patients.

	The significant importance of the national developments was recognised by Arun. He highlighted the challenges around children's services and emphasised the Trust' strengths, acknowledging the external award for positive developments around the Digital Plan. Lynn Andrews and Deborah Good, Non-Executive Directors, praised the report, commenting that the Board updates from the Chair and CEO reflected how the Trust Strategy was coming to life. They both extended praise for the achievements realised. It was noted that the next steps were to focus on Neighbourhood Health (to be discussed at the October Board Strategy and Development Session), of which Living Well was fundamental, along with the 24/7 Government ambition. Mark clarified that there was no longer support from the ICB and the Trust was working with partners to provide accessible mental health services. He added the national brief was very much about collaborative working and the Trust was hoping to be chosen as one of the 42 development sites. **RESOLVED: The Board of Directors scrutinised the report and noted the risks and actions being taken.**
DHCFT/ 2025/061	**INTEGRATED PERFORMANCE REPORT (IPR)** The IPR provided an update on key Operations, Finance, People and Quality measures at the end of May 2025. Executive Directors drew attention to the following areas and responded to questions: **Operations** On behalf of Vikki Ashton Taylor, Deputy Chief Executive and Chief Delivery Officer, Tumi Banda, Director of Nursing, AHPs, Quality and Patient Experience, summarised performance within Operations. Particular attention was paid to the Perinatal Mental Health service, which was continuing to support high numbers of self-referred, pregnant women and new mothers each month. It was noted that Trust teams were performing well in terms of dementia diagnosis rates and access to Child and Adolescent Mental Health services. Tumi was pleased to report that the number of inappropriate OoA placements had been reduced to eight and that the opening of new buildings through the MRfD programme should help to sustain this improvement. He added that appropriate OoA placements were also decreasing. It was noted that the transition of the Talking Therapies service was now successfully complete. It was further noted that waiting times for some services remained an issue, including for Adult ASD Assessment and for Community Paediatrics due to demand exceeding capacity by 380%. Efforts to reduce waiting times were making a positive difference in some of these areas, including in Adult ASD Assessment, where the number of completed assessments per month was extremely high. Finally, Tumi confirmed that work was underway to analyse and reduce the wait times for callers to the Mental Health Helpline and Support service. Deborah recommended an analysis be provided, to reflect the appropriateness and volume of repeat calls. In response, Mark advised that the Mental Health Services Assessment Tool (Men-Set) was to review the Helpline as part of the emergency care pathway. On receipt, the report would be presented to the Finance and Performance and Quality and Safeguarding Committees, ahead of submission to Board. Geoff highlighted that there were technical issues around the way people get through to the Helpline and that the new process required callers to select the Mental Health option when calling 111, whereas the previous method did not connect them directly. He added that some of the frequent callers were from OoA and the timescale to transition to the new systems was not yet known. Tony pointed out that the matter was within the control of the ICB.

Referring to the repatriation of OoA patients, Lynn asked for information on the phasing? Tumi advised that for the Psychiatric Intensive Care Unit (PICU), this would be over the next three weeks and be based on patient experience, as depending on where individuals were in the pathway, it may be best for them to remain where they are. In relation to the Enhanced Care Unit (ECU), decisions would be made over the next two weeks in relation to the best clinical care and patient experience.

Finance

James Sabin, Director of Finance, reported that the Trust had an overall adjusted deficit of £1.3m at the end of May, which was in line with planned projections. The current forecast was that the Trust would achieve its break-even plan for the 2025/26 financial year, in line with regional and national requirements.

The continued reduction in agency and bank spend was noted.

The impact on costs associated with OoA placements, due to the delay in the opening of the Carsington Unit, was highlighted. However, James confirmed it had been possible to contain the financial pressure and that costs should begin to decrease now that the unit was open.

In recognition of the positive achievements and situation, Tony commented that the level of control was the best it had been in his three years with the Trust. He added the Trust was consistently improving its delivery and extended thanks to all those involved.

People

Rebecca Oakley, Director of People, Organisational Development and Inclusion, reported further improvements made in staff training levels and colleagues receiving annual appraisals and regular supervision. The requirement for data cleansing to be undertaken was pointed out by Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary, to ensure non-clinical roles were not included for clinical supervision.

It was noted that staff turnover remained in line with other similar trusts, both regionally and nationally.

In relation to absence, Rebecca informed that an Absence Oversight Group had been established. She reiterated that the use of agency staff had reduced significantly.

The recent changes to visa and immigration rules were discussed in relation to the effect on the recruitment of Healthcare Support Workers. Lynn stated that having a diverse selection of staff for effective delivery of services was fundamental and Rebecca advised the Trust was working with NHS Employers to mitigate the situation as a system. It was noted that the eligible salary threshold equated to less than £100 variance.

The final points highlighted included the closure meeting of the proposed Operating Model consultation and the potential impact of the Resident Doctors' industrial action on training and appraisal compliance. Mark notified of an urgent CEO meeting the next day with NHSE to agree plans to manage the five day industrial action, 25 July to 30 July.

Quality

The data indicated that the Trust was performing well in medication safety, falls prevention and complaints handling.

Tumi stipulated that more work was needed to ensure compliance with the Trust's Care Programme Approach (CPA) and the review of Care Plans. He advised that the services with lower rates had recovery plans in place and weekly 'crosscheck' meetings had been convened, for both Adult and Older Adult Community Mental Health services.

	It was noted that the use of seclusion in Inpatient services had risen slightly in recent weeks, which was attributed to the opening of the Derwent Unit, which had its own seclusion suite, unlike the previous building in Chesterfield (the Hartington Unit). Tumi assured that Inpatient teams were being supported to minimise the use of seclusion. The target to improve CPA compliance from 86% to 95% by August was queried by Geoff, he challenged if this was a realistic expectation? Accepting that the target would not be reached overall, Tumi justified that setting the target had helped with data analysis and with staff development for challenged teams. Tumi stated that the Trust was adhering to the CPA framework and policy at the present time. He added that he was in liaison with Arun and Vikki to transition to the robust Personalised Care Framework, which was in consultation. Lynn reflected on the in-depth discussions held at the Quality and Safeguarding Committee around CPA. She explained that SystmOne was the host for all data and that another system was being trialled. Whilst in agreement that 95% was an aspirational target, she recognised the opportunity to really focus on the patients to ensure they received the right care and her confidence in the process was reiterated. The topic of conversation moved to the Care Hours per Patient Day (CHPPD) metric. Tumi affirmed that it was helpful to compare against other organisations and that the Trust regularly reviewed its safer staffing. It was noted that whilst other organisations' Nursing staffing levels had increased, the Trust included Allied Health Professions and he was confident the patients' core needs were being met in terms of acuity and the number of staff by band. **RESOLVED: The Board of Directors obtained significant assurance on current performance across the areas presented.**
DHCFT/ 2025/062	**CORPORATE COST REDUCTION (FOR RETROSPECTIVE APPROVAL)** Vikki joined the meeting at 11.07am. It was noted that all NHS trusts had been asked to reduce Corporate costs by 50% of the perceived growth between 2018/19 and 2023/24. James confirmed the Trust was already on track to deliver the national ask and the Finance team had reported back to NHS England to confirm this. In recognition of the good work, Tony applauded the practice of the Trust setting its own standards. He added that the topic was covered regularly at the Finance and Performance Committee. A typographical error was pointed out under the heading '*Procurement (2023/24 cost opportunity to LQ - £0)*' of the report, where '*complaint*' should have stated '*compliant*'. Mark and Arun pointed out the substantial risk for the Trust with closure of the Commissioning Service Unit, which could impact the Trust's reliance on Arden Gem, the significant provider of IT services. It was noted that the Trust would work with Derbyshire Community Health Services NHS FT to procure a new supplier. **RESOLVED: The Board of Directors:** **1. Noted the Trust's corporate cost reduction submission** **2. Retrospectively approved the submission** **3. Agreed for ongoing monitoring to continue via the Trust Delivery Group, Executive Leadership Team, Finance and Performance Committee and Board as routine financial oversight where necessary.**
DHCFT/ 2025/063	**FIT AND PROPER PERSONS TEST – CHAIR'S ANNUAL DECLARATION** Justine presented the Chair's declaration that all Trust Board Directors met the fitness test and did not meet any of the 'unfit' criteria, confirming that the Board is fit and proper. Evidence of the compliance had been submitted to NHS England by the 30 June deadline.

	It was noted that whilst the Trust did not receive feedback on submissions, any negative findings would be addressed appropriately. **RESOLVED: The Board of Directors:** **1. Received full assurance from the Chair's declaration that that all Board Directors met the fitness test and did not meet any of the 'unfit' criteria and that the Board was fit and proper** **2. Noted the compliance against the national Fit and Proper Persons Test (FPPT) Framework.**
DHCFT/ 2025/064	**WINTER PLAN - 2025/26** The Board received a paper on the Trust's commitment and plans towards the Winter Plan for 2025/26. Vikki reported that the plan had been developed together with partners in the Derby and Derbyshire Integrated Care System. This was in preparation for increased pressures during the winter due to factors such as the rise in flu and respiratory illnesses and a peak in demand for Trust services during school holidays and the new year period. It was noted that a 4% increase in demand for inpatient admissions was projected. The plan showed how that increase could be met through the Trust's Inpatient wards and with the use of OoA beds if required; supported by Crisis services in the Community, who were able to wrap care around people and prevent hospitalisations. A recent self-assessment of urgent mental health care, overseen by NHS England, would help to identify gaps within pathways and make improvements in time for the winter. The final plan would be presented at the September Board. Vikki pointed out that unlike previous years, systems would not be awarded any non-recurrent funding to help Acute trusts. She added that whilst Mental Health services didn't traditionally experience the same spikes in demand, the plan was to ensure capacity to support partners. Observing that this was a very robust plan, Lynn enquired if there was anything to add to support Children's services and focus on the impact of sickness absences on Trust staff? Vikki confirmed that the Operational Divisions were reviewing the component parts of the plan and she would ensure the additions were included. **RESOLVED: The Board of Directors:** **1. Noted the planning and timeline for finalising the Winter Plan 2025/26** **2. Confirmed the Board was assured of the planning and governance routes.**
DHCFT/ 2025/065	**FUNDAMENTAL STANDARDS OF CARE** The Board received an update on the Fundamental Standards of Care and performance against the set standards as set out in the Care Quality Commission (CQC) key lines of enquiry. Amongst the positives noted in the report were the: • recent CQC inspection of Older Adult Inpatient services • safe staffing levels achieved in Inpatient areas • successful implementation of a refreshed smoke-free policy across Trust sites. The Trust had recently launched a new training course covering suicide prevention, risk assessment and safety training. It was noted that the course had been co-produced with an Expert by Experience and one of the Trust's Mental Health Nurses. The training had been recognised nationally for its innovative approach and was receiving good feedback from Trust colleagues. Tumi advised the Trust was increasing the number of 'Fundamentals Standards of Care' visits, to see how care was being delivered in practice. Moving forward, individuals with lived experience would join the Directors and Governors at these visits.

	Rebecca asked if someone who had gone through the Culture of Care programme might attend a future People and Culture, Quality and Safeguarding Committee and/or Board meeting to share how the learning had impacted? Tumi welcomed the opportunity to showcase good work. Observing a contradiction within the safer staffing information, Andrew Harkness, Non-Executive Director, pointed out the national benchmarking indicated the Trust levels were lower than comparators, however the report advised all requirements were met, questioning how different metrics elicit different responses. Tumi explained that CHPPD does not take into account safety and he resolved to improve the narrative. Mark echoed the observation and asked Lynn, as Chair of the Quality and Safeguarding Committee, for her perspective. Lynn, responded that there had been a positive shift in understanding what the issues were and in relation to the CQC framework. She welcomed improvements in the way the information was presented and requested that it also include relevant triangulation. It was confirmed that CHPDD was disregarded by a lot of organisations but the data had to be submitted nationally. Tony agreed it was important to use metrics the Trust was confident with and James commented that the grades and levels of staff rostered explained any discrepancy. It was noted that limited assurance had been recommended as the Committee was not confident processes were fully embedded across the Trust. The report, showing good levels of compliance against standards during service visits, was commended by Justine. In particular, she drew attention to the Well Led sections as a reminder the Board needed to challenge and compare itself with the new quality statements within the new CQC assessment framework and confirmed this would be included in the October Board Strategy and Development Session. Tony requested it be formally noted how pleased the Board was with the positive CQC inspection outcome. **RESOLVED: The Board of Directors accepted limited assurance on the Fundamental Standards of Care Compliance, on the basis that there was improved delivery of the standards in some areas whilst others required further improvement.**
DHCFT/ 2025/066	**QUALITY DELIVERY PLAN (QDP) FOR RATIFICATION** Tumi was delighted to present the final version of the Quality Delivery Plan (QDP). He advised there had been a great deal of colleague involvement and that the document aligned with the 10 Year Health Plan. It was noted that the QDP described the three pillars of quality care, with associated objectives and delivery measures for each, that apply across all Trust services: • Effectiveness – providing evidence-based care to improve patient outcomes • Safety – providing care that will not cause harm and is timely • Experience – providing an experience that is personalised, compassionate, respectful and dignified. Tony thanked Tumi for his leadership and congratulated him on the public launch of the QDP. Lynn stated that implementation was now key and Mark was pleased at the alignment with the Trust Strategy, recognising the hard work by many people. **RESOLVED: The Board of Directors ratified the final iteration of the Quality Delivery Plan.**
DHCFT/ 2025/067	**BOARD COMMITTEE ASSURANCE SUMMARIES** The Board Assurance summaries from recent meetings of the Trust Board Committees were accepted as a clear representation of the priorities that were discussed and will be taken forward in forthcoming meetings. The following points were brought to the attention of the Board by Committee Chairs:

	Quality and Safeguarding Committee (4 June and 9 July): Lynn Andrews, Committee Chair, reiterated the positive inspection of the Trust's Older Adult services by the CQC. The great progress with the MRfD programme was emphasised and the focus for the Committee was now to oversee transition to the Model of Care. It was noted that there was a robust plan in place to address the lack of management around medical devices and this had effective support from the Executives. Arun mentioned the Suicide Strategy paper, which had been introduced to the Committee in July and would be presented to Board in September. **Post-meeting note, item included on Forward Plan**. **Mental Health Act Committee (12 June):** Geoff Lewins, who had deputised as Committee Chair, expressed his pleasure that Deborah Good, Committee Chair, had returned to duties. He indicated there were quite a few areas of non-compliance that the Committee was not happy with, in particular around the reading of S132 rights. However, it was noted that there had been some improvements with Training reporting. Arun confirmed an action plan was in development and Tumi explained the main aspect was that rights should be read within 24 hours of admission by any member of staff, however, accountability sat with the Nursing team. A fortnightly cross check review had been incorporated. **Audit and Risk Committee (18 June):** Geoff, Committee Chair, declared the purpose of this meeting was to sign off the annual report and accounts, which had been successfully achieved with no issues. He commended the great work by all concerned. **People and Culture Committee (3 July):** In the absence of Ralph Knibbs, Committee Chair, Geoff summarised that there were no specific issues to highlight. He applauded the Assurance Dashboard and the great information in the IPR. Rebecca made reference to Medical Job Planning, the Oversight Group and the associated action plan. **Finance and Performance Committee (8 July):** Tony Edwards, Committee Chair, mentioned the limitations due to the affordability and cost pressure associated with Ward 35, now that the MRfD programme was in its final stage. It was noted that a Strategic Portfolio Oversight Group had been established and included Andrew Harkness, Non-Executive Director, for added oversight and assurance. It had been agreed that despite all the required actions being met, on the Board Assurance Framework, the Committee agreed to continue scrutiny around cyber risks. **RESOLVED: The Board of Directors noted the Board Assurance Summaries.**
DHCFT/ 2025/068	**REPORTS FOR NOTING FOLLOWING ASSURANCE AT BOARD COMMITTEES** **People and Culture Committee** Flu Vaccination Plan – winter 2025/26 In the absence of Ralph, Rebecca outlined the Trust's approach to flu vaccination for winter 2025/26, which was built on the 2024/25 campaign; aligned with NHS England's winter planning guidance and the ICB Midlands Key Lines of Enquiry. It was noted that the plan was responsive, linked to the winter plan and that progress would be monitored via the Committee. **RESOLVED: The Board of Directors:** **1. Noted changes to the delivery model** **2. Recognised challenges to achieving proposed target.** **Quality and Safeguarding Committee** Guardian of Safe Working Hours (GoSWH) annual report

	Additional information was reported by Lynn, who advised that part of the agreement between the Department of Health and Social Care and the British Medical Association (BMA) Resident Doctors Committee to end the industrial action in summer 2024, included the promise of further resources, along with amendments to the terms and conditions of the 2016 contract. As these had not yet materialised, Lynn reported a formal request, to delay the go live date of the exception report reforms, had been made to NHS Employers. It was noted that the issue was being discussed with the Trust's Resident Doctor Local Negotiating Committee representatives and at the Resident Doctor Forum. **RESOLVED: The Board of Directors:** **1. Noted the contents of the report** **2. Supported the implementation of exception reporting reform as to be outlined by upcoming contractual changes, as well as guidance from the BMA and NHS Employers.**
DHCFT/ 2025/069	**CONSIDERATION OF ANY ITEMS AFFECTING THE BOARD ASSURANCE FRAMEWORK (BAF)** Due to the Trust's reliance on the Commissioning Support Unit (CSU), the Board agreed the issued should be lodged and once the risks and mitigations had been identified, further consideration was needed. Tony requested the item be included on the next Finance and Performance Committee agenda. **Post-meeting note, added to Finance and Performance Committee Forward Plan**.
DHCFT/ 2025/070	**MEETING EFFECTIVENESS** Lynn suggested the Board Story would be more powerful if delivered by a service user and Tony agreed this was a missed opportunity. Feedback from the observers included the following comments: *"Great meeting. The Board Committee Assurance reports were of particular interest"* *"There is value in reading the papers beforehand and to attend in person to listen to the discussions"* *"All children should be prioritised, not just those in care"* *"Great news of the PICU opening today!"* *"The inclusion of visuals is really useful, presenting information in an understandable format".* Tony was thanked for stepping in to chair the meeting at short notice and it was highlighted that this was his final meeting with the Trust. The Board paid tribute to Tony's contributions and remarked at the amazing support he had provided over the last three years. In particular, Mark was appreciative of the direct, clear and forthright help provided and he reflected on Tony's softer side, which was not always evident. Tony's positive impact on the success of the Trust was recognised.
The next meeting to be held in public session will be held in person on 23 September 2025 at 9.30am in Conference Rooms A and B, Centre for Research and Development, Kingsway, Derby.	

Chief Executive's Report

Purpose of Report

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

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

Executive Summary

National context

NHS Oversight Framework (NOF) 2025/26 – segmentation confirmed

In my last report, I gave a summary on how this new one year framework sets out how NHS England (NHSE) will assess Integrated Care Boards (ICBs) and providers against a range of agreed metrics, promoting improvement while helping to identify organisations needing support. NHSE delayed confirming provider segmentation positions to allow additional data testing. The Trust's position has now been confirmed as Segment 4.

This is a disappointing outcome for us, having initially expected Segment 3. I understand that further testing of the national data has resulted in both upward and downward changes to segmentation. We have been informed that we moved because of one metric being removed for all Mental Health trusts (restrictive intervention) which we perform well against. In addition, I understand that the metric for access to Children and Young People's services hasn't been assessed for all relevant providers, which in turn has affected all trusts who have been assessed against it.

There are, though, several measures and standards which we need to improve, all of which feature as part of our current improvement work, which are overseen via our Board assurance and committee meetings. These include people waiting longer than 52 weeks in our Community Paediatric service, 60-day length of stay and face-to-face crisis response.

The full comparative data was published on 8 September, and we can now see how our performance compares to other trusts. We will be working with NHSE on what the practical support and intervention, if any, will mean in Segment 4.

NHS Oversight Framework (NOF) – assessing provider capability

As part of the NOF, NHSE will assess provider capability, using this alongside providers' NOF segments to judge what actions or support are appropriate at each trust. We have been asked to submit a self-assessment and are currently working through this to meet the October submission date.

Guidance sets out how trusts should annually self-assess their capability across six domains:

- Strategy, leadership and planning
- Quality of care
- People and culture
- Access and delivery of services
- Productivity and value for money
- Financial performance and oversight.

NHS Providers 'on the day briefing ' sets out a useful summary.

Industrial action

Resident Doctors across the country took part in industrial action from 7.00am on Friday, 25 July until 7.00am on Wednesday, 30 July. As a Trust, we established an Incident Management team, which met numerous times before and during the industrial action, working with colleagues to ensure patient safety. I am pleased to confirm that we were able to maintain safe services for the entirety of the five-day strike.

Regional and local context

Opening of Kingfisher House and Audrey House

There have been two significant developments in our Making Room for Dignity (MRfD) programme in recent months. Kingfisher House, our new Psychiatric Intensive Care Unit (PICU) for male patients, opened its doors on Tuesday, 22 July. This was followed on Wednesday, 6 August by the opening of Audrey House as an Enhanced Care Unit (ECU) for female patients. The smooth opening of both units was the result of some great preparation by a range of teams including Operational, Nursing, Allied Health Professional, Medical and Corporate colleagues.

These two units, both located on the Kingsway site in Derby, are the fourth and fifth buildings to open in our MRfD programme and will be important in achieving our planned reduction in out-of-area placements, by providing focused support to patients presenting with a higher level of acuity than can be supported on our wards at the Carsington Unit, Derwent Unit and Radbourne Unit. I would like to express my thanks to everybody who has played a role in the operationalisation of these new services.

I'm looking forward to the further development of the Radbourne Unit over the months ahead.

CQC inspection of Inpatient Forensic service

During August, the CQC completed a focused inspection at the Kedleston Unit – our low-secure Forensic Mental Health Inpatient Unit. We are awaiting the inspectors' official report but are pleased at the initial feedback suggesting that the service is caring and compassionate, reflecting our 'patient focused' strategic priority.

Additional investment into Child and Adolescent Mental Health services (CAMHS)

Derby and Derbyshire ICB has agreed £1.5m from the System's Service Development Fund, allocated for Mental Health, into the county's CAMHS in order to help reduce waiting times. Derbyshire Healthcare will receive £986k while Chesterfield Royal Hospital NHS FT, which provides CAMHS in North Derbyshire, will receive £560k. The investment will be extremely welcome as we continue to face the challenge of a steep rise in demand for this important Mental Health service.

Welcoming our Board members

I'm pleased to welcome Jo Hanley to the Trust's Board of Directors as a Non-Executive Director (NED). I have no doubt that we will benefit from Jo's experience and insight on financial matters and transformational change. I expect Jo to be an excellent Chair of our Finance and Performance Committee.

Lynn Andrews, one of our existing NEDs, was successfully appointed as the Trust's new Deputy Chair, and has already started in this role, following the departure of Tony Edwards. Thank you to Tony for his significant contribution to the Trust's Board of Directors over recent years.

In other Board news, I am delighted to confirm the appointment of Dr Girish Kunigiri as the Trust's new Executive Medical Director. Girish currently works as Chief Medical Officer at Lincolnshire Partnership NHS Foundation Trust and has many years' experience as a Consultant Psychiatrist in the East Midlands area. He will commence in post on Wednesday, 29 October 2025.

Our former Medical Director, Dr Arun Chidambaram, left the Trust on 19 September to take up a new role as Medical Director at Greater Manchester Mental Health NHS Foundation Trust. I would like to thank Arun for his leadership at the Trust over the last three years and wish him well in his new role.

Dr Mark Broadhurst (substantively the Trust's Deputy Medical Director) is now the Trust's Interim Executive Medical Director, and I am grateful to Mark for stepping up into this interim role until Girish commences in October.

Welcoming our new international doctors

Earlier this year, a small team representing the Trust visited Chennai in India, to recruit medical colleagues to work in teams where we have longstanding vacancies. Many of these new medical colleagues arrived during August and have been undergoing a two-week training programme before joining our services, where I am sure they will be warmly welcomed.

This recruitment approach has been undertaken in partnership with the University of Derby, to provide specific skills-training needed by doctors practising in the UK. Our process has also been shared through learning from other trusts providing similar services to our own, through a scheme offered by the General Medical Council (GMC).

Nationally, Psychiatry has become more attractive for doctors in training (now referred to as Resident Doctors) and we expect that, in the medium to long term, we will benefit from a more locally trained medical workforce. For now, however, we are delighted to welcome our new international colleagues who will bring experience and skill to the Trust.

Partnership work with Derby City Council

Our Psychiatry Teaching Unit (PTU) has collaborated with Derby City Council on a project that offers a rare and invaluable opportunity for medical students to spend time with Transition2 learners, all of whom have who have learning disabilities, Autism, attention deficit hyperactivity disorder (ADHD) or learning difficulties. Through structured sessions and informal interactions at Transition2, PTU medical students engage in real conversations, shared activities and reflective learning – experiences that go far beyond what a textbook or clinical placement can provide. The collaboration is a unique partnership that showcases how meaningful connections, and purposeful collaboration, can improve understanding, inspire growth, and build a more inclusive and compassionate future for health and social care. It is a really positive partnership, and I look forward to seeing it grow further in the future - building understanding, breaking down barriers, and shaping the future of inclusive healthcare.

Clustering of Integrated Care Boards (ICBs)

The Derby and Derbyshire NHS ICB has confirmed that it will be part of a clustering arrangement with ICBs from Lincolnshire, Nottingham and Nottinghamshire, following approval of this arrangement by NHS England. The objective of clustering is to strengthen ICBs as strategic health commissioners, which will be central to realising the ambitions set out in the national 10-Year Health Plan. Clustering at this scale will also support the required reduction in running costs that all ICBs nationally have been tasked with achieving and ensure sustainability. While each ICB will remain a separate legal entity for the present time, there will be a single Chair, Chief Executive and Board across the 'DLN' cluster, as it is currently being referred to.

The Chair will be Dr Kathy McLean, who was already serving as the Chair of Derby and Derbyshire ICB and Nottingham and Nottinghamshire ICB.

East Midlands Alliance – Common Board Paper and Alliance Plan for 2025/26

Attached at **Appendix 1** is the latest common board paper, which provides a summary of the work and plans of the East Midlands Alliance. This paper is shared with the six Boards of the providers that make up the East Midlands Alliance for mental health, learning disabilities and autism. Also attached at **Appendix 2** is the Alliance Plan for 2025/26.

Recent achievements

Staff recognition scheme winner

Congratulations to Michelle Trolley, Community Outreach Nursery Nurse in the Perinatal Community Team (North), who was our DEED recognition scheme winner for the month of July. Michelle was nominated for her outstanding efforts in building a relationship with the Chesterfield Asian Association and organising a community fun day focused on Perinatal Mental Health.

Congratulations, too, to our DEED winner for June: Amber Griffiths, a Domestic in Hotel Services, who is based at the Derwent Unit. Amber was recognised for her hard work creating a document to enable all staff to view when and how often the curtains have been changed in the unit. Amber used her IT skills to develop the easy-to-view document, which is proving a valuable resource for everyone.

Award nominations

Trust colleagues continue to excel and be recognised at the highest level:

- Our **Occupational Therapy** team has been shortlisted in the Mental Health Innovation of the Year category at the HSJ Awards for improving the efficiency and person-centredness of occupational therapy input into care-plans in our forensic mental health and rehabilitation service
- The **Specialist Integrated Family Support** team has been named as a finalist at the 2025 Nursing Times Awards. The team, part of our 0-19 Children's service for Derby city, was shortlisted in the Public Health Nursing category for their efforts to reduce the health inequalities experienced by asylum seeking and migrant families. Since many of these families arrive at short notice with multiple health needs, the team takes a holistic approach but responds quickly, identifying health conditions and preventing the need for more complex or urgent care by ensuring those conditions are not left untreated. Their work is a great example of the value of preventative care in the community
- The **Healthcare Support Worker Development** team has been shortlisted for the 'Workforce Team of the Year Award' at the Nursing Times Workforce Awards 2025. The team was nominated for the ICARE programme, which provides pastoral support and targeted training designed to address the emotional, educational, and wellbeing needs of newly employed Healthcare Support Workers. The programme has contributed to increased staff confidence, retention and career progression, and has received national recognition for its outcomes
- **Janet Taylor and Elaine Rickett** have received merit awards from the Royal College of Occupational Therapists (RCOT). These awards recognise the remarkable achievements RCOT members have made throughout their careers, celebrating dedication, leadership and making a lasting impact on the occupational therapy profession
- Trust colleagues have been shortlisted in a record eight categories at the **APNA (Asian Professionals National Alliance) NHS Awards**. These awards recognise individuals and teams who have demonstrated excellence, leadership and dedication to equality, diversity and inclusion, making a significant impact on healthcare and their communities. Trust nominees include Nicole Ellis, Brighton Makombe, Nicole Vutabwarova, Arzoo Nasir, Sifo Dlamni, Kalwran Sangha and the Living Well Programme team. Congratulations also to Ateeq Hussain, who is nominated in the Rising Star category for his work in his previous role at Leeds Teaching Hospitals NHS Trust
- Trust colleague **Fred Warlow** has been shortlisted for a Derbyshire and Nottinghamshire Apprenticeship Award in the Intermediate Apprentice of the Year category – a fantastic recognition of Fred's dedication and impact as a Customer Services Apprentice at the Trust.

Other national recognition

The East Midlands Gambling Harms service has received fantastic feedback in the national review of the service's performance over the first quarter of the year.

I understand the national team could not have been more complementary about the service, its performance and potential for future innovation. Congratulations to everyone involved.

Staff engagement

Staff conference

Every year, we hold a staff conference where representatives from teams gather to discuss the future of the Trust. This year, the conference was held in Chesterfield on 15 July. The theme for the day was 'adapting to a changing landscape'. Over 100 colleagues attended to reflect on how we can be caring but also daring in the way we reshape our services in the months and years ahead in line with the 10-Year Health Plan for England. We identified three themes that reflected our conversations throughout the day: the importance of culture and our mindset; of being brave and bold; and of taking collective and personal accountability and ownership. It was a really valuable day, and the feedback from those who attended was extremely positive.

HEARTS Awards

The Trust's annual awards for staff and volunteers are known as the HEARTS Awards – Honouring Exceptional and Really Terrific Staff. This year, we have received an impressive 184 nominations, surpassing the total from previous years. This strong response reflects the enthusiasm of colleagues across the Trust to recognise the outstanding contributions of their colleagues, and of service users and partners to celebrate our fantastic workforce. The finalists will be announced in September and the winners will be announced in October.

Team visits

Although I have been on leave and therefore, haven't been able to visit as many teams/bases as usual, I have continued to get out and about to see our colleagues and service users at the following sites:

- On 28 August I went to see our new international Doctors, who are undertaking their induction with the Trust. These Doctors have joined us in service areas where we have had difficulty recruiting in the past and we are very pleased to welcome them to the Trust
- I met with the team at Tissington House on 2 September
- On 4 September I spent time with colleagues on the Aspiring to Be programme at the North Wingfield Community Centre listening to their thoughts and discussing ideas on the theme "Navigating organisational dynamics, systems thinking and structural insights"
- On 9 September I held a "coffee and conversation" session for staff to come and talk to me at our Killamarsh base in Sheffield
- I also visited the Adult Community Mental Health team at Ilkeston Resource Centre on 10 September.

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

- Arun Chidambaram, Medical Director visited The Liaison team at Royal Derby Hospital, the Buxton Community Mental Health team and also joined a Board visit to the Chaplaincy team
- Vikki Ashton Taylor, Deputy CEO and Chief Delivery Officer, visited the Undergraduate Medical Education team south - Psychiatry Teaching Unit at Royal Derby Hospital (with Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary), and also made visits to Tissington House, Carsington Unit, Sycamore Ward at the Derwent Unit at Chesterfield Royal Hospital, Belper Pride, Kingfisher Ward at the Carsington Unit, Audrey House, Radbourne Unit and The Old Vicarage at Bolsover.
- Tumi Banda, Director of Nursing, AHPs, Quality and Patient Experience, visited the Clinical Health Psychology team, the Health Protection Unit and also visited the Kedleston Unit
- Justine visited the south Undergraduate Medical Education Unit and also the Physical Health Monitoring team

- James Sabin, Director of Finance, joined a Board visit to the In-Reach and Liaison team in Ilkeston
- Rebecca Oakley, Director of People, Organisational Development and Inclusion, visited the Crisis team, High Peak & Dales.

NHS birthday celebrations

A large number of colleagues across the Trust participated in the celebrations for the NHS birthday in July. There were two events, an NHS BIG Tea and an NHS park run, that colleagues were asked to get involved in, and these raised over £640 for the Trust's charitable fund.

In memoriam: Kevin Bagshaw

In July we received the very sad news that Trust colleague Kevin Bagshaw (Kev) had unexpectedly passed away. Kev was a well-known and well-respected colleague who had worked for the Trust, in a variety of roles, for over 45 years.

We held a short, virtual memorial and one-minute round of applause for Kev, which all colleagues were invited to attend. We are also planning to remember Kev in the memorial garden at Kingsway Hospital.

Raising awareness and community engagement

Thank you to colleagues who have supported recent community approaches, by representing the Trust at a Deaf Day in Chaddesden, Derbyshire Constabulary's Deaf Advisory Group, Derby Caribbean Carnival and Belper Pride. This is part of the delivery of our ongoing plan, to increase our community and stakeholder engagement with groups that support the aims of the Trust Strategy.

18 July to 17 August was South Asian Heritage Month, which saw the re-launch of our BME Staff Network. To celebrate the month, we shared blogs from five South Asian colleagues about their heritage and personal journeys.

The Trust also communicated on social media around GCSE and A' Level results days, offering support and guidance for what can be a very stressful day for many.

At the time of writing, we are looking forward to having Trust representatives attending the Baton of Hope event on Saturday, 13 September, as the baton passes through Derbyshire. This is part of a national suicide prevention initiative, where the baton will symbolically travel throughout the UK, representing a journey of hope as the baton is passed from one person to another. World Suicide Prevention Day is on 10 September each year and is an important event in the Trust's calendar, as we try to reach out to our communities and remind them of the importance of speaking up about mental wellbeing.

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

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

Common Board paper

August 2025

1. Introduction

This paper provides a summary of the work and plans of the East Midlands Alliance including the discussions and agreements from the East Midlands Alliance Board meeting held in June 2025.

The same Board paper, agreed by the CEO group, is shared with the six Boards of the providers that make up the East Midlands Alliance for mental health, learning disabilities and autism.

2. The East Midlands Alliance

The East Midlands Alliance is made up of the six largest providers of mental health services in the East Midlands region:

- Derbyshire Healthcare
- Leicestershire Partnership
- Lincolnshire Partnership
- Northamptonshire Healthcare
- Nottinghamshire Healthcare
- St Andrew's Healthcare

The Alliance has agreed a **vision** for the Alliance:

Working together in partnership to enable the best mental health, learning disability and autism care and support for the people of the East Midlands.

The Alliance has also agreed a set of **values**:

- Working together
- Respectful
- Integrity
- Supportive

The Alliance agreed a set of **principles**:

- Patient first
- Care closer to home and maximising independence
- Subsidiarity – take decisions as locally as possible
- Collaboration by consent
- Not acting to the detriment of others
- Sharing and applying learning at pace

The Alliance agreed five **strategic objectives**:

1. Quality improvement and productivity
2. Enabling safe care
3. Developing our workforce
4. Improving population health
5. Reducing inequalities

This common Board paper includes summaries of the recent work under each of the strategic objectives.

3. Alliance Plan

A new Alliance Plan for 2025/26 has been agreed by the Chief Executive group. The HR Director, Strategy Director, Medical and Nurse Director groups have reviewed and fed into the draft plan. The Alliance Board meetings will receive quarterly updates on delivery against the agreed plan. The 2025/26 Alliance Plan plan is appended to this paper.

4. Quality improvement and productivity

4.1 Mental Health Act best practice workshops

The Alliance has used funding from NHS England to commission Weightmans to run a series of best practice workshops between April and December 2025. The workshops are a mix of online and in-person sessions focusing on topics agreed by the Medical and Nurse Director forum.

The Mental Health Act best practice workshops in 2025 will focus on:

- Adult eating disorders
- MHA reform
- Person-centred care and considerations
- MH detention and statutory forms
- Mental capacity and the Court of Protection
- Perinatal mental health

- CAMHS and detention
- CAMHS and eating disorders for under 18's
- Digital considerations: AI technology, risk and regulation
- Part III patients and the law
- First-Tier Tribunal – procedural matters
- Part IV of MHA – appropriate treatment and the role of professionals
- Perinatal mental health
- Complex presentations of veterans and related issues
- Adult safeguarding and the law
- First-Tier Tribunal masterclass – mock tribunal
- MHA reform

The slides and a recording of each workshop session will be posted on a closed part of the Weightmans website for the Alliance providers to access. The workshop slides are shared with the CEO group at their fortnightly meetings. Attendance at the first five sessions ranged between 35 and 65 staff from the Alliance.

There are also bespoke Board sessions for each Alliance provider Board and a CEO session on the new Mental Health Act. Each Alliance provider Board can agree to receive a general update on the Mental Health Act reforms or to have a specific focus on a topic of interest.

4.2 Joint Medical Job Planning

The Alliance has secured funding from NHS England to establish a collective programme of work on medical job planning in mental health, to fund local activity and share learning.

The Medical Directors from Leicestershire Partnership NHS Trust and Lincolnshire Partnership NHS Foundation Trust led a successful bid for funding. The Alliance Medical and Nurse Director forum in early July discussed potential priorities for the use of the funds. Further discussions will take place with NHS England and a fuller proposal will be shared with the Alliance Board in September.

4.3 Therapy Supervision

The Alliance Board in June agreed to distribute the remaining Therapy Supervision funds held by the Alliance to support local activity to increase the pool of therapy supervisors. Each provider was asked to submit a proposal to use the available funding in 2025/26. The CEO group approved a set of funding proposals in July 2025.

The Alliance Board also agreed to establish a new Therapy leads forum to meet quarterly to share improvement and innovation activities.

4.4 Sharing productivity and efficiency plans

The Chief Finance Officers joined an Alliance Chief Executive meeting in April 2025 to share the detail of their 2025/26 financial plans with a focus on productivity and efficiency.

At the Alliance Board in June, the CEOs spent some time discussing ideas and opportunities to work together to improve productivity and efficiency. The Board heard of examples including planned work between Nottinghamshire Healthcare and Derbyshire Healthcare on IT and digital provision, and the work between Northamptonshire Healthcare and Leicestershire Partnership on shared leadership of some of their corporate functions.

The Alliance Board discussed the potential for joint work across the Alliance to digitise the Mental Health Act process. The CEOs agreed to build on some work being undertaken separately by Derbyshire Healthcare and St Andrew's Healthcare on digitising the Mental Health Act process. The Alliance Medical and Nurse Director forum meeting in July discussed the opportunities and agreed to undertake a baseline audit of what each Alliance provider has in place, their plans and what they would like to achieve through any potential joint work.

The Alliance Strategy Director forum meeting in July included some work with Health Innovation East Midlands (HIEM) to shape an Innovation Exchange that they are running in September on productivity in healthcare. The Innovation Exchange will focus on digital solutions to improve productivity. The Strategy Directors encouraged HIEM to consider corporate as well as service provision opportunities to use digital technology to improve productivity, efficiency and effectiveness.

The Alliance Board in June also discussed efficiency opportunities relating to the provision of legal advice. The CEOs agreed to draw the Corporate Governance leads together to discuss opportunities relating to legal advice and legal costs. The CEOs also agreed to draw the CFOs together to discuss efficiency opportunities by working together on procurement.

4.5 Open Dialogue pilot

Lincolnshire Partnership was prioritised by the CEOs to pilot an Open Dialogue model on behalf of the Alliance. Feedback and learning from the pilot phase will be shared with the Alliance Board in September.

4.6 National Inpatient Quality Improvement programme

The Alliance has continued to work with the regional lead for the national Inpatient Quality Improvement programme through the Medical and Nurse Director forum. The focus in 2025 has been on Housing and Mental Health, and on the development of a system demand and capacity model for mental health.

5. Enabling safe care

5.1 Patient Safety programme

The joint Alliance work on enabling safe care is largely delivered through the Alliance Patient Safety programme which is run with Health Innovation East Midlands. The national mental health patient safety programme ended in 2022. The Alliance secured funding to continue the programme in the East Midlands for a further two years and has recently agreed a further programme extension for 2025 to 2027.

The programme is sponsored by the Medical and Nurse Director forum and is chaired by the Medical Director from St Andrew's Healthcare.

The Alliance and Health Innovation East Midlands ran a celebration and learning event which was led by people with lived experience in March 2025. The event showcased the joint work across the East Midlands through the three existing Communities of Practice:

- Improving sexual safety
- Reducing suicide and self-harm
- Reducing restrictive practice

The work programme for 2025 to 2027 includes continued support to these three Communities of Practice. The Alliance learning event on 3 October will include a session on the outputs from the work of these groups.

As part of the reducing restrictive practice workstream, each Alliance provider received an updated confidential report on their benchmarked use of restrictive practice following an audit of each provider. A themed regional report was also shared with the Alliance.

The fourth workstream from the 2023 to 2025 programme focused on the use of mechanical restraint in High Secure settings in England and Scotland. This work has been completed, and a confidential report has been shared with the High Secure providers and NHS England.

The focus for the 2025 to 2027 Patient Safety programme is on three new priorities:

- The development of a common safety framework
- The development of tools to support the reduction of the risk of physical health deterioration in severe mental illness
- A review with recommendations on the effective use of Physician Associates in Mental Health providers in the East Midlands

The Alliance Board in June had a deep dive into the work plan and next steps with the lead from Health Innovation East Midlands.

The common safety framework for the East Midlands Alliance will be developed by consensus and include common standards, common approaches and common domains. This would enhance rather than replace existing provider approaches and enable benchmarking and learning. The Board highlighted this as a key priority and one to develop with the Medical and Nurse Director forum.

The second new area of focus is on physical health deterioration for mental health patients. The Board discussed a potential alert system, a focus on obesity, inequity in access to weight loss support, the potential role of resident doctors and for Physician Associates with a focus on physical health.

The third new priority is a review of the use of Physician Associates in mental health in the East Midlands. Learning will be shared across the Alliance of the roles undertaken by Physician Associates, what has led to their successful deployment and any issues identified. The Board encouraged this part of the review to consider the value of the Physician Associate role alongside other alternative and new roles.

The work programme was also discussed and approved by the Alliance Medical and Nurse Director forum in July. Nominations have now been sought from the Alliance providers to participate in the new priorities. The Alliance Board agreed to receive quarterly updates on the Patient Safety programme.

Linked to this programme, the Alliance and Health Innovation East Midlands will share learning from the pilot sites for Martha's Rule in mental health.

6. Developing our workforce

6.1 Retaining and developing Clinical Support Workers and their managers

The Alliance has run a successful programme to support the development, retention and career aspirations of Clinical Support Workers. Across the Alliance there have been issues with the recruitment and retention of Clinical Support Workers. The Alliance secured significant external funding to run a shared package of development programmes.

The core programme is called Developing Healthcare Talent. It is complemented by a programme that works with the line managers of Clinical Support Workers, known as the Developing Healthcare Leaders programme. Over 400 staff have been through the programmes to date. Both courses have high completion rates, and the feedback has been very positive. Case studies for both programmes have been developed and shared nationally.

The Alliance will run six further cohorts of the core Clinical Support Worker development programme and six further cohorts of the Clinical Support Worker line manager development programme in 2025/26.

The HR Director forum has also agreed to establish a Community of Practice for the Clinical Support Worker line managers that have completed the development programme to provide on-going support and learning.

The HR Director network meeting in June heard feedback from all six Alliance providers on their use of funding in 2024/25 for local recruitment and retention activities focused on Clinical Support Workers.

The Alliance Board in June agreed to support a proposal from each Alliance provider to use some further Clinical Support Worker funding in 2025/26. The Alliance Board asked the HR Directors to run a further sharing of learning session in March 2026 focused on the various local activities undertaken this year.

6.2 Recruitment and Retention Payments and Golden Hello audit

The Alliance Board agreed to ask the HR Director network to run an update to the audit of special recruitment and retention payments in the East Midlands. This audit will be reviewed at the next HR Director network meeting and then shared with the CEO group.

6.3 Sharing learning on initiatives to tackle violence and aggression towards staff

The HR Director network agreed to run a learning workshop on programmes to address violence and aggression towards staff in the autumn.

7. Improving population health

7.1 Collective bed planning and piloting the CAMHS Day Care model

The Alliance Board has agreed to develop a case for change and Outline Business Case in relation to specialist and general mental health beds looking at opportunities to improve and localise care through joint action in the East Midlands. This work builds on recent bed reviews undertaken by the CAMHS and Perinatal regional Collaboratives.

The Alliance Boards in April and June received updates on work between the Strategy, Medical and Finance Directors on the opportunities for collective bed planning in relation to regional specialised services. The cross-profession bed planning group has met three times to consider opportunities to reduce Out of Area Placements and to bring care closer to home through a collective approach to planning how best to use the beds available across the Alliance footprint.

Potential changes to the use of beds are linked to the effective delivery of the CAMHS Day Care model. This is a new national approach to support Children and Young People through an enhanced Day Care model and to reduce the reliance on beds and inpatient admission. The Alliance Board and CEO meetings have agreed to pilot the Day Care approach in Leicestershire and Lincolnshire. The CEOs also agreed to prioritise Derbyshire as the next system for the Day Care roll out, based on the learning from the two pilots.

The next steps are to establish the Day Care pilots and to develop a case for change for the wider joint bed planning. There is further work to be undertaken through the lead providers for the Adult Eating Disorders, Perinatal and Children and Adolescent Mental Health collaboratives.

7.2 Long term funding of Specialist service models to move care closer to home

The Alliance Board has agreed to have a focus at the next meeting on a long-term funding model for CAMHS tier 3.5 services and the recurrent funding of the Waterlily programme in Adult Eating Disorders.

7.3 Regional Gambling Addictions service

The Alliance Board has reviewed plans and progress to increase the number of referrals to the regional Gambling Addictions service. The number and spread of referrals have increased as the actions have been implemented. The Alliance Medical and Nurse Director forum received a presentation from the Gambling Addiction service in July 2025.

7.4 Future Collaborative Hub provision

The Alliance CEOs have sponsored work to develop and implement a proposal for a single Collaborative Hub in the East Midlands and revised governance arrangements for the Collaborative and Alliance.

The Alliance Board in June reviewed the progress made by a small group of lead directors for the regional collaboratives in mapping out options for the future provision of hub support to those collaboratives. There are currently two hubs in the East Midlands, one providing support to the Impact Forensic collaborative, and the other supporting the CAMHS, Adult Eating Disorder and Perinatal collaboratives.

An NHS England commissioned independent review report into the Impact Forensic collaborative hub recommended that a single hub is developed for the East Midlands.

The Alliance Board welcomed the work that has been undertaken to consider how an improved and more responsive support service might be delivered through a new model, while reducing the overall cost, by removing duplication.

The CEOs asked that a fuller proposal is developed that responds to the advice of HR leads and includes a timetable for delivery. The CEOs also asked the same group to consider options to streamline the governance of the regional Collaboratives and the Alliance.

8. Reducing inequalities

8.1 Patient and Carer Race Equality Framework

The East Midlands Alliance has prioritised the sharing of learning and roll out of the Patient and Carer Race Equality Framework (PCREF). The Alliance will run a further PCREF forum in the autumn.

The Alliance has also been working with the national PCREF team to test approaches for the development of a national reporting template. As part of this work, the Alliance Board has

agreed to set relevant PCREF measures for each regional Collaborative and monitor the actions to improve them through the Alliance Board.

8.2 Women's Secure pathway

The Impact Forensic collaborative is working with the East Midlands ICBs to address the health inequalities experienced by women from the East Midlands by transforming the women's secure pathway.

8.3 Rolling out the Waterlily Eating Disorder support programme

The Adult Eating Disorder Collaborative will present proposals to recurrently fund the Waterlily programme in all counties of the East Midlands to the Alliance Board in September.

9. Regional mental health collaboratives

9.1 Op COURAGE in the East Midlands

Op COURAGE is an NHS service developed with people who have served in the Armed Forces and experienced mental ill-health. In the Midlands (East and West), Op COURAGE is delivered in partnership by Lincolnshire Partnership NHS Foundation Trust, Birmingham and Solihull Mental Health NHS Foundation Trust, Coventry and Warwickshire Partnership NHS Trust, St Andrew's Healthcare, Walking with the Wounded, The Ripple Pond, Tom Harrison House, and Mental Health Matters.

The Op Courage update to the June Alliance Board highlighted the waiting list for assessment that is increasing due to demand outstripping capacity each month. This is influenced by the number of referrals, vacancies and sickness levels.

The Op Courage services across England are under review by NHS England due to demand and capacity issues across the service in all areas. This has meant that the previously submitted business case for further investment has been put on hold. Local reviews to look at how the service can be delivered differently to meet demand within current capacity are ongoing.

9.2 Perinatal Collaborative

The specialist Perinatal collaborative for the East Midlands, led by Derbyshire Healthcare NHS Foundation Trust, is a partnership to deliver high-quality care for pregnant women and new mothers with serious mental illnesses who require admission to a Mother and Baby Unit, and to ensure seamless support between Mother and Baby Units and community perinatal mental health teams.

The Alliance Board in June received an update on plans for a further Perinatal Clinical and Professional Learning event in July. The Board also heard that both Perinatal providers had seen a decrease in occupancy levels in Quarter 4 of 2024/25.

9.3 Impact Forensic Collaborative

The Alliance Board in June received the Impact Annual Report and an update on the Forensic Collaborative that highlighted that there were 3,750 fewer occupied bed days in 2024/25 compared to 2023/24.

The Impact report explained that a new male low secure 10 bedded ward opened in June 2025 at St Andrew's. It also highlighted that the WEMMS service decommissioning has been extended by six months to September 2025.

The Alliance Board also noted a paper from the Impact Forensic Collaborative on Male Secure provision and Reach Out in the West Midlands using Male Secure beds at St Andrew's.

9.4 CAMHS Collaborative

The Alliance Board in June noted that a business case for the expansion of the Family Ambassador Programme into the CAMHS Enhanced Community offer was approved by the Collaborative Commissioning and Contracting meeting in May.

The Board also heard that the Enhanced Care Referral Team are now offering face to face access assessments in all areas of the East Midlands.

Admissions into CAMHS inpatient services reduced in Quarter 4 of 2024/25 in comparison to Quarter 3. The admission of patients on the Transforming Care cohort have decreased significantly in 2024-25 in comparison to 2023-24.

The Alliance Board restated their previous support for the prioritisation of Leicestershire as the first pilot site followed by Lincolnshire and Derbyshire.

9.5 Adult Eating Disorders Collaborative

The Alliance Board in June received an update on the increased inpatient activity and extra package of care costs. The Board asked to receive an updated Medium Term financial position at the Alliance Board in September. This will include plans to recurrently fund the Waterlily programme across the East Midlands.

9.6 Gambling Harm

The Alliance Board heard about the positive impact of work to increase and sustain referral numbers and the appointment of a new dedicated Communications Officer to focus on the broad promotion and coordination of all event and media engagement activities, improving awareness of the service to increase reach and ultimately new referrals.

10. Alliance communications and events

10.1 Alliance newsletter

A further quarterly newsletter was shared in late July. The newsletter provides headline information on stories of interest and refers readers to the Alliance website for further detail. The website (www.eastmidlandsalliance.org.uk) provides a hub for information about the Alliance and the provider collaboratives.

10.2 Alliance learning event

The Alliance Board agreed to hold a further Alliance learning event for the Boards of the Alliance providers on 3 October. The event will take place at the St Andrew's Healthcare site in Northampton. The event will include a focus on the work of the Patient Safety programme. Each CEO has been asked to nominate Board colleagues to be included in the invitation to the event.

11. Actions and recommendations

The Boards of the Alliance providers are asked to:

I. Note the Alliance Plan for 2025/26;

II. Note the progress made under each strategic objective;

III. Receive the updates from each regional mental health collaborative;

IV. Note the progress on Alliance communications and the plans for a wider Board event in October.

Attachments

a. Alliance Plan for 2025/26

East Midlands Alliance
for Mental Health, Learning Disabilities and Autism

Alliance Plan for 2025/26

Final version

July 2025

Enabling safe care

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

Priorities for 2025/26	Lead	Delivery date
We will develop a common Patient Safety framework	Patient Safety programme with HIEM reporting to the Medical and Nurse Directors	March 2026
We will develop tools to support the reduction of the risk of physical health deterioration in severe mental illness	Patient Safety programme with HIEM reporting to the Medical and Nurse Directors	March 2026
We will produce a review with recommendations on the effective use of Physician Associates in Mental Health providers	Patient Safety programme with HIEM reporting to the Medical and Nurse Directors	March 2026
We will continue to run a sexual safety Community of practice across inpatient wards in the East Midlands.	Patient Safety programme with HIEM reporting to the Medical and Nurse Directors	March 2026
We will continue to run a suicide and self-harm reduction community of practice in the East Midlands	Patient Safety programme with HIEM reporting to the Medical and Nurse Directors	March 2026
We will continue to run a restrictive practice reduction community of practice in the East Midlands	Patient Safety programme with HIEM reporting to the Medical and Nurse Directors	March 2026
We will share learning from the pilot sites for Martha's Rule in mental health	Pilots and HIEM	March 2026

Quality improvement and productivity

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

Priorities for 2025/26	**Lead**	**Delivery date**
We will work with the regional lead for the national Inpatient Quality Improvement programme.	Medical and Nurse Directors	March 2026
We will share our detailed cost improvement plans and update on delivery.	Chief Finance Officer forum	October 2025
We will share the early lessons and initial output from the Open Dialogue pilot in Lincolnshire across the East Midlands.	Lincolnshire Partnership	October 2025
We will hold an Alliance learning event for Board members at St Andrew's on 3 October.	Communications team	October 2025
We will establish a new Therapy leads forum to meet quarterly to share improvement and innovation activities.	Therapy leads	September 2025
We will develop and run a programme of workshops to share best practice on the application of the Mental Health Act. • Adult eating disorders • MHA reform part 1 update • Person-centred care and considerations • MH detention and statutory forms • Mental capacity and the Court of Protection • Perinatal mental health • CAMHS and detention	Northamptonshire Healthcare leading with Medical and Nurse Directors	December 2025

• CAMHS and eating disorders for under 18's • Digital considerations: AI technology, risk and regulation • Part III patients and the law • First-Tier Tribunal – procedural matters • Part IV of MHA – appropriate treatment and the role of professionals • Perinatal mental health • Complex presentations of veterans and related issues • Adult safeguarding and the law • First-Tier Tribunal masterclass – mock tribunal • MHA reform part 2 update There will also be bespoke Board sessions for each Alliance provider and a CEO session on the new Mental health Act in September 2025.		
We will establish a collective programme of work on medical job planning in mental health, fund local activity and share learning.	Leicestershire Partnership and Lincolnshire Partnership with the Medical Directors.	March 2026

Developing our workforce

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

Priorities for 2025/26	Lead	Delivery date
We will run six further cohorts of the core Clinical Support Worker development programme.	HR Director network	March 2026
We will run six further cohorts of the Clinical Support Worker line manager development programme.	HR Director network	March 2026
We will run one further cohort of the New Horizons programme for internationally recruited nurses.	HR Director network	July 2025
We will establish a Community of Practice for the Clinical Support Worker line managers that have completed the development programme to provide on-going support and learning.	HR Director network	October 2025
We will run a further set of local Clinical Support Worker recruitment and retention activities and share learning in March 2026.	HR Director network	March 2026
We will produce a bi-monthly workforce benchmarking report.	Nottinghamshire leading on behalf of the HR Director network	July 2025
We will re-run the RRP and Golden Hello audit in autumn 2025	HR Director network	October 2025
We will run a learning workshop on programmes to address violence and aggression towards staff	HR Director network	October 2025

Improving population health

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

Priorities for 2025/26	Lead	Delivery date
We will develop a case for change and Outline Business Case in relation to specialist and general mental health beds looking at opportunities to improve and localise care through joint action in the East Midlands.	Strategy, Finance and Medical Directors	September 2025
We will agree a long-term funding model for CAMHS tier 3.5 services.	CAMHS collaborative	September 2025
We will recurrently fund the Waterlily programme in Adult Eating Disorders.	AED collaborative	September 2025
We will deliver the East Midlands Provider Collaborative commissioning intentions for 2024-26	Impact collaborative	March 2026
We will increase the number of referrals to the new regional Gambling Addictions service.	Derbyshire leading with Medical and Nurse Directors	March 2026
We will develop and implement a proposal for a single Collaborative Hub in the East Midlands and revised governance arrangements for the Collaborative and Alliance.	Lead Directors for the Specialist collaboratives	March 2026
We will run a pilot against the national CAMHS Day Hospital specification and share learning. This will inform a plan to roll out similar provision linked to the existing Tier 3.5 model.	CAMHS collaborative	March 2026
The Alliance CEOs will work with the new ICB clusters to review opportunities for joint work, further delegation and the future commissioning of Specialist services	CEO group	March 2026

Reducing inequalities

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

Priorities for 2025/26	**Lead**	**Delivery date**
We will run a Patient and Carer Race Equality Framework forum for the East Midlands.	PCREF network	Meetings in September and February
We will work with the national PCREF team to test approaches for the development of a national reporting template.	PCREF forum	December 2025
We will agree a relevant PCREF measure for each regional Collaborative and monitor the actions to improve them through the Alliance Board.	Collaboratives and Alliance Board	September 2025
We will work with ICB's to address the health inequalities experienced by women from the East Midlands by transforming the women's secure pathway.	Impact and Strategy Directors	March 2026
We will work with the Medical and Nurse Director forum to increase awareness of the specialist services available, to review referral and decision to admit data and address any issues of apparent inequality.	Medical and Nurse Director forum	December 2025
We will recurrently fund Waterlily programme in all counties of the East Midlands - Adult Eating Disorders.	AED collaborative	September 2025

Integrated Performance Report

Purpose of Report

The purpose of the report is to provide a high level view of performance against a number of operational, financial, people and quality metrics, and to provide assurance regarding actions being taken to improve performance. The data period is up to the end of July 2025 for internal measures, and to the end of June 2025 where the data source is NHS England.

Executive Summary

Operational

Top three things to note from this report

1. **NHS oversight framework challenges:** these are new metrics in the report used by NHS England to league table NHS providers. **Crisis response:** the requirement is for patients referred as "urgent" to be seen face to face within 24 hours. The Trust is around 6% below the provider median for this metric. There are a number of process and system challenges to overcome in order to improve the reported position: 30% of referrals are early discharge patients who are referred to crisis but then remain on the ward for around two weeks before being discharged. Another 30% have known data quality issues, with staff incorrectly recording as an 'admin event' or recording the contact method as 'administration'. A performance improvement plan is in place. **Proportion of people waiting over 52 weeks for community services:** 65% of children waiting have been waiting over 52 weeks, which is a significant outlier: The majority of these long waits are for Community Paediatrics. This is a known area of significant challenge and has been widely reported to Board and commissioners over several years. A performance improvement plan is in place to slow the growth of the waiting list through optimising existing resources, and also to address the other service with long waits which are for children's physiotherapy. **Acute inpatients with discharged with a length of stay of 60 plus days:** length of stay is around 6% higher than the provider median. Delays to discharge of patients who are clinically ready for discharge is having some impact on lengths of stay of 60 days plus (1.5%). An acute flow performance improvement plan is in place. **Children and young people accessing mental health services:** This is a measure of the annual change in the number of children and young people accessing mental health services. The Trust's position reduced by 1.1% compared with the previous year, which placed in the lowest 25% of providers. The national median was an increase of 5.4%. The reason the Trust appears to be performing badly this year compared with 12 months ago is the time limited waiting list initiative, which increased the volume of people seen and effectively reduced the waiting list and waiting times. With the introduction of this new metric the service has now become a victim of its own success, with current performance being measured against waiting list initiative performance. This financial year in order to cut waiting times the ICB has invested in CAMHS. This is recurrent investment and is the first year of a three-year service improvement programme. The investment will enable recruitment of more children and young people's mental health practitioners, with the aim of reducing waiting times to four weeks over the course of the programme and will positively impact on the access metric.
2. **High performing areas:** the areas where a consistently high level performance can be seen include access to perinatal mental health services, individual work placement support access, children and young people eating disorder referral to treatment waiting times, inpatient discharges followed up within 72 hours, dementia diagnosis, and adult ASD assessments completed per month.

3. **Challenging areas:** the other areas where standards are not currently being achieved include inappropriate out of area placements (July 25), early intervention referral to treatment, the adult ASD assessment waiting list (although the Trust continues to significantly exceed the commissioned activity level), and the mental health helpline performance against speed of answering calls, and proportion of calls abandoned. Performance improvement plans have been formulated for the most challenging areas and are summarised in the main body of the report. There are also some problems with the quality/functioning of clinical space as part of the Making Room for Dignity build which have led to temporary bedroom closures.

Financial

At the end of July there is an overall deficit of £1.9m, which has been adjusted for the Private Finance Initiative (PFI) adjustment related to the International Financial Reporting Standards (IFRS) 16 accounting change, bringing the adjusted financial position to a deficit of £1.7m, 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.

People

High performing areas: the areas where targets are consistently achieved include annual appraisals, completion of compulsory training, and the annual turnover rate.

Challenging areas: the areas where performance is most challenging include sickness absence, and completion of clinical and management supervision.

Quality

High performing areas: the areas where targets are consistently achieved include the number of compliments being received, and the rate of restrictive interventions per 1,000 bed days.

Challenging areas: the areas where performance is most challenging include inpatients who are clinically ready for discharge, annual care plan reviews of patients on the Care Programme Approach, incidents of moderate to catastrophic harm, the use of restrictive interventions and falls on inpatient wards.

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 a more detailed view of performance over time as it enables the differentiation between common cause and special cause variation.

Consultation

Versions of this report have been presented to the Trust Delivery Group and the Finance and Performance Committee.

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:

- This report reflects performance related to the Trust's service portfolio. Therefore, any decisions that are taken as a result of the information provided in this report are 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. For example, as parts of the report relate specifically to access to Trust services, it will need to be ensured 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 any further assurance is required.

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

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Derbyshire Healthcare
NHS Foundation Trust

Integrated Performance Report

OPERATIONAL PERFORMANCE

Deputy Chief Executive/ Chief Delivery Officer:
Vikki Ashton Taylor

Responsible Committee: **Finance & Performance Committee**

Executive Summary

Inflow

- **Percentage of patients in crisis to receive face-to-face contact within 24 hours:** NHS England have introduced this metric this financial year which is a measure of the proportion of urgent referrals made to crisis teams and mental health single points of access who were seen face to face within 24 hours. In the latest data the Trust achieved 57%, against the provider median of 58%. For adult single points of access this is a major practice change, as the operational policy has always stipulated a response time of 48 hours for urgent referrals, owing to the service being classed as planned care and not an urgent or crisis provision. A recovery action plan is in place with compliance expected from November 2025.
- **Mental health Helpline:** From official statistics in development that have been published by NHS England[1], the Trust's mental health helpline is reported as performing less favourably when compared with other providers: Proportion of calls answered within 60 seconds: DHcFT 57%, National 70%. Average speed to answer calls: DHcFT 78 seconds, National 206 seconds (standard = 20 seconds). Proportion of answered calls abandoned after call steering IVR[2]: DHcFT 50%, National 25%. Demand on the helpline has been increasing through various extensions of the service offer over the last 3 years to include Street Triage, Mental Health Response Vehicle, shift to include mental health related activity from 111 (helpline now being the NHS 111 Mental Health Option 2) and Right Care Right Place (RCRP) as well as still providing the original service from when the line was established which includes urgent care and mental health wellbeing support. Despite the significant evolution of changes and demand on the helpline all of this has come without any additional funding. A recovery action plan is in development.

Outflow

- **Inappropriate out of area adult acute placements:** although there has been a significant reduction from a high of 28 back in January, to the current position of 8, the requirement for placements remains higher than desired. However, the new male PICU for Derbyshire is now open (July 25) and all the new wards are in operation, which should further positively impact. Inappropriate out of area placements to reduce to 3 or less by September 2025
- **Proportion of inpatients discharged with 60 days plus length of stay:** For length of stay, in the latest data published by NHSE, 29% of adult and older adult acute inpatients discharged from trust beds had a length stay of 60 days or more. The national median was 25% and the threshold for the lowest 25% of providers was 21%. It is important to note that the average length of stay of the current adult acute inpatients is 60 days, with 50 patients (30%) having a length of stay over 60 days at the time of writing. This means that when these long stayers get discharged over future months the reported position is likely to get worse before it can start to get better. The new build adult acute inpatient units are now open in Chesterfield and Derby, as well as the male PICU in Derby. The units 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.
- **Three day follow-up:** the national standard for follow-up continues to be exceeded.
- **Average length of stay for adult acute, older adult and PICU mental health beds:** length of stay continues to be inflated by delayed discharges. The average length of stay to discharge ready was below target at 49.7 days. A comprehensive recovery action plan is in place with a recovery is expected by end September 2025.

[1] Access to crisis care via NHS 111 - Mental Health, June 2025 - NHS England Digital

[2] IVR = interactive voice response

Elective/access

- **Women accessing specialist perinatal mental health service**: increasing numbers of women are being supported by the service, which now ranks 2nd highest in the region against the national access standard.
- **Adult autistic spectrum disorder assessment (ASD):** activity levels exceed the commissioned target, however waiting times remain high at around 56 weeks, with demand far exceeding capacity. Negotiations continue with the Integrated Care Board around a new model of service delivery.
- **Community waits over 52 weeks:** waiting times continue to grow month on month owing to ongoing pathway issues and high levels of demand exceeding capacity by 38% in paediatrics. A recovery action plan is being developed in conjunction with the ICB to reduce the speed of growth of the waiting list. This metric relates to people waiting for children's community health services (not mental health). The services provided by the Trust are community paediatrics, physiotherapy, occupational therapy, looked after children team, and nursing & therapy support for long term conditions. In the latest data published by NHSE (June 25), 65% of people have been waiting over 52 weeks for Trust services. This is significantly higher than any other organisation. The vast majority of the long waits are neurodevelopmental referrals to community paediatrics. Community Paediatricians at DHCFT are specialist medical professionals responsible for assessing and managing the developmental, behavioural, and physical health needs of children and young people (CYP), particularly those with complex or long-term conditions. Community Paediatricians are central to the assessment of children with suspected Autistic Spectrum Disorder (ASD), Attention Deficit Hyperactivity Disorder (ADHD), and other neurodevelopmental conditions. They participate in multidisciplinary triage and diagnostic pathways, particularly for children under 5 with complex developmental presentations. As has been regularly reported to Trust Board, demand has exceeded commissioned capacity in this service for many years, resulting in lengthening waits to be seen. The expected demand for neurodevelopmental services based on population is 115 assessments per month, and this is the basis upon which the service is commissioned. An average of 116 assessments per month are being completed, and so the service is slightly exceeding contractual expectations, however demand far exceeds this level, with an average of 357 referrals per month being received. There is ICB reluctance to increase commissioned capacity, as the driver for demand is not health, but is education. Traditionally schools were required to follow a graduated response, with school educational psychologists undertaking triage and assessment in the first instance, and schools providing pastoral support. However, for schools that have become academies this is not a requirement. As a result the number of educational psychologist roles has reduced significantly, and academies refer directly to health without any triage. In addition, for children with educational healthcare plans (EHP) schools are given money for additional support. This has resulted in a 40% increase in EHP referrals. To support recovery the Trust has introduced neurodevelopmental hubs, working with the community to triage cases much earlier on upstream. This is having a positive impact and has reduced the average number of new referrals received to around 250 per month in recent months.
- **Early intervention in psychosis:** the early intervention services assess people who are suspected of experiencing a first episode pf psychosis. The national standard is to undertake an assessment within two weeks of people being referred into the service (target 60%). Historically the target has consistently been exceeded, but since April 2025 the target has not been achieved. From February to May 2025 the volume of referrals received increased by 36% compared with the same period in 2024, which directly correlates with the service moving from a compliant to non-compliant position with the assessment standard. It is not clear at present what is driving the increase in referrals into the service. A recovery action plan is in place with anticipated recovery by December 2025.
- **Adult Autism Spectrum Disorder (ASD) assessment**: At the end of July there were 1356 adults waiting for ASD assessment, with an average waiting time of 56 weeks and a longest wait of 127 weeks. The service is commissioned to undertake 26 assessments per month but receives around 95 referrals a month, which explains why the waiting list is so significant. However, the new model of assessment that was devised and implemented resulted in a significant increase in the number of assessments that could be completed within commissioned resources, and for the last 19 months the waiting list has been reducing month on month. The National Institute for Health and Care Excellence (NICE) recommend a maximum wait of three months (13 weeks)

from referral to assessment[3]. To get to that position with no increase in commissioned capacity the waiting list would need to reduce to around 219 people. Extrapolating the waiting list data into the future indicates that if the same level of reduction continues, this position will be reached in 23 months' time.

- **Children and young people mental health access:** This financial year NHS England have introduced a new metric which is a measure of the annual change in the number of children and young people accessing mental health services. In the latest published data the Trust's position had reduced by 1.1% compared with the previous year, which placed in the lowest 25% of providers. The national median was an increase of 5.4%. The reason the Trust appears to be performing badly this year compared with 12 months ago is that the service implemented a time limited waiting list initiative which increased the volume of people seen and effectively reduced the waiting list and waiting times. With the introduction of this new metric the service has now become a victim of its own success, with current performance being measured against waiting list initiative performance.

Month	Apr-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
C&YP mh 1 plus contact	3045	3495	3535	3485	3475	3415	3415	3430	3425	3420	3455	3470	3485	3455	3465
Change v 12 months ago		14.78%	16.28%	10.11%	7.25%	4.27%	2.86%	2.39%	1.63%	0.29%	0.00%	0.00%	0.29%	-1.14%	-1.98%

From the data above, it can be seen that the level of contacts reduced between August 2024 and December 2024, therefore it is expected that the year on year comparison position will significantly improve from August 2025.performance has remained significantly high since December 2023, however when benchmarked against peers the annual increase in activity is lower than others, placing the Trust in segment 3. A recovery action plan is to be developed.

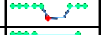
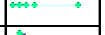
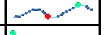
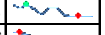
Collaboratives

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.

[3] Quality statement 1: Diagnostic assessment by an autism team | Autism | Quality standards | NICE

NHS
Derbyshire Healthcare
NHS Foundation Trust

OPERATIONAL KEY PERFORMANCE INDICATORS

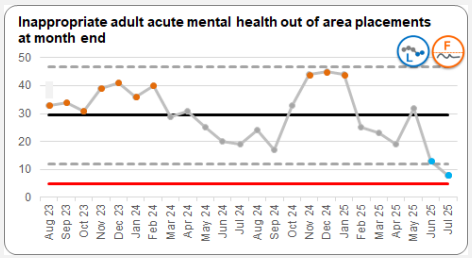
Measure	Target	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	
Long term plan 2025/26														
Inappropriate adult acute mental health out of area placements at month end**	5	24	17	33	44	45	44	25	23	19	32	13	8	
Women accessing specialist perinatal mental health services (rolling 12 months)*	1242	1195	1220	1250	1290	1310	1300	1300	1305	1305	1310	1390		
Perinatal access rate (ICB)*	10%	11.2%	11.4%	11.7%	12.0%	12.3%	12.1%	12.1%	12.2%	12.3%	12.2%	12.5%		
Individual work placement support access (rolling 12 months)*	690	705	695	700	675	665	660	700	715	715	715	745		
Average length of stay for adult acute, older adult & PICU mental health beds	55	55	50	52	58	62	65	67	66	63	59	64	61	
NHS oversight framework 2025/26														
Proportion of people waiting over 52-weeks for community services*	0%	46%	43%	48%	50%	56%	58%	61%	63%	62%	64%	65%		
Children and young people accessing NHS-funded MH services - annual change*	5.7%	4.3%	2.9%	2.4%	1.6%	0.3%	0.0%	0.0%	0.3%	-1.1%	-2.0%	0.6%		
Proportion of acute inpatients discharged with 60 days plus length of stay	20%	15%	18%	18%	25%	25%	24%	27%	23%	21%	18%	31%	33%	
Percentage of patients in crisis to receive face-to-face contact within 24 hours*	70%	44%	39%	32%	42%	44%	44%	47%	53%	57%	50%	49%		
Key operational measures														
Children & young people eating disorder routine referrals seen within 4 weeks*	95%	100%	100%	100%	100%	100%	94%	95%	95%	100%	100%	100%		
Children & young people eating disorder urgent referrals seen within 1 week*	95%	100%	100%	100%	100%	#N/A	#N/A	#N/A	#N/A	#N/A	100%	#N/A		
Inpatient discharges followed up within 72 hours	80%	84%	94%	91%	90%	80%	92%	87%	88%	90%	89%	90%	87%	
Dementia diagnosis rate (ICB)*	68%	68.5%	68.6%	68.8%	69.0%	68.9%	68.4%	68.5%	68.8%	69.0%	69.3%	69.2%	68.9%	
Early intervention in psychosis 2 week waits from referral to treatment - complete	60%	100%	84%	68%	92%	71%	54%	76%	65%	56%	47%	43%	37%	
Early intervention in psychosis 2 week waits from referral to treatment - incomplete	60%	94%	83%	100%	77%	53%	81%	80%	56%	48%	46%	46%	50%	
Adult ASD assessment – number of people waiting at month end	219	1858	1889	1821	1685	1596	1709	1602	1495	1472	1399	1382	1356	
Adult ASD assessment – average wait (weeks)	18	57	55	56	58	60	54	54	57	55	56	54	56	
Adult ASD assessment – number of assessments completed per month	26	88	77	93	85	61	75	93	67	59	55	61	64	

*Data source = NHS England

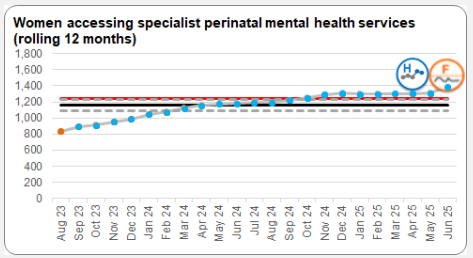
** measure includes adult acute and PICU placements

OPERATIONAL KEY PERFORMANCE INDICATORS – STATISTICAL PROCESS CONTROL CHARTS

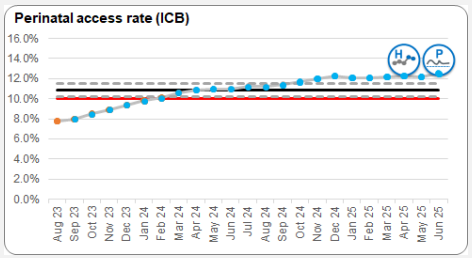
Inappropriate adult acute mental health out of area placements at month end



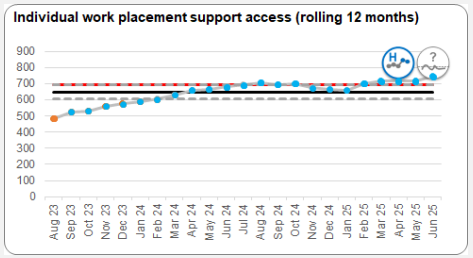
Women accessing specialist perinatal mental health services (rolling 12 months)



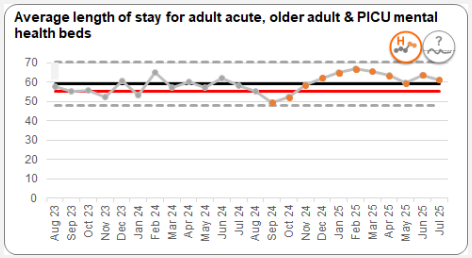
Perinatal access rate (ICB)



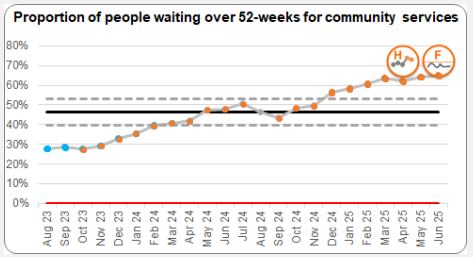
Individual work placement support access (rolling 12 months)



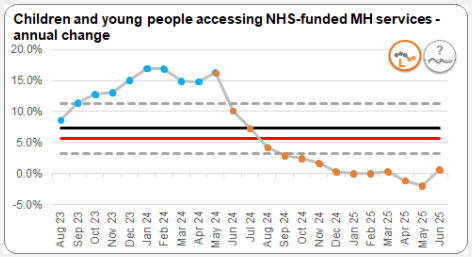
Average length of stay for adult acute, older adult & PICU mental health beds



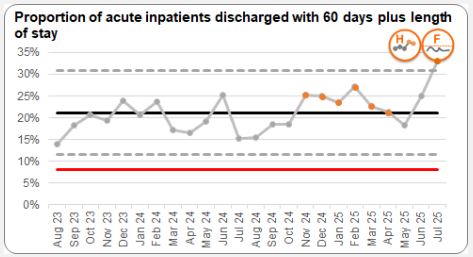
Proportion of people waiting over 52-weeks for community services



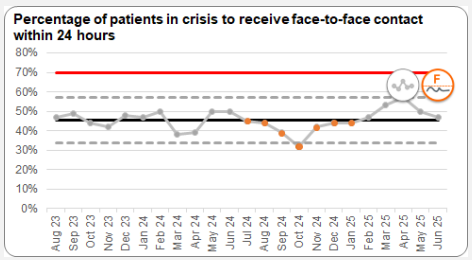
Children and young people accessing NHS-funded MH services - annual change



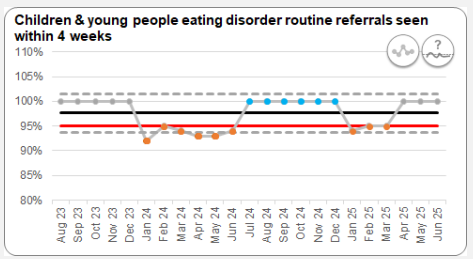
Proportion of acute inpatients discharged with 60 days plus length of stay



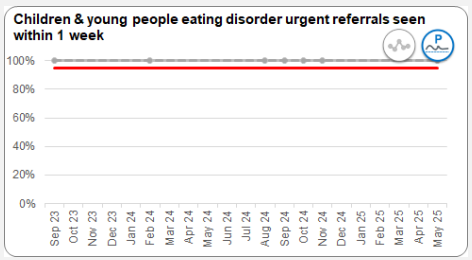
Percentage of patients in crisis to receive face-to-face contact within 24 hours



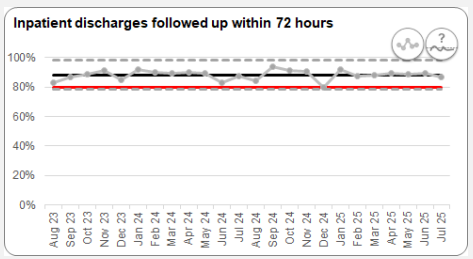
Children & young people eating disorder routine referrals seen within 4 weeks



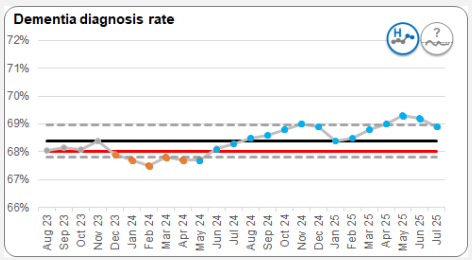
Children & young people eating disorder urgent referrals seen within 1 week



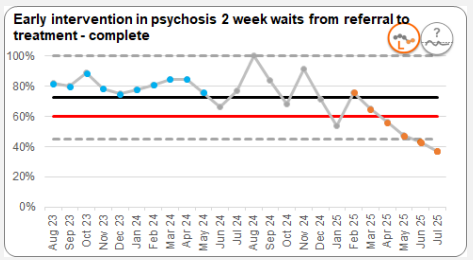
Inpatient discharges followed up within 72 hours



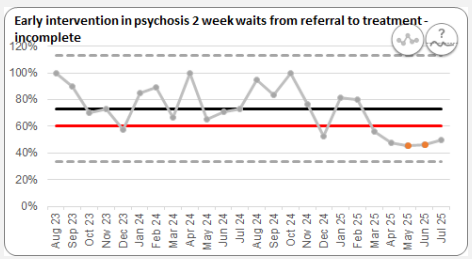
Dementia diagnosis rate



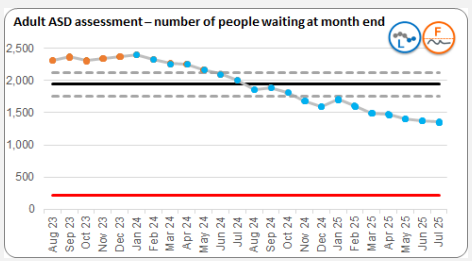
Early intervention in psychosis 2 week waits from referral to treatment - complete



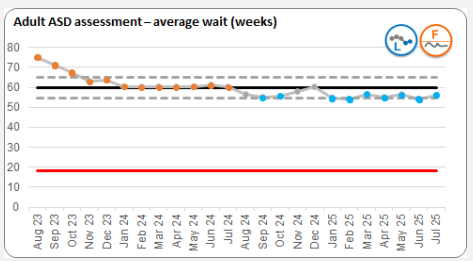
Early intervention in psychosis 2 week waits from referral to treatment - incomplete



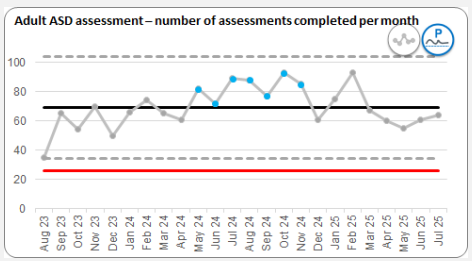
Adult ASD assessment – number of people waiting at month end



Adult ASD assessment – average wait (weeks)



Adult ASD assessment – number of assessments completed per month



TRANSFORMATION AND IMPROVEMENT

The Transformation and Improvement Portfolio is supporting achievement of improved performance across a number of measures across the IPR with key updates below.

FLOW PATHWAY

National Planning Priority 2025-25: Reduction of adult acute mental health inappropriate out of area placements

DHcFT Operational Planning Assumption 2025/26: Phased reduction of adult acute inappropriate out of area placements aligned to agreed trajectory for 2025/26

Interventions:

A rapid improvement plan is in delivery for the Flow Pathway applying 30/60/90 day improvement methodology to assess, implement, and scale improvements in a measurable and sustainable way with interventions across the 'end to end' pathway:

Pathway	Work stream
Inflow	1. Admission review form and process
	2. Safety Huddles and MaST (Digital tool) application
Inflow and Flow	3. Operational management and controls
Flow	4. Purposeful admission and 72hr review
	5. Rapid review (Red2Green) evaluation
	6. Inpatient leave protocol
Outflow	7. Clinically ready for discharge
Enabling	8. Data
Strategic	9. 'End to end' pathway

Opportunities for further intervention to support improvement are being considered through the JUCD Men-SAT review supported by the NHSE Mental Health Improvement Support Team, with their formal report recently received. We are also fully engaged with the new Midlands Learning and Improvement Network, through which there is a focus on shared learning to deliver improved length of stay.

The final work stream above is supporting the development of a strategic programme to improve our 'end to end' care pathways and processes across Inflow, Flow and Outflow ensuring every person who needs acute mental health care receives timely access in, or close to, home.

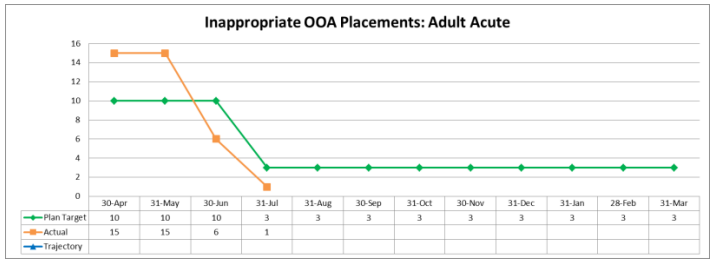
Action is currently focused on design of a strategic approach for integration and localisation of services in alignment with the 10 Year Health Plan ambition to transform mental health services into 24/7 neighbourhood care models, the Men-SAT report, and new Operating Model to be implemented in September.

A workshop approach is to be implemented, applying intelligence and insights in development of the model, pathway and strategic Inflow implementation plan for delivery from Q4 and into 2026-27.

Impact:

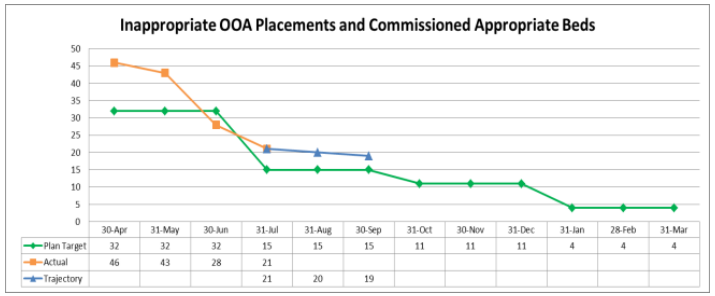
Delivery of the improvement trajectory over April and May was impacted by delays against the anticipated opening dates of both acute units and associated transitional challenges requiring operation within a more limited bed base.

Accelerated focus through the rapid improvement plan has supported recovery, with the OOA position on 31 July at 3, below the month end trajectory of 1. This position has since further improved to zero at 13 August 2025.



Focus for the next plan period is on further reducing long length inpatient stays aligned to the opportunity identified through the Model Hospital benchmarking system and supporting sustainability of the inappropriate OoA position at zero.

The Operational Plan ambition that follows achievement of zero OOA placements in phased withdrawal from the privately commissioned beds. A revised trajectory was agreed for this, reflecting delays against the anticipated opening dates across the new units. The revised trajectory was achieved at end July 2025 with ongoing action to further reduce beds over Q2.



TRANSFORMATION AND IMPROVEMENT

The Transformation and Improvement Portfolio is supporting achievement of improved performance across a number of measures across the IPR with key updates below.

COMMUNITY AND CRISIS

National Planning Priority 2025/26: Various as set out below

DHcFT Operational Planning Assumption 2025/26: Defined for individual metrics as below

Interventions:	**Impact:**
Metric: Access standards for Mental Health Helpline An improvement plan is in place comprising operational, improvement, and transformational solutions over 11 work streams that include: One access point though 111 mental health option and closure of the 0800 number; Addressing technical telephony system issues; Demand and capacity modelling; Developing the professional line; Enhanced data reporting through SystmOne; Resolution of NHSE data reporting; Resourcing of helpline and Mental health response vehicle; Triage process; High intensity users: and design of the strategic service model.	**Metric: Access standards for Mental Health Helpline** Phased recovery: • Phase 1 – Operational and technical issues by 1st Nov-25 • Phase 2 – Service model (to incl. demand and capacity modelling) and staffing by 1 April 2026 • Trajectory chart in development for next version IPR.
Metric: People in mental health crisis seen face to face within 24 hours For crisis services an improvement plan is in place comprising operational, improvement and transformational solutions over eight work streams that include: Accurate triage and logging; Consistent overnight staffing; Review of triage functions; Modelling of demand and capacity; Streamlining administrative tasks; Weekly cross check meetings; Development of data reporting for emergency duty; Digital pilot for use of ambient voice technology. For community services a plan is in design to include revision of the standard operating procedure for response to urgent referrals; and development processes for review and correction of referral urgency level to drive accurate data capture.	**Metric: People in mental health crisis seen face to face within 24 hours** • Recovery anticipated by November 2025. • Trajectory chart in development for next version IPR.
Metric: Early intervention in psychosis two week referral to treatment An improvement plan is in place comprising operational, improvement and transformational solutions over eight work streams that include: Enhanced operational controls and breach analysis to inform learning and improvement action; Demand and capacity modelling; Workforce review; Pathway development in partnership with crisis service with potential prescribing before assessment and diagnoses; Review of assessment and allocation processes; and Review of flow along the pathways with the aim of ensuring effective deployment of all available capacity within the service.	**Metric: Early intervention in psychosis two2 week referral to treatment** • Recovery anticipated by December 2025. • Trajectory chart in development for next version IPR.

TRANSFORMATION AND IMPROVEMENT

The Transformation and Improvement Portfolio is supporting achievement of improved performance across a number of measures across the IPR with key updates below.

ELECTIVE ACCESS

National Planning Priority 2025/26: Various as set out below

DHcFT Operational Planning Assumption 2025/26: Defined for individual metrics as below

Interventions:	**Impact:**
Metric: Waits over 52 weeks for community services Neurodevelopmental hubs have been established working with community services for earlier upstream triage. This is delivering positive impact, reducing the average number of new referrals received to around 250 in recent months. An improvement and transformation plan is in design to further address the imbalance to include: 1. Addressing the referral pathway and reviewing processes with all partners. 2. Enhancing internal efficiency and productivity through optimisation of assessment processes and workflows. 3. Exploring options to increase capacity through recruitment, partnership and alternative workforce/ service models.	**Metric: Waits over 52 weeks for community services** The quantifiable impact of each action in the recovery action plan below is currently being developed up and will inform the trajectory and timescale for improvement. This will be included within and tracked via future versions of the IPR.
Metric: Children and young people accessing community mental health services Performance against the new oversight framework metric measuring contacts vs 12 months prior has been impacted a time limited waiting list initiative in 2024/24 which successfully reduced the backlog through additional capacity that was not subject to recurrent funding. Current performance is being measured against waiting list initiative performance and this will correct from August 2025. Following submission of a business case to expand capacity in routine CAMHS services through reducing wait times, enhancing timely access, improving service flow, and increasing participation, the ICB has recently committed £0.986k in recurrent system development funding to DHcFT in order to expand capacity within routine CAMHS services.	**Metric: People in mental health crisis seen face to face within 24 hours** Annual issue with comparative capacity will correct from August 2025. Agreed investment will support achievement of a four to six week waiting period for comprehensive assessment and an additional four to six weeks to access care coordination or treatment by February 2027. Trajectory chart in development for next version IPR.
Metric: Adult autistic spectrum disorder assessment service The service is commissioned to deliver 26 assessments per month but receives around 95 referrals with demand outstripping capacity. A new model has been implemented to increase productivity and volume of assessments that can be completed within commissioned resources, and for the last 19 months the waiting list has been reducing month on month. Digital solutions to further improve productivity and the volume of assessments that can be delivered within current capacity are currently being explored.	**Metric: Adult autistic spectrum disorder assessment service** Trajectory is on track to achieve national standard for referral to assessment within 3 months (13 weeks) in 23 months' time. Trajectory chart in development for next version IPR.

TRANSFORMATION AND IMPROVEMENT

The Transformation and Improvement Portfolio is supporting achievement of improved performance across IPR measures through collaboration with key updates below.

JOINED UP PATHWAYS AND SERVICES: EAST MIDLANDS ALLIANCE

National Planning Priority 2025/26: Various as set out below

Interventions:	Impact:
East Midlands IMPACT Collaborative St Andrews has been issued with a CQC Notice of Proposal for civil enforcement action. All 'placing' commissioners have been notified in line with the request from NHSE. In 2024/25 a small surplus was achieved. Financial stability for providers and reconfiguration of services to balance demand and capacity is an ongoing priority for 2025/26. Women's Enhanced Medium Secure Service decommissioning is extended by 6 months until September 2025. Proposals with respect to male medium secure capacity remain under discussion by the Chief Executive Group.	**East Midlands IMPACT Collaborative** There is a reducing IMPACT inpatient population and despite increases in the general population of the region, fewer people per capita are being hosted in secure care now since the PC started in 2020. In 2024/25 there were 3,750 less occupied bed days than the prior year. A new male low secure 10 bedded ward opened on 1 June at St Andrews to support shift of activity from Part 1 providers to Part 2.
East Midlands CAMHS Collaborative The Patient Safety Incident Investigation following an unexpected patient death at St Andrews on 27 October 2024 is ongoing. Safeguarding reviews are delayed whilst the incident is out with Police. Reduced capacity within GAU units to admit patients requiring NG feeding is resulting in this cohort waiting longer to be admitted with placement outside natural clinical flow being considered. A task and finish group is developing a day service specification with the aim of piloting a service in the East Midlands in line with the draft commissioner guidance.	**East Midlands CAMHS Collaborative** The Enhanced Care Referral Team is now offering face to face access assessments across the East Midlands and a six month review has been completed with next steps agreed to consolidate progress. A business case for the expansion of the Family Ambassador Programme into the CAMHS Enhanced Community offer was approved by the Collaborative on 7 May.
East Midlands AED Collaborative Due to increased inpatient activity and extra package of care costs a new risk has been raised relating to the potential in year deficit position and availability of funding for Waterlily and other transformation into 26-27. The LPT procurement timeline for new AED services has been delayed with an associated risk of reputational damage as this will delay proposed service opening dates. The patient admitted as a result of the bespoke procurement remains admitted at Cygnet Ealing but the commissioning of the placement has now been handed over to Derby and Derbyshire ICB. They remain in long term segregation with minimal progress on exit plans. The report from the learning event to review this patient's pathway has been submitted and recommendations are being progressed through the Clinical Reference Group.	**East Midlands AED Collaborative** The new Cygnet Elowen Hospital in Shipley, Derbyshire is due to open in Q2, increasing the number of AED beds within the EM. Following increased incidents in NG feeding, Welford senior nursing staff received NG training from University Hospital of Leicestershire to facilitate a train the trainer programme. All nursing staff have now been trained/retrained and are going through a new sign off process.
East Midlands Perinatal Provider Collaborative There are no performance or quality concerns for escalation. Interim mitigations are in place with regards to high room temperatures at The Beeches whilst awaiting installation of air conditioning. Both units have seen a decrease in admissions and occupancy levels in Q4. Variation between units noted within the baseline bed assessment continues to be the focus of clinically led discussions with consideration via the upcoming learning event.	**East Midlands Perinatal Provider Collaborative** Focus remains on continuous improvement of services and action agreed following the successful clinical learning event in January has been progressed with a further event focused on improving referral processes across the two units scheduled for July 2025.
East Midlands Gambling Harm Service DHcFT is still awaiting confirmation of additional service funding in line with recent changes associated with the gambling levy-based revenue. Whilst there are active considerations for expanding the service in line with NHSE proposals, clarity is required on the available funding envelope to inform plan development The improvement action plan implemented to support the increase in referrals and overall service activity has now concluded with the service making progress across all domains including increasing referral numbers, improving referral retention, enhancing service accessibility, and strengthening recovery support.	**East Midlands Gambling Harm Service** A dedicated Communications Officer has been secured in post until March 2026. The role will continue to focus on the broad promotion and coordination of all event and media engagement activities, improving awareness of the service to increase reach and ultimately new referrals.
Operation Courage Midlands The service currently has a waiting list for assessment that is increasing due to demand outstripping capacity month on month. The OpCourage services across England are under review by NHSE due to demand and capacity issues across the service in all areas. As a result the previously submitted business case for further investment has been put on hold.	**Operation Courage Midlands** The partnership continues to receive positive feedback from NHSE in relation to the development of pathways and the transparent and collaborative approach to addressing challenges.

FINANCIAL PERFORMANCE

Director of Finance:
James Sabin

Responsible Committee: **Finance and Performance Committee**

Executive Summary

Overall

At the end of July there is an overall deficit of £1.9m, which has been adjusted for the Private Finance Initiative (PFI) adjustment related to the International Financial Reporting Standards (IFRS) 16 accounting change, bringing the adjusted financial position to a deficit of £1.7m, 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 July efficiencies delivered to the plan of £4.09m. The forecast assumes the full efficiency plan is met in full.

Agency

Agency expenditure at the end of July is £0.9m, which equates to 1.5% of the total pay expenditure, and is below plan by £0.2m. Forecast agency expenditure is £3.0m which is below plan by £0.5m. The two highest areas of agency usage continue to relate to consultants and nursing staff.

Adult Acute Out of Area Placements

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 July expenditure was above plan by £1.4m. The forecast assumes an improving trajectory, with expenditure forecast to be above plan by £4.7m.

Capital Expenditure

At the end of July capital expenditure was below plan against both the system capital allocation by £0.9m. Capital expenditure is forecast to spend in full by the end of the financial year.

Cash

Cash at the end of July is at £25.8m which is higher than plan by £6.1m due to the timing of receipts but is forecast to be on plan at £25.4m by the end of the financial year. There are no concerns in relation to debt recovery.

Better Payment Practice Code

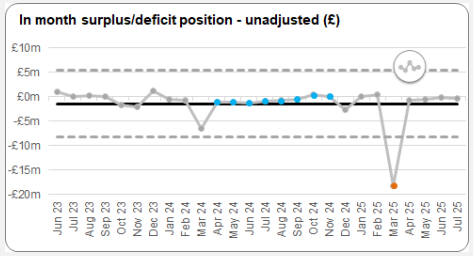
The Better Payment Practice Code (BPPC) sets a target for 95% of all invoices to be paid within 30 days. BPPC is measured across both invoice value and volume of invoices. At the end of July, both the value and volume of invoices exceeded the target at 99.0% and 97.6% respectively.

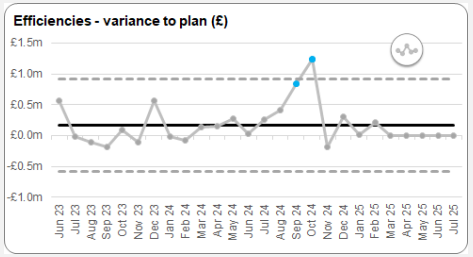
Derbyshire Healthcare NHS Foundation Trust

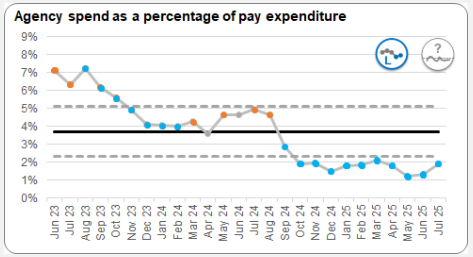
FINANCIAL KEY PERFORMANCE INDICATORS

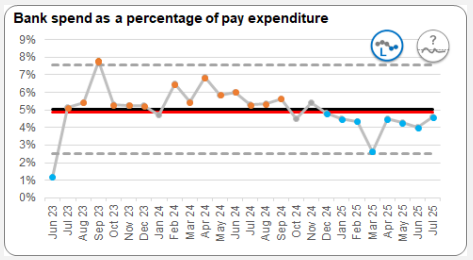
Measure	Target	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	
Financial Performance														
In month surplus/deficit position - unadjusted (£)	-	-£ 733,285	-£ 474,924	£ 352,759	£ 105,217	-£ 2,657,992	-£ 27,320	£ 505,698	-£ 18,160,011	-£ 759,497	-£ 618,647	-£ 181,431	-£ 356,503	
Efficiencies - variance to plan (£)	-	£ 419,265	£ 845,205	£ 1,244,087	-£ 192,100	£ 307,496	£ 11,618	£ 209,050	£ -	£ -	£ -	£ -	£ -	
Agency spend as a percentage of pay expenditure	3.7%	4.6%	2.8%	1.9%	1.9%	1.5%	1.8%	1.8%	2.1%	1.8%	1.2%	1.3%	1.9%	
Bank spend as a percentage of pay expenditure	4.9%	5.4%	5.6%	4.5%	5.4%	4.8%	4.5%	4.4%	2.6%	4.5%	4.3%	4.0%	4.6%	
Adult acute out of area expenditure (£000)	-	£ 675	£ 488	£ 666	£ 1,095	£ 1,012	£ 1,062	£ 889	£ 654	£ 799	£ 1,110	£ 977	£ 839	
Capital expenditure variance to plan (£)	-	-£ 356,000	£ 654,000	£ 2,260,000	£ 1,304,000	-£ 1,047,000	-£ 1,969,000	-£ 3,798,000	-£ 6,307,000	-£ 953,000	-£ 1,907,000	-£ 107,000	-£ 333,000	
Better Payment Practice Code (BPPC) by volume	95%	97.1%	97.3%	97.4%	96.9%	97.0%	96.9%	97.0%	97.6%	97.6%	97.2%	97.5%	97.6%	
Better Payment Practice Code (BPPC) by value	95%	97.3%	97.6%	97.9%	97.3%	97.4%	97.7%	97.7%	99.8%	98.2%	98.4%	98.7%	99.0%	
Cash (£000)	-	£ 21,063	£ 19,286	£ 26,380	£ 34,412	£ 31,559	£ 26,415	£ 24,296	£ 19,071	£ 20,204	£ 17,589	£ 17,175	£ 25,805	
Liquidity (days)	-	-18	-16	-17	-13	-19	-23	-25	-12	-13	-14	-19	-16	
NHS oversight framework 2025/26														
Planned surplus/deficit year to date - adjusted (£)	£ -	-£ 3,764,046	-£ 4,213,227	-£ 4,773,453	-£ 5,228,326	-£ 5,540,510	-£ 5,813,263	-£ 6,154,302	-£ 6,383,704	-£ 643,118	-£ 1,289,243	-£ 1,442,742	-£ 1,714,677	
Variance year to date to financial plan - adjusted (£)	tbc	-£ 43,203	£ 149,187	£ 1,289,294	£ 2,066,357	-£ 52,346	£ 420,664	£ 1,466,422	£ 6,384,643	£ 26,588	£ 43,183	£ 76,791	£ 63,671	
Relative difference in costs	<100%								93.76%					

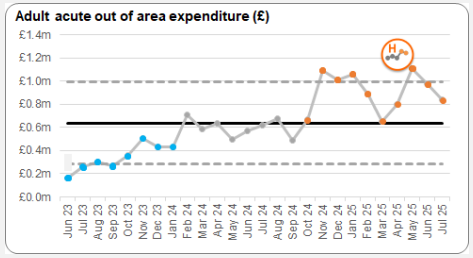
FINANCIAL KEY PERFORMANCE INDICATORS – STATISTICAL PROCESS CONTROL CHARTS

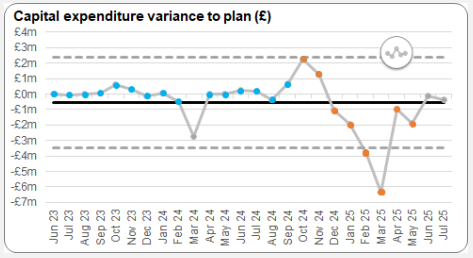


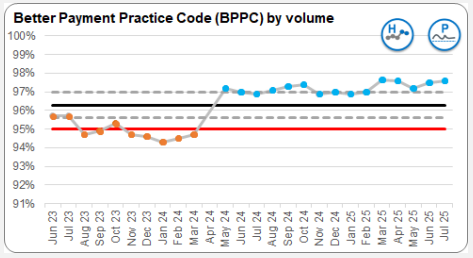


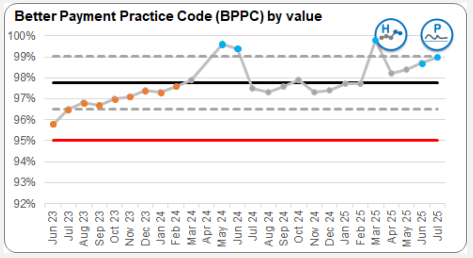


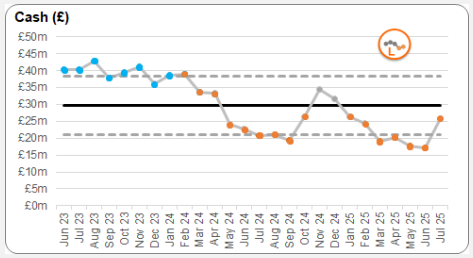


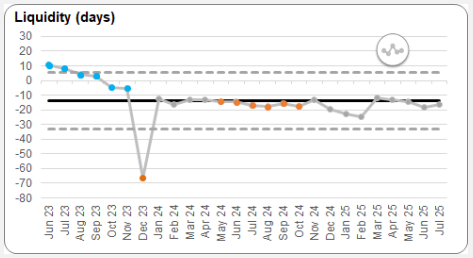


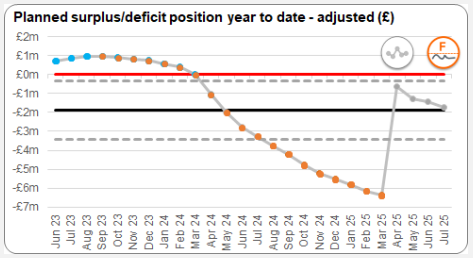


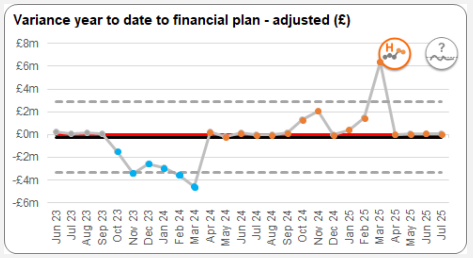


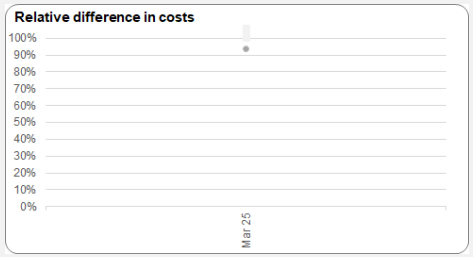




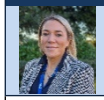








PEOPLE PERFORMANCE



Director of People, Organisational Development and Inclusion: **Rebecca Oakley**

Responsible Committee: **People and Culture Committee**

Executive Summary

Update

Annual appraisals: compliance continues to remain high at 91% and has surpassed the 90% Trust target. Compliance within Corporate services has improved during the last two months and is above the 90% target. Efforts continue to address both appraisals that are out of date and those coming up for renewal.

Annual turnover: this continues to remain in line with national and regional comparators and has remained below the Trust's 12% upper tolerance for the last year.

Compulsory training: overall, the 85% target has been achieved for the last two years. Compliance remains high at 94% which has been achieved for the last three consecutive months.

Annual sickness absence rate: this is running at 5.66%, a reduction of 0.09% compared to the previous reporting period. Anxiety, stress or depression related illness remains the highest reason for sickness absence, followed by Surgery and other musculoskeletal problems. 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.

Filled posts: at the end of July, 90% 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.

Agency usage: this 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.

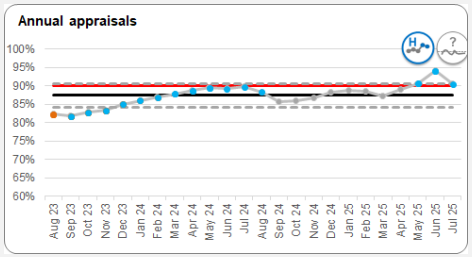
Supervision: compliance continues to remain a challenge in both clinical supervision at 82% and management supervision at 86%. Efforts continue to work with Teams with low compliance and rates are expected to increase over the coming months.

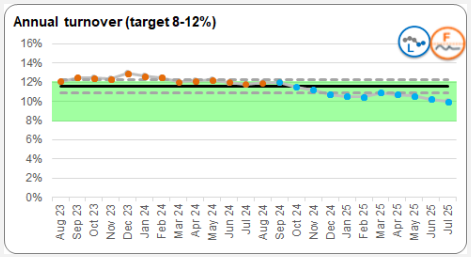
NHS
Derbyshire Healthcare
NHS Foundation Trust

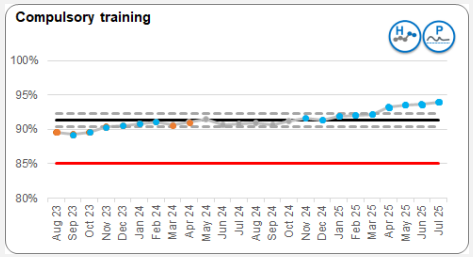
PEOPLE KEY PERFORMANCE INDICATORS

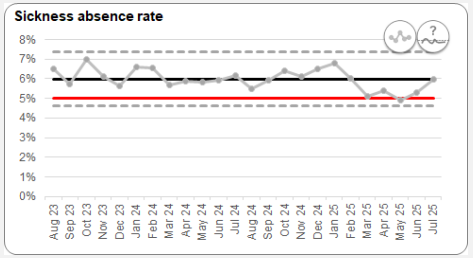
Measure	Target	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	
People Performance														
Annual appraisals	90%	88%	86%	86%	87%	88%	89%	89%	87%	89%	91%	94%	91%	
Annual turnover (target 8-12%)	12%	12%	12%	11%	11%	11%	11%	10%	11%	11%	11%	10%	10%	
Compulsory training	85%	91%	91%	91%	92%	91%	92%	92%	92%	93%	94%	94%	94%	
Filled posts	100%	88%	86%	85%	85%	86%	87%	88%	88%	88%	89%	89%	90%	
Bank staff use	5%	5.7%	5.3%	5.4%	5.2%	5.4%	4.3%	4.5%	4.4%	4.5%	4.0%	4.1%	3.9%	
Agency staff use	1.9%	1.1%	1.1%	1.0%	0.7%	0.6%	0.6%	0.7%	0.7%	0.3%	0.4%	0.3%	0.4%	
Management supervision	100%	84%	85%	85%	85%	87%	87%	86%	86%	84%	85%	86%	85.9%	
Clinical supervision	100%	81%	84%	84%	85%	85%	85%	84%	83%	81%	83%	82%	81.5%	
NHS oversight framework 2025/26														
Sickness absence rate	5%	6.3%	6.9%	7.9%	7.4%	8.0%	8.1%	7.3%	6.1%	6.4%	5.9%	5.3%	6.0%	
NHS Staff Survey - raising concerns sub-score	7.0	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8	
NHS staff survey engagement theme score	7	7.23	7.23	7.23	7.23	7.07	7.07	7.07	7.07	7.07	7.07	7.07	7.07	
National Education and Training Survey overall satisfaction score (C.)	76.2%	79.5%	79.5%	79.5%	79.5%	78.9%	78.9%	78.9%	78.9%	78.9%	78.9%	78.9%	78.9%	

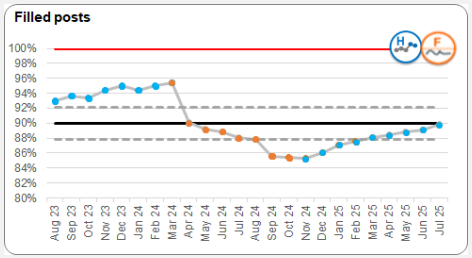
PEOPLE KEY PERFORMANCE INDICATORS – STATISTICAL PROCESS CONTROL CHARTS

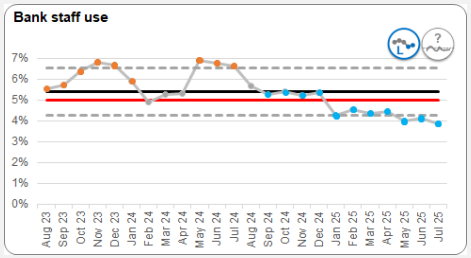


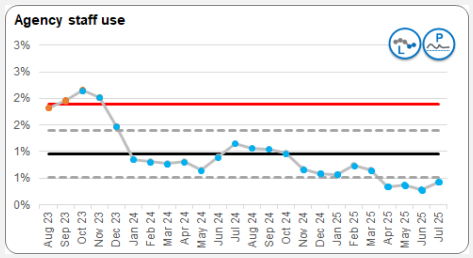


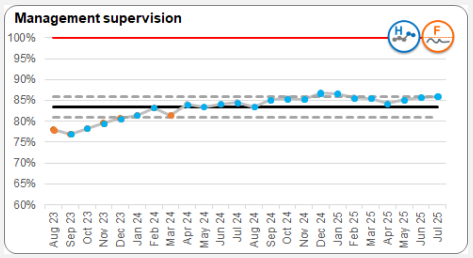


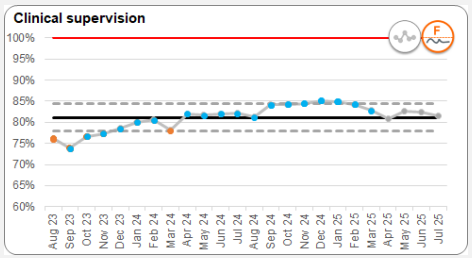


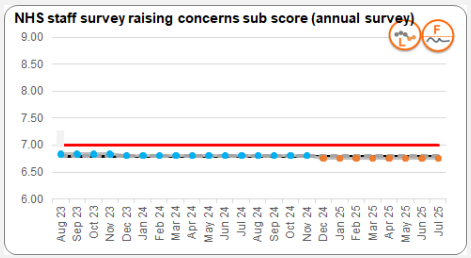


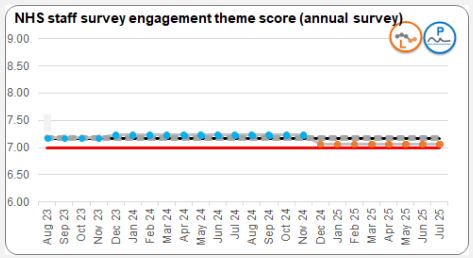


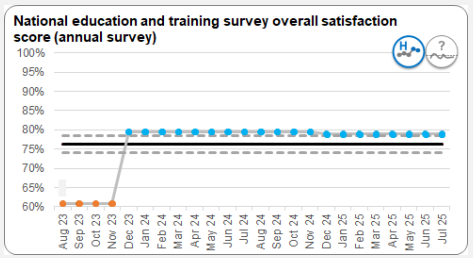












QUALITY PERFORMANCE

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

Responsible Committee: **Quality and Safety Committee**

Executive Summary

Update

Quick resolution (QR) complaints: remain within acceptable limits, though an increase has been seen due to a resolution of a backlog of complaints.

Closer look (formal investigations): are below mean and stable. Themes continue to be monitored and escalated through governance committees.

Clinically ready for discharge (CRfD): common cause 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 programme approach (CPA): current compliance is steady at 79% against a 95% target. However, with the exclusion of inpatient services where CPA is not routinely updated, the figure is 88%. Due to a combination of vacancy and long term and short term sickness within services, improvements have not been made as quickly as expected however, targeted improvement plans and weekly “cross check” meetings are underway and Digital support is being provided to support the accuracy of recording and the improvements made since January 2025 have been sustained.

Medication safety incidents: following a pattern of common cause variation. Low harm incidents dominate, particularly in temperature monitoring. Ongoing task and finish group, monthly incident reviews, competency assessments, and governance reporting continue to support safe practice.

Moderate/catastrophic harm incidents: increased trajectory over past three months due to sustained reporting linked to self-harm in Adult and Older People’s services. The increase in incidents has also been influenced by the opening of the Enhanced Care Unit (ECU) and Psychiatric Intensive Care Unit (PICU) in July 2025 and a number of incidents relating to high temperatures in the Perinatal ward. As temperatures fall the incident reports related to high temperatures are expected to reduce.

Restrictive practices

- **Prone restraint:** above Trust margin (12 incidents); related to opening of ECU and PICU in July 2025
- **Physical restraint:** above margin (45 incidents); continued to follow a pattern of common cause variation and margin to be reviewed in relation to opening of ECU and PICU in July 2025
- **Seclusion episodes:** remain above threshold (14), influenced by new seclusion facility at Derwent Unit and opening of ECU and PICU in July 2025. Margin to be reviewed in light of this.

Falls Incidents: still above margin but decreasing. Mostly minor/no harm. Linked to frailty, ward occupancy and multiple incidents linked to 1 unwell individual and the numbers are expected to fall following identification of specialist placement. Individual risk management plans, use of bed sensors, and biweekly reviews with shared learning in place to support reduction of numbers.

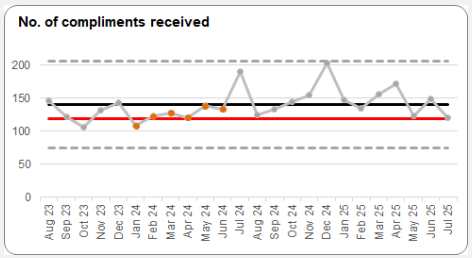
Care hours per patient day: below national averages: 9.34 hours vs. national 11.5. This includes lower figures for both registered nurses (3.86 vs. 3.9) and support workers (5.22 vs. 7.5), indicating staffing challenges.

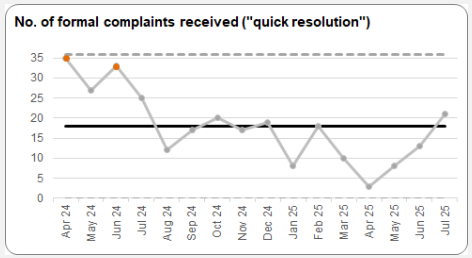
NHS
Derbyshire Healthcare
NHS Foundation Trust

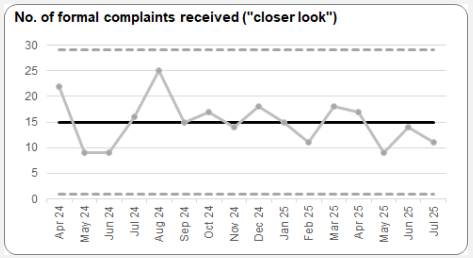
QUALITY PERFORMANCE INDICATORS

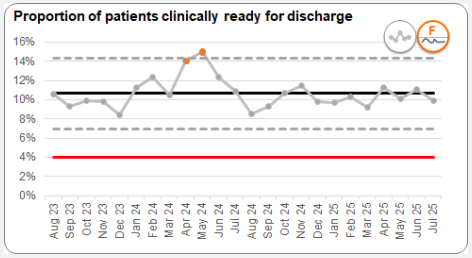
Measure	Target	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	
Quality performance														
No. of compliments received	119	125	134	145	155	203	148	135	157	172	124	149	120	
No. of formal complaints received ("quick resolution")		12	17	20	17	19	8	18	10	3	8	13	21	
No. of formal complaints received ("closer look")		25	15	17	14	18	15	11	18	17	9	14	11	
Proportion of patients clinically ready for discharge	4%	8%	9%	11%	11%	10%	10%	10%	9%	11%	10%	11%	10%	
Proportion of patients on CPA >12 months who have had their care plan reviewed	95%	70%	72%	74%	75%	74%	72%	77%	76%	80%	80%	78%	79%	
Patients who have their employment status recorded as "in employment"		12%	11%	12%	12%	12%	12%	12%	12%	12%	12%	12%	12%	
Patients who have their accommodation status recorded as "settled"		48%	48%	49%	49%	49%	48%	47%	47%	48%	49%	49%	50%	
Number of medication incidents		86	49	55	45	71	62	55	92	69	63	71	95	
No. of incidents of moderate to catastrophic actual harm	48	47	45	68	67	57	59	63	51	66	56	76	91	
No. of incidents requiring Duty of Candour	1	1	1	0	1	0	0	0	1	0	1	1	1	
No. of incidents involving prone restraint	12	10	5	19	8	8	5	8	14	7	5	10	14	
No. of incidents involving physical restraint	46	80	64	103	92	52	67	114	103	65	73	81	114	
No. of new episodes of patients held in seclusion	14	16	17	14	10	14	9	9	25	14	20	8	18	
No. of falls on inpatient wards	30	39	39	37	39	40	22	36	40	45	37	58	38	
NHS oversight framework 2025/26														
Rate of restrictive interventions use per 1000 bed days (data source: NHSE)	19	12	8	11	12	7	6	12	8	4	5	2		
Community mental health survey satisfaction rate (out of 10)	6.7	6.50	6.50	6.50	6.50	6.50								
CQC safe inspection score (if awarded within the preceding 2 years)		not applicable - last rated in 2019												

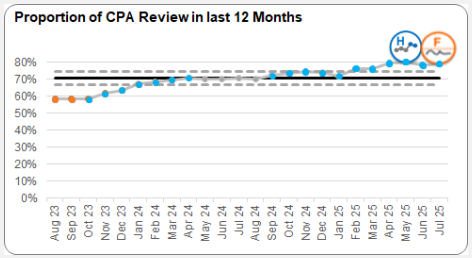
QUALITY KEY PERFORMANCE INDICATORS – STATISTICAL PROCESS CONTROL CHARTS

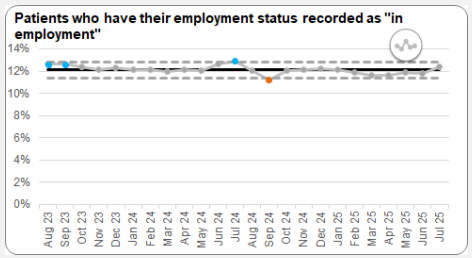


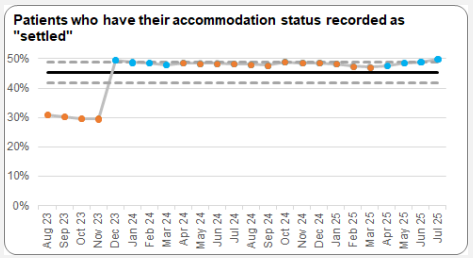


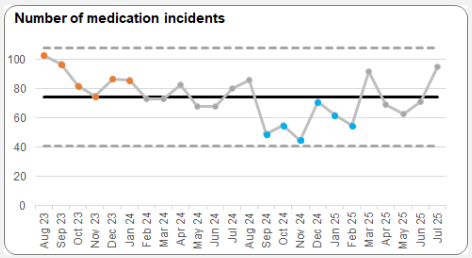


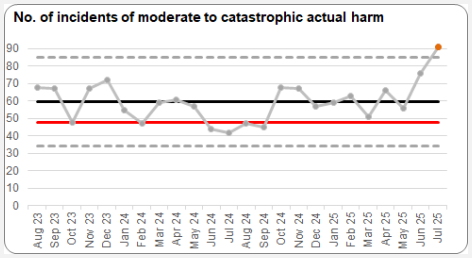


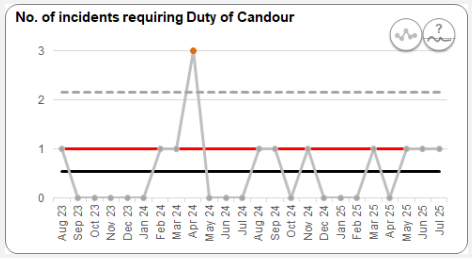


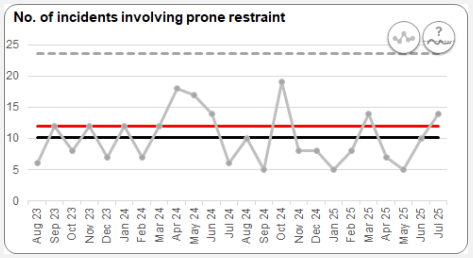


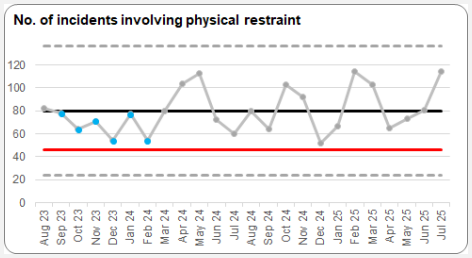


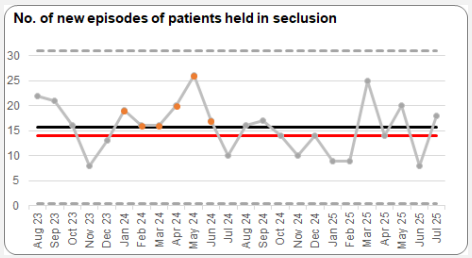


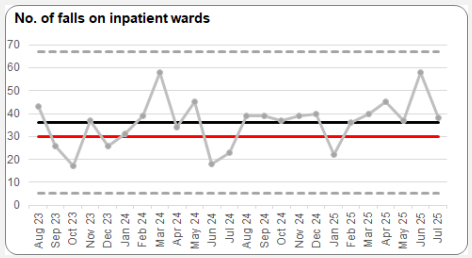


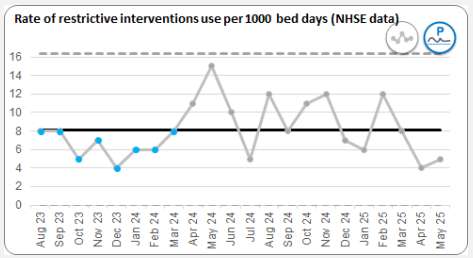


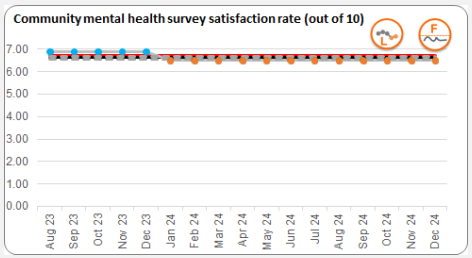








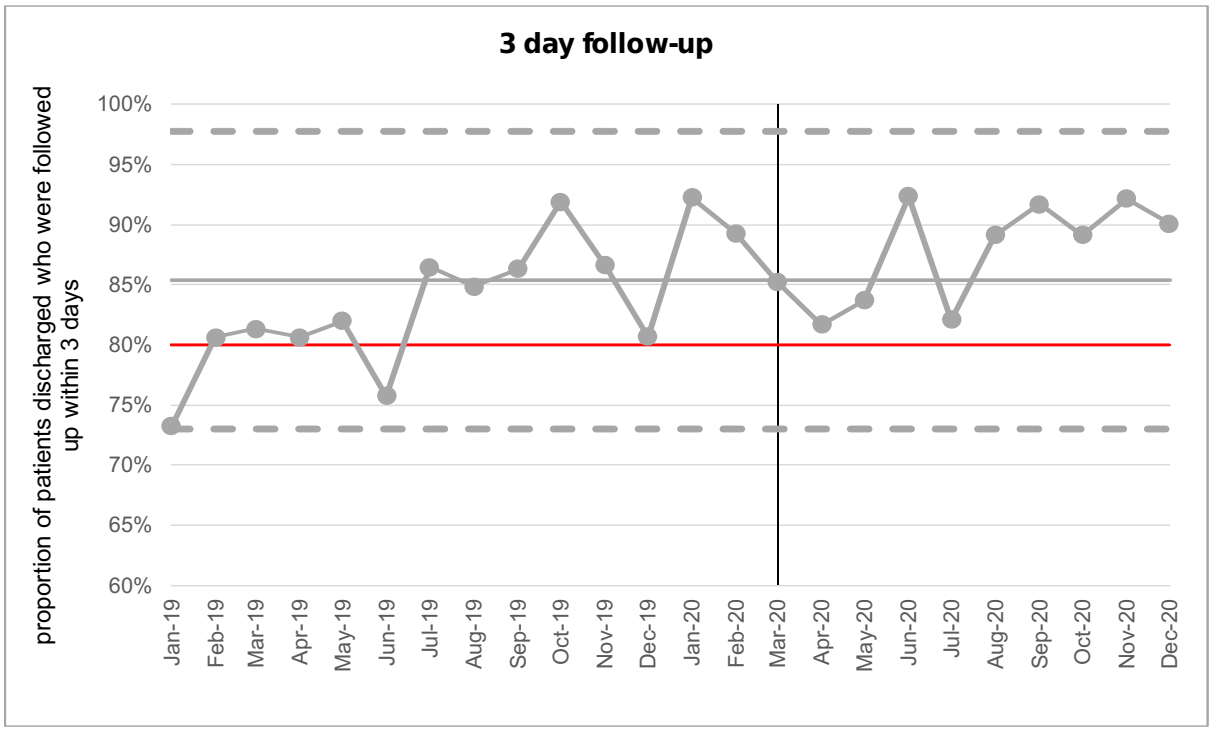




Appendix 1

Statistical Process Control Chart (SPC) Guidance

Example SPC chart:



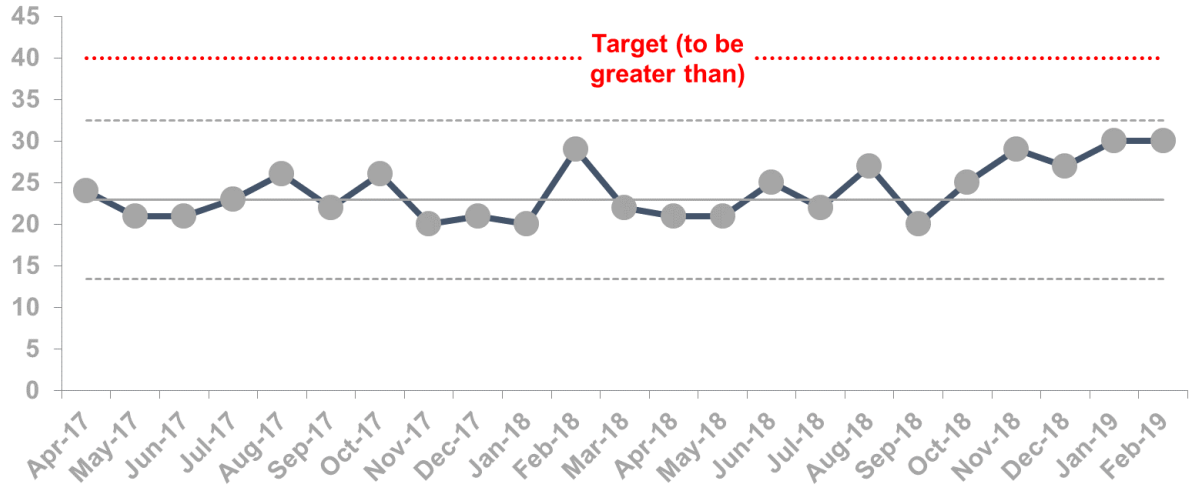
- The red line is the target
- The grey dots are the actual performance each month. They are coloured grey as performance each month is normal in this example
- The solid grey line is the average (mean) of all the grey dots
- The grey dotted lines are called process limits, or control limits.

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.

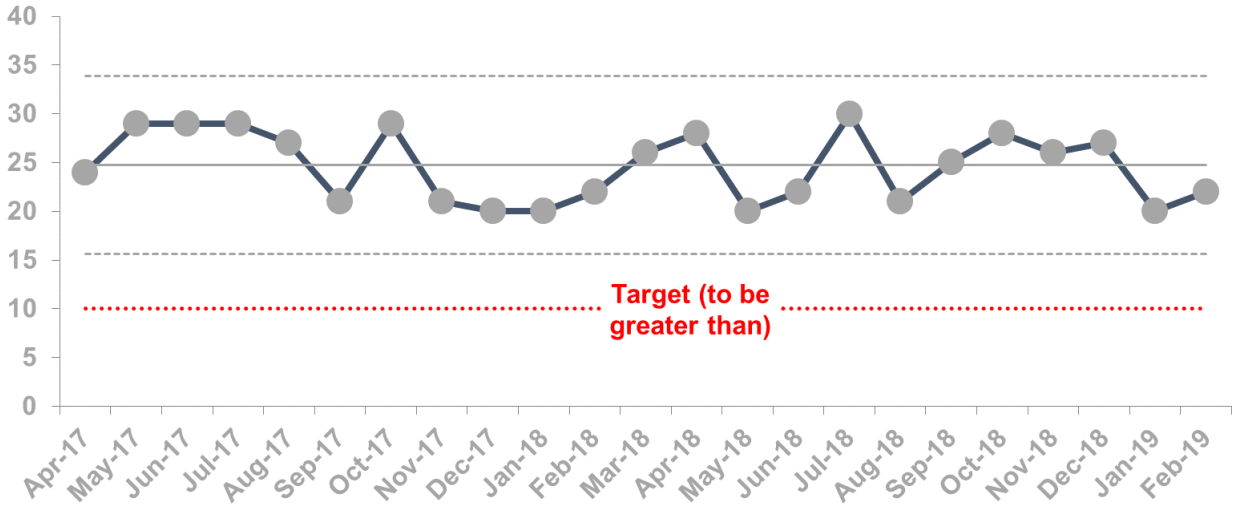
Things to look out for:

1. A process that is not working:



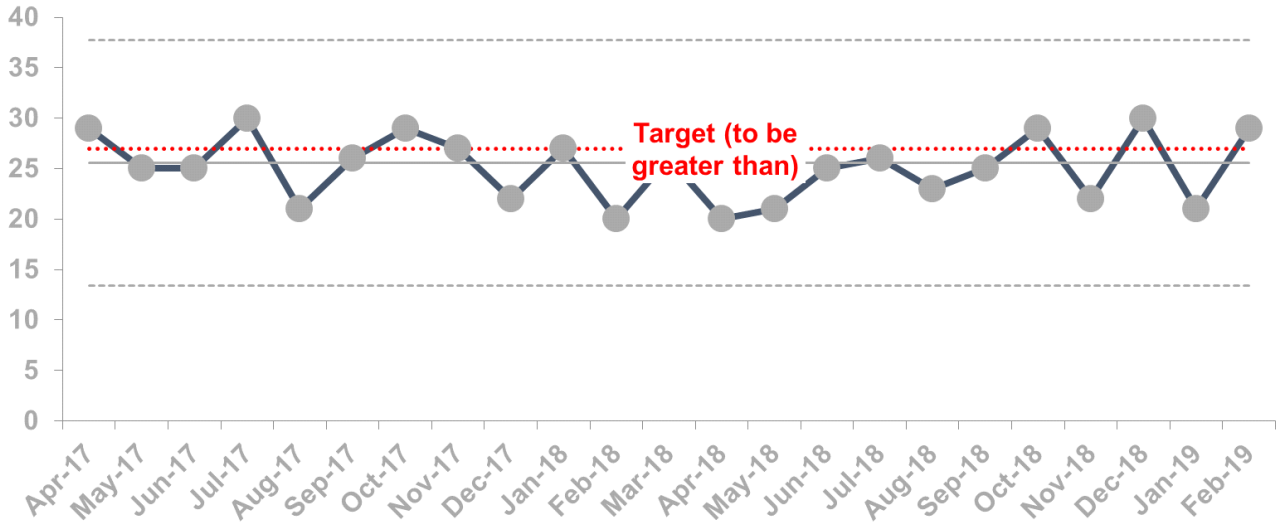
In this example the target is higher than the upper dotted grey line. This means that the target will never be achieved. To achieve the target, we need to change how we do things.

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:

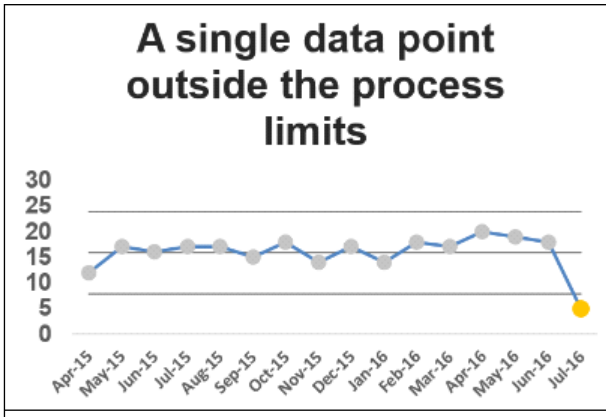
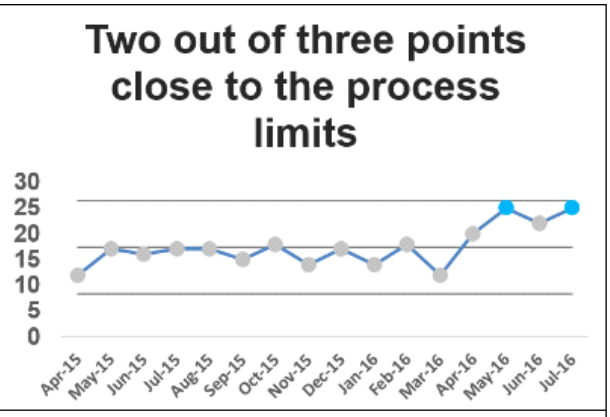


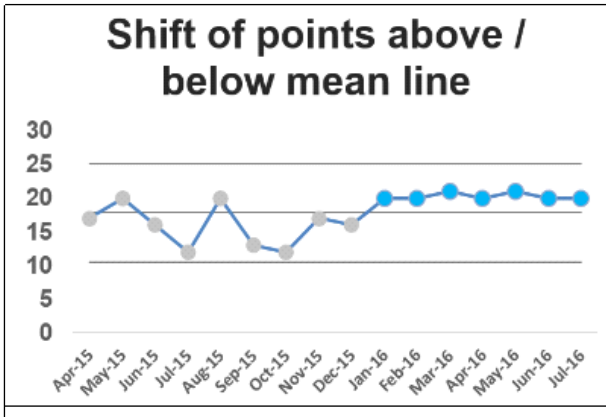
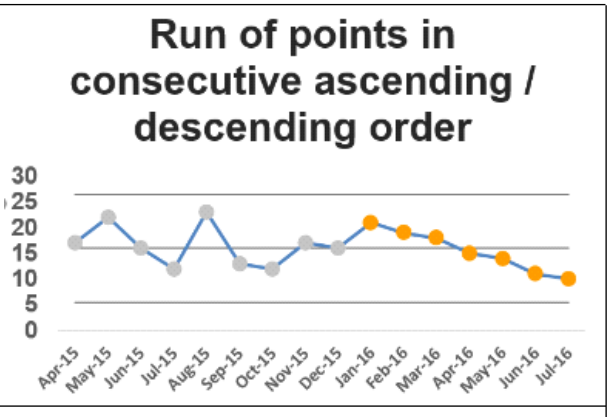
In this example, the target line sits between the two grey dotted lines. As it is normal for the grey dots to fall anywhere between the two dotted grey lines, this means that it is entirely random as to whether or not the target will be achieved. So, this system is unreliable and needs to be redesigned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

	
In this example the July 2016 perfomance is significantly lower than expected and falls beneath the lower grey dotted line.	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.

	
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.	A run of seven points in consecutive ascending or descending order is significant. In this example things are getting worse over time.

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.

Emergency Preparedness, Resilience and Response (EPRR) annual report and Core Standards

Purpose of Report

To provide an update on the EPRR Core Standards compliance and submissions for 2024/25. It will outline the progress made within the EPRR portfolio and identify the ongoing actions to further improve and develop within the next three years.

In addition to this, the EPRR and Business Continuity Policy has been included for ratification. There are no changes in the document, just merging of two policies together. This is a requirement of the core standards for sign off at a senior level.

Executive Summary

This annual report highlights the 10 domains within the EPRR Core Standards and provides a summary of progress throughout 2024/25. This year has proved challenging with a number of incidents, planned events and exercises. It has seen an increased the level of embedding business continuity within the Trust through local services exercises. The team has been requested to support with regional and national working groups to review and update EPRR guidance documents.

The spreadsheet has been completed, however, it is not easy to read. Therefore, the report is split into each domain and provides an outline of key areas. Where the four partials remain, additional narrative has been provided. The 360 Audit Assurance report has just been finalised and received with a significant assurance outcome.

The Trust has made significant progress in embedding business continuity within its services. This year we have ensured that teams complete a service specific exercise to test their local processes, and this has identified a number of lessons for teams locally. As a result of this, local business impact analysis and business continuity plans have been reviewed and learning incorporated.

The below provides an overview against the current compliance for the August submission.

As a Trust we are measured against the following domains:

- Governance [100% fully compliant]
- Duty to risk assess [100% fully compliant]
- Duty to maintain plans [80% fully compliant]
- Command and control [100% fully compliant]
- Training and exercising [100% fully compliant]
- Response [100% fully compliant]
- Warning and informing [100% fully compliant]
- Co-operation [100% fully compliant]
- Business continuity [100% fully compliant]
- HazMat/Chemical, Biological, Radiological and Nuclear (CBRN) [80% fully compliant].

Based on actions completed, documents ratified and signed off it is anticipated that only four standards will remain partial compliance. This would continue with a **substantial compliance** rating, with remaining standards completed by December 2025. This is caveated with the EPRR team capacity to complete required actions finalise plans and documents as required. It also requires input from clinical colleagues and support from EPRR link workers.

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 Trust continues to prepare and respond to incidents as required
- The workplan is ongoing to support further development and monitoring through the EPRR Steering Group.

Consultation

A version of the report has been received at Finance and Performance Committee and Trust Delivery Group.

Governance or Legal Issues

- Civil Contingencies Act 2004
- NHS Emergency Preparedness, Resilience and Response Framework 2022
- NHS Core Standards.

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:

Any potential equality and diversity implications will be assessed and managed as plans are reviewed, developed and implemented. Initial response to an incident will always consider preservation of life as a priority above all other issues. Following the initial lifesaving phase all REGARDS issues will be considered in detail.

Recommendations

The Board of Directors is requested to:

1. Be assured of ongoing work to improve and continue the Trust's level of compliance with the EPRR core standards
2. Retrospectively approve the Core Standards submission to NHSE and ICB following approval at the Trust Delivery Group and Finance and Performance Committee.

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

Report prepared by: **Celia Robbins**
EPRR Lead

NHS
Derbyshire Healthcare
NHS Foundation Trust

Emergency Preparedness, Resiliance and Response (EPRR) Core Standards

update and annual report

2024 vs 2025 Submission

Derbyshire Healthcare
NHS Foundation Trust

- Post confirm and challenge – Substantial compliance maintained
- Submitting substantial compliance subject to confirm and challenge session (27 October 2025)
- Four partials remain
- Plans continue to be proportional and relevant to the Trust – EPRR led with multi-disciplinary support
- EPRR expertise requested at a regional and national level for NHSE projects/national guidance reviews.

Domains

Derbyshire Healthcare
NHS Foundation Trust

Domain	Total	Fully Complaint		Partially compliant		Non-compliant	
		2023/24	Aug 2025	2023/24	Aug 2025	2023/24	Aug 2025
Governance	6	5	6	1	0	0	0
Duty to risk asses	2	2	2	0	0	0	0
Duty to maintain plans	11	11	9	0	2	0	0
Command and control	2	2	2	0	0	0	0
Training and exercising	4	4	4	0	0	0	0
Response	5	5	5	0	0	0	0
Warning & Informing	4	4	4	0	0	0	0
Cooperation	4	4	4	0	0	0	0
Business Continuity	10	9	10	1	0	0	0
HazMat/CBRN	10	6	8	4	2	0	0
Total	58	52	54	6	4	0	0

Partials

Derbyshire Healthcare
NHS Foundation Trust

- Maintaining Plans x2
  - Lockdown
  - Evacuation and Shelter
- CBRN/HazMat x2
  - Training Resource
  - Exercising

Overview of 2024/2025

NHS
Derbyshire Healthcare
NHS Foundation Trust

Six exercises contributed and participated in

15 EPRR Incidents requiring an Incident Management Team

Three awareness campaigns highlighting the need for EPRR

66% of services have completed local exercising

System wide and internal testing of plans

Embedding business continuity at all levels

Governance and Risk

Derbyshire Healthcare
NHS Foundation Trust

- EPRR Plans have received annual review
- EPRR Policy and Business Continuity Policy merged and ratified at Trust Board
- Progress in continuous improvement and learning from events and incidents
- Update to National Risk Register – reflected in local Trust register .

Compliance outcome

Duty to Maintain Plans

Derbyshire Healthcare
NHS Foundation Trust

- 75% of EPRR plans received annual review
- Evacuation and Shelter – Partial
  - Need to develop further plans and incorporating the Making Room for Dignity (MRfD) developments into the plan
- Lockdown – partial
  - New national guidance (Martyn's Law) further work required by the Trust to enhance the current plan
- Incident Response Plan – currently being review
  - Changes within Trust structure and learning from incidents and exercises to be incorporated.

Command and Control & Response

Derbyshire Healthcare
NHS Foundation Trust

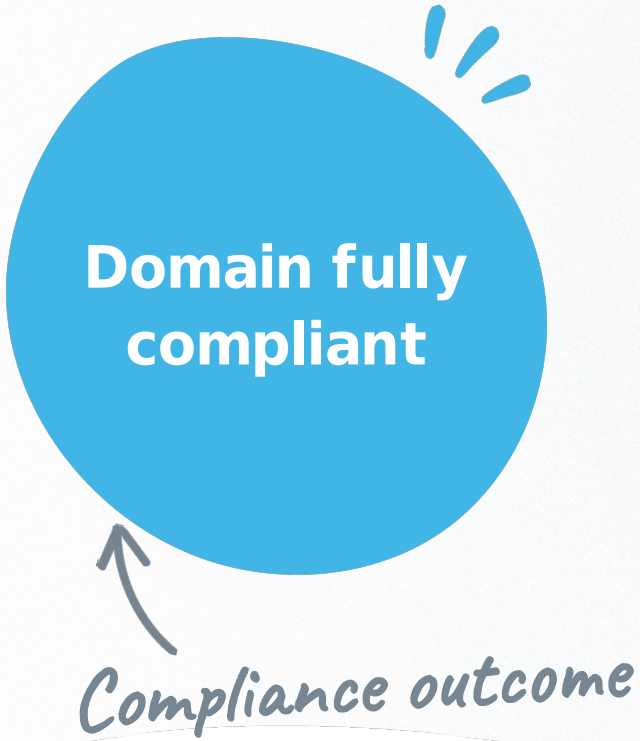
Both domains fully compliant

Compliance outcome

- Operational On Call Management provided 24/7
- Changes to support managers out of hours – additional resources generated
- Development of a handbook
- Reporting incident changes – opportunity to thematically review events and develop additional support as required
- Responded to several EPRR Incidents within the last 12 months
- Ability to provide physical or virtual incident management response.

Training and Exercising

Derbyshire Healthcare
NHS Foundation Trust



- National Occupational Standards updated – reflected within local training
- 72% compliance for incident management training
- General staff awareness - #30days30ways, Business Continuity Awareness Week, CEO Engagement Session
- Major internal exercise, Exercise Krakus, involving planning group, agreed objectives and post exercise report. Support from National Grid (Electricity) to provide subject matter expertise.

Warning, Informing and Co-operation

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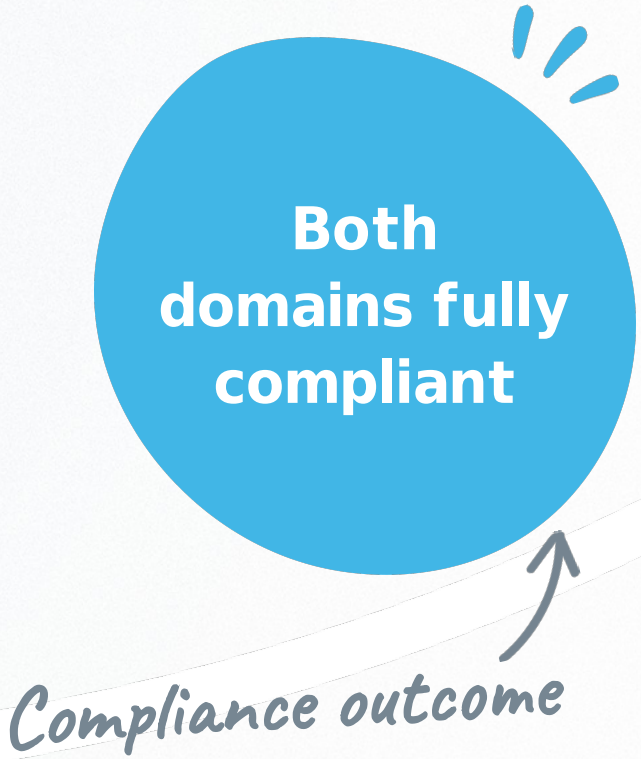
- EPRR Communications during an Incident Plan has received annual review
- Communications team support in Incident Management Training providing key knowledge and expertise
- EPRR team continue to be actively involved in system planning and preparation of plans
- EPRR team support with regional task and finish groups.



Business Continuity (BC)

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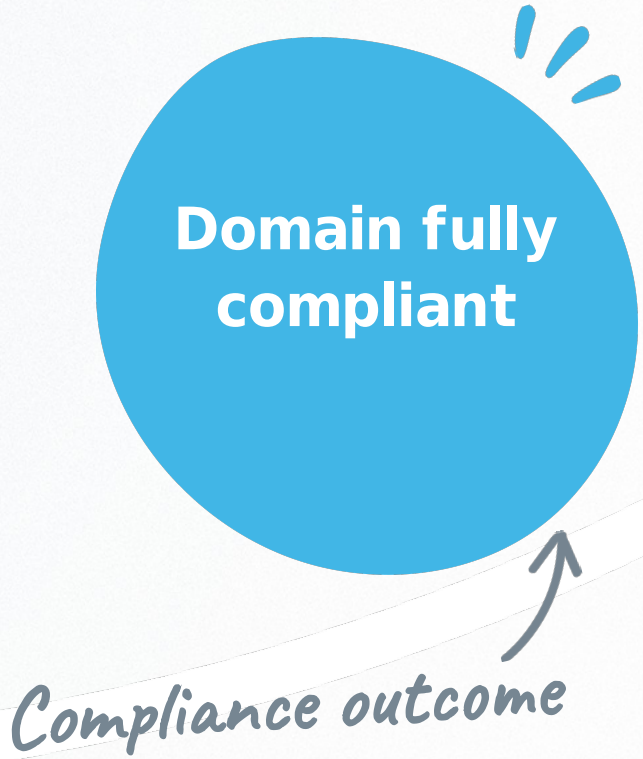
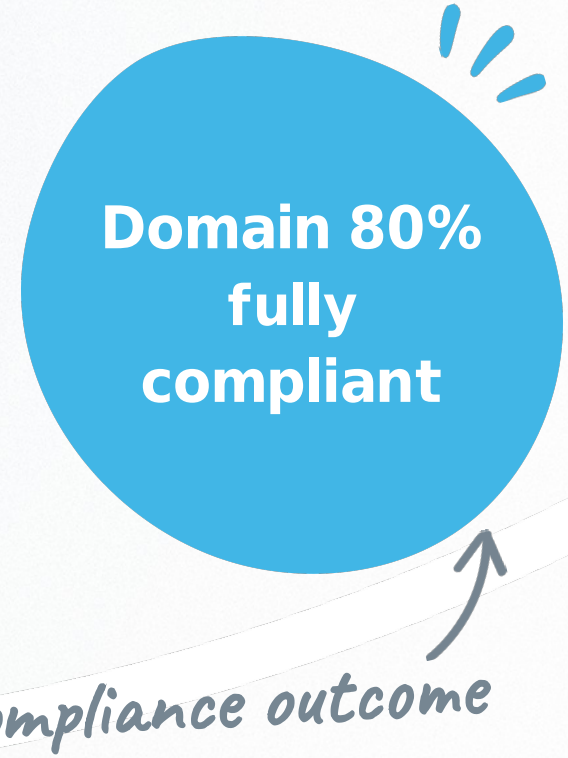
- 360 Assurance audit completed – significant assurance
- Maintaining strategic critical services list
- Further work regarding third party suppliers and their BC arrangements – collaboratively working with Contracting and Procurement teams
- Drop in annual review of local BC plans compliance, however, large number of local exercises to test their arrangements. Learning is now being captured and included in the reviewing of documents.



Chemical, Biological, Radiological and Nuclear (CBRN)

Derbyshire Healthcare
NHS Foundation Trust

- Major review and update to the HazMat/CBRN and Counter Terrorism Plan, incorporating new and updated national guidance
- Training Resource – partial
  - Reviewing EPRR team skills and capability to deliver local training
- Exercising – partial
  - The Trust is required to complete a specific Initial Operational Response (IOR) exercise, this is included within the workplan for multiple sites during the next year
- Remains low risk for the Trust.



Assurance and Risk

Derbyshire Healthcare
NHS Foundation Trust

- EPRR Steering Group – Trust-wide
- Health partners are consulted on with each updated document
- ICB and NHSE scrutinize each plan – specific plans requests to evidence that comments have been incorporated
- Workplan has been updated and reflects outstanding actions and maintaining current compliance
- Core standards submitted 29 August 2025
- Self assessment submitted ‘Substantial’ await confirm and challenge session for final outcome.

Please select type of organisation: **Mental Health Providers**

Click button to format the workbook

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	9	2	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	5	5	0	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	10	0	0
Hazmat/CBRN	10	8	2	0
CBRN Support to acute Trusts	0	0	0	0
Total	58	54	4	0

Overall assessment:

Instructions:
Step 1: If you see a yellow ribb
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Step 6: In the Action Plan tab,

	Core standards	Interoperable capabilities
Fully compliant	58	135
Substantially compliant	52	120
Partially compliant	45	104
Non compliant		

Publishing Approval Reference: 000719

Substantially compliant

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nisation from the drop-down at the top of this page
orkbook' button.
essment RAG in the 'EPRR Core Standards' tab
nly: Complete the Self-Assessment in the 'Interoperable capabilities' tab
click on the 'Format Action Plan' button.

Overall self assesment rating:

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Domain 1 - Governance **Domain 2 - Duty to risk assess** **Domain 3 - Duty to maintain Plans**										
16	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Commentary: This plan has not been reviewed during 24/25, this is due to a number of changes within the Trusts physical infrastructure and changes to services delivered. Meetings have been scheduled to support a full review of the plan with clinical colleagues and supporting services. This will piece of work will be completed alongside the site specific lockdown plans Evidence: Evacuation and Shelter Plan v1	Partially compliant	Number of changes to the Trust estate through the Making Room for Dignity Programme and eradication of dormitories. Works are now completed for this plan to be reviewed by the MDT within the newly established sites.	CR	December	This is a significant piece of work which requires a number of additional colleagues to support with its development and review. It will take time to ensure the individual site plans are proportionate and relevant to each location.
17	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Commentary: This plan has not been reviewed during 24/25, this is due to a number of changes within the Trusts physical infrastructure and changes to services delivered. Meetings have been scheduled to support a full review of the plan with clinical colleagues and supporting services. This will piece of work will be completed alongside the evacuation and shelter plans. The Counter Terrorism plan has been reviewed and updated to reflect national guidance. There is a section relating to lockdown but not site specific information. Evidence: HazMat/CBRNe and Counter Terrorism Plan DHCFT V3	Partially compliant	Number of changes to the Trust estate through the Making Room for Dignity Programme and eradication of dormitories. Works are now completed for this plan to be reviewed by the MDT within the newly established sites.	CR	December	This is a significant piece of work which requires a number of additional colleagues to support with its development and review. It will take time to ensure the individual site plans are proportionate and relevant to each location.
Domain 4 - Command and control **Domain 5 - Training and exercising** **Domain 6 - Response** **Domain 7 - Warning and informing** **Domain 8 - Cooperation** **Domain 9 - Business Continuity** **Domain 10 - CBRN**										
63	**Hazmat/CBRN**	**Hazmat/CBRN training resource**	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training programme to deliver capability against the risk assessment	Commentary: Work is ongoing to add the ProtectUK e-learning package onto the local training platform. A strategic session was planned for the Board development day but did not go ahead due to the presenter being unavailable. It is scheduled for 25/26 and included on the workplan. Evidence EPRR Workplan v2	Partially compliant	Training framework to include additional information relating to this training. Dates to be confirmed and locations identified to support delivery of this. On the workplan for 25/26	CR	October	Framework will be completed sooner, dates will be ongoing throughout the year.
66	**Hazmat/CBRN**	**Exercising**	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	Commentary: Unfortunately the Trust has not been successful in completing this for 24/25. This is due to a number of factors. It has been included on the 25/26 workplan. Evidence: EPRR Workplan v2	Partially compliant	Exercises to be held across a number of sites within the Trust catchment. Included within the workplan.	CR	December	EPRR Team to work with local teams/managers and identify suitable dates for the exercises.

Derbyshire Healthcare
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Emergency Preparedness, Resilience and Response and Business Continuity Policy

See also	Located in the following folder on the Trust intranet
Business Continuity Policy	Emergency Planning
Adverse Weather Plan	Trust Document/Plan
Counter Terrorism Plan DHCFT	Trust Document/Plan
EPRR Incident Communications Plan	Trust Document/Plan
EPRR Incident Response Plan	Trust Document/Plan
Management of VIP High Profile Patients Plan	Trust Document/Plan

Service area	Issue date	Issue no.	Review date	
Trust Wide	September 2025	3	September 2028	
Ratified by	**Ratification date**	**Committee/Group responsible for review**		
Trust Board	September 2025	EPRR Steering Group		

Document published on the Trust Intranet under: Insert policy category

Did you print this document?

Please be advised that the Trust discourages retention of hard copies of policies and can only guarantee that the Policy on the Trust Intranet site is the most up-to date version

ACCESSIBLE INFORMATION STANDARD

The Accessible Information Standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of service users.

Ensure you have considered an agreed process for: Sending out correspondence in alternative formats and appointments for patients / service users with communication needs, where this is applicable.

Checklist for Emergency Preparedness, Resilience and Response and Business Continuity Policy

Summary (Plain English)
The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. This work falls under the title of Emergency Preparedness, Resilience and Response (EPRR). This policy outlines our obligations under the relevant legislation and the NHSE EPRR Framework and how it will be delivered. Business Continuity is ensuring we can continue to provide services to patients in the event of a disruption. The policy outlines the strategic framework for the management and development for each element of the business continuity management system. It is supported by local business continuity plans and operational action cards.

Title of policy	Emergency Preparedness, Resilience and Response and Business Continuity Policy		
Aim of policy	To outline the Emergency preparedness, resilience and response requirements for the Trust and adhere to the legal and statutory responsibilities.		
Sponsor (Director lead)	Chief Delivery Officer		
Author	EPRR Lead		
Name of policy being replaced	EPRR Policy v2 Business Continuity Policy v4	**Version No of previous policy:**	

Reason for document production	To ensure the Trust complies with relevant legislation. Requirement for the EPRR Core Standards and ISO22301
Commissioning individual or group	*EPRR Steering Group*

Individuals or groups who have been consulted	**Date**	**Response**
EPRR Steering Group	January 2020	
EPRR Steering Group	October 2023	Wide response, held by EPRR team
Derbyshire EPRR Leads	October 2023	Wide response, held by EPRR team

Nil	July 2025	Merging of two documents, no changes

Version control (for minor amendments)

Date	Author	Comment
July 2025	*EPRR Lead*	Merging of EPRR Policy and BC Policy for ratification at Trust Board. Minor changes to role name changes and grammar/spelling

Contents

Emergency Preparedness, Resilience and Response & Business Continuity Policy

In the event of a EPRR Incident please refer to the EPRR Incident Response Plan.

1. Introduction

Derbyshire Healthcare NHS Foundation Trust (DHCFT) is committed to achieving and maintaining the statutory requirements and standards of best practice, required to effectively prepare for, respond to and recover from a wide range of incidents and emergencies. The focus is to minimize the threat of disruption to critical activities, patient's safety and quality of care throughout the establishment of an effective Emergency Preparedness, Resilience and Response (EPRR) work stream within the Trust.

The Civil Contingencies Act (2004) establishes a clear set of roles and responsibilities for those involved in emergency preparation and response at a local level. The Act divides responders into two categories, imposing a different set of duties on each. Category 1 responders are at the core of response to most emergencies, this would include the ambulance service, Foundation and Acute Trusts, and as such they are required to comply with the full responsibilities of the act. Category 2 organisations are cooperating bodies; they are less likely to be involved in the heart of planning work but will be heavily involved in incidents that affected their own sector.

Mental Health and Community Trusts are not listed within the act; the NHS Act as amended by the Health and Social Care Act 2012 and the NHS Standard Contract, stipulates the requirements for providers of funded health care to have appropriate arrangements in place for emergencies. The NHS England EPRR Framework 2022 also provides strategic national guidance to NHS Trusts regarding the roles and responsibilities for planning for and responding to incidents and emergencies.

This policy indicates the program of EPRR work to ensure that the Trust can respond to and prepare for all incidents and emergencies. It is supported by the national core standards assessment process whereby the Trust is held accountable and provides an internal check and challenge to our arrangements. In addition, it supports the requirement to conform to the ISO22301 – Societal Security – Business Continuity Management and associated guidance.

2. Purpose

This policy identifies the requirement to establish a robust framework for the delivery and maintenance of EPRR, including business continuity, as an integral component of the Trust's normal working practices. The Trust is accustomed to fluctuations in demand for services. Whilst at times this may lead to facilities being fully stretched, such fluctuations are managed without activation of special measures by means of an established management process and escalation procedure.

This policy outlines the framework by which EPRR arrangements will be managed and coordinated across the Trust when established procedures are no longer sufficient to successful manage the issue. It covers the EPRR management process that will lead to the production of Business Continuity (BC) and incident response plans and supporting arrangements.

The objectives of this policy are:

- To ensure an integrated EPRR process is in place across the Trust that is built upon the duties as defined in the Civil Contingencies Act: risk assessment, cooperation with partners, information sharing, communicating with the public, emergency planning and business continuity.
- To ensure systems are established to maintain the continuity of essential services when faced with a range of disruptive challenges.
- To consider the impacts of an incident for those with protected characteristics and ensure our response does not adversely impact upon them.
- Systems and facilities are in place to ensure the health, safety and welfare of all staff in an EPRR related incident.
- To ensure that plans are aligned with and support other resilience arrangements within the local health economy and Derbyshire Resilience Partnership forum.
- To embed a culture of EPRR within the Trust in line with the Trust values.
- Ensure inclusion of suppliers and contractors as part of the EPRR planning and response, developing additional plans as required.
- To use the BCSM to identify, protect and maintain critical activities in order to deliver a service to a minimal acceptable level
- Develop plans, arrangements and processes which tolerate, treat, transfer or terminate the impact of any disruption to the Trust's prioritized activities.
- To maintain, exercise and test the plans, arrangements and processes and where lessons are identified revise the documents so that the elements of the business continuity management system remain current 'live' and effective in operation.

EPRR Context
Great Care: to ensure the Trust can respond to all types of incidents and reduce the impact/effects on the communities we serve.
Great Place to Work: to ensure colleagues are aware of their role and responsibility during an incident.
Best use of resources: ensuring all relevant processes are in place to provide as far as reasonably possible ongoing services. This can be achieved through all aspects of EPRR including business continuity planning.
Great partner: to support and develop system working in response to EPRR related incidents and contribute to the health and wellbeing of Derby & Derbyshire.

3. Legislation Compliance

The following legislation, regulation and guidance has been used to inform this policy as it places statutory duties upon the Trust.

- Civil Contingencies Act 2004 and associated guidance
- Health & Social Care Act 2012 & 2022
- NHS England Emergency Preparedness, Resilience and Response Framework 2022
- NHSE EPRR Core Standards
- ISO22301 Societal Security – Business Continuity Management Systems – Requirements

4. Integrated Emergency Management (IEM)

4.1. Definitions

Emergency Preparedness – The extent to which emergency planning enables the effective and efficient prevention, reduction, control, mitigation of, and response to emergencies.

Resilience – Ability of the community, services, area or infrastructure to detect, prevent and, if necessary, to withstand, handle and recover from disruptive challenges.

Response – Decisions and actions taken in accordance with the strategic, tactical and operational objectives defined by emergency responders.

Emergency – Under Section 1 of the CCA 2004 an "emergency" means

- "(a) *an event or situation which threatens serious damage to human welfare in a place in the United Kingdom;*
- *(b) an event or situation which threatens serious damage to the environment of a place in the United Kingdom;*
- *(c) war, or terrorism, which threatens serious damage to the security of the United Kingdom*".

Incident – For the NHS, incidents are classed as either:

- Business Continuity Incident
- Critical Incident
- Major Incident

Each will impact upon service delivery within the NHS, may undermine public confidence and require contingency plans to be implemented. NHS organisations should be confident of the severity of any incident that may warrant a major incident declaration, particularly where this may be due to internal capacity pressures, if a critical incident has not been raised previously through the appropriate local escalation procedure.

A **business continuity incident** is an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level. (This could be a surge in demand requiring resources to be temporarily redeployed)

A **critical incident** is any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special measures and support from other agencies, to restore normal operating functions.

A **major incident** is any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented. For the NHS this will include any event defined as an emergency above.

NHS Incident Response Levels

NHS England have established four incident levels dependent upon the scale and complexity of an incident requiring a more coordinated approach. For clarity these levels must be used by all NHS organisations when referring to incidents.

Incident level	
Level 1	An incident that can be responded to and managed by a local health provider organisation within their respective business as usual capabilities and business continuity plans in liaison with local commissioners.
Level 2	An incident that requires the response of a number of health providers within a defined health economy and will require NHS coordination by the local commissioner(s) in liaison with the NHS England local office.
Level 3	An incident that requires the response of a number of health organisations across geographical areas within a NHS England region. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level.
Level 4	An incident that requires NHS England National Command and Control to support the NHS response. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level.

4.2. Acronyms

AEO	Accountable Emergency Officer
COO	Chief Operating Officer
ELT	Executive Leadership Team
EPRR	Emergency Preparedness, Resilience and Response
F&P	Finance and Performance Committee
HEPOG	Health Emergency Planning Operational Group
LHRP	Local Health Resilience Partnership
LRF / DRF	Local Resilience Forum / Derbyshire Resilience Partnership
PIR	Post Incident Report
PXR	Post Exercise Report
SOP	Standard Operating Procedure

5. Roles and Responsibilities

5.1. Chief Executive

The Chief Executive is

- Responsible for ensuring the Trust is meeting its legal and statutory obligations relating to EPRR.
- Accountable to the Board for ensuring that systems are in place to facilitate an effective response and recovery to all types of EPRR related incidents.

- Required to appoint an Executive Board Director as the Accountable Emergency Officer who will be assigned the responsibilities below.

5.2. Accountable Emergency Officer (AEO)

The Chief Delivery Officer will have lead responsibility for EPRR arrangements across the Trust as the Accountable Emergency Officer. They have the executive authority and responsibility for ensuring that the organisation complies with legal and policy requirements. They will provide assurance to the Board that strategies, systems, training, plans and policies are in place to ensure the organization responds appropriately in the event of an incident.

Specifically, the AEO will be responsible for ensuring that their organisation:

- itself and any sub-contractors are compliant with the EPRR requirements as set out in the CCA 2004, the 2005 Regulations, the NHS Act 2006, the Health and Care Act 2022 and the NHS Standard Contract, including this Framework and the Core Standards.
- is properly prepared and resourced to deal with an incident.
- itself and any sub-contractors it commissions have robust business continuity planning arrangements in place that align to ISO 22301 or subsequent guidance that may supersede this.
- has a robust surge capacity plan that provides an integrated organisational response and has been tested with other providers and partner organisations in the local area served.
- complies with any requirements of NHS England, or agents thereof, in respect of monitoring compliance.
- provides NHS England with such information as it may require for the purpose of discharging its EPRR functions.
- will attend, engage with and effectively contribute to any governance meetings, sub-groups or working groups of the LHRP and/or LRF, as appropriate.
- Providing 6 monthly reports to the Finance and Performance Committee regarding Emergency Preparedness, Resilience and Response, and an annual report to the Board.
- Ensuring that the EPRR & Sustainability Lead, the On-Call Team and the Emergency Preparedness, Resilience and Response Steering Group (EPRR Steering Group) have sufficient resources available for the Trust to effectively fulfil its Emergency Preparedness, Resilience and Response responsibilities.
- taking the role of DHCFT Strategic Commander in the event of an incident response being required (see Incident Response Plan for further details).

In the absence of the AEO, one of the Operational Managing Directors will provide cover as a deputy.

5.3. Non-Executive Director

The AEO is supported by a Non-Executive Director to endorse assurance to the Board that the Trust is meeting its obligations with respect to EPRR and relevant statutory duties under the Civil Contingencies Act 2004 and the NHS Act 2006 (as amended). This includes assurance that the Trust has allocated sufficient experience and qualified resource to meet these requirements. This role will be fulfilled by the Chair of the Finance and Performance Committee.

5.4. EPRR & Sustainability Lead

The EPRR & Sustainability lead is responsible for:

- Support the AEO in implementing the EPRR agenda across the Trust.
- Develop, disseminate and maintain the Trust's EPRR policies, procedures, plans and arrangements.
- ensuring the Trust has appropriate response and recovery plans in place that are regularly reviewed, tested and circulated to partners.
- providing internal liaison and subject matter expertise in matters pertaining to EPRR and Business Continuity.
- ensuring a robust training and exercising process is in place ensuring relevant roles are trained to fulfil roles when responding to emergencies.
- facilitating any assurance processes pertaining to EPRR.
- providing recommendations and subject matter expertise to DHCFT projects ensuring EPRR is considered within processes.
- To chair the EPRR Steering Group meeting
- Maintain the on-call rotas and documentation.
- Keep up to date with emerging risks, recommendations, guidance and statutory responsibilities to ensure the Trust is current in its EPRR processes.
- Represent the Trust at the Local Resilience Forum subgroups, external meetings and working groups as required.
- Ensure/facilitate post incident debriefs are conducted so that lessons may be identified and monitored.
- Manage the incident coordination centers
- Embed a business continuity culture into the organisation.
- Undertake an annual internal audit.
- Provide the administration and assist with service exercises.
- Develop training and ongoing support for development of a Business Impact Analysis and Business Continuity Plans.
- Monitoring of national guidance in relation to business continuity.
- Provide reports on performance against business continuity management system objectives for EPRR steering group, Finance and Performance Committee, Executive Leadership Team and the Trust Board.

- To be proactively and positively inclusive of protected characteristics and encourage managers to consider the impacts of a disruption on individuals and the demographics of their service users.

5.5. EPRR Steering Group

The purpose of the EPRR Steering Group is to provide the Board, via the Finance and Performance Committee, with assurance that appropriate systems are in place to enable the Trust to respond to, manage and recover from any type of disruptive event or emergency. In addition to directing and driving the recovery, reset and sustainability programme across all clinical and corporate functions.

Its function is to ensure the Trust meets the statutory and best practice responsibilities outlined in:

- Civil Contingencies Act (2004)
- NHS England Emergency Preparedness, Resilience and Response Framework (2022)
- ISO 22301 Societal Security and Business Continuity
- NHS Green Plan
- Health and Care Act (2022)

To support this, the EPRR Steering Group has the following objectives:

- To promote and support the Trust values within the Emergency Preparedness, Resilience and Response (EPRR) portfolio.
- To communicate and embed EPRR throughout the Trust
- To determine and develop EPRR arrangements and agree the framework for their implementation.
- To create a work plan incorporating, plans and policies, training, exercising and audits.
- Use of digital technology to enhance patient experience, improve efficiency and optimise performance.
- To oversee the following documents
  - EPRR Core Standards Self-Assessment
  - EPRR Incident Response Plan
  - Business Continuity Policy
  - EPRR Policy
  - Adverse Weather Plan
  - Counter Terrorism Plan – including the management of self-presenters (HazMat)
  - Management of VIP and High-Profile Patients
  - EPRR Training Framework

5.6. General Managers / Heads of Service

General Managers and Heads of Service are responsible for ensuring.

- that their departments/divisions have appropriate regularly updated EPRR arrangements (including local Business Continuity Plans and Business Impact Assessments) in place and that these complement the Trust wide response to emergencies.
- full engagement/compliance with planning for EPRR processes and training and exercising to ensure preparedness across the Trust.
- internal disaster/emergency alerts are maintained and tested regularly (six-monthly) to communicate actions in the event of an incident.
- appropriate attendance and engagement at the Trust EPRR Steering group.
- in the event of local incidents that departmental debriefs are conducted promptly (as soon as reasonably practicably possible) utilising the Trust `hot debrief` process and then sent onwards to EPRR to ensure collation in the Trust Post Incident Debrief (PID) report.

5.7. Service Managers

- Develop operational business impact analysis and feed into the development of action cards for their individual areas
- Make staff aware of plans during local induction
- Continue to promote awareness of business continuity plans and action cards

5.8. All staff

All staff will

- Be familiar with the arrangements and their roles & responsibilities detailed in the local plans and action cards.
- Undergo training and participate in exercises that test response, recovery and continuity plans.
- Responsible for cooperating in maintaining a safe level of service across the Trust, in line with this policy.
- Ensure their contact details are correct and up to date.

5.9. On Call (1st and 2nd On Call)

These roles have been pre-identified as having key responsibilities in an incident response in the absence of the Accountable Emergency Officer or Deputy i.e., OOH's:

- 2nd on call: will act as the Trust Strategic Commander for DHCFT in incidents providing strategic direction and oversight for the Tactical Command Team.
- 1st on call: will act as the Trust Incident Manager for DHCFT in incidents providing tactical direction and coordination of front-line services to minimise disruption whilst providing patient care in incidents, and/or coordination of the Trust in the event of 'internal' incidents.

5.10. 3rd Party Contractors

Any 3rd Party contractors that are requested to do work on behalf of or for the Trust will be expected to ensure that:

- They have robust Business Continuity and EPRR response and recovery elements in place. The Trust should be assured these are in place as part of the contracting process, managed by Contracting and Procurement Teams.
- They engage fully with EPRR processes as required as part of the Trust's EPRR arrangements.
- Where required subject matter expertise is provided to the Trust for the purpose of response and recovery.

6. Incident Response

If the Trust activates one or more of its emergency plans, all Trust staff must take appropriate action and follow the plan(s). All incidents will be managed under a 3-tier command and control structure of Operational (Bleep Holders), Tactical (General Managers/Service Managers or First On-Call Managers) and Strategic (Executive Director or Second On-Call Managers):

Operational: The level at which the management of immediate 'hands on' work is undertaken.

Tactical: The purpose of the tactical level is to ensure that the actions taken by the operational level are coordinated, coherent and integrated in order to achieve maximum effectiveness, efficiency and desired outcomes.

Strategic: The purpose of the strategic level is to:

- Consider the incident in its wider context.
- Determine longer-term and wider impacts and risks with strategic implications.
- Define and communicate the overarching strategy and objectives for the response.
- Establish the framework, policy and parameters for tactical and operational tiers.
- Monitor the context, risks (including financial and reputational), impacts and progress towards defined objectives.

All other Trust policies remain effective during a business continuity, critical or major incident, unless explicit direction is received from the Incident Director. If a member of staff with a role-specific action card decides not to follow a prescribed action within one of the Trust's emergency plans, they must clearly record this decision, alongside any justification in a logbook (which can be found in the Incident Coordination Centres) and submit this to the EPRR & Sustainability Lead at the end of the incident.

7. EPRR Process

7.1. Underpinning Principles for NHS EPRR

a) Preparedness and anticipation

The NHS need to anticipate and manage the consequences of incidents and emergencies by identifying risks and understanding direct and indirect consequences, where possible. All individuals and organisations that might have to respond to incidents should be properly prepared. This includes having clarity of roles and responsibilities, specific and generic plans, and rehearsing arrangements periodically. All organisations should be able to demonstrate clear training and exercising schedules that deliver against this principle.

b) Continuity

The response to incidents should be grounded within organisation's existing functions and their familiar ways of working. Actions will need to be faster, on a larger scale and in more testing circumstances during a response to an incident.

c) Subsidiarity

Decisions should be taken at the lowest appropriate level, with coordination at the highest necessary level. Local responders should be the building blocks of response for an incident of any scale.

d) Communication

Good two-way communication is critical to any effective response. Reliable information must be passed correctly and without delay between those who need to know, including the public.

e) Cooperation and integration

Positive engagement based on mutual trust and understanding will facilitate information sharing. Effective coordination should be exercised between and within organisations and local, regional and national tiers of a response. This includes active mutual aid across organisations, within the UK and across international boundaries as appropriate.

f) Direction

Clarity of purpose should be delivered through an awareness of the strategic aim and supporting objectives for the response. These should be agreed and understood by all involved in managing the response to an incident.

7.2. EPRR Governance

The EPRR Steering group meet quarterly to ensure the progression of the EPRR portfolio within the Trust. It reports directly to Finance and Performance (F&P) Committee. The Committee received six monthly updates on the developments of the EPRR Portfolio incorporating the following areas:

- Plans and policy governance.
- Risk assessment overview
- Training and exercising compliance.
- Incidents
- Debrief and lessons identified.

F&P Committee ensures rigorous scrutiny and oversight and directly to the Trust Board which is an open public meeting. An annual report is shared with the Trust Board for assurance and oversight.

7.3. EPRR reporting lines

EPRR sits within Operational division with the CDO as the AEO. The EPRR & Sustainability Lead in line with guidance has direct reporting lines and responsible to Managing Director, however, has access and accountability to the AEO in their role as accountable for EPRR within the Trust.

EPRR sits under the Finance and Performance Committee to ensure appropriate reporting and escalation into the Board. EPRR will have access to the Board as required for those issues requiring escalation.

7.4. EPRR Resourcing

The Trust has funded the EPRR resource to support arrangements for planning and response to incidents. This should be suitable for the size of the organisation and the requirements for meeting the EPRR framework and core standards. The Executive Leadership Team and Trust Board are assured and committed to ensuring suitable and effective resourcing of the EPRR Team to deliver the statutory and regulatory responsibilities of the Trust in relation to the EPRR functions. The provision of resources includes purchasing specific items/equipment needed to support incident response.

This program of work is led by the EPRR & Sustainability Lead with accountability to the Managing Director/Chief Psychologist, and responsibility to the AEO. Additional staff may be co-opted for a period to support delivery of specific tasks or set work and delegated tasks.

7.5. EPRR Funding

EPRR is funded as part of the Operations Divisional budget. Any additional resources would need to be discussed and agreed by the Executive Leadership Team. In the event of responding to an incident or event it is expected that financial considerations should not impact on the speed or scale of the response required.

For specific responses costs can be captured and reported by finance to identify any additional resources. Each organisation has a requirement to commit to meeting the financial requirements of a response. Where an incident moves to a Level 4 response there is the potential for additional funding to be made available through the Department of Health & Social Care. This will be coordinated by the NHSE regional finance team.

7.6. EPRR Work Plan

Any work or projects on the EPRR work plan should be based on risk and in response to an identified gap in the Trust's existing EPRR arrangements. This will be activities undertaken during the academic year. These will be based upon:

- The Trust's statutory requirements national expectations for EPRR
- Requirements for the NHS England Core Standards for EPRR
- Outcomes of any review carried out on the Trust's plans, policies, or procedures.
- Lessons identified and recommendations as a result of exercise or incident, internally or from multi-agency partners.
- Best practice

The work plan will be owned by the EPRR Steering Group and progress will be monitored at the six weekly meetings. A full review will be undertaken annually. The EPRR team will own and manage the workplan and reporting processes as outlined in 7.3.

7.7. Consultation of plans and arrangements

The Trust ensures that all plans are consulted on with key partners to ensure shared learning and a holistic overview of EPRR arrangements. During the consultation phase, this document will be shared with internal colleagues and external key stakeholders as appropriate.
This will be as a minimum:

1) EPRR Steering Group
2) Internal subject matter experts
    a. Infection, Prevention and Control
    b. Forensic and Rehab services
    c. Specialist commissioned services.
    d. Additional experts as required.
3) System Partners
    a. Derby and Derbyshire Integrated Care Board
    b. Derbyshire Community Health Services
    c. University Hospitals of Derby and Burton
    d. Chesterfield Royal Hospital
    e. EMAS

f. Derbyshire Health United
g. NHS England Midlands EPRR Team
h. UK Health Security Agency

Other agencies may be added in dependent upon subject matter experts. A timeframe will be established for comments to be returned ahead of amendments and going through a formal governance structure for sign off. Comments received will be considered as part of the wider response and accepted or rejected depending upon content. The EPRR & Sustainability lead will make the final decision what final amendments are required. All comments will be logged and auditable, comments received after a given timeframe will be recorded but not necessarily acted upon if the document has been signed off.

7.8. Maintenance of Plans

All documents within the EPRR portfolio will follow a process for maintenance and review. Policies will follow a three yearly cycle based on the Trust current governance process. Other plans and documents will be reviewed considering the content and risk associated; this could range from an annual review to biennial review. This will be clear from the governance table on each front sheet.

Documents will also be subject to review under the following parameters.

- Change led: where audits (internal or external) identify the need, updates to system plans, changes in national guidance / legislation.
- Post incident / exercise: where the debrief has identified lessons and changes need to be incorporated into the existing documents.

The following documents will be managed by the EPRR Team but not necessarily prepared/written by the EPRR Team

- EPRR Policy
  - EPRR Incident Response Plan
  - Adverse Weather Plan
  - Counter Terrorism Plan including CBRN/Hazmat response
  - Management of VIP and High Profile Patients
  - New and Emerging Infectious Diseases Plan
  - EPRR Incident Communications Plan
- Business Continuity Policy
  - Service Level Business Impact Analysis
  - Service Level Business Continuity Plans
- Plans under further development
  - Whole hospital evacuation plan
  - Psycho-social response plan

7.9. EPRR Document Retention

Following an incident, internal investigations, external scrutiny and/or legal challenges may be made. These may include coroners' inquests, public inquiries, criminal investigations and civil action.

When planning for and responding to an incident, all decisions made, or actions taken must be recorded and stored in a way that can be retrieved later to provide evidence. It may be necessary to provide all documentation; therefore, robust and auditable systems for documentation and decision-making must be maintained. Best practice for the retention of documents is shown in the table below.

Category	Examples	Minimum retention period	Final action
Incidents (declared)	Decision logbooks, on call logbook, incident related documents including plans and organisational structure. Paper and electronic records	30yrs	Review, archive or destroy under confidential conditions
Exercise	Paper and electronic records	10yrs	Review, archive or destroy under confidential conditions
EPRR	Incident response plans, guidance, standard operating procedures, core standards for assurance Electronic records	30yrs	Review, archive or destroy under confidential conditions

7.10. Availability of Plans

Plans will be made available to ensure full engagement and awareness by staff within the Trust. As documents are updated, this will be cascaded through the EPRR link colleagues for each service/division and emailed directly to on call staff for reference and information. All Trust plans are available on the Trust intranet, the on-call SharePoint site and through Resilience Direct.

7.11. Information Sharing

When an incident occurs a variety of agencies will respond, and others will support the response remotely. The emergency will place those affected at risk. People who are more vulnerable may be at a higher risk. It is in the interest of those affected people for personal data to be shared amongst emergency responders. Sharing personal

data will assist in response and in the identification of those most likely to be adversely affected or vulnerable, linked to an emergency response.

The data to be shared will be dependent upon the nature of the incident but will generally be limited in scope and volume. Due to the urgent nature of needing to share data obtaining consent will usually be impractical. The agency holding the primary data will already have satisfied the consent requirements when they gathered the data prior to the incident.

DHCFT has a responsibility to share relevant information with other responder agencies, this must be necessary and required for the response. All data requests should consider information governance processes and how that information is to be shared and no data will be shared without the authorization of the Caldicott Guardian.

The Trust is part of and a signatory of the Derby and Derbyshire LRF information sharing agreement specifically for civil emergencies.

8. Business Continuity Management

DHCFT will take the approach required by the ISO22301:2012 standard and its associated guidelines, dovetailed with the BCi Good Practice Guide (2018) which will ensure that the Trust develops a business continuity management system which is in line with the Civil Contingencies Act (2004) statutory requirements and the NHSE Emergency Preparedness, Resilience and Response Framework and NHSE Core Standards. This approach, based on best practice, will ensure that the organisation can achieve its objectives for business continuity. This document provides a strategic framework for DHCFT which establishes how the Trust will drive its business continuity management programme towards compliance with ISO 22301:2012. It adapts the well-established BCM lifecycle and applies it to DHCFT which is shown in Figure 2.

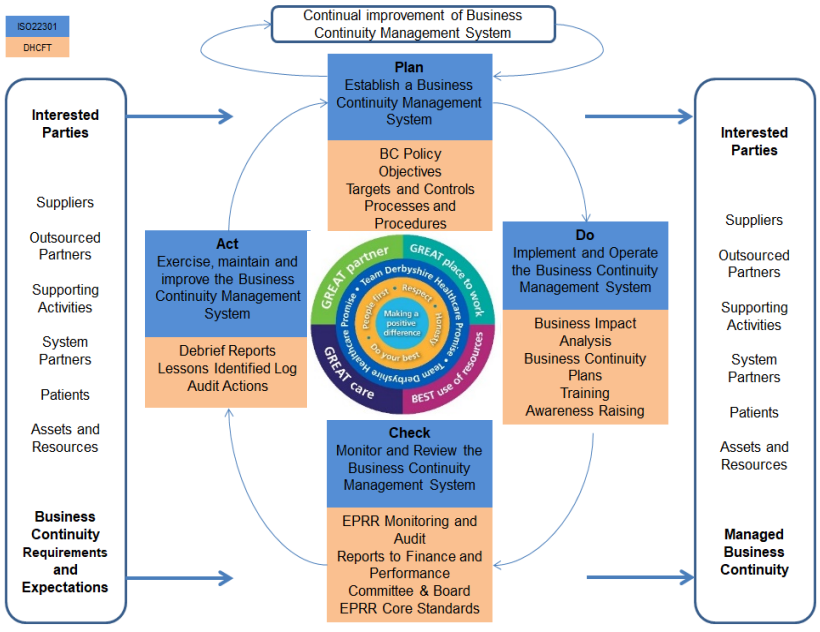
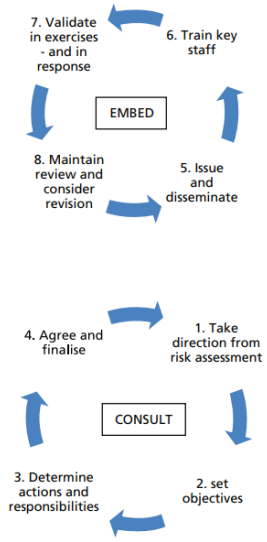


Figure 2 – PDCA Model applied to DHCFT Business Continuity Management

9. Cycle of Preparedness

9.1. Risk Management

Risk management is an integral part of the Trust and the first step in the emergency planning and business continuity process; it ensures our plans are proportionate to risks. The National Risk Register and Derbyshire Community Risk Register will inform the development of the Trust's EPRR risk assessment. The overarching risk will be held on Datix and supported with an additional report monitored through the EPRR Steering group, where risks begin to escalate or cause concern, i.e., impact upon delivery of services, reduced confidence in mitigations or risk to staff safety, this will be cascaded to ELT and LHRP as appropriate. An update will be provided to each HEPOG meeting on the current risks the Trust is responding to/managing. The additional document is available from the EPRR Team by request.



Should a risk be identified in a Business Continuity Plan which cannot be mitigated to an acceptable level this will be escalated through the teams governance programmes/COAT and uploaded onto the Business Continuity risk group on the DATIX platform, this may include but not limited to staffing skill mix, staff shortages, communications and climate change. The DATIX risks are continually assessed by the service for which it effects.

The Trust Risk Management Strategy 2023-2025 will support the EPRR risk register development. The risk appetite statement is available from the strategy, but the key definitions are outlined below.

Risk Appetite	What it Means
No Appetite	We are not prepared to accept uncertainty of outcomes for this type of risk.
Low Appetite	We accept that a low level of uncertainty exists but expect that risks are managed to a level that may not substantially impede the ability to achieve objectives
Moderate Appetite	We accept a moderate level of uncertainty but expect that risks are managed to a level that may only delay or disrupt achievement of objectives, but will not stop their progress
High Appetite	We accept a high level of uncertainty and expect that risks may only be managed to a level that may significantly impede the ability to achieve objectives

The Trust recognises that it is impossible to deliver its services and achieve positive outcomes for its stakeholders without taking risks. Indeed, only by taking risks can the Trust realise its aims and strategic objectives. It must, however, take risks in a controlled manner, thus reducing its exposure to a level deemed acceptable from time to time by the Board and, by extension, external inspectors/regulators and relevant legislation.

The Trust has a low threshold for risks that impact on safety. The Trust has a greater appetite to take considered risks in terms of their impact on operational and reputational issues. The Trust has the greatest appetite to pursue quality improvement and innovation and will take opportunities where positive results can be anticipated.

Methods of controlling risks must be balanced to support innovation and the imaginative use of resources when it is to achieve substantial benefit. In addition, the Trust may accept some high risks because of the cost of controlling them. As a general principle the Trust will seek to control all risks which have the potential to:

- Cause significant harm (physical and/or psychological) to patients, staff, visitors, contractors and other stakeholders.
- Have severe financial consequences which could jeopardise the Trust's viability.
- Jeopardise significantly the Trust's ability to carry out its operational activities.
- Threaten the Trust's compliance with law and regulation.
- Endanger notably the reputation of the Trust.

The absence of Business Continuity may have critical consequences; therefore, the Trust adopts the process as part of good management practice towards the reduction of risk; thus ensuring that the Trust strategy and core values are achieved.

The business continuity management system requires more than simply writing business continuity plans! The Trust is committed to an on-going management and governance process, fully supported by the Board which is appropriately resourced.

- Each service/team will develop and maintain an operational business impact analysis.
- General Managers / Service Managers will develop and maintain a tactical level business impact analysis and a Divisional / Service Business Continuity Plan
    - As part of this, each service should proactively consider patients and service users' needs by undertaking an EIRA in order to consider the disadvantages to all protected groups and take action to address those disadvantages in the event of a disruption.
- Each service will complete risk assessments in relation to its business continuity risks.

  - Both points should be managed through the COAT meetings / team governance processes.
- Each Division / Team will test annually its business continuity arrangements via an exercise or debrief of a business continuity event and produce a report of the lessons identified.
- A level of 75% compliance is required by each division / service. This includes:
  - General staff awareness
  - Operational Business Impact Analysis
  - Tactical Business Continuity Plan
  - Communication Exercise
  - Training and Exercising BCP
  - Incident Debrief Reports – where appropriate

9.2. Planning

Incident response plans should contain a framework for response. There should be sufficient background information so that responders can make informed decisions. DHCFT will have a single Incident Response Plan which will establish a common response framework and will be supplemented by a series of specific emergency plans to set out the detailed response arrangements for specific risks.

Once a plan has been prepared, it must be maintained systematically to ensure it remains up-to-date and fit for purpose at any time in readiness for an incident or emergency, this will be the responsibility of the EPRR & Sustainability Lead.

9.3. Training and Exercising

As outlined in the NHS England EPRR Framework 2022, the Trust is required to undertake, at a minimum, the following level of exercising, and this is to be articulated in the training and exercising strategy, together with all supporting events which build EPRR capability:

- 6 monthly 'Communications Cascade' test
- Annual 'Tabletop' exercise
- Annual Business Continuity exercise
- Three yearly 'Live' exercise
- Three yearly 'Command Post' exercise.

The Trust EPRR training and exercising framework will confirm how the Trust will conduct EPRR related training and exercising activities, who will be involved, with what equipment and facilities and how often. This will be shared and supported through the Training and Education Group which the EPRR & Sustainability Lead is a core member. It will also consider Trust engagement in external LRF activities and those non-Trust staff that have a role in the emergency plans such as contractors and multi-agency partners.

The EPRR & Sustainability Lead will design a training system to provide opportunities for staff involved in the planning for, or response to, an incident or emergency, to receive appropriate training. Managers are responsible for ensuring staff have conducted the required training and are able to perform their duties.

The EPRR & Sustainability Lead will ensure that National Occupational Standards (NOS) are adopted for the training of commanders at all levels of response as part of the training and exercising strategy. This, as part of the core standards assurance process, proves "competency" in responding to incidents and emergencies and leads toward a level of professional development.

The Trust will test the effectiveness of all emergency plans by carrying out exercises at varying levels, to a plan drawn up and managed by the EPRR & Sustainability Lead, against standards and approved by the EPRR Steering Group. It should be noted that where an incident occurs that utilises a 'full incident mode', this will replace the requirement for an exercise.

Business Continuity Specific training requirements

- The EPRR Team will provide training to relevant members of staff depending upon their role. There is an expectation that once the documents have been completed, local teams will advise staff of their existence and routinely discuss them and their responsibilities.
- Once the plan has been approved through the divisional/team governance process there is an expectation that the team will exercise the document within 12months to check its validity and accuracy. This will be facilitated through the EPRR Steering Group and reported into Finance & Performance Committee twice yearly.

9.4. Recovery

Following an incident, the Trust will implement recovery processes to return to optimal safe levels of service delivery across the organisation. This will consider the following areas:

- Humanitarian aspects
- Economic
- Environmental
- Estates and Infrastructure
- Operational updates
- Governance processes

This list will be guided by the nature of the incident and works needed to recover and or regenerate. Further information is available within the Incident Response plan.

9.5. Continuous Improvement Process

As soon as practicable following an exercise or incident debriefs will be conducted, this can take two main forms within the Trust; a hot debrief and a structured debrief;

this is outlined within the Trust Debrief SOP. Post incident/Exercise reports will be constructed by the EPRR team for any incidents that require the activation of a Trust EPRR related plan. This process may also be followed where key learning has been identified but activation of a document was not required. The report and actions will be presented to the EPRR Steering Group for sign off.

Exception to this is where incidents have a moderate impact on the ability of the Trust or system to function, these will be presented to ELT. Severe incidents that have major impacts on patients/staff safety or the ability for the Trust to provide services, and significant impacts on the financial or reputational status of the Trust will be presented to ELT and F&P. All actions pertaining to the PIR or PXR will be captured within the EPRR Steering Group action log and update reports provided to the relevant governance group.

The Trust will also feed into the wider system and regional learning forums following an incident or exercise. Key learning will be presented to HEPOG and updated as appropriate. Where the Trust is involved in a multi-agency incident, the Trust will provide a representative to participate in the Derbyshire Resilience Partnership debriefing process.

10. Monitoring and Evaluation

The EPRR Team will conduct internal audits at planned intervals to provide information on whether the BCMS conforms to this policy and requirement for a business continuity management system is as required by the ISO 22301 and to ensure that this is effectively implemented and maintained.

This will be conducted through a programme to visit a selection of departments and audit different elements of the business continuity management system each year. The reports from the audit programme will be presented to the EPRR Steering Group. Any lessons identified or corrective action required will be managed by the local manager.

The Trust will continually improve the suitability, adequacy and effectiveness of the business continuity management.

Equality Impact Assessment Template: Front Sheet

(To be completed for Stage 1 and updated for Stage 2)

Question	Response
Name of policy being assessed	Emergency Preparedness, Resilience and Response & Business Continuity Policy
Summary of aims and objectives of the policy	This policy outlines the Emergency preparedness, resilience and response requirements for the Trust and the legal and statutory responsibilities.
Is this a new or existing policy?	Existing
Please state which organisation is the EIA being completed for? • Derbyshire Healthcare NHS FT • Joint Derbyshire Healthcare NHS FT and Derbyshire Community Health Services • Other (please give details)	Derbyshire Healthcare NHS Foundation Trust
Division/Team/Service	EPRR Team
Date Stage 1 completed: Screening for Relevance	July 2025
Is a Stage 2: EIA required to be completed after Stage 1? Please provide justification	
Date Stage 2 EIA completed	
Name/s, job title/s and contact/s details of person/s completing this assessment	EPRR Lead Dhcft.eprr@nhs.net
Name, job title and contact details of responsible lead Director /Associate Director/Head of Service	
Has this EIA been logged in your Division/Service/Team EIA Tracker?	

Equality Impact Assessment Template: Stage 1 Screening For Relevance

(Please use plain English **http://www.plainenglish.co.uk/**, avoiding jargon and acronyms)

Question	Response
1a: Summary of aims and objectives of the policy	
1b: Please state who this policy will affect? • Patients or Service Users • Carers or families • Commissioned Services • Communities, in placed based settings • Staff - • Partners • Stakeholder organisations • Others (give details)	This policy is Trust wide and informs the organisation how it will prepare and respond to EPRR incidents and business continuity disruptions. This overarching document provides the governance for which all other EPRR and BC documents sit. This policy will affect all those listed.
1c: Will the policy impact equality and or inequalities? • Access to or participation in a service • Levels of representation in our workforce • Reducing quality of life (i.e., health, poverty education, standard of living)	Due to the nature of EPRR, we will be considering the impact a disruption/incident will have upon; the services we provide to our patients and service users and for our staff. During an incident we need to ensure that the actions and decisions taken by managers consider the protected characteristics for their customer base and community profile. Each plan developed as part of the risk profile will need to ensure an EIRA is completed to consider the specific needs during that particular incident. Managers preparing their business continuity plans must take into consideration the impacts of reducing services, amending delivery method and alternative outcomes during an incident and the effect that could have on all people associated with the Trust.
1d: If there are 'no' impact on equality and or inequalities, please provide an explanation?	

1e: If there are impacts on equality and or inequalities complete stage 2 EIA If you plan to complete the assessment at a later stage, please state the timescale for this	

EIA Completed by: Insert job title, not name
Date:

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 23 September 2025

Mental Health Services Assessment Tool (Men-SAT) report

Purpose of Report

To update the Board of Directors on the recommendations and action plan following the Mental Health Intensive Support team supported application of the Mental Health services Assessment Tool.

Executive Summary

The Mental Health Improvement Support team (MHIST) improves the care of mental health patients through hands-on, multi-specialist implementation support for staff, teams and systems.

The Joined Up Care Derbyshire (JUCD) System engaged the MHIST team in March to support in application of the Mental Health Services Assessment Tool (Men-SAT) improvement tool. The Men-SAT application review was launched in May 2025 and comprised a series of virtual whole System workshops, concluding in June with a full day summit and series of site visits by the MHIST team to DHcFT and broader System services across the mental health pathway.

The report enclosed at Appendix 1 sets out the findings of the MHIST team, with eight recommendations made that will support sustainable improvement of services and pathways. Whilst some actions are for DHcFT alone, the majority require System-led action and support in order to fully unlock the identified opportunity.

The second enclosed report at Appendix 2 highlights the recommendations that are for DHcFT to lead and our high level action plan. As described across the report, the majority of recommendations align with the existing Patient Flow transformation programme plan over Q3 and Q4 and the intent to take a data driven ‘end to end’ pathway approach in improving patient flow through community, crisis and acute pathways. There is also alignment with ambitions that sit within the Quality Delivery Plan. Where actions do not map to an existing programme, such as the review of our access policy, these have been incorporated as additions within our existing programme architecture.

Progress in delivering the internal action plan will be overseen through the Patient Flow Delivery Group with assurance and escalation as appropriate to the Strategic Portfolio Oversight Group.

For actions that require System collaboration and commitment, the Integrated Care Board is leading a process of action planning and work remains underway to define the detailed delivery plan for implementation of recommendations. Design and delivery of this plan will be overseen by the JUCD Mental Health Learning Disability and Autism (LD&A) Delivery Board.

On 5 September 2025. the Men-SAT report was presented by the CEO to the JUCD NHS Executive Group as a further mechanism to secure ownership of recommendations and action across System partners.

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

Risks associated with delivery of the transformation and improvement portfolio will be reflected in the programme risk registers, managed through the Patient Flow Delivery Group and escalated where appropriate to the Strategic Portfolio Oversight Group.

Consultation

- The proposal for engagement of the MHIST support offer was approved by the JUCD Mental Health LD&A Delivery Board and the Urgent and Emergency Care Delivery Board with all partners committed to involvement and engagement with the review
- The Men-SAT report is being actively shared across partner organisations and through key System governance to include the NHS Executive and Mental Health LD&A Delivery Board
- The enclosed reports will be shared with the DHcFT Board in September 2025.

Governance or Legal Issues

The Men-SAT improvement findings and recommendations draw from a wide range of published literature, policy and 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:

Application of the Men-SAT recommendations will support positive impact through the identification and action of inequalities or areas of unmet need across the pathway.

Recommendations

The Board of Directors is requested to:

1. Note the Men-SAT report and recommendations
2. Support implementation of the associated action plan.

Report presented by:	**Vikki Taylor** **Chief Delivery Officer and Deputy CEO**
Report prepared by:	**Maria Riley** **Assistant Director of Transformation**

UEC Mental Health Services Assessment Tool (Men-SAT) Report: **Derby and Derbyshire ICB**

Mental Health Improvement Support Team

Version: **2.0**
Version date: **01/08/25**

Report structure

Introduction

This report aims to provide Derby and Derbyshire Integrated Care Board (ICB) and system partners with key improvement opportunities for the system across the Mental Health Urgent and Emergency Care pathway. The outputs highlighted in the report were formed through a method of structured self assessment through the Mental Health Assessment Tool (Men-SAT) process.

During the initial scoping phase, the system identified some key challenges to be addressed, including high bed occupancy levels leading to patients being placed in out of area placements and challenges in flow in the acute inpatient areas, clinically ready for discharge and 12 hour plus breaches in the emergency departments. The system also wanted to explore the effectiveness of crisis and community provision including crisis alternatives. The Men-SAT process was a 12-week programme included system online workshops, a facilitated system summit that took place on 18th June 2025 concluding with service site visits on 19th June 2025.

Strengths

Seeking a collective system view supports strategic thinking and the development of collaboration on improvement.

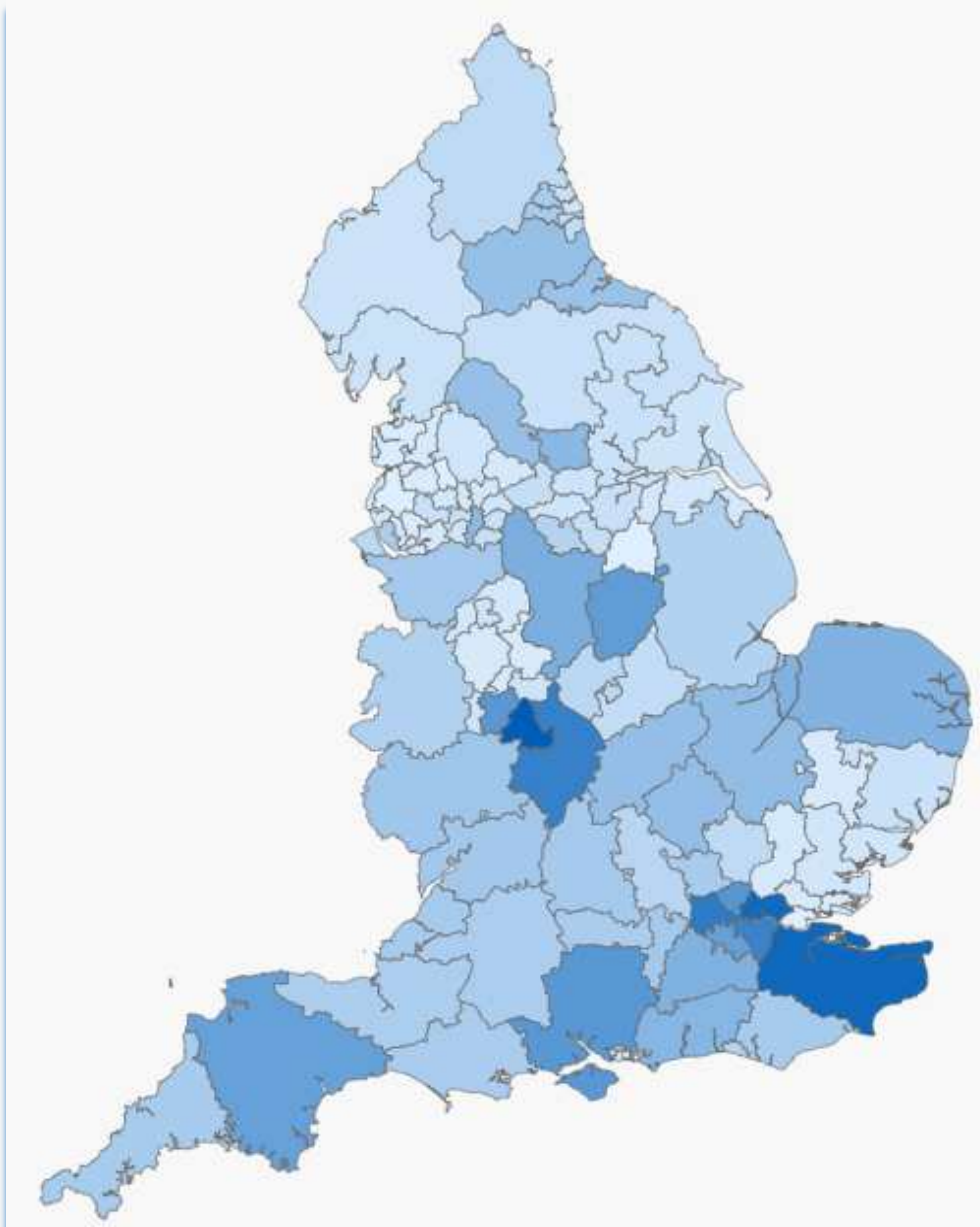
Limitations

It is of note that whilst attempts were made by the ICB to engage all system partners through out the process and the system summit day, there were partners absent from Voluntary Community Faith and Social Enterprise group (VCFSE), East Midlands Ambulance Service, Derbyshire Police, University Hospitals of Derby and Burton NHS Foundation Trust and Chesterfield Royal Hospital NHS Foundation Trust.

This UEC Men-SAT summary report is provided to facilitate discussion. The interpretation of Mental Health Improvement Support Team (MHIST) findings should be followed up with more detailed local discussion. As such, all data and views shared by stakeholders in their feedback to MHIST should be verified by system partners to reach a shared understanding of the position in the areas of concern highlighted in this report, as part of the process of achieving improvement in the MH UEC pathway.

Acknowledgements

The Mental Health Improvement Support Team (MHIST) would like to thank all the staff, stakeholders and service users who have engaged with us over the course of undertaking the UEC Men-SAT process. We have really valued the openness and candour that has been shown during the discussions.



The Mental Health Improvement Support Team

There are nearly **2 million** people in contact with mental health services in England and many more waiting to receive help.

The **Mental Health Improvement Support Team** improves the care of mental health patients through hands-on, multi-specialist implementation support for staff, teams and systems (NHS, VCFSE and independent sector).

We provide a universal offer, a targeted support offer and an intensive support offer according to need.

Who we are and how we work

Credible expert support

- Senior experience of **clinical and operational delivery** and **service improvement**
- **Technical knowledge and expertise** to assess service quality, pathway processes and efficiency
- Knowledge of good practice and the **critical success factors to deliver national targets** and the conditions that sustain them
- **Expertise** in sound **data management** and how to develop robust governance and reporting systems for **effective oversight and decision-making**

Empowering improvement

- **Collaboration and system focus** – we secure senior level and engagement and bring staff together to develop a shared purpose
- **Friendly and approachable, inclusive and empowering** – we model inclusive leadership behaviours and values to draw on the assets of all staff
- **Clarity and alignment** – we help systems join the dots between governance, roles and responsibilities, performance and support needs

Capability building

- We deliver **clear recommendations** that enable **sustainable improvements**
- We provide **practical tools and guidance** to improve patient care
- We promote **knowledge transfer and capability building** of local teams through our use of tools, KLoEs, webinars, workshops and coaching
- We **champion and mentor local leaders** at all levels, helping them to build confidence in their improvement role

Executive Summary

This report presents findings and recommendations from the Mental Health Services Assessment Tool (Men-SAT) undertaken with the Derby and Derbyshire Integrated Care Board (ICB) system during May and June 2025. It identifies good practice, challenges, and improvement opportunities across the Urgent and Emergency Care (UEC) mental health pathway.

It is of note that whilst attempts were made by the ICB to engage all system partners throughout the process and the system summit day, there were partners absent including VCFSE, East Midlands Ambulance Service, Derbyshire Police, and University Hospitals of Derby and Burton NHS Foundation Trust. Given this there will be limitations and the findings and recommendations in this report will need to be discussed in more detail as a whole system.

During the initial scoping phase, the system identified some key challenges to be addressed, including high bed occupancy levels leading to patients being placed in out of area placements and challenges in flow in the acute inpatient areas, clinically ready for discharge and 12-hour breaches in the emergency departments. The system also wanted to explore the effectiveness of crisis and community provision including crisis alternatives.

Throughout the Men-SAT we seek to focus on improvements that are realistic in terms of achieving successful and sustainable implementation. It is recognised that the scale of opportunities may be greater than the leadership and delivery resource capacity to deliver. This will be particularly true at present across the Derbyshire system given the scale of organisational change impacting services throughout the system. During the site visits, Derbyshire Healthcare NHS Foundation Trust staff expressed concerns that implementation of the future operating model and associated reduction in posts will reduce team cohesion and effectiveness, and this – and the broader system change programme – should be acknowledged as a risk to both improvement initiatives arising from this process and operational delivery.

We saw widespread evidence of highly committed and cohesive staff teams focused on patient care and experience and heard many examples of good practice within services which are described in the main body of the report. Throughout the summit there was widespread agreement that effective system engagement – inclusive of all voices – is critical to achieving improvement within the MH UEC pathway.

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The Men-SAT process enabled rich discussions amongst system partners which generated a number of significant opportunities to improve Derbyshire's urgent and emergency mental health care system through better integration, clearer referral pathways, and more consistent service models.

Key opportunities included:

- Enhancing early discharge processes to improve flow form inpatient care and promote least restrictive care through home treatment
- Optimising crisis alternatives to support individuals to get the right care in the right place to meet need
- Exploring opportunities to better integrate ways of working across CMHTs and assessment services.
- Addressing geographic and service gaps – particularly for children, young people and those with complex needs – to improve equity in access and provision
- Strengthening governance, developing a unified mental health strategy, and embedding clinical, community and the lived experience voices in decision-making as this is critical to meaningful and sustained improvement

Additionally, standardising data use, improving workforce planning, and fostering system-wide collaboration offer with strong potential to drive sustainable improvements in care quality and access.

At the summit day we heard very loudly the importance of prevention, equity and collaborative engagement from system partners, and taking this into account with the top priorities that emerged from partners discussions during the summit day, the recommendations that follow are a synthesis of the main prioritised opportunities for improvement.

Executive Summary

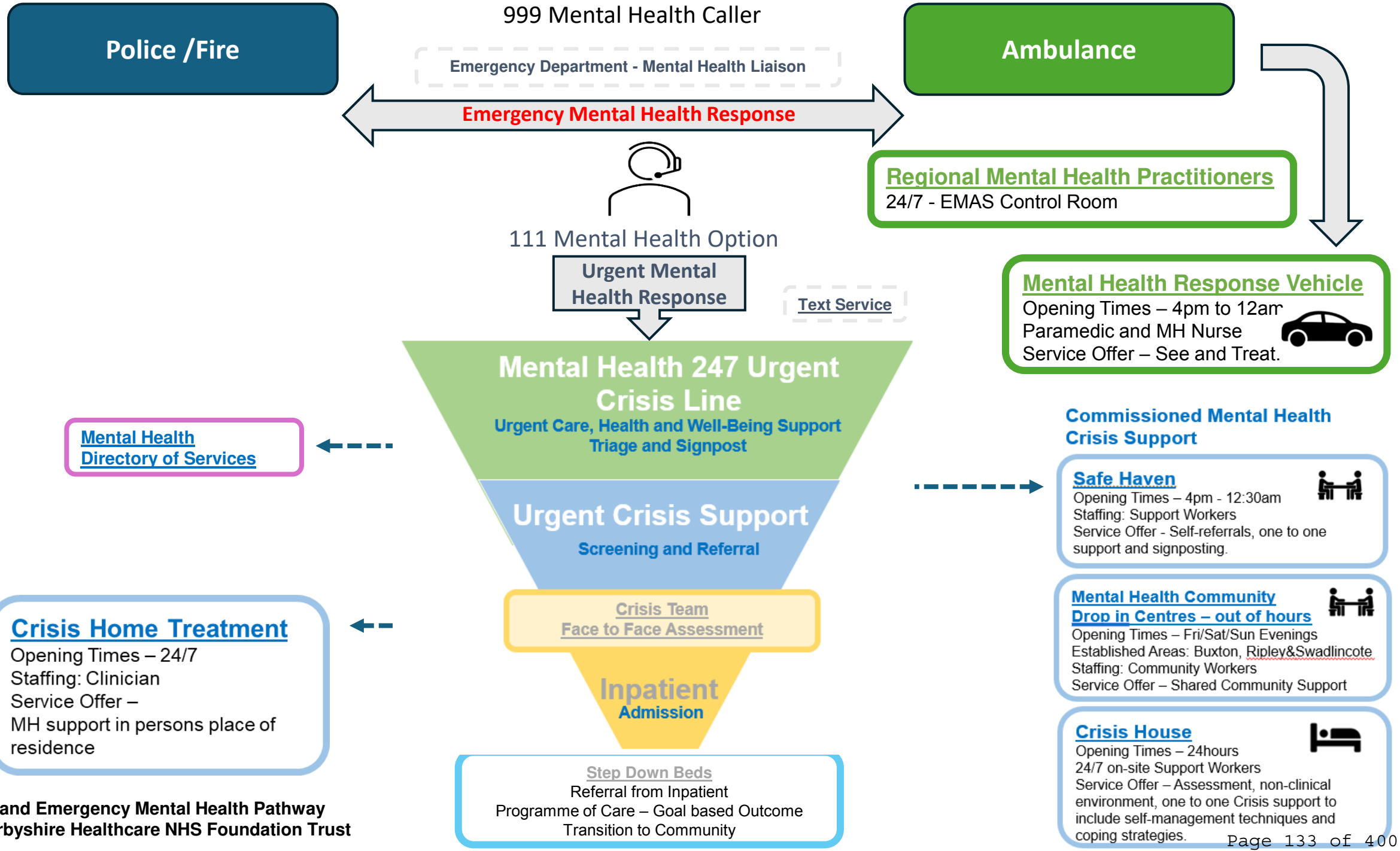
Recommendations

1. The ICB must create the conditions for success by ensuring that its strategic priorities are informed by all system partners and its governance structure supports multiagency communication and effective oversight to ascertain the quality and impact of its services
2. The ICB should play an enabling role in developing plans to remove barriers to seamless care delivery by ensuring that all parts of the system share a common understanding of a comprehensive pathway in which services are optimised to facilitate flow through the pathway
3. System partners should review the interfaces across the Mental Health UEC pathway with a view to achieving a shared understanding amongst partners of the service offer and referral thresholds to reduce variation in clinical models and improve equity in access
4. Derbyshire Healthcare NHS Foundation Trust should, as a priority, work with commissioners and University Hospitals of Derby and Burton NHS Foundation Trust to review current plans for the location of the Crisis Assessment Service pilot and relook at opportunities for premises that are co-located with the ED
5. System partners should work together to seek rapid improvements to both the resourcing and operation of the Mental Health Helpline model to improve access into the system and optimise the service provided
6. Develop a system wide workforce strategy for both Adults and CYP to ensure that the right workforce is in place to meet the needs of the population, including considering what workforce is needed to meet the unmet social needs of service users across the system
7. Convene a group to review the intelligence on High Intensity Users across the system and develop co-ordinated plans to ensure appropriate resource allocation and that service users receive the right care in the right place at the right time
8. Agree priority actions for strengthening the use of data and intelligence to inform system planning and service delivery

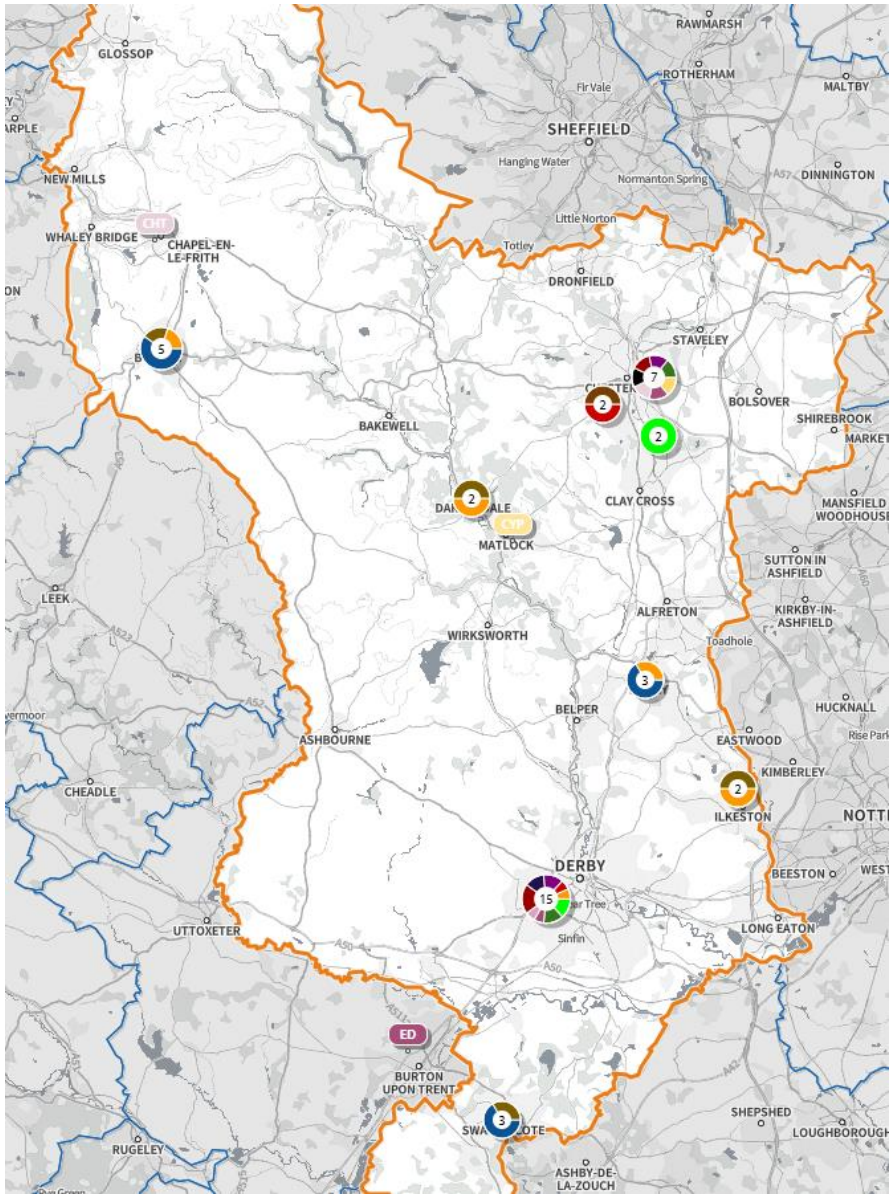
Glossary

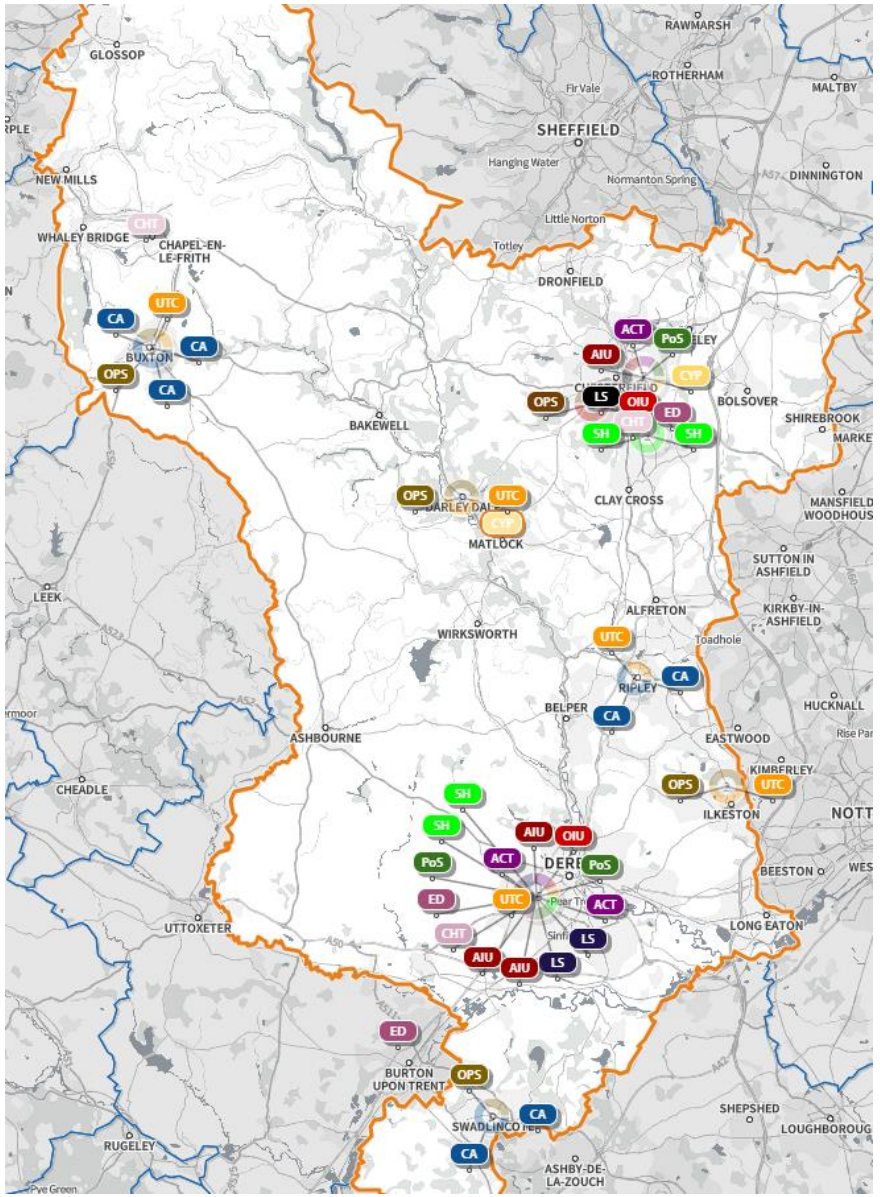
AHP	Allied Health Professional
AMHP	Approved Mental Health Professional
AWOL	Absent Without Leave
CAMHS	Child and Adolescent Mental Health Services
CETR	Care Education Treatment Review
CRHT	Crisis Resolution Home Treatment Teams
CMHT	Community Mental Health Teams
CNDRH	Chesterfield North Derbyshire Royal Hospital
CRfD	Clinically Ready for Discharge
CYP	Children and Young People
DHFT	Derbyshire Healthcare NHS Foundation Trust
DoS	Directory of Services
EBE	Experts by Experience
ED	Emergency Department
EPR	Electronic Patient Record
GIRFT	Getting it Right First Time
HBPoS	Health Based Place of Safety
HIU	High Intensity User
ICB	Integrated Care Board
ICS	Integrated Care System
JSNA	Joint Strategic Needs Assessment
KPI	Key Performance Indicator
LTP	Long Term Plan
MH	Mental Health
MDT	Multi Disciplinary Team
MHIST	Mental Health Improvement Support Team
MHRV	Mental Health Response Vehicle
Men-SAT	Mental Health Service Assessment Tool
MHLDA	Mental Health, Learning Disability and Autism Board
MHRVS	Mental Health Response Vehicles Service
PLAN	Psychiatric Liaison Accreditation Network
PoS	Place of Safety
QI	Quality Improvement
RCRP	Right Care Right Person
VCFSE	Voluntary, Community, Faith and Social Enterprise
UEC	Urgent and Emergency Care

System Overview



18+ Urgent and Emergency Mental Health Pathway
Source: Derbyshire Healthcare NHS Foundation Trust





Key	
Acute Trusts	ACT
Crisis Alternatives	CA
Children and Young People	CYP
Older People Services	OPS
Adult Inpatient Units	AIU
Older adult inpatient units	OIU
Liaison Services	LS
Crisis Resolution and Home Treatment team	CHT
Emergency Departments	ED
Places of Safety	PoS
Safe Havens and Crisis beds	SH
Urgent Treatment Centres	UTC

Key Findings

Pathways and integration – good practice

CMHT	Crisis support	Inpatients	A&E
CMHTs have a defined Assertive Outreach model and differentiated short term and long term offers. MDT meeting approach – “Urgent 7” which identifies patients requiring increased intervention to prevent further deterioration. CAMHS community and crisis pathways – joined up approach to escalation and system working. Active support while you wait cited by CMHT for patients on waiting list, also in line with policy.	CRHT benchmarking against fidelity standards. Crisis Helpline integrated working between DHCFT and P3. Crisis House / Safe Haven do not automatically turn away clients under the influence of substance misuse at time of presentation, as understand vulnerability and link to suicide rates. Waythrough could clearly articulate their challenges in engaging their local Asian British communities and were actively trying to address.	The Early Discharge Team work to a 48 hour follow up standard, rather than the national 72-hour standard. Length of stay is just below the England average.	Liaison services are PLAN accredited and perform very highly on response time standards. Strong “business as usual” relationships between Chesterfield Royal Hospital and Liaison. Specialist psych liaison older adults' manager and substance misuse team located in Royal Derby ED making a huge difference to volume of patients waiting.

Pathways and integration – opportunities

System discussions consistently emphasised the importance of pathway connectivity between teams', services and all providers. Pivotal to the discussions was the shared ambition of moving toward a preventative model of care and the need to maximise all resources including community assets. We heard very loudly the need for engagement with all system partners and leaders including faith leaders in local neighbourhoods and communities to help support improvement in care pathways and improved health outcomes.

Access

- We did not see widespread evidence of a shared understanding of the extent to which there are inequalities in service access, experience or outcomes. The ICBs mental health programme board plan 25/26 for adults does not explicitly address this. However, health inequalities is identified within the board improvement plan for children and young people.
- There is no overarching system wide view of the access standards across the mental health UEC pathway. We heard that DHFT had an access policy with clear mechanisms for review, but this is not inclusive of crisis alternatives. The access policy is not publicly facing, and not all system stakeholders were aware of the different points of access to the mental health trust or other mental UEC services such as crisis alternatives
- The Mental Health Helpline currently receives around 5,000 calls per month. It was reported that five patients accounted for 20% of helpline activity. This will need verification in local conversations. We heard that whilst there was a high intensity user (HIU) worker based in CNDRH with a focus of physical health "frequent attenders" there was no system wide HIU programme within Derbyshire that was focused on all frequent users of service (regardless of need).
- The Mental Health Helpline is currently accessed by patients via two core routes; DHCFT 0800 number and 111 #MH. Currently two thirds of all calls to the helpline come via the 0800 number. The plan is to move to a single point of access through 111#MH in line with national strategy. We heard that frequent user's access via 0800, and it is known that some callers residing outside the county access the helpline for regular emotional support via this route, therefore in the event of moving to 111 #MH, current access by frequent users during this transition will require consideration, clinical management and support.

Pathways and integration – opportunities

- The mental health crisis model currently offers mental health triage and emotional support and a dedicated professional line for crisis assessment. Since 2024 it has also provided the clinician resource to the mental health response vehicle (only covering Derby city) without any additional funded resource. Data indicates that Derbyshire has a high abandoned call rates of 29 percent. The ability to staff the MHRV has also been variable due to availability of clinician resources. We heard that capacity to meet call answer times is impacted on by the team's current model of including emotional telephone support and the need to staff the mental health response vehicle. There has been no recent demand and capacity modelling undertaken.

Flow: referrals and thresholds

- Throughout the Men-SAT process there has been consistent view for the need to improve flow through the whole pathway. We have heard that there is a lack of system wide understanding of the bottlenecks to flow across the UEC mental health pathway. There are perceived and actual gaps in acceptance criteria across teams resulting in a lack of clarity and a feeling that teams are often working against each other. Examples of this could be seen in the referral pathways from community mental health teams to crisis home treatment teams and access to safe haven crisis house alternatives. Anecdotally we heard that there were several factors contributing to this:
    - Demand pressures have led to perceived and explicit tightening of acceptance threshold criteria, which can be a cause of conflict between teams and is a significant impediment to seamless patient care.
    - Some teams felt there was a lack of understanding of other teams' remits and models
    - We heard frequently that service specifications were out of date and/or no longer informing service models and KPIs
    - There is a perceived, and potentially real, under-resourcing in CMHTs and imbalance in the resource levels across CMHTs resulting in teams being less able to proactively manage deteriorating patients

Pathways and integration – opportunities

- Data indicates Derbyshire has very high bed occupancy levels contributing to challenges in inpatient flow. We heard that there have been concerted improvement efforts including multi-disciplinary daily board rounds, mini MADEs and a focus of action-based escalation. During site visits we heard that one barrier to flow was confidence in crisis and community services to provide a wraparound early discharge model of care.
    - Early discharge teams' ability to optimise early discharge is being limited by inpatient teams' confidence to discharge to a responsive home treatment offer (cited in the north of county).
    - Early discharge flow is impacted by not being able to discharge fast enough due to capacity issues with care coordinators, leaving crisis teams doing a lot of 'holding work'.
    - Crisis alternatives not currently being utillised as part of early discharge home treatment interventions.
    - There are several barriers to discharge such as housing, immigration visas, social care packages and benefits support.

ED avoidance

- There is a plan for a test of concept pilot for a Mental Health Clinical Assessment Service (CAS) to be located at Albany House (Kingsway site). This is not a co-located site with acute services, mental health liaison or crisis teams. We heard concerns that this could lead to the failure of the pilot and the ability to manage a patient's holistic needs, especially those that might still need physical care. The CAS would be isolated from other MH UEC services impacting on the connectivity and ability to provide seamless pathways of care. Nationally good practice models have been able to demonstrate optimal efficacy through co-location.
- We heard that historically there had been plans to have a co-located service at both Royal Derby Hospital and Chesterfield Royal hospital but at that time no funding for staffing could be attained. We heard that there could now be opportunity to revisit conversations around the utilisation of a 6 bedded facility on the Royal Derby site.

Pathways and integration – opportunities

- We heard and saw data suggesting a high percentage of people assessed by psychiatric liaison and crisis teams have social care issues as being primary factors for mental health crisis. Current models of care are associated with health-based models and that opportunities for building preventative pathways in local communities, voluntary sector and social care are not currently fully optimised.
- Anecdotally we heard that as much as 40% of those presenting to ED are not known to services. If data intelligence is validated and correct this may indicate missed opportunities for earlier interventions through access to crisis alternatives.
- Waiting for Mental Health Act assessments in the emergency department can be a cause for delay. We heard that AMHP capacity is frequently stretched and accessing a section doctor out of hours can be challenging. Chesterfield Royal Hospital and Chesterfield Liaison team have worked together to seek solutions and opportunities to reduce delays. An example of improvement is using on-call acute medical registrars as the second doctor. We heard this has provided a more responsive service than relying on Section 12 approved doctors' availability lists.
- During the summit day we heard there are no CAMHs beds physically located in Derbyshire. Derbyshire commissioned CAMHs beds within a neighbouring county are frequently not accessible, leading to impacts on flow out of ED and paediatric settings. We have since heard that through the provider collaborative there has recently been the introduction of the 3.5 tier service which has enabled Derbyshire to provide greater wrap around care in the community and resulted in a significant reduction in the requirement for beds.

Pathways and integration – opportunities

Optimising crisis alternatives

- There is geographic variation in the crisis house models. The crisis house in Chesterfield provides up to a 7-day stay, it is an alternative to hospital admission with a focus of short-term intervention to support stabilisation. We heard that they had strong links with P3 housing link workers which aided discharge flow. The crisis house in Derby provides up to 12 weeks' accommodation to support the transition from inpatient care to independent living [*Subsequently, we were told that the 12- week offer is not reflected in their contract and that both Chesterfield and Derby Crisis Houses are covered by the same service specification*]. Prior to accepting an admission, onward housing must be arranged, which can sometimes act as a barrier to accessing the crisis house and contributory to delays in inpatient discharge. This is a growing challenge given the referrals are for individuals with increasing health and social need complexity. Currently, the facility is underutilised and there are inequalities in access (we were told that 99% of clients are White British).
- We heard within the summit and on-site visits that there are gaps in provision of crisis alternatives based on geography and hours of operation. Crisis beds and safe havens are centrally located in Chesterfield and Derby city. We did hear that the High Peak and Derbyshire Dales localities were poorly serviced due to lack of crisis alternative provision. The three crisis café drop-in services are located in the outer areas of Derbyshire but offer only limited opening hours three days per week.
- The crisis house in Chesterfield was under utilised with occupancy rates being as low as 34 percent in January 2025 and still below the target of 80 percent. There is a lack of consistency and shared understanding regarding the appropriate thresholds that this service can safely support, that requires further system exploration.
- Access to the crisis house beds is managed by the crisis home treatment teams and no other team or agency can refer to the crisis house directly. We heard that this was a barrier to access given the thresholds for crisis assessment and home treatment were often much higher than the risk thresholds of community home treatment. For example, currently a community mental health team could not refer to the crisis house in the event that a patient was deteriorating and requiring additional wrap around support.

Pathways and integration – opportunities

Optimising crisis alternatives

- Safe Haven and Crisis services in Chesterfield and Derby City support drop in and self-referral. User feedback is consistently positive. We heard that there is opportunity for the service to be further optimised as currently not used to capacity. We heard that safe havens had no direct access for crisis assessment in-reach and have to phone helpline (professional) to access crisis assessment and face to face assessment would not be at the safe haven. We heard that direct crisis assessment in-reach would be a more responsive approach and support hospital avoidance.
- There is currently no safe haven crisis alternative for children and young people within Derby City or Derbyshire. [*We were subsequently told that expanding Safe Haven services to include CYP had been explored but due to unmitigated safeguarding risks, this was not considered viable at the time*].
- It is evident in the ICB CYP mental health programme plan 25/26 that there are plans to address gaps within the crisis mental health pathways, although milestones and full implementation details are not clearly identified. It is also recommended that this is inclusive of VCFSE crisis alternative provision which is currently absent within the programme plan.

Pathways and integration – opportunities

Gaps in the pathway

- There are currently no pathways for Emotionally Unstable Personality Disorder (EUPD), and the existing Emotional Regulation Pathway (ERP) is facing capacity issues, with only one ERP nurse available within the Community Mental Health Team (CMHT). The Psychiatric Liaison teams report a high number of EUPD presentations in the Emergency Department, leading to increased inpatient admissions. Quality concerns have arisen due to the acuity of patients and the opening of new wards, resulting in an over-reliance on agency and bank staff. This lack of consistent therapeutic relationships impacts the quality of care for this client group. While staff are highly committed to providing good quality care, this situation can negatively affect their well-being.
- There has been a rise in referrals for Autism and ADHD assessments, but there is no commissioned ADHD service available. The existing Specialist Autism Team (SAT) has strict referral criteria and offers limited crisis response. Long waiting times for neurodevelopmental and ADHD assessments, combined with limited onward treatment pathways, have increased the demand on Community Mental Health Teams (CMHTs).
- Helpline is all age but access to CYP urgent crisis face to face assessment is not 24/7 and there is also variation between north and south service models. Derby and South Derbyshire have a CYP crisis and liaison service open 7 days a week, 8 am till 11pm whereas in the north of the county urgent assessments out of hours are facilitated via on call consultant cover.
- There are no CAMHS beds in Derbyshire and commissioned beds are in a neighbouring county. We heard that access to these beds was a significant challenge as often the Derbyshire commissioned beds were occupied by non-Derbyshire patients. We have since heard that through the provider collaborative there has recently been the introduction of the 3.5 tier service which has enabled Derbyshire to provide greater wrap around care in the community and resulted in a significant reduction in the requirement for beds.
- There is high demand for specialist inpatient eating disorders services for adults and children and this was a known gap in provision resulting in admissions often being into acute hospitals impacting on individuals have access to the right skills and specialist care.
- It is evident that the ICB have identified the gaps in CYP, eating disorders and ADHD and autism within the 25/26 programme plan, however specific milestones and implementation approaches are not clearly identified.

Workforce and environment – good practice

- We saw widespread evidence of highly committed and cohesive staff teams focused on patient care and experience.
- The Making Dignity Count estates programme has been a great success and demonstration of what can be achieved given a clear vision with collaboration and leadership. The new build inpatient units (Carsington and Derwent) appear to be with bright, spacious, calm environments with excellent design features for patients, families/carers and staff, and staff have shown adaptability and resilience in adjusting to changes and teething estate problems.
- We heard that there were low vacancy rates across inpatient units and there had been sustained high interest from newly registered nurses and Allied Health Professionals (AHPs).
- Without exception we saw evidence of a passionate clinical voice with leadership vision and capability. We heard very loudly the desire to be engaged and involved in improvement initiatives across UEC pathways.
- There were examples given of nontraditional supervision models such as medical teams group supervision with the Area Service Manager and attendance at the weekly operational/clinical performance meetings.
- Chesterfield Royal Emergency Department providing the second doctor for mental health act assessments, with the training and supervision provided by Chesterfield mental health liaison.
- The homelessness support role in City crisis team was reported to be highly effective in facilitating discharge and reducing length of stay (however the postholder was on maternity leave and suitable cover was not in place).
- Excellent Band 4 'bed flow coordinators' who take pressure off clinicians as manage all communication, bed availability and liaise with Out of area (OOA) patients.
- At both Derby and Chesterfield there is a separate Paediatric Emergency Department that receives CYP presenting in crisis, with good multi-agency working and use of system processes such as pre-admission CETR.

Workforce and environment – opportunities

Strategy

- There is no system wide mental health workforce plan for Derbyshire and Derby City ICB and in turn no strategic view of the skills, competencies and training needs required across the UEC crisis pathway. MH Providers do provide a workforce development plan which is aligned to Evidence Based Treatment Pathways, however, we did not hear evidence that this is delivered in a systematic way.
- We heard limited evidence of the use of peer support roles within inpatient, crisis assessment home treatment or liaison teams. Examples offered were as part of the crisis alternative safe havens and cafes. There was limited evidence of the voice of lived experience being embedded in paid roles at all levels of the main mental health provider trust of ICB.
- Stakeholders raised concern that there was still no national guidance or staffing establishment model for community mental health services creating challenge in setting what “good skill mix” looks like.
- During the summit and on site visits we heard several clinical leaders describe positive innovations and improvements at team level. This included self assessment against quality standards in the absence of accreditation and using data to inform MDT process. There was however concern raised that clinicians did not always feel listened to and therefore the opportunity to share and scale ideas missed. Clinical leaders do not always feel engaged or heard and told us they would welcome opportunities that support and empower the clinical voice.
- We heard that vacancy control processes lead to significant delays in filling vacancies, reducing capacity and increasing staff overload.
- We heard that there were some examples of teams and services adopting Quality Improvement (QI) methodologies as a structured approach to enhance processes and outcomes, but that this was not universally embedded in a robust way across the system. For example, different organisations have different processes and approaches to improvement. We heard during online workshops a desire to have a standardised approach to quality improvement and a need to collaborate as a whole system.

Workforce and environment – opportunities

Capacity

- We heard views from several teams that the lack of capacity in CMHTs was a barrier to flow. The City CMHT base houses a large proportion of the Trust workforce and overcrowding causes issues with staff ability to hot desk and access suitable meeting space. A shortage of parking can lead to delays and missed appointments
- Teams and pathways are often heavily reliant on key individuals, and in some cases, continuity and resilience planning is either absent or ineffective. For instance, there is only one homelessness worker covering inpatient and crisis services, whose role has been crucial in facilitating patient flow by addressing housing and benefits issues. This worker is currently on maternity leave and has not been replaced, which has significantly impacted patient flow.

Workforce and environment – opportunities

Section 135 and 136

- Health based places of safety (HBPoS) are co-located to the main mental health inpatient units and have been designed with in line with guidance. We heard that there has been a significant increase in Section 135/136 activity. The increase in section 135/136 activity has resulted in “overspill” into the Emergency Department (predominantly Derby City) as a place of safety due to the designated Health Based Places of Safety being at capacity. Chesterfield and Derby ED have designated paediatrics environments, but adults would need to be observed and managed within general majors. Neither of these environments are conducive to the management of section 135/136 or the management of acute mental health disturbance for both children or adults.
- The designated Health Based Places of Safety have dedicated staffing and a clinical lead overseeing the three HBPoS. We heard that the clinical lead has positive relationships with partner agencies.
- There is a specific protocol for police to call ahead to HBPoS or the emergency department before attending and only consider the Emergency Department in the event of the person requiring medical treatment or if all HBPoS are full. We heard from acute partners that police did not always adhere to this protocol.
- We did not hear that there was an established approach for police to call the professional line to seek mental health alternatives to section135/136 detentions. Whilst police have access to the crisis professional line, they have no authority to request dispatch of the mental health response vehicle which could be seen as a limitation in seeking alternatives to section 135/136 detentions.
- We did not hear that there was any specific mental health training in place for police officers
- There is a monthly multi agency mental health act forum where data is used to review and monitor activity and trends. We heard this was a positive forum with good multi agency attendance.

Technology, data and intelligence

Good practice

- Internal sign-off process for key data in MHSDS submissions and good alignment between local and national data in most instances (DHFT and VCFSE)
- Effective scorecards available for key operational performance (DHFT)
- The MaST system is an effective tool – we heard and observed a CMHT use the MaST system to be able to identify potential deteriorating patients through the visibility of activity data from across the trust and contact points and respond proactively meaning escalating risk and deterioration can be assertively managed

Issues and improvement opportunities

- There are known issues with the Crisis 111 option 2 telephone system leading to increased abandoned call rates and ‘lost callers’
- There is no view of call stacking/call waits on the help line professional line
- There are opportunities for greater data sharing, e.g. the development of a system wide UEC MH pathway pressures dashboard
- There is not a common understanding of the value of outcomes data and an inconsistent approach to their use
- In some systems, there are multiple ways in which to enter data which leads to inconsistencies in data capture and reports
- VCFSE and social care partners are unable to access key information held in DHFT’s EPR (SystmOne)
- Not all VCFSE commissioned providers input into the MHSDS and therefore their impact is not fully captured.
- It is good practice to understand the pattern of breaches and delays by examining EMAS data

Strategy, governance and system leadership

Good practice

- Right Care Right Person (RCRP): Derbyshire have taken a responsive approach to implementing RCRP and have developed a multi agency agreement with the purpose of providing guidance for healthcare organisations and emergency response services towards appropriate decision making, in line with the Right Care Right Person national agreement, and to ensure people encountering some form of mental health distress receive the most appropriate response from mental health professionals.
    - There is an established governance structure with multi-agency workstreams and named leads, including executive oversight and escalation pathways.
    - A CYP workstream has commenced led by Police with a focus of engaging CYP colleagues across Health, LA, Safeguarding teams and Criminal Justice Service
    - There remain elements of development around implementation including:
        - Completion and implementation of a RCRP dashboard
        - Multi agency Standard operating Procedures (SOPS) to be fully mobilised into practice
        - Completion and sign off of RCRP Data Sharing Agreement
- Mental Health Act Forum: Derbyshire has a multi agency attendance at the monthly forum which includes a system view of section 136 data

MHIST were subsequently informed that Derbyshire has been recognised and nominated as an area of good practice by the Midlands Region and Royal College of Psychiatrists for the work and approach to implementing Right Care Right Person.

Strategy, governance and system leadership

Issues and improvement opportunities

We heard and have highlighted in this report, many examples of good practice within individual mental health services in the Derbyshire. However, it is also clear that the effectiveness of the Derbyshire system's urgent mental health pathway could be strengthened by an enhanced strategic focus and governance as currently, there are limitations due to:

a) An absence of clear set of objectives, goals and outcomes to unite all system partners in coordinated action on shared priorities

- The Derby and Derbyshire system could not confirm that it has a clear Mental Health Strategy and vision in place for adults nor a clear Children and Young People (CYP) local transformation plan that is current to deliver 24/7 all age urgent/crisis mental health care.
- We heard at the summit and from staff in services about the opportunities for early intervention to prevent crisis and for a coordinated strategic focus in addressing determinants of mental ill health and crises in regard to social issues and housing (page 16)
- It was unclear how the Derbyshire system, could confirm the outcomes being achieved, the extent to which services are adding value or addressing the unmet need. We heard of variation in use of outcomes and types of measures being used between different teams and providers. Moreover, there was no systematic system wide way of using outcomes for improvement.

Strategy, governance and system leadership

b) Limited confidence expressed by system partners in the strength of engagement and partnership working and whether current plans are based on a shared understanding on the issues, risks and gaps in mental health services.

- Throughout the summit day there was an overwhelming agreement that system engagement inclusive of all voices was critical to achieving improvement within the MH UEC pathway.
- We heard that Experts by Experience (18+) and VCFSE partners do not feel their voices are equal to other partners. The potential to make more use of community assets and faith groups in strategic planning and delivery of services was highlighted during the summit.
- We heard from EBE (18+) and their advocates of their strong desire to be involved early in the design process of policy actions and the mental health service offer as they felt that the patient voice is not strongly represented in the system collective leadership.
- The absence of key stakeholders at the summit suggests engagement issues and the need to strengthen/ lack of ‘whole system’ approach.

Strategy, governance and system leadership

c) Service gaps and inconsistencies in service models in different parts of the county

- There are gaps in pathway for patient groups: access to 24/7 urgent crisis assessment for CYP, people with EUPD, people requiring ADHD assessment (see p19), and an absence of a coordinated effort to address people with complex needs who are high intensity users of urgent and emergency care services.
- There are geographic gaps in provision leading to potential inequalities, for example the north of the county does not have access to a Mental Health Response Vehicle (MHRV). Derbyshire Dales do not have crisis alternatives but are able to access community resources available in Buxton, Chesterfield and Ripley due to geographic proximity. [*We were subsequently informed that the location of crisis alternatives was informed by data and intelligence at the time of commissioning as to where this was most needed*]. Whilst service operating hours have been optimised to meet periods of high demand, inconsistencies in service operating hours can be a cause of confusion for patients and referring professionals.
- There are gaps and variation between crisis drop in hubs, geographically and in hours of opening gaps within the provision
- There are differences in models of provision between the North and South of the county for CYP services and in the crisis houses bed model.

d) Limited clinical involvement in strategic discussions and service development

- We heard that the clinical voice and representation in strategic discussions of the pathway and service development was limited. Clinicians within the Derbyshire system including community services did they feel heard, a missed opportunity to utilise their specialist knowledge to ensure the pathway works well across teams and organisational boundaries.
- We also heard of challenges in achieving dedicated leadership time to change mindsets and lead pathway developments as these activities were not consistently accounted for as part of their job plans.

Strategy, governance and system leadership

e) Limitations in existing governance structures, processes and their cohesiveness

- There are separate boards for Mental Health UEC rather than one overarching UEC delivery board impacting on partner attendance and parity of mental health priorities. We heard that the MHLDA board runs at the same time as the UEC delivery board further impacting on parity of esteem for mental health.
- Significant work has been undertaken around community transformation (Living well) and work continues to progress around neighbourhoods. During the summit we heard that transformation between community and urgent care were not joined up. Stakeholders were wanting greater opportunities for connection.
- Staff expressed a lack of clarity on the current governance structures, in respect of their purpose and decision-making remit of some meeting forums. Staff also desired for better connection between system partners across organisational boundaries.
- The current governance structure in the adult urgent care pathway does not have responsive escalation processes that support frontline staff to resolve issues to enable treatment of patients in the right place of the pathway. During the summit we heard of effective operational multiagency working groups for the CYP MH pathway in which effective and responsive operational escalation processes had been developed for the CYP urgent care pathway which had the confidence of partners and staff. This was credited with reduced attendance at, and use of A&E as part of care plans in the under 18's. This could be an opportunity of good practice to emulate and harness in the adult urgent mental healthcare pathway.
- It was widely acknowledged by the ICB and partners that there needed to be better use of benchmarking data, as a key component of strategic commissioning. In the summit, partners also acknowledged gaps in the data analytical resources to underpin this and equally gaps in data literacy to support the interpretation of data for effective decision making.

There was also expressed concern in the summit among partners about the current NHS context in the scale of organisational changes that will impact on leadership and delivery resource to drive the recognised improvement opportunities.

Recommendations

Foundations for Sustainable Improvements

The Mental Health Improvement Support Team have set out the following key foundation principles that should be in place to empower systems/ teams to create meaningful change and enable sustained improvement:

SYSTEM LEADERSHIP

Visible Leadership Advocacy – Senior leaders must actively communicate and champion change to inspire engagement ('winning hearts and minds').

Unified Leadership Accountability – A unitary leadership approach minimises silos and fosters a collaborative culture.

Stable Leadership Support – Consistent leadership at the board and senior levels ensures sustained improvement and rapid progress at the frontline.

Board Development & Cultural Change – Equipping leaders with the right tools, behaviours, and capabilities drives cultural transformation and accelerates delivery.

Capacity for Improvement Leadership – When internal staff leading improvement efforts have dedicated capacity, progress is more sustainable.

SYSTEM GOVERNANCE AND OVERSIGHT

Effective Escalation Mechanisms – Ensuring systems have clearly agreed escalation protocols across system partners including clearly defined escalation times to support services who are waiting for long periods.

Effective Governance & Reporting Structures – Well-established governance, reporting, and escalation routes ensure quality governance and risk management are embedded effectively.

System Oversight of the whole pathways i.e. UEC Mental Health pathway – Taking a whole system pathway approach is about developing a shared understanding of the system level issues using the data and valuing each other's viewpoints.

SYSTEM INTELLIGENCE LED

Proactive demand and capacity – A comprehensive view of demand across key system partnerships should form the foundation of clinical and operational leadership discussions and decision-making processes to ensure more coordinated and effective service delivery.

Reducing Health Inequalities – A clear system overview of health inequalities within local populations is incorporated/considered into governance and KPIs reviews/developments so that the information that's available is used to improve services and outcomes.

Outcome Monitoring – Standardisation of outcomes across all stakeholders enables meaningful comparisons and ensures that data can be used effectively to monitor impact of services and drive improvements across the entire system.

SYSTEM ENGAGEMENT

Staff Involvement in Change – Engaging frontline staff directly affected by change to improve buy-in and ensure practical implementation.

Clear and Continuous Communication – Regular updates on intent, progress, and upcoming changes keep stakeholders aligned and engaged.

Awareness & Coordination – A broad understanding of the scale of actions, necessary resources, and interdependencies to prevent conflicts and inefficiencies.

Urgency & Responsiveness – A strong sense of urgency to act, a proactive approach to support, and a deep understanding of the consequences of inaction.

SYSTEM RESOURCES

Sustained Resource Allocation – Ensuring resources are safeguarded for embedding new practices, even in financially constrained environments.

Organisational Readiness – A strong cultural foundation and robust infrastructure (e.g., IT and clinical systems) are critical for successful implementation.

Robust Quality Improvement (QI) Resources – A well-developed QI infrastructure within the organisation to support continuous improvement.

Dedicated Project Management Office (PMO) Support – Essential resources to drive rapid improvements, especially in large, complex initiatives.

Acknowledgment of Internal Capacity Needs – A system-wide commitment to recognising and providing the internal resources necessary for sustained improvement.

LEARNING CULTURE

Leveraging Existing Best Practices – Identifying, harnessing, and spreading proven successful practices enhances overall efficiency.

Sustainable Improvement Actions – Focus on long-term solutions that address root causes, rather than short-term fixes to meet regulatory demands.

System-Wide Improvement Approach – Improvement efforts should extend beyond individual providers, fostering system-wide capability and collaboration.

Recommendation 1

The ICB must create the conditions for success by ensuring that its strategic priorities are informed by all system partners and that its governance structure supports multiagency communication, timely escalation and effective oversight to ascertain the quality and impact of its services

The following identified opportunities will support the ICB to realise this:

- The development of a strategic plan of action that unites all system partners to achieve coordinated action on the adult and CYP UEC MH pathway based, harnessing the totality of community assets while maximising opportunities for preventative pathways with partners in the voluntary sector and social care
- A single UEC delivery board which achieves parity in the oversight of Mental Health UEC pathway flow issues as integral part of the overall UEC pathway
- A more clearly defined and documented governance structure that links statutory and non statutory partners across organisational boundaries for effective oversight and proactive management of the mental health pathway, with clearly identified decision-making subgroups that consider key work programmes such as workforce development, data infrastructure, pathway development
- Strengthened engagement and partnership working, amplifying the voice of clinical leadership, service users and carers as essential inputs at strategic and operational levels of the governance structure for a well-informed view of the risks, issues, gaps and inconsistencies in services in the county
- Systems to support timely and responsive multiagency operational escalation processes for resolution of issues in the adult urgent care pathway so that people are supported in the right services, learning from similar practice in the CYP urgent care pathway
- A governance framework to support flow of information for staff at all levels to manage access and quality in the mental health pathway and urgent care pathway, and to confirm to the ICB with routine benchmarking data, the outcomes achieved, the impact of investment and disinvestment, and the extent of unmet need in population groups

Recommendation 2

The ICB should play an enabling role in developing plans to remove barriers to seamless care delivery by ensuring that all parts of the system share a common understanding of a comprehensive pathway in which all component services are optimised to facilitate flow through the pathway

Opportunities identified include:

- Develop a system wide plan to reduce geographic inequities for both children and adults in access to mental health UEC services across the ICB
- Develop a standardised approach to quality improvement across the system
- As a system consider how to provide equitable access across Derby City and Derbyshire to mental health response vehicles
- Increase awareness of community assets, VCFSE provision and crisis alternatives across the whole county. Utilise existing resources such as the 'Rethink Derbyshire mental health support map'
- Consider the inter-dependencies of improvement and transformation plans between mental health UEC and community mental health pathways and explore opportunities to better integrate ways of working across CMHTs and assessment services
- Increase awareness of crisis alternatives across the whole Mental Health UEC pathway in terms of where and when they operate, and service offer
- In line with the ICB programme plan to reduce unwarranted variation in CYP access, address the variation in the CYP clinical model for 24/7 access to a face-to-face urgent assessment and crisis intervention
- Review current oversight and escalation processes for access to CAMHS inpatient beds ensuring this includes oversight of Derbyshire commissioned beds being used by other commissioning authorities
- Convene a system group to look at current care pathways for individuals requiring specialist eating disorders inpatient care, mapping against an optimal NICE guidance pathway with the aim of identifying any gaps in the clinical model and capacity

Recommendation 3

Review the interfaces across the Mental Health UEC pathway with a view to achieving a shared understanding amongst partners of the service offer and referral thresholds to reduce variation in clinical models and improve equity in access

Flow: referrals and thresholds

- For DHFT to ensure the access policy is public facing and is also easily accessible to system partners
- For the ICB with DHFT to consider how to ensure there is a shared understanding of access standards for all services
- To review referral thresholds between services by mapping through the lens of service user and staff experience
- Undertake pathway mapping to identify and improve key bottlenecks to flow across the UEC MH pathways
- Explore opportunities for improving the understanding of roles and responsibilities between teams and providers of services across the system

Optimising discharge to home treatment interventions through early discharge

- Review the early discharge function with the purpose of improving referrer confidence to home treatment interventions
- Using case study approaches undertake an analysis of what multi team resources would be required to provide resilient wrap around community home treatment as an alternative to hospital admission

Optimising access to crisis alternatives

- Review the gatekeeping and access routes into Safe haven houses and consider direct pathways from community mental health teams for patients displaying evidence of deterioration and relapse
- Explore variation in service models and eliminate any areas of unwarranted variation
- Using a population needs approach review access and provision of safe havens and drop in hubs to fully understand gaps in provision

Recommendation 4

Derbyshire Healthcare NHS Foundation Trust should, as a priority, work with commissioners and University Hospitals of Derby and Burton NHS Foundation Trust to review plans for the location of the Crisis Assessment Service pilot and relook at opportunities for premises that are co-located with the Royal Derby Hospital ED

- The NHS UEC Care Plan identifies co-located mental health crisis assessment centres (CAS) as a priority action. The NHS 10-year plan published in June 2025 commits to investment in developing more dedicated mental health emergency departments, to ensure patients get fast, same day access to specialist support in an appropriate setting.
- There is a plan for a test of concept pilot for a Mental Health Crisis Assessment Service (CAS) to be located at Albany House (Kingsway site). This is not a co-located site with acute services, mental health liaison or crisis teams. We heard concerns that this could lead to the failure of the pilot and the ability to manage a patient's holistic needs, especially those that might still need physical care. The CAS would be isolated from other MH UEC services impacting on the connectivity and ability to provide seamless pathways of care. Nationally good practice models have been able to demonstrate optimal efficacy through co-location.
- Historically there had been plans to have a co-located service at both Royal Derby Hospital and Chesterfield Royal hospital but at that time no funding for staffing could be attained. We heard that there could now be opportunity to revisit conversations around the utilisation of a 6 bedded facility on the Royal Derby site.

Recommendation 5

System partners should work together to seek rapid improvements to both the resourcing and operation of the Mental Health Helpline model to improve access into the system and optimise the service provided

- Crisis Helpline – Prioritise demand and capacity modelling to support in the understanding of required resource to meet the multiple functions of the service.
  - access to mental health triage
  - delivery of a 24/7 emotional support offer.
  - Clinical staff resource deployment to MHRV 7 days a week
- DHFT should expedite efforts to fully address the technical issues with telephony systems potentially leading to dropped calls and discrepancies in the data.
- The national drive is to have 111 #2 MH as the primary access point for crisis access lines. Should DHFT develop plans to close down the 0800 line, it should ensure that the transition is robustly managed with consideration of the clinical management and support needs of frequent users and those users who have moved away from Derbyshire but continue to access the Mental Health Helpline.

Recommendation 6

Develop a system wide workforce strategy for both Adults and CYP to ensure that the right workforce is in place to meet the needs of the population, including considering what workforce is needed to meet the unmet social needs of service users across the system

- Ensure the voice of lived experience is being embedded into a range of paid roles at various levels within the mental health system
- Undertaking system wide training needs analysis that is underpinned by population needs analysis (including SEND data) would support a workforce to meet population need
- Undertake demand and capacity modelling of the community mental health teams, considering the level of need and access in relation to population need and size
- Consideration of the VCFSE training needs must be considered as part of the MH Crisis workforce strategy, to ensure that VCFSE organisations are seen and valued as an integral partner within the UEC MH pathway
- DHFT to develop a programme of work to introduce job planning across all staff members, not just medics and psychologists, to support a greater understanding of capacity to meet demand
- Review the need for specific skills sets such as housing officers when workforce planning with the aim improve flow addressing known flow challenges

Recommendation 7

Convene a group to review the intelligence on High Intensity Users across the system and develop co-ordinated plans to ensure appropriate resource allocation and that service users receive the right care in the right place at the right time

- Successful High Intensity User (HIU) programmes support the overall productivity and efficiency drive in the NHS, and can lead to between 38% and 84% reductions in A&E attendances and between 24% and 84% reductions in non-elective admissions[1]
- Research from the British Red Cross has shown a clear link between high intensity use of UEC services and wider health inequalities and deprivation.
- HIU services can support UEC pathway pressures whilst at the same time addressing health inequalities, helping to free up frontline resources to see other patients and reduce costs.
- High intensity use of UEC is associated with focussing help for primarily non-medical factors including housing instability, social isolation, loneliness and deprivation as well as poor physical and mental health.
- Benefits for clients after engagement with a HIU service include feeling more confident to look after their health; having improved wellbeing; and feeling less lonely.
- As a system, Derby and Derbyshire ICB have the opportunity to review and pull together insights on HIU in different services and develop a co-ordinated HIU programme to best meet the needs of this group of patients.

[1] NHS England High Intensity User programme: https://www.england.nhs.uk/high-intensity-use-programme/

Recommendation 8

Agree priority actions for strengthening the use of data and intelligence to inform system planning and service delivery

Opportunities identified include:

- Development of a system wide UEC MH pathway dashboard to inform strategic and tactical planning.
- Development of a plan to ensure that the value of using Patient Reported Outcome Measures (PROMs) is well understood across the system, and that a comprehensive and cohesive approach to outcome measurement recording and reporting informs service delivery and planning.
- Strengthening the use of Patient Reported Experience Measures to help inform and prioritise service improvement opportunities.
- Making better use of service utililsation data to highlight bottlenecks and inform demand and capacity planning.
- Developing better intelligence on levels of access to different services, in particularly to highlight any inequalities relating to geography, ethnicity, age and other important demographic data.

Appendix I
Data Pack

Urgent and emergency mental health system overview:

Derby and Derbyshire ICB

Nick Gitsham
Mental Health Improvement Support Team
18th June 2025

The Mental Health Needs Index (MHNI)

	ICB Core Services
2023/24	£101.7 billion
Need adjustments *% of overall spend shown, though needs may vary for services across the country*	69.6% General and acute 11.8% Mental Health 9.3% Prescribing 5.6% Community 3.7% Maternity **Utilisation models 89.8%** Health inequalities and Unmet need 10.2%

Target shares: Components of formula

The ICB allocations model is made up of 3 distinct formulae for which we calculate target shares

ICB Core Services | **Primary Medical Care** | **Specialised Commissioning**

The ICB core services model is made up of a number of components or 'segments':

General and acute	hospital inpatient, outpatient and A&E services
Maternity	services relating to births
Mental health	acute and community MH and LD services plus IAPT services
Community services	district nursing and intermediate care
Prescribing	costs of medicines prescribed in primary care
Remoteness, MFF, PFI	unavoidable costs of delivering services, including MFF and PFI
Health inequalities	adjustment based on rates of avoidable mortality

Any part of the model may be affected by local population demographics.

For example, sex, age, morbidity (number and severity of physical and mental health conditions), rates of disability, excess deaths and deprivation, plus wider factors associated with health needs including housing status and unemployment.

For each distinct formula a health inequalities and unmet need adjustment is added.

Analysis overseen by ACRA (Advisory Committee on Resource Allocation) is used to define the metric, but the weighting of the adjustment (within overall target allocations) is a policy decision determined by NHS England.

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https://www.england.nhs.uk/publication/infographics-fair-shares-a-guide-to-nhs-allocations/

The Mental Health Needs Index (MHNI)

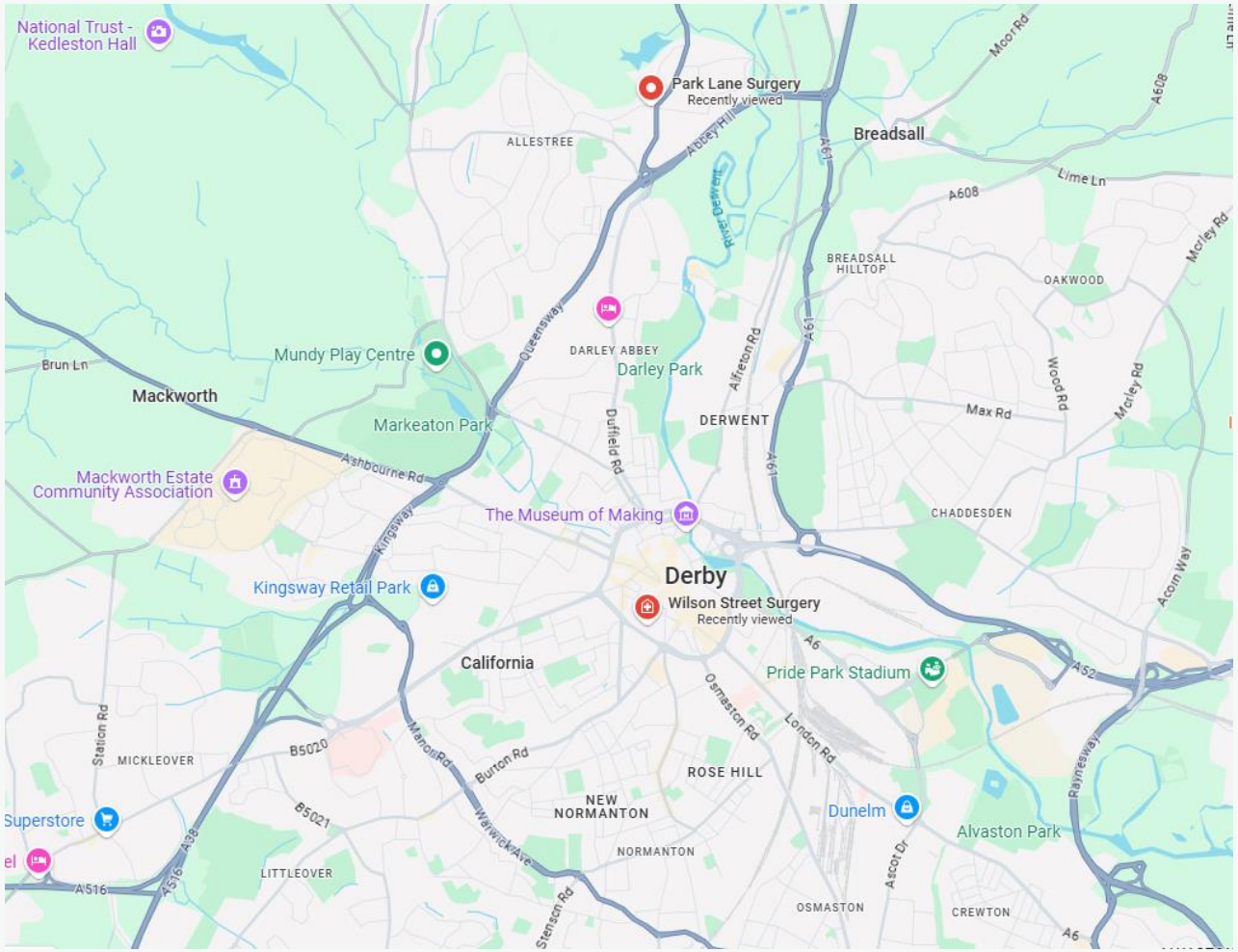
- Uses demographic data and data on healthcare usage (primary care and secondary care) to calculate the level of need for mental health services
- Allows population data to be adjusted to better reflect differences in levels of need for mental health services in different areas
- Is used as part of the allocation process for determining ICB baseline budgets for core services

Region	Practices	Registered population	Normalised weighted population	Mental health need Index
North East and Yorkshire	1005	9,074,080	9,650,235	1.063
North West	985	7,750,348	8,563,818	1.105
Midlands	**1304**	**11,714,391**	**11,524,545**	**0.984**
East of England	668	7,147,884	6,124,591	0.857
London	1195	10,735,452	12,662,471	1.180
South East	836	9,658,727	8,021,123	0.830
South West	560	6,073,749	5,607,846	0.923
England	6553	62,154,630	62,154,630	1.000

Integrated Care Board	Practices	Registered population	Normalised weighted population	Mental health need Index
NHS Birmingham and Solihull ICB	183	1,581,800	1,970,218	1.246
NHS Black Country ICB	182	1,301,945	1,436,318	1.103
NHS Coventry and Warwickshire ICB	120	1,072,943	960,730	0.895
NHS Derby and Derbyshire ICB	**118**	**1,119,823**	**1,091,794**	**0.975**
NHS Herefordshire and Worcestershire ICB	80	825,997	694,034	0.840
NHS Leicester, Leicestershire and Rutland ICB	135	1,205,962	1,046,599	0.868
NHS Lincolnshire ICB	84	815,338	734,164	0.900
NHS Northamptonshire ICB	69	825,535	742,443	0.899
NHS Nottingham and Nottinghamshire ICB	136	1,256,182	1,264,883	1.007
NHS Shropshire, Telford and Wrekin ICB	52	528,748	487,619	0.922
NHS Staffordshire and Stoke-on-Trent ICB	145	1,180,120	1,095,744	0.929

Data source: NHS England ICB Allocations d-mental-health-need

System Overview: Mental Health Needs Index



There is significant variation in the relative level of need across the ICB

Practice level range:

0.557
Park Lane Surgery, Allestree, Derby

1.536
Wilson Street Surgery, Derby

Data source: NHS England ICB Allocations d-mental-health-need

Investment overview: 2024/25 planned spend

	England (£m)	Derbyshire ICB (£m)
Total mental health	15,742.6	259.6
Talking Therapies	936.4	13.2
EIP	266.3	2.6
Adult crisis	832.6	11.1
A&E and ward liaison	331.3	6.8
CYP MH ICB spend*	1,142.0	22.5

	England	Derbyshire ICB
Population	62,154,630	1,119,823
Weighted population	62,154,630	1,091,794

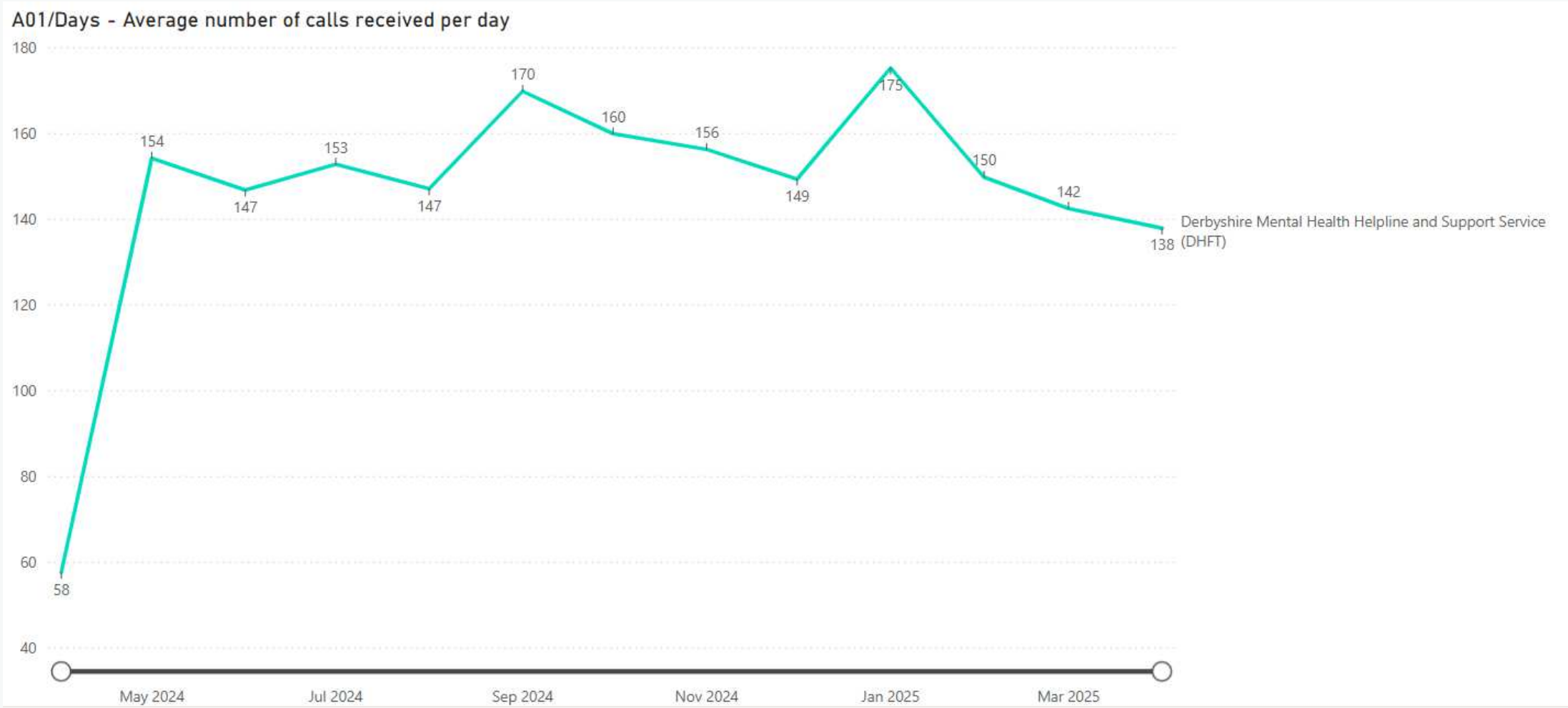
Spend per weighted 10,000 population

	England (£k)	Derbyshire ICB (£k)
Total mental health	2,533	2,378
Talking Therapies	151	121
EIP	43	24
Adult crisis	134	102
A&E and ward liaison	53	62
CYP MH ICB spend*	184	206

Data source: NHS England Mental Health Dashboard Q1 2024-25; NHS England ICB Allocations d-mental-health-need
Excludes specialised commissioning
* Excludes learning disability and eating disorders

Crisis Care

Access to mental health crisis care via NHS 111 #2



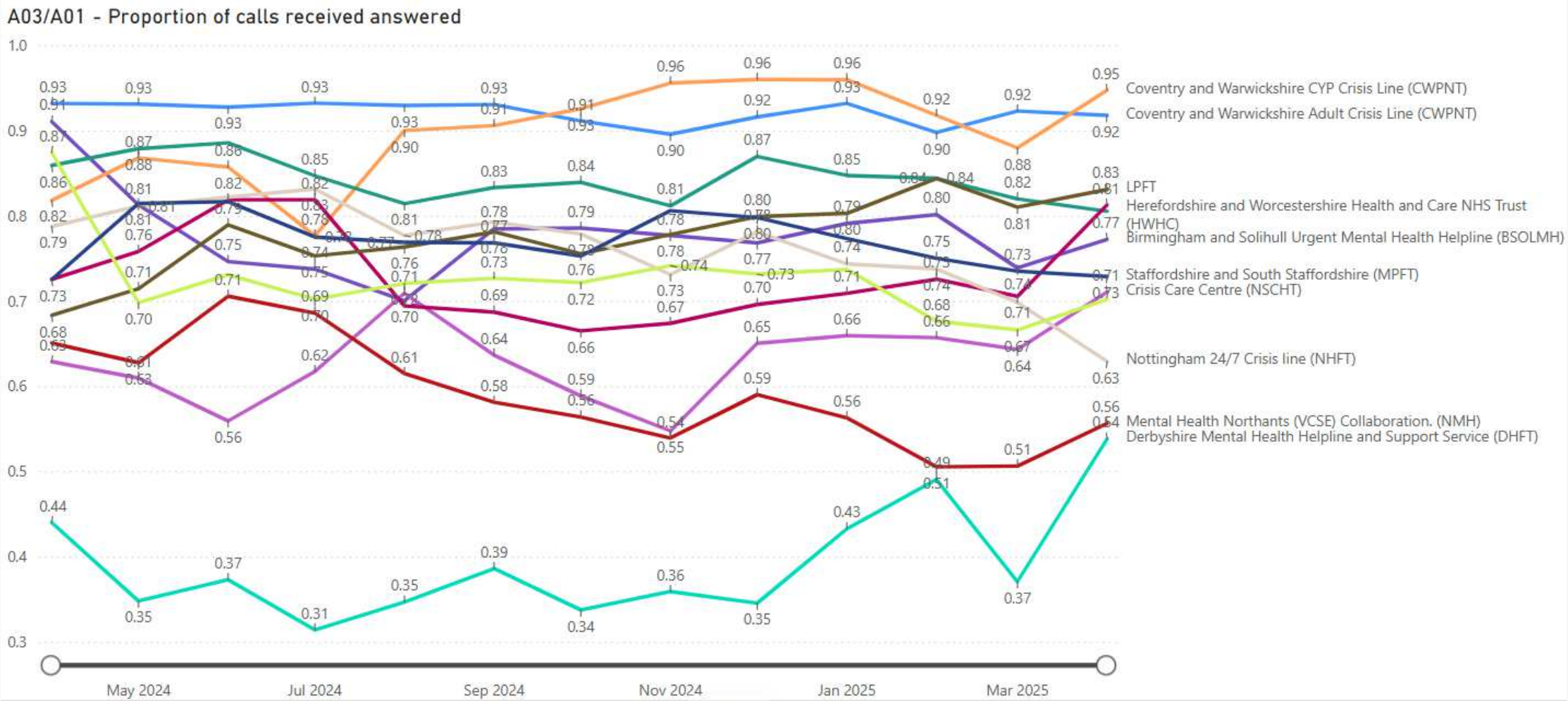
Data Source: [NHS England Experimental Statistics]

Access to crisis care via NHS 111 (April 2025)

	Average call answer time	% calls abandoned after call steering	% calls answered	% calls answered in 60 seconds or less
Standard	≤ 20 seconds	≤ 3%	–	–
England (111)	45 seconds	2.5%	94%	86%
England (111 #2)	184 seconds	23%	73%	71%
Derbyshire	**88 seconds**	**29%**	**54%**	**58%**

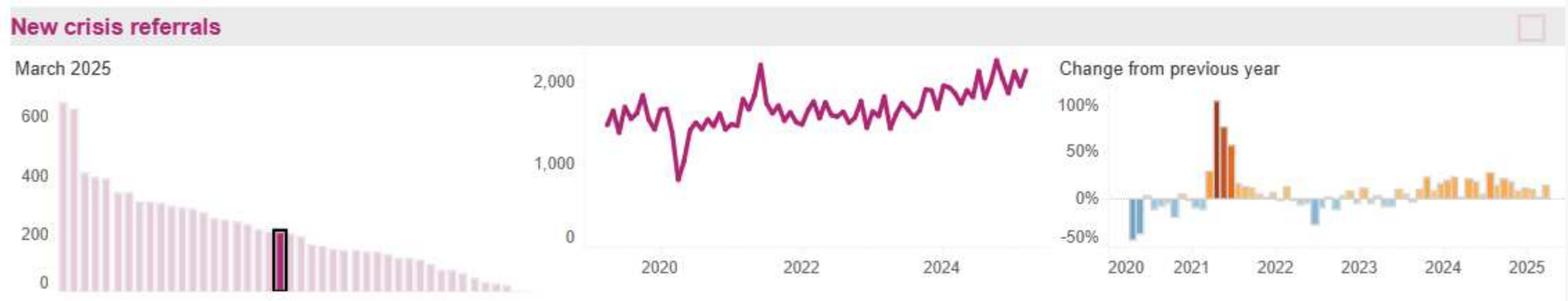
Data Source: IUCADC; NHS England Experimental Statistics

Access to crisis care via NHS 111 (April 2025)



Data Source: [NHS England Experimental Statistics]

Referrals to Community Crisis Services (all age)

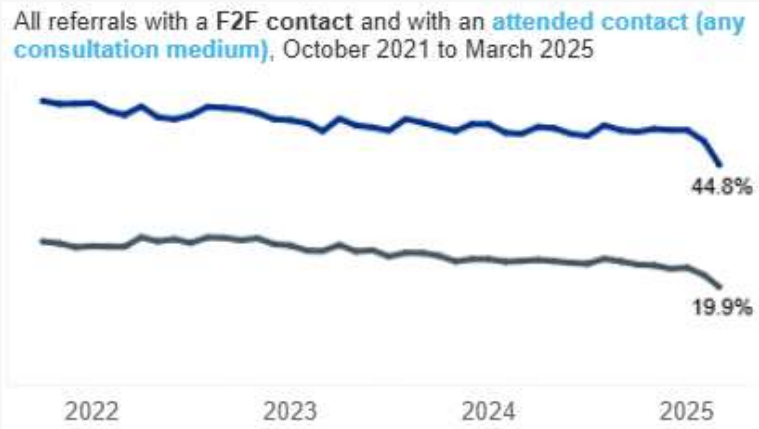


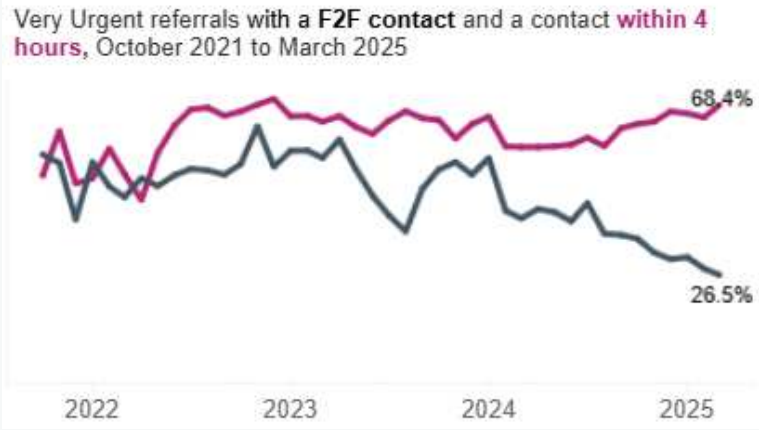
Rate per 100k population

Data source: MHSDS, ECDS, MHLDA SitRep (All-age UEC pathway pressures dashboard, Apr 2019-Mar 2025)

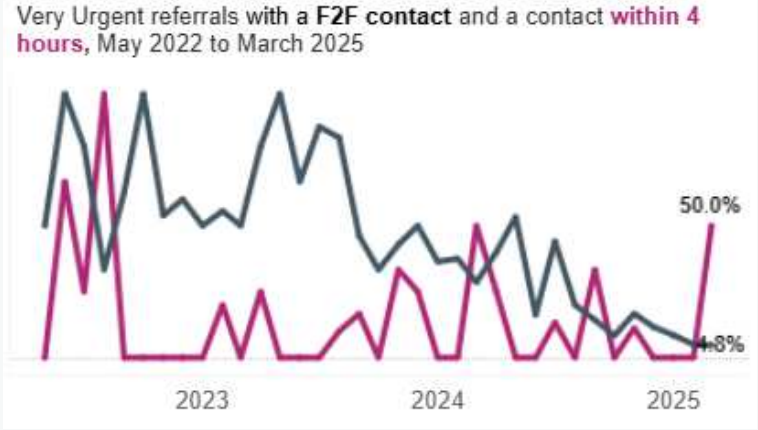
Community Crisis Services Response Times (all age)

England





Derby and Derbyshire ICB



Data Source: [UECMH Dashboard]

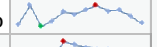
Mental Health Inpatients

Derbyshire Healthcare Balanced Scorecard (adults)

Key Performance Indicator	Target	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
Operational														
Average length of stay - discharged patients	40	63	45	42	50	52	56	60	64	62	49	49	47	
Admissions	n/a	84	85	77	95	81	77	71	88	73	84	72	78	
Emotionally unstable personality disorder admissions	n/a	10	14	18	11	10	5	8	6	8	10	5	4	
Mental Health Act admissions	n/a	86%	77%	74%	71%	73%	66%	76%	78%	75%	81%	82%	78%	
Discharges	n/a	75	89	76	75	77	74	60	82	69	88	78	76	
Bed occupancy	85%	91%	100%	97%	98%	100%	99.5%	101%	97%	104%	103%	103%	102%	
Patients clinically ready for discharge - proportion of beds	3.5%	9.1%	8.8%	10.0%	6.8%	6.5%	8.4%	6.6%	7.5%	4.7%	6.8%	7.8%	10.3%	
Bed days occupied by patients clinically ready for discharge	0	350	328	276	281	335	342	294	328	109	303	327	444	
Inappropriate out of area acute patients at month end	0	4	9	7	4	22	26	25	27	8	6	6	16	
Inappropriate out of area PICU patients at month end	0	10	10	16	12	13	20	18	18	19	19	16	12	
Appropriate out of area acute patients at month end	0	19	20	21	23	21	20	24	25	26	24	26	22	
Appropriate out of area PICU patients at month end	0	7	6	7	8	7	9	11	12	14	14	10	14	
72 hour follow-up post discharge	80%	83%	89%	86%	96%	93%	91%	78%	90%	93%	88%	92%	87%	
Inpatient missing and absent patients	0	46	22	33	20	40	26	31	13	28	24	18	30	
Mental health liaison 1 hour compliance	95%	96%	97%	94.97%	93%	99%	97%	98%	98%	97%	97%	97%	98%	
Mental health liaison 24 hour compliance	95%	99%	98%	97%	98%	99%	97%	98%	99%	97%	97%	96%	99%	
Mental health liaison 12 hour breaches	0	8	11	21	18	30	27	15	27	14	23	21	27	
Mental health liaison 24 hour breaches	0			14	8	19	26	12	14	3	6	12	5	
Mental health liaison 72 hour breaches	0			0	0	1	1	1	0	0	0	0	0	
Crisis gatekeeping that avoided informal admission	60%	76%	67%	63%	57%	56%	64%	64%	59%	62%	61%	66%	53%	
Crisis teams caseload	n/a	128	118	113	125	128	112	89	115	90	79	99	101	

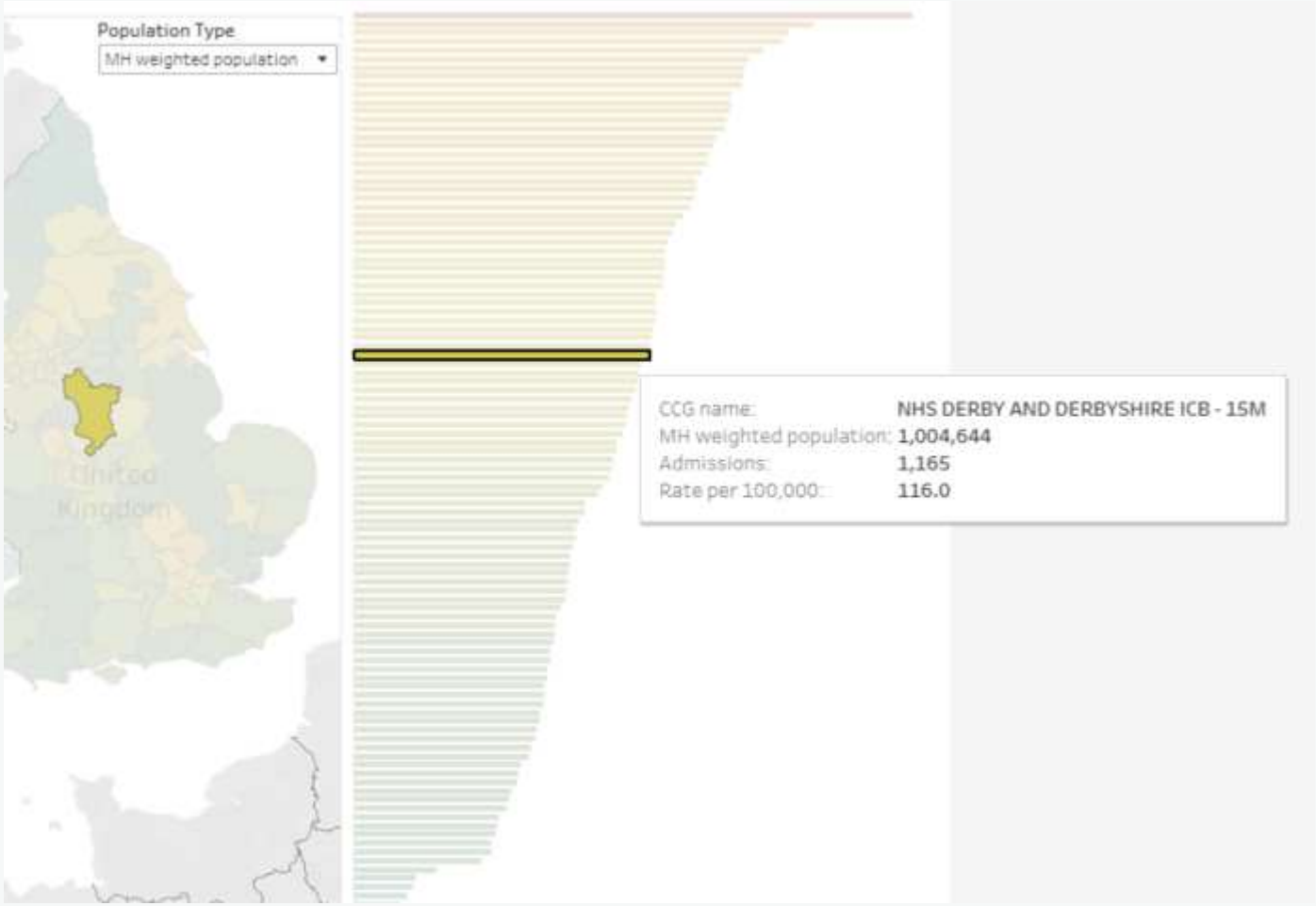
Data source: Performance & Delivery Team – Derbyshire Healthcare NHS Foundation Trust

Derbyshire Healthcare Balanced Scorecard (older adults)

Key Performance Indicator	Target	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
Operational														
Inpatients														
Bluebell ward mean length of stay to discharged	79								38	82	85	157	43	
Cubley female ward mean length of stay to discharged	79	116	106	73	64	57	221	131	145	76	156	152	15	
Cubley male ward mean length of stay to discharged	79	104	121	87	109	252	81	45	163	141	110	110	96	
Tissington ward mean length of stay to discharged	79	93	36	64	59	62	158	57	85	95	124	47	121	
Mental Health Act admissions	n/a	53%	57%	86%	64%	91%	96%	80%	77%	85%	90%	67%	73%	
Admissions	n/a	15	9	22	14	11	16	15	22	13	20	21	22	
Discharges	n/a	12	13	24	13	11	14	10	20	12	19	21	17	
Bluebell ward bed occupancy	85%								81%	97%	96%	101%	83%	
Cubley female ward bed occupancy	85%	59%	61%	48%	55%	65%	63%	78%	70%	65%	83%	75%	89%	
Cubley male ward bed occupancy	85%	62%	58%	65%	81%	87%	79%	79%	86%	93%	97%	94%	96%	
Tissington ward bed occupancy	85%	89%	104%	87%	92%	98%	96%	100%	104%	99%	100%	96%	90%	
Patients clinically ready for discharge - proportion of beds	3.5%	23.9%	21.5%	17.6%	23.6%	39.4%	36.2%	33.6%	31.8%	31.7%	21.3%	20.9%	18.7%	
Bed days occupied by patients clinically ready for discharge	0	380	447	328	456	696	532	566	568	522	410	375	365	
Notional cost of CRFD beds (based on est £575 a day)	£ -	219k	257k	189k	262k	400k	306k	325k	327k	300k	236k	216k	210k	
72 hour follow-up post discharge	80%	100%	100%	85%	86%	100%	100%	100%	94%	75%	81%	89%	86%	
Inpatient missing and absent patients	0	1	0	1	0	0	0	1	0	2	0	0	0	
Restrictive interventions	n/a	10	20	10	21	15	19	9	6	16	16	4	11	

Data source: Performance & Delivery Team – Derbyshire Healthcare NHS Foundation Trust

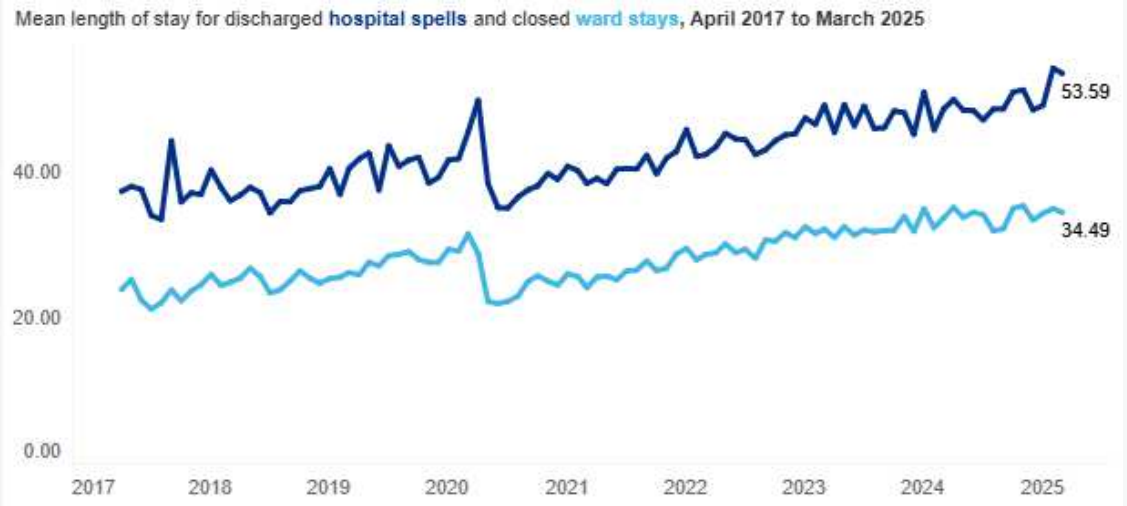
Admissions (adult acute mental health)



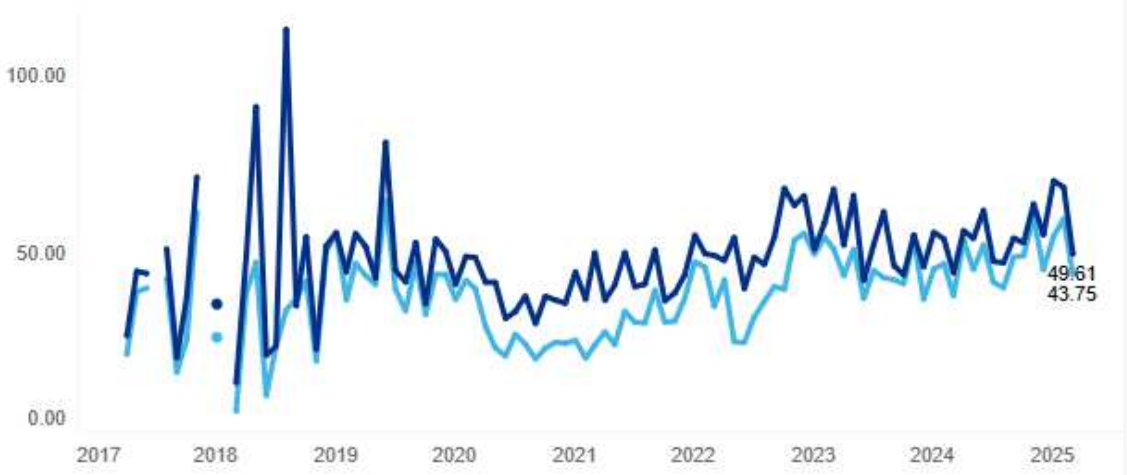
Data source: MHSDS (Acute Mental Health Dashboard)

LOS (adult acute mental health)

England



Derby and Derbyshire ICB

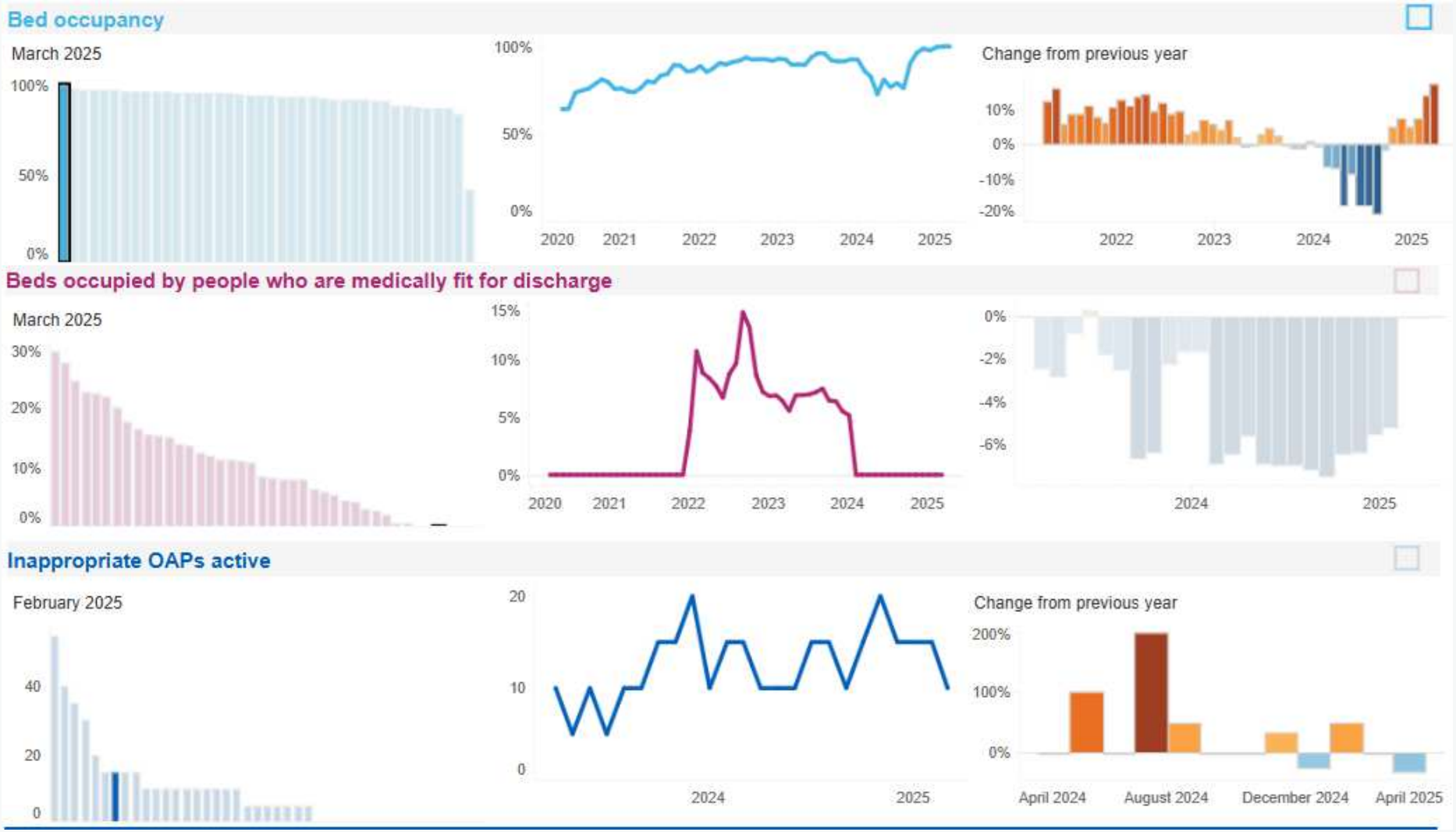


Data source: MHSDS (Acute Mental Health Dashboard)

Bed days (adult acute mental health)

Data source: MHSDS (Acute Mental Health Dashboard)

Bed usage (adult acute mental health)

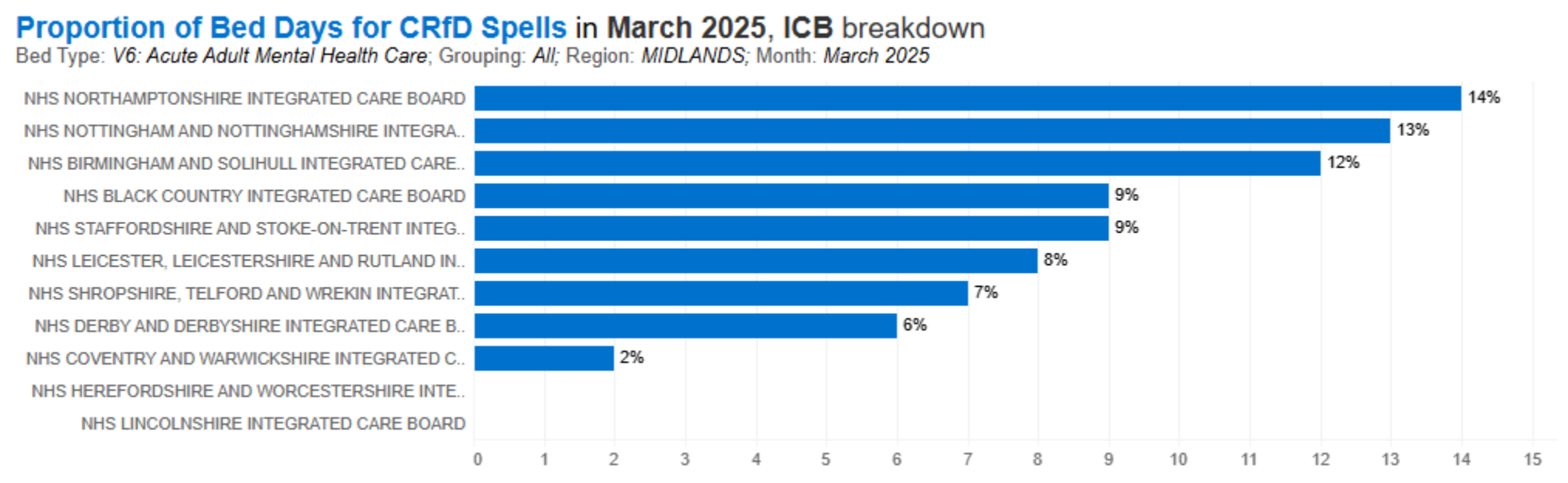


Data source: MHSDS, ECDS, MHLDA SitRep (All-age UEC pathway pressures dashboard, Apr 2019-Mar 2025)

Bed usage (adult acute mental health)

Data source: MHSDS (Mental Heath Acute Dashboard)

Bed usage (adult acute mental health)



Data source: MHSDS (Acute Mental Health Dashboard)

A&E

A&E system overview (March 2025)

ICS1 - Banner View of SEDIT Metrics

NHS DERBY & DERBYSHIRE ICB

SEDIT Extra DQ ICS1 ICS2 GIRFT NHS

Latest refresh: 6/7/2025 12:47:35 PM
Latest available data: April 2025

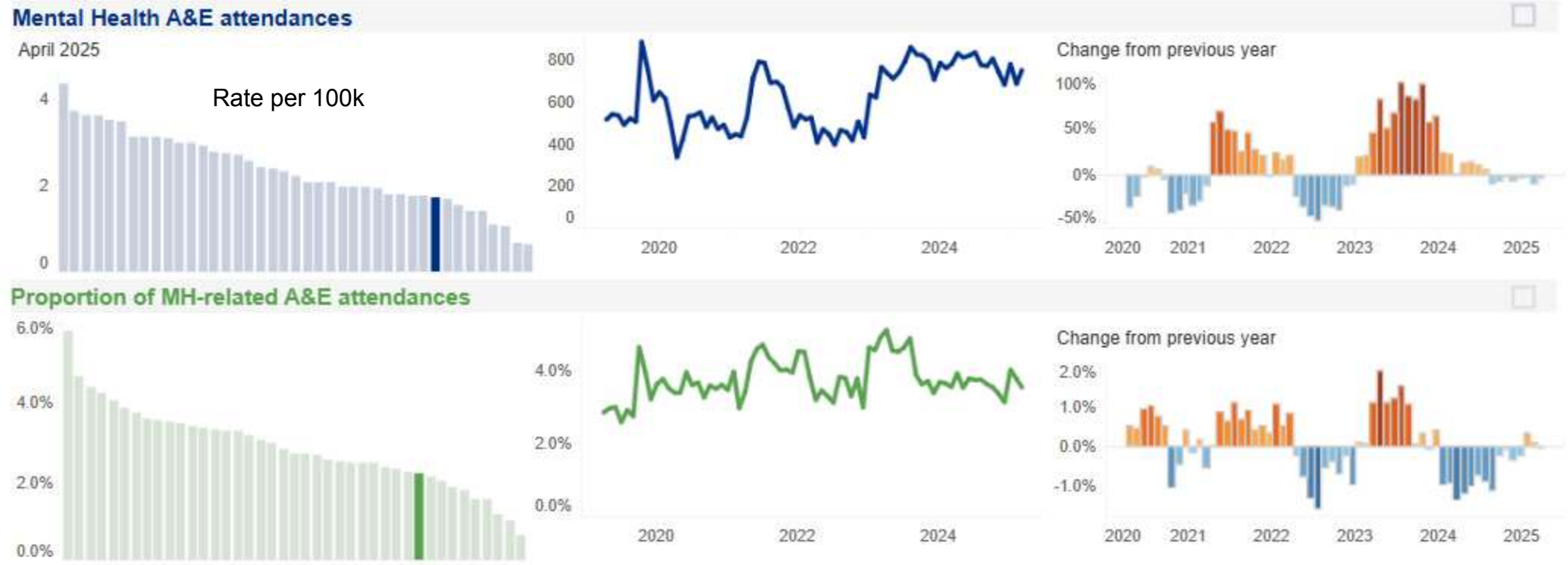
Select for same co-located Type 3 UTC Sites: All Sites

1st quartile 2nd quartile 3rd quartile 4th quartile

	Activity		Workforce		Cubicles and Beds		Case-mix		Quality & Ranking	
	T1 Attendances last 12 months (rolling 12 months)	Admissions via ED last 12 months (rolling 12 months)	ED consultants (wte)	ED registered nurses (wte)	ED majors & resus cubicles	G&A beds (site)	Average age of patients admitted from ED	GIRFT-EM ED acuity index	CQC urgent & emergency services "Overall" ED rating	GIRFT-EM index of patient flow (GEMI)
NHS DERBY & DERBYSHIRE ICB	339,888 310/day	94,219 86.04/day	50.42	317.13 321	94 95	1,954 2,069	59 years	N/A		
Chesterfield Royal Hospital	79,354 237/day	36,325 100/day	7.78	55.44	31 37	531 585	62 years		Good	
Queen's Hospital Burton	74,793 223/day	24,153 66/day	9.00	88.00	19 24	379 408	57 years		Requires improvement	
Royal Derby Hospital	157,501 470/day	33,804 93/day	33.64	173.69	44	1,017 1,056	62 years		Good	

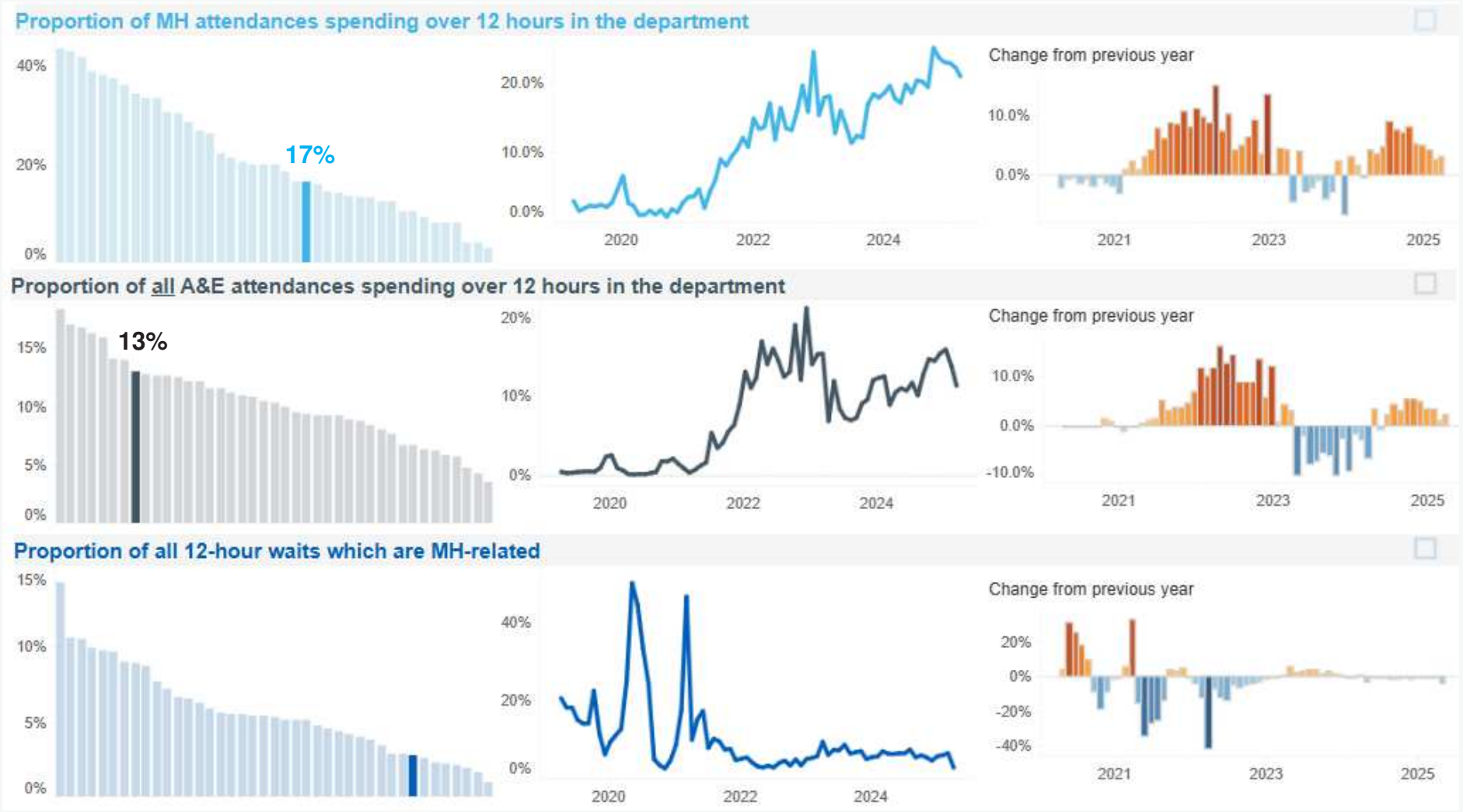
Data source: ECDS (SEDIT Dashboard)

A&E attendances (all age)



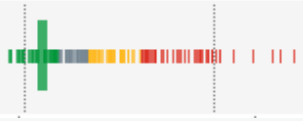
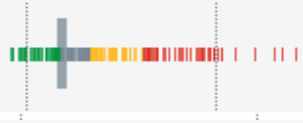
Data source: MHSDS, ECDS, MHLDA SitRep (All-age UEC pathway pressures dashboard, Apr 2019-Mar 2025)

A&E 12 hour breaches (all age)



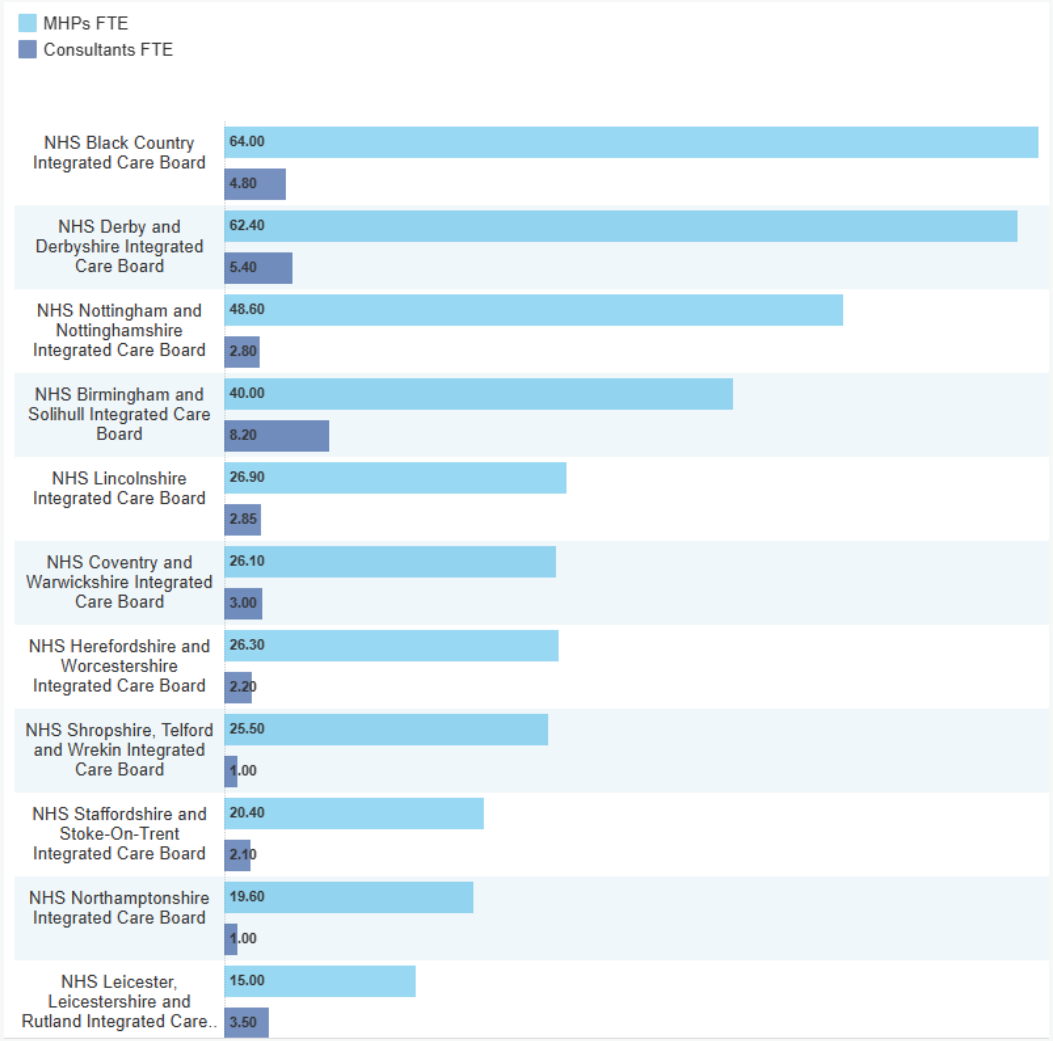
Data source: MHSDS, ECDS, MHLDA SitRep (All-age UEC pathway pressures dashboard, Apr 2019-Mar 2025)

Site level data (March 2025)

				England Mean	England LQ	England Median	England UQ		
Chesterfield Royal Hospital									
MHBR-12 (mental health breach rate >12 hours for all MH patients)	%	11.7	%	20.6	11.7	19.5	28.0		
MHPD-12 (mental health patient delay >12 hours of all MH patients)		5.3		14.4	7.3	10.9	17.3		
Queen's Hospital Burton									
MHBR-12 (mental health breach rate >12 hours for all MH patients)	%	10.9	%	20.6	11.7	19.5	28.0		
MHPD-12 (mental health patient delay >12 hours of all MH patients)		7.5		14.4	7.3	10.9	17.3		
Royal Derby Hospital									
MHBR-12 (mental health breach rate >12 hours for all MH patients)	%	32.4	%	20.6	11.7	19.5	28.0		
MHPD-12 (mental health patient delay >12 hours of all MH patients)		7.6		14.4	7.3	10.9	17.3		

Data source: ECDS (SEDIT Dashboard)

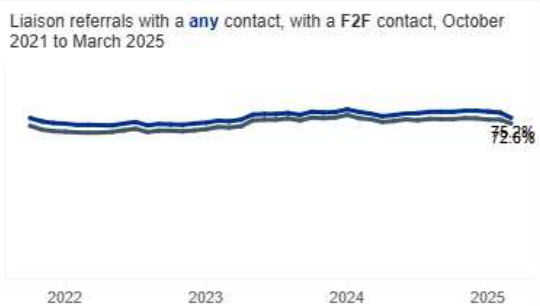
Liaison psychiatry workforce

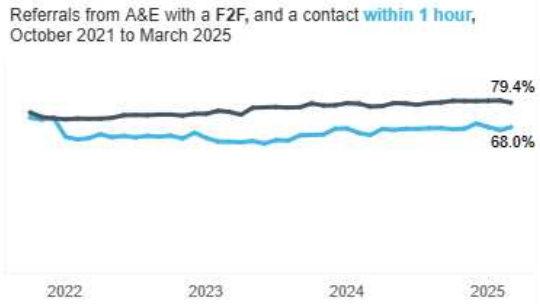


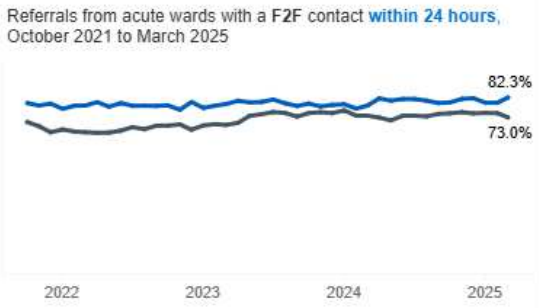
Data source: MHSDS, ECDS (Urgent and Emergency Mental Health Dashboard)

Liaison psychiatry (all age)

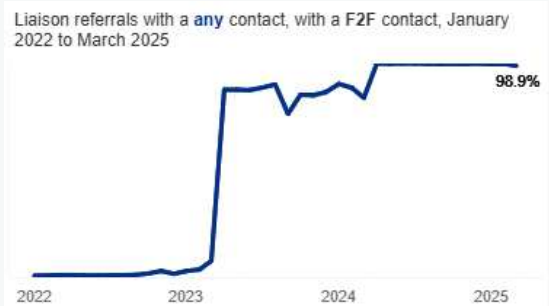
England

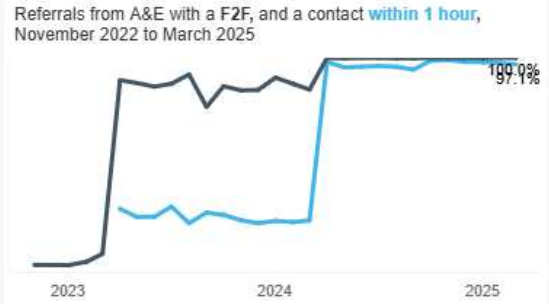


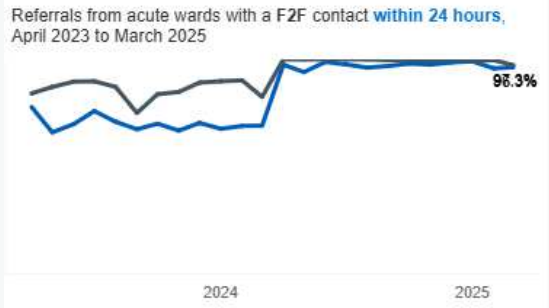


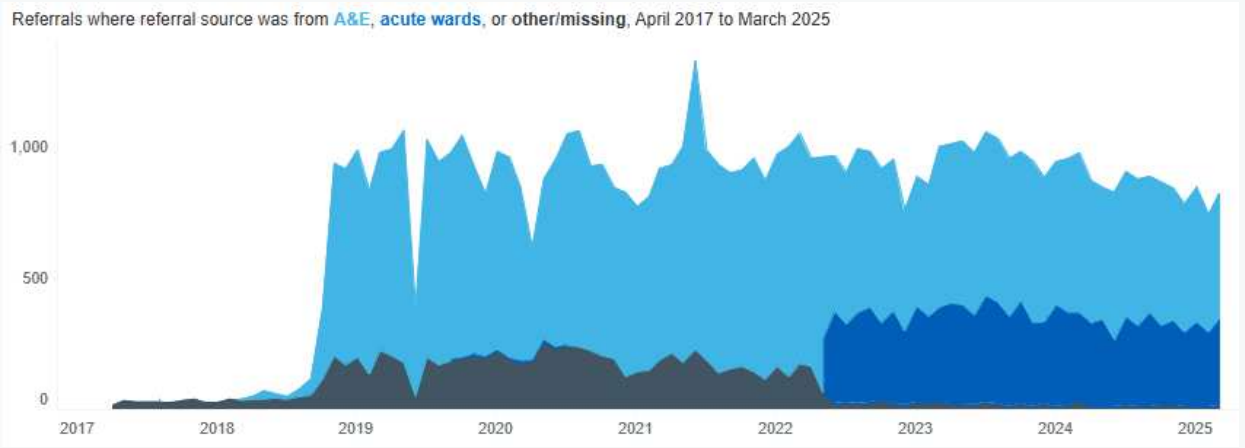


Derby and Derbyshire ICB









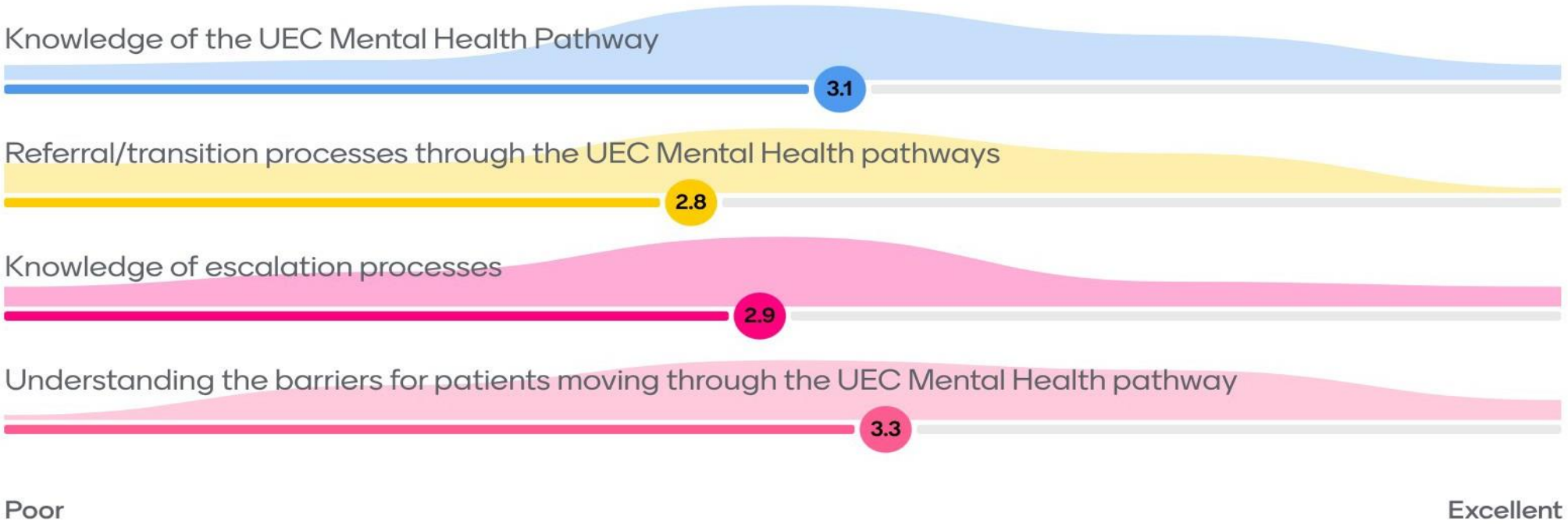
Data source: MHSDS, ECDS (Urgent and Emergency Mental Health Dashboard)

Appendix II
Summit Survey Reponses

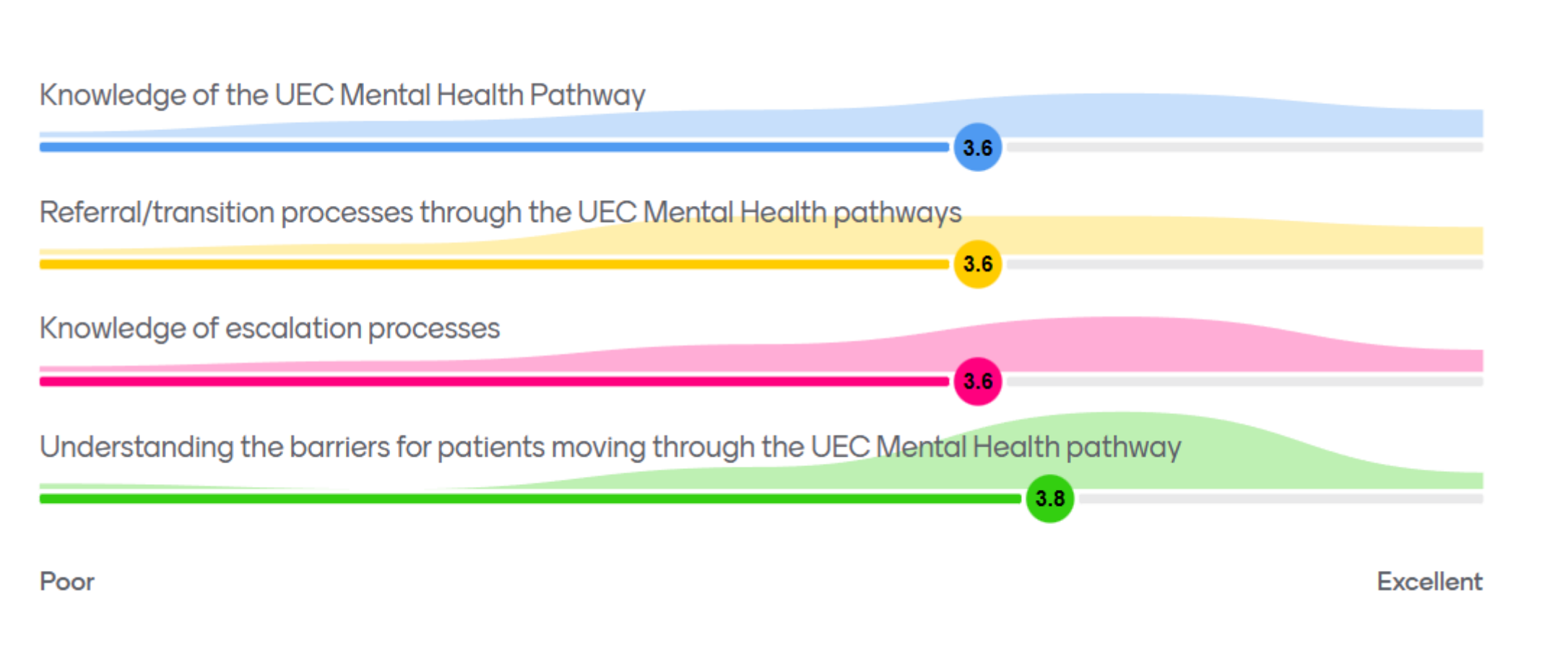
What are you hoping to achieve as a result of the UEC Men-SAT process?

Feedback on what participants rated themselves prior to undertaking the Men-SAT summit

On a scale of 1-5, where 1 is poor and 5 is excellent, how would you rate yourself in the following areas?



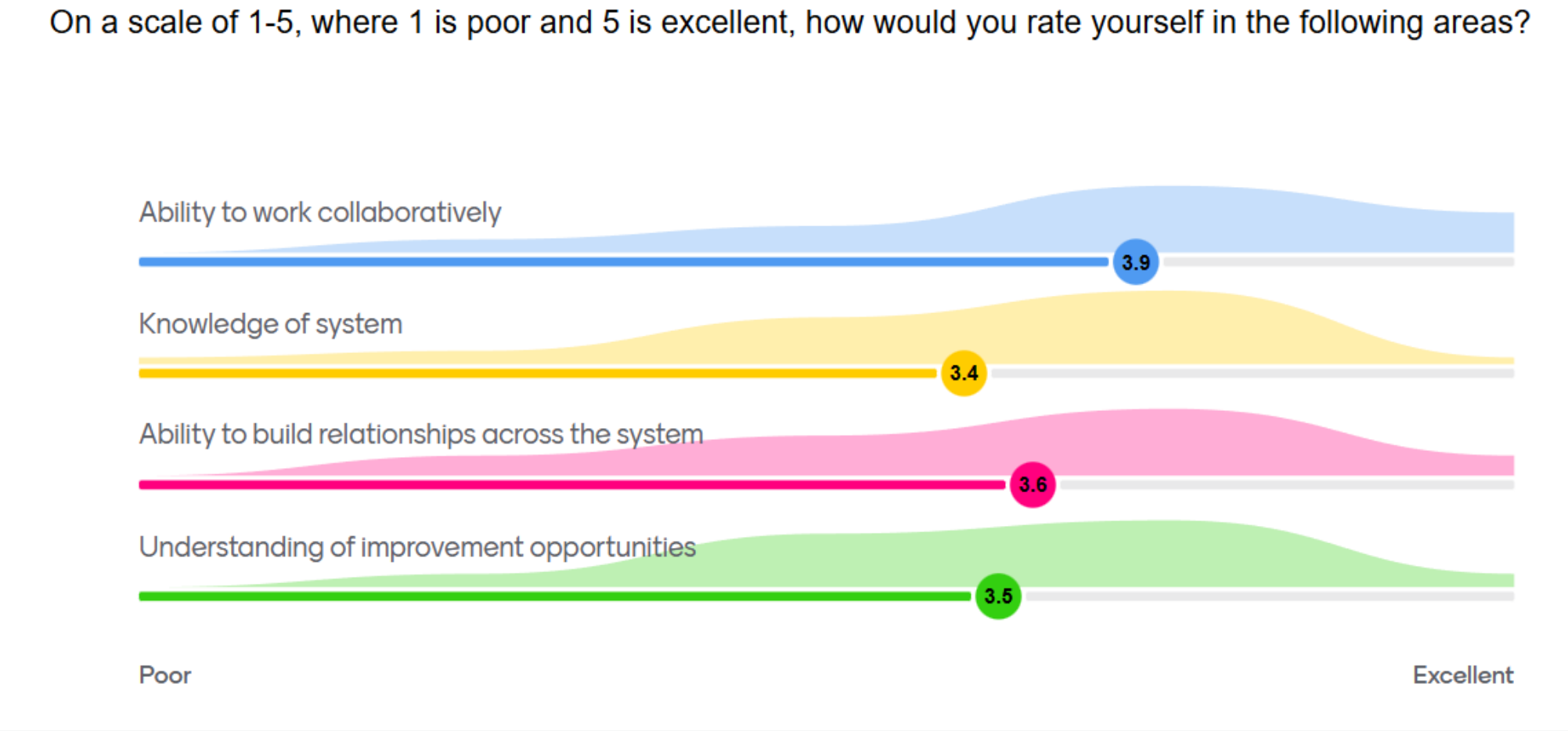
Feedback on what participants rated themselves post the Men-SAT summit



•All identified learning outcomes improved following the Men-SAT.

•Please note there is no unique identifier, so we cannot suggest a sole individual improved their learning, rather, knowledge improved across the group

Feedback on what participants rated themselves post the Men-SAT summit



•All identified learning outcomes improved following the Men-SAT.

•Please note there is no unique identifier, so we cannot suggest a sole individual improved their learning, rather, knowledge improved across the group

Appendix III
Relevant guidance

Guidance documents

QNCRHT Standards - https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/qncrhtt/htas-standards
PLAN Standards - https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/psychiatric-liaison-accreditation-network-plan/plan-standards
Practice Guidelines for Mental Health Helpline Response and Crisis Resolution and Home Treatment Teams- https://nhsengland.sharepoint.com/sites/MentalHealthImprovement/Shared%20Documents/ED%20MH%20Maturity%20Tool/Key%20Docs%20to%20hyperlink/practice-guidelines-for-crisis-line-response-and-crhtt's-2022.pdf
NICE Self-harm: assessment, management and preventing recurrence: https://www.nice.org.uk/guidance/ng225/resources/selfharm-assessment-management-and-preventing-recurrence-pdf-66143837346757
Just Culture - https://www.england.nhs.uk/patient-safety/a-just-culture-guide/
Guidance for commissioners: service provision for Section 136 of the Mental Health Act 1983- https://www.rcpsych.ac.uk/pdf/PS02_2013.pdf
GIRFT Mental Health – Adult Crisis and Acute Care - https://gettingitrightfirsttime.co.uk/wp-content/uploads/2021/09/Mental-Health-Sept21i.pdf
GIRFT Children and Young Peoples Mental Health Services- https://nhsengland.sharepoint.com/sites/MentalHealthImprovement/Shared%20Documents/ED%20MH%20Maturity%20Tool/GIRFT%20Children%20Mental%20Health%2030-3-22j.pdf
Royal College of Emergency Medicine, Mental Health in Emergency Departments, A toolkit for improving care- https://rcem.ac.uk/wp-content/uploads/2021/10/Mental_Health_Toolkit_June21.pdf
British Red Cross- High Intensity Use Programmes- Nowhere else to turn: https://www.redcross.org.uk/nowhere-to-turn
Urgent and Emergency Care Recovery Plan- January 2023: NHS England » Delivery plan for recovering urgent and emergency care services
NICE guidance (September 2022) Self-harm: assessment, management and preventing recurrence (nice.org.uk)
NICE guidance (February 2014) Psychosis and schizophrenia in adults: prevention and management (nice.org.uk)
NICE guidance (January 2009) Borderline personality disorder: recognition and management (nice.org.uk)
NICE guidance (September 2014) Bipolar disorder: assessment and management (nice.org.uk)

MHIST Contact Details

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NHS
Derbyshire Healthcare
NHS Foundation Trust

DHcFT Men-SAT Action Mapping

August 2025

Men-SAT Report Action Mapping

Derbyshire Healthcare NHS Foundation Trust

Recommendation	Lead Org.	Opportunities	Action	Owner	Timescale	Assurance
1. The ICB must create the conditions for success by ensuring that its strategic priorities are informed by all system partners and that its governance structure supports multiagency communication, timely escalation and effective oversight to ascertain the quality and impact of its services	ICB	The following identified opportunities will support the ICB to realise this: • The development of a strategic plan of action that unites all system partners to achieve coordinated action on the adult and CYP UEC MH pathway based, harnessing the totality of community assets while maximising opportunities for preventative pathways with partners in the voluntary sector and social care • A single UEC delivery board which achieves parity in the oversight of Mental Health UEC pathway flow issues as integral part of the overall UEC pathway • A more clearly defined and documented governance structure that links statutory and non statutory partners across organisational boundaries for effective oversight and proactive management of the mental health pathway, with clearly identified decision-making subgroups that consider key work programmes such as workforce development, data infrastructure, pathway development • Strengthened engagement and partnership working, amplifying the voice of clinical leadership, service users and carers as essential inputs at strategic and operational levels of the governance structure for a well-informed view of the risks, issues, gaps and inconsistencies in services in the county • Systems to support timely and responsive multiagency operational escalation processes for resolution of issues in the adult urgent care pathway so that people are supported in the right services, learning from similar practice in the CYP urgent care pathway • A governance framework to support flow of information for staff at all levels to manage access and quality in the mental health pathway and urgent care pathway, and to confirm to the ICB with routine benchmarking data, the outcomes achieved, the impact of investment and disinvestment, and the extent of unmet need in population groups	ICB led action plan in development.			

Men-SAT Report Action Mapping

Derbyshire Healthcare NHS Foundation Trust

Recommendation	Lead Org.	Opportunities (DHcFT highlighted in green font)	Action	Owner	Timescale	Assurance
2. The ICB should play an enabling role in developing plans to remove barriers to seamless care delivery by ensuring that all parts of the system share a common understanding of a comprehensive pathway in which all component services are optimised to facilitate flow through the pathway	ICB	Opportunities identified include: • Develop a system wide plan to reduce geographic inequities for both children and adults in access to mental health UEC services across the ICB • Develop a standardised approach to quality improvement across the system • As a system consider how to provide equitable access across Derby City and Derbyshire to mental health response vehicles • Increase awareness of community assets, VCFSE provision and crisis alternatives across the whole county. Utilise existing resources such as the 'Rethink Derbyshire mental health support map' • Consider the inter-dependencies of improvement and transformation plans between mental health UEC and community mental health pathways and explore opportunities to better integrate ways of working across CMHTs and assessment services • Increase awareness of crisis alternatives across the whole Mental Health UEC pathway in terms of where and when they operate, and service offer • In line with the ICB programme plan to reduce unwarranted variation in CYP access, address the variation in the CYP clinical model for 24/7 access to a face-to-face urgent assessment and crisis intervention • Review current oversight and escalation processes for access to CAMHS inpatient beds ensuring this includes oversight of Derbyshire commissioned beds being used by other commissioning authorities • Convene a system group to look at current care pathways for individuals requiring specialist eating disorders inpatient care, mapping against an optimal NICE guidance pathway with the aim of identifying any gaps in the clinical model and capacity	ICB led action plan in development. Action is aligned to existing DHcFT Patient Flow Transformation Programme. Review of pathways and opportunities for integration of services scheduled via series of workshops over Q3. Delivery plan to be developed for Q4 and into 2026-27.	Chief Delivery Officer & Deputy CEO	Complete Review: Q3 Deliver Plan: Q4 into 26-27	Strategic Portfolio Oversight Group

Men-SAT Report Action Mapping

Derbyshire Healthcare NHS Foundation Trust

Recommendation	Lead Org.	Opportunities (DHcFT highlighted in green font)	Action	Owner	Timescale	Assurance
3. Review the interfaces across the Mental Health UEC pathway with a view to achieving a shared understanding amongst partners of the service offer and referral thresholds to reduce variation in clinical models and improve equity in access	ICB & DHcFT	Flow: referrals and thresholds • For DHFT to ensure the access policy is public facing and is also easily accessible to system partners • For the ICB with DHFT to consider how to ensure there is a shared understanding of access standards for all services • To review referral thresholds between services by mapping through the lens of service user and staff experience • Undertake pathway mapping to identify and improve key bottlenecks to flow across the UEC MH pathways • Explore opportunities for improving the understanding of roles and responsibilities between teams and providers of services across the system Optimising discharge to home treatment interventions through early discharge • Review the early discharge function with the purpose of improving referrer confidence to home treatment interventions • Using case study approaches undertake an analysis of what multi team resources would be required to provide resilient wrap around community home treatment as an alternative to hospital admission Optimising access to crisis alternatives • Review the gatekeeping and access routes into Safe haven houses and consider direct pathways from community mental health teams for patients displaying evidence of deterioration and relapse • Explore variation in service models and eliminate any areas of unwarranted variation • Using a population needs approach review access and provision of safe havens and drop in hubs to fully understand gaps in provision	Review of DHcFT Access Policy now included within Patient Flow Transformation Programme Plan for delivery in Q3. Action for pathway and thresholds is aligned to existing DHcFT Patient Flow Transformation Programme. Review of pathways and opportunities for integration of services scheduled via series of workshops over Q3. Delivery plan to be developed for Q4 and into 2026-27. ICB led action plan in development	Chief Delivery Officer & Deputy CEO Chief Delivery Officer & Deputy CEO	Complete Review: Q3 Launch new policy Q4 Complete Review: Q3 Deliver Plan: Q4 into 26-27	Strategic Portfolio Oversight Group Strategic Portfolio Oversight Group

Men-SAT Report Action Mapping

Derbyshire Healthcare NHS Foundation Trust

Recommendation	Lead Org.	Opportunities (DHcFT highlighted in green font)	Action	Owner	Timescale	Assurance
4. Derbyshire Healthcare NHS Foundation Trust should, as a priority, work with commissioners and University Hospitals of Derby and Burton NHS Foundation Trust to review plans for the location of the Crisis Assessment Service pilot and relook at opportunities for premises that are co-located with the Royal Derby Hospital ED	DHcFT	• The NHS UEC Care Plan identifies co-located mental health crisis assessment centres (CAS) as a priority action. The NHS 10-year plan published in June 2025 commits to investment in developing more dedicated mental health emergency departments, to ensure patients get fast, same day access to specialist support in an appropriate setting. • There is a plan for a test of concept pilot for a Mental Health Crisis Assessment Service (CAS) to be located at Albany House (Kingsway site). This is not a co-located site with acute services, mental health liaison or crisis teams. We heard concerns that this could lead to the failure of the pilot and the ability to manage a patient's holistic needs, especially those that might still need physical care. The CAS would be isolated from other MH UEC services impacting on the connectivity and ability to provide seamless pathways of care. Nationally good practice models have been able to demonstrate optimal efficacy through co-location. • Historically there had been plans to have a co-located service at both Royal Derby Hospital and Chesterfield Royal hospital but at that time no funding for staffing could be attained. We heard that there could now be opportunity to revisit conversations around the utilisation of a 6 bedded facility on the Royal Derby site.	MH UEC Hub development action is aligned to existing DHcFT Patient Flow Transformation Programme. UHDB accommodation explored and no potential for availability for 18+ months. Alternative DHcFT estate under review with final decision September 2025. Plan to operationalise unit to be determined on agreement of location and potential interdependencies.	Chief Delivery Officer & Deputy CEO	Agree location: Sept 2025 Operationalise unit: TBC	Strategic Portfolio Oversight Group

Men-SAT Report Action Mapping

Derbyshire Healthcare NHS Foundation Trust

Recommendation	Lead Org.	Opportunities (DHcFT highlighted in green font)	Action	Owner	Timescale	Assurance
5. System partners should work together to seek rapid improvements to both the resourcing and operation of the Mental Health Helpline model to improve access into the system and optimise the service provided	ICB & DHcFT	• Crisis Helpline – Prioritise demand and capacity modelling to support in the understanding of required resource to meet the multiple functions of the service. - access to mental health triage - delivery of a 24/7 emotional support offer. - Clinical staff resource deployment to MHRV 7 days a week • DHFT should expedite efforts to fully address the technical issues with telephony systems potentially leading to dropped calls and discrepancies in the data. • The national drive is to have 111 #2 MH as the primary access point for crisis access lines. Should DHFT develop plans to close down the 0800 line, it should ensure that the transition is robustly managed with consideration of the clinical management and support needs of frequent users and those users who have moved away from Derbyshire but continue to access the Mental Health Helpline.	Crisis Helpline action is aligned to existing DHcFT Recovery Plan. Sustainable service solution requires strategic action and this has therefore been incorporated as an addition to the Patient Flow Transformation Programme	Chief Delivery Officer & Deputy CEO	Phased Plan: Phase 1: Recovery operational and technical issues by November 25 Phase 2: Sustainable service model and resourcing by April 26	Strategic Portfolio Oversight Group

Men-SAT Report Action Mapping

Derbyshire Healthcare NHS Foundation Trust

Recommendation	Lead Org.	Opportunities (DHcFT highlighted in green font)	Action	Owner	Timescale	Assurance
6. Develop a system wide workforce strategy for both Adults and CYP to ensure that the right workforce is in place to meet the needs of the population, including considering what workforce is needed to meet the unmet social needs of service users across the system	ICB & DHcFT	• Ensure the voice of lived experience is being embedded into a range of paid roles at various levels within the mental health system	ICB led action plan in development			
		• Undertaking system wide training needs analysis that is underpinned by population needs analysis (including SEND data) would support a workforce to meet population need	Developing lived experience roles is aligned to action within the existing Strategic Plan and enabling Quality Delivery Plan.	Director of Nursing	Development of roles and functions by Q4	Strategic Portfolio Oversight Group
		• Undertake demand and capacity modelling of the community mental health teams, considering the level of need and access in relation to population need and size	Demand and capacity modelling is aligned to existing DHcFT Patient Flow Transformation Programme with this scheduled to be undertake over Q3.	Chief Delivery Officer & Deputy CEO	Complete Review: Q3 Deliver Plan: Q4 into 26-27	Strategic Portfolio Oversight Group
		• Consideration of the VCFSE training needs must be considered as part of the MH Crisis workforce strategy, to ensure that VCFSE organisations are seen and valued as an integral partner within the UEC MH pathway				
		• DHFT to develop a programme of work to introduce job planning across all staff members, not just medics and psychologists, to support a greater understanding of capacity to meet demand	Development of job planning is to full service planning is aligned to demand and capacity planning action above. A detailed plan is in place to achieve the national standards for medical job planning and a placeholder will be made in the Patient Flow Transformation Plan within timeline to be agreed in Q4	Chief Delivery Officer & Deputy CEO	Agree timeline in Q4 aligned to medical job planning progress	Strategic Portfolio Oversight Group
		• Review the need for specific skills sets such as housing officers when workforce planning with the aim improve flow addressing known flow challenges				

Men-SAT Report Action Mapping

Derbyshire Healthcare NHS Foundation Trust

Recommendation	Lead Org.	Opportunities (DHcFT highlighted in green font)	Action	Owner	Timescale	Assurance
7. Convene a group to review the intelligence on High Intensity Users across the system and develop co-ordinated plans to ensure appropriate resource allocation and that service users receive the right care in the right place at the right time	ICB	• Successful High Intensity User (HIU) programmes support the overall productivity and efficiency drive in the NHS, and can lead to between 38% and 84% reductions in A&E attendances and between 24% and 84% reductions in non-elective admissions[1] • Research from the British Red Cross has shown a clear link between high intensity use of UEC services and wider health inequalities and deprivation. • HIU services can support UEC pathway pressures whilst at the same time addressing health inequalities, helping to free up frontline resources to see other patients and reduce costs. • High intensity use of UEC is associated with focussing help for primarily non-medical factors including housing instability, social isolation, loneliness and deprivation as well as poor physical and mental health. • Benefits for clients after engagement with a HIU service include feeling more confident to look after their health; having improved wellbeing; and feeling less lonely. • As a system, Derby and Derbyshire ICB have the opportunity to review and pull together insights on HIU in different services and develop a co-ordinated HIU programme to best meet the needs of this group of patients.	ICB led action plan in development.			

Men-SAT Report Action Mapping

Derbyshire Healthcare NHS Foundation Trust

Recommendation	Lead Org.	Opportunities (DHcFT highlighted in green font)	Action	Owner	Timescale	Assurance
8. Agree priority actions for strengthening the use of data and intelligence to inform system planning and service delivery	ICB	Opportunities identified include: • Development of a system wide UEC MH pathway dashboard to inform strategic and tactical planning. • Development of a plan to ensure that the value of using Patient Reported Outcome Measures (PROMs) is well understood across the system, and that a comprehensive and cohesive approach to outcome measurement recording and reporting informs service delivery and planning. • Strengthening the use of Patient Reported Experience Measures to help inform and prioritise service improvement opportunities. • Making better use of service utilisation data to highlight bottlenecks and inform demand and capacity planning. • Developing better intelligence on levels of access to different services, in particularly to highlight any inequalities relating to geography, ethnicity, age and other important demographic data.	ICB led action plan in development Strengthening use of PROMS through ReQoL is aligned to action within the existing Strategic Plan and enabling Quality Delivery Plan. Service utilisation data is aligned to existing DHcFT Patient Flow Transformation Programme and the plan to complete demand and capacity planning over Q3.	Director of Nursing Chief Delivery Officer & Deputy CEO	Reporting and assurance mechanisms in place by Q4 Complete Review: Q3 Deliver Plan: Q4 into 26-27	Strategic Portfolio Oversight Group Strategic Portfolio Oversight Group

Derbyshire Healthcare NHS Foundation Trust
Report to Board of Directors – 23 September 2025

Winter Plan - 2025/26

Purpose of Report

The purpose of this report is to inform the Public Board of the Trust's finalised Winter Plan for 2025/26 and to obtain the Board of Directors' assurance and approval.

Executive Summary

In planning, preparedness and assurance for winter 2025/26, the Trust is required to submit a Winter Plan to the Integrated Care Board (ICB) in support of a System Winter Plan that is submitted to NHSE, to provide assurance against preparation and prevention as part of the response to winter. The winter period is defined from October 2025 to February 2026.

In support of this paper please see included the following items:

- DHcFT Winter Plan 2025/26
- Quality and Equality Impact Assessment (QEIA)
- Board Assurance Statement.

On 26 August, the Trust Development Group approved the finalised plan and supporting documents and on 4 September, the QEIA was ratified at the QEIA panel.

The Board is requested to confirm assurance against the plan and provide full approval by way of CEO and Chair signature to the NHSE Board Assurance Statement on behalf of the Board of Directors.

In addition to the Trust governance route, the DHcFT Winter Plan has been submitted to the ICB, who have reviewed all organisational plans against an ICB-led 'System Testing Exercise' on 1 August. The plans will be further tested at a 'Regional Winter Planning Stress Test Exercise' on 17 September.

A System review of the Winter 2025/26 experience and impact is scheduled to take place via an ICB-led 'Winter Wash Up' session in April 2026. This will include patient and staff stories, learning and successes and any for future improvements.

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 identified.

Consultation

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

Governance or Legal Issues

- Organisational governance route is via Trust Delivery Group and Trust Board
- System level governance route is via Urgent Emergency Care and Mental Health Learning Disability and 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 are requested to:

1. Confirm assurance for the Trust Winter Plan 2025/26.
2. Approve the Board Assurance Statement, by way of CEO and Chair signature.

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

Report prepared by: **Stephanie Harris**
Strategic Transformation Programme Lead

DHcFT Winter Plan - 2025/26

Scope

In support of planning, preparedness and assurance for Winter 2025/26 this document will provide a shared awareness and understanding of the Trusts standard provision in place over winter, where there is any increase in resources, to include both staffing and service offer and a summary of support and escalation routes available in support of any episodes of pressure during the winter period.

The winter period covers October 2025 to February 2026.

National Background

It has been recognised at national level that both the scale of the challenge ahead and the significant change underway across the wider NHS landscape will need to be taken into account in this year's winter planning. The national message is that we are preparing for a difficult winter period, shaped not only by seasonal pressures but also by structural transitions that will require exceptional leadership, resilience, and co-ordination.

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.

Against this backdrop, it is more important than ever that we focus on prevention as a critical pillar of our winter response.

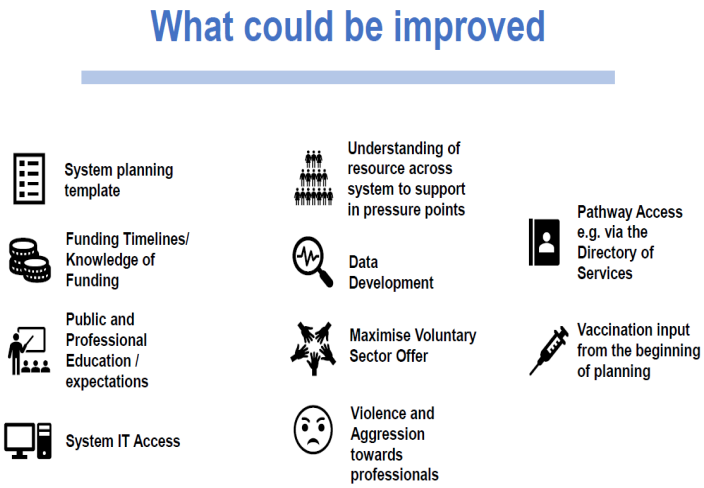
Content

This Winter Plan document for DHcFT is separated into six parts:

PART 1 - Assurance Reporting

1. Learning from 2024/25

The ICB led a 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:



The Trust shares a view with System partners that the agreed priorities for 2025/26 include:

From a DHcFT perspective, the last two years have shown the peak of demand increases during summer months, school holidays and the new year period.

2. Mitigating Wider System Change

The Trust is implementing a new operating model, the organisation will maintain standards and manage risk across 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.

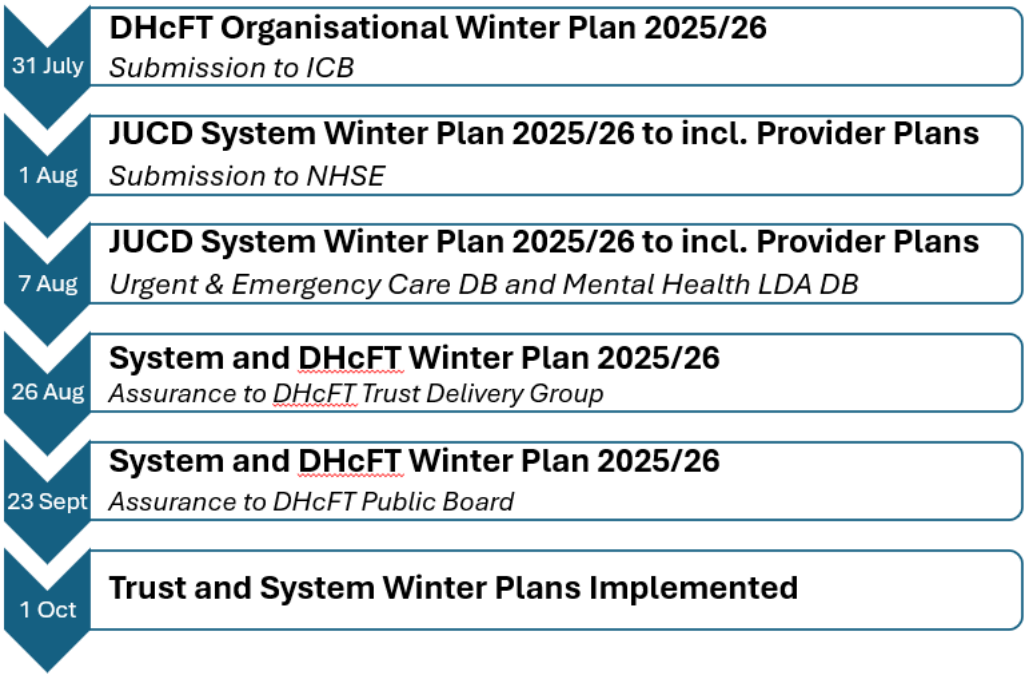
3. Leadership Capacity – Appointing a Designated Winter Director

The Trust's designated lead for winter is Vikki Ashton 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.

4. Assurance on Delivery Impact

The Board is asked 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.



PART 2 - Operational Planning and Data Expectations

Demand and Capacity:

The Trust has planned sufficient capacity to meet the expected demand this winter, based on a projected increase of 4%.

DHcFT's current bed base is outlined in the table below:

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**

In addition to the capacity outlined in the table above, the Trust has eight additional surge beds available across the two wards at the Radbourne Unit. These beds will be made available if required during any peak periods of demand during winter.

Psychiatric Intensive Care Unit (PICU) beds (14 beds – Kingfisher House, Carsington Unit) and Enhanced Care Unit (ECU) beds (eight beds – Audrey House) opened in July 2025. The Trust having its own PICU and ECU beds will support improvements to flow including length of stay benefits.

The Trust also has access to additional capacity in Mill Lodge and Sherwood. The plans are that Mill Lodge and Sherwood bed capacity will reduce following the opening of the specialist beds; PICU and the ECU beds. The phased reduction plan is as follows:

Q3 = eight beds : four Mill Lodge and four Sherwood
Q4 = reduce to one bed at Mill Lodge

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 (ED) whilst awaiting a mental health bed for assessment and advisory purposes
- Crisis Resolution and Home Treatment Service (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 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 sseven 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.

The Trust will remain focused on determining the most effective use of capacity against demand at all times to include forward planning around discharges to help reduce bed occupancy. There are also ongoing plans in place to ensure there are sufficient resources across the community pathways during peak periods of demand periods with a view to support admission avoidance and timely discharge.

Vaccination uptake

The Trust trajectory is based on a five year plan that is aimed to achieve 5% above 2018/19 which equates to 29.6% of staff to be vaccinated against flu. The plans in place are set to achieve this target. Vaccination clinics will be jointly established between DHcFT and Derbyshire Community Health Services (DCHS).

This is only Flu vaccinations as this year as healthcare workers are not being vaccinated against Covid.

IPC Management

The forecast is that there will likely be many pathogens at the same time this year, ie Covid; norovirus; RSV; and Flu. The challenging climate of primary care access will likely impact the system resulting in expected pressures for DHcFT demand and capacity across all service provisions in particular across urgent care pathways.

For DHcFT, the main concern is the transfer of patients between DHcFT and the EDs. The risks include:

a) blocking ED
b) the time it takes to convey and be assessed
c) transmitting infections from ED.

Mitigations include a standard operating procedure between DHcFT and University Hospitals of Derby and Burton (UHDB) to provide a direct pathway of support for Respiratory and Gastroenterology, which will include bypassing ED and direct access to specialists for assessment.

Workforce Resilience

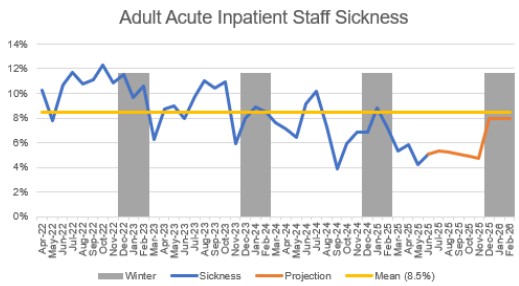
To support the sustainbility of workforce over the winter period the Trust has an enhanced programme of wellbeing support and staff vaccination plans in place.

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. A responsive vacancy and agency panel are in place and will increase their frequency of meeting during the winter period to ensure the Trust can respond in a timely manner to any needs for surge staffing withing process. We have a strong process for industrial action that has been utilised over the last two years and scucessfully mitigated key risks. This approach will continue to be in place for the winter period and an Incident Management team provides 24/7 response to any risks that arise over the industrial action periods.

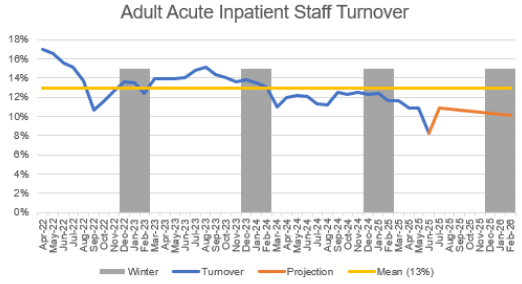
Key Data Insights

Anticipated Workforce Pressure

Historically the winter period has shown no significant change in sickness, averaging 9%.

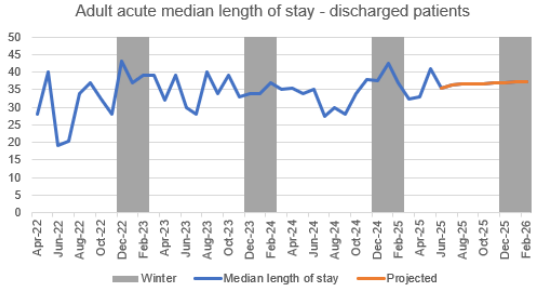


Historically the winter period has shown no significant change in vacancy rates; continued position ranging between 10-14%.

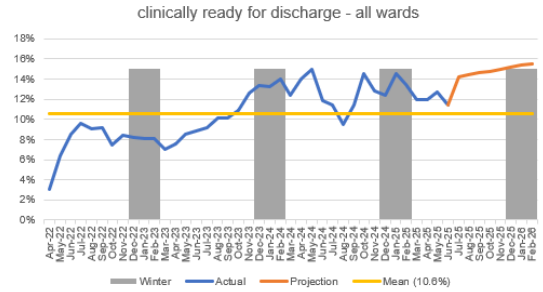


Length of Stay and Clinically Ready for Discharge

Historically there is no evidence of any significant change to length of stay over winter.



Clinically ready for discharge patients averages at 10.6% of the Trust's capacity and is dependent on system partner support.



Mental Health Liaison and Emergency Departments

The table below is overlayed with a heat map which demonstrates that mental health attendances in the Emergency Departments are a very small proportion of all ED attendances and have been reducing over the last 12 months, despite overall A&E attendances increasing.

A&E total attendances: Type 1 - Major A&E, Type 2 - Single Specialty, & Type 3 - Other A&E/Minor Injury Unit														
Provider	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Chesterfield	7,917	8,764	8,697	8,758	8,492	8,495	8,911	8,568	8,639	8,765	8,568	9,058	8,642	9,449
Derby & Burton	27,311	30,362	30,169	29,926	28,622	30,182	32,092	29,778	30,040	30,697	30,240	32,278	31,066	32,964
Total	35,228	39,126	38,866	38,684	37,114	38,677	41,003	38,346	38,679	39,462	38,808	41,336	39,708	42,413

Provider	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Chesterfield	8,836	9,239	8,819	12,925	13,735	13,236	13,464	12,501	11,980	14,335	13,493	13,950	13,599
Derby & Burton	31,485	31,844	28,360	30,078	32,098	31,891	31,960	28,765	26,629	31,343	31,426	32,515	32,785
Total	40,321	41,083	37,179	43,003	45,833	45,127	45,424	41,266	38,609	45,678	44,919	46,465	46,384

Referrals to mental health liaison														
Team	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
MH Liaison North	335	322	317	360	341	326	379	316	287	320	308	322	321	301
MH Liaison South	623	640	590	640	649	590	540	556	540	579	571	596	556	549
Total	958	962	907	1000	990	916	919	872	827	899	879	918	877	850

Team	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
MH Liaison North	325	338	317	347	361	313	280	349	282	325	299	292	294
MH Liaison South	510	570	561	543	517	533	504	501	466	512	539	525	546
Total	835	908	878	890	878	846	784	850	748	837	838	817	840

Mental health presentations as a proportion of total A&E attendances														
Team	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
MH Liaison North	4.2%	3.7%	3.6%	4.1%	4.0%	3.8%	4.3%	3.7%	3.3%	3.7%	3.6%	3.6%	3.7%	3.2%
MH Liaison South	2.3%	2.1%	2.0%	2.1%	2.3%	2.0%	1.7%	1.9%	1.8%	1.9%	1.9%	1.8%	1.8%	1.7%
Total	2.7%	2.5%	2.3%	2.6%	2.7%	2.4%	2.2%	2.3%	2.1%	2.3%	2.3%	2.2%	2.2%	2.0%

Team	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
MH Liaison North	3.7%	3.7%	3.6%	2.7%	2.6%	2.4%	2.1%	2.8%	2.4%	2.3%	2.2%	2.1%	2.2%
MH Liaison South	1.6%	1.8%	2.0%	1.8%	1.6%	1.7%	1.6%	1.7%	1.7%	1.6%	1.7%	1.6%	1.7%
Total	2.1%	2.2%	2.4%	2.1%	1.9%	1.9%	1.7%	2.1%	1.9%	1.8%	1.9%	1.8%	1.8%

PART 3 - Overview of the Trust Directorates – Provision and Impact

Mental Health Crisis and Assessment Services 1 of 2

Service Area	Provision	Capacity and Resource i.e. New/Increased/Reduced/No Change	Expected Impact	Delivery and Status
Mental Health Crisis Line	111 Mental Health Option went live in April-24. This involves all mental health calls via 111 being routed to the mental health crisis line. NHSE and Local Comms plans are in place to inform the public domain of this service offer.	**No change** in the Crisis Line capacity or resource.	**Benefits** – direct public access for mental health urgent crisis support. **Risks** - No increase in resources to manage the increasing demand on the Crisis Line with expectations the demand will continue to increase over winter potentially resulting in capacity and demand issues.	
	Crisis Line and EMAS pathway for Clinician-to-Clinician Handover to Crisis Alternatives.	**No change** in capacity or resource, however, alternative pathways implemented to support mental health demand.	**Benefits** – EMAS will have the ability to convey to crisis alternative services; avoiding ED attendance. No foreseen risk.	
	Professional Line – Direct access to a mental health clinician for emergency services.	**No change.**	**Benefits** - enhanced support to emergency services and pathways. No foreseen risk.	
	Deaf and Hard of Hearing Line – implemented from December 2023 following NHSE mandate.	**No change** - in place long term.	**Benefits** - reducing inequalities and access to mental health services. No foreseen risk.	
Crisis Alternatives	Community Drop in Centres, Safe Havens and Crisis Houses.	**No change** to capacity. Enhanced Comms in place over Winter to support utilisation.	**Benefits** - alternative pathways to ED and/or admission. No foreseen risk. **Risks** – Service continuity/contracts and Staffing. ICB have extended contracts until March-26, organisations workforce plans are aimed at local recruitment to support access during winter and severe weather conditions.	
Mental Health Response Vehicle	Joint EMAS Paramedic and Mental Health Nurse See and Treat Model in place 7days a week, 4pm-1am.	**New Resource** – in place long term.	**Benefits** – reducing dispatch of an ambulance for mental health related calls, reducing mental health attendance at ED and supporting purposeful admissions. **Risks** – Staffing which has been mitigated by offering electric vehicle (EV-FRV) training to all paramedics, providing a wider selection of staff to support shifts via bank.	

Mental Health Crisis and Assessment Services 2 of 2

Service Area	Provision	Capacity and Resource i.e. New/Increased/Reduced/No Change	Expected Impact	Delivery Date and Status
72hour (3-day) Review and Purposeful Admission	There is a Gate Keeping process in place to support the decision to admit. Each admission is then followed up by an MDM within 72hours to determine if the decision to admit still stands or if an alternative to admission can be sought. If admission remains then the MDT further formalises the decision to admit to ensure there is a clear plan for the purpose of this particular admission.	**No Change** - The Gate Keeping MDMs can be impacted by capacity and resource in some areas however no current change to resource. Considering admin support which would be an increase.	**Benefits** - Having a clear Purpose of Admission can aid positive flow through a person's inpatient journey. Early discharge planning reduces length of stay along with frequency and duration of any subsequent readmission. Purpose of Admission has a positive influence on a patient's overall length of stay (LOS) and increases patient satisfaction. MDM is attended by a range of professionals to include community, crisis, inpatients and social care. Community teams further support the process by carrying out an admission review for all patients on the community case load to identify themes of good practice and missed opportunities for ongoing learning.	
Section 136	Dedicated Section 136 Staffing Model	**New Resource** – in place long term.	**Benefits** – dedicated and experienced section 136 staffing team improving patient experience and providing improved access and availability of the Health Based Place of Safety suites to support flow.	
	Joint Risk Assessment Handover Tool to support Handover of section 136 detainees from Police to Health	**No change.**	**Benefits** – increased efficiencies around the management of section 136 to improve flow and patient experience. No foreseen Risk.	
	Health Based Place of Safety Suites - Currently 2 HBPOS Suites – 1 at each unit.	**Increased Resource** - 3 HBPOS Suites as part of the Making Room for Dignity New Build Project. In place long term. Expected Feb-25.	**Benefits** - Additional capacity to support section 136 and improve flow. No foreseen Risk.	
Mental Health Liaison	The Mental Health Liaison Teams reach into those patients in acute inpatient beds or ED whilst awaiting a mental health bed.	**No change.**	**Benefits** – improve flow for those waiting for a mental health bed in ED and provide mental health support to those waiting in ED with a combined physical and mental health need. No foreseen Risk.	

Mental Health Adult Inpatients 1 of 2

Service Area	Provision	Capacity and Resource i.e. New/Increased/Reduced/No Change	Expected Impact	Delivery Date and Status
Inpatients	Integrated Flow Function	**Increase in Resource** – via Discharge Funding, supporting flow and discharge functions through acute and community services.	**Benefits** – System wide approach. Mental health care is often disconnected from the wider health and care system, and as a result, people do not always receive co-ordinated support for their physical health, mental health and wider social needs. **Risks** - Funding ends April 2026 but in terms of Winter the resource will remain in place.	
Inpatients	Step Down Pathway	**Reduced Capacity** – funding only for 4 step down beds at any one time.	**Benefits** - The Step-Down model is aimed at improving flow and optimising LOS; reducing the number of people who are delayed on wards but are clinically ready to be discharged. The provision will enable early discharge, minimize delay in transfer of care, and release capacity in the adult acute wards within DHcFT. **Risk**- demand for step down is higher than the commissioned 4 beds. Patients are also becoming blocked in step down due to no exit plan, housing or placement.	
7-Day Process	To apply 7 day discharge process	**Reduced:** There is evidence to support that 7- day discharge occurs however this would either be planned or as a result of patient choice. There is no regular RMO cover at the weekends other than on call.	**Benefits**- Apply 7-day working to enable people who are clinically ready for discharge to be discharged over weekends and bank holidays, and allow people who require admission timely access to local beds. **Risks**- lack of resource to provide regular 7 day review of patients.	
Inappropriate Out of Area Placements	To have zero inappropriate Out of Area Beds	**Reduced** - DHcFT have seen a varied use of OOA beds over the last 12 months due to demand in bed requests and challenges with bed flow and on going challenges in flow with patients who are Clinically ready for discharge. . Increased resource to OOA co-Ordinator to support the review and discharge planning of all OOA patients. July 2025 reduced to 2 Inappropriate OOA beds.	**Benefits** – There will always be a need for some OOA use for appropriate beds, such as staff member admissions. **Risks** – Patients in OOA beds are often a long way from home and their local community support, family, friends and carers. On-going use of OOA beds has financial implications.	

Mental Health Adult Inpatients 2 of 2

Service Area	Provision	Capacity and Resource i.e. New/Increased/Reduced/No Change	Expected Impact	Delivery Date and Status
Making Room for Dignity Programme	To include PICU provision in Derbyshire.	**New Capacity/ Change** – PICU Beds open in July 2025.	**Benefits** - A PICU provision in Derbyshire will generate improved flow, admission capacity in adult acute inpatients, enabling associated community teams to work closely with the inpatient team, creating capacity to repatriate PICU patients when appropriate to do so and further resulting in a potential reduction for the requirement of psychiatric intensive care.	
Clinically Ready for Discharge	To reduce the amount of patients who are CRFD	No change – number of cases vary but continue to remain high with no additional resource to manage the CRFD capacity.	**Benefits**- CRFD numbers remain static, with patients each week being added to CRFD list. However; since start of 2025 there have been 57 discharges across Adult and 55 Older Adult who were CRFD and discussed in MADE. **Challenges**- remain with providers coming forward on the framework to assess and accept both Adult and Older Adult patients. As well as funding not always agreed with provider costs being too high to meet the needs of the patient. The LOS of those CRFD to discharge is reducing for Adults. Current mean LOS is 46 from being identified as CRFD to discharge. Mini made twice weekly and MADE twice weekly. Ability to review actions not transacted/ getting immediate funding approval/ increase in out of panel decisions/ ICB support for OOA patients to resolve issues of response and delays. City social care re-engaged. Housing attended MADE however deemed not always appropriate or required, therefore separate meetings trialled and links with housing to discuss specific patients with a duty of refer to plan and support discharge pathway. Challenge in increase use of step down beds with no exit plan= starting to see blockages in step down placements.	

Mental Health Older Adult Inpatients

Service Area	Provision	Capacity and Resource i.e. New/Increased/Reduced/No Change	Expected Impact	Delivery Date and Status
Purposeful Admission and Gatekeeping	DRRT/ IRHTT Neither team 24 hours	No Change-	DRRT South assessed 419 patients in previous 12 months 97 were admitted	
Inpatients	36 Dementia beds South 30 functional beds South and North County	Change in Functional beds- 12 – can flex to 14 beds created at stand alone Bluebell ward to serve North patients	Reduced need to send out of area/ ring fenced OA beds	
Inappropriate Out of Area Placements	Use of OOA beds low	No change	OOA bed use remains low and the ability to flex o 14 beds Bluebell has supported diversion. This has meant South patients in North beds but not OOA	
Inpatients	Stepdown pathway	No change	Remains unavailable to over 65's and people with dementia	
Inpatients	Discharge flow/ CRFD/ MADE	Change- Increased frequency of MADE/ CRFD	To support flow and discharge with varying effect	

Mental Health Learning Disabilities and Autism

Service Area	Provision	Capacity and Resource i.e. New/Increased/Reduced/No Change	Expected Impact	Delivery and Status
LD Intensive Support Team	Continued service provision across the county with single operational leadership across north and south teams as part of integration.	**Temporary Increase** in staffing areas due to closure of Hillside ATU (DCHS) and redeployment, however possible increase in demand due to the acuity of cohort changing.	Benefit- temporary further Support to reduce ED attendance and hospital admission for LD cohort Risks: Moving to one single leadership across DCHS/DHcFT and One EPR	
Inreach and Hospital Avoidance	Supports both inpatient wards and MH community teams working with patients who have LD/A	**Reduced capacity** due to workforce changes, Joint processes in place to support capacity South provision only	Risk- Demand will outstrip capacity resulting in reduced support to inpatient and MH community teams for LD/A cohort.	
VCSE Support/Commissioned services	Health and Wellbeing navigators in autism assessment service Short-Term Intervention Team providing wrap-around support alongside Crisis services	**No change** to capacity Operational and working to capacity	Supports people pre and post-diagnosis, reducing complaints, reducing crisis episodes Increased support to patients needing more intensive community based support- reducing ED attendance and hospital admissions	
Specialist Autism Team	Continued service provision across the county.	**No change** to resource or capacity.		
Community LD/Crisis Services	Community teams and trainee ACPs and NMP working across to support ADHD/ reducing health inequalities, physical health and STOMP/STAMP	**Increased provision** to support the demand during winter especially around respiratory conditions.	Progress has been made however, improvements remain ongoing to ensure reasonable adjustments and talking health inequalities is addressed via: -GM enrolled in Fellowship on population health commencing from Sept 25 - ACP leading on internal training programme - coproduced service on transition to ensure meeting needs of patients transitioning from CAMHsID to Adult LD.	

Mental Health Community Services

Service Area	Provision	Capacity and Resource i.e. Increased/Reduced/No Change	Expected Impact	Delivery and Status
Community Mental Health Services - Urgent Care Transformation	Continued use of Management and Supervision Tool (MaST) and safety huddles to ensure teams focus input to those at greatest need and at risk of going into crisis and/or admission	**No change** as this is still being embedded as business as usual with the medics to support flow. Potential increase in referral to Crisis teams.	**Benefits** – Increase in flow and productivity. Proactive approach to hospital avoidance.	
Community Mental Health Services – Urgent Care Transformation	Contingency Planning as an output of the daily safety huddles - Patients at risk of admission to have robust contingency plan in place to identify alternatives and where possible avoid admission to hospital.	**Reduced** – increased activity as part of contingency planning and hospital avoidance, may result in reduced capacity in the CMHTs and potential increase in referrals to Crisis teams for home treatment.	**Risk** – focus will be given to those patients identified to be at risk of admission, drawing resource away from routine interventions, including initial conversations at the front door	
Community Mental Health Services – Urgent Care Transformation	Service user admission survey to review all admissions, to identify themes around missed opportunities and good practice	**No change** – as this is a new process, data needs to be analysed to understand areas of learning and implement changes to individual care plans and pathways.	**Benefits** – Improved pathways and personalised care. Long term potential reduction in avoidable admissions.	
Living Well – Short-Term Offer	Mobilisation of Phase 2 of the CMHF transformation, expanding front door to include introductions from other agencies.	**Reduced** – Already seen a 55% increase in referrals to community teams over the last 18 months. There will be reduced capacity due to further increase in demand.	**Benefits** – more people will be promptly seen, which (Timely access to care, reduction in crisis situations, improvement in quality of life of the service user) **Risk** – Longer waits for intervention in the community once assesses, leading to delays in treatment and potential deterioration in mental health requiring crisis support and/or admission.	

Mental Health Children, Complex Health, Therapy services and 0-19 Public Health Services

Service Area	Provision	Capacity and Resource i.e. Increased/Reduced/No Change	Expected Impact	Delivery Date and Status
CAMHS Urgent Care / Day service	Liaison – hospital based urgent assessment, brief follow up and intervention Crisis team – hospital at home care, enhanced interventions, supplement to recovery team, facilitating early discharge	**No change expected.** If reduced staffing, opportunities to combine services and operate a hub model to support CAMHS recovery teams and children at risk.	Risks – Can be managed by implementation of BCP and implementing hub model. Case review to identify all high-risk cases	
CAMHS Eating Disorder	Community Assessment, formulation, management those with eating disorders. In reach to paediatric wards	**Risk of ward attendance and response to urgent referrals.** BCP to include digital offer and alignment with CAMHS hub.	Effective case management and admission avoidance plans in place to include support to system partners i.e. inpatients.	
CAMHS Intellectual Disabilities	Specialist assessment, psychological intervention, care coordination, medication management	Support to be provided by the Escalation team and TCP re CYP at risk of admission. In house support from the Day Service to avoid hospital admission.	Effective case management and admission avoidance plans in place to include support to system partners i.e. inpatients. Priority review of service operation to discharge from hospital.	
0-19 – Health Visiting	Primary birth visits and follow up with families at risk will take place prior to the bank holidays.	**No Change.** No service provision in place during bank holidays.	Effective case management.	
Complex Health and Therapies	Cover to rapid response rota , Non accidental injury rota, safeguarding advice – CICA Team provision would need to be reviewed.	**Risk of reduced workforce** - Reduced Community Paediatrician to cover rota. To consider alignment of the rota with CRHFT. Potential gaps would need locum cover.	Risk – Gaps in rota cover. Consider skill mix review to provide support. Possible links to CRHFT.	

PART 4 – Staffing Levels during Identified Pressure Points – Christmas and New Year

Planned Staffing Levels – Peak Demand Period of Christmas and New Year

Staffing Level
Baseline
Increased
Safer
Weekend
Not Operational

Service Area	Lead	Christmas Period 22 to 24 Dec-2025	Christmas - 25 Dec *Bank Holiday*	Christmas - 26 Dec *Bank Holiday*	Christmas Period 27 to 31 Dec-2027	New Year - 1 Jan-26 *Bank Holiday*	New Year Period 2 to 4 Dec-2026	Post Pressure Period 5 to 11 Jan-2026
Adult Inpatient Wards	Lee Doyle / David Tucker	Safer Staffing						
Older Adult Inpatient Wards		Safer Staffing						
Section 136 Suites		Baseline Staffing						
Crisis Home Treatment Services		Safer Staffing	Weekend Staffing	Weekend Staffing	Safer Staffing	Weekend Staffing	Safer Staffing	Baseline Staffing
Helpline - 111 Mental Health Option		Baseline Staffing						
Mental Health Liaison in ED		Baseline Staffing						
Learning, Disability and Autism		SAT & IST in place	IST in place	IST in place	IST in place & SAT weekdays	IST in place	IST in place & SAT weekdays	IST in place & SAT weekdays
Children and Young Peoples Crisis Services		Baseline Staffing						
Community Services - CMHT and Living Well		Baseline Staffing	Not Operational	Not Operational	Baseline Staffing	Not Operational	Baseline Staffing	Baseline Staffing

Crisis and Assessment Services Additional Assurance due to association with System-Level Urgent Care Pathways

Crisis Home Treatment Services are generally lower staffing over the Christmas period due to a consistently 'quieter' time in terms of planned activity. However, rotas are always staffed at 'safe staffing levels; underpinned by safer staffing protocols. The key bank holidays during the Christmas and New Year period are staffed at weekend staffing levels; previous years have proven this level to be proportionate.

Liaison and the Helpline are staffed to usual staffing levels to include the key bank holiday days – helpline acuity is often unchanged.

Contingency Planning is in place across all Crisis and Assessment Services to include cover across teams if urgent support is required as well as access to an alternative offer of telephone and/or video appointments is available if deemed necessary, ie if a two-person visit cannot be facilitated or adverse weather.

PART 5 – Communications and Media Plans

The Trust's Winter Communications Plan includes:

- Proactive media statements as part of its Emergency Preparedness, Resilience and Response (EPRR) strategy
- Trust statements for slow-burn or emerging incidents - such as cold weather events to include information around preparations and response.

Adverse Weather Plan

Process:

- Notification from UK Health Security Agency (UKHSA) or the Met Office
- EPRR team initiates a risk assessment.
- Cascade – Comms team to cascade to all staff accordingly

Actions:

- Issuing internal communications via all-staff emails
- Focus (Trust-wide news)
- Staff Facebook group depending on the alert level (yellow, amber, red)
- Disseminating public-facing messages tailored to the severity of the alert and its impact on services
- Attending Incident Management Team (IMT) meetings if service disruption is anticipated, and reflecting key decisions in communications
- Sharing guidance for vulnerable service users, including older adults, children, and those with long-term health conditions.

Public Health messaging

The Trust plays a central role in supporting public health messaging by disseminating national guidance from UKHSA and NHS England, including social media assets and toolkits; amplifying system-wide messages, such as heatwave or cold weather safety tips, through its own channels; and coordinating with system partners during pressure periods to ensure consistent messaging across Derbyshire.

Media Management

The Trust follows a structured approach outlined in the **Media Handling Policy** - all media inquiries are referred to the Communications team (who issue statements on behalf of the Trust), media training is provided to Executive Directors and incident spokespeople to ensure readiness for interviews. The Communications team also maintains a media monitoring system to track coverage and respond to inaccuracies or emerging issues.

PART 6 – Summary of Support and Escalation Routes

Support via Urgent Care Pathways and System Partners

SERVICE	DURING WINTER
Helpline	247 Service Offer remains includes access to Crisis Teams Public - 111 Mental Health Option Professional - 01246 932350
Crisis Alternatives	Same service offer remains over Winter – details in green table below.
Police	Police operate with the same staffing levels across the year albeit staffing numbers are boosted on 'break-up Friday and New Years Eve. This includes extra patrols and capability to deal with anticipated demand.
EMAS	EMAS staffing remains the same across the year however, if demand and pressures are extremely heightened throughout Winter, staffing numbers are boosted via overtime offers to increase staffing numbers.
Link below to providing information - local and national links and resources which is regularly... **Derby & Derbyshire - Emotional Health & Wellbeing**	

Service	Provider	Address	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Mental Health Helpline	DHcFT	Phoneline – 111 MH Option 2	Open 24hours 7 days a week **All Ages						
Mental Health Response Vehicle	EMAS	Phoneline via 999	4pm –12am	4pm –12am	4pm – 12am	4pm – 12am	4pm – 12am	4pm – 12am	4pm – 12am
Crisis Support Drop- In-Service	MIND	Clough Street (within Market Street Car Park), Buxton, SK17 6LJ					6pm – 11pm	6pm – 11pm	2.30pm – 5.30pm
Crisis Support Drop- In-Service	MIND	The Croft, Slack Lane, Ripley, DE5 3HF. (Just off Ripley Market Place.)					6pm – 11pm	6pm – 11pm	2.30pm – 5.30pm
Crisis Support Drop- In-Service	MIND	12-14 West Street (opposite the Empire Cinema), Swadlincote, DE11 9DE.					6pm – 11pm	6pm – 11pm	2.30pm – 5.30pm
Safe Haven	Waythrough	309 Burton Road, Derby DE23 6AG. Phone: 0330 008 3722.	4.30pm – 12.30am	4.30pm – 12.30am	4.30pm – 12.30am	4.30pm – 12.30am	4.30pm – 12.30am	4.30pm – 12.30am	4.30pm – 12.30am
Crisis House	Waythrough		Open 24hours 7 days a week						
Safe Haven	P3	188 North Wingfield Road, Grassmoor, Chesterfield, S42 5ED Phone: 01246 949410	4.30pm – 12.30am	4.30pm – 12.30am	4.30pm – 12.30am	4.30pm – 12.30am	4.30pm – 12.30am	4.30pm – 12.30am	4.30pm – 12.30am
Crisis House	P3		Open 24hours 7 days a week						

Escalation Routes

Derbyshire Healthcare Escalation Route

In Hours:

Operational/Clinical Staff – Area Service Manager – General Manager – Managing Director

Useful Contacts:

Bed Management team - dhcft.acutebedmanagementteam@nhs.net
Section 136 team - dhcft.136suite@nhs.net

Out of Hours – Clinical Decision Making

Bleep Holder – Resident Doctor – On-Call Consultant
Main Swithboard 24 hours – 01332 623700

Out of Hours – Operational Decision Making

First On-Call
Main Swithboard 24 hours – 01332 623700

Derby Hospital and Chesterfield Hospital Escalation Route

In Hours:

Operational – General Manager – Divisional Director

Out of Hours:

Operational – On-Call

Police Escalation Route

The police escalation route outlined below is the escalation process over a 24 hour period. Each escalation step is managed via a request to escalate at the given stage.

All Hours:

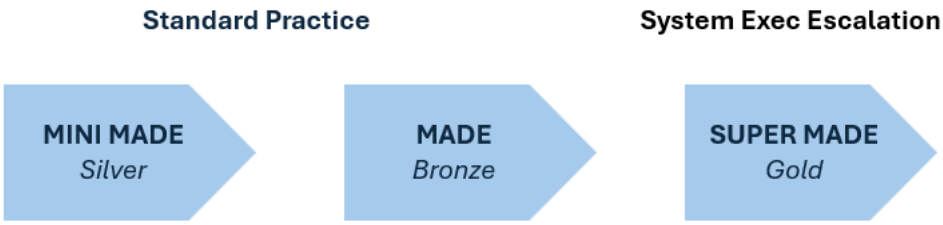
Operational – Force Incident Manager – Critical Incident Manager – Gold Commander

ICB Health and Social Care Escalation

Email: ddicb.ddscc@nhs.net

Command and Control – Patient Flow

For patient Flow escalation for Clinical Ready for Discharge cases, standard process and escalation step is outlined below. This process is in place all year round with agreement it can be utilised as much as needed throughout the winter period.



National Quality Board quality impact assessment (QIA) tool

Please refer to the Quality impact assessment framework for full guidance on the purpose and process of QIAs.

Summary of proposal

Directorate:	**Trust Level**			QIA ID:	
Project lead completing QIA:	**Stephanie Harris**			QIA version:	
Executive lead and/or project sponsor:	**Vikki Ashton-Taylor / David Tucker**	Accountable clinical lead:		Date:	

Proposal name:	**DHcFT Trust Winter Plan 2025/26**		
Proposal overview:	To gain assurance around the response and delivery of the proposed risks and mitigations associated with the Trusts Winter Plan 2025/26 that is aimed to respond to anticipated demands of pressures during the winter period.		
Proposal approved by:	**QEIA Panel - DHcFT**		
Area(s) affected (for example, service, provider, system):	**DHcFT**	Stakeholders identified as affected by the proposal:	**N/A – system partners reflected in ICB system plan.**
Engagement work completed for the proposal to date (including engagement with stakeholders):	**31st July first submission 12 August updated submission post testing exercise.**	Engagement work planned for the proposal:	**Not applicable**
Funding arrangements and financial implications for proposal:	**Not applicable**		
Any known gaps in available evidence and plans to address them:	**None known**		

Summary of assessment and screening tool

Summary (completion by project proposal team)										Screening (if included in process)	
NQB domain	**Impact**			**Initial assessment**			**Revised assessment**			**Sufficient evidence provided? Y/N**	**Recommendation**
	Positive	Neutral	Negative	Consequence	Likelihood	Risk score	Consequence	Likelihood	Risk score		
Patient safety	x			3	3	9	2	3	6		
Clinical effectiveness	x			3	4	12	2	3	6		
Experience	x			3	4	12	2	3	9		
Well led		x		2	4	8	2	2	4		
Sustainable		x		1	1	1	1	1	1		
Equitable		x		-	-	-	-	-	-		
Workforce	x			4	3	12	2	2	4		
Performance		x		-	-	-	-	-	-		
Strategic objectives		x		3	3	9	3	1	3		
Protected characteristics (if using combined or integrated QIA and EHIA process)	**Impact**			**Initial assessment**			**Revised assessment**			**Sufficient evidence provided? Y/N**	**Recommendation**
	Positive	Neutral	Negative	Consequence	Likelihood	Risk score	Consequence	Likelihood	Risk score		
Age	x			4	4	16	3	3	9		
Disability		X		-	-	-	-	-	-		
Gender reassignment		X		-	-	-	-	-	-		
Marriage or civil partnership		X		-	-	-	-	-	-		
Pregnancy and maternity		X		-	-	-	-	-	-		
Race		X		-	-	-	-	-	-		

Religion and belief		X		-	-	-	-	-	-		
Sex		X		-	-	-	-	-	-		
Sexual Orientation		X		-	-	-	-	-	-		

QIA review:

QIA review stage required following triage or screening (if screening step within process):	Stage 1 – Recommend QIA panel, multidisciplinary team group or accountable clinical lead approve		Stage 2 – Full QIA panel, multidisciplinary team group or accountable clinical lead review	
	Yes/No: Rationale:		Yes/No: Rationale:	
Date of review:				
Membership of QIA panel or multidisciplinary team group as applicable:				
Outcome of QIA review:	Approved - mitigations and key performance indicators are appropriate	Requires further information and re-submission	Amendments to project or proposal required to reduce impact on care quality	Project or proposal not approved to proceed, for example, impact on care quality exceeds risk appetite
Requested review frequency:			**Date for next submission:**	
Date reported to quality committee or equivalent:				

Part 1: Assessment of impact

NQB domain	Impact			Description of impact Summarise the main impact (positive or negative) on the domain.	Evidence to demonstrate impact	Initial assessment			Mitigations Proposed mitigations to reduce any negative impacts. Please re-score risk of impact once expected mitigation are accounted for.	Revised assessment			KPIs Outline KPIs which will be used to monitor positive and negative impacts on domain.
	Positive	Neutral	Negative			Consequence	Likelihood	Risk score		Consequence	Likelihood	Risk score	
Patient safety **For example:** - What does safety intelligence currently show about the areas affected? - Will the change lead to a reduction or increase in the safety risks to patients and services user? - Will there be any impact of infection prevention and control as part of this change? - Could the change impact on likelihood of harm experienced by patients and services users? - Does the change impact on medicines safety or medical devices safety?	X			Infection prevention and control.	The Trust trajectory is based on a five-year plan that is aimed to achieve 5% above 2018/19 which equates to 29.6% of staff to be vaccinated against flu. This is only Flu vaccinations as this year as healthcare workers are not being vaccinated against covid.	3	3	9	Reinforce hand hygiene and PPE protocols, especially in high-risk zones and during outbreaks. Maintain rigorous cleaning schedules for clinical areas, waiting rooms, and high-touch surfaces. Promote flu vaccinations for staff and eligible patients to reduce transmission.	2	3	6	Not applicable
Clinical effectiveness **For example:** - Will the change impact on avoidable readmission rates? - Will the change impact on the timeliness of access to care? - Will the change impact on any reported effectiveness outcomes? - Will the change see an impact on the use of evidence-based standards?	X			Clinical Care and Risk Management	The forecast is that there will likely be many pathogens at the same time this year i.e. covid, norovirus, RSV and Flu resulting in an increase demand on services i.e. longer lengths of stay, staffing etc.	3	4	12	Implement robust and efficient protocols with a particular focus on vulnerable patients to prioritise patients based on acuity and avoid delays in critical care. (e.g. frail elderly, respiratory / Gastro conditions) to prevent deterioration. Ensure timely pathways and escalation routes are clear and accessible for staff managing high-risk patients.	2	3	6	Not applicable

Experience **For example:** - Will there be a change in satisfaction levels reported by people using the service and their unpaid carers? - Will people using services and their unpaid carers experience longer or reduced waiting times for services? - Will people using services and their unpaid carers find it easier or harder to access services? - Will the change effect the opportunity for people's choice within a pathway? - Will the change enable care to be provided closer to home?	X			Flow and capacity management	DHcFT has planned sufficient capacity to meet the expected demand this winter, based on a projected increase of 4%.	3	4	12	Coordinate with community services to facilitate timely discharge and avoid bed blocking. Use escalation protocols for increased demand, including opening surge beds or alternatives to admission. Monitor real-time capacity dashboards to inform decision-making and resource allocation.	3	3	9	Not applicable
Well led **For example:** - Will there be an impact on the staff working within the setting or service areas? - Will there be a change in satisfaction levels reported by staff? - Will there be change to the way in which staff within the service are expected to work, such as number of hours or impact on workload? - Will there be any changes to the oversight and accountability requirements for the service, is it clear where these responsibilities will sit? - Will there be an impact on the recruitment and retention of staff working in the service area?		X		Governance and Learning		2	4	8	Track safety incidents and near misses to identify patterns, missed opportunities and act on lessons learned. Audit compliance with winter protocols and share feedback with teams. Celebrate good practice and innovation to boost morale and encourage continuous improvement. Hold daily safety huddles to share updates, risks, and staffing concerns across teams. Ensure clear signage and patient information to reduce confusion and improve experience.	2	2	4	Not applicable

Sustainable **For example:** - Will there be a financial impact from the change? For example, will there be an impact on any elements of the supply chain? - What is the effect on the long-term sustainability of the service or care pathway? - Will changes to resources (such as staff, time, energy, buildings) be required? - Will changes affect the environmental impact of the service (such as energy demand, increased waste, refurbishment required)? - Will it impact on efficiency and waste? - Is there a likely impact on other contracts or system partners that provide associated services or elements of the pathway? - Will there be an impact on the travel requirements (increases or reductions) and needs for staff, patients and service users as part of the proposal?		X		No financial impact. Sustainability - Winter Plan 2025/26 only. Winter duration: Oct-25 to Feb-26	Temporary period of provision and plans.	1	1	1	Not applicable.	1	1	1	Not applicable
Equitable **For example:** - Has a related EQIA been completed? Are you aware of any groups of people who may be positively or negatively impacted by the proposed change? - How does the change support the reduction in variation experienced by different groups of people? - How does the change support a reduction in health inequalities for groups of people – at a provider and system level? - Does the change have an impact on the accessibility of the service for any identified groups of patients or service users?				See Part 2 below									

Workforce - Will the change impact on the required skill mix of staff? - Will the proposal impact on training provision and availability of placements? - Will the change have an impact on the competencies of staff working within the service?	X			Workforce planning and support	DHcFT has a sustainable workforce plan over the winter period to include response plans to industrial action, if requried.	4	3	12	Deploy surge staffing plans with flexible rotas, effective rostering, agency and redeployment where skill mix allows to ensure sufficient strategies to cover peak demand. Provide wellbeing support for staff, including access to rest areas, mental health resources, and enhanced programme of wellbeing support. Industrial Action and strong processes that have been previously enacted and include 24/7 response to any risks that arise over the industrial action periods.	2	2	4	Not applicable
Performance - Will the change impact of the services or organisation's ability to meet national and or local performance targets? - Will the change affect the performance of care pathways?		X		Not applicable									
Strategic Objectives - Does the proposal impact on the organisation's strategic objectives? - Does the proposal align with the wider objective and ambitions of the NHS? - Does this proposal impact on the joint forward plan for the ICB, and partnership working across		X		Nationally led and locally led at system and trust level.	Reflects DHcFT and system partners where appropriate.	3	3	9	Engage with local partners (e.g. ambulance services, social care) for joined-up winter response. Testing Exercises in place at system level and regional level.	3	1	3	Not applicable

ICBs? -													

Part 2: Assessment of impact against Equality Duties if QEIA

	Impact			Description of impact	Evidence to demonstrate impact	Initial assessment			Mitigations	Revised assessment post mitigations			KPIs
	Positive	Neutral	Negative			Consequence	Likelihood	Risk score		Consequence	Likelihood	Risk score	
Protected characteristics													
Age – for example, older people, middle years, early years, children and young people	X			Expected increase of Respiratory and Gastro cases of the elderly during winter.	Early data from 2024/25 has underlined that flu and respiratory illness will again be major drivers of system pressure. The risks include: a) blocking ED. b) time it takes to convey and be assessed. c) Transmitting infections from ED.	4	4	16	Mitigations include a standard operating procedure between DHcFT and UHDB to provide a direct pathway of support for Respiratory and Gastroenterology which will include bypassing ED and direct access to specialists for assessment.	3	3	9	N / A
Disability – for example physical, sensory and learning impairment;		X		N / A	N / A				N / A				N / A

mental health condition; long-term conditions													
Gender reassignment		X		N / A	N / A				N / A				N / A
Marriage and civil partnership: people married or in a civil partnership.		X		N / A	N / A				N / A				N / A
Pregnancy and maternity: women before and after childbirth and who are breastfeeding		X		N / A	N / A				N / A				N / A
Race		X		N / A	N / A				N / A				N / A
Religion and belief: people with different religions, faiths or beliefs, or none		X		N / A	N / A				N / A				N / A
Sex: men, women		X		N / A	N / A				N / A				N / A
Sexual orientation: Lesbian; Gay; Bisexual; Heterosexual.		X		N / A	N / A				N / A				N / A

Consequences scores: 1 Insignificant, 2 Minor, 3 Moderate, 4 Major, 5 Severe
Likelihood scores: 1 Rare, 2 Unlikely, 3 Possible, 4 Likely, 5 Almost certain

Likelihood	Consequences				
	1 (Insignificant)	2 (Minor)	3 (Moderate)	4 (Major)	5 (Catastrophic)
1 (Rare)	1	2	3	4	5
2 (Unlikely)	2	4	6	8	10
3 (Possible)	3	6	9	12	15
4 (Likely)	4	8	12	16	20
5 (Almost certain)	5	10	15	20	25

Winter Planning 2025/26

Board Assurance Statement (BAS)

NHS Trust

Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the CEO and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Trust's name.

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 2025/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 2025/26 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025.**

Provider:	Double click on the template header to add details

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.	Yes	Plans and Assurance Report to Trust Board - 22 Jul-25. Finalised version to…. TDG – 26 Aug-2025 Trust Board – 23 Sep-2025
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	TBA – 23 Sep-2025	QEIA completed and approved by DHcFT QEIA Panel on 10 Sep-2025. Scheduled for approval at Board on 23 Sep-2025
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Yes	
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	Led by ICB on 1 Aug-2025
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	Vikki Ashton Taylor – Deputy Chief Executive and Chief Delivery Officer
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.	Yes	
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Yes	To be monitored through Trust Delivery Group and by exception through the Board sub-committees (Quality and Safeguarding).
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off and returned to NHS England in Apr-2025.	Yes	To be monitored through Trust Delivery Group and by exception through the Board sub-committees (Finance and Performance).

Provider CEO name	Date	Provider Chair name	Date
Mark Powell	August 2025	Selina Ullah	August 2025

Section B: 2025/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	Yes	
Capacity		
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	Yes	Demand and Capacity Profile led by ICB has been complete at Trust level.
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	Yes	
4. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	Yes	Aligned to Trust Flow Plan. Note the Trust does not use P3.
5. Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	N/A	
Infection Prevention and Control (IPC)		
6. IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	Yes	
7. Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	Yes	
8. A patient cohorting plan including risk-based escalation is in place and	Yes	

	understood by site management teams, ready to be activated as needed.		
Leadership			
9.	On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	Operational and clinical rotas in place.
10.	Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	Fully operational.
Specific actions for Mental Health Trusts			
11.	A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	Yes	24/7 helpline and all in place including bank holidays.
12.	Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	Yes	Aligned to the Flow recovery plans.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 23 September 2025

Strategic Plan - 2025-28: Q1 progress update

Purpose of Report

To update the Board of Directors on progress in delivery of the Strategic Plan at the end of Quarter 1 (Q1) 2025/26.

Executive Summary

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

The enclosed report provides an update at the end of Q1 2025/26 on delivery of priorities and deliverables within the year one roadmap. The format is presented to reflect a status position at the current quarter end date and the expected position at the year end. The report also offers a view on completeness of intended assurances, which have been mapped to the papers received by agreed oversight forum.

Aligned to action overseen by the Strategic Portfolio Oversight Group mapping has been reviewed and assured on completeness of the plan deliverables to Executive Director objectives and associated quarterly reviews. Delivery status has also been considered by individual Executive Directors and the collective Executive Leadership Team.

At the end of Q1, of the 15 priorities for delivery of success, 10 are rag rated green and five are rag rated amber. Focused work is underway on these amber rated strategic plan deliverables:

1.4: Improve access to our services and achieve all target wait times

Access and waiting times are challenged across a number of services with recovery plans being overseen by the Trust Delivery Group and Finance and Performance Committee. These include people waiting longer than 52 week in our community paediatric service, 60-day length of stay and face-to-face crisis response.

2.1 to 2.4: People deliverables

Progress across deliverables has been challenged over Q1 due to the requirement to invest significant leadership team capacity in the new operating model. Recovery of all deliverables is expected over the remainder of 2025/26 with progress being overseen by the People and Culture Committee.

At this quarter end, one plan deliverable: Improving access to our services and achieving all target wait times, is deemed to be at risk in terms of annual roadmap delivery. Access recovery plans for some services are not expected to deliver a compliant position by the 2025/26 year end. All other deliverables are deemed to be on track for delivery by Q4 aligned to annual roadmap delivery.

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

Risks and Assurances

- The Strategic Plan aligns with and seeks to enact the Trust's strategy
- The source and forum for assurance is defined for each priority
- Risks to delivery will be managed via the Board Assurance Framework.

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

Recommendations

The Board of Directors is requested to note the progress in delivery of the Strategic Plan at the end of Q1 2025/26.

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

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

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NHS Foundation Trust

Strategic Plan 2025 - 2028

Progress Update: Q1 2025 – 2026

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 2025-26	Q1 Progress Update	Status		Assurance mapped to Q1 papers
			Q1 Actual	Q4 Expected	
1.1 Improve safety and effectiveness in line with our quality ambitions	1.1.1 Develop and implement Quality Delivery Plan, agree improvement ambitions and measures, and establish associated governance 1.1.2 Monitor performance and implement action plans to address any identified improvement opportunities 1.1.3 Implement national initiatives including Culture of Care inpatient quality improvement programme and Patient Carer Race and Equality Framework	1.1.1 Quality Delivery Plan in final draft having been co-designed with stakeholders over Q1 and to be presented to QSC for final approval in July. 1.1.2 Quality monitoring developed over Q1 with fundamental standards of care implemented across community and inpatient wards and cross checks fully embedded. Action plans delivered as appropriate to address identified areas of improvement with assurance overseen by QSC. 1.1.3 Progress maintained with Culture of Care programme and mitigation plan in place to address delay in recruitment to patient experience posts with appointments to be made in Q2.	On track	Expected on plan at Q4	Agreed assurances considered by Quality and Safeguarding Committee (QSC)
1.2 Improve experience for, and empower, service users patients and carers	1.2.1 Define and agree experience measures across all services 1.2.2 Review and refine feedback mechanisms across all services 1.2.3 Monitor feedback and implement plan to address any identified improvement aligned to transformation and continuous improvement portfolio 1.2.4 Develop and agree framework for empowerment 1.2.5 Design and launch education programme 1.2.6 Develop and implement engagement through to co-production framework	1.2.1 Measures of experience defined through new Quality Delivery Plan with progress to be made Q2 in the development of aligned reporting dashboards to track and assure delivery. 1.2.2 Feedback mechanisms reviewed in Q1 with identified development priority being focus on effective spread and standardisation of approach across all services over Q2-Q4. 1.2.3 Feedback monitoring maintained over Q1 with key development in agreement of remuneration offer and funding stream for lived experience roles across all services. 1.2.4 Approach defined within Quality Delivery Plan and action plans in delivery. 1.2.5 Education programme developed over Q1 with focus on targeted education and awareness raising on topics such as suicide prevention, Continued progress to be made towards the ambition over Q2. 1.2.6 Work plan for advancing coproduction and participation developed over Q1 and to be launched in Q2 aligned to new operating model.	On track	Expected on plan at Q4	Agreed assurances considered by QSC
1.3 Develop effective quality governance systems and processes that facilitate shared learning and support a positive safety culture	1.3.1 Review, refresh and embed quality governance systems aligned to new Quality Delivery Plan 1.3.2 Refine Learning Culture and Safety Group as a mechanism to develop and assure a positive safety culture 1.3.3. Agree preferred model and design plan for transition from Care Programme Approach to support safe care co-ordination	1.3.1 Existing quality governance systems mapped over Q1 with development to be aligned with Quality Delivery Plan and new operating model over Q2. 1.3.2 Safety defined within new Quality Delivery Plan and existing mechanisms evaluated over Q1. Priority for focus in Q2 on alignment and connection of approach and learning mechanisms under new operating model 1.3.3 Decision agreed to implement new NHSE Personalised Care Framework. Final framework and guidance expected to be published by NHSE in Q2 with aligned implementation plan to be developed and agreed.	On track	Expected on plan at Q4	Agreed assurances considered by QSC
1.4 Improve access to our services and achieve all target wait times	1.4.1 Launch and deliver year 1 Clinical Services Delivery Plan with a focus on improving access and on understanding and addressing health inequalities 1.4.2 Design framework for disproportionate allocation of resources based on needs of our population 1.4.3 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	1.4.1 Clinical Services Delivery plan remains in development with draft to be considered via internal governance and assurance committees in Q2. 1.4.2 Framework for disproportionate allocation of resources in development aligned to Clinical Services Delivery Plan as above. 1.4.3 Achievement of all target waiting times overseen in Q1 via internal performance framework and FPC. Focus for Q1 on flow improvement action plan to reduce OOA placements, with Operational Plan trajectory achieved at end of Q1. Oversight and reporting developed for Q2 aligned to new National Oversight Framework with continued focus on flow improvement alongside other challenged access targets.	Delivery plan delayed Access challenged across specific services	Expected on plan at Q4 Access recovery in specific services beyond 2025-26	Due once final draft plan agreed IPR considered by Finance and Performance Committee (FPC)

Delivery concerns at Q1 to be managed via management oversight forum and escalated to Quality and Safety Committee as required

1.1.3: Planned recruitment to patient experience posts will support achievement of progress and delivery of ambitions within the Culture of Care programme.

People

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

NHS Derbyshire Healthcare NHS Foundation Trust

Priorities for delivery of success	Roadmap to delivery of success 2025-26	Q1 Progress Update	Status Q1 Actual	Status Q4 Expected	Assurance mapped to Q1 Papers
2.1 Be recognised for attracting and retaining the best people	2.1.1 Improve our recruitment and retention processes and systems to provide assurance on the experience of our people 2.1.2 Support managers to support our people to fulfil their potential and deliver new roles 2.1.3 Further mature and embed our workforce planning approach and develop multi-year Trust strategic workforce plan which reflects our role as system partner.	2.1.1 Retention approach strengthened with 'Stay Survey' at 3, 6 and 18 months for all new starters. SLA for recruitment services finalised with clear KPIs aligned to PCC dashboard and quarterly performance review. 2.2.2 Cultural competency training roll out commenced for managers with a priority focus on inpatient wards along with international recruits and non English nationals. 2.2.3 Trust level workforce plan for 2026-27 under development with Divisional level plans to follow on conclusion of operating model. Strategic workforce planning to be progressed over Q2-Q4 aligned to 10 Year Health Plan.	Delivery behind plan at Q1	Expected on plan at Q4	Agreed assurances considered by People and Culture Committee (PCC)
2.2 Be recognised for supporting and developing our people to work confidently in their roles	2.2.1 Launch roadmap for leadership development and roll out year 1 plan including senior leadership programme 2.2.2 Embed talent management and succession planning framework 2.2.3 Develop standards and governance for advanced professional practice across roles 2.2.4 Develop learning culture for all staff including regular career conversations	2.2.1 Leadership development deep dive considered by PCC with mid level leadership programme now live and a greater breadth of programme from aspiring to senior leaders to be launched September aligned to national competency framework. 2.2.2 Learning from pilot phase of new talent management and succession planning framework being applied to develop next phase of action. 2.2.3 Focus through Training and Education Steering Group on strengthening commissioning of professional programmes. Careers event being planned for October 2025 to share what is available and secure insight on gaps. 2.2.4 Action progressed to embed learning culture aligned to accountability framework (see 2.3.1 below) with focus also on supporting managers to facilitate effective appraisal and career conversations as routine practice.	Delivery behind plan at Q1	Expected on plan at Q4	Agreed assurances considered by PCC
2.3 Be recognised by our people for our values driven and inclusive culture	2.3.1 Embed personal accountability charter within the people management and appraisal framework and develop competence of managers in restorative just culture 2.3.2 Deliver year 1 plan to develop EDI framework with a focus on diversity in recruitment and development offer, and equipping leaders with skills and data to improve 2.3.3 Refresh and deliver improvement plans for Workforce Race Equality and Disability Equality Standards	2.3.1 Deep dive on accountability framework considered by PCC with series of actions underway, including working with 'A Kind Life' to embed behaviours and routine practice. 2.3.2 and 2.3.3 EDI, WRES and WDES plans approved by PCC and in delivery with a focus on agreed priorities of anti racism strategy, developing and supporting networks, and governance and accountability.	Delivery behind plan at Q1	Expected on plan at Q4	Agreed assurances considered by PCC
2.4 Be recognised as a Trust that supports and promotes the wellbeing of our people	2.4.1 Embed a flexible working culture, supporting colleagues to balance home and work life and support delivery of services ,with clear action plans for delivery within one year 2.4.2 Continue to embed annual health and wellbeing assessment and deliver year 1 development plan 2.4.3 Develop psychology support and offer for staff 2.4.4 Review and refine attendance management policy and approaches to support colleagues and managers	2.4.1 Plan agreed and in delivery to embed flexible working, including new system to record requests and associated decisions, along with training for managers and individuals in application of policy. 2.4.2 Refresh of HWB assessment underway with plan to establish an SLA and review all associated KPIs in Q2. 2.4.3 Potential model developed for psychological support, however this will require additional funding stream. Formal consideration and decision on business case to be taken in Q2 via appropriate governance route. 2.4.4 Working group established to review absence management processes and support with identified key driver of absence aligned to psychological support business case referenced above.	Delivery behind plan at Q1	Expected on plan at Q4	Agreed assurances considered by PCC

Delivery concerns at Q1 to be managed via management oversight forum and escalated to People and Culture Committee as required

2.4.3: Delivery of a psychological support offer for staff will require investment for which there is no current funding stream. The business case has not yet been presented through internal governance and this will take place in Q2.

Cross cutting: National development of approach across people and leadership offers challenge in the timing and alignment of Trust action to ensure we harness opportunities but prevent delay. This remains under active consideration and management.

Productive

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

NHS
Derbyshire Healthcare
NHS Foundation Trust

Priorities for delivery of success	Roadmap to delivery of success 2025-26	Q1 Progress Update	Status		Assurance mapped to Q1 papers
			Q1 Actual	Q4 Expected	
3.1 Achieve financial sustainability through improved clinical and operational productivity	3.1.1 Agree core priorities and deliverables for 25-26, to include reduction of OOA and premium spend 3.1.2 Deliver agreed financial plan on pathway towards financial balance and sustainability 3.1.3 Deliver year 1 plan for international medical recruitment on path to eradicate medical agency spend 3.1.4 Understand productivity and sustainability across all services and plan for optimisation or consider exit 3.1.5 Implement data flow for new national currency model 3.1.6 Develop literacy of our people in financial, capacity and activity planning	3.1.1 Financial plan agreed and accepted by ICB and NHSE with system deficit support of £45m enabling break even position across partners. 3.1.2 Financial plan on track for delivery at the end of Q1. This includes achieving national targets on agency and bank reduction. 3.1.3 International medical recruitment progressed to agreed plan and timeline over Q1. 3.1.4 Engagement with NHSE pilot in Q1 with plan to recruit lead to develop productivity approach over Q2-4. 3.1.5 National currency model currently on hold. National cost collection submission made in Q1 with outputs to be evaluated on publication in Q2/3. 3.1.6 HFMA e-learning platform procured with access to 50 modules. Plan for launch and roll out aligned to new operating model over Q3-Q4.	On track	Expected on plan at Q4	Agreed assurances considered by Finance and Performance Committee (FPC)
3.2 Transform our clinical pathways and operating model	3.2.1 Establish vision and ambitious transformation plan for integrated 'end to end' pathway and model of care across community and acute services and align to partnership development approach 3.2.2 Design and implement new operating model and accountability framework for delivery of services 3.2.3 Design and launch transformation plan for corporate services 3.2.4 Implement year 1 of agreed transformation programme 3.2.5 Implement transformation and improvement framework 3.2.6 Develop population health approach within the clinical transformation programme	3.2.1 Framework established in Q1 to develop vision and plan, alongside key enablers to support insight on opportunities, including data and intelligence, national learning and NHSE Men-SAT support offer. Approach to be developed over Q2 in alignment with newly published 10 Year Health Plan. 3.2.2 Operating model in delivery with progress regularly reported to and overseen by PCC. Process to be concluded in Q2 with new model operationalised in Q3. 3.2.3 JUCD Provider Collaborative detailed work programme and benefits realisation plan developed and approved comprising five enabling corporate services with co-ordinated Trust plans to be developed in Q2. 3.2.4 Strategic Portfolio Group established in Q1 to oversee design and delivery of transformation portfolio with assurances on progress received by FPC. 3.2.5 Progress made in implementation of agreed framework with key actions being enhancement of programme management and oversight arrangements, aligned to SPOG above. Assurance on progress considered by FPC. 3.2.6 Population health intelligence being actively considered through development of the model of care across community and crisis to ensure this is aligned to local need. Approach to be further developed over Q2.	On track	Expected on plan at Q4	Agreed assurances considered by Finance and Performance Committee (FPC) and People and Culture Committee (PCC)
3.3 Optimise our assets and enabling resources to improve services and care	3.3.1 Deliver and track realisation of intended benefits from the Making Room for Dignity (MRfD) programme 3.3.2 Launch and deliver year 1 of agreed Estates Plan 3.3.3 Launch and deliver year 1 of agreed Digital Plan with a focus on consolidating gains from existing assets including EPR and design of 'end to end' digital workflow	3.3.1 MRfD programme operationalised over Q1 with final two buildings to open Q2. Formal benefits evaluation completed in Q1 for Bluebell with acute units scheduled for evaluation in Q2 and PICU/ECU in Q3. 3.3.2 Estates Plan drafted and consulted upon over Q1 with final version to be re-presented to FPC for approval Q2. 3.3.3 Clinical Digital Plan drafted over Q1 alongside development of priority work streams including EPR optimisation and pilot for ambient scribing. Event in planning for Q3 to support trust digital ambitions.	On track	Expected on plan at Q4	Agreed assurances considered by FPC
3.4 Reduce emissions we control directly (the NHS Carbon Footprint)	3.4.1 Deliver year 1 of agreed Sustainability Plan and achieve a reduction on emissions in 2025-26 on course for 80% long term target	3.4.1 Sustainability Plan drafted in readiness for national submission deadline of July and progress made in delivery of key actions including EV chargers. Development of associated Travel Plan a defined priority for Q3 through Q4.	On track	Expected on plan at Q4	Agreed assurances considered by FPC

Delivery concerns at Q1 to be managed via management oversight forum and escalated to Finance and Performance Committee as required

3.1.4: Acceleration of productivity approach dependant on allocation of dedicated resource with plan for recruitment currently on hold aligned to operating model and related corporate services.

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.

NHS Derbyshire Healthcare NHS Foundation Trust

Priorities for delivery of success	Roadmap to delivery of success 2025-26	Q1 Progress Update	Status Q1 Actual	Status Q4 Expected	Assurance mapped to Q1 papers
4.1 Build partnerships that deliver on the needs of our communities	4.1.1 Develop our partnership within the East Midlands Alliance, to enable the best mental health, learning disability and autism care and support for the people of the East Midlands and deliver year 1 plan across the priorities for: 1. Quality improvement and productivity 2. Enabling safe care 3. Developing our workforce 4. Improving population health 5.Reducing inequalities 4.1.2 Develop our role as Perinatal Lead Provider and in leading Gambling Harm services within the East Midlands. 4.1.3 Develop our strategic partnership with University of Derby and associated implementation plan 4.1.4 Develop partnerships within the JUCD Provider Collaborative with a year one focus on collaboration across services for Children and Young People 4.1.5 Deliver Community and Stakeholder Engagement Plan with year 1 priority focus on the deaf community, black communities and new migrant families 4.1.6 Proactively engage with regional and national learning collaboratives 4.1.7 Work in partnership to develop financial model and full business case for income generating business unit	4.1.1 East Midlands Alliance development plan for 2025-26 agreed and in delivery over the five agreed priorities with progress overseen through the Alliance Board and updates via Chief Executive Report to Board of Directors. 4.1.2 Action in developing East Midlands collaboratives reported to and overseen by Finance and Performance Committee. Highlights in Q1 include focus on continuous improvement and further clinical learning event for Perinatal, and continued progress made for Gambling Harm in increasing referrals and overall service activity. 4.1.3 Strategic partnership agreement signed with University of Derby with associated plan agreed and in delivery aligned to 4.3 below. 4.1.4 JUCD Provider Collaborative detailed work programme and benefits realisation plan developed and approved comprising five enabling corporate services and four clinical pathways, including Children and Young People. Co-ordination of deliverables with DHcFT programme to be overseen in Q2 via Strategic Portfolio Oversight Group. 4.1.5 Progress made on Community and Stakeholder Engagement Plan agreed priorities with further Board Development conversation to affirm approach, new guide to Trust services to aid conversations with stakeholders, and focus on attendance at community events to support relationship development. 4.1.6 Active engagement maintained in learning collaboratives with highlights in Q1 being progress on the Culture of Care programme supported by the National Collaborating Centre for Mental Health, along with the new Midlands Learning and Improvement Network with a priority focus on improving length of stay. 4.1.7 Action delivered via working group to secure insight and learning, evaluate opportunities, and apply this in developing the model for an income generating business unit. Timeline and milestone plan to full business case to be considered by the Strategic Portfolio Oversight in Q2.	On track	Expected on plan at Q4	Agreed assurances considered by the Finance and Performance Committee and the Board of Directors
4.2 Excel in our role as an anchor organisation	4.2.1 Apply datasets alongside local demographics to establish baseline position and inform actions to develop our role across five domains: as an employer, a procurer, as a holder of property and assets, as a partner, and in sustainability	4.2.1 Aligned to agreed timeline, action progressed over Q1 to secure learning and establish baseline to inform development of plan in Q2.	On track	Expected on plan at Q4	Assurance not yet due
4.3 Achieve University Hospital Trust status	4.3.1 Develop our strategic partnerships with academic institutions and deliver year 1 plan to develop research capability 4.3.2 Design and implement year 1 of action plan to be a centre for education across disciplines and achieve University Hospital Trust status	4.3.1 and 4.3.2 Strategic partnership agreement signed with University of Derby with associated plan agreed and in delivery to develop and strengthen research capability, and support ambition to achieve University Hospital status. Progress reported to and overseen by Board of Directors.	On track	Expected on plan at Q4	Agreed assurances considered by the Board of Directors

Delivery concerns at Q1 to be managed via management oversight forum and escalated to Finance and Performance Committee as required

4.2.1: Derbyshire anchor organisation stocktake completed in August 2024 has not been progressed to harness opportunities for enhanced collaboration with no meetings of the system anchor group over the last year.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 23 September 2025

Board Assurance Framework (BAF)
issue 2, version 2.3, 2025/26

Purpose of Report

To meet the requirement for Boards to produce an Assurance Framework. This report details the current BAF, issue 2, version 2.3 for 2025/26.

Executive Summary

Director Leads, Deputy Directors, Directors of Operations, Operational Leads and Trust Senior Managers have reviewed the risks to the Trust's strategic objectives for 2025/26 and provided comprehensive updates for this issue of the BAF.

Progress against risks has been updated to ensure it reflects the current status; any updates relating to prior versions are held on the archived BAF reports.

Every key gap in control and linked actions have been reviewed, the next quarterly review being due for Issue 3 (by 30 September 2025) unless a specific target date is identified.

Summary of updates

Patient Focused – Our services will deliver safe and high-quality care

Risk 1A: There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board

Root causes have been updated and additional controls have been identified.

The Trust Strategy and reference to the priorities have been included where appropriate.

The risks associated with the loss of Talking Mental Health services remains as a key gap in controls. The RAG rating is improved as the transitioning of services to another provider progressed. However, the Deputy Chief Executive and Chief Delivery Officer identifies the need to monitor post-transfer to understand any impact on our services – this will be reviewed after September.

Risk 1B: There is a risk that the Trust does not deliver key regulatory and strategic requirements related to dormitory eradication and Psychiatric Intensive Care Unit (PICU) and that the Trust estate more generally is not maintained sufficiently well to comply with regulatory and legislative requirements

The impact rating has been reduced from 5 to 3 by the Director of Nursing, AHPs, Quality and Patient Experience, reducing the risk rating from high to moderate. This is as a result of the opening of the Carsington Unit, Derwent Unit and PICU and improved environments with clinical benefit being realised. This also closes two of the key gaps in control with the eradication of dormitory style inpatient settings and the provision of an accessible Derbyshire-wide Psychiatric Intensive Care Unit (PICU).

The action to refurbish the Radbourne Unit has an improved RAG rating, going from red to green with the recommencement of work on the unit.

Risk 1C: There is a risk that the Trust's increasing dependence on digital technology for the delivery of care and operations increases the Trust's exposure to the impact of a major outage

The one key gap in controls has been closed as all actions have been completed and live testing of the emergency response plans has taken place which provides assurance against the overarching risk.

Given this status, the Executive Leadership Team (ELT) was asked to decide if this risk should remain on the BAF report and it was agreed that it should. The Audit and Risk Committee then requested that the risk, root causes and any key gaps in control, were all thoroughly reviewed and updated. This has been completed by the Interim Information Management, Technology and Records Lead. The high rated, Trust-wide related operational risk has also been linked to Risk 1C.

Risk 1D: There is a risk that the organisation is in breach of essential standards for privacy and dignity in its acute bedded care facility as it has not fully completed its dormitory eradication programme. This may result in regulatory action if mitigation to improve safety does not occur

Internal and external assurances have been updated.

People - Derbyshire Healthcare is a great place to work

The Director of People, Organisational Development and Inclusion has thoroughly reviewed risks 2A and 2B and has also cross-referenced the People Plan with the BAF People risks. The exercise was undertaken to ensure that all in the People Plan is reflected in the BAF as a means of closing any key gaps in control and monitoring progress to manage/mitigate the risks. The summary being:

- The People Plan maps to the BAF People risks. The root causes of risks 2A and 2B link directly to the priorities that the People Plan intends to deliver on, which in turn would reduce the root causes to the BAF risks and close key gaps in control
- The People Plan and the delivery of the priorities is an internal assurance against BAF risks 2A and 2B
- The measures of success (of delivery of the People Plan) are reflected in the BAF report in the 'Actions to close key gaps in control' and the 'Impact on risk to be measured by' columns where there is direct cross-referencing.

The People Plan and what successful delivery of it will look like has been cited in the actions narrative where applicable.

An additional key gap in control has been added to risk 2A:

> *Lack of a stable positive culture due to high levels of organisational change impacting on morale*

Actions to close the gap, current status and progress have all been recorded. The RAG rating was agreed at the People and Culture Committee in July.

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

Two key gaps in control have been removed as they are reflected in the additional root causes.

One key gap in controls has an improved RAG rating as the Director of Finance has noted the completion of the 2025/26 financial plan.

Partnerships - Our organisation will identify new ways of working, through new collaborative approaches

One key gap in control has a RAG rating of green:

> *System partners report that Derbyshire Healthcare NHS Foundation Trust is inward looking and not easy to work with*

Given the progress with actions, the Trust's developed working relationship with social services and ICB colleagues, the MADE events and the active membership of all Neighbourhood (Place) Alliance Groups, the ELT was asked to decide if this gap and linked actions can be closed and removed from the next issue of the BAF report, however, feedback was not received and so it remains in the report.

Operational Risks

The linked operational risks (high/extreme, Trust-wide) have been updated by the Risk and Assurance Manager based on progress summaries recorded in Datix by the Risk Handlers.

Risk 2325: Risk to public due to management of Section 37/41

This has been removed from Risk 1A as it has been re-assessed by the Risk Handler as moderate.

Risk 23465: Clinical Risks to Children Due To Lack of Wheelchair Services

This is a newly logged risk linked to Risk 1A. The Risk Handler has recorded progress and has been asked to record any actions that can be taken to reduce/mitigate the risk.

Risk 23501: Risk to Service Delivery - Patient Safety Team

This is a newly logged risk linked to Risk 1A but is overdue for review. The Risk Handler has been asked to re-assess the current risk rating to ensure that it meets the criteria for a high overall rating and has been asked to review progress and record actions to reduce/mitigate the risk as some controls are identified in Datix.

Risk 23563: Risk to Service Provision by Arden & Gem to the Trust

This is a newly logged risk linked to Risk 1C. The record will be updated as more information is released by the government regarding alternative solutions and timeframes.

BAF Reporting Cycle/Format

All changes/updates to this issue of the BAF, compared with Issue 1 2025/26, are in tracked changes (blue text). All text that has been stricken through will be removed from the next issue (Issue 3 2025/26).

Board committees also receive extracts from the current version of the BAF report to review the risks they are responsible for. All updates received from the Board committees are incorporated into the BAF.

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

Risks and Assurances

This paper details the risks to the (BAF) risks and provides assurance on the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives.

Consultation

The BAF report is regularly reviewed and updated by:

- Executive Directors
- Deputy Directors
- Managing Directors
- Directors of Operations
- Operational Leads
- General Managers
- Operational Risk Handlers

Formal Reviews

- Executive Leadership Team, Issue 2.1: 8 July 2025
- Audit and Risk Committee, Issue 2.2: 24 July 2025
- Audit and Risk Committee, Issue 2.2 with ops risk update: 3 September 2025 (virtual)

Governance or Legal Issues

Governance or legal implications relating to individual risks are referred to in the BAF itself, where relevant.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Specific elements within each BAF risk and associated actions are addressed by the relevant Director Lead in taking forward.

Recommendations

The Board of Directors is requested to:

1. Review and Approve Issue 2 of the BAF for 2025/26 and the assurance the paper provides of the process of the review, scrutiny and update in seeking to identify and mitigate risks to achieving the Trust's strategic objectives
2. Continue to receive updates in line with the forward plan for the Trust Board.

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

Report prepared by: **Kel Sims**
Risk and Assurance Manager

Board Assurance Framework 2025/26 – Issue 2.3 Board September 2025

Trust Strategic Priorities	
Patient Focused - Our services will deliver safe and high-quality care	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 - Derbyshire Healthcare is a great place to work	We will attract, involve and retain staff creating a positive culture and sense of belonging
Productive - Our services will be productive, demonstrate best value for our population and be cost effective	We will improve our productivity and design and deliver services that are financially sustainable
Partnerships - Our organisation will identify new ways of working, through new collaborative approaches	We will collaborate with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities

Risks to Trust Strategic Priorities 2025/26

Ref	Risk	Director Lead	Risk Rating	Responsible Committee
Patient Focused - Our services will deliver safe and high-quality care				
25-26 1A	There is a risk that the Trust will fail to provide standards for safety, and effectiveness as required by our patients, regulators, partners and our Board, There is also a risk of poor patient experience and outcomes	Director of Nursing, AHPs and Patient Experience (DON) / Medical Director (MD)	**HIGH**	Quality and Safeguarding Committee
25-26 1B	There is a risk that the Trust does not deliver key regulatory and strategic requirements related to dormitory eradication and Psychiatric Intensive Care Unit (PICU) and that the Trust estate more generally is not maintained sufficiently well to comply with regulatory and legislative requirements	Chief Delivery Officer (CDO) / Director of Finance (DOF)	~~**HIGH**~~ **MODERATE**	Finance and Performance Committee
25-26 1C	There is a risk that the Trusts increasing dependence on digital technology for the delivery of care and operations increases the Trusts exposure to the impact of a major outage	Chief Delivery Officer (CDO) / Medical Director (MD)	**MODERATE**	Finance and Performance Committee
25-26 1D	There is a risk that the organisation is in breach of essential standards for privacy and dignity in its acute bedded care facility as it has not fully completed its dormitory eradication programme. This may result in regulatory action if mitigation to improve safety does not occur	Director of Nursing, AHPs and Patient Experience (DON) / Chief Delivery Officer (CDO)	**MODERATE**	Quality and Safeguarding Committee
People - Derbyshire Healthcare is a great place to work				
25-26 2A	There is a risk that we are unable to create the right culture with high levels of staff morale	Director of People, Organisational Development and Inclusion (DPOI)	**HIGH**	People and Culture Committee

25-26 2B	There is a risk that we do not have an adequate supply of a diverse workforce with the right people with the right skills to support and deliver safe high-quality care	Director of People, Organisational Development and Inclusion (DPOI)	**HIGH**	People and Culture Committee
Productive - Our services will be productive, demonstrate best value for our population and be cost effective				
25-26 3A	There is a risk that the Trust fails to deliver its revenue and capital financial plans for 2025/26 caused by factors including non-delivery of Cost Improvement Programme (CIP) targets and increased cost pressures not mitigated resulting in a threat to our financial sustainability and delivery of our statutory financial duties	Director of Finance (DOF)	**MODERATE**	Finance and Performance Committee
Partnerships - Our organisation will identify new ways of working, through new collaborative approaches				
25-26 4A	There is a risk that the effects of both nationally and locally driven changes to roles and responsibilities within the Integrated Care Board (ICB), and with its partners may impact negatively on the cohesiveness of the Derbyshire health and care system in our organisation	Chief Delivery Officer (CDO)	**MODERATE**	Trust Board
25-26 4B	There is a risk of reputational damage if the Trust is not viewed as a strong partner both within the Derby and Derbyshire Integrated Care System (ICS) and more broadly within the East Midlands Mental Health Provider Alliance	Chief Delivery Officer (CDO)	**MODERATE**	Trust Board
25-26 4C	There is a risk to safe, effective clinical care across Derbyshire impacting upon patients, due to not achieving national standards and variation of clinical practice and service commissioning in the Learning Disability (LD) Transforming Care Partnership	Chief Delivery Officer (CDO)	**HIGH**	Trust Board

Patient Focused - Our services will deliver safe and high-quality care

There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board

Impact: May lead to avoidable harm including increased morbidity and mortality; delays in recovery; and longer episodes of treatment; affecting patients, their family members, staff or the public

Root causes:

a) Workforce supply and lack of capacity to deliver effective care across hotspot areas, increasing risks in the clinical and medical workforce

~~b) Loss of Talking Mental Health Derby (TMHD) as a Trust delivered service and challenge to clear links with primary and secondary and specialist care. Growth of waiting list during transition period leading to management of greater risk~~

~~c)~~b) Risk of substantial increase in clinical demand in some services, including high caseloads and wait lists in some community services

~~d)~~c) Intermittent lack of compliance with Care Quality Commission (CQC) standards

~~e)~~d) National Oversight Framework (NOF) Level 3 - Financial position and out of area placements and continued monitoring of quality standards ~~in acute services~~across all Trust services

~~f)~~e) Lack of embedded outcome measures at service level

~~g)~~f) Lack of compliance with physical healthcare monitoring in primary and secondary care, not at the required level for reductions in mortality

~~h)~~g) Restoration and recovery of access standards in autism and memory assessment services

~~i)~~h) Lack of appropriate environment to support high quality care, i.e. single gender dormitories and PICU leading to out of area (OOA) bed use for PICU

~~j)~~i) Local NHS Trusts will offer Recruitment and Retention Premium to Consultant Psychiatrists in specialist services and other clinical staff due to competitive practices that destabilises Trust clinical services and leads to a deterioration in waiting time and potentially in safety

~~k)~~j) Data quality could be adversely affected due to the Electronic Patient Record (EPR) and its application

~~l)~~k) Health inequalities across Derbyshire. Initial insights show gaps in access to service, case load and worsening patient outcomes for our patients

~~m)~~l) Sustained pressure in the crisis and acute care pathway with bed occupancy over 85% and increased waiting time for patients to access bedded care from the community

~~n)~~m) Gaps in Advocacy for Children who are under 18

~~o)~~n) Capacity to learn from other organisations in their ability to maintain adequate mortality, serious incidents and learning reviews to respond to improve practice and to also comply with the coroner's formal requirements

~~p)~~o) Lack of systematic capture of patient experience and feedback in our services

~~q)~~p) Lack of learning from patient or carer feedback from complaints and concerns due to delayed investigations and responses

q) Safety and learning culture, learning from internal incidents, complaints and other sources of feedback is not developing and needs to be further embedded

r) Inconsistent approach to working with families and carers, involving the care of family members

Board Assurance Framework 2025/26 – Issue 2.3 Board September 2025

BAF Ref: 25-26 1A	**Director Lead**: Tumi Banda (DON) / Dr Arun Chidambaram (MD)	**Responsible Committee**: Quality and Safeguarding Committee

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Appetite**		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Quality governance structures, teams and processes to identify quality related issues; mandatory training; Duty of Candour processes; clinical audits and research; health and safety audits; risk assessments; physical health care screening and monitoring; monitoring and effective responses to infection and control guidance, EQUAL unannounced visits to services and anonymised bright ideas service improvement ideas. Feedback intelligence from independent advocacy, Director visits in and out of hours and Board visits

Detective – Quality dashboard reporting; Board visits virtual clinical service contact visits; incident, complaints and risk investigation; clinical audit; Fire Safety Regulations (FSR) compliance checks; mortality review process; physical health care monitoring clinics pilots; safety check log; Head of Nursing and Matron compliance visits, reviewed model of announced and unannounced visits to service throughout the 24-hour period; Fundamental Standards of Care visits; quality cross-checks: Inpatient and Community

Directive – Trust Strategy; ~~Physical Health Care Strategy;~~ Joint Child Adult and Family Safeguarding Strategy; Patient and Carer Experience Strategy; Patient Safety Incident Response Plan (PSIRP); clinical strategies; policies and procedures available via Trust intranet; Central Alerting System (CAS) alerts; Risk Management Strategy; clinical sub committees of the Quality and Safeguarding Committee

Assurances on controls – Internal	**Assurances on controls – External**
Trust quality and performance dashboards Scrutiny of Quality Account by committees Programme of physical healthcare and other clinical audits and associated plans Infection Control Board Assurance Framework reported to NHS England Positive and Safe self-assessment Head of Nursing and Matron compliance visits Board visits and out of hours visits Fundamental Standards of Care visits Clinical audits Incident reporting and monitoring systems through Datix Quality and safeguarding workplan Trust risk registers and scrutiny of the Risk Management Strategy by Board committees	National enquiry into suicide and homicide NHS Litigation Authority (NHSLA) scorecard demonstrating low levels of claims Safety Thermometer identifies positive position against national benchmark CQC comprehensive review 2020 Trust is rated Good Trust fully compliant with National Quality Board Learning from Deaths guidance Engagement meetings with CQC taking place Patient Safety Incident Response Framework (PSIRF) implementation CQC inspection for acute and PICU December 2024 Regular NOF Level 3 meetings with NHS England (NHSE) and Integrated Care Board (ICB) ICB local review to ensure there are clear policies in place to meet the needs of people in Derbyshire with severe mental health illness Adult and Children Safeguarding Boards (Derby City and Derbyshire County) ICB Quality System Group for Integrated Care System (ICS) quality system monitoring

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Summary of progress	Action rating
Implementation of Trust Strategy priority 1:~~of revised priority actions for 'High Quality Patient Focused Care'~~ which supports ~~the Trust strategy and~~ patient outcomes with~~and~~ guidance and standards for quality care	To ensure adherence with guidance and compliance with standards of care, and to measure improvements in patient outcomes to meet Trust Strategy priority 1 To develop and implement a Quality Plan and a Continuous Improvement Plan To develop an improved learning culture within the Trust [ACTIONS OWNER: DON]	Compliance with suite of metrics and reporting schedule detailed in quality dashboard Internal reporting against self-assessment CQC inspection and assessment as a measurement tool Fundamental S~~s~~tandards of C~~c~~are Patient and carer feedback Compliance with statutory and regulatory requirements, such as infection prevention control, safer staffing, patient safety incident rates and Health and Safety legislation	~~(30.06.25)~~ (30.09.25)	Quality Surveillance Dashboard revision is in progress A CQC/Fundamental Standards Trust Oversight Group has been established. This is now business as usual for quality assurance CQC oversight forum to review compliance to the Single Assessment Framework and related regulatory requirements ~~CQC Executive Oversight Group in place. Now complete and the objective to improve quality of care in acute services has been achieved. The service is now rated good~~ Regular review of performance through Divisional Performance Reviews (DPRs) ~~now embedded. We are now using the scorecard report with a data informed approach in the DPRs~~ ~~A new Trust Strategy has been launched which sets out a clear direction for~~	AMBER

				~~patient focussed improvements~~ New Quality Plan to be completed by July 2025	
Gap in operating standards and clinical risks for acute and community mental health services	Improve the assessment interventions and risk management of patients requiring enhanced input or assertive outreach services Compile outcome measures for acute and community services and create relevant dashboards for the services to inform areas for improvement Improvement of both inpatient and community care settings – Environments need to be improved [ACTIONS OWNER: DON] Set out improvement plans to achieve Royal College of Psychiatrists (RCP) accreditation across services [ACTION OWNERS: MD/DON/CDO] Implement Community Mental Health Framework (CMHF) Improve the out of area (OOA) placements and facilitate care closer to home [ACTION OWNER: CDO/DON]	Improve working with carers and families Improving risk assessment and care planning for patients in community settings Deliver the assertive outreach pathway to support patients with complex care needs Improvement in operating standards compliance to be overseen by Quality and Safeguarding Committee Implemented Acute Inpatient Mental Health Service Accreditation (RCP Standards) reported in Divisional Performance Reviews and Quality Account Implemented Mental Health Community Framework to Quality and Safeguarding Committee Aim for no inappropriate out of area placements	(31.12.25)	Increased performance management scrutiny and unannounced site visits undertaken with compliance checks Monitoring Fundamental Standards of Care and the quality measures through the Quality Dashboard Internal Trust programme Board in place to strengthen contribution and involvement in system-wide programme and delivery Living Well transformation mobilisation completed March 2025 Viability of the model may be at risk due to possibility of the social worker component not being funded by the ICB The funding has now been agreed for 2025/26 for social care and the voluntary sector to support the CMHF. The programme team supporting the delivery has been reduced and is	AMBER

				committed for a further two years to support transformation Dashboard has been generated for inpatient acute services. DON leads a fortnightly forum around achieving compliance CQC have reinspected acute inpatients areas and adjusted the rating to good Implement and monitor the ten areas of focus to reduce and eradicate OOA placements including MADE events and working with system partners	
Learning from independent and national forums on current issues affecting patient safety outcomes and experience	Participate in collaborative local and regional forums to gather learning Revisit all assurances and scrutinise practice, gathering intelligence and implement an improvement plan to enable all services to provide the highest standard of care which would be expected Monitor and implement the lessons from CQC Section 48 from other providers [ACTIONS OWNERS: DON/MD]	Ensuring that staff are aware of how to raise concerns and speak up Implement the Accountability Framework Strengthen out of hours, weekends and night announced and unannounced visits. To promote access to multiple managers, relationships, so colleagues feel empowered to report any concerns Professional leads are in place and supported by Employee Relations to ensure that registered professional staff are	(30.09.25)	Options for staff to have conversations about care delivery and raise concerns available include Trust-wide and divisional engagements, Freedom to Speak Up, Schwartz Rounds Improvements in engagement of temporary staff identified Increased visibility of senior staff through Board visits and out of hours visits Robust oversight of patient safety incidents,	AMBER

		aware of the requirements to practice in line with their professional codes Uphold safeguarding standards including PIPOT Timely investigation and response to concerns and complaints		concerns, complaints, and compliments with scrutiny from independent partners, e.g. Healthwatch and experts by experience being core members of Patient and Carer Experience Committee External partnership working including Healthwatch and advocacy services within safeguarding and secure services. The Trust provides assurance and participates in external reviews alongside the ICB and Adult Safeguarding Board Trust-wide Learning, Culture and Safety Group established, providing oversight of teams/services with repeating patterns for improvements to be made Four wards are currently actively participating in Culture of Care quality collaborative Working Group for Independent Mental Health Homicide Review in place	
Clinical improvement in the current use and transformation of Care Programme Approach	Identify the Trust's preferred alternative model to replace CPA	Review of changes to national policy to replace CPA	(30.09.25)	Ongoing oversight of CPA continues with focus on	AMBER

(CPA), to support safe community practice	Establish transition plan which includes communications and training strategy and clear timeline for go live of the new system and detailing when use of CPA will cease Implement an improvement plan to enable all services to provide the highest standard of care [ACTIONS OWNERS: DON/MD]	Safe and effective practice is in place Improve patient safety risk assessment, care planning and CPA review compliance in community services		care planning and risk assessment CPA training continues at present until alternative identified National consultation underway on a personalised care framework ~~Further review of this action to take place over quarter 1 and quarter 2 – This is part of the transformation plan for moving away from CPA~~	
Review of the new Major Conditions Strategy and Suicide Prevention Strategy for England: To be considered as Trust Clinical Plan developed	Scrutinise new policy direction and develop new plans Routinely review incidents for learning in suicide prevention including cluster analysis and benchmarking [ACTIONS OWNERS: DON/MD]	Adjust strategy and policy to meet requirements Undertake a cluster analysis of in-patient and acute care pathway deaths	~~(30.06.25)~~ (30.09.25)	Review of new strategy for Major Conditions and Suicide Prevention PSIRF priorities focusing on prevention and oversight, linked to new strategies Trust Clinical Plan in development	AMBER
Review of Patient Carer Race and Equality Framework (PCREF) and develop implementation plan	Revisit new policy direction and develop new plans [ACTION OWNER: MD]	Review framework and develop implementation plan	~~(30.06.25)~~ (30.09.25)	New Patient and Carer Strategy has gone through QSG and will be launched in line with the wider Trust Strategy EDI lead is in position for PCREF Central oversight and resource to be identified	AMBER
Risks associated with the loss of Talking Mental Health services to an independent provider following	Liaise with ICB and Vita Heath Group Review patients on waiting list	Working with ICB to close waiting list	~~30.06.25~~	Contract awarded to new provider January 2025	~~AMBER~~ GREEN

a procurement process undertaken by the ICB. Risks include managing patients on the growing waiting list, the impact on staff and a potential for increased referrals to secondary mental health services in the future	Escalate risks and the size of the waiting list with the ICB Utilise all mutual aid Regular staff engagement ongoing [ACTIONS OWNER: VT]	Joint transition planning with new provider for those on the waiting list Expectation that staff will transition to new provider under TUPE arrangement Monitor for any impact on other Trust waiting lists post-transfer to the new provider	~~30.06.25~~ ~~30.06.25~~ (30.09.25)	Transition meetings commenced with new provider and with ICB Ongoing engagement with staff to support during the transition	

Related operational high/extreme risks on the Corporate Risk Register:

ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating
22790	Corporate Services – Pharmacy	Prescribing Valproate: Failure to comply with MHRA patient safety regulations	24.05.23: ePMA now deployed to all services in the Trust which will help with our understanding of valproate use and can be incorporated into planning. Reporting will need to be constructed as part of the optimisation of ePMA 13.11.24: Agreed at Medicines Management Committee (MMC) that risk remains high and has been escalated from MMC to QSC. Some prescribers have yet to act in female cases of child bearing potential highlighted to them by pharmacy colleagues several months ago 30.01.25: Await specific medical profession action plan from consultant colleagues. Other elements of the trust-wide action plan have been progressed as far as possible 02.04.25: Dr Walker has volunteered to lead the Psychiatrist response and a plan is now awaited. To review at next MMC (May) 23.05.25: Reviewed at MMC – No change, still await medical action plan	28.02.22	10.10.25	HIGH
23465	Children's Services – Complex Health & Paediatric Therapy	Clinical Risks to Children Due To Lack of Wheelchair Services	Service provision has changed and now only supplying wheelchairs for children and adults who use then within both indoors and outdoors. Previously have provided for children to use outdoors only. This could impact our service delivery and time significantly as we will have to support with assessments / charity funding and altering therapy needs 04.06.25 - Meeting with ICB who agreed to complete a review of the service criteria regarding children with neurological and neuromuscular conditions	29.04.25	31.10.25	HIGH

23501	Corporate Services – Clinical Quality	Risk to Service Delivery - Patient Safety Team	There are currently 10 learning responses that require allocation with a further 24 investigations overdue. Coroners, staff, patients and families are waiting for the outcome of these learning responses. Risks include: Distress to families/carers who are waiting for the outcome of learning responses - Risk of further harm Reputation damage for the Trust Possible increased distress for staff who are involved in the process **Update requested from the Risk Handler (Patient Safety Lead)**	08.05.25	13.08.25	HIGH

Patient Focused - Our services will deliver safe and high-quality care

There is a risk that the Trust does not deliver key regulatory and strategic requirements related to dormitory eradication and PICU and that the Trust estate more generally is not maintained sufficiently well to comply with regulatory and legislative requirements

Impact:
Low quality care environment specifically related to dormitory wards
Crowded staff environment
Patient safety and dignity risks associated with dormitory in-patient bedded care
Non-compliance with statutory care environments
Non-compliance with statutory health and safety requirements
Final ward refurbishment at risk on affordability grounds
Completion of the full Dormitory eradication programme has been delayed until 2026/27

Root causes:

a. Long term under investment in NHS capital projects and estate
b. Limited opportunity for Trust large scale capital investment
c. Increasing expectations in care and working environments as national capital strategy and surrounding legislative and regulatory requirements evolve
d. National capital funding restrictions for business-as-usual capital programme for Trusts and Integrated Care Systems
e. Cost creep in the development has added pressure to the Making Room for Dignity programme and the ability to complete the Radbourne Unit refurbishments. Whilst funding is secured in relation to the first ward, issues with the foundations are driving up costs and delaying the completion of the programme

BAF Ref: 25-26 1B	**Director Lead**: Vikki Ashton Taylor (CDO) / James Sabin (DOF)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Appetite**		
High	Likelihood 4	Impact 4	~~High~~Moderate	Likelihood 3	Impact ~~5~~3	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Routine environmental assessments for statutory health and safety requirements; environmental risk assessments reported through Datix; Infection, Prevention Control (IPC) risk assessments
Detective – Reporting progress against Premises Assurance Model (PAM) to the Executive Leadership Team (ELT); Dormitory Eradication Board reports into Trust Board
Directive – Capital Action Team (CAT) role in scrutiny of capital projects; IPC policy and procedure; Continuous Improvement Plan – ~~Confirmed launch date is 01.04.25~~Launch date to be confirmed; Estates Plan – In final stages with early draft having been through governance~~development~~

Assurances on controls – Internal	Assurances on controls – External
IPC risk assessments Health and safety audits Premises Assurance Model System (PAMS) reporting Making Room for Dignity Programme Committee structure and working groups	Mental Health Capital funding secured External authorised reports for statutory health and safety requirements Estates and facilities management internal audit Regional reporting and NHSE oversight Gateway review process – Positive feedback from first stages

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
~~Lack of adherence to emerging national guidance and policy requiring the elimination of mixed sex wards and dormitory style inpatient facilities~~	~~Deliver two new adult acute 54-bed units with a single room en-suite with additional staffing and new model of care~~ ~~[ACTION OWNER: CDO]~~	~~Delivery of approved business cases~~ ~~Completion of the units~~ ~~CQC approval and sign off~~ ~~Successful transition and opening of the units~~	~~31.03.26~~	~~Two new build adult acute unit FBCs nationally approved September 2022, funded by £80m national PDC and £18.6m CDEL. ICS supported and approved revenue funding~~ ~~Derwent Unit opened in March 2025~~ ~~Carsington Unit opening delayed due to necessary ensuite shower remediation~~	~~AMBER~~ BLUE
	Radbourne Unit dormitory eradication refurbishment to provide two 17-bed wards with single room en-suite, with additional staffing and new model of care, to complete dormitory eradication in Southern Derbyshire. Service users continue to receive care in non-compliant wards until this refurbishment is completed	Delivery of approved business case Completion of the units CQC approval and sign off Successful transition and opening of the units	31.03.27	FBC and revenue funding approved by ICS. National PDC capital funding approved by NHSE ~~Radbourne Ward 32 refurb commenced but then paused due to patient safety and noise issues.~~	~~RED~~ AMBER

	National PDC capital funding approval [ACTIONS OWNER: CDO]			Now that the Carsington Unit is open, refurbishment of the Radbourne Unit can recommence. Expected completion 2026/27 ~~Recommencement of refurbishment delayed due to remediation work needed at Carsington Unit~~ Ward 35 refurb scheduled Radbourne Unit will progress with one ward due for completion in 2025/26 and one in 2026/27 – Expected completion date updated	
Lack of an accessible Derbyshire wide Psychiatric Intensive Care Unit (PICU)	Delivery of local PICU arrangements (new build and associated projects taking into account gender considerations) National PDC capital funding approval [ACTIONS OWNER: CDO]	Agreed programme of work with capital funding to support it Approved business case CQC sign off Successful opening and transition of out of area PICU male patients	~~31.05.25~~ Complete	FBC approved by ICS PICU fully funded by national and Trust capital ~~The Derbyshire Male PICU practical completion delayed due to necessary ensuite shower remediation. Audrey House Enhanced Care Unit delayed opening due to building control certification – Expected opening May 2025~~ The Derbyshire Male PICU Unit is now open and operational The Audrey House Female Enhanced Care Unit is now open and operational	~~AMBER~~ BLUE

Related operational high/extreme risks on the Corporate Risk Register: None

Patient Focused - Our services will deliver safe and high-quality care

Board Assurance Framework 2025/26 – Issue 2.3 Board September 2025

There is a risk that the Trust's increasing dependence on digital technology for the delivery of care and operations increases the Trust's exposure to the impact of a major outage

Impact: ~~This could lead to the disruption in the provision of services with risk to patient safety~~
There is a risk that the Trust's digital infrastructure, systems, or data may be compromised due to an outage or failure to maintain adequate cybersecurity measures. This could lead to significant disruption to clinical services, compromise of sensitive patient or staff data, reputational damage, regulatory breaches, and potential harm to patients

Root causes:

a. Increasing reliance on a single electronic patient record
b. Increasing use of video software for the direct provision of care and operational purposes
c. Increased staff home working
d. Increasing electronic collaboration across health~~, and~~ social care and voluntary sector partnering organisations~~rs~~
e. Increasing global instability and risk from state supported cyber attacks
f. Increase in locally developed system solutions to support DHCFT and partner operations and performance~~, i.e., flu vaccination, health risk assessments~~

BAF Ref: 25-26 1C	**Director Lead**: Vikki Ashton Taylor (CDO) / Dr Arun Chidambaram (MD)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Appetite**		
Moderate	Likelihood 3	Impact 4	Moderate	Likelihood 3	Impact 4	Moderate	Likelihood 2	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Trust utilises NHS provided solutions as widely as possible, i.e., Office 365, NHS Mail to ensure compliance with mandated requirements. Use of the secure Health and Social Care Network (HSCN) specified by NHS Digital. Mandatory ~~S~~ staff training on data security and protection at induction and annual refresher. Regular all staff communications regarding safe ways of working and phishing emails. Contract with NHS Arden and Greater East Midlands Commissioning Support Unit provides information governance and security services, includes review of risks and addressing of vulnerabilities. Subscription with NHS Digital Care Certification Programme highlights cyber vulnerabilities and monitors Trust's compliance against them
Detective – Cyber essentials framework: NHS Digital encourage all organisations to comply. Advanced Threat Protection (ATP) monitors every server and device to highlight threats and software vulnerabilities
Directive – Compliance with NHS Digital requirements. Monthly rigor review meeting with NHS Arden and Greater East Midlands Commissioning Support Unit. Security and Protection Policies and Procedures. Business continuity policy and procedure; Digital Plan – In development

Assurances on controls – Internal	**Assurances on controls – External**
IM&T Strategy delivery update to F&P – Annual	Templar Cyber Organisational Readiness Report (CORS)
Embedded programme of software and hardware upgrades	Annual external cyber review and penetration test commissioned~~by Dynac~~ (vulnerability scan)
Live testing of business continuity plans	Data Security and Protection (DSP) annual review by Internal Audit
Digital Plan – In development	

	Compliance with DSP Toolkit; high levels of training compliance

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
~~Business continuity plans reflect changes to service delivery such as increased phone and video contacts~~	~~All services to review business continuity plans to ensure they take account of the increased use of phone and video contacts for care provision and also use of video conferencing for operational delivery~~ ~~[ACTION OWNER: CDO]~~	~~Reporting to the Divisional Performance Reviews (DPRs)~~	~~(30.06.25)~~	~~Business continuity training for Trust Leads started March 2024. Revised business continuity policy was ratified April 2024. Wider business continuity work (e.g. audit) took place in Quarter 2 as part of the EPRR Core Standards Recovery Action Plan – This is on track and expecting to be substantially compliant in the regional assessment~~	~~GREEN~~ BLUE
NHS 10 year plan to abolish Commissioning Support Units (CSU). By Spring 2027 Arden GEM CSU is likely to be abolished and DHCFT no longer and to benefit from respective cyber, network and technical services and support	Added to Trust risk register and tracked by IMT&R senior team. National changes tracked via regional forum and Technical Design Authority. Alternative options – Plan in progress leading to options appraisal. Options may include: Some services provided in-house by DHCFT, contract with another supplier (NHS or private), wait for possible rebrand / merger of Arden Gem CSU and contract with new entity		(31.12.25)	Initial fact finding and options document prepared for F&P Quarterly review leading to deadline in spring 2027	AMBER
Unsupported IT devices are a potential security risk	Routine review and update of Trust assets. Ongoing cycle to refresh kit and update assets to comply with security updates	Compliance with monthly rigour and service reviews Removal of any unsupported devices/assets with each wave of security updates	(31.12.25)	DHCFT the first Trust in the midlands to be fully compliant and phase out Windows 10 devices. Cycle will repeat with next wave of security updates Ongoing - Monthly rigour and service review meetings with IT service supplier	AMBER

Related operational high/extreme risks on the Corporate Risk Register: ~~None~~

ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating
23563	IT, IM and Patient Records	Risk to Service Provision by ArdenGem to the Trust	The government have announced that all CSUs will cease to exist by Spring 2027. All the technology used within the Trust is supported by AGEM who are one of the CSUs targeted by the government. The skills provided by AGEM do not exist in the Trust. An alternative delivery solution will need to be identified and a transition plan developed. We await more clarity on the timescales and options available	08.07.25	08.10.25	HIGH

Patient Focused - Our services will deliver safe and high-quality care
There is a risk that the organisation is in breach of essential standards for privacy and dignity in its acute bedded care facility as it has not fully completed its dormitory eradication programme. This may result in regulatory action if mitigation to improve safety does not occur

Impact: May adversely impact on regulatory requirements to provide safe and quality care. Patients' dignity and privacy may be impacted. Enforcement regulatory notices may issued against the Trust that may impact on Trust reputation and restrictions to capital could be applied.

Root causes:

a) There was commitment across mental health services to eradicate dormitories by 2022 – Although the Trust has active plans for Making Room for Dignity with a fully funded programme, with the building and infrastructure commencing, the Trust has not delivered in the set timeframes
b) Infrastructure does not comply with current standards
c) Outdated approach of delivering mental health care in dormitories does not comply with current guidance
d) Dormitories compromise patient privacy and dignity due to the dormitory layout
e) Dormitories do not comply with Infection, Prevention and Control (IPC) guidance when isolation is required
f) Dormitories could compromise Health and Safety regulations and increase risks, e.g. fire safety
g) Dormitories are not therapeutic spaces to provide mental health care in

BAF Ref: 25-26 1D	**Director Lead**: Tumi Banda (DON) / Vikki Ashton Taylor (CDO)	**Responsible Committee**: Quality and Safeguarding Committee

Key Controls

Initial risk rating			**Current risk rating**			**Target risk rating**			**Risk appetite**		
Moderate	Likelihood 3	Impact 4	Moderate	Likelihood 3	Impact 4	Moderate	Moderate 3	High 4	Accepted	Tolerated	Not Accepted

Preventative – Screening of each admission considering safety, care and infection control needs supported by the infection control team, health and safety audits; risk assessments; physical health care screening and monitoring; Maintaining environments and cleaning, Director and senior leader visits. Board visits. Quality governance structures, teams and processes to identify quality related issues. EQUAL unannounced visits to services and anonymised bright ideas service improvement ideas

Detective – Quality dashboard reporting; Board visits virtual clinical service contact visits; incident, complaints, and risk investigation; Fire Safety Regulations (FSR) compliance checks; mortality review process; physical health care monitoring clinics pilots; safety check log; Head of Nursing and Matron compliance visits, reviewed model of announced and unannounced visits to service throughout the 24 hour period, cleaning schedules and maintenance logs. Compliance to Delivering Same Sex Accommodation requirements

Directive – Trust Strategy; Physical Health Care Strategy; Safeguarding Strategy; Suicide Reduction Strategy; clinical strategies; policies and procedures available via Trust intranet; Central Alerting System (CAS) alerts; Risk Management Strategy; clinical sub committees of the Quality and Safeguarding Committee, Making Room for Dignity programme (MRfD)

Assurances on controls – Internal	**Assurances on controls – External**
Trust quality and performance dashboards	Delivery of Same Sex Accommodation Guidance
Bed Management processes	Safety Thermometer identifies positive position against national benchmark
Scrutiny of Quality Account by committees	Mental Health Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards
Programme of physical healthcare and other clinical audits	CQC comprehensive review 2020 Trust is rated Good
Infection Control Board Assurance Framework reported to NHSE	Estates and Facilities Management internal audit
Positive and Safe self-assessment	

Head of Nursing/Matron compliance visits Cleaning and maintenance schedules ~~IPC training Level 1 and 2~~Mandatory training Trust targets of 85% compliance minimum Continuous Improvement Plan – ~~Confirmed launch date is 01.04.25~~Launch date to be confirmed	CQC inspection adult acute December 2024 – Rated good CQC inspection older adults, April/May 2025 – Rated good ~~(April 2024)~~ Patient Safety Incident Response Framework (PSIRF) implementation Monitoring of IPC standards compliance and reporting – ICS IPC Team

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Inpatients care is delivered in wards with dormitories, that compromise on patient dignity, privacy and effective IPC practice	Implement bed management process that ensure that admissions are screened to comply to gender, safety and IPC requirements Ensure that the environments are routinely check by clinicians, estates, and domestic staff Infection Prevention and Control monitoring, and training compliance Effective monitoring of the clinical environments by clinical, estates and domestic staff Monitor delivery of same sex guidance through Quality and Safeguarding Committee [ACTIONS OWNERS: DON/CDO]	Monitor and report breaches of same sex admission Monitoring of maintenance and cleaning schedules Head of Nursing and Matron environmental walkabouts Infection and Prevention and Control reports and monitoring of infections – To comply with the Infection Control Handbook and complete the required level of auditing Provision of other rooms for privacy and confidentiality across the estate	~~(30.06.25)~~ (30.09.25)	~~Level 1 and level 2 IPC~~Mandatory training are above compliance target and there is improved governance and monitoring Fully funded programme of work in place – Making Room for Dignity programme is progressing Bed management processes updated in line with the new available estate ~~Amended gatekeeping and purposeful admission process was launched in April 2024. This is having a positive impact on robust bed management processes~~ ~~A risk management summit has been organised to review the risk register to streamline required risk assessments and update in-line with the move to the new inpatient units~~ All Adult Acute inpatient facilities are currently single sex. However, the original design for one ward	~~AMBER~~ GREEN

				(Sycamore) enables the ability to flex between being single sex and mixed sex as appropriate. The PICU and Enhanced Care Unit are also single sex	

Related operational high/extreme risks on the Corporate Risk Register: None

People - Derbyshire Healthcare is a great place to work

Board Assurance Framework 2025/26 – Issue 2.3 Board September 2025

There is a risk that we are unable to create the right culture with high levels of staff morale

Impact: This could impact on the wellbeing and motivation of our people as well as the quality and effectiveness of the services we provide. This could also impact on our ability to recruit as well as maintain staff, with a potential negative impact on the broader reputation of Derbyshire Healthcare

Root causes:

a) The growth of and increasing complexity of demand on our services and therefore our workforce
b) Lack of consistency and expectations of managers and leaders
c) Lack of strategic development pathway for leaders
d) The number of leadership layers we have
e) Lack of accountability across the leadership levels
f) The volatile work environments where staff can be exposed to harm and trauma
g) The need to develop cultural competence and confidence that is needed to value and create a sense of belonging for people of all backgrounds, ethnicities and with lived experience
h) National, system and provider mandated changes connected to financial position of the NHS
~~Employee Relations service sits outside of the trust in a shared joint venture which impacts on quality of service and accountability of responsiveness~~

BAF Ref: 25-26 2A	**Director Lead**: Rebecca Oakley (DPOI)	**Responsible Committee**: People and Culture Committee

Key Controls

Initial risk rating			**Current risk rating**			**Target risk rating**			**Risk appetite**		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 3	Accepted	Tolerated	Not Accepted

Preventative – Freedom to Speak Up Guardian (FTSUG) self-assessment and six monthly reports; actions taken from staff survey results, people performance reviews and actions, training and education meeting, Equality, Diversion and Inclusion (EDI) steering group, staff networks, health and wellbeing network
Detective – National staff survey, Quarterly Pulse Checks, FTSUG log and escalations; staff network engagement; WRES, WDES, wellbeing champion network, executive led engagement sessions; non-executive, executive and deputy visits to teams
Directive – Joined Up Care Derbyshire (JUCD) People Strategy, National People Plan; strategic people priorities

Assurances on controls – Internal	**Assurances on controls – External**
National staff survey and reporting into board, ELT and divisions Quarterly pulse check and action planning process Exit interview analysis and reporting People Plan	Benchmarking in mental health Trusts and at system level Staff survey analysis and reporting

Key gaps in control	**Actions to close gaps in control**	**Impact on risk to be measured by**	**Expected completion or (review)**	**Progress against action**	**Action rating**
Lack of planned leadership development growth, stretch programmes and opportunities	Leadership section of the People Plan to align to organisational leadership needs	Percentage of leaders with development plan as part of objectives	~~(30.06.25)~~ (30.09.25)	~~Third cohort of Aspiring-2-Be leadership course launched~~	AMBER

including coaching and mentoring	Delivery of the People Plan priority: To be recognised for supporting and developing our people to work confidently in their roles Review and development of Trust leadership offer and impact [ACTIONS OWNER: DPOI]	Percentage of employees accessing leadership development programmes		~~Leadership Strategic Approach finalised and signed off at ELT and PCC in June 2024~~ ~~Senior leadership programme agreed and dates being finalised~~ ~~Leadership forum now embedded and running regularly~~ Senior triumvirate leadership programme commissioned and will commence post operating model consultation for all relevant posts	
Lack of progress across EDI including staff networks and reporting (WRES/WDES/gender pay gap)	Staff networks have an embedded operating framework through which to maximise the impact of staff networks Clear measurable EDI plan that includes all national reporting and Trust level actions Support to bi-monthly network Chairs meetings through DPI, Head of EDI and EDI Manager Delivery of People Plan priority: To be recognised by our people for our values driven and inclusive culture [ACTIONS OWNER: DPOI]	Clarify on role and function of staff network chairs and objectives for each network – Reviewed twice a year Annual updates by network Chairs of engagement undertaken to be included in annual reports Year on year change WRES/WDES, staff surveys and lived experience of staff through staff networks	~~(30.06.25)~~ (30.09.25)	Framework, including clear actions to progress and signed off at PCC Head of EDI commenc~~ed~~eding in post 31.03.25 2024 Gender Pay Gap report indicates improvements in reducing the gender pay gap High level action plan on EDI priorities presented to May PCC	AMBER
Lack of ownership and embedded models of care and cultures across MRfD workforce resulting in retention and turnover challenges and inconsistency of approach across MRfD programme	Review of all commissioned and in house owned programmes both clinical and non-clinical to be clear of the 'ask' and the 'why' Clear framework to ensure alignment across all programmes	Delivery against plan including attendance on programmes Staff survey measures Bespoke MRfD surveys to measure awareness and impact of programmes	~~(30.06.25)~~ (30.09.25)	Revised programme board and workstreams to ensure alignment and learning from gateway review ~~Progress on measures is phasing to the opening of the new wards~~	RED

	Comprehensive plan of delivery and outcome measures [ACTIONS OWNER: DPOI]			Bluebell ward commenceding organisational development culture programme in May 2025~~, Derwent wards will be 12 weeks post opening (end of June 2025)~~	
Not yet embedded the Trust personal accountability framework and inconsistent support for Employee Relations (ER) informal and formal cases	Fully embed Trust personal accountability framework across all teams and individuals to have ownership of their own behaviours Development and delivery of ER training for managers on cases and investigations Establish new ER services in Trust (currently in a shared service) [ACTIONS OWNER: DPOI]	Reduction in length of cases Reduction in formal cases Attendance at training by managers on cases and investigations Establishment of new ER in-house team	~~(30.06.25)~~ (30.09.25)	ER ~~service currently transitioning~~team transitioned out of DCHS Joint Venture into DHCFT ~~– Completion expected 01.06.25~~June 2025 ~~Capsticks case manager training commenced and ongoing roll out~~ Case investigator training currently being rolled out to support Pool of eight bank investigators recruited and commencing training A kind life just culture training programme commissioned, will incorporate personal accountability framework	RED
Inconsistent approach to flexible working impacting on staff morale	Develop and embed a clear approach to flexible working that supports service delivery and staff Develop a clear and consistent way of recording and reviewing flexible working that supports both managers and staff [ACTIONS OWNER: DPOI]	Ability to record and track number of flexible working arrangements in place Staff engagement measures via staff survey and pulse check	~~(30.06.25)~~ (30.09.25)	Design of flexible working system linked to ESR to record requests for flexible working and approved requests in progress ~~Progress under review – Updates to follow in next BAF issue~~	RED

Lack of robust absence management policy and processes that support both managers and staff	Review and relaunch a new absence management policy Review support provided to managers to review and move forward long term sickness absence cases Review Occupational Health access, support and usage to ensure maximising service and being used to Delivery of People Plan priority: To be recognised as a Trust that supports and promotes the wellbeing of our people [ACTIONS OWNER: DPOI]	Reduction in absence management across both long and short term absences Reduction in Occupational Health DNAs Staff survey and pulse check	~~(30.06.25)~~ (30.09.25)	Absence plan developed and presented to PCC Oversight working group established Notice given to Goodshape (external absence management system) to enable in-house absence management to be developed	RED
Lack of a stable positive culture due to high levels of organisational change impacting on morale	Review and develop organisational change policy to ensure clear and supportive approach for managers and staff Clear wellbeing processes for occupational health and other support mechanisms Effective, clear and open communication channels	Staff survey and pulse check engagement scores Financial balance	(30.09.25)	Fast track process for Occupational Health in organisational change Phase 1 operating model programme commenced	RED

Related operational high/extreme risks on the Corporate Risk Register: None

People - Derbyshire Healthcare is a great place to work

There is a risk that we do not have an adequate supply of a diverse workforce with the right of people with the right skills to support and deliver safe high-quality care

Impact: May lead to reduced staffing levels and skill gaps which impact on safe staffing levels and addressing health inequalities in patient facing services and the ability of our supporting and corporate teams to support front line services

Root causes:

a. There are occupational shortages nationally which mean that the supply of some professions create long term vacancies and a lack of workforce planning in solutions to fill the gaps
b.
c. Pressures on workforce development and Continued Professional Development (CPD) funding may risk ability to develop skills and expertise
d. Disproportionate growth in senior leadership posts in correlation with frontline clinical posts
e. Lack of triangulation of workforce and finance data
National and regional Recruitment Retention Premium (RRP) applications to hard to recruit posts impacting on Trust recruitment and retention

BAF Ref: 25-26 2B	**Director Lead**: Rebecca Oakley (DPOI)	**Responsible Committee**: People and Culture Committee

Key Controls

Initial risk rating			**Current risk rating**			**Target risk rating**			**Risk appetite**		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Alliance, system and national Human Resources forums for sharing best practice and risk mitigation, website, workforce plan
Detective – People Performance Report in TLT, ELT and PCC; Bank Improvement Group; Combined Delivery Group with multi-disciplinary team (MDT) input; Medical Staffing Group, Sustainability Meeting; FTSU culture; exit interview process stay interview process
Directive –JUCD Careers Team; JUCD and People and Inclusion meeting; recruitment policy and procedure; TRAC recruitment system; safe staffing plans

Assurances on controls – Internal	**Assurances on controls – External**
People Performance Report at ELT and PCC People Dashboard in PCC PCC forward plan and deep dive plan Workforce plan Embedded recruitment and retention scheme People Plan	Healthcare Support Workers (HCSW) submissions System operational planning process Safe staffing report Regular NOF Level 3 meetings with NHSE and ICB (in relation to Making Room for Dignity (MRfD) recruitment)

Key gaps in control	**Actions to close gaps in control**	**Impact on risk to be measured by**	**Expected completion or (review)**	**Progress against action**	**Action rating**
An integrated workforce plan and planning process that feeds into pipeline plans and ensures we have the right people in the right place with the right skills	Develop a Trust Workforce Plan linking demand and capacity, workforce redesign to ensure a fully funded workforce Develop vacancy rate data and breakdown variances in vacancy data	Reduced v~~V~~acancy rates Time taken to fill vacant posts Transformational posts, e.g. apprenticeships all identified	~~(30.06.25)~~ (30.09.25)	~~Work commenced to map apprenticeship plan and resources required~~ ~~Agency reduction plan in place and having impact~~	AMBER

	Delivery of all People Plan priorities: Attracting a high skilled and diverse range of applicants to our roles Retaining our diverse talent through growth and development Staff are delivering at the top of their professional standards Opportunities for professional and career development [ACTIONS OWNER: DPOI]	Reduction in agency costs Improved retention rates		~~Agency summit took place October and November 2024 to focus on medical and acute agency spend (highest areas)~~ Executive-led vacancy control meeting takes place every week for approval of all vacancies and workforce expenditure increases, i.e., job evaluation	
We do not have an effective and embedded succession talent management processes	Develop a Talent Management Strategy Pilot career conversations for senior leaders and roll out career conversations for all colleagues Work as a system to develop system-wide approach to talent management and align where best for the Trusts Delivery of all People Plan priorities: Attracting a high skilled and diverse range of applicants to our roles Retaining our diverse talent through growth and development [ACTIONS OWNER: DPOI]	Career conversations taking place Internal appointments/promotions Reduction in t~~T~~urnover rate Key staff survey measures	~~(30.06.25)~~ (30.09.25)	Talent Strategy finalised Talent programme for senior executive leadership completed – to be run for senior leadership team following finalised operating model ~~Talent programme relaunched following learning from previous pilot with clear engagement timescales and expectations~~ Talent and succession planning part of every Executive Director's objectives	RED
Onboarding and retention process and planning needs to be embedded (this includes MRfD and challenges on retention of high numbers of newly qualified nurses)	Understand the key retention issues for posts/teams/professions with the highest turnover to deliver People Plan priorities to attract and retain newly qualified nurses Ensure 'stay conversations' form part of regular 1:1s	Improvements to turnover Staff survey engagement scores	~~(30.06.25)~~ (30.09.25	Additional posts added to the preceptorship team to support retention of high numbers of newly qualified staff Stay Surveys launched at months 3, 6 and 12	AMBER

	Develop NHS retention framework for nursing [ACTIONS OWNER: DPOI]				
Lack of inclusive recruitment practices and actions to consider the needs of people from different backgrounds, to support our commitment to embedding an inclusive culture	All chairs of recruitment panels have undergone inclusive chairs recruitment training Data driven recruitment practices Delivery of People Plan priority: To be recognised by our people for our values driven and inclusive culture [ACTIONS OWNER: DPOI]	WRES and WDES data shows year on year improvement, staff survey and lived experience of staff Increase the proportion of applications from ethnic minority groups, increase likelihood of shortlisting and reduce disparity in all areas	~~(30.06.25)~~ (30.09.25)	Inclusive recruitment for chairs training commenced Cultural competence training commissioned and being rolled out, initially focusing on acute wards	RED
Effectiveness of recruitment policy, practice and processes	Review and develop existing recruitment Key Performance Indicators (KPIs) to ensure fit for purpose Where appropriate move away from TRAC to advertise jobs and use fast track processes, e.g. Indeed/MSforms Develop cohort recruitment for key posts Improve the multidisciplinary working (HR, communications and recruiting managers) to enable better planned and executed campaigns [ACTIONS OWNER: DPOI]	Time to recruit Number of applicants applying and successfully shortlisted Campaign impact and reach Financial savings through cohort recruitment	~~(30.06.25)~~ (30.09.25)	~~Trust Strategic Recruitment and Retention Lead appointed~~ ~~Successful recruitment events in place including attendance at universities~~ A range of recruitment methods are deployed to ensure we attract a diverse range of applicants Revised Service Level Agreement and KPIs in place for recruitment service ~~On track with MRfD recruitment posts and plans in place for hard to recruit posts~~	AMBER
Agency and bank usage control measures and reduction	Ensure bank and agency usage is controlled by clear processes and measures with accountability at team level on spend Agency off framework usage is managed with clear expectations Plan in place to reduce and align to agency price cap for all posts	Agency and bank usage reduction Agency off framework nil return Agency price cap achieved Bank usage is appropriate and available to support where needed	~~(30.06.25)~~ (30.09.25)	Ongoing weekly agency approval in place for approval of all agency requests Assistant Director of Workforce is co-chair of national regional agency reduction group Consistent agency reduction demonstrated	AMBER

	Bank staff are recognised and rewarded appropriately [ACTIONS OWNER: DPOI]				

Related operational high/extreme risks on the Corporate Risk Register: None

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

There is a risk that the Trust fails to deliver its revenue and capital financial plans for 2025/26 caused by factors including non-delivery of Cost Improvement Programme (CIP) targets and increased cost pressures not mitigated resulting in a threat to our financial sustainability and delivery of our statutory financial duties

Impact: The Trust becomes financially unsustainable. The Trust's National Oversight Framework rating has deteriorated and this could lead to a lack of organisational direct control in the longer term via increased regional and national intervention. Corrective action is needed and progress towards financial balance is required. Whilst our planned deficit has reduced in 2024/25 it is still a long way to breakeven. In addition, we have an ambitious CIP requirement approaching 6% due to cost pressures

Root causes:

a) Financial detriment (revenue, cash and/or capital) resulting from large capital development programme, in particular dormitory eradication and associated capital schemes

b) Organisational financial detriment created by commissioning decisions or wider 'system-first' decisions including enactment of risk-sharing agreement in partnership arrangements or changes in NHS financial arrangements. System financial position resulting in required additional financial savings to support the System position from Mental Health funds
b) Non-delivery of expected financial benefits from transformational activities
c) Non-delivery of required levels of efficiency improvement
d) Lack of sufficient cash and working capital
e) Loss due to material fraud or criminal activity
f) Unexpected income loss or non-receipt of expected transformation income (e.g. long-term plan (LTP) and Mental Health Investment Standard (MHIS) without removal of associated costs
g) Costs to deliver services exceed programmes the Trust financial resources available
h) Lack of cultural shift/behaviours to return to financial cost control regime. Areas of non-compliance with Standing Financial Instructions (SFIs) and financial duties. Ineffective grip and control measures to control inappropriate spending
i) Inability to reduce temporary staffing expenditure
j) Inability to reduce inappropriate out of area placements and effectively manage flow
k) Inability to manage increasing demand and acuity in our inpatient settings
l) Trust reluctance to remove costs in line with non-recurring income removal due to wider system impact (financial and Equality Impact Assessment concerns)
m) Inability to timely respond due to the volume and bottlenecks associated with large levels of organisational change and transformation simultaneously ongoing
n) Level and pace of organisational change may result in extended timelines due to capacity across a range of services including People teams, staffside and wellbeing support
~~l)~~o) Exit costs will impact on our financial sustainability

BAF Ref: 25-26 3A	**Director Lead**: James Sabin (DOF)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Appetite**		
Moderate	Likelihood 2	Impact 5	Moderate	Likelihood 2	Impact 5	Moderate	Likelihood 2	Impact 5	Accepted	Tolerated	Not Accepted

Preventative – Operating plan and financial plan agreed for 2025/26 in line with ICB requirement. Integrated Care Board (ICB) signed off and fully support the dormitory eradication programme and are supporting this through to completion as a pre-commitment. Devoted and adequate team for Programme delivery. High quality business cases. Regular meetings with NHSE on programme progress. Meaningful stakeholder engagement (internal and external). Robust cash flow forecasting and delivery. Multi-disciplinary development of financial plans for new of work. System sign-off and appropriate governance arrangements for new programmes of work: Budget training, segregation of duties, management of commissioning risk through system engagement and leadership, mandatory counter fraud training and annual counter fraud work programme: Enhanced cash management and forecasting aligned to large capital and transformational programmes

Detective – Risk logs and programme-reporting (capital/transformation) informs ongoing financial risk assessment: Audits (internal, external and in-house); scrutiny of financial delivery, bank reconciliations; continuous improvement including cost improvement planning (CIP) and efficiency / QI delivery; contract performance, local counter fraud scrutiny

Directive – Business plans and templates set out clear financial plans and assumptions: Standing financial instructions; CIP Monitoring, Performance management reviews, Treasury management procedures, budget control, delegated limits, recruitment approval processes; business case approval process; invest to save/Quality Improvement methodology and protocol and Plan Do Study Act. Risk and gain share agreements; new strengthened governance processes around the Making Room for Dignity Capital Programme

Assurances on controls – Internal	Assurances on controls – External
Operational plan; financial planning including CIP planning, processes and delivery monitoring CIP programme group established to strengthen oversight. Further work and governance changes planned to drive the transformational plans and monitor progress Vacancy control process in place with Executive oversight Performance management processes in place and being refreshed to add to assurance levels. Now also established and in place for 2025/26 for corporate functions Dormitory eradication and PICU programme monitoring and reporting Appropriate monitoring and reporting of financial delivery – Trust overall and programme-specific Assurance levels gained at Finance and Performance Committee (F&P) Delivery of Counter fraud and audit work programme with completed and embedded actions for all recommendations Independent assurance via internal auditors including HFMA checklist, external auditors and counter fraud specialist that the figures reported are valid and systems and processes for financial governance are adequate New governance process in place for the Making Room for Dignity programme and action plan in place in relation to the gateway review findings	Monthly reporting into ICB and NHSE, in addition to Trust internal reporting All CIP plans and progress reporting into the EPMO for shared system oversight across the ICB NHSE feedback throughout progress of dormitory eradication Programme and business cases in programme Systems Finance and Estates Committee/System Project Management Office/system DOF meetings Internal Audits – Financial integrity and key financial systems audits External Audits – Strong record of high-quality statutory reporting with unqualified opinion National Fraud Initiative – No areas of concern Local counter fraud work – Referrals show good counter fraud awareness and reporting in Trust and no material losses have been incurred. Use of risk-based activity in new counter fraud standards Information Toolkit rating – Evidencing strong cyber risk management Programme Director, Senior Responsible Officer completed NHS Better Business Case Training Regular NOF Level 3 meetings with NHSE and ICB A clean year-end position and clean Value for Money (VFM) assessment as part of our year end audit

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Trust cash and capital risks related to national funded acute capital programme: ~~- Inflation cost risk~~	~~Risk share arrangements with PSCP~~ ~~Programme approach and engagement with all stakeholders. Close involvement with NHSE~~	Cash and capital reporting as part of finance reporting into F&P and Board forecasting evidence of plan delivery and/or	~~(30.06.25)~~ (30.09.25)	Regular oversight of capital and cash position. Reporting to Trust Programme meetings and Committees on risks and mitigations	AMBER

~~- Risk-share~~ ~~- Cashflow timings and variability~~ ~~- Guaranteed Maximum Price exceeds national funding envelope (due to hyperinflation and other factors)~~ Increased cost pressure now aligned to final refurbishment project	~~Discussions ongoing with ICB and NHSE around the Making Room for Dignity cost pressure. Although initial ask was supported, the cost pressure has grown materially in relation to the adult acute units, We are also not in a position to meet the conditions as now the pressure has grown and W~~we will not have a Guaranteed Maximum Price (GMP) for Radbourne Until late Quarter 4 Further discussions are ongoing with NHSE Progressing another VAT claim to part fund final stage [ACTIONS OWNER: DOF]	indicates areas of required management action ~~New governance process will report formally into ELT and F&P then upwards to Board~~		~~Hyper-inflation cost risk is reducing~~ ~~We have reached a deal with IHP (building contractor) and concluded the cost of the adult acute units. Further risks are mitigated Any minor contract variations are now customer driven and cosmetic~~ Significant cost pressures on Radbourne Unit Refurb. ~~Options being revisited in light of growing pressure. Kier recommencement of refurbishment delayed, incurring additional delay costs, due to necessary remediation work at Carsington Unit~~ The decision and affordability question of the second ward will be worked up in quarter ~~1~~ 4 aligned to receipt of the GMP VAT rebate continues to flow to Trust. Still ongoing and reducing current/ongoing payments – Resolved for the North and ongoing for the South. Resolution anticipated in quarter ~~1~~2	
~~System capital programme funding shortfall for self-funded Trust capital programme~~ ~~System Capital Departmental Expenditure Limit (CDEL) inadequacy for system capital requirements~~	~~Access any new national funding streams (e.g. digital or cyber) in year to maximise system capital plan in order to redirect CDEL capital for this cost pressure and other needed schemes [ACTION OWNER: DOF]~~	~~There remains a risk we will overcommit our CDEL allocation in 2024/25 (likely by £4M)~~ ~~Ward 35 decision is a key risk later this year and would have wider impact on the strategic objective to eradicate all dorms~~ ~~Although national funding has been confirmed, it is now known this is not sufficient, we will have an issue to address with the ICB~~	~~(30.06.25)~~	~~The system is managing the overspend on dormitories in 2024/25. We are expecting to live within our collective CDEL~~ ~~System capital plan has been submitted as part of planning process. We have also fed in the 10 year capital plan as part of a wider ICB system-wide return~~ ~~A detailed system plan has been developed for 2025/26 and is not a considered a cause for concern.~~	~~AMBER~~

		~~To proceed at risk (affordability, cashflow and CDEL breach concerns) or pause/stop/abandon which would not deliver dormitory eradication and reduce bed capacity. Alternative more cost effective options to be explored but overall pressure remains~~		~~The Radbourne Unit development is supported as a pre-commitment~~ ~~Risk remains in relation to the Making Room for Dignity cost pressure and discussions with ICB and NHSE remain ongoing. The GMP will not be known until quarter 3~~	
Additional revenue related to new builds, refurbishments and PICU not fully funded by system Some partners moving away from business case assumptions and previous agreements Re-costing service provision, increasing Service Level Agreements	Close partnership working with ICB and system partners. ~~Early recruitment to staffing built into revenue plan of the Trust and funded by the system (both income and expenditure in the plan) as part of operating plan for 2024/25. Full year effect of funding passed over for 2025/26 contract~~ [ACTION~~S~~ OWNER: DOF]	Monitoring and reporting of income allocations and expenditure in year Transparent reporting of position shared with ICB to reduce challenge and ensure joint understanding and support	~~(31.05.25)~~ (30.09.25)	MHLDA DB agreed to oversee revenue delivery contained within programme spend ~~Capital delay has led to reduced revenue risk and slippage~~ ~~Supporting non-recurrent revenue costs associated with dormitories and wider system~~	AMBER
Insufficient substantive staffing into vacancies and temporary staffing costs for bank and agency staff do not reduce	Additional management action and oversight Agency progress monitored and strengthened links to CIP oversight group Direct engagement solution being implemented re medics Agency actions and controls are working and costs continue to reduce [ACTIONS OWNER: DPOI/DOF]	Enhanced bank and agency costs reported as part of wider financial and workforce reporting Continued workforce strategies progressed to reduce agency and increase bank reducing risk Continued reduced run rates evidence in spend Continued reduction in breaches in rates and framework providers	~~(30.06.25)~~ (30.09.25)	Reports to ELT and F&P outlining current areas of pressure and required actions to be taken in year in order to remain on plan	AMBER
~~Non-delivery of required recurrent cost reduction and improved efficiency and Quality Improvement~~	~~Compilation and delivery of planned Trust efficiencies and quality improvements to deliver 2025/26 plan~~	~~Efficiency and QI reporting to executives and F&P~~	~~(30.06.25)~~	~~CIP gap continues to reduce. The percentage which has been identified recurrently continues to increase~~	~~AMBER~~

	~~including recurrent long term cost reductions to return to breakeven~~ ~~Planning for 2025/26 has led to a recent ask for directorates to develop plans of between 3-5% in addition to various transformation plans. In total the Trust is chasing a reduction in costs of approaching 6%.~~ ~~CIP governance and reporting processes strengthened. Close links to wider work re agency reduction, effective rostering and vacancy control [ACTIONS OWNERS: DOF/DPOI]~~			~~Executive vacancy panel established in December 2023~~ ~~Performance meetings are in place for clinical directorates and plans are being put in place in future for corporate areas~~ ~~Performance related additional controls are being developed to help close the CIP gap and ensure mitigation is in place~~ ~~Risk reducing due to continued progress~~	
Financial cost pressures created both internally and by system first decisions leading to the requirement for mitigations to close both the internal gap and the system financial gap	Additional 'stretch' management action required to reduce other cost and mitigate impact to achieve overall financial position Long list of unpalatable options drawn up and supported in principle by Board for further review. These are for consideration post planning nationally due to potential to impact patients and core Trust NHS offer. Need to develop these into costed and prioritised plans with clarity of patient and wider staff impact [ACTIONS OWNER: DOF/MD/DON/CDO]		~~(30.06.25)~~ (30.09.25)	The financial position for Derbyshire is a risk to the statutory duties for DHCFT to manage its financial position Financial plan for 2025/26 is ~~almost~~ concluded but we need to continue to work on reducing the deficit as part of our longer term financial sustainability All new investments to follow governance processes with business cases via ELT, F&P and Board where appropriate and will require wider system support Further system grip and control and investigation and intervention processes maybe added	~~RED~~ AMBER

Related operational high/extreme risks on the Corporate Risk Register: None

Partnerships - Our organisation will identify new ways of working, through new collaborative approaches
Principal risk: There is a risk that the effects of both nationally and locally driven changes to roles and responsibilities within the Integrated Care Board (ICB), and with its partners may impact negatively on the cohesiveness of the Derbyshire health and care system in our organisation **Impact:** Quality of services and patient experience may deteriorate. Financial position of the Derbyshire Health and Care system worsens; working relationships across the system deteriorates; loss of confidence from regulators in the Derbyshire system **Root causes:**

a) Senior management relationships across organisations and organisational expectations of role and responsibilities
b) Creation of mental health, learning disability and autism provider collaborative may destabilise some of the established relationships in place across Derbyshire
c) Creation of system level governance structures, for example Provider Collaborative Leadership Board, may impact on provider Foundation Trust governance arrangements and decision-making processes
d) Staff impacted by change, may lead to increased staff turnover in teams supporting the delivery of the Mental Health Long-Term Plan and subsequent loss of organisational memory
e) The Trust taking on additional lead-provider responsibilities at an ICS or regional level could impact on the quality, performance and financial risks faced by the organisation

BAF Ref: 25-26 4A	**Director Lead**: Vikki Ashton Taylor (CDO)	**Responsible Committee**: Trust Board

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Appetite**		
High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 3	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Governance structures in place at a system and Delivery Board level. Ongoing close communication with NHSE, mental health and learning disability teams at a regional and national level. Assumed NHSE led appointment process to new ICS Board positions
Detective – Continuing engagement in all Joined up Care Derbyshire governance from DHCFT representatives. Due diligence processes undertaken prior to accepting any lead provider responsibilities
Directive – Mental Health, Learning Disability and Autism System Delivery Board to engage widely across membership on the development of any provider collaborative with agreed plans and processes. Gateway process run by NHSE prior to agreement to establish the Trust as lead-provider in any regional collaborative

Assurances on controls – Internal	**Assurances on controls – External**
Regular reporting of position to Board by CEO Regular ELT updates and discussions NED Board members on JUCD committees and Board Board agreement required prior to undertaking of lead-provider responsibilities	Mental Health and Learning Disability assurance meetings with NHSE and ICB Gateway process run by NHSE prior to agreement to establish a Trust as lead-provider in regional collaboratives Representation on system-wide governance groups

Key gaps in control	**Actions to close gaps in control**	**Impact on risk to be measured by**	**Expected completion or (review)**	**Progress against action**	**Action rating**
Increased governance at ICB and system level may create delays to decision making and cause increased governance burden	Keep Trust structures under continuous review against the wider governance landscape, including the provider collaboratives and alliance arrangements – This in turn may lead to a formal change of DHCFT governance arrangements	Board level assurance that the Trust's corporate governance systems are compatible with the new ways of working that would allow both Trust and system objectives to be achieved	~~(30.06.25)~~ (30.09.25)	We have implemented a new divisional performance review process, underpinned by balanced scorecards. To ensure operational performance delivery of MHLDA constitutional	AMBER

	Continue to influence within the system to ensure Lean and safe decision making and governance arrangements [ACTIONS OWNERS: CEO/DCA]	Board level assurance that the Trust's risks have been fully articulated and understood within the wider integrated care system		standards that DHCFT is a lead or main provider Derbyshire Provider Collaborative Leadership Board have an agreed work programme as approved by ICB The Trust is an active member of and provides regular assurance to system-wide governance groups, e.g. their quality and safety group Memorandums of understanding and alliance agreements are in place where appropriate, i.e. LD Alliance Trust's risks reported to the ICB monthly for cross-reference with other providers for the ICB BAF	

Related operational high/extreme risks on the Corporate Risk Register: None

Partnerships - Our organisation will identify new ways of working, through new collaborative approaches
There is a risk of reputational damage if the Trust is not viewed as a strong partner both within the Derby and Derbyshire Integrated Care System (ICS) and more broadly within the East Midlands Mental Health Provider Alliance **Impact:** May have detrimental impact on patient experience and quality of care provided for people accessing services.

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Root causes:

a) Silo working within the organisation
b) Not actively engaging enough as part of a broader multi-agency partnership at Place and community level
c) Increasing national expectations in provider collaboration and multi-disciplinary delivery model at Place level

BAF Ref: 25-26 4B	**Director Lead**: Vikki Ashton Taylor (DSPT)	**Responsible Committee**: Trust Board

Key Controls

Initial risk rating			**Current risk rating**			**Target risk rating**			**Risk appetite**		
High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 3	Moderate	Likelihood 3	Impact 3	Accepted	Tolerated	Not Accepted

Preventative – Active membership in each Local Place Alliance; Active participation in Integrated Place Executive; Meaningful stakeholder engagement (internal and external); Multi-disciplinary and cross organisational development and implementation of services
Detective – Quality Improvement (QI) delivery; Contract performance; Continuing engagement in all Joined up Care Derbyshire governance from DHCFT representatives
Directive – Integrated Care Strategy; Joint Forward Plan (JFP); Trust Strategy

Assurances on controls – Internal	**Assurances on controls – External**
Appointment to Managing Director roles Regular TLT and ELT updates and discussions NED Board members on JUCD committees Developing collaborative plans with system partners to recognise and mitigate gaps within the system for ADHD and ASD diagnostics	Monthly Mental Health and Learning Disability assurance meetings with NHSE Monthly reporting by County and City Places to JUCD Place Executive Patient surveys conducted by Healthwatch CEO on ICB Board and Integrated Care Partnership (ICP) Regular NOF Level 3 meetings with NHSE and ICB

Key gaps in control	**Actions to close gaps in control**	**Impact on risk to be measured by**	**Expected completion or (review)**	**Progress against action**	**Action rating**
Some core constitutional targets not being met and risk to making progress, at pace and scale, resulting in some patients being cared for outside of Derby and Derbyshire	New internal performance improvement group Recovery action plans for areas where Trust constitutional standards are not being met	Improvement in performance in constitutional standards Recovery action plans in place in all required areas	~~(30.06.25)~~ (30.09.25)	In-year progress delivering recovery action plans: Performance improvement in dementia diagnosis and perinatal access has resulted in DHCFT now delivering the	RED

	Improvement plan for joint autism service (with system partners) [ACTIONS OWNERS: CDO]	Feedback from social care on awareness of the Autism Strategy and reduction in autism waiting times		core constitutional targets in this area and others Ongoing work to reduce inappropriate Out of Area Placements, underpinned by a Recovery Action Plan continues including a twice weekly Multi-Agency Discharge Event, roll out of home treatment service, and piloting weekend working for community mental health teams. New build facilities including a local PICU, will support improved patient flow and improved quality of care as the above will enable patients to be treated locally Flow improvement plan is impacting and out of area bed numbers and acute length of stay are reducing Performance reviews are in place for all divisions to monitor performance	
System partners report that DHCFT is inward looking and not easy to work with	To build stronger working relations and build stronger integrated ways of working and be more accessible, both from an organisational and service perspective To deliver more integrated care [ACTIONS OWNER: CDO]	Increased delivery of integrated services	~~(30.06.25)~~ (30.09.25)	~~Active membership of Derby City PLACE Board, PLACE County Partnership Board, and the integrated PLACE executive~~ ~~Senior management representation named for all PLACE Alliance groups.~~ Collaborative development of community mental health 24/7	GREEN

				pilot alongside general practice partners Twice weekly mini MADE and weekly MADE events takinge place ~~every week~~. This is helping to develop our working relationship with social care and ICB colleagues whilst focusing on reducing length of stay and Clinically Ready For Discharge numbers Active membership of all Neighbourhood (Place) Alliance Groups, executive	
Police partners report they do not always feel supported by mental health services and are under pressure to respond to mental health crisis	To reduce inpatient absent and missing cases To support Police with education and training where appropriate To streamline process and timeline for 136 suite admissions and handover [ACTIONS OWNER: CDO]	Reduction in inpatient absent and missing cases Training sessions offered to Police partners: • Police mental health awareness training sessions • Suicide prevention work • Joint working with Trust safeguarding teams • Collaborative response to Right care Right Person (RCRP) Increased handovers completed within one hour	~~(30.06.25)~~ (30.09.25)	Police are a formal member of the MHLDA DB Mental Health Response Vehicle (MHRV) to be implemented during 2024/25, to jointly provide a Trust and Police response to mental ill health calls Crisis café have opened in Buxton, Ripley and Swadlincote – This reduces demand on Police call-outs Trust is a member of the RCRP implementation executive group covering the Derbyshire system With the opening of the Carsington we now have a third Section 136 Suite. The three units are supported with additional resources enabling a	AMBER

				more responsive 136 provision within Derbyshire	
Patient and carers groups report that they would like to see more progress in service user and carer involvement and moving from engagement to decision making	Peer support strategy and objectives for EQUAL and the Mental Health Engagement Group [ACTION OWNERS: DON/MD]	Peer support element will be included in the Quality Plan, to be launched in July 2025~~strategy~~ Co-production in Patient and Carer Race Equality Framework (PCREF) requirements	~~(30.06.25)~~ (30.09.25)	EQUAL group established to support service user and carer engagement and informs future service improvements across the East Midlands Perinatal Mental Health Provider Collaborative DON has worked with the Patient and Carers Committee, EQUAL and the Carers Engagement Group to review their terms of reference and linkages to strengthen the cross-working of the groups	AMBER

Related operational high/extreme risks on the Corporate Risk Register: None

Partnerships - Our organisation will identify new ways of working, through new collaborative approaches
There is a risk to safe, effective clinical care across Derbyshire impacting upon patients, due to not achieving national standards and variation of clinical practice and service commissioning in the Learning Disability (LD) Transforming Care Partnership **Impact:** Poor partnership and system working could impact on the experience and quality of care provided for people with a ND disorder in Derbyshire **Root causes:** a) The community Intensive Support Team and Learning Disability models have non-standardised operating models and require more capacity

b) Currently the delivery and commissioning partnership in Derbyshire have not met national standards or local ambitions for more robust community-based offers, working across the geography and in an integrated way with partners including social care and the voluntary sector
c) The collective vision for Learning Disability services across Derbyshire and the formal outcome to achieve repatriation to Derbyshire has not been effective with some people remaining in outsourced areas of England for extended and significant periods of time
d) Health inequalities across our Derbyshire footprint – Initial insights continue to show gaps in access to service, case load and worsening patient outcomes. Mitigations need to be built alongside DCHS and the ICB
e)

BAF Ref: 25-26 4C	**Director Lead**: Vikki Ashton Taylor (CDO)	**Responsible Committee**: Quality and Safeguarding Committee – DHCFT Quality and Performance Committee – Derbyshire ICS Mental Health, LD and Autism Board in terms of system operational delivery

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Appetite**		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 3	Accepted	Tolerated	Not Accepted

Preventative – Health and safety audits; risk assessments; investment in estates development; workforce plan covering recruitment and retention. Mental Health Act Code of Practice
Detective – CQC inspection reports; Board visits virtual clinical service contact visits; incident, complaints and risk investigations; safety check log; Head of Nursing and Matron compliance visits
Directive – Trust Strategy; Physical Health Care Strategy; Safeguarding Strategy; Trust Policy Dashboard

Assurances on controls – Internal	**Assurances on controls – External**
Regional and national escalation process – Internal preparation	Advisory support provided by DHCFT to the system on bedded care standards for Learning Disability in-patient services Involvement of Local Government Association to deliver a peer review Involvement of external consultants

Key gaps in control	**Actions to close gaps in control**	**Impact on risk to be measured by**	**Expected completion or (review)**	**Summary of progress on action**	**Action rating**
The community Intensive Support Team and Learning Disability models require improvement	Review all models of support offered by the Intensive Support Team (IST) [ACTION OWNERS: CDO/DON/MD]	Outcome of review – Improved models of support	~~(30.06.25)~~ (30.09.25)	ICB have presented to both providers on how to ensure community offers are enhanced further through the review of pathway offers where resource is disproportionately allocated	AMBER

				Ongoing discussions to commit more resources to community pathways The Trust is working alongside DCHS and has established an integrated service provision for neurodevelopmental services across both organisations The integrated model continues with a governance structure aligned	
Improvements are required in rapidly returning patients who access Learning Disabilities and Autism (LD&A) services to local care to enable them to live in the least restrictive manner, as close to home as possible	Continue to work on developed delivery improvement plan, owned by system partners. This includes new cohort stratification– Key action to implement embed approach to ensure focussed system action on existing inpatients who are placed inappropriately and out of area [ACTION OWNER: CDO]	Improvement plans developed and implemented resulting in a stabilised service and positive outcomes for patients Enhancing and reviewing Listening and Engagement Active Partnerships (LEAP) procedures Improvement plans in admission avoidance, crisis alternatives to admission, including improvement in the use of Dynamic Support Registers as a means of admission avoidance Reduction in delayed discharges in units across the country resulting in NHSE escalations	~~(30.06.25)~~ (30.09.25)	Derbyshire is no-longer in national escalation regarding performance with inpatient services after demonstrating improvement against plans New Dynamic Support Pathway (DSP) launched following cross-agency redesign work Cross-system delivery plan continues to be monitored through Neurodevelopmental Delivery group Board – Includes action plan in response to inflow, flow and outflow as discussed with NHSE and ICB leaders The Trust with the ICB continues to meet with	AMBER

				NHSE on a quarterly basis to monitor performance and transformation, focussing on those patients with a long length of stay and who are Clinically Ready for Discharge	

Related operational high/extreme risks on the Corporate Risk Register:

ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating
23314	Corporate Services – IM&T	Interpretation of data submitted within NHSE datasets risks erroneous views on the Trust	30.10.24: NHSE interpret and analyse data submitted within mandated NHSE submissions. This analysis is not fed back to the Trust to allow them to validate and comment on before being published to the wider NHSE community, ICBs and others. This may also include historical analysis where the Trust has no way of rectifying any issues that might be raised. With this there is a risk that external organisations to the Trust are forming views on the Trust based on erroneous information 10.06.25: Risk still resides and will remain so until NHSE, regional sections of NHSE and ICB's communicate and coordinate methodologies prior to publishing analysis	30.10.24	26.11.25	HIGH

Risk Rating
The full Risk Matrix is included in the Trust's Risk Management Strategy

Risk Assessment Matrix					
Risk Score = Consequence Rating X Likelihood Rating					
	CONSEQUENCE				
LIKELIHOOD	INSIGNIFICANT 1	MINOR 2	MODERATE 3	MAJOR 4	CATASTROPHIC 5
RARE 1	1	2	3	4	5
UNLIKEY 2	2	4	6	8	10

RISK RATING	RISK APPETITE
Very Low	Accepted
Low	
Moderate	Tolerated
High	Not Accepted
Extreme	

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POSSIBLE	**3**	**3**	**6**	**9**	**12**	**15**
LIKELY	**4**	**4**	**8**	**12**	**16**	**20**
ALMOST CERTAIN	**5**	**5**	**10**	**15**	**20**	**25**

Actions Against Gaps in Key Controls - Expected completion dates to be included or next review dates to be shown in brackets	**Action Rating**
Action **completed**	**Blue**
Action **on track** to completion within proposed timeframe	**Green**
Action **implemented in part** with potential risks to meeting proposed timeframe	**Amber**
Action **not completed** to original or formally agreed revised timeframe. Revised plan of action required	**Red**

Action Owners

CEO	Chief Executive Officer
DOF	Director of Finance
MD	Medical Director
CDO	Deputy Chief Executive / Chief Delivery Officer
DON	Director of Nursing, AHPs and Patient Experience
DPOI	Director of People, Organisational Development and Inclusion
DCA	Director of Corporate Affairs and Trust Secretary

Definitions

Preventative	A control that limits the possibility of an undesirable outcome
Directive	A control designed to cause or encourage a desirable event to occur
Detective	A control that identifies errors after the event

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 23 September 2025

Freedom to Speak Up Guardian (FTSUG) report

Purpose of Report

This paper is a half-yearly report to ensure Derbyshire Healthcare Foundation Trust (DHcFT) Board is aware of Freedom to Speak Up (FTSU) cases within the Trust; an analysis of trends within the organisation and actions being taken to improve speaking up culture.

Executive Summary

The FTSU report to Board sets out the number of cases and themes raised in the last six months from January to June 2025 at DHcFT.

Total case numbers: 116 cases seen in this report to Board for the period are a 4.1% percentage reduction on the 121 cases reported in the March 2025 FTSU report to Board for the period July to December 2025.

Emerging, or ongoing, themes include:

Ongoing theme: bullying and harassment/Worker safety and wellbeing: Sexual Safety and Boundaries. A few staff have spoken to the FTSUG about concerns related to sexual safety. The staff came from one Division within the Trust. These concerns were escalated to senior leaders. Staff were concerned about their wellbeing around these issues.
Ongoing theme: bullying and harassment including racism/discrimination
There has been an increase on the preceding quarter in staff experiencing an element of bullying and harassment. 28.4% of cases raised to the FTSUG from January to June 2025 included an element of bullying and harassment which also include discrimination and racism. Reports of racism from patients and, to a lesser extent, discrimination experienced by staff towards other staff is an ongoing theme and has been raised in previous reports to Board.

The report also contains a list of actions taken to enhance visibility and promote FTSU to ensure that speaking up culture is continuously improved.

The Speaking Up Champions' network also supports workers to raise their concerns at the earliest opportunity and signposts workers to the FTSUG for advice and guidance.

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

Risks and assurances

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

- Reporting on speaking up is presented to the Trust Board and the Audit and Risk Committee (ARC) every six months to provide assurance on progress made. The People and Culture Committee (PCC) also receives FTSU information as part of the wider staff feedback dashboard
- The Audit and Risk Committee continues to monitor the progress of the FTSU action plan
- There are risks to having a culture where workers do not feel able to safely voice their concerns. There are potential impacts on patient safety, clinical effectiveness and patient and staff experience, as well as possible reputational risks and regulatory impact.

Consultation

Executive Leadership Team.

Governance or Legal Issues

Trusts are required to have a FTSUG as part of the NHS standard contract terms and conditions.

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:

- Assurance is sought by the FTSUG, that concerns logged from staff with protected characteristics are supported by Employee Relations/Equality, Diversity and Inclusion (EDI) processes; and that any wider issues are being considered by senior Trust leadership
- This report highlights some areas of good practice, including having FTSU Champions from a diverse range of backgrounds, as well as numbers of Black and Minority Ethnic (BME) colleagues speaking up.

Recommendations

The Board of Directors is requested to:

1. Support the current mechanisms and activities in place for raising awareness of the FTSU agenda
2. Discuss the report and determine whether it sufficiently assures the Board of the FTSU agenda at the Trust and that those proposals made by the FTSUG promote a culture of open and honest communication to support staff to speak up.

Report presented and: **Tamera Howard**
prepared by: **Freedom to Speak Up Guardian**

Freedom to Speak Up Guardian (FTSUG) – half-yearly report

1. Introduction

1.1 The Freedom to Speak Up Guardian (FTSUG) is part of a culture of speaking up and acts to enable patient safety concerns to be identified and addressed at an early stage. Freedom to Speak Up (FTSU) has three components: improving and protecting patient safety, improving and supporting worker experience and visibly promoting learning cultures that embrace continual development. The Care Quality Commission (CQC) assesses an NHS trust's speaking up culture under the Well-Led domain of its inspections.

1.2 The FTSU report covers the period from January to June 2025: Quarter 4 (Q4) 2024/25 and Q1 2025/26. Reporting to the Board is on a six-monthly basis.

2. Aim

2.1 This report aims to provide the Board with:

- Information on the number of cases being dealt with by the FTSUG and themes identified from January to June 2025
- Information on what the Trust has learnt and what improvements have been made as a result of workers speaking up.
- Actions taken to improve FTSU culture in the Trust, including progress in the promotion of the FTSUG role and addressing barriers to up
- Updates from the National Guardians Office (NGO)
- Key recommendations to Board.

3. Summary of Freedom to Speak Up Concerns

3.1 Concerns are categorised in accordance with NGO guidance. The NGO requires concerns relating to Patient Safety and Quality, Bullying and Harassment, Inappropriate Attitudes and Behaviours, Worker Safety and Wellbeing, Public Interest Disclosure Act (PIDA) concerns, anonymous concerns and those suffering detriment or demeaning treatment, as a result of speaking up, to be reported on a quarterly basis.

3.2 **Table 1** show the FTSU case number comparison for DHcFT in 2023/24 and 2024/25 and the average for Mental Health trusts in 2023/24. This shows a 79.5% increase in number of FTSU cases from 2023/24 to 2024/25.

Table 1

DHcFT FTSU Cases 2023/24	DHcFT FTSU Cases 2024/25	Average annual cases for MH trusts in 2023/24*
132	237	110

*(**Speaking Up to FTSUGs: 2023/24**)

Table 2 shows that the FTSUG logged 40 cases in Q1 2024/25 and 76 cases in Q4 2023/24. In Q1 2025/26, 55 cases have been logged (12/09/2025). In 2024/25, DHcFT averaged 59.25 cases per quarter (12 months).

3.3 **Patient Safety and Quality:** During Q4 2024/25 and Q1 2025/26, patient safety and quality concerns represented 16.4% of cases. From July to December 2024, they represented 9.1% of cases. Patient safety and quality concerns are directed to the Director of Nursing, AHPs, Quality and Patient Experience and to the Medical Director.
According to the Summary of Speaking Up to FTSUGs: 2023/24, patient safety concerns represented 18.7% of all concerns nationally.

Table 2: FTSU Data Q4 2024/25 and Q1 2025/26

Types of Concerns (Themes)	Q4 2024/25	Q1 2025/26
Patient Safety and Quality (NGO/PIDA)	14	5
Bullying and Harassment (NGO/PIDA)	21	12
Inappropriate Attitudes & Behaviours (NGO)	40	10
Worker Safety and Wellbeing (NGO)	49	25
Potential Fraud or Criminal Offence (PIDA)	2	0
Total Cases (individuals) reported to FTSUG*	**76**	**40**
Public Interest Disclosure Act (PIDA) concerns	37	17
Reportable to NGO: Bullying and Harassment / Patient Safety / Worker Safety / Inappropriate Attitudes and Behaviours*	124	52
Anonymous / Not known / Other	5	1
Person indicates suffering detriment as a result of speaking up	1	1
Number of cases that have received feedback	**71**	**39**

***Individuals (cases) approaching FTSUG may log more than one concern theme.**

3.4 **Bullying and Harassment concerns** represented 28.4% of cases raised to the FTSUG from January to June 2025. This is an increase on the 16.5% of cases raised from July to December 2024. 19.8% of concerns included an element of bullying and harassment nationally during 2023/24. (Summary of Speaking Up to FTSUGs: 2023/24). Bullying and harassment FTSU case levels for DHcFT for 12 months from July 2024 to June 2025 were at 22.4%.

The FTSUG promotes the Trust's Dignity at Work policy, Trust Wellbeing offers, staff-side/union support and Employee Relations where staff require information and support around bullying and harassment matters as well as links to staff networks and the Equality, Diversity and Inclusion (EDI team).

3.5 **Inappropriate Attitudes and Behaviours concerns** represented 43.1% cases raised to the FTSUG from January to June 2025. This is an increase on the 29.7% of cases raised from July to December 2024. The NGO figure for this theme in 2023/24 was 38.5% (Summary of Speaking Up to FTSUGs: 2023/24).

3.6 **Worker Safety and Wellbeing concerns:** 70.5% of cases involved an element of worker safety and wellbeing in Q4 2024/25 and Q1 2025/26. This is a significant increase on the 48.8% of cases seen in July to December 2025. Nationally in 2023/24, the average for worker safety and wellbeing was 32.3%. (Summary of Speaking Up to FTSUGs: 2023/24). The FTSUG believes this increase is due to high numbers of staff reporting the impact of the speaking up issues on their wellbeing including absence of health issues.

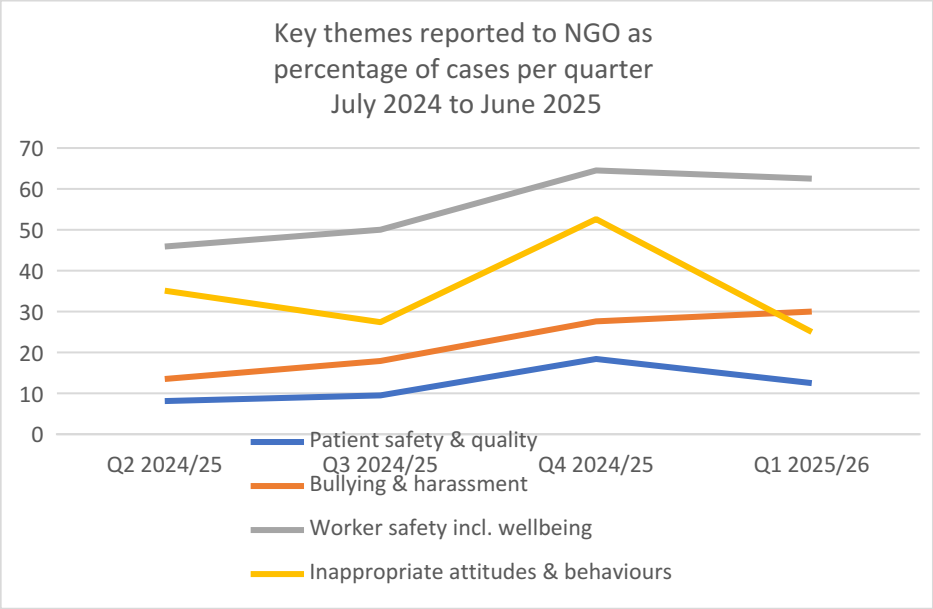
Figure 1 shows Bullying and Harassment, Inappropriate Attitudes and Behaviours, Patient Safety and Quality and Worker Safety and Wellbeing cases as percentage of number of cases per quarter as reported by the FTSUG to the NGO over the March 2024 to April 2025 period (12 months).

The FTSUG introduced reporting on the FTSU portal for questions relating to worker wellbeing and attendance in light of issues being spoken up about. Table 3 shows this information for Q4 2024/25 and Q1 2025/26.

Table 3: Percentage of workers experiencing wellbeing and attendance in relation to their FTSU case:

Issues reported around wellbeing and attendance in relation to their FTSU case:	Q4 2024/25	Q1 2025/26
Currently on sick leave	15.8%	22.5%
Has taken sick leave and now back at work	21%	47.50%
Considering taking sick leave	23.7%	45%
Experiencing work related stress (staff safety and wellbeing theme)	29%	60%
Had a stress risk assessment (as a percentage of those experiencing work related stress)	0%	4.2%
Had an Occupational Health referral	10.5%	32.5%

Figure 1

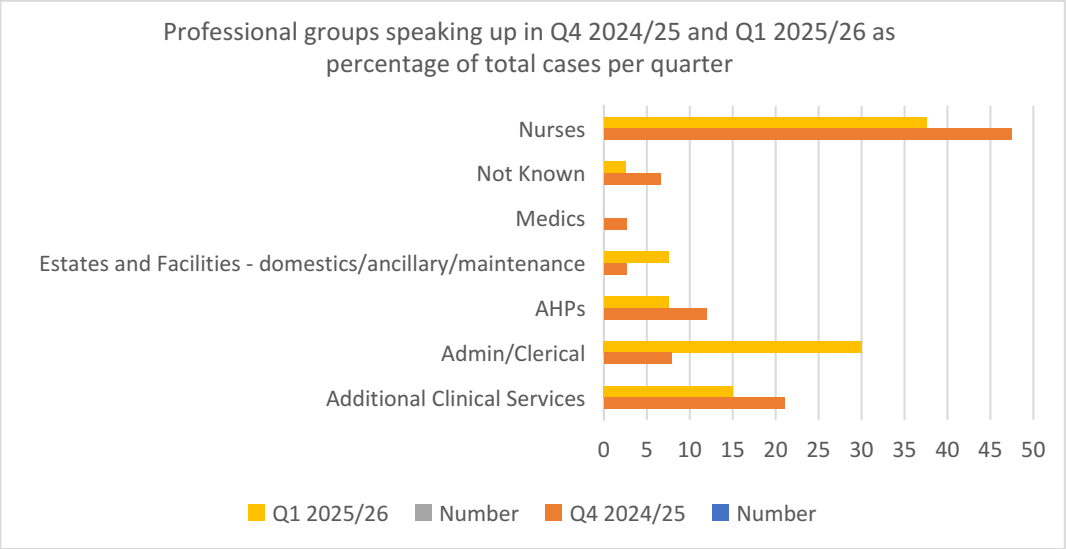


3.7 **Professional groups**: In Q4 2024/25 and Q1 2025/26, 44% of staff approaching the FTSUG were Nurses. This is an increase on Nurses approaching in Q2 and Q3 2024/25 at 33.8% of staff. It is also higher than the national average reported by the NGO at 28.3%. (Summary of Speaking Up to FTSUGs: 2023/24). Divisions were fairly equitable in terms of nurses reporting concerns. A third of the admin and clerical concerns reported in Q1 2025/26 came from one Division.

3.8 **Experiencing Detriment or Demeaning treatment:** In Q4 2024/25 and Q1 2025/26, 1.7% of workers reported that they had experienced a detriment or demeaning treatment as a result of speaking up. In Q2 and Q3 2024/25 this was 0.8%. NGO average for detriment in 2023/24 was 4% (Summary of Speaking Up to FTSUGs: 2023/24).

3.9 **Ethnicity of Workers:** From January to June 2025, 34.5% of colleagues speaking up identified as Black and Minority Ethnic (BME). This is an increase on Q2 and Q3 2024/25, where 25.6% of staff speaking up identified as BME. 18.95% of DHcFT staff are from BME communities (Equality and Diversity Dashboard June 2024).

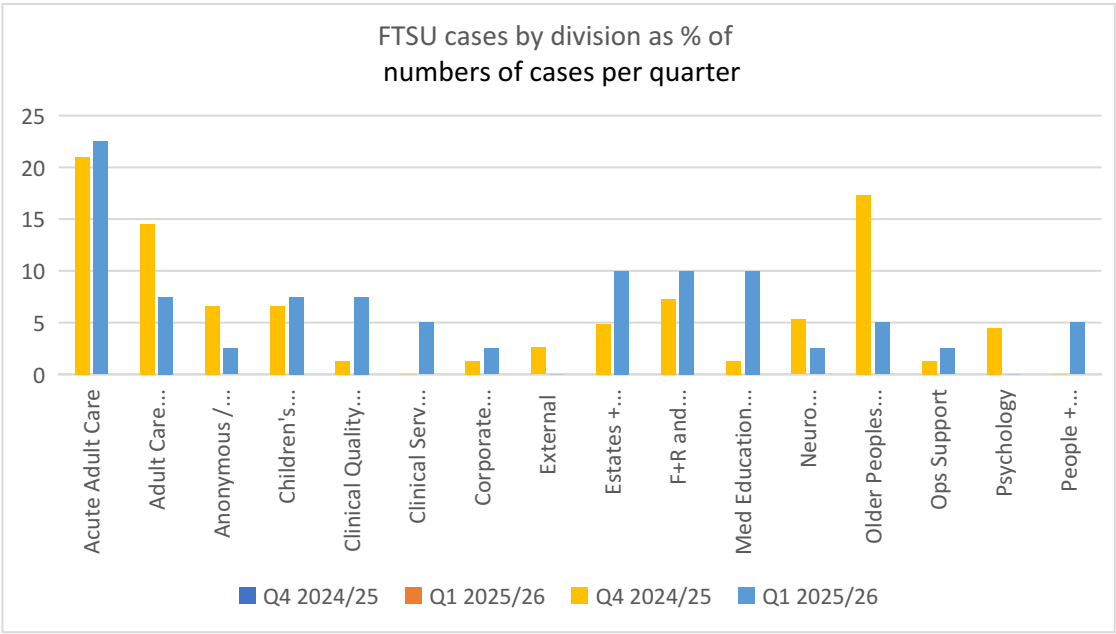
Figure 2: Professional groups speaking up in Q4 2024/25 and Q1 2025/26 as percentage of total cases per quarter



3.10 **Anonymous, Confidential or Open concerns:** Anonymous concerns were 5.2% of concerns. In Q2 and Q3 2024/25, anonymous concerns represented 5.8% of cases. This is lower than anonymous concerns reported nationally in 2023/24, which were 9.5% (Summary of Speaking Up to FTSUGs: 2023/24).

3.11 **Concerns raised by Division:** Figure 3 shows the number of cases from Divisions across the Trust. There are high numbers of concerns from Older Adults in Q4 2024/25 as a group of older adults staff spoke up at a drop-in regarding some concerns.

Figure 3: FTSU Case Numbers by Division as a percentage of total cases for Q1 2025/26 and Q4 2024/25



4. Emerging or ongoing themes with learning/action points Q1 2025/26 and Q4 2024/25

4.1 Bullying and harassment/Worker safety and wellbeing: Sexual Safety and Boundaries

A few staff have spoken to me about concerns related to sexual safety. The staff came from one Division. These concerns were escalated to senior leaders. One staff member was concerned about the lack of wellbeing and support for their concern and that of their colleague.

These concerns were referred to People services leads. Another worker disclosed their issues around possible sexual safety issues to the FTSUG. The workers concerns were escalated into to a formal Employee Relations process and the colleague has been directed to Resolve for support. This worker expressed concerns about being able to provide evidence to support their concerns and getting other staff to speak up as witnesses feeling that the 'closed style culture in this Division' would prevent this happening.

Learning and improvement

- A sexual safety working group has been set up. Staff attending include Employee Relations leads and colleagues, including Organisational Development lead, EDI lead, Psychology lead, Safeguarding leads/staff and the FTSUG
- The Trust, along with a large number of other NHS organisations, has signed up to the sexual safety charter
- The Trust has undertaken a self-audit against the national sexual safety framework and a report was recently prepared and submitted to the Trust-wide Delivery Group Executive Leadership Team and the Quality and Safeguarding Committee (September 2025)
- A sexual safety and boundaries training package is being developed for delivery to staff
- Divisions where there are a number of issues will receive bespoke training for staff
- The policy is currently being reviewed in line with the national policy. This will include sections on wellbeing support. The Trust has made contact with their EAP provider, and whilst they don't offer specific support, they will signpost staff to the most appropriate national wellbeing offers should they receive a call about sexual safety concerns
- The Employee Relations team will receive training on sexual safety in October 2025 and team-based reflective learning is being developed.

4.2 **Policy, process and procedure, patient experience, worker safety and wellbeing, health and safety**

Several staff approached the FTSUG regarding parking on site at our Kingsway site. This involved concerns about staff not being able to access parking when they needed to, irresponsible parking where emergency vehicle access was restricted and where staff were parking on verges/pavements and restricting safe movement of staff and patients. All concerns were escalated appropriately to senior leaders and health and safety leads.

Learning and improvement

- Parking issues have improved considerably with the opening of an overflow car park close to the Kedleston Unit and further spaces created outside the Carsington Unit
- Workers who park irresponsibly are receiving notices on their cars asking them to move their vehicle.

4.3 **Worker safety and wellbeing: Lived Experience Workers**

Some staff in Lived Experience roles spoke up to the FTSUG. There were concerns from these workers about their wellbeing within in Trust as well as broader concerns around lack of support structures surrounding all lived experience roles in the Trust. One worker had left their role as they did not feel supported in the area they were working in and it was adversely impacting on their mental health. They were able to recruit to another role in a different setting within the Trust, which does not directly make use of their Lived Experience skills. The other worker has entered into a formal process within the Trust, after a history of raising issues around lived experience working and a feeling that appropriate changes were not implemented. This worker indicated that the concern was shared by other colleagues in lived experience roles. This worker's safety and wellbeing concern around lived experience roles, has led to concerns that lived experience colleagues are at risk of serious mental health issues if appropriate action is not taken.

Learning and Improvement

- The development and implementation of a policy or guidance to support lived experience roles is taking place
- A review of wellbeing support structures surrounding each lived experience role, ensuring they are individualised to the persons needs may be required
- Ensuring that managers of lived experience roles are appropriately trained is also a recommendation
- An ongoing wider-Trust address of mental health stigma and discrimination, an understanding of legal obligations around reasonable adjustments and disability as well as greater understanding of psychological safety.

4.4 **Policy, process and procedure: Workers contacting ACAS**

During this reporting period, the FTSUG had six workers speak up about making contact with ACAS for further advice and guidance including around early conciliation. Early conciliation through ACAS is the initial step in trying to resolve workplace disputes without the need to make an Employment Tribunal claim. Some of these discussions were around disability discrimination. This is the first time the FTSUG has had so many workers discuss making contact with ACAS and also asking for direct support in ACAS meetings from the FTSUG. The FTSUG does not support with this and workers were directed to their union/staff-side if they were members.

Learning and improvement

- An informal discussion was held by the FTSUG with a People services lead regarding this information
- In the 2024-2025 period, ACAS dealt with over 117,951 individual early conciliation cases, a 13% increase from the previous year and the highest number since the COVID-19 pandemic. The majority of these cases, around nine out of 10, were resolved or made progress toward settlement, meaning only about one in 10 notifications led to an employment tribunal hearing. This suggests that nationally a greater number of staff are contacting ACAS.

4.5 **Bullying and harassment including racism/discrimination**

28.4% of cases raised to the FTSUG from January to June 2025 included an element of bullying and harassment this also includes reporting on discrimination including racism.

Reports of racism and discrimination from patients and to a lesser extent discrimination experienced by staff from staff is an ongoing theme and has been raised in previous reports to Board. For example, in this reporting quarter, those supporting bank and agency staff spoke up to the FTSUG about the racism that they believe agency and bank staff are experiencing in the Trust. Another colleague, a Nurse, directly emailed the FTSUG and Executive leaders about the racism they were experiencing in an acute setting from a patient and there were other similar reports.

Workers were signposted to unions/staff-side, if members, and to wellbeing support and Employee Relations for further information on support and escalating cases. Some workers will also seek support from the EDI team and/or the BME staff network. The FTSUG has also been part of a working group around racism at an acute unit.

Learning and improvement

- The Trust will be bringing in A Kind Life programme to support improvements in Trust culture and adhering to Trust values. A Kind Life works in partnership with the organisation to craft core values, purposeful behaviours and learning resources that will help cultivate positive workplace experiences. These solutions are tailored to produce lasting change. This programme will also include training around being an Active Bystander (September 2025) which will be delivered more widely in the future. There has also been a programme of online and face-to-face inclusion training for a range of acute based staff

- The EDI lead has a recently established Race Equality Working Group (REWG) which has been set up to lead, co-ordinate and monitor the delivery of the Trust's Race Equality Strategy; tackle racial disparities within the workforce and services; embed anti-racism as a core organisational principle; and lead on the development of a robust, Trust-wide response to racism experienced by staff from patients or the public
- The REWG will also lead, co-ordinate and monitor the delivery of the Trust's Race Equality Strategy; tackle racial disparities within the workforce and services and embed anti-racism as a core organisational principle.

5. Improving Speaking Up Culture

5.1 **Improving visibility and networking:** The FTSUG presents at monthly Trust Inductions and attends team meetings on request. The FTSUG holds regular face-to-face drop-ins in some acute settings including the Radbourne Unit and at Cubley Court. The FTSU is involved in listening events in specific areas of the Trust in relation to concerns.

5.2 **Supporting communities who face barriers to speaking up:** The FTSUG presents on FTSU to the north/south Resident Doctors group, to preceptees and students/trainees and to Healthcare Support Workers on the Trust's award-winning iCare programme.

5.3 **Triangulation of data and FTSU:** the FTSUG meets with senior leaders, including the Director and Deputy Director of People and Organisational Development and Inclusion, to discuss triangulation of data and the Chief Executive and Deputy Chief Executive. The FTSUG produces a report for the People and Culture Committee to support the triangulation of data from FTSU.

5.4 **Network of FTSU Champions:** The FTSUG holds monthly catch-up meetings with Speaking Up Champions to share good practice, support any speaking up matters and to share NGO information. Champions referred in 23% of concerns during January to June 2025. DHcFT currently has **42 FTSU Champions** who come from a range of Divisions across the Trust. Children's services and Adult Community Care have created their own network of Divisional champions and the FTSUG meets bi-monthly with the Children's services group. The recently updated FTSU Champions poster is available on Focus (staff intranet).

5.5 **Non-Executive Directors:** the FTSUG is supported by Geoff Lewins, Non-Executive Director (NED) lead for Speaking Up. The FTSUG holds monthly meetings with the NED to share FTSUG practice and areas for support and development.

6. Learning, Improvement and Development in relation to Speaking Up Culture within the Trust

6.1 **Evaluation feedback on Speaking Up:** An evaluation form for individuals who have spoken up is sent out following contact with the FTSUG using an online link. 74.3% (26 of 35 respondents) from January to June 2025 said 'yes' they would speak up again. These questions are suggested by the NGO.

6.2 **Derbyshire Integrated Care System (ICS):** the FTSUG meets monthly with other ICS FTSUGs to discuss system arrangements around FTSU.

6.3 **Speak Up e-learning training launch:** Speak Up e-learning training launched for all staff on 1 April 2024. Currently at 92% compliance across the organisation (August 2025). The FTSUG hopes to see Listen Up training for managers added to the mandatory e-learning in the near future or to provide the equivalent face-to-face training.

7. National Guardian's Office and related National Changes

7.1 The **National Guardian's Office (NGO)**: NHS England and the Department of Health and Social Care have confirmed that the Freedom to Speak Up Guardian role will remain part of NHS Standard Contract for 2026/27, providing certainty about the future of the guardian role.

The National Guardian's Office will be closed in 2026 and NHS England will take over responsibility for national support and guidance of guardians from 2026/27 onwards. Until then, the National Guardian's Office remains the primary point of contact and support for all guardians. The confirmation of the continuation of the role reinforces the essential role guardians play in developing safer, fairer, and more transparent healthcare systems throughout England. A **letter** was sent to all guardians on 13 August 2025.

8. Conclusion

8.1 Being free to speak up and psychological safety represent a significant cultural change across the NHS. Success is not only the responsibility of the FTSUG. It is important that the Trust continues to learn from concerns that workers raise and to build an environment where workers know their concerns, and feedback, are taken seriously and welcomed as an opportunity to guide service improvement and development.

8.2 The Board will continue to use the positive culture around speaking up to drive recommendations from the report forward and to deliver meaningful and visible responses to Trust-wide concerns.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 23 September 2025

Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) request for delegated authority

Purpose of Report

To update the Trust Board on progress with the work on the 2024/25 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) submissions.

To request Board delegated authority for the People and Culture Committee (PCC) meeting to approve the Action Plan Submissions for 31 October deadlines respectively.

Executive Summary

The WRES is a set of evidence-based indicators that compare the workplace experience of Black and Minority Ethnic (BME) staff and White staff. The WDES compares the workplace experience of Disabled and non-disabled staff.

NHS organisations must submit the WRES and WDES datasets to NHS England by 31 August 2025 and this year's submission has been made. The WRES and WDES dataset and corresponding action plan must then be agreed by the Board and published on the Trust's public-facing website by 31 October 2025. Finally, the completed reports must then be shared with commissioners as part of the quality schedule. As in previous years, delegated authority is requested due to the time tabling set by NHS England. From the submission and subsequent analysis of data to approval by the Board, too small a window remains in which to consult and co-create actions.

The proposed actions will be developed with representatives from the BME and Disability and Wellbeing Network (DAWN) staff networks and explicitly link to the Trust's values and strategic priorities.

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

Delivery against the action plans for the WRES and WDES is monitored by the Trust Delivery Group.

Consultation

We have commenced the process of engagement with Network Chairs and this will progress further as outlined in the paper in September to be published in October.

Governance or Legal Issues

- Reporting the WRES and WDES is a mandatory requirement of the NHS Standard Contract. The Trust is required to submit the WRES and WDES datasets to NHS England by 31 August 2025. This has been completed
- The WRES and WDES dataset and action plan must be published on the Trust's external website by 31 October 2025
- Undertaking the WRES and WDES demonstrates the Trust's commitment to the Equality Act 2010 and the Public Sector Equality Duty.

Aligning with national EDI (Equality, Diversity and Inclusion) programmes of work

The WRES and WDES are key measures in the Trust's data monitoring for workforce equality. Each Standard is comprised of data from the Staff Survey and ESR (Electronic Staff Record). The veracity of each Standard rests, to some extent, on the data quality and completion rates in ESR and the staff survey.

The WRES and WDES, alongside other metrics, will also drive improvements and reduce race and disability disparity patients and their care, as it encourages the development of a more diverse, empowered, and valued workforce, and a better understanding of race and disability equality across the Trust's workforce and that of the NHS nationally.

Recommendations

The Board of Directors is requested to give delegated authority to the People and Culture Committee to approve the 2024/25 WRES and WDES action plans.

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

Report prepared by: **Rebecca Oakley**
Director of People, Organisational Development and Inclusion

Board Committee Assurance Summary Reports to Trust Board – 23 September 2025

The following summaries cover the meetings that have been held since the last public Board meeting held on 22 July 2025 and are received for information.

- Audit and Risk Committee 24 July
- Finance and Performance Committee 9 September
- Quality and Safeguarding Committee 10 September
- Mental Health Act Committee 11 September
- People and Culture Committee 16 September

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

Audit and Risk Committee – key assurance levels agreed – 24 July 2025	
	Review of Board Assurance Framework (BAF) Issue 2.2, 2025/26 The cyber risk will remain on the BAF, due to the evolving nature of the threat worldwide. A holding risk was to be added to the BAF awaiting further specifics in relation to the closure of Commissioning Service Units and other key organisations listed in the Dash review. It was agreed to ensure the funding risk related to Assertive Outreach funding was added to the BAF. as well as increased transparency around the Trust's over-delivery of services compared to the level contracted. The review process received **significant assurance** and the Committee approved this version of the BAF.
	Operational Risk Management The Committee accepted **significant assurance** on the risk management process, noting the total number of recorded risks and overdue assessments. **Limited assurance** was accepted in relation to overall compliance for risk reviews. The main issues were summarised and it was agreed the relevant areas would be escalated to Executive Leads.
	Prescribing Valproate update The Medical Director presented the action plan, which included identifying patients on valproate and ensuring compliance with Medical and Healthcare products Regulatory Agency (MHRA) regulations. The plan involved reviewing patients during clinic visits and implementing a paper-based risk acknowledgment form. The Committee to continue monitoring progress against the actions.
	Data Security and Protection (DSP) report The DSP Toolkit had been completed and had received a positive audit report. The Trust had achieved high levels of compliance, ensuring that staff were aware of data security protocols and best practices.

	Measures to help mitigate the risk of data breaches and ensure compliance with regulatory requirements included regular reviews of relevant policies and procedures and the use of technology to monitor and protect sensitive information. Receiving **significant assurance**, the Committee congratulated the DSP group for the excellent performance over the last year.
	Data Quality update – Operational Indicators Data Validation report The Committee received the six-monthly report on data quality. Discussions included the complexities of SystmOne and the importance of following standard operating procedures to ensure accurate and reliable data, along with the need for regular training for clinicians to ensure they are familiar with the latest procedures and best practices. The Trust regularly reviews mobile 'phone ownership and use which had led to cost-savings by ensuring the most efficient allocation and use. The Committee accepted **significant assurance** from the work that had been undertaken to ensure good quality data was maintained.
	Conflicts of Interest and Declarations of Interest update The Committee noted the continued return rates for most areas of declarations and received **significant assurance** that the requirement to make declarations was embedded into Trust processes. There is a '£25 or over' declaration threshold and an opportunity to promote the charity to benefit from cash gifts. Additional safeguards are being implemented, including a cross-referencing exercise of the Trust's declarations with declarations of sponsorship by pharmaceutical companies and checks against Companies House data.
	Waiver of Standing Financial Instructions (SFIs) Register The Committee received the waiver log for 2024/25, noting that the majority of waivers were related to Estates and Capital projects, with many linked to the Making Room for Dignity programme. The Committee was **significantly assured** that Tendering and Contracting processes were conducted in accordance with the Trust's Standing Financial Instructions and any waivers and non-competitive quotations are logged and reviewed.
	Standing Financial Instructions (SFIs) – Review of Changes The Committee reviewed the SFIs and agreed the proposed changes ahead of ratification at Trust Board.
	Internal Audit progress Attention was drawn to the last few reports from the 2024/25 Internal Audit Plan: • Payroll (moderate assurance) • Quality Governance (moderate assurance) • Ligatures (significant assurance) • Derby and Derbyshire Integrated Care System - MSK Community triage and service provision. It was noted that good progress continued in relation to the 2025/26 Plan and that the final report for the Data Security and Protection Toolkit had been issued, with a good result for the Trust.
	Counter Fraud progress The key points raised included: <u>Fraud Awareness and Training</u> Following the working whilst sick exercise completed in 2024/25, the Counter Fraud Specialist (CFS) had issued an article to raise awareness for the Trust's Communications team, including the definition of fraud, what working whilst sick fraud entailed and a link to a training video.

	It was noted the e-learning module, 'counter fraud for finance staff' had been added to the Trust's suite for relevant staff to complete as part of their mandatory training.
	External Audit progress The external auditor confirmed that the audit was finalised and the Head of Internal Audit Opinion issued. The value for money work would be presented to the Council of Governors later in the year. It was noted that the audit certificate remained outstanding and that instructions from the National Audit Office were awaited.
	External Audit Key Performance Indicators (KPIs) The external audit KPIs were summarised, confirming that reporting deadlines had been met.
	Clinical Audit 2024/25 annual report and 2025/26 Clinical Audit Plan It was reported that the overall completion rate for Clinical Audits was 50% but the Trust's prioritisation had been to focus on audits that would have the greatest impact on quality rather than the number completed. Following consideration, the Committee received **limited assurance** from the evidence provided noting the ongoing actions being taken to improve processes and outcomes.
	Claims Handling Policy and Procedures As part of its three-yearly cycle, the Committee noted the amendments and ratified the Policy.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework:** None. **Next scheduled meeting:** 23 October 2025.
Committee Chair: Geoff Lewins	**Executive Leads: Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary and James Sabin, Director of Finance**
Finance and Performance Committee – key assurance levels for items – 9 September 2025	
	Making Room for Dignity (MRfD) programme update Programme progressing across Bluebell Ward, Derwent Unit, Carsington Unit, Kingfisher House and Audrey House; remaining issues being actively managed (e.g. building control certification, heating issues, infrastructure incidents). Two incidents at Psychiatric Intensive Care Unit (PICU) resulted in no patient harm; below standard workmanship identified and rectified at contractor's expense; ongoing robustness review and contractual remediation. Transition to business-as-usual in train with scaled-back programme governance, post-project evaluations and benefits realisation reporting being compiled and scheduled via governance prior to formal submission to NHS England (NHSE). **Significant Assurance** was agreed.
	Assurance on delivery of Digital Plan – DEFERRED
	Estates Plan The Estates Plan is integrated into the Strategic Portfolio Oversight Group. The Committee received an update on progress on property management, accommodation policy, partnership working and backlog surveys. Decarbonisation planning is underway; smart monitoring used for utilisation optimisation; resourcing constraints were noted. Support is needed to enhance the look and stye of the plan (similar to the Quality Delivery Plan) before final submission to the intranet, however the content was supported. **Significant Assurance** was agreed on the Estates Plan.

	Green Plan The Trust's Green Plan comprises of workstreams (workforce; sustainable care models; digital; travel; estates; supply chain; waste), with leads allocated and annual updates planned. The resource constraint was acknowledged (c.2 days/week dedicated at present); dashboards and reporting are being developed with benchmarking learning from neighbouring trusts. The Green Plan feeds into the wider-System plan. Minor tweaks required before formal publishing. It was also noted that a decarbonisation survey is in progress to support strategic plan and access to national funding; new builds decarbonised with focus now on remainder of estate. The Committee will continue to receive routine updates. **Significant Assurance** was agreed on the Green Plan.
	Financial Governance and Performance – Month 4 Finance Report The year-to-date deficit of £1.7m at Month 4 was noted; this is aligned to plan; with a forecast break-even by year-end; strong cash; no immediate concerns on debts/contractual disputes. Efficiency cost improvement programme (CIP) delivery £4.1m to date against £14.8m full-year plan; agency and bank expenditure under plan due to reduced reliance, recruitment, and departure of a high-cost patient. Pharmacy overspend primarily driven by drug cost inflation/market pressures; central inflation funding adjustments expected; accountability for drug spend to being devolved to clinicians. Out-of-area placements remain a key financial risk; focus on reducing clinically ready for discharge patients and partnership work to address delays. **Significant Assurance** was agreed on the update against the plan.
	Procurement update The Committee noted the team changes include recruitment of deputy head; the small team delivered £246k savings (telecoms and transport contracts); strengthened spending controls and stakeholder engagement. A centralised contract database is being embedded; all contracts reviewed for compliance with the new Procurement Act; transition plan aligned to contract expiries; no major compliance issues have been identified. Priorities were outlined as: full implementation of contract management system; Oracle optimisation; "no purchase order, no pay" rollout; embedding sustainability and social value into contracts; system collaboration increasing (eg exploring VAT savings via consolidated IT contracts with Deloitte). It was recognised that the Trust is at the start of an improvement journey with confidence that continued progress will be seen. Continue with six-monthly progress updates. **Significant Assurance** was agreed on the update.
	National Cost Collection Submission – post-submission report The return has been submitted; areas of non-compliance include up-to-date electronic job plans for medical consultants and accurate estate utilisation data. (limited progress from last year). This is a recognised area of national interest and focus and more progress now underway. A Data Quality Group is being established to drive improvements with reporting lines through Audit and Risk Committee and Clinical Digital Strategy Group; governance being reviewed for comprehensive coverage. No concerns.
	Operational Performance Report The Committee received an update on the high-performing areas: perinatal access; eating disorder referrals and treatment waits; 72-hour post-discharge follow-up; dementia diagnosis; autism spectrum disorder (ASD) assessments completed per month; individual placement support; Children and Young People (CYP) eating disorder services. Key challenges: inappropriate out-of-area placements (target zero; currently two); inpatient length of stay; 52+ week community waits; CYP mental health access; crisis response times; long ASD waiting lists despite activity above commissioned levels.

	ASD assessments: Trust delivering 50–60/month vs 26 commissioned; additional activity currently unpaid; funding discussions ongoing with Integrated Care Board (ICB), including backlog clearance options. Flow and discharge: weekly multi-agency reviews of clinically ready for discharge patients; delays often due to procurement of appropriate care placements, particularly for older adults. Reporting: commitment to enhance narrative in future reports with focused thematic analysis of key changes, sticking points and system factors. Given challenges highlighted and overall increased focus regarding the Trust's National Oversight Framework (NOF) rating, **limited Assurance** was agreed overall. Although not material, data quality issues still present an ongoing area of focus.
	Arden & Gem Commissioning Support Units (CSU) update The Trust relies on Arden & GEM CSU for technical support, data and cybersecurity; CSUs are being closed under the 10 Year Plan proposals. Four options for affected services were outlined: in-house, via Chesterfield; await rebranded offer or seek a new provider. "Wait and watch" noted as least risky at present. Annual CSU spend is circa £3m; the Trust needs to understand contract value and efficiency; and consider economies of scale/hosting; the procurement rules and TUPE challenges were highlighted. In terms of next steps: maintain watching brief; provide regular updates; clarify decision timelines and procurement requirements given system-wide impact. **Limited assurance** was agreed, given the uncertain future of this service provision. However, the Committee was assured regarding internal engagement, management and planning.
	Mental Health Services Assessment Tool (Men-SAT) report A System-wide review has generated eight recommendations for Derbyshire Healthcare and partners (strategic alignment; enabling roles for ICB; improved crisis assessment co-location; enhanced mental health helpline operations). Opportunities: optimise crisis alternatives; address ADHD and eating disorder service gaps; improve data intelligence; lack of Children and Adolescent Mental Health services (CAMHS) beds in Derbyshire noted; System-wide workforce planning required. Review largely confirmed known issues but provided shared reference point and action plan; Derbyshire Healthcare to lead some initiatives; ICB to provide System leadership during organisational change.
	System updates: ICB Finance Committee/System Directors of Finance The risk of loss of deficit support due to off-plan performance in the acute sector was noted; some acute trusts may face cash pressures by Christmas; NHS England expects alignment between CIP delivery and cash management. Early arrival of draft planning guidance implies earlier focus on 2026/27 planning and transformation; prioritisation of challenging efficiency schemes and adequate delivery resourcing required.
	Emergency Incident Response Plan and Procedures – DEFERRED
	Board Assurance Framework (BAF) 2025/26 risks overview (and consider forward plan of deep dives) Based on discussions above, the proposed areas to consider for BAF emphasis/Corporate Risk updates: • Digital services transition risk (Arden & GEM dependency, procurement/TUPE) • Estates build quality and contractor performance risk (MRfD defects/incidents) • Operational performance risks (Out of area placements (OAPs; 52+ week waits; crisis response) • Financial sustainability risks (recurring CIP pipeline; pharmacy inflation exposure) • Data quality/compliance risks (job planning; estates utilisation; NCC) • Green Plan delivery risk (resource and funding for decarbonisation).

Any other business - Strengthening Financial Management and supporting Delivery in 2025/26

The Committee emphasised focus on recurring CIPs, transparent reporting of delivery and risks, and earlier planning for 2026/27 to underpin medium-term sustainability.

Escalations to Board or other Committees:

- System financial risk: potential loss of deficit support and acute trust cash pressures—note System-wide implications and alignment expectations from NHSE
- Digital services transition: dependency on Arden & GEM CSU and forthcoming decision points—potential procurement/TUPE and cybersecurity continuity risks
- Operational pressure: out-of-area placements and long waits (ASD/52-week waits) with funding gap vs commissioned activity—ICB engagement required.

Items added to the Board Assurance Framework: as listed above.

Agreed Actions:

1. Psychiatric Intensive Care Unit (PICU) robustness review - outcomes and any additional actions following incidents to be reported to a future meeting. (Action: Andy Harrison)
2. Share six-facet survey results, including disability access audits, with the relevant committee once received. (Action: Andy Donoghue; Sponsor: James Sabin)
3. Analyse and report on the cause of the significant reduction in out-of-area placements around January/February prior to unit opening. (Action: Louise Braham)
4. Enhance future Operational Performance Reports with a focused narrative on top two to three changes, progress and sticking points per period. (Action: Louise Braham)
5. Maintain a watching brief on Arden & GEM CSU transition and provide regular update, setting out key decision deadlines and procurement implications at the next meeting. (Action: Alex Rose, Arun Chidambaram).

Next scheduled meeting: 4 November 2025.

Committee Chair: Jo Hanley	**Executive Lead: James Sabin, Director of Finance**

Quality and Safeguarding Committee – key assurance levels for items – 10 September 2025

Director of Nursing update

Learning from external inspections it was reported that the team has been tracking governance and quality assurance from other organisations, focussing on patient experience, timely responses and safeguarding to enable the transfer of learning into the organisation.

Delivery of Same Sex Accommodation the Committee noted the challenges encountered around transgender patients as the policy remained inadequate due to lack of NHS national guidance, which is expected by the year end. Legal advice has been sought and risk evaluation meetings are being held for each case.

Patient Experience and Patient Safety teams due to ongoing staffing issues, there has been reliance on bank workers and there is a backlog of complaint responses. It was noted that short-term mitigations are in place.

East Midlands Alliance (EMA) Perinatal Mental Health Provider Collaborative

There were no current quality concerns raised.

The Committee noted that learning events had continued with strong engagement, and admissions and bed days remained consistent, with no out-of-area patients from the East Midlands in quarter 1.

Significant assurance was received on the quality and safety of services provided.

Policy Review

The Committee ratified the ‘Right Care, Right Person System Policy’. It was noted that welfare concern calls would be triaged by East Midlands Ambulance Service (EMAS) and a pilot for a mental health practitioner in the police control room was proposed.

Fundamental Standards of Care

The Committee accepted **significant assurance** that the action plan for Working Age Adult Acute wards had been fully assured at operational and governance levels, with final executive sign-off pending.

CQC Mental Health Act inspections of Bluebell and Oak wards were positive, with minor actions underway. The CQC Core inspection at Keddleston Unit inspection had received positive informal feedback and the final report was awaited. An action plan will then be created to monitor and improve compliance in some of the areas that had been picked up, for example, Supervision and Appraisal compliance.

Limited assurance was accepted around the regulatory inspections and Fundamental Standards of Care compliance

Quality Dashboard

Monitoring a rise in seclusions and restraints following the opening of new buildings was reported, with a clinical support group formed to address sustained acuity.

Absconding incidents had shifted in nature to those not returning on time from leave, and medication incidents relating to administration were under review with Pharmacy and Nursing leads.

The Committee noted that sexual safety incidents had decreased. The situation would need to be closely monitored in light of transgender patient placements.

It was highlighted that venous thromboembolism (VTE) risk assessment compliance remained at around 80%, with ongoing efforts to improve recording and ensure assessments are completed by medics. Data quality issues were being addressed through training and cross-checks.

Progress towards clinical performance targets received **limited assurance**.

Patient Safety report

The Committee accepted **limited assurance** and noted that the Trust had launched a comprehensive suicide prevention training package, with plans to report compliance figures once all modules are live. Thematic analyses of falls and inpatient suicides are ongoing.

Safeguarding Children and Adults at Risk annual report

Significant assurance was received from the report regarding the fulfilment of legal and statutory duties.

It was noted that Safeguarding teams for adults and children are fully staffed except for a named doctor for children, with temporary arrangements in place.

The Trust had received significant assurance from external safeguarding boards and the ICB, with only the substantive appointment of the named doctor role outstanding. Engagement with Multi Agency Public Protection Agency (MAPPA) and Prevent continues, and objectives for the coming year are aligned with the Trust Strategy.

Children in Care annual report

Noting work within the Trust and continued partnership working to ensure the best outcome for this vulnerable group, the Committee accepted **significant assurance**.

The paper highlighted the number of children in care in Derby remains stable compared to national trends, with foster placements being the most common. Ethnicity data was representative, though challenges exist in categorising unaccompanied asylum seeker children.

The emergence of online harms as a safeguarding risk, particularly for young people was discussed and the Committee noted ongoing work to address social media-related risks and to ensure staff supervision in Safeguarding teams.

Sexual Safety report

The Committee accepted **significant assurance** that the Trust has met the requirements of the Sexual Safety Charter and work is continuing to ensure full embedment.

	It was reported that the Trust had seen a reduction in staff-to-staff and staff-to-patient sexual safety incidents, attributed to induction training, campaigns and strong action on professional standards. All incidents are reported to the police, and a dedicated group oversees policy and governance.
	Medicines and Pharmacy Annual Report It was noted that no issues for alert had been identified and a medical action plan for valproate was under development. The Committee agreed to continue supporting the value and role of the Medicine Management Committee and subcommittees at reviewing and taking appropriate action around medicine safety and governance within the Trust.
	Clinical Audit update The Committee noted the progress made to implement policy and consider the evidence provided on the effectiveness of Clinical Audit systems and outcomes. It was reported that most audits are now conducted by Quality Improvement (QI) trained staff, with a focus on system-based actions for sustainability. **Limited assurance** was received due to inconsistent application of otherwise sound design controls.
	National Institute for Health and Care Excellence (NICE) Guidance Compliance The report highlighted that NICE guidance is embedded in the Trust's Quality Delivery Plan and audit processes, forming part of continuous quality monitoring. It was noted that three NICE guidelines had been updated with changes in practice and four non-NICE national guidance documents reviewed, covering areas such as suicide prevention and dementia in people with intellectual disabilities. The Committee accepted **limited assurance** around the integration of NICE into usual practice.
	Strategic Portfolio Oversight Group update It was highlighted that the Group had achieved the planned objectives for the first quarter, particularly with publication of the Quality Delivery Plan. However, it was cautioned that future quarters would be more challenging due to ambitious targets and capacity constraints. Assurance is provided through regular updates to the Board.
	Care Planning/Person-Centred Care The sustained improvements in Adult Acute Care planning compliance were highlighted. However, it was noted that challenges persist in Perinatal and Specialist services due to vacancies and data capture issues. It was proposed to close the current time-bound improvement plan and move to targeted support given this was the effective method which has achieved improvements. Monthly reporting for non-compliant areas will remain. The need for strong medical leadership and ownership of data at Divisional levels was emphasised. The Committee noted the contents of the report and accepted **limited assurance** on progress against actions.
	Learning from Deaths/Mortality report The report set out the action taken to address risks identified from learning, such as strengthening ligature risk audits and improving communication with acute hospitals. **Limited assurance** was accepted of the Trust's approach to learning from deaths.
	Suicide and Self-Harm Prevention Strategy The Committee noted the updated document which reflects best practice guidance within mental health and incorporates local learning through patient safety workstreams. Importantly the strategy is aligned with Deby & Derbyshire work and sets out the 8 priorities for achievement between now and 2028.

Escalations to Board or other Committees: None.

Items added to the Board Assurance Framework: None.

Next scheduled meeting: 8 October 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 – 11 September 2025

MHA Operational Group

The Committee receives updates from the Mental Health Act Operational Group. Future meetings of the Operational Group will have General Manager representation.

MHA Managers Report

The MHA Quarterly Report covering MHA Office activity from 1 April to 30 June 2025 was considered. Points of note included:

- Compliance data on the reading of Section 132 rights has improved in some of the acute inpatient areas following escalation and focus. An Operational Manager is supporting improvements, a dashboard has been developed and data integrity is being monitored, other services areas were still underperforming and although the Committee was more assured of the direction of travel, improvements still need to be made
- Audit results on Section 62 urgent treatment requests highlighted that requests for Second Opinion Appointed Doctors were routinely being requested later than desirable and the issue continues to be monitored
- It was noted that advocacy support for Derby City patients would improve now another Independent Mental Health Advocate had been appointed.

Limited assurance was agreed due to the underperformance in a number of areas.

Mental Health Act Mandatory Training Report

The Committee noted an improved compliance.

Significant assurance was agreed based on the improved compliance and meeting of training targets.

Report on Complaints from Patients, detained under the Mental Health Act

The Committee received a report on complaints from patients who are detained under the Mental Health Act. At present, there is no discernible trend from complaints and concerns regarding patients on a Section, when broken down by ward due to low numbers. The expectation, as the data builds up over time. Will be to identify trends, and therefore, actions, can be created.

The Committee noted the complaints categories recorded and agreed **significant assurance** that all complaints are investigated on an individual level for learning and best practice.

Report of Use of Section 136 Suites

The latest data on the use of Section 136 suites was presented, showing an increase in use that had been expected due to the opening of the new 136 suites. The new units have been successfully recruited to and patient feedback has been good. Physical healthcare checks for persons detained on a Section136 had also improved. A Joint Risk Assessment Handover Tool has been developed and is now part of process and policy to support the decision and management of risk for Police to safely handover to our services.

Significant assurance was agreed on the processes for use of the 136 suites.

Restrictive Practice Quality Report

The report showed progress in key areas of observation compliance, training, and the management of restrictive practices. The transition to new hospital environments is yielding positive outcomes, particularly in digital performance and ward safety. The importance of targeted actions to address

inconsistencies was discussed. Following the opening of the Derwent and Carsington units from May 2025, the Trust Blanket Restriction and Locked Door policies have been updated to reflect the implementation of controlled access to all inpatient wards and hospital front doors.

Limited assurance was agreed based on areas of underperformance for recording and training.

Mental Health (MH) Bill

The Committee received the outline governance structure that will be used within the Trust to implement the MH Bill. A working group will oversee the implementation plan.

Policy Review

The Committee approved the following policies:

- Mental Health Tribunal Policy and Procedures
- Associate Hospital Managers Policy
- Delegated Scheme of Authority Policy amends (related to the 360 Audit).

Escalations to Board or other Committees: None.

Items added to the Board Assurance Framework: None.

Next scheduled meeting: 18 December 2025.

Committee Chair: Deborah Good	**Executive Lead: Arun Chidambaram, Medical Director**

People and Culture Committee – key assurance levels agreed – 16 September 2025

People and Inclusion Assurance Dashboard

The Committee reviewed current performance. The main points were:

Mandatory Training: improvements in mandatory and role-specific training compliance were reported, along with new processes for managing the number of colleagues that did not attend (DNAs), including closer engagement with operational colleagues and the Training and Education Group.

Recruitment: the Committee discussed the ongoing recruitment delays, the impact of the Vacancy Control Panel process and actions to support those staff affected by recent UK visa changes. The need for improved onboarding and retention of newly qualified staff and Healthcare Support Workers was highlighted. It was agreed that a deep dive would be undertaken to address strategic and operational challenges.

Agency and Bank Staffing: the ongoing use of agency staff for Healthcare Support Workers emphasised the need for improved recruitment and management of bank staff. It was noted that the issue had been escalated to the Temporary Staffing team.

Supervision and Appraisal Compliance: disappointment was expressed at the lack of improvement and the Committee was informed of increased scrutiny around Clinical Supervision, with monthly reporting to the Executive team, along with focus on those teams below 75% compliance. Attention was drawn to the importance of leadership accountability.

Significant assurance was accepted on progress shown for Mandatory Training, Staff Turnover, Vacancies and Recruitment, Temporary Staff Usage and Freedom to Speak Up and **limited assurance** on Attendance and Absence, Clinical Supervision and annual Appraisals.

Making Room for Dignity (MRfD) Programme update

Limited assurance was received on actions and progress around recruitment.

The Committee was advised that safe staffing levels had been met overall, with ongoing challenges with Healthcare Support Workers. A new programme to reset the recruitment offer was described. This included a review of bank staff engagement, career progression and piloting AI-driven rostering solutions to fill gaps.

It was noted that a transition from manual to digital reporting for Model of Care training would align with ESR and improve accuracy.

	The need for clearer assurance on the cultural transformation was discussed, suggesting integration of the Organisational Development, Model of Care and Culture of Care programmes, with plans to triangulate measures for future reporting.
	People Plan The Committee reviewed the draft People Plan and gave feedback on ambition and clarity of priorities. It was agreed to emphasis the Equality, Diversity and Inclusion (EDI) and digital elements, with suggestions to focus on measurable outcomes and strategic partnerships. It was further agreed that the plan would be resubmitted in November, following review.
	System Developments – verbal update Cluster Model: the move to cluster model meetings was described, noting the differences in approach and the need for clarity on future collaboration. Executive Co-ordination: it was noted that there had been no direct contact around strategy or planning across the broader cluster and no formal announcement about the new Chief Executive, which highlighted ongoing uncertainty and the need for joined-up executive communication.
	Deep Dive – Employee Relations The successful transition of the Employee Relations team was reported, along with ongoing team development sessions and positive feedback from staff about feeling valued and supported. The Committee noted the positive impacts for the Trust, which included • Reduced length of ongoing cases • Closure of long-standing cases • Introduction of key performance indicators (KPIs) for Terms of Reference and case progression • Escalation processes for KPI breaches • New training for managers and Bank Investigators • Radical review of key policies to reflect the desired organisational culture.
	Workforce Plan – 2025/26 The expanded Workforce Plan was outlined, highlighting alignment with finance and the inclusion of national priorities. The need for more granular, Divisional-level planning and to improve operational ownership and live updates was emphasised. The Committee agreed to revisit the Workforce Plan in six months, following implementation of the new operating model, to provide assurance on Divisional engagement and progress towards strategic workforce objectives.
	Staff Survey 2025 – Trust and Divisional actions The Committee received a comprehensive update on the action plans, which highlighted strong Divisional engagement. A presentation on the Perinatal team's approach to staff engagement was well received and included high survey completion rates, monthly accountability for action plans, leadership philosophy, team building, and innovative practices such as the 'three hat challenge' and Wellbeing Champions. Opportunities to share the good practice across the Trust were discussed.
	A Kind Life programme update The three components of the programme, which had a phased launch planned in November, were described: • Respective resolution • Active Bystander training • Facilitated conversations It was noted that the programme supports early intervention in Employee Relations cases, aligns with policy changes and expands the pool of staff to facilitate informal resolutions.

	The Committee agreed the programme provided **significant assurance** as an enabler for cultural change, with plans to monitor its impact and ensure staff-side engagement.
	Equality, Diversity and Inclusion (EDI) Plan and Priorities update and Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports and action plans Progress on the EDI agenda was discussed, including the relaunch of the BME staff network, development of the anti-racism statement, and the integration of WRES and WDES action plans with input from staff networks and alignment with the Cox case recommendations. It was noted that the Race Equality Strategy and action plan, co-developed with the BME network, was scheduled to be launched alongside the Board's Anti-Racist Statement. It was agreed that the WRES and WDES reports and action plans should be refined due to the importance of engaging staff networks with implementation and ensuring intersectionality with other protected characteristics. The good work in progress was acknowledged.
	Policy Status Dashboard The Committee noted that the Volunteer Programme Policy and Procedure (including Approved Visitors, Celebrities and VIPs) as being resurrected, following previous lapses due to staff changes. Alignment with patient experience and lived experience worker policies was to be considered..
	Review of People and Culture Committee Board Assurance Framework (BAF) Risks Further to the discussions around the Workforce Plan, consideration was given to the amending the current risk assessment rating from amber to red. However, it was noted that the Trust has a good grip of its workforce which was recognised across the System. Due to the imminent changes of the new operating model, it was agreed to revisit the rating in six months' time.
	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:** 6 November 2025.
Committee Chair: Ralph Knibbs	**Executive Lead: Rebecca Oakley, Director of People, Organisational Development and Inclusion**

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 23 September 2025

Safer Staffing annual report

Purpose of Report

To provide a statement to the Board on the required skill mix and provide assurance to the on the work being undertaken to monitor and develop the skill mix of staff across the Trust to ensure safe services.

Executive Summary

This annual review outlines Trust progress and challenges in maintaining safe staffing across Inpatient services, aligned with the National Quality Board (NQB) safe staffing guidance and the NHS Long Term Workforce Plan's priorities: Train, Retain, and Reform.

Key Highlights

Strategic Workforce Alignment

The Trust continues to embed the NHS Workforce Plan by:

- Expanding education and training opportunities
- Strengthening retention strategies
- Reforming team structures and embracing new roles to boost productivity.

Safer Staffing and Establishment Review

- Staffing models follow enhanced ratios beyond national guidelines, accounting for ward acuity and absence headroom
- An evidence-based Establishment Review Framework is in place and full implementation of the Mental Health Optimal Staffing Tool (MHOST) is expected by September 2025
- Staffing ratios are reviewed and updated to reflect service needs, including the removal of environmental zonal observations in new facilities (Derwent and Carsington Units).

Staffing Levels and average Fill Rates

- Qualified staff fill rates are consistently around 94–116% during the day but drop to 83–97% at night
- Non-registered staff fill rates significantly exceed norms—ranging from 153% to 180% - primarily due to observation needs on female wards
- Monthly e-roster governance checks introduced in March 2025 aim to reduce overstaffing while maintaining safety.

Sickness and Absenteeism

- Adult Acute Division sickness rate: 6.72%, above the NHS average of 5.3%
- Causes include stress, respiratory and gastrointestinal illnesses
- Mitigations include excess hours worked by staff, which may impact wellbeing and increase fatigue risks.

Vacancy and Workforce Position

- Overall vacancy rate: 11.19% (↑), with Registered Nurses at 0.07% (↓) and Healthcare Support Staff at 26.78% (↑)
- High vacancy rates in Band 3 (unregistered staff) roles linked to service expansion and the "Making Room for Dignity" (MRfD) programme
- Establishment data collection and vacancy tracking continues via financial budget comparisons.

Temporary Staffing and Agency Use

- Agency usage fell by 12% in Adult Acute but rose in Children's services (+30%) and Adult Community (+16%)
- 87–91% of requested shifts are filled, with improved Bank fill rates and declining agency use
- A monthly governance group oversees agency use and promotes quality assurance and cost control.

Recruitment and Retention

- Trust leaver rates for Registered Nurses (4.2%) and Medics (5.3%) are better than regional averages
- Allied Health Professionals leaver rate (6.5%) remains above peers
- Key retention risks: retirement, relocation, pay and work-life balance.

Next Steps

- Full rollout of the MHOST tool and establishment review panels by September 2025
- Continued reduction in non-essential agency staffing
- Further investment in unregistered workforce and sustainable recruitment models
- Ongoing monitoring of roster efficiency and staff wellbeing to safeguard service quality.

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 report provides evidence of progress and assurance that we are working towards our aspiration to ensure that we have the right staff in the right place at the right time
- The Trust sits above national benchmarking figures linked to staffing levels and shows a lower percentage of vacancies and turnover of staff compared to national and regional benchmarks
- In the redesign of services, ward size reductions and changes in environments, a full review of skill mix has been undertaken to re-evaluate the clinical risks to meet required standards.

Consultation

- Head of Nursing team
- Director of Nursing, AHPs, Quality and Patient Experience
- Lead Allied Health Professional
- Deputy Director of Nursing
- Managing Director Acute Services
- Quality and Safeguarding Committee.

Governance or Legal Issues

- Outcome 4 (Regulation 9 Care and Welfare of People Who Use Services)
- Outcome 14 (Regulation 23 Supporting Staff)
- Outcome 16 (Regulation 10 Assessing and Monitoring the Quality-of-Service Provision)
- National Quality Board guidance on Safe Staffing (2016)
- Safe, sustainable, and productive staffing in mental health services
- Improvement resource to help standardise safe, sustainable, and productive staffing decisions in mental health services. Edition 1 (January 2018).

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations/inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.

Recommendations

The Board of Directors is requested to note the contents of the report and the scrutiny and assurance received at the Quality and Safeguarding Committee.

Report presented by: **Lynn Andrews**
Chair, Quality and Safeguarding Committee

Report prepared by: **Joseph Thompson**
Assistant Director for Clinical and Professional Practice

Safer Staffing annual report

Introduction

The Trust approach to safe staffing continues to focus on the ability of the organisation to provide a person-centred, trauma-informed care, patient pathway that has the right staff with the right skills and for those staff to be in the right place at the right time in line with NQB guidance and working in line with the NHS Long Term Workforce Plan which was released in June 2023.

The strategic direction for the long term Plan, falls into three clear priority areas:

- **Train:** significantly increasing education and training to record levels, as well as increasing apprenticeships and alternative routes into professional roles, to deliver more Doctors and Dentists, more Nurses and Midwives, and more of other professional groups, including new roles designed to better meet the changing needs of patients and support the ongoing transformation of care.

- **Retain:** ensuring that we keep more of the staff we have within the health service by better supporting people throughout their careers, boosting the flexibilities we offer our staff to work in ways that suit them and work for patients, and continuing to improve the culture and leadership across NHS organisations.

- **Reform:** improving productivity by working and training in different ways, building broader teams with flexible skills, changing education and training to deliver more staff in roles and services where they are needed most, and ensuring staff have the right skills to take advantage of new technology that frees up clinicians' time to care, increases flexibility in deployment and provides the care patients need more effectively and efficiently.

In line with these guiding documents, this report will focus on the Trust's approach to staffing including:

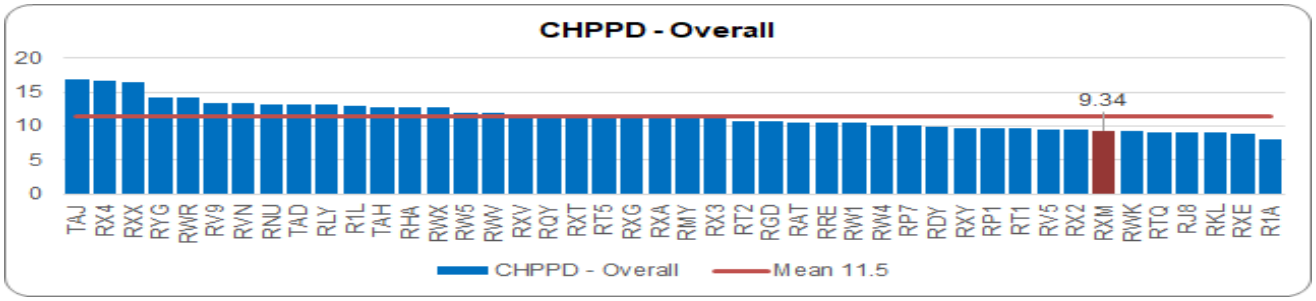
- Care Hours per Patient Day and safer staffing
- Current vacancy position and impact
- Recruitment and retention.

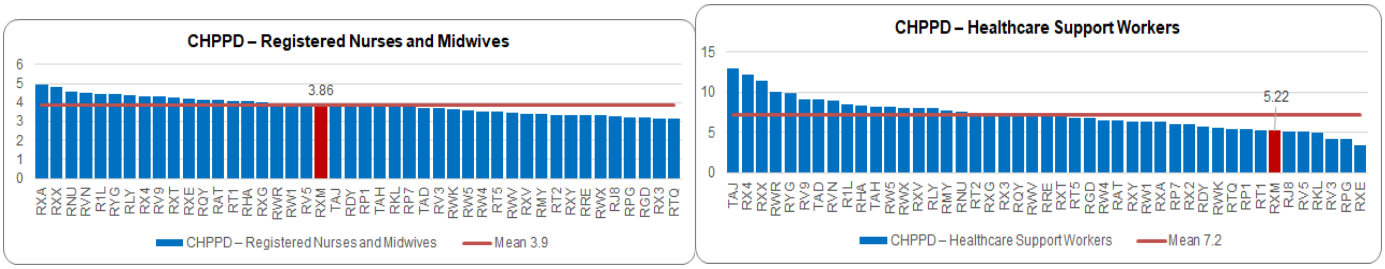
Care Hours Per Patient Day (CHPPD)

CHPPD includes total staff time spent on direct patient care but also on activities such as preparing medicines, updating patient records and sharing care information with other staff and departments. It covers both temporary and permanent care staff but excludes student Nurses and student Midwives and staff working across more than one ward. CHPPD relates only to hospital wards where patients stay overnight.

The charts below indicate that the Trust's CHPPD overall achieved 9.34 hours, which is 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. This is a reduction of 2.15 hours when compared with the report in October 2024.

By itself, CHPPD does not reflect the total amount of care provided on a ward, nor does it directly show whether care is safe, effective or responsive. Therefore, it should be considered alongside measures of quality and safety. There is no indication from triangulating CHPPD and safety metrics, such as restrictive practice measures, incidents reported, assessment and care planning compliance that care provided in the inpatient settings is unsafe.





Data source: NHS England » Care hours per patient day (CHPPD) data

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. Since the last reporting October 2024, this is a reduction of 1.9 and 1.59 respectively. This could have been impacted by data quality following the renaming of some wards and a change in June 2025 in how the data is collected. This will be reviewed with an update presented in the next report.

Additional roles

Safer Staffing and Skill Mix

Table A below shows the Trust's safer staffing levels related to the care hours per patient day. This data is used to input and set up e-Roster structures for inpatient area teams and is also publicly displayed and available for the Integrated Care Board (ICB) and CQC visibility. The safer staffing numbers in this table were reviewed and agreed in the Executive Leadership Meeting in May 2025 and are based on a staffing ratio of one qualified staff member per six to eight patients (depending on ward size and patient acuity) with the psychiatric intensive care unit (PICU) being staffed a minimum of 1/3 above the Acute ward establishment. The Royal College of Psychiatry's Accreditation of Inpatient Mental Health Services (AIMs) programme, identifies that an inpatient setting is required to follow minimum ratio of one qualified staff member per 10 patients. The ratio adopted by DHcFT allows and takes into account, the location of individual wards and includes headroom for absence from work (eg, sickness and training) to reduce the possibility of shifts where the required ratio is not met. In addition, a newly qualified professional and inexperienced workforce has been considered when agreeing the current establishment.

Table A

Inpatient Service Expected Staffing Levels									
	Morning Reg'd	Morning Unreg'd	Morning Total	Afternoon Reg'd	Afternoon Unreg'd	Afternoon Total	Night Reg'd	Night Unreg'd	Night Total
Kingfisher Ward	3	6	9	3	6	9	2	6	8
Audrey House	3	3	6	3	3	6	2	2	4
Cubley Court (M)	3	4	7	3	4	7	2	3	5
Cubley Court (F)	3	4	7	3	4	7	2	3	5
Tissington Ward	3	3	6	3	3	6	2	2	4
Bluebell Ward	3	4	7	3	4	7	2	4	6
The Beeches	2	3	5	2	3	5	1	3	4
Cherry Tree Close	2	3	5	2	3	5	2	1	3
Kedleston Unit	4	4	8	4	4	8	2	4	6
Ward 33 (Robin)	3	3	6	3	3	6	2	2	4
Ward 34 (Ward 35)	3	3	6	3	3	6	2	3	5
Ward 35 (Dove)	3	3	6	3	3	6	2	2	4
Ward 36 (Ward 36)	3	3	6	3	3	6	2	3	5
Wren Ward	3	3	6	3	3	6	2	2	4
Sycamore Ward	3	3	6	3	3	6	2	2	4
Oak Ward	3	3	6	3	3	6	2	2	4
Willow Ward	3	3	6	3	3	6	2	2	4

It is important to acknowledge that these figures do not take into consideration staff that do not sit within shift numbers, eg Advanced Clinical Practitioners, Recreational Workers, Physiotherapy, Hub staff and Occupational Therapists, who also add to the quality-of-care experience in the safer staffing of the units.

Safe Staffing Establishment Review

In September 2024, the Trust introduced an evidence-based professional judgement framework tool to enable the Trust to review trends for each service in respect of clinical dependency, observations, use of additional temporary staffing, rostering practice and management of incidents, complaints, training and supervision to reach a conclusion as to whether the levels of staffing allocated in budgets is appropriate to the level of clinical activity, having first determined that observations and other clinical activities, which drive staffing needs, are appropriately prescribed and stepped down, and that rosters are well managed. The review concluded with reduction in Acute ward staffing levels which have not adversely impacted on staff or patient safety and benchmarked against other organisation and units.

In the year ahead the inpatient safer staffing and establishment reviews will be conducted using Mental Health Optimising Staffing Tool (MHOST). Staff training has been completed with support from NHSE.

DHcFT Expected Staffing Levels

As of May 2025, the expected staffing levels for the working age adult inpatient wards have been reviewed in line with the MRfD programme and have been agreed as per table A above. There is an expectation that when enhanced therapeutic observation levels are required, the first one is absorbed within the expected staffing levels and any subsequent advanced levels observation would require enhanced staffing (by one member of unregistered staff). If a patient is placed in seclusion, then the staffing levels are expected to be increased by one member of unregistered staff to enable capacity coordination of this intervention. If patients require an escort or overnight stay at an acute hospital, staffing is also increased to accommodate this.

The female wards had environmental zonal observations in place and to accommodate these they ran on an extra two members of unregistered staff for each shift. However, now they have moved over to the new hospital environment (The Derwent and Carsington Units), the environmental zonal observations are no longer required.

Table B below, shows if the safer staffing numbers are met since the last report in October 2024. The table shows red when staffing numbers are below 80% or above 130%, which is the level reflected nationally in similar organisations.

Table B

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-2024	94%	122%	83%	180%
Nov-2024	101%	119%	87%	174%
Dec-2024	116%	123%	95%	173%
Jan-2025	114%	116%	97%	173%
Feb-2025	106%	112%	93%	153%
Mar-2025	109%	124%	96%	172%
Apr-2025	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 MRfD programme.

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 doing 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.

Short- and long-term sickness rates also continue to impact on safer staffing numbers with a sickness absence rate of 6.72% as of May 2025 in the Adult Acute Division, against a national sickness absence rate for Nurses and Health Visitors in the NHS of 5.3%. Both these figures exceed pre-pandemic levels with “colds, coughs and flu”, “gastrointestinal problems” and “anxiety/stress/depression/other psychiatric illness” as the most common reasons for absence.

Use of temporary staffing is now monitored via a monthly Temporary Staffing Quality and Governance Meeting, co-chaired by the Clinical Quality and Temporary Staffing service and includes Divisional operational representation. Any issues related to staff working over European Working Time Directive (EWTD) are picked up and actioned via this forum.

Furthermore, the following actions are being taken to ensure wards are safely staffed:

- Recruitment of registered and non-registered staff into all ward areas continues
- Fast-track recruitment is offered to all final year Nursing students at Derby, Nottingham and Sheffield Universities and this programme was reviewed in January 2025 with recommendations to ensure the quality of candidates actioned in February 2025
- Additional capacity has been put in place to support the volume of preceptorship Nurses on the Inpatient wards
- All General Managers to work with local teams to ensure suitable mitigations are in place to address shortfalls or over-staffing in workforce
- The new establishment review process completed.

Current Vacancy Position and Impact

Data from NHS England shows a national vacancy rate of 7.5%. As of May 2025, the Trust has an overall vacancy rate of 11.19%. Registered Nurses and unregistered Healthcare Support staff have a vacancy rate of 0.07% and 26.78%. This indicates an improvement in the vacancy rate for registered staff but an increase in the vacancy rate for unregistered Healthcare Support staff, when compared with the last report. This is likely due to the MRfD programme and extra recruitment that has been required to staff the PICU and the Audrey House Enhanced Care Unit. The Trust is currently evaluating registered Nursing Associate (RNA) apprenticeships and how this role can be most effectively utilised within Trust services. A number of services have unfilled RNA vacancies and other services have RNAs in post with no funded position as part of their current establishment. This will be explored as part of the afore-mentioned establishment review process to ensure there is a clear and consistent approach to use of RNAs across the Trust.

Currently, to capture the current vacancy position, we compare the “budgeted” and “in post” from the financial budget statements, and the information detailed below in Table C is correct as of 20 June 2025.

Table C

Staff funded/In Post as of May 2025						
Ward	**Band 6 Nurse Funded**	**Band 6 Nurse in Post**	**Band 5 Nurse Funded**	**Band 5 Nurse in Post**	**Band 3 Funded**	**Band 3 in Post**
Inpat Rehab CTC Kingsway	2.00	1.00	10.61	9.71	19.50	16.97
Ward 33 RU	3.00	3.00	15.40	15.20	18.26	11.76
Ward 35 RU	3.00	4.00	15.40	14.80	18.26	9.20
Ward 36 RU	3.00	3.00	15.40	13.56	18.26	13.40
Perinatal Inpatient	4.40	4.60	8.70	8.33	*16.06	*15.43
Ward 34 RU	3.00	4.00	15.40	8.00	18.26	11.40
Tissington	2.00	1.80	12.55	11.33	19.42	14.75
Cubley Male Kingsway	3.00	3.00	12.62	12.40	25.55	24.64
Cubley Female Kingsway	3.00	2.00	10.33	8.60	29.63	26.14
Bluebell Ward	1.80	1.80	11.42	10.20	22.65	17.09
Kingfisher House (PICU)	5.16	3.00	11.94	9.00	27.38	3.00
Audrey House (ECU)	3.00	3.00	15.60	9.00	17.60	8.76

Wren Ward	3.00	3.00	14.80	13.00	15.37	10.92
Sycamore Ward	3.00	2.91	16.20	11.40	23.71	15.00
Willow Ward	3.60	3.40	14.20	17.00	19.13	17.90
Oak Ward	3.00	1.40	14.40	17.60	18.87	15.60
Kedleston	2.00	2.00	16.00	13.37	25.69	20.82
Total	**50.96**	**46.91**	**230.97**	**202.5**	**353.6**	**237.35**

** combined Band 3 and Band 4*

Temporary staffing and Agency Use

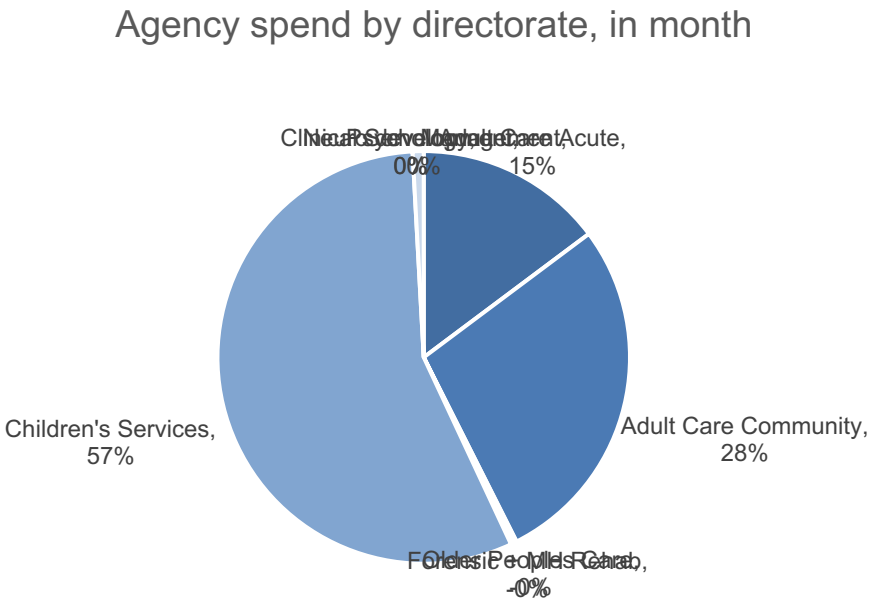
As per Chart A below, the main agency spend by Directorate in May 2025 is, Children's services, Adult Care Community and Adult Acute services respectively. Based on a comparison to the report in October, this reflects a 30% increase in agency use in Children's services; a 16% increase in Adult Care Community services and a 12% reduction in Adult Care Acute services. No agency was used in other Trust services. Analysis suggests that this is due to high levels of Medical and Nursing vacancies and additional staff required to manage levels of Enhanced Therapeutic Observations and Care (ETOC).

As per Table D below, the number of temporary staffing and agency shifts requested by the Trust as a whole has reduced between February and May 2025 and of those requested 87% have been filled on average.

Table D

2024/25	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY
Total number of shift requests	4,993	4,718	4,255	3,854	3,660	4,578	3,513	3,444
Total number of shifts filled	4,364	4,079	3,653	3,336	3,091	3,900	3,068	3,122
Number of Shift filled by Bank	3,504	3,232	2,827	2,862	2,643	3,400	2,726	2,833
Number of shifts filled by Agency	860	847	826	387	448	500	342	289
Bank Fill rate	70%	69%	66%	74%	72%	74%	78%	82%
Agency Fill rate	17%	18%	19%	10%	12%	11%	10%	8%
Fill rate (%) (benchmark 80%)	**87.4%**	**86.5%**	**85.9%**	**86.6%**	**84.5%**	**85.2%**	**87.3%**	**90.7%**

Chart A



Activity related to agency and temporary staffing use is monitored in a monthly Temporary Workforce Strategy Group and is reported on and monitored at the Monthly Trust Delivery Group meeting. Actions to reduce agency spend and use of temporary staff include:

- Attendance at ETOC Network meetings to network with other providers to explore quality improvement initiatives to reduce use of ETOC
- Use of ETOC linked to temporary staffing and agency included as part of monthly Provider Workforce Return submissions from June 2025
- General Managers to ensure robust process in place to authorise expenditure on agency staffing
- General Managers to ensure processes to reduce unregistered agency workforce are fully implemented.

Recruitment and Retention

As per the table below, on average, DHcFT has a lower-than-average proportion of registered Nurses, and Medics leaving the Trust when compared both nationally and with our regional peers. However, the Trust is over-average in relation to Allied Health Professionals. Health Visitors leaving the Trust are in line with the regional average.

Table E

Leaver Rates over the past 12 months (data from March 2025)		
Profession	**DHcFT leavers' rate**	**Regional Peer leavers' rate**
Registered Nurses	4.2%	4.7%
Medical and Dental	5.3%	6.8%
Allied Health Professionals	6.5%	4.8%
Health Visitors	3.8%	3.8 %

Analysis of the data from the NHS "Model Hospital" over a rolling 12-month period, suggests that the main reason for staff leaving the Trust continued to be retirement, relocation, work life balance and pay. Health visiting continues to be impacted by staff leaving to get jobs nearer to home as they train in Derbyshire and then get a job nearer to where they live. The Trust still has a higher proportion than average of Allied Health Professionals leaving when compared with our regional peers.

A lower-than-average number of staff leaving a service is a good indication of their satisfaction at work.

Actions

To improve recruitment and retention to the Trust, several initiatives are currently live such as:

- Recruitment of registered and non-registered staff into all ward areas continues
- Fast-track recruitment is offered to all final year Nursing students at Derby, Nottingham and Sheffield Universities and this programme was reviewed in January 2025 with recommendations to ensure the quality of candidates actioned in February 2025
- Additional capacity has been put in place to support the volume of preceptorship Nurses on the Inpatient wards
- As of May 2025, DHcFT has recruited seven international Nurses who are placed on the functional Older People's and Working Age Adult Mental Health wards
- Recruitment campaigns for registered Nurses (Band 5) include pro-actively promoting roles to registered Nurses via a range of platforms including Facebook, LinkedIn and Indeed. This will aim to target the passive applicants and highlight the benefits of working for the Trust
- For specialist and hard-to-fill roles, such as Medical Consultants/Staff Grade Doctors, an applicant pack has been developed and we have used paid job board advertisements to support those specific campaigns, such as British Medical Journal and LinkedIn. Campaigns will be developed, and bespoke strategies will vary depending on the roles recruited to. For specialist hard-to-fill Consultants, a Recruitment and Retention Premia (RRP) is being offered to make the Trust more competitive
- Continued engagement with current staff to aid retention and wellbeing
- Further engagement with the Universities of Derby, Nottingham and Leicester has continued to encourage soon to qualify staff to apply for roles across the Trust once qualified
- Promotion of the wellbeing offer at all staff engagement events.

Conclusion

The Trust demonstrates a clear commitment to safe staffing through strategic alignment, enhanced governance, and proactive workforce planning. While CHPPD and Band 3 vacancies remain below optimal levels, robust mitigations and upcoming tools such as MHOST aim to stabilise staffing and support service transformation. Recruitment and retention efforts are showing positive outcomes, particularly for registered Nurses, and agency dependency is trending downwards. Safer staffing was monitored and achieved in the fiscal year 2024/25 and changes to staff levels have not adversely impacted on staff and patient safety.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 23 September 2025

Standing Financial Instructions (SFIs) Policy and Procedures
for approval

Purpose of Report

The Standing Financial Instructions (SFIs) have been reviewed and the proposed changes are being presented to the Board of Directors for final ratification.

Executive Summary

SFIs are due for the annual review. The proposed updates have been agreed by the Audit and Risk Committee in July.

General updates have been made throughout the document; the more significant changes are as follows:

- The Petty cash section 7.8 has been updated to reflect some recommendations that were highlighted as part of the external audit of annual accounts. Auditors raised concerns about the level of cash that is being held across the Trust. Therefore, the volume and value of petty cash has been reviewed
- Section 9 regarding the Trust Credit card has been updated to add in reference to the Trusts purchasing cards
- The Procurement section (section 8.3) has been updated to reflect the change in the Procurement Act 2023
- Section 8.16 has been updated to make it easier to understand the authorisation route when approving and authorising contracts
- The staff appointment section (section 10.3) has been added to reference that the Trust's recruitment and job evaluation processes must be followed
- Rent reviews (section 14.5) has been updated to include a sentence to say that they are reported to the Capital Programme Group for consideration due to the impact leases have on capital
- Section 22.3 regarding insurance arrangements now captures the new insurance arrangements that are now in place following the new builds
- Appendix 1, added 'nominated representative'.

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

These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust. They have been updated to clarify procedures that should be followed to ensure Trust's financial transactions are carried out in accordance with the law and with Government policy.

Consultation

Senior staff within the Finance Department have updated the SFIs with input from the Head of Procurement; Head of Contracting; General Manager Information Management, Technology and Records; Deputy Director of People, Organisational Development and Inclusion and Assistant Director of Legal, Governance and Mental Health Legislation.

These proposed changes have been presented to the Trust Delivery Group and agreed at the Audit and Risk Committee on 24 July 2025.

Counter Fraud have also reviewed the revised SFIs.

Governance or Legal Issues

These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

The nature and remit of this document means that it has no impact on equality, diversity or inclusion and therefore, does not impact those with protected characteristics.

Recommendations

The Board of Directors is requested to ratify the Standing Financial Instructions Policy and Procedures.

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

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

Derbyshire Healthcare
NHS Foundation Trust

Standing Financial Instructions Policy and Procedure

See also:	Located in the following policy folder on the Trust Intranet
Corporate Governance Framework	
Treasury Management Policy	Corporate and Risk
Counter Fraud and Bribery Policy and Procedures	Corporate and Risk
Disciplinary Policy and Procedure	People and Inclusion
Conflicts of Interest Policy	Corporate and Risk

Service area	Issue date	Issue no.	Review date	
Trust wide	October 2025~~4~~	1	October 2026~~5~~	
Ratified by	**Ratification date**	**Committee/Group responsible for review:**		
Trust Board	~~01 October 2024~~	Audit and Risk Committee		

Document published on the Trust Intranet under:

Did you print this document?

Please be advised that the Trust discourages retention of hard copies of policies and can only guarantee that the Policy on the Trust Intranet site is the most up-to date version

ACCESSIBLE INFORMATION STANDARD

The Accessible Information Standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of service users.

Ensure you have considered an agreed process for: sending out correspondence in alternative formats and appointments for patients / service users with communication needs, where this is applicable.

Making a positive difference

Checklist for Standing Financial Instructions

Summary
These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust.

Name / Title of policy/procedure	Standing Financial Instructions	
Aim of Policy	These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust.	
Sponsor (Director lead)	Director of Finance	
Author(s)	Deputy Director of Finance Financial Controller	
Name of policy being replaced	Standing Financial Instructions	**Version No of previous policy:**

Reason for document production:	To provide a reference document and guidance detailing the financial responsibilities which apply to everyone working for the Trust.
Commissioning individual or group:	Director of Finance

Individuals or groups who have been consulted:	**Date:**	**Response**
General Manager IM&T	07/07/2025	No changes
Head of Contracting	03/07/2025	Updates to section 8.16
Head of ~~Strategic~~ Procurement ~~and Tendering~~	07/07/2025	Updates to section 8.3
Assistant Director of Corporate, Legal and Mental Health Legislation	14/07/2025	Update to Appendix 1

~~Acting~~ Deputy Director of People and Inclusion	07/07/2025	Updates to section 10.3
~~Executive Leadership Team~~Trust Delivery Group	21/07/2025	Approved
Counter Fraud	13/08/2025	No changes
Audit and Risk Committee	24/07/2025	Approved
Trust Board		

Version control (for minor amendments)

Date	Author	Comment
	Job title, not name	

Standing Financial Instructions

Table of contents

1. STANDING FINANCIAL INSTRUCTIONS

INTRODUCTION

1.1 Who Should Read These Standing Financial Procedures (SFIs)?

These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes.

You should read these SFIs and be aware of their relevance to you as you discharge your responsibilities if you are:

- A Director of the Trust
- A Service Manager
- A Senior Manager in a support function
- A budget holder
- Involved in placing orders for goods/services on behalf of the Trust
- Involved in negotiating contracts/other arrangements for the provision of goods/services
- Involved with the handling and safe custody of patients' monies and valuables
- Involved in the administration of Charitable Funds

ALL staff must be made aware of section 11 Standards of Business Conduct, within the Standing Orders of the Board of Directors and Standards of Business Conduct.

Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Director of Finance MUST BE SOUGHT BEFORE YOU ACT. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

Overriding Standing Financial Instructions

If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit and Risk Committee for referring action or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.

1.2 TERMINOLOGY

1.2.1 Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions; and:

"Trust" means the Derbyshire Healthcare NHS Foundation Trust;
"Board" means the Board of Directors of the Trust;
"Budget" means a resource, expressed in financial terms and whole time equivalent (WTE) terms, proposed by the Trust for the purpose of carrying out, for a specific period, any or all the functions of the Trust;
"Chief Executive" means the Chief Officer of the Trust;
"Director of Finance" means the Chief Financial Officer of the Trust, who is also the Director of Finance;
"Budget Holder" means the Director or member of staff with delegated authority to manage finances (Income and Expenditure, Revenue and Capital) for a specific area of the Trust;
"Legal Advisor" means the Trust appointed person properly qualified to provide legal advice.

1.2.2 Wherever the title Chief Executive, Director of Finance, or other nominated officer is used in these instructions, it shall be deemed to include such other directors or staff who have been duly authorised to represent them.

1.2.3 Wherever the term "staff" is used it shall be deemed to include staff of third parties contracted to the Trust when acting on behalf of the Trust.

1.2.4 Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

1.3 RESPONSIBILITIES AND DELEGATION

1.3.1 The Board of Directors

The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

(d) defining specific responsibilities placed on members of the Board and staff as indicated in the Scheme of Delegation document.

They may delegate executive responsibility for the performance of operational functions to the Chief Executive in accordance with the Trust's approved Scheme of Delegation.

1.3.2 The Chair

The Chair is responsible for leading the Trust Board and for ensuring that it successfully discharges its overall responsibility for the organisation as a whole.

1.3.3 The Chief Executive

Within these SFIs it is acknowledged that the Chief Executive is ultimately accountable to the Trust Board and it is the duty of the Chief Executive to:

- Implement the financial policies of the Trust Board in order to ensure that the Trust Board meets its obligations to perform its functions within the available resources.
- Ensure all staff are notified of the requirements of the Standing Financial Instructions.
- Delegate the management of resources to officers of the Trust in accordance with the Trust's approved Scheme of Delegation.
- Ensure that the Trust's financial obligations and targets are met.
- Take responsibility for the Trust's system of internal control.

In performing these duties the Chief Executive will take due consideration of the advice given by the Director of Finance.

It is a duty of the Chief Executive to ensure that members of the Trust Board and, staff and all new appointees are notified of, and put in a position to understand, their responsibilities within these Instructions.

1.3.4 The Director of Finance

The Director of Finance is responsible for:

- implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;
- maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;
- ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time.

The duties of the Director of Finance also include:

- the provision of financial advice to the Trust and its directors and staff;
- the design, implementation and supervision of systems of internal financial control; and
- the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.3.5 All Board Members and Staff

All members of the Trust Board and staff of the Trust have a responsibility for:

- the security of the Trust's assets;
- avoiding loss;
- exercising economy and efficiency in the use of resources; and
- conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

For all members of the Board and any staff who carry out a financial function, the form in which financial records are kept and the manner in which members of the Trust Board and staff discharge their duties must be to the satisfaction of the Director of Finance.

1.3.6 Budget Holders

Have a responsibility to:

- Monitor activities to ensure resources are utilised in an effective and efficient manner;
- Ensure activities are conducted within the constraints of budgets;
- Provide all information and explanations required by the Director of Finance to ensure financial control, enacted through the business of the operational meetings, ~~Executive Leadership Team~~Trust Delivery Group, Finance and Performance Committee and the Trust Board;
- Ensure the security of Trust Assets including property, equipment and cash.

1.3.7 Contractors and their Staff

Any contractor or staff of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

2. AUDIT

2.1 THE AUDIT AND RISK COMMITTEE

2.1.1 In accordance with Standing Orders, the Trust Board shall formally establish an Audit and Risk Committee, with clearly defined terms of reference (which are contained in the Scheme of Delegation) and following guidance from the NHS Audit Committee Handbook, which will provide an independent and objective view of internal control including financial control.

2.1.2 Where the Audit and Risk Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wish to raise, the Chair should raise the matter at a full meeting of the Trust Board. Exceptionally, the matter may need to be referred to the Department of Health or NHS England.

2.2 ROLE OF THE DIRECTOR OF FINANCE

2.2.1 The Director of Finance is responsible for:

a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;
b) ensuring an internal audit service exists to review, evaluate and report on the effectiveness of internal financial control to meet mandatory audit standards;
c) ensuring that an annual audit report is prepared by Internal Audit and External Audit and as required by the Audit and Risk Committee and the Trust Board in accordance with current Department of Health and NHS England guidance.

2.2.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b) access at all reasonable times to any land, premises or staff of the Trust;

c) the production of any cash, stores or other property of the Trust under a member of staff's control;

d) explanations concerning any matter under investigation.

2.3 THE ROLE OF INTERNAL AUDIT

2.3.1 Internal Audit will review, appraise and report upon:

a) Internal Audit shall independently verify the Annual Governance Statement and other declarations in accordance with guidance from the Department of Health.

b) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

c) the adequacy and application of financial and other related management controls;

d) the suitability of financial and other related management data;

e) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:
(i) fraud and other offences,
(ii) waste, extravagance, inefficient administration,
(iii) poor value for money or other causes.

2.3.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the

exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately, who shall in turn notify the Trust's Local Counter Fraud Specialist.

2.3.3 The Head of Internal Audit will normally attend Audit and Risk Committee meetings and has a right of access to all Audit and Risk Committee members, the Chair and Chief Executive of the Trust.

2.3.4 The Head of Internal Audit shall report to the Director of Finance who shall refer audit reports to the appropriate officers designated by the Chief Executive.

2.4 THE ROLE OF EXTERNAL AUDIT

2.4.1 The Trust's external auditor is appointed by the Council of Governors and is paid for by the Trust. The Auditor must comply with the principles set out in the Audit Code for NHS Foundation Trusts.

2.4.2 The Governors must ensure that a cost-effective external audit service is provided and periodically review arrangements in conjunction with the Audit and Risk Committee.

2.5 External Auditors for non-Audit Services

2.5.1 The independence and objectivity of the external auditors is an important element supporting good governance within the Trust. The auditor should be, and should be seen to be, impartial and independent. Accordingly, the auditor should not carry out any other work for an audited body if that work would impair their independence in carrying out any of their statutory duties or might reasonably be perceived as doing so.

2.5.2 Prohibited non-audit services
To ensure that the auditor's independence and objectivity is not impaired it is important the external auditors do not:

- Audit their own work
- Make management decisions on behalf of the Trust
- Undertake activities which (potentially) result in conflicts of interest
- Act as advocates for the Trust
- Creating any threat to their independence

Therefore, the Trust will apply the following prohibitions on non-audit work by the external auditor:

- Providing any services specifically prohibited by UK law or supporting guidance.
- Work related to the accounting records and financial statements that will ultimately be subject to external audit.
- Taxation assignments where there is no fixed fee or the fixed fee is greater than that allowed in this policy (see below).
- Internal audit services.

- Design/implementation of financial information technology systems.
- Valuations services where the valuation has a potentially material impact upon the Trust's financial statements.
- Legal and litigation support or advice where the outcome could have a potentially material impact upon the Trust's financial statements.
- Provision of senior recruitment services.

2.5.3 Permitted non-audit services

Where the work is not disallowed under the previous paragraph the external auditors may be considered for individual assignments. In the majority of cases such assignments will be subject to formal tendering procedures held in accordance with the Trust's SFIs.

In certain circumstances the external auditors' detailed understanding of the Trust's business may result in a recommendation from the Director of Finance to the Audit and Risk Committee for the external auditors to be retained to undertake a permitted non-audit exercise, rather than undertake a formal tendering procedure. This may be, e.g., for reasons of efficiency, confidentiality or expert understanding of the Trust's position. These could include:

- Advice on the preparation of financial information and the application of GAAP or training support for accounting projects and in relation to accounting standards.
- Audit related services as defined in the APB Ethical Standard 5 (Revised).
- Assistance in tax compliance activities and advice on recent developments and/or complex or high-risk areas.

Secondments between the external auditors and the Trust will also be acceptable for lower (sub-Board) positions.

2.5.4 There is no financial limit in any one financial year relating to non-audit assignments secured by external audit through competitive tendering procedures. Nonetheless, the potential for the compromising of independence and objectivity must always be considered. Therefore, it will be the duty of the Director of Finance to draw the attention of the Audit and Risk Committee if the external auditor is awarded non-audit work to a value equal to or greater than the value of the external audit contract in any one financial year.

There will be a strict limit applied to any assignment awarded directly to the external auditor without a competitive tendering process. The value of any one assignment must not exceed £10,000 and there can be no more than two such assignments in any one financial year.

2.5.5 For awards made to the external auditor through a competitive tendering process – the approval will follow existing SFI requirements and will be reported by the Director of Finance to the next Audit and Risk Committee.

For awards made to the external auditor directly, without a competitive tendering process – a written request will be submitted to the Audit and Risk Committee. The Committee will give its consent either at a scheduled meeting or by written consent (as appropriate) based upon a submission which covers:-

- The service to be provided
- An explanation of the rationale for appointing the external auditor
- The safeguards in place to mitigate the threat to auditor independence (e.g., the application of 'Ethical Walls' by the audit firm)
- Estimate of fees and expenses
- An analysis of the expected total proportion of fees earned by the external auditors in the year which will be earned by non-audit work

The Audit and Risk Committee will need to provide approval on a formal, recorded, basis.

2.5.6 For the avoidance of doubt the phrase 'external auditor' in this policy covers not only the audit partner signing-off the Trust's accounts, nor the audit section or department undertaking the external audit but also the firm providing the audit.

2.5.7 Adherence to this policy will be monitored by the Audit and Risk Committee.

2.6 FRAUD and BRIBERY

In line with their responsibilities the Trust Chief Executive and Director of Finance shall ensure compliance with Secretary of State guidelines on fraud and bribery.

The Trust shall nominate an accredited individual to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by the NHS Counter Fraud Authority. The Trust has in place a Counter Fraud Champion who is currently the Trust Secretary.

The LCFS shall report to the Trust Director of Finance and work alongside NHS Counter Fraud Authority to ensure there is a zero-tolerance approach to Fraud and Bribery within the Trust.

The LCFS will provide a written report, at least annually, detailing the counter fraud work within the Trust which will be presented to the Audit and Risk Committee.

In accordance with the Trust Fraud and Bribery Policy, any suspicions involving financial crime must be reported to the Local Counter Fraud Specialist, and / or the Executive Director of Finance or via the NHS Fraud Reporting Line. All reported concerns will be treated in the strictest confidence and professionally investigated in accordance with the Fraud Act 2006 and Bribery Act 2010. Where evidence of Fraud and / or Bribery is identified all available sanctions will be pursued against offenders. This may include internal and professional body disciplinary sanctions, criminal prosecution and civil action to recover identified losses.

2.6.1 Sanctions and Redress

The Trust is committed to pursuing and / or supporting NHS Counter Fraud Authority in pursuing the full range of available sanctions (criminal, civil and disciplinary) against those found to have committed fraud and / or bribery.

The Trust seeks to recover, and / or support NHS Counter Fraud Authority in seeking to recover NHS funds that have been lost or diverted through fraud and / or bribery.

The Trust publicises cases that have led to successful recovery of NHS funds.

2.7 SECURITY MANAGEMENT

In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

The Trust shall nominate a Non-Executive Director to ensure security has a high profile and is considered appropriately in the Trust's strategic direction.
The Chief Executive has overall responsibility for security management. Key responsibilities are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

3. BUSINESS PLANNING, BUDGETARY CONTROL

3.1 PREPARATION & APPROVAL OF OPERATIONAL FINANCIAL PLANS AND BUDGETS

3.1.1 The Chief Executive will compile and submit to the Board an operational financial plan in accordance with current NHS England guidelines with due regard to the views of Council of Governors. The operational financial plan will include:

- In accordance with NHS England annual plan guidance, statements of the significant assumptions on which the plan is based;
- details of major changes in workforce, service delivery or resources to achieve the plan;
- any other relevant information as required by the regulator's guidance issued for the planning submission.

3.1.2 At the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit revenue and capital expenditure start budgets for approval by the Trust Board. Such budgets will:

- be in accordance with the aims and objectives set out in the operational plan;
- accord with workload and workforce plans;
- be produced following discussion with appropriate budget holders;
- be prepared within the limits of available funds;
- demonstrate the achievement of key financial targets such as strategic financial objectives of the Trust and the regulatory financial regime as advised by NHS England;
- identify potential risks and mitigations.

3.1.3 The Director of Finance shall monitor financial performance against budget and plan, and report financial performance to the Trust Board and subsequently to NHS England as required, in the appropriate templates issued by NHS England.

3.1.4 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled. This will be enacted through the business of appropriate meetings with managers and the Trust Board.

3.1.5 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

3.2 BUDGETARY DELEGATION

3.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing with a clear definition of:

- the amount of the budget and the purpose(s) of each budget heading;
- achievement of planned levels of service and individual or group responsibilities;
- the provision of regular reports and authority to exercise virement.

3.2.2 From time to time NHS England may issue guidance or instructions regarding additional approval processes for certain types of Trust expenditure. Where Foundation Trusts are required to comply, NHS England's approval process, as defined by their guidance, will override the authority to authorise as laid out in the Trust standing financial instruction, only for the specific type of expenditure concerned.

In cases where compliance with any additional approval regime by NHS England is v*oluntary*, the Chief Executive will determine the appropriate course of action for the Trust and will notify budget holders accordingly, with the support of the Director of Finance.

3.2.3 In exceptional circumstances where large invoices are received which exceed the limits set out on 3.2.2i, then the Chief Executive and Director of Finance can jointly approve.

3.2.4 Authority for virements between budgets relating to a particular service or function shall be limited to:

over £500,000	Countersigned by relevant Executive Director / Director of Finance
£100,000 to £500,000	Countersigned by Managing Directors /General Manager / Head of Service
Up to £100,000 *	Budget holder (* or total budget if less than £100,000)

3.2.2i With the exception of expenditure referred to in para 3.2.2 and 3.2.3 authority to authorise any one revenue order shall be limited to:

£1,000,000 and above	*Board of Directors*
£500,000 to £999,999	*Chief Executive **and** Director of Finance.to jointly approve*
£200,000 to £500,000	*Chief Executive or Director of Finance.*
up to £200,000	*Deputy Chief Executive or Deputy Director of Finance*
up to £200,000	*Executive Directors voting and non-voting but not Non-Executive Directors*
Up to £50,000	*Managing Directors*
Up to £30,000	*Financial Controller*
Up to £10,000	*General Managers and Assistant/Associate Directors*
Up to £1,000	*Area Service managers and Heads of Service*
Up to £100	*Budget Holders*

3.2.2ii With the exception of expenditure referred to in para 3.3.2 authority for planned expenditure of Capital Resources shall be limited to:

Expenditure on an individual project up to £100,000	Approved by the Capital Project group
Expenditure on an individual project between £100,000 and £1,000,000	Jointly approved by the Director of Finance and one other Executive Director
Proposed expenditure on a project in excess of £1,000,000	Board approval required (and process to be in accordance with NHS England guidance)

3.2.4 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI 13).

3.2.5 The budgetary total or virement limits set by the Trust Board above must not be exceeded. Expenditure for which no provision has been made in an approved budget and which is not subject to funding under delegated powers of virement

shall only be incurred after proper authorisation - i.e. by the Chief Executive or the Board of Directors as appropriate within delegated limits.

3.2.6 Unless approved by the Chief Executive, after taking the advice of the Director of Finance; budgets shall only be used for the purpose for which they were provided. Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.2.6 Non-recurring budgets shall not be used to finance recurring expenditure without the authority in writing of the Chief Executive.

3.3 BUDGETARY CONTROL AND REPORTING

3.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include monthly financial information presented to the Trust Board in a form approved by the Trust Board.

a) Detailed financial information to Finance and Performance Committee covering but not limited to:
   i) Income and expenditure position for year to date and forecast year end position
   ii) Statement of Financial Position including any key exceptions
   iii) Cash levels and key drivers
   iv) Capital expenditure against plan.
   v) Agency performance
   vi) Key financial risks and mitigations
b) the production of timely, accurate and comprehensive advice and financial reports to each budget holder, covering the areas for which they are responsible;
c) investigation and reporting of variances;
d) monitoring of management action to correct variances;
e) arrangements for the authorisation of budget transfers;
f) on-going training and support to budget holders to enable them to manage successfully.

3.3.2 The Director of Finance shall keep the Chief Executive and the Board of Directors informed of the financial consequences of changes in policy, pay awards, and other events and trends, whether national, local or internal, affecting budgets and shall advise on the financial and economic aspects of future plans and projects.

3.3.3 All Budget Holders are responsible for ensuring that:
a) any likely overspending or reduction of income is not incurred without the prior consent of the Trust Board;
b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and
c) no permanent staff are appointed without the approval of the Chief Executive as per 10.3.1.ii other than those provided for in the budgeted establishment as approved by the Trust Board.

d) In the exceptional circumstance where a member of staff is engaged through terms deemed as 'off-payroll' by Her Majesty's Revenue and Customs (HMRC) and/ or NHS England, the relevant budget holder who is seeking to make these arrangements is responsible for ensuring compliance with HMRC rules and regulations and reporting, as informed by the Director of People, Organsiational Development and Inclusion. All off-payroll engagements should be approved by a Director before commencement.
e) Where costs may be committed by a third party there must be appropriately authorised by a specific governance process defined by a local operating procedure.
f) Off-payroll arrangements will be reported to ~~Executive Leadership Team~~Trust Delivery Group and to Finance and Performance Committee on a regular basis in advance of the annual reporting requirements.

3.3.4 The Chief Executive or Director delegated by the Chief Executive is responsible for identifying and implementing cost improvements and value for money initiatives in accordance with the requirements of the Annual Plan and a balanced budget.

3.4 MONITORING RETURNS

The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted, accurately and on time and in the required format, to the requisite Organisation.

4. ANNUAL ACCOUNTS AND REPORTS

4.1 The Director of Finance, on behalf of the Trust, will:

i. prepare and submit financial returns in such a form as directed by NHS England, with the approval of HM Treasury, specifically in accordance with International Financial Reporting Standards (as applied in the NHS England Annual Reporting Manual and the Department of Health Group Accounting Manual as well as HM Treasury's Financial Reporting Manual - FReM);
ii. lay audited accounts before Parliament and send a copy to NHS England in accordance with the Annual Reporting Manual.

4.2 The Trust's Annual Accounts must be audited by an auditor appointed by the Council of Governors. The Audited Annual Accounts must be presented to the Annual Public Meeting of the Trust.

4.3 The Trust will compile and publish an Annual Report in accordance with NHS England's Annual Reporting Manual.

5. BANKING ARRANGEMENTS

5.1 GENERAL

5.1.1 The Director of Finance shall monitor financial performance for working capital against budget and plan, periodically review them, and report to the Trust Board.

All funds of the Trust shall be held in accounts in the name of the Trust. Only staff authorised by the Director of Finance may open a bank account in the name of the Trust.

5.1.2 The Board shall approve the banking arrangements and agree (or delegate agreement on their behalf of) the Treasury Management Policy prepared by the Director of Finance.

5.1.3 Bank and Government Banking Service (GBS) Accounts

The Director of Finance is responsible for:

a) bank accounts and Government Banking Service accounts;

b) establishing separate bank accounts for the Trust's non-exchequer funds where appropriate;

c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;

d) reporting to the Trust Board all arrangements made with the Trust's bankers for accounts to be overdrawn;

e) reporting to Trust Board any proposals to draw down any or all of the Trust's working capital facility if such a facility is in place;

f) ensuring the Trust does not exceed the limit of its approved working capital facility if such a facility is in place;

g) monitoring compliance with DH guidance on the level of cleared funds.

5.1.4 ONLY authorised signatories within the Financial Control Team may make changes to Trust banking mandates including Direct Debits. No other persons within the Trust should activate, deactivate or make any changes whatsoever to any Trust direct debit arrangements. Staff wishing to do so should contact the Financial Controller.

5.2 BANKING PROCEDURES

5.2.1 The Director of Finance will prepare financial procedures on the operation of bank accounts for the approval of the Board of Directors.

5.2.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated in accordance with approved procedures.

5.3 TENDERING AND REVIEW

5.3.1 Any commercial banking arrangements of the Trust should be reviewed at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business.

5.3.2 Competitive tenders should be sought at least every 3 years. The results of the tendering exercise should be approved by the Board. This review is not necessary for GBS accounts.

6. INCOME, FEES AND CHARGES

6.1 INCOME SYSTEMS

6.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due. These systems shall include income due under contracts or extra-contractual arrangements for the provision of Trust services.

6.1.2 The Director of Finance is also responsible for the prompt banking of all monies received.

6.2 FEES AND CHARGES

6.2.1 The Trust shall refer to NHS England's Approved Costing Guidance in setting prices for contracts and services provided to other organisations, where applicable. However, pricing strategies will be determined by appropriate Trust Committees.

6.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

6.2.3 All staff must inform the Director of Finance promptly of money due arising from transactions which they initiate or deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions. The Director of Finance and the Chief Executive shall approve all contracts for income.

6.3 DEBT RECOVERY

6.3.1 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts. Income not received should be dealt with in accordance with losses procedures. This includes the use of external debt recovery agents.

6.3.2 Should any staff detect that an overpayment has been made they should report immediately to the Director of Finance in order that recovery procedures can be initiated. The Trust will follow the overpayment policy in recovering debt owed as a result of employee benefit overpayment.

7. SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

7.1 The Director of Finance and/or the Director responsible for the cashier's service shall prescribe and is responsible for systems and procedures for any staff handling cash, pre-signed cheques and negotiable securities on behalf of the Trust, including:

i. approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable.
ii. the security and control of any such stationery.
iii. procedures for receiving and banking of cash, cheques and other forms of payment.
iv. circumstances in which unofficial funds may be deposited in safes.
v. prescribing systems and procedures for handling cash and negotiable instruments on behalf of the Trust. Where the Shared Services Organisation undertakes such issues as stated in 7.1, detailed requirements will be specified in a Service Level Agreement with the Shared Services Organisation.
vi. Issuing of High Street vouchers and the appropriate use of these vouchers.

7.2 Staff shall be informed in writing on appointment, of their responsibilities and duties for the collection, handling or distribution of cash, cheques, etc. Any staff whose duty it is to collect or hold cash shall be audited by the finance team to ensure the appropriate controls are in place for the safe keeping of the cash.

7.3 During the absence (e.g. on holiday) of the holder of a safe or cash-box key, the member of staff who acts in their place shall be subject to the same controls as the normal holder of the key. There shall be written discharge for the safe and/or cash-box contents on the transfer of responsibilities and the discharge document must be retained for inspection.

7.4 All cash, cheques and other forms of payment received by any other staff shall be passed immediately to the holder of a safe or cash-box key or to the cashier, from whom a signed receipt shall be obtained. No member of staff should keep Trust cash, cheques or other forms of payment, for whatever purpose, on Trust premises unless the Financial Controller is aware of the existence of such arrangements and can support and be assured on the systems and processes for the probity of such arrangements.

7.5 Official money may never be used for the encashment of private cheques.

7.6 The opening of coin operated machines (including telephones) and the counting and recording of the takings shall be undertaken by two members of staff together, unless authorised in writing by the Director of Finance. The coin-box keys shall be held only by a nominated member of staff.

7.7 Any loss or shortfall of cash, cheques or other cash equivalents, however occasioned, shall be reported immediately to the Financial Control Team in accordance with the agreed procedure for reporting losses (see also Section 16 Disposals, Losses and Special Payments).

7.8 Petty Cash

7.8.1 All new floats or amendments to floats are authorised by the Director of Finance or Deputy Director of Finance, they will only be approved if they are essential to the service.

7.8.2 **Petty Cash Limits floats are limited to £100 unless the amount reimbursed within a quarter is more and these will be considered on a case by case basis. The limits will be set as follows:**

£50	**Amount reimbursed in a month are less than £50**
£100	**Amounts reimbursed in a month are between £50 and £100**
Above £100	**Considered on a case by case basis dependent on spend within a month**

7.8.3 All Petty Cash Floats must be held in a secure place and remain under the control of the designated Float Holder/Accounting Officer. The float holders who are going off duty and coming on duty will both check the petty cash together and a formal record of the check will be documented.

7.8.43 Petty Cash disbursements should be for the purpose agreed when the float was established. All disbursements must be supported by receipt(s). In circumstances where staff require an advance of cash to make a purchase, a record must be kept of the details and amount issued to ensure that all cash can effectively be accounted for until receipts and unspent cash are returned within 24 hours. Advances of cash need to be authorised by either the Director of Finance, Deputy Director of Finance or the Financial Controller prior to the advance being issued.

7.8.45 Reimbursements will not be made unless both signatories provided match the authorised signatories that is held on record for the float.

7.8.65 In exceptional circumstances Petty Cash above £50 may be issued with prior authorisation from the Director of Finance, Deputy Director of Finance or the Financial Controller.

7.9 Trust Credit Card

7.9.1 The Trust will hold ~~a~~ credit cards in order to support the procurement process in allowing more flexibility to purchase goods but limited to exceptional circumstances. Standard procurement processes should be followed and suppliers set up through the usual procurement system to ensure good procurement governance. If the Trust credit card is used then the Trust's procurement processes will still need to be followed but the credit card will enable quicker payments to be made.

7.9.2 Access to the Trust credit card will be limited to Financial Control, Deputy Director of Finance and the Emergency Planning and Continuity Manager ~~and Procurement~~. The cards whilst not in use will be kept in a secure safe. Local procedures need to be in place to ensure the security of the credit card.

7.9.3 Fuel Purchasing Cards are held by the Estates Department, these should be kept in a secure place when not in use and documentation kept on usage.

7.9.4 ~~Purchasing cards for PC World are held by the Financial Control Team. Local procedures need to be in place to ensure the security of these cards.~~ **Teams with Sum Up Purchasing cards must have local procedures in place to ensure they are being secured and used appropriately which can be audited by Financial Control**

7.9.5 Trust Purchasing Cards must follow trust procedures , be kept in a safe place and documentation available.

7.9.6 Pre-paid purchasing cards will be issued and audited by Financial Control who will put in place agreed limts and restrictions on the card as agreed with by the requester of the card.

7.10 Chip and Pin machines

7.10.1 The Trust holds ~~5~~ chip and pin machines at various locations across the Trust.

7.10.2 The card holder is present when the card machine is in use and no payments are taken over the phone.

7.10.3 Local Procedures need to be in place to ensure the security of the machines.

8. TENDERING AND CONTRACTING PROCEDURE

8.1 **Duty to comply with Standing Orders** and Standing Financial Instructions

8.1.1 Every contract (other than for the delivery of Trust services delivered in accordance with the National Contract and commissioned by NHS or other Commissioners, (see 8.21) where made by the Trust, shall comply with these Standing Financial Instructions.

8.1.2 An exception from any of the following provisions of these Standing Financial Instructions may be made by the direction of the Trust or, in an emergency, by the Chair and Chief Executive, in accordance with SO 4.

8.1.3 Staff undertaking procurement activity should refer to the Trust Procurement Manual for further detailed information. The manual also includes reference to the 'No PO no pay' policy.

8.2 Bribery Act

All staff involved in tendering and contracting and other budget holder activities should be aware of the Bribery Act 2010 and should ensure that all dealings with other organisations and their staff do not bring them in breach of the Act. That could leave them open to criminal proceedings being commenced.

8.3 ~~Public Contract Regulations 2015~~ Procurement Act 2023

~~On 1 January 2021 the OJEU regulations were transposed into English Law and our public procurement rules are governed under the Public Contract Regulations (PCR) 2015. Procedures for awarding all forms of contracts under PCR2015 shall have effect as if incorporated in these Standing Financial Instructions.~~

~~Any rules pertaining to public procurement under PCR2015 cannot be waived.~~

The Procurement Act 2023 is UK legislation designed to modernise public procurement, making it simpler, more flexible, and more transparent. It aims to create a more competitive landscape for businesses, particularly small and medium-sized enterprises (SMEs) and social enterprises, while ensuring public funds are spent effectively. The Act came into force on February 24, 2025.

The Procurement Act 2023 represents a significant shift in how public procurement is conducted in the UK, promoting a more dynamic, inclusive, and accountable system.

8.4 Investment approach

Any potential major investment decision must be guided by relevant current Foundation Trust guidance, which sets out governance processes for all major investments undertaken by NHS foundation trusts.

8.5 Tendering

All tendering activity must be compliant with Procurement Regulations 2024 or any other such policy that may supersede it.

Formal Competitive Tendering

The standard method of procurement by the Trust shall be by way of competitive tender. The Trust shall ensure that such tenders are invited for the supply of goods, materials and manufactured articles and for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH); for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals.

8.5.1 Tender and Quotation Limits

The procurement of all goods and services should be preceded by a requisition and official order. By exception, urgent and/or emergency situations may be reasons why this is not possible and in these cases confirmation orders should be raised.

8.5.2 General Position on Quotations and Tendering

Below £10,000 (inc VAT) good purchasing practice is necessary i.e. seeking the best value for money.

8.5.3 The Trust's Procurement Department must be consulted prior to the commencement of any of the processes listed below

- For purchases between £10,000 (inc VAT) and below PCR2015 limit three written quotations are required.

- Supplies and service contracts above the current PCR 2015 threshold require full compliance with the relevant PCR 2015 procedure.

- In the event that purchases between £10,000 (inc VAT) and £25,000 (inc VAT) are procured through a compliant PCR 2015 framework there is no requirement to obtain additional quotations. For purchases above £25,000 (inc VAT) procured through a compliant PCR 2015 framework the Head of Procurement can recommend to Executives whether further competition is required. At all times value for money should be a prime consideration, even when procuring from a compliant framework.

- With regards to small works procurement (as defined by PCR 2015) these rules shall override any other obligation contained in these Standing Financial Instructions relating to tender and quotation requirements.

8.6 Formal tendering procedures may be waived by officers to whom powers have been delegated by the Chief Executive without reference to the Chief Executive except in (c) to (f) below where:

(a) The estimated expenditure or income does not, or is not reasonably expected to, exceed £25,000 (inc VAT) (in which case quotations process not tender process should be followed), or

(b) Where the supply is proposed under special arrangements negotiated by the DH or Regulator in which event the said special arrangements must be complied with;

(c) The timescale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for single tender;

(d) Specialist expertise is required and is available from only one source;

(e) The task is essential to complete the project, **and** arises as a consequence

of a recently completed assignment and engaging different consultants for the new task would be inappropriate; this reason for waiver cannot be enacted if NHS England approval is required for management consultancy or other defined expenditure;

(f) There is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering.

Requests for waiving formal tendering procedures should be in the form of a letter signed by the Chief Executive or their nominated deputy. These should then be entered in the waiver register and reviewed by the Audit and Risk Committee.

A waiver is not required for year two onwards of contracts that have already been through the procurement process that is outlined in these Standing Financial Instructions.

8.7 The limited application of the single tender rules should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided by the Chief Executive that competitive tendering is not applicable and should be waived by virtue of the above, the fact of the waiver and the reasons should be recorded in writing to the Chief Executive and documented in a register held by the Trust Secretary.

8.8 Tendering procedures are set out in ~~the~~ Appendix 1.

8.9 **Quotations** - are required where formal tendering procedures do not apply where expenditure is expected to exceed £10,000 (inc VAT).

8.10 Where quotations are required they should be obtained from at least three firms/individuals.

8.11 All quotations should be treated as confidential and should be retained for inspection.

8.12 The Chief Executive or their nominated officer should evaluate the quotations and select the one which gives the best value for money. If this is not the lowest then this fact and the reasons why the lowest quotation was not chosen should be in a permanent record.

8.13 Non-competitive quotations in writing may be obtained for the following purposes:

(a) the supply of goods/services of a special character for which it is not, in the opinion of the Chief Executive or their nominated officer, possible or desirable to obtain competitive quotations;

(b) the goods/services are required urgently.

Instances of, and reasons for, non-competitive quotations are to be entered in the waiver register and reviewed by the Audit and Risk Committee.

8.14 Where tendering or competitive quotation is not required:-

The Trust shall procure goods and services in accordance with procurement procedures approved by the Trust as laid out in the Trust Procurement Manual.

8.15 **Contracts** - The Trust may only enter into contracts within its statutory powers and shall comply with:

(a) its Establishment and Amendment Orders

(b) The Trust's Standing Orders

(c) The Trust's Standing Financial Instructions

(d) PCR 2015 and other statutory provisions

(e) any relevant directions from NHS England

(f) such of the NHS Standard Contract Conditions as are applicable

Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

8.16 Save for deeds and contracts relating to the disposal, acquisition or leasing of land and buildings, the following shall apply:

~~All contract documents, up to the value of £200,000, shall be signed on behalf of the Trust by an Executive Director **(voting or non-voting)** or nominated officer. Documents above £200,000 shall be signed by the Director or Finance, Chief Executive or nominated officer with appropriate approval limit. Every contract, the value of which exceeds £500,000, shall be executed under the signature of two **Executive Director (voting or non-voting)** duly authorised by the Chief Executive and not from the originating department.~~

Contract value range	**Authorised to approve contract**	**Authorised to sign contract**
Over £500k	Managing Director or Executive Director	Executive Director (voting or non-voting) and Chief Executive
Over £200k	Managing Director or Executive Director	One of the following; Director of Finance, Chief Executive or nominated officer (with appropriate approval limit).
Up to £200k	Managing Director	One of the following; Executive Director (voting or non-voting), nominated officer, Deputy Chief Executive or Deputy Director of Finance
Up to £50k	General Manager	Managing Director

Up to £10k	Area Service Manager	General Manager
Up to £1k	Deputy Area Service Manager	Area Service Manager

All deeds and contracts relating to the disposal, acquisition or leasing of land or property, shall be executed under the Common Seal of the Trust and be signed by the **Trust Secretary** or a **Nominated Deputy** and an **Executive Director (voting or non-voting)** duly authorised by the Chief Executive and not from the originating department.

8.17 In all contracts made by the Trust, the Board shall endeavour to obtain best value for money. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

8.18 **Personnel and Agency or Temporary Staff Contracts** - The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment regarding staff, agency staff or temporary staff service contracts.

8.18.1 Where a member of staff is employed using such temporary arrangements the Director of People, Organisational Development and Inclusion will ensure that up-to-date guidance is available to managers and that compliance with such guidance is appropriately monitored and enforced to ensure that the Trust is able to comply with regulatory requirements including those of NHS England and Her Majesty's Revenue and Customs (HMRC).

8.19 **Healthcare Services Agreements** – service agreements with commissioners for the supply of healthcare services, are subject to the separate and specific provisions of the terms of authorisation of the Trust and must be in the form of legally binding contracts.

8.20 **Cancellation of Contracts** – Except where specific provision is made in model forms of contracts approved for use within the NHS and in accordance with SFIs 8.18 and 8.19, every contract shall include a written clause empowering the Trust to terminate the Contract and to recover from the Contractor the amount of any loss resulting from such cancellation if the Contractor or any person employed by the Contractor or acting on behalf of the Contractor has offered, paid or given, directly or indirectly, any gift in money or any other form to any employee or agent of the Trust as an inducement or reward in connection with their behaviour in relation to the Contract, or appears to have committed any offence under the Bribery Act 2010 or other appropriate legislation.

8.21.1 **Determination of Contracts for Failure to Deliver Goods or Materials** – There shall be inserted in every written contract for the supply of goods or materials a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the Trust may without prejudice determine the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good (a) such default, or (b) in the event of the contract being wholly determined the goods or materials remaining to be delivered. The clause shall further secure that the amount by which the cost of so purchasing other goods or materials exceeds

the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.

8.22 The Chief Executive shall nominate officers with power to negotiate for the provision of healthcare services with purchasers of healthcare.

8.23 **Contracts Involving Funds Held on Trust** - shall do so individually to a specific named fund. Such contracts involving charitable funds shall comply with the requirements of the Charities Act.

9. NHS SERVICE AGREEMENTS AND CONTRACTS FOR THE PROVISION OF SERVICES

9.1 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable contracts with service commissioners for the provision of health services. In discharging this responsibility, the Chief Executive shall take into account:

(a) The National Contract framework
(b) Local health service planning priorities
(c) The cost, price and volume of services to be provided and method of payment;
(d) The standards and detailed specifications for service quality expected;

The Trust will work with any partner agencies involved in both the delivery and the commissioning of the service required. The contract will apportion responsibility for mitigating any contractual risks and the financial arrangements should reflect this.

The Chief Executive, as the Accounting Officer, will need to ensure that regular reports are provided to the Trust Board detailing actual and forecast income from contracts, this responsibility has been delegated to the Executive Director of Finance.

This will include information on any costing arrangements subject to local currency agreements, including any changes to payment systems e.g. National Tariff Payment System.

The decommissioning of any healthcare service will require approval by Trust Board.

10. EMPLOYMENT TERMS AND CONDITIONS

10.1 REMUNERATION

10.1.1 The Board should formally agree and record in the minutes of its meetings, the precise terms of reference of the Remuneration and Appointments Committee, specifying which posts fall within its area of responsibility, its composition, and the

arrangements for reporting. The terms of reference of this committee are contained in the Scheme of Delegation.

10.1.2 Except where Agenda for Change rules apply, the Trust Board will approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those staff not covered by the Committee.

10.1.3 The remuneration of the Chair and Non-executive Directors will be determined by the Council of Governors in accordance with the Foundation Trust Constitution.

10.2 FUNDED ESTABLISHMENT

10.2.1 The workforce plans incorporated within the annual budgets will form the funded establishment.

10.3 STAFF APPOINTMENTS

10.3.1 No Director or staff may engage, re-engage employees, or re-grade job roles~~staff~~, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

i) Unless within the approved budget and funded establishment limit and in accordance with appropriate guidance on such employment.
ii) In certain circumstances, following the consideration of an 'Invest to Save' Business Case at ELT, the Chief Executive and the Director of Finance may approve appointments to unfunded posts. These posts must have a return on investment over an agreed period of time. Any agreements that are made will be reviewed and evaluated on a regular basis in order to access the impact on delivering efficiencies laid out in the business case.

10.3.2 The Board will approve procedures presented by the Chief Executive for the determination of pay rates, conditions of service, etc., for staff.

10.3.3 When engaging staff or regrading roles the Trust's recruitment and job evaluation processes must be followed.

10.4 PROCESSING OF PAYROLL

10.4.1 The Director of People, Organisation Development and Inclusion is responsible for:

i) specifying timetables for submission of properly authorised time records and other notifications;
ii) making recommendations to the Director of Finance on the final determination of pay;
iii) making payment on agreed dates;
iv) agreeing methods of payment.
v) maintaining and enforcing a Trust under and overpayment policy and seeking to recover any overpayments in line with that policy.

10.4.2 The Director of Finance and the Director of People, Organisational Development and Inclusion **will** as appropriate, issue instructions regarding:

ii) verification and documentation of data;
iii) the timetable for receipt and preparation of payroll data and the payment of staff;
iv) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
v) security and confidentiality of payroll information;
vi) checks to be applied to completed payroll before and after payment;
vii) authority to release payroll data under the provisions of the Data Protection Act;
viii) methods of payment available to various categories of staff;
ix) pay advances and their recovery;
x) procedures for payment by cheque or bank credit:
xi) procedures for the recall of cheques or bank credits;
xii) maintenance of regular and independent reconciliation of pay control accounts;
xiii) separation of duties of preparing records and handling cash; and
xiv) a system to ensure the recovery from leavers of payments and property due to the Trust.
xv) A system to record and report specific employee costs as required by guidance for example “high-cost off-payroll” employee costs.
xvi) Maintenance of an up to date authorised signatory list for pay.

10.4.3 Nominated managers have delegated responsibility for:

i) Ensuring all members of staff with any secondary employment complete all required declarations in line with secondary employment policy or successor policy in place at the time.
ii) Ensuring all staff absences are appropriately authorised. In the event of unauthorised absence the line manager is responsible for notifying payroll services to ensure payment for unauthorised absence is prevented or recovered.
iii) Submitting time records, and other notifications in accordance with agreed timetables.
iv) Completing time records and other notifications in accordance with the instructions of and in the form prescribed by the Director of People, Organisation Development and Inclusion or the Director of Finance.
v) Submitting termination forms electronically immediately upon receiving confirmation of a member of staff’s resignation, termination or retirement. Where a member of staff fails to report for duty in circumstances that suggest they have left without notice, the Director of People, Organisational Development and Inclusion must be informed at the earliest opportunity.
vi) Submitting all employee-related updates promptly to avoid over or under payment and to ensure that staff records are accurate and up to date for their area of responsibility. These requirements include but are not limited to new starters, change forms and leavers.

vii) An authoriser must ensure that timesheets, expense claims and other such notifications are appropriately checked and agreed as accurate before authorisation is given.
viii) Ensuring that all Rostering systems for their area of responsibility are accurately maintained, in accordance with Trust policy, to ensure correct and timely payments are made to appropriate staff.

10.4.4 The Director of People, Organisational Development and Inclusion and the Director of Finance shall ensure that the chosen method for providing the payroll service is supported by appropriate contracted terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

10.4.5 In terminating a contract through the use of severance payments, the affordability of the payment should be assessed by the Director of Finance before proceeding. The Director of People, Organisational Development and Inclusion is responsible for ensuring all appropriate regulatory due process is followed for all types of termination payments. The proposed payment must be authorised by the Chief Executive via the use of the "Termination of Contract – Severance Payments Proforma". This document outlines the details and circumstances of the proposed severance payment. The Director of People, ~~Organiational~~Organisational Development and Inclusion must ensure this guidance is maintained in line with current regulatory requirements.

All exit packages must be within the contractual limits or less. Where the Director of People, Organisational Development and Inclusion and the Remuneration and Appointments Committee proposes payment which exceeds contractual limits, appropriate approval must be sought from NHS England and the Treasury in line with regulatory policy.

In line with Freedom to Speak Up requirements the Chief Executive will personally review all settlement agreements that contain confidentiality clauses to ensure that such clauses are in the public interest.

Such settlement agreements will be made available for inspection by the CQC as part of their assessment to determine if the organisation is well-led
If the settlement requires Treasury approval the Trust will demonstrate that the confidentiality clause is in the public interest in that particular case.

10.5 CONTRACT OF EMPLOYMENT

10.5.1 The Trust Board shall delegate responsibility to the Director of People, Organisational Development and Inclusion for:

- ensuring that all staff are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and
- dealing with variations to contracts of employment; and

- dealing with termination of contracts of employment (except those cases subject to disciplinary rules and procedures) upon the advice of the Director of Finance on affordability.

11. NON-PAY EXPENDITURE

11.1 DELEGATION OF AUTHORITY

11.1.1 The Trust Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

Budget holders so delegated, and others who the Budget Holders shall formally nominate shall be authorised to approve requisitions, invoices and petty cash, subject to appropriate segregation of duties and subject to the scope and limit(s) of their budget(s).

11.1.2 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

11.2 CHOICE, REQUISITIONING, ORDERING, RECEIPT AND PAYMENT FOR GOODS AND SERVICES

11.2.1 Any member of staff authorised to requisition goods or services shall comply with procedures issued by the Director of Finance and**,** in choosing the item to be supplied or the service to be performed**,** shall always obtain the best value for money for the Trust. In so doing, the advice of the Procurement department shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance and the Chief Executive shall be consulted.

11.2.2 The Director of Finance shall be responsible for the prompt payment of all properly authorised accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance. Payment for goods and services shall only be made once the goods and services are received (except for prepayments as below). Such requirements will be specified in a Service Level Agreement with the Shared Services Organisation as appropriate.

11.2.3 Official orders must state the Trust's terms and conditions of trade and be consecutively numbered. They must only be issued to, and used by, those duly authorised by the Chief Executive and be in a form approved by the Director of Finance.

11.2.4 All goods, services, or works shall be ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash. Verbal orders may only be issued very exceptionally - by a member of staff designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked

"Confirmation Order". Goods may not be taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase.

11.2.5 The Director of Finance will:

(a) advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed.

(b) prepare procedural instructions where not already provided in the Scheme of Delegation or procedure notes for budget holders on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) maintain a list of Directors/staff, authorised to certify invoices.

(e) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

i) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

ii) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

iii) Instructions to staff regarding the handling and payment of accounts within the Finance Department.

iv) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as in SFI 11.2.6).

11.2.6 Prepayments are only permitted where exceptional circumstances apply. In such instances, where material (in excess of £10,000):

a) the appropriate Executive Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;

b) the Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed; and

c) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and he must immediately inform the appropriate Executive Director or Chief Executive if problems are encountered, along with their Finance Manager who can ensure the correct accounting treatment is performed.

11.2.7 Managers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

a) all contracts (other than for a simple purchase permitted within the Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance and the Trust Secretary in advance of any commitment being made;

b) contracts above specified thresholds are advertised and awarded in accordance with Public Contract Regulation rules on public procurement;

c) where consultancy advice is being considered, the approval and procurement of such advice must be in accordance with current regulatory guidance for Foundation Trusts. When considering consultancy advice internal approval from the Director of Finance should be sought in line with delegated responsibility limits and always before any business case is sent for external approval from the Regulator. Wherever possible the preferred bidder should assist in the preparation of the required business case to the Regulator. The term consultancy advice is defined as the provision, to management, of objective advice and assistance relating to strategy, structure, management of operations of an organisation in pursuit of its purposes and objectives. Such assistance will be provided outside the “business as usual” (BAU) environment when in-house skills are not available and will be of no essential consequence and time-limited. Services may include the identification of options with recommendations and/or assistance with (but not delivery of) the implementation of solutions. If in any doubt this is to be referred to the Director of Finance or Deputy for clarification.

d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Directors or staff, other than:

i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

ii) conventional hospitality, such as lunches in the course of working visits;

iii) the Conflicts of Interest Policy must be adhered to in all cases.

e) no requisition/purchase order is to be placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

f) all goods, services, or works should be ordered on an official purchase order including wherever possible works and services executed in accordance with a contract but excluding purchases from petty cash;

g) verbal orders must only be issued very exceptionally - by a member of staff designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds or regulatory guidance;

i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

j) changes to the list of Directors/staff authorised to certify invoices are notified to the Director of Finance;

k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance; and petty cash records are maintained in a form as determined by the Director of Finance;

l) payments to local authorities and voluntary organisations made under the powers of the NHS Act shall comply with procedures laid down by the Director of Finance which shall be in accordance with these Acts.

12. EXTERNAL BORROWING AND INVESTMENTS

12.1 EXTERNAL BORROWING

12.1.1 The Director of Finance is responsible for ensuring that the sum of borrowing from all sources both short term and long term represents value for money, comply with any Regulatory limits and guidance and does not adversely impact on future cash flows.

12.1.2 Any application for a temporary loan or overdraft will only be made by the Director of Finance or by a member of staff so delegated by them and in any event a duly authorised signatory.

12.1.3 The Director of Finance must prepare detailed procedural instructions concerning applications for temporary loans and overdrafts.

12.1.4 All external borrowing must be consistent with the plans outlined in the current Business Plan and be recommended by Finance and Performance Committee to the Trust Board.

12.1.5 The Trust holds a separate Treasury Management Policy which covers both borrowings and investment in more detail.

12.2 INVESTMENTS

12.2.1 Foundation Trusts have discretion to invest surplus money for the purposes of, or in connection with, their functions. The Chief Executive, as accountable officer, is responsible for ensuring that surplus operating cash is invested in accordance with the Board of Directors' duty to safeguard and properly account for the use of public money.

12.2.2 The Director of Finance is responsible for advising the Trust Board on investment strategies for cash surpluses in accordance with best practice guidance and in line with NHS England's most current published guidance for Foundation Trusts.

13. CAPITAL EXPENDITURE AND PRIVATE FINANCE

13.1 CAPITAL INVESTMENT

13.1.1 All bids for Capital Investment should be approved by the Board of Directors (with due regard to the Trust's cash position and any associated investment strategies).

13.1.2 The Trust will follow NHS England's Cash and Capital Regime and where applicable approval will be sought for any investment and property business cases in line with the requirements of the guidance. See NHS England: 'Capital guidance update 2023/24' and NHS England 'capital investment and property business case approval guidance for NHS trusts and foundation trusts'.

13.1.3 The Trust will follow NHS England capital regime in relation to system sign off and working within CDEL limits set by the Regulator.

13.1.4 The Chief Executive is responsible for ensuring that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans.

13.1.5 The Trust shall appoint the Capital Project Group or other appropriate meeting structure whose responsibilities shall be:

a) the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost and meet their overall purpose; and

b) ensuring that capital investment is not undertaken without commissioner(s)/ partner(s) written support, where required, and the availability of resources to finance all revenue consequences and capital charges; and

c) to ensure that a robust financial appraisal is undertaken as appropriate for all business cases (which have been approved by the Trust's Finance and Performance committee as appropriate); and

d) to ensure that appropriate project management and control arrangements are in place; and

e) that the Director of Finance has certified professionally to the costs and revenue consequences detailed in business cases.

13.1.6 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of "Estatecode". The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

13.1.7 The approval of a capital programme shall not constitute approval for expenditure on any scheme. The Chief Executive shall issue to the manager responsible for any scheme (through the Capital Project Group):

- specific authority to commit expenditure;
- authority to proceed to tender or obtain quotations;
- approval to accept a successful tender or quotation and to place an order.

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with "Estatecode" guidance and the Trust's Standing Orders.

13.1.8 The Director of Finance shall issue the capital investment framework and procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

13.1.9 Delegated limits for the signing-off of expenditure on capital monies are covered in these SFIs.

13.2.1 The section below covers the approval process before orders are placed.

Expenditure on an individual project up to £100,000	Approved by the Capital Project Group
Expenditure on an individual project between £100,000 and £1,000,000	Jointly approved by the Director of Finance and one other Executive Director

Proposed expenditure on a project in excess of £1,000,000	Board approval required (and process to be in accordance with NHS England guidance)

13.2.2 The extent and progress of the manner in which Capital Investment monies are spent will be regularly reported to the ~~Executive Leadership Team~~Trust Delivery Group and Finance and Performance Committee. Any variation to the approved capital expenditure plan will require appropriate authorisation, in accordance with the above limits and be appropriately reported to regulators.

14. ASSET REGISTERS AND SECURITY OF ASSETS

14.1 ASSET REGISTERS

14.1.1 The Chief Executive is responsible for ensuring that a system exists for the maintenance of registers of assets, taking account of the advice of the Director of Finance on the form of any register and the means of updating and arranging for a periodic physical check of assets against the asset register to be conducted.

The Trust shall maintain an asset register recording fixed assets. The composition of information to be held within these registers shall be specified in the Trust's capital accounting policies.

14.1.2 Budget holders must confirm to the Director of Finance any fixed asset additions within their remit. Additions to the asset register will be validated by reference to:

- properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;
- stores, requisitions and wages records for own materials and labour with overheads; and
- lease agreements in respect of assets held under a finance lease and capitalised.

14.1.3 Budget holders must notify the Director of Finance where they propose that assets are to be sold, scrapped, or otherwise disposed of. Each disposal must be validated by reference to authorisation documents and invoices (where appropriate) and accounted for appropriately. (see disposals and condemnations section).

Budget holders must seek approval from the Trust Board to declare any land or buildings as surplus to NHS requirements and available for disposal and income.

The route to market for any sale of land and buildings will be determined by the Associate Director ~~Head~~ of Estates and Facilities and the Director of Finance but with final agreement by the Trust Board.

Budget holders and service managers must notify the Financial Controller if assets are being transferred between buildings or otherwise relocated, to allow for the asset register to be updated.

If any assets remain in empty buildings, it is the exiting service manager that is responsible for those assets until the building has been handed over to a new service or to Estates.

No assets that have been identified to hold Commissioner Requested Services in accordance with the NHS England Licence Agreement are allowed to be sold without prior consultation and agreement with NHS England in line with current guidance and approval from the Board. The trust asset register includes a list of all assets which have been identified as being locations of Commissioner Requested Services.

14.1.4 The value of owned buildings shall be indexed to current values and all assets shall be depreciated using methods and rates as specified by the appropriate accounting policies in use in the Trust. Periodically non-current assets will be subject to a formal revaluation exercise as described in the relevant Trust accounting policies. The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

14.1.5 The Director of Finance of the Trust shall calculate and pay capital charges as required.

14.2 SECURITY OF ASSETS

14.2.1 The overall control of assets is the responsibility of the Chief Executive.

14.2.2 Asset control procedures (including fixed assets, cash, cheques, and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

- identification of additions and disposals;
- recording managerial responsibility for each asset;
- physical security of assets;
- periodic verification of the existence of, condition of, and title to, assets recorded;
- identification and reporting of all costs associated with the retention of an asset; and
- reporting, recording and safekeeping of cash, cheques and negotiable instruments.

14.2.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

14.2.4 Whilst each member of staff has a responsibility for the security of property of the Trust, it is the responsibility of Directors and senior staff in all disciplines to apply

such appropriate routine security practices in relation to NHS property as may be determined by the Board of Directors. Any breach of agreed security practices must be reported in accordance with instructions.

14.2.5 Any damage to Trust premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Directors and staff in accordance with both security policies and the losses procedure.

14.2.6 The organisation will take all necessary steps to recover financial losses due to fraud, theft of, or criminal damage to, its assets on a case by case basis in a timely manner.

The impact of the recovery of financial losses due to theft or criminal damage of its assets is regularly monitored and soundly evaluated by ~~Executive Leadership Team~~Trust Delivery Group and, where appropriate, improvements are made to the redress arrangements and the organisations approach to recovery.

14.2.7 IT assets and where practical Plant, Property and Equipment, should be marked as Trust property.

14.2.8 Where appropriate the Trust's assets should be covered by the NHS arrangements for the pooling of insurance**.**

14.2.9 Each member of staff has a responsibility for the security of property of the Trust whilst working remotely or from home, see separate Home Working Policy.

14.3 PARTNERING ARRANGEMENTS, LEASE ACQUISITIONS AND LEASE ASSIGNMENTS

14.3.1 Partnering arrangements involving the occupation of another party's property (NHS or non NHS) or allowing another party to occupy part of the Trust's property, even if no financial consideration is involved, must be covered by formal agreement.

14.3.2 All arrangements where the Trust use or occupy a room, part or all of a building for any length of time must be covered by an appropriate written agreement.

14.3.3 Lease acquisition of properties must be covered by a formal lease arrangement.

14.3.4 The decision to sub-let a Trust property or to take on an assigned lease must be covered by a formal agreement or assignment.

14.3.5 The Trust Secretary must be consulted on the legal position and will advise on the need for lease or license agreement and its content.

14.3.6 The Associate Director ~~Head~~ of Estates and Facilities is responsible for negotiating the heads of terms and will advise on matters of Health & Safety, rates, utilities, maintenance and insurance obligations.

14.3.7 The Director of Finance must be consulted to advise on the appropriate accounting treatment under IFRS 16. Following the change in accounting treatment and new leases to be funded from Business as Usual capital allocations, all new leases must go through the Capital Project Group for approval or recommendation depending on capital limits set out in 13.2.1.

14.3.8 The Trust Secretary is responsible for maintaining a full record of all agreements in a Trust-wide property database. This will include termination dates, break clause details, rent review dates, notice periods and financial commitments.

14.4 LEASE TERMINATIONS

14.4.1 The decision to vacate a Trust property must be covered by formal agreement.

14.4.2 The Trust Secretary must be consulted on the legal position and will advise on the notice to the landlord.

14.4.3 The Associate Director ~~Head~~ of Estates and Facilities will facilitate the assessment of dilapidations and cancellation notifications e.g. rates, insurances, utilities.

14.4.4 The Director of Finance must be informed to ensure payments are cancelled in line with the agreement.

14.4.5 A full record of the agreement is to be maintained in the Trust wide property database.

14.5 RENT REVIEWS

14.5.1 As part of the responsibility for record management there is a need to ensure that rent reviews are carried out in accordance with the lease agreement, and that agreement is either concluded within 2 months of the review date, or that the Finance department are advised of the liability that the budget holder may face. Rent Reviews shall be reported to the Capital Programme Group for consideration prior to being formally agreed.

15. STORES AND RECEIPT OF GOODS

15.1 Stores, i.e. controlled stores and departmental stores for immediate use should be:

- kept to a minimum;
- subjected to annual stock take;
- valued in accordance with Trust accounting policy.

15.2 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to a member of staff by the Chief Executive. The day-to-day responsibility may be delegated by the Chief Executive to departmental staff and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The

control of Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer.

15.3 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager or Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

15.4 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

15.5 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all material items in stock at least once a year.

15.6 Where a complete system of stock control is not justified, alternative arrangements shall require the approval of the Director of Finance.

15.7 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also 16, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

15.8 For goods supplied by NHS Supply Chain**,** the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Director of Finance who shall satisfy himself that the goods have been received before accepting the recharge.

15.9 The Trust will follow any guidance issued by NHS England in relation to any centrally procured goods such as PPE.

16. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

16.1 DISPOSALS AND CONDEMNATIONS

16.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers. Every effort should be made by managers to maintain assets of property plant and equipment in good order.

16.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Director of Finance of the

estimated market value of the item, taking account of professional advice where appropriate.

16.1.3 Surplus property, plant and equipment or any other Trust asset, which is in serviceable order, should not be disposed of. Due process must be followed whereby the surplus asset is reallocated within the Trust or temporarily stored appropriately. Requests to otherwise dispose of any serviceable asset must be approved by the head of department and notified to the Director of Finance.

16.1.4 All unserviceable articles shall be condemned or otherwise disposed of by a member of staff authorised for that purpose by the Director of Finance. The Condemning Officer shall record condemnation in a form approved by the Director of Finance, which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second member of staff authorised for the purpose by the Director of Finance.

16.1.5 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

16.2 LOSSES AND SPECIAL PAYMENTS

16.2.1 The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

16.2.2 Any member of staff discovering or suspecting a loss of any kind must immediately inform their head of department, who must inform the Chief Executive and the Director of Finance at the earliest opportunity. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved, but if the case involves suspicion of fraud, then the matter should be reported to the Local Counter Fraud Specialist for a criminal investigation. Consideration of police involvement will be discussed with the Local Counter Fraud Specialist. All security-related incidents must be reported to the Trust's Security Management Specialist.

16.2.3 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a financial nature, the Trust's Local Counter Fraud Specialist must also be notified at the earliest opportunity.

16.2.4 The Board of Directors shall approve the writing-off of losses. This approval is delegated to the Chief Executive (or Director of Finance / Deputy Director of Finance) in accordance with the Scheme of Delegation. Write-offs will only be reported to Audit and Risk Committee on an exceptional basis by value.

16.2.5 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

16.2.6 For any loss, the Director of Finance should, in consultation with the Trust Secretary, consider whether an insurance claim can be made.

16.2.7 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

16.2.8 No special payments exceeding delegated limits shall be made without the prior approval of the relevant body

16.2.9 Losses and special payments will only be reported to the Audit and Risk Committee on an exceptional basis by value or volume if there becomes any issue with a certain area.

17 INFORMATION MANAGEMENT AND TECHNOLOGY

17.1 The Director with responsibility for Information Management and Information Technology, who is responsible for the accuracy and security of the computerised (including financial) data and information of the Trust, shall be responsible for devising and maintaining appropriate Information Management and Technology procedures and policies for the Trust.

17.2 The Director responsible for IM&T shall ensure that financial IM&T systems are developed and maintained in an appropriate manner, even in the event that the maintenance of such a system is outsourced.

17.3 The Director of Finance and the Director responsible for IM&T shall ensure that contracts for computer services for financial applications with another health organisation**,** any other agency or Shared Services Organisation shall clearly define the responsibility of all parties for the information governance, security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

17.4 Where another health organisation**,** any other agency or Shared Service Organisation provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

17.5 Where computer systems have an impact on corporate financial systems the Director of Finance shall satisfy themself that:

(a) systems acquisition, development and maintenance are in line with financial requirements;
(b) data produced by financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;
(c) Only appropriate persons shall have access to such data; and
(d) such computer audit reviews as are considered necessary are being carried out.
(e) Adequate business continuity/disaster recovery arrangements are in place.

17.6 The Director of Finance shall ensure that financial risks to the Trust arising from the use of IM&T are effectively identified and considered and appropriate action taken to mitigate or control risk.

17.7 Freedom of Information

All Directors shall ensure that processes are in place and are subject to adequate control for the provision of information requests in line with The Freedom of Information (FOI) Act 2000.

18. PATIENTS' PROPERTY

18.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in Trust property. Employees are required to follow the Trust Policy and Procedure for Service Users' Finance and Property.

18.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by;

a) notices and information booklets,
b) Trust admission documentation and property records,
c) the verbal advice of administrative and/or nursing staff responsible for admissions.

The Trust will not accept responsibility or liability for patients' property brought into Trust premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

18.3 The Chief Operating Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

18.4 Where Department of Health instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Director of Finance.

18.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

18.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

18.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor in writing.

19. CHARITABLE FUNDS

19.1 INTRODUCTION

19.1.1 Charitable funds are those gifts, donations and endowments held on trust for purposes relating to the Derbyshire Healthcare NHS Foundation Trust. They are administered on behalf of the Trust by the Directors of the Derbyshire Community Healthcare Services NHS Foundation Trust, acting as agents of the charitable fund.

19.1.2 The discharge of the DCHS's corporate trustee responsibilities is distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes. The Director of Finance shall ensure that each charitable fund is managed appropriately with regard to its purpose and to its requirements.

19.2 The Director of Finance shall periodically review the charitable funds in existence and shall make recommendations to the trustees regarding the potential for rationalisation of such charitable funds within statutory guidelines.

20. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT

20.1 The Trust Secretary shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. Staff should be aware of and comply with the Trust's 'Conflict of Interest Policy'.

20.2 Staff should make themselves aware of, and comply with, the Bribery Act 2010, Code of Conduct for NHS Managers 2002, and the Code of Practice for the Pharmaceutical Industry 2012 relating to hospitality / gifts from pharmaceutical / external industry.

21. RETENTION OF DOCUMENTS

21.1 The Chief Executive shall be responsible for maintaining a Policy and Procedure for the Retention, Preservation and Destruction of Records which all employees must follow.

21.2 Any documents held in archives shall be capable of retrieval by authorised persons.

21.3 Documents held under the requirements of current directions shall only be destroyed at the express instigation of the Chief Executive, and records shall be maintained of documents so destroyed in accordance with the Policy and Procedure for the Retention, Preservation and Destruction of Records.

21.4 Associated policies which employees should be familiar with are: the Policy and Procedure for Offsite Records Storage, Policy and Procedure for Disposal of Confidential Information and the Information Lifecycle Management Policy and Procedure.

22. RISK MANAGEMENT AND INSURANCE

22.1 The Chief Executive shall ensure that the Trust has a programme of risk management, which will be approved and monitored by the Board of Directors. Employees must comply with the Trust Risk Management policies and procedures.

22.2 The programme of financial risk management shall include:

a) process for identifying and quantifying risks and potential liabilities.

b) engendering among all levels of staff a positive attitude towards the control of risk.

c) management processes to ensure all significant financial risks and potential liabilities are addressed, including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk.

d) contingency plans to offset the impact of adverse events.

e) audit arrangements including internal audit, clinical audit, health and safety review.

f) arrangements to review the risk management programme.

The existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of internal control within the annual report and accounts.

The Trust Secretary shall ensure that insurance arrangements exist in accordance with the risk management programme.

Insurance arrangements with commercial insurers

22.3 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, three exceptions when the Trust may enter into insurance arrangements with commercial insurers. The exceptions are;

a) Trusts may enter commercial arrangements for insuring motor vehicles owned or leased by the Trust including insuring third party liability arising from their use.

b) where the Trust is involved with a contractual arrangement to lease a building and the landlord or Private Finance Initiative consortium in respect of the PFI contract require that commercial insurance arrangements are entered into or the value of the building is in excess of the value covered by the NHS Resolution and further cover is required.

c) Where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for NHS purpose the activity may be covered in a risk pool. Confirmation of coverage on the risk pool must be obtained from the NHS Litigation Authority. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements, the Director of Finance and Trust Secretary should consult the Department of Health.

APPENDIX 1

Tendering Procedure

1. Invitation to tender

(i) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

(ii) All invitations to tender shall state that no tender will be accepted unless:

(a) submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive or nominated Manager;

(b) that tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

(c) It is submitted in accordance with the instructions issued via The Trust's electronic contract management system

(iii) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

(iv) Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

2. Receipt and safe custody of tenders

The Trust Secretary or their nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening. In the case of tenders submitted by The Trust's electronic contract management, the tender maybe opened by the Head of Procurement.

The date and time of receipt of each tender shall be endorsed on the tender envelope/package.

3. Opening tenders and Register of tenders

(i) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two Directors which will include, if available ~~y~~ the Trust Secretary or their nominated representative and a Director who is not from the originating department. In the case of tenders submitted by the Trust's electronic contract management, the tender may be opened by the Head of Procurement. These tenders are held in a secure environment compliant with ISO27001 infrastructure and available as a CESG accredited HMG Impact Level 3 service which allows handling of "restricted documents" classification. In this case sub sections (ii), (vi) and (vii) do not apply.

(ii) A voting member of the Trust Board will be required to be one of the two approved persons present for the opening of tenders estimated above £400,000. The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the Trust's Scheme of Delegation.

(iii) The 'originating' Department will be taken to mean the Department sponsoring or commissioning the tender.

(iv) The involvement of Finance Directorate staff in the preparation of a tender proposal will not preclude the Director of Finance from serving as one of the directors to open tenders. The involvement of estates staff in the preparation of a tender proposal will not preclude the Director who has the portfolio responsibility for Estates from serving as one of the directors to open tenders.

(v) All Executive Directors will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.

(vi) Every tender received shall be marked with the date of opening and initialled by those present at the opening.

(vii) A register shall be maintained by the Trust Secretary, or a person authorised by him, to show for each set of competitive tender invitations despatched, including those handled under the electronic contract management system (see 3 (i) above):

- the name of all firms individuals invited;
- the names of firms individuals from which tenders have been received;
- the date the tenders were opened;
- the persons present at the opening;

- the price shown on each tender;
- a note where price alterations have been made on the tender.

Each entry to this register shall be signed by those present.

A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

(viii) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon their own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders.

4. Admissibility

(i) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

(ii) Where only one tender is sought and/or received, the Chief Executive and Director of Finance shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

5. Late tenders

(i) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or their nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

(ii) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or their nominated officer or if the process of evaluation and adjudication has not started.

(iii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Trust Secretary or their nominated officer.

6. Acceptance of formal tenders

(i) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of their tender before the award of a contract will not disqualify the tender.

(ii) The most economically advantageous tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary; such good and sufficient reasons will be determined by those within the Trust with the requiste skill and experience in the matter being tendered for. Such reasons shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

a) experience and qualifications of team members;
b) understanding of client's needs;
c) feasibility and credibility of proposed approach;
d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

(iii) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

(iv) The use of these procedures must demonstrate that the award of the contract was:

a) not in excess of the going market rate / price current at the time the contract was awarded;

b) that best value for money was achieved.

(v) All tenders should be treated as confidential and should be retained for inspection.

7. Tender reports to the Trust Board

Reports to the Trust Board will be made on an exceptional circumstance basis only.

8. List of approved firms

a) Responsibility for maintaining list

A manager nominated by the Chief Executive shall on behalf of the Trust maintain lists of approved firms from whom tenders and quotations may be invited. These shall be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial

competence the Trust is satisfied. All suppliers must be made aware of the Trust's terms and conditions of contract.

b) Building and Engineering Construction Works

(i) Invitations to tender shall be made only to firms included on the approved list of tenderers compiled in accordance with this Instruction or on the separate maintenance lists compiled in accordance with "Estmancode" guidance (Health Notice HN(78)147).

(ii) Firms included on the approved list of tenderers shall ensure that when engaging, training, promoting or dismissing staff or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equal Pay Act 1970, the Sex Discrimination Act 1975, the Race Relations Act 1976, the Disabled Persons (Employment) Act 1944 and Equality Act 2010 and any amending and/or related legislation.

(iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

c) Financial Standing and Technical Competence of Contractors

The Director of Finance may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

9. Exceptions to using approved contractors

If in the opinion of the Chief Executive and the Director of Finance or the Director with lead responsibility for clinical governance it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

EQUALITY IMPACT ASSESSMENT TEMPLATE: FRONT SHEET.

(To be completed for Stage 1 and updated for Stage 2)

Please note 'policy' refers to strategy, project, commissioning, saving plan etc

Question	Response
Name of 'policy' being assessed	Standing Financial Instructions
Summary of aims and objectives of the 'policy'	The Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. The Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust.
Is this a new or existing 'policy'?	Existing
Please state which organisation is the EIA being completed for? • Derbyshire Healthcare NHS FT • Joint Derbyshire Healthcare NHS FT and Derbyshire Community Health Services • Other (please give details)	Derbyshire Healthcare NHS FT
Division/Team/Service	Trust wide
Date Stage 1 completed: Screening for Relevance:	10/07/2025
Is a Stage 2: EIA required to be completed after Stage 1? Please provide justification	No
Date Stage 2 EIA completed:	
Name/s, job title/s and contact/s details of person/s completing this assessment	Rachel Leyland, Deputy Director of Finance
Name, job title and contact details of responsible lead Director /Associate Director/Head of Service	James Sabin, Director of Finance

Has this EIA been logged in your Division/Service/Team EIA Tracker?	

EQUALITY IMPACT ASSESSMENT TEMPLATE: STAGE 1 SCREENING FOR RELEVANCE

(Please use plain English http://www.plainenglish.co.uk/, avoiding jargon and acronyms. EIA's are viewed by a wide range of people including decision-makers and the wider public)

Question	Response
1a: Summary of aims and objectives of the 'policy'	The Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. The Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust.
1b: Please state who this 'policy' will affect? • Patients or Service Users • Carers or families • Commissioned Services • Communities, in placed based settings • Staff - • Partners • Stakeholder organisations • Others (give details)	Staff
1c: Will the 'policy' impact equality and or inequalities? • Access to or participation in a service • Levels of representation in our workforce • Reducing quality of life (i.e., health, poverty education, standard of living)	No
1d: If there are 'no' impact on equality and or inequalities, please provide an explanation?	The nature and remit of this document means that it has no impact on equality, diversity or inclusion and therefore does not impact those with protected characteristics.
1e: If there are impacts on equality and or inequalities complete stage 2 EIA	

If you plan to complete the assessment at a later stage, please state the timescale for this.	

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 Strategic Plan (quaterly update)	X		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					
	Receipt of Reports (following assurance at People and Culture Committee (PCC)):						
DPODI	Annual Approval of Modern Slavery Statement (PCC - Mar, to be published on Trust website on approval)	X					
DPODI	Staff Survey results (PCC - Mar)						X
DPODI	Annual Gender Pay Gap report for approval (PCC - May)	X					
DPODI	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					
DCEO/CDO	Mental Health Services Assessment Tool (Men-SAT), including action plan (via Trust Delivery Group and Finance and Performance Committee)			X			
DPODI	Receipt of Reports (following assurance at People and Culture Committee (PCC)):						
DPODI	Workforce Plan annual review (PCC - Sep)				X		
	Receipt of Reports (following assurance at Quality and Safeguarding Committee (QSC)):						
DoN/MD	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				X	
DoN	Outcome of patient stories (every two years, due Mar-2026)						X
	Receipt of Reports (following assurance at People and Culture Committee (PCC)):						
MD	Medical Appraisal and Revalidation - annual report (PCC - May)	X					
	Receipt of Reports (following assurance at Quality and Safeguarding Committee (QSC)):						
DoN	Guardian of Safe Working Hours report (QSC - quarterly)		AR		X	X	
DoN	Infection Prevention and Control annual report and IPC BAF (QSC - Oct)				X		
DoN	Looked After Children - annual report (QSC - Sep)				X		
DoN	Quality Delivery Plan (QSC - Jul)		X				
DoN	Delivery of Same Sex Accommodation (QSC - Oct)				X		
DoN	Safeguarding Children and Adults at Risk - Annual report (QSC - Sep)				X		
DoN	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	X			
POLICY REVIEW							
DCEO/CDO	Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity (BC) Policy (30-Nov-2026)			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			

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
A	
A&E	Accident & Emergency
ABPI	Association of British Pharmaceutical Industry
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)

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
CCQI	College Centre for Quality Improvement
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
CSU	Commissioning Support Unit
CTO	Community Treatment Order
CTR	Care and Treatment Review
CUF	Cost Uplift Factor

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
CYP	Children and Young People
D	
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
EI	Early Intervention
EIA	Equality Impact Assessment
EIP	Early Intervention In Psychosis
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
FIG	Feedback Intelligence Group
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)

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
HEE	Health Education England
HES	Hospital Episode Statistics
HFMA	Healthcare Financial Management Association
HoNOS	Health of the Nation Outcome Scores
HoP	Head of Practice
HOPE(s)	The HOPE(s) model is an ambitious human rights-based approach to working with individuals in segregation, developed from research and clinical practice
HSCIC	Health and Social Care Information Centre
HSE	Health and Safety Executive
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
IIC	Inclusive Intercultural Communication
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
KSF	Knowledge and Skills Framework
L	
LA	Local Authority
LAC	Looked After Children
LCFS	Local Counter Fraud Specialist
LA – CYPD	Local Authority – Children and Young People Divisions
LADO	Local Authority Designated Officer
LD	Learning Disabilities
LD/A	Learning Disability and Autism
LeDeR	Learning Disabilities Mortality Review
LFPSE	Learning 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	
M&E	Mechanical and Electrical
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
Men-SAT	Mental Health Services Assessment Tool
MFA	Multi-Factor Authentication
MFF	Market Forces Factor
MHA	Mental Health Act
MHAC	Mental Health Act Committee

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
MHIN	Mental Health Intelligence Network
MHIS	Mental Health Investment Standard
MHLDA	Mental Health, Learning Disabilities and Autism
MHLT	Mental Health Liaison Team
MHOST	Mental Health Optimal Staffing Tool
MHRA	Medical and Healthcare products Regulatory Agency
MHRT	Mental Health Review Tribunal
MHRV	Mental Health Response Vehicle
MHSDS	Mental Health Services Data Set
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
NCISH	National Confidential Inquiry into Suicide and Safety
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
NPSA	National Patient Safety Alert
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
P	
PAB	Programme Assurance Board
PAG	Programme Advisory Group
PALS	Patient Advice and Liaison Service
PAM	Payment Activity Matrix
PARC	Psychosis and the reduction of cannabis (and other drugs)
PARIS	This is an electronic patient record system
PbR	Payment by Results
PCC	Police & Crime Commissioner
PCC	People and Culture Committee
PCLB	Provider Collaborative Leadership Board
PCN	Primary Care Networks
PCOG	Patient and Carer Operational Group
PCREF	Patient and Carers Race Equality Framework
PDC	Public Dividend Capital
PDF	Portable Document Format
PDSA	Plan, Do, Study, Act
PFI	Private Finance Initiative
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
PTU	Psychiatry Teaching Unit
PYE	Part Year Effect

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
Q	
QAG	Quality Assurance Group
QASI	Quality Assurance Serious Incidents
Q&SC	Quality and Safeguarding Committee
QEIA	Quality and Equality Impact Assessment
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity Programme
QOF	Quality and Outcomes Framework
R	
RAID	Rapid Assessment, Interface and Discharge
RAP	Recovery Action Plan
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
RoDP	Recognition of Deteriorating Patient
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
SAT	Specialist Autism Team
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
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
SPOG	Strategic Portfolio Oversight Group
SPOR	Single Point of Referral
SSQD	Specialised Services Quality Dashboards
SSRB	Senior Salaries Review Board
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
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

12 September 2025