Derbyshire Healthcare NHS Foundation Trust

Public Trust Board Meeting

25 November 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, 25 November 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	Lynn Andrews
2	9.35	Board Story – From Patient to Nurse – my experience at Derbyshire Healthcare NHS FT	Tumi Banda
3	10.00	Minutes of the Board of Directors meeting held on 23 September 2025	Lynn Andrews
4		Matters Arising	
5		Questions from members of the public	
6	10.05	Chair's update	Lynn Andrews
7	10.15	Chief Executive's update	Mark Powell
OPERATIONAL PERFORMANCE			
8	10.25	Integrated Performance report (Operations, Finance, People and Quality)	Vikki Ashton Taylor/ James Sabin/ Rebecca Oakley/Tumi Banda/
BREAK 10.55am			
QUALITY GOVERNANCE			
9	11.05	Transformation and Continuous Improvement (bi-annual)	Vikki Ashton Taylor
STRATEGIC PLANNING AND CORPORATE GOVERNANCE			
10	11.15	Trust Strategic Plan update	Vikki Ashton Taylor
11	11.25	Board Assurance Framework (BAF) update	Justine Fitzjohn
12	11.30	Trust Sealings (six-monthly, for information)	Justine Fitzjohn
13	11.35	Delivery of Same Sex Accommodation – Declaration of Compliance	Tumi Banda
14	11.40	Suicide and Self-Harm Prevention Strategy (for ratification)	Girish Kunigiri
15	11.45	Board Committee Assurance Summaries	Committee Chairs

REPORTS FOR NOTING FOLLOWING ASSURANCE AT BOARD COMMITTEES				
16	12.10		People and Culture Committee	Ralph Knibbs
		16.1	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) strategic implications (retrospective sign-off following assurance at People and Culture Committee)	
		16.2	10 Point Plan to Improve Resident Doctors' Working Lives	
			Quality and Safeguarding Committee	Lynn Andrews
		16.3	Children in Care annual report	
		16.4	Guardian of Safe Working Hours report	
		16.5	Infection Prevention and Control (IPC) annual report	
		16.6	Safeguarding Children and Adults at Risk annual report	
		16.7	Learning from Deaths/Mortality report (01-Apr-2025 to 30-Jun-2025)	
		16.8	Learning from Deaths/Mortality report (01-Jul-2025 to 30-Sep-2025)	
POLICY REVIEW				
17	12.20	17.1	Policy for Engagement between the Board of Directors and the Council of Governors	Justine Fitzjohn
CLOSING BUSINESS				
18	12.25		Consideration of any items affecting the Board Assurance Framework (BAF)	Lynn Andrews
19			Meeting effectiveness	
FOR INFORMATION				
Forward Plans - 2025/26 and 2026/27 Glossary of NHS Acronyms Summary of Council of Governors meeting held 23 September 2025				

Next meeting:

Date:	**Time:**	**Location:**
27 January 2026	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.

There are no planned fire drills on the meeting date. Therefore, should the fire alarm sound, attendees should follow the green signage located above doorways and in the corridors and calmly evacuate the building by the stairwell exit. The lift should not be used and instructions from staff or fire wardens should be followed.

The assembly point is located by the disabled parking area at the front of the Ashbourne Centre.

Should assistance be required (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. 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 • Vice Chair/Senior Independent Director – NHS Providers Board of Trustees	(e) (e) (e) (e) (e) (e)
Chioma Akpom *Designate from 06-Oct-2025 to 30--Nov-2025* Non-Executive Director	• Director, Narini Limited	(a)
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 *until 30-Nov-2025* 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 • Ordinary Member for Mental Health, NHS Derby and Derbyshire Integrated Care Board (ICB), NHS Lincolnshire ICB and NHS Nottingham and Nottinghamshire ICB cluster	(d) (e)
Vikki Ashton Taylor Deputy Chief Executive and Chief Delivery Officer	• Magistrate, covering mainly Derbyshire and Nottinghamshire Courts	(e)
Mark Broadhurst *from 22-Sep-2025* Interim Medical Director	• Conduct independent psychiatric clinic as a "sole trader". Does not compete for NHS patients.	(b)
Girish Kunigiri *from 29-Oct-2025* Medical Director	• Trustee for the Bridge, Homelessness to Hope, Leicester • Vice Chair, ECT and Related Treatments Committee, Royal College of Psychiatry	(d) (d)
James Sabin Director of Finance	• Spouse works at Sheffield Health & Social Care NHS Foundation Trust as Head of Capital and Therapeutic Environment	(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

v1.1 DRAFT MINUTES

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, 23 September 2025

MEETING HELD IN PUBLIC

Commenced: 9.30am Closed: 12:38pm

PRESENT	Selina Ullah	Trust Chair
	Lynn Andrews	Deputy Trust Chair and Non-Executive Director
	Ralph Knibbs	Senior Independent Director
	Deborah Good	Non-Executive Director
	Jo Hanley	Non-Executive Director
	Geoff Lewins	Non-Executive Director
	Vikki Ashton Taylor	Deputy Chief Executive and Chief Delivery Officer
	Tumi Banda	Director of Nursing, Allied Health Professions (AHP), Quality and Patient Experience
	Mark Broadhurst	Interim Medical Director
	Justine Fitzjohn	Director of Corporate Affairs and Trust Secretary
	Rebecca Oakley	Director of People, Organisational Development and Inclusion
	James Sabin	Director of Finance
IN ATTENDANCE	Anna Shaw	Associate Director of Communications and Engagement
DHCFT2025/072	Becki Priest	Deputy Director of Practice and Transformation and Lead Allied Health Professional (AHP)
DHCFT2025/072	Nicola Ruston	Clinical Lead, Children's Occupational Therapy
DHCFT2025/072	Anna Fisher	Operational Lead, Paediatric Occupational Therapy
DHCFT2025/084	Tam Howard	Freedom to Speak Up Guardian
	Jo Bradbury	Corporate Governance Officer
APOLOGIES	Andrew Harkness	Non-Executive Director
	Mark Powell	Chief Executive
OBSERVERS	Dave Allen	Public Governor – Chesterfield

DHCFT/ 2025/071	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** Trust Chair, Selina Ullah welcomed Board colleagues and observers to today's meeting, introducing Jo Hanley, newly- appointed Chair of the Finance and Performance Committee and Mark Broadhurst, Interim Medical Director. Speakers for the Board Story were also welcomed. The Register of Directors' Interest for 2025/26 was noted and no declarations of interest were raised with any of today's agenda items. Apologies were as listed and it was noted that Vikki Ashton Taylor, Deputy Chief Executive and Chief Delivery Officer, would deputise in the absence of Mark Powell, Chief Executive.

DHCFT/ 2025/072	**BOARD STORY – CHILDREN'S OCCUPATIONAL THERAPY SERVICE** The Board welcomed Anna Fisher, Operational Lead, Paediatric Occupational Therapy and Nicola Ruston, Clinical Lead, Children's Occupational Therapy, whose team supports children and young people up to the age of 25 with a range of complex conditions. Anna explained that the team had identified challenges with its capacity, resulting in long waiting times to access the service. The Board noted that a range of different initiatives had been put in place, including a review of the waiting list, introduction of group assessments, a new triage referral scheme to ensure only appropriate referrals went through for appointments and additional patient information both online and in hard copy to support people waiting to access the service. These measures had been successful in reducing the wait time, with clearer escalation pathways now in place with partners and better job planning processes. This has allowed the team to introduce regular caseload reviews, identify specific pathways for development and ensure equity of the service across the county. Subsequently, the team has experienced better wellbeing and lower levels of absence, together with higher rates of positive feedback from patients and families. Commenting on the motivational and inspirational account, Deborah Good, Non-Executive Director (NED) applauded the turnaround in productivity and asked if there was one main initiative that had impacted most. In response, Nicola emphasised the triage booking system, which indicated if the condition was physical or a voluntary reluctance. She acknowledged the risk that staff may have felt micro-managed, however, this had not been the case. The team had been accommodating and enthusiastic. Highlighting that sometimes positive change has a negative impact elsewhere, Lynn Andrews, Deputy Trust Chair, queried f this had been identified and was interested to know how the good practice can be shared. Anna confirmed that no processes had been removed, the care pathway had been streamlined, which had led to improved effectiveness. She added that the desired outcome from visits is now set in advance, with focus on educating the family. Recognising the volume of implementation, Jo Hanley, NED asked how the changes had been identified. Anna replied that the team was dissatisfied with the wait times and whilst waiting well, there was a concern that the children's needs were not communicated by the family. It was noted that the first step was a group assessment and screen, which enabled signposting at the outset and categorisation of caseloads was helpful, for example, the frequency that a caseload of 100 needed to be seen. Jo praised the driving force of the continuous improvement mindset. It was noted that commitment and passion from the team had been enhanced through regular staff meetings, engagement and welcomed input. The robust team included highly skilled Band 7 practitioners with a good team ethos, who were happy to learn from each other and share ideas and outcomes. It was highlighted that the team is now in a better position, with increased structure and autonomy. As the Wellbeing NED lead for the Trust, Ralph Knibbs, Senior Independent Director, asked about any stress factors that had come to light. Anna stated there had been none and the leaders advocated the Trust's Wellbeing services in all meetings. Tumi Banda, Director Nursing, AHPs, Quality and Patient Experience, was interested in the reference to Job Planning, which did not always translate well from Medics to other professions. It was confirmed that a split of 70/30 had been agreed for direct clinical care – visit child, come back, write up notes. The team had appreciated the scientific equation of the numbers. **RESOLVED: The Board of Directors was greatly inspired by the presentation and keen to share the learning and replicate the progress within other Trust services.**

DHCFT/ 2025/073	**MINUTES OF THE PREVIOUS BOARD OF DIRECTORS MEETING** The draft minutes of the previous meeting held on 22 July 2025 were accepted as a correct record of the meeting, subject to the below amendment, in relation to Minute DHCFT/2025/061, Integrated Performance Report, Quality: *From: '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'.* *To: '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 from CPA 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 current host for all data and that an additional system, Management and Supervision Tool (MaST), 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'.* **Post-meeting note, amendment made.**
DHCFT/ 2025/074	**MATTERS ARISING** There were matters arising from the minutes, which Selina asked to be clarified. Referring to Board Stories, she asked how the loop was closed so the Board is aware of outcomes. Tumi responded that all stories are catalogued along with any practice/process adjustments and this would be included with the annual Patient Experience report, to be authored by Becki Priest, Deputy Director of Practice and Transformation and Lead Allied Health Professional (AHP). Reflecting on the Trust's ambition that Living Well would be one of 42 neighbourhood pilots, Vikki confirmed that unfortunately, the Trust had not been awarded. However, it had been recognised as a Derbyshire System and the intention is to continue building on that. Following the announced closure of the Commissioning Service Units (CSU), Deborah was interested in the procurement of a new supplier with Derbyshire Community Health Services NHS Foundation Trust. James Sabin, Director of Finance, confirmed that the very complex issue had been discussed by the Finance and Performance Committee. As the closure is scheduled for March 2027, this provides the opportunity for careful consideration.
DHCFT/ 2025/075	**QUESTIONS FROM MEMBERS OF THE PUBLIC** No questions had been received.
DHCFT/ 2025/076	**CHAIR'S UPDATE - VERBAL** Selina reflected on the level of change taking place within the NHS at national, system and local level, pointing out that as a provider Trust, despite the focus on finances, it remains essential to provide safe, compassionate and efficient services. She added that the Board Story amplified the potential to meet some of the challenges effectively. It was noted that Selina is a Trustee of NHS Providers and that media emphasis is currently on the voice of providers, especially Mental Health trusts and the 10-Year Health Plan, with little reference to the trials being faced. A recent meeting of Chief Executives and Chairs focused on waiting lists and elective recovery, which are not receiving the same attention as Acute waiting lists. It was highlighted that the resignation of Claire Murdoch, NHE Mental Health Director, would impact negatively on services providing and championing Mental Health care. Selina recognised that

	Claire had been a major advocate for Mental Health services and the loss added to the uncertainty of the operational environment. In relation to the new Care Quality Commission (CQC) inspection framework, Selina was pleased to state the Trust is ahead of the curve and the CQC is listening to feedback from NHS trusts, making the change less onerous. Pointing out the benefits for the Trust to be involved in the CQC engagement group, Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary, agreed that the CQC was positively open to understanding Trust services and moving forward, inspections would be undertaken by subject specialists – reflecting a different approach. Selina reported that Dr Kathy McLean had been appointed as the Chair designate for the clustered ICBs and news of the appointed Chief Executive was awaited. On a positive note, Selina and Vikki had attended the opening of the Cavendish Building at the University of Derby, where current and potential future initiatives had been discussed. It was noted that the Trust has a Memorandum of Understanding with the university and the Trust had an ambition to become a Teaching Trust by working together to focus on strategic priorities. In addition to welcoming the new members of the Trust's Board of Directors, Jo Hanley and Mark Broadhurst, Selina was delighted to announce that Dr Girish Kunigiri would commence as the new Medical Director on 29 October. On behalf of the Board, she extended thanks to Dr Arun Chidambaram, Medical Director and Tony Edward, Deputy Trust Chair, who recently left the Trust. **RESOLVED: The Board of Directors noted the content of the Chair's update.**
DHCFT/ 2025/077	**CHIEF EXECUTIVE'S UPDATE** In the absence of the CEO, Vikki presented the update, which included detail of the recently published, new NHS Oversight Framework (NOF). Vikki expressed the Trust's disappointment in the Trust's Segment 4 rating, resulting from the re-basing of certain performance metrics. It was noted that the required improvements around length of stay, face-to-face Crisis response and wait times for Paediatric services, are being progressed. In addition, Justine is leading submission of a national, provider capability self-assessment. Reporting on the opening of Kingfisher House, Psychiatric Care Unit (PICU) and Audrey House, Enhanced Care Unit (ECU), Vikki emphasised the importance of this as part of the Making Room for Dignity Programme, highlighting that this is the first provision of its kind within Derby and Derbyshire and would significantly improve accessibility for the local community. A visit to the Trust's Forensic Inpatient services by the CQC had elicited positive feedback, commending the patient focused approach. Vikki also thanked staff on the Kedleston Unit as early indications were that encouraging feedback would be received within the inspection report. Other key areas highlights included award nominations and a high level of staff engagement. Vikki was delighted to welcome 10 internationally trained Doctors to the organisation, who were now working across Trust services. Included with the paper, was the East Midlands Alliance Plan for 2025/26, which summarised collaborative work across the region to improve pathways for patients, with plans for the coming year. **RESOLVED: The Board of Directors noted the report.**
DHCFT/ 2025/078	**INTEGRATED PERFORMANCE REPORT (IPR)** A new style performance report outlined progress in line with the NHS Oversight Framework (NOF) and 10-Year Health Plan, for the data period 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 Directors drew attention to the following areas and responded to questions:

Operations

In relation to the NOF challenges, it was emphasised that that the improvements or impacts made by other organisations is unknown. Vikki highlighted that recovery action plans are in place to improve the Trust's 24-hour crisis response and to reduce the length of time people are waiting to access the Trust's Community Paediatric services (recognising Derbyshire had not received investment to support this aim, as had occurred in other parts of the country). It was noted that the number of inappropriate out of area (OoA) placements continues to reduce following the opening of the new, local services.

Based on four key operational measures, Vikki mentioned that James was looking at the productivity metric to ascertain the opportunity to move from NOF Segment 4 to Segment 3. She added there was focused effort to improve Acute patient flow, driving down the use of inappropriate OoA beds, with a significantly improved position.

Drawing attention to the average speed to answer calls to the Mental Health Helpline (Trust average, 78 seconds; national average 20 seconds), Geoff Lewins, Non-Executive Director, asked if this might be a typographical error. Vikki agreed to check the detail and respond. **Post-meeting note, data checked and is correct**. The Board noted that this is the only Trust in the UK to have an '0800' number, all others use '111' press 2 and this was impacting on the average speed performance. However, the ICB has some concerns about closing the 0800 number. It was emphasised that many calls received by the Trust are from out of area.

Reflecting on the 52-week wait for Community services, Geoff reasoned that other providers must have the same issue and he questioned how they had addressed it. In response, Vikki confirmed this was a national issue and that some providers have received capacity commissioning.

Finance

James confirmed the adjusted financial position to a deficit of £1.7m remains on track to deliver the year's plan. He pointed out the risks to delivering the financial plan, which included:

- delivery of efficiencies in full
- Adult Acute OoA placements
- bank and agency usage above planned levels
- unfunded posts and other emerging pressures.

People

It was noted that compliance with recording Clinical and Managerial Supervision is a current focus. Rebecca Oakley, Director of People, Organisational Development and Inclusion, highlighted that a new absence management system, launched in the summer, was providing better data while making financial savings. She added that the NHS Staff Survey is currently open, and colleagues are being encouraged to share their feedback.

In line with support being provided to those experiencing community unrest and discrimination, the Board welcomed today's signing of a new Anti-Racism Statement.

In relation to Clinical Supervision, the increased scrutiny and escalation of non-compliance to the Executives was noted.

Lynn applauded the great work around anti-racism and the focused engagement session that had been held.

Quality

Following the opening of Audrey House and Kingfisher House, Tumi reported that seclusions remain above the threshold, influenced by the new seclusion facility and advised that staff are being supported to use other interventions. It was noted that the environment had been damaged already.

	There had been an increase in self-harm incidents and the use of restraints, which would be explored from a clinical perspective. Steady progress with the Care Programme Approach was highlighted and Tumi confirmed this is overseen by the Quality and Safeguarding Committee. He added that due to the imminent change over to the Personal Care Framework, it would not be conducive to amend the metrics at this point. Referring to the pockets of non-conformance demonstrated in the IPR, Justine pondered the mixed assurance levels and in light of the NOF segmentation, the Board agreed to accept limited assurance. **RESOLVED: The Board of Directors: Confirmed that limited assurance obtained on current performance across the areas presented.**
DHCFT/ 2025/079	**EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) ANNUAL REPORT AND CORE STANDARDS** The Board received an update on the EPRR Core Standards compliance and submissions for 2024/25, which reflected significant work and progress in Trust plans, resulting in high compliance and assurance. This had been confirmed with substantial assurance being received from a recent audit. Vikki was confident that following submission to the ICB and NHSE, the Trust would retain substantial compliance. It was noted that the Trust is measured against the following domains and that further work was required on a couple areas of non-compliance: • 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]. Highlighting that acute trusts are more likely to respond to HazMat situations, Vikki confirmed the Trust was working on a safe and pragmatic response in the event of a related incident. In addition, the EPRR and Business Continuity Policy was included for ratification. It was noted that there were no changes to the documents, just merging of two policies together. The Board recognised the good performance and achievement within challenging areas and the EPRR team was thanked for the progress. **RESOLVED: The Board of Directors:** **1. Was assured of ongoing work to improve and continue the Trust's level of compliance with the EPRR core standards** **2. Retrospectively approved the Core Standards submission to NHSE and ICB following approval at the Trust Delivery Group and Finance and Performance Committee.**
DHCFT/ 2025/080	**MENTAL HEALTH SERVICES ASSESSMENT TOOL (MEN-SAT)** Vikki reported that a new tool, Men-SAT, aims to build capability and knowledge transfer across the NHS, bringing together examples of good practice for urgent and emergency care. It was noted that System partners had received support from NHS England with the use of Men-SAT, which focused on improvements to patient flow. For example, a joint approach to help with those people clinically ready for discharge. Following several workshops provided by the national

	team, a number of recommendations were agreed. Vikki confirmed the Trust has developed an action plan to feed into the broader Derby and Derbyshire Plan. Reflecting on the detailed report presented to the Finance and Performance Committee, Jo stated that there are clear areas the ICB must lead, including a broader plan to be ICB-led, which needs to be driven forward. Geoff expressed some concern around the volume of plans and co-ordination of the sequencing. In response, Vikki ensured there would be one integrated plan, which would be monitored through internal governance. It was emphasised that accountability for Men-SAT rests with the ICB and with better understanding of the new ICB cluster, would be the opportunity to review the governance framework. **RESOLVED: The Board of Directors:** **1. Noted the Men-SAT report and recommendations** **2. Supported implementation of the associated action plan.**
DHCFT/ 2025/081	**<u>WINTER PLAN</u>** Vikki presented this year's Winter Plan for Board assurance and approval, following incorporation of the feedback received at the July Board. It was noted that the Plan has been developed in response to previous learning about where peaks in demand fall (including over bank holidays) and that the Trust had participated in System-wide planning, including a stress test run by NHSE in September. Vikki added that appointments are now available for Trust colleagues to receive a flu vaccination. Ralph welcomed the inclusion of the Quality and Equality Impact Assessment for transparency. **RESOLVED: The Board of Directors:** **1. Confirmed assurance for the Trust Winter Plan 2025/26** **2. Approved the Board Assurance Statement, by way of CEO and Chair signature.**
DHCFT/ 2025/082	**<u>STRATEGIC PLAN – 2025-2028 – PROGRESS UPDATE, QUARTER 1 (Q1), 2025/26</u>** The Board received the first quarterly assurance report, based on the launch of the new Strategy. Highlighting that the document sets out progress against priorities, Vikki affirmed that the Plan is overseen by the Strategic Portfolio Oversight Group, supported by Andrew Harkness, Non-Executive Director (NED), to ensure linkage between the Executives and NEDs. Attention was drawn to the high number of areas that were rag-rated green, along with a small number of rag-rated amber, projecting full delivery at the year end. Vikki emphasised that the main focus was on improving access to services and waiting lists. The Board was pleased to see the Plan was on the right trajectory and looked forward to the quarterly updates. **RESOLVED: The Board of Directors noted the progress in delivery of the Strategic Plan at the end of Q1 2025/26.**
DHCFT/ 2025/083	**<u>BOARD ASSURANCE FRAMEWORK (BAF) UPDATE, ISSUE 2, VERSION 2.3, 2025/26</u>** Justine presented Issue 2 of the BAF, which had been thoroughly reviewed, and explained that progress against risks had been updated to ensure the current status is reflected and every key gap in control and linked action had been reviewed. It was highlighted that the abolishment of the Commissioning Support Units by spring 2027 had been included.

	Pointing out the long-standing sodium valproate operational risk, Geoff mentioned that to close down the issue, the Medicine Management Committee needed to be assured that there is an adequate Medical Action Plan and it was noted that the Audit and Risk Committee would receive an update in October. Lynn gave some context for the sluggish progression by advising that valproate review is annual and this is being monitored at the Quality and Safeguarding Committee. Geoff referred to cyber-crime and the recent events at Heathrow Airport, where deployment of ransomware had disrupted systems. He asked about similar dangers associated for the Trust from its suppliers. James confirmed that Business Continuity Plans are requested for all services procured by the organisation. The Board was advised that the MRfD Benefits Realisation statements were due at the next Finance and Performance Committee in November. James advised that NHSE require these at three months' post opening with more formal accounts at six, 12 and 24 months. Ralph emphasised the need to include how the Trust is assured the right culture is being created through the transformation programmes and how this would be embedded and sustained moving forward. It was noted that oversight had been mapped in with the Finance and Performance Committee and Board for early December. **RESOLVED: The Board of Directors:** **1. Reviewed and approved 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. Agreed to continue to receive updates in line with the forward plan for the Trust Board.**
DHCFT/ 2025/084	**FREEDOM TO SPEAK UP GUARDIAN REPORT (SIX-MONTHLY)** The report, covering January to June 2025, was presented by Tam Howard, Freedom to Speak Up Guardian, and gave a trend analysis of cases within the Trust and the actions being taken to improve the speaking up culture. It was noted that cases within the Trust had increased by 79.5% between 2023/24 and 2024/25, which was deemed to be a positive reflection that more people are speaking up. Tam highlighted that worker safety and wellbeing, related to sexual safety and bullying and harassment, including racism/discrimination, are ongoing themes. She was optimistic that the Trust's partnership with the 'A Kind Life' programme and the setting up of the Sexual Safety and Race Equality Working Groups would be beneficial in reducing similar concerns moving forward. Sincere gratitude was expressed to Geoff and Justine for their ongoing support of the FTSU culture at the Trust. The difficulty to assess whether the increased number of cases was a reflection of more events or more people speaking up was acknowledged, with Tam surmising it was a little of both. However, she did highlight that the new operating model had not raised as many concerns as had been expected. Recognising the compassionate and understanding attributes, brought to the role by Tam, Ralph expressed his wish to thank her publicly. He drew attention to the noticeable improvement since he had joined the Trust three years earlier, which evidenced the confidence staff had in the process. James asked if stress risk assessments were being used appropriately. Rebecca explained this was not the simplest procedure and it would be forming part of a QI programme. As the Trust moves away from 'People First' and launches the 'A Kind Life' Programme, along with the introduction of the Personal Accountability Charter, Rebecca asked Tam if she had seen any impact. Tam responded that there had been a shift with staff taking more accountability but she

	had also seen some distressed staff speaking to her following their behaviour being questioned under the charter. It was noted that managers would be supported to start those difficult conversations through the 'A Kind Life' programme. Selina stated that the points raised should be part of an ongoing conversation between the individual and their manager, along with the appraisal process. Referring to the Personal Accountability Framework, she added, this was something the Trust has signed up to and a reminder of working responsibilities The Board was informed that 13 October was 'Wear Green Wednesday' during Speak Up week. **RESOLVED: The Board of Directors:** **1. Supported the current mechanisms and activities in place for raising awareness of the FTSU agenda** **2. Determined the report sufficiently assures the Board of the FTSU agenda at the Trust and that those proposals made by the FTSUG promote a culture of open and honest communication to support staff to speak up.**
DHCFT/ 2025/085	**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** It was noted that on 16 September, the People and Culture Committee reviewed the WRES and WDES reports and action plans and asked for some amendments to be made. It had been agreed that engagement with the BME and Disability and Wellbeing Network (DAWN) staff networks was crucial, along with the inclusion of explicit links to the Trust's values and strategic priorities. **RESOLVED: The Board of Directors granted delegated authority to the People and Culture Committee to approve the 2024/25 WRES and WDES action plans.**
DHCFT/ 2025/086	**BOARD COMMITTEE ASSURANCE SUMMARIES** The Board Assurance summaries from recent meetings of the Trust Board Committees were accepted as a clear representation of the priorities that were discussed and will be taken forward in forthcoming meetings. The following points were brought to the attention of the Board by Committee Chairs: **Audit and Risk Committee, 24 July** The main headline reported by Geoff Lewins, Chair, was in relation to Operational Risk Management, which was a perennial issue. He stated that despite the efforts of Kel Sims, Risk and Assurance Manager, compliance falls below target. It was noted the Committee had asked for this to be escalated to the Executive Leadership Team (ELT). Reflecting on the Clinical Audit, Lynn confirmed that the Quality and Safeguarding Committee had not been satisfied with the % completion rate and had similarly accepted limited assurance. **Finance and Performance Committee, 9 September** Acknowledging that financial performance was as expected, Jo Hanley, Chair, emphasised the ongoing challenge to deliver the Cost Improvement Programmes. The good control of contracts was highlighted, along with the need to work with System partners around the provision of additional services in-house or via other providers. **Quality and Safeguarding Committee, 10 September** Lynn Andrews, Chair, was pleased to advise that the East Midlands Alliance, Perinatal service was performing well. Additional detail had been requested around patient experience.

	Due to the very detailed Patient Safety report, the Committee had received limited assurance and moving forward, the main risks are to be identified. The Committee had no issues with the Children in Care and Children and Adult Safeguarding Annual reports. However, it had not been fully assured around Care Planning/Person-Centred Care. Lynn referred to the final iteration of the very comprehensive Suicide and Self-Harm Prevention Strategy, which had been approved by the Committee. **Mental Health Act Committee, 11 September** Despite the recognised improvements, Deborah Good, Chair, commented that this was inconsistent in relation to the Reading of Rights compliance and this had been escalated to the Trust Delivery Group. It was noted that the implementation of and recruitment to the S136 suites had been successful with good patient feedback. However, limited assurance was agreed from the Restrictive Practice Quality report based on areas of underperformance for recording and training. Major changes to the Mental Health Bill were noted and Justine stated the impact was not to be under-estimated. It was noted that a working group will oversee the implementation plan and it was likely that the System would seek guidance from the Trust, with the level of expertise held in this field. **People and Culture Committee, 16 September** Ralph, Knibbs, Chair, mentioned the Assurance Dashboard and that plans are in place to improve appraisal compliance. He added the need for clear assurance around the Making Room for Dignity culture transformation. A deep dive on Employee Relations and the recent transfer of the team to the Trust, focused on key areas and demonstrated improved compassion and understanding. In support of this, the 'A Kind Life' programme, will focus on respective resolution, active bystander training and facilitated conversations. **RESOLVED: The Board of Directors noted the Board Assurance Summaries.**
DHCFT/ 2025/087	**<u>REPORTS FOR NOTING ON ASSURANCE</u>** The Safer Staffing report was received for information and noting having previously provided assurance to the Quality and Safeguarding Committee on 10 September. Lynn stated that the report had progressed significantly since Tumi came into post and the Trust was meeting safer staffing levels. The overall vacancy rate of 11.19% was queried by Selina, pointing out there was a disconnect as universities had commented on the difficulty to secure jobs. Rebecca explained that there was a national issue, as some trusts are only able to offer newly qualified staff Healthcare Assistant roles and fortunately, the Trust wasn't in that position. Tumi added that a Band 5, 6 or 7 Nurse was able to cover any clinical shift. Lynn highlighted that the People and Culture Committee had been asked for a more detailed overview of Band 5 posts, including: • vacancy position nationally • student difficulty securing a job • retention of high number of newly recruited staff. **RESOLVED: The Board of Directors noted the contents of the report and the scrutiny and assurance received at the Quality and Safeguarding Committee.**

DHCFT/ 2025/088	**STANDING FINANCIAL INSTRUCTIONS (SFIS) POLICY AND PROCEDURE** The Standing Financial Instructions (SFIs) had been reviewed and presented to ELT and the Audit and Risk Committee and the Board was now asked for final ratification. The more significant changes were highlighted: • 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 Trust's 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'. **RESOLVED: The Board of Directors ratified the Standing Financial Instructions Policy and Procedures.**
DHCFT/ 2025/089	**CONSIDERATION OF ANY ITEMS AFFECTING THE BOARD ASSURANCE FRAMEWORK (BAF)** No issues were identified for inclusion in the BAF.
DHCFT/ 2025/090	**MEETING EFFECTIVENESS** A plea was made for a patient or local member of staff to present the Board Story and due to the tight deadlines following rearranged Committee meetings, it was asked for clear assurances to be included in the Board Assurance Summaries. Pointing out the need for quality discussion, Selina recommended improved Executive Summaries and Dave Allen, Public Governor, Chesterfield welcomed the Summary Sheet indicating the page numbers. It was noted that the Board would now sign the Anti-Racism Statement.
The next meeting to be held in public session will be held in person on 25 November 2025 at 9.30am in Conference Rooms A and B, Centre for Research and Development, Kingsway, Derby.	

Derbyshire Healthcare NHS Foundation Trust
Report to the Public Board of Directors – 25 November 2025

Chair's update

Purpose of Report

This report is intended to provide the Board with the Trust Chair's reflections on my activity with and for the Trust since the previous Board meeting on 23 September 2025. The structure of this report reflects the role that I have as Trust Chair.

This report will also include an update from Lynn Andrews, Deputy Chair, and the work she has undertaken while covering for me in November.

Our Trust and Staff

1. On 10 October, myself and Non-Executive Directors (NEDs), Lynn Andrews and Deborah Good and Executive Director, James Sabin, met with the Psychology team at their monthly team meeting. Rather innovatively, the meeting took place at Markeaton Park. We walked and talked, concluding the walk at the onsite café. We further talked about the service, the challenges and the opportunities, as well as speaking to a wide range of team members. I spoke to three new Psychology Trainees who said the team had made them feel welcome and they were excited to learn more about the Trust and to gain further experience.
2. We officially opened the Derwent Unit on 10 October and the Carsington Unit on 6 November. The King's representative, Lord Lieutenant, Elizabeth Fothergill, CBE, officially opened the Unit. The pride in the environment and the satisfaction amongst patients and colleagues was palpable. A big thank you to all the colleagues involved in the opening including the Estates and Facilities team, the Communication and Engagement team and the various clinical teams and managers who ensured a smooth opening and who proudly showed the guests around the Unit. Lynn and Ralph Knibbs, Senior Independent Director, also attended. Lynn, in her capacity as Deputy Chair, officiated on my behalf at the opening of the Carsington Unit.

3. I attended the CEO engagement hour on 21 October. The Trust has been going through a period of change, internally within the organisation with considerable change and uncertainty, and also externally with change at a system level and nationally.

Given this context, the online CEO engagement hour is a much-needed space for colleagues at all levels to hear from the CEO about developments, policy directions and performance expectations of the Trust first-hand, as well as an opportunity to raise matters directly with the senior leadership team. I find these sessions extremely useful in understanding the impact of Board decisions and planned changes on our front-line colleagues.

4. On 21 October, I met with Dr Girish Kunigiri, Executive Medical Director, who joined the Trust in November. We discussed his initial assessment of the Trust and some of our priorities and vision for the future in ensuring the Trust continues to build on our record of involvement and inclusion of patients and service users, strengthening and widening our research and supporting the development of innovative clinical education in partnership with the Deanery and the Universities of Derby and Nottingham.

5. The Annual Staff Awards is always a much awaited event, and this year was no different. With over 250 nominations for the awards, the judges had a very difficult job shortlisting the finalists. The awards is an excellent reminder of the wonderful, dedicated colleagues we have, who work tirelessly to make the experience of care received by patients and their carers the best it can be. Congratulations to all the nominees, the finalists and winners - you are all exemplars of what it means to be a member of Team Derbyshire Healthcare. A special thanks to the Communication and Engagement team and Shirley Houston, Engagement Officer, who put a huge effort into collating the nominations and everything in between to culminate a successful ceremony.

Council of Governors

6. I met with Susan Ryan and Hazel Parkyn on 20 October, in their roles of Lead and Deputy Lead Governors. The purpose of these meetings between the Trust Chair and the Lead and Deputy Lead Governors is to ensure that we are open and transparent around the challenges and issues that the Trust is dealing with. They are also an important way of building a relationship and understanding of the workings of the Board and the Council of Governors and ensuring any areas of interest, development needs and of concerns are noted and addressed, either via the Governance Committee, joint development sessions or the Council of Governors.

7. I met with the Staff Governors on 20 October. I was able to pick up an issue with catering over the weekend which I was able to share with the CEO who further engaged with ward colleagues and the catering service.

8. On 22 October, the Governance Committee, chaired by Marie Hickman, took place. We discussed feedback from the Annual Members Meeting which was all very positive. A big thank you to Denise Baxendale, Membership and Involvement Manager, who puts so much work into ensuring a successful Annual Members Meeting every year. No sooner have we done one then the planning for next years' Members Meeting begins. A small Task and Finish Group has been set up to plan next years' meeting. Thank you to all the Governors and colleagues who attended.
9. The next Governance Committee takes place on 17 December 2025.
10. The next Joint Board and Council of Governors development session will be held on 27 January 2026.

Board of Directors

11. On 2 October, a Confidential Board meeting took place. Business items included; post project evaluation for elements of our Making Room for Dignity Programme, a confidential inquest update and discussion on the Trust's Provider Capability Self-Assessment. The majority of the Board's business is carried out in public meetings, with confidential meetings held by exception and generally on commercial or legal grounds. These meetings are held to ensure the Board is sighted on sudden, unexpected changes/developments which may have a risk for the Trust or for matters which are at a developmental stage.
12. I would like to take the opportunity to welcome Chioma Akpom to the Board of Directors. Chioma will chair the Audit and Risk Committee, taking over from Geoff Lewins. Chioma comes with a wealth of experience in audit and assurance and transformation in the global banking sector. She is currently Global Head of Audit with HSBC Banking Group. I met with Chioma on 7 October as part of her induction. The Board and I look forward to working with Chioma.
13. I met with the CEO for the quarterly review of his objectives on 7 October. These meetings enable us to discuss how the Trust is making progress and improvements in relation to the Trust Strategy, Delivery Plan, our people and culture.
14. On 15 October, the Board Strategy and Development Session took place. As well as discussing the progress with the Delivery Plan, we discussed models of care, integration, neighbourhood working and Trust priorities. We also discussed and finalised the Trust anti-racism statement for publication (see attached Appendix A).
15. Board members and I have met with Mark Greenfield, who is a coach and an Organisational Development specialist, to provide input in the design of our Board development programme. Successful boards and organisations invest time and resources in board development continuously. Given we have two new NEDs and a new Executive Director, a rapidly changing environment, financial pressures and the focus on quality and safety, it is crucial that we spend time and energy on ensuring the Board is working optimally to deliver the Trust Strategy for our patients and colleagues.
16. On 10 November, an Extraordinary Confidential Board meeting was held, chaired by Lynn on my behalf. The purpose of the meeting was for the Board to have its initial, formative discussions on operational Planning for 2026/27.
17. I have also continued to meet with all NEDs individually on a quarterly basis. Since the last Board meeting, I have met with Andrew Harkness and Deborah Good. We use these quarterly meetings to review progress against their objectives, any developmental needs and to discuss any issues of mutual interest.
18. Sadly, we say goodbye to Geoff Lewins, who has been the chair of the Audit and Risk Committee for the last eight years. During this time, he has provided Board scrutiny and assurance on transformation programmes, including the implementation of electronic patient records and electronic prescribing, as well as chairing the System Digital Transformation Committee.

Geoff is also the Board Freedom to Speak Up NED Lead, and has been a reciprocal mentor to staff, a champion of continuous improvement and an invaluable source of corporate/Board memory, as well as a purveyor of quotes and anecdotes. I would like to acknowledge Geoff's contributions and service to the Trust and thank him. We will miss him, and we wish him all the best for the future.

System Collaboration and Working

19. On 4 November, the Provider Collaboration Board meeting was held. Lynn, attended this meeting on my behalf and has provided more detail about this in her report (see Appendix B).

Regulators, NHS Providers (NHSP) and NHS Confederation (NHSC) and others

20. On 14 October, I met with Dr Runa Saha, lead for Derby University Medical School. We spoke about our mutual interest in health inequalities and the need to widen opportunities for people from economically challenged backgrounds into education, research in mental health and our ambition to become a University Trust.

21. On 18 October, I attended the Asian Professionals' National Alliance (APNA NHS) conference, along with colleagues who were finalist in the APNA Awards. We had a record eight finalists in separate categories. This is real recognition of the Trust's culture and commitment to equality, diversity and inclusion in all that we do. In 2023, we won the APNA Trust of the Year Award.

22. I was on a panel on health inequalities experienced by women at the APNA conference, which was well received.

23. At the request of the Muslim Women's Council in Bradford, on 18 October, I gave a presentation on the mental health inequalities and barriers to care and treatment, experienced by women from a Muslim background. The audience consisted of 200 women, mainly from a Muslim background. There was much discussion afterwards. The need for cultural competency and culturally appropriate service models of care with input from those with lived experience/knowledge was highlighted as key as well as training delivered by individuals from those communities.

24. I attend fortnightly briefings from NHS England for the Midlands region, which has been essential to understand the challenges and expectations of provider trusts.

25. On 21 October, I met with the Head of Equalities at Park Run, UK to discuss their new strategy which is in development, and the opportunities to address health inequalities. I have requested Vikki Ashton Taylor, Deputy CEO and Chief Delivery Officer and Andrew Harkness, NED to be involved.

26. As a Trustee of NHS Providers, I attend the NHS Providers Board meetings. Due to wider NHS financial pressures there has been a growing expectation amongst NHS organisations that having two member organisations representing providers, ie NHS Providers (NHSP) and NHS Confederation (NHSC) was financially challenging.

Having one consolidated membership organisation would be better value for money, as well as having a joined up stronger voice for the sector. I am on the NHS Providers Advisory Group, which has worked with the steering group to oversee the consultations with members, to scrutinise the strategic purpose and case for change, the business model, and the necessary due diligence. On 20 October, the Advisory Group recommended to the Board of NHSP to merge NHSP with NHSC. A joint board meeting between NHSP and NHSC was held on 29 October, followed by an extraordinary NHSP Board meeting to ratify the decision to merge. Due to tight timescales and the work that needed to be covered, it has been an intense period with frequent meetings and progress updates. I am now on the Transition Committee, and I will also be on the interview panel for the new CEO of the new legal entity. A name for the new organisation has yet to be finalised.

27. On a personal note, I am now the Vice Chair of NHS Providers and the Senior Independent Director until the new legal entity is established next year.

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

Risks and Assurances

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

Consultation

This report has not been to other groups or committees.

Governance or Legal Issues

Covered as part of the individual items.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

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

Demonstrating inclusive leadership at Board level

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

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

Recommendations

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

Report presented by: **Lynn Andrews**
Deputy Chair

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

RACISM HAS NO PLACE HERE.

NHS

Derbyshire Healthcare

NHS Foundation Trust

A statement from the Trust's Board of Directors

Racism - whether overt or subtle, individual or systemic - has no place in our organisation. It breaks trust, harms lives, and deepens health inequalities. We recognise the damage it causes, and we refuse to be bystanders.

At Derbyshire Healthcare, we believe in the power of compassion, inclusion, and dignity for all. Every person deserves to feel safe, valued, and respected - in our services, our teams, and our communities.

Our values drive this commitment. They call us to foster inclusive environments, cultivate belonging, and champion diversity within our workforce and the communities we serve. We listen with intent to lived experiences. We speak up. We reflect. And we take meaningful action.

We also recognise that racism does not exist in isolation - it intersects with other forms of discrimination. We are committed to tackling all inequalities, wherever and however they appear.

When people feel safe and empowered, they thrive. When our culture is rooted in fairness, the care we provide becomes more compassionate, more effective, and more human.

Anti-racism is not a passive belief - it is a shared responsibility. It is a standard we are proud to uphold, and it lies at the heart of who we are and the future we are building together.

Our values

Caring **Inclusive** **Ambitious** **Belonging** **Collaborative**

WE MAKE A POSITIVE DIFFERENCE IN EVERYTHING WE DO

Appendix B

Deputy Chair's Report to the Board of Directors

Since commencing the Deputy Chair role on 1 August 2025, I have focused on developing my knowledge and effectiveness in supporting the Chair, attending key meetings, and engaging with patients and staff across the Trust.

Partnerships

I attended **East Midlands Alliance Annual event for Boards** at St Andrews in Northampton, which provided valuable opportunities for networking and understanding regional developments in such areas as Neighbourhood models, mental health emergency care, digital innovation and financial planning. The event also highlighted improvement initiatives, including the '*Hear Us'* post-incident debrief model and projects for reducing self-harm and length of stay for Child and Adolescent Mental Health services (CAMHS).

- The day began with the national context sharing perspectives on the emerging plans for Neighbourhood Models, Mental Health Emergency care, Digital and early discussions on the financial modelling
- The improvement initiative called '*Hear Us'* was presented, explaining the benefits of post-incident debrief using a four-staged model, the focuses on enablers when it worked well, rather than exploring barriers
- Reducing incidence in self-harm without increasing restrictive practice within a female acute ward
- Reducing length of stay in CAMHS In-patient Tier 4 service, utilising Experts by Experience throughout the admission process.

The **Derbyshire Provider Collaborative Board** met on 4 November and reviewed their Terms of Reference and considered their reporting arrangements with the new Integrated Commissioning Board (ICB). There was also refinement of their formal reporting arrangements with Provider Boards to ensure key messages reach Boards in-between annual reports.

The main part of the meeting concentrated on:

- The Programme update, including discussions on Procurement and Estates, Digital and Data
- Provider Collaborative Transformation update
- Community Transformation Board Programme update, including feedback from a recent workshop considering the Neurodivergent Pathway.

Patients

I was privileged to attend the **opening ceremony** of the Carsington Unit (our 54-bedded Mental Health Adult Acute Unit), Audrey House (eight-bedded Enhanced Care Unit for females) and the Kingfisher House (our 14-bedded Psychiatric Intensive Care Unit (PICU)). I had the pleasure of escorting Elizabeth Fothergill, CBE, His Majesty's Lord Lieutenant of Derbyshire, around the Units, who officially opened our facilities on Friday, 7 November. It was great to meet so many staff and patients while we went round the facilities, all of whom were very complimentary about the environment and the care they were receiving. I wish to take a moment to thank all the staff who helped to make the opening ceremony a success. This now ensures we can deliver single sex accommodation in all of these new facilities, offering privacy and dignity, and enhancing a therapeutic recovery.

I shadowed the Neurodivergence team, who were undertaking a **Fundamental Standards quality visit** for the Learning Disability and Autism Intensive Support services, who work out of St Andrews House, at the start of the November. The team undertook a 15-Steps Challenge, focusing on seeing the services from a patient/visitors/carers perspective and noting their first impressions on arrival.

Areas of the Fundamental Standards visit covered compliance and quality, physical health, ligature risks, incidents and complaints, and on learning lessons leading to changes in practice, leadership insights and the environment. The visit reinforced the Trust's commitment to safe, high-quality care, and highlighted strong leadership, effective quality assurance processes and exemplary staff engagement.

People

As part of the Board visit programme, I met with the **Patient Experience team,** alongside colleagues, including Ruth Day, Public Governor, Derby city west. Discussions covered communication challenges, the potential of Artificial Intelligence (AI) to support productivity and staff training opportunities within the new Care Groups. The team demonstrated compassionate and strong commitment to ensuring the patients' voices are heard.

In summary, this period has been marked by valuable learning, meaningful engagement with staff and patients and active participation in collaborative and governance activities. These experiences have deepened my understanding of the Trust's operations and strengthened my ability to support the Chair and Board in ensuring safe, effective and compassionate care across our services.

Report presented and prepared by:	**Lynn Andrews** **Deputy Chair**

Chief Executive's update

Purpose of Report

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

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

Executive Summary

National and regional context

Planning guidance

At the end of October NHS England published the Medium Term Planning Framework – delivering change together 2026/27 to 2028/29.

The NHS's Medium Term Planning Framework (MTPF) marks a significant shift from short-term, centrally directed planning to a more locally empowered, long-term approach. Developed collaboratively with leaders across all sectors of the NHS, the framework aims to address fundamental challenges, improve care, and restore public confidence. It aligns with the ambitions of the 10 Year Health Plan and responds to the need for sustainable, locally driven transformation.

Key drivers for change include:

- Ending short-termism and empowering local leadership
- Addressing financial discipline and productivity
- Rewiring the NHS operating model to foster innovation and frontline autonomy
- Accelerating improvements in waiting times, access, and quality of care.

The framework is underpinned by a multi-year revenue and capital settlement, with real-terms funding increases through 2028/29. This enables a move away from annual cycles to medium-term planning, supporting:

- A new payment model for urgent and emergency care (UEC) with incentives for productivity and prevention.
- Fairer distribution of funding across the NHS, moving towards a "fair shares" model
- A requirement for all Integrated Care Boards (ICBs) and providers to deliver balanced or surplus financial positions, with a minimum 2% annual productivity improvement
- Greater transparency through routine publication of trust-level productivity data.

Productivity gains will be driven by:

- Reducing unnecessary follow-up outpatient activity via digital-first, patient-led models
- Accelerating digital transformation and service redesign
- Targeted action to address inefficiencies and unwarranted variation across the system.

The submission, which will be developed and submitted again as a system, has a national deadline of 18 December 2025. Extra-ordinary confidential meetings of the Board and of the Finance and Performance Committee have been arranged to approve the Trust's submission.

NHS England: building on progress in the second half of the year

Sir Jim Mackey, NHS England Chief Executive (CEO), set out the priorities for the remainder of this year at an event attended by NHS CEOs in September, these were:

- Maintaining financial discipline
- Delivering the priorities set out in the operational plan in relation to urgent and emergency care, elective care waits, and primary care
- Resilience during winter
- Strong and visible leadership.

Improving Health Literacy

NHS Providers have launched a new guide on the benefits of improving health literacy which are to reduce health inequalities; boost productivity and improve patient experience. It includes actions for Boards to adopt to reduce disparities in care and outcomes. In summary, the suggested actions are:

1. Provide clear leadership for becoming a health literate organisation
2. Understand communities and current levels of health literacy
3. Review and update resources to ensure services are fully accessible
4. Train and empower staff on the implementation of health literacy interventions
5. Co-produce resources with communities
6. Evaluate the impact of health literacy interventions over time.

These actions will be carried forward by the Medical Director who is the Executive Lead for health inequalities.

Industrial action

Following a recent vote, Resident Doctors across the country participated in industrial action between 14-19 November. Our Incident Management team (IMT) was re-established to manage this process and ensure patient safety.

Integrated Care Board (ICB) Cluster CEO

In my update to the Board in September, I confirmed Dr Kathy McLean's appointment as the Chair of the new DLN cluster, which includes Derby and Derbyshire, Lincolnshire and Nottingham and Nottinghamshire. On 1 October 2025, Amanda Sullivan commenced in post as the new cluster Chief Executive, with Executive appointments also being made last month.

Local context

Official Opening of new facilities

Over recent weeks, Elizabeth Fothergill, CBE, His Majesty's Lord-Lieutenant of Derbyshire has led two celebration events to officially open the Trust's new mental health facilities.

In Chesterfield the official opening of the Derwent Unit coincided with World Mental Health Day on 10 October. In Derby, the new Carsington Unit, Kingfisher House and Audrey House were officially opened on 7 November. The openings mark a major milestone in the Trust's Making Room for Dignity programme.

Staff and patients participated in celebration events that took place at each of our newly-built or refurbished units, to recognise the significant level of work and investment in creating these fantastic new facilities for the people of Derbyshire.

Care Quality Commission (CQC) inspection

Congratulations to colleagues at the Kedleston Unit, whose good rating has been confirmed following publication of the report following the recent visit from the CQC.

A monitoring visit under Section 120 of the Mental Health Act took place between 7-10 October. The Trust has received informal feedback from the visit, which focused on how assessment and detention processes are managed, the quality of partnership working and the experience of people using services. All adult wards across the Radbourne, Carsington and Derwent Units were part of the inspection. We are now awaiting formal feedback from the visit.

Welcoming new Board members

On Wednesday 29 October, we welcomed Dr Girish Kunigiri as the Trust's new Executive Medical Director. Girish joins us from Lincolnshire Partnership NHS Foundation Trust, where he was the Trust's Chief Medical Officer. He brings experience as a consultant psychiatrist in the East Midlands and is currently the Clinical Director for Mental Health Midlands. We look forward to working with Girish as he joins the Trust's Board of Directors.

Thank you to our Interim Medical Director, Dr Mark Broadhurst, who has provided some much-needed continuity and support over recent months. Mark will continue to support Girish over the coming weeks, prior to returning to his role as Consultant Psychiatrist.

Today is the last Board meeting for Geoff Lewins who has been a Non-Executive Director since 2017. I would like to take this opportunity to say thank you to Geoff for all he has contributed over many years. Geoff's experience and personality will be very much missed.

In December we will formally welcome Chioma Akpom as our new Non-Executive Director.

Substance Misuse services

I am extremely disappointed to confirm we were recently made aware that the Trust was unsuccessful in the bids we had entered to continue our provision of Substance Misuse services for adults, children and young people in Derby. The Trust has a long and positive history of providing local Substance Misuse services.

We now know that public health commissioners intend for the services to transfer to two charities (Cranstoun and Change Grow Live Services) from April 2026. A working group has been established to manage this transition over the coming months and ensure colleagues receive appropriate support.

New Trust operating model

Changes to the Trust's operating model, discussed in my Board report last month, came into effect this week. The new model creates two new Divisions, with five care groups. Earlier this year a review was undertaken of senior management structures across our Operational, Clinical Quality and Medical Divisions. The main aim of the review and subsequent changes was to deliver a new triumvirate leadership and management approach to support the delivery of the strategic priorities outlined in the new Trust Strategy.

Emergency Preparedness Resilience and Response (EPRR) assurance process 2024/25

I am pleased to confirm the Trust has received a rating of substantial compliance against the national EPRR standards for 2024/25. This is a great testament to the hard work of the EPRR team which supported and encouraged all teams to provide their evidence against the standards.

Recent achievements

The Mental Health Liaison team north has successfully achieved re-accreditation with PLAN – The Psychiatric Liaison Accreditation Network. PLAN is a prestigious quality improvement and accreditation network for psychiatric liaison services across the UK. It focuses on facilitating quality improvement and development in Liaison Psychiatry services through a supportive peer-review model, enabling communication, and the sharing of best practices between services.

- A team of Trust Occupational Therapists is changing the way care is planned for patients in Acute Mental Health Inpatient services, thanks to a new framework that puts personal goals at the centre of recovery. A study published in the British Medical Journal (BMJ) Open Quality outlines how the Trust introduced the Goal-Directed Care Planning (GDCP) approach across three hospital wards. The framework helps occupational therapists work with patients to identify goals that matter to them – such as returning home, regaining independence or preparing to go back to work, and then build care plans around those goals
- Congratulations to the winners of the recent art competition, who were announced at last month's Annual Members' Meeting (AMM). The quality of the artwork entered in the competition was outstanding and pieces are now on display for people to enjoy at the Carsington Unit.

Award nominations

- Our finalists at the APNA (Asian Professionals National Alliance) NHS Awards in October took home eight certificates of merits: APNA Hero Award – Clinical or Non-Clinical: Brighton Makombe; Impactful EDI Champion (Individual Award): Nicole Ellis; Mentoring and Coaching Champion: Arzoo Nasir; Digital Leader – Driving ED&I Using Technologies: Living Well; Digital Leader – Driving EDI and Using Technologies: Nicole Vutabwarova; Impactful EDI Champion (Individual Award): Sifo Dlamni; Mentoring and Coaching Champion: Kalwran Sangha; and Rising Star: Ateeq Hussain
- Congratulations to Fred Warlow who received a highly commended award recognition at the Derbyshire and Nottinghamshire Apprenticeship Awards in October. Fred was a finalist in the 'Intermediate Apprentice of the Year' category, in recognition of his role and contributions as a Customer Services Apprentice in the Trust's e-Roster team
- Sycamore Ward at the Derwent Unit were our DEED recognition scheme winners for September. The ward was nominated for multiple DEED awards due to patient testimonials highlighting the team's compassionate, transformative care and a culture of openness and support.
- In August our DEED winner was Joanne Green, Service Manager, High Peak Community Mental Health Team. Joanne was nominated for offering reliable advice, helping colleagues during challenging times, and making a meaningful difference to how others feel at work. Her support has been deeply appreciated and has had a positive impact on team wellbeing.

Other national recognition

Our Chair, Selina Ullah was named by the HSJ (Health Service Journal) as one of the 50 most influential Black, Asian and minority ethnic people in health. Consultant Psychiatrist, Dr Subodh Dave, was also named a Rising Star for his work with the Royal College of Psychiatrists and Doctors in Distress.

Staff engagement

- The Trust held its annual HEARTS staff awards ceremony on 22 October. Among this year's award recipients was an employee with nearly five decades of dedicated long service, as well as a doctor recognised for his exceptional support to patients thanks to his practical expertise and compassionate approach. This year we received the highest number of nominations to date (over 180) for the awards from both inside and outside the organisation
- In the last two months, I have joined colleagues in their celebrations and awareness raising for World Mental Health Day, with our Child and Adolescent Mental Health services (CAMHS) team hosting an event to support local children and young people. I also attended part of the Peer Support Day at the Radbourne Unit and joined the Expert Patient celebration day
- In response to feedback in last year's Staff Survey we have held a focused Careers Week and Staff Survey Week. This year's Staff Survey closes on 28 November
- Last week the Trust held our first ever Digital Futures Day. This was an exciting and interactive session where we brought together a number of clinical colleagues to explore new approaches and technologies that could support our existing digital infrastructure and transform patient pathways
- On 1 October, we held a special ceremony in the memorial garden at Kingsway Hospital to remember colleagues Jane Giles and Kevin (Kev) Bagshaw, whom we sadly lost this year. A plant and plaque were placed in the garden in memory of both Jane and Kev. I know the garden is well visited and I encourage people to use this special space to remember our former colleagues.

Team visits

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

- On 7 October I joined a Board visit to the Children in Care and Adoption team in Sinfin, Derby
- I met with the team at the Carsington Unit on 20 October
- On 6 November I spent time with the team at Kingfisher House
- I spent time with Teams at the Radbourne Unit on 10 November to promote the importance of the Staff Survey
- I also joined a Board Visit to the School Nursing team at St Paul's House in Derby on 24 November.

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

- Mark Broadhurst, Interim Medical Director attended the opening ceremonies of the Derwent Unit on 10 October and the Carsington and Kingfisher Units on 7 November
- Vikki Ashton Taylor, Deputy CEO and Chief Delivery Officer visited the Chesterfield Crisis Team and the Mental Health Liaison team on 25 September. She also attended the opening of the Derwent Unit on 10 October and took part in a Mental Health Act visit on 27 October. She visited the Employment Specialist Team at Ilkeston Resource Centre on 20 November
- Tumi Banda, Director of Nursing, AHPs, Quality and Patient Experience visited Dale Bank View in Swadlincote on 25 September, attended a walk with the Older Adult Team on 7 October, was present at the opening of the Derwent Unit on 10 October, attended a Culture of Care visit at Cubley Court on 29 October, spent time shadowing one of the Trust's Clinical Matrons at the Carsington Unit on 6 November and will return during Staff Survey Week on 11 November

- Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary visited the Physiotherapy team at Kingsway on 28 October and attended the opening of the Carsington and Kingfisher Units on 7 November. She also lent her support during Staff Survey Week, visiting various teams on 13 November
- Rebecca Oakley, Director of People, Organisational Effectiveness and Inclusion, attended the opening of the Derwent Unit on 10 October, and visited the Carsington Unit on 29 October, along with visits to various sites in Chesterfield on 12 November during Staff Survey week
- James Sabin, Director of Finance, visited the Radbourne Unit on 14 October and attended Midway Day Hospital in Ilkeston for a Coffee and Conversation Session on 16 October.

Raising awareness and community engagement

Supporting each other in challenging times

Recent months have been an unsettling time for many colleagues and communities. Within the Trust we held a number of conversations, discussing ways to support each other during community unrest. In response, focused guidance has been developed on supporting each other in challenging times. This includes information on protests, the use of social media and dealing with racial, ethnic or faith-related abuse. Changes are also now in place to manage how we report any incidents of racism and any wider discrimination related to protected characteristics.

Since the last Board meeting, I have visited members of Community Action Derby to continue our conversations on strengthening our community links and have also attended the Derby City and South Derbyshire Mental Health Carers Forum to hear from those who support people who use our services.

One of our 4Ps is Partnerships and significant work has been taking place across the county to deliver the Trust's community and stakeholder plan. Last month a new Deaf Focus Group was introduced, bringing together representatives from the Trust, the British Deaf Association (BDA) and Communication Unlimited. The group agreed on the following areas of focus – communication, access and interactions, looking at both short-term and long-term ambitions.

Awareness events

In October, the Trust marked a wide range of awareness events that celebrated diversity, promoted wellbeing and recognised professional contributions across the Trust. Black History Month was a central focus, honouring the legacy and impact of Black NHS staff under the theme 'Standing firm in power and pride'. National Coming Out Day and Hate Crime Awareness Week further reinforced the Trust's commitment to inclusion and safety, supported by active staff networks.

The month also spotlighted mental health and professional development. World Mental Health Day addressed access to services during global emergencies, with training, open days, and resources offered to staff. Speak Up Week promoted a culture of openness, while ADHD Awareness Month aimed to dispel myths and share evidence-based insights. Careers Week provided tailored growth opportunities, and several professional recognition days – including Allied Health Professional (AHP) Day, SAS Week, World Pharmacy Technician Day and World Occupational Therapy Day – celebrated the expertise and dedication of key NHS roles. Diwali and World Menopause Day added cultural and health-focused dimensions, rounding out a month of meaningful engagement across the Trust.

Service user and carer feedback

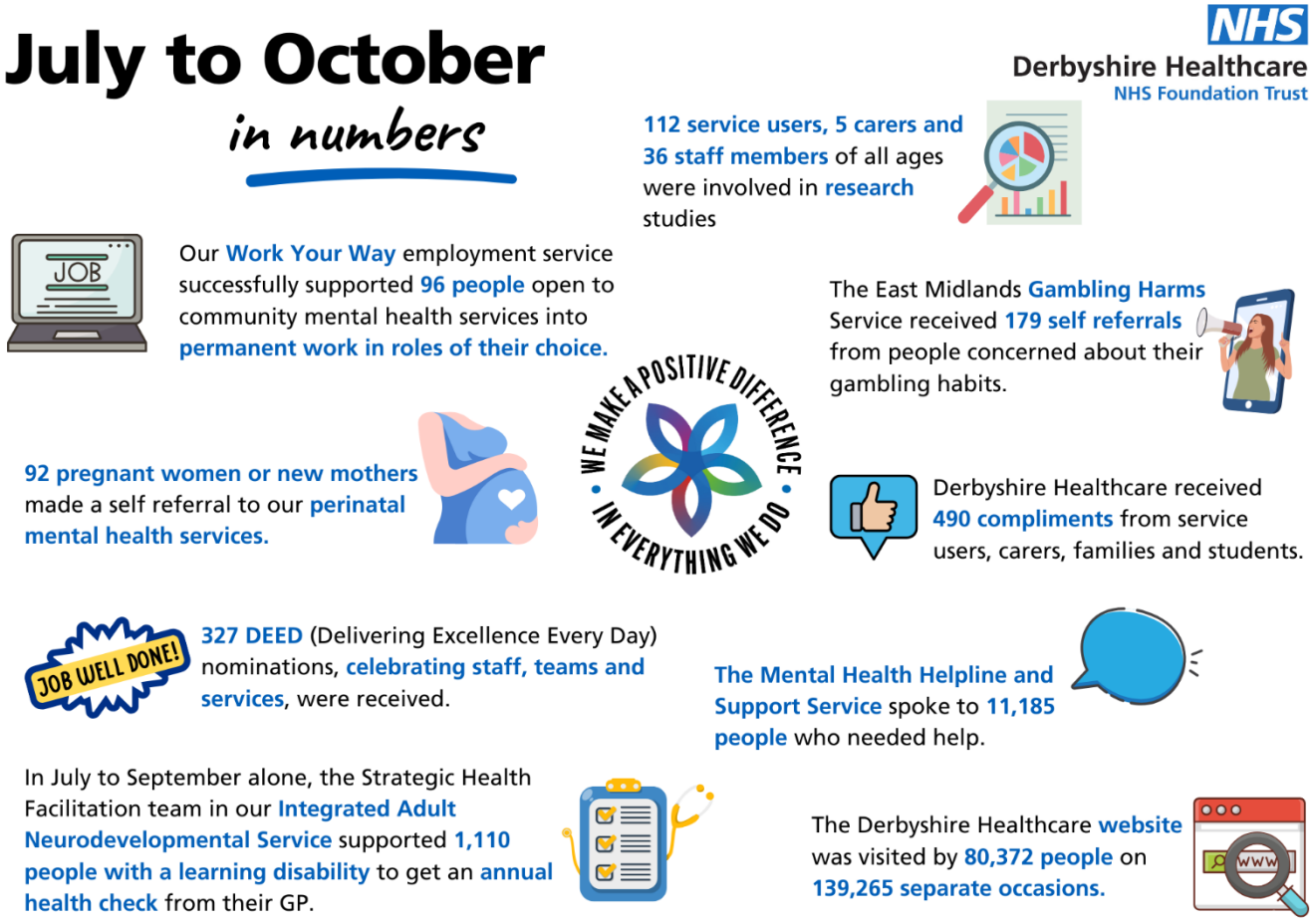
Feedback from patients and carers is crucial for the continuous improvement of our healthcare services. It provides valuable insights into patient experience, highlighting areas where we excel and identifying opportunities for enhancement. By actively listening to our patients, we can ensure that our services are patient-centred, responsive, and of the highest quality. In this context, I would like to share two pieces of feedback from service users.

The first is a card from the mother of a service user, who expressed, *"my heartfelt thanks to you and the consultants, doctors and mental health nurses and staff at 'Willow' Unit where my daughter spent three and a half weeks and received the best care. She is still receiving 'back-up' care at home. Since she was diagnosed with OCD and getting the appropriate medication, she has returned to the job she loves."*

The second was from a service user who had attended the S136 Suite at the Carsington Unit, who relayed, *"Thank you for treating me with an incredible level of compassion, dignity, care and respect. Thank you for making me feel safe in what was an extremely difficult and distressing situation and remaining professional and non-judgemental. I will never forget the level of humanity in those moments, and I will never be able to express my gratitude by words.*

You are all an absolute credit to the service and NHS and have reminded me there are still people who care."

Feedback such as this is a great reminder of why we are here, and the difference we can make to the lives of people when they are at their most vulnerable.



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 always requires consideration of a repeat Equality Impact Assessment, even though this will have been completed nationally.

Recommendations

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

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

Integrated Performance Report

Purpose of Report

The purpose of 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 September 2025 for internal measures, and to the end of August 2025 where the data source is NHS England.

Executive Summary

The report provides oversight of performance against a number of key long term plan, NHS oversight framework, and internal operational measures.

Operational

Notable changes since the last report:

- **Inappropriate out of area (OoA) placements:** there has been a significant reduction from a high of 28 back in January, to the position of four in September: one acute and three female Psychiatric Intensive Care Unit (PICU)
- **Early intervention in psychosis:** two-week referral to treatment is now back on target for people waiting for treatment and is now close to target for completed treatments.

Top three things to note from this report:

1. **NHS Oversight Framework (NOF) challenges**

   Please note, the NOF scores and segmentations are measured and published on a quarterly basis by NHS England, with the quarter 2 (Q2) results expected to be published in late November. Performance improvement plans are in progress for all the challenging areas of the framework and are summarised in the main body of the report.

   Proportion of people waiting over 52 weeks for Community services: new data is available for this metric owing to the data being submitted manually by providers to NHSE each month. In September, the position increased to 68% of children waiting over 52 weeks. The majority of these long waits are for Community Paediatrics, mainly for Autistic Spectrum Disorder (ASD) or Attention Deficit Hyperactive Disorder (ADHD) assessments. Advice from NHSE on application of the national dataset standards for neurodevelopmental activity and waits has supported a shift in data submission from the Community services dataset towards the Mental Health services dataset. This will offer published data within a reporting route that is more consistently applied by peer providers. The Information Management, Technology and Records team (IMT&R) is currently exploring the route and timeline to effect this change prior to a formal decision being considered by the Executive Leadership Team (ELT). From a NOF perspective, removing the neurodevelopmental waits would reduce the waits over 52 weeks from 65% down to around 19%. In Q1 this would have dropped the Trust from second highest to 14th highest but remained well within quartile 4: the threshold for quartile 3 was 6%. The NHSE ranking score for this measure would have reduced and the overall Trust score would have reduced. This would still place in segment 4 overall but would have ranked just one place above the segment 3 threshold.

   Crisis response: the requirement is for patients referred as “urgent” to be seen face to face within 24 hours. In Q1 the Trust was around 6% below the provider median for this metric.

A performance improvement plan is in place and being implemented. Internal data indicates that this is making steady improvements which should be reflected in a much-improved position in the official NHSE data by Q3.

Proportion of Acute inpatients discharged with a length of stay of 60 plus days: the rolling three months' position has improved for the last two months but remains higher than desired. Currently 33% (52) of Adult Acute inpatients have a length of stay to date of 60 plus days. Three of these patients would have had a length of stay under 60 days if discharged when clinically ready. A performance improvement plan is in progress with improvement expected by Q3 end.

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. In quarter 1 the Trust's position increased by 0.57% compared with the previous year, which placed in the lowest 25% of providers. The provider median was an increase of 7%. This financial year in order to cut waiting times the Integrated Care Board (ICB) has invested in Children and Adolescent Mental Health services (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. A performance improvement plan is in progress.

2. High performing areas

The areas where a consistently high level of 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 the adult ASD assessment waiting list (although the Trust continues to significantly exceed commissioned activity levels), 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.

Financial

At the end of September, there is an overall deficit of £1.7m, 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 £1.3m, which is better than plan by £0.2m.

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. Currently efficiencies are ahead of plan at the end of month 6 by £0.2m, delivering savings of £6.6m and are forecasting full delivery of £14.8m by the end of the financial year. There has been a further change in the forecast between recurrent and non-recurrent schemes, which reflects the reduced savings from the operating model in year which is being mitigated by non-recurrent one-off benefits
- Adult Acute OoA placements. Expenditure is currently above plan by £2.1m year to date (YTD) and is forecast to be above plan by £3.4m. The forecast assumed current levels for October and then a reducing trajectory in line with the plan plus an additional five placements
- Usage of bank and agency above planned levels. Currently agency and bank are within planned levels and are forecast to remain below the plan at the end of the financial year.

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 or are improving include a reduction in the number of patients absconding from Inpatient wards, the rate of restrictive interventions per 1,000 bed day and an improvement in compliance with Care Programme Approach (CPA) reviews across the Trust.

Challenging areas: the areas where performance is most challenging include inpatients who are clinically ready for discharge, 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 limited assurance: weaknesses in the design or inconsistent application of controls put the achievement of the system's objectives at risk in the areas reviewed. (see Appendix 2)
2. Determine whether any further assurance is required.

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

James Sabin
Director of Finance

Rebecca Oakley
Director of People, Organisational Development and Inclusion

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

Report prepared by: **Pete Henson**
Head of Performance and Delivery

Rachel Leyland
Deputy Director of Finance

Liam Carrier
Assistant Director of Workforce Transformation

Joseph Thompson
Assistant Director of Clinical Professional Practice

Derbyshire Healthcare
NHS Foundation Trust

Integrated Performance Report

November 2025

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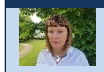
OPERATIONAL PERFORMANCE



Deputy Chief Executive/ Chief Delivery Officer:
Vikki Ashton Taylor

Responsible Committee: **Finance and Performance Committee**

Executive Summary

Inflow

- **Percentage of patients in crisis to receive face-to-face contact within 24 hours:** NHS England has 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 NOF ratings (Q1) the Trust achieved 51%, against the provider median of 57%. The Trust's Adult Single Points of Access provide planned care and are not an urgent or crisis provision, and should not be receiving urgent referrals, which indicates a categorisation error on some referrals received. This will be addressed through data quality improvement. In the most recently published monthly data[1] (Aug-2025) the Trust ranked 31st out of 46 NHS mental health providers, achieving 53% against the provider median of 57.5%. A performance improvement plan is in place with significant improvement expected from November 2025.
- **Mental health helpline:** From the latest official statistics in development that have been published by NHS England (Aug-2025), the Trust's Mental Health Helpline is reported as performing less favourably when compared with other providers in the Midlands regarding the proportion of calls abandoned after call steering interactive voice response: 50%. In comparison, the national average for calls abandoned was 27%. Demand on the helpline has been increasing through various extensions of the service offer over the last three 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 performance improvement plan has been developed and is in progress.

Outflow

- **Inappropriate out of area (OoA) Adult Acute placements:** there has been a significant reduction from a high of 28 back in January to the current position of four: two acute and two female Psychiatric Intensive Care Unit (PICU). The new male PICU for Derbyshire opened in Jul-2025 and all the new wards are in operation, which should further positively impact. A comprehensive inappropriate out of area placements performance improvement plan has been implemented.
- **Proportion of Adult Acute inpatients discharged with 60 days plus length of stay:** In Q1 the national median was 25% and the threshold for the lowest 25% of providers was 21%. 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. This means that when the 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. 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. In the most recently published monthly data[1] the Trust ranked 10th highest out of 46 NHS mental health providers, with performance of 28% against the provider median of 24%. A comprehensive performance improvement plan is in place with recovery expected by the end of Dec-2025.
- **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* for the three months to Sep-2025 was below target at 50.4 days. In the most recently published monthly data[1] the Trust ranked 21st highest out of 46 NHS mental health providers, with performance of 60 days against the provider median of 58.
- **Three day follow-up:** the national standard for follow-up continues to be exceeded.

[1] Mental Health Services Monthly Statistics - NHS England Digital

Elective/access

- **Women accessing specialist Perinatal Mental Health service**: increasing numbers of women are being supported by the service, which in the latest NHSE data ranks 3rd highest in the region against the national access standard.
- **Adult autistic spectrum disorder assessment (ASD):** activity levels continue to exceed the commissioned target for assessments, with the full year target almost exceeded after just 6 months. Waiting times remain high at around 56 weeks, with demand far exceeding capacity. The waiting list has reduced by 27% over the last 12 months but remains high at over 1,300 people. Negotiations are still continuing with the ICB around a new model of service delivery.
- **Community waits over 52 weeks:** In September the position increased to 68% of children waiting over 52 weeks to be seen. The majority of these long waits are for Community Paediatrics, mainly for ASD or ADHD assessments. Advice from NHSE on application of the national dataset standards for neurodevelopmental activity and waits has supported a shift in data submission from the Community services dataset towards the Mental Health services dataset. This will offer published data within a reporting route that is more consistently applied by peer providers. The Information management, Technology and Records team (IMT&R) is currently exploring the route and timeline to effect this change prior to a formal decision being considered by the Executive Leadership Team. From an NOF perspective, removing the neurodevelopmental waits would reduce the waits over 52 weeks from 65% down to around 19%. In Q1 this would have dropped the Trust from second highest to 14th highest but remained well within quartile 4: the threshold for quartile 3 was 6%. The NHSE ranking score for this measure would have reduced, and the overall Trust score would have reduced. This would still place in segment 4 overall but would have ranked just one place above the segment 3 threshold.
- **Early intervention in psychosis:** the early intervention services assess people who are suspected of experiencing a first episode of psychosis. The national standard is to undertake an assessment within two weeks of people being referred into the service (target 60%). Historically, the target had consistently been exceeded. However, since Apr-2025 the target has not been achieved. A performance improvement plan is in place, with anticipated recovery by Dec-2025. The positive impact of the plan can already be seen - two-week referral to treatment is now back on target for people currently waiting for treatment and performance is now close to target for waiting time to completed treatment.
- **Children and young people mental health access:** This is a measure of the annual change in the number of distinct children and young people having at least one contact with Mental Health services. In the latest published data[2] (Aug-2025) the Trust's position had increased by 1.8% compared with 12 months ago, which placed 27th out of 50 when benchmarked against the other NHS mental health providers. The national median was an increase of 4%. This financial year the ICB has invested in CAMHS in order to reduce waiting times. 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. A performance improvement plan is in progress.

Collaboratives

- **Transforming care programme:** all but one of the eight 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, which is the number of children and young people in specialised or secure inpatient care (target three, actual four).

[2] Mental Health Services Monthly Statistics - NHS England Digital

NHS
Derbyshire Healthcare
NHS Foundation Trust

Measure	Target	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	
Long term plan 2025/26														
Inappropriate adult acute & PICU mental health out of area placements at month end^	5	33	44	45	44	25	23	19	32	13	8	13	4	
Women accessing specialist perinatal mental health services (rolling 12 months)* ^^	1242	1280	1325	1340	1335	1340	1345	1340	1350	1390	1390	1395		
Perinatal access rate (ICB)*	10%	11.9%	12.2%	12.4%	12.3%	12.4%	12.4%	12.3%	12.5%	12.8%	12.9%	12.9%		
Individual work placement support access (rolling 12 months)*	690	700	675	665	660	700	715	715	715	745	765	760		
Average length of stay for adult acute, older adult & PICU mental health beds**	55	52	58	62	65	67	66	63	59	64	61	60	59	
NHS oversight framework 2025/26														
Proportion of people waiting over 52-weeks for community services*	0%	48%	50%	56%	58%	61%	63%	62%	64%	65%	64%	65%	68%	
Children and young people accessing NHS-funded MH services - annual change*	15.9%	2.4%	1.6%	0.3%	0.0%	0.0%	0.3%	-1.1%	-2.0%	0.6%	0.7%	1.8%		
Proportion of acute inpatients aged 18-64 discharged with 60 days plus length of stay**	20.6%	18%	25%	25%	24%	27%	23%	21%	18%	31%	33%	27%	27%	
Percentage of patients in crisis to receive face-to-face contact within 24 hours*	65.4%	32%	42%	44%	44%	47%	53%	57%	50%	47%	52%	53%		
Key operational measures														
Children & young people eating disorder routine referrals seen within 4 weeks*	95%	100%	100%	100%	94%	95%	95%	100%	100%	100%	100%	100%	100%	
Children & young people eating disorder urgent referrals seen within 1 week*	95%	100%	100%	#N/A	#N/A	#N/A	#N/A	#N/A	100%	#N/A	#N/A	#N/A	#N/A	
Inpatient discharges followed up within 72 hours	80%	91%	90%	80%	92%	87%	88%	90%	89%	90%	87%	88%	92%	
Dementia diagnosis rate (ICB)*	68%	68.8%	69.0%	68.9%	68.4%	68.5%	68.8%	69.0%	69.3%	69.2%	68.9%	68.6%		
Early intervention in psychosis 2 week waits from referral to treatment - complete	60%	68%	92%	71%	54%	76%	65%	56%	47%	43%	37%	39%	52%	
Early intervention in psychosis 2 week waits from referral to treatment - incomplete	60%	100%	77%	53%	81%	80%	56%	48%	46%	46%	50%	58%	75%	
Adult ASD assessment – number of people waiting at month end	219	1821	1685	1596	1709	1602	1495	1472	1399	1382	1356	1365	1332	
Adult ASD assessment – average wait (weeks)	18	56	58	60	54	54	57	55	56	54	56	53	56	
Adult ASD assessment – number of assessments completed per month	26	93	85	61	75	93	67	59	55	61	64	29	36	

^ The ICB now only accept a maximum of 3 PICU placements as continuity of care

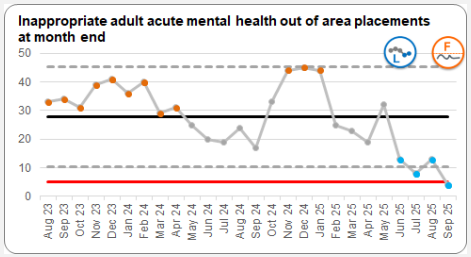
* Data source = NHS England. Expected publication date of September data (October data re dementia diagnosis) is 20 November 2025

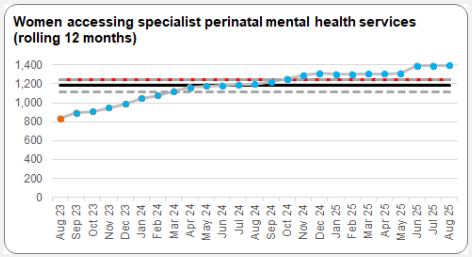
^^ Perinatal and maternal mental health services

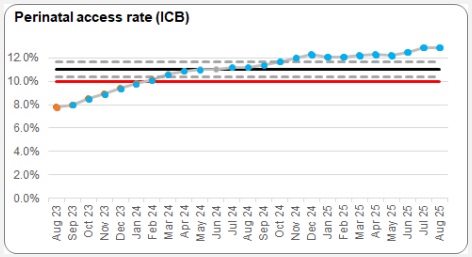
** Rolling 3 months, length of inpatient spell of patients discharged

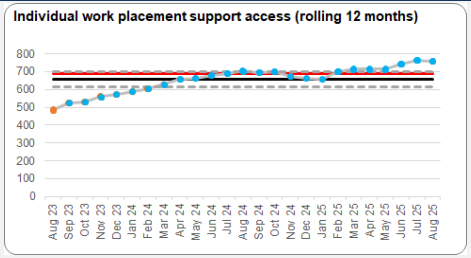
NHS oversight framework targets = minimum level required to have been placed in the top quartile in quarter 1

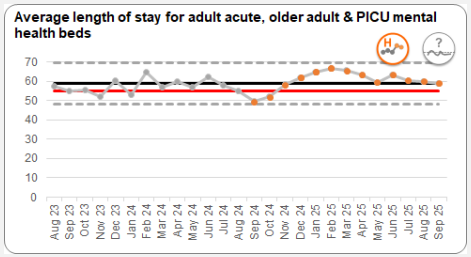
Operational Key Performance Indicators – Statistical Process Control Charts

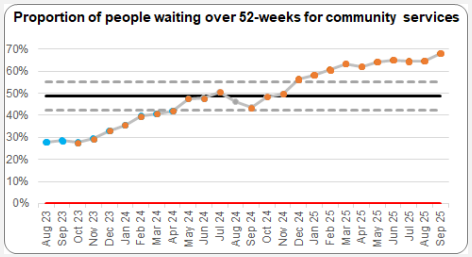


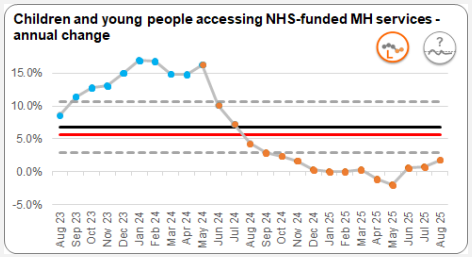


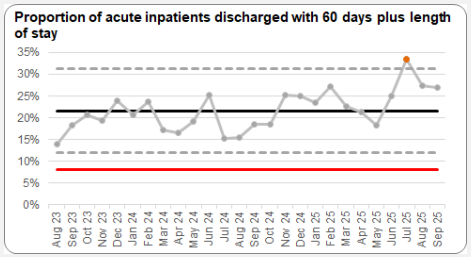


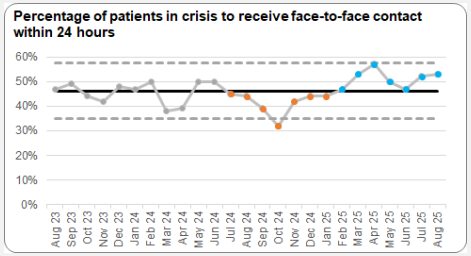


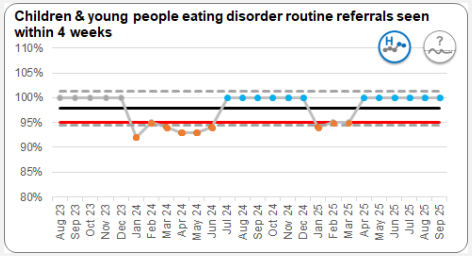


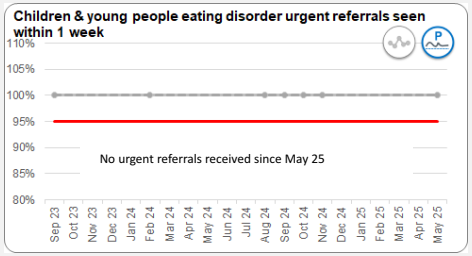


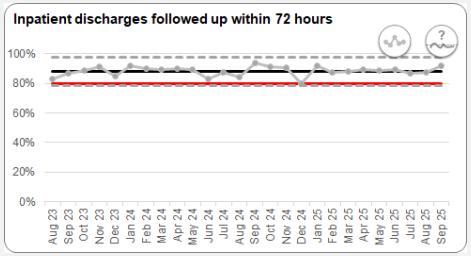


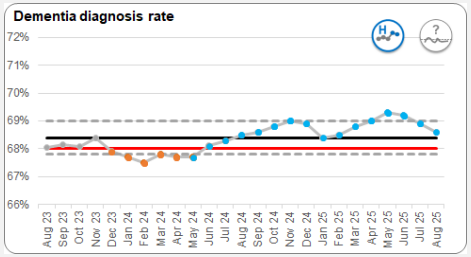


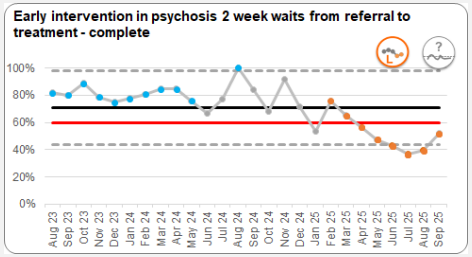


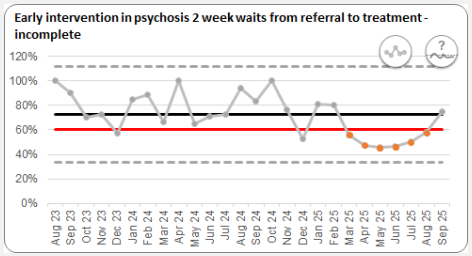


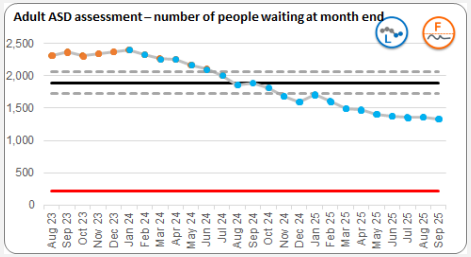


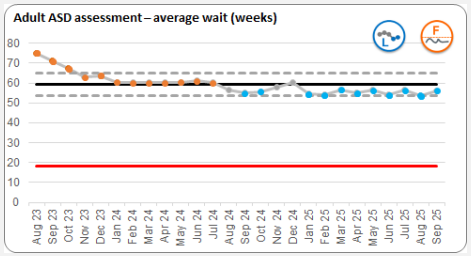


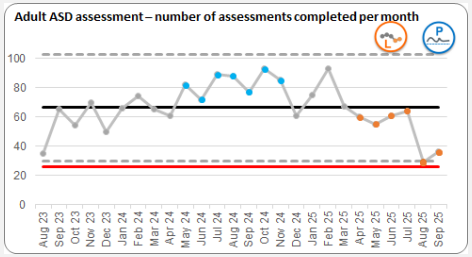


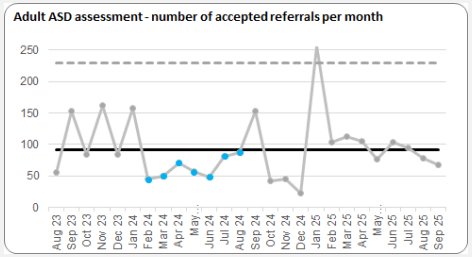












TRANSFORMATION AND IMPROVEMENT

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 72 hour 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 identified through the JUCD Men-SAT review supported by the NHSE Mental Health Improvement Support Team have been incorporated to the action plan. 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.

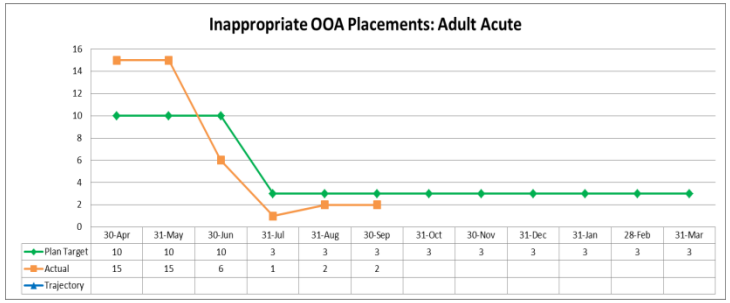
Action is currently focused on design of a strategic approach for integration and localisation of services in alignment with the 10 Year Health Plan ambition to transform mental health services into 24/7 neighbourhood care models; with a Board development session hosted on 15-Oct to define strategic intent.

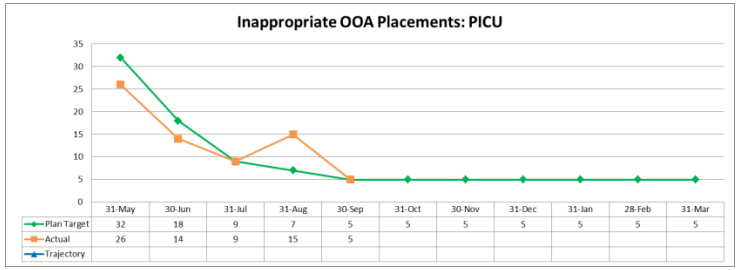
A workshop approach is being implemented with frontline teams, applying intelligence and insights in development of the model, pathway and strategic Inflow implementation plan for delivery from Q4 and into 2026/27. The first workshop was hosted on 26-Sep-2025 with a further two scheduled over coming months.

Impact:

Delivery of the improvement trajectory over Q1 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 out of area placement position on 30 September 2025 below the month end trajectory.





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 out of area position.

The Operational Plan ambition that follows achievement of reduced out of area placements is phased withdrawal from the privately commissioned beds. A revised trajectory has been agreed for this in Q3, reflecting delays against the anticipated opening dates across the new units.

TRANSFORMATION AND IMPROVEMENT

NHS Derbyshire Healthcare NHS Foundation Trust

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 01-Nov-2025 Phase 2 – Service model (to include demand and capacity modelling) and staffing by 01-Apr-2026
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 Nov-2025.
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 two-week referral to treatment** Recovery anticipated by Dec-2025.

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** Neurodevelopmental waits are not expected to be recoverable without significant additional investment; however the data quality improvement work should result in a significant reduction in the proportion waiting over 52 weeks. Advice from NHSE on application of the national dataset standards for neurodevelopmental activity and waits has supported a shift in data submission from the community services dataset towards the mental health services dataset. This will offer published data within a reporting route that is more consistently applied by peer providers. The IMT&R team is currently exploring the route and timeline to effect this change prior to a formal decision being considered by ELT.
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 2024/25 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 Aug-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.	**Metric: People in mental health crisis seen face to face within 24 hours** Annual issue with comparative capacity will correct from Aug-2025. Agreed investment will support achievement of a 4-6 week waiting period for comprehensive assessment and an additional 4-6 weeks to access care co-ordination or treatment by Feb-2027.
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 three months (13 weeks) by Jun-2027.

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 Care Quality Commission (CQC) Notice of Proposal for civil enforcement action. All 'placing' commissioners have been notified in line with the request from NHSE. 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 six months until Sep-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 Provider Collaborative 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-Jun 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 in Oct-2024 has been completed and improvement action planned. Safeguarding reviews are delayed whilst the incident is out with police. The Collaborative escalated St Andrews Healthcare to intensive quality assurance and improvement level of surveillance in August. Admissions into Inpatient services reduced in Q1 in comparison to Q4 and are below average for the year. There is an increasing trend of admissions of patients in the Transforming Care cohort over the last four quarters. The Task and Finish Group completed development of the day service specification, and this has been presented to and agreed by the Provider Collaborative Programme Board.	**East Midlands CAMHS Collaborative** Business case for the expansion of the Family Ambassador Programme into the CAMHS Enhanced Community offer was approved by the relevant governance in May 2025. The CAMHS Provider Collaborative have been shortlisted for the HSJ Awards for Provider Collaborative of the Year.
East Midlands Adult Eating Disorders (AED) Collaborative Lincolnshire Partnership Trust has experienced difficulties associated with the unplanned absence of the Consultant Psychiatrist. The Lincolnshire System has recently reached out to Medical Directors and the Provider Collaborative for support. Following the increase in activity Q4, there has been a significant decrease in Q1, resulting in reduced out of area admissions and a slight decrease in activity on Welford Ward. Due to decreased activity in Q1, it is looking likely there will be sufficient surplus in 2025/26 to fund Waterlily in full into 2026/27.	**East Midlands AED Collaborative** A contract has now been awarded for the new adult eating disorder unit, Nova Ward at Cygnet Elowen in Shipley, increasing inpatient capacity within the East Midlands by 12 beds. The ward is due to open to admissions on 25-Aug. Welford Ward is trialling a new application (AIRMID) for sharing some clinical records with patients.
East Midlands Perinatal Provider Collaborative There are no performance or quality concerns for escalation. Interim mitigations remain in place with regards to high room temperatures at The Beeches whilst awaiting installation of air conditioning. Admissions and occupied bed days in Q1 have been consistent with Q4, although there has been a steady decrease in activity of patients originating from the East Midlands patients over the last 12 months.	**East Midlands Perinatal Provider Collaborative** Perinatal learning events are continuing, with good attendance from both Inpatient and Community teams at the event held on 2-Jul. The learning at the event was based on recommendations from the Mothers and Babies: Reducing Risk through Audits and confidential Enquiries (MBRACCE) report 2024.
East Midlands Gambling Harm Service In anticipation of additional funding associated with the gambling levy, the service is developing an expanded model of care to increase its reach across the East Midlands. The service has increased its annual referral target by 10% in response to higher demand with this on track to be achieved by year end. There are no waiting lists, and access remains within agreed timeframe protocols. The service is adopting more suitable clinical measures to better track patient progress throughout treatment.	**East Midlands Gambling Harm Service** The service is enhancing understanding of how medications and health conditions influence gambling-related behaviours, using SystmOne insights to shape wider clinical practice. Patient feedback continues to demonstrate the positive and tangible difference the service makes in people's lives.

FINANCIAL PERFORMANCE

Director of Finance:
James Sabin

Responsible Committee: **Finance and Performance Committee**

Executive Summary

Overall

At the end of September there is an overall deficit of £1.7m, 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 £1.3m, which is ahead of plan by £0.2m.

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.

Efficiencies

The plan includes an efficiency requirement of £14.8m with the plan assuming 82% is delivered recurrently. At the end of September, efficiencies delivered over plan by £0.2m delivering savings of £6.6m. The forecast assumes the full efficiency plan is met in full. There has been a further change in the forecast between recurrent and non-recurrent schemes, which reflects the reduced savings from the operating model in year being mitigated by non-recurrent one-off benefits.

Agency

Agency expenditure at the end of September is £1.4m, which equates to 1.2% of the total pay expenditure, and is below plan by £0.3m. Forecast agency expenditure is £2.5m which is below plan by £0.9m. The two highest areas of agency usage continue to relate to consultants and nursing staff.

Adult Acute Out of Area (OoA) Placements

The biggest area of risk is in relation to Adult Acute OoA placements, with expenditure being above plan by £2.1m YTD and is forecast to be above plan by £3.4m. The forecast assumed current levels for October and then a reducing trajectory in line with the plan plus an additional five placements.

Capital Expenditure

Capital is below plan at the end of Sep £1.4m. The plan included a 5% over planning assumption. It has been agreed for all organisations to remove the over planning assumption from the forecast at month 6. Therefore, our capital expenditure is now forecast to be under plan by £105k.

Cash

Cash at the end of Sep is at £25.1m, which is higher than plan by £4.6m due to the timing of receipts. Cash levels at the end of Mar-2026 are forecast to be £23.9m, which is £1.5m below plan. Cash is forecast to be below plan due to some of the non-recurrent efficiencies being delivered through non-cash related benefits. There are no concerns in relation to debt recovery.

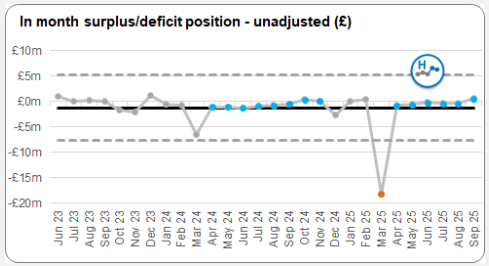
Better Payment Practice Code

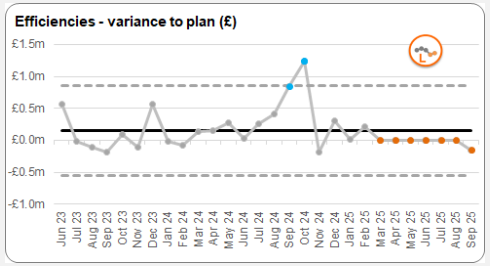
The Better Payment Practice Code (BPPC) sets a target for 95% of all invoices to be paid within 30 days. BPPC is measured across both invoice value and volume of invoices. At the end of Sep, both the value and volume of invoices exceeded the target at 99% and 97% respectively.

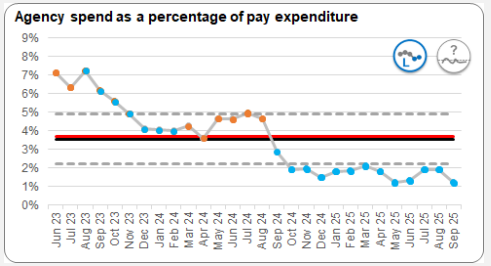
NHS
Derbyshire Healthcare
NHS Foundation Trust

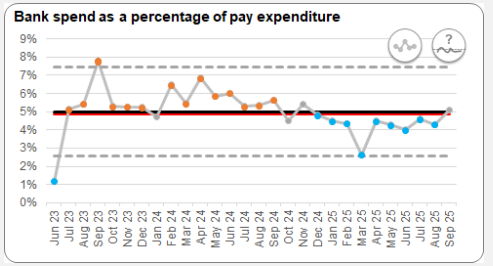
Measure	Target	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	
Financial Performance														
In month surplus/deficit position - unadjusted (£)	-	£ 352,759	£ 105,217	-£ 2,657,992	-£ 27,320	£ 505,698	-£ 18,160,011	-£ 759,497	-£ 618,647	-£ 181,431	-£ 356,503	-£ 340,743	£ 546,298	
Efficiencies - variance to plan (£)	-	£ 1,244,087	-£ 192,100	£ 307,496	£ 11,618	£ 209,050	£ -	£ -	£ -	£ -	£ -	£ -	-£ 153,000	
Agency spend as a percentage of pay expenditure	3.7%	1.9%	1.9%	1.5%	1.8%	1.8%	2.1%	1.8%	1.2%	1.3%	1.9%	1.9%	1.2%	
Bank spend as a percentage of pay expenditure	4.9%	4.5%	5.4%	4.8%	4.5%	4.4%	2.6%	4.5%	4.3%	4.0%	4.6%	4.3%	5.1%	
Adult acute out of area expenditure (£000)	-	£ 666	£ 1,095	£ 1,012	£ 1,062	£ 889	£ 654	£ 799	£ 1,110	£ 977	£ 839	£ 618	£ 660	
Capital expenditure variance to plan (£)	-	£ 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	-£ 640,000	-£ 917,000	
Better Payment Practice Code (BPPC) by volume	95%	97.4%	96.9%	97.0%	96.9%	97.0%	97.6%	97.6%	97.2%	97.5%	97.6%	97.4%	97.4%	
Better Payment Practice Code (BPPC) by value	95%	97.9%	97.3%	97.4%	97.7%	97.7%	99.8%	98.2%	98.4%	98.7%	99.0%	99.2%	98.9%	
Cash (£000)	-	£ 26,380	£ 34,412	£ 31,559	£ 26,415	£ 24,296	£ 19,071	£ 20,204	£ 17,589	£ 17,175	£ 25,805	£ 29,130	£ 25,167	
Liquidity (days)	-	-17	-13	-19	-23	-25	-12	-13	-14	-19	-16	-16	-16	
NHS oversight framework 2025/26														
Planned surplus/deficit year to date - adjusted (£)	£ -	-£ 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	-£ 1,986,468	-£ 1,521,049	
Variance year to date to financial plan - adjusted (£)	tbc	£ 1,289,294	£ 2,066,357	-£ 52,346	£ 420,664	£ 1,466,422	£ 6,384,643	£ 26,588	£ 43,183	£ 76,791	£ 63,671	£ 65,060	£ 207,015	
Relative difference in costs	<100%						93.76%							

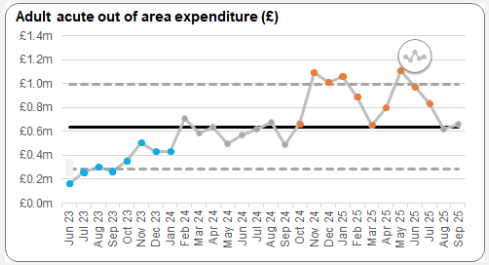
Financial Key Performance Indicators – Statistical Process Control Charts

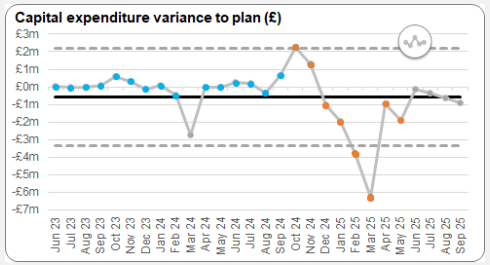


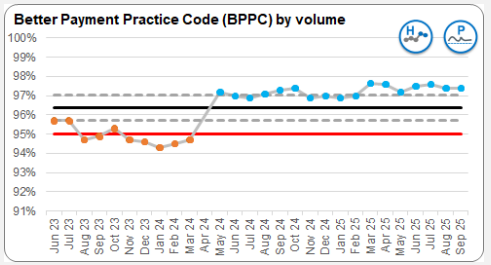


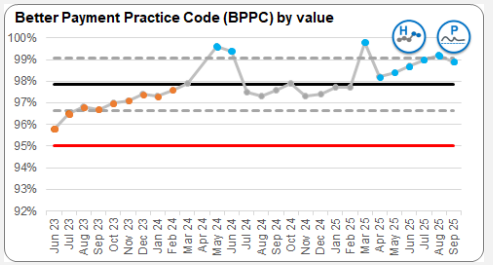


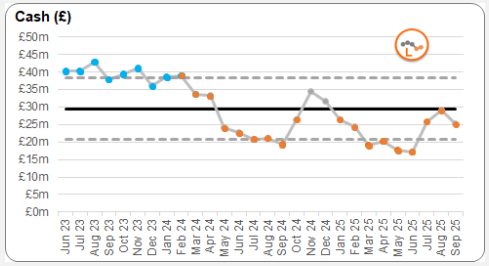


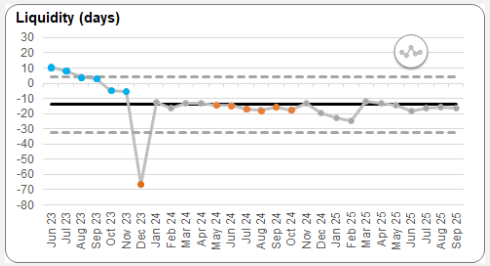


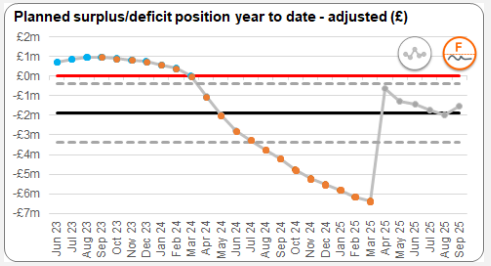


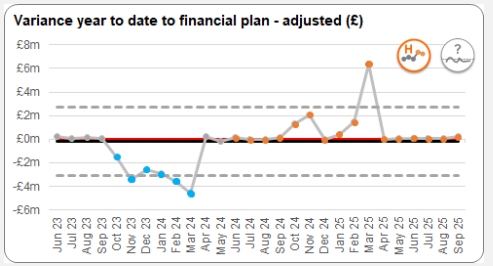




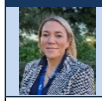








PEOPLE PERFORMANCE



Director of People, Organisational Development and Inclusion:
Rebecca Oakley

Responsible Committee: **People and Culture Committee**

Executive Summary

Update

Annual appraisals: continue to remain high at 93% and has surpassed the 90% Trust target for the last five consecutive months. Incremental increase in compliance continues to occur in addition to maintaining high compliance rates. Efforts to address both appraisals that are out of date and those approaching renewal continues.

Annual turnover: remains in line with national and regional comparators and has remained below the Trusts 12% upper tolerance limit for the last year.

Compulsory training: compliance continues to remain high at 95% and has surpassed the 85% target for several years. Incremental increase in compliance continues to occur in addition to maintaining high compliance rates.

Sickness absence: for the month of Sep-2025 is running at 5.80%, an increase of 0.18% compared to the same period last year. The annual sickness absence rate is running at 5.69%, a reduction of 0.41% compared to the same period last year. Anxiety, stress or depression related illness remains the highest reason for sickness absence, followed by other musculoskeletal problems. Following formation of the absence oversight group, the focus will be on development of its delivery plan. A high-level overview has been produced which focuses on monitoring absence, policy compliance, hot spot areas, support for managers and support for our people. A Quality Improvement approach will continue to be taken to assist with reducing absence levels.

Filled posts: by contracted staff at the end of Sep was 91% of funded posts. 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 continues to see a staged adjustment to vacancies throughout the year as service developments and cost improvement programmes are delivered.

Agency usage: has reduced significantly over recent months. The authorisation panel to oversee agency requests across the Trust continues to remain in place.

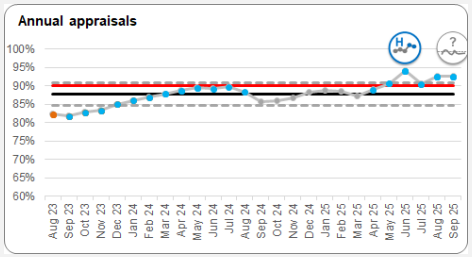
Supervision: compliance continues to remain a challenge in both clinical supervision at 83% and management supervision at 87%. Whilst there has been incremental improvement in compliance, efforts continue to work with Teams with low compliance and rates are expected to increase further over the coming months.

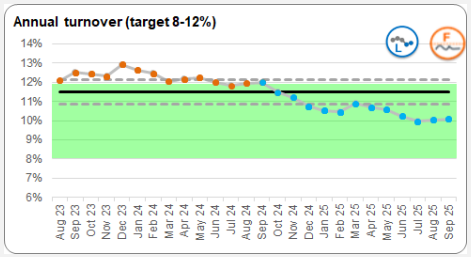
NHS
Derbyshire Healthcare
NHS Foundation Trust

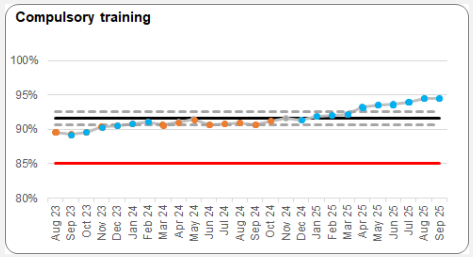
Measure	Target	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	
People Performance														
Annual appraisals	90%	86%	87%	88%	89%	89%	87%	89%	91%	94%	91%	93%	93%	
Annual turnover (target 8-12%)	12%	11%	11%	11%	11%	10%	11%	11%	11%	10%	10%	10%	10%	
Compulsory training	85%	91%	92%	91%	92%	92%	92%	93%	94%	94%	94%	95%	95%	
Filled posts	100%	85%	85%	86%	87%	88%	88%	88%	89%	89%	90%	90%	91%	
Bank staff use	5%	5.4%	5.2%	5.4%	4.3%	4.5%	4.4%	4.5%	4.0%	4.1%	3.9%	4.5%	5.1%	
Agency staff use	1.9%	1.0%	0.7%	0.6%	0.6%	0.7%	0.7%	0.3%	0.4%	0.3%	0.4%	0.5%	0.4%	
Management supervision	100%	85%	85%	87%	87%	86%	86%	84%	85%	86%	86%	85%	87%	
Clinical supervision	100%	84%	85%	85%	85%	84%	83%	81%	83%	82%	82%	82%	83%	
NHS oversight framework 2025/26														
Sickness absence rate	5%	6.3%	6.1%	6.5%	6.8%	5.8%	5.1%	5.4%	4.9%	5.3%	5.8%	5.5%	5.8%	
Annual NHS Staff Survey - raising concerns sub-score*	7.0	6.81	6.81	6.76	6.76	6.76	6.76	6.76	6.76	6.76	6.76	6.76	6.76	
Annual NHS staff survey engagement theme score*	7	7.23	7.23	7.07	7.07	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%	78.9%	78.9%	78.9%	78.9%	78.9%	78.9%	78.9%	78.9%	78.9%	78.9%	

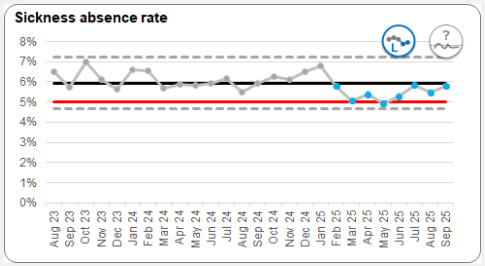
*2025 results are due to be published in March 2026
**2025 survey is currently in progress closing 2 December 2025, with the results to be published next year

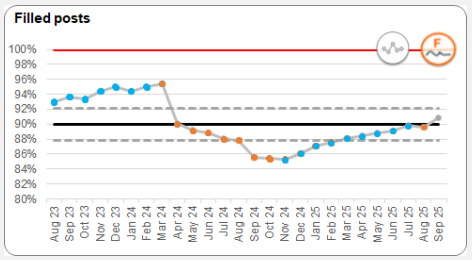
People Key Performance Indicators – Statistical Process Control Charts

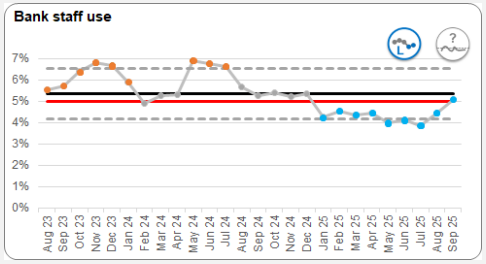


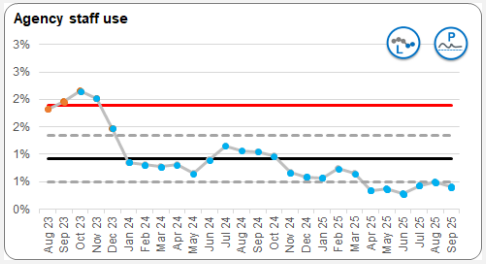


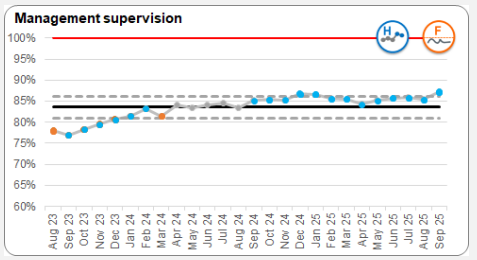


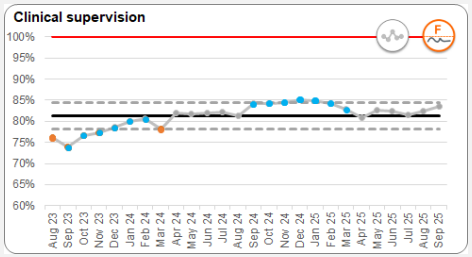


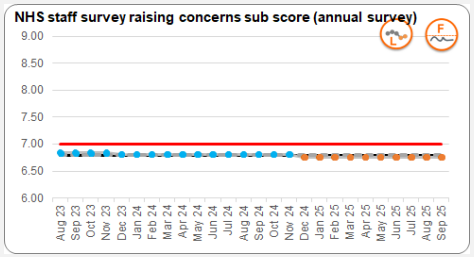


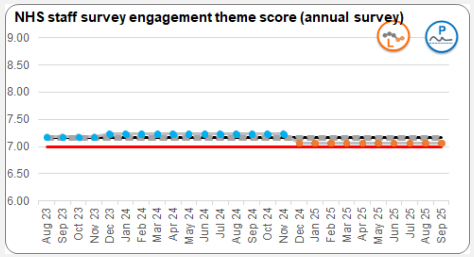


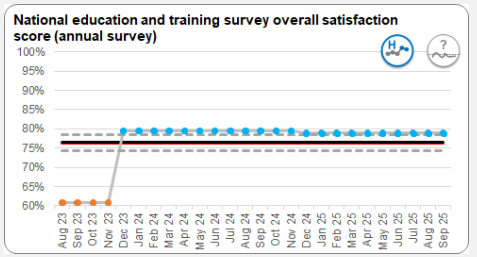












QUALITY PERFORMANCE

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 and are following a pattern of expected variation.

Closer look (CL) (formal investigations): CL complaints have increased, likely linked to new service's opening. Themes continue to be monitored and escalated through governance committees.

Clinically ready for discharge (CRfD): common cause variation pattern has continued. Discharge delays are primarily owing to housing, funding, and care placement barriers. Twice-weekly multi-agency discharge event (MADE) meetings and a new 72-hour admission review have now been implemented to support intervention and escalation.

Care programme approach (CPA): current compliance has improved 81% against a 95% target, with the exclusion of Inpatient services as any patient on CPA would also be open to a Community team and therefore, would be counted twice. 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 have been sustained and continue to be seen.

Incidents meeting Duty of Candour (DoC) threshold

An increase was noted between July and Sep-2025 in incidents that met the threshold for DoC disclosure. The duty was discharged in all cases and any DoC incident is reviewed within the twice weekly Trust Serious Incident Groups. This is expected to reduce by the next report.

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 sustained increase in incidents has also been influenced by the opening of the Enhanced Care Unit (ECU) and Psychiatric Intensive Care Unit (PICU) in Jul-2025. To highlight incidents of racism, from Sep-2025 these incidents are logged as major on Datix to ensure they are seen by senior management. Although the classification is subsequently changed by the Patient Safety team this is likely to increase the numbers of major Datix reported by the Trust.

Restrictive practices

- **Prone restraint:** above Trust margin (12 incidents); related to opening of ECU and PICU in Jul-2025 continued to follow a common cause variation pattern but increased in line with the increase in episodes of seclusion between Jul and Aug-2025
- **Physical restraint:** above margin (45 incidents); continued to follow a pattern of common cause variation and average increase expected due to opening of ECU and PICU
- **Seclusion episodes:** remain above threshold (14), influenced by new seclusion facility at Derwent Unit and opening of ECU and PICU in Jul-2025. Average increase expected in relation to opening of new facilities.

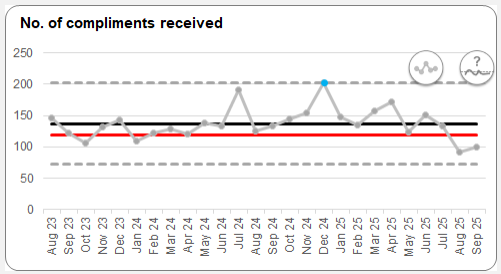
Falls Incidents: still above margin of 25. Mostly minor/no harm. Linked to frailty, ward occupancy and multiple incidents linked to small number of individuals. Individual risk management plans, use of bed sensors and bi-weekly reviews with shared learning in place to support reduction of numbers but overall average expected to rise due to edition of Bluebell Ward.

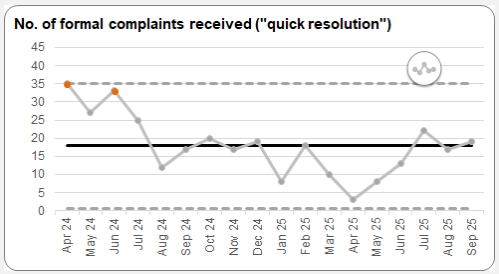
Care hours per patient day: below national averages: 9.34 hours v national 11.5. This includes lower figures for both registered Nurses (3.86 v 3.9) and Support Workers (5.22 v 7.5), indicating staffing challenges.

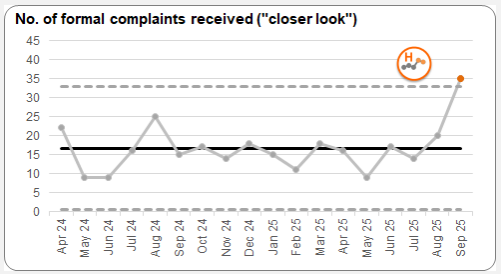
Measure	Target	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	
Quality performance														
No. of compliments received	119	145	155	203	148	135	157	172	124	149	120	92	100	
No. of formal complaints received ("quick resolution")		20	17	19	8	18	10	3	8	13	21	17	19	
No. of formal complaints received ("closer look")		17	14	18	15	11	18	17	9	14	11	20	35	
Proportion of patients clinically ready for discharge	4%	11%	11%	10%	10%	10%	9%	11%	10%	11%	10%	11%	11%	
Proportion of patients on CPA >12 months who have had their care plan reviewed	95%	75%	75%	75%	73%	73%	76%	80%	81%	79%	80%	79%	78%	
Patients who have their employment status recorded as "in employment"		12%	12%	12%	12%	12%	12%	12%	12%	12%	12%	13%	13%	
Patients who have their accommodation status recorded as "settled"		49%	49%	49%	48%	47%	47%	48%	49%	49%	50%	51%	52%	
Number of medication incidents		55	45	71	62	55	92	69	63	71	95	98	98	
No. of incidents of moderate to catastrophic actual harm	48	68	67	57	59	63	51	66	56	76	91	62	111	
No. of incidents requiring Duty of Candour	1	0	1	0	0	0	1	0	1	1	1	2	4	
No. of incidents involving prone restraint	12	19	8	8	5	8	14	7	5	10	14	25	18	
No. of incidents involving physical restraint	46	103	92	52	67	114	103	65	73	81	114	144	100	
No. of new episodes of patients held in seclusion	14	14	10	14	9	9	25	14	20	8	18	39	23	
No. of falls on inpatient wards	30	37	39	40	22	36	40	45	37	58	38	46	57	
NHS oversight framework 2025/26														
Annual community mental health survey satisfaction rate (out of 10)*	6.7	6.50	6.50	6.50	6.50	6.50	6.50	6.50	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												

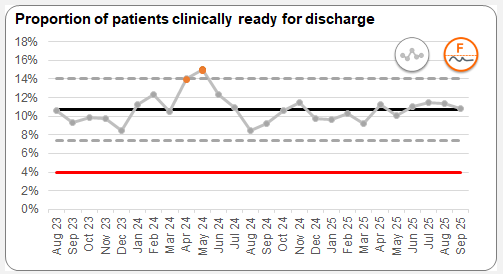
*the 2025 results are due to be published in Spring 2026

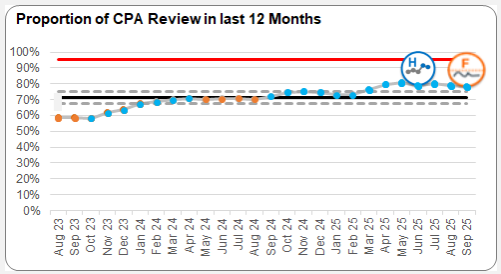
Quality Key Performance Indicators – Statistical Process Control Charts

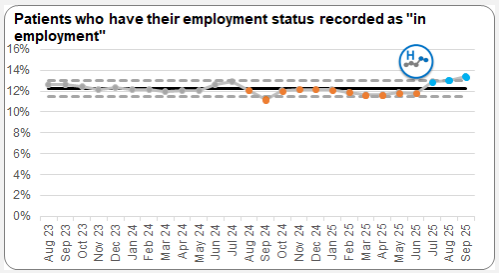


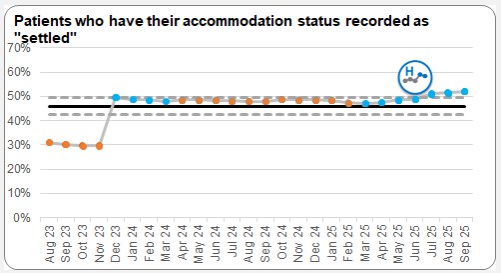


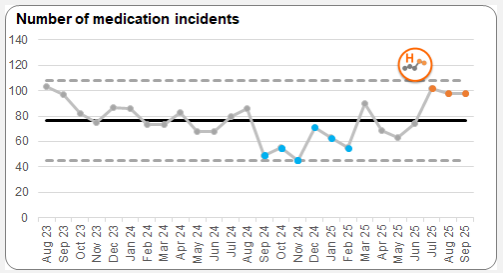


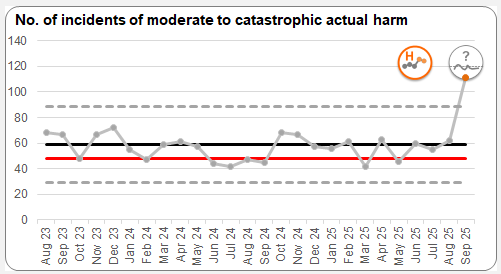


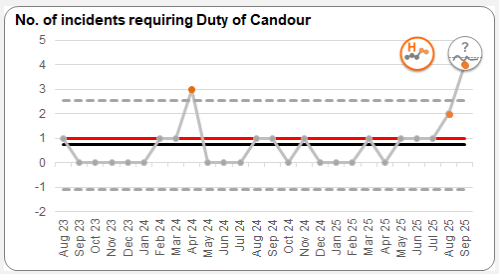


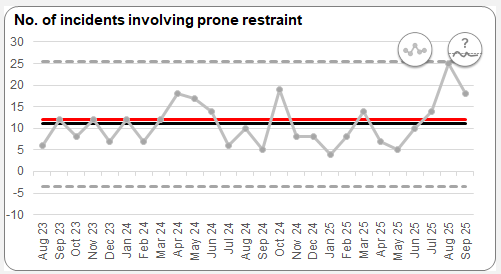


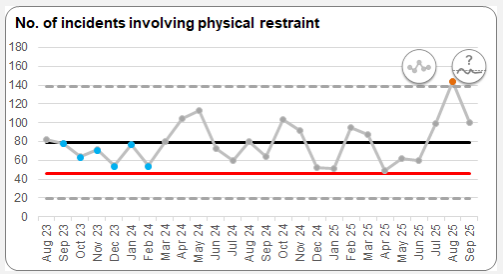


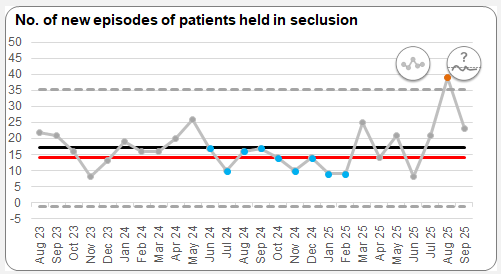


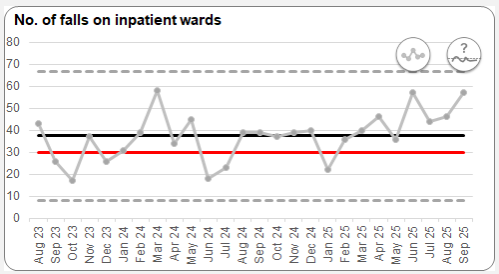


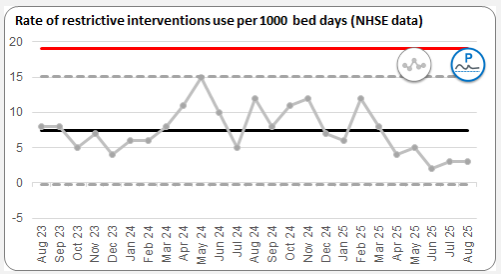


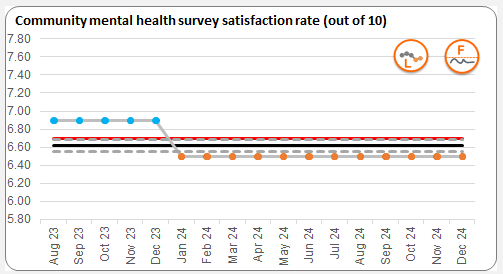








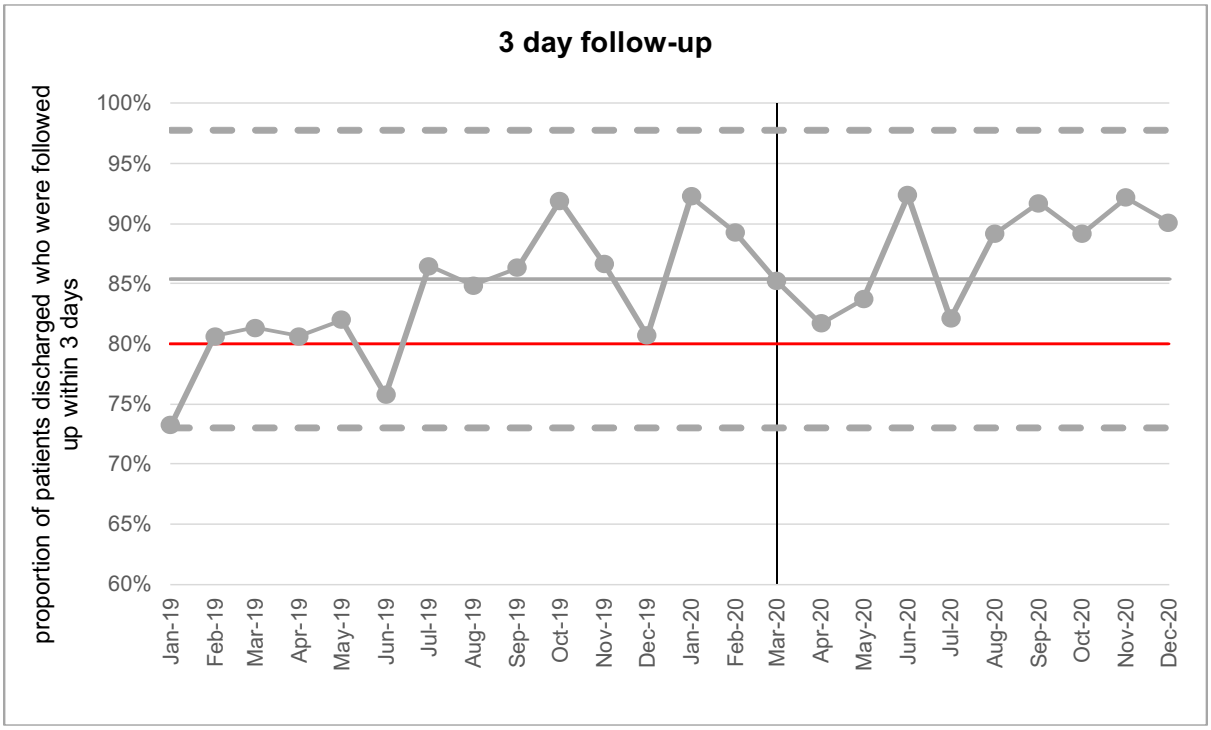




Appendix 1

Statistical Process Control Chart (SPC) Guidance

Example SPC chart:



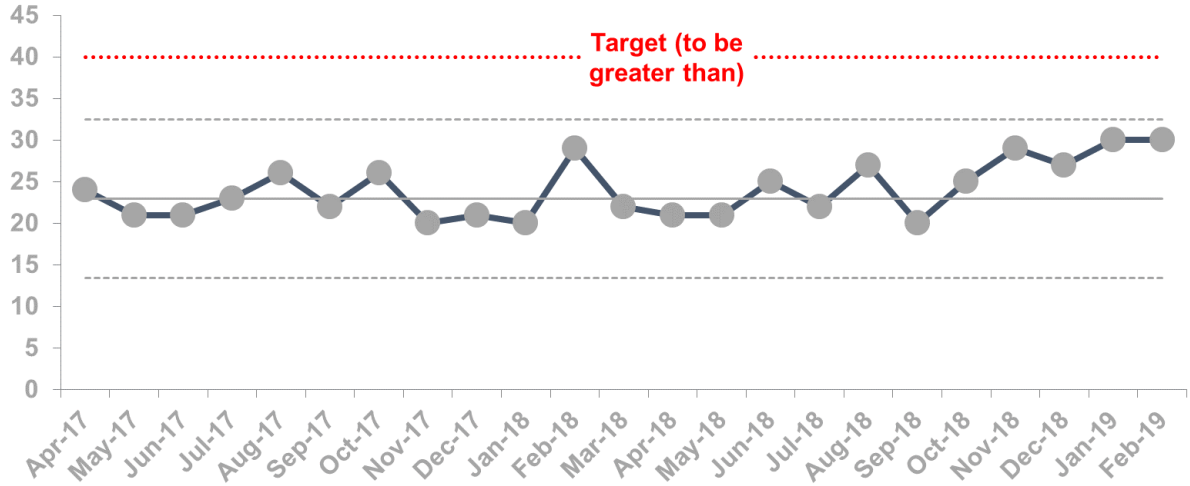
- The red line is the target
- The grey dots are the actual performance each month. They are coloured grey as performance each month is normal in this example
- The solid grey line is the average (mean) of all the grey dots
- The grey dotted lines are called process limits, or control limits.

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.

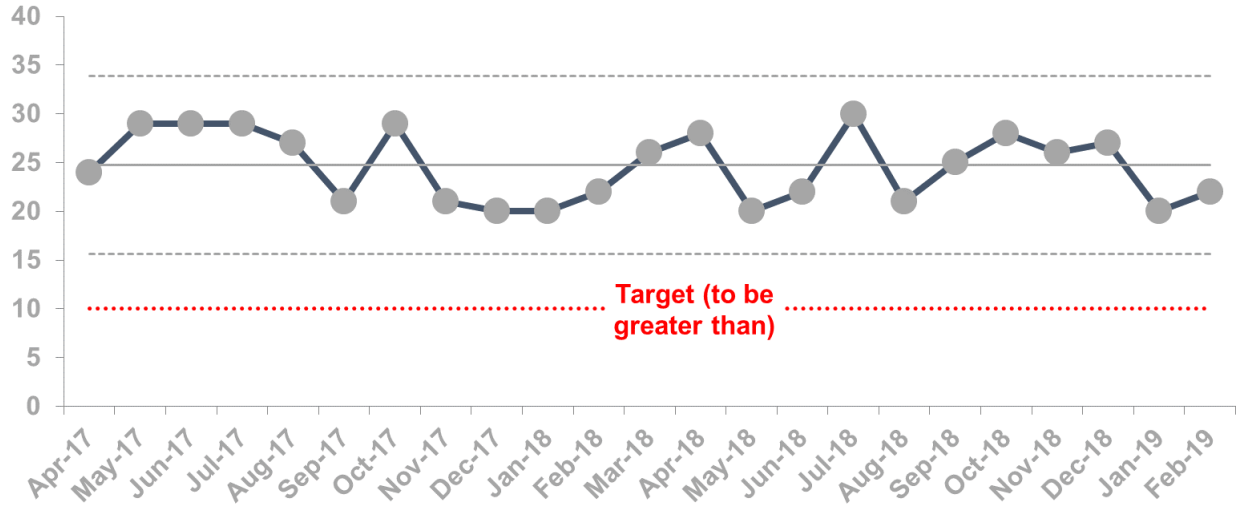
Things to look out for:

1. A process that is not working:



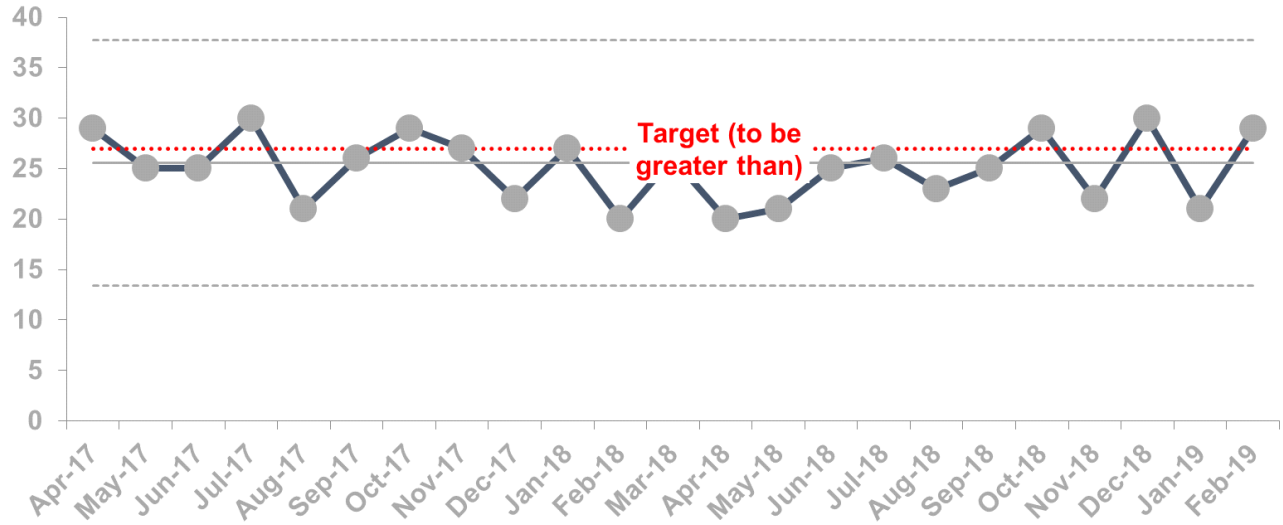
In this example the target is higher than the upper dotted grey line. This means that the target will never be achieved. To achieve the target, we need to change how we do things.

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:

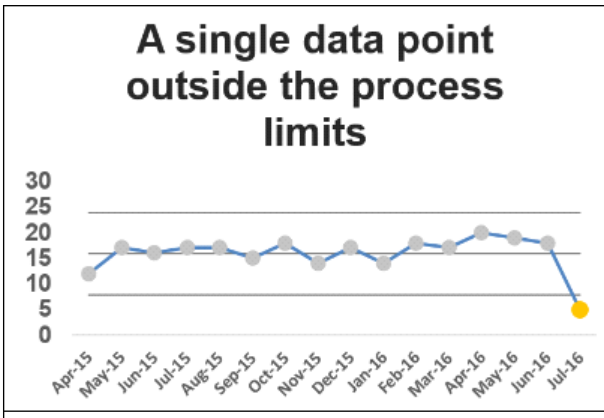
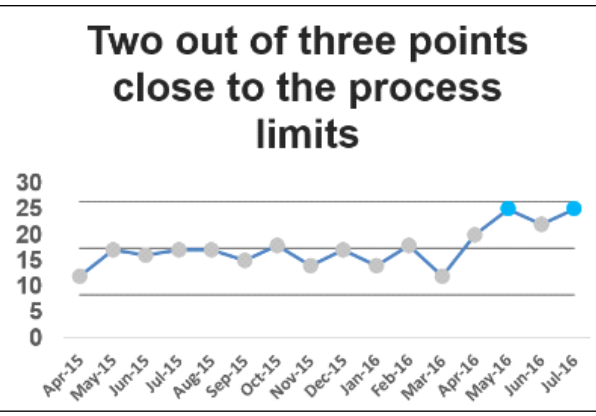


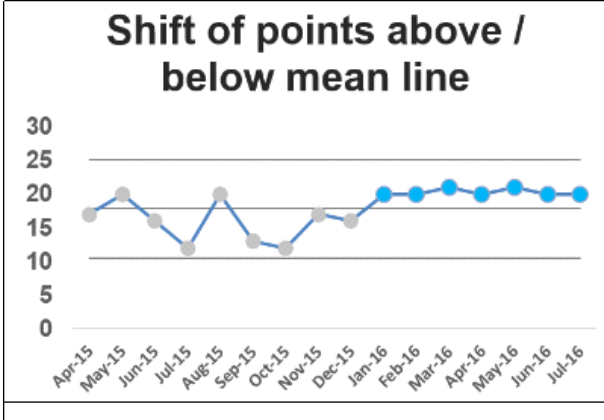
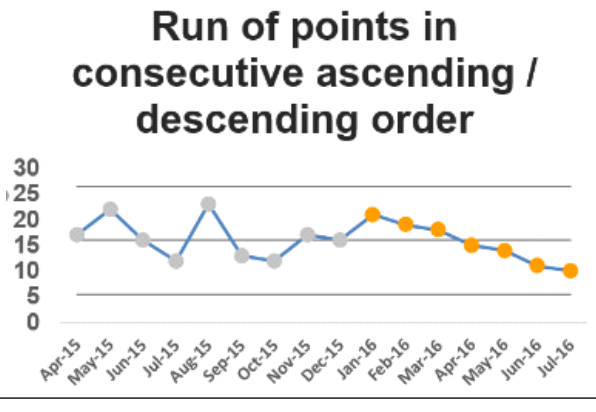
In this example, the target line sits between the two grey dotted lines. As it is normal for the grey dots to fall anywhere between the two dotted grey lines, this means that it is entirely random as to whether or not the target will be achieved. So, this system is unreliable and needs to be redesigned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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 25 November 2025

Transformation and Continuous Improvement report

Purpose of Report

To provide the Board of Directors with a progress update on development of the Transformation and Continuous Improvement Framework and associated Delivery Plan.

Executive Summary

Action supporting development of continuous improvement and transformation arrangements at the Trust remains in delivery aligned to the agreed Transformation and Continuous Improvement Framework.

Delivering education in improvement methodology continues to be a core offer of the function with 764 staff trained to various levels of practice and coverage of roles across the Trust (708 staff) and Derbyshire System (56 staff). There continues to be a good level of advanced education uptake in the Trust with this currently standing around 44%. There is also a good spread of uptake across functional areas, with education targeted to focus areas as required.

System partners have changed direction in their chosen improvement approach, withdrawing from the new subscription based quality, service improvement and redesign (QSIR) model and their aligned commitment to a collaborative education offer. Our offer of access to Trust education for System colleagues will be adjusted over the next period given the withdrawal of partner capacity for collaborative delivery. We will continue to proactively engage with discussions regarding the restoration of a collaborative education offer given the demonstrated benefits this offers.

The Strategic Portfolio Oversight Group (SPOG) is now established to oversee assurance that all aspects of the Strategic Plan are on track for implementation according to agreed timescales, and to oversee the design and delivery of a portfolio of transformation and improvement that is aligned to achieve organisational strategic intent. Programme documentation and oversight arrangements established through the Making Room for Dignity (MRfD) and Patient Flow programmes provided a blueprint for standardisation across the entire transformation and improvement portfolio for 2025/26 and beyond. Through the first three meetings of SPOG, programme oversight and reporting arrangements have been further refined to offer assurance over governance, leadership and accountability, resources and progress on delivery.

Focus has been maintained on development of the continuous improvement framework within the Trust. The narrative at Appendix 1 provides an overview of activities in delivering improvement education, the current projects under design and delivery within the LiveQI platform and two case studies from the current improvement portfolio. Attention remains focused on the development of arrangements for supporting improvement practice beyond the classroom education, and on fostering the network and community of improvement practitioners across the Trust.

Aligned to the NHS IMPACT framework design has been progressed for the launch of an enhanced organisational approach to continuous improvement in Q3 of 2025/26, parallel with the conclusion of the phase one operating model. This will offer an opportunity to accelerate progress in creating the conditions for successful continuous improvement into action. Planned action will incorporate key activities such as mapping of improvement capacity and capability across the new leadership structure and a focus on embedding improvement practice and improvement routines within the forward operating model. There will also be a focus on learning from, sharing and celebrating success; to include a new monthly forum for exchange and conversation, a shared library for short-form case studies of improvement initiatives and a network for development of peer communication and support.

Over the last quarter, a significant focus of improvement activities and resources has been on maintaining improvement of the patient flow pathway and supporting plans for improvement of access across services. Our refreshed approach for flow improvement is fully aligned with national efforts to strengthen the application of improvement to our most complex challenges across the country. NHS IMPACT Mental Health Learning and Improvement networks were launched in each region in June 2025. These are hosted at regional level, bringing together people, providers and systems to work on the greatest challenges. The Trust is proactively engaged with the Midlands network where the priority focus is on application of continuous improvement methodology to reduce length of stay for Adult Mental Health, in full alignment with our internal Patient Flow Improvement Plan.

Concurrently, with the rapid improvement plan, we are seeking to accelerate development of our longer term plan for transformation of the 'end to end' pathway and define how the Trust care pathways and service will be redesigned in alignment with the Neighbourhood Mental Health model of care and delivery of this through 24/7 Neighbourhood Mental Health Hubs and Mental Health Urgent Care Assessment Centres.

To support the development of strategic plans, the Trust has proactively engaged with a System development support offer from the Mental Health Improvement Support team. The resulting Mental Health services assessment tool (Men-SAT) report has been presented to the Board, with assurance that recommendations have been aligned with our transformation and improvement portfolio.

In September, we launched a series of workshops for Trust people and teams to support the co-design of our next phase of transformation for Community and Crisis services. Our aim through these forums is to establish a strategic plan for Derbyshire that delivers well-managed patient flows through Community and Crisis pathways, and between services, to ensure people receive the right treatment at the right time.

Digital transformation is a key enabler of the Trust's strategic ambitions and planning has been progressed over the last quarter for a Digital Futures Day on 18 November 2025. This forum will offer an opportunity to consider our opportunities and harness the insights of our clinicians in supporting the development of our Strategic Digital Plan and the roadmap for delivery of this.

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 Transformation and Improvement Framework sets out the proposed approach for management of risk and assurance over delivery of transformational and continuous improvement activities at the Trust.

Consultation

The Transformation and Improvement Framework has been developed in consultation with relevant stakeholders across the trust and has been discussed and approved via the Trust Leadership Team and Executive Leadership Team.

Governance or Legal Issues

The Transformation and Improvement Framework sets out the proposed governance arrangements associated with transformational and continuous improvement activities at the Trust.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Content of the Transformation and Improvement Framework is expected to have a neutral impact on those with protected characteristics.

Recommendations

The Board of Directors is requested to note the progress and next steps for implementation of the Transformation and Improvement Framework.

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

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

Appendix 1 – Continuous Improvement update

Improvement education programme

A total of 764 staff and System partners have completed or are currently participating within an improvement education offer, with a further 32 booked in to upcoming sessions. This does not include induction and leadership education such as 'Aspiring to Be' which incorporate an integrated improvement component.

Of the 764 trained, 708 are Trust staff and 56 are colleagues from across the Integrated Care System (ICS) (see table below).

Education of ICS partners commenced in 2025 as a collaborative initiative to increase knowledge and skills in improvement methodology across the system, particluarly where there is typically less access such as primary care and the Integrated Care Board (ICB). We have routinely opened up education spaces to partners, and on occasion have held dedicated education sessions for the ICB and others. Whilst this has been well received with positive feedback, we will be adjusting our offer by limiting System partner education to late notice capacity on Trust education. This is driven by a changed direction in chosen improvement approach across system partners who have withdrawn commitment and capacity for collaborative delivery aligned to the new national QSIR model. We will continue to proactively engage with discussions regarding the restoration of a collaborative education offer for 2026/27 and beyond given the demonstrated benefits this offers.

System Partner Improvement Training by Type and Organisation

Organisation	Grand Total
CRH	1
DCHS	6
Derbyshire Health United	4
DHCFT	**708**
EMAS	7
NHS Derby and Derbyshire ICB	19
NHS Nottingham and Nottinghamshire ICB	1
UHDB	2
OTHERS	7
Staff who have left or leaving	9
Grand Total	**764**

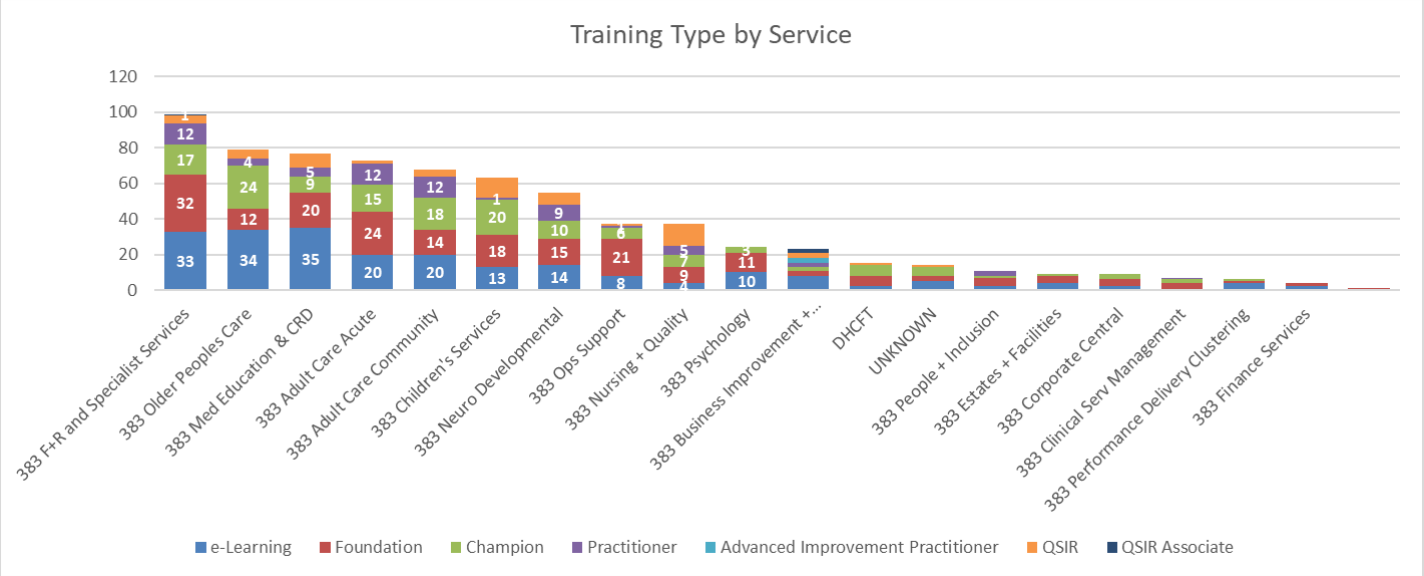
Trust Improvement Training Completion by Type

QI TRAINING	e-Learning	Fundamentals	Foundation	Champion	Practitioner	QSIR	QSIR Associate	Advanced Improvement Practitioner	TOTAL
Staff Trained by Course Type	225	36	188	176	69	64	3	3	**764**

44% of Trust staff have attained the higher level of Champion (two-day) improvement education and above.

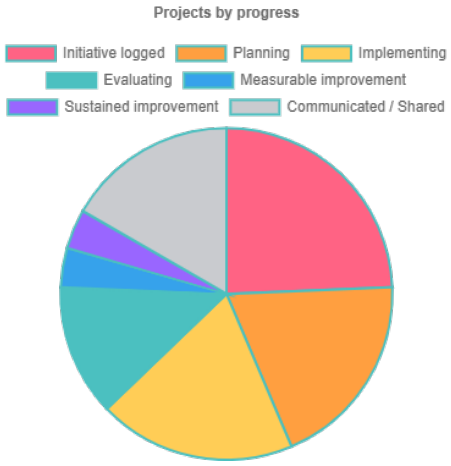
There is a good general spread of education across service areas, but education has also been targeted to areas where there is improvement and transformation work planned or underway. There has been focus on identified senior and leadership roles where it is important to demonstrate commitment to our improvement approach and establish this in practice within leadership behaviours. Areas where there are identified opportunities for development will continue to be targeted, including across senior leadership roles aligned to be new operating model.

Improvement Training by Service Area



In delivering the forward framework, arrangements are being focused on supporting improvement practice beyond classroom education and further developing a coaching approach through the network and community of improvement practitioners across the Trust.

LiveQI Improvement Platform and Further Developments for Programme Management Office (PMO)

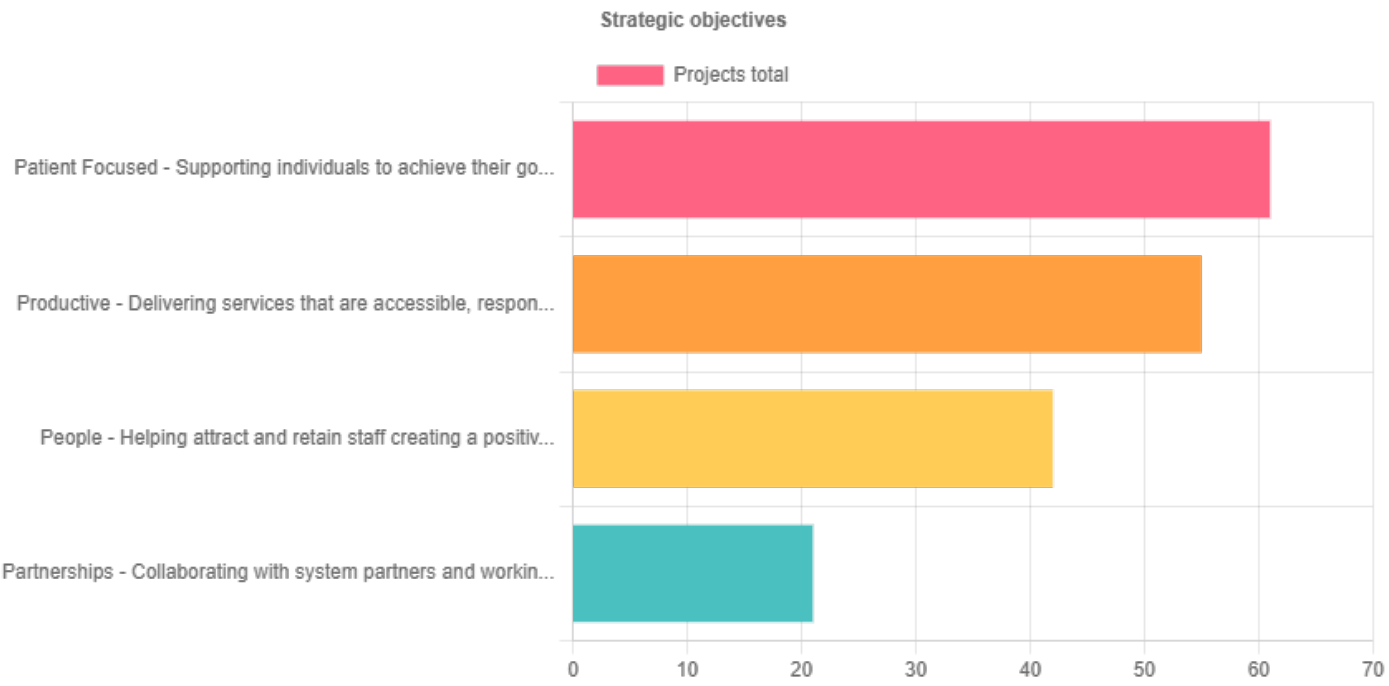


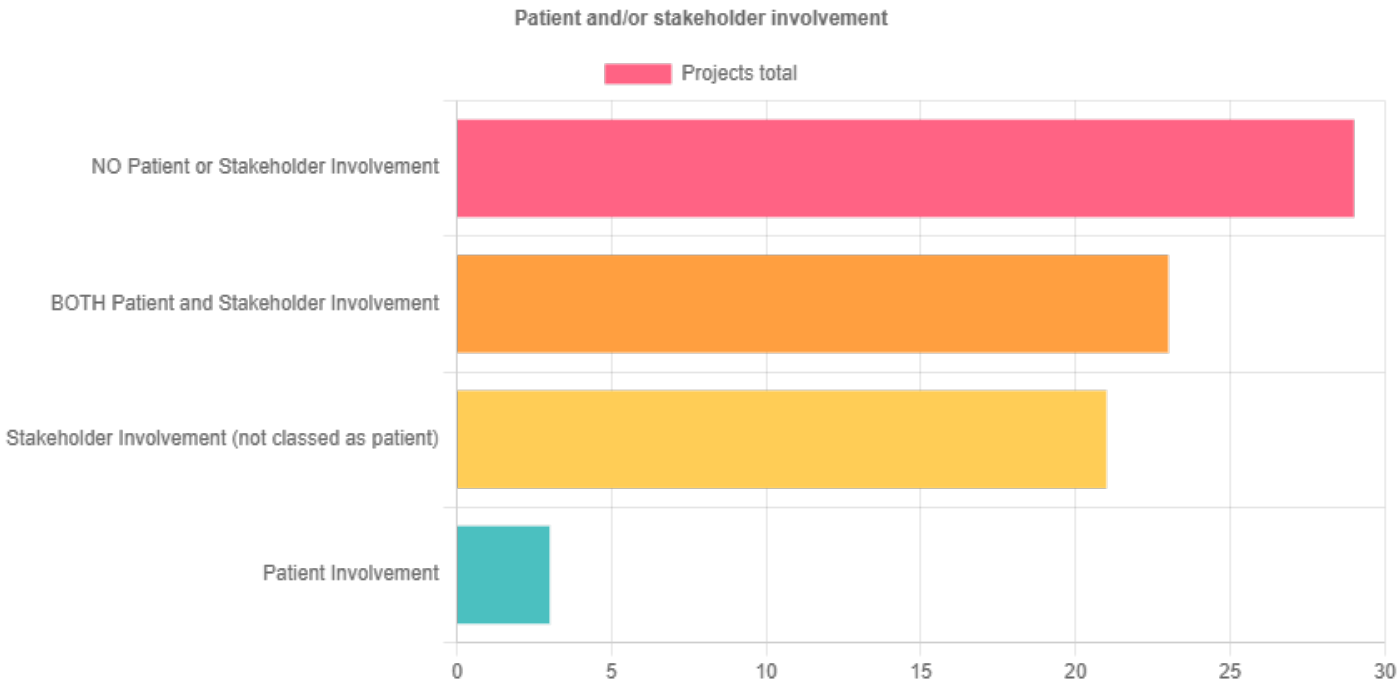
LiveQI is the trust's platform for managing improvement initiatives.

It is available to all trust staff to use and collaborate in their improvement activities.

There are currently 78 projects in LiveQI at various stages of development and completion (up from 68 at last report). Of these 15 are in planning, 15 in implementation and 10 in evaluation. There are 13 which are completed, communicated and shared.

The charts below show projects relative to the strategic priorities, and against the level of stakeholder and patient involvement; recognising that greater engagement, involvement and co-production is a key focus area for forward development.





- 78% (61/78) of projects are Patient focused
- 71% (55/78) identify Productivity as a key aim
- 54% (42/78) focus on our People and how we work
- 27% (21/78) identify Partnership benefits
- 29% (23/78) of projects have patient and/or stakeholder involvement. This is slightly down since the last report due to an increase in the period, of projects with no patient or stakeholder involvement, but is above the baseline of 27% set at the start of the new system and above the level captured in the previous system at less than 5%.

Further System Developments to Incorporate Programme Management Office (PMO)

Aligned to the new framework overseen by the Strategic Portfolio Oversight Group, plans are now underway to further develop the LiveQI platform to incorporate the digital PMO. It was our original intent to manage Trust documentation across the transformation portfolio within the existing Joined Up Care Derbyshire (JUCD) digital ePMO solution; however, this application is being evaluated and may not continue in use beyond the existing contract, risking investment of time in building content and training users on a PMO tool that will be discontinued. An in-house solution will offer additional value in use of a common solution for local improvement activities and transformation projects, with functionality to manage transition of projects across the whole lifecycle. Beyond this we are also looking to incorporate the management of performance and Care Quality Commission improvement plans alongside clinical audits within the solution, with the architecture for PMO development offering a blueprint for these subsequent developments. Development of the PMO is progressing with an expectation of commencement of testing in Q3.

There is interest from local and regional partners in the LiveQI solution currently in operation, and the development work planned for the PMO. We will offer demonstrations and actively seek to collaborate with partners who express an interest in use of our in-house developed solution.

Improvement projects currently active in LiveQI

Projects currently active within the LiveQI platform are focused on the following aims:

Safety huddle pilot ♦ Mindfulness walking group ♦ Review of Forensic Community Mental Health ♦ Increase Physio interventions ♦ Improve transition pathway from Child and Adolescent Mental Health services (CAMHS) to Adult ♦ Heidi Health artificial intelligence (AI) ♦ Enhancing clinical supervision ♦ Compliance with Medical and Healthcare products Regulatory Agency (MHRA) re Sodium Valproate prescribing and counselling ♦ Urgent Access SystmOne1 cost reduction ♦ Mental Health Act (MHA) Tissue viability training ♦ Admin optimisation ♦ Improving communication with families on Inpatient units ♦ Caring for the whole person ♦ Management of holistic health ♦ Reflective practice in Older People's Mental Health (OPMH) ♦ Stop smoking clinics ♦ Occupational Therapy (OT) referral process ♦ Community Mental Health team (CMHT) Duty ♦ Assessment of waist circumference ♦ Medical student Inpatient ward experience ♦ Shift pattern pilot ♦ Length of Stay (LoS) on Cubley ♦ MHA Healthcare Assistant (HCA) support ♦ Duty desk functionality ♦ Increase video consultations ♦ Autism Spectrum Disorder (ASD) Nurse pilot in Amber Valley CMHT ♦ Personal Assistant (PA) efficiency ♦ Older Adult Inpatient rosters ♦ ACP CAMHS Physical Health ♦ Inpatient leave ♦ Clean air at schools ♦ multi-agency discharge event (MADE) Quality Improvement (QI) project ♦ New Models of Care ♦ Culture of Care Programme ♦ ACP comprehensive geriatric assessment ♦ Oxehealth digital observations♦ Paliperidone Pharmacist-led clinic ♦ Diversifying skill mix ♦ Psychotic depression ♦ Community Rehabilitation Pathway ♦ Psychiatric Emergency team (PET) process ♦ Patient communications ♦ Mental Health 111 Press 2 Helpline ♦ Medic caseload reduction ♦ multi-professional approved clinician (MPAC) pilot ♦ QI Junior doctor induction ♦ Relational security pilot ♦ Taxi usage project ♦ Day Hospitals ♦ Memory Assessment service (MAS) ♦ Psychiatric Liaison Assessment of Dementia project ♦ Management and Supervision Tool (MaST) ♦ Reducing falls ♦ Bilateral base pilot ♦ Clinical triage algorithm ♦ Duty desk function ♦ Trust meetings ♦ Increase video consultation ♦ ASD Nurse pilot ♦ Admin support project ♦ Older Adult inpatient roster ♦ Responsible clinician pilot ♦ Medical bank.

Where the above continuous improvement projects have scale and spread opportunities, and/or deliver efficiency benefits, these will be recognised through transfer to the formal annual programme and financial tracking via the PMO solution.

Case Studies of Continuous Improvement Activity (from LiveQI Library)

Case Study 1:

Title: Paediatric Physiotherapy Wait Times

Date: 25 September 2025

Author: Kimberley Peters (Transformation Lead)

Project Lead: Alison Powles (Ops) and Kirsty Butterfield (Clinical)

Aim of the initiative and time-period

Reduce Paediatric Physiotherapy wait times from July 2025.

Rationale and background - A problem or opportunity, how did you know?

Families accessing the Paediatric Physiotherapy service experience significant waits. In June 2025, there were 261 children waiting to be seen, the average wait time was 33 weeks, and the longest wait was 117 weeks. The waiting list for Paediatric Physiotherapy was paused to undertake pathway redesign and service transformation and to undertake RAG rating and targeted intervention to manage risks within the existing caseload and waiting list. Capacity and Demand modelling based upon the revised efficient pathway identified that the service was able to deliver <65% of the current demand (excluding the waiting list) with the current staffing levels.

Improvement Process

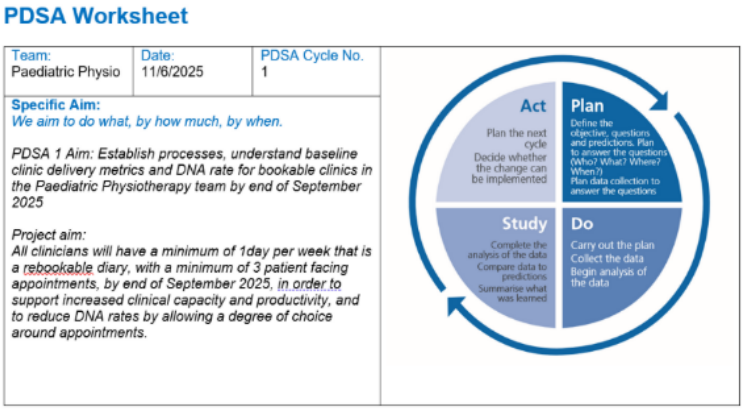
The team was supported in their improvement approach to develop a driver diagram and identify priority improvement and transformation activities to deliver pathway efficiencies, increased clinical capacity, reduced demand and an improved staffing model (primary drivers).

Change Idea

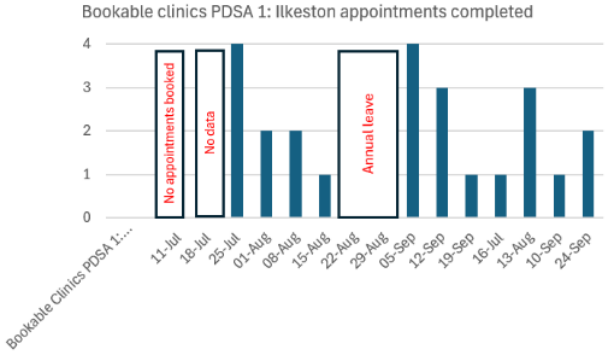
Priority change ideas include (i) implementing Job Plans with clear expectations for a minimum contact number, (ii) partnering with the Chesterfield Royal Hospital (CRH) Paediatric Physiotherapy team to provide weekend clinics for a cohort of children who are the longest waiting (Code 6 cohort), and (iii) implementing bookable clinics across the City and County.

Results – What happened and who benefitted?

A PDSA cycle of the weekend clinics with CRH staff delivered 35 appointments for families with the longest waits, 84% of these children were discharged after the appointment, 80% of families offered an appointment 'out of area' (OoA) accepted an appointment, resulting in approximately 15% reduction in the overall waiting. The continuation of this partnership working is being considered for families with the longest waits and the Code 6 cohort and has identified an additional opportunity to call families who are long waiters in the code 6 cohort as some families felt an appointment was no longer required, and some families agreed to the appointment but were not clear why this had been offered.



The team also intends to deliver one day per week of bookable clinic time per member of staff to deliver a minimum of three face to face appointments. PDSA 1 involving one member of clinical staff developed the processes for families to be identified and booked in for appointments and monitored the completeness of the clinic bookings and non-attendance (DNA) rate. 40 clinic appointments slots were offered across two venues between 11 July and 24 September (11 weeks), 24/40 (60%) slots were booked, and 21/40 (52%) were completed. Of those which did not occur 10/40 (25%) were unfilled, 7/40 (17.5%) were cancelled or blocked out by the member of staff, 3/24 (12.5%) were cancelled by the parent and 1/24 (4%) was a DNA.



PDSA 2 will increase the number of staff offering bookable clinics up to three and increase the amount of clinic slots booked and completed.

Conclusions and Learning

Despite the ongoing transformation work, September 2025 service data suggests the number of children waiting to be seen is 252 with an average wait of 36 weeks; the longest wait is 126 weeks. Remaining challenges continue to be unfilled clinical vacancies, the need to direct clinical capacity at known risks within the RAG rated caseload and an increased, urgent demand to support children returning to school. This informs the ongoing improvement drive and delivery of transformation.

Case Study 2:

Title: Oxevision Programme

Date: 26 September 2025

Author: Caroline Jones

Project Lead: Richard Morrow

Aim of the initiative and time-period

Oxevision is a contactless, vision-based monitoring system which monitors vital signs measurements, such as heart rate, breathing rate and location and movement without disturbing the patient, including through the night. This allows for greater privacy, dignity and experience for the patient and better outcomes.

Implementation of Oxevision was initiated in 2023, with the project then extended to include the MRfD programme sites. A phased approach has been taken to implementation with Phase 1 Aftercare becoming operational from January 2025. Phase 2 has been placed on hold due to MRfD timeframes and is currently in the contracting stage, likely to conclude spring 2026.

Rationale and background - a problem or opportunity, how did you know?

Opportunity to use technology to support the new Model of Care and new MRfD environments.

Historically used in key seclusion spaces, which came with challenges in different expectations and engagement in different practice. Decision to roll out widely across inpatient spaces. Intended benefits:

- Reduce the frequency and severity of falls
- Reduce self-harm risk, particularly ligatures
- Improve physical health monitoring
- Enhance staff and patient experience and safety
- Improve sleep hygiene
- Improve night observations
- Reduce avoidable 1-2-1s and enable positive risk taking in stepping down 1-2-1s where clinically appropriate
- Improve care planning through activity and behavioural data
- Improve the culture of data informed clinical decision making and engagement.

CI Process

Partnership working both internally and externally. Collaborative working with the Information Management, Technology and Records (IMT&R) team and digital, capital projects, ward teams, patients and carers. Stakeholder engagement:

- Steering group
- Installation subgroup
- Clinical subgroup
- Clinical aftercare group.

Communication of the project was through Focus, also using posters and leaflets.

Resources for training staff included the use of an online platform which enabled flexible, accessible 24/7 training and support.

Results – What happened and who benefitted?

c400 staff trained in use of the platform. Staff benefits and patient benefits are being achieved through use and application of system.

Phase 1 is now live in Kedleston Unit, Cherry Tree Bungalows, Audrey House.

Extension to Phase 1 linked to MRfD is now live in Bluebell Ward, Derwent Unit, Carsington, and Kingfisher House.

Phase 2 implementation for Tissington House and Cubley Court commencing autumn 2025.

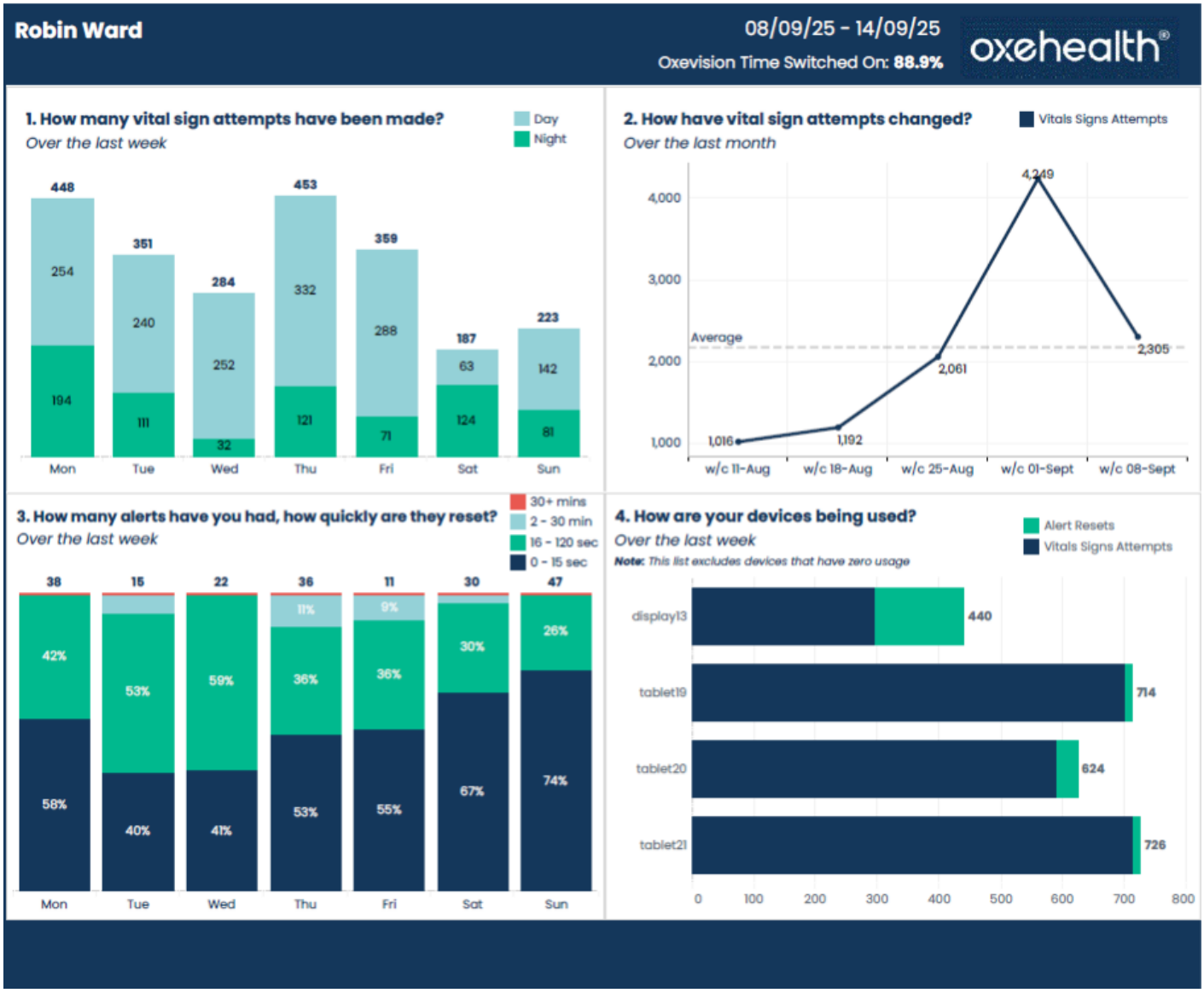
Usage reports are made available to clinical stakeholders to explore clinical impact.

Triangulation with Datix events from incidents have been informed by review following the governance process.

Conclusions and Learning

Usage reports both monthly and weekly (example below) show activity of the platform in the space allowing teams to reflect on the clinical activity and practice. This informs continual improvement in how system can be optimised in different areas.

There is an opportunity to develop greater integration with SystmOne, to incorporate timely clinical recording. The subgroups were combined in 2024 to help with the communication.



Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 25 November 2025

Trust Strategic Plan - 2025-28: Q2 Progress update

Purpose of Report

To update the Board of Directors on progress in delivery of the Strategic Plan at the end of quarter 2 (Q2) 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 Q2 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.

At the end of Q2 a number of concerns are identified, with escalation as appropriate to take place over through respective Board assurance committees. Focus is being placed on the following amber rated strategic plan deliverables:

1.2: Improve experience for, and empower, service users patients and carers

Progress has been made over the last quarter in developing our approach and arrangements but this will be accelerated supported by appointments into the new operating model and recruitment to remunerated lived experience roles.

1.3: Develop effective quality governance systems and processes that facilitate shared learning and support a positive safety culture

Action has again been progressed but will be supported by enhanced arrangements within the new operating model.

Delay in publication of new national Personalised Care Framework is impacting the expected timeline to develop aligned implementation plan.

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

The Clinical Services Delivery Plan remains in draft with progress to be made in development over forward quarters.

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.

2.1 to 2.4: People deliverables

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

At this quarter end, one plan deliverable is deemed to be at risk in terms of annual roadmap delivery. Access recovery plans for some services will not deliver a compliant position by the 2025/26 year end.

All other deliverables are deemed to be on track for delivery by quarter four 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 Strategy and 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 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 Q2 2025/26.

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

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

NHS
Derbyshire Healthcare
NHS Foundation Trust

Strategic Plan 2025 - 2028

Progress Update: Q2 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.

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Derbyshire Healthcare
NHS Foundation Trust

Priorities for delivery of success	Roadmap to delivery of success 2025-26	Q2 Progress Update	Status Q2 Actual	Status Q4 Expected	Assurance mapped to Q2 papers
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 approved and published in Q2 including roadmap to delivery and measures of success. 1.1.2 Quality monitoring continuously developed over Q2 with fundamental standards of care and cross checked fully embedded across community and inpatient wards. Action plans delivered as appropriate to address identified areas of improvement with assurance overseen by QSC. 1.1.3 Progress maintained in Culture of Care programme with self assessment in progress to inform next phase of plan for Q3-Q4. PCREF lead appointed and due to commence in post Q3.	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 over Q3 in development of aligned reporting dashboards to track and assure delivery. 1.2.2 Feedback mechanisms further developed in Q2 with forward focus on effective spread and standardisation of approach across all services over Q3 and plan to relaunch electronic patient survey in Q4. 1.2.3 Feedback monitoring maintained over Q2 with key developments in progress being recruitment to remunerated lived experience roles across all services and renewed patient and carer experience meeting. 1.2.4 Approach defined within Quality Delivery Plan and action plans in delivery aligned to 1.2.3 above. 1.2.5 Education programme focused over Q2 towards targeted education and awareness raising on suicide prevention and safety planning. Care plan training programme developed for roll out from Q3. 1.2.6 Work plan for advancing coproduction and participation developed and lived experience partners now invited to be part of fundamental care standard and quality visits. Further development planned over Q3-Q4.	Delivery behind plan at Q2	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 Plan for development of quality governance systems defined within the new Quality Delivery Plan. Action in delivery aligned to new operating model and to be progressed over Q3-Q4. 1.3.2 Safety defined within new Quality Delivery Plan and associated development plan in delivery with a focus for Q3 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 Q3 with aligned implementation plan to be developed and agreed.	Delivery behind plan at Q2	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 considered by new Medical Director and via internal governance and assurance committees over Q3. 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 Q2 via internal performance framework and FPC. Focus for Q2 on flow improvement action plan to reduce OOA placements, with Operational Plan trajectory achieved at end of Q2. Oversight and reporting developed for Q3 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 Q2 to be managed via management oversight forum and escalated to Quality and Safety Committee as required

1.3.3: Delay in publication of new national Personalised Care Framework impacting expected timeline to develop aligned implementation plan.

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	Q2 Progress Update	Status Q2 Actual	Status Q4 Expected	Assurance mapped to Q2 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' operational at 3, 6, 18 months for all new starters. Cohort recruitment progressed in Q2 for Health Care Assistants and Registered Nurses. Recovery plan in design for key off plan metrics, including time to recruit, with delivery and expected impact from Q3. 2.2.2 Cultural competency training roll out progressed with delivery almost complete across the priority focus area on inpatient wards along with international recruits and non English nationals. Broader roll out of training to commence in Q3. 2.2.3 Trust level workforce plan presented to PCC and to flow to Board in Q3. Care Group level plans for form next stage of development aligned to new operating model and to include EDI actions and targets. Strategic workforce planning to be progressed over Q3-Q4 aligned to national planning framework.	Delivery behind plan at Q2	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 Senior triumvirate leadership programme commissioned and scheduled to roll out from January 2026 aligned to national competency framework. Programme securing accreditation Chartered Management Institute. 2.2.2 Next phase of talent management and succession planning agreed for commencement in February 2026 to flow from appointments to the new Operating Model. 2.2.3 Focus retained through Training and Education Steering Group on strengthening commissioning of professional programmes. Careers event being hosted in 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 Q2	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 Action plan following PCC deep dive on accountability framework in delivery, including working with 'A Kind Life' to embed behaviours and routine practice and 'Active Bystander' training supporting development of learning culture. Focus being placed on active conversations to prevent formal escalation. Guidance published and engagement sessions hosted to support colleagues and equip leaders to cascade support through the recent community unrest. 2.3.2 and 2.3.3 EDI, WRES and WDES plans approved with delivery of priorities supported through the staff networks. Anti racism strategy and statement published with enhanced assurance oversight through quarterly report to Trust Delivery Group.	Delivery behind plan at Q2	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 in delivery to embed flexible working, including new system and training in application of the policy. Progress to be accelerated flowing from appointments in to the new operating model and flexible working system to be finalised Q3 2.4.2 Refresh of HWB assessment and all associated KPIs completed with review and decision on SLA to be taken in October. 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 Q3 via appropriate governance route. 2.4.4 New absence management software launched and successfully embedded in Q2. Absence Oversight Group established to oversee delivery of identified actions including support for colleagues aligned to psychological support business case.	Delivery behind plan at Q2	Expected on plan at Q4	Agreed assurances considered by PCC

Delivery concerns at Q2 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 Q3.

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	Q2 Progress Update	Status Q2 Actual	Status Q4 Expected	Assurance mapped to Q2 papers
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. Medium term financial planning now underway aligned to national framework. 3.1.2 Financial plan remains on track at the end of Q2, including achievement of targets on agency and bank. 3.1.3 International medical recruitment completed aligned to agreed plan and timeline over Q2. 3.1.4 Engagement maintained with NHSE pilot and plan for recruitment of lead to develop productivity approach over Q3-4. Governance of productivity, efficiency and wider enablers such as data quality under review. 3.1.5 National currency model currently on hold. National cost collection submission made in Q1 with outputs to be evaluated on publication in Q3. 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 NHSE Men-Sat review completed in Q2 with recommendations applied to inform urgent care transformation plan. Community and crisis workshop series commenced in Q2 to support development of vision and plan. Board development session scheduled to develop strategic intent for neighbourhood mental health model over Q3. 3.2.2 Phase one operating model concluded in Q2 with action now in progress to operationalise, including via Triumvirate Leadership Transition sessions to be hosted through Q3. Phase two in design and to be launched in Q3. 3.2.3 JUCD Provider Collaborative work programme and benefits realisation plan in delivery comprising five enabling corporate services with co-ordinated Trust plans to be developed Q3 and deep dive scheduled for SPOG. 3.2.4 Assurance over design and delivery of transformation portfolio developed over Q2 overseen by the new Strategic Portfolio Group and FPC. Oversight of delivery progress to be maintained over Q3. 3.2.5 Continued progress over Q2 in implementation of framework with key actions being enhancement of programme management and oversight arrangements and design of new approach for continuous improvement. 3.2.6 Population health intelligence being actively considered through development of the neighbourhood and urgent models of care to ensure these are aligned to local need. Approach to be further developed over Q3.	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 fully operationalised over Q2. Formal benefits evaluation underway for both acute units aligned to agreed timeline with report to be published in Q3 and PICU/ECU report due Q4. 3.3.2 Estates Plan narrative and content approved by FPC in Q2 with next step to develop version for publication. 3.3.3 Clinical Digital Plan developed over Q2 alongside development of priority work streams including EPR optimisation and pilot for ambient voice technology. Digital Futures event scheduled for 18 November to support further development of digital strategic intent aligned to 10 Year Health Plan, along with the roadmap for delivery.	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 narrative and content approved by FPC in Q2 with next step to develop version for publication. Progress made in delivery of key actions including EV chargers. Development of an 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 Q2 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 to be progressed in Q3.

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	Q2 Progress Update	Status Q2 Actual	Status Q4 Expected	Assurance mapped to Q2 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 Q2 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 in delivery comprising five enabling corporate services and four clinical pathways, including Children and Young People. Co-ordinated Trust plans to be developed Q3 and deep dive scheduled for Strategic Portfolio Oversight Group. 4.1.5 Continued progress made on agreed priorities within the Community and Stakeholder Engagement Plan. A new Deaf focus group has been established and an action plan in place. Relationships have been established that will support identification of priorities and a plan for the Black community. Research colleagues are supporting the development of an approach that can support multiple ambitions within this remit. 4.1.6 Active engagement maintained in learning collaboratives with highlights in Q2 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. Board development session hosted to develop strategic intent. Timeline and milestone plan to full business case being overseen via the Strategic Portfolio Oversight Group.	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 Action progressed over Q2 to secure learning and establish baseline to inform development of plan. Engagement in Q2 with system partners through JUCD Anchor Group to harness opportunities for action at scale with JUCD system plan in design and trust plan to be developed in full alignment to maximise potential opportunities and benefits for communities.	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 Q2 to be managed via management oversight forum and escalated to Finance and Performance Committee as required

4.2.1: Action to progress the 2024 Derbyshire anchor organisation stocktake via the system anchor group lacks pace with only one meeting in the year to date and limited action in harnessing opportunities for enhanced collaboration.

Derbyshire Healthcare NHS Foundation Trust
Report to the Trust Board – 25 November 2025

Board Assurance Framework (BAF) update
Issue 3, version 3.3, 2025/26

Purpose of Report

To meet the requirement for boards to produce an Assurance Framework. This report details the current BAF, Issue 3, version 3.3 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 gaps in control and linked actions have been reviewed, the next quarterly review being due for Issue 4 (by 31 December 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

The controls and assurances section has been updated.

The Psychiatric Intensive Care Unit (PICU) and the associated out of area (OoA) gaps in control have been closed so reference has been removed from the root causes.

Two key gaps in control have been closed:

> *Implementation of Trust Strategy priority 1, which supports patient outcomes with guidance and standards for quality care*

All actions are complete and all measures are met. The recent Care Quality Commission (CQC) inspections are rated Good.

> *Risks associated with the loss of Talking Mental Health services to an independent provider…*

The Transfer of Undertakings (Protection of Employment) Regulations (TUPE) and staff transitions were completed June 2025, staff are no longer Trust employees.

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

The Carsington Unit and Derwent Unit are now open and updates have been made accordingly.

The action to refurbish the Radbourne Unit has updated timescales applied.

Risks 1B and 1D are now identical as they have morphed over time. The Chief Delivery Officer (CDO) and the Director of Nursing (DoN) agreed to combine the content, keeping Risk 1B and closing Risk 1D. Root causes, controls and assurances currently cited across both risks were then detailed in Risk 1B and presented to the Executive Leadership Team (ELT) and the Audit and Risk Committee (ARC).

ARC requested that rather than merging Risks 1B and 1D they should be closed and a new risk (1E) was added for the outstanding risk of regulatory breaches due to inpatient accommodation, allocated to the Quality and Safeguarding Committee as the responsible committee. This has been reflected in this version of the BAF report for review and approval by Board.

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

Both key gaps were identified and included in last issue – to be reviewed again by end of Quarter 3 (Q3) and further measures to be identified.

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

See Risk 1B above.

People - Derbyshire Healthcare is a great place to work

The Director of People, Organisational Development and Inclusion (DPOI) has thoroughly reviewed risks 2A and 2B and updated all key gaps in control, noting the current status and work undertaken to close them.

The People and Culture Committee have also received Issue 3 of the BAF report; there were no further updates to make.

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

The Director of Finance (DoF) has thoroughly reviewed Risk 3A and updated to provide a current status.

A new operational risk was logged relating to possible adverse effects on Trust finances due to a reduction in student placements. This was included in the BAF reports submitted to ELT and ARC but has since been removed as it's been re-rated to low.

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

The clustering of Integrated Care Boards (ICBs) has been noted in the updates provided by the CDO. Measures and progress updates have been refreshed to reflect the current status.

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 23501: Risk to Service Delivery - Patient Safety team

Updates have been provided by the Safer Care Co-ordinator in the absence of the Patient Safety Lead (Risk Handler).

Risk 21620: IT system collapse due to cyber attack

Following recent review this Trust-wide risk has an increased rating, going from moderate to high. It is mirrored by recent national security concerns - High severity alerts for quick response to patch and update our device security.

BAF Reporting Cycle/Format

All changes/updates to this issue of the BAF, compared with Issue 2 2025/26, are in tracked changes (blue text). All text that has been stricken through will be removed from the next issue (Issue 4 2025/26).

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

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

Risks and Assurances

This paper details the risks to the Board Assurance Framework (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 3.1: 8 October 2025
- Audit and Risk Committee, Issue 3.2: 24 October 2025

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 3 of the BAF for 2025/26 and the assurance the paper provides of the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives
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 3.3 November 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, Quality 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)~~	~~**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~~
25-26 1E	There is a risk that the Trust does not deliver key regulatory and strategic requirements related to dormitory eradication and that the Trust estate is not maintained sufficiently well to comply with regulatory and legislative requirements	Director of Nursing, AHPs, Quality and Patient Experience (DON)	**MODERATE**	Quality and Safeguarding Committee

Board Assurance Framework 2025/26 – Issue 3.3 Board November 2025

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~~ across the Integrated Care Boards (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

Board Assurance Framework 2025/26 – Issue 3.3 Board November 2025

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

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

Impact: May lead to avoidable harm including increased morbidity and mortality; delays in recovery; and longer episodes of treatment; affecting patients, their family members, carers, 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) Risk of substantial increase in clinical demand in some services, including high caseloads and wait lists in some community services
c) Intermittent lack of compliance with Care Quality Commission (CQC) standards
d) National Oversight Framework (NOF) Level 3 - Financial position and out of area placements and continued monitoring of quality standards across all Trust services
e) Lack of embedded outcome measures at service level
f) Lack of compliance with physical healthcare monitoring in primary and secondary care, not at the required level for reductions in mortality
g) Restoration and recovery of access standards in autism and memory assessment services
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~~
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
j) Data quality could be adversely affected due to the Electronic Patient Record (EPR) and its application
k) Health inequalities across Derbyshire. Initial insights show gaps in access to service, case load and worsening patient outcomes for our patients
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
m) Gaps in Advocacy for Children who are under 18
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
o) Lack of systematic capture of patient experience and feedback in our services
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

BAF Ref: 25-26 1A	**Director Lead**: Tumi Banda (DON) / Girish Kunigiri ~~Mark Broadhurst~~ (~~Interim~~ 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; 15 Steps challenge commencing in inpatient services; patient survey; friends and family test
Directive – Trust Strategy; Quality Delivery Plan; Joint Child Adult and Family Safeguarding Strategy; Patient and Carer Experience pledges and associated workplans ~~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 Patient, family and carer feedback 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 rated Good; Wards for older people with mental health problems, July 2025 rated Good; Forensic inpatient or secure wards, September 2025 rated Good 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, which supports patient outcomes with 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~~	~~Compliance with suite of metrics and reporting schedule detailed in quality dashboard~~	~~(30.09.25)~~	~~Quality Surveillance Dashboard revision is in progress~~	~~AMBER~~ BLUE

	~~To develop and implement a Quality Plan and a Continuous Improvement Plan~~ ~~To develop an improved learning culture within the Trust~~ ~~[ACTIONS OWNER: DON]~~	~~Internal reporting against self-assessment~~ ~~CQC inspection and assessment as a measurement tool~~ ~~Fundamental Standards of Care~~ ~~Patient and carer feedback~~ ~~Compliance with statutory and regulatory requirements, such as infection prevention control, safer staffing, patient safety incident rates and Health and Safety legislation~~		~~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~~ ~~Regular review of performance through Divisional Performance Reviews (DPRs)~~ ~~New Quality Plan published August 2025 to be completed by July 2025~~ ~~Creation of patient and carer dashboard capturing patient and carer pledges and workplan~~ ~~Commencement of 15 steps challenge~~	
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	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	(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	AMBER

	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 [ACTIONS OWNER: CDO/DON]	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		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 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 of older adults and forensic inpatient services to good	

				Implement and monitor the ten High Impact Actions including MADE events and working with system partners. Inappropriate OOA bed use has significantly reduced ~~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 aware of the requirements to practice in line with their professional codes Uphold safeguarding standards including PIPOT	~~(30.09.25)~~ (31.12.25)	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 – New programme/dates launched September 2025 Robust oversight of patient safety incidents, concerns, complaints, and compliments with scrutiny from independent partners, e.g. Healthwatch and experts by experience being core	AMBER

		Timely investigation and response to concerns and complaints		members of Patient and Carer Experience Committee 15 Steps is being launched through Patient Experience, planned for October 2025 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 Significant Level of assurance received in 2025 from ICB on the	

				Safeguarding Accountability and Assurance Framework review and Section 11 compliance	
Clinical improvement in the current use and transformation of Care Programme Approach (CPA), to support safe community practice	Identify the Trust's preferred alternative model to replace CPA Establish transition plan which includes communications and training strategy and clear timeline for go live of the new system and detailing when use of CPA will cease Implement an improvement plan to enable all services to provide the highest standard of care [ACTIONS OWNERS: DON/MD]	Review of changes to national policy to replace CPA Safe and effective practice is in place Improve patient safety risk assessment, care planning and CPA review compliance in community services	~~(30.09.25)~~ (31.12.25)	Ongoing oversight of CPA continues with focus on care planning and risk assessment CPA training continues at present until alternative identified – Not yet confirmed National consultation underway on a personalised care framework, latest draft was published in September 2025	AMBER
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	~~(30.09.25)~~ (31.12.25)	Review of new strategy for Major Conditions and Suicide Prevention PSIRF priorities focusing on prevention and oversight, linked to new strategies Suicide Prevention Lead recruited Risk assessment, safety planning and suicide awareness training now rolled out with plan to extend to module 2 in October ~~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	~~(30.09.25)~~ (31.12.25)	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 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~~	~~Liaise with ICB and Vita Heath Group~~ ~~Review patients on waiting list~~ ~~Escalate risks and the size of the waiting list with the ICB~~ ~~Utilise all mutual aid~~ ~~Regular staff engagement ongoing [ACTIONS OWNER: VT]~~	~~Working with ICB to close waiting list~~ ~~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~~	~~(30.09.25)~~ ~~(31.12.25)~~	~~Contract awarded to new provider January 2025~~ ~~TUPE transfer and staff transitions completed June 2025~~ ~~Transition meetings commenced with new provider and with ICB~~ ~~Ongoing engagement with staff to support during the transition~~	~~GREEN~~ ~~BLUE~~

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 07.10.25: Interim MD update: Medics working with pharmacy and IT to identify if SystmOne can help to improve compliance with Valproate prescribing	28.02.22	17.01.26	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 within both indoors and outdoors. Previously provided for children to use outdoors only. This could impact on 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 24.09.25: Inequity of service increasing with new referrals, assessment waits vary from 4 weeks to over a year	29.04.25	24.12.25	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 06.10.25: There is a reduction in overdue allocations, however it should be noted that this is due to a significant portion being allocated into bank therefore this is not an improvement overall Only 3 substantive members of the Exec review group have appropriate training to review and approve investigations, the remainder have not completed a learning response Increase in overdue learning responses, Trust timeframes not being met, lack of training for new starters. No further training scheduled or designed for full patient safety incident investigations	08.05.25	06.01.26	**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	Moderate	Likelihood 3	Impact 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 – Launch date to be confirmed; Estates Plan – In final stages with early draft having been through governance

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	Radbourne Unit dormitory eradication refurbishment to provide two 17-bed wards with single room en-suite, with additional staffing and new model of care, to complete dormitory eradication in Southern Derbyshire. Service users continue to receive care in non-compliant wards until this refurbishment is completed National PDC capital funding approval [ACTION OWNER: CDO]	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 Now that the Carsington Unit is open, refurbishment of the Radbourne Unit can recommence. Expected completion 2026/27 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	AMBER

Related operational high/extreme risks on the Corporate Risk Register: None

Board Assurance Framework 2025/26 – Issue 3.3 Board November 2025

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

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

Impact:
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, social care and voluntary sector partnering organisations
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

BAF Ref: 25-26 1C	**Director Lead**: ~~Vikki Ashton Taylor (CDO) /~~ Girish Kunigiri ~~Mark Broadhurst~~ (~~Interim~~ 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 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 Embedded programme of software and hardware upgrades Live testing of business continuity plans Digital Plan – In development	Templar Cyber Organisational Readiness Report (CORS) Annual external cyber review and penetration test commissioned (vulnerability scan) Data Security and Protection (DSP) annual review by Internal Audit Compliance with DSP Toolkit; high levels of training compliance

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
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 [ACTION OWNER: MD]		(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 [ACTION OWNER: MD]	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:

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. 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 07.11.25: Options appraisal tracked by F&P and ELT. New Internal Trust project team set up. Contract / SLA provided by Arden GEM along with first cut and top level non pay / pay details. ICS governance meetings with Technical Design Authority (TDS) and Derbyshire Digital Delivery Board (D3B). Arden GEM planning to support client provider organisations are staggered for offboarding and in advance of January 2027	08.07.25	07.02.26	HIGH
21620	IT, IM and Patient Records	IT system collapse due to cyber attack	03.10.25: Risk reviewed at IMT&R senior team meeting. It is mirrored by recent national security concerns - High severity alerts for quick response to patch and update our device security. Also mirrored in other organisations highlighted in recent news. Uplifted rating, possible to likely, moderate to high	08.02.19	03.01.26	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 Bed Management processes Scrutiny of Quality Account by committees Programme of physical healthcare and other clinical audits Infection Control Board Assurance Framework reported to NHSE Positive and Safe self-assessment Head of Nursing/Matron compliance visits Cleaning and maintenance schedules Mandatory training Trust targets of 85% compliance minimum Continuous Improvement Plan – Launch date to be confirmed	Delivery of Same Sex Accommodation Guidance Safety Thermometer identifies positive position against national benchmark Mental Health Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards CQC comprehensive review 2020 Trust is rated Good Estates and Facilities Management internal audit CQC inspection adult acute December 2024 – Rated good CQC inspection older adults, April/May 2025 – Rated good 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	(30.09.25)	Mandatory training are above compliance target 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 All Adult Acute inpatient facilities are currently single sex. However, the original design for one ward (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	GREEN

Related operational high/extreme risks on the Corporate Risk Register: None

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

There is a risk that the Trust does not deliver key regulatory and strategic requirements related to dormitory eradication and that the Trust estate 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 cost unknown until we receive the final Guaranteed Maximum Price (GMP) in late Quarter 3
Completion of the full Dormitory eradication programme has been delayed until early 2027/28

Root causes:

g. Long term under investment in NHS capital projects and estate
h. Limited opportunity for Trust large scale capital investment
i. Increasing expectations in care and working environments as national capital strategy and surrounding legislative and regulatory requirements evolve
j. National capital funding restrictions for business-as-usual capital programme for Trusts and Integrated Care Systems
k. 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 1E	**Director Lead**: Tumi Banda (DON)	**Responsible Committee**: Quality and Safeguarding Committee

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 – 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; Quality dashboard reporting; Board visits virtual clinical service contact visits; incident, complaints, and risk investigation
Directive – Capital Action Team (CAT) role in scrutiny of capital projects; IPC policy and procedure; Continuous Improvement Plan – Launch date to be confirmed; Estates Plan – In final stages with early draft having been through governance; 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

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 Trust quality and performance dashboards Bed Management processes Scrutiny of Quality Account by committees Programme of physical healthcare and other clinical audits Infection Control Board Assurance Framework reported to NHSE Positive and Safe self-assessment Head of Nursing/Matron compliance visits Cleaning and maintenance schedules Continuous Improvement Plan – Launch date to be confirmed Estates and facilities management internal audit	Mental Health Capital funding secured External authorised reports for statutory health and safety requirements Regional reporting and NHSE oversight Gateway review process – Positive feedback from first stages Safety Thermometer identifies positive position against national benchmark Mental Health Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards CQC inspection adult acute December 2024 – Rated good CQC inspection older adults, April/May 2025 – Rated good 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
Lack of adherence to emerging national guidance and policy requiring the elimination of mixed sex wards and dormitory style inpatient facilities	Opening of ECU, PICU and new acute units with single rooms and en-suite facilities 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 [ACTIONS OWNER: DON/CDO] National PDC capital funding approval [ACTION OWNER: DOF]	Delivery of approved business case Completion of the units CQC approval and sign off Successful transition and opening of the units	30.06.28	FBC and revenue funding approved by ICS. National PDC capital funding approved by NHSE Carsington Unit and Derwent Unit are now open Bed management processes updated in line with the new available estate All Adult Acute inpatient facilities are currently single sex. The original design for one ward (Sycamore) also enables the ability to flex	AMBER

				between being single sex and mixed sex as appropriate. The PICU and Enhanced Care Unit are also single sex Refurbishment of the Radbourne Unit can recommence. Expected completion early 2027/28 Radbourne Unit will progress with one ward due for completion early 2026/27 and one in 2027/28 – Expected completion date updated	

Related operational high/extreme risks on the Corporate Risk Register: None

People - Derbyshire Healthcare is a great place to work

There is a risk that we are unable to create the right culture with high levels of staff morale

Impact: This could impact on the wellbeing and motivation of our people as well as the quality and effectiveness of the services we provide. This could also impact on our ability to recruit as well as maintain staff, with a potential negative impact on the broader reputation of Derbyshire Healthcare

Root causes:

a) The growth of and increasing complexity of demand on our services and therefore our workforce
b) Lack of consistency and expectations of managers and leaders
c) Lack of strategic development pathway for leaders
d) The number of leadership layers we have
e) Lack of accountability across the leadership levels
f) The volatile work environments where staff can be exposed to harm and trauma
g) The need to develop cultural competence and confidence that is needed to value and create a sense of belonging for people of all backgrounds, ethnicities and with lived experience
h) National, system and provider mandated changes connected to financial position of the NHS

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

Board Assurance Framework 2025/26 – Issue 3.3 Board November 2025

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Lack of planned leadership development growth, stretch programmes and opportunities including coaching and mentoring	Leadership section of the People Plan to align to organisational leadership needs 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 leaders with development plan as part of objectives Percentage of employees accessing leadership development programmes	~~(30.09.25)~~ (31.12.25)	~~Senior triumvirate leadership programme commissioned and will commence post operating model consultation for all relevant posts~~ People Plan presented at People and Culture Committee (PCC) for initial comments, final sign due November 2025 – Includes clear direction on leadership development Leadership Service Level Agreement developed with joint venture delivery team	AMBER
Lack of progress across EDI including staff networks and reporting (WRES/WDES/gender pay gap)	Staff networks have an embedded operating framework through which to maximise the impact of staff networks Clear measurable EDI plan that includes all national reporting and Trust level actions Support to bi-monthly network Chairs meetings through DPI, Head of EDI and EDI Manager 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	~~(30.09.25)~~ (31.12.25)	Framework, including clear actions to progress and signed off at PCC Race equality plan developed in conjunction with BME network and supports key actions in WRES ~~Head of EDI commenced 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	Review of all commissioned and in house owned programmes both clinical	Delivery against plan including attendance on programmes	~~(30.09.25)~~ (31.12.25)	Revised programme board and workstreams to ensure	RED

workforce resulting in retention and turnover challenges and inconsistency of approach across MRfD programme	and non-clinical to be clear of the 'ask' and the 'why' Clear framework to ensure alignment across all programmes Comprehensive plan of delivery and outcome measures [ACTIONS OWNER: DPOI]	Staff survey measures Bespoke MRfD surveys to measure awareness and impact of programmes		alignment and learning from gateway review Bluebell ward and Sycamore ward ~~commenced~~ organisational development culture programme completed ~~in May 2025~~. Remaining wards planned for November 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	~~(30.09.25)~~ (31.12.25)	ER team transitioned out of DCHS Joint Venture into DHCFT June 2025 ~~Case investigator training currently being rolled out to support~~ Pool of eight bank investigators recruited~~-~~, trained and commenced on key investigations ~~and commencing training~~ A kind life just culture training programme commissioned, will incorporate personal accountability framework. Active Bystander training being rolled out	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	~~(30.09.25)~~ (31.12.25)	Design of flexible working system linked to ESR to record requests for flexible working and approved requests in progress	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 Improvements as part of NOF segment data	~~(30.09.25)~~ (31.12.25)	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)~~ (31.12.25)	Fast track process for Occupational Health in organisational change Phase 1a operating model programme completed ~~commenced~~	RED

Related operational high/extreme risks on the Corporate Risk Register: None

Board Assurance Framework 2025/26 – Issue 3.3 Board November 2025

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)

Board Assurance Framework 2025/26 – Issue 3.3 Board November 2025

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
An integrated workforce plan and planning process that feeds into pipeline plans and ensures we have the right people in the right place with the right skills	Develop a Trust Workforce Plan linking demand and capacity, workforce redesign to ensure a fully funded workforce Develop vacancy rate data and breakdown variances in vacancy data 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]	Reduced vacancy rates Time taken to fill vacant posts Transformational posts, e.g. apprenticeships all identified Reduction in agency costs Improved retention rates	~~(30.09.25)~~ (31.12.25)	Executive-led vacancy control meeting takes place every week for approval of all vacancies and workforce expenditure increases, i.e., job evaluation	AMBER
We do not have an effective and embedded succession talent management processes	Develop a Talent Management Strategy Pilot career conversations for senior leaders and roll out career conversations for all colleagues Work as a system to develop system-wide approach to talent management and align where best for the Trusts 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 turnover rate Key staff survey measures	~~(30.09.25)~~ (31.12.25)	Talent Strategy finalised Talent programme for senior executive leadership completed – to be run for senior leadership team following finalised operating model 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 Develop NHS retention framework for nursing [ACTIONS OWNER: DPOI]	Improvements to turnover Staff survey engagement scores	~~(30.09.25)~~ (31.12.25)	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
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	~~(30.09.25)~~ (31.12.25)	Inclusive recruitment for chairs training: Ongoing roll out ~~commenced~~ Cultural competence training commissioned ~~and being~~ rolled out, initially focusing on acute wards and now expanding wider. Board have also completed the training	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	~~(30.09.25)~~ (31.12.25)	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	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 and bank usage reduction Agency off framework nil return	~~(30.09.25)~~ (31.12.25)	Ongoing weekly agency approval in place for approval of all agency requests	AMBER

	Agency off framework usage is managed with clear expectations Plan in place to reduce and align to agency price cap for all posts Bank staff are recognised and rewarded appropriately [ACTIONS OWNER: DPOI]	Agency price cap achieved Bank usage is appropriate and available to support where needed		Assistant Director of Workforce is co-chair of national regional agency reduction group Consistent agency reduction demonstrated	

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
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

Board Assurance Framework 2025/26 – Issue 3.3 Board November 2025

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	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

New governance process in place for the Making Room for Dignity programme and action plan in place in relation to the gateway review findings	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: Increased cost pressure now aligned to final refurbishment project	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]	Cash and capital reporting as part of finance reporting into F&P and Board forecasting evidence of plan delivery and/or indicates areas of required management action	~~(30.09.25)~~ (31.12.25)	Regular oversight of capital and cash position. Reporting to Trust Programme meetings and Committees on risks and mitigations Significant cost pressures on Radbourne Unit Refurb. The decision and affordability question of the second ward will be worked up in quarter 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 2~~	AMBER
Additional revenue related to new builds, refurbishments and PICU not fully funded by system Some partners moving away from business case assumptions and previous agreements Re-costing service provision, increasing Service Level Agreements	Close partnership working with ICB and system partners. [ACTIONOWNER: 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	~~(30.09.25)~~ (31.12.25)	MHLDA DB agreed to oversee revenue delivery contained within programme spend Still working through inter-Trust charges with Chesterfield Royal Hospital. No major concerns flagged to date	AMBER
Insufficient substantive staffing into vacancies and temporary staffing costs for	Additional management action and oversight	Enhanced bank and agency costs reported as part of wider	~~(30.09.25)~~ (31.12.25)	Reports to ELT and F&P outlining current areas of pressure and	AMBER

bank and agency staff do not reduce	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]	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		required actions to be taken in year in order to remain on plan	
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]		~~(30.09.25)~~ (31.12.25)	Financial plan for 2025/26 is 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	AMBER

Related operational high/extreme risks on the Corporate Risk Register: None

Board Assurance Framework 2025/26 – Issue 3.3 Board November 2025

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

Principal risk: There is a risk that the effects of both nationally and locally driven changes to roles and responsibilities ~~within~~ across the Integrated Care Boards (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
~~e)~~f) Clustering of ICBs

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	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

Board agreement required prior to undertaking of lead-provider responsibilities	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~~ Changes to governance at ICB and system level may create delays to decision making and cause increased governance burden	Keep Trust structures under continuous review against the wider governance landscape, including the provider collaboratives and alliance arrangements – This in turn may lead to a formal change of DHCFT governance arrangements Continue to influence within the system to ensure Lean and safe decision making and governance arrangements [ACTIONS OWNERS: CEO/DCA]	Board level assurance that the Trust's corporate governance systems are compatible with the new ways of working that would allow both Trust and system objectives to be achieved Board level assurance that the Trust's risks have been fully articulated and understood within the wider integrated care system	~~(30.09.25)~~ (31.12.25)	We have implemented a new divisional performance review process, underpinned by balanced scorecards. To ensure operational performance delivery of MHLDA constitutional standards that DHCFT is a lead or main provider Derbyshire Provider Collaborative Leadership Board have an agreed work programme as approved by ICB The Trust is an active member of and provides regular assurance to system-wide governance groups, e.g. their quality and safety group Memorandums of understanding and alliance agreements are in place where appropriate, i.e. LD Alliance Trust's risks reported to the ICB monthly for cross-reference with other providers for the ICB BAF	AMBER

Related operational high/extreme risks on the Corporate Risk Register: None

Board Assurance Framework 2025/26 – Issue 3.3 Board November 2025

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

There is a risk of reputational damage if the Trust is not viewed as a strong partner both within the Derby and Derbyshire Integrated Care System (ICS) and more broadly within the East Midlands Mental Health Provider Alliance

Impact:
May have detrimental impact on patient experience and quality of care provided for people accessing services.

Root causes:

a) Silo working within the organisation
b) Not actively engaging enough as part of a broader multi-agency partnership at Place and community level
c) Increasing national expectations in provider collaboration and multi-disciplinary delivery model at Place level

BAF Ref: 25-26 4B	**Director Lead**: Vikki Ashton Taylor (DSPT)	**Responsible Committee**: Trust Board

Key Controls

Initial risk rating			Current risk rating			Target risk rating			Risk appetite		
High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 3	Moderate	Likelihood 3	Impact 3	Accepted	Tolerated	Not Accepted

Preventative – Active membership in each Local Place Alliance; Active participation in Integrated Place Executive; Meaningful stakeholder engagement (internal and external); Multi-disciplinary and cross organisational development and implementation of services
Detective – Quality Improvement (QI) delivery; Contract performance; Continuing engagement in all Joined up Care Derbyshire governance from DHCFT representatives
Directive – Integrated Care Strategy; Joint Forward Plan (JFP); Trust Strategy

Assurances on controls – Internal	Assurances on controls – External
Appointment to Managing Director roles Regular TLT and ELT updates and discussions NED Board members on JUCD committees Developing collaborative plans with system partners to recognise and mitigate gaps within the system for ADHD and ASD diagnostics	Monthly Mental Health and Learning Disability assurance meetings with NHSE Monthly reporting by County and City Places to JUCD Place Executive Patient surveys conducted by Healthwatch CEO on ICB Board and Integrated Care Partnership (ICP) Regular NOF Level 3 meetings with NHSE and ICB

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Some core constitutional targets not being met and risk to making progress, at pace and scale, resulting in some patients being cared for outside of Derby and Derbyshire	New internal performance improvement group Recovery action plans for areas where Trust constitutional standards are not being met Improvement plan for joint autism service (with system partners) [ACTIONS OWNERS: CDO]	Improvement in performance of~~in~~ constitutional standards and NHS Oversight Framework (NOF) metrics Recovery action plans in place in all required areas ~~Feedback from social care on awareness of the Autism Strategy and reduction in autism waiting times~~	~~(30.09.25)~~ (31.12.25)	In-year progress delivering recovery action plans: Performance improvement in dementia diagnosis and perinatal access has resulted in DHCFT now delivering the core constitutional targets in this area and others Significant reduction in number of inappropriate ~~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 Recovery Action Plans in place in relation to key access targets, measured in the NOF	RED

				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	~~(30.09.25)~~ (31.12.25)	Collaborative development of community mental health 24/7 pilot alongside general practice partners Twice weekly mini MADE and weekly MADE events taking place. 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 Engagement with partners continues	GREEN
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)	~~(30.09.25)~~ (31.12.25)	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 cafés have opened in Buxton, Ripley and Swadlincote – This reduces demand on Police call-outs Trust is a member of the RCRP implementation executive	AMBER

		Increased handovers completed within one hour		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 more responsive 136 provision within Derbyshire, harnessing effective working relationships with Police	
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 Co-production in Patient and Carer Race Equality Framework (PCREF) requirements	~~(30.09.25)~~ (31.12.25)	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	~~(30.09.25)~~ (31.12.25)	ICB have presented to both providers on how to ensure community offers are enhanced further through the review of pathway offers where resource is disproportionately allocated Ongoing discussions to commit more resources to community pathways The Trust is working alongside DCHS and has established an integrated service provision for neurodevelopmental services across both organisations The integrated model continues with a governance structure aligned	AMBER
Improvements are required in rapidly returning patients who access Learning Disabilities and Autism (LD&A) services to local care to enable them to live in the least restrictive manner, as close to home as possible	Continue to work on developed delivery improvement plan, owned by system partners. This includes new cohort stratification– Key action to implement embed approach to ensure focussed system action on existing inpatients who are placed inappropriately and out of area [ACTION OWNER: CDO]	Improvement plans developed and implemented resulting in a stabilised service and positive outcomes for patients Enhancing and reviewing Listening and Engagement Active Partnerships (LEAP) procedures Improvement plans in admission avoidance, crisis alternatives to admission, including	~~(30.09.25)~~ (31.12.25)	Derbyshire is no-longer in national escalation regarding performance with inpatient services after demonstrating improvement against plans New Dynamic Support Pathway (DSP) launched following cross-agency redesign work	AMBER

		improvement in the use of Dynamic Support Registers as a means of admission avoidance Reduction in delayed discharges in units across the country resulting in NHSE escalations		Cross-system delivery plan continues to be monitored through Neurodevelopmental Delivery group Board – Includes action plan in response to inflow, flow and outflow as discussed with NHSE and ICB leaders The Trust with the ICB continues to meet with NHSE on a quarterly basis to monitor performance and transformation, focussing on those patients with a long length of stay and who are Clinically Ready for Discharge	

Related operational high/extreme risks on the Corporate Risk Register:

ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating
23314	Corporate Services – IM&T	Interpretation of data submitted within NHSE datasets risks erroneous views on the Trust	30.10.24: NHSE interpret and analyse data submitted within mandated NHSE submissions. This analysis is not fed back to the Trust to allow them to validate and comment on before being published to the wider NHSE community, ICBs and others. This may also include historical analysis where the Trust has no way of rectifying any issues that might be raised. With this there is a risk that external organisations to the Trust are forming views on the Trust based on erroneous information 10.10.25: 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	12.01.26	HIGH

Board Assurance Framework 2025/26 – Issue 3.3 Board November 2025

Risk Rating
The full Risk Matrix is included in the Trust's Risk Management Strategy

Risk Assessment Matrix					
Risk Score = Consequence Rating X Likelihood Rating					
	CONSEQUENCE				
LIKELIHOOD	INSIGNIFICANT 1	MINOR 2	MODERATE 3	MAJOR 4	CATASTROPHIC 5
RARE 1	1	2	3	4	5
UNLIKEY 2	2	4	6	8	10
POSSIBLE 3	3	6	9	12	15
LIKELY 4	4	8	12	16	20
ALMOST CERTAIN 5	5	10	15	20	25

RISK RATING	RISK APPETITE
Very Low	Accepted
Low	
Moderate	Tolerated
High	Not Accepted
Extreme	

Actions Against Gaps in Key Controls - Expected completion dates to be included or next review dates to be shown in brackets	Action Rating
Action **completed**	Blue
Action **on track** to completion within proposed timeframe	Green
Action **implemented in part** with potential risks to meeting proposed timeframe	Amber
Action **not completed** to original or formally agreed revised timeframe. Revised plan of action required	Red

Action Owners

CEO	Chief Executive Officer
DOF	Director of Finance
MD	Medical Director
CDO	Deputy Chief Executive / Chief Delivery Officer
DON	Director of Nursing, AHPs, Quality 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 – 25 November 2025

Trust Sealings

Purpose of Report

This report provides the Trust Board with a six-month update of the authorised use of the Trust Seal since the last report to the Board on 3 June 2025.

Executive Summary

The Trust's Standing Financial Instructions (point 8.16) were revised in September 2024 to allow a more practical process for the signing of contracts, as the size of the organisation's contract values have grown. The authorised signatory limits reflect the delegated expenditure limits in point 3.2.

Now only deeds and contracts relating to the disposal, acquisition or leasing of land or property need to be executed under the Common Seal of the Trust.

In accordance with the Standing Orders of the Board (section 12 point 6) a report of all sealing shall be made to the Trust Board twice a year. The report will contain details of the seal number, the description of the document and date of sealing. The register will be retained by the Trust Secretary.

A report on use of the seal was last made to the Board on 3 June 2025. Since the last report, the Trust Seal was used as follows:

- DHCFT/135 (28 May 2025) Logistics services agreement between 1) D-HIVE Ltd, 2) Lead Derwent Member - Derbyshire Healthcare NHS Foundation Trust, 3) NHS Derby and Derbyshire ICB, 4) University of Derby and Burton NHS Foundation Trust, 5) Derbyshire Community Health Services NHS Foundation Trust
- DHCFT/136 (4 June 2025) Renewal lease relating to first floor office at Erewash House, Station Road, Ilkeston, Derbyshire between 1) Orion Developments UK Ltd and 2) Derbyshire Healthcare NHS Foundation Trust

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

Risks and Assurances

Use of the Trust Seal has been undertaken in accordance with the Standing Financial Instructions and Standing Orders of the Board of Directors.

Consultation

N/A.

Governance or Legal Issues

The affixing of the seal is consistent with the Board's responsibilities outlined within the Standing Financial Instructions and Standing Orders of the Board of Directors.

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

Recommendations

The Board of Directors is requested to note the authorised use of the Trust Seal since the last report to the Board on 3 June 2025 and receive full assurance that this has been undertaken in accordance with the Standing Financial Instructions and Standing Orders of the Board of Directors.

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

Report prepared by: **Emma Warrilow**
Personal Assistant

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 25 November 2025

Delivery of Same Sex Accommodation annual report

Purpose of Report

Report on the compliance of the delivery of same sex accommodation guidance and the annual declaration.

Executive Summary

The Trust has the required policies and governance in place to ensure that the guidance is applied, monitored and reported on to the Board.

There were two unavoidable breaches reported from April 2024 to March 2025; one on Pleasley Ward and one on Cherry Tree Close in the Rehabilitation Unit.

The report on the Delivery of Same Sex Accommodation was presented to the Quality and Safeguarding Committee in October 2025. The Committee received significant assurance that the Trust has robust processes to prevent breaches, monitor and address breaches when they do occur.

The Quality and Safeguarding Committee accepted the Delivery of Same Sex Accommodation Compliance declaration.

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.	

Risks and Assurances

- Trust policies are in place and there is governance in place to ensure that patient safety and dignity are maintained
- The patient accommodation in the wards is compliant with delivery of same sex accommodation.

Consultation

The report was discussed in the Safeguarding Committee on 8 October 2025.

Governance or Legal Issues

- Delivering same-sex accommodation' guidance (NHS, 2019).
- Equality Act (2020)
- CQC Standards Guidance - Health and Social Care Act 2008 (Regulated Activities Regulations 2014: Regulation 10.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

There is a lack of guidance on how to support transgender people due to the change in the law, an individualised approach to be taken to ensure safety, dignity and privacy of all the patients.

Recommendations

The Board of Directors is requested to:

1. Receive significant assurance that the Trust has robust processes to prevent breaches, monitor and address breaches when they do occur
2. Approve the Delivery of Same Sex Accommodation Compliance Declaration.

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

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

Same Sex Accommodation Annual report, including annual Declaration of Compliance

The purpose of this report is to provide the Trust Board with a summary of the Trust position for the financial year 2024/25 regarding compliance with NHS England (NHSE) requirements to eliminate Mixed Sex Accommodation (MSA) breaches within all inpatient areas and compliance with national 'Delivering same-sex accommodation' guidance (NHS, 2019).

The Trust has an annual requirement to declare and publish compliance with delivering same sex accommodation:

- Every patient has the right to receive high quality care that is safe and effective and respects their privacy and dignity. Providers are expected to have a zero-tolerance approach to mixed-sex accommodation, except where it is in the overall best interest of all patients affected
- A mixed-sex accommodation breach occurs at the point a patient is admitted to mixed-sex accommodation outside the guidance
- Patients should not normally have to share sleeping accommodation with members of a different sex.
- Patients should not have to share toilet or bathroom facilities with members of a different sex
- Patients should not have to walk through an area occupied by patients of a different sex to reach toilets or bathrooms; this excludes corridors
- Women-only day rooms should be provided in Mental Health Inpatient units.

There were two breaches reported from April 2024 to March 2025, one was on Pleasley Ward and the second one was in Cherry Tree Close in the Rehabilitation Unit. These were unavoidable breaches, the incidents were managed and reported appropriately, no harm was reported. With the completion of the building works in Cherry Tree Close and the purpose-built Bluebell Ward for older adults, the risks from the two incidents have been fully mitigated.

The Trust has the required policies and monitoring in place to ensure compliance to the delivery of same sex accommodation. The Bed Management team retains the gatekeeping function for all inpatient admissions. New guidance to support transgender people will be implemented when the available.

Concerns and dissatisfaction regarding the admission decisions are being monitored by the Patient Experience team.

Declaration of Compliance

Derbyshire Healthcare Foundation Trust is pleased to confirm that we are compliant with the Government's requirement to eliminate mixed-sex accommodation. We continue to offer and improve our in-patient facilities, resources and culture to ensure that patients that are admitted to our hospitals and specialist in-patient units will only share the room where they sleep with members of the same sex and that same-sex toilets and bathrooms will be close to their bedroom area where there are no ensuite facilities.

The organisation has mixed gender wards, and the accommodation is compliant in the delivery of same sex accommodation requirements.

How do we monitor compliance of our standards?

We monitor compliance through a variety of local and service line actions, these include, bed management and gate keeping, monitoring of Datix incidents and reports, local quality audits and observations within practice.

What do I do if I think I am admitted to accommodation that does not comply with the Government standards?

Talk to your named Keyworker. If this does not resolve your concerns, you can ask to speak to the Patient Experience team, dhcft.patientexperience@nhs.net

Director of Nursing, AHPs, Quality and Patient Experience

November 2025

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 25 November 2025

Suicide and Self-Harm Prevention Strategy

Purpose of Report

To present the updated Trust Suicide and Self-Harm Prevention Strategy.

Executive Summary

Feedback has been sought and an easy read summary produced, that can be easily accessed and understood by all staff team. In response to received feedback, relevant changes have been incorporated.

The updated strategy incorporates the 2023-2025 NHS England national guidelines, along with other national bodies, applying them at a local level.

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

Risks and Assurances

- Reflects best practice guidance within mental health
- Incorporates local learning through patient safety workstreams.

Consultation

Staff; service users, care representatives and the Quality and Safeguarding Committee.

Governance or Legal Issues

Previously shared with the Quality and Safeguarding Committee.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

None.

Recommendations

The Board of Directors is requested to ratify the updated Strategy.

Report presented by: **Girish Kunigiri**
Medical Director

Report prepared by: **Johannes Leitner**
Suicide Prevention Lead

Derbyshire Healthcare
NHS Foundation Trust

Derbyshire Healthcare NHS FT Suicide and Self-Harm Prevention Strategy 2025

www.derbyshirehealthcareft.nhs.uk
DHCFT DERBYSHCFT NHS_DERBYSHIREHEALTHCARE

Contents:

1. Forewords:

"As someone who has been bereaved by suicide at a young age, you don't think it will happen to you. Until it does. Before stepping into the world of suicide prevention, other than dealing with some mild anxiety, mental health and suicide had never crossed my radar. After finding my best friend, when she died by suicide, my whole life changed. So many unanswered questions, so many emotions, so much pain, anger and guilt and I didn't know what to do with it or how to understand it.

When someone takes their own life, the ripple effect is devastating. The pain that the individuals feel which ultimately means they make that decision to end their own life is unimaginable. And the majority of the time, they don't realise how to get the support they need and what help is out there. Yes, we are becoming more open about our feelings as a society, but the stigma still remains.

I now know the signs, the conversation starters and am more knowledgeable on the subject, however, I am educated on this because I have been through it. Most of the time people only tend to learn about why prevention is so crucial when it happens to them and realise that no one else should have to go through this kind of pain. We need to work together, we need to utilise our services, professionals, clinicians and advocates to reach every single person in order to stop suicide.

This is exactly what we are aiming for across Derbyshire and this paper highlights how we can achieve this and what role we all can play. If you are sat here thinking 'well, what can I do?', the answer is, is that there is a role for everyone. Educate yourselves, do the training, start the conversation, change people's attitudes, spread awareness. People's lives depend on it."

Ellie Scott, expert by lived experience

"We are a values led organisation and are committed to high standards of quality. We have developed this strategy with a strong focus on lived experience. Our strategy is underpinned by evidence borne out of quantitative data and qualitative data that includes the voice of lived experience and subject matter professional experts. We have incorporated all the learning within our organisation and in our system within this strategy. We are aware that addressing stigma around mental health, self-harm and suicide amongst the general public and also professionals is important in addressing suicide risk.

Whilst we prioritise the service users who are accessing our interventions, we have incorporated interventions that will deliver the preventative aspects in the wider system aligning with initiatives by our system partners including primary care. We have launched on safety planning that aligns with national guidance issued in April 2025. We hope that this strategy delivers the best outcomes for our people in Derby and Derbyshire."

Dr Arun Chidambaram

Executive Medical Director, DHcFT

2. Executive Summary

We are pleased to present our Derbyshire Healthcare NHS Foundation Trust's (DHcFT) updated Suicide and Self Harm Prevention Strategy. This plan is anchored on the key national policy documents and current research on suicide and suicide prevention, as set out in the National Suicide Prevention Strategy 2023-2028 (DHSE 2023) and aided further by the 2025 National Confidential Inquiry into Suicide and Safety (NCISH) reports. It includes recommendations from the NHS England "Staying Safe from Suicide- Best Practice Guidance" (NHSE 2025) along with other resources as set out below. It also incorporates the recommendations from the Johnson Reports and ensures greater prominence is given to the risks and challenges involved within inpatient context and great postvention support for both staff and families/carers involved.

The 2023-2028 National Suicide Prevention Strategy outlines over 100 actions designed to halve the suicide rate and provide sustained reductions and the key actions as outlined above are incorporated into our local strategy. The Suicide Prevention in England: five-year cross-sector strategy (2023) identified that though the current suicide rate is not significantly higher than in 2012, the rate is not falling. We must do all we can to prevent more suicides, save many more lives and ultimately reduce suicide rates. While this strategy is set out for the Trust, as all the above documents make clear, suicide is everyone's business. The strategy is guided by the belief that suicide is not inevitable for anyone, and there are opportunities for mental health services can improve clinical practice to reduce suicide among those with mental ill health difficulties. While this strategy is set out for the Trust, as all the above documents make clear, suicide is everyone's business.

The aim of the strategy is to translate national strategies into effective local initiatives which improve care and reduce the risk of suicide in those individuals being cared for by DHcFT services, while acknowledging that approaches to prevention must be wide-ranging to address often multiple underlying causes. The Strategy is meant to be a dynamic document. The Trust will continue to work collaboratively with service users, their families, friends and carers, staff, statutory and other partner organisations and third sector providers to ensure that this Suicide and Self-Harm Prevention Strategy continues to evolve and align with local needs as well as updated national strategy. Set out below are the eight strategic priorities which are incorporated into this strategy:

The eight Strategic Priorities of the 2023-2028 National Suicide Prevention Strategy incorporated into this Strategy:

- **Improving data and evidence use and collection**
- **Tailored targeted support for priority groups**
- **Addressing common risk factors**
- **Promoting online safety and responsible media portrayals**
- **Providing effective cross sector crisis support**
- **Reducing access to the means and methods of suicide**
- **Providing effective bereavement support**
- **Making suicide prevention everyone's business.**

3. The Case for Suicide and Self-Harm Prevention

Suicide is the act of intentionally causing one's own death. Suicide in both Derbyshire and nationwide is a major public health issue and as such merits a concerted public health response. It may appear an individual act but it has deep and significant social impacts. A key principle of this strategy is that suicide is everyone's business, we all share responsibility to look out for one another. Prevention is not about forcing life, but helping people have hope, stability, meaning and connection. It's recognised that suicide and self-harm risk can be shaped by trauma, injustice, discrimination and access to care and support. The World Health Organisation's latest estimates around 700-800k deaths globally each year by suicide. The effects of self-harm and suicide are long lasting and socially devastating. The Samaritans estimate that on average at least 10 people are intimately affected by every suicide and as many as 135 people may be affected by a single suicide. Those bereaved by suicide are at increased risk of suicide themselves. Many people, including friends, family, professionals, colleagues and wider society will feel the impact, which is why the national strategy recognises secondary trauma and the importance of postvention support for staff, families and carers.

The link between suicide and poor mental health has been well established. Although the cause is frequently attributed to a mental disorder such as depression, bipolar disorder, schizophrenia, borderline personality disorder or substance use, around 75% of those who die by suicide were not in contact with mental health services at the time of their death. Many suicides can happen impulsively in moments of crisis or a breakdown in the ability to deal with life stresses such as financial problems, relationship disputes or chronic pain. Each of those deaths is a personal and preventable tragedy. Sadly most people working for our Trust are likely to have been impacted by suicide which can have a devastating impact. As such it's vital to support staff wellbeing with a safe, compassionate and supportive approach particularly to help deal with the risks of secondary trauma.

As the NHS's Suicide Prevention Strategy highlights: suicide truly is everyone's business and suicide prevention efforts include reducing access to means of suicide such as medications, treating high-risk groups with mental illness, alcohol or substance use, and providing better information and support to those bereaved by suicide. This requires a coordinated response from all health, social care and third sector groups. Our Trust has a vital role to play in suicide prevention working in partnership with other agencies.

The updated DHcFT Strategy, written after consultation with stakeholders, is influenced by both the national and regional strategy developed in liaison with Public Health Derbyshire. Our key strategic priorities have been developed, reviewed and rewritten on the basis of feedback gained and shared locally, nationally and internationally. Our strategy also benefits from local Derbyshire expertise particularly in the fields of self-harm and compassionate care and is founded on the core values and standards of the Trust. This Strategy sets out the priority areas on which we must focus.

- To reduce the suicide rate over the next five years – with initial reductions observed within half this time or sooner
- To improve support for people who have self-harmed and implement new initiatives both on the ward and in the community
- To improve support for people bereaved by suicide
- To improve Suicide Prevention and Risk Management training for all staff.

This DHcFT Strategy outlines the Trust's commitment to suicide prevention by promoting and evidencing a culture that focuses on understanding; continuous learning; continuous service improvement and compassionate engagement with all. We will promote an honest and open culture, avoid blame and defensive practice and encouraging shared learning.

People who use the services of the Trust have the right and expectation to the following core care standards:

- **Assessment: We will give you time to find out with you what your needs are**
- **Care planning: You will have a clear collaborative care plan**
- **Review: We will check that things are working for you**
- **If you're an inpatient, we will make sure your discharge, leave or transfer of care work well for you.**
- **Safety Plans: We will work with you to offer a collaborative safety plan**
- **Families and carers: We will work with families and carers**
- **Involvement and choice: You will be involved in decisions about your care as much as you want and are able to be keep yourself and others safe.**
- **We will help you and others to be as safe as you can be**

4.Statistics and Data: Local and National review

In the UK and in Derbyshire, suicide is the leading cause of death among all under 35 year olds. In England and Wales there are around 5500 registered deaths by suicide each year. It's estimated that 10-25 times that number attempt suicide. Almost one third of 17-24 year olds has self-harmed at some point, a figure that rises to 69.5% of young people with a probable mental health condition. It's the third leading cause of death for people age 15-29. Suicide remains the leading cause of death for men under the age of 50. Of those deaths, over a quarter of all suicides were accounted of by individuals in contact with mental health services. It is very clearly a major health crisis, locally, nationally and globally.

Self-Harm and Suicide

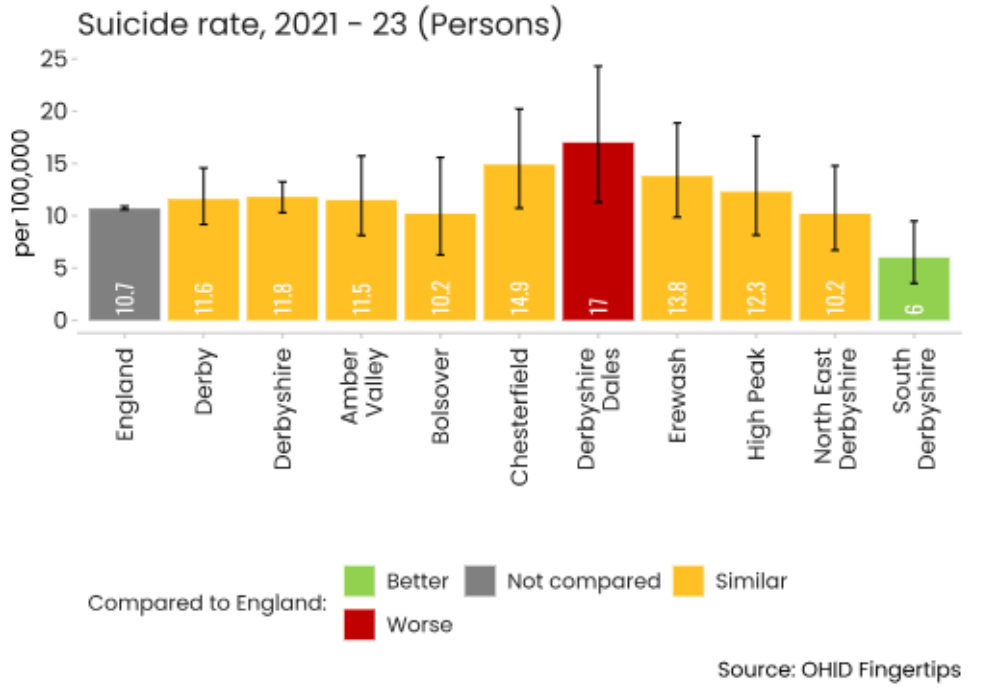
Self-harm is a significant predisposition for suicide. Around 50% of people who die by suicide have a history of self-harm. People who have self-harmed have a 30-50 times higher risk of suicide than the general population. Around one in 25 people who have been in hospital and self-harmed will die by suicide, usually within five years of admission. The risk of suicide is highest in the first year after hospital presentation for people who have self-harmed. There is a direct association between deliberate self-harm and suicide attempts, with more than nine in 10 adolescents with suicide attempts also reporting deliberate self-harm. As deliberate self-harm increase in diversity of methods so does the likelihood of suicide attempts. Depression and anxiety appear as significant predictors of suicide attempts in adolescent self-harmers.

Socio-demographic characteristics of patients who died by suicide in the UK (2011-2021)

Of those individuals in contact with mental health services, research shows they had higher rates of socio-economic adversity and isolation, indicated by unemployment and living alone. The majority (12,027, 66%) were male patients and 73% were unmarried. 1,552 (9%) were aged under 25, and 237 (1%) were aged under 18; 14% were aged 65 and above. In 2016-2021, 305 (5%) of all patients were known to identify as lesbian, gay, or bisexual and 53 (1%) were within a trans (including transsexual, non-binary) group. Veterans also account for a disproportionate amount of around 2% of all deaths by suicide.

Derbyshire Data and DHcFT Datix Data:

Historically, on average around 85 people a year die from suicide in Derbyshire (ONS 2023). The average for the county of Derbyshire (excluding the city of Derby) is around 12.0 per 100k which is above the national average of 11.2. Derbyshire has a higher percentage of elderly deaths than the national average. The latest data for Derby city (2022) was that there were 32 registered deaths with an average of 10.7 per 100k which is just below the national average. In Derbyshire, it's one of the top causes of death of people under the age of 35. The national male suicide rate was 17.1 per 100k with a female suicide rate of 5.6 per 100k. Males aged 45-49 had the highest suicide rate and 25.3 per 100k. This is mirrored within Derbyshire:



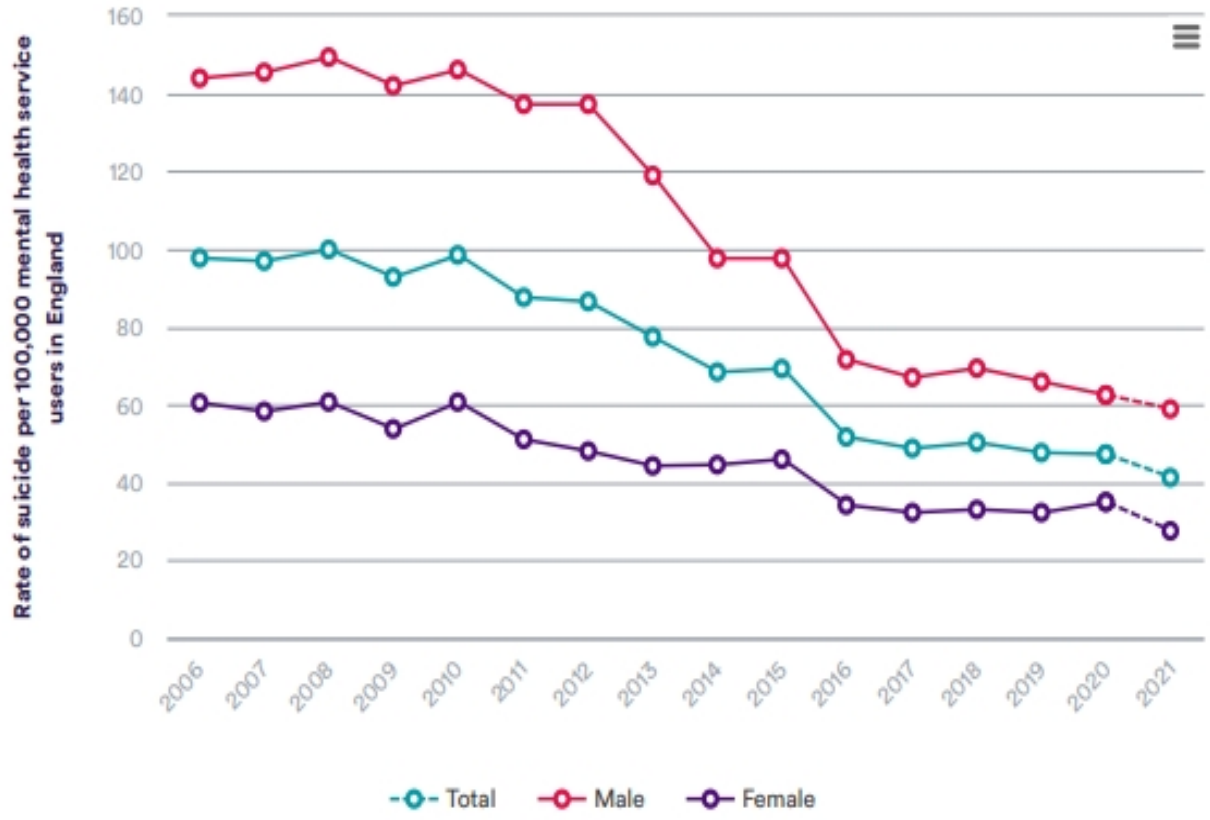
Suicide risk is higher in men aged 35-54, people with mental health problems and people who experience socio-economic disadvantage. The figures of 73% male and 27% female locally, loosely mirrors the national statistics. Across Derbyshire 85% of deaths are white ethnicity, of which 95% are British.

Every death by suicide has a broad impact which includes pain, grief and suffering, alongside costs of care, loss of productivity and earnings. It is estimated that at least 10 people are intimately affected by every suicide. As many as 135 people may be affected by a single suicide and those bereaved by suicide are at increased risk suicide themselves. Secondary trauma needs to be addressed by greater staff support.

Inpatient and Clinical Care: Suicide while under the Care of Mental Health Services:

Inpatient wards are an environment where staff can monitor, assess and respond to distress. People admitted to mental health wards are often at a higher risk of suicide. However, the wards and staff have greater capacity to restrict the means to suicide and provide compassionate and supportive care. The new wards opened at Kingsway and in Chesterfield have paid particular attention to mitigating risks such as ligature points and improved observation.

UK figures show that 26% of deaths by suicide are by people who are under the care of mental health services. While this number has declined significantly over the past two decades, there is still a significant amount of positive work that can be done.



The National Confidential Inquiry (NCISH) 2025 annual report noted that:

There were 4,718 (27%) patients who died by suicide in acute care settings, including in-patients (5%), and post-discharge care (13%) or crisis resolution/home treatment (13%), with overlap between the latter two groups. This is an average of 429 deaths per year.

There were an estimated 72 suicides by mental health in-patients in 2022, around 4% of all patient suicides in that year. Of all in-patients:

- 40% died on the ward
- 50% were off the ward on agreed leave
- 10% had left the ward without staff agreement or left with agreement but failed to return.

The proportion of in-patients who died on the ward has increased by 31% between 2012-2015 and 2019-2022.

There were an estimated 198 deaths by suicide in the three months after discharge from mental health in-patient care in 2022, 11% of all patient suicides. The number and rate of post-discharge suicide has risen since 2017. Of all patients who died in the first week after discharge, the highest number occurred on day three (63 patients, 20%) post-discharge (taking day one as the day of discharge). However, in 2019-2022 the highest number occurred on day six (20 patients, 22%).

The National Confidential Inquiry into suicide and safety (NCISH) in mental health noted that the majority of suicides that occurred in people receiving support from mental health services were people considered low risk at the time of death. Between 2011-2021, there were 4,767 (28%) patients who died by suicide in acute mental health care settings across the UK, namely inpatients (6%), post-discharge care (14%) and crisis resolution/home treatment (13%), this is an average of 433 deaths per year. There were an estimated 193 deaths by suicide in the three months after discharge from mental health in-patient care in the UK (excluding Northern Ireland) in 2021, 12% of all patient suicides. The highest risk was in the first one to two weeks after discharge, with the highest number of deaths overall occurring on day three post-discharge. The four most common method for deaths by suicide include hanging, suffocation or strangulation (55.2%) followed by poisoning (21.6%), jumping or lying in front of a moving object such as a train (7.2%) and fall and fracture (5.4%).

In 2011-2021, there were 117 deaths by suicide in inpatients who were aged under 25, 7% of all patients aged under 25 died by suicide, an average of 11 deaths per year. 20 were aged under 18, although the final figure is likely to be higher as some inquests relating to deaths of young people in the report period are yet to be held. There was no fall in the total number of inpatients aged under 25 over the reporting period.

5. Strategic Priorities:

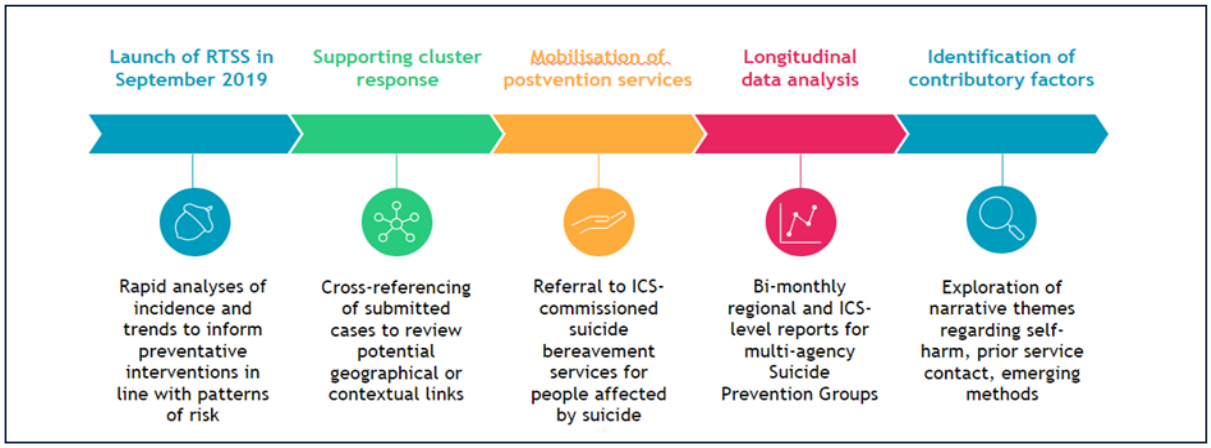
1. Aims of the Strategy:

The NHS national strategy highlights eight key areas which this local Strategy focuses on. This Strategy recognises the importance of tailoring suicide prevention to meet the needs of Derbyshire's varied population groups, especially vulnerable ones such as the young people, elderly, and those with a history of mental illness, for effective prevention. Our Strategy aligns closely with the National Suicide Prevention Strategy, which underscores a multi-faceted approach to preventing suicide risk. This includes targeting support towards at-risk groups, promoting mental health education, and ensuring timely and effective interventions. Evidence from key academic literature supports these initiatives, highlighting the effectiveness of early intervention, community-based programs, and improved access to mental health services. Our key actions for 2025-2028 incorporate the eight priorities outlined in the National Suicide Prevention Strategy along with the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) 2024 updates.

Local priorities incorporate the national strategy as follows:

There are various sources of data nationally and locally which cover Derbyshire as outlined below. The Trust will continue to work closely in partnership with organisations like Public Health England in collating and analysing county wide data. In particular it will focus on analysing Datix data for themes and application of recommendations and actions.

1.1 The Near to Real Time Suspected Suicide surveillance (nRTSSS) for England is now active in Derbyshire and attempts to provide ongoing data to provide an early warning system for indications of changes in trends in suicide through analysis of data on suspected suicides. A key aim is to enable Derbyshire Public Health team and its partners such as the Trust to consider and agree if interventions are required after a death has occurred where the circumstances suggest suicide in advance of the coroners' conclusion. It can help identify if there are clusters or trends of deaths at particular sites leading to earlier interventions.



1.2 Derbyshire Healthcare Foundation Trust is one of only three sites nationally that has an embedded research team which hosts the Derby Site Multi-Centre study for Self-Harm monitoring and Suicide Prevention Research (CSSR). This has been in operation since 2013, in recognition of the significant level of local activity undertaken in the area over many years. It provides a robust mechanism to collect data on self-harm and suicide which provides some of the leading quality data collection in the UK.

In collaboration with the clinical professionals, at this stage the Mental Health Liaison team based at the Royal Derby Hospital- the centre works to:

- **conduct a series of studies on the epidemiology, clinical management, outcome and prevention of self-harm and suicide**
- **provide local data analysis seeks to better understand Derby's population needs around self-harm, to evaluate and inform local care provision and strategic approaches to the prevention of self-harm and suicide**
- **through the multi-centre collaboration, the research provides representative and reliable data on self-harm in England.**

In terms of improved clinical practice, the following is expected:

- **an increase understanding and awareness around experiences of distress and despair through good quality research, service evaluation and quality improvement**
- **embed research activity within routine clinical practice, conduct studies based upon current clinical need, and facilitate the implementation of research findings into practice**
- **inform clinical care procedures and policies on a local, national, and international level**
- **monitoring and research of self-harm related emergency department attendances in Derby and contrasting data with England**
- **conduct a series of studies on the epidemiology, clinical management, outcome and prevention of self-harm and suicide**
- **provide Local data analysis seeks to better understand Derby's population needs around self-harm, to evaluate and inform local care provision and strategic approaches to the prevention of self-harm and suicide**
- **through the multi-centre collaboration, the research provides representative and reliable data on self-harm in England.**

In terms of clinical and operational practice the aim is to use and embed this data into practice and the research team is working with clinical teams to improve practice and contribute more to suicide prevention. There are areas within the Trust where data is collected but not fully utilised and this is something that the research team is working to improve.

- **1.3 Datix:** Datix is a system used by the Trust for incident reporting and risk management. It's a tool that allows healthcare staff to report incidents, risks, or near misses, and helps organisations learn from these events to improve patient safety. It has the following aims:

- Learning from Incidents:
  Datix allows organisations to analyse incident data, identify trends, and implement changes to prevent future incidents
- Compliance:
  It helps healthcare providers meet regulatory requirements and demonstrate a commitment to patient safety
- Culture of Safety: By encouraging incident reporting, Datix contributes to a culture where staff feel comfortable reporting concerns and where learning from mistakes is valued.

The recommendation from this strategy is that there is quarterly local analysis of the Trust's Datix reporting system which seeks to identify trends and themes and shares this data through with all relevant clinical teams.

Serious Incidents and Patient Safety: The Learning from Patient Safety Events (LFPSE) service is now newly in use across the NHS for the recording and analysis of patient safety events that occur in healthcare. At this time it provides two main services:

1. Record a patient safety event - organisations, staff and patients will be able to record the details of patient safety events, contributing to a national NHS wide data source to support learning and improvement.
2. Access data about recorded patient safety events - providers and commissioners can access data that has been submitted by their teams, in order to better understand their local recording practices and culture, and to support local safety improvement work.

Strategic Priority 1: Improving Data and Evidence use and collection

Identified Strategic Outcomes	Actions or Objectives
Continue to Improve data collection and Analysis across all teams within the Trust. Work with partner organisations and other Trusts to share relevant data to help reduced deaths by suicide and provide postvention support and review. Identify and Apply successful initiatives from other Trusts within DHcFT	Embed research activity within routine clinical practice, conduct studies based upon current clinical need, and facilitate the implementation of research findings into practice Integrated use of Patient Reported Outcome Measures such as ReQol 10 into clinical teams with clear and regular audit processes Embed research activity within routine clinical practice, conduct studies based upon current clinical need, and facilitate the implementation of research findings into practice Quarterly review of Datix and nRTSSS "real Time" data to identify trends and feedback to relevant teams.

Strategic Priority 2: Tailored targeted Support for Priority Groups

This aspect of the strategy is to ensure recognition and bespoke action for groups that historically present as at higher risk of suicide and provide accessible and effective interventions. The at risk groups identified within the strategy are as follows:

1. **People in contact with mental health services** • 26% of all people who died by suicide (2011-2021) had recent contact with mental health services (12 months prior to their death).

2. People in contact with the justice system • People in contact with the justice system have higher rates of suicide and self-harm behaviour than the general population. 13% of the national population dying by suicide were in contact with the criminal justice system in the year preceding death, a proportion greater than any other area. Our data shows 13% of general population suicides were in community justice pathways before death. Suicide risks were highest among individuals receiving police cautions, and those having recent or impending prosecution for sexual offences. Findings have implications for the training and practice of clinicians identifying and assessing suicidality and offering support to those at elevated risk.

3. Autistic people • It is estimated that around one in seven people (more than 15% of people in the UK) are neurodivergent, meaning that the brain functions, learns and processes information differently. Evidence suggests that suicide is one of the leading causes of early death in autistic people, with those diagnosed with autism and no other learning disability being over nine times more likely to die by suicide. Staff also need to be mindful of the likely large numbers of people who are undiagnosed, and the impact this may have on their health and wellbeing, as well as acknowledgment of the lengthy waiting times people often experience before receiving a clinical assessment. This is also prevalent in other neurodiversity conditions, such as ADHD.

4. People with a history of self-harm • Evidence shows that the risk of suicide among those who have self-harmed is much greater than that of the general population, with the risk elevated by between 30 to 100-fold in the year following an episode of self-harm. More than half of people who self-harm present with a significant suicide risk.

5. Children and Young People • Sadly the leading cause of death for both males and females under the age of 35 both nationally and locally is suicide. • Studies have found that up to 54% of suicides in young people had a history of previous self-harm. • Antecedents to children and young people's suicides are varied, including academic pressures, bullying (including cyber bullying), bereavement, physical health conditions, family problems, social isolation and abuse or neglect.

6. Middle aged men • Men are three times more likely to die by suicide than women • Males aged 45 to 64 have the highest suicide rate for any demographic with a rate of 22.4 deaths per 100k in 2023. This is the highest rate since 2010. A factor particularly important in this group is occupation, with low skilled labour within the construction industry having three times higher rate of suicide than the national average for men. Other key factors include living in the most deprived areas, unemployment and/or financial hardship and difficulties.

- **7. Pregnant women and new mothers** • Suicide continues to be the leading cause of direct maternal death between six weeks and 12 months after birth, accounting for a staggering 39% of deaths in this period. 37% of the women who died were known to have a previous or existing mental health condition.
- The disparity in outcomes for black and ethnic minority women continues. Black women are nearly four times more likely to die during and after pregnancy, and Asian women are twice as likely compared to their white counterparts.

8. Those who have been bereaved by suicide • It is well documented that bereavement due to suicide is different to other forms of loss, including other forms of traumatic or sudden death. Research has shown that bereavement by suicide is associated with a significant rise in suicide risk and poorer mental health. • Evidence suggests family, friends and acquaintances who are bereaved by suicide may have a risk of dying by suicide that is up to three times higher than the general population.

Other risk factors and high-risk groups include (but are not limited to):

• People who misuse alcohol and drugs

• People who have experienced domestic abuse

• People experiencing problem gambling • Data suggests between 4-11% of suicides in the UK are gambling related

• People with access to means, such as firearms and pesticides, which can largely be driven by specific occupational groups

• Armed forces personal and the veteran community

• Nurses and health care professionals

• Financial instability and hardship, including unemployment

• Relationship breakdown

• Trauma: Whether acute (such as accidents or violence) or chronic (such as ongoing abuse), significantly increases suicide risk. Individuals who have experienced trauma may struggle with emotional pain, hopelessness, and suicidal thoughts.

• Childhood abuse, sexual trauma, and combat-related trauma are all associated with increased suicide risk

• People experiencing discrimination and prejudice

• Derbyshire has one of the highest percentages of deaf people in the UK who can face increased barriers when trying to access mental health care.

Identified Strategic Outcomes	Actions or Objectives
Ensure that there is awareness among all staff of priority groups at higher risk of self-harm and suicide. Ensure risk assessments and narrative recognise and put in place formulations and safety plans which account for the groups identified above. Ensure staff meet core training standards set out in NICE guidelines on Self-Harm, assessment, management and preventing recurrence (2022).	A new risk management and suicide and self-harm prevention training has been created and will be part of all clinical staffs training. It meets NICE guidelines and addresses recommendations in the Johnson Reports. This training explores identifying the red flags and risks amongst the priority groups outlined above. Follow up face to face post online training review to be offered to all clinical teams led by the trust's Suicide Prevention Lead. The Trust will work towards all people identified in the above priority groups to be offered a personal collaborative safety plan. Evaluation of clinical interventions through the use of regular clinical audits.

Strategic Priority 3: Addressing Common Risk Factors

The NHS 2023-28 National Suicide strategy identifies the following key common risk factors:

- people with mental health conditions, particularly depression, bipolar disorder and substance misuse
- social isolation and loneliness
- financial stress or unemployment
- relationship breakdown or family conflict
- history of trauma or abuse
- chronic pain or physical illness
- previous suicide attempts or family history of suicide
- access to means.

Identified Strategic Outcomes	Actions or Objectives
Ensure that there is awareness and recognition among all clinical staff of these common risk factors and that effective formulations are documented which account for them. Increase the use of collaborative safety plans to all patients with common risk factors. These are plans that the patient keeps with them through any care transitions. Increased availability of community based mental health services. Strengthen Partnership working throughout the county. Improving continuity of care and care transitions – particularly focusing on leave and discharge.	Staff to complete the new risk management, suicide and self-harm prevention training. This will be followed up with review training by the Suicide Prevention Lead. • **do not** use risk assessment tools and scales to predict future suicide or repetition of self-harm • **do not** use risk assessment tools and scales to determine who should and should not be offered treatment or who should be discharged • **do not** use risk stratification into low, medium, or high risk to predict future suicide or repetition of self-harm • **do not** use risk stratification into low, medium, or high risk to determine who should be offered treatment or who should be discharged • focus the assessment on the person's needs and how to support their immediate and long-term psychological and physical safety • mental health professionals should undertake a risk formulation • People presenting with identified risk factors to be offered a collaborative safety plan Implement routine screening for people presenting with common risk factors and suicidal ideation in primary and secondary mental health services. Promote self-assessment tools and appropriate signposting. Continued support and expansion of the Additional Roles Reimbursement Scheme with Mental Health Professionals based in Primary Care Networks under DHcFT contracts. Greater integration and communication between services with clearly identified and supported transition pathways. The care teams will actively involve patients, families and carers wherever possible.

Strategic Priority 4: Promoting Online Safety and Responsible Media Portrayals

According to the Derbyshire observatory around 91% of residents in Derbyshire use the internet. This includes social media sites and communication services like WhatsApp. The internet can influence suicide in both positive and negative ways.

Using the internet in terms of suicidality can be broken into 2 categories: The first is seeking help and support for suicidal thoughts and behaviours (help seeking). The second is exposure of harmful content such as websites or pro suicide forums which identify methods and may encourage or glorify suicide.

Positive Aspects of online media

- means for people to communicate their thoughts feelings and experiences of mental health issues
- due to the nature of social media the provided support can be anonymous and easily accessible
- they can be effective platforms to engage in two way communication and to build connections with mass audiences, stakeholders and influencers
- they can share crisis lines and provide educational resources
- they can offer practical help and share personal stories
- the online world and apps such as TikTok may provide an alternative means to engage particularly with young people and students with suicidal feelings who are typically reluctant to seek help
- promoting appropriate language around suicide.

Negative Aspects of online media

- exposure to harmful content such as pro-suicide websites or forums
- algorithms which promote harmful content
- graphic or triggering messages, images or videos which can increase distress in vulnerable individuals
- contagion: risk of increased suicide can occur when a high profile suicide takes place, particularly if discussed in a sensationalised or romanticised manner
- hotspots: media identification of sites which can be seen as places to attempt suicide
- people sharing information or encouraging harmful behaviour in WhatsApp or other groups with people who are in-patients or in a care setting
- cyberbullying; online abuse and harassment
- social media presenting idealised lives which can lead to low self-esteem and feelings of inadequacy or hopelessness
- isolation and disconnection – excessive internet use can lead to reduced real world social interaction and online interactions may lack emotional depth and support
- the ability to order substances or tools online for use in suicide or self-harm
- risk from Artificial Intelligence chat programs being a factor in suicide.

Research indicates internet websites detailing the use of specific suicide methods have increased over the last decade with indications that explicit descriptions of suicide methods have led to an increase in death by suicide through the same methods. Limiting access to the most lethal methods of suicide can reduce the overall number of suicides.

The 2023 Online Safety Act was created with the aim of increasing online safety. The strongest protections in the Act have been designed to protect children, ensuring that major platforms will need to be more transparent about which kinds of potentially harmful content they allow, and give people more control over the types of content they want to see.

- Ofcom is the independent regulator of Online Safety and it has a broad range of powers to assess and enforce providers' compliance with Act
- Of note in relation to suicide is that promoting or facilitating suicide and is now a criminal offense.

However, there are significant difficulties in banning content, particularly if the website originates outside of the UK.

Identified Strategic Outcomes	Actions or Objectives
Awareness of internet usage to be explored during initial assessments	Staff to complete the new risk management, suicide and self-harm prevention training and incorporate assessment and monitoring of digital risk into their risk narratives and formulations
Integration of online safety into mental health care	This includes asking about internet use, particularly for young people or people in crisis. Explore exposure to harmful content and cyberbullying
Monitoring and reporting of harmful online content and groups, particularly in an inpatient care setting	Promote Safe and Supportive use of online resources such as NHS approved Mental Health Apps like Papyrus, the Samaritans or YoungMinds, etc
Positive outreach and engagement with the community through activities which have a good online presence.	Integrate online safety Collaborate in creating safety plans which incorporate online behaviour and safety such as "digital detox" periods and identification of safe online spaces or people
	Monitor and escalate any concerns about harmful online use
	Promote and support positive social media such as World Suicide Prevention Day and Baton of Hope. Promote a Trust Presence/Activities at these events.

Strategic Priority 5: Providing Effective Cross Sector Crisis Support

The Government's National Suicide Prevention strategy (2023-2028) prioritises joined up crisis care across the NHS, voluntary and social sectors alongside other partners. It emphasises strengthened information sharing between families, carers and services to promote smoother and more robust pathways of support for post crisis care. Research by NCISH suggests that, of all deaths by suicide by people in contact with mental health services in England between 2010 and 2020, 15% were under the care of crisis resolution and home treatment teams (CRHTTs). This is equivalent to 180 suicides per year on average. NHS 24/7 mental health crisis Helplines currently receive around 200k calls each month. And many more people are in contact with crisis services referred by other organisations, including those from the voluntary sector. Also of note is that long standing restrictions on older adult access to crisis services have been removed.

Crisis teams work across Derby and Derbyshire and provide urgent and more intensive community based support as an alternative to hospital admission. They offer both a 24 hour, all age Crisis service with an aim to provide an initial assessment within 24 hours. Alongside this is a 24 hour Mental Health Helpline service. The Crisis teams receive referrals from a variety of sources including primary care and is also open to self-referrals and referrals from carers. Alongside that are Mental Health Liaison teams based at A&E departments at the Royal Derby Hospital and Chesterfield Royal Hospital who provide mental health assessments, formulations and relevant signposting for people presenting at A&E departments.

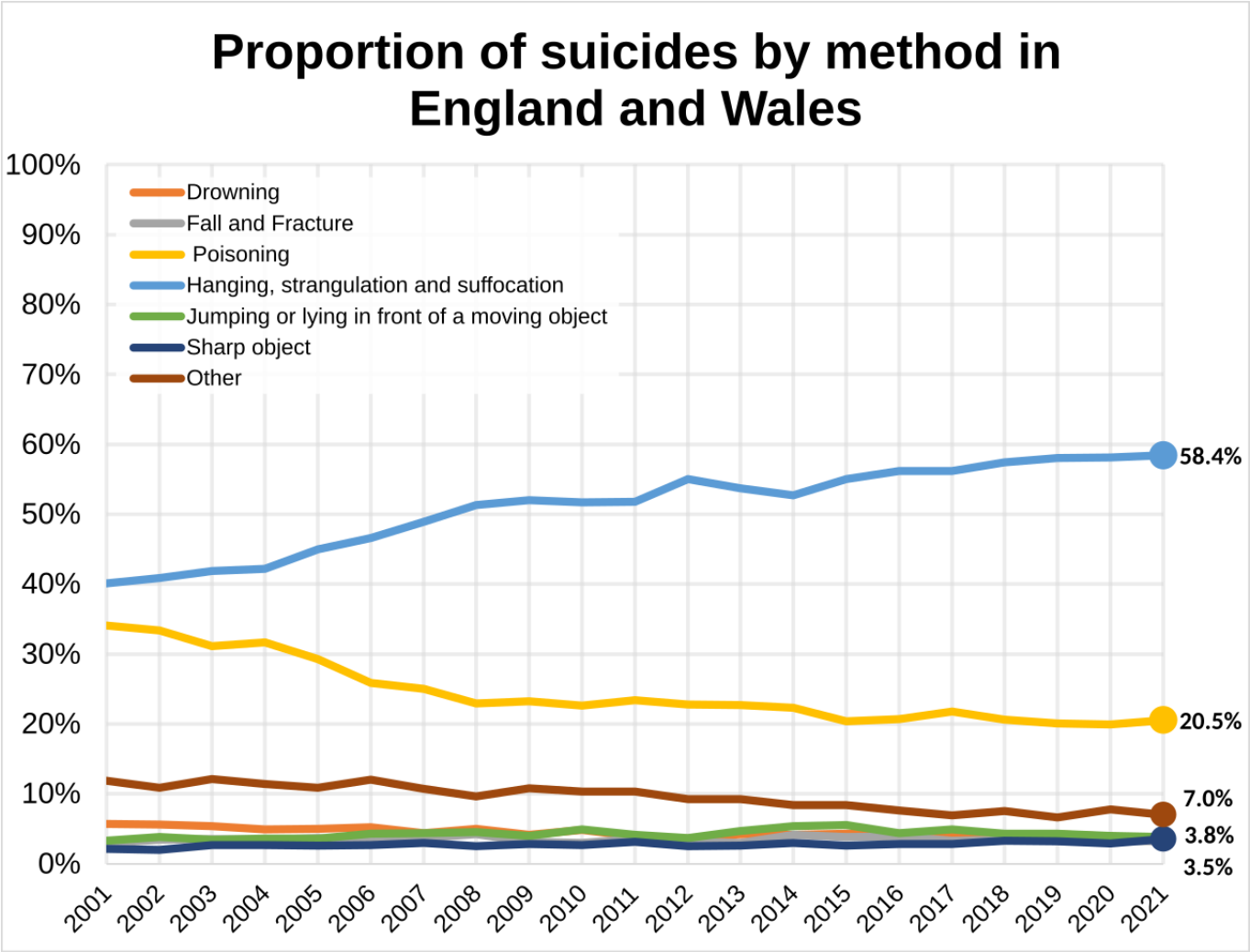
The community Mental Health Framework (CMHF) provided a new model of community mental health provision, designed on an asset-based view of communities and integrated working across mental health trusts, the voluntary sector and social care (Living Well Teams) alongside Mental Health Practitioners based in GP Services. DHcFT crisis teams link in with these services to both accept referrals and signpost on. DHcFT is also part of the Derbyshire Self-Harm and Suicide Prevention partnership forum, which brings organisations to work together across Derby and Derbyshire to help tackle the issue of suicide.

Identified Strategic Outcomes	Actions or Objectives
Improved cross sector crisis support for suicide and self-harm prevention. Positive outreach by the Trust to engage and work with a variety of cross sector organisations. Offer training and support to partner organisations and industries particularly those such as the construction sector with higher rates of suicide.	• Formalise engagement with Primary care Networks/ GP Practices and regular communication and Mental Health Practitioners • Look to formalise partnerships with other organisations such as the Police, Housing, Colleges, social prescribers, transport networks and voluntary organisations • Develop co- delivered models with organisations like Papyrus or Samaritans • Attend multi-agency risk reviews and risk conferences • Offer more out of hours options beyond hospital (such as safe havens or crisis cafes) • Avoid “signposting only”. Use warm handovers to trusted local services such as bereavement support • Always involve families and carers where possible and appropriate • Create collaborative safety plans that stay with the person.

Strategic Priority 6: Reducing Access to the Means and Methods of Suicide

Historically, we know that one of the most impactful practical interventions is to reduce access and limit awareness of and access to the means and methods of suicide, providing more time to intervene with effective longer-term actions and preventative support. In the mid-20th century inhalation of domestic gas was the most common method of suicide, this was completely eliminated in the 1990s as a result of it’s replacement with non-poisonous natural gas. Studies show that the UK had a 43% reduction in deaths due to paracetamol overdoses after legislation limiting pack sizes and the number of packs available to buy was introduced in 1998. Follow up studies have shown that this reduction in deaths was not just a temporary trend but persisted over the years following the legislation. The reduction in deaths was also accompanied by a decrease in liver transplant registrations for paracetamol-induced liver damage, further indicating the impact of the legislation on the severity of overdoses

The most common method used in England and Wales is the use of a ligature which accounts for 59.4% of male and 45% of female suicides. This is has seen a significant rise over the last 20 years.



This is followed by poisoning which usually involves medication overdoses. Most common self-poisoning medicines in people under the care of mental health services - 33% used opiates or opioids, 11% antipsychotic drugs, 9% tricyclic antidepressants, 9% selective serotonin re-uptake inhibitors (SSRIs) or serotonin and noradrenaline re-uptake inhibitors (SNRIs) and 7% paracetamol and opiate combinations. Non-opiate analgesics were reported to be used in 7% of deaths by self-poisoning; most of which involved paracetamol (6% of deaths) These two methods account for almost 80% of deaths by suicide. This is followed by jumping or lying in front of a moving object, most often on trainlines.

The effectiveness of interventions for reducing access to locations which have a high suicide rate has been well evidenced. For example, the construction of safety barriers has been shown to successfully reduce suicides on particular bridges. These interventions should always go hand in hand with additional measures, including help from others, increasing opportunities for help-seeking, and addressing awareness and reputation of specific locations as a ‘suicide site’.

The new wards at Kingsway and in Chesterfield have extensive ligature safety built into their design which should provide a safer ward environment. Clinical staff will also undertake the new risk management, suicide and self-harm prevention training with follow up review training ensuring staff are aware of how to do a collaborative safety plan with patients alongside care plans and risk assessments.

Identified Strategic Outcomes	Actions or Objectives
Reduce access to the means and methods of suicide and self in healthcare and community settings, particularly opportunities for the use of ligatures Reduce self-harm rates on the inpatient wards Awareness and information sharing of emerging methods of suicide and self-harm.	Regular reviews of ligature points in in-patient settings as per local policy Noted the new wards in Kingsway have had significant efforts put in place during the construction to reduce the risk of the use of ligatures Regular reviews of observation levels and best practice in line DHcFT Observation and search policy Clearly documented observation policies for inpatients at higher risk which account for the level of risk presented Promote ward based QI projects on reducing self-harm DHcFT Clinicians/Prescribers to limit the number of prescribed medications to individuals at risk of suicide or self-harm and consider prescribing medications less toxic if taken as an overdose Individualised, collaborative safety plans to be developed which account for access to means and means reduction in a home environment along with development of alternative coping strategies Documented response to questions asking about availability of methods and means of suicide and self-harm, particularly around hoarding of medication Exploration and documentation of methods and medications used in chronic pain control such as opiates Audit and identify data and trends of ongoing and emerging risks.

Strategic Priority 7: Providing Effective Postvention support to staff and carers

Suicide postvention refers to actions taken after a suspected death by suicide to support people who have been affected and to help prevent further deaths by suicide. Those bereaved by a suicide are at increased risk of mental health and emotional concerns and may also be at increased risk of suicide themselves. Suicide bereavement has also been identified as a risk factor for attempted suicide; approximately 7-9% of people bereaved by suicide, subsequently attempt suicide themselves. This effect can endure over a long time periods. Provision of timely and effective support and information is therefore important to help the grieving process and prevent longer-term distress. Suicides can also have a profound effect on local communities, including friends, work colleagues and neighbours, but also teachers, healthcare professionals, witnesses to the incident and emergency service workers. The Samaritans estimate that death by suicide will impact around on average around 135 people.

Within DHcFT we need to ensure that there is:

• Effective and timely support provided to those affected by suicide – to both relatives of patients who have died by suicide to staff involved and patients whose relatives have died by suicide

• An effective local response is in place in the aftermath of a suicide

• Information and support are provided to families, friends and colleagues who are concerned about someone who may be at risk of suicide (eg Think Family).

When a suicide occurs on an inpatient unit, the Trust has a structured and compassionate response involving follow up with families and carers at the earliest opportunity by those leading care. The ward itself will follow up with an urgent review and link in with safeguarding as appropriate. A review of patient records, including all documentation and notes, care plans, risk assessments and safety plans is led by the Trust's Patient Safety team. After notification of a death by suicide and confirmation on the NHS summary care record, the Trust's Family Liaison office will send out a condolence letter within five working days offering help and support and whether the family had any questions that they would like addressed. If there is no address on the system then the Family Liaison Officer will attempt to contact via phone. If there is a serious investigation this will incorporate and respond to the families' questions and offer ongoing support to them including signposting to relevant support organisations. There are many resources which offer support, including resources available online to support people bereaved by suicide such as "Help is at Hand" in partnership with the support after suicide partnership and the National Suicide Prevention Alliance, is a resource that provides emotional and practical support for people bereaved by suicide or other unexplained death, and people in contact with those bereaved through suicide.

Sadly, many staff working for DHcFT have directly or indirectly experienced the impact of suicide of someone under their care or their team's care. Feelings reported include shock, sadness, guilt, anxiety, anger, fear, responsibility and self-doubt. It is important to remember that you are not alone. Clinicians said that talking to colleagues or managers, including those who had been through similar circumstances, was immensely helpful, particularly if the process was as open, transparent and inclusive as possible.

While there are currently no national guidelines regarding postvention support for staff, the University of Surrey along with the NHS reviewed postvention support and guidance for NHS Staff (2024). Its major findings concluded:

• A 'carry on' culture deprived staff of the space they needed to process and 'feel' their own feelings in response to their colleague's suicide

• Staff need spaces and time where they can be together, talk, share and process what has happened

• Offers of support are of varied quality and accessibility; they often fail to meet staff needs and support is sometimes completely absent

• In response to failings and absence of support, staff take steps to 'fill in the gaps' but sometimes 'fall through the gaps'

• Supporters are often also deeply affected by the suicide but put their own emotional responses on hold to tend to the needs of their team

• Supporters were often unknowledgeable about suicide and untrained in delivering postvention support. This left them feeling unsure and inadequate and left their teams without robust and safe support

• Many supporters were unsupported in the task of delivering postvention and were attempting support deliver.

As a Mental Health team, it is important to consider all staff members who have been involved in the patient's care. However peripherally, whether bank or agency staff and to ensure as far as possible that everyone is informed in a timely manner. Remember that some staff who have been involved in looking after the patient may have recently left the team (eg students or trainees on placements). It is also important to think about the non-clinical staff who have been involved in the patient's care, such as those who work in administration or domestic jobs. These employees may be particularly vulnerable to being affected by the death because they have not had the training or experience that many clinicians have, and they too may have had a close relationship with the person who has died. While staff can be signposted on to excellent support like the Employee Assistance Programme, which provides confidential counselling and independent support to NHS staff, it's imperative that the Trust provides high quality postvention support and debriefs.

Identified Strategic Outcomes	Actions or Objectives
Promote staff education and awareness of the importance of supporting those bereaved by suicide	A clear postvention support policy for the family and carers of people who have taken their lives by suicide and for staff to be developed by the Suicide Prevention lead
Update the Trust's postvention support procedures in line with national best practice	Continuing with the support offered by the Patient Safety team and Family Liaison Officer
Engage with those bereaved by suicide to determine their immediate and longer-term needs in the aftermath of a suicide. These needs can reoccur at any time	Links between Family Liaison workers and groups engaged in supporting those bereaved by suicide, eg Papyrus and Survivors of Bereaved by Suicide (SOBS)
Ensure DHcFT managers are aware of their responsibility and trained (in line with BSI Guidance) in how to support the needs of our staff affected by suicide or experiencing mental distress, suicidal thoughts or intent	Recognition and exploration of potential long-term needs, eg anniversary of bereavement Ongoing development of a clinically accountable culture and change the experience of staff who fear a blame culture
Review innovative approaches for staff support such as a "lived experience buddy" which is being promoted by DCHS.	Training and reviews for managers offering postvention support for staff affected by suicide Make available up-to-date managers guidance for supporting staff through a Serious Incident investigation and the Coroners' process.

Strategic Priority 8: Making Suicide Prevention Everyone's business

Bringing down suicide rates and reducing these preventable deaths is everyone's business. We all have a part to play. Every person, organisation and service in Derbyshire and throughout the UK has a role to play. While we know from Office for National Statistics (ONS) data that suicide is slightly higher in Derbyshire than in England as a whole, with rates showing an increase over the last few years, good progress has been made to tackle the stigma surrounding suicide and mental health. DHcFT is in a position where it can provide positive outreach into the community, engaging more with citizens, voluntary and community sector organisations, within the NHS, linking in with Public Health England and local authorities, employers, emergency services, and others.

There has been good engagement from the communications and other departments within the Trust around positive engagement with things like World Suicide Prevention Day and positive local community engagement in a variety of local events promoting good mental health. It has reached out to organisations such as Network Rail and aims to work more closely with these organisations to promote suicide prevention.

Ideally, there is a national and local conversation so that everyone - from individuals through to organisations and services – feels responsible for ensuring that they are consistently using language that supports people while reducing shame and stigma. This supports everyone to feel able to seek support whenever they need and there is and employers have an essential role to play in supporting practices and conversations that help prevent suicides. There are multiple ways this can be done, for example, through employment assistance programmes, line manager training or peer support networks which may help in trades like the construction industry, where suicide rates remain disproportionately high. NHS England has developed a prevention and postvention toolkit for employers focused on NHS employees, though it has relevance to all occupations.

In Derbyshire we know that people with lived experience of suicide attempts and suicide bereavement can be leaders in suicide prevention. They can positively influence decisions, provision, and change and have already contributed both to this document and to the new DHcFT suicide prevention and risk management modules that are mandatory for all clinical staff. The Trust will aim to work more closely with the voluntary sector and other community organisations and partners in co-production, which places lived experience at the core of what we do and is helping bring about effective and positive systemic change with greater integration and community engagement. The Trust will continue to support and expand the role of Mental Health Practitioners in primary care to help Improve systemic primary care responses to suicide, self-harm and risk factors, so that people who seek help from primary care are included and supported, linking in as appropriate with other services such as secondary mental health services or primary health care services such as social prescribers. A key aspect of this are ongoing audits using Patient Related Outcome Measures, such as ReQol 10 with feedback integrated into the process of care and supporting more effective engagement with mental health services. This particularly applies to signposting on and sharing of information in relevant primary and secondary care services.

Identified Strategic Outcomes	Actions or Objectives
Staff to continue to promote positive mental health and anti-stigma work, particularly those engaged with local organisations to help dispel myths about suicide that persist amongst professionals and the general public Staff continue to use opportunities to positively engage with the wider community Reduce stigma for staff around suicide - maintain and open and supportive culture of care and support Continue to develop links with local communities to build resilience Continue to work closely with partner organisations such as Public Health England alongside with organisations such as Network Rail and British Transport Police Work with primary care to raise awareness of suicide among people with physical health conditions.	• Make every contact count: linking in to improve suicide awareness at touchpoints with the system • Positive engagement by all DHcFT staff promoting suicide and self-harm prevention and attendance at events such as World Suicide Prevention day and “Baton of Hope” events taking place in Derbyshire alongside engagement at the many ongoing local events, such as Farmer’s Fayres, etc • Staff stigma – staff to feel safe and able to be supported to be open about their own mental health and wellbeing • Continue to develop links with local communities to build resilience through the ARRs workers and engagement with community organisations and meetings • Continue to work closely with partner organisations such as Public Health England alongside with organisations such as Network Rail and British Transport Police and with positive outreach to businesses with high rates of death by suicide such as the construction industry • Ensure access to mental health support particularly for people with chronic physical health conditions through services such as the Mental Health Practitioners based at GP surgeries • Provide high quality mental health care measured by regular patient outcome measures and audits.

Representation and Input in this strategy document:

The Strategy has set out the key strategic objectives for DHcFT from 2025-2028. It draws on guidance from the 2023-2028 NHS National Suicide Prevention Strategy.

Our staff play a key role in promoting this Strategy. Any contact should be meaningful and positive with a "no wrong door" approach – when people experiencing suicidal thoughts or feelings reach out, they receive timely support, no matter what service the individual initially accesses.

The Trust will work with colleagues and partners to understand and share learning from serious incidents, investigations, near misses and inquests and continue to implement and self-assess against the NCISH recommendations 'safer services toolkit.

As part of our plan, we will ensure that ALL our workforce understands these key messages using the new Suicide and Self-Harm Prevention and Risk Management training designed to improve clinical staff assessments, risk assessment and formulation skills. An awareness by staff on offering safety plans to all people under the care of the trust but with a particular focus on those that may present as being at increased risk of self-harm and suicide. We will work with our partners and services to provide an accessible and coordinated mental wellbeing approach to those that access services in primary, secondary and tertiary services across DHcFT.

Ambition of the strategy:

We will follow the recommendations from the National Confidential Inquiry into Suicide and Safety in Mental Health to have actions in the 10 ways to improve safety:

1. Safer wards
2. Early follow up on discharge
3. No out of area admissions
4. 24 hour crisis teams
5. Family involvement in learning lessons
6. Guidance on depression
7. Personalised risk management
8. Outreach teams
9. Low staff turnover
10. Reducing alcohol and drug misuse

We will monitor and evaluate outcomes and prioritise high risk groups for targeted interventions.

Staff at DHcFT frequently receive extremely positive feedback from people under the care of our mental health services due to their skilled and compassionate work. The Trust's Personal Accountability Charter services emphasise the importance of compassionate, empathetic and collaborative approach, with individuals taking responsibility for their own wellbeing and recovery, while also ensuring that services are delivered with accountability, transparency, and a commitment to continuous improvement. It promotes a culture where individuals are empowered to participate in their care, and services are delivered with compassion, respect, and a focus on positive outcomes as set out in the Trust's Personal Accountability Charter:

The following are the key documents which inform the contents of this strategy:

I would particularly like to thank the Suicide and Self-Harm Prevention Group for their guidance and input into updating this Strategy. I'd also like to thank members of the Crisis team and ward teams for their thoughts and welcome ongoing feedback.

This is intended to be a dynamic document with ongoing (at least bi-annual) updates.

- Suicide prevention in England: 5-year cross-sector strategy (2023) – https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028/suicide-prevention-in-england-5-year-cross-sector-strategy
- NCISH Annual report 2025: UK patient and general population data 2012-2022- NCISH | Annual report 2025: UK patient and general population data, 2012-2022
- Fit for the future: 10 Year Health Plan for England - executive summary (accessible version) - GOV.UK (July 2025)
- House of Commons: suicide prevention policy and strategy – https://commonslibrary.parliament.uk/research-briefings/cbp-8221/
- Self-harm and suicide prevention competency framework (2023)– https://www.rcpsych.ac.uk/improving-care/nccmh/competence-frameworks/self-harm-and-suicide-prevention-competence-frameworks
- National Zero Suicide Alliance – https://zerosuicidealliance.com/
- Royal College of psychiatrists CR 234. Supporting mental health staff following the death of a patient by suicide (2022)- https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2022-college-reports/cr234
- Suicide prevention in England: 5-year cross-sector strategy (2023) – https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028/suicide-prevention-in-england-5-year-cross-sector-strategy
- NHS employee suicide: a postvention toolkit to help manage the impact and provide support (2023)- https://www.nhsconfed.org/publications/nhs-employee-suicide-postvention-toolkit-impact-support
- DHcFT Externally commissioned Johnson Reports 2024 reviewing deaths by suicide while under the care of DHcFT.
- Help is at hand – Support After Suicide https://supportaftersuicide.org.uk/resource/help-is-at-hand/

Board Committee Assurance Summary Reports to Trust Board – 25 November 2025

The following summaries cover the meetings that have been held since the last public Board meeting held on 23 September 2025 and are received for information.

- Quality and Safeguarding Committee 8 October and 13 November
- Audit and Risk Committee 23 October
- Finance and Performance Committee 28 October (Extra-ordinary) and 4 November
- People and Culture Committee 6 November

Key:

	Full Assurance received during the meeting with the accompanying report
	Significant assurance received during the meeting with the accompanying report
	Limited assurance received during the meeting with the accompanying report
	No Assurance received during the meeting with the accompanying report
	items shared **for information** to advise the committee on progress and next steps

Quality and Safeguarding Committee – key assurance levels for items – 8 October 2025	
	Director of Nursing update The Committee noted the key points: Clinical Quality Directorate Operating Model: it was confirmed that all roles are now appointed to, with lines of accountability clearly defined and that the structure will be effective from November. Chief Nursing Officer, England – 15 Year Nursing Strategy: consultation is ongoing and the Strategy is aligned to the 10 Year Health Plan. Publication is expected later in the year. Personalised Care Framework: the framework that will potentially replace the Care Programme Approach (CPA) remains out for national consultation and not yet been ratified. The Trust is involved with the consultation. Making Room for Dignity (MRfD): the Psychiatric Intensive Care Unit (PICU) has teamed up with Northamptonshire Healthcare NHS Foundation Trust, to learn from their expertise.
	Fundamental Standards of Care **Significant assurance** was accepted on preparations for the forthcoming Section 120 of the Mental Health Act monitoring visit, with robust governance and planning arrangements in place to ensure organisational readiness. However, **limited assurance** was accepted on the completion of actions, noting that while progress has been made, some actions remain outstanding or overdue. The Committee applauded the step change, with improved practices being embedded, sustained and continuing to progress as business as usual. In recognition of the overall *'Good'* rating and high performance in some domains the Committee accepted **significant assurance** on the Kedleston Unit core inspection. In relation to compliance with Regulation 18 (Staffing) and actions on advocacy, appraisals/supervisions, food portions and Section 17 leave require sustained delivery, the Committee accepted **limited assurance**. **Significant assurance was accepted** on the Fundamentals of Care programme in relation to effective implementation due to recurring themes. However, **limited assurance** was accepted around effective implementation due to recurring themes.
	Making Room for Dignity (MRfD) Evaluation of Policies and Standard Operating Procedures Following real-life testing of the policies due to recent incidents (IT outage at the Carsington Unit and damage to the seclusion area by a patient) it was agreed that they are adequate and holding.

	Additional confidence was gained from positive quality inspections by the Care Quality Commission and the Integrated Care Board. The Committee noted that all documents are version controlled and published on the intranet. **Significant assurance** was received that the policies and SOPs are fit for purpose and are to be monitored in line with existing governance.
	Guardian of Safe Working Hours (GoSWH) quarterly report The Committee noted that the current focus was quantifying the rota workloads for out of hours cover in the south. The delayed National exception reporting reform is now scheduled for implementation on 4 February and it was highlighted that NHS Employers have published draft contractual wording. The GoSWH announced that following completion of his three year term, his last day in the role would be 30 November. Recruitment into the role is in progress. The Committee extended sincere thanks the positive support provided to Resident Doctors and the strengthened processes.
	Assertive Outreach (AO) Community Mental Health Treatment (quarterly update) It was highlighted that the AO Working Group was to focus on local action plans, with particular attention to the below: 1. Personalised assessment of risk across community and inpatient teams 2. Joint discharge planning arrangements between the person, their family, the inpatient and community team (alongside other involved agencies) 3. Multi-agency working and information sharing 4. Working closely with families 5. Eliminating Out of Area (OoA) placements in line with ICB three-year plans. The Committee noted that AO is supporting 145 open cases across Community Mental Health teams, with projected future growth. Due to limited workforce capacity, that cases are being closely monitored through dedicated, monthly supervision for AO workers. Accepting **limited assurance** on current performance, the Committee acknowledged the areas being worked on include ensuring carers and families are supported and participate in the care that is being delivered and that the Trust is still using the Care Programme Approach until the new model is confirmed.
	Risk report (quarterly) The Committee accepted **significant assurance** from the report in relation to risk management and compliance with the reporting schedule. It was noted that there are currently 567 open risks, 59 overdue; an increase in Inpatient environmental and therapeutic activity risks following new unit openings and 44 high/extreme risks in all categories. Delayed response in updating risks was being investigated through cross check meetings and Fundamentals of Care visits. Consideration was given to reshaping the Patient Safety report and the Risk report to reflect a clear picture of the Trust's Patient Safety risks and how these are being mitigated.
	Getting it Right First Time (GiRFT) Positive examples of sustained rehabilitation and recovery were shared in relation to the people the service is working with. It was highlighted that people are either being kept out of hospital or supported to earlier discharge. The present caseload of 27, in addition to nine people going through triage and assessment was noted and it was confirmed that every referral is triaged. However, a major challenge to acceptance is often the accommodation situation, management of which is inconsistent across the county, with 8k people on the housing list. It was agreed for discussions to be revisited later in the year via the Quality Dashboard. The Committee applauded the provision of six Occupational Therapy (OT) student placements, four of which had been OT Apprenticeship placements.
	Delivery of Same Sex Accommodation (DSSA) – annual update

	It was reported that there had been two, unavoidable breaches of non-compliance during the reporting period, 1 April 2024 to 30 March 2025. The incidents were recorded in Datix and safeguarding was ensured in terms of supporting the need at the time. The Committee noted that with completion of the building works on Cherry Tree and the purpose-built Bluebell ward, the risk is now fully mitigated. The robust processes to prevent, monitor and address breaches when they do occur provided the Committee with **significant assurance** and the DSSA Compliance Declaration was accepted and recommended for Board, subject to minor amendments.
	Patient Experience report (quarterly) The Committee praised the well-constructed report which reflected additional integration and improved strategic focus. It was noted that a proposed dashboard will broaden the data scope and be captured by the Patient and Carer Operational Group. The inconsistent approach in relation to Volunteers and Peer Support Workers across the Trust is being addressed. It was advised that the number of complaints has been holding steady and following the transfer of Talking Therapies out of the Trust, as anticipated, the number of compliments has reduced. In relation to complaint themes, in order to reduce the risk of misplacement and due to the limited space available, patients are being discouraged from bringing a lot of personal items, which can often trigger complaints. Other topics include concerns around food portion size, waiting lists and barriers to accessing services. The critical importance of accurate contact and ethnicity records was highlighted and that improvements to data collection are being investigated. Noting the improvements made and the substantial delay in responding to some cases, **limited assurance** was received.
	Quality Delivery Plan (QDP) – quarterly update The Committee noted the reduced capacity of the Patient Safety and Physical Healthcare teams, which had affected progress against the QDP in Quarters 1 and 2. Other influences included the 10 Year Plan; National Oversight Framework, the new operating model and impending changes around the Single Assessment Framework. Despite the volume of measures included in the QDP, it was reported that each is being tracked and would be delivered over the three year course. Fundamental Standard of Care, continued improvements around Patient Experience and Safeguarding assurance were all now embedded as business as usual. The Committee received **limited assurance** on progress and delivery of the QDP to date.
	Board Visits - Themes and Findings (quarterly) The Committee noted the assurances provided and the associated risks (coverage balance, feedback consistency and scheduling), to provide oversight of the 2026 schedule, and supported the proposal to strengthen representation of non-clinical teams to ensure balance across the organisation. The trialling of a new MS Teams form was highlighted, which aims to simplify the feedback recording.
	Care Planning/Person-Centred Care Marginal gains around Care Planning were highlighted, especially within Acute services who had maintained high compliance despite voluminous turnover. It had been emphasised across the Trust that CPA is the current framework being used with quality checks in place. The potential to achieve the set compliance targets was discussed and due to the ongoing consultation around the Personalised Care Framework, it was suggested that any changes should wait, and that the current focus should remain on CPA and ensuring that every patient has a Care Plan. Accepting the recommended level of **limited assurance**, the Committee was optimistic that the next report would reflect significant assurance of the processes in place.

Patient and Carers Race Equality Framework (PCREF)

It was highlighted that the establishment of a Steering Group would address the definite gaps in governance.

The enablement of tailored care was being obstructed due to the absence of ethnicity data and the Committee noted that the Trust is learning from Coventry and Warwickshire Partnership NHS Trust in order to improve this.

The continued theme around the lack of demographic data was recognised.

Transformation and Continuous Improvement Framework (annual update)

The work completed around the Acute patient pathway and the subsequent reduction of inappropriate OoA placements, was given as an example of how continuous improvement is making an exceptional impact. The previous lack of continuity and flow of care was highlighted, with placements as far away as Bristol and Glasgow.

Whilst it is not possible for the Trust to lead the required strategy to mitigate the current social care and housing concerns, it was reported that these are being stressed with the housing leads of Derby city and Derby county councils to influence as much as possible.

Review of Quality and Safeguarding Board Assurance Framework (BAF)

The Committee noted that Risks 1B and 1D are now identical as they have morphed over time. The Executive Leadership Team was considering merging the content; keeping Risk 1B and closing Risk 1D.

Once the measures for the 10 Year Health Plan are confirmed, these will be added to the BAF.

Escalations to Board or other Committees: None.

Items added to the Board Assurance Framework: None.

Next scheduled meeting: 13 November 2025.

Committee Chair: Lynn Andrews	**Executive Lead: Tumi Banda, Director of Nursing, AHPs, Quality and Patient Experience**

Quality and Safeguarding Committee – key assurance levels for items – 13 November 2025

Director of Nursing update

The Committee noted the key points:

Planning Framework and Staffing Changes: the shift from annual to mid- and long-term planning was described, together with the impact of the ban on Bands 2 and 3 agency staff use and the need for robust processes to ensure compliance and safe staffing.

Night Visits and Staff Engagement: night visits to several units had identified some unfamiliarity with alarm systems and the need to ensure night staff are engaged with all team briefings.

Care Quality Commission (CQC) Community Inspection Preparation: upcoming visits were discussed and were expected to focus on assertive outreach, physical health, medication optimisation, patient experience and the use of Electronic Patient Record (EPR) in the Community. The Trust continues conducting self-assessments through Fundamental Standards visits to identify and mitigate risks.

Fundamental Standards of Care

The Committee noted positive feedback following a Section 120 Mental Health Act visit, along with areas for improvement, such as advocacy and police concerns about handovers and 136 Suite closures.

Discrepancies between prescribed care models and actual practice were discussed, particularly regarding overnight leave from the Psychiatric Intensive Care Unit (PICU), clarifying that the issue is practice-based rather than due to bed shortages.

The importance of embedding and monitoring improved supervision and appraisal compliance to ensure sustained progress was emphasised.

The Committee received **significant assurance** on the Trust's overall response to recent CQC and Mental Health Act visits, with strong governance and sustained progress on actions and **significant assurance** on organisational readiness for CQC inspection under the Single Assessment Framework.

Split assurance was received on the Fundamentals of Care programme, recognising strengthened frameworks and oversight but variation in implementation across services.

Infection Prevention and Control (IPC) annual report and Board Assurance Framework (BAF)

The report provided the Committee with **significant assurance**.

The key points included robust water testing processes during new builds, improvements in cleaning standards due to single-use facilities and adjustments to cleaning schedules and staffing.

It was noted that the Trust had managed limited outbreaks of flu and Covid, with effective isolation, deep cleaning and maintained contingency plans for emerging diseases, supported by System-wide approaches for expensive equipment.

The IPC BAF evidenced high compliance, with minor gaps in occupational health and training being addressed.

Following previous CQC and NHS England findings, the Committee applauded revisions to the Matron's job descriptions, which emphasised infection control leadership, aiming to improve standards and accountability.

The low flu vaccination rates, national trends and ongoing campaigns to improve uptake were discussed, noting the impact of flu on staff sickness and service delivery.

Ligature Risk Reduction report (six-monthly)

The Committee noted that all actions from the 360 audit plan on ligature risks have been completed and closed, with improved policies, mapping and communication tools now in place.

An increase in incidents involving door tops, especially in female wards, was noted; while alarms have mitigated harm, the trend is being prioritised for further action and vigilance.

Concerns were raised about the timeline for rolling out ligature and suicide prevention training, with agreement to review and expedite training for high-risk areas.

Whilst mitigations are in place, ongoing trends and incomplete training justified **limited assurance**.

Patient Safety report

Providing **limited assurance**, the report covered all major and catastrophic incidents, with thematic analysis triggered by clusters or outliers and highlighted the need for improved triangulation with other quality data.

Ongoing staffing shortages in the Patient Safety team were pointed out, which have affected the timeliness and efficiency of learning processes, though all required reviews continue. Team functionality and capacity issues continue to be addressed.

The Committee requested a deep dive into the Learning the Lessons Oversight Committee to clarify its effectiveness and integration.

It was suggested that future reports are co-authored with quality leads to better reflect ongoing work and provide a more joined-up narrative on actions and learning.

Physical Healthcare report (six-monthly)

The Committee was informed that all physical health policies have been reviewed and ratified, with improvements in training and induction for new Medics and targeted work on nutrition and fluid compliance.

It was highlighted that a pilot project funded by the Integrated Care Board (ICB) had improved annual health check engagement for patients with serious mental illness, though future funding is uncertain.

Risks around the availability and calibration of medical devices were discussed, along with the need to integrate EPR systems for better data flow.

	The progress and achievements outlined in the report provided the Committee with **limited assurance**.
	Quality Dashboard (bi-monthly) The dashboard highlighted trends in restrictive practice, complaints response rates, racial abuse incident reporting and ongoing risks in bed occupancy and discharge delays. An increase in restrictive practices, particularly prone restraint, was noted, with training identified as a key intervention to reduce its use during seclusion. The Committee requested clearer reporting on the percentage of complaints responded to within policy timeframes and it was confirmed that work is underway to improve data extraction and reporting. Attention was drawn to a new indicator for racial abuse incidents, which are now classified as high risk and tracked as a key metric, with initiatives in place to address and monitor the impact of interventions. As the Trust is operating above 100% bed occupancy, there are daily escalation calls and System support to address discharge delays and length of stay, which remain above national averages. It was agreed that future reports will include specific updates on risk mitigation plans and progress, to provide ongoing assurance to the Committee. **Limited assurance** was received on progress towards clinical performance targets.
	Community Mental Health Patient Experience Survey Results of the national survey reflected feedback captured was predominantly from older adults with a response rate below the national average. The Committee noted plans to increase the response rate and engage younger service users through Peer Support and alternative communication methods. It was highlighted that action plans will address key areas of concern, including crisis support and signposting for financial advice, with both the Trust Quality Delivery Plan and team-level interventions planned. Receiving **limited assurance**, it was noted that the current survey action plans may not impact on this year's results given the timing. However, effort has been made to improve patient experience which links directly to the Community Mental Health Survey Action Plan.
	Care Planning/Person-Centred Care The Committee was updated on sustained improvements in Care Planning and the Care Programme Approach (CPA) compliance, with preparations underway for transition to the new Personalised Care Framework, pending receipt of national guidance. It was noted that the Trust has achieved high rates of Care Co-ordinator allocation, with ongoing support for teams experiencing high sickness or vacancies. Noting the sustained position the Committee concluded the report provided **limited assurance** on progress against actions.
	Divisional Performance Reviews (DPR) (quarterly) The purpose of the report is to provide assurance of good quality governance within the Trust. The plan to replace current DPRs with two Divisional Assurance Boards was outlined and will include Executive attendance and performance reviews with care groups, aiming for greater efficiency. Risks around data quality and the impact of organisational change on delivery were discussed. **Significant assurance** was accepted from the performance review process.
	Learning from Deaths (including LeDeR)//Mortality report It was noted that 11 learning responses had been approved for closure during the reporting period (1 July 2025 to 30 September 2025). The main themes included: • Risk Assessment and Management • Referral and triage processes, assessment methods

	• Awaiting list management • Communication delays and gaps – internal and external • Care planning and documentation. The Committee accepted **limited assurance** of the Trust's approach to learning from deaths with the need for stronger governance on the impact of sharing lessons.
	Board Assurance Framework (BAF) – key risks identified: The narrative around learning from Patient Safety incidents to be adapted to include the need for triangulation of data between quality leads.
	Policy Status Dashboard The Committee ratified the Blanket Restrictions Policy and Procedures. A two-month extension was approved for the Equality Impact Assessment (EIA) Toolkit Policy and Procedure, to allow consideration by the Policy Review Group (PRG) and EDI Working Group, with the final version to be presented to the Committee February 2026.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework:** None. **Next scheduled meeting:** 10 December 2025.
Committee Chair: Lynn Andrews	**Executive Lead: Tumi Banda, Director of Nursing, AHPs, Quality and Patient Experience**
Audit and Risk Committee – key assurance levels agreed – 23 October 2025	
	Review of Board Assurance Framework (BAF) Issue 3, Version 3.2, 2025/26 Following significant progress in eradicating dormitory accommodation and the subsequent closure of many of the related actions, the Committee agreed the two risks 1B and 1D should be closed down and a new risk, incorporating the remaining actions, be created. Inclusion of patient and family feedback was welcomed and it was agreed the term 'carers' would be explicitly referenced. The review process received **significant assurance** and the Committee approved this version of the BAF.
	Operational Risk Management (quarterly update) Following a risk assessment project, the Committee noted a significant reduction in the total number of risks, from 780 to 570. Due to the expanded space, sky gardens, gym and access zones of the new units, an increase in reported risks was highlighted. The Committee was advised these risks are managed through patient assessment, supervision and regular review by the Therapy and Nursing leads. It was pointed out that the Trust has adopted the Care Quality Commission (CQC) Ligature Risk system, which considers the environment and also takes into account patient need. **Significant assurance** was accepted on the risk management process.
	Risk Management Strategy – 2023-2025 and risk Management Strategy 2026-2028 for review It was reported that all planned objectives, training and reporting schedules for the current risk management strategy have been achieved, with quarterly reporting now in place following audit recommendations to improve sustainability. The Committee noted that current practices are to continue in the new strategy. Accepting that the draft 2026-2028 Strategy will be updated when the new operating model is confirmed, the Committee received **significant assurance** from the paper. In addition the proposal to extend the Strategy to align with the fiscal year was approved. It was agreed to receive the final version for virtual approval in December 2025.

	Review of 2024/25 Annual Report and Accounts production Improvements in the timeliness and quality of submissions compared to previous years were highlighted. The Committee acknowledged that the Trust has robust processes in place and noted the learning identified from the 2024/25 Annual Report and Accounts, ahead of the process commencing for 2025/26.
	Salary Overpayments update **Limited assurance** was received on the impact of actions already taken, noting that further work is still required. The Committee recognised the improved position compared to previous volumes and values and noted that the number of late terminations had been halved as a result of increased follow-up with managers. It was emphasised that prompt recovery of overpayments is key, with repayment plans agreed as quickly as possible.
	Implementation of the Freedom to Speak Up Policy Framework, to include Self-Review update (six-monthly) The update provided the Committee with **significant assurance**. The value of drop-in sessions for staff to raise concerns was highlighted, along with the high engagement in certain Divisions. The Committee noted the importance of triangulating FTSU data with other staff feedback mechanisms and integrating Tam's work more closely with People Services to address themes and support staff during organisational changes.
	Data Security and Protection update The Committee acknowledged that all actions from the previous DS&P Toolkit 360 Assurance Audit had been completed within the deadlines and that work on the current Toolkit is on target to complete the baseline submission of 31 December 2025. It was noted that mandatory data security training remains at 98% and that despite high volumes, all subject access requests have been responded to within an average of 11 days, which is ahead of the statutory deadline of 30 days.
	Internal Audit progress report Key highlights included the issue of final reports for Business Continuity (significant assurance) and Medical Revalidation and Appraisal (moderate assurance). In addition, all due actions have been implemented by their due date, providing a first time implementation rate of 100%. It was noted that the Care Planning audit would be retrospective, as the Trust's move from the Care Programme Approach to the Personalised Care Framework was not yet confirmed. Benchmarking data on fit and proper person audits was presented, reflecting that the Trust's processes are robust and compliant. The challenges of maintaining comprehensive records was highlighted.
	Counter Fraud, Bribery and Corruption progress report The Committee was briefed on new legislation effective from September 2025, outlining next steps to ensure compliance and mitigate associated risks, including recording relevant risks and updating procedures. In order to raise awareness, it was noted that drop-in sessions for HR, Finance, Procurement, and other teams are scheduled during International Fraud Awareness Week, with additional sessions planned for early 2026. Following the working while sick exercise, it was confirmed that there were 11 open cases pending closure. The exercise had looked at substantive DHcFT staff working on the DHcFT flexible workforce bank. Awareness had been raised and articles issued to the Trust providing case studies and different scenarios. It was noted that there had been no new referrals since the articles were issued.
	External Audit progress report

The report confirmed that all actions for 2024/25 are complete pending National Audit Office confirmation and outlined planning for the 2025/26 audit, with no significant changes anticipated.

It was noted that the Audit Strategy Memorandums would be presented to the Committee in early 2026.

Escalations to Board or other Committees: An escalation to the People and Culture Committee was suggested; to conduct a review of Employment Contract wording to expediate deductions from pay following Salary Overpayments.

Items added to the Board Assurance Framework: None.

Next scheduled meeting: 22 January 2026.

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 – 28 October 2025 (Extra-ordinary)

Initial Financial Plan Submission (pre-guidance)

The Committee noted the key points:

- The Trust is developing a medium-term financial plan aiming for break-even over the next three years, with deficit support reducing from £45m this year to zero in two years across the collective System. (Noted that none received by the Trust in 2025/26)
- New national planning guidance not yet reflected in the System submission
- Includes a move to multi-year settlements, new payment models and a focus on digital transformation
- Growth is modelled at a modest 1%, with half supporting deficit reduction and half for transformation
- Underlying deficit now estimated at £4.5m (down from £8.1m) after income stream clarifications and a confirmed uplift in depreciation funding being made recurrent
- 2026/27 Cost Improvement Programme (CIP) target is c£12.3m (5% of turnover), with 70% expected to be recurrent savings per System ask
- Key risks include delivery of CIPs, agency and bank staff cost reductions and achieving national targets for out-of-area (OoA) placements and waiting lists reduction progress given growing demand
- Capital planning underway, with a focus on funding for Radbourne Unit refurbishments and mapping System-wide pre-commitments
- Full three-year workforce plan to be submitted by 19 November.

Significant assurance was accepted around the pre-guidance process.

- The Trust is working closely with the ICB to clarify recurrent/non-recurrent income and investment needs
- Concerns were raised about the impact of system-wide financial challenges, particularly in neighbouring Nottinghamshire
- Progress on reducing OoA placements was noted, but concerns remain about Community waiting times, especially in Children's services
- Further national productivity and benchmarking data awaited to inform efficiency plans.

<u>Agreed Actions</u>

- Report explicit risk and assumptions to the next Committee and future Trust Board
- Map internal governance and sign-off processes

Significant assurance was accepted on the medium term financial plan.

Recognising gaps in CIPs and the additional work required to have a credible, deliverable plan and clear risk level, **limited assurance** was accepted.

Escalations to Board or other Committees: None

	Items added to the Board Assurance Framework: It was noted at some point the finance BAF risk will need updating to reflect the core 26/27 risk rather than the 25/26 risk but it was accepted this is usually done in Q4. **Next scheduled meeting:** 4 November 2025.
Committee Chair: Jo Hanley	**Executive Lead: James Sabin, Director of Finance**
Finance and Performance Committee – key assurance levels for items – 4 November 2025	
	Making Room for Dignity (MRfD) Programme update It was explained that the Programme is moving to business as usual, subject to sign-off by the Programme Committee and Executives. The main unresolved issue is heating and ventilation at various sites, with different solutions required for gyms, offices, and kitchens; these will be managed by the Estates Capital team. It was confirmed that benefits tracking and post-project evaluation monitoring will continue via governance and final reports due six months post-opening.
	Assurance on delivery of Digital Plan – DEFERRED
	Transfer of Neurodevelopmental and Older People's Mental Health services from Derbyshire Community Health Services to Derbyshire Healthcare NHS FT (DHcFT) It was reported that due diligence and governance arrangements are in place for the transfer, ensuring the inclusion of appropriate funding, factoring in overheads and lease components, opportunities for financial efficiencies, particularly in Older Adult services with higher staffing levels. ICB final approval is awaited. The Trust is awaiting final approval from the ICB, along with consent to proceed with staff consultation **Significant Assurance** was accepted around the early stages of the process.
	Financial Governance and Performance – Month 6 Finance Report A comprehensive finance update was provided, covering current performance, cost pressures, agency and bank reduction, capital monitoring, underlying deficit, and the need for robust cost improvement plans (CIP) for the coming years. It was reported that the Trust is ahead of plan year-to-date, with agency and bank costs reducing, and most Divisions on track, although the Acute Division remains a concern due to OoA spending. The Committee noted the Trust is slightly ahead on CIP delivery, though further planning is needed for next year's target of £12m+. No central funding is expected for industrial action costs. The **Medium-Term Financial Plan and underlying deficit** submission was acknowledged and endorsed. The Committee accepted **significant Assurance** from the report.
	Contracts update The Committee reviewed the contract risk log, discussed ongoing risks such as Perinatal commissioning, OoA activity and mitigation strategies. The potential for AI to support market scanning and bid preparation, with compliance to tender instructions was discussed. In recognition that the Trust is working on some of the gaps with commissioners post-Covid, **significant assurance** was accepted.

	Continuous Improvement The role of the Strategic Portfolio Oversight Group (SPOG) in overseeing large-scale transformation programmes was described, with quarterly meetings and Board reporting, while smaller improvement initiatives are tracked through a live quality improvement database. The spread of training in improvement methodology, with confirmation there are no significant gaps was noted. The Committee accepted **significant assurance** whilst recognising the need to strengthen the connection between improvement projects and cost reduction.
	Operational Performance report Improvements in early intervention targets and Crisis service response times were noted, with recovery action plans leading to better performance. It was highlighted that the majority of long waits are for autism and ADHD assessments and resolution options included handing the contract back to the ICB. Attention was drawn to the ongoing efforts with local authorities to increase care home capacity to reduce delays around those patients clinically ready for discharge. The report provided the Committee with **limited assurance**.
	Arden and Gem – Commissioning Service Units (CSU) update – DEFERRED
	Operational and Financial Planning – 2026/27 The Committee received a summary of the national planning framework, which requires the Trust to work to a c5% CIP and aims for a 1.5% margin in year four and 3% in year five, with limited growth funding and increased expectations for agency and bank reductions. The next steps include workshops to develop the 2026/27 CIP plan, a dedicated Board Development Session on financial sustainability and continued operational work to reduce overheads and protect frontline jobs. **Significant assurance** was accepted.
	System updates: ICB Finance Committee/System Directors of Finance (DoFs) It was explained that deficits in neighbouring acute trusts could lead to pressure on the Trust's cash reserves, with national teams encouraging System-level solutions and potential requests to share cash. It was emphasised that the Trust is committed to protecting its cash for future capital investment, resisting pressure to support other organisations and monitoring the risk of delayed contract payments.
	Health and Safety report Improvements in incident reporting and reductions in violence and absence were attributed to the new environments and ongoing practical training, with regular drills to ensure staff readiness. It was noted that efforts are underway to improve contract management for medical devices, with ongoing collaboration between Clinical and Finance teams. The report provided the Committee with **significant assurance**.
	Board Assurance Framework 2025/26 risks overview (and consider forward plan of deep dives) The BAF had been updated and was considered appropriate.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework:** None. **Next scheduled meeting:** 13 January 2025.
Committee Chair: Jo Hanley	**Executive Lead: James Sabin, Director of Finance**

People and Culture Committee – key assurance levels agreed – 8 November 2025

People and Inclusion Assurance Dashboard

The Committee reviewed current performance. The main points were:

Mandatory Training: it was reported that Infection Prevention and Control (IPC) training compliance had improved to 86%, with ongoing efforts to maintain compliance across all role-specific training.

Recruitment: the ongoing recruitment challenges were discussed, particularly the extended time to hire due to the vacancy control panel (VCP) process and pre-employment checks. The team is working with joint venture partners to address data discrepancies and streamline processes, especially for high-risk roles such as Healthcare Support Workers and Registered Mental Health Nurses.

Absence Management: the Committee noted the establishment of an absence oversight group to focus on both long-term and short-term absence, coaching for managers and policy reviews. A session with senior leadership at Derby University is planned to gather operational feedback on the absence policy.

Supervision: it was highlighted that supervision rates are gradually increasing but remain below the 90% target. All teams below 75% compliance are being followed up, and the alignment of new workforce systems is expected to improve data accuracy and accountability.

Personal Accountability Charter: The Committee also discussed the implementation of the Personal Accountability Charter, sharing examples of its impact. The need for more sophisticated measures of cultural change, including the potential for bespoke staff survey questions and the development of a 'cultural barometer' at team, Division and Trust level was highlighted. The importance of linking the Charter with other key initiatives such as inclusive behaviours, anti-racism strategies and Employee Relations was also emphasised and it was suggested that sharing anonymised stories could help embed the Charter across the organisation.

Significant assurance was accepted on progress shown for mandatory training, staff turnover, Temporary Staffing usage and FTSU and
limited assurance on vacancies and recruitment, attendance and absence, Clinical Supervision and Annual Appraisals

Making Room for Dignity (MRfD) – Organisational Development (OD) Programme

The Committee discussed integration of the Programme with other development initiatives, such as the Model of Care Programme, Culture of Care Programme and multi-disciplinary working. Approaches for ongoing evaluation and support were considered.

The rollout of the Programme in partnership with the University of Derby was noted, along with the positive feedback received from teams and facilitators, and also the value of off-site sessions for team development.

It was agreed that frequent follow-up and reflection was important, along with the use of operational metrics to monitor the ongoing impact.

Significant assurance was received on ensuring that the people and OD culture elements of MRfD have been considered and appropriate interventions have been designed and commissioned.

Due to its infancy, the Committee accepted **limited assurance** on the impact of the OD Programme to date.

Medical Job Planning Performance and Assurance Plan (quarterly)

Compliance rates of 88% for Consultants and 93% for SAS doctors were reported, with the Trust ranking in the top third regionally. Steps to move from level one to level four (gold standard) in job planning, including the introduction of e-Rostering and team job planning, with a target of 95% compliance by next April, were outlined.

The importance of evaluating the quality of job plans, not just quantity, and the challenges of matching capacity and demand in mental health settings was highlighted.

The Committee noted plans to use medical job planning as a foundation for broader service team planning, aiming to create internal benchmarks and improve productivity through integrated operational and workforce planning.

	NHSE Workforce Training and Education Self-Assessment The Committee reviewed the self-assessment and accepted **significant assurance** of the process. Approval of the submission was agreed, subject to the addition of assurance statements regarding process and direction of travel.
	People Plan – final sign-off The committee signed off the three year people plan, following wider engagement with colleagues. The need for clear policies on psychological support for staff was acknowledged, especially in cases of work-related incidents. The development of a more consistent approach was agreed, along with working in partnership with staff-side as a key enabler for successful implementation. The Committee discussed the need for clear, achievable measures and aspirational targets, such as aiming for 100% leadership development participation among managers. The final version of the People Plan was approved.
	System Developments – verbal update The overview included an update on System-level workforce collaboration, including financial pressures, workforce returns and early discussions on the national target operating model for People services.
	10 Point Plan to improve Resident Doctors' working lives It was noted that significant progress has already been achieved to address the plan, with the 'Improving Working Lives for Resident Doctors' Task and Finish Group meeting every six weeks to monitor progress of actions aligned to the national plan. The Committee was **significantly assured** that the Trust is responding effectively to the 10 Point Plan and that there is a clear governance structure in place, demonstrating Board commitment.
	Job Evaluation – national and local process improvements The Committee discussed the current state of job evaluation processes, national drivers, training plans and the need for equal pay audits, with a focus on nursing profiles and regional collaboration. In line with national standards, the Trust plans to train more job evaluators and improve policy and job design training, with five staff scheduled for consistency checking training in January.
	Health and Wellbeing update – focus on Sexual Safety Framework The update informed that the Trust's progress on the sexual safety agenda included, policy development, a delivery plan, training and awareness raising. It was noted that a sexual safety hub is being launched to centralise resources and improve signposting for staff support. The Committee agreed to accept **limited assurance** at this stage, recognising the ongoing work and the need for further progress. It was agreed that collaboration with the Quality and Safeguarding Committee ensures appropriate focus on both staff and patient aspects.
	Temporary Staffing Workforce – Agency (update on current position) The report indicated that agency usage remains a challenge but is under target compared to other trusts, with most spend on Medics and Healthcare Support Workers. To support compliance with the national ban on Band 2 and 3 agency staff by February, it was noted that a large bank recruitment project is underway, along with re-engagement of inactive bank workers.
	Policy Status Dashboard It was noted that two new policies, 'Supporting Colleagues with known Lived Experience in the Workplace Policy' and 'Mandatory Training Policy' were awaiting wider review before presentation to the Policy Review Group.
	Review of People and Culture Committee Board Assurance Framework (BAF) Risks – issue 3, 2025/26

	Due to the scale of work and the impact, the Committee agreed to add Job Evaluation to the BAF. It was agreed to revisit the absence management risk to demonstrate that a deep dive and action plan would be presented to the Committee in January. In relation to the new operating model, an update was suggested to reflect the Trust's preparedness for the next phase.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework:** None. **Next scheduled meeting:** 14 January 2026.
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 – 25 November 2025

Workforce Race Equality Standard (WRES) 2024/25 and Workforce Disability Equality Standard (WDES) 2024/25

Purpose of Report

The attached reports are the Workforce Race and Disability Equality Standards (WRES and WDES). Both reports provide narrative to the WRES and WDES data sets submitted to NHS England by 31 August 2025. The data and narrative are accompanied by action plans. Following Board delegated authority in September, the People and Culture Committee virtually approved the reports.

Executive Summary

The WRES and WDES are nationally mandated data collection frameworks to enable NHS Commissioners and providers to measure race and disability equality in organisations. The indicators in each report are set out in turn with an explanation and show trends over time where possible.

The reports are to be published on the Trust's public website and so the data and explanations are presented in a straightforward manner to enable ease of understanding for the public and all colleagues in the Trust.

Rather than being stand-alone data exercises, the WRES and WDES are intended to form part of the broader equality, diversity and inclusion landscape.

It is proposed that the Trust Delivery Group will have quarterly oversight of progress made towards these action areas and there is an ongoing dialogue with staff networks and representatives on a regular basis throughout the year.

Strategic Considerations	
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	
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 WRES and WDES datasets have been submitted to NHS England in time for the deadline of 31 August 2025
- The EDI Steering Group will have quarterly oversight on progress on the above action areas.

Consultation

- People and Culture Committee
- The action plan will remain a live document and will be updated and co-owned with the BME and DAWN staff networks.

Governance or Legal Issues

Section 149 of the Equality Act sets out the Public Sector Equality Duty (PSED), which offers protection in relation to employment, as well as access to goods and services. The PSED strengthens the duty on employers to eliminate discrimination and advance equality of opportunity for staff with protected characteristics and foster good relations between people.

Public Sector Equality Duty & Equality Impact Risk Analysis

In complying with the WRES and WDES data collection and action plans, reports must identify the equality related impacts on the nine protected characteristics of age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity. The REGARDS group of people includes people with Economic disadvantage in addition to others covered by protected characteristics.

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

The WRES and WDES seek to measure some aspects of race and disability equality at the Trust. They provide useful numerical data which illuminate where the Trust has made progress and where further work is needed. The aggregated data model (BME and White, Disabled and non-Disabled) can risk overlooking disparities within groups (for example different types of disability) and particular risks to groups based on intersectional identity, for example, additional discrimination experienced by ethnic minority women or those who identify as White from a Roma, Gypsy or Traveller identity.

Recommendations

The Board of Directors is requested to:

1. Note approval of the WRES and WDES reports by the People and Culture Committee prior to publication on the Trust's public-facing website
2. Agree for the Trust Delivery Group to have quarterly oversight on progress towards action areas with progress updates to the People and Culture Committee.

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

Report prepared by: **Shaminder Uppal**
Head of Equality, Diversity and Inclusion

Alex Dougall
Strategic Recruitment Lead

Derbyshire Healthcare
NHS Foundation Trust

Workforce Race Equality Standard (WRES)

Annual Report 2024/25

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WE MAKE A POSITIVE DIFFERENCE IN EVERYTHING WE DO

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Introduction

The Workforce Race Equality Standard (WRES) is a data collection framework which measures elements of race equality in NHS organisations. Implementing the WRES is a requirement for NHS Commissioners and NHS healthcare providers including independent organisations through the NHS contract.

The WRES is designed around nine indicators, or measures, which compare Black and Minority Ethnic (BME) colleagues and their White counterparts. We acknowledge and respect that not everyone is comfortable with the term “BME” and prefer other terms instead. However, in following national guidance, this report uses consistent terminology. We also acknowledge that comparing two groups has the disadvantage of masking disparities within each group.

Five indicators of the WRES are populated with workforce data from our Electronic Staff Record (ESR) and show comparative data for BME and White staff. This includes the distribution of staff in each pay band, access to training, likelihood of being appointed following shortlisting, likelihood of entering a formal disciplinary process, and representation in very senior leadership. The remaining four indicators are populated with comparative data from the national Staff Survey and includes: experiences of bullying, harassment, and abuse from colleagues and the public; discrimination, and perceptions of fairness in career progression. The Staff Survey data also shows us the engagement levels of BME and White staff comparatively. Numerical data1 gleaned from the WRES provides a degree of insight into race equality at the Trust but is best used in conjunction with additional information (such as Freedom to Speak Up, employee relations and recruitment) and the qualitative data from the lived experiences of our colleagues themselves.

Each indicator is set out separately in this report with narrative content and main trends written in italics.

As a public service, our Trust is bound by the Public Sector Equality Duty and, as such, we are committed to:

•Eliminating unlawful discrimination, harassment, and victimisation

•Advancing equality of opportunity between people

•Fostering good relations between people.

In progressing towards these goals, the WRES data is accompanied by an action plan approved by the Trust Board of Directors.

As a relatively small Trust, our numerical data expressed as percentages or ratios can be more prone to fluctuation. For example, where only a small number of staff are counted (fewer than 10), a small number of additional recruits, or leavers, can have a bigger impact on percentage scores than in larger groups of staff. In the report, we have highlighted where this might be the case and shown data trends over time to give the most accurate picture.

Context

The Trust serves the population of Derby City and Derbyshire County, both of which have different profiles in race and ethnicity. In the *2021 census, Derbyshire County was 6.3% BME2. In the NHS nationally, 28.6% of staff are from a BME background* (NHS England).*

A snapshot of data taken on *31 March 2025 shows the total number of staff employed by Derbyshire Healthcare was 3287. Of these, 670 identified as BME and 2576 identified as White.* There was no data recorded for 41 members of staff. The proportion of BME staff over time is as follows:

	2018	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**
Total % of BME staff employed within the Trust as of 31 March	12.6	12.9	13.8	15.5	16.7	18.5	18.95	20.38

From 2018 to 2024, the number of BME staff has increased from 314 to 670. This is an increase from 12.6% in 2018 to 20.38% in 2025. Trust diversity has increased year on year since 2018.

Indicator 1

The table below shows staff distribution across pay bands (Under Band 1 to Very Senior Manager (VSM). Data are collected in three main occupational groups: non-clinical, clinical (non-medical), and clinical (medical and dental). The figures as of 31 March 2025 are shown in the following table. The headcount figure is the total headcount.

Non-clinical workforce 2025	**White**	**BME**	**Unknown**
Under B1	0	0	0
B1	1	0	0
B2	151	61	6
B3	177	29	1
B4	150	17	3
B5	77	16	0
B6	49	8	1
B7	31	4	0
B8A	21	0	0
B8B	16	0	0
B8C	10	1	0
B8D	4	0	0
B9	3	0	0

VSM	4	2	0
	694	**138**	**11**

Clinical Workforce 2025	**White**	**BME**	**Unknown**
Under B1	0	0	0
B1	0	0	0
B2	3	3	0
B3	265	165	9
B4	127	18	0
B5	282	159	7
B6	697	122	10
B7	342	41	4
B8A	89	17	0
B8B	52	4	0
B8C	18	2	0
B8D	6	0	0
B9	1	1	0
VSM	0	0	0
	1882	**532**	**30**

Consultants	**White**	**BME**	**Unknown**
Medical & Dental	32	47	3
Of which senior medical mgr.	4	11	0
Non-cons career grade	12	28	0
Trainee grades	10	30	4
	58	**116**	**7**

Non-Clinical

In 2025, the overall percentage of BME staff in non-clinical roles (16.37%) is slightly lower than the figure across the whole Trust (20.38%). 56.7% of the total number of BME staff are concentrated in Bands 2 to 4. Despite a reduction of BME staff in bands 2 and 3 from 2023, in 2024 47.2% of White staff were in the equivalent bands 2.

In terms of the total number of non-clinical staff at 8a and above 4.9% are BME (3) and 95.1% are White (58). This is a very slight change from last year.

11 Unknowns have been excluded for this narrative paragraph.

Clinical (non-medical)

The overall percentage of BME staff in clinical (non-medical) roles is slightly higher (21.8%) than the Trust average. Further analysis of groups of staff can bring some of the disparities into sharper focus. **For example, the majority of registered nurses (amongst others) are employed at Bands 5, 6 and 7 and, to an extent, the band increase represents career progression.**

For Bands 8a and above BME staff comprise of 12.6% of the clinical workforce and White staff 87.4%. 4.5% of BME staff are in bands 8a and above compared to 8.8% of white staff. Although this has not changed considerably from the previous year, further action is required to understand barriers to BME applying for and/or being appointed to Band 8a and above jobs.

30 Unknowns have been excluded for this narrative paragraph

Clinical (medical and dental)

In Clinical (Medical and dental) roles, the disparity is not represented by total numbers in the same way for other groups. For this staff group, disparities can include clinical awards, academic posts, and fitness to practice referrals. This is analysed further in the Medical WRES (MWRES) which will be published in February 2025.

Indicator 2

Relative likelihood of staff being appointed from shortlisting across all posts calculated for the 12 months prior to 31 March in the reporting year. If a candidate is shortlisted, it means they have met the person specification criteria to be interviewed for the post they are applying for.

The table below shows the “disparity ratio” where complete parity, or equality, is represented by the number 1. A number of 2 would be that a shortlisted candidate is twice as likely to be appointed.

In Indicator 2, a number above 1 shows the extent to which a White candidate is more likely to be appointed. A figure above 1:00 indicates that White candidates are more likely than BME candidates to be appointed from shortlisting. The table below shows this trend over the past six years.

2019	2020	2021	2022	2023	2024	2025
2.86	2.02	1.60	1.78	1.75	2.1	1.81

The above table shows a continuing disparity over time with a slight decrease from 2.1 to 1.81. Given the overall large numbers of shortlisted and appointed candidates, there is a possibility that the overall figure masks wider disparities in particular areas and bands.

The figure has dropped from 2.1 in 2024 to 1.81 in 2025 however further analysis is required to understand at local level where issues are. As there are less roles at higher bands, progression needs to be monitored over a longer period and reviewed alongside staff survey training data and leaving reasons for BME staff.

Representation across pay bands continues to be influenced by consultant-level roles, but there remains clear underrepresentation of BME staff in higher pay bands, particularly in non-clinical roles.

Further analysis is required to understand the roles where BME applications have been shortlisted and reasons as to why they have not been successful. The numbers of withdrawals for shortlisted candidates will be monitored to see if there is any trends in this data and an understanding of the diversity of applicants by band will help identify specific issues across the Trust.

There are also external factors that can have an impact on applications for certain roles such as government changes to immigration polices so the impact this has on application numbers can be reviewed.

Indicator 3

The table below shows relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. A figure above 1 would indicate BME staff are more likely to enter the formal disciplinary process.

2018	2019	2020	2021	2022	2023	2024	2025
3.03	2.45	1.43	10.52	0.0	2.70	2.1	1.81

Disciplinary data	White	BME	Unknown
Total staff in workforce	2576	670	41
Number of staff entering formal disciplinary	13	4	0
Relative likelihood %	0.5	0.59	
Relative Likelihood	1.81		

This indicator shows the likelihood of entering formal discipline compared to the proportion of BME and White staff in the whole organisation. In summary, the disparity ratio in 2021 shows the greatest disparity but this score is unrepresentative of the small number of total discipline cases

overall. The potentially more concerning figure is in 2023. As seen previously, BME staff continue to be more likely than White staff to enter the formal disciplinary process.

The numerical data here is of some value but needs supplementing with qualitative data to understand the full picture behind the cases. In 2024 and 2025 there are reductions in the number cases for BME employees, but the overall pattern remains that BME staff are proportionately more likely to enter formal discipline than are White staff.

Indicator 4

The table below shows the relative likelihood of staff accessing non-mandatory training and CPD. A figure above 1 would indicate BME staff are less likely to access non-mandatory training and CPD.

2018	2019	2020	2021	2022	2023	2024	2025
1.53	0.97	1.13	1.52	0.73	1.31	0.84	0.75

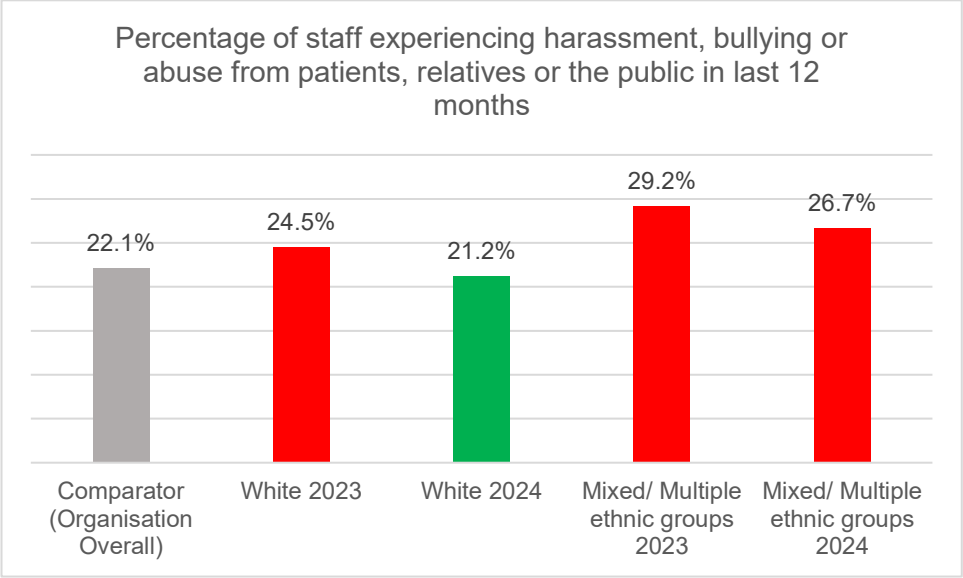
It may be that there is more equitable access to professional development learning, but this is not translating into progression so further work needs to be done to understand the barriers to progression for BME staff across services.

Indicators 5-8

Data for the following Indicators are taken from the 2024 NHS staff survey and do not include figures for 2025 as those results will be published early 2026. A benchmarking report compares Derbyshire Healthcare to other Mental Health and Learning Disability Trusts (50 organisations are in the benchmarking group)

Indicator 5

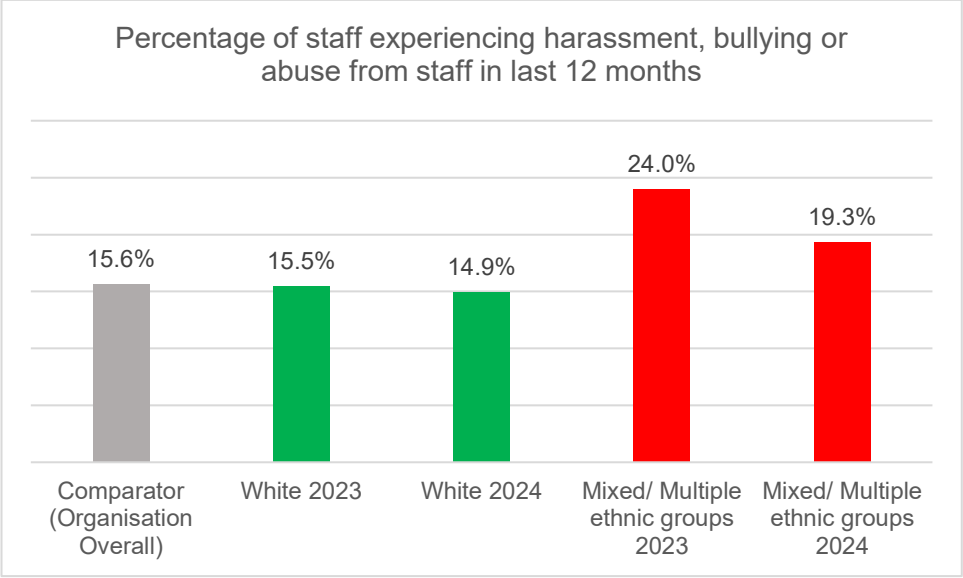
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or members of the public in the last 12 months.



In 2024, the percentage for BME staff experiencing harassment, bullying or abuse from patients, relatives or members of the public was 26.7% and has reduced slightly from 2023 but is still higher than white staff.
The 2023 figure for White staff was 24.5% and has decreased in 2024 to 21.2%.

Indicator 6

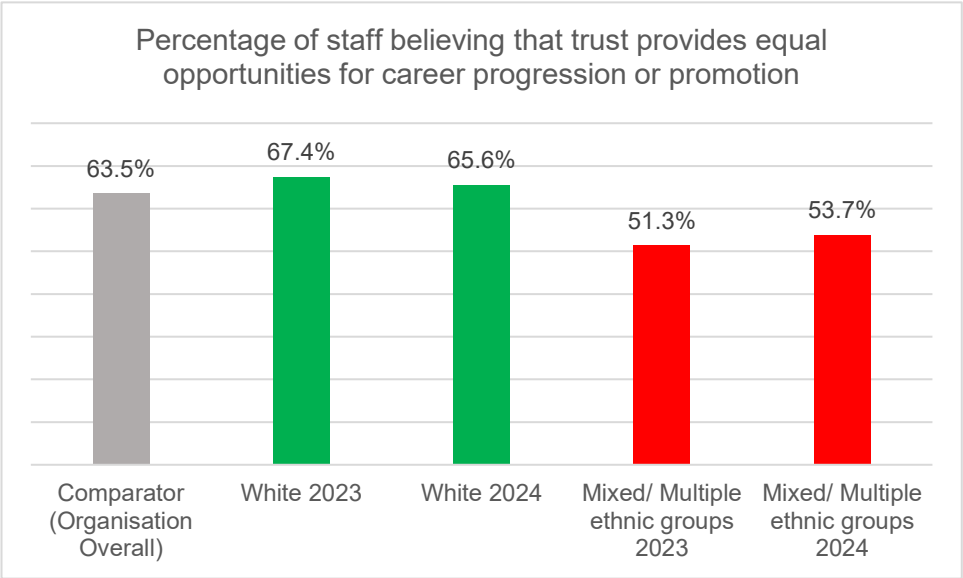
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.



In 2024, the percentage of BME staff experiencing harassment, bullying or abuse from staff was 19.3% compared to 14.9% for White staff. A persistent disparity has remained where BME staff are more likely to experience harassment.
For BME staff, the figure is higher than the benchmarking group, for White staff it is slightly lower.

Indicator 7

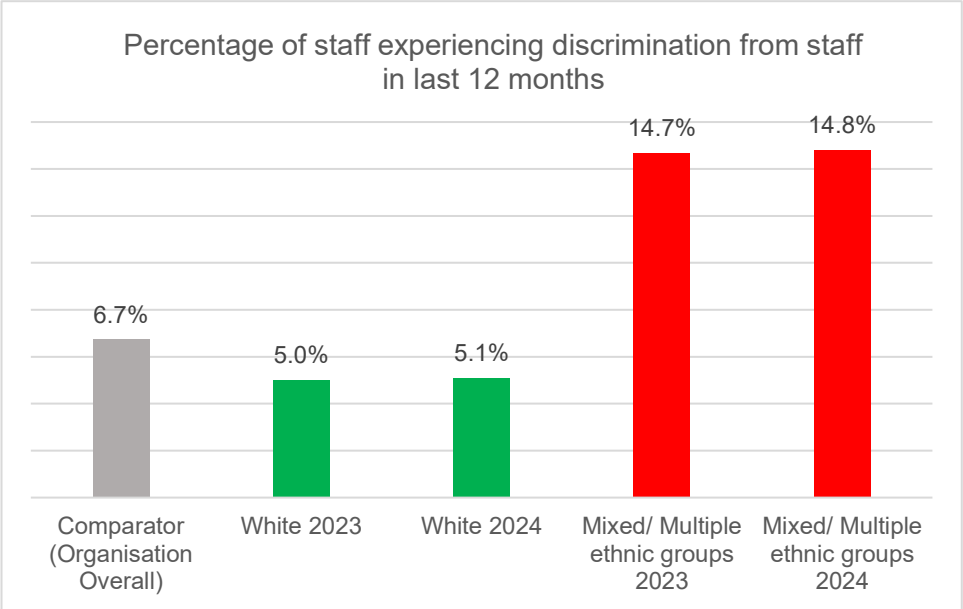
Percentage believing that the Trust provides equal opportunities for career progression or promotion.



In 2024, the percentage for BME staff believing that the trust provides equal opportunities for career progression was 53.7% compared to 65.6% for White staff. This is a slight increase from last year. A wide and persistent disparity remains.
Over time, the picture at the Trust is largely consistent with other trusts in the benchmarking group. Compared to that group, our figure is marginally higher for White staff at the trust and lower for BME staff.

Indicator 8

Percentage of staff who have personally experienced discrimination at work from their manager/team leader or other colleagues in the last 12 months.

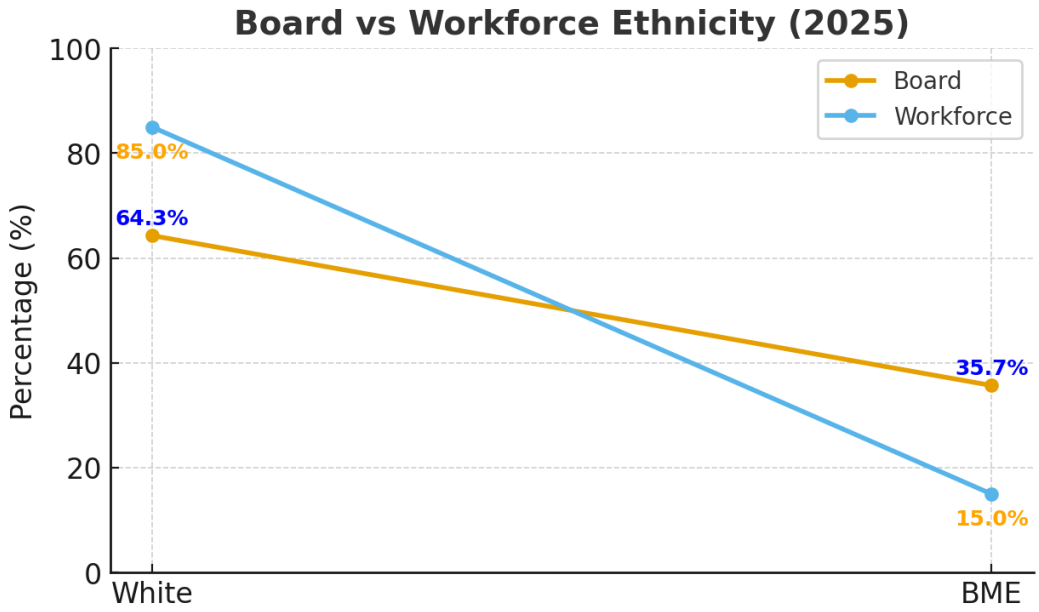


In 2024, the percentage of BME staff who have personally experienced discrimination at work from their manager/team leader or other colleagues was 14.8% compared to 5.1% for White staff. The data has remained consistent for both groups over time and a persistent disparity remains.

Indicator 9

Board Membership

Board vs Workforce Ethnicity (2025)
The chart below shows the comparison between Board membership and overall workforce ethnicity. This demonstrates that BME representation at Board level (35.7%) is significantly higher than in the overall workforce (15%).



Board Membership 2025	White	BME
Total	**9**	**5**
of which are voting Board members	7	5
Non-voting members	2	0
Exec Board members	4	3
Non-exec Board members	5	2
% Board members by ethnicity	**64.3**	**35.7**

This table shows the representation of BME staff at board level.
In 2024, the percentage figure for BME staff across the whole workforce is 18.95% and the percentage for BME voting Board members is: 38.5%. The difference is therefore 19.55%. The previous year difference was 14.8%.

Conclusions

The Workforce Race Equality Standard (WRES) provides the Trust with clear measures of where disparities exist and allows us to track progress over time. Since data collection began in 2018, we have been able to identify both areas of positive improvement and persistent challenges that require focused action.

There are encouraging signs of progress. Since 2022, reported incidents of bullying, harassment and discrimination from colleagues, managers, and members of the public have reduced. While BME staff continue to experience these behaviours at higher rates than white colleagues, the downward trend indicates that interventions and awareness-raising initiatives are beginning to have an impact. Engagement with the BME staff network has strengthened, ensuring that lived experiences are shaping conversations and informing decision-making across the Trust. We are also seeing encouraging signs of greater diversity within entry-level recruitment and in medical roles.

However, challenges remain. BME staff are less likely than white colleagues to feel that the Trust provides equal opportunities for career progression or promotion, and they remain over-represented in lower pay bands across both clinical and non-clinical roles (excluding medical posts). Representation at senior levels, particularly Band 8a and above, remains limited. Addressing these disparities is essential if we are to create a fairer and more inclusive organisation.

While WRES data tells us the “what”, we remain committed to understanding the “why”. To maximise the impact of the WRES, the findings and actions will be embedded into the Trust’s wider programme of cultural transformation. In doing so, we aim to deliver sustained progress, ensure accountability, and create a workplace where all staff feel supported, valued, and able to thrive.

Action Plan

Action Area	Activities	Who	When	Status
Bullying, Harassment, Abuse and Discrimination	Candidates put forward for the Active Bystander Train-the-Trainer programme as well as visual displays to support the active bystander initiative.	EDI Team and others (in progress).	September 2025	Training was completed in September 2025 by the Freedom to Speak Up Guardian, FTSU Champions, HR, People and Inclusion teams, and clinical staff. Train the Trainer sessions will be delivered from January 2026 onwards.
Inclusive Recruitment	Continue delivery of Chair of panel inclusive recruitment and selection training.	Strategic Recruitment Lead.	October 2025	Training was piloted in 2024/25 and delivered to Trust Leadership Team. Further roll out will commence October 2025.

	Review data by staff type to identify any barriers for BME staff.	Strategic Recruitment Lead, Head of EDI.	January 2026	To commence November 2025.
	Review and monitor outcomes of BME applicants at Band 8a and above.	Strategic Recruitment Lead.	February 2026	To commence November 2025.
	Review panel diversity for roles at Band 8a and above.	Strategic Recruitment Lead.	February 2026	Progress will be monitored through the EDI Working Group. Work is underway to develop refreshed Recruitment Manager Training, aimed at strengthening inclusive recruitment practices and ensuring alignment with the Trust's updated Equality, Diversity and Inclusion priorities.
	Review withdrawal data of applicants to understand if this disproportionally disadvantages particular groups.	Strategic Recruitment Lead.	March 2026	Progress tracked through EDI Working group Q1 2026.
Progression and Promotion	Review of Recruitment Inclusion Guardians.	Head of EDI Strategic Recruitment Lead.	November 2025	Progress tracked through EDI Working group Q1 2026.
Culture of Inclusion and Belonging	The Anti Racism strategy was launched in October 2025. An Anti-Racist statement has been approved by the Board and publicly shared in October 2025. We will work closely with the BME Staff Network through regular meetings as part of the Equality, Diversity and Inclusion (EDI) Working Group. This group will help lead and support the EDI Plan. The BME Network will agree on yearly action plans and review progress regularly to make sure the work is on track and making a difference.	Head of EDI/EDI Team/Key Stakeholders.	October 2025	Strategy launched October 2025. The Anti-Racism Strategy incorporates the recommendations from the Michelle Cox Review, with implementation work already underway.

	Utilising exit interviews to understand reasons for BME staff leaving the Trust.	EDI Team/Divisional People Team.	December 2025	The Organisational Development and Recruitment Lead will work with the EDI Team to identify themes from staff leaving data and information gathered through exit interviews.

Derbyshire Healthcare
NHS Foundation Trust

Workforce Disability Equality Standard (WDES)

Annual Report 2024/25

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Introduction

The Workforce Disability Equality Standard (WDES) is a data collection framework which measures elements of disability equality in NHS organisations. Implementing the WDES is a requirement for NHS Commissioners and NHS healthcare providers including independent organisations through the NHS contract.

The WDES is designed around ten indicators, or measures, which compare disabled colleagues and their non-disabled counterparts. We acknowledge and respect that some people with disabilities do not refer to themselves as Disabled, denoting this part of their identity. However, in following national guidance, this report uses consistent terminology and refers to "disabled staff" or staff with a 'Long lasting condition or illness'. We also acknowledge that comparing two groups has the disadvantage of masking disparities within each group.

Four indicators of the WDES are populated with workforce data from our Electronic Staff Record (ESR) and show comparative data for disabled and non-disabled staff. This includes the distribution of staff in each pay band, likelihood of being appointed following shortlisting, likelihood of entering a formal capability process, and representation in very senior leadership. A further five indicators are populated with comparative data from the national Staff Survey and includes: experiences of bullying, harassment, and abuse; discrimination, feeling pressure to come into work while unwell, engagement and perceptions of fairness in career progression. The remaining metric refers to whether the voices of disabled staff are heard within the organisation.

Numerical data[1] from the WDES provides a degree of insight into race equality at the Trust but is best used in conjunction with additional information (such as Freedom to Speak Up, employee relations and recruitment) and the qualitative data from the lived experiences of our colleagues themselves. The data on ESR relating to our disabled staff is incomplete although this has increased in accuracy following a concerted effort to improve. This is explored below in more detail.

As a public service, our Trust is bound by the Public Sector Equality Duty and, as such, we are committed to:

- Eliminating unlawful discrimination, harassment, and victimisation
- Advancing equality of opportunity between people
- Fostering good relations between people.

In progressing towards these goals, the WDES data is accompanied by an action plan approved by the Trust Board of Directors.

[1] As a relatively small Trust, our numerical data expressed as percentages or ratios can be more prone to fluctuation. For example, where only a small number of staff are counted (fewer than 10), a small number of additional recruits, or leavers, can have a bigger impact on percentage scores than in larger groups of staff. In the report, we have highlighted where this might be the case and shown data trends over time to give the most accurate picture.

Context

The Trust serves the population of Derby City and Derbyshire County, both of which have different profiles in terms of disability. In the 2021 census, data shows the percentage of people indicating that their day-to-day activities were limited by a long-lasting condition or illness. In Derbyshire the figure was 20.1%. This definition is unlikely to cover various conditions which might be defined as a disability. Similarly, the NHS Staff Survey asks whether staff have a disability or long-term condition, and this is recorded differently on ESR as solely a disability. This slightly hinders getting accurate data, however, the WDES does indicate clear trends and disparities between disabled and non-disabled staff.

Figures from the Department for Work and Pensions in 2021/22 indicate that 24% of the total population have a disability[2]. The Trust in 2024 had 10.25% who disclosed a disability which is below the Derbyshire County average.

At 31 March 2025, 11.53% of the Trust workforce had declared a disability — a continued increase year on year, but still below both local and national population averages.

A snapshot of data taken on 31 March 2025 shows the total number of staff employed by Derbyshire Healthcare NHS Foundation Trust was 3,453. Of these:

- 398 identified as Disabled (11.53%)
- 2,633 identified as non-Disabled (76.3%)
- 422 had no disability status recorded (12.2%)

Recorded proportion of disabled staff employed within the Trust

Year	% of Disabled Staff	Headcount (n)	Notes
2018	Unavailable	–	No data recorded
2019	4.5%	115	First formal dataset
2020	4.4%	117	Relatively stable
2021	5.3%	149	Noticeable rise
2022	6.7%	194	Continued growth
2023	8.9%	273	Almost doubled since 2019
2024	10.25%	339	First time above 10%
2025	11.53%	398	Highest to date

Year	2018	2019	2020	2021	2022	2023	2024	2025
% (headcount)	Unavailable	4.5% (115)	4.4% (117)	5.3% (149)	6.7% (194)	8.9% (273)	10.25% (339)	11.53% (398)

[2] UK disability statistics: Prevalence and life experiences - House of Commons Library (parliament.uk)

Indicator 1

Indicator 1 measures the distribution of staff across pay bands (Bands <1 to Very Senior Manager). Data are presented in three main occupational groups: non-clinical, clinical (non-medical), and clinical (medical and dental). Figures are shown for 2024 and 2025. The percentage figure is the proportion of Disabled or non-Disabled staff within each pay band. Percentage figures are rounded to whole numbers.

Non-Clinical

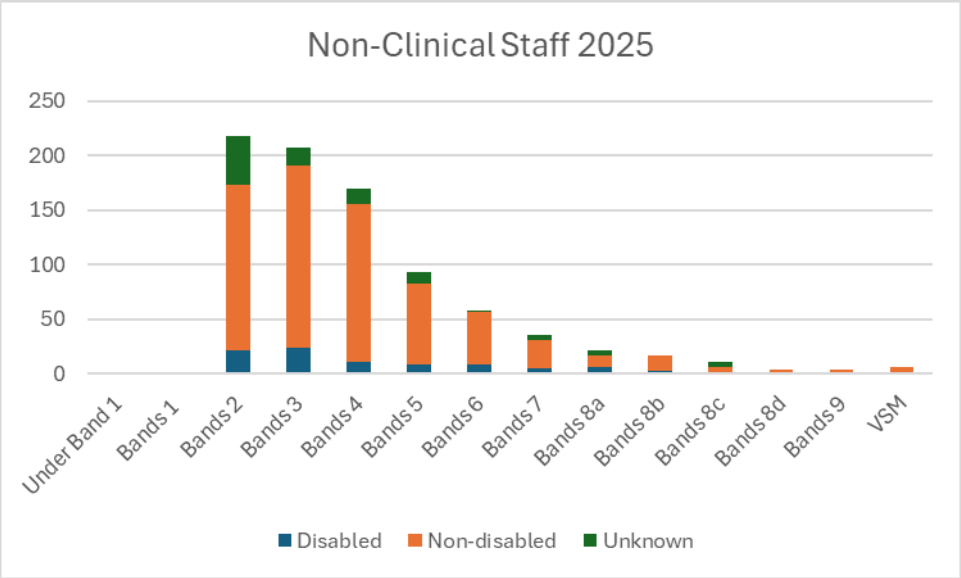
Pay Band	2025 Disabled # (%)	2025 Non-Disabled # (%)	2025 Unknown # (%)	2024 Disabled # (%)	2024 Non-Disabled # (%)
Cluster 1 Bands <1 to 4	50 (8.8%)	431 (75.6%)	89 (15.6%)	45 (8%)	402 (73%)
Cluster 2 Bands 5 to 7	18 (9.5%)	149 (78.4%)	23 (12.1%)	19 (11%)	132 (76%)
Cluster 3 Bands 8a to 8b	8 (21.1%)	23 (60.5%)	7 (18.4%)	6 (18%)	19 (58%)
Cluster 4 Bands 8c to 9 and VSM	0 (0%)	18 (78.3%)	5 (21.7%)	1 (4%)	21 (84%)

Clinical

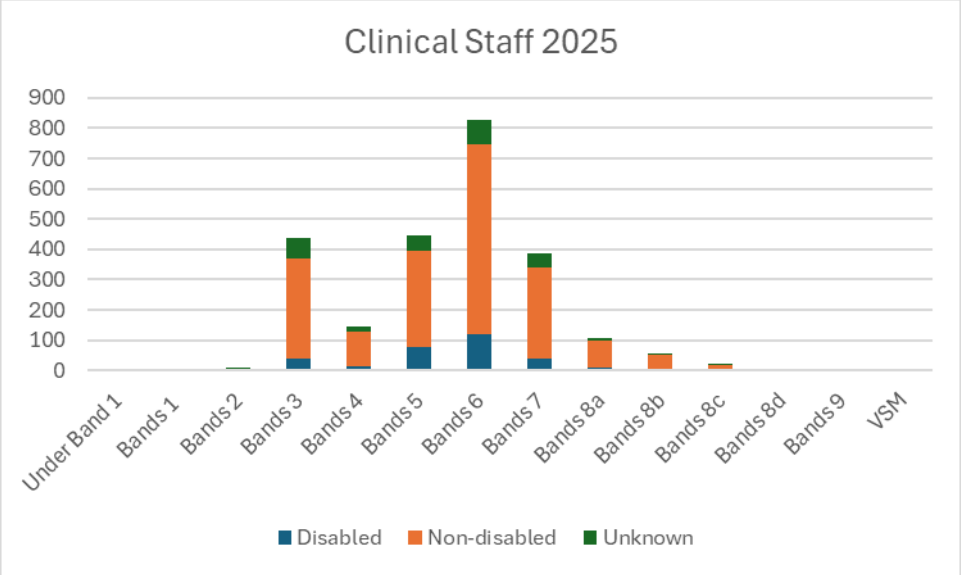
Pay Band	2025 Disabled # (%)	2025 Non-Disabled # (%)	2025 Unknown # (%)	2024 Disabled # (%)	2024 Non-Disabled # (%)
Cluster 1 Bands <1 to 4	51 (9.1%)	413 (73.5%)	98 (17.4%)	41 (8%)	372 (72%)
Cluster 2 Bands 5 to 7	188 (11.9%)	1185 (74.9%)	209 (13.2%)	140 (10%)	1091 (75%)
Cluster 3 Bands 8a to 8b	15 (9.5%)	129 (81.6%)	14 (8.9%)	13 (9%)	112 (79%)
Cluster 4 Bands 8c to 9 & VSM	2 (8.3%)	19 (79.2%)	3 (12.5%)	1 (4%)	20 (87%)

Medical and Dental

Pay Band	2025 Disabled # (%)	2025 Non-Disabled # (%)	2025 Unknown # (%)	2024 Disabled # (%)	2024 Non-Disabled # (%)
Consultants	4 (5.1%)	53 (67.1%)	22 (27.8%)	5 (6%)	52 (64%)
Non-consultant career grade	1 (2.5%)	27 (67.5%)	12 (30.0%)	1 (3%)	22 (58%)
Trainees	2 (4.8%)	28 (66.7%)	12 (28.6%)	1 (3%)	27 (69%)



The number of unknowns has reduced, and the overall percentage of recorded disabled staff has steadily increased. This gives us more confidence in the data derived from ESR.



Indicator 2

Indicator 2 – Relative likelihood of staff being appointed from shortlisting

Indicator 2 measures the relative likelihood of staff being appointed from shortlisting across all posts, calculated for the 12 months prior to 31 March in the reporting year. If a candidate is shortlisted, it means they have met the criteria to be interviewed for the post they are applying for.

Indicator 2 is expressed as a disparity ratio where complete parity, or equality, is represented by the number 1. A number of 2 would mean that a candidate is twice as likely to be appointed. In Indicator 2, a value above 1 shows the extent to which a non-disabled candidate is more likely to be appointed. The table below shows this trend over time.

Year	2018	2019	2020	2021	2022	2023	2024	2025
Indicator 2 (Relative likelihood)	2.88	1.40	1.05	1.05	1.04	1.17	0.76	0.90

In 2025, Disabled applicants were slightly more likely to be appointed than non-Disabled applicants, though the disparity was small (0.90). This compares to 0.76 in 2024, showing a shift towards parity. Manager training and guidance are expected to strengthen this area further.

Although there is no direct evidence of this, training for managers on awareness of disabilities and putting reasonable adjustments in place at the candidate's request may increase the chance of disabled applicants being successful at selection events. Further guidance and awareness are required to ensure applicants feel confident to request reasonable adjustments and managers have the knowledge to implement these effectively. Work also continues to encourage staff to have the confidence to disclose disabilities.

The clear trend over time shows that there is a reduced disparity in shortlisting. However, caution should be exercised given the large numbers of shortlisted and appointed candidates. The more disability data that is submitted, the better the quality of future analysis will be. There is a possibility that the overall figure masks some disparities in particular areas, and further data analysis is required to look at shortlisting in relation to different types of disability and progression.

Indicator 3

Indicator 3 – Relative likelihood of staff entering the formal capability process
Indicator 3 measures the relative likelihood of staff entering the formal capability process, calculated for the 12 months prior to 31 March in the reporting year. From 2022 this is calculated over a 2-year period and the figure divided by two, hence the appearance of halves in the headcount figure. A figure above 1 would indicate disabled staff are more likely to enter the formal capability process.

Year	2018	2019	2020	2021	2022	2023	2024	2025
Indicator 3 (Relative likelihood)	Unavailable	0.0	0.0	0.0	0.0	0.0	0.0	13.23
Average Headcount Disabled	Unavailable	0	0	0	0	0	0.5	1
Average Headcount Non-disabled	Unavailable	0	0	0	0	0	0.5	0.5

Given the very low number of formal capability cases overall, this indicator offers limited insight into the comparative experiences of disabled and non-disabled staff when there are performance concerns. This will need to be monitored over a longer period.

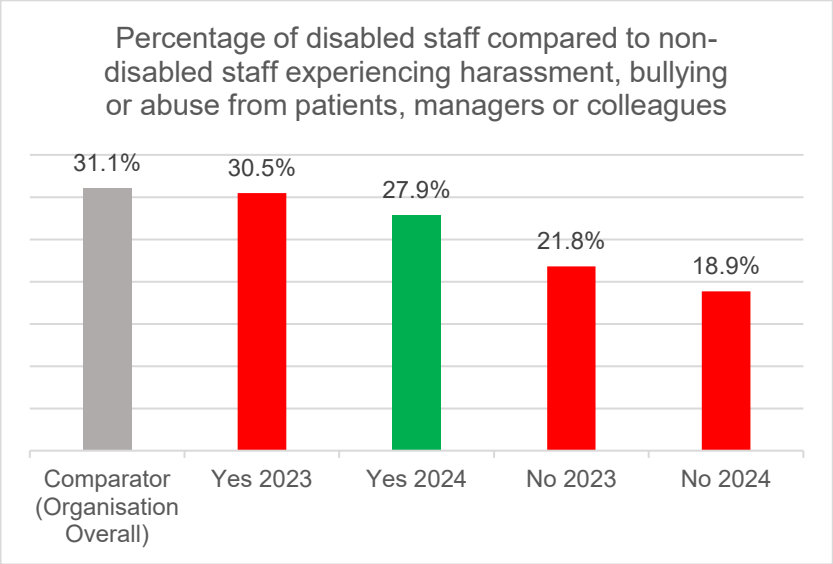
It should be noted that the 2025 figure (13.23) is based on very small numbers of cases. This creates a disproportionately high relative likelihood value that does not necessarily reflect a systemic issue. Monitoring over multiple years with larger case numbers will provide a more reliable trend.

Indicators 4a to 9b

Data for the following Indicators are taken from the 2024 NHS staff survey[3] that was published in March 2025. A benchmarking report compares Derbyshire Healthcare to other Mental Health and Learning Disability Trusts (50 organisations are in the benchmarking group) as well as comparing those with a disability to those that do not. On the charts below 'Yes' refers to those that have declared a disability and 'No' refers to those that haven't.

Indicator 4a

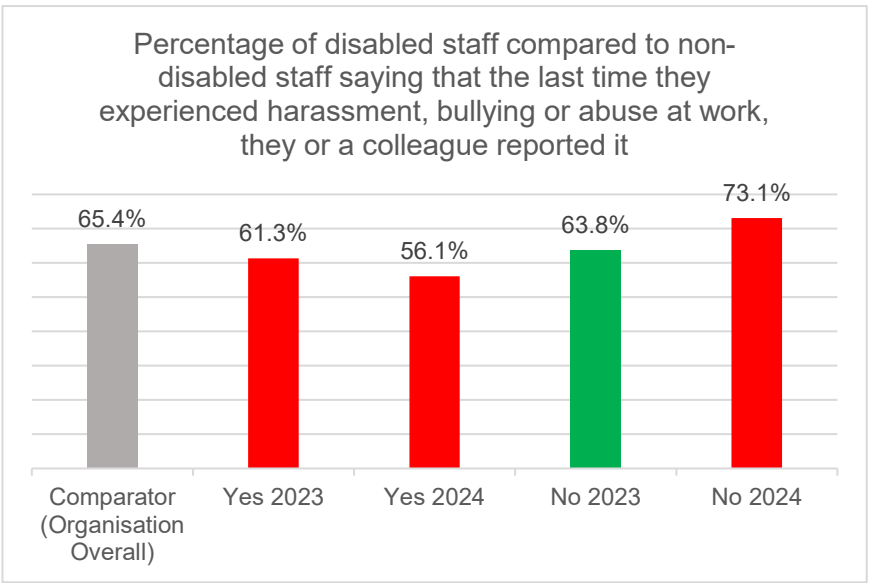
This indicator shows the percentage of disabled staff experiencing harassment, bullying or abuse from patients, service users or members of the public in the last 12 months.



In 2024, the percentage of staff with a long-lasting health condition that experienced harassment, bullying or abuse from patients, managers or colleagues, was 27.9% compared to 30.5% last year. This compares to 31.1% for the wider organisation. The figure has fallen steadily, but remains higher for staff with long terms conditions compared to those who don't.

Indicator 4b

This indicator shows the percentage of staff stating that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

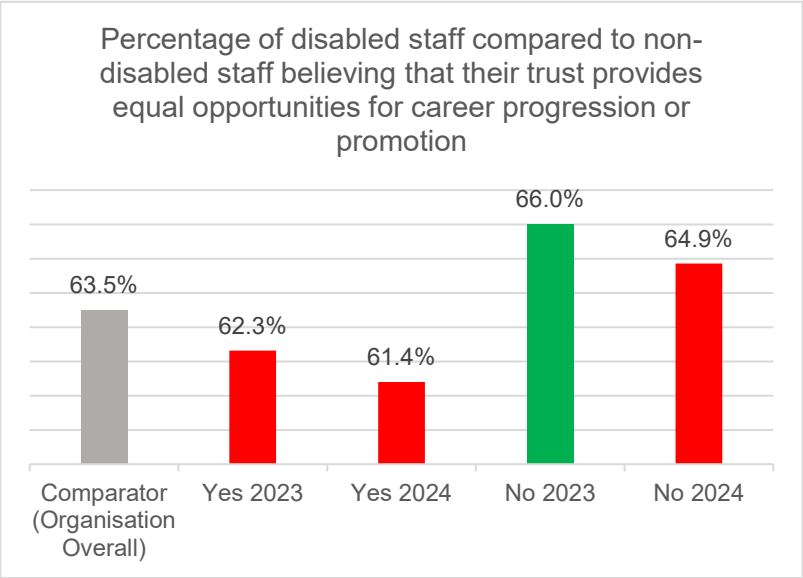


In 2024, the percentage of staff who stated that they reported harassment and bullying at work with a disability was 56.1% compared to 73.1% of staff without. The figures have shown a decrease from 2023.
The Trust figures are similar to those in the benchmarking group.

[3] The full data set is available here: NHS Staff Survey Benchmark report 2022 (nhsstaffsurveys.com)

Indicator 5

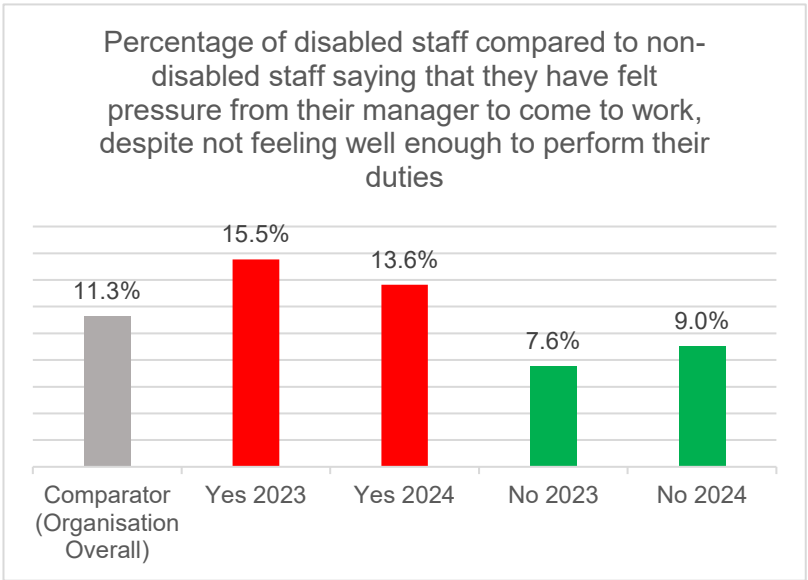
This metric shows the percentage of staff who believe that the organisation provides equal opportunities for career progression or promotion.



In 2024, the percentage of staff who believed that the organisation provides equal opportunities that declared a disability was 61.4% compared to 64.9% of staff without a disability. The figure for both groups has reduced slightly from 2023.
The Trust figures are similar to those in the benchmarking group.

Indicator 6

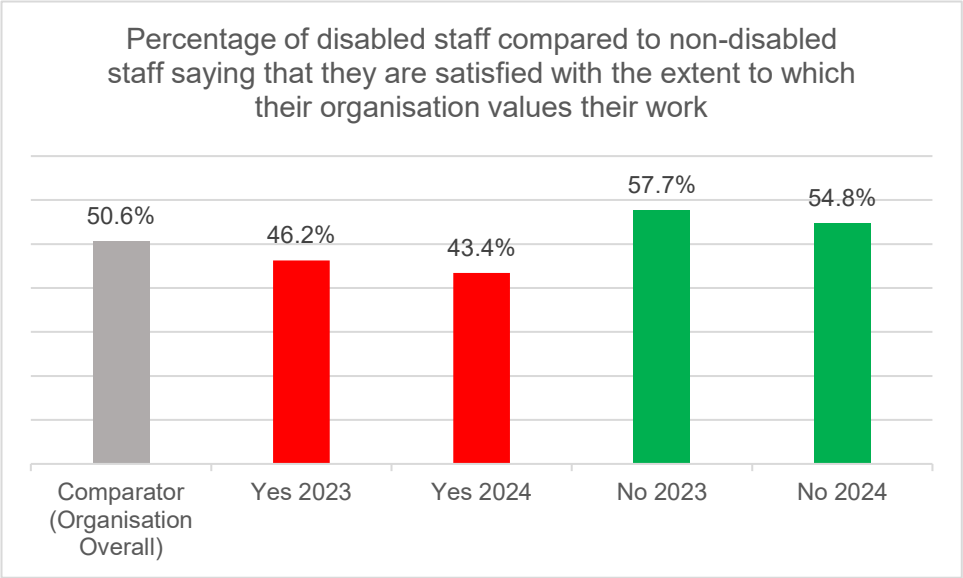
Percentage of staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.



In 2024, the percentage of staff with a disability that felt pressure to come to work despite not feeling well enough was 13.6% compared to 9% of staff without a disability. The figure for those with a disability has decreased however it is still higher than staff without a disability.

Indicator 7

Percentage of staff saying they are satisfied with the extent to which the organisation values their work.

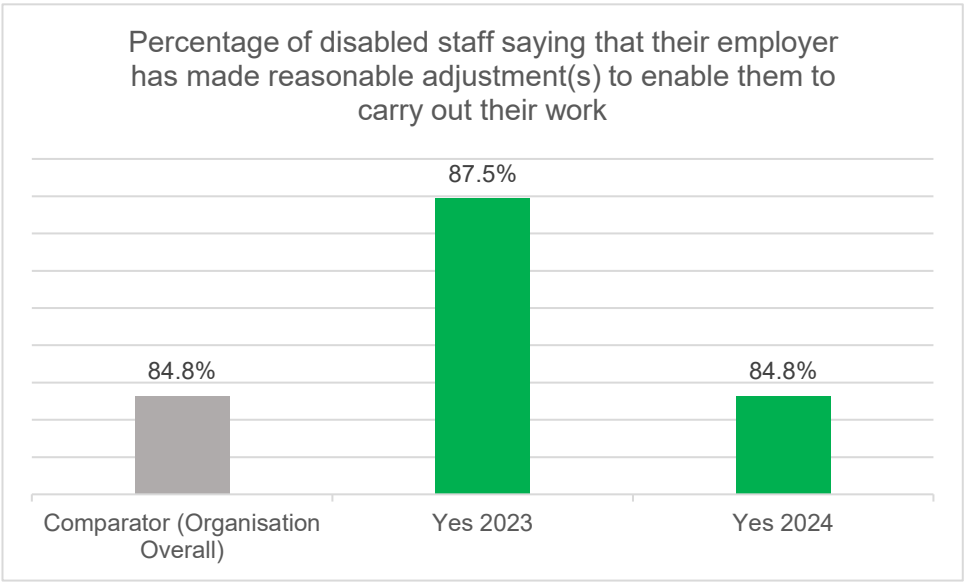


In 2024 43.4% of disabled staff felt their organisation values their work which reduced from 2023 which is significantly lower than staff without a disability (54.8%).

Indicator 8

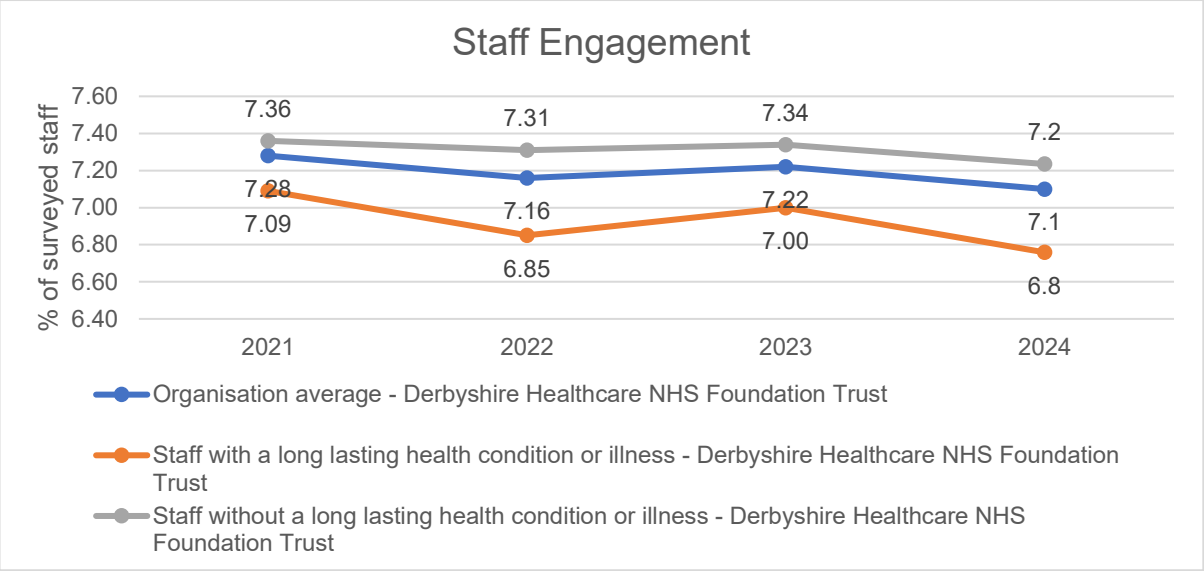
Percentage of staff with a long-lasting health condition or illness saying their employer has made reasonable adjustments to enable them to carry out their work.

Figures in the staff survey state that 84.8% of staff with a long-lasting condition or illness felt that reasonable adjustments had been made. This compared to a benchmarked figure of 84.8%. This did reduce from 2023, though where 87.5% felt their employer made reasonable adjustments.



Indicator 9a

Staff engagement score for disabled staff, compared to non-disabled staff. The data shows a decrease in staff engagement in 2024 for all groups.



Indicator 9b

Has your trust taken action to facilitate the voices of disabled staff in your organisation to be heard (Yes/No).

Yes – action has been taken to facilitate the voices of Disabled staff.

- Relaunch of the DAWN Staff Network with increased membership and visibility
- Reciprocal mentoring programme between Disabled staff and senior leaders
- A central budget for reasonable adjustments
- Disability awareness campaigns aligned to National Inclusion Week.

Indicator 10

At 31 March 2025, the Trust Board had 14 members.

- 1 member (7.1%) declared a disability, compared with 11.5% of the Trust workforce.
- There are currently no Disabled executive directors.

* This represents a gap of 4.4% compared with the workforce profile. Improving senior-level representation remains a strategic priority. *

Conclusions

The 2024/25 WDES results highlight both the progress Derbyshire Healthcare has made and the challenges that remain. Encouragingly, declaration rates are at their highest level, recruitment disparities have reduced, and the vast majority of staff with a long-term condition report that reasonable adjustments are in place. These gains reflect the commitment of colleagues, including the DAWN staff network, and demonstrate that change is possible when action is prioritised.

However, persistent disparities – particularly in relation to senior-level representation, experiences of bullying, harassment and discrimination, and the disproportionate use of capability processes – show that further work is needed. The differences between ESR and staff survey reporting remind us that data only tells part of the story, and that the voices of Disabled colleagues must remain central in shaping our response.

Looking ahead, our focus will be on embedding disability inclusion at every level of the Trust: improving declaration rates, strengthening inclusive recruitment, supporting managers with the knowledge and confidence to lead inclusively, and ensuring Disabled staff are represented in decision-making. By combining robust data with lived experience, we will continue to drive meaningful change and work towards a fairer, more inclusive workplace for all.

Action Plan

In June 2023, NHS England published its EDI Improvement Plan[4] with six high impact actions, some of which are aligned to the WDES objectives below.

Action Area	Activities	Who	When	Status
Bullying, Harassment, Abuse and Discrimination	Candidates put forward for the Active Bystander Train-the-Trainer programme as well as visual displays to support the active bystander initiative.	EDI Team and others (in progress).	September 2025	Training is booked for September 2025.
Culture of Inclusion and Belonging	We will work closely with the Dawn Staff Network through regular meetings as part of the Equality, Diversity and Inclusion (EDI) Working Group. This group will help lead and support the EDI Plan. The Dawn Network will agree on yearly action plans and review progress regularly to make sure the work is on track and making a difference.	Head of EDI/EDI Team/Key Stakeholders.	October 2025	The EDI Working Group that was set up in October 2025 will help bring together and align all priorities with the Workforce Disability Equality Standard (WDES) objectives, ensuring a joined-up approach to improving inclusion and accessibility across the Trust.
Inclusive Recruitment	Continue delivery of Chair of panel inclusive recruitment and selection training.	Strategic Recruitment Lead.	October 2025	Training was piloted in 2024/25 and delivered to Trust Leadership Team. Further roll out will commence October 2025.
	Develop action plans to become disability confident leader.	Chair of DAWN, Head of EDI, Strategic	October 2025	Work has commenced and is being tracked

[4] NHS equality, diversity, and inclusion improvement plan (england.nhs.uk)

		Recruitment Lead.		through DAWN network and TDG.
	Manager sessions on reasonable adjustments.	Head of EDI, Head of Employee Relations Strategic Recruitment Lead.	October 2025	Relaunch of new process on RA taking place October 2025 and will include manager sessions.
Progression and Promotion	Review of Recruitment Inclusion Guardians.	Head of EDI.	November 2025	October 2025.
	Utilising exit interviews to understand reasons for disabled staff leaving the Trust.	Head of EDI. Divisional People Lead.	October 2025.	In progress – further work on sharing data and actions to take place October 2025.
	Implement divisional actions plans based on staff survey data and results.	Head of EDI. Organisational Development Lead/Strategic Recruitment Lead.	October 2025.	February 2026.
	Lauch new reasonable adjustment process.	Head of Employee Relations.	November 2025	Taking place October 2025.

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10 Point Plan to improve Resident Doctors' working lives

Purpose of Report

To provide an update on progress following the letter received from NHSE, sent to all trusts in August 2025, introducing a 10 Point Plan to improve Resident Doctors' working lives.

Executive Summary

Significant progress has been achieved within a short space of time in order to address the 10 Point Plan, as set out by NHS England. Key areas of progress include eliminating mandatory training duplication for rotating Resident Doctors, course-related expenses reimbursement for Resident Doctors being streamlined and ongoing promotion of a supportive culture within Medical Education to support workplace wellbeing.

The 'Improving Working lives for Resident Doctors' Task and Finish Group, led by Rebecca Oakley and Mark Broadhurst, will feed into the People and Culture Committee. There are significant links and overlap with the previous Task and Finish Group led by Dr Jawahar (Guardian of Safe Working Hours) which focused on the response to the 2024 Improving working lives of Doctors in training.

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

Failure to implement the 10 Point Plan may jeopardise the Trust's standing as a postgraduate, local education provider, impacting patient care.

Consultation

Consultation has taken place with Medical Education, Medical Staffing, Resident Doctor representatives and the People and Culture Committee.

Governance or Legal Issues

NHS England has set out clear expectations for all Trusts to achieve within a limited time frame.

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:

Whilst this request from NHSE does not ask for any specific equality actions, as part of our regular workforce monitoring and EDI priorities we will consider the broader equality risks for this particular part of the medical workforce.

Recommendations

The Board of Directors is requested to:

1. Take significant assurance that the Trust is responding to the 10 Point Plan to improve Resident Doctors' working lives, with progress made across all points
2. Take significant assurance that there is a clear governance structure in place to ensure ongoing progress and demonstrate Board commitment.

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

Report prepared by: **Dr Abbas Ramji**
Director of Medical Education

Rebecca Oakley
Director of People, Organisational Development and Inclusion

10 Point Plan to improve Resident Doctors' working lives

Introduction

Resident Doctors are an integral part of the NHS, forming an essential section of Medical staffing within DHcFT. However, nationally, despite previous commitments to act on the concerns they have repeatedly raised about how they are treated as a rotating part of the workforce, many of these problems – payroll errors, poor rota management, lack of access to rest facilities and hot food and unnecessarily repeating training – persist.

These concerns are within our gift to address, in order to promote morale and ensure the Trust remains one of the leading local education providers in the region, which is positive for effective and safe patient care, as well as recruitment of the senior Medical workforce of the future.

NHS England has set out a 10 Point Plan to improve Resident Doctors' working lives – see attached letter to trusts from NHS England, dated 28 August 2025 for further details.

This plan sets out clear expectations for providers, with a 12-week delivery window for initial actions and further milestones extending into 2026.

Action

A Task and Finish Group was set up and led by Dr Jawahar, Guardian of Safe Working Hours (GoSWH) in response to the 2024 request for action on Improving the working lives of Doctors in training. Much of this work overlaps with the 2025 10 Point Plan. Therefore, the Trust is in a positive position to respond to the NHSE requests. As Dr Jawahar is now disbanding this group, the Director of People, Organisational Development and Inclusion and the Interim Medical Director have established a working group to ensure all 10 points are fully implemented and ongoing monitoring takes place.

1. Workplace wellbeing

The Joint Local Negotiating Committee (JLNC) discussed and actioned 'BMA Wellbeing guidance (Five priorities for improving wellbeing in the workplace (bma.org.uk)) items in 2021. This builds on the Trust's agreement to the Fatigue and Facilities Charter in 2018.

Protecting training time - Rotating resident doctors will have specific training requirements for their programmes dependant on their grade (eg portfolio, mandatory training, regional teaching, etc). Personalised work schedules are being used as an enabler.

Onboarding processes are covered as part of the Resident Doctor induction, and specific guidance has been developed for residents that join 'out of sync'. Resident Doctor representatives have reviewed both general and local inductions. Director of Medical Education (DME) communications to supervisors have subsequently been updated and a crib sheet for Clinical Supervisor local inductions has been developed.

2. Rota and schedule transparency

Rota Co-ordinator - Currently this role is fulfilled through a combination of Medical Education and Medical Staffing. It is recognised that the ideal scenario is to have dedicated resource for this.

Work schedules at eight weeks and rosters by six weeks - Work schedules (determines pay and repeating pattern of shifts) are drawn up by Medical Staffing. Rosters (live rotas) are drawn up by Medical Education. Targets are met by medical staffing in line with the Health Education England (HEE) code of practice. Delays (rare) are due to not being given details of the resident from the Deanery. For less than full-time (LTFT) residents, the Good Rostering Guide is followed (NHSE-BMA-Good-rostering-170518-final_0.pdf (nhsemployers.org)

Live rotas - Rotas are already live for south resident doctors and now live rotas have been rolled out for north residents as well.

Self/preferential rostering is not in place as we felt this was referring to self-rostering systems, like those seen within emergency medicine.

3. Annual leave reform

There is an established, well-functioning, annual leave process in place. However, there is no guidance document/policy. The working group agreed that this will be included in the Trust Annual Leave Policy and Guidance and this is currently being updated.

4. Board level leadership

The Executive Medical Director has regular 1 to 1 sessions with the Directors of Medical Education. The Medical Director and GoSWH report to the Board.

National Educational Training Survey (NETS) and GMC surveys – there was a need to embed reporting and sanctioned action plans. This has now been added as a standing item on the Trust Medical Training Committee (TMTC) agenda in order to create a governance framework.

5. Payroll accuracy

Rotating Doctors are more at risk of such errors. Board governance framework for monitoring payroll errors has been asked for. There are policies/procedures to identify and swiftly correct payroll errors.

6. Eliminating mandatory training duplication

Rotating Doctors' learning passports are aligned with the Core Skills Training Framework, using e-Learning for Healthcare (e-LfH)/ESR as the default.. In addition to the core skills training framework (CSTF) (Statutory and Mandatory Training - elearning for healthcare (e-lfh.org.uk)), DHcFT asks for Medicine Management 3, NEWS2,COMHAD and SCRs.

Adopting the NHS Digital Staff passport: Functionality of the Staff Passport requires all relevant organisations in the region to be enrolled. ESR with current functionality should be able to do this through the inter-authority transfer (IAT) process.

7. Exception reporting

Exception reporting processes are firmly embedded, the GoSWH proactively monitors and addresses any exception reports. The exception reporting process is covered at the Resident Doctors' induction.

8. Course-related expenses reimbursement

Reversing payments for course fees during study leave – Up until recently. Resident Doctors paid course fees up-front and were reimbursed after attending eligible courses. NHS England had put this down as an action for them rather than for trusts. However, DHcFT was exploring this beforehand and planned to pursue this independently. There has been some recent progress on this; from 1 October 2025, NHSE has updated that up-front payment of expenses for Resident Doctors will be starting. In terms of our own process, it will continue as now, with Resident Doctors supplying copies of receipts so that we can process them for reimbursement from our Trust (for Core trainees/higher specialty training (HSTs)). This reimbursement will now be at an earlier stage in the process, as certificates of attendance are no longer needed to process reimbursement.

9. Rotation reform

The Department of Health and Social Care (DHSC) and NHS England will develop and launch pilot rotational schemes and continue to look at wider reform. A review of how rotations are managed is now underway and is being led by the DHSC in conjunction with the British Medical Association (BMA). NHS England is working closely with the BMA to fully understand trainees' concerns and to find constructive and workable solutions to address their needs as a matter of priority.

Within 12 weeks, NHS England will: develop and launch suggested pilots of reformed rotational changes, while continuing to look at wider reform.

10. Lead employer model expansion

NHS England will produce a roadmap for extending the Lead Employer model to cover all Resident Doctors and Dentists. NHS England is committed to extending the Lead Employer model to cover all Resident Doctors and Dentists in training. This change will eliminate the need for trainees to change employers with each rotation, reducing duplication and administrative errors while improving continuity, efficiency, and the overall training experience.

By October 2025, NHS England will: develop a comprehensive and financially sustainable roadmap, underpinned by a robust business case. This will include detailed recommendations on costing and funding, service catalogue requirements and pricing models for national implementation. The roadmap will provide a clear framework for expanding Lead Employer arrangements across the system.

Current pay arrangements for Resident Doctors: Foundation and GP trainees are paid under lead employer arrangements. GP trainees by Mersey and West Lancs Teaching Hospitals, and Foundation trainees in the south by University Hospitals of Derby and Burton (UHDB) and Foundation trainees in the north by Chesterfield Royal Hospital.

There is no lead employer arrangement for Core and Higher Psychiatry trainees. These Resident Doctors rotate between DHcFT, Nottinghamshire Healthcare and Lincoln and are paid by the relevant trust where they are working on placement.

- No current Board governance framework
- Input is via the joint venture with DCHS, then goes to UHDB (both inputting into ESR)
- Owing to the above, there is a limit to what DHcFT can report on and directly control.

Summary of DHcFT progress against plan

1. **Workplace wellbeing** – we have already adopted the BMA wellbeing guidance and fatigue, as well as the Fatigue and Facilities Charter. The Safe Learning Environment Charter was presented at the DME Board Meeting on 3 October 2025. This will need to be considered by Deputy Directors of Medical Education (DDME) together with GoSWH, as well as Local Negotiating Committee: Amber (Lead: Dr Nick Long, Deputy Director of Medical Education).

2. **Rota and schedule transparency** – work schedules and live rotas are drawn up within target times. However, the Trust to consider a Rota Co-ordinator role and the utility of e-Rostering solutions currently being implemented (Patchwork Rostering System; Resident Doctor implementation live April 2026), as currently this role is fulfilled by a combination of Medical Staffing and Medical Education: Amber (Lead: Teresa Ellis and Elizabeth Shelley).

3. **Annual leave reform** - whilst good annual leave practice is covered during induction, there is no guidance document/policy – this is currently being developed Amber (Lead: Teresa Ellis).

4. **Board-level leadership** – a role description for Senior Lead for Resident Doctor Experience (SLRDE) has been released on 2 October 2025. This, together with actioning Resident Doctor peer representation will need to need to be considered through joint discussion between DME and Medical Director: Amber (Lead: Dr Ritu Gupta and Dr Abbas Ramji, Directors of Medical Education). However, it is proposed that the Senior Lead for Resident Doctor Experience is Girish Kunigiri. Medical Director, and an appointment is made to a Resident Doctor peer representative who would sit on the working group and feed directly into the People and Culture Committee and Board.

5. **Payroll accuracy** - payroll Board governance framework is not in place. It was an ask in the Improving Working Lives document from April 2024. However, there are not that many residents that we employ directly, and payroll itself is outsourced. Therefore, It is difficult to create a framework that would be responsive to issues that arise, Green.

6. **Eliminating mandatory training duplication** - rotating Doctors' learning passports are aligned with the CSTF. ESR has IAT ability: Green.

7. **Exception reporting** - exception reporting processes are firmly embedded: Green.

8. **Course-related expenses reimbursement** – relevant course reimbursement can now take place as soon as Resident Doctors submit receipts: Green.

9. **Rotation reform** – being developed by NHS England. No current action requested from the Trust.

10. **Lead employer model expansion** - being developed by NHS England. No current action requested from the Trust.

Summary

Significant progress has been achieved within a short space of time in order to address the 10 Point Plan, as set out by NHS England.

Key areas of progress include eliminating mandatory training duplication for rotating Resident Doctors, course-related expenses reimbursement for Resident Doctors being streamlined, and ongoing promotion of a supportive culture within Medical Education to support workplace wellbeing.

There is a new national reporting requirement to submit basic workforce numbers and rota compliance on a quarterly basis, which has now been submitted (first submission deadline 31 October 2025) and it is expected that the level of reporting detail will increase over the coming months.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 25 November 2025

Children in Care annual report 2024/25

Purpose of Report

The purpose of this report is to provide Derbyshire Healthcare NHS Foundation Trust (DHcFT) an overview of the progress, challenges, opportunities, and future priorities to support and improve the health and wellbeing of Children in Care in Derby City. This is an assurance report to provide the Board with scrutiny of this on how this service is discharging its legal duties and clinical standard requirements.

Executive Summary

- The report includes all cohorts of Children in Care that Derby City Local Authority is responsible for, no matter where they live
- The report provides significant assurance on the provision, performance, and outcomes for children in the service. All Health performance have been maintained to ensure outcomes for our children
- It is recognised that the Children in Care Health team has core competencies, specialist skills, knowledge, and attitudes to act as advocates, undertake health assessments and identify and manage health needs
- The Designated Nurse for Children in Care and Named Nurse for Children in Care have been involved in the roll-out of the Dental Pathway to support the improvement of children and young people being seen by a dentist
- The Designated Nurse for Children in Care and the Sexual Health service have met and discussed the sexual health needs for Children in Care. It has now been agreed that some of our most vulnerable children and young people can be offered an ACORN Card which provides an opportunity for the young person to have priority access to the Sexual Health service.

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 organisation will assure measures are put into place in accordance with the service specification
- Maintain working relationships with other partner agencies/services
- The statutory timescales will be monitored, and evidence is provided and scrutinised, in order, to achieve outcomes
- Training compliance will be scrutinized to ensure competency of staff to the right level.

Consultation

- This report has been developed by the Named Nurse for Children in Care with information that is held by both provider and local authority
- Various members of the wider Children in Care team have contributed to the report
- A child-friendly annual report will be developed in a leaflet form
- Quality and Safeguarding Committee, 10 September 2025.

Governance or Legal Issues

- The Trust meets statutory obligations and legal duties regarding: Mental Health Act [1983]; Mental Capacity Act [2005]; The Care Act [2014]; Children and Families Act [2014]; Human Rights Act [1998] Domestic Violence, Crime and Victims Act [2004] and our internal systems, structures and processes are joined up and effective
- The Trust meets the required standards for our Regulators and our Professional Regulatory bodies Codes of Practice, ie Safe, Caring, Effective, Responsive, Well-led and Safeguarding are one of the gold threads that runs throughout. We apply national guidelines and evidence based best practice. eg NICE, DoH, National Statistics
- The Trust contributes as an equal partner in multi-Agency forums, eg MAPPA; MARAC; Channel; Child and Adult Safeguarding Boards and subgroups and takes part in peer assessment, benchmarking and self-assessment and assurance
- The Trust invests in staff across multiple agencies and services to ensure high levels of competence and confidence and achieve consistently good practice that is constantly updated and refreshed within a culture of learning from both successful and adverse situations.

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:

- Empowerment - of the individual to make decisions
- Protection - support and representation for those in need
- Prevention - of abuse/neglect as well as helping the person to reduce the risks of harm and abuse that are unacceptable to them
- Proportionality - responses should be least restrictive to the person’s rights
- Partnerships - working collaboratively to prevent, identify and respond to harm
- Accountability - and transparency in delivering safeguarding.

Recommendations

The Board of Directors is requested to:

1. Give appropriate feedback
2. Receive significant assurance of the work within the Trust around Children in Care and young people and the continued partnership working to ensure the best outcome is achieved for this vulnerable group of children and young people
3. Accept the annual report and agree on the key priorities set for 2024/25.

Report presented by: **Lynn Andrews**
Chair, Quality and Safeguarding Committee

Report prepared by: **Kelly Thompson**
Named Nurse Children in Care

Derbyshire Healthcare
NHS Foundation Trust

ANNUAL REPORT FOR DERBY CITY LOOKED AFTER CHILDREN PROVISION

Year 2024/25

Contributors:

Kelly Thompson (Named Nurse for Children in Care – DHcFT)

Dr V Kapoor (Designated Doctor for Children in Care – DHcFT)

Dr S Mehta (Medical Advisor for Children in Care and Adoption – DHcFT)

Lisa Ogden (Admin Co-ordinator – DHcFT)

Section 1: Introduction and context

The purpose of this report is to provide Derbyshire Healthcare NHS Foundation Trust (DHcFT) an overview of the progress, challenges, opportunities, and future plans to support and improve the health and wellbeing of looked after children in Derby City. This includes all cohorts of looked after children that Derby City Local Authority are responsible for, no matter where they live (see section 4 for explanation of the differing cohorts).

1.1. The report will outline how Commissioners, Designated Professionals, Local Authority and Health Providers have worked together in partnership to meet the health needs of children in care in Derby City; in line with the statutory guidance 'Promoting the health and wellbeing of looked after children' (DH, 2015).

It will summarise key improvements, service performance; along with setting out the objectives and priorities for the next financial year (2025/26) for Children in Care in Derby City.

1.2. This report has been compiled in partnership with the Named Nurse for Children in Care, the Medical Advisors and Specialist Children in Care Nurses and Admin.

1.3. Within all national and local policies and guidance the service is known as Looked after Children, however within Derbyshire Healthcare NHS Foundation Trust the service is known as Children in Care.

Context

1.4. **Definition of a looked after child/ child in care**

A child that is being looked after by the Local Authority; they might be living with:

- Foster parents
- At home with their parents under the supervision of Children's Social Care
- In Local Authority or private residential children's homes
- Other residential settings such as schools or secure units.

They might have been placed in care voluntarily by parents struggling to cope, or Children's Social Care may have intervened because a child was at significant risk of harm.

Health and wellbeing of looked after children

1.5. It is well recognised that children's early experiences have a significant impact on their development and future life chances. As a result of their experiences and blended effects of poverty, poor parenting, chaotic lifestyles, abuse and neglect, looked after children often are at greater risk and have poorer health than their peers (DfE, DH, 2015).

Ref: Promoting the health and well-being of looked-after children, March 2015, Department for Education and Department of Health

1.6. The Royal College of Paediatrics and Child Health (2020) states that looked after children and young people have greater mental health problems, along with developmental and physical health concerns such as speech and language problems, bedwetting, coordination difficulties and sight problems. Furthermore, the Department for Education and Department of Health

(2015) argue that almost half of children in care have a diagnosable mental health disorder and two thirds have special educational needs. When there are delays in identifying or meeting the emotional and mental health needs this can have a detrimental effect on all aspects of their lives leading to unhappy unhealthy lives as adults.

Ref: Promoting the health and well-being of looked-after children, March 2015, Department for Education and Department of Health

Ref: Looked after children: Knowledge, skills and competencies of health care staff, Intercollegiate Role Framework, December 2020, Royal College of Paediatrics and Child Health

Section 2: Statutory Framework, Legislation and Guidance

The statutory guidance focused around Looked after Children is in abundance; the key documents and legislation are outlined as follows:

2.1 **Children Act (1989)**

Under this Act a child is defined as being 'looked after' by the local authority if the child or young person is in their care for a continuous period of more than 24 hours by the authority.

There are four main groups:

- **Section 20** children who are accommodated under a voluntary agreement with their parents
- **Section 31 and 38** children who are subject to an interim care order or care order
- **Section 44 and 46** children are subject to emergency orders
- **Section 21** children who are compulsory accommodated including children remanded to the care of the local authority or subject to criminal justice supervision with a residence requirement.

2.2 **Adoption and Children Act (2002)**

This Act modernised the law regarding adoptive parenting in the UK and international adoption. It also enabled more people to be considered by the adoption agency as prospective adoptive parents. This Act also places the needs of the child being adopted above all else.

2.3 **Children and Young People's Act (2008)**

The purpose of the Act is to extend the statutory framework for children in care in England and Wales and to ensure that such young people receive high quality care and services which are focused on and tailored to their needs

2.4 **Children and Families Act (2014)**

This Act strengthens the timeliness of processes in place to ensure children are adopted sooner. Due regard is given to the greater protection of vulnerable children including those with additional needs

2.5 **Promoting the health and wellbeing of looked after children (March 2015)**

This guidance was issued by the Department of health and Education. It is published for Local Authorities, Clinical Commissioning Groups now Integrated Care Boards - ICB, Service Providers and NHS England.

2.6 **Looked after children: Knowledge, skills and competences of health care staff intercollegiate role framework (December 2020)**
This document sets out specific knowledge skills and competencies for professionals working in dedicated roles for looked after children

2.7 **The Children and Social Work Act (2017)**

Improves decision making and support for looked after and previously looked after children in England and Wales

- Improve joint work at local level to safeguard children and enabling enhanced learning to improve practice in child protection
- Enabling the establishment of new regulatory regime for the social work profession
- Improve the provision of relationship and sex education in schools

Section 3: Looked after Children data and profile

National and local data

3.1 The number of looked after children has increased steadily over the past eight years. There were 83,840 Looked after Children on 31 March 2023, an increase of 2%, compared to 31 March 2022. (Department for Education DfE, Department of Health DH, 2023).

3.2 **Number of children looked after in England from 31 March 2015 to 2025**

2015	**69,540**
2016	**70,440**
2017	**72,670**
2018	**75,420**
2019	**78,150**
2020	**80,080**
2021	**80,850**
2022	**82,170**
2023	**83,840**
2024	**83,630**
2025	**83,630**

Ref: Data made available from Derby City Local Authority Informatics Department

3.3 **Number of children looked after in Derby from 31 March 2017 to 31 March 2025**

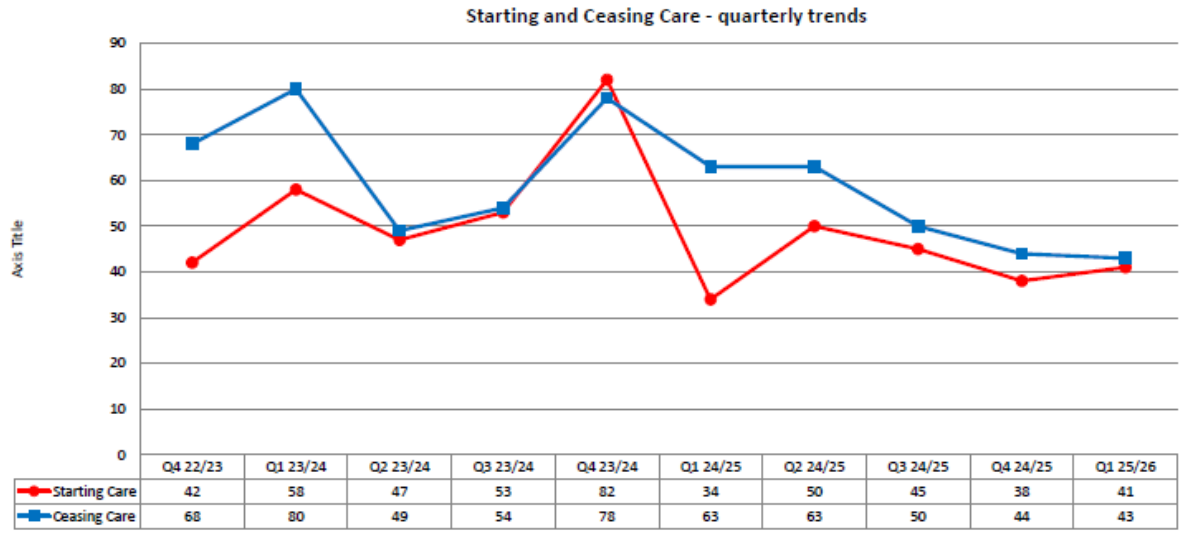
2017	**448**	**0.8% decrease from 2016**
2018	491	8% increase from 2017
2019	562	12% increase from 2018
2020	588	4.6% increase from 2019
2021	642	9.4% increase from 2020
2022	627	2.3% decrease from 2021
2023	621	1.1% decrease from 2022
2024	598	3.7% decrease from 2023
2025	545	8.9% decrease from 2024

Ref: Data made available from Derby City Local Authority Informatics Department

At the end of the year on 31 March 2025, Derby had 545 children in care. This represents a decrease from the 598 children recorded at the end of the previous year which equates to an 8.9% decrease.

3.4 Children in Care - starting and ceasing care - quarterly trends.

There was an increase in the number of entrants into care during Q2 2024-25. The total number of children who entered care in 2024-25 was 167 compared to 240 in 2023-24. There were 220 children who ceased to be looked after in 2024-25, a decrease from the previous year. Derby's rate of ceasing care was higher than the national average. Adoption rates in Derby increased to 12%, higher than national averages.

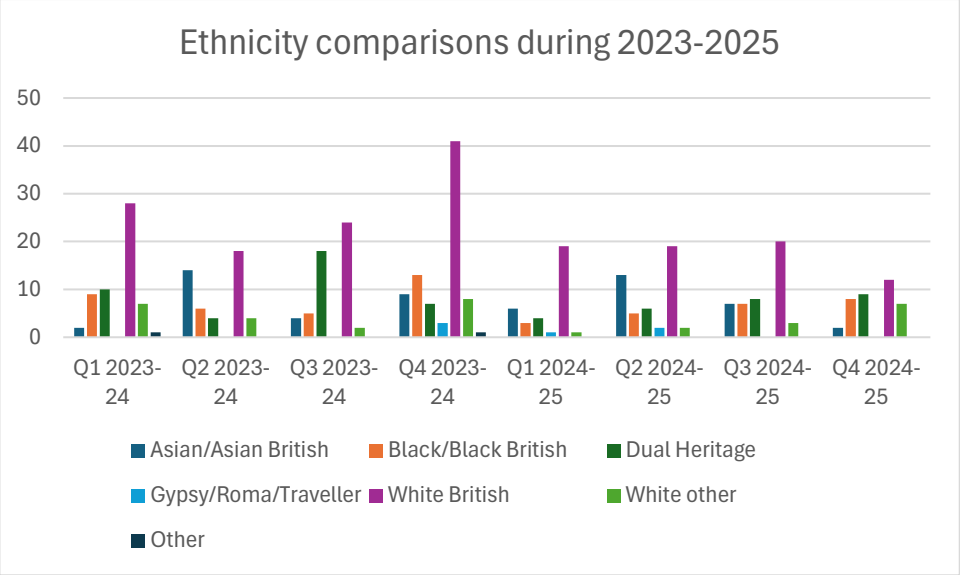


	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25	Q1 25/26
Starting Care	42	58	47	53	82	34	50	45	38	41
Ceasing Care	68	80	49	54	78	63	63	50	44	43

Ref: Data made available from Derby City Local Authority Informatics Department

Profile of looked after children in Derby City

3.5 Ethnicity comparisons over the last three years:



Ref: Data made available from Derby City Local Authority Informatics Department

The Children in Care team acknowledge, adapt, and respond to the many changes in demographics of children in care, and understand that different ethnicities are changing. The Children in Care team are dedicated to ensuring that the care offered is culturally adapted to each ethnicity demographic and offer a culturally competent service.

The placement team try to match ethnicity/culture where they can, however this is not always possible due to the balancing of availability and timings. Culture and identity are always discussed at Looked after Children reviews and plans are put in place to ensure the child's needs are being met and fulfilled. The Review Health Assessment pre-checklist has a section to prompt the nurses to confirm the ethnicity and to consider if care offered is culturally adapted and offers a culturally competent service.

Unaccompanied Asylum-Seeking Children (UASC) leaflets (gender specific and general health) are available in different languages for our children in care.

Derby City Local Authority are linked to the East Midlands Migration group. Any relevant information is distributed to the Designated Nurse for Looked after Children and shared with the Children in Care Team.

The Local Authority have employed a specific UASC team, in order, to support the continuity and cultural compatibility.

The Children in Care Team have a Trauma Informed Navigator, employed by Derbyshire Healthcare Foundation Trust, in the team. The role of the Trauma Informed Navigator is to support our Unaccompanied Asylum-Seeking Children and Young People with their health needs by signposting to specialist services.

White British remains the most dominant ethnicity of our Children in Care. There was an increase of Asian/Asian British children and young people who entered care during quarter 2.

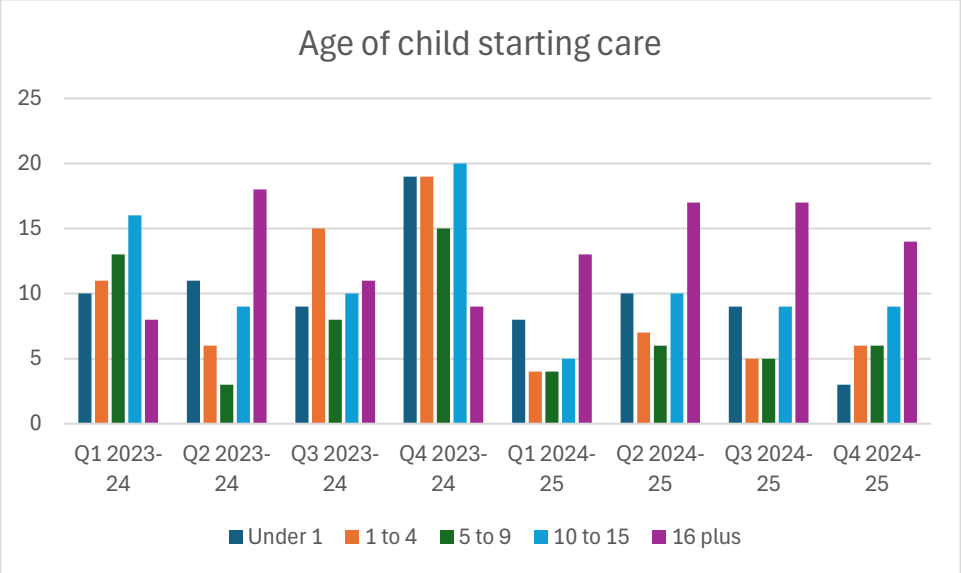
3.6 Gender of looked after children in March 2025

Gender	
Male	55%
Female	44%

Ref: Provisional data made available from Derby City Local Authority Informatics Department

There were 300 males and 245 females in care on 31 March 2025. This equates to a split of 55% male versus 44% female. There were 55 more boys than girls in care on 31 March 2025.

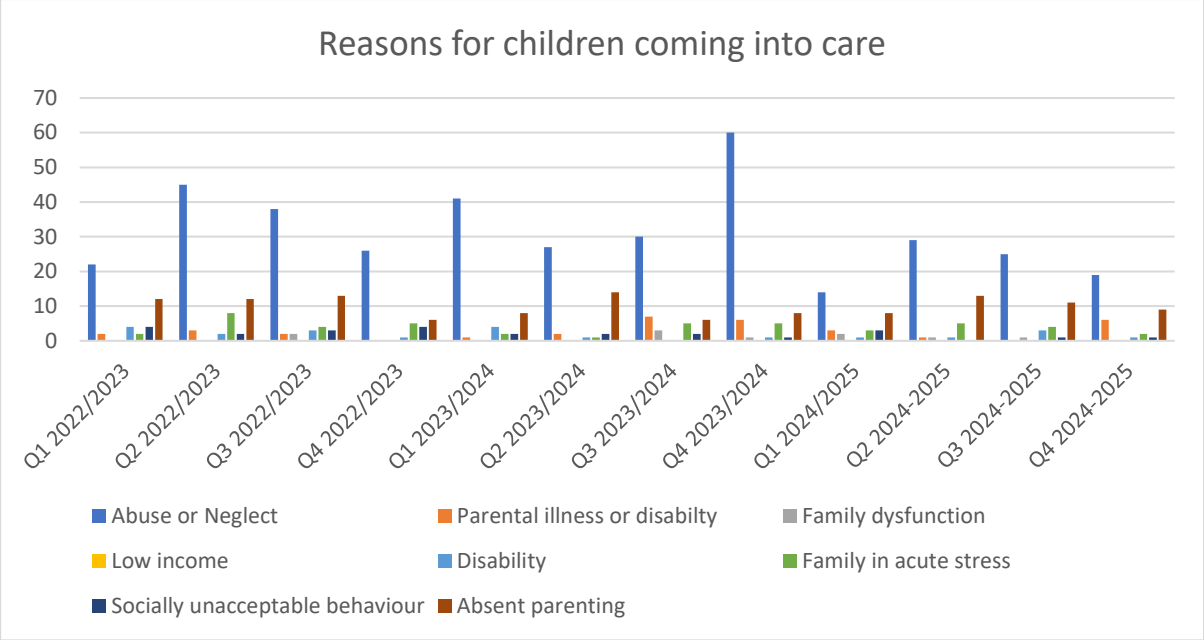
3.7 **Age comparisons over the last two years:**



Ref: Data made available from Derby City Local Authority Informatics Department

The number of babies in care aged less than 1 year old increased during quarter two. The 10-15 age group have decreased during quarter one. Increase in older children (16+) entering care, with a rise to 37.2% in 2024-25, likely linked to the increase in UASC

3.8 **Reasons for children coming into care and ceasing care – comparison per quarter over the last three years:**

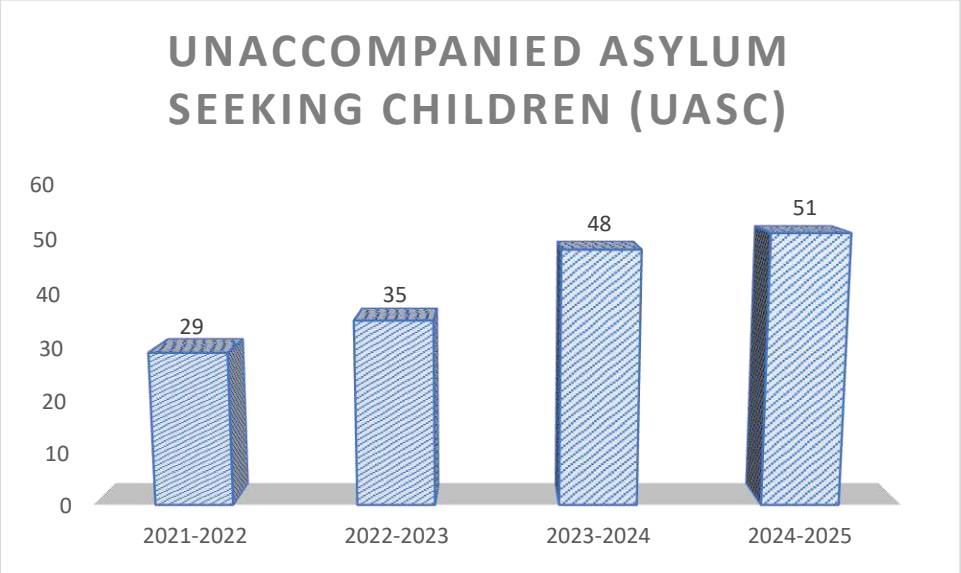


Ref: Data made available from Derby City Local Authority Informatics Department

Abuse and neglect remain the most dominant reason for children/young people coming into care, with absent parenting being the second main reason. There has been a decrease in children entering care due to Abuse or Neglect, but an increase due to Absent Parenting and parental illness.

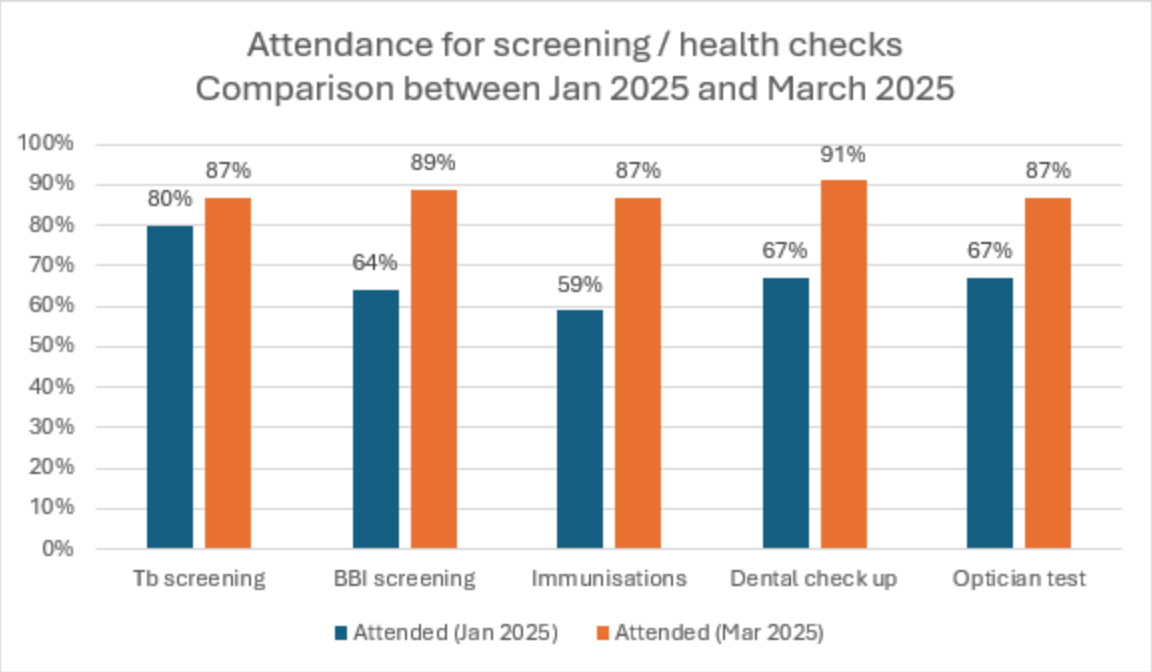
3.9 Unaccompanied Asylum Seeker Children (UASC) 2022-25

The number of Unaccompanied Asylum-Seeking Children (UASC) increased in Derby during 2024-25. On 31 March 2025, Derby had 51 UASC in care (provisional), compared to 48 at the previous year end, marking a 6% increase. This is the largest number of UASC recorded in Derby over the past seven years. Below is a graph showing number of UASC children looked after at year end.



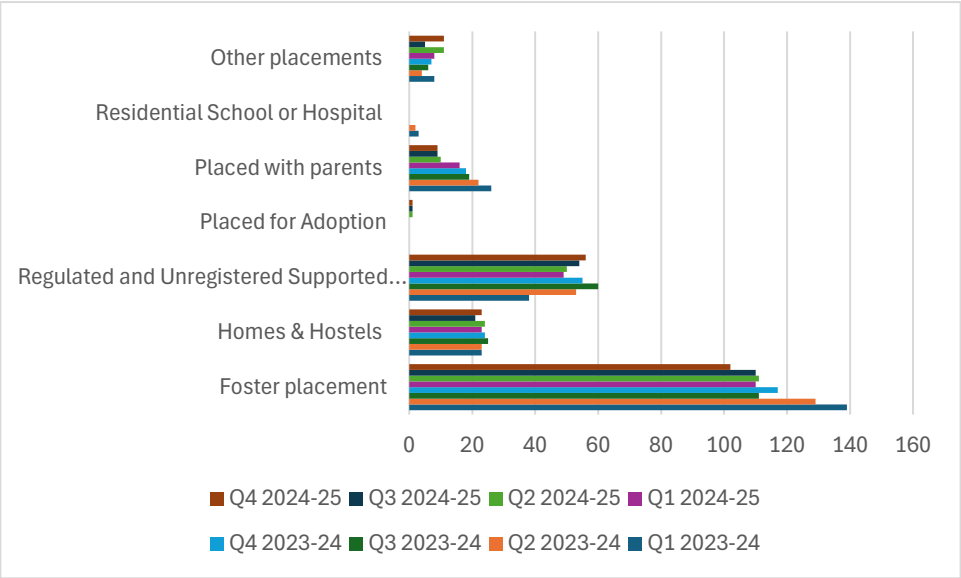
Ref: Data made available from Derby City Local Authority Informatics Department

In December 2024 the team were successful in recruiting a Trauma Informed Navigator to support the Unaccompanied Asylum-Seeking Children (UASC). The role is to offer an additional level of health navigation for our UASC. Part of their role will be to facilitate the young people making informed choice and having a full understanding of the need for the screening, suggested screening / interventions suggested and to have their immunisations in the UK, even if they consider themselves fully immunised in their country of origin. Below is a graph to evidence the improvements made with Unaccompanied Asylum-Seeking Children attending health appointments following on from the Trauma Informed Navigator's support and signposting to health services.



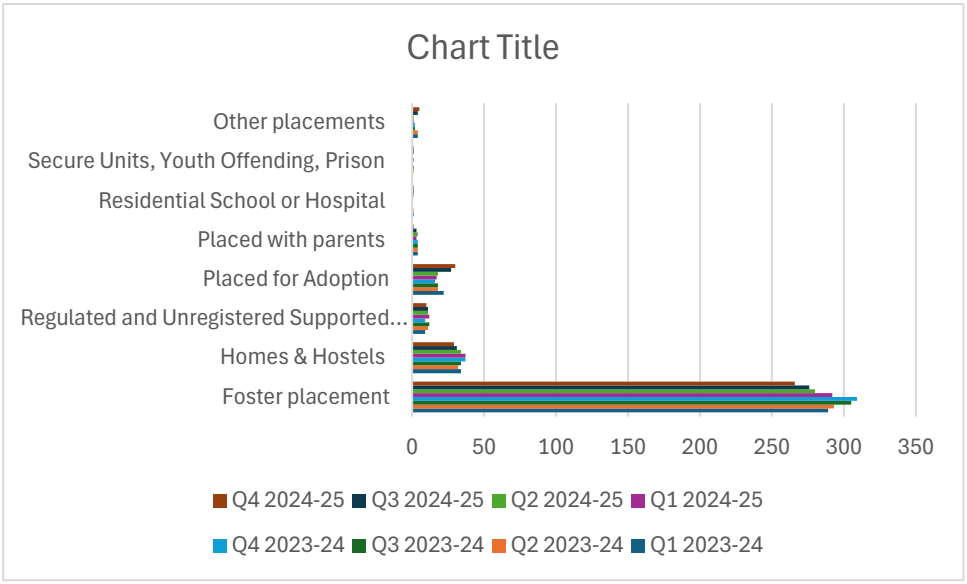
It is clear from the comparative data between Jan 2025, prior to Trauma Informed Navigator being fully in post and the data collection in March 2025, that the role holder is having a significant impact on supporting UASC having their screening and dental / eye health checks.

3.10 Location of Placement



Ref: Data made available from Derby City Local Authority Informatics Department

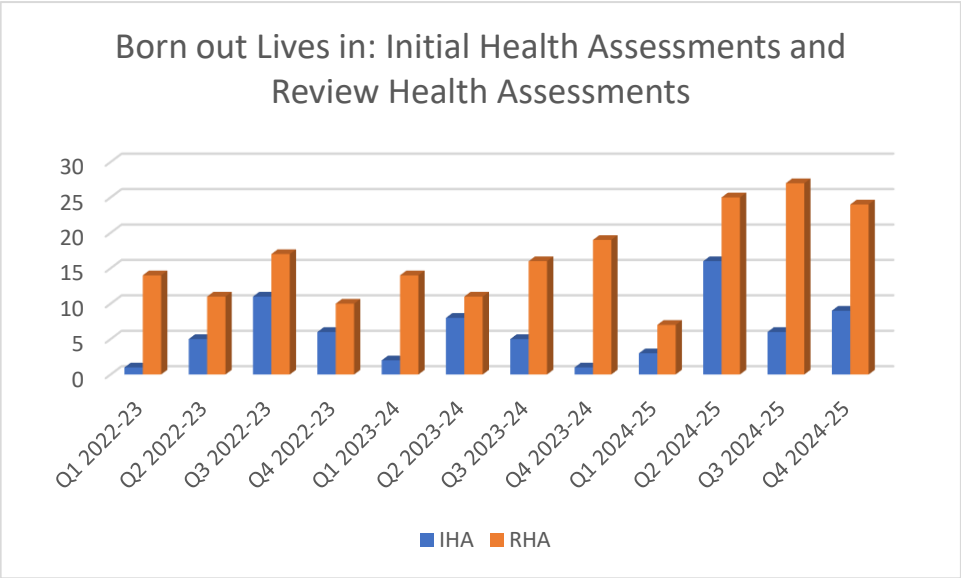
The above graph shows the type of placements inside the city boundary. Most of the Children in care are in foster placements.



Ref: Data made available from Derby City Local Authority Informatics Department

The above graph shows the type of placements outside the city boundary. Most of the Children in care are in foster placements. There were more children adopted outside the city boundary.

3.10 Children in Care – Born out Lives in Derby City

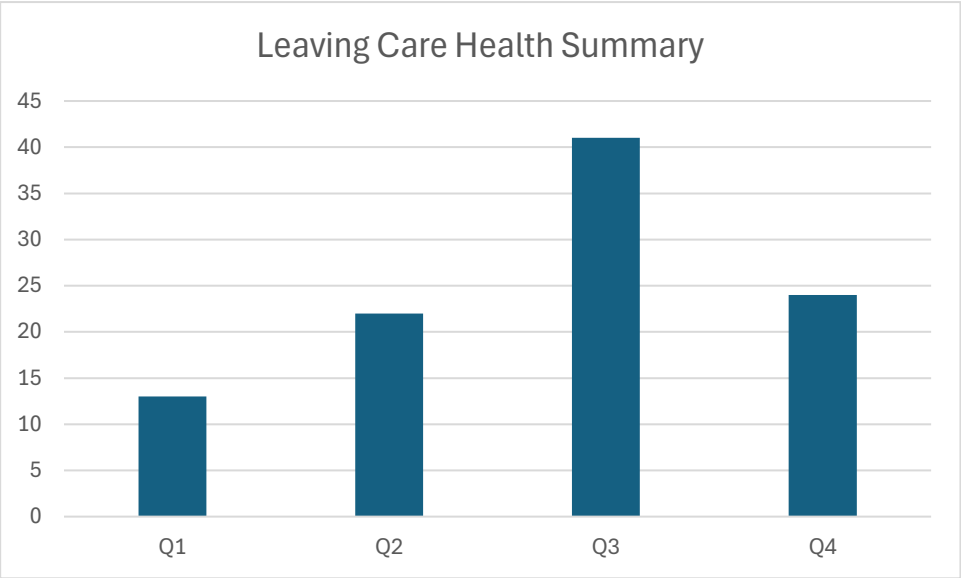


Ref: Data made available from Derby City Children in Care Quarterly Dashboard

BORN OUT, LIVES IN – Looked after Children that were born in another area outside of Derby City (or taken into care by an external Local Authority) but reside in Derby City. Children in Care placed in Derby City from other Local Authorities are supported by the 0-19 Service. Derby City Children in Care Team will undertake Health Assessments on behalf of other Local Authorities upon request. There was an increase in requests for Initial Health Assessments in 2024-2025, quarter two. In 2024-2025 from quarter two there has been an increase in requests for Review Health Assessments to be completed by the Children in Care Team. The number of 'was not brought' to appointments for children born out living in Derby in 2024-2025 were 20 for the initial Health Assessment and 32 for the Review Health Assessment. It is the responsibility of the originating Local Authority to ensure children and young people placed in Derby City have an Initial Health Assessment and Review Health Assessment within the statutory requirement.

3.11 Children in Care – Leaving Care Health Summary

All Children in Care will receive a Health History Summary following from their Review Health Assessment between the ages of 17 and 18 years. During the Review Health Assessment between ages 16 and 17 years the Leaving Care Health Summary will be discussed with the young person and verbal consent will be obtained for the nurse to complete a health history following on from their last Review Health Assessment. The number of Leaving Care Health Summaries completed during 2024-2025 are shown below:



Section 4: DHcFT service provision for Looked after Children

4.1 The DHcFT Children in Care health team have core competencies, specialist skills, knowledge, and attitudes to act as advocates, undertake health assessments, identify, and manage health needs and provide support/training to Foster Carers and Children's homes (in line with the Intercollegiate Role Framework, RCN, RCGP, 2020). The team also contribute to health care plans for all looked after children including children with special educational needs and/or disabilities.

4.2 The team continue to improve their offer for Children in Care by including the delivery of health promotion to children and young people, support for care leavers, development of a robust system to collate health histories for care leavers, improved identification of risk of child exploitation (including boys/young men) and provision for children who have special needs and/or disability.

4.3 The staffing levels for the health team at the end of the financial year (March 2024) were as follows:

Designation	Hours	WTE
Designated Doctor	2 PA's	0.2
Designated Nurse (DDICB)	37.5 hours	1
Named Nurse	30 hours	0.8
Specialist Nurse	37.5 hours	1
Specialist Nurse	26 hours	0.7

Specialist Nurse	22.5 hours	0.6
Specialist Nurse	22.5 hours	0.6
Trauma Informed Navigator	37.5 hours	1
Band 4 Admin Coordinator	30 hours	0.8
Band 3 Administrator	Vacancy	0.8
Band 3 Administrator	26 hours	0.7

4.4 BORN IN, LIVES IN – Looked after Children born in Derby City (or taken into care by Derby City Local Authority) and reside within the City.

BORN IN, LIVES OUT (placed near home) – Looked after Children that were born in Derby City (or taken into care by Derby City Local Authority) but reside within approximately 20 miles away from Derby City in another Local Authority area.

BORN IN, LIVES OUT (at a distance) – Looked after Children that were born in Derby City (or taken into care by Derby City Local Authority) but reside in another Local Authority area over 20 miles away from Derby City.

BORN OUT, LIVES IN – Looked after Children that were born in another area outside of Derby City (or taken into care by an external Local Authority) but reside in Derby City. Children in Care placed in Derby City from other Local Authorities are supported by the 0-19 Service. Derby City Children in Care Team will undertake Health assessments on behalf of other Local Authorities upon request.

Section 5: Children in Care and Adoption Administrators

5.1 The Children in Care administrative team consists of an Administrator Coordinator (Band 4) and two Administrators (two at Band 3). The team is currently recruiting for a second Band 3 administrator due to a member of the team recently retiring.

The purpose of all three roles is to provide a comprehensive administrative support service to the Children in Care Health Team, ensuring that all administration needs are fully met and that the administrative processes and procedures run smoothly. Responding and making decisions where necessary and following up any actions from health professionals from local and external areas with confidentiality, discretion, and diplomacy due to the sensitive information being shared regarding these vulnerable children. The admin team have built close working relationships with the local authority to be able to deliver the service to the highest standard.

5.3 The admin team continue to strive to deliver the best possible service and make improvements to our administration systems and processes. The Admin Co-ordinator has worked hard to maintain an oversight of compliance and has highlighted any issues or challenges to both the Operational Lead and Named Nurse/Clinical Lead. The Admin Co-ordinator has introduced weekly compliance reports to ensure that any concerns are recognised early and will then communicate and discuss any concerns (consent issues, Initial Health Assessment compliance, Review Health Assessments, Local Authority responses) with the Operational

Lead and Named Nurse as and when is needed. We have improved the Initial Health Assessment consent form and Blood Borne Infection consent. Alongside the Named Nurse and Designated Doctor, we developed an information sheet on Blood Borne Infection Screening for birth parents, foster carers and young people over the age of 16 years to ensure that correct consent is obtained by the social worker in a timely manner to ensure compliance. The Admin Co-ordinator has updated the consent process and the Blood Borne Infection testing process to ensure that information is gathered in a timely manner. The Admin Coordinator and Team Administrators continue to dedicate time to ensure 'Groups and Relationships' within the electronic patient record are kept up to date. We have also made improvements to the spreadsheets we use, making them easier to understand and easier to access. All Initial Health Assessment requests are now on one spreadsheet instead of multiple spreadsheets and the same with Review Health Assessment requests. This has improved data collection. We have also updated the pathway and process for requesting Forms M&B (Mother and Baby) – meaning we are now receiving these back for children coming into care under the age of 8 years. The Forms M&B provide essential information to support the Adoption Support Specialist Liaison Nurse and the Doctors for Adoption when collating information for the Adoption Decision Making report.

Section 6: Health Data and Performance for Year 2024/25

6.1 Health data and Local Authority performance is a mandated submission to the Department for Education on a yearly basis and the table below summarises the performance over the last four years:

** Please note all health data for 2024/25 is provisional until submitted to the Department for Education**

Health Data Indicator	Year 2020/21	Year 2021/22	Year 2022/23	Year 2023/24	Year 2024/25
Annual health assessments	93.8%	92.6%	92.9%	93.8%	95.3%
Dental checks	29.2%	77%	90.6	85.3%	87.8%
Immunisations up to date	93.1%	94.1%	95.3%	96.1%	94.1%
Development checks (two RHAs in the 12 months for under 5 years old)	96.6%	86.9%	98.6%	94.1%	96.8%

NB: the data is only mandatory for those children/young people in care for a period of 12 months or more.

6.2 **Annual Health Assessments** – Health assessment checks have increased from 93.8% to 95.3%, an increase of 1.5% (405 out of 425). This is higher than the latest national figure of

89.0%, higher than the East Midlands average of 88.4% and above the comparator authority average of 90.2%

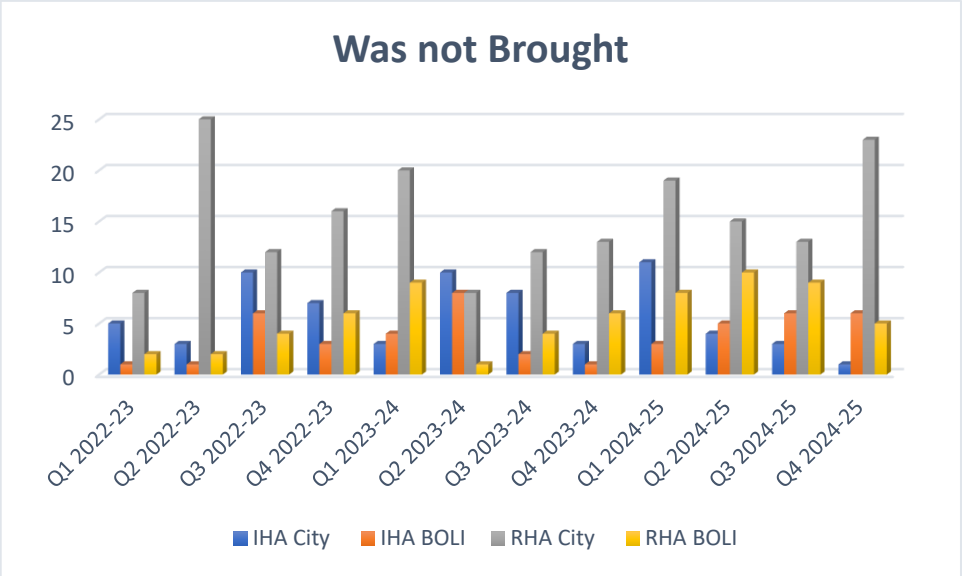
Dental Checks - Dental checks have increased from 85.3% to 87.8%, an increase of 2.5% (373 out of 425). This is higher than the latest national figure of 78.9%, higher than the East Midlands average of 79.9% and above the comparator authority average of 85.0%

Immunisations - Up to date immunisations has decreased from 96.1% to 94.1%, a decrease of 2.0% (400 out of 425). Despite the decrease, Derby remains higher than the latest national figure of 82.2%, higher than the East Midlands average of 74.5% and above the comparator authority average of 89.3%

Development Checks - Health assessment checks have increased from 94.1% to 96.8%, an increase of 2.7% (61 out of 63). This is higher than the latest national figure of 87.7%, higher than the East Midlands average of 94.2% and above the comparator authority average of 94.0%

6.3 Since the Children in Care team have access and the mechanism to update Liquid Logic (Local Authority IT system), the accuracy of heath data has significantly improved. The Named Nurse for Children in care and the Designated Nurse for Children in Care meet on a quarterly basis to ensure all the correct information is recorded and any outstanding information is passed onto the Children in Care Nurses and admin to chase.

6.4 Shown in the table below are the number of children in care who were not brought to their health assessments during 2022-23, 2023-24 and 2024-25.



Ref: Data made available from Derby City Children in Care Quarterly Dashboard

The above includes children born in Derby living within a 20-mile radius and children from out of area placed within Derby City.

Some of the reasons for 'was not brought' to their appointment are shown below:

- Young person refused to attend.

- Foster carer not aware of the appointment – it is the responsibility of the social worker to inform the foster carer of the Initial Health Assessment appointment date and time.
- Foster carer forgot to cancel.
- Child placed with parent.
- Foster carer did not receive the appointment letter.
- Foster carer mislaid the appointment letter.

Any 'was not brought' or cancellation of the health assessment appointment, for whatever reason, can have a huge impact on our compliance. The Children in Care Team have a 'was not brought' pathway to follow if a child is not brought to their appointment.

It is the responsibility of the social worker to inform birth parents and foster carers of the Initial Health Assessment appointments.

Two years ago, the Children in Care Team changed to hybrid printing, this is a more efficient way of sending appointment letters out for Review Health Assessments, the aim is to prevent carers not receiving the appointment letter in a timely manner resulting in a decrease in 'was not brought'. Despite the change to hybrid printing of appointment letters, there is still a high number of 'was not brought' particularly in quarter one and four for the Review Health Assessments and quarter one for the Derby City Initial Health Assessments. The Named Nurse CiC will continue to work closely with the Designated Nurse CiC, the Local Authority and the team to look at the reasons for 'was not brought' and how we can reduce the numbers over 2025-2026.

Section 7: Analysis of Adoption and Medical Adviser Activity

This section is compiled by Derby City medical adviser
Dr S Mehta,
Children in Care and Adoption Team, Derby City

This section of the report has been prepared based upon the information available from DHCFT data and data provided by the Local Authority regarding adoption related work. The section has been compiled by Derby City medical advisers, Dr Sujata Mehta and Dr. Mehwish Ishfaq, Children in Care and Adoption Team, Derby City.

ADOPTION ACTIVITY

The format of the reports provided for ADM (Agency decision maker) has been working well over the past year and the feedback from the agency has been positive. This has proved to be helpful to the medical advisers who provide the report and to the readers of these reports as they are more comprehensive and nicely summarised in the beginning of the report. The workload has also been more streamlined with designated time and clinic slots to complete these reports and reports have generally been going out on time, meeting strict deadlines.

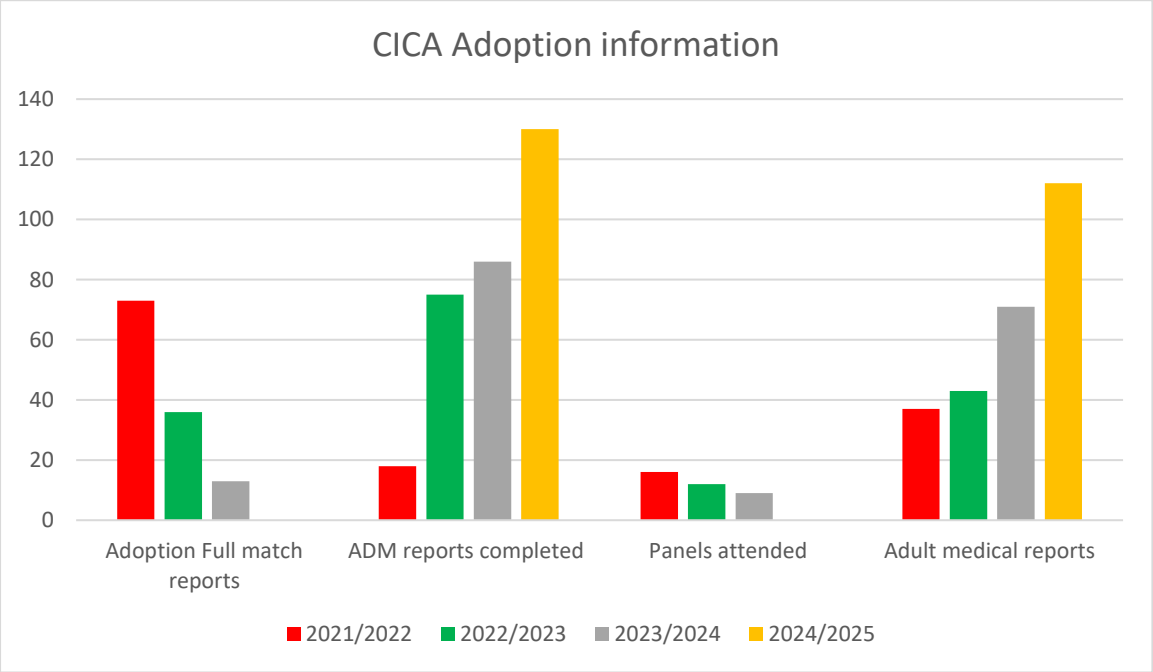
7.1 There had been two Medical Advisors contributing to the Adoption work for Derby city until December 2023. From January 2024, one of the Medical Advisors has left to take on a new role and the other went on maternity leave. A new Medical Advisor started in post from October 2023 and, in conjunction with the Named Nurse for Children in Care and more

recently the Adoption Support Specialist Liaison Nurse, has been contributing to the adoption work by preparing the reports for those coming up for adoption at the Agency Decision Making and matching stage. However, attending or contributing to Adoption panels has not been happening since January 2024 due to shortage of staff, the Adoption panels were covered by other Medical Advisers for Adoption East Midlands.

7.2 The Regionalised Adoption service (Adoption East Midlands) continues to work incorporating four neighbouring regions of Derby City, Derbyshire, Nottingham City and Nottinghamshire. The cases for matching the Derby City children continue to be heard at any of the panels within the region, attended by different medical advisers. An efficient and timely liaison between different medical advisers is needed to explore and clarify any issues in advance of panel, which may get affected by the capacity issues, requiring Medical Advisers to always be available as queries may arise from any panel.

7.3 The following adoption activity data is provided by Adoption East Midlands (From 1st April 2024 to 31st March 2025)

- Total number of adoption children's medical reports (Matching reports) 0 – (13 in 2023-24)
- Total number of ADM Reports –130 (86 in 2023-24, this was new additional work following Somerset ruling since January 2022)
- Total number of adult medical reports – 67, which includes reports for fostering and adoptive parents, (71 in 2023-24)
- Total number of panels attended (advice provided by Derby City medical advisers) – 0 (9 in 2023-24)
- Number of Prospective adopter consultations undertaken 2 - (4 in 2023-24)



There continues to be a rise in the number of reports at the ADM stage and adult medical reports which includes reports for fostering and adoptive parents.

There were one prospective adopter consultations undertaken formally (by telephone, none face to face) during this period, as the previously agreed regional process continued for prospective adopter consultations providing the preadoption advice in a targeted and formal way in writing. We continue to invite questions in writing from adopters via the Social Worker, which are responded to in writing, included on the report if possible, or separately if received later, also the report format is very comprehensive and includes any history and implications in detail. A telephonic consultation is only provided in selected cases, if requested, to answer any specific queries which remain or if the child has a very significant or complex medical condition.

7.4 The training sessions by Medical Advisors for prospective adopters, foster carers and Social Workers happened twice last year, incorporating training on common clinical issues in an adoption scenario, i.e. impact of maternal smoking, alcohol and drug misuse in pregnancy and Blood Borne Infection screening in vulnerable and high-risk children. It is hoped that this activity will continue.

7.5 The Medical Advisors attend regular quarterly Adoption East Midlands meetings with other Medical Advisors and panel advisors (plus commissioners if appropriate). They also attend panel training days twice a year.

7.6 The Named Doctor for Children in Care and the Named Nurse for Children in Care also deliver a training lecture on Children in Care and Adoption as part of the GP vocational training course in Derby.

Section 8: Derby and Derbyshire Development Day

8.1 The Named Nurses for Children in Care for Derby City and Derbyshire and the Designated Nurses for Children in Care for Derby and Derbyshire Integrated Care Board held a development day for Derby City and Derbyshire Children in Care Teams.

8.2 The Sexual Health Service delivered a session on the fast pass to Sexual Health Services for Children in Care. It has now been agreed that some of our most vulnerable children and young people can be offered an ACORN Card which provides an opportunity for the young person to have priority access to the Sexual health Service. ACORN cards should be only given to those Children in Care / Care Experienced Young People who are struggling to access sexual health—needing quicker appointments, support with accessing and those not previously engaged with the service.

8.3 The Child and Adolescent Mental Health Service, CAMHS delivered a session on their service delivery in the City and South Derbyshire.

8.4 There was an opportunity for networking, nurse, doctors, and admin got into mixed groups to look at challenges, best practice, and priorities for the year ahead. It was agreed to set up a working group to look at Healthy Lifestyle and obesity, there are plans to develop a pathway in 2025-2026.

8.5 Joined up Care Derbyshire delivered a session around their offer in supporting care leavers.

8.6 The East Midlands Named Nurses also planned a development day for all East Midlands Specialist Children in Care Nurses. This was a virtual session to provide opportunities for learning and networking.

8.7 The Named Nurses delivered a session on their own areas including information on age range covered, numbers of children in care within their own boundaries, number of children in care placed outside of their boundaries, and number of children in care placed within their own boundaries by other local authorities.

8.8 A session was delivered by Re-Solve on solvent misuse, the impact on children and young people, support available and asking the question at health assessments.

8.9 CoramBAAF delivered a session on the new proposed health assessment forms.

8.10 A representative delivered a session on Unaccompanied Asylum-Seeking Children.

8.11 One of the East Midlands Designated Nurse provided an update on what is currently happening within the East Midlands and the networking session gave the Specialist Nurses for Children in Care to go into breakout rooms to discuss service offer. The breakout rooms were a mix of nurses from each team.

Section 9 Summary of achievements in year 2024/25

During the period of 2024/25 the Children in Care health team have continued to experience some changes and it has been acknowledged despite this the Specialist Nurses, Medical Advisors and Administration Team have shown innovation and marked improvements within their service delivery.

The following are an indication of the progress made and not an exhaustive list of achievements:

9.1 The end of year Health Performance Data continues to remain positive as shown in section 6.

9.2 The Designated Nurse, Designated Doctor, Named Nurse, and the Administrator Coordinator have continued to strengthen existing relationships and networks with key professionals, local partners, and agencies locally and regionally, which has facilitated information sharing, health outcomes and the voice of the child (including those out of area).

9.3 Health access to Liquid Logic Child Social Care system continues to improve information sharing between agencies (in the best interest of looked after children) and has a positive impact on the accuracy and validity of health data reportable to Department for Education. At the end of each quarter health information is uploaded onto Liquid Logic and any missing information is followed up by the Children in Care Team.

9.4 Reporting and assurance into the DDICB Quality and Performance Committee have been strengthened via quarterly reporting of performance and quality of the Children in Care service. This has allowed the Named Nurse for Children in Care the opportunity to access and interrogate health data more robustly internally within the Trust, using relevant and useful reporting systems. This in-depth provision of evidence has enabled a more robust way of working at both team and service level and influenced improvements.

9.5 The Specialist Nurses for Children in Care are link nurses to the Local Authority Residential Children's Homes. There are two Specialist Nurses who link with each Local Authority Residential Children's Home. Over 2024-2025 the link nurses have continued to offer health drop-in sessions to each home on a variety of health topics chosen by each home depending on the health needs of the children and young people residing there. These have either been delivered by the Specialist Nurses for Children in Care or jointly with another health service,

such as the drugs and alcohol service or the sexual health service. Topics have also included sleep and healthy/unhealthy relationships.

9.6 Foster carer sessions have been delivered face to face over 2024-2025. Some of the topics covered have included, mental health, attachment, and Re-Solv. The foster carers choose the topics for the year, and these have been delivered by the Designated Nurse CiC, Named Nurse CiC, Specialist Nurses for CiC and some have been supported by external services.

9.7 The Named Nurse from Derby City and Derbyshire held a successful development day for both Children in care teams which was funded by Derby and Derbyshire Integrated Care Board. There were a variety of presentations on the day as discussed in section 8.

9.8 The children in Care Team have provided opportunities for students to shadow the team throughout 2024-2025.

9.9 The Designated Nurse for Children in Care and the Sexual Health Service have met and discussed the sexual health needs for Children in Care. It has now been agreed that some of our most vulnerable children and young people can be offered an ACORN Card which provides an opportunity for the young person to have priority access to the Sexual health Service. ACORN cards should be only given to those Children in Care / Care Experienced Young People who are struggling to access sexual health—needing quicker appointments, support with accessing and those not previously engaged with the service.

9.10 Enhanced Case Management meetings have continued. These are a multidisciplinary meeting focusing on certain topics appropriate to the young person using an outcomes-based tool.

9.11 Developed Blood Borne Infection Screening information sheet for birth parents, young people over the age of 16 years and Unaccompanied Asylum-Seeking Young People. The information provided provides an opportunity for birth parents and the young people to make an informed decision to consent to having the blood borne infection screening.

9.12 It was identified that we had not received any mother and baby forms except for one during 2024/25 despite an agreed pathway being in place between Derbyshire Healthcare NHS Foundation Trust (DHcFT), University Hospital Derby and Burton (UHDB) and the Local Authority (LA). The Named Nurse Children in Care, one of the Doctors and the Admin Coordinator got together to look at how we could improve the process and ensure this was circulated to the relevant professionals. Following discussions with the representative at UHDB the pathway was updated and circulated to the Local Authority, the Children's Adoption Permanence Team, the Designated Nurse Children in Care and UHDB to circulate to the relevant professionals. The Children in Care Admin Team will continue to monitor the number of Mother and Baby forms received and the plan is to audit this in September 2025.

9.13 As discussed in section 3.9 the Children in Care have a Trauma Informed Navigator in the team who supports the Unaccompanied Asylum-Seeking Children whilst they are in care. The team were successful in recruiting a new Trauma Informed Navigator in December 2024.

9.14 The Children in Care Team have a Wellbeing Champion within the team to support the team's wellbeing. One of the Specialist Nurses for Children in Care has successfully attended training for this and delivers wellbeing sessions once a month during lunchtime. The sessions have included some wellbeing interactive sessions and discussions. The Wellbeing Champion will provide updates through email approximately once a week which include any Trust wellbeing

updates, wellbeing quotes and general check in. The team appreciate these sessions and updates.

9.15 During 2024/25 there have been ongoing discussions between the Doctor for Adoption, the Named Nurse Children in Care and the Children's Adoption Permanence Team to improve processes around Adoption Decision Making (ADM) reports. The Named nurse Children in Care has supported the Doctor for Adoption in preparing reports ready for ADM. The Named Nurse Children in Care will collate all health information relevant for the report and the Doctor for Adoption will write the implications and check before approving for the report to be sent. During quarter four there were discussions held with management as part of the transformation process, and it was approved for an Adoption Support Specialist Liaison Nurse to be recruited to as a new role to support with ADM reports and the adoption planning. This role was appointed to in May 2025.

Section 10: Priorities for Year 2025/26

10.1 **DHcFT Provider key priorities for 2025/26:**

- To continue to work closely with the Designated Nurse CiC, the Local Authority and the Children in Care Team to reduce 'was not brought' to appointments.
- To continue to deliver health promotion within the Local Authority Residential Children's Homes.
- To continue to offer the ACORN card for access to Sexual health Services.
- To review the Initial Health Assessment paperwork, to update and improve
- To review the Review Health Assessment paperwork alongside the Derbyshire Children in care Team, to update and improve.
- To continue to represent health at the Enhanced Case management Meetings and Health Meetings with the Local Authority Children's Residential Homes.
- To continue to deliver health sessions and drop-in sessions to foster carers.
- To continue to provide health passports and health history summaries – review layout and content.
- To attend working group around Healthy Lifestyle. One nurse to represent Derby City.
- Any feedback obtained from carers and young people about our services which identifies any learning or changes required to improve the experience of carers, children and young people within our services are acted upon and communicated to the Trust, our foster carers and young people to improve services.
- To audit the Forms M&B
- To review the Review Health Assessment paperwork
- To ensure the Service Action Plan is updated.
- To continue to work closely with the County Children in Care Team working towards the Joined-up Care Derbyshire Approach.
- To build relationships with the leaving care team to improve support around transition.
- To submit the Markers of Good Practice Assurance Tool.
- Continue to provide opportunities for students.

Year 2024/25 Annual Report Children in Care (CIC)

What the CIC health team think they have done well this year…

The health team have provided health sessions for foster carers to help people who care for you

We have a Trauma Informed Navigator in the team to support Unaccompanied Asylum-Seeking Children with their health

We prefer to see you face to face, however we can also offer virtual and telephone appointments depending on your needs

We are able to provide some young people with an ACORN pass—this will support access to sexual health services in a timely manner

How you have helped the CIC health team with your ideas this year...

The health team are constantly trying to improve on capturing your voice during your health assessments

You have given us useful feedback about our health assessments and we always try to improve what we offer you

You have given us ideas on what your Leaving Care Health Summary should look like and what is in it. We have changed it after your feedback

We have link nurses to the Local Authority Children's Homes who deliver sessions on 'your health'

Written by Derbyshire Healthcare NHS Foundation Trust

Date: July 2025

Where is the health team based?

Sinfin Health Centre, Arleston Road, Sinfin

How do I contact them?

Telephone: 01332 389220

When do they work?

Monday—Friday

9.00am until 5.00pm

What can the health team help me with?

Ask us for advice on how to eat healthier, look after your health, general health advice for teenagers and children

And your health assessments….

Inside this report

What do the numbers tell you?

	How well did we do in 2024/2025	What is our goal?	
Your yearly health assessment (over 5 yrs old)	95.3%	90.2%	
Your twice a year health assessment (under 5 yrs old)	96.8%	94%	
Have you been to the dentist for your check up?	87.8%	85%	
Have you had all your injections for your age?	94.1%	89.3%	

Good News

We are trying to support you to attend the **dentist** and to have your **injections**.

If you want to talk to us about going to the dentist or having an injection, please let us know and talk to us about how you feel.

We're here to help.

Dental checks have improved now....YES!!

What we plan to do next year...

We will continue to improve the quality of your health assessments

We will continue to offer health drop-in sessions to foster carers and young people

We will continue to improve how quickly we see you for your health assessment when you come into care

We will review your feedback following a health assessment and look at ways in which we can improve our service using 'you said, we did'

We want to hear your voice...

If you want to tell us how we are doing or you have ideas on how we can do better, PLEASE tell us!

TO ALL OF **YOU**

Guardian of Safe Working Hours (GoSWH) quarterly report (October 2025)

Purpose of Report

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

Executive Summary

The Board is requested to note:

1. **Exception reports**
   a. ST4+ exception reports continue to be for non-resident on call (NROC) rest requirement breaches and all are in the south
   b. One exception report from a GP registrar resulted in payment as the time between their current and next shift dropped below 11 hours. The reason for staying late was due to an absent night doctor
   c. Other exception reports resulted in time off in lieu (TOIL) (ward doctors staying late).
2. **Rota workloads**
   a. An hour's monitoring baseline exercise was completed in the summer in the south and has recently been repeated (analysis). The repeated hours monitoring took place circa one month after the Psychiatric Intensive Care Unit (PICU) opened, where it was felt to be an accurate representation of the workload in the south. One possible outcome is a business case to have two doctors resident overnight, compared to the current one doctor
   b. Numbers of bleeps have been looked into by the Acute services Division, noting that these are frequent and a proxy for doctor workload in the south (one shift returned 50+ bleeps)
   c. There have also been incident forms submitted in the south owing to delays in the resident doctor attending wards. These have been looked in to by Medical Education colleagues and appear to reflect increased workloads.
3. **Exception reporting reform**
   a. The initial go-live date for exception reporting reform was set at September 2025. This was delayed and the new implementation date is 4 February. In preparation for this, draft contractual wording has been published, with further implementation guidance due to be published. There is also the opportunity to be an early adopter site (https://www.nhsemployers.org/news/supporting-early-implementation-exception-reporting-reforms), which the GoSW will look to explore.
4. **GoSW role**
   a. The GoSW has served notice on his three-year term, provisionally due to finish 30 November
   b. The GoSW has committed to drafting the Improving Working Lives of Doctors in Training (https://www.england.nhs.uk/long-read/improving-the-working-lives-of-doctors-in-training/) report before demitting. This will supplement the recently published 10 point plan to improve resident doctors' working lives (https://www.england.nhs.uk/long-read/10-point-plan-to-improve-resident-doctors-working-lives/).

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

Risks and Assurances

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

Consultation

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

Governance or Legal Issues

None.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

None.

Recommendations

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

Report presented by: **Lynn Andrews**
Chair, Quality and Safeguarding Committee

Report prepared by: **Dr Kaanthan Jawahar**
Guardian of Safe Working Hours

GUARDIAN OF SAFE WORKING HOURS - QUARTERLY REPORT (October 2025)

1. Resident doctor data

Extended information supplied from 30 May to 29 September.

Numbers in post for resident doctors in training

Numbers of doctors in post WTE	North	South
FY1	3	5
FY2	2.8	4.6
GP ST	6	6.4
CT	9.8	13.8
HSTs	4.6	6
Paediatrics ST	0	1.4

Key

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

2. Exception Reports

Aggregated data, covering the period **30 May to 29 September**:

Location	No of exceptions raised	No of exceptions closed	No of exceptions outstanding
North	6	5	1
South	14	12	2
Total	**20**	**17**	**3**

Grade	No of exceptions raised	No of exceptions closed	No of exceptions outstanding
CT1-3	9	9	0
ST4-7	7	5	2
GP	1	1	0
Foundation	3	2	1
Total	**20**	**17**	**3**

Action taken

Location	Payment	TOIL	Not agreed	No action required
North	0	5	1	
South	6	6	2	
Total	**6**	**11**	**3**	

Response time

Grade	48 hours	7 days	Longer than 7 days	Open
CT1-3	0	9	0	0
Foundation	0	2	0	1
ST4-7	0	5	0	2
GP	0	1	0	0

- ST4+ exception reports continue to be for non-resident on call (NROC) rest requirement breaches, and all are in the South.
- One exception report from a GP registrar resulted in payment as the time between their current and next shift dropped below 11 hours. The reason for staying late was due to an absent night doctor.
- Other exception reports resulted in TOIL (ward doctors staying late).

3. Work schedule reviews

- No formal work schedule reviews undertaken.

4. Fines

- Current balance: £1,926.89
- £2,162 was spent on the resident doctor away day in July 2025.

5. Locum/Bank Shifts covered (28 March to 29 September 2025)

	North	Cost	South	Cost
Locum/bank shifts covered	83	£56095	128	£77960
Agency locum shifts covered	0		0	

- Industrial action shifts are included in the costs above (July)
- Medical staffing advise there is a high level of sickness at present, resulting in further locum shifts, including weekends.

6. Agency Locum (28 March 2025 to 29 September 2025)

Nil.

7. Vacancies (28 March 2025 to 29 September 2025)

	North	South
CT1-CT3	1.2	0.2
ST4-7	2.4	1
GP registrars	0.7	0.8
Foundation	0.2	0

8. Qualitative information

- **Rota workloads**
  - An hours monitoring baseline exercise was completed in the summer in the south and has recently been repeated (analysis). The repeated hours monitoring took place circa one month after the PICU opened, where it was felt to be an accurate representation of the workload in the south. One possible outcome is a business case to have two doctors resident overnight, compared to the current one doctor
  - Numbers of bleeps have been looked in to by the acute services division, noting that these are frequent and a proxy for doctor workload in the South (one shift returned 50+ bleeps)
  - There have also been incident forms submitted in the south owing to delays in the resident doctor attending wards. These have been looked in to by Medical Education colleagues and appear to reflect increased workloads.
- **Exception reporting reform**
  - The initial go-live date for exception reporting reform was set at September 2025. This was delayed and the new implementation date is 4th February. In preparation for this, draft contractual wording has been published, with further implementation guidance due to be published. There is also the opportunity to be an early adopter site (https://www.nhsemployers.org/news/supporting-early-implementation-exception-reporting-reforms), which the GoSW will look to explore.
- **GoSW role**
  - The GoSW has served notice on his 3 year term, provisionally due to finish on 30th November.
  - The GoSW has committed to drafting the Improving Working Lives of Doctors in Training (https://www.england.nhs.uk/long-read/improving-the-working-lives-of-doctors-in-training/) report before demitting. This will supplement the recently published 10 point plan to improve resident doctors' working lives (https://www.england.nhs.uk/long-read/10-point-plan-to-improve-resident-doctors-working-lives/).

9. Compliance of rotas

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

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

None not already covered.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 25 November 2025

Infection Prevention and Control (IPC) annual report - 2024/25

Purpose of Report

To provide a comprehensive overview of IPC performance for 2025, including compliance against key standards, estates improvements, PLACE outcomes, governance arrangements, and cultural embedding.

Executive Summary

- Completion of the Making Room for Dignity (MRfD) project, delivering five new sites and significant upgrades to Trust estates
- Sustained high standards of cleanliness, with Trust and inpatient averages above 98%
- PLACE assessment scores above national averages in all domains
- IPC training compliance: Level 1 – 96%, Level 2 – 86%
- All IPC policies in date and compliant
- Limited outbreaks, all contained with no harm to patients
- Continued development of IPC link nurses and leadership
- Ongoing capital investment in estates and facilities
- Cleaning standards consistently exceed national benchmarks
- PLACE benchmarking shows DHcFT above peer group averages
- Regular audits, walk-arounds and check-and-challenge processes in place
- Outbreaks managed promptly and effectively
- IPC training compliance monitored and improved
- Estates and Facilities teams maintain high standards and respond proactively to challenges.

The Trust has moved beyond post-pandemic reflection but recognises that legacy issues remain. Embedding day-to-day IPC standards that are not command-and-control driven is the key focus. Data shows good compliance, but inspections highlight that strong leadership and regular check-and-challenge remain essential. The opening of MRfD buildings, organisational leadership changes and NHS uncertainty present challenges. IPC standards must be maintained and grip on control measures remains tight.

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

- Audit programme compliant with national guidance.
- Robust cleanliness measures and outbreak oversight
- All IPC policies in date and aligned with updated guidance.

The Trust can provide significant assurance that IPC risks are effectively managed, and controls are operating as intended. Noting that continued work is required to embed IPC culture fully and sustain improvements without reliance on external enforcement.

Consultation

Prepared in consultation with:

- IPC Committee
- Estates
- Divisional colleagues
- IPC Strategic Action Group
- Health Protection Unit
- Quality and Safeguarding Committee.

Governance or Legal Issues

Compliance with Health and Social Care Act 2008 Code of Practice and CQC standards confirmed.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

No adverse impact identified. Learning from Covid-19 health inequalities research informs current approaches.

Recommendations

The Board of Directors is requested to:

1. Note surveillance of healthcare associated infections, outbreaks and training compliance
2. Receive assurance on cleanliness and governance
3. Note the significant assurance received by the Quality and Safeguarding Committee.

Report presented by: **Lynn Andrews**
Chair, Quality and Safeguarding Committee

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

Derbyshire Healthcare
NHS Foundation Trust

Infection Prevention and Control (IPC)

Annual Report – 2024/25

www.derbyshirehealthcareft.nhs.uk

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WE MAKE A POSITIVE DIFFERENCE IN EVERYTHING WE DO

Introduction

The Trust has moved beyond the immediate post-pandemic period, yet recognises that some legacy issues remain, as the pandemic remains the last major IPC challenge experienced by staff. The focus for 2024/25 has shifted to embedding day-to-day IPC practice standards that are not command-and-control driven, but instead foster a culture of stewardship, curiosity, and continuous improvement.

Data shows good compliance with IPC standards, but practice indicates that strong leadership and regular check-and-challenge remain essential, as the culture of good IPC stewardship is not yet fully embedded. The recent opening of the Making Room for Dignity (MRfD) buildings, changes to leadership across the organisation, and ongoing uncertainty within the NHS present challenges. Nevertheless, IPC standards must be maintained, and the grip on control measures remains tight.

Performance against infection control standards and management activities remains high. Reported cases of key alert organisms are very low, and outbreaks have been limited and well managed. Inspection and audit of clinical areas have been maintained, and essential works continue. The Trust remains an active part of the System IPC Strategic Action Group (IPCSAG) and regularly attends regional learning events. The standalone IPC Committee continues to provide oversight, and the Trust works closely with partners and NHSE to ensure readiness for emerging disease threats and has had its EPRR plan approved.

The legacy effect of COVID testing remains challenging as the message has been to give gravitas to the impact of all respiratory virus threats; Flu, CSV etc rather than focus on COVID. The move away from COVID vaccination for Health Care Workers has helped shift focus but national uptake rates remain low compared to pre-pandemic levels for Flu vaccine.

National context

Nationally, rates of healthcare associated infection have stabilised, but vigilance remains essential. The Trust continues to benchmark well against peers, with low incidences of MRSA, C. difficile, and other key organisms. Cleanliness and proactive IPC measures remain a priority, with a shift from reactive to preventative approaches. The trust has benchmarked well in regard to PLACE in 20924 and appears to have maintained standards in 2025.

Structures within Derbyshire Healthcare NHS Foundation Trust

The Chief Executive holds overall responsibility, with the Executive Director of Nursing & Patient Experience as DIPC. The Assistant Director of Professional Standards and Physical Health leads day-to-day IPC work, supported by Heads of Nursing, the Health Protection Unit, and Estates and Facilities. The standalone IPC Committee provides strategic oversight.

Key achievements of 2024/25

- Completion of the MRfD project, delivering five new sites and significant upgrades to Trust estates
- Sustained high standards of cleanliness, with Trust and inpatient averages above 98%
- PLACE assessment scores above national averages in all domains
- IPC training compliance: Level 1 – 96%, Level 2 – 86%
- All IPC policies in date and compliant
- Limited outbreaks, all contained with no harm to patients
- Continued development of IPC link nurses and leadership
- Ongoing capital investment in estates and facilities.

KPI Overview – Infection Surveillance and Compliance

Indicator	Target	Performance	Evidence Source
MRSA bacteraemia cases	0 HCAI cases	Apr 2024–Apr 2025: 5 cases (none HCAI) Apr 2025 to date: 2 cases (none HCAI)	National Monitoring Programme
C. difficile infections	≤ National threshold	Apr 2024–Apr 2025: 3 cases (none HCAI) Apr 2025 to date: 2 cases (none HCAI)	National Monitoring Programme
IPC Training Level 1	≥ 90%	96%	Workforce Training Records
IPC Training Level 2	≥ 90%	86%	Workforce Training Records
Cleaning Compliance	≥ 90%	Trust Average: 98.99% (Inpatient Avg: 99.2%)	National Cleaning Standards
IPC Policies in Date	100%	All IPC policies confirmed in date	DHGCFT Policy Dashboard
Outbreak Reporting	100%	2 x D&V (Nov & Dec 2024), 1 x suspected Flu (Feb 2025) – all contained, no harm	IPC Outbreak Logs

Flu campaign

The flu campaign for 2024/25 saw a significant reduction in uptake compared to previous years uptake rates for Flu. This was a national trend, and the Trust performance is consistent with other similar providers. The target for 25/26 is set at 40.7% on the national Federated Data Platform (FDP). In addition, providers have been asked to assure that patients being discharged to other care provides (nursing homes, hospital placements etc) are vaccinated fir Flu. This was a request made after the orders for Flu vaccines had been placed. However, the Trust has commenced a screening and vaccination programme to meet this need.

Assurances

Governance and guidance changes

National Infection Prevention and Control Manual (NIPCM) – Version 2.12 updated July 2025:

- Changes to **hand hygiene standards**, **Type IIR mask use**, and **waste disposal protocols**
- Addendum for **High Consequence Infectious Diseases (HCID)** and Mpox guidance updates. [england.nhs.uk], [nipcm.hps....cot.nhs.uk]
- All IPC policies have been reviewed and updated to reflect changes in the NIPCM (July 2025), UKHSA PPE guidance, and NHS England education framework.

NHS England IPC Education Framework – embedded in training compliance and audit processes. [england.nhs.uk]

UKHSA PPE Guidance – revised risk assessment for donning/doffing and respiratory protection. [nipcm.hps....cot.nhs.uk]

NICE QS61 and **Health and Social Care Act 2008 Code of Practice** remain unchanged but referenced in updated policies. [Standard I...edure 2025 | Word]

Updated **audit tools** and monitoring frameworks aligned with NHS England standards.
Cleaning Scores:

- Cleaning standards across all new and existing sites have remained consistently high, with scores well above the 5-star (90%) rating

- In the 2024 PLACE assessment, Derbyshire Healthcare NHS Foundation Trust achieved a cleanliness score of 99.0%, exceeding both the national average for mental health and learning disability trusts (98.3%) and placing the Trust towards the top of the national range (96.0% – 100.0%).

Area	**%**
Cherry Tree Close	99.04
Cubley Court Female	98.05
Cubley Court Male	98.18
Dove	99.67
Kedleston Unit	98.95
Kingfisher	98.65
Oak	98.89
Robin	99.34
Sycamore	99
The Beeches	99.78
Tissington House	99.26
Ward 35	99.01
Ward 36	99.3
Willow	100
Wren	99.42
Inpatient Average	**99.2**
Trust Average	**98.99**

Operational Challenges:

- The expansion in bedroom and bathroom facilities has increased the demand for daily cleaning and maintenance
- While this has presented challenges in maintaining sufficient domestic cover, the Estates team has worked proactively to address these pressures, ensuring standards are upheld.

Quality Assurance:

- Regular audits, daily walk-around checks and enhanced check-and-challenge processes have been implemented to monitor and sustain environmental tidiness and hygiene
- These measures have contributed to the Trust's consistently high cleaning scores and positive inspection feedback.

Continuous Improvement:

- The Trust remains committed to maintaining and further improving cleaning standards, with ongoing investment in staff training, resources, and audit frameworks.

Emerging Diseases

Post-pandemic infectious disease surveillance in the UK has remained high. There have been regular meetings throughout the last year focussed upon the seasonal impact of respiratory illness as we have seen cases of Flu, COVID, CSV surge during winter 2023 and spring 2024.

Mpox Clade 1 continues to be monitored as a HCID of concern. Measles and Pertussis have also seen increased case rates in recent years. Flu remans a significant concern in the UK alongside other respiratory infections with the 2025/26 flu season anticipated to be challenging across the health sector.

The Trust, alongside other regional providers, has evolved its Emergency Preparedness Response Plans in anticipation of future surges in infection. This is increasing as post-pandemic negativity towards vaccination programmes and a widening belief that they are not effective amongst society is reducing the resilience and safety net built up over years of previously wide reaching and successful vaccination programmes. The decline in vaccination uptake is a concern being explored across the health and social care community as it has significant patient safety implications.

The organisation has updated its Board Assurance Framework (BAF) (appendix 1).

Next steps and priorities

- Embed IPC practice as part of everyday culture, moving beyond command-and-control approaches
- Strengthen leadership and stewardship at all levels
- Maintain high standards in new MRfD buildings and across the estate
- Continue to improve training compliance and audit processes
- Address legacy issues from the pandemic, supporting staff and maintaining resilience.

Continued focus on strong, visible clinical leadership will continue to see practice at the highest standards, with staff empowered to seek advice and support where needed. Strong leadership also brings consistency of standards.

Potential risks in delivery

- Organisational capacity and financial pressures
- Staff vaccination uptake
- Maintaining cleaning standards amid operational challenges
- Monitoring of external contracts and statutory standards
- Sustaining support for estates and water safety programmes.

Conclusion

The Trust has demonstrated significant progress in Infection Prevention and Control during 2025, moving beyond the immediate post-pandemic phase while recognising that some legacy challenges remain. High compliance scores, robust governance structures, and improved estates provide assurance that IPC standards are being maintained. However, inspections and cultural observations indicate that embedding IPC principles into everyday practice - beyond command-and-control approaches - requires continued leadership visibility, staff engagement, and sustained focus.

The opening of new MRfD facilities, organisational changes and wider NHS uncertainty present operational challenges, but the Trust’s commitment to maintaining grip on IPC controls remains clear. Updated national guidance has been incorporated into policies and practice, and the Board Assurance Framework confirms strong compliance overall.

Assurance Level

Significant Assurance with Actions Required
Rationale:
Evidence of strong governance, compliance, and improvement:

- Policies in date and aligned with updated guidance
- High PLACE and cleaning scores
- Robust audit and oversight via IPC Committee.

Cultural embedding and sustainability are still developing, requiring ongoing leadership focus and operational support.

Richard Morrow
Assistant Director of Public and Physical Healthcare
5 November 2025.

Health and Social Care Act 2012 Standards	
Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.	• A standalone IPC committed has been formed following feedback and discussion with NHSE to oversee IPC matters. • Review and update of local policies and inclusion of revised and updated national guidance. • Regular incident reviews through SI and DATIX flags. • Tissue viability and infection control support network (internal champions, and link to regional and national networks). • Annual training updates and policy and procedure updates. DHCFT provides and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	• PLACE annual reviews, regular walk arounds - cleanliness / estates checks. • National Cleaning standards and cleanliness ratings are displayed for each ward. • Supportive and responsive estates and facilities teams.
Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.	• Updated guidance reviewed when circulated and policies adjusted. Increased vigilance for c. diff and oversight of hospital acquired infections. • Annual audit plan and oversight of antibiotic stewardship.
The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing / medical care in a timely fashion.	• Updated and accessible policies are available through updated trust intranet site. • Infection control link nurses and support nurses to discuss / assess and liaise with colleagues to provide advice and support for techniques, interventions and unusual or unclear presentations. • Support to develop management plans to compliment care planning around the holistic needs of service receivers.
That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.	• VTE assessments are carried out as an assessment baseline when people come into our in-patient services. • Prophylactic prescribing is in place to ensure that risks are mitigated where possible. • EPR enables alerts to be flagged for conditions where transmission or susceptibility is identified on a medium- or long-term basis. • Liaise with ICB, Public UKHSA and NHSE to ensure national or regional concerns are responded to appropriately.
Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	• DHCFT has updated and reviewed policies and procedures. • All colleagues have access to standard and transmission-based PPE and hygiene products. • Blended model of e-learning and face to face training. • Post incident analysis and shared learning following infection control incidents. • Signage displayed in high traffic and vulnerable areas.
The provision or ability to secure adequate isolation facilities.	• Individual rooms available with bathroom facilities when required. • Isolation / Cohort Nursing plans implemented as required.
The ability to secure adequate access to laboratory support as appropriate.	• UKHSA and regional IPCSAG support available. • National network and support system linked into NHSE available,
That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.	• Individual management plans using Heath Protection Unit guidance are in place. • Monitoring of updates to infection control guidance. • Updated IPC BAF submitted to Board.
That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention, and control.	• DHCFT Health Protection Unit (HPU) have an established relationship with Occupational Health provision. • Swift access to assessment and advice is available. • Feedback to managers and colleagues is provided to ensure swift resolution to concerns and adjustments can be made.


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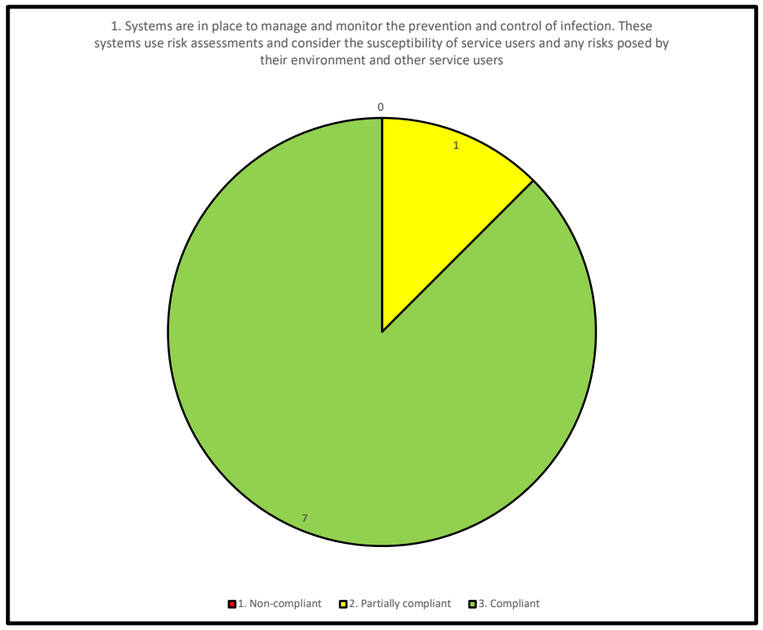
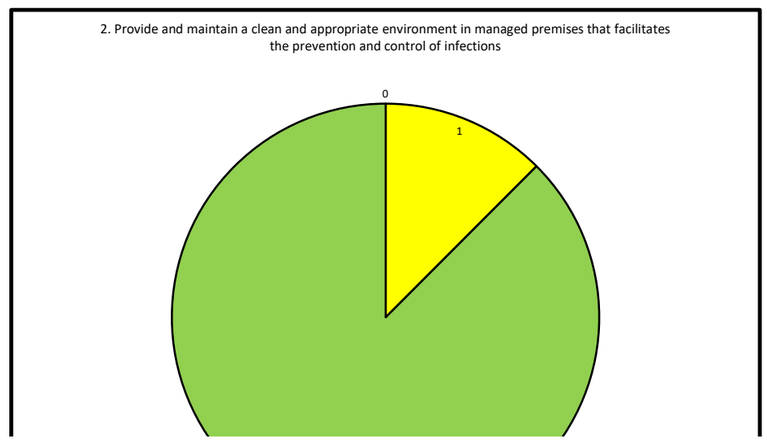
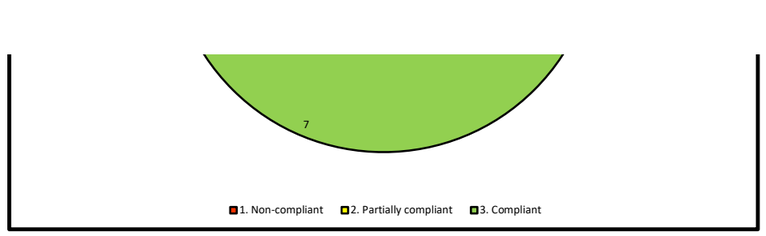
Infection Prevention and Control board assurance framework v5.0

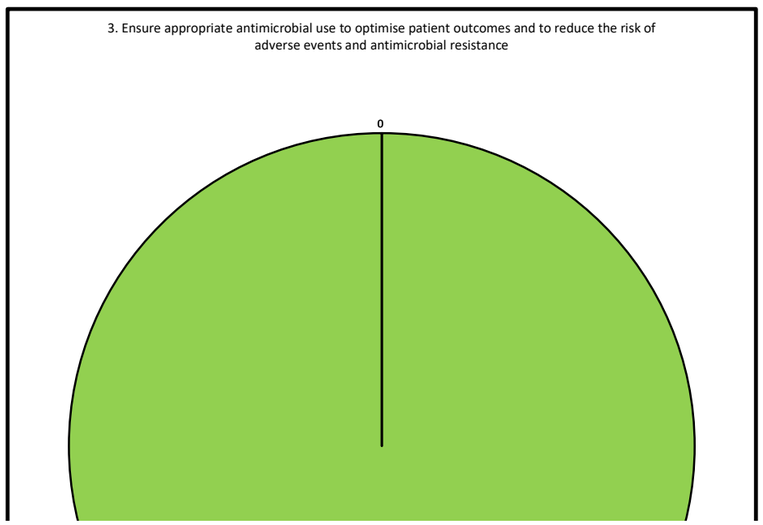
	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them						
Organisational or board systems and process should be in place to ensure that:						
1.1	There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	The Trust has a quarterly Infection Control Committee meeting chaired by Trust AD Public and Physical Health Care (Deputy DIPC). This committee reports to the Qualty and safe Gaurding Committee chaired by the DIPC.	None	The System IPC SAG and regional NHSE IPC meetigs are attended by Deputy DIPC and updates, findings and regional assurance requitemnts are	N/A	3. Compliant
1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	Infections are reported through DATIX system.	None.	The System IPC SAG and regional NHSE IPC meetigs are attended by Deputy	N/A	3. Compliant
1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	Inciednts are reported through the DATIX ssytem and IPC incidents are flagged to IPC link Nurse for support. Clinical records and lisiaon with Nursing and medical team is provided on review.	None.	Incidents reported vis Pathology lab or other sources are checked by IPC team to ensure they are logged onto DATIX.	N/A	3. Compliant
1.4	They implement, monitor, and report adherence to the NIPCM.	Clinical records and liaison with Nursing and medical team is provided on review. Incidents are shaed and overseen by colleagues in IPCSAG	None.	IPCSAG and CQRG provide feedback around Trust	N/A	3. Compliant
1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	Survelilance are routinely moniored and AMR prescribng and infection rates are monitoed at trsust and system level.	None	IPCSAG provide feedback around Trust complianace and reporting standards. AMR monitoring group and Schedule 4	N/A	3. Compliant
1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	Audit framework in place with over view by PHCIC. / IPCSAG.	None	IPCSAG provide feedback around Trust complianace and reporting standards. AMR monitoring group	N/A	3. Compliant
1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	All staff udertke level 1 training and clincial staff undertake level 2 training. New frameowrk being impemented.	None	New framework introducing level 3 IPC for leads is being developed ahead of	Matrons and identifed leads to complete level 3.	2. Partially compliant
1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings)	HPU and AD Public and Physical Hath care are avilable to support teams to undertake local risk assessments. Infection control link nurses also provode local support.	None	Infection link worker forum is being developed further.	N/A	3. Compliant
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections						
System and process are in place to ensure that:						
2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	National Cleaning Standards are dispayed as per guidnace for all ward areas.	None	N/A	N/A	3. Compliant
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.	Progarmme was undertaken in 2022/23 and schedued for delivery 2023/24.	None	N/A	Site visits were undertaken in 2024- good standard met.	3. Compliant
2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	Equipment cleaning policy identifies roles and responbilites for cleanliness and audits assure agianst comlaince with standards.	Recent audits have highlighted gaps in frequency of checks.	Enhanced ovesight of	gaps still identified in repeat au	2. Partially compliant



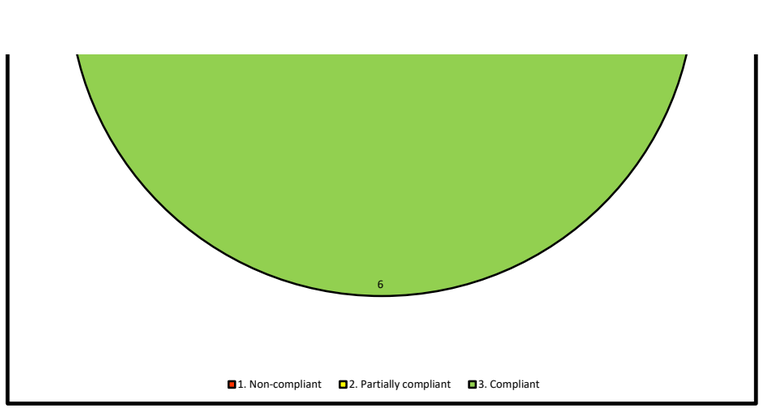


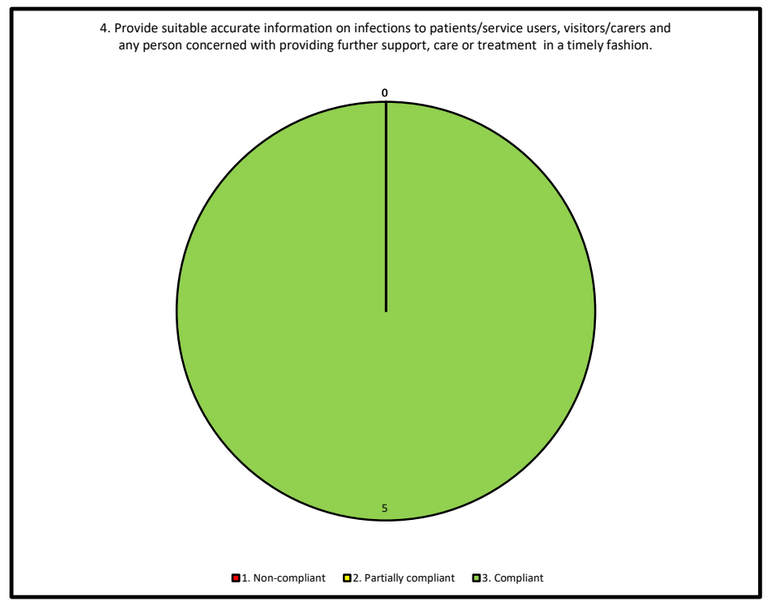
2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	Monitored by eastates and facilities team, assurance checks are reported to Heath and safty group or esclated to Deputy Director for IPC. Water safety group intied in March 2024 following Legionella outbrea in neighbouring trust and changes to trust facilities through programme of works under@Making Room for Dignity' (MRFD) campaign.	None	N/A	N/A	3. Compliant
2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	IPC lead is included in new buld deveopemnt programme and assurance checks for key stages of building developemnt requested / reviewed as required.	None	N/A	N/A	3. Compliant
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	Laundry contract is managed by external provider and reviewed by Housekeeping services with input from IPC lead.	None	N/A	N/A	3. Compliant
2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	Safe dispaosal of helathccare waste is managed in accordance with current regulations.	None	N/A	N/A	3. Compliant
2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06.	N/A to DHCFT setting	N/A	N/A	N/A	0. Not applicable
2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.	Processses are in place for the labelling and storage of food stuffs brought in for service users and checked by staff. Food hygiene training (level 2 and 3) is available and attendnace / compliance monitored.	N/A	Review of incidents a	N/A	3. Compliant
3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance						
Systems and process are in place to ensure that:						
3.1	Ensure clarity of responsibility for AMR within governance responsibilities, including how antimicrobial stewardship (AMS) aspects of Care Quality Commission (CQC) Regulation 12 to prevent individuals from receiving unsafe care and treatment and prevent avoidable harm or risk of harm.	Trust atttend regional AMS group, report to Schedule 4 oversight group for AMS prescribing and attend IPCSAG. Medicine management committee and IPC Committee also review with oversight report bi-annually (within PH upadte paper) sent to QSCG.	None	N/A	N/A	3. Compliant
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.	Included withn Medicianes managemnt and PHCIC annula reprots.	None	N/A	N/A	3. Compliant
3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan. A formal operational lead for AMS is in post with time in their job description. Monitor patterns and trends of sentinel infections and antimicrobial use, the impact of early, accurate diagnosis and intervention upon outcomes and lengths of stay. Where there is variation with other providers which requires attention, develop plans to address unwarranted variation and to support National AMR Plan ambitions.	Medical Director is identifed lead for AMR prescribing.	None	N/A	N/A	3. Compliant



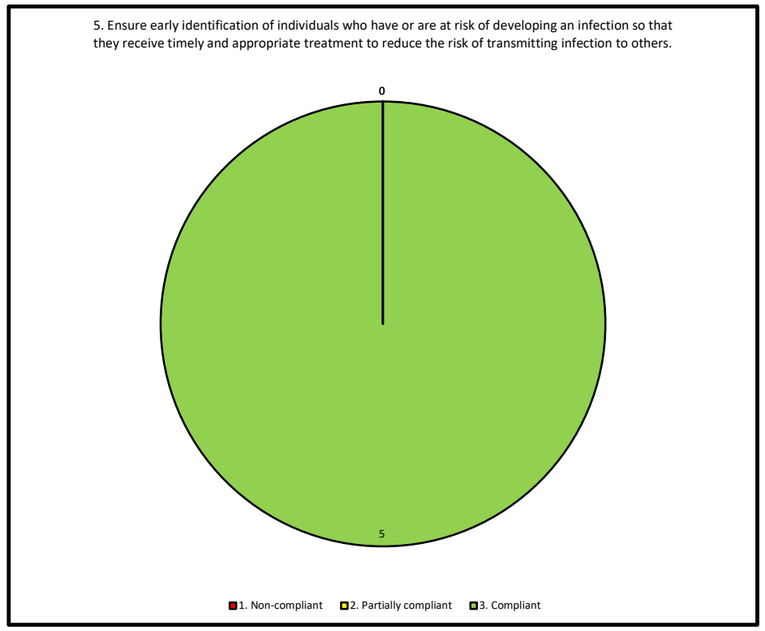


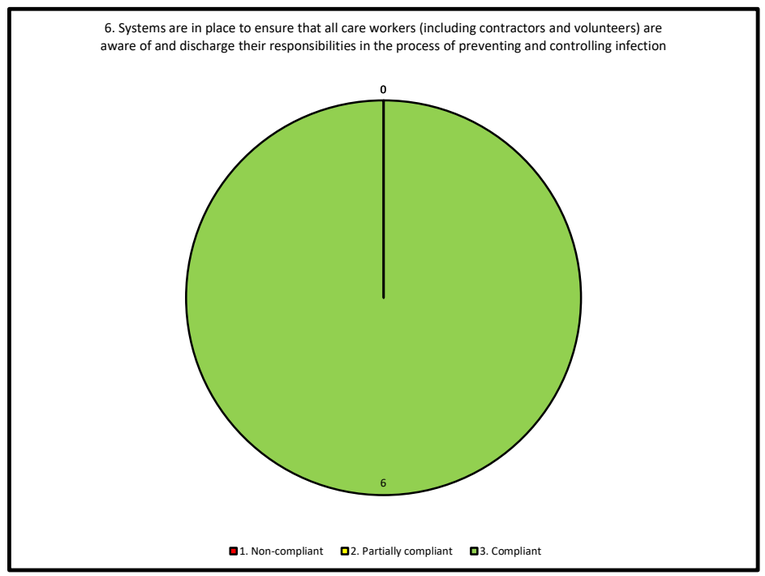
3.4	To optimise patient outcomes and minimise inappropriate prescribing: • Monitor and improve compliance with NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' • Ensure adherence to the principles of Start Smart, Then Focus is implemented and monitored in secondary care. • Ensure AMS is included in mandatory training using national materials such as 'Start Smart, Then Focus' and 'Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET)'.	Trust is a low volume prescriber, howver tracking straems are ustiklised in accordance with locally 9system level) agreed priorities.	None	N/A	N/A	3. Compliant
3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMS are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: • total antimicrobial prescribing. • broad-spectrum prescribing. • intravenous route prescribing. • treatment course length.	Schedule 4 cmlaince is monitored via system level CQRG.	None	N/A	N/A	3. Compliant
3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)	DHCFT work with local partners and report agianst locally agreed high priority areas.	None	None	v.low incidents within trust belo	3. Compliant
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion						
Systems and processes are in place to ensure that:						
4.1	Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	IPCSAG and AMR group coordinate locally agreed aannula action plans and areas of high incidence / prevalnce. DHCFT monitor ia ccordance with these local tragets.	None	N/A	N/A	3. Compliant
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (eg digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate.	Information leaflets related to treatment or condiotn are provided and avialble in a range of formats.	None	N/A	N/A	3. Compliant
4.3	The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.	Local signage, community meetings etc will discuss locally implemented IPC measures. Face masks/ hand hygiene etc are available for service users as required.	None	N/A	N/A	3. Compliant
4.4	Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include: •hand hygiene, respiratory hygiene, PPE (mask use if applicable) •Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (eg cleanliness) •Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. •Provide published materials from national/local public health campaigns (eg AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors and advocates to minimise the risk of transmission of infections.	Cleaning standards are dispalyed. PPE / IPC support measures available and checked, signange in place, cmmunity eetings to discuss local measures or advice provided. Community rates monitored and escelation plans in place if transmission risk is ncreased / detected.	HCID PPE requiremnts are being explored across MH providers to identify most appropriate / proportionate approach.	Community metings and proactive contact in the event of any infection being identifed. Working with NHSE and local providers to ensure HCID preparedness is compliant wth training package being released in 2025.	N/A	3. Compliant



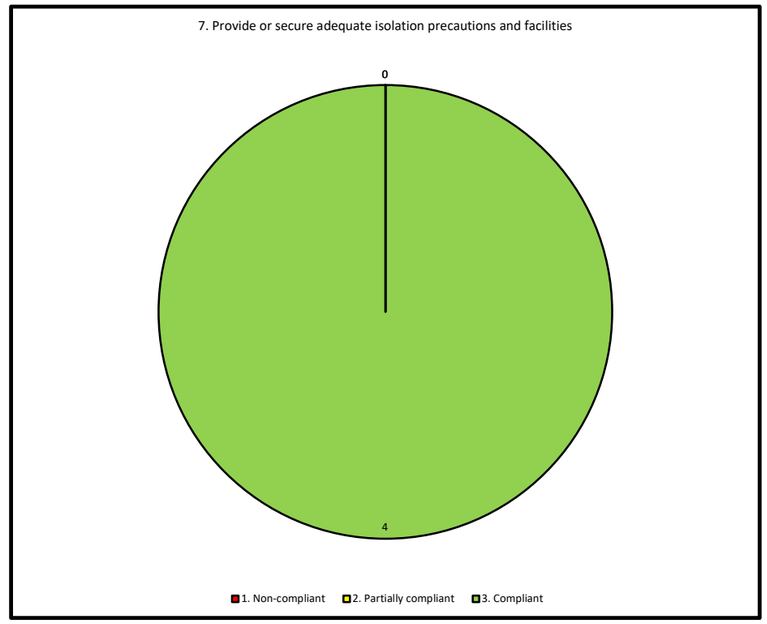


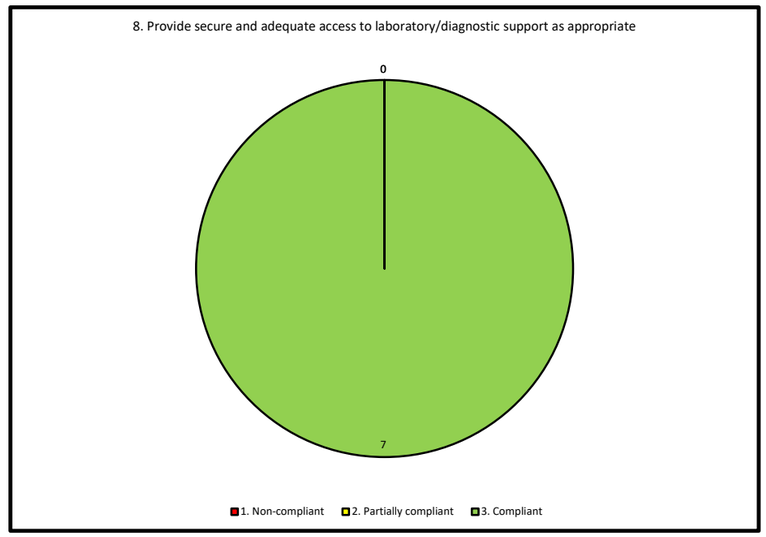
4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.	Signage and emergency signage available at all sites. Service user care plans implemented as required in the vevent of suspected / idenifed infection being deteeced.	None	N/A	N/A	3. Compliant
5.Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.						
Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM:						
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.	screening processes are in place on admission into care settings for inpatents.	None	N/A	N/A	3. Compliant
5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes. The Isolation prioritisation tool is available to assist in patient placement and ongoing isolation decisions.	NEWS2 and symptomatic monitoring is undertaken by clincial team providing care to the patient.	None	N/A	**N/A**	3. Compliant
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	Pertinent clincial information is handed over on transfer from or to the oragnisation.	None	SBARD sysem is in us	N/A	3. Compliant
5.4	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	Signange appropriate to care setting is displayed.	none	signange checks agai	care setting is mental helath fio	3. Compliant
5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	Infectious incidents are monitored and traced by HPU with oversight and monitoring processes implemented accordingly.	None	N/A	Pre-emptve monitoring prior to	3. Compliant
6.Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection						
Systems and processes are in place to ensure:						
6.1	Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	IPC training, link nurses and policies are all focussed on improving undertanding of SICP and when to escalte to TBP based upon local dynamic risk assessment	None	reuglar communicati	N/A	3. Compliant
6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	IC training is montored via performance reports across all divisions.	None	N/A	N/A	3. Compliant
6.3	Monitoring compliance and update IPC training programs as required.	As above	None	N/A	N/A	3. Compliant
6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	As above	None	N/A	N/A	3. Compliant
6.5	That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	Staff who undertake AGP procedures are routinely fit tested as per H and S requirements.	None	N/A	Changes to national guidmace reflected in step down of all inpatent staff requiring FFP3 mask fitting. Agreed at QSCG in	3. Compliant
6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	Any addirtonal training requirements are idnetifed and supported by training and develpemnt team.	None	N/A	N/A	3. Compliant
7. Provide or secure adequate isolation precautions and facilities						
Systems and processes are in place in line with the NIPCM to ensure that:						

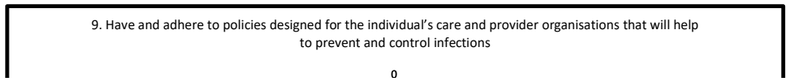




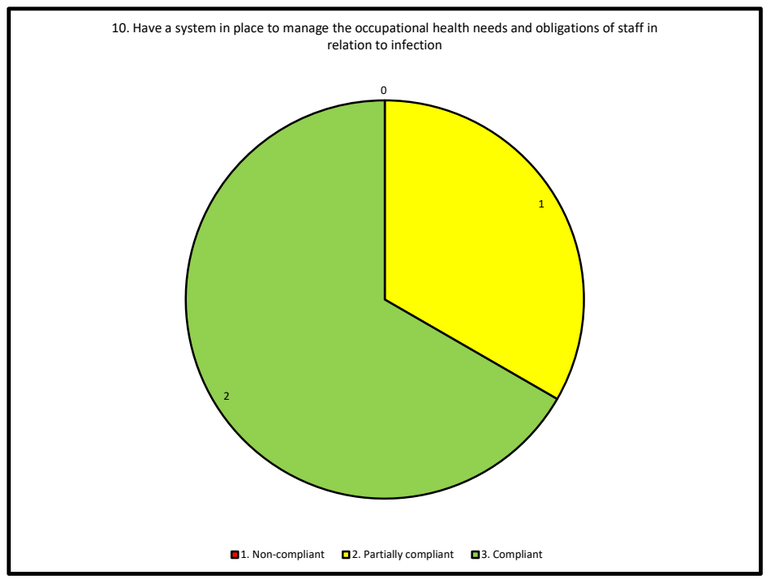
7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	Screening and support processes are in pace with advice available form HPU regarding tretament / cohorting / managemnt of indivisudals and groups as required.	None.	Post incident reviews	N/A	3. Compliant
7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: •single rooms are in short supply and if there are two or more patients with the same confirmed infection. •there are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	Apprpriate cohorting arrangents are available across al areas with flexibility to supporrt either infectious patients or those who need enahnced protection (e.g. NMABS eligible). Proportionate to risks presented.	None	N/A	N/A	3. Compliant
7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	TBP meaures are available to step up as required in all settings.	None	N/A	N/A	3. Compliant
7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	DHCFT are comlaint with this guidance as per national and locally agreed protocols.	None	N/A	N/A	3. Compliant
8.Provide secure and adequate access to laboratory/diagnostic support as appropriate						
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:						
8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	DHCFT are comlaint with this guiance.	None	N/A	N/A	3. Compliant
8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	DATIX and cross referece with pathology labs for patents involved with DHCFT in place. Local IPC netwrok supports review of patients who have moved between poviders to identify lead	None	N/A	N/A	3. Compliant
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.	Path lab services provided bylocal acute provider, specialst mntiroing for claozapine bloods provided under sperate contract.	None	N/A	N/A	3. Compliant
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	DHCFT is compliant with current testing protocosls.	None	N/A	N/A	3. Compliant
8.5	Patients/service users who develops symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.	DHCFT iscompliant with current testing protocosls.	None	N/A	N/A	3. Compliant
8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens.	DHCFT is compliant with current testing protocols and has arrangements in pace through IPCSAG and EPRR to step up testing when required / directed.	None	N/A	N/A	3. Compliant
8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	DHCFT is compliant with current testing protocols.	None	N/A	N/A	3. Compliant
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections						







9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA, NIPCM including the NHSE A to Z pathogens list). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident by the registered provider. The SICPs monitoring tool can be applied to aid this process.	DHCFT has policies in place for common and known infections. EPRR processes are in place for new and emerging	New and emerging virus policy is under review and needs completion and sign off.	policy in place.	N/A	3. Compliant
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection						
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:						
10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	Processes are in palce with local managent teams and supported by OH services in accordnace with current national protocols.	None	N/A	N/A	3. Compliant
10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	Processes are in palce with local managent teams and supported by OH services in accordnace with current national protocols.	None	N/A	N/A	3. Compliant
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	Processes are in palce with local managent teams and supported by OH services in accordnace with current national protocols.	MMR checks idetfied a numebr of colleagu	N/A	N/A	2. Partially compliant



Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 25 November 2025

Safeguarding Children and Adults at Risk annual report 2024/25

Purpose of Report

The annual report provides assurance to the Trust that we are meeting our legal and statutory performance and governance requirements and governance requirements to the Safeguarding Children Partnership and Adult Safeguarding Board.

Executive Summary

- The Trust has had a successful year and continues to fully discharge its statutory safeguarding duties
- The Trust officers have successfully discharged the duties as set in legislation and requirements outlined by the Health Regulator, the Care Quality Commission (CQC). The annual report includes how the Trust has been independently scrutinised and assessed
- The report describes the challenges and achievements faced in the year and overall, this has been a successful year
- The report monitors trends in activity and analyses the themes from this activity and uses the referral information and helpline activity to adapt training, plan clinical audits or develop policy and procedure from learning reviews, which have been maintained in this year
- Safeguarding Unit, including the Multi-Agency Safeguarding Hub (MASH) health activity over the year 2024/25 and its activity, and impact
- The report provides quantitative, qualitative and narrative evidence of the scope and extent of work undertaken within the year and how the Safeguarding Unit assures itself that it is meeting its duties by development of its staff who work with children, young people, adults, and their families. This report is offered with significant assurance on the work of the Unit by the team
- Audit activity is included in the report. Feedback of audit has been included in the report to provide evidence on the internal and external governance process and how the Unit provides quality improvement of practice
- The report describes the new initiatives/objectives/priorities 2024/25 which have been developed with partners and based upon themes and learning. Sexual safety continues to be a priority area with significant scrutiny and focus on practice
- Overall, we offer this report with significant assurance to the Quality and Safeguarding Committee on our systems, governance, learning and improvement of standards of practice. The report demonstrates a robust system of scrutiny and a commitment to sound practice.

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 team seeks to actively mitigate and manage risk. Where necessary risks are escalated to the Committee as part of the reporting process from the Safeguarding Children and Safeguarding Adults Operational Groups
- The Board can obtain assurance that the Safeguarding Unit, including MASH Health, Section 11 Audit, the Local Authority and Markers of Good Practice and the Safeguarding Accountability and Assurance Framework (SAAF). This framework builds on its predecessor by strengthening the NHS commitment to promoting the safety, protection and welfare of children, young people and adults
- This national framework has been developed in partnership with other arm's length and professional bodies. It has been updated to reflect changes in policy and legislation since its last iteration and seeks to clarify the roles and responsibilities in relation to system working. In addition, it provides the flexibility needed at local level to support the professional practice of individuals and the partnerships needed to promote healthy behaviours to keep individuals and communities safe from harm
- SAAF is meeting its legal and statutory duties and obligations.

Consultation

- The team has consulted internally and with partners throughout the year as appropriate to specific areas of activity, for example, policy development, public protection developments, refining processes within the MASH
- The report is written after consultation between the Assistant Directors for both Safeguarding Adults and Children
- Quality and Safeguarding Committee, 10 September 2025.

Governance or Legal Issues

The Trust meets statutory obligations and legal duties with regard to: Mental Health Act [1983]; Mental Capacity Act [2005]; The Care Act [2014]; Children and Families Act [2014]; Human Rights Act [1998] Domestic Violence, Crime and Victims Act [2004] and our internal systems, structures and processes are joined up and effective.

Statutory guidance issued under Section 29 Of The Counter-Terrorism And Security Act 2015
Section 26 of the Counter -Terrorism and Security Act 2015 (the Act) places a duty on certain bodies ("specified authorities" listed in Schedule 6 to the Act), in the exercise of their functions, to have "due regard to the need to prevent people from being drawn into terrorism". This guidance is issued under Section 29 of the Act. The Act states that the authorities subject to the provisions must have regard to this guidance when carrying out the duty.

Health Specified Authorities
80 - The Health specified Authorities in Schedule 6 to the Act are as follows:

NHS Trusts
NHS Foundation Trusts.

- NHS England has incorporated 'Prevent' into its safeguarding arrangements, so that Prevent awareness and other relevant training is delivered to all staff who provide services to NHS patients. These arrangements have been effective and should continue
- The Chief Nursing Officer in NHS England has responsibility for all safeguarding and a Safeguarding Lead, working to the Director of Nursing, is responsible for the overview and management of embedding the Prevent programme into safeguarding procedures across the NHS. This is replicated in our Trust.

Section 325 to 327B of the Criminal Justice Act 2003 (CJA) established Multi-Agency Public Protection Arrangements (MAPPA) in each of the 42 criminal justice areas of England and Wales.

These arrangements are designed to protect the public, including victims of crime, from serious harm by sexual or violent and other dangerous offenders. MAPPA are the statutory arrangements for managing sexual and violent offenders. MAPPA is not a statutory body but is a mechanism through which agencies can better discharge their statutory responsibilities and protect the public in a co-ordinated manner.

The Trust meets the required standards for our regulators and our professional regulatory bodies Codes of Practice, ie, Safe, Caring, Effective, Responsive, Well Led and Safeguarding are the gold threads that runs throughout. We apply national guidelines and evidence based best practice, eg, NICE, DoH, National Statistics.

The Trust contributes as an equal partner in multi-Agency forums eg, MAPPA; MARAC; Channel; Child and Adult Safeguarding Boards and sub groups and takes part in peer assessment, benchmarking and self-assessment and assurance.

The Trust invests in staff across multiple agencies and services to ensure high levels of competence and confidence and achieve consistently good practice that is constantly updated and refreshed within a culture of learning from both successful and adverse situations.

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 re-assignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity (REGARDS people (Race, Economic disadvantage, Gender, Age, Religion or believe, Disability and Sexual orientation), including risks, and say how these risks are to be managed.

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

The field of safeguarding adults at risk of abuse is underpinned by the following six key principles:

- **Empowerment** – of the individual to make decisions
- **Protection** – support and representation for those in need
- **Prevention** – of abuse/neglect as well as helping the person to reduce the risks of harm and abuse that are unacceptable to them
- **Proportionality** - responses should be least restrictive to the person's rights
- **Partnerships** – working collaboratively to prevent, identify and respond to harm
- **Accountability** – and transparency in delivering safeguarding. Safeguarding is intended to support those most vulnerable to being at risk of abuse, many of whom have protected characteristics relating to age, gender, disability, religion and sexual orientation. The intention of safeguarding governance and due diligence is to recognise the vulnerability to abuse of people engaging with Trust services and apply the principles to all aspects of safeguarding practice.

The Trust cannot mitigate all the population health outcomes for children and adults in our community. However, it can influence the wider system and put in place preventative or detective measures to reduce preventable harms.

The Trust cannot stop abuse, but it can assess, engage, offer early detection and intervene to reduce the impact of abuse and monitor the harms associated with being at risk of harm.

Recommendations

The Board of Directors is requested to:

1. Receive and approve the Safeguarding Children and Adults annual report
2. Receive the report which is provided significant assurance to the Quality and Safeguarding Committee regarding the fulfilment of legal and statutory duties.

Report presented by: **Lynn Andrews**
Chair, Quality and Safeguarding Committee

Report prepared by: **Safeguarding Team, including MASH Health, Safeguarding Trainers and the Operational Team members**

A special thank you to Deborah Archer, Safeguarding Unit Co-ordinator

Derbyshire Healthcare
NHS Foundation Trust

Safeguarding Children and Adults at Risk Annual Report 2024/25

Derbyshire Healthcare NHS Foundation Trust
Reporting Period: 1 April 2024–31 March 2025
Date of Submission: 28 August 2025

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WE MAKE A POSITIVE DIFFERENCE IN EVERYTHING WE DO

INTRODUCTION

The safeguarding of all Derbyshire Healthcare NHS Foundation Trust patients, adults, children and young people and their families remains the highest of priorities. Safeguarding and 'Think Family' is integrated within all Divisions.

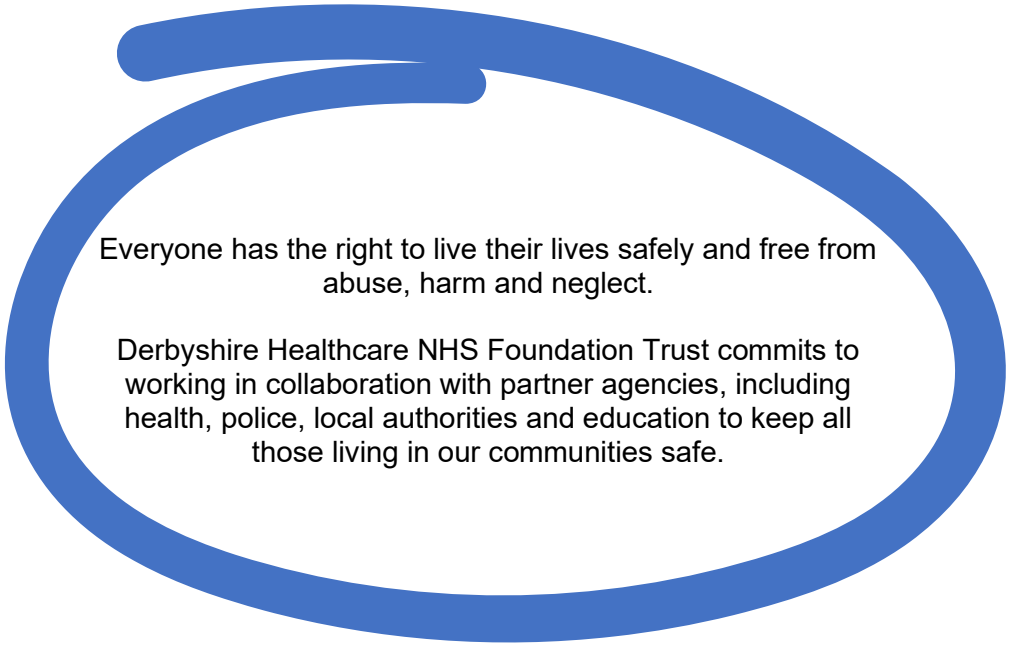
DHcFT has a statutory responsibility for ensuring safe systems of care are delivered and to ensure that, the Trust discharges its functions regarding safeguarding and the promotion of welfare of children, young people and adults at risk. The purpose of this report is to provide a review and analysis of the year's safeguarding activity and our objectives for the coming year.

This report provides the Board with an overview of how we have fulfilled our safeguarding statutory requirements and our contributions across Derby City/Derbyshire the Safeguarding Children Partnerships and Adult Board arrangements and our collaboration with providers and system colleagues.

Again, a big thank you to all the staff within the Trust for all their continued commitment and the hard work that goes towards safeguarding our staff, communities and people who use our services. As a Trust team, we will to do our utmost to continue '*keeping up the great work'* so we can continue to move forward together and with our partners agencies.

We have had a busy 12 months, characterised by high levels of activity, increased complexity of calls for advice, strategy discussions and referrals.

As a Trust, we strive to develop and grow together and learn and develop in all areas of Safeguarding.



MAP OF TRUST LOCALITY

SAFEGUARDING UNIT REPORTING STRUCTURE

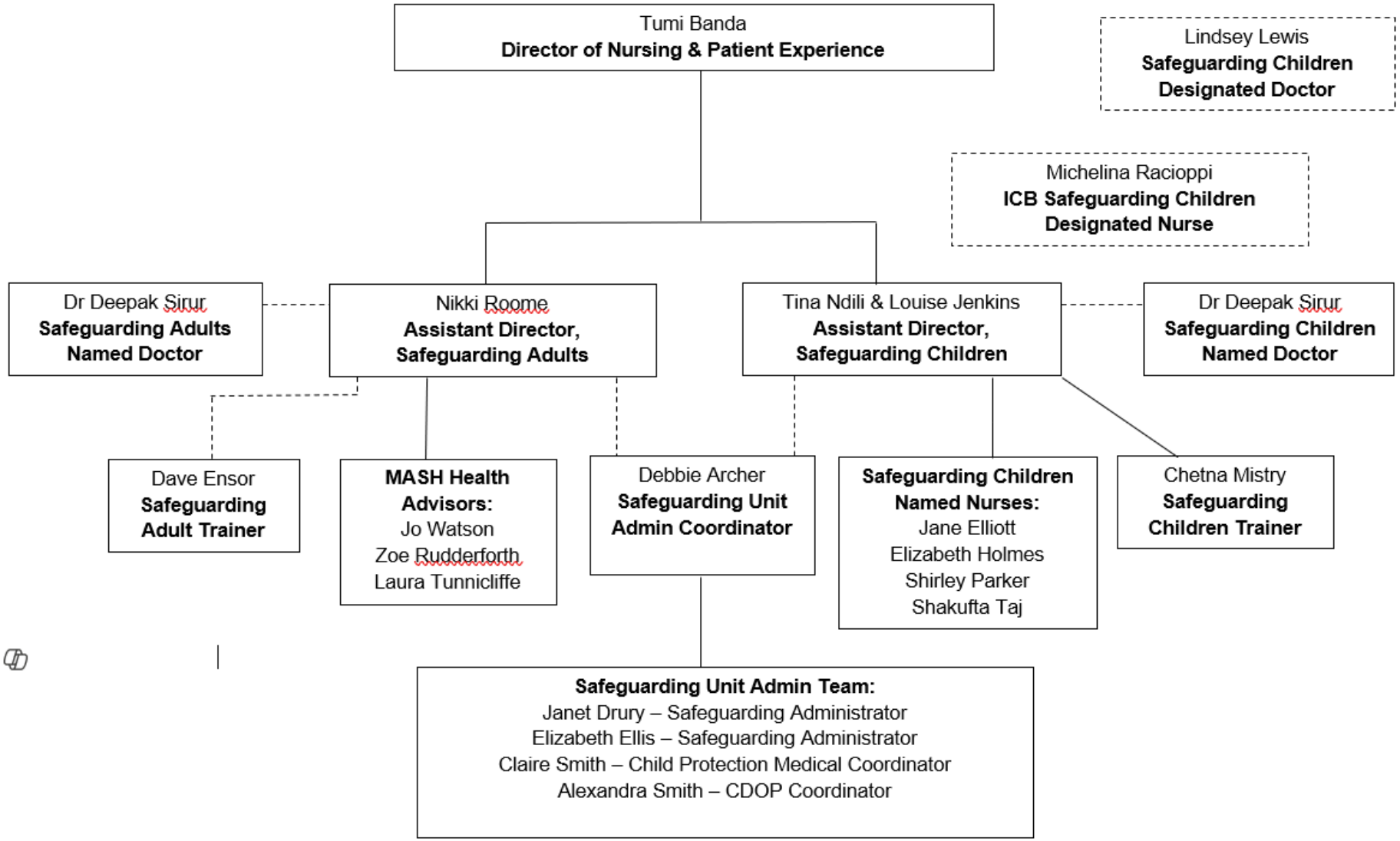
DHcFT is committed to partnership working to discharge its statutory duties with Derby City and Derbyshire Safeguarding Children Partnership and Adult Safeguarding Boards. There is Trust representation and attendance at all subgroups and multi-agency meetings. Effective safeguarding relies on strong partnerships working, open culture, transparency, consistency, respectful challenge and co-operation.

Safeguarding Children and Adults Operational Groups report on a twice-yearly basis to the Quality and Safeguarding Committee which reports directly to the Trust Board.

The Safeguarding Unit prepares a monthly Safeguarding Information Report that is issued to all Clinical Operational Assurance Team (COAT) meetings for the Trust. This report includes Specialist, Children's, CAMHS, Older Adults, Working Age Adults, Forensic, Psychology and Learning Disabilities. The report ensures that all new guidance, legislation, policy, learning and relevant information is circulated to ensure staff are aware and updated as necessary.

Both Safeguarding Operational Groups escalate matters that require Executive or Committee consideration/inclusion in the Trust Risk Register but, equally, can escalate good news stories and lessons learned to share across the organisation.

SAFEGUARDING UNIT STRUCTURE



SAFEGUARDING LEGISLATION

Safeguarding adults and children is enshrined within UK law and is key to ensuring that all NHS statutory safeguarding functions are fulfilled asper legislation, statutory guidance, and regulations.

The NHSE Safeguarding Accountability and Assurance Framework (2024) (SAAF) provides the strategic framework for ensuring strategic system oversight of safeguarding priorities.

Key national legislation and guidance for safeguarding are: (this list is not exhaustive)

DHcFT Safeguarding Policy and Procedures are located on the Trust Intranet for staff to refer to and are regularly reviewed and updated.

Links to Policies:

Safeguarding_Children_Procedures.docx

Safeguarding_Adults_Policy_and_Procedures.docx

SAFEGUARDING CHILDREN'S PERFORMANCE DASHBOARD – 2024/25

		Quarter 2024/25				
Item	Metric	1	2	3	4	Comments
1	Number of advice calls received and reported	359	372	379	343	Became apparent at the end of 2023/24 we were not capturing advice calls in relation to adults. Hence, increase seen as capturing differently using new advice template which included children and adults.
2	Number of supervision/group sessions	146	139	88	121	
3	Number of Information Exchange Form Research completed/strategy discussions or meetings attended	114	99	100	100	
4	Number of child Protection medicals – Suspected NAI and Neglect	46	49	21	19	
5	Number of children discussed at Channel	4	8	9	14	
6	Number of MARAC cases with children discussed at MARAC	212	226	293	251	
7	Number of referrals to CSC	14	13	20	3	
8	CIC Caseload - Born In Lives In	232	216	216	212	
	CIC Caseload - Born In Lives Out	355	345	346	344	
	CIC Caseload - Born Out Lives In	13	10	7	4	
	Total CIC Caseload	600	571	569	560	
9	Number of Child Deaths	14	12	18	9	
10	Number of children referred for risk of FGM	2	2	1	2	
11	Number of children on a child in need plan	169	153	140	135	
12	Number of Early Help Assessments (EHA) completed	148	101	134	96	
13	Number of STANDARD Domestic Violence Notifications received from the Police.	643	564	246	285	Reduction from Q2 due to changes in Police sharing DV PPNs with health. Discussions took place via P&P and new DV Pathway agreed in January 2025.
	Number of MEDIUM Domestic Violence Notifications received from the Police.	452	447	387	438	
	Number of HIGH Domestic Violence Notifications received from the Police.	89	92	53	90	
14	Number of children on a child protection plan	316	311	310	304	

15	Number of children on an Education Health Care Plan (EHCP)	276	166	166	112	
	Number of children on an EHCP who are on a Child Protection Plan	2	0	0	0	
	Number of children on an EHCP who are on a Child In Need Plan	0	0	0	0	
16	Number of children admitted to an adult inpatient bed	1	0	0	0	
17	Number of young carers	16	13	13	12	
18	How many babies on the Trust Mother and Baby Unit	12	16	14	11	
	How many of these are on a Child Protection Plan	1	0	0	1	
19	Number of LADO Referrals made	0	0	2	0	One unfounded and one on hold due to Police investigation.

Key for acronyms within Dashboard:

NAI	Non-Accidental Injury
MARAC	Multi Agency Risk Assessment Committee
CSC	Children's Social Care
CIC	Children in Care
DV	Domestic Violence

Analysis of Safeguarding Children Performance Dashboard

The Safeguarding Children's Performance Dashboard for 2024/25 provides quarterly analysis of various child protection and welfare metrics, highlighting significant trends and key activities related to child safety and support services.

- Advice Calls and Supervision Sessions: The number of advice calls exhibited slight fluctuations across the quarters, this was supported by changes in data capturing for both adults and children. Supervision and group sessions varied, reaching a low in Q3 and rebounding in Q4. Valuable feedback is received for the cascade model used in the organisation and we continue to review this offer
- Child Protection and Case Metrics: There was a notable decrease in Child Protection medicals in Q3 and Q4, while the number of children discussed at Channel and MARAC cases showed an upward trend. The total Children in Care caseload experienced a slight decline over the year
- Domestic Violence Notifications and Child Plans: Standard Domestic Violence notifications from the police dropped significantly after Q2 due to changes in data sharing protocols, while medium and high notifications remained stable. The number of children on child protection and child in need plans showed a gradual decrease.

SAFEGUARDING ADULTS' PERFORMANCE DASHBOARD – 2024/25

	METRIC	QTR1	QTR2	QTR3	QTR4
1	Number of adult safeguarding referrals made where allegation is within their own service	104	98	102	126
2	Number of PiPoT referrals made by the Trust	0	2	1	0
3	Full attendance at MAPPA 3 meetings (monthly)	100%	100%	100%	100%
4	Number of MAPPA cases within the Trust	1	4	4	3
5	Number of cases discussed at Channel	11	15	15	16

6	MASH Health strategy discussions for children		104	123	120	98
7	MASH Health strategy discussions for adults		12	34	18	19
8	Number of domestic violence medium cases discussed at triage		316	355	310	324
9	Number of urgent DoLs authorised		2	9	5	4
10	Number of Standard DoLs applied for to the LA		2	8	0	0
11	Number of people with an authorised DoLS granted by Supervisory body		0	0	0	0
12	Number of referrals to coroner for people who have passed away and have an authorised DoLS granted by Supervisory body		0	0	0	0
13	Sexual Safety in Trust Inpatient Service. Incidents of alleged inappropriate sexual behaviour, sexual assault and sexual abuse to a patient by another patient or other party	Other Party to Patient	9	8	12	8
		Patient to Other Party	1	1	1	3
		Patient to Patient	4	1	4	2
		Patient to Staff	2	3	4	3
		Staff to Patient	5	2	5	3
		Staff to Staff	0	0	0	0

Analysis of Safeguarding Adult Performance Dashboard

The performance dashboard continues to provide data that offers a level of assurance to the Trust regarding safeguarding activity, trends, and areas of challenge.

Where we see themes emerging, we have endeavoured to provide more learning for staff. We identified themes around domestic violence which has focussed bespoke learning from Domestic Homicide Reviews for in-patient staff.

The Adult Safeguarding Trainer remains in post and the safeguarding training compliance has improved and the evaluations continue to be positive. The improved compliance is felt to be in part to be due to the delivery of safeguarding training on MS Teams.

The Operational meeting provides a safe space to discuss complex cases and safeguarding themes that may need to be raised with the Safeguarding Adults Board or require further focus in our training. It is also used as a forum to feedback learning from Domestic Homicide Reviews and Safeguarding Adult Reviews.

The Safeguarding team continues to ensure that the organisation understands the importance of the right referral at the right time to ensure the referrals submitted are appropriate and of good quality.

MASH Health Advisors continue to consistently meet the required Key Performance Indicators as part of this Trust contracted activity.

The quality priority and improvement work around professional boundaries and sexual safety is ongoing and visible throughout DHcFT. We have responded to all sexual safety incidents in a timely manner offering support and assurance to our service users, staff and our multi-agency partners. We have provided training to the i-care programme around sexual safety and boundaries which has had positive feedback. Sexual safety training has now commenced within other areas within the organisation.

The performance and evidence provided in this Annual Report demonstrates that we have continued to meet our statutory and Public Protection duties and also reflects the key strategic priorities of the Derby and Derbyshire Safeguarding Adult Boards, Prevention: Making Safeguarding Personal and Quality Assurance.

DHcFT SAFEGUARDING CHILDREN TRAINING POSITION

Introduction

This annual report informs on Safeguarding Children Mandatory Training at Derbyshire Healthcare NHS Foundation Trust for the financial year 2024/25. It covers training compliance, capacity, challenges and improvements.

Compliance (see tables 1 and 2)

From 1 April 2024 to 31 March 2025, all levels of Safeguarding Children training compliance increased, meeting the Trust's compliance target. Level 2 compliance improved despite poor attendance in live synchronous sessions, indicating competence was attained through e-Learning. Level 3 training saw the biggest increase from 29% to 89%. This was due to a new trainer joining (author of the report) and resolving system inaccuracies. Level 3 competency is also awarded to those accessing Level 3 training with the Derby and Derbyshire Safeguarding Children Partnership and training provided by professional bodies that align their training with the Intercollegiate Document for Safeguarding Children (2019). Level 4 was delivered by an external trainer.

Training Capacity (see table 3)

Training was delivered through a mix of e-Learning and live synchronous sessions via Microsoft Teams. Level 1 and 2 were available as e-Learning, with Level 2 also offered monthly as live synchronous sessions. Level 3 was delivered exclusively through live synchronous sessions. Approximately six sessions a month were offered.

Over the year, 1,929 training seats for Level 2 and 3 were offered, 59% (n =1,138) of seats were occupied. Level 2 had the most unoccupied seats at 74% (n=215) and Level 3 had 35% (n= 576) unoccupied seats.

An additional 75 live synchronous seats were made available to Substance Misuse services (not employed by the Trust but offer a service on behalf of the Trust) Phoenix and Derbyshire Substance Misuse service (DASS). This was because they reported they were struggling to access Derby and Derbyshire Safeguarding Children Partnership Level 3 Safeguarding Children training (their usual training provider). 59% (n= 44) of these seats were occupied.

Challenges

Challenges included poor attendance in live synchronous sessions, system inaccuracies in training alignment and no training availability during the period of the previous trainer leaving and current trainer coming into post. To address these challenges, efforts were made to contact non-compliant staff, correct training records and provide additional training opportunities.

Progress

The ESR team realigned training requirements to the Core Skills Training Framework. Bespoke training sessions were provided for specific teams, and additional seats were made available to services facing access issues. A Safeguarding Children Resource pack with national and local guidance and policy links was produced this financial year and is regularly updated and shared with participants to enhance learning.

Table 1

01/04/2024					
Competency name	**Total n**	**Compliant n**	**Compliant %**	**Non-Compliant n**	**Not Compliant %**
Total	**3515**	**1030**	**29%**	**2485**	**71%**
Safeguarding Children Level 1 - 3 Yearly	731	506	60%	225	31%
Safeguarding Children Level 2 -3 yearly	749	460	61%	289	39%
Safeguarding - Children Level 3 - 1 yearly	319	22	7%	297	93%
Safeguarding Children Level 3 - 3 yearly	1499	28	28%	1471	98%
Safeguarding Children - Level 4 - annual	23	21	91%	2	9%
NHS|CSTF|Safeguarding Children (Version 2) - Level 2 - No Specified Renewal|	214	12	6%	202	94%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - No Specified Renewal|	1	1	100%	0	0%

Table 2

31/03/2025					
Competency name	**Total n**	**Compliant n**	**Compliant %**	**Non-Compliant n**	**Not Compliant %**
Total	**3146**	**2815**	**89%**	**331**	**11%**
Safeguarding Children Level 1 - 3 Yearly	670	620	93%	50	7%
Safeguarding Children Level 2 -3 Yearly	571	516	90%	55	10%
Safeguarding - Children Level 3 - 1 Yearly	345	325	94%	20	6%
Safeguarding Children Level 3 - 3 yearly	1560	1354	87%	206	13%
Safeguarding Children - Level 4 - annual	31	22	71%	9	29%

Table 3

Attendance 2024/2025					
Capacity & Occupancy	**Capacity**	**Occupied Seats (n)**	**Occupied Seats (%)**	**Unoccupied Seats (n)**	**Unoccupied Seats(%)**
Total	**1929**	**1138**	**59%**	**791**	**41%**
Level 2	290	75	26%	215	74%
Level 3	1,639	1,063	65%	576	35%

DHCFT SAFEGUARDING ADULTS – TRAINING POSITION

This report provides an update to the 383 Safeguarding Adults Level 3 (including Levels 1 & 2, plus DOLS, MCA & Wrap/PREVENT) training in DHcFT covering dates 1 April 2024 to 31 March 2025.

Since the start of the Covid-19 pandemic, all training classes at Level 3 have been delivered via Microsoft Teams.

Target audience for Safeguarding Adults (UKL Skills for Health – Core Skills Training Framework [v1.6.2]):

- **Level 1:** all staff working in health care settings
- **Level 2:** all practitioners who have regular contact with patients, their families or carers, or the public
- **Level 3:** registered health care staff who engage in assessing, planning, intervening and evaluating the needs of adults where there are safeguarding concerns (as appropriate to role).

1 April 2024

Training Name	Target Group	Compliant	Non-Compliant	Compliant %	Change from 2023
383|LOCAL|C Safeguarding - Adults Level 1 (Non Clinical) (3 Yearly)|	773	643	130	83%	Down 7%
383|LOCAL|C Safeguarding - Adults Level 1+2 (All Clinical) (3 yearly)|	543	487	146	92%	Up 5%
383|LOCAL|R Safeguarding - Adults Level 3 (3 Yearly)|	1776	1551	225	87%	Down 5%

1 April 2025

Training Name	Target Group	Compliant	Non-Compliant	Compliant %	Change from last year
NHS|CSTF| Safeguarding Adults - Level 1 - 3 Years|	764	689	75	90%	Up 7%
NHS|CSTF| Safeguarding Adults (Version 2) - Level 2 - 3 Years|	542	507	35	94%	Up 2%
NHS|CSTF| Safeguarding Adults (Version 2) - Level 3 - 3 Years|	1834	1710	124	93%	Up 6%

In the period 1 April 2023 to 31 March 2024, there have been 59 classes with an initial maximum enrollee number of 26 for 32 classes, increased to 30 per class since November (27 classes) in anticipation of increase in staffing due to new wards. This has given a potential 1,642 attendees over the year. However, there have been 883 attendees, achieving compliance in this subject, which is a 54% attendance rate. Most common reasons given by staff for withdrawing are staffing/work commitments/sickness. In total, five classes rescheduled due to lack of attendees since November.

All MCA, DoLs and PREVENT training at Level 3 has been included in a full day training package alongside the Safeguarding Adults level 3. All staff members attending the class will receive full compliance in Safeguarding Adults Level 3 (including Levels 1 & 2), MCA, DoLs, Prevent and WRAP. This has proved to be effective in Training Passport compliance.

Half day Level 2 classes have been developed, specifically for non-registered staff, delivered via MS Teams. The first was 2 February 2024, 21 classes, with five rescheduled due to lack of bookings. Each class had 28 spaces – 588 in spaces in total. However, 234 attended in total (including the rescheduled) giving 40% attendance (24% increase on last year). These are separate to e-Learning Levels 1 and 2 classes available and has slowly increased in numbers since 1 April, but remains low, as staff are citing work commitments/or alternatively use e-Learning option for convenience.

Actions taken to increase attendance for all levels

There are still a number of staff that book and do not attend. Reasons given are (in order of activity): work commitments/staff shortages; illness; lack of childcare; personal reasons; no reason given.

Requesting compliance reports from Systems Information team enables identification nearing, or 'out of date' and then 'bcc' emailing all to advise of their status. Staff are advised to check ESR and book onto available classes. Personal liaison to offer last minute cancellations taking other blended approaches to encouraging staff participation. This is reported to be effective in reaching compliance.

SAFEGUARDING CHILDREN ADVICE THEMES

Top five advice themes:

	2023/24	**2024/25**
1	Parenting Skills/Capacity/Basic Care	Parenting Skills/Capacity/Basic Care
2	Neglect	Domestic Abuse
3	Physical Injury/Abuse	Neglect
4	Domestic Abuse	Physical Injury/Abuse
5	Emotional Abuse	Emotional Abuse

We continue to analyse the calls for advice into the Safeguarding Unit:

- Domestic Abuse is again in the top five themes. Staff are more confident and competent in dealing with Domestic Abuse in their practice, are more familiar with procedures and the impact on families. Domestic abuse remains a Trust priority and is covered extensively in safeguarding training
- Neglect is still a significant issue/challenge within our organisation. Parenting skills/capacity, basic care, and self-neglect features regularly
- Due to the nature of a large proportion of the Trust patient group, we have a large number of staff concerns around our patients'/clients' capacity to parent, where mental health, substance misuse and or learning disability features.

SAFEGUARDING ADULT ADVICE THEMES

Top five advice themes:

	2024/25
1	Mental Health/Psychological
2	Domestic Abuse
3	Physical Injury/Abuse
4	Historic Abuse
5	Financial Abuse

We continue to analyse the calls for adult advice coming into the Safeguarding Unit so we can identify themes. This does not include the advice calls that go to MASH Health.

CHILDREN'S AUDITS

The continuous quality audits continue across the Division in Children's, where five records as a minimum are audited per team. The compliance has seen a steady increase and Service Managers' feedback that the audit supports the areas with safety, risk and care planning.

- In CAMHS, we have seen an improvement in Care Plan content and physical health has also been considered more as part of this care, which is documented well, work around templates to support this is underway

- Record sharing is currently being reviewed to support the documentation and when this takes place to support the patient journey. Good sharing in and out and capacity capturing also noted
- More information added into the narratives on the risk assessment has also been discussed with the team to support the compliance and understanding of risk and the formulation of these documents
- Observing an improved quality of care documentation and goals being attempted under the goals node
- In 0-19 services, continuous work around analysis is underway as this has been a theme in terms of lack of analysis, the Safeguarding Trainer is developing a package. Improved compliance of audit completion can be seen throughout the year
- In Complex Health and Therapies, the themes for improvements are Care Plans, risk screen and goals to be worked on whilst development of the new templates takes place.

ADULT AUDITS

Multi-agency audits are undertaken three-monthly by City and County Adult Safeguarding Boards. DHcFT contributes to these. The learning from the audits is reflected in Level 3 training and disseminated throughout the Trust via information sharing documents, by the learning on one page document (LOOP).

Themes for the last year have been:

- Domestic Abuse in Older Adults
- Financial Abuse
- Low Level Risk Referrals
- Domestic Abuse where a safeguarding referral has been received for a person over the age of 65
- Safeguarding adult referrals where the person is in receipt of a direct payment
- Safeguarding referrals where a crime has been committed
- Safeguarding referrals where the person had a dementia diagnosis.

SECTION 11 AUDIT

NHS Derby and Derbyshire integrated Care Board (DDICB) and Derby and Derbyshire Safeguarding Children Partnership (DDSCP) wrote to the Trust on 6 June 2025 after receiving the Section 11 self-assessment and undertaking the virtual safeguarding children quality meeting on the 20 May 2025.

The assurance was noted as below in Table 1.

Table 1

Section 11 compliance rating (2023/24)	
Standard 1	**Full compliance except Section 1.3 rated amber/green**
Standard 2	**Full compliance**
Standard 3	**Full compliance**
Standard 4	**Full Compliance**
Standard 5	**Full compliance**

The ICB wrote, *"We would like to take this opportunity in thanking you and the Safeguarding team for your hard work and strong commitment to safeguarding children, young people and families in Derby and Derbyshire"*.

Standard 1

Dr Deepak Sirur, took on a sessional one programmed activity (PA) commitment to act as interim Named Doctor for Children, Safeguarding, we thank him for his continued support to this priority role.

The Trust is looking at various options after there has been no success in the new permanent appointment of a Paediatrician into this position. We are now looking to partner with other trusts in the long term. Due to this interim position, full compliance to this section could not be awarded.

SAFEGUARDING ADULTS' ASSURANCE FRAMEWORK (SAAF)

The SAAF return was submitted in December 2024 and the SAAF interview was completed by the ICB in July 2025.

SEXUAL SAFETY

Work continues to strengthen our understanding around sexual safety for people who use or service and people who work within our service. Involvement in the East Midlands Community of practice continues with sharing of policies and work around sexual safety.

Staff have completed a sexual safety questionnaire which evidences they know how to recognise and respond to sexual safety incidents.

DHcFT has produced a video to alert staff to recognise issues around behaviours and boundaries. This is widely shared throughout the Trust.

There has been a video for patients produced and circulated throughout the Trust and Inpatient Units for patients to increase understanding about their sexual safety.

Sexual safety has been embedded into the i-care programme. Following the success of the i-care programme for new starters and recognising increasing requests to book longer serving Support Workers onto the programme.

Sexual safety has been included in the new Supervision Policy to reflect the importance of discussing sexual safety and helping staff understand that people are better protected when they are empowered to speak out about unwanted sexual behaviour and can speak openly about their sexual safety concerns.

Delivery of sexual safety training has started in other areas of the organisation.

The Trust has signed up to the Sexual Safety in Healthcare Charter which makes clear its intention and commitment to provide a safe environment for staff, patients, carers and visitors, which is free of unwanted sexualised behaviour. NHS England has established a national Charter for Sexual Safety in Healthcare which is based upon 10 core principles.

Derbyshire Healthcare has become a signatory of the Charter. To meet our organisational obligations as signatories, we are committed to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce, which we will achieve through establishing a clear plan demonstrating the actions we will take to embed the Charter's 10 principles.

The Sexual Safety and Personal Boundaries Policy and Procedure has been ratified and is in place for the Trust. The Policy has been developed to promote the sexual safety and sexual health of individuals who use our services as well as staff members and visitors to Trust services.

A sexual safety working group has been set up to ensure that this area remains a priority within the organisation. Reports are submitted on a twice-yearly basis to the Quality and Safeguarding Committee which reports directly to the Trust Board.

PUBLIC PROTECTION

MARAC – Multi-Agency Risk Assessment Conference

The Multi-Agency Risk Assessment Conference (MARAC) is a multi-agency approach to managing cases of domestic abuse where the victim has been identified as being at high risk of serious harm or homicide. MARAC meetings bring together representatives from both statutory and voluntary agencies with the aim of sharing information and developing a safety plan for victims and their families with a view to reducing the risks and the likelihood of repeat victimisation.

The victim does not attend the meetings but is represented by an Independent Domestic Violence Advisor (IDVA) who speaks on their behalf. MARAC meetings are held every week, alternating between the south of the county and the north. This allows cases from both areas of the county to be discussed fortnightly.

For the period 2 April 2024 to 18 March 2025, there were 1,163 MARAC referrals for South MARAC (Erewash, Derby City and South Derbyshire), which is a significant increase from the previous year (953 referrals). In an attempt to try and reduce numbers, MARAC have now implemented a MARAC Repeat Referral Form where repeat cases are sent out to agencies to establish whether there is any new information that warrants the case going back to be discussed.

In relation to North MARAC (not attended by DHcFT Safeguarding Team), arrangements were made for DHcFT mental health representation at this meeting. However, we have been made aware that there has been no mental health representation for some time and we are in discussions to resolve.

Since the last annual report, the role of the MARAC mental health representative in Derby City and Erewash has been handed back from the Safeguarding team to the respective Mental Health teams to attend the MARAC. South Derbyshire mental health is currently in the process of being handed over and this should be completed within the upcoming months. Charlie Hall remains as the MARAC representative for children's health. The MARAC research form used by School Nurses and Health Visitors, along with a user's guide, has been approved by CRG and is in now in use by all professionals.

MAPPA (Multi-agency Public Protection Arrangements)

The purpose of MAPPA is to *"Protect the public, including previous victims of crime, from serious harm by sexual and violent offenders*" (MAPPA Guidance (2012) Version 4.0, Section 1). These arrangements are statutory.

It does this by ensuring that all relevant agencies work together effectively to:

- Identify all MAPPA offenders.
- Complete comprehensive multi-agency risk assessments
- Devise, implement and review robust multi-agency risk management plans.
- Focus the available resources in a way which best protects the public from serious harm.

DHcFT continues to maintain 100% attendance at MAPPA 3 meetings and case reviews.

DHcFT attends out of area MAPPA 3 meetings where the offender is known to Derbyshire.

PREVENT:

The 2011 Prevent Strategy has three specific strategic objectives.

- Respond to the ideological challenge of terrorism and the threat we face from those who promote these views
- Prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support
- Work with sectors and institutions where there are risks of radicalisation that we need to address.

Channel is a part of the UK's Prevent strategy; it is a voluntary program requiring consent from the individual before any support is offered. This consent is crucial for participation in Channel. Support is tailored to the individual's needs after consent is given. DHcFT has a Prevent Policy which reflects our commitment to the strategy.

DHcFT is fully committed to attendance at the Channel meetings. The Assistant Director of both Safeguarding Adults and Children and the Named Safeguarding Doctor attend the Channel meetings. We continue to maintain 100% attendance at these meetings.

Our Level 3 safeguarding adults training supports this process by focus on understanding the risk of radicalisation to ensure staff understand the risk and build the capabilities to deal with it, communicate and promote the importance of the duty; and ensure staff implement the duty effectively.

SOCEX:

The aim of SOCEX tactical meetings is to create a single, whole system response, working in partnership to reduce the threat of serious organised crime and exploitation, protecting our communities.

The priorities are as follows:

- Pursue: Deliver an effective multi-agency collaboration to target, disrupt and prosecute exploiters
- Prevent: Prevent people from engaging in serious organised crime or becoming victims of exploitation
- Protect: Protect the community from the risk of serious organised crime and exploitation and increasing awareness and resilience against this threat
- Prepare: Working together to ensure an effective multi-agency structure and response to serious organised crime and exploitation.

The meeting (SOCEX) structures allow operational, tactical, and strategic oversight of exploitation and serious organised crime disruption across the County of Derbyshire. This is underpinned by information and intelligence sharing which will have, or has the potential to have, an impact on the communities of Derbyshire, across each Local Authority and Operational Policing Division. The team work to a delivery plan.

Both Assistant Directors of Safeguarding Adults and Children attend the tactical partnership meeting to provide a multi-agency response to identified areas of emerging threat and risk in relation to the exploitation of children, vulnerable adults and the emergence of serious and organised crime.

MASH HEALTH ADVISORS 2023/24

The aim of this report is to reflect on the Health Advisors activity from 1 April 2024 to 31 March 2025.

<u>MASH Adults</u>

MASH health received approximately 2,049 referrals from Adult Social Care, this is a 24% increase in referrals from the previous year. A total of 1,626 professionals were liaised with in relation to these referrals which is a 37% increase in the number of health and multi-agency colleagues liaised with in relation to these referrals from the previous year. This is likely due to an increase in the complexity of the adult safeguarding referrals being received into MASH Health. A total of 83 Adult strategy discussions were attended which is on par with the previous year's figures.

The themes of abuse for adult safeguarding remains largely consistent with previous years, with DA, Financial and Material, Self Neglect, Psychological, neglect and acts of omission, Physical and Sexual being the main categories of abuse for referrals. There has been an increase in referrals whereby substance misuse and mental health are a factor. It is unclear if this is due to either better recognition of substance misuse and mental health issues in individuals or if there is an increase in these concerns for individuals. There has also been an increase in 'criteria not met' referrals, this is likely to be due to an improved screening process by Adult Social Care and application of thresholds.

<u>MASH Children</u>

MASH health attended a total of 445 strategy meeting which is a decrease of 20% on the previous year. There continues to be a large number of both children and adults being considered as part of these strategy discussions. The complexity of children's strategy discussions has increased, with large numbers of individuals being considered. There continues to be an impact in the MASH from the increase in violent crime including knife crime in Derby City. A decrease in the number of strategy discussions may be attributable to the MASH Team having an improved response to complex cases linked to violent crime – for example, one strategy discussion may consider a number of individuals and their families associated with the incident. Overall, the main themes of abuse remain consistent with previous years with Physical and Sexual abuse along with Domestic abuse being the main categories.

Domestic abuse triage

A total of 1,305 medium risk domestic abuse cases were discussed at medium risk domestic abuse triage – an increase of 16% on the previous year.

Protecting Children Online (PCOT)

There has been a 44% increase in the number of PCOT cases being discussed within PCOT triage. Work has been taking place regarding a Terms of Reference and improved processed in relation to PCOT which will be reported on in the next annual report.

Advice calls

MASH Health Advisors completed a total of 163 advice calls during this period, which is a 62% increase on the previous year's figures. This data is collected from emails received from the Safeguarding unit. However, many colleagues in the Trust now contact MASH health direct and therefore, this figure is likely to be slightly higher. Advice calls are in relation to safeguarding adult concerns for the Trust.

Delegated inquiries

MASH health continues to complete section 42 delegated enquiries for incidents that take place on DHcFT Inpatient wards. These figures remain largely comparable with the previous year.

LEARNING FROM REVIEWS

Child Safeguarding Practice Reviews (CSPR)

DHcFT has been involved in no Child Safeguarding Practice Reviews (CSPR) throughout the year. Previous reviews are at different stages of completion within the formal processes. The Trust is fully engaged with all Partnership activity.

DHcFT has engaged with all relevant reviews and shared and applied the learning from these reviews into the organisation and teams.

Overarching key themes and priority areas have been evident through statutory Safeguarding Reviews in 2024/25 have been identified as the following:

- Domestic Abuse
- Online Harms
- Neglect

The Trust's Quality and Safeguarding Committee is kept abreast of all CSPR via reports and in turn, updates the Trust Board. We continue to strengthen the response to learning from reviews on behalf of the Trust.

Learning briefs and best practice guidance are developed by the Partnership to disseminate the learning throughout the organisations.

Domestic Homicide Reviews (DHRs) and Safeguarding Adult Reviews [SARs]

The Trust is actively involved in Domestic Homicide Reviews and Safeguarding Adult Reviews. Work continues to complete outstanding actions from previously published reports. These actions are overseen by the relevant Adult Safeguarding Board and Community Safety Partnership.

Learning briefs are developed by the Adult Safeguarding Boards to disseminate the learning to partner organisations. The Trust cascades learning via various routes, including professional meetings and organisational reporting. The recommendations and learning are incorporated into our Level 3 safeguarding training.

Focussed learning has been undertaken within the Trust around specific themes identified form SAR/DHR recommendations. This year there have been focussed sessions within the Trust around the theme of domestic abuse and professional curiosity.

DEVELOPMENT OPPORTUNITIES AND SUCCESSION PLANNING

Due to previous secondment opportunities, there has been a successful appointment to a substantive, part-time Health Advisor and MARAC lead role.

The Safeguarding Adult Trainer has been transferred to DHcFT in the TUPE process from Derbyshire Community Health Services.

Due to the retire and return of the Assistant Director of Safeguarding Children, on a part time basis, there has been a successful recruitment to a substantive, part-time post. We acknowledge this now a job share to cover the full time role.

OBJECTIVES 2025/26

Led by the operational group and assurance on progress provided to the Quality and Safeguarding Committee.

Objectives/Initiatives	
1	To provide strategic influence and support to DHcFT.
2	To strengthen and improve the quality of safeguarding across DHcFT by monitoring, evaluating and identifying good practice and areas for improvement in the effectiveness of practice.
3	To respond to national amendments to legislation and statutory guidance.
4	To continue to develop and integrate the Children's and Adults Safeguarding team within the Trust. Option paper available.
5	To ensure that succession planning, develop expertise within the workforce and consider talent management and support development by secondments into the Safeguarding Unit.
6	To continue to support staff around complex cases and to provide safeguarding leadership to the organisation.
7	To support CQC actions/standards improvements and initiatives and ensure it remains a golden thread throughout the organisation.
8	To work in partnership with agencies in regard to multi-agency audits and to continue to undertake internal safeguarding audits and disseminate the learning.
9	To continue to ensure that Think Family remains the focus in everything we do.
10	To continue to undertake a joint City/County Section 11, SEND self-assessments and SAAF. To ensure actions are identified and completed.
11	Assuring Sexual Safety within Trust services continues for patients and staff, in line with this being a Trust Quality priority.
12	To work alongside staff around quality of referrals, threshold, and escalation.
13	To commission annual Level 4 safeguarding training 2024.
14	To ensure full participation in multi-agency child safeguarding practice reviews, learning reviews and Domestic Homicide reviews and SARs. Ensuring that all recommendations are completed and learning disseminated throughout DHcFT.
15	To work alongside both Children's Safeguarding Partnership and the Adult Safeguarding Board around their agreed priorities for 2024/25.
16	To ensure safeguarding representation on relevant internal, external meetings and subgroups. Carry out any related activity/actions.
17	To ensure quality, assurance and governance to the Trust's Quality and Safeguarding Committee.
18	Major organisational changes have been introduced and will continue within the Trust. Mitigation and highlighting the safeguarding risks within these changes will continue to be raised by the Safeguarding team to support the process and ensure safe transition.

19	To continue to promote the equality and diversity ambitions of the Trust at every opportunity in meetings, training, supervision, advice and discussions.
20	To ensure safeguarding is integral within the Single Assessment Framework and staff fully understand safeguarding within the in-assessment process.
21	To ensure information, guidance, legislation and learning the lessons is cascaded and shared widely within the Trust via the safeguarding information sharing document and presented/issued to each COAT meeting.
22	To continue to design, deliver, update and evaluate the safeguarding training programme.
23	To be ambitious, collaborative, inclusive and caring within our approach to the wider safeguarding agenda to continue to make a positive difference in everything we do.
24	To welcome new staff to the organisation to create a culture that is open and transparent to create a safe working environment and making safeguarding everyone's responsibility.

GLOSSARY OF ACRONYMS

Acronym	Full Form
CCG	Clinical Commissioning Group
CIC	Children In Care
CRG	Clinical Reference Group
CQC	Care Quality Commission
COAT	Clinical Operational Assurance Team
CPA	Care Programme Approach
CSE	Child Sexual Exploitation
CSC	Children's Social Care
CSPR	Child Safeguarding Practice Review
DCHS	Derbyshire Community Health Services
DDSCP	Derby City and Derbyshire County Safeguarding Children Partnership
DDCCG	Derby and Derbyshire Clinical Commissioning Group
DHcFT	Derbyshire Healthcare Foundation Trust
DHRS	Domestic Homicide Reviews
DV	Domestic Violence
DOLS	Deprivation Of Liberty Safeguards
ESR	Electronic Staff Records
IEF	Information Exchange Form
KPI	Key Performance Indicators
MDMs	Multi-Disciplinary Meeting
MAPPA	Multi-Agency Public Protection Arrangement
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hub
MCA	Mental Capacity Act
MHA	Mental Health Act
MOGP	Markers Of Good Practice
MSP	Making Safeguarding Personal
MST	Microsoft Team
NAI	Non-Accidental Injury
PDL	Professional Development Lead
PCOT	Protecting Children Online Team
POLIT	Police Online Investigation Team
RAG	Red Amber Green (rating)

SAAF	Safeguarding Accountability and Assurance Framework
SAPDB	Safeguarding Adults Performance Dashboard
SARS	Safeguarding Adults Reviews
SEND	Special Educational Needs and Disabilities
SUDI	Sudden Unexplained Death in Infancy
TOC	Triangle Of Care
TUPE	Transfer of Undertakings (Protection of Employment
WRAP	Workshop to Raise Awareness of Prevent

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Learning from Deaths/Mortality report

Purpose of Report

The 'National Guidance on Learning from Deaths' requires each trust to collect and publish specified information on a quarterly basis. This report covers the period 1 April 2025 to 30 June 2025. The Board of Directors is requested to accept this Mortality Report as assurance of the Trust's approach and agree for the report to be published on the Trust's website as per national guidance.

Executive Summary

The Trust received 498 death notifications of patients who had been in contact with our services in the last year. There is very little variation between male and female deaths; 264 male deaths were reported, compared to 234 females.

There have been seven Learning Disability deaths in the reporting timeframe, one of which relate to patient with a diagnosis of autism.

There has been one inpatient Suspected Suicide of a patient reported as missing from the ward.

The Trust commissioned seven Learning Responses surrounding deaths through Case Record Review. There were four Patient Safety Incident Investigations commissioned, all of which are ongoing. Learning emerging from Case Record Reviews and Patient Safety Incident Investigations (PSII) raises themes in relation to:

Risk Management, comprehensive risk assessments being completed/reviewed to reflect needs, are individualised and holistic

Communication and Teamwork, need to enhance communication between multi-disciplinary teams (MDTs) and the importance of open and transparent communication with patients and families

Supporting staff with complex case management particularly around safeguarding, risk management and clinical decision-making in complex cases

Patient Safety and Incident Reporting, developing a culture of openness, where incidents, near misses and concerns are reported, managed and responded to, to support the dissemination of learning.

The newly-established Learning the Lessons Oversight Committee will hold oversight for actions resulting from Learning Responses, quality improvement plans, early learning and thematic analysis of incidents including deaths supported by subgroups within each service to improve ownership, accountability, joined up working.

Medical Examiner Officers have been established in all Acute trusts in England with their role extended to community deaths not referred to the coroners, to provide independent scrutiny. There is an agreement in place for cause of death information to be released to the Trust Patient Safety team for patients open to our service (six months prior to death) with the University Hospitals of Derby and Burton and Chesterfield Royal Hospital. This has been impacted by technical issues and a shortage of medical examiners. The Trust will continue to meet with Medical Examiners to improve this access and put into place a formal agreement.

Good practice identified through case note reviews is fed back to clinicians involved as part of our appreciative learning.

A process has been implemented within the Electronic Patient Record, which aids staff in identifying deaths which meet the threshold for Datix reporting. This process fulfils stage one of the Learning from Deaths Guidance in that all deaths are considered for red flags.

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

Risks and Assurances

This report provides limited assurance to the Quality and Safeguarding Committee that the Trust is following recommendations outlined in the National Guidance on Learning from Deaths.

Consultation

This report has been reviewed by the Medical Director, the Executive Incident Review Group membership and the Quality and Safeguarding Committee.

Governance or Legal Issues

There are no legal issues arising from this report.

The Care Quality Commission Regulations - this report provides assurance as follows:

- Outcome 4 (Regulation 9) Care and welfare of people who use services
- Outcome 14 (Regulation 23) Supporting staff
- Outcome 16 (Regulation 10) Assessing and monitoring the quality of service provision
- Duty of Candour (Regulation 20).

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

- Between 1 April 2025 to 30 June 2025, there was very little variation between male and female deaths; 264 male deaths were reported, compared to 234 female deaths
- No unexpected trends were identified according to ethnic origin or religion.

Recommendations

The Board of Directors is requested to accept this report with limited assurance of the Trust's approach and agree for the report to be published on the Trust's website as per national guidance.

Report presented by: **Lynn Andrews**
Chair, Quality and Safeguarding Committee

Report prepared by: **Rachel Williams**
Lead Professional for Patient Safety

Louise Hamilton
Safer Care Co-ordinator

Davinia Connelly
Operational Patient Safety Manager

Learning from Deaths/Mortality report (quarterly)

1. Background

In line with the Care Quality Commission's (CQC) recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a framework for NHS Trusts - 'National Guidance on Learning from Deaths'. The purpose of the framework is to introduce a more standardised approach to the way NHS trusts report, investigate, and learn from patient deaths, which should lead to better quality investigations and improved embedded learning. To date, the Trust has met all the required guidelines.

The report presents the data for 1 April 2025 to 30 June 2025.

2. Current Position and Progress

- Cause of death information is currently being sought through the Coroner offices in Chesterfield and Derby but only a very small number of cause of deaths have been made available
- Medical Examiner Officers at acute trusts provide independent scrutiny of non-coronial deaths, including those in the community. Medical Examiners are senior doctors from a range of specialties, including general practice, who provide independent scrutiny of deaths not taken at the outset for coroner investigation. They carry out a proportionate review of medical records and liaise with doctors completing the Medical Certificate of Cause of Death (MCCD). They give families and next of kin an opportunity to ask questions and raise concerns. There is an agreement in place for cause of death information to be released to the Trust's Patient Safety team for patients open to our service in the six months prior to their death. This agreement is in place with the University Hospitals of Derby and Burton and Chesterfield Royal Hospital, via working relationships between the corresponding Patient Safety teams. This has been slow to come into force due to numerous technical issues with the various EPR systems and a shortage of Medical Examiners. The Trust will continue to meet with Medical Examiners to improve this access and put into place a formal agreement
- Regular audits continue to be undertaken to ensure compliance with policy and procedure and any necessary amendments made. This has included auditing complaint data against names of deceased patients to ensure this meets the requirements specified in the National guidance. The last audit was completed 7 August 2025
- A process has been implemented within the Electronic Patient Record, which aids staff in identifying deaths which meet the threshold for Datix reporting. This process fulfils stage one of the Learning from Deaths in that all deaths are considered for red flags as identified under the national Learning from Deaths procedure. This is a significant improvement in process and will release capacity within the service to re-deploy into other priorities, such as actions and high-profile incident management. The plan will also allow for more joined up working with Corporate and Legal services ensuring better sharing of information and identification of priorities for both services
- In line with changes being made to the assurance and oversight of learning post-incident, the Trust Mortality Committee was replaced with the Learning the Lessons Oversight Committee. This Committee will have oversight and governance responsibility for incidents which include Mortality red flags and be responsible for overseeing the dissemination of learning post-incident. The Committee will work with service line Learning the Lessons groups to develop and drive forward quality improvement programmes across the Trust. Further resource and prioritisation is required to support implementation
- We are in the process of re-establishing the Regional Mortality Review Networking Group at DHcFT. Prior to the COVID-19 pandemic, we were active members of this group, which provided a valuable forum for shared learning and collaboration across organisations. As the group has not met for some time, we are taking steps to restart it and will be inviting colleagues from Leicester Partnership Trust (LPT), Coventry, Nottinghamshire, and other Midlands-based mental health trusts. The aim is to strengthen regional links, share learning from mortality reviews, and support continuous improvement in patient safety
- We are developing an Incident Review Tool (IRT) Audit Group to strengthen our approach to incident learning under the Patient Safety Incident Response Framework (PSIRF). The purpose of the group will be to ensure that outcomes from incident reviews are being shared appropriately, learning is effectively disseminated across services, and that there is alignment between the IRT process and the broader PSIRF requirements. This will support improved consistency, transparency, and assurance that learning from incidents is fully embedded into practice

- Following release of the Annual Learning from Deaths report 2024/25, an error was identified in the reported number of Talking Mental Health Derbyshire (TMHD) deaths. The report initially showed **27 cases**, however, this was incorrect due to a system issue which was not correctly filtering deaths by the team the individual was under at the time of death. A review was undertaken by the Patient Safety team, with support from IT and the database lead, to re-check each case. This confirmed that the actual figure was **18 cases**, not 27. Of these, **one case** met the Trust's red flag criteria and was reported via Datix. The system error that caused the incorrect figure has since been fixed, ensuring that future data pulls will display the correct information. Work is ongoing with the Records Team to confirm further details where possible (eg cause of death), but assurance has been given that the overall figure and reporting process are now accurate.

  As it stands, there have been **19 Improving Access to Physical Therapies (IAPT) deaths** (including one newly reported case during the previous reporting period).

  Two cases have been referred to the coroner, one case has been to inquest with a confirmed Narrative Conclusion - death was due to a combination of traumatic injury secondary to recurrent falls and alcoholic ketoacidosis secondary to significant and excessive alcohol consumption, the second case is awaiting on an inquest hearing to be listed.

  We have received **cause of death (CoD)** information for **13 deaths**, all of which were confirmed as natural causes.

  CoD is still awaited for **three deaths**.

3. Data Summary of all Deaths

Note that Inpatient and Learning Disability (LD) data is based upon whether the patient has an open Inpatient or LD referral at time of death.

The following table outlines information from 1 April 2025 to 30 June 2025:

	Apr	May	Jun
Total Deaths Per Month	167	177	154
LD Referral Deaths	3	1	3

Correct as at 6 August 2025.

Between 1 April 2025 and 30 June 2025, the Trust received 498 death notifications of patients who had been in contact with our services. Of these deaths, 264 patients were male, 234 female, 395 were white British and nine Asian British. The youngest age was zero years, the oldest age recorded was 102. The Trust has reported seven Learning Disability deaths in the reporting timeframe and one death of a patient with a diagnosis of autism.

4. Review of Deaths

Total number of deaths between 1 April 2025 and 30 June 2025 reported on Datix.	50 "Unexpected deaths" 11 "Suspected Suicide deaths" 7 "Expected - end of life pathway" NB some expected deaths have been rejected so these incidents are not included in the above figure. One patient died off the ward whilst an inpatient due to a suspected suicide. *W108844*
Incidents assigned for a review.	57 incidents assigned to the Operational Incident Group. One incident to be confirmed.

Only deaths which meet the criteria below should be reported through the Trust incident reporting system (Datix) and these are also reviewed using the process of the *Incident Reporting and Investigation Policy and Procedure.*

Any patient, open to services within the last six months, who has died and meets the following:

- Homicide – perpetrator or victim
- Domestic homicide - perpetrator or victim
- Suicide/self-inflicted death, or suspected suicide
- Death following overdose
- Death whilst an inpatient
- Death of an inpatient who died within 30 days of discharge from a DHcFT hospital
- Death following an inpatient transfer to acute hospital
- Death of patient on a Section of the Mental Health Act or Deprivation of Liberty Safeguards (DoLS) authorisation
- Death of patient following absconsion from an Inpatient unit
- Death following a physical restraint
- Death of a patient with a learning disability
- Death of a patient where there has been a complaint by family/carer the Ombudsman or where staff have raised a significant concern about the quality-of-care provision
- Death of a child (this will also be subject to scrutiny by the Child Death Overview Panel)
- Death of a patient open to safeguarding procedures at the time of death, which could be related to the death
- Death of a patient with historical safeguarding concerns, which could be related to the death
- Death where a previous Coroner's Regulation 28 has been issued
- Death of a staff member whilst on duty
- Death of a child under the age of 18 of a current or previous service user who has died in suspicious circumstances
- Where an external organisation has highlighted concerns following the death of a patient, whether they were open to the Trust at time of death or not
- Death of a patient with autism
- Death of a patient who had a diagnosis of psychosis within the last episode of care
- Death of a patient who had a diagnosis of an eating disorder within the last episode of care or within six months of discharge
- Death of a patient open to Crisis Home Resolution team or equivalent at the time of death.

5. Inpatient Deaths

There has been one Inpatient death for the period, which relates to a male patient who had left the ward and was reported missing. This death is categorised as a 'Suspected Suicide' and is subject to full Patient Safety Incident Investigation, which is being undertaken by an external company commissioned by the Trust.

6. Learning Responses for 2023/24, 2024/25 and 2025/26

The table below outlines the number of deaths that have been recorded through the Trust incident reporting system Datix and the learning response that has been commissioned. All deaths reported through the Datix system meeting the Trust 'red flag' will have an Incident Review Tool completed. This is then reviewed and a decision made as to whether a further Learning Response is required.

Financial Year	Datix	Case Record Review	Patient Safety Incident Investigation
2023/24	119 deaths	39	16
2024/25	141 deaths	23	3
2025/26	68 deaths	7	4

Please note: 57 deaths are currently awaiting a decision.

7. Duty of Candour (DoC) for 1 April 2025 to 30 June 2025

Between 1 April 2025 and 30 June 2025, there were zero deaths which met the criteria for DoC. There have been no deaths determined to be DoC for 2025/26. However, it should be noted there are Learning Responses for this period which remain active.

7. Learning from Deaths Procedure

The Trust has now completed a move in terms of its mortality process; a process has been implemented within the Electronic Patient Record which aids staff in identifying deaths which meet the threshold for Datix reporting. This process fulfils stage one of the Learning from Deaths in that all deaths are considered for red flags as identified under the national Learning from Deaths procedure. This is a significant improvement in process and will release some capacity within the service to re-deploy into other priorities such as actions and high-profile incident management. The plan will also allow for more joined up working with Corporate and Legal services, ensuring better sharing of information and identification of priorities for both services.

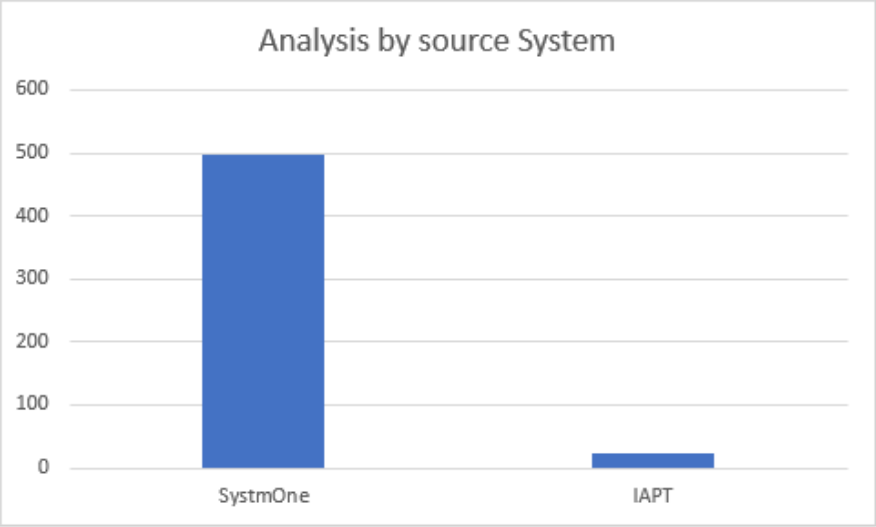
There is a process for weekly random audits of deaths against the red flags to provide assurance that the new process is working as intended.

As mentioned previously, the Patient Safety team is revising the function of its Mortality case record review process and developing an Incident Review Tool (IRT) Audit Group. All national mortality red flags now sit within the Trust's overarching red flags for the reporting of deaths as an incident. A plan has been agreed to re-appropriate the resource to strengthen our approach to incident learning under the Patient Safety Incident Response Framework (PSIRF).

The process will work to ensure that outcomes from incident reviews are being shared appropriately, learning is effectively disseminated across services, and that there is alignment between the IRT process and the broader PSIRF requirements.

8. Analysis of Data

8.1. Analysis per notification system since 1 April 2025 to 30 June 2025

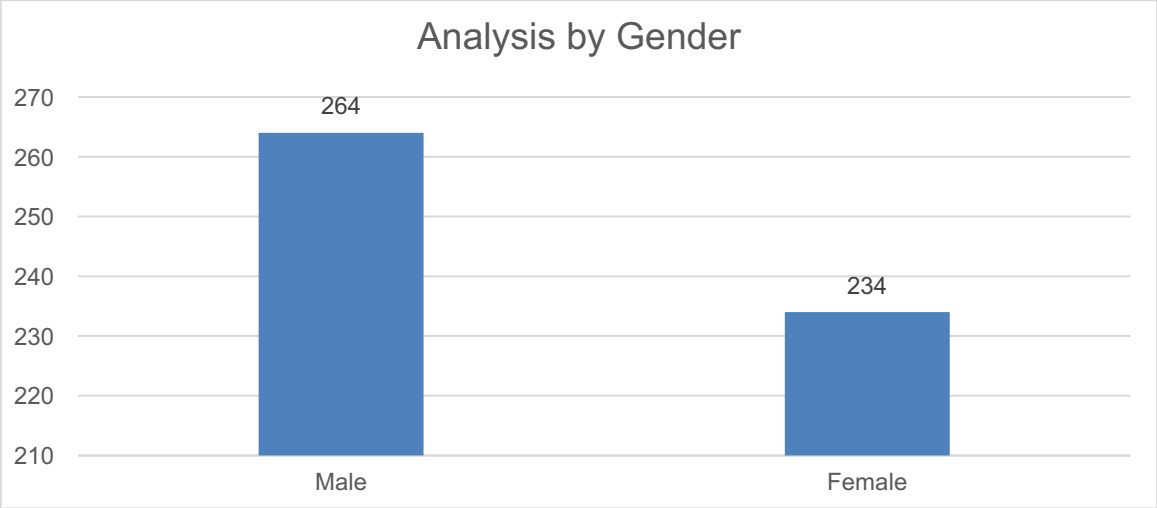


System	Number of Deaths
SystmOne	496
IAPT	22
Grand Total	**498**

The data above shows the total number of deaths reported by each notification system. The majority of death notifications were predominately pulled from SystmOne. This clinical record system is aligned to our largest population of patients and a population at greatest risk of death due to the proportion of older people in our care.

8.2. Analysis by Gender

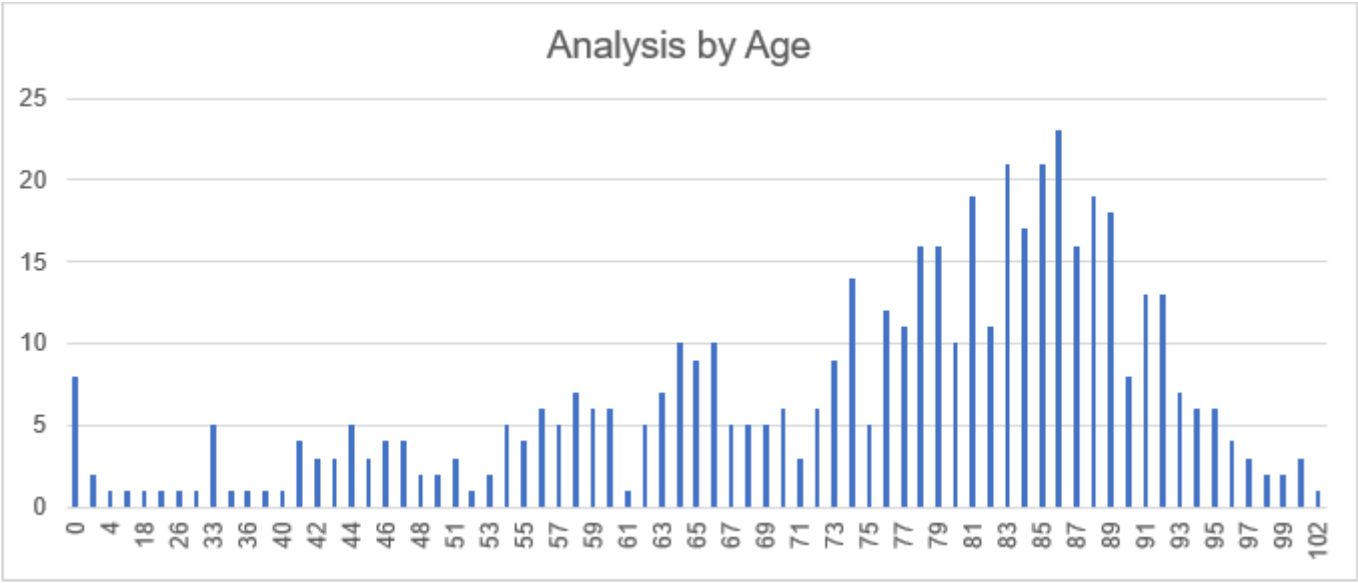
The data below shows the total number of deaths by gender 1 April 2025 to 30 June 2025. There is very little variation between male and female deaths; 234 female deaths were reported. compared to 264 males.



Gender	Number of Deaths
Male	264
Female	234
Grand Total	**498**

8.3. Analysis by Age Group

The youngest age was classed as zero, and the oldest age was 102 years. Most deaths occurred within the 78 to 89 age groups:



8.4. Learning Disability Deaths (LD)

The Trust reviews all deaths relating to patients diagnosed with a Learning Disability. The Trust also currently sends all Learning Disability deaths that have been reported through the Datix system to the LeDeR programme. Scoping is planned with operational services through their Learning the Lessons subgroups to consider the most appropriate management process for Learning Disability deaths moving forward.

	Apr	May	Jun
LD Deaths	3	1	3
Autism	0	0	1

Since 1 January 2022, the Trust has been required to report any death of a patient with autism. To date, fifteen patients have been referred.

During 1 April 2025 to 30 June 2025, the Trust has recorded seven Learning Disability deaths. The Trust now receives a quarterly update from LeDeR which highlights national good practice and identified learning; this is shared in the Mortality monthly meeting.

8.5. Analysis by Ethnicity

White British is the highest recorded ethnicity group with 395 recorded deaths; 28 deaths had no recorded ethnicity assigned. The following chart outlines all ethnicity groups:

Ethnicity	Number of Deaths
White - British	395
Other Ethnic Groups - Any other ethnic group	58
Not Known	24
Asian or Asian British - Indian	7
Not stated	4
White - Any other White background	3
Black or Black British - Any other Black background	2
Mixed - White and Black Caribbean	1
Asian or Asian British - Pakistani	1
Black or Black British - Caribbean	1
Asian or Asian British - Any other Asian background	1
Mixed - Any other mixed background	1
Grand Total	**498**

8.6. Analysis by Religion

Christianity is the highest recorded religion group with 192 recorded deaths, 122 deaths had no recorded religion assigned. The chart below outlines all religion groups:

Religion	Number of Deaths
Christian	183
Not religious	140
(blank)	83
Patient religion unknown	39
Church of England, follower of	15
Christian religion	9
Church of England	7
Roman Catholic	4
Sikh	3
Catholic: non Roman Catholic	2
Atheist movement	2
Methodist	2
Pagan	2
Anglican	1
Agnostic movement	1
Atheist	1
Catholic religion	1
Buddhist	1
Protestant	1
Rastafarian movement	1
Grand Total	**498**

8.7. Analysis by Sexual Orientation

Heterosexual or straight is the highest recorded sexual orientation group with 341 recorded deaths, 153 have no recorded information available. The chart below outlines all sexual orientation groups:

Sexual Orientation	Number of Deaths
Heterosexual	341
(blank)	130
Sexual orientation not given - patient refused	12
Sexual orientation unknown	7
Not stated (person asked but declined to provide a response about their sexual orientation)	3
Homosexual	1
Unknown	1
Homosexuality NOS	1
Bisexual	1
Male homosexual	1
Grand Total	**498**

8.8. Analysis by Disability

The table below details the top eight categories by disability. Gross motor disability was the highest recorded disability group with 97 recorded deaths:

Disability	Number of Deaths
Gross motor disability	97
Disability	46
Patient reports no current disability	41
Intellectual functioning disability	19
Emotional behaviour disability	17
Hearing disability	14
Disability Questionnaire - Behavioural and Emotional	8
Disability Questionnaire - Progressive Conditions and Physical Health	7

There have been 228 deaths with a disability assigned and the remainder were blank or had no assigned disability.

9. Recommendations and Learning

There has been no marked change to the themes emerging for the reporting period. Works are required to consider the way themes are captured within the Datix system and how services access and disseminate these. It is acknowledged that improvement is needed in relation to the following areas:

Improving **Risk Management** to ensure comprehensive risk assessments are completed and reviewed which accurately reflect patient need and mitigate risk. This aligns to the development of the Trust Risk Assessment, Safety Planning and Suicide Prevention works which includes a training package and revised Suicide Prevention strategy. Works have also been initiated for a Trust wide review of the ‘rag rating’ of risk and how this is applied. This will consider national guidance and work as done within service to ensure consistent and appropriate management of risk.

Ensuring that **Care Plans** are individualized and reflect the holistic needs of patients, including their psychological, emotional and physical wellbeing.

Improving **Communication and Teamwork**, a re-occurring theme which identifies the need to enhance communication between MDTs and the importance of open and transparent communication with patients and families, particularly around critical decisions and care pathways.

Supporting Staff with complex case management by identifying gaps in training and guidance, particularly related to safeguarding, risk management, and clinical decision-making to support staff in being equipped with the skills and knowledge they need to deal with complex cases.

Patient Safety Thread and Incident Reporting, to encourage a culture of openness where all incidents, near misses, and concerns are reported and acted upon. Ensuring that incidents are appropriately managed and responded too to support the dissemination of learning to reduce risk to patients.

The table below **Themes Arising from Incident Learning Responses** provides detail in relation active works and improvement needs.

Themes arising from incident learning responses

Improvement issue	Improvement plan
Transfer, Leave and Discharge	**Transfer of the deteriorating patient** Transfer and return of patients between inpatient services for the Trust and Acute providers, including handover of information, and the way patients are conveyed. A quality improvement project was completed between Derby Hospital and DHcFT to develop a transfer and handover proforma. Further works are needed to support its implementation as this appears inconsistently used within inpatient services. The lead for this work is currently not in work and this is under re-allocation. **Self-harm of patients whilst on leave from inpatient services and Section 17 leave arrangements** Issues in relation to leave arrangements for inpatient services including follow up. A further thematic review was completed on conclusion of a cluster of inpatient suspected suicide incidents. An action plan was developed. This will require alignment to current incidents for inpatient services and allocation to an appropriate lead.
Suicide Prevention	**Suicide Prevention training** This is being led by the Trust Medical Director and has been incorporated into the new Risk Assessment, Safety Planning and Suicide Prevention training package currently being rolled out. A Trust Suicide Prevention Lead was appointed and this links into current training development as well as a review of the trust Suicide Prevention strategy.
Training and awareness of Emotionally Unstable Personality Disorder	Development of a training and awareness package for all services in relation to EUPD which is being led by the Trust Medical Director.
Multi-agency engagement following incidents	It is known that patients are often known to multiple services both internally and externally. Works have been commissioned to consider agreements needed to enhance multi-agency working with partner agencies when an incident investigation has been commissioned to improve shared learning and enhance family liaison and support.
Physical Health management within inpatient environments	The recognition of deteriorating patient (RODP) training has been embedded within the Trust level 2 and 3 resuscitation training and has been updated with Mental Health Inpatient specific scenarios, this will be rolled out across Inpatient services with learning form incidents incorporated as part of the training scenarios. In addition to this the check and challenge meetings for adult and Community performance reviews utilise the Power Bi dashboards to focus on specific health metrics for improvement, these are overseen by the Executive Director of Nursing, AHPs, Quality and Patient Experience and the Assistant Director of Practice Compliance.
MDT process improvements within CMHTs	EPR and recording documentation for MDT is in place, further works are needed to ensure its qualitive function. This is an emerging theme from current PSI investigations and an action plan will be developed.
Self-harm within inpatient environments including management of contraband	**Ligature Risk Reduction** **Structural Changes** • Refreshed ligature risk assessments across inpatient and community settings, with targeted upgrades including anti-barricade doors and door replacements • Heat maps and updated floor plans introduced to visually flag high-risk areas, now embedded into assessment workflows • New guidance and SOPs for ligature knife and scissors management implemented, including buffer stock protocols. **Governance Processes** • Ratification of updated Ligature Risk Reduction Policy and Procedure by Health and Safety Committee and CQC Oversight Group

Improvement issue	Improvement plan
	• Launch of a centralised risk assessment tool by IMT to track actions, assign ownership, and maintain audit trails • External audit by 360 Assurance completed, highlighting areas for improved socialisation and red risk resolution. **Training and Staff Awareness** • Ligature risk training embedded into staff passports and delivered via train-the-trainer model • Compliance monitored through dashboards and local audits; system notification issues under review • MDT roles clarified in policy and reinforced through training to promote shared accountability. **Contraband Management & Search Policy - Enhancements** • Clarification of Contraband Definitions: Staff guidance has been reinforced to clearly define prohibited items, including weapons, sharp objects, illicit substances, alcohol, tobacco, and non-prescribed medications • PICU-Specific Controls: The SOP for PICU outlines restricted access to personal property, cutlery tracking protocols, and airlock-controlled entry to Kingfisher House • Delivery Handling SOP: A new SOP introduces structured procedures for parcel receipt, patient consent, and lawful search and confiscation. **Search Policy updates** • Expanded Search Types: The revised policy includes detailed procedures for body, belongings, room, strip, and environmental searches, with clear guidance on consent and proportionality • Consent and Cultural Sensitivity: The policy now includes provisions for patients who may object to searches on religious or cultural grounds, and outlines gender-sensitive practices • Visitor Protocols: New guidance addresses actions when visitors are suspected of carrying dangerous or illicit items, including documentation and disposal procedures. **SOP Revisions and Governance** • Policy Communication: Despite rapid implementation, concerns were raised about consultant awareness of policy changes. A briefing was proposed to clarify roles and responsibilities across MDTs • SOP Adjustments: Updates include changes to leave arrangements and post-hospital visit protocols, reducing restrictions for patients not on red pathways • Governance Oversight: SOPs for PICU and Female Enhanced Care Unit were reviewed and aligned with mobilisation plans for new builds under the “Making Room for Dignity” programme.
Dissemination of learning and service improvements following incidents including assurance and governance	Improve the way the trust learns and improves from incidents, to include a revision to processes in place in relation to internal investigation recommendations, Case Record Review learning, Incident Review Tool learning and the revised Trust Mortality process. Develop pathway to offer clear governance processes. Embed service line learning briefings specific to service learning. Trust-wide learning the lessons to share high level responses and learning. Develop better ways for monitoring and reporting emerging themes. Joined up working between services. Improved monitoring of high-profile cases and joined up working between services involved. Development of more collaborative Learning Responses.

Improvement issue	Improvement plan
Application of red flags and flow of incidents resulting in death	Improvement in the application and identification of red flags for reporting death. Revision of current red flags for relevance given changes both nationally and locally. Redesign the function of the 'Mortality' process within structures through the Learning the Lessons subgroups. Review the purpose and function of the Mortality Case Record Review panel and redesign this to one of audit and assurance is underway. This will now act as an assurance audit over deaths closed to the Operational Incident review group and thematic analysis by service for service identified themes.
Interface between Mental Health and Substance Misuse service	Suspected Suicide of a patient who has a dual diagnosis of substance misuse and mental health but has been rejected by Community Mental Health services, is an area which has been noted through Case Record Review. This has been selected as a new local priority for the trust. Themes will be feed into Learning the Lessons subgroups for both services to jointly develop and improvement plan.
Substance Misuse services and Adult Acute Inpatient environments	Learning Responses for unexpected deaths post discharge/ whilst on leave have highlighted gaps around knowledge, support and process for the management and support of risk in relation to addiction and substance misuse. This will be a focus for the Inpatient Service Learning the Lessons process. Currently impacted by structure redevelopment.
Risk assessment, management, and care planning	Included within the Risk Assessment, Safety Planning and Suicide Prevention training package which will consist of four modules and incorporate suicide prevention. Working group established in relation to the application and effectiveness of risk 'rag rating' Trust-wide.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 25 November 2025

Learning from Deaths/Mortality report

Purpose of Report

The 'National Guidance on Learning from Deaths' requires each trust to collect and publish specified information on a quarterly basis. This report covers the period 1 July 2025 to 30 September 2025. The Quality and Safeguarding Committee accepted this Mortality report as assurance of the Trust's approach and agreed for the report to be considered by the Trust Board of Directors and published on the Trust's website as per national guidance.

Executive Summary

The Trust received 456 death notifications of patients who had been in contact with our services in the last year. There is very little variation between male and female deaths; 242 male deaths were reported, compared to 213 females.

There have been 10 Learning Disability deaths in the reporting timeframe, one of which relate to patient with a diagnosis of autism.

There has been one inpatient unexpected death due to physical health causes.

The Trust commissioned seven Learning Responses surrounding deaths through Case Record Review. There were four Patient Safety Incident Investigations commissioned, all of which are ongoing. Learning emerging from Case Record Reviews and Patient Safety Incident Investigations (PSII).

There have been 11 learning responses approved for closure. Main themes include:

- Risk Assessment and Management
- Referral and triage processes, assessment methods
- Awaiting list management
- Communication delays and gaps – internal and external
- Care planning and documentation

These areas will be reviewed through the Learning the Lessons Oversight Committee, where appropriate improvement groups will be established to oversee implementation. The Learning the Lessons Oversight Committee will hold oversight for actions resulting from Learning Responses, quality improvement plans.

The Trust Patient Safety team continues to meet with Medical Examiners to improve the flow of information in relation to cause of death.

Good practice identified through case note reviews is fed back to clinicians involved as part of our appreciative learning.

The mortality process within the EPR is now established with weekly audits to review compliance.

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

Risks and Assurances

This report provided limited assurance to the Quality and Safeguarding Committee that the Trust is following recommendations outlined in the National Guidance on Learning from Deaths.

Consultation

This report has been reviewed by the Interim Medical Director, Executive Incident Review Group membership and the Quality and Safeguarding Committee.

Governance or Legal Issues

There are no legal issues arising from this report.

The Care Quality Commission Regulations - this report provides assurance as follows:

- Outcome 4 (Regulation 9) Care and welfare of people who use services
- Outcome 14 (Regulation 23) Supporting staff
- Outcome 16 (Regulation 10) Assessing and monitoring the quality of service provision
- Duty of Candour (Regulation 20).

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

- Between 1 July 2025 to 30 September 2025, there was very little variation between male and female deaths; 242 male deaths were reported, compared to 213 female deaths
- No unexpected trends were identified according to ethnic origin or religion.

Recommendations

The Board of Directors is requested to accept this report with limited assurance of the Trust's approach and agree for the report to be published on the Trust's website as per national guidance.

Report presented by: **Lynn Andrews**
Chair, Quality and Safeguarding Committee

Report prepared by: **Louise Hamilton**
Safer Care Co-ordinator

Davinia Connelly
Operational Patient Safety Manager

Learning from Deaths/Mortality report (quarterly)

1. Background

In line with the Care Quality Commission's (CQC) recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a framework for NHS Trusts - 'National Guidance on Learning from Deaths'. The purpose of the framework is to introduce a more standardised approach to the way NHS trusts report, investigate, and learn from patient deaths, which should lead to better quality investigations and improved embedded learning. To date, the Trust has met all the required guidelines.

The report presents the data for 1 July 2025 to 30 September 2025.

2. Current Position and Progress

- Cause of death information is currently being sought through the Coroner offices in Chesterfield and Derby but only a very small number of cause of deaths have been made available
- Medical Examiner Officers at acute trusts provide independent scrutiny of non-coronial deaths including those in the community. They carry out a proportionate review of medical records and liaise with doctors completing the Medical Certificate of Cause of Death (MCCD). They give families and next of kin an opportunity to ask questions and raise concerns. There is an agreement in place for cause of death information to be released to the Trust's Patient Safety team for patients open to our service in the six months prior to their death. This agreement is in place with University Hospitals of Derby and Burton (UHDB) and Chesterfield Royal Hospital via working relationships between the corresponding Patient Safety teams. This has been slow to come into force due to numerous technical issues for the varies EPR systems and a shortage of medical examiners
- Regular audits continue to be undertaken to ensure compliance with policy and procedure for the reporting of Red Flag deaths. This includes auditing complaint data against names of deceased patients to ensure this meets the requirements specified in the National guidance. The last audit was completed 7 August 2025
- A process is now embedded within the Electronic Patient Record, which aids staff in identifying deaths which meet the threshold for Datix reporting. This process fulfils stage one of the Learning from Deaths. procedure
- In line with changes being made to the assurance and oversight of learning post-incident, the Trust Mortality Committee was replaced with the Learning the Lessons Oversight Committee. This committee will have oversight and governance responsibility for incidents which include mortality red flags and be responsible for overseeing the dissemination of learning post-incident. The committee will work with service line Learning the Lessons groups to develop and drive forward quality improvement programmes across the Trust. Further resource and prioritisation is required to support implementation
- We are in the process of re-establishing the Regional Mortality Review Networking Group at Derbyshire Healthcare NHS Foundation Trust (DHcFT). The aim is to strengthen regional links, share learning from mortality reviews, and support continuous improvement in patient safety
- We are developing an Incident Review Tool (IRT) Audit Group to strengthen our approach to incident learning under the Patient Safety Incident Response Framework (PSIRF). The purpose is to ensure that outcomes from incident reviews are being shared appropriately, learning is effectively disseminated across services, and that there is alignment between the IRT process and the broader PSIRF requirements.

3. Data Summary of all Deaths

Note that Inpatient and Learning Disability (LD) data is based upon whether the patient has an open Inpatient or LD referral at time of death.

The following table outlines information from 1 July 2025 to 30 September 2025:

	Jul	Aug	Sep
Total Deaths Per Month	163	148	145
LD Referral Deaths	4	1	5

Correct as at 13 October 2025

Between 1 July 2025 and 30 September 2025, the Trust received 456 death notifications of patients who had been in contact with our services. Of these deaths, 242 patients were male, 213 female and one unknown gender, 365 were white British and nine Asian British. The youngest age was zero years, the oldest age recorded was 101. The Trust has reported ten Learning Disability deaths in the reporting timeframe and one death of a patient with a diagnosis of autism.

4. Review of Deaths

Total number of deaths between 1 July 2025 and 30 September 2025 reported on Datix.	57 “Unexpected deaths” Five “Suspected Suicide deaths” Nine “Expected - end of life pathway” one death occurred on inpatient ward NB some expected deaths have been rejected so these incidents are not included in the above figure.
Incidents assigned for a review.	69 incidents assigned to the Operational Incident Group. Two incidents to be confirmed.

Only deaths which meet the criteria below should be reported through the Trust incident reporting system (Datix) and these are also reviewed using the process of the *Incident Reporting and Investigation Policy and Procedure.*

Any patient, open to services within the last six months, who has died and meets the following:

- Homicide – perpetrator or victim
- Domestic homicide - perpetrator or victim
- Suicide/self-inflicted death, or suspected suicide
- Death following overdose
- Death whilst an inpatient
- Death of an inpatient who died within 30 days of discharge from a DHcFT hospital
- Death following an inpatient transfer to acute hospital
- Death of patient on a Section of the Mental Health Act or Deprivation of Liberty Safeguards (DoLS) authorisation
- Death of patient following absconsion from an Inpatient unit
- Death following a physical restraint
- Death of a patient with a learning disability
- Death of a patient where there has been a complaint by family/carer the Ombudsman or where staff have raised a significant concern about the quality-of-care provision
- Death of a child (this will also be subject to scrutiny by the Child Death Overview Panel)
- Death of a patient open to safeguarding procedures at the time of death, which could be related to the death
- Death of a patient with historical safeguarding concerns, which could be related to the death
- Death where a previous Coroner’s Regulation 28 has been issued
- Death of a staff member whilst on duty
- Death of a child under the age of 18 of a current or previous service user who has died in suspicious circumstances
- Where an external organisation has highlighted concerns following the death of a patient, whether they were open to the Trust at time of death or not
- Death of a patient with autism
- Death of a patient who had a diagnosis of psychosis within the last episode of care
- Death of a patient who had a diagnosis of an eating disorder within the last episode of care or within six months of discharge
- Death of a patient open to Crisis Home Resolution team or equivalent at the time of death.

5. Inpatient Deaths

There has been 1 inpatient death for the period which relates to a female patient who died due to physical health causes.

6. Learning Responses for 2023/24, 2024/25 and 2025/26

The table below outlines the number of deaths that have been recorded through the Trust incident reporting system Datix and the learning response that has been commissioned. All deaths reported through the Datix system meeting the Trust 'red flag' will have an Incident Review Tool completed. This is then reviewed, and a decision made as to whether a further Learning Response is required.

Financial Year	Datix	Case Record Review	Patient Safety Incident Investigation
2023/24	119 deaths	39	16
2024/25	141 deaths	23	3
2025/26	87 deaths	12	4

Please note: 49 deaths are currently awaiting a decision.

7. Duty of Candour (DoC) for 1 July 2025 to 30 September 2025

Between 1 July 2025 and 30 September 2025, there were zero deaths which met the criteria for DoC. There have been no deaths determined to be DoC for 2025/26. One death has been identified during this financial year as DoC having occurred 2024/25; the Trust continues to support this family in engagement. It should be noted there are Learning Responses for this period which remain active and therefore, DoC figures change.

8. Learning from Deaths Procedure

The Trust has now completed a move in terms of its mortality process; a process has been implemented within the Electronic Patient Record which aids staff in identifying deaths which meet the threshold for Datix reporting. This process fulfils stage one of the Learning from Deaths in that all deaths are considered for red flags as identified under the national Learning from Deaths procedure. This will also allow for more joined up working with Corporate and Legal services, ensuring better sharing of information and identification of priorities for both services. Weekly random audits continue for deaths against the red flags to provide assurance that the new process is working as intended.

The Patient Safety team has been revising the function of its Mortality case record review process and developing an Incident Review Tool (IRT) Audit process which will be allocated to Medical and Nursing colleagues. All national mortality red flags sit within the Trust's overarching red flags for the reporting of deaths as an incident.

The process will work to ensure that outcomes from incident reviews are being shared appropriately, learning is effectively disseminated across services, and that there is alignment between the IRT process and the broader PSIRF requirements.

9. Analysis of Data

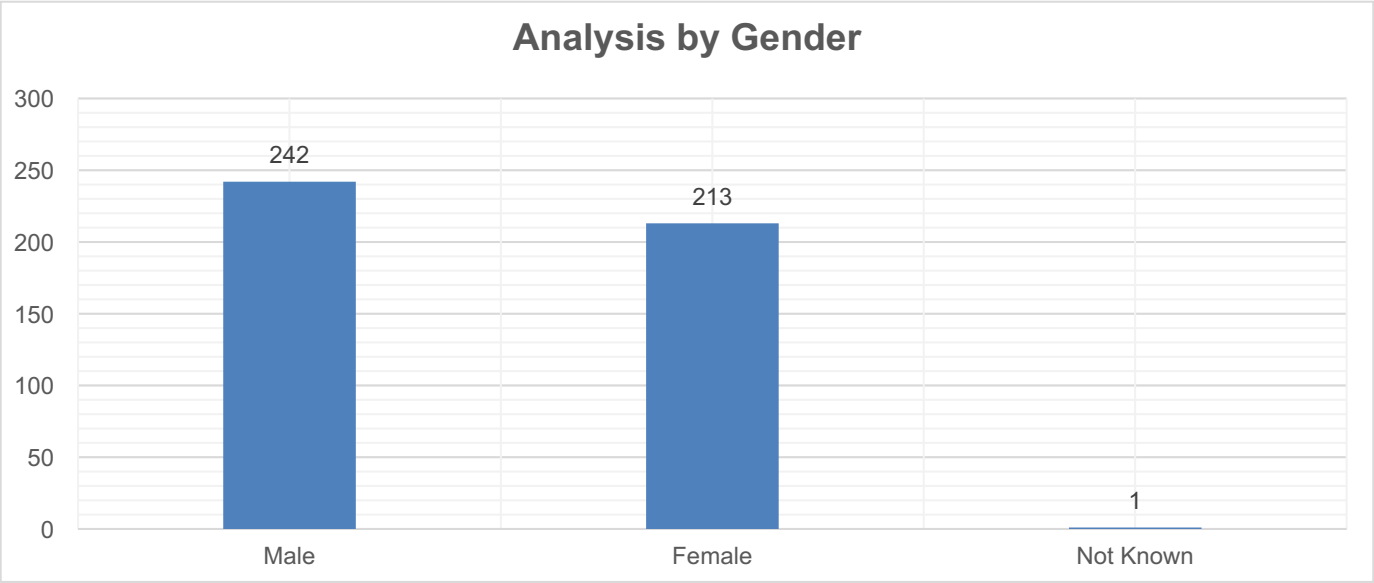
9.1. Analysis per notification system since 1 July 2025 to 30 September 2025

System	Number of Deaths
SystmOne	456
Grand Total	**456**

The data above shows the total number of deaths reported by each notification system. All of the death notifications were pulled from SystmOne. This clinical record system is aligned to our largest population of patients and a population at greatest risk of death due to the proportion of older people in our care.

9.2. Analysis by Gender

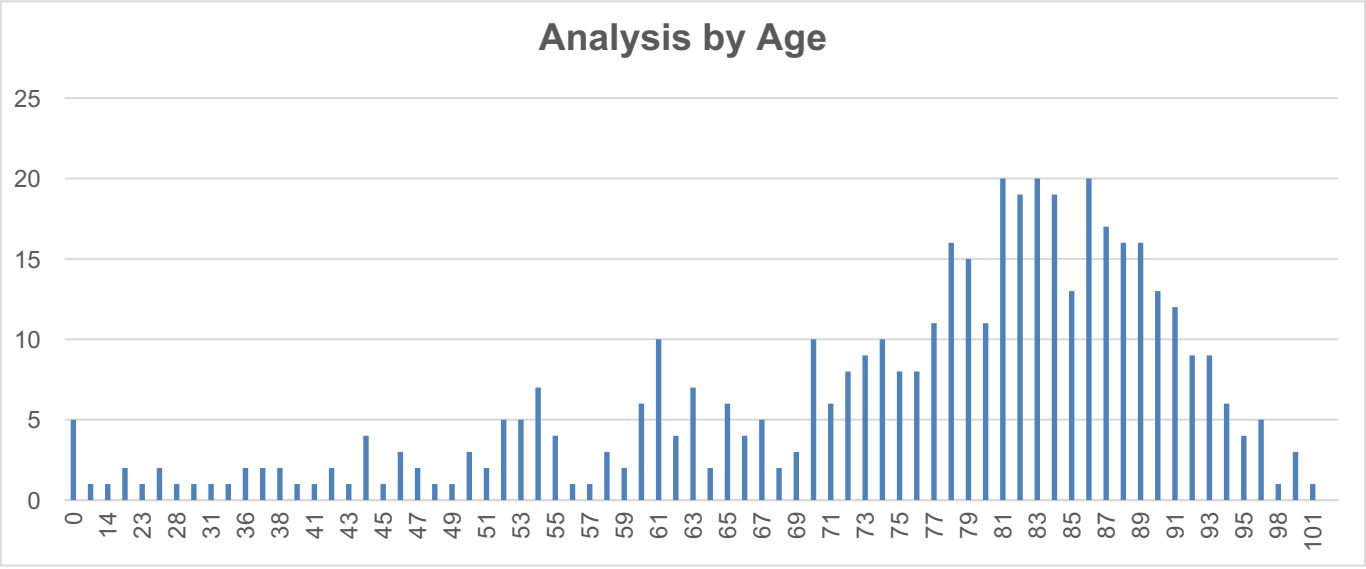
The data below shows the total number of deaths by gender 1 July 2025 to 30 September 2025. There is very little variation between male and female deaths; 213 female deaths were reported. compared to 242 males.



Gender	Number of Deaths
Male	242
Female	213
Not Known	1
Grand Total	**456**

9.3. Analysis by Age Group

The youngest age was classed as zero, and the oldest age was 101 years. Most deaths occurred within the 78 to 89 age groups:



9.4. Learning Disability Deaths (LD)

The Trust reviews all deaths relating to patients diagnosed with a Learning Disability. The Trust also currently sends all Learning Disability deaths that have been reported through the Datix system to the LeDeR programme. Scoping is planned with operational services through their Learning the Lessons subgroups to consider the most appropriate management process for Learning Disability deaths moving forward.

	Jul	Aug	Sep
LD Deaths	4	1	5
Autism	0	1	0

Since 1 January 2022, the Trust has been required to report any death of a patient with autism. To date, 16 patients have been referred.

During 1 July 2025 to 30 September 2025, the Trust has recorded 10 Learning Disability deaths. The Trust now receives a quarterly update from LeDeR which highlights national good practice and identified learning; this is shared in the Mortality monthly meeting. Benchmarking will take place in relation to the use of DATIS to manage the reporting requirements around Learning Disability deaths.

9.5. Analysis by Ethnicity

White British is the highest recorded ethnicity group with 365 recorded deaths; 24 deaths had no recorded ethnicity assigned. The following chart outlines all ethnicity groups:

Ethnicity	Number of Deaths
White - British	365
Other Ethnic Groups - Any other ethnic group	46
Not Known	22
White - Any other White background	5
Asian or Asian British - Indian	4
White - Irish	4
Asian or Asian British - Pakistani	3
Not stated	2
Asian or Asian British - Any other Asian background	2
Mixed - Any other mixed background	1
Black or Black British - African	1
Mixed - White and Black Caribbean	1
Grand Total	**456**

9.6. Analysis by Religion

Christianity is the highest recorded religion group with 176 recorded deaths, 237 deaths had no recorded religion assigned. The chart below outlines all religion groups:

Religion	Number of Deaths
Christian	176
Not religious	130
(blank)	79
Patient religion unknown	28
Church of England	11
Church of England, follower of	11
Christian religion	7
Sikh	4
Roman Catholic	3
Muslim	3
Catholic religion	1
Methodist	1
Atheist	1
Jehovah's Witness religion	1
Grand Total	**456**

9.7. Analysis by Sexual Orientation

Heterosexual or straight is the highest recorded sexual orientation group with 326 recorded deaths, 130 have no recorded information available. The chart below outlines all sexual orientation groups:

Sexual Orientation	Number of Deaths
Heterosexual	326
(blank)	105
Sexual orientation not given - patient refused	15
Sexual orientation unknown	8
Not stated (person asked but declined to provide a response about their sexual orientation)	2
Grand Total	**456**

9.8. Analysis by Disability

The table below details the top eight categories by disability. Gross motor disability was the highest recorded disability group with 95 recorded deaths:

Disability	Number of Deaths
Gross motor disability	87
Disability	44
Intellectual functioning disability	27
Hearing disability	15
Emotional behaviour disability	10
Disability Questionnaire - Mobility and Gross Motor	8
Disability Questionnaire - Behavioural and Emotional	7
Disability Questionnaire - Progressive Conditions and Physical Health	6

There have been 220 deaths with a disability assigned and the remainder were blank or had no assigned disability.

10. Closed Learning response outcomes for the period

There have been 11 learning responses approved for closure through the Executive Incident Review group. Below are the main findings and areas for recommendation which highlight both systemic and process-level issues.

Risk Assessment and Management

Risk assessments must be dynamic and regularly updated. Every patient should have a comprehensive risk management and safety plan, including community safety strategies.

Perinatal Community Mental Health team (CMHT)

Key areas for improvement: referral and triage processes, assessment methods, waiting list management, and information sharing with GPs, professionals, families, and carers.

Falls Monitoring

Enhanced processes are in place and reviewed at multiple levels.

Recognition of Deteriorating Patients

- Ongoing work to improve training and physical health monitoring for early detection
- End-of-Life Care: Staff need further training in communication, especially for care planning and discharge.

Handover and Communication

- Handover checklists must be meaningful; communication with families requires strengthening
- Effective handovers and staff familiarity with patients
- Referrals to Substance Misuse teams where appropriate.

Care Planning and Documentation

- Some cases lacked formal Care Plans, though planning was evident in notes or letters
- Naloxone was not consistently discussed/offered for patients with substance use history
- Reasonable adjustments for neurodiverse patients were not always documented
- Use of unlicensed medicines requires better documentation and oversight.

Delays and Communication Gaps

- Delays in mental health assessments due to physical health present a risk
- Address changes, communication lapses led to missed correspondence and gaps in care.

These areas will be reviewed through the Learning the Lessons Oversight Committee, where appropriate improvement groups will be established to oversee implementation. Some main areas of focus will be:

- Managing patient consent, including for photos
- Adherence to observation and engagement policies
- Exploring methods of communication. including text messaging for appointment reminders
- CPN allocation, triage and prioritisation
- Multi-disciplinary team (MDT) functioning and recording
- Use templates to highlight risk indicators and ensure care plan consistency
- Improve processes for geographic transitions and handovers
- Ensure alerts and risk indicators are entered into electronic records.

It should be noted that some of the above will be team/service specific.

Policy for Engagement with the Board of Directors and Council of Governors

Purpose of Report

The Board of Directors, in consultation with the Council of Governors, approved the first version of this policy in 2016 and it has been revised every three years. The policy has been reviewed to ensure it reflects the current Code of Governance, the Trust's Constitution, Standing Orders and locally agreed protocols developed by the Council of Governors, for example the process for the appointment of the Lead and Deputy Lead Governor. The Board is asked to approve this new version.

Executive Summary

The policy covers a range of important areas including:

- Relationship between the Trust Board and the Council of Governors
- Handling of concerns
- Powers and duties, roles and responsibilities of the Trust Board and the Council of Governors
- Role of the Senior Independent Director
- Grounds and procedure for the removal of the Chair or a Non-Executive Director
- Dispute Resolution Procedure.

The policy also encompasses those activities which we have developed within the Trust such as the joint Board/Council of Governor sessions and the 'holding to account' questions formulated at the Governance Committee and answered by the Non-Executive Directors at the Council of Governors.

Therefore, the purpose of this policy is to:

- Set out the systems and structures to promote a constructive working relationship between the Council of Governors and the Trust Board
- Set out a process for dealing with problems that may arise, as recommended by Code of Governance for NHS Provider Trusts.

Recommended changes, highlighted in yellow in Version 4 (attached) are:

- Revisions to names of organisation, posts and guidance
- Obligations of the Trust Board and Council of Governors to the Integrated Care System
- Mirroring the 2025 amendments within the Trust's Constitution, including copying over the dispute resolution process.

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

Strategic considerations and assurances

- This Policy for Engagement clarifies the respective roles and responsibilities of the Board and the Council of Governors
- This policy outlines the assurance of the Board and the Council of Governors to maintain commitment to the Nolan principles which are a foundation of our roles.

Consultation

This policy was originally developed through the Governance Committee and the revision has also been through this Committee.

Governance or Legal issues

This policy outlines the commitment by the Board of Directors and governors to developing engagement and two-way communication to carry out their respective roles effectively.

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

The Policy includes an EIRA (Equality Impact Risk Analysis) that states that Governors are fully supported by the Trust and reasonable adjustments implemented. Governors are offered on-going support and training to ensure that they can carry out their role. This includes provision of Support Workers where required and working with individual Governors to ensure they have access to information in a preferred format (for example, in hard copy rather than email). Governors are also supported to attend meetings where they have disability and/or access issues.

Recommendations

The Board of Directors is requested to approve the revised policy document.

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

Derbyshire Healthcare NHS Foundation Trust

Policy for engagement between the Trust Board and the Council of Governors

See also:	Located in the following policy folder on the Trust Intranet
Trust Constitution	N/A – latest version is available on the NHS England

Service area	Issue date	Issue no.	Review date	
Trust wide	November 2025	04	30 November 2028	
Ratified by	**Ratification date**	**Responsibility for review:**		
Board of Directors	25 November 2025	Board of Directors		

Document published on the Trust Intranet under: Corporate Policies and Procedures

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 Policy for engagement between the Trust Board and the Council of Governors

Summary (Plain English) Summarise the main points of the policy below in a style that is clear and easy to

The Policy outlines the commitment by the Board of Directors and governors to developing engagement and two-way communication to carry out their respective roles effectively.

Name / Title	Policy for Engagement between the Trust Board and the Council of Governors	
Aim of Policy	To outline the commitment by the Board of Directors and governors to developing engagement and two-way communication to carry out their respective roles effectively.	
Sponsor	Director of Corporate Affairs and Trust Secretary	
Author(s)	Director of Corporate Affairs and Trust Secretary	
Name of policy being replaced	Policy for Engagement between the Trust Board and the Council of Governors	**Version No of previous policy:** **03**

Reason for document production:	Governance best practise, requirement of Code of Governance.
Commissioning individual or group:	Trust Board and Council of Governors

Individuals or groups who have been consulted		
Governance Committee	22 October 2025	Supported
Trust Board	25 November 2025	Approved

Version control (for minor amendments)

Date	Author	Comment
October 2019	Trust Secretary	Change from Director of Corporate Affairs and Trust Secretary to Trust Secretary Amendment to 3.4.1 to allow more flexibility on areas of focus when the Trust Board and Council of Governor meet jointly. Amendment to 3.8 to match with the changes agreed at the Council of Governors meeting in May 2019 regarding the Lead Governor and Deputy Lead Governor role.
October 2022	Trust Secretary	3 yearly review, minimal changes, references to Draft 2022 Code of Governance and Integrated System working added.
October 2025	Director of Corporate Affairs and Trust Secretary	3 yearly review, changes including to job titles, reference to ICS working, referencing the new Code of Governance and duplicating the dispute resolution process from the 2025 Constitution update.

Policy for engagement between the Trust Board and Council of Governors

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Policy for engagement between the Trust Board and the Council of Governors

1. Introduction

The Trust Board is accountable to the community it serves and discharges that responsibility through its relationship with the Council of Governors. The Council of Governors represents the community and its major stakeholders, including staff, through elected and nominated members.

The Board leads the Trust by undertaking four key roles:

- setting strategy
- supervising the work of the executive in the delivery of the strategy and through seeking assurance that systems of control are robust and reliable
- setting and leading a positive culture for the board and the organisation
- giving account and answering to key stakeholders, particularly Councils of Governors.

The statutory general duties of the Council of Governors are:

- to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and
- to represent the interests of the members of the Trust ~~corporation~~ as a whole and the interests of the public and to support collaboration and system working.

The Trust Board recognises that it needs to enable the Council to hold it to account, in the first instance through the Non-Executive Directors. The Trust Board commits to consult governors on all strategic issues and material service developments before decisions are made, recognising that governor feedback enables a better informed and more effective Board.

Governors provide an important assurance role for the Trust by scrutinising the performance of the Board. The Trust Board and Council of Governors commit to work together constructively, based on openness and transparency, good communication and strong mutual understanding. They respect the different roles of each and have common aim to work in the best interests of the organisation and the Integrated Care System (ICS). The Trust Board will continue to keep governors updated on shared ICS plans, decisions and delivery that directly affect the Trust and its patients.

This policy outlines the commitment by the Board of Directors and governors to developing engagement and two-way communication to carry out their respective roles effectively.

- The Trust Board and Council of Governors are committed to building and maintaining an open and constructive working relationship. Under-pinning such a relationship is the need for clarity on the respective roles and responsibilities.

  The Code of Governance for NHS Provider Trusts (Code of Governance) recommends that each Foundation Trust should have a Policy for Engagement between the Trust Board and the Council of Governors, which clearly sets out how the two bodies will interact with one another for the benefit of the Trust.

- This policy for engagement clarifies the respective roles and responsibilities of the Board and the Council of Governors, and describes the information flow between the two groups. The policy describes the involvement of governors in forward planning, and the role they plan in respect of holding the Trust Board to account.

- This policy for engagement also sets out a process should the governors have a concern about the performance of the Board, compliance with the licence or the welfare of the Trust. It also describes the process should the governors have significant concerns about the performance of the Chair or Non-Executive Directors.

- This policy is intended to provide clear guidance and a useful framework for both the Trust Board and Council of Governors.

The policy also encompasses those activities which we have developed within the Trust such as the Joint Board/Council of Governor sessions and Governor/Non-Executive Director informal sessions.

In developing this policy both the Board and the Council of Governors are keen to maintain commitment to the Nolan principles which are a foundation of our roles:

The Nolan Principles - The Seven Principles of Public Life

Selflessness
Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

Integrity
Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

Objectivity
In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability
Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness
Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership
Holders of public office should promote and support these principles by leadership and example.

2. Purpose

2.1 The Board is committed to building and maintaining an open and constructive working relationship with the Council of Governors. The Board believes that it is important that the respective powers and roles of the Trust Board and the Council of Governors are clear, and are followed in practice.

2.2 There may be times where the Council of Governors has concerns about the running of the Trust. The Code of Governance recommends that the Council of Governors should establish a Policy for Engagement with the Trust Board for those circumstances when they have concerns about the performance of the Trust Board, compliance with its licence or the welfare of the Trust.

2.2 The purpose of this policy is therefore to:

- set out the systems and structures to promote a constructive working relationship between the Council of Governors and the Trust Board
- set out a process for dealing with problems that may arise, as recommended by the Code of Governance.

2.3 This policy complements the Trust's arrangements for governor communication with NHS England (NHSE) and the Care Quality Commission (CQC) where governors have concluded that a Trust has failed, or is failing, to act in accordance with its constitution, or Chapter 5 of the Health and Social Care Act (2006) and where it is considered that the intervention of NHSE or the CQC

may be appropriate. That is, it is the role of the Lead Governor to contact regulators in this instance.

3. Relationship between the Trust Board and the Council of Governors

3.1 Powers and Duties, Roles and Responsibilities

3.1.1 The respective powers and roles of the Trust Board and the Council of Governors are set out in their Standing Orders and the Trust Constitution.

3.1.2 The Trust Board and the Council of Governors should understand their respective roles and seek to follow them in practice. Any concerns or queries should be raised with the Chair, Trust Secretary or Lead Governor.

3.1.3 The Trust will provide induction and ongoing training regarding roles and responsibilities.

3.2 Trust Board and Council of Governors

3.2.1 In order to facilitate communication between the Trust Board and Council of Governors, governors can raise questions linked to the agenda of each public Trust Board meeting. As per established arrangements for public questions to the Trust Board, these should be submitted to Board Secretary at least 48 hours prior to the Board meeting.

3.2.2 Should a governor raise a question at the Trust Board, they will receive a response within seven working days of the meeting.

3.2.3 Governors may, by informing the Chair, request an item to be added to the agenda of the Council of Governors for discussion, or via the Governance Committee, or raise as 'any other business' at the Council of Governors meeting.

3.2.4 Governors will have the opportunity to raise questions about the affairs of the Trust with any Director present at a meeting of the Council of Governors. Wherever possible, questions should be submitted to the Chair in advance of the meeting, to enable a reasonable time to be allocated during the meeting. Where this is not possible, a written response will be provided within seven days of the meeting. In practice governors raise formal 'holding to account' questions at Council of Governors meetings which are answered by Non-Executive Directors. These questions are formulated at Governance Committee meetings.

3.2.5 Whilst a confidential part of Board of Director meetings will be held in private the agenda from these meetings will be made available for governors, via the

Lead Governor if requested. The public Trust Board papers will be sent to governors electronically and are also available from the Trust website prior to the meeting.

3.3 Role of the Chair

3.3.1 The Chair is responsible for leadership of the Trust Board and the Council of Governors, ensuring their effectiveness on all aspects of the role and setting their agenda. The Chair is responsible for ensuring that the two groups work together effectively, and that they receive the information they require to carry out their duties.

3.3.2 In the Chair's absence meetings of the Council of Governors will be chaired by the Deputy Chair of the Trust Board.

3.3.3 The Chair will ensure that the views of governors and members are communicated to the Trust Board and that the Council of Governors is informed of key Trust Board decisions.

3.3.4 The Chair will meet with the Lead Governor and the Deputy Lead Governor, and will have 1:1 meetings with individual governors as reasonably requested.

3.4 Role of the Trust Board

3.4.1 The Trust Board will formally meet with the Council of Governors at least once a year to discuss areas of mutual benefit.

3.5 Role of Non-Executive Directors and the Senior Independent Director

3.5.1 Non-Executive Directors will be invited to attend meetings of the Council of Governors, make presentations and answer questions as appropriate.

3.5.2 Non-Executive Directors will commit time to build effective relationships with governors and governors and Non-Executive Directors will agree to spend time together to understand each other's perspectives and build good levels of mutual understanding.

3.5.2 The Senior Independent Director will be available to the Council of Governors and individual governors if they have concerns which contact through the normal channels of Chair has failed to resolve or for which such contact is inappropriate. The Senior Independent Director should attend sufficient meetings of the Council of Governors Council to listen to their views in order to help develop a balanced understanding of the issues and concerns of the governors and members.

3.5.3 The role of the Senior Independent Director is set out in Appendix B.

3.5.4 The process to be followed in dealing with concerns is set out in Section 4.

3.6 Role of Executive Directors

3.6.1 Executive Directors (including the Chief Executive or deputy) will be invited to attend Council of Governors meetings, and be asked to facilitate discussions and answer questions as appropriate.

3.7 Role of the Governors

3.7.1 Governors are required to meet the statutory duties as set out in Appendix A.

3.8 Role of the Lead Governor and Deputy Lead Governor of the Council of Governors

3.8.1 As Lead Governor:

- Act as a direct link between the governors and NHSE in situations where it would be inappropriate to go through the Chair
- Act as the point of contact between the Council of Governors and the CQC
- Prioritise agenda items for the Council of Governors and ensure action plans are followed
- In exceptional circumstances, act as deputy to the Trust Chair in situations relating to the Council of Governors when it is not appropriate for the usual Trust Deputy Chair to act into this role
- Maintain regular communication with the Chair, conducting regular reviews of the performance of the Trust
- Be a Member of the Nominations and Remuneration Committee
- Represent concerns that governors may have (either as a body, or individually) to the Chair
- To undertake appropriate action where non-compliance or any misconduct is alleged under the Governors' Code of Conduct, as set out in the Code, which could include, together with the Chair addressing inappropriate action by any Governor and raising the matter at the Governance Committee subject to Nominations and Remuneration Committee approval.
- Lead the appraisal process for the Council of Governors, and facilitate the Council of Governors review of effectiveness
- Maintain a close working relationship with the Senior Independent Director (SID) of the Board of Directors
- Together with the SID carry out the appraisal of the Chair
- Agree the format of regular Council of Governor meetings
- As representative of the Trust's Council of Governors establish and maintain working relationships with Non-Executive Directors, the Board of Directors and

forge links with external bodies such as CQC, ICS partners including Health and Wellbeing Boards and Council of Governors of other foundation trusts.

- Together with the Chair, mutually agree with a Governor any formal time away from the role. The Lead Governor will then provide support following return of that governor from a leave of absence.

3.8.2 Deputy Lead Governor

3.8.2.1 The Deputy Lead Governor is not a mandated role. The duties are:

- To deputise for the Lead Governor in their absence through illness or other clashing commitments
- To cover for the Lead Governor, where the Lead Governor may have a conflict of interest in taking part in an activity
- To offer support alongside the Lead Governor in maintaining working relationships with external bodies as detailed in the Lead Governor Role Description.
- To familiarise themselves with the workings of the Trust, NHSE/I and any other agencies in order to carry out their role.

3.9 Council of Governors involvement in forward planning

3.9.1 When the Trust Board is engaged in strategic planning (e.g. annual planning, strategic direction) governors will be involved in the process so that the views of members can be properly canvassed and fed into the process.

3.10 Accountability

3.10.1 The Council of Governors has a role to hold the Non-Executive Directors individually and collectively to account for the performance of the Trust Board, including ensuring the Trust Board acts so that the Trust does not breach its licence. In order to carry out this role, the Council of Governors will be provided with high quality information that is relevant to the decisions they have to make. The information needs of the Council of Governors will be discussed as part of the induction process and subject to ongoing review, and the governors will be consulted in the planning of agendas of Council of Governors meetings.

3.10.2 The Code of Governance provides that the Trust Board will notify the Council of Governors of any major new developments or changes to the Trust's financial condition, performance of its business or expectations as to its performance, that if made public would be likely to lead to a substantial change to the financial

well-being, healthcare delivery performance or reputational standing of the Trust.

3.10.3 The Health & Social Care Act 2012 (as amended) places a mandatory duty on the Board of Directors to consult with and seek the agreement of the Council of Governors on 'significant transactions' including mergers, acquisition, dissolution, separation, raising additional services from activities other than via its principal purpose and raising the threshold of funds raised from private patients as outlined in the Trust's Constitution.

3.10.4 The Council of Governors have the powers to call an Executive Director to the Council of Governors for the purpose of obtaining information about the Trust's performance of its functions or the Director's performance of their duties.

4. Handling of Concerns

4.1 A concern, in the meaning of this policy, must be directly related to either:

- The performance of the Trust Board, or
- Compliance with the licence, or
- The welfare of the Trust

Other matters that do not constitute a concern can be raised with the Chair to be discussed at the appropriate forum (see para 3.2.2-3.2.4).

4.2 Stage 1 – Informal

4.2.1 In the event that the Council of Governors has a concern of the type described above, every attempt should be made to resolve the matter firstly by discussion with the Chair. Where it affects financial matters, the Director of Finance should be involved. The Lead Governor should normally represent the Council of Governors in these matters, and they will consider whether additional representation is required.

4.2.2 Every attempt should be made to resolve concerns in an appropriate way, and as quickly as possible. This may involve the Chair convening a meeting with governors, and/or requesting reports from the Chief Executive, Director of Finance or another director or officer of the Trust, or a report from the Audit and Risk Committee or other committee, and providing comments on any proposed remedial action.

4.2.3 The outcome of the matter will be reported to the next formal meeting of the Council of Governors, who will consider whether the matter has been resolved satisfactorily.

4.3 Stage 2 – Formal

4.3.1 This is the formal stage where stage 1 has failed to produce a resolution and the services of an independent person are required. In this case the Senior Independent Director assumes the role of mediator, as recommended by the Code of Governance, and conducts an investigation.

4.3.2 The decision to proceed to Stage 2 and beyond will always be considered by the full Council of Governors, at an extraordinary, private meeting. This is to ensure that any decision is a collective Council of Governors decision. The decision to proceed to Stage 2 must be collectively agreed by a majority of the Council of Governors present at a meeting which is quorate. In the event that the Council of Governors does not agree to proceed to Stage 2, that decision is final.

4.3.3 Evidence requirements

Any concern should be supported by relevant evidence. It cannot be based on hearsay alone, and should meet the following criteria:

- Any written statement must be from an identifiable person(s) who must sign the statement and be willing to be interviewed under either stage of this process.
- Other documentation must originate from a bona fide organisation and the source must be clearly identifiable. Newspaper articles will not be accepted as prima facie evidence but may be admitted as supporting evidence.
- Where the concern includes hearsay, e.g. media reports, the Council of Governors may require the Trust Board to provide explanations and, if necessary, evidence to show that the hearsay reports are untrue.

4.3.4 Investigation and Decision of the Senior Independent Director.

4.3.4.1 The Senior Independent Director's role is to seek to resolve the matter in the best interests of the Trust.

4.3.4.2 The Senior Independent Director will produce a written report of their findings and recommendations and present it to the Council of Governors and Trust Board. The report will address the issues raised by the Council of Governors, and will also consider whether action is required to repair any breakdown in the relationship between the Trust Board and the Council of Governors.

4.3.4.3 The decision of the Senior Independent Director will be final in resolving the matter in the best interests of the Trust.

4.3.4.4 In the event that the Council of Governors' remain dissatisfied with the Senior Independent Director's decision, the options in paragraph 4.4 may be considered.

4.4 Action in event of Stage 2 failing to achieve resolution

4.4.1 If the Council of Governors does not consider that the matter has been adequately resolved, they have four options:

- Accept the failure to reach a resolution of the matter and consider the matter closed; or
- Seek the intervention of another independent mediator (i.e. a Chair or Senior Independent Director from another NHS Foundation Trust) in order to seek resolution of the matter, or
- Inform NHS England if the Trust is at risk of breaching its licence.
- Follow the Dispute Resolution Procedure (as outlined at Appendix D).

4.5 Removal of the Chair or any Non-Executive Director

4.5.1 In relation to concerns raised in accordance with this policy, the Council of Governors should only exercise its power to remove the Chair or any Non-Executive Directors after exhausting all other means of engagement with the Trust Board.

4.5.2 The procedure for removing the Chair or a Non-Executive Director is set out in Appendix C.

Appendix A: Powers and duties of the Trust Board and the Council of Governors

Trust Board:	**Council of Governors:**
All the powers of the Trust are to be exercised by the Trust Board. The Trust Board may do anything which appears to it to be necessary or desirable for the purposes of or in connection with the functions of the Trust, subject to any restrictions in its licence. The powers of the Trust Board include, but are not limited to, the ability to borrow and invest money, acquire and dispose of property, enter into contracts, accept gifts of property (including property to be held on Trust for the purposes of the Foundation Trust or for any purposes relating to the health service), and employ staff.	The Council of Governors cannot veto decisions made by the Trust Board.
The Trust Board must submit forward planning information and annual reports and accounts to NHSE, after consulting with the Council of Governors and having regard to their views.	The Council of Governors is to be consulted on forward planning by the Trust Board, and the Trust Board must have regard to their views.
The Trust Board will present the annual report and accounts and the auditors report to the Council of Governors and will lay a copy of the annual accounts, and any report of the auditor on them before Parliament, and once it has done so, send copies of these documents to NHSE, along with the annual report.	The Council of Governors is to be presented with the annual report and accounts and the report of the auditor on them, at a general meeting of the Council of Governors.
It is for the Non-Executive Directors to appoint and remove the Chief Executive. The appointment of the Chief Executive (by the Non-Executive Directors) requires the approval of the Council of Governors.	The Council of Governors is to approve the appointment of the Chief Executive by the Non-Executive Directors. The appointment requires the approval of a majority of the Council of Governors.

Trust Board:	Council of Governors:
It is for a committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors to appoint or remove the Executive Directors	The Council of Governors is to appoint the chair and other Non-Executive Directors of the NHS Foundation Trust at a general meeting of the Council of Governors. The appointment requires the approval of a majority of the members of the Council of Governors. If the Council of Governors is to remove the Chair or Non-Executive Directors of the NHS Foundation Trust, such removal must occur at a general meeting of the Council of Governors and it requires the approval of three quarters of the members of the Council of Governors.
The Trust Board must establish a committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other Executive Directors	The Council of Governors is to decide the remuneration and allowances, and the other terms and conditions of office, of the Non-Executive Directors. The decision requires the approval of a majority of the members of the Council of Governors.
The Trust Board must establish a committee of Non-Executive Directors to act as an Audit Committee	The Council of Governors is to appoint or remove the external auditor at a general meeting of the Council of Governors. The appointment and removal requires the approval of a majority of the members of the Council of Governors.
Provide active leadership of the Trust within a framework of prudent and effective controls which enable risk to be assessed and managed.	Represent the interests of the Trust's members and partner organisations in the local health economy, as well as the interests of the wider public.

Trust Board:	Council of Governors:
Set the Trust's strategic aims, taking into consideration the views of the Council of Governors, ensuring that the financial and staffing resources are in place for the Trust to meet its objectives, and review management performance.	Regularly feedback information about the Trust, its vision and its performance to the constituencies and the stakeholder organisations that either elected or appointed them.
Ensure compliance by the Trust with its licence, its Constitution, mandatory guidance issued by regulators, relevant statutory requirements and contractual obligations.	Act in the best interests of the Trust and the wider ICS and adhere to Trust values and governor Code of Conduct.
Ensure the quality and safety of healthcare services, education, training and research delivered by the Trust and apply the principles and standards of clinical governance set out by relevant NHS bodies.	Hold the Non-Executive Directors individually and collectively to account for the performance of the Trust Board including ensuring the Trust Board acts so that the Trust does not breach its licence.
Ensure that adequate systems and processes are maintained to measure and monitor the Trust's effectiveness, efficiency and economy as well as the quality of its healthcare delivery.	Acknowledge the overall responsibility of the Trust Board for running the Trust and should not try to use the powers of the Council of Governors to veto decisions of the Trust Board.
Regularly review the performance of the Trust in these areas against regulatory requirements and approved plans and objectives.	Establish a policy for engagement with the Trust Board for those circumstances when they have concerns about the performance of the Trust Board, compliance with its licence or the welfare of the Trust.
Establish the values and standards of conduct for the Trust and its staff in accordance with NHS values and accepted standards of behaviour in public life, and operate a Code of Conduct that builds on the values of the Trust and reflects high standards of probity and responsibility.	Inform NHSE if the Trust is at risk of breaching its licence if these concerns cannot be resolved at a local level.

Trust Board:	Council of Governors:
Ensure that there is a formal, rigorous and transparent procedure for the appointment or election of new members to the Trust Board, and satisfy itself that plans are in place for orderly succession of appointments to the Trust Board so as to maintain an appropriate balance of skills and experience within the Trust and on the Trust Board, and ensure planned and progressive refreshing of the Trust Board.	Agree a process for the evaluation of the Chair and the Non-Executive Directors, with the Chair and the Non-Executive Directors, and agree the outcomes of the evaluations.
Present a balanced and understandable assessment of the Trust's position and prospects.	Agree with the Audit and Risk Committee of the Trust Board the criteria for appointing, reappointing and removing external auditors.
Maintain a sound system of internal control to safeguard public and private investment, the Trust's assets, patient safety and service quality.	Work with the Trust Board on such other matters for the benefit of the Trust as may be agreed between them.
Establish formal and transparent arrangements for considering how they should apply the financial reporting and internal control principles and for maintaining an appropriate relationship with the Trust's auditors.	Assess its own collective performance and its impact on the Trust, and communicate this to the members of the Trust.
Consult and involve members, patients, clients and the local community, and monitor how representative the Trust's membership is and the level of effectiveness of member engagement.	Liaise with members via membership emails and publications. When appropriate hold meetings with members, which could include constituency meetings to ensure Member's interests are represented and Trust information is fed back.
Ensure that the Trust co-operates with other NHS bodies, local authorities and other relevant organisations with an interest in the local health economy.	The Council of Governors may look at the nature of the Trust's "collaboration with system partners" as an indicator of organisational performance.

Trust Board:	Council of Governors:
Work with the Council of Governors on such other matters for the benefit of the Trust as may be agreed between them.	Raise issues and matters for discussion: Contact Chair/Membership and Involvement Manager to identify an appropriate forum and to submit items for meetings, eg - Request items to be included in the Council of Governors (or Governance Committee) agenda or raise matters under Any Other Business - Raise formal questions for response by the Trust Board - Ask questions of the Chief Executive at Council of Governors meetings.
Follow the principles of openness and transparency in its proceedings and decision making unless this conflicts with a need to protect the wider interests of the public or the Trust (including commercial in confidence matters) and make clear how potential conflicts of interests are dealt with.	
Undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors.	

Appendix B: Role of the Senior Independent Director

The Senior Independent Director (SID) will be a Non-Executive Director of the Trust Board.

The SID's role will be

- To be available to the Trust Directors if they have concerns which cannot be resolved through the normal channels (or is inappropriate) of the Chair or Chief Executive.

- To support the Chair in resolving disputes between individual Trust Board members in respect of their role as a director of the Trust.

In respect of the Council of Governors

- To be available to members and governors if they have concerns which cannot be resolved through the normal channels (or is inappropriate) of the Chair or Chief Executive. To maintain sufficient contact with governors to understand their issues and concerns, including building an effective relationship with the Lead Governor.

- To help resolving disagreements between the Council of Governors and Trust Board in accordance with the policy setting out the approach to be taken in these circumstances

- To agree a process for evaluating the performance of the Chair and to agree appropriate processes for reporting such evaluation annually to the governor Nominations and Remuneration Committee.

- To work with the Chair to establish a policy for engagement of the Council of Governors with the Trust Board.

APPENDIX C: Grounds and Procedure for the Removal of the Chair or any Non-Executive Director

Introduction

The Council of Governors has the power to remove the Chair and any Non-Executive Director of the Trust. Such removal must occur at a general meeting of the Council of Governors and requires the approval of three quarters of the members of the Council of Governors.

In relation to concerns raised under the Policy for Engagement, the Council of Governors should only exercise its power to remove a Non-Executive Director after exhausting all other means of engagement with the Trust Board, as set out in that policy.

Grounds for removal

The removal of a Non-Executive Director should be based on the following criteria. Grounds for removal can include the following:

a) they are not qualified, or are disqualified, from becoming or continuing as a Non-Executive Director under the Constitution
b) they have failed to attend meetings of the Trust Board for a period of six months
c) they have failed to discharge his/her duties as a Non-Executive Director
d) they have knowingly or recklessly made a false declaration for any purpose provided for under the Constitution or in the 2006 Act (as amended)
e) they have knowingly or recklessly failed to declare a conflict of interest
f) their continuing as a Non-Executive Director would be likely to:
    I. prejudice the ability of the Trust to fulfil its principal purpose or other of its purposes under the Constitution or otherwise to discharge its duties or functions
    II. harm the Trust's work with other persons or bodies with whom it is engaged or may be engaged in the provisions of goods or services
    III. adversely affect public confidence in the goods and services provided by the Trust; or otherwise bring the Trust into disrepute
g) they have failed or refused to comply with the regulatory framework, the Standing Orders, or any Code of Conduct which the Trust shall have published from time to time
h) they have refused without reasonable cause to undertake any training which the Trust requires all Non-Executive Directors to undertake
i) they purport to represent the views of any professional body, political party or trade union of which he is a member
j) it is not in the interests of the Trust for the Non-Executive Director to continue to hold office
k) they do not meet the criteria as outlined in the Trust Fit and Proper Persons Test policy.

The following list provides examples of matters which may indicate to the Council of Governors that it is no longer in the interests of the Trust that a Non-Executive Director continues in office. The list is not intended to be exhaustive or definitive; the Council of Governors will consider each case on its merits, taking account of all relevant factors.

a) If an annual appraisal or sequence of appraisals is unsatisfactory
b) If the Non-Executive Director loses the confidence of the Trust Board
c) If the Non-Executive Director loses the confidence of the public or local community in a substantial way
d) If the Non-Executive Director fails to monitor the performance of the Trust in an effective way
e) If the Non-Executive Director fails to deliver work against pre- agreed targets incorporated within their annual objectives
f) If there is a terminal breakdown in essential relationships, e.g. between a Chair and a Chief Executive or between a Non-Executive Director and the Chair or the rest of the Trust Board.

Procedure

a) The Council of Governors should raise issues to the Chair or in the case of the Chair to the Senior Independent Director prior to any formal action to remove a Non-Executive Director or the Chair.
b) Any proposal to remove a Non-Executive Director can be proposed by a Council member, the Chair, or the Trust Board. Any proposal for removal proposed by a Governor must be seconded by not less than ten Governors.
b) The Non-Executive Director will be notified in writing of the allegations, and be invited to submit a response.
c) The Non-Executive Director is entitled to address the Council of Governors at the meeting considering the proposal to remove him/her.
d) The Trust Board may make representations to the Council of Governors whether they are for, or against the resolution, or even if they are divided.
e) The Council of Governors may consider any relevant evidence, e.g. appraisal documentation or witness statements.
f) The Council of Governors should take professional advice, via the Trust Secretary, prior to removing a Non-Executive Director.
g) In relation to concerns raised in accordance with the Policy for Engagement, the Council of Governors should only exercise its power to remove a Non-Executive Director after exhausting all other means of engagement with the Trust Board.

Chair of meetings

The Chair may normally express an opinion on the appointment and removal of a Non-Executive Director, but does not have formal voting rights at the Council of Governors in a vote to remove the Non-Executive Director.

A decision to remove the Chair or a Non-Executive Director will only be effective if such decision is approved by not less than three quarters of the total number of the Council of Governors.

The Chair should also consider, however, whether in particular circumstances a conflict of interest arises in dealing with the removal of a Non-Executive Director, and if so, stand aside for that part of the meeting.

For the removal of the Chair, the Senior Independent Director will preside at meetings of the Council of Governors.

Removal and disqualification of governors

The process for the removal and disqualification of governors is covered in Annex 5 of the Trust's constitution.

Appendix D: Dispute Resolution Procedure between the Board of Directors and Council of Governors (extracted from 9.1 of the Trust's Constitution)

9.1.1 The Council of Governors and the Board of Directors shall be committed to developing and maintaining a constructive and positive relationship. The aim at all times is to resolve any potential or actual differences of opinion quickly, through discussion and negotiation.

9.1.1.1 Governors can raise concerns with the Trust Secretary who may in the first instance be able to resolve the matter informally.

9.1.1.2 Where the Trust Secretary has been unable to resolve the matter, the Lead Governor shall be the first point of contact when Governors wish to seek advice and/or raise issues and who acts as the Council of Governors lead representative to the Chair on Governor matters or the Deputy Chair if the dispute involves the Chair).

9.1.2 If the Chair (or Deputy Chair) cannot achieve resolution of a disagreement through informal efforts the Chair will follow the dispute resolution procedure described below. The aim is to resolve the matter at the first available opportunity and only to follow this procedure if initial action fails to achieve resolution:

(a) The Secretary will call a joint meeting ("Resolution Meeting") of the members of the Council of Governors and Board of Directors, to take place as soon as possible, but no later than twenty clear days following the date of the request. The meeting must comprise two thirds of the membership of the Council of Governors and two thirds of the membership of the Board of Directors. The meeting will be held in private. A Disputes Statement should set out clearly and concisely the issue or issues giving rise to the dispute. The aim of the meeting will be to achieve resolution of the conflict. The Chair will have the right to appoint an independent facilitator to assist the process. Every reasonable effort must be made to reach agreement.

(b) If a Resolution Meeting of the members of the Council of Governors and Board of Directors fails to resolve a conflict, the Board of Directors will decide the disputed matter.

(c) If following the formal Resolution Meeting, and the decision of the Board of Directors, the Council of Governors considers that implementation of the decision will result in the Trust failing to comply with its Licence; the Council of Governors, through the Lead Governor, will notify NHS England of the specific issue of non-compliance.

9.1.3 The right to call a Resolution Meeting rests with following, in the sequence of

escalation shown:
(a) the Chair;
(b) the Chief Executive;
(c) two thirds of the members of the Council of Governors;
(d) two thirds of the members of the Board of Directors.

REGARDS EIRA: Assessing Equality Relevance (Stage 1)

1. Name of the service / policy / project or proposal (give a brief description):

Policy for Engagement between the Trust Board and the Council of Governors The policy was first developed in 2016 incorporating best practice and comments from governors through the Governance Committee. The Council of Governors supported the first version on 6 September and it was approved by the Board of Directors at its meeting on 5 October 2016. It will be reviewed at three year intervals.

2. Answer the questions in the table below to determine equality relevance:
Governors are fully supported by the Trust and reasonable adjustments implemented. Governors are offered on-going support and training to ensure that they can carry out their role. This includes provision of support workers where required and working with individual governors to ensure they have access to information in a preferred format (for example, in hard copy rather than email). Governors are also supported to attend meetings where they have disability and/or access issues.

	Yes	No	Insufficient data / info to determine
Does the project / proposal affect service users, employees or the wider community, and potentially have a significant effect in terms of equality?		x	
Is it a major project / proposal, significantly affecting how functions are delivered in terms of equality?		x	
Will the project / proposal have a significant effect on how other organisations operate in terms of equality?	x		See note above
Does the decision/ proposal relate to functions that previous engagement has identified as being important to particular protected groups?	x		See note above
Does or could the decision / proposal affect different protected groups differently?		x	
Does it relate to an area with known inequalities?	x		

Does it relate to an area where equality objectives have been set by our organisation?			

3. On a scale of high, medium or low assess the policy in terms of equality relevance.

	Tick below:	Notes:
High		If ticked all 'Yes' or 'Insufficient data'
Medium	Yes	If ticked some 'Yes' and / or 'Insufficient data' and some 'No'
Low		If ticked all 'No'

EIRA completed by :Director of Corporate Affairs and Trust Secretary
Date: Oct 2025

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
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			
DoF	Year-end Position 2024/25	X					
Receipt of Reports (following assurance at Quality and Safeguarding Committee (QSC)):							
DoN/MD	Safer Staffing annual review (QSC - Jul)			X			
QUALITY GOVERNANCE							
DoN/MD	Assertive Outreach Community Health Treatment - Action Plan update	X				X	
DoN	Fundamental Standards of Care report (CQC Domains)		X			X	
DoN	Outcome of patient stories (every two years, due Mar-2026)						X
DCEO/CDO	Transformation and Continuous Improvement (bi-annual)	X			X		
DCEO/CDO/MD/DoN	Winter Plan		X	X			
Receipt of Reports (following assurance at People and Culture Committee (PCC)):							
MD	10 Point Plan to Improve the Lives of Resident Doctors (PCC - Nov)				X		
MD	Medical Appraisal and Revalidation - annual report (PCC - May)	X					
Receipt of Reports (following assurance at Quality and Safeguarding Committee (QSC)):							
DoN	Children in Care/Looked After Children - annual report (QSC - Sep)				X		
DoN	Guardian of Safe Working Hours report (QSC - quarterly)		AR		X	X	
DoN	Delivery of Same Sex Accommodation (QSC - Oct)				X		
DoN	Infection Prevention and Control annual report and IPC BAF (QSC - Oct)				X		
DoN	Quality Delivery Plan (QSC - Jul)		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
STRATEGIC PLANNING AND CORPORATE GOVERNANCE							
DoF/DCEO/CDO/ DPODI	2025/26 Plan	X					
DoCA/TS	Annual Review of Register of Interests	X					
DoCA/TS	Board Assurance Framework update	X		X	X		X
DoCA/TS	Continuation of Services Condition 7 - Provider Licence	X					
CHAIR	Fit and Proper Person Declaration		X				
FTSUG	Freedom to Speak Up Guardian report (six-monthly)			X			X
MD	Patient and Carers Race Equality Framework - annual					X	
MD	Suicide and Self-Harm Prevention Strategy				X		
DoCA/TS	Trust Sealings (six-monthly - for information)	X			X		
DCEO/CDO	Trust Strategic Plan (quarterly update)	X		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		
Receipt of Reports (following assurance at Audit and Risk Committee (ARC)):							
DoCA/TS	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 Gender Pay Gap report for approval (PCC - May)	X					
DPODI	Annual Approval of Modern Slavery Statement (PCC - Mar, to be published on Trust website on approval)	X					
DPODI	Flu Campaign annual report (PCC - Jul)		X				
DPODI	Staff Survey results (PCC - Mar)						X
Committee Chairs	Board Committee Assurance Summaries	X	X	X	X	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			

KEY

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

FORWARD PLAN - BOARD - 2026/27		19-May-2026	02-Jul-2026	22-Sep-2026	24-Nov-2026	26-Jan-2027	23-Mar-2027
	Deadline for Approved Papers	07-May-2026	09-Jul-2026	10-Sep-2026	12-Nov-2026	14-Jan-2027	11-Mar-2027
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
OPERATIONAL PERFORMANCE							
DCEO/CDO	Emergency Preparedness, Resilience and Response (EPRR) Core Standards			X			
DCEO/CDO/DoN/ DoF/DPODI	Integrated Performance report (Operations, Finance, People and Quality)	X	X	X	X	X	X
DCEO/CDO	ICB Joint Forward Plan (ad hoc inclusion with CEO update)						
DoF	Year-end Position 2025/26	X					
Receipt of Reports (for noting following assurance at Quality and Safeguarding Committee (QSC)):							
DoN/MD	Safer Staffing annual review (QSC Jul)			X			
QUALITY GOVERNANCE							
DoN	Fundamental Standards of Care report (CQC Domains) (6-monthly)		X			X	
DoN/MD	Assertive Outreach Treatment - Community Mental Health Action Plan update	X			X		
DoN	Outcome of patient stories (every two years, due Mar-2026, then Mar-2028)						
DCEO/CDO	Transformation and Continuous Improvement (bi-annual)	X			X		
DCEO/CDO/MD/DoN	Winter Plan		X	X			
Receipt of Reports (for noting following assurance at People and Culture Committee (PCC)):							
MD	10 Point Plan to Improve the Lives of Resident Doctors (PCC - Nov)				X		
MD	Medical Appraisal and Revalidation - annual report (PCC Apr)	X					
Receipt of Reports (for noting following assurance at Quality and Safeguarding Committee (QSC)):							
DoN	Guardian of Safe Working Hours report (QSC quarterly / annual report Jun)	X	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	Delivery of Same Sex Accommodation (QSC Oct)				X		
DoN	Safeguarding Children and Adults at Risk - annual report (QSC AR Sep)				X		
DoN	SEND - Special Educational Needs and Disabilities annual report (QSC May/Jun)	X					
MD	Learning from Deaths/Mortality report (QSC quarterly)		AR		X	X	X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE							
DoF/DCEO/CDO/ DPODI	2025/26 Plan (annual)	X					
DoCA/TS	Annual Review of Register of Interests	X					
DoCA/TS	Board Assurance Framework update	X		X	X		X
Committee Chairs	Board Committee Assurance Summaries	X	X	X	X	X	X
DoCA/TS	Continuation of Services Condition 7 - Provider Licence	X					
CHAIR	Fit and Proper Person Declaration		X				
FTSUG	Freedom to Speak Up Guardian report (six-monthly)			X			X
DoCA/TS	Trust Sealings (six-monthly - for information)	X			X		
DCEO/CDO	Trust Strategic Plan (quarterly update, to include 4 Ps Delivery Plans)	X		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	
Receipt of Reports (for noting following assurance at Audit and Risk Committee (ARC)):							
DoCA/TS	Year-end Governance reporting from Board Committees and approval of Terms of Reference (ToRs) (ARC Apr)	X					
Receipt of Reports (for noting following assurance at People and Culture Committee (PCC)):							
DPODI	2025/26 Flu Campaign annual report (PCC Jul)			X			
DPODI	Annual Approval of Modern Slavery Statement (PCC Mar, to be published on Trust website on approval)	X					
DPODI	Annual Gender Pay Gap report for approval (data for previous year reporting deadline Mar - PCC Jul)			X			
DPODI	Staff Survey results (PCC Mar)						X
POLICY REVIEW							
DoF	Standing Financial Instructions Policy and Procedures (31-Oct-2026)			X			

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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
A	
A&E	Accident & Emergency
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
APNA NHS	Asican Professionals' National Alliance
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
BI	Business Intelligence
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 Disabilities
BME	Black and Minority Ethnic group
BoD	Board of Directors
BPD	Borderline Personality Disorder
BPPC	Better Payment Practice Code
C	
CANSAS	Camberwell Assessment of Need Short Appraisal Schedule
CAMHS	Child and Adolescent Mental Health Services
CASSH	Care and Support Specialised Housing

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
CBT	Cognitive Behavioural Therapy
CBRN	Chemical, Biological, Radiological and Nuclear
CCG	Clinical Commissioning Group (defunct from 1 July 2022)
CCQI	College Centre for Quality Improvement
CCT	Community Care Team
CDEL	Capital Departmental Expenditure Limit
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
CERT	Community Enhanced Rehabilitation team
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
CHIME	Connectedness, Hope, Identity, Meaning, Empowerment recovery
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
CMO	Chief Medical Officer
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
CSF	Commissioner Sustainability Fund
CSPR	Child Safeguarding Practice Review
CSTF	Core Skills Training Framework
CSU	Commissioning Support Unit
CTO	Community Treatment Order
CTR	Care and Treatment Review
CUF	Cost Uplift Factor
CYP	Children and Young People
D	
DAG	Divisional Assurance Group
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
DDME	Deputy Director of Medical Education
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
DHSC	Department of Health and Social Care
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	

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
EAP	Employee Assistance Programme
EbE	Expert by Experience
ECT	Enhanced Care Team
ECT	Electroconvulsive Therapy
ECW	Enhanced Care Ward
ED	Emergency Department
EDS2	Equality Delivery System 2
EHA	Early Help Assessment
EHCP	Education, Health and Care Plan
EHIC	European Health Insurance Card
EHR	Electronic Health Record
EI	Early Intervention
EIA	Equality Impact Assessment
EIP	Early Intervention In Psychosis
EIS	Early Intervention Service
e-LfH	e-Learning for Healthcare
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
EQIA	Equality Impact Assessment
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
FCMHT	Forensic Community Mental Health
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
GBO	Goal Based Outcome

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
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
HCAI	Healthcare Associated Infection
HCHS	Hospital and Community Health Services (NHS)
HCP	Healthy Child Programme
H1	First half of a fiscal year (April through September)
H2	Second half of a fiscal year (October through the following March)
HEE	Health Education England
HES	Hospital Episode Statistics
HFMA	Healthcare Financial Management Association
HoNOS	Health of the Nation Outcome Scores
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
HST	Higher Specialty Training
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)
IMHA	Independent Mental Health Advocacy
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
INQUEST	Official, public inquiry to discover the facts about a death. An inquest is conducted by a coroner to determine who the deceased was, and how, when, and where they died, especially in cases of sudden, violent, or unexplained deaths
IPC SAG	Infection Prevention and Control Strategic Action Group
IPP	Imprisonment for Public Protection
IPR	Integrated Performance Report
IPS	Individual Placement and Support
IPT	Interpersonal Psychotherapy
IRHTT	In-reach Home Treatment Team
IRT	Incident Review Tool
J	
JCVI	Joint Committee on Vaccination and Immunisation
JDF	Junior Doctor Forum
JLNC	Joint Local Negotiating Committee
JNCC	Joint Negotiating Consultative Committee
JTAI	Joint Targeted Area Inspections
JUCB	Joined Up Care Board
JUCD	Joined Up Care Derbyshire
K	
KLOE	Key Lines of Enquiry (CQC)
KPI	Key Performance Indicator
KSF	Knowledge and Skills Framework
L	
LA	Local Authority
LAC	Looked After Children
LCFS	Local Counter Fraud Specialist
LA – CYPD	Local Authority – Children and Young People Divisions
LADO	Local Authority Designated Officer
LD	Learning Disabilities
LD/A	Learning Disability and Autism
LeDeR	Learning Disabilities Mortality Review
LFPSE	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
LTFT	Less Than Full-Time
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
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
MBRACCE	Mothers and Babies: Reducing Risk through Audits and confidential Enquiries
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
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
MHPS	Maintaining High Professional Standards
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	Medicine 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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
NETS	National Educational Training Survey
NGO	National Guardian's Office
NHS	National Health Service
NHSC	NHS Confederation
NHSCFA	NHS Counter Fraud Authority
NHSE	National Health Service England
NHSI	National Health Service Improvement
NHSEI	NHS England and NHS Improvement
NHSP	NHS Providers
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
NOF	NHS Oversight Framework
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
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
PET	Psychiatric Emergency Team
PFI	Private Finance Initiative
PFF	Probation Feedback Form
PFR	Provider Finance Return
PHC	Public Health Commissioners

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
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
PHSO	Parliamentary and Health Service Ombudsman
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
PSIRP	Patient Safety Incident Review Plan
PSQG	Patient Safety and Quality Group
PSR	Provider Selection Regime
PTU	Psychiatry Teaching Unit
PYE	Part Year Effect
Q	
QAG	Quality Assurance Group
QASI	Quality Assurance Serious Incidents
Q&SC	Quality and Safeguarding Committee
QEIA	Quality and Equality Impact Assessment
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity Programme
QOF	Quality and Outcomes Framework
QSIR	Quality, Service Improvement and Redesign
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
RFI	Request for Information
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
SAB	Safeguarding Adults Board
SAF	Single Assessment 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
SLR	Service Line Reporting
SLRDE	Senior Lead for Resident Doctor Experience
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
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
VCSE	Voluntary, Community and Social Enterprise organisations
VdTMoCA	Vona du Toit Model of Creative Ability *(a practical guide for Acute Mental Health Occupational Therapy Practice)*
VFM	Value For Money
VO	Vertical Observatory
VTE	Venous Thromboembolism
W	
WAP	Wireless Application Protocol
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent
Y	
YTD	Year to Date

17 November 2025

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 25 November 2025

Report from the Council of Governors meeting

The Council of Governors has met once since the last report, on 23 September 2025. The meeting was conducted as a hybrid meeting.

Submitted Questions from Members or the Public

One question was submitted by a Trust member:

"Relating to family members visiting biologically related patients who have been sectioned – are there NHS rules? If so, do these vary by Trust?"

The response was given by the Chair.

Chief Executive's update

On behalf of the Chief Executive, the Deputy Chief Executive and Chief Delivery Officer, presented the update which focused on:

- NHS Oversight Framework in and particular to the Trust's Segment 4 position
- The recent opening of Kingfisher House, Psychiatric Intensive Care Unit and Audrey House (Enhance Care Unit)
- The Care Quality Commission's recent inspection of the forensic inpatient services
- The successful recruitment of 10 doctors from Chennai, India and the induction process
- Confirmation that Derby and Derbyshire NHS Integrated Care Board (ICB) will be part of a clustering arrangement with ICBs from Lincolnshire, Nottingham and Nottinghamshire, following approval of this arrangement by NHS England.

Presentation of the Annual Report and Accounts 2024/25 and Report from the External Auditors

The Annual Report and Accounts 2024/25 were presented to the Council of Governors. It was confirmed that they will also be presented, consistent with financial reporting, at the Annual Members Meeting on 2 October 2025.

The representative from the Trust's external auditors, Forvis Mazars, provided a summary of the positive annual report letter and outlined their responsibilities as follows:

- Give an opinion on the Trust's financial statements
- Assess the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (the value for money conclusion).

The representative from Forvis Mazars confirmed that the audit was completed by the deadline and that they had not identified any significant weaknesses which would require further work or wider reporting.

Non-Executive Director's report

Geoff Lewins, Non-Executive Director, presented an overview of his role and activities at the Trust. This included the annual report of the Audit and Risk Committee.

Verbal Summary of Integrated Performance Report (IPR)

Non-Executive Directors gave a verbal summary of the IPR focusing on key Finance, Performance and Workforce measures.

Report from the Governance Committee

The Co-Chair of the Governance Committee presented a report of the meeting held on 19 August 2025. The Council of Governors approved the Governance Committee's recommendation to ratify the Committee's terms of reference for a further year.

Any other business

The Council of Governors noted that:

- Jane Chukwudi, Public Governor is resigning from the role to take up employment in the Trust and conveyed their appreciated for her commitment to the role
- The Membership and Involvement Manager was in discussions with the University of Nottingham regarding the Appointed Governor vacancy
- The Annual Members Meeting is taking place on 2 October and has been widely promoted across Derby and Derbyshire
- The Governor's annual effectiveness survey has been launched
- The finalists of the Trust's 'what make me happy' art competition have been published on the Trust website. The winners will be announced at the Annual Members Meeting
- The Governor meetings for 2026/27 have been finalised and will be circulated to Governors.

They also congratulated Jo Foster, Staff Governor, on her 40 years of service in the NHS as a Nurse.

RECOMMENDATION

The Trust Board is asked to note the summary report from the Council of Governors meeting held on 23 September 2025.