NHS
Derbyshire Healthcare
NHS Foundation Trust

PUBLIC BOARD MEETING
TUESDAY, 4 MARCH 2025 TO COMMENCE AT 9.30AM
CONFERENCE ROOMS A&B, RESEARCH & DEVELOPMENT CENTRE, KINGSWAY, DERBY, DE22 3LZ

	TIME	AGENDA	LED BY
1.	9:30	Chair's welcome, opening remarks, apologies and declarations of interest 1.1 Trust Vision and Values 1.2 Register of Interests 2024/25	Selina Ullah
PATIENT STORY			
2.	9.35	Patient Story – My Journey from Service User to Recovery	Tumi Banda
STANDING ITEMS			
3.	10.00	Minutes of the Board of Directors meeting held on 14 January 2025	Selina Ullah
4.		Action Matrix and Matters Arising	
5.		Questions from members of the public	
6.	10.05	Chair's update	Selina Ullah
7.	10.15	Chief Executive's update	Mark Powell
OPERATIONAL PERFORMANCE			
8.	10.25	Integrated Performance report to include Finance, People Performance and Quality	Tumi Banda/Arun Chidambaram/ Rebecca Oakley/James Sabin
10.55am BREAK			
9.	11.05	Strategic Plan 2025-2028	Mark Powell
10.	11.15	Joined Up Care Derbyshire (JUCD) Provider Collaborative – governance arrangements, work programme and Memorandum of Understanding (MoU)	Tamsin Hooton
STRATEGIC PLANNING AND CORPORATE GOVERNANCE			
11.	11.25	Board Assurance Framework update	Justine Fitzjohn
12.	11.35	Approval of revised Trust Constitution	Justine Fitzjohn
13.	11.40	NHS Staff Survey 2024 – National Results	Rebecca Oakley
14.	11.50	Freedom to Speak Up Guardian (FTSU) report (six-monthly)	Tam Howard
BOARD COMMITTEE ASSURANCE			
15.	12.00	Board Committee Assurance Summaries	Committee Chairs
REPORTS FOR NOTING ON ASSURANCE AT BOARD COMMITTEES			
16.	12.20	Quality and Safeguarding Committee 16.1 Learning from Deaths/Mortality Report	Lynn Andrews
CLOSING BUSINESS			
17.	12.25	Consideration of any items affecting the Board Assurance Framework (BAF)	Selina Ullah
18.		Meeting effectiveness	
FOR INFORMATION			
Forward Plan 2024/25 and 2025/26 Glossary of NHS Acronyms			

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

The next meeting will be held on 3 June 2025 at 9.30am in Conference Rooms A and B, Centre for Research and Development, Kingsway. Arrangements will be notified on the Trust website seven days in advance of the meeting.

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

Strategy on a page

NHS
Derbyshire Healthcare
NHS Foundation Trust

Our vision

We make a positive difference in everything we do

Our strategic priorities

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.

Partnerships

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

People

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

Productive

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

Our values

Caring

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

Inclusive

We respect everyone in all we do.

Ambitious

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

Belonging

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

Collaborative

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

WE MAKE A POSITIVE DIFFERENCE IN EVERYTHING WE DO

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 2024/25		
NAME	**INTEREST DISCLOSED**	**TYPE**
Vikki Ashton Taylor Deputy Chief Executive and Chief Delivery Officer	• Magistrate, covering mainly Derbyshire and Nottinghamshire Courts	(e)
Tony Edwards Deputy Trust Chair	• Independent Member of Governing Council, University of Derby	(a)
Deborah Good Non-Executive Director	• Trustee of Artcore, Derby	(e)
Andrew Harkness Non-Executive Director	• Spouse, Nicola Harkness, works at Staffordshire and Stoke-on-Trent Integrated Care Board	(e)
Ashiedu Joel *(until 31-Jul-2024)* Non-Executive Director	• Director, Ashioma Consults Ltd • Director, Peter Joel & Associates Ltd • Director, The Bridge East Midlands • Director, Together Leicester • Lay Member, University of Sheffield Governing Council • Fellow, Society for Leadership Fellows Windsor Castle • Elected Member, Leicester City Council • School of Business and Law Advisory Board Member, De Montfort University • Independent Chair, Derby and Derbyshire Drug and Alcohol Strategic Partnership • Justice of the Peace, Leicester, Leicestershire and Rutland Magistracy	(a) (a) (a) (a) (a) (a) (a) (a) (e) (e)
Ralph Knibbs Senior Independent Director	• Trustee of the charity called Star* Scheme	(d)
Geoff Lewins Non-Executive Director	• Director, Arkwright Society Ltd • Director, Cromford Mill Limited (wholly owned trading subsidiary of Arkwright Society)	(a) (a)
Mark Powell Chief Executive	• Treasurer, Derby Athletic Club	(d) (e)
James Sabin Director of Finance	• Spouse works at Sheffield Health & Social Care NHS Foundation Trust as Head of Capital and Therapeutic Environments	(e)
Selina Ullah Trust Chair	• Director/Trustee, Manchester Central Library Development Trust • Non-Executive Director, General Pharmaceutical Council • Non-Executive Director, Locala Community Partnerships CIC • Non-Executive Director, Accent Housing Group • Director, Muslim Women's Council • Trustee and Board member of NHS Providers representing Mental Health Providers	(e) (e) (e) (e) (e) (e)
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).

NHS
Derbyshire Healthcare
NHS Foundation Trust

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

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

Tuesday, 14 January 2025

MEETING HELD IN PUBLIC

Commenced: 09.30am Closed: 12:11pm

PRESENT	Selina Ullah	Trust Chair
	Tony Edwards	Deputy Trust Chair
	Lynn Andrews	Non-Executive Director
	Deborah Good	Non-Executive Director
	Geoff Lewins	Non-Executive Director
	Mark Powell	Chief Executive
	Vikki Ashton Taylor	Deputy Chief Executive and Chief Delivery Officer
	Tumi Banda	Director of Nursing, Allied Health Professionals, Quality and Patient Experience
	Dr Arun Chidambaram	Medical Director
	Justine Fitzjohn	Director of Corporate Affairs and Trust Secretary
	Rebecca Oakley	Director of People, Organisational Development and Inclusion
	James Sabin	Director of Finance
IN ATTENDANCE	Anna Shaw	Deputy Director of Communications and Engagement
DHCFT2025/002	Emma Bailey	Practice Facilitator - Preceptorship
DHCFT2025/002	Abirami Indra	International Recruit
DHCFT2025/002	Faisal Rose	International Recruit
DHCFT2025/002	Ansha Sasi	International Recruit
	Jo Bradbury	Corporate Governance Officer
APOLOGIES	Ralph Knibbs	Senior Independent Director
OBSERVERS	Sandra Austin	Equal Network Advisors

DHCFT 2025/001	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** Trust Chair, Selina Ullah, welcomed Board colleagues and observers to the first meeting of 2025. Selina opened the meeting by sharing her optimism for the year ahead. However, she acknowledged it will be financially challenging with very little money for growth. She emphasised the focus on elective recovery and also recognised the potential opportunities, new ideas and innovations. The need to meet the challenges as a team with colleagues and partners was highlighted, and this is underpinned in the new Trust Strategy. Selina pointed out the Trust's responsibility to the residents of Derbyshire and encouraged colleagues to come forward and help to make some of the tough decisions that will be necessary. The guests for the Board Story were greeted and Emma Bailey, Practice Facilitator – Preceptorship and international recruits, Faisal Rose, Ansha Sasi and Abirami Indra, were urged to feel comfortable and supported.

	Andrew Harkness, Non-Executive Director, was welcomed to his first meeting of the Board of Directors and it was noted that Andrew brings a wealth of public health experience in commissioning, transformation, population health management and health inequalities. Apologies were as stated. There were no declarations of interest on agenda items. However, the Board noted an update to the current Declarations of Interests Register, as Selina is no longer associated with the Solicitors Regulation Authority.
DHCFT 2025/002	**<u>BOARD STORY – ACROSS CONTINENTS, INTERNATIONALLY EDUCATED NURSES IN DERBYSHIRE</u>** Tumi Banda, Director of Nursing, AHPs, Quality and Patient Experience, initiated the Board Story by stating how privileged he was to have met the seven internationally qualified colleagues and hear their heartwarming story of ambition. Having witnessed these people at work, he had been in awe at their ability and would have longed to possess such skills when he had been newly qualified. Emma introduced herself and advised that Faisal would be spokesperson on behalf of the group. Faisal shared the collective experiences of the international cohort, who had joined the Trust in 2024, from India and Pakistan, and had started working on the wards at the Hartington Unit. These were himself, Abirami, Ansha, Athira Kunnathuvalappil Devadason, Sona Varkey. Riya Raju and Rakhi Ravindran. It was noted that Faisal's roots were in Punjab, Pakistan and once qualified he had relocated to Malta, where he gained over ten years' experience as a Mental Health Nurse. The seven nurses were inspired to move to Derbyshire due to the range of growth opportunities and the ability to work in diverse settings. Faisal shared that the stunning countryside, strong sense of community and the reputation of its healthcare facilities for fostering professional growth were also attractive factors. In recollection of the recruitment process, Faisal advised this had been smooth and well organised with clear communication. He suggested that detailed information on local housing, cultural adaptations and a buddy system would have been a welcome addition. It was noted that a clear timeline and updates during the visa process would also have been helpful. As some of the cohort had a general nursing background, the transition to mental health nursing was difficult, as was adapting to the pace and different protocols. However, Faisal confirmed that teams have been welcoming and everyone feels supported and valued. In addition, Faisal recommended it would be useful to introduce cultural awareness training for all staff and to have had access to the e-learning modules earlier, although a preference for face-to-face learning was indicated. The Board expressed their appreciation for today's attendance and in reference to the English weather, jested their surprise at the move from warmer climes. In response to the identified challenges, the induction process had been extended to three months, and training for teams around communications had been introduced. Furthermore, Emma confirmed the recruits will benefit from a year-long preceptorship. The development of an international network was discussed for the provision of support, and it was agreed that Tumi and Rebecca Oakley, Director of People, Organisational

	Development and Inclusion, would help with this. Emma confirmed the Trust has already opened links with Chesterfield Royal Hospital NHS FT and other students. Rebecca extended thanks to Emma and Suzanne Pancisi, Care Co-ordinator, Derbyshire Community Health Services NHS FT (DCHS), for the support given and for overcoming the obstacle faced along the way, which included the securing of suitable accommodation and the language barrier. From a career perspective, she was asked how the Trust can support the journey for the new recruits. Faisal was thankful for Emma's support with the Objective Structured Clinical Examination (OSCE) and said he was privileged to work for the Trust and is looking forward to giving his best to the role. Ansha stated the move has been her best decision yet and she was thankful for the on-ward orientation and support. Abirami appreciated the professional teaching road. She added her focus is learning about the different situations faced within an in-patient ward. It was recognised that at the outset, there had been some ward resistance, however Rebecca was delighted to share that all wards are now keen to welcome an 'international recruit'. She added that learning from this first round will help to improve future international recruitment campaigns. Tumi emphasised the importance of accepting other cultures, along with not judging communication hurdles as a skill level. **RESOLVED: The Board of Directors was greatly inspired by the presentation and noted the value of pastoral support and the suggestion to include a buddy system, together with the need to provide more information on local housing and cultural adaptations.**
DHCFT/ 2025/003	**MINUTES OF THE PREVIOUS BOARD OF DIRECTORS MEETING** The draft minutes of the previous meeting held on 5 November 2024 were accepted as a correct record of the meeting.
DHCFT/ 2025/004	**ACTION MATRIX AND MATTERS ARISING** In relation to Action Reference DHCFT/2024/098, Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary, agreed that revision dates on the Board Assurance Framework (BAF) should be robustly challenged. However, she stated that some entries are quite long-term and it is perfectly legitimate to extend the review dates. In response, Lynn Andrews, Non-Executive Director, made a plea for suggested timescales to be realistic and achievable.
DHCFT/ 2025/005	**QUESTIONS FROM MEMBERS OF THE PUBLIC** No questions had been received.
DHCFT/ 2025/006	**CHAIR'S UPDATE** Selina provided the Board with her reflections on activity with, and for, the Trust since the previous Board meeting on 5 November 2024. Details of several service visits were shared, which had provided insight into Trust services and it was recognised that colleagues are passionate about patient care and are working hard to overcome various challenges in order to deliver high quality care. As part of the Trust's annual Christmas competition, teams based at the Radbourne Unit had been visited and Selina reflected on the diversity of people supported by the unit and

	their positive feedback. On behalf of the Board, she thanked colleagues for their ongoing commitment and the dedication shown. Together with Vikki Ashton Taylor, Deputy Chief Executive and Chief Delivery Officer, Selina had visited Medical Education, the Hope and Resilience Hub, Jackie's Pantry, the Beeches, Perinatal Community South team, and Wards 33, 34 and 36. The engagement of patients was particularly impressive, in the making and displaying of the Christmas decorations and the strong sense of inclusion expressed by a very diverse group of patients, who presented their work and spoke of their sense of safety and inclusion on the ward. Selina was delighted to share that the competition winner was Ward 36; it had been the patients that wanted to show the work completed, which embraced an inclusive Christmas tree. She added that they felt safe and included. It was noted that one patient had had multiple admissions to other providers. However, they felt 'seen' on this ward. Selina stipulated that detail such as this doesn't always translate through the papers and that triangulation comes via the lived experience on the wards, both formally and informally. The help and support received from the Governors was highlighted. Selina advised the tenure is coming to an end for some members and she was hopeful they would stand for re-election. It was noted that the Governance Committee on 4 December was the final meeting for David Charnock, Chair, as he has taken retirement from the University of Nottingham, and he was the appointed Trust Governor representing the University. The Board was informed that David has been an active member of the Council of Governors and was involved in the Nominations and Remunerations Committee. He had supported the recruitment of nearly all of the Non-Executive Directors and the Trust Chair. David was thanked on behalf of the Board for his service to the Trust and wished success in the next chapter of his life. Selina was thanked for bringing her visits to life and Lynn made a plea to quickly capture the diversity that had been witnessed, by appropriate means, such as video, photo or similar, as 'seeing is understanding'. Vikki agreed to investigate this further and was hopeful that at least one of the patients would be able to replicate the feedback. **Post-meeting note, the patients have now been discharged. However, Vikki confirmed the Trust will continue to record appropriate examples wherever possible.** Deborah Good, Non-Executive Director, had been captivated by Selina's account and agreed there would be substantial benefits from recording quality evidence promptly via appropriate methods. The Executives were challenged to consider how the Trust can build culture change evidence into its DNA and capture such events as 'business as usual'. Mark Powell, Chief Executive, reflected that he had also had the pleasure of judging Christmas decorations and had visited a lot of non-patient facing areas, where diversity is just as prevalent. He agreed the Trust must act swiftly to capture evidence by alternative means. **RESOLVED: The Board of Directors considered the content of the Chair's update.**
DHCFT/ 2025/007	**<u>CHIEF EXECUTIVE'S UPDATE</u>** Mark's report covered current local issues and national policy developments. The report also reflected a wider view of the Trust's operating environment. Mark highlighted the key points, which included details of service visits. He thanked everyone who had supported the successful opening on the new Bluebell Ward for Older Adults on 7 January and confirmed he would be meeting colleagues and patients there later

	that week. It was noted that wider learning would be used to inform the subsequent moves of the Acute Inpatient services. Mark's report provided a national update on the ongoing Change NHS engagement ahead of the new 10-year health plan this spring. He also shared details of a recent report from the Centre for Mental Health, focused on 'Care *Beyond Beds – Exploring Alternatives to Hospital Based Mental Health Care'* CentreforMH CareBeyondBeds.pdf. The report showed that small-scale, incremental improvement to inpatient care will not be enough to create the systemic change needed. A radical overhaul of the system is required, with a reorientation to meeting people's needs far earlier, closer to home, in settings that are therapeutic and accessible. The Staff Survey completed late last year, had elicited a marginal increase compared to last year's engagement and Mark confirmed the aim for positive actions in response. An update from the East Midlands Alliance was shared with all partner providers. Mark noted positive development in CAMHS services across the East Midlands supporting a greater number of children and young people in the community. It was noted that on 20 November, the Trust had celebrated its annual HEARTS awards, sponsored by Integrated Health Projects (IHP), Kier Construction and Tilia Homes, in recognition of individual Trust employees and teams who have gone above and beyond the call of duty and performed at a consistently high level over the last year to support patients, carers and fellow colleagues. Mark congratulated the winners and everyone who was nominated and shortlisted for an award. Supplementary to the written paper, Mark informed that once received, the Mental Health Investment Standard (MHIS) will give clarity on the national requirements and how they link to the 10-year plan, especially for Children's, Mental Health and Learning Disabilities services. He was hopeful there will be significant stays and focused measures to ensure the same visibility as for physical health. **RESOLVED: The Board of Directors scrutinised the report and sought assurance around the key issues raised.**
DHCFT/ 2025/008	**INTEGRATED PERFORMANCE REPORT (IPR)** This report provided the Board of Directors with an update of how the Trust was performing at the end of November 2024, in relation to key finance, performance, and workforce measures. **Operations** Vikki presented an overview of Trust operational performance and highlighted three areas of particular attention: Mental Health Response Vehicle: In partnership with East Midlands Ambulance Service (EMAS), a new Derbyshire mental health response vehicle, manned with a paramedic and a mental health worker, commenced service in October and is dispatched to mental health-related incidents between 4.00pm and 12.00midnight, seven days a week. The initiative aims to provide support in the community, reducing the number of people attending Accident and Emergency (A&E) for mental health needs. Vikki advised that in 2023, 55% of the patients with a mental health need seen by EMAS were conveyed to hospital. In November 2024, following the launch of the mental health response vehicle, this figure had reduced to 12% and the latest data places this between 7-9%. The Board noted the positive, collaborative working. Talking Mental Health/Improving Access to Psychological Therapies (IAPT): Vikki stated that the Trust continues to deliver above the locally commissioned amount and is awaiting the outcome of a recent Integrated Care Board (ICB) procurement process. The Board

noted concerns about local people waiting to access the service, with current waiting lists already high. Vikki confirmed that the Trust is working hard to manage the forthcoming transition for both patients and colleagues.

Inappropriate Out of Area (OoA) Placements: The number of inappropriate OoA remains an ongoing challenge and the Board acknowledged the impact of this on patients and families. Vikki explained that teams are proactively managing high lengths of stay, patients who are clinically ready for discharge (CRFD) and opportunities wider than admission. The pilot of a new seven day a week community mental health service has also commenced.

It was noted that the Trust is engaged with Ian Davison, Deputy Managing Director, Business Information Services Director and Chief Digital and Information Officer North of England Care System Support (NECS). Ian has advocated the Trust's Recovery Action Plan and recommended a deep dive to analyse further to address those issues and provide care closer to home for these individuals.

Geoff Lewins, Non-Executive Director, voiced his enthusiasm in relation to the Response Vehicle. He asked if performance data was being collected and if there is scope to expand the provision. Vikki affirmed that the data is monitored and a positive impact will result in additional hours and vehicles. It was noted that the service has been introduced in response to a national request.

In relation to the operational element, Lynn was keen to understand the Trust's plans to warrant effective safeguarding and to remain vigilant in relation to multi-agency discharge events (MADE). It was noted that a number of actions are underway, such as mini-MADEs; increased frequency to review of those CRFD with partners, supported by more senior colleagues; daily ward and clinical reviews and improved multi-disciplinary team (MDT) working.

Tony Edwards, Deputy Chair, reflected on the substantial scrutiny at the Finance and Performance Committee yesterday, around insufficient beds and he stressed that the OoA position should not influence the 'Care in the Community' strategy. He added that the drive to avoid usage of Trust services should be encouraged. He applauded the direction of travel and the evidenced benefits.

Mark declared his concern for patients and their carers and family, in relation to the impact of inappropriate OoA placements. He confirmed the recovery plan is being led by Vikki. However, this is a collective responsibility with clinicians. The importance of increased scrutiny and assurance at the various committees was stressed, in order to ensure patient safety, liaison and positive experience.

Regarding non-continuance of the IAPT service, Mark confirmed the Trust is working with ICB colleagues to manage the situation and transition of the 2.5k patient waiting list. It was noted that the response is not yet right for ensuring patients are waiting well. Mark also highlighted his commitment to the wellbeing of colleagues in that service.

The Trust's expertise at exploring assurance for new services was pointed out and Tony suggested there should also be a more formal process for exiting services. It was agreed that this would serve as duty of care in safeguarding staff and patients and is to be investigated further at Quality and Safeguarding Committee (for patients and employees). **Action**.

Finance

It was noted that the Trust's financial position is on track to deliver the planned £6.4m deficit, although James emphasised the year ahead will be challenging.

There had been much analysis on MRfD spend at the Finance and Performance Committee yesterday and Tony advised there is surplus cash within the system, due to spend being

below the expected rate. He pointed out that savings from Cost Improvement Programmes (CIP) are good, however, more work is needed on recurrent savings.

It was noted that clarity is required around which vacancies are delayed to the new financial year and which may no longer be required. Lynn drew attention to the agency spend and it was noted that the Trust has good financial managers that engage regularly with Finance to manage this.

People

Rebecca reported on the continued progress being made with training and appraisal compliance and suggested the expectation be raised. It was noted that the Trust is part of a national review of statutory and mandatory training, to expediate portability.

There had been small improvements around absence, however, Rebecca pointed out a substantial number of 'did not attend' (DNA) to Occupational Health appointments.

It was noted that improvement to agency spend is being addressed by a regional group.

The appraisal target of 90% was challenged by Tony. He pointed out that 87% is a low achievement in light of the impact this tool has on developing culture and accountability. Rebecca was in agreement and made association with the Personal Accountability Charter. It was agreed that consideration be given to compliance levels and proposed amendments submitted to the People and Culture and Finance and Performance Committees. **Action, Rebecca.**

The encouraging progress with agency spend was applauded by Geoff. He queried if hotspots around training are being addressed and if the downward trend in vacancies is due to recruitment issues.

In response, the Board was informed that hotspots are assessed during the Divisional Lead reviews. Rebecca confirmed there is a clear grip on vacancies and it is a conscious decision to hold back the expenditure.

Mark recommended a breakdown and analysis of Vacancy Control Panel decisions be presented to the People and Culture and Quality and Safeguarding Committees for triangulation and assurance. **Action, Rebecca.**

Quality

Tumi reported that following the CQC's re-visit to the Trust's Acute inpatient units in December, positive feedback had been received on the improvements put in place since their visit in spring 2024. He added that this reflects significant progress at both the Radbourne and Hartington Units. The Board thanked colleagues involved in making these positive changes across the Acute units.

From a quality perspective, it was noted that seclusion rates are reducing in Trust Inpatient services, leading to restrictive practice as required. However, the number of patients CRFD had increased and Tumi confirmed that each has a risk plan and a care plan.

In relation to CRFD, Deborah asked how the Trust's partners are supporting in relation to the lack of affordable housing and social care. Tumi confirmed all options are being considered in unison with social work leads, including multi-disciplinary MADEs and that plans for discharge are agreed at admittance. Vikki stated there is a system-wide oversight group providing the Trust with an escalation route. She confirmed that all partners are engaged, and the ICBs and local authorities of Derby city and Derby county provide a level of seniority. It was noted that the legal framework for housing represents a long timeframe.

Review of the IPR controls that are used was queried and it was noted that these should change based on historical data.

	RESOLVED: The Board of Directors: **1. Accepted significant assurance on current performance across the areas presented and noted the achievement of particular objectives at risk detailed in appendix 2** **2. Agreed that this report incorporates the key elements of assurance to the Trust Board that would otherwise have come from Finance and Performance Committee and People and Culture Committee reporting.**
DHCFT/ 2025/009	**<u>TRUST STRATEGY PROGRESS UPDATE</u>** This report, presented by Vikki, provided the Board with an update on progress since the launch of the new 2024–2028 Trust Strategy in October 2024, and provided a final update on the remaining actions set out in the previous 2022–2025 Trust Strategy. It was noted that the three remaining actions will be transferred to the new delivery plan, which is in the process of being finalised. Tony acknowledged the substantial amount of the Strategy that had been delivered and pointed out that, with the exception of Justine and Geoff, the Trust had a new Board and had inherited the Strategy from its predecessors. **RESOLVED: The Board of Directors noted the progress following Trust Board approval of the new 2024–2028 Trust Strategy, and the intention to add the as yet incomplete actions from the previous strategy to the delivery plan for the new strategy to enable oversight and assurance on future implementation.**

DHCFT/ 2025/010	**<u>FUNDAMENTAL STANDARDS OF CARE</u>**
	
	The report provided the Board with an update on the below actions:
	
	• Care Quality Commission (CQC) visit to Acute care in April 2024 action plan
	• Mock CQC visits
	• Fundamental Standards of Care and community teams
	• Update on:
	  o Safeguarding concerns
	  o Serious incidents
	  o Regulation 28
	• Missing/AWOL patients from Radbourne unit.
	
	It was noted that some aspects of this paper had not yet gone through the Quality and Safeguarding Committee, due to the sequencing of meetings.
	
	Tumi reported that following the CQC's unannounced reinspection of the Radbourne and Hartington Units in December, no safety concerns were raised. In terms of action plans, the position remained as limited assurance and will be overseen by the Quality and Safeguarding Committee.
	
	Following the accuracy check, the positive report had now been received, and Tumi was delighted to announce the overall rating of Trust Acute services is changed from 'requires improvement' to 'good''. Whilst some areas were highlighted as people absent without leave (AWOL), the plan with the local police and the locked doors policy has been approved by the CQC.
	
	Mark welcomed the summary and the positive re-inspection report, which is testament to everyone's hard work and evidences the improvements made to those services. He added that the move to the new Adult Acute units allows the Trust to aspire to an even better rating. Mark's caveat of further improvement and replication across other services was noted.

	In agreement, Selina commented that 'good' is great, however, the ambition is to be rated as 'outstanding'. **RESOLVED: The Board of Directors:** **1. Noted the improved position on the Fundamental Standards of Care in the Adult Acute Wards** **2. Accepted limited assurance on the Fundamental Standards of Care Compliance, Quality and Safeguarding Committee is yet to review the report and the action plan following publication of the April report.**
DHCFT/ 2025/011	**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: **Mental Health Act Committee:** Supported by the new proactive monitoring and reminder system embedded within the department, there had been no lapses in Community Treatment Orders (CTSs) activity. The Committee had received limited assurance from the Training report due to the number of areas not meeting the target. The positive action and progress in relation to the use of Section 135/136 Suites was noted. The Committee had recognised that its focus had drifted, with elements of duplication across other groups. As a result, membership has now been revisited to direct the spotlight on assurance and compliance. **People and Culture Committee:** In the absence of Ralph Knibbs, Committee Chair, Deborah reported the key points from the meeting held 26 November. This included the split assurance levels around performance, with significant accepted for mandatory training, staff turnover, vacancies/recruitment, bank usage and Freedom to Speak Up and limited accepted for attendance and absence, Employee Relations, clinical supervision and appraisals. Deborah reiterated the point made earlier, by Tony, in relation to acceptable targets and progress for Appraisals. The recent 360 Assurance audit of Health and Wellbeing processes had recommended that a Service Level Agreement will build in more of the expectations. Consideration had been given to the Annual Workforce Plan and the Temporary Staffing Workforce with significant assurance received around effective systems, processes and the reduction of agency usage. Rebecca confirmed a target of c65% to capture exit interviews and it was noted the Trust is to re-introduce the Stay Survey. In relation to less experienced staff, Selina asked how the safety aspect of the new builds is progressing. Tumi advised there will be experienced support from Matrons and Clinical Leads, with an increased presence on wards. In addition, there is to be heightened multi-disciplinary team working, with extended activities provided by Allied Health Professionals. It was noted that positive and safe training will support colleagues moving teams and ensure the correct balance of experience and newly qualified, along with help to implement the Standard Operating Procedures. **Finance and Performance Committee:** Tony Edwards, Committee Chair, gave a verbal overview of yesterday's meeting, which had focused on the Making Room for Dignity (MRfD) programme finances and the Radbourne Unit approach, planning, assumptions, vacancies, capital and covered safer staffing. It was noted that a review of collaborations and alliances had been undertaken, along with consideration of Out of Area placements and Emergency Preparedness.

	Quality and Safeguarding Committee: National and strategic issues had been discussed and consideration given to learning from Cygnet ACER in relation to the reduction of ligature risk. Lynn Andrews, Committee Chair, reflected on the Special Educational Needs and Disabilities (SEND) inspection, which recommended improved strategic direction and collaborative working. It was noted that a substantial number of complaints remain and the Committee is monitoring this. **RESOLVED: The Board of Directors noted the Board Committee Assurance Summaries.**
DHCFT 2024/012	**REPORTS FOR NOTING ON ASSURANCE FROM BOARD COMMITTEES** **Quality and Safeguarding Committee** Learning from Deaths/Mortality 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 August 2024 to 30 September 2024. **RESOLVED: The Board of Directors accepted this Mortality Report as assurance of the Trust's approach and agreed for the report to be published on the Trust's website as per national guidance.** Learning Difficulty and Autistic People (LeDeR) Update The paper updated the Board on Learning Disabilities Mortality Review (LeDeR) performance from October 2024, and the quarterly LeDeR report (Q2). Arun Chidambaram, Medical Director, highlighted the importance of feeding this learning into the system. **RESOLVED: The Board of Directors noted the scrutiny and limited assurance received at the Quality and Safeguarding Committee on performance based on resources from the LeDeR team.** Guardian of Safe Working (GoSW) Hours Report This quarterly report provides data about the number of resident doctors in the Trust, full transition to the 2016 Resident Doctor contract (Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016) 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. **RESOLVED: The Board of Directors noted the scrutiny and significant assurance received at the Quality and Safeguarding Committee that the duties and requirements as set out in the 2016 Resident Doctor contract are being met.** **Mental Health Act Committee** Patient and Carers Race Equality Framework (PCREF) The Board received the briefing on the requirements of PCREF and how they align with the current function of Board Committees and the need for central oversight. Deborah explained that scrutiny and assurance is to be shared between the Mental Health Act and Quality and Safeguarding Committees. It was noted that the recently recruited EDI Lead will provide additional capacity to take forward this mandatory requirement. Arun added that an internal applicant has expressed interest and if successful, would provide dedicated support.

	Mark indicated there is the opportunity to work with other providers within the EM Alliance and pointed out there may be associated funding. He suggested Arun make contact with Graeme Jones, Chief Executive, Mental Health Alliance, for further support. The importance of embedding PCREF into the Trust's inclusion work was noted. **RESOLVED: The Board of Directors:** **1. Noted the three domains of deliverables and key components and their relationship with Committee functions** **2. Noted the plan for mobilising dedicated resource in the context of current capacity constraints** **3. Noted the scrutiny this briefing received at the Quality and Safeguarding and Mental Health Act Committees.**
DHCFT/ 2025/013	**CONSIDERATION OF ANY ITEMS AFFECTING THE BOARD ASSURANCE FRAMEWORK (BAF)** The Board reflected if there were any changes needed to the BAF following its discussions and: • Agreed the need to challenge Exec leads for realistic review dates not just quarter by quarter • Requested the latest Out of Area situation to be reflected as a strategic risk • Requested for latest CQC situation to be reflected.
DHCFT/ 2025/14	**MEETING EFFECTIVENESS** Mark drew attention to the numerous distractions over the course of the meeting, referring to audible notifications from 'phones, lap tops and iPads. He made a plea for this to be considered at future meetings. Sandra Austin, Equal Network Advisors, had found the Board Story particularly interesting, along with the Trust's efforts to ensure the new recruits feel welcome. These sentiments were echoed by Anna Shaw, Associate Director of Communications and Engagement, who added that a summary of the meeting is to be shared, ahead of the published minutes. Feeding back on his first Public Board meeting, Andrew commented positively overall and highlighted the Board Story. He added the importance of effective time management and had found some papers were articulated well, whilst others could be improved upon. In relation to process changes, he queried if the documented targets move in point of time. It was suggested that further clarification might be included to confirm which reports are for discussion and which for decision. Vikki was able to confirm that the limits do change automatically and are reviewed on a regular basis by Pete Henson, Head of Performance, Delivery and Clustering.
The next meeting to be held in public session will be held in person on 4 March 2025 at 9.30am in Conference Rooms A and B, Centre for Research and Development, Kingsway, Derby.	

ACTION MATRIX - BOARD OF DIRECTORS - MARCH 2025

Date	Minute Ref	Item	Lead	Action	Completion Date	Current Position	
14-Jan-2025	DHCFT/2025/008	Integrated Performance Report (IPR) People	Rebecca Oakley	Compliance levels for Appraisals to be considered and proposed amendments submitted to the People and Culture and Finance and Performance Committees.	25-Mar-2025	Included on the agenda for People and Culture Committee, 25-Mar-2025.	Green
14-Jan-2025	DHCFT/2025/008	Integrated Performance Report (IPR) People	Rebecca Oakley	Compliance levels for Appraisals to be considered and proposed amendments submitted to the People and Culture and Finance and Performance Committees.	25-Mar-2025	Included on the agenda for People and Culture Committee, 25-Mar-2025.	Green
14-Jan-2025	DHCFT/2025/008	Integrated Performance Report (IPR) Operations	Tumi Banda	Investigation of a more formal process for exiting services, to ensure a positive patient/employee experience and that they are waiting well.	11-Mar-2025	Tumi to provide a response within a relevant paper, at the Quality and Safeguarding Committee, 11-Mar-2025	Green

Key:					
	Action Overdue	RED		**0**	**0%**
	Action Ongoing/Update Required	AMBER		**0**	**0%**
	Resolved	GREEN		**3**	**100%**
	Agenda item for future meeting	YELLOW		**0**	**0%**
				3	**100%**

Trust Chair's report to the Board of Directors

Purpose of Report

This report is intended to provide the Board with the Trust Chair's reflections on activity with, and for, the Trust since the previous Board meeting on 14 January 2025. The structure of this report reflects the role that I have as Trust Chair.

Our Trust and Staff

1. On 20 January the Non-Executive Directors (NEDs) and I were invited to join our consultants at the Joint Medical Senate and Trust Board bi-annual meeting. This meeting provided an insight as to some of the operational issues medical colleagues were facing and some of the solutions they were exploring, including the use of digital tools to improve productivity and to release more time for clinical work. It was useful to hear how some of the aspirations align with the Trust's strategic priorities, including the clinical strategy and our ambition to become a University Hospital.
2. I attended the Chief Executive Officer (CEO) Engagement Hour on 22 January, which provided an opportunity to hear from our colleagues.
3. On 28 January I visited a number of services including the Finance team and the Mental Health Act team. I was met by the full Finance team, who presented the various aspects of their work. I heard about how they support managers with their budget management and resources, enable the Trust to run efficiently and in compliance with sound financial governance as well as doing developmental work to support project proposals. It was a most interesting and enjoyable visit, and I would like to thank James Sabin, Director of Finance and Rachel Leyland, Deputy Director of Finance, for the very organised and co-ordinated visit. I was equally impressed by our Mental Health Act Officers, although a much smaller team, their passion and enthusiasm for their work was very evident. They spoke about how they ensure the Trust operates within the Mental Health Act and ensures that patients are not deprived of their liberty unless it is for assessment and treatment. They also support patients to appeal their detention and the use of the Community Treatment Order. They spoke of how the Mental Health Act Committee was being refocussed and streamlined to ensure the voice of the patient is central and the outcomes are positive under the leadership of Deborah Good, Non-Executive Director (NED), who chairs the Committee and Arun Chidambaram, Medical Director, Executive Lead. I also visited the Adult Crisis team on 4 February. I was struck by the level of risk that is managed in the community by this team and the tremendous work they do in managing patients in the community and in their homes, whilst being under huge pressure from the family members to admit them into Inpatient services. Adele Morrow and her colleagues spoke of the expertise and experience in the team, both clinical and administrative. I spoke to a number of students on placement, as well as newly qualified Band 5 Nurses, who expressed the support they had received from the team and the Trust.
4. Following the Medical Senate, I met with Dr Karny Jawahar on 28 January. Dr Jawahar leads the Liaison Psychiatry team, based in the University Hospital of Derby and Burton NHS Foundation Trust (UHDB). We discussed the Alcohol Care team, which works as integral part of the Liaison team. However, the funding for the Alcohol team is coming to an end in April. This initiative has been funded by NHS England (NHSE) on a short-term basis.

I also met with Dr Rais Ahmed, Consultant Psychiatrist and Medical Lead on Clinical Transformation. Rais is also the Associate Registrar and Chair of the Local Medical Council with the Royal College of Psychiatrists. We discussed future developments and opportunities for the Trust to collaborate with the Royal College.

5. I had the pleasure of receiving gifts from the family of Barry Whitehead, who was a patient cared by the Dementia Rapid Response Team, and who sadly passed away before Christmas. Barry's wife, Sylvia, his daughter, Claire and his grandson, Jack, came to see the gifts they had donated. Jack ran a half marathon and raised £2,300. The family donated just under half of the money to the Dementia Rapid Response team as a way of saying thank you for the care and attention the team had given to Barry and the family. The team bought various items which can be used with other similar patients to encourage communication, sharing of memories, promote manual dexterity, and support relaxation. We also heard from Sylvia about her Barry, and his love of football, his work as an HR specialist and their holidays all over the world. It was a fitting tribute to a remarkable gentleman. My thanks on behalf of the Trust to Barry's family and to Pam Holburn, Team Manager and the team for their care and compassion.

Council of Governors

6. I would like to take the opportunity to welcome our new governors and some of our Governors who have been re-elected as governors. They are as follows:

- Angela Kerry – public governor, Amber Valley (re-elected for second term of office)
- Neil Baker – public governor, Bolsover and North East Derbyshire Jill Ryalls – public governor, Chesterfield (re-elected for second term of office)
- Jane Chukwudi – public governor, Derby City East
- Ruth Day – public governor, Derby City West
- Andrew Beaumont – public governor, Erewash (re-elected for third term of office)
- Christopher Williams – public governor, Erewash
- Hazel Parkyn – public governor, South Derbyshire (re-elected for second term of office)
- Mathew Joseph – staff governor, Medical (re-elected for a second term).

Their terms of office began on 1 February and will end on 31 January 2028. The Board and I look forward to working with the Governors, who bring a wealth of experience and knowledge to the Trust and thank the retiring Governors for their contributions.

On 15 January I met with the Staff Governors, Laurie Durrant and Marie Hickman. They both provided useful feedback from colleagues and a sense check of how it feels in the organisation. This gives me and them the opportunity to pick up on any issues that may require attention, as well as hear from them how colleagues are feeling with new developments, any changes and the general sense of wellbeing and challenge within the organisation.

7. I facilitated a focus group of the Governors on 29 January to gather their feedback on the performance of our Non-Executive Directors (NEDs) in preparation for their appraisals. I am grateful for their feedback on individuals which was insightful. Some of the Governors also volunteered their assessment of the NED team as a whole. They saw them working together, being a strong, knowledgeable and formidable team. One Governor, who has been involved with Trust in differing capacities over the years, said the current NEDs are the best NED team the Trust has ever had.
8. I held a virtual Governors catch up meeting on 3 February.
9. The Nominations and Remunerations Committee met on 3 February to receive the request to progress planning for the recruitment of NEDs, as terms of appointment for two individuals are coming to an end later this year.
10. The Governance Committee, chaired by Marie Hickman, met on 5 February. Tony Edwards, Deputy Chair attended in my place. The Governors received an update on the Improving Access to Psychological Therapies (IAPT) position and Living Well. Further information has been requested concerning these areas, which will be shared as the situation develops.
11. The next meeting of the Council of Governors will be on 3 June, following the Public Board meeting on that day. The next Governance Committee takes place on 15 April.

Board of Directors

12. We welcomed Andrew Harkness as NED to the Board. Andrew is in the process of being onboarded with an induction programme in place.
13. On 21 January and 4 February, Extraordinary Confidential Board meetings were held. The Board were appraised of a number of matters linked to the delivery of priorities.
14. I continue to meet with my NED colleagues on a quarterly basis to review their objectives, development needs and to discuss their perspectives on how the Board and Trust is delivering Trust priorities. This quarter I met with Deborah Good and Tony Edwards.
15. On 26 February, the Board held its development day at the Pakistan Community Centre in Peartree, Derby. This is the first time the current Board has held a session in the community. This is very much in the spirit of our new strategy regarding engagement and understanding the communities we serve. I would like to thank Ejaz Sarwar, Deputy CEO, Community Action Derby and his team and the Centre for the warm welcome we received.

System Collaboration and Working

16. The Provider Collaborative Chairs held a face to face meeting at the Florence Nightingale Community Hospital on 29 January. The size and range of services, including diagnostic services at the community hospital, was most impressive and suggests the infrastructure for the left shift of Acute to Community is strong. We discussed how we could work together at pace given the recent Planning Guidance and Operating Framework and the likelihood of a very challenging financial year which will require the providers to collaborate, become more efficient and also consider what is core services.
17. I attended the NHS England patient and public reference group which was informative and demonstrated the range of stakeholders involved and the aspiration to produce an engagement strategy that is fit for the vision of the future.
18. I have continued to meet regularly with the Chairs of the East Midlands Trusts with the Regional Director and Executives, providing the chairs with the performance of the region against national targets and guidance and communication from NHSE.

19. On 13 January, the CEO and I met with Kathy McLean, Chair of Joined Up Care Derbyshire (JUCD) and CEO, JUCD, Chris Clayton, as part of a series of scheduled meetings going forward as a means of keeping each other appraised of what is going on within our respective organisations and as a means of staying connected to wider system developments and pressures.

Regulators, NHS Providers, NHS Confederation and others

20. On 5 February I attended the NHS Providers Board meeting in London. The opportunity to hear from a national policy influencing perspective is both insightful and sobering of the challenges ahead for the NHS in 2025/26.
21. I continue to join the NHS Confederation Chairs weekly online meetings, where the key items for discussion centre on policy and operational issues with external speakers. These meetings are both informative and a means of support for Chairs of Mental Health and Learning Disabilities Trusts.
22. I have attended regular briefings from NHSE for the Midlands region. The emphasis in the most recent meetings has been on elective recovery, the need to work as a whole system in managing the ongoing pressures and financial plans. The planning guidance and the financial allocations for 2025/26 were received at the end of January and work is in progress to submit financial plans as providers and as systems.
23. I have also joined the weekly calls established for Chairs of Mental Health trusts hosted by the Mental Health Network in collaboration with the Good Governance Institute.

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

Risks and Assurances

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

Consultation

This report has not been to other groups or committees.

Governance or Legal Issues

Covered as part of the individual items.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

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

Demonstrating inclusive leadership at Board level

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

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

Recommendations

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

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 4 March 2025

Chief Executive's Report

Purpose of report

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

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

Executive summary

National context

NHS planning guidance 2025/26

The NHS priorities and operational planning guidance for 2025/26 was released late in January and sets out a focused, smaller number of national priorities for 2025/26.

The national priorities have been confirmed as:

- Reducing the time people wait for planned care
- Improving A&E waiting times and ambulance response times
- Improving access to mental health services. This includes improving patient flow in mental health crisis and acute pathways by reducing the average length of stay in adult acute beds and improving access to mental health services for children and young people.

Whilst I welcome the focus on crisis care and increased focus on mental health services for children and young people, I am disappointed that several of the current priorities related to Mental Health, Learning Disabilities, Autism and Children's services have been de-prioritised, with no additional funding being identified to make the significant transformation needed across our sector. Although there is commitment to retaining the Mental Health Investment Standard, this doesn't come with any more investment, and we will therefore need to work with our commissioners to decide which services and developments that were introduced in previous years continue.

Within Mental Health, Learning Disability and Autism services, the outlined priorities are to:

- Reduce reliance on mental health inpatient care for people with a learning disability and autistic people
- Reduce inequalities for both adults and children/young people
- Reduce the average length of stay in adult acute mental health beds
- Increase the number of children and young people accessing services
- Expand mental health support teams in schools.

The guidance also sets out a policy shift towards a neighbourhood health service to prevent admissions and improve access to care.

The neighbourhood health approach aims to create healthier communities, helping people of all ages live healthy, active and independent lives for as long as possible while improving their experience of health and social care, and increasingly managing their own care.

This is to be achieved by better connecting and optimising health and care services through the three key shifts we have previously discussed (from hospital to community, from treatment to prevention and from analogue to digital).

The new neighbourhood health guidelines confirm that all parts of the health and care system will need to work closely together to support people's needs, building on existing multi-disciplinary working, such as primary care networks, provider collaboratives and collaboration with the voluntary, community, faith and social enterprise (VCFSE) sector. We will also need to work with partners across the system and local communities, to define population boundaries for neighbourhood health and develop a shared vision and outcomes.

This shift is welcomed and does align with how we work already but provides a further impetus and intent to what we have set out in our new Strategy.

Along with the reduction in priorities and shift towards neighbourhood health, the guidance also sets out the financial landscape for the NHS in 2025/26. The level of cost savings required in the coming year is going to be extremely challenging and all healthcare systems will need to take difficult decisions about how to prioritise their resources.

As well as achieving the priorities outlined above, providers will need to reduce their cost base by at least 1% and achieve an additional 4% productivity savings during the year. This is in line with the challenging 5% savings we have been discussing recently, and we should not underestimate how challenging this will be for us locally.

The report reflects a national increase of 14% in patient contacts, set against a 19% increase in NHS staff over the last four years, signalling a national requirement to review growth in our workforce and reduce expenditure on temporary staffing and support functions to levels that were in place in 2022. There are also targets to reduce agency expenditure by 30% and bank use by at least 10%, whilst driving improvements in operational and clinical productivity.

Regional and local context

The opening of Bluebell Ward

I'm delighted to inform the Board that Bluebell Ward, the first of our new and refurbished facilities to open as part of the Making Room for Dignity programme opened at Walton Hospital in Chesterfield on 7 January. Bluebell Ward provides older adults with a dedicated unit, replacing the provision previously offered through Pleasley Ward at the Hartington Unit.

Bluebell Ward offers 12 ensuite bedrooms, reducing local provision of mental health services though dormitory style accommodation. We have already received a high level of positive feedback that has about the new facilities and the associated impact on people's health and wellbeing.

The programme's remaining facilities continue to develop, with the new Derwent and Carsington Units scheduled to open this Spring. They will be followed by the new enhanced care unit at Audrey House and Kingfisher House, the new Psychiatric Intensive Care Unit (PICU). This will allow the refurbishment of the Radbourne Unit to commence as the final part of the programme.

Colleagues are undertaking training in the new model of care that will be offered across our new services, which aims to achieve purposeful admissions, sensory interventions and a trauma-informed approach to care.

Care Quality Commission (CQC)

In my January report, I informed the Board that we were waiting for the Care Quality Commission (CQC) to publish their report following their return inspection to the Trust's acute inpatient units.

The report has now been published and reflects significant progress at both the Radbourne and Hartington Units, with a change in the overall rating of our Acute services from requires improvement to good. There have also been improvements to the ratings for the safety and well-led domains that are now both good too.

In addition, the CQC also formally removed the temporary restrictions that were put in place relating to our admission of female patients on Wards 33 and 35 of the Radbourne Unit.

I want to offer my thanks to everyone who has been involved in making these positive changes. Whilst there is still work to do to embed these changes and continue to make further improvements, this is extremely positive news and reflects the progress made by our teams.

National Oversight Framework (NOF)

We continue to have regular NOF Segment 3 meetings with the Integrated Care Board (ICB) and NHSE. An important factor in this process will be to jointly agree the exit criteria back to NOF Segment 2 against the areas flagged around quality, operational and financial performance. The recent CQC improvements are a key factor in ensuring that we can move towards segment 2.

Talking Therapy services

In February the Integrated Care Board (ICB) for Derby and Derbyshire publicly confirmed the Vita Health Group had been selected as the preferred bidder to provide NHS Talking Therapies services in Derby and Derbyshire, from 1 July 2025. The decision to award the contract has taken longer than had been anticipated. This has presented some significant challenges to our team who currently provide this service. Our team has, through a period of uncertainty for themselves, remained extremely professional in ensuring they continue to provide the best possible service to people who access this service.

The transition to a new provider presents risks, that will need to be managed. We have, over the course of the last few months, raised several risks to the ICB about the transition. This includes the growing waiting list and therefore, our inability to provide treatment to some people before 1 July. In addition, we are seeing colleagues leave our service to take up roles elsewhere, thus impacting on service capacity to see patients. We have committed to work closely with the ICB and Vita Health Group over the coming weeks and months to ensure an effective transition for both staff and patients.

International recruitment

In January we arranged for a small group to visit Chennai, India, with the aim of recruiting up to 10 doctors to join the Trust and work in teams where we have longstanding vacancies. I'm pleased to share that the trip was successful, with a high level of interest in the opportunities we have available locally. Arun Chidambaram, our Medical Director, will remain in close contact with the candidates interviewed in Chennai, to complete the recruitment process and relocation to Derbyshire.

This approach has been taken by other trusts providing similar services to our own, through a scheme offered by the General Medical Council (GMC). To support this work, we are partnering with the University of Derby to provide specific skills training for this group of doctors on practising in the UK.

Staff engagement

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

- Visit to our new Bluebell Ward on 16 January
- Attended the Carers Engagement Meeting on 3 February
- Visit to Dovedale Day Hospital on 5 February
- Visit to Radbourne Unit on 25 February.

MP visits

In January I met with Louise Jones, MP for North East Derbyshire, for a tour of the Derwent Unit in Chesterfield. Louise was very impressed with the amount of co-production that has gone in to bringing the unit to fruition. This has included working with colleagues across our current inpatient units, carers, service users and partners.

In February. I met with John Whitby, MP for Derbyshire Dales, for a tour of the Carsington Unit and Kingfisher House (PICU), both at Kingsway, Derby. Again, he was delighted to see the progress that is being made.

Recent achievements:

- I'm pleased to confirm the Trust has retained its two-star accreditation in a recent Triangle of Care assessment by the Carers Trust. This recognises our commitment to working with and supporting carers at every level of the care journey within our services. My thanks to colleagues, carer champions, partners, and carer representatives who have helped us to achieve this
- The Carers Trust also asked to include the Early Intervention service (EIS) as an example of positive practice at a forthcoming meeting of the parliamentary Health and Social Care Committee's inquiry into Community Mental Health services. This is in recognition of the success of the EIS Family and Friends Support Group. Congratulations to the EIS team
- The Beeches have successfully received accreditation from the College Centre for Quality Improvement (CCQI), who help providers, users and commissioners of Mental Health services to assess and improve the care they provide. I know this was a challenging process, with standards becoming higher each year the accreditation process takes place. Congratulations to everyone who supported this process, with a particular note to Georgina Hadfield for her role in leading the accreditation and submitting appropriate evidence to the panel
- The Work Yor Way team, a group of Trust employment specialists and Peer Support Workers trained at finding jobs for people who have accessed mental health services in Derbyshire, have received a glowing review from the national body that oversees it, following a two-day inspection. The team was awarded a national quality mark by the organisation Individual Placement and Support (IPS) Grow as a result of a recent 'fidelity review' involving two days of observations and meetings
- Our Finance team was recently awarded level 1 of the Towards Excellence Accreditation by the NHS Finance Leadership Council. The accreditation lasts for three years and reflects the continuous development of our Finance team, recognising the highest standards of financial competence and commitment to skills development
- Francesca Scrivener-Greene, Speech and Language Therapy Apprentice, was presented with a county-wide Healthcare Support Worker (HCSW) Award for her contribution to the profession. She was awarded the 'Student of the Year Award' by Joined Up Care Derbyshire for adding value to the Speech and Language service through providing alternative methods of communication with those who cannot rely on speech alone
- Congratulations to our recent Delivering Excellence Every Day (DEED) winners. Joe Morgan, Digital and Design Officer, for the Communications and Engagement team, was our DEED winner for December 2024. Joe was nominated for his design work to develop a new Trust Strategy, with the new brand identity capturing the sentiment of the feedback shared by staff in the engagement sessions last year
- January's DEED winner was Lizzie Barton, Health Visitor for the Intensive team within Children's Services. Lizzie was nominated for going above and beyond to support a family in need during the festive period, even outside of her working hours. She was praised particularly for her ability to develop great working relationships with the families she cares for – well done, Lizzie!

Raising awareness

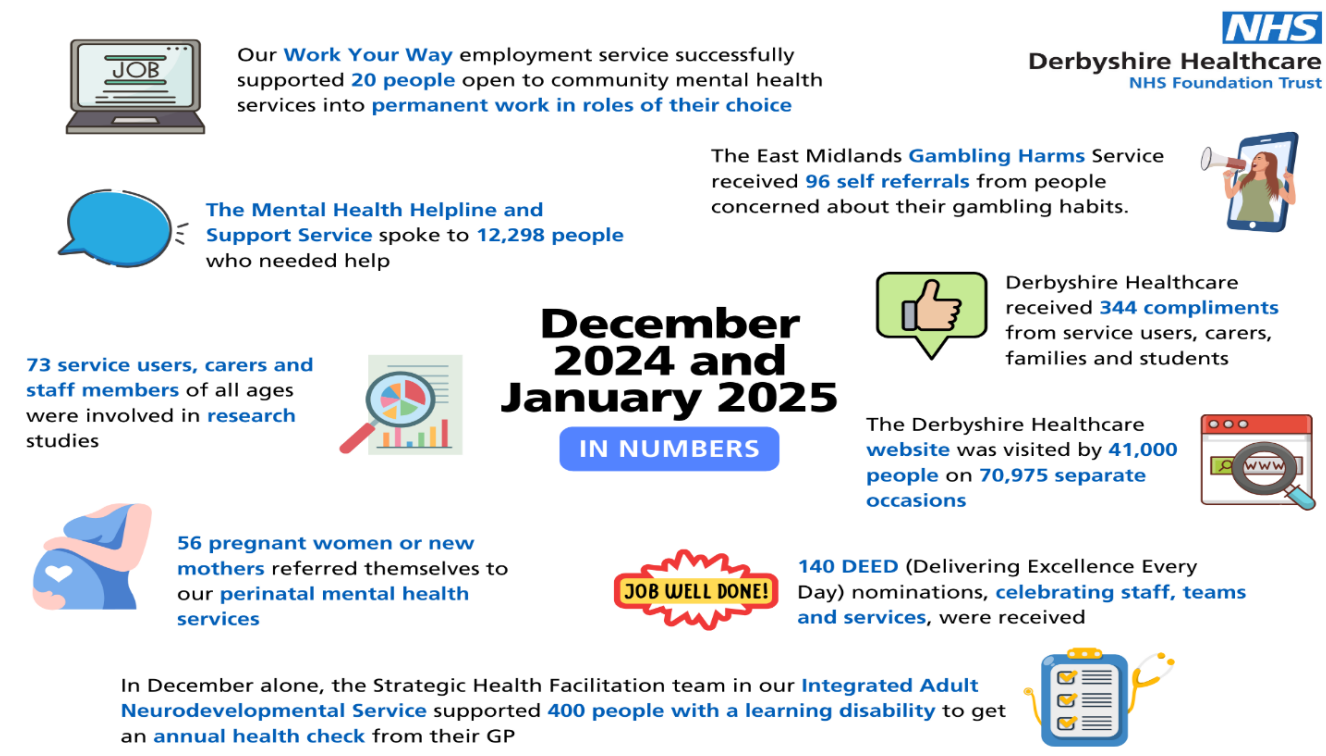
Over recent months, the Trust has supported awareness raising for a range of different events, including International Day of Persons with Disabilities, International Volunteers Day, Human Rights Day and Holocaust Memorial Day.

In December, we issued a series of support-focused pieces directing the public to our services, such as the East Midland's Gambling Harms Service, local organisations providing urgent mental health crisis support available in Derby and Derbyshire, access to our Derby Drug and Alcohol service as well as our Eating Disorder services. We also worked with the local media to provide useful advice to people ahead of the festive period, knowing this can be a difficult time for many people.

February saw a number of important dates including lesbian, gay, bisexual and transgender (LGBT) History Month, Time to Talk Day, Children's Mental Health Week and National Race Equality Week. As part of Time to Talk Day, David Mellors, ex-army veteran and current Peer Support Worker, shared his experience of complex, post-traumatic stress disorder as a veteran, and how he received support from local charities, NHS therapists and the Trust's early intervention service to better navigate his mental health in a healthier way. Our teams also attended the Derbion shopping centre, offering support and guidance on mental health and wellbeing.

We will also be celebrating the work of our teams on Mental Health Nurses Day and sharing information during Eating Disorders Awareness Week.

Trust activity



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

Risks and Assurances

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

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

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

Recommendations

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

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 4 March 2025

Integrated Performance Report

Purpose of Report

The purpose of this report is to provide the Board of Directors with an update of how the Trust was performing at the end of January 2025. The report focuses on key finance, performance, and workforce measures.

Executive Summary

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

Operational Performance

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

Most challenging areas:

- Waiting times for adult autistic spectrum disorder (ASD) assessment – demand continues to outstrip capacity. However, the high volume of assessments completed by the team over the last 13 months is making a positive difference on the number of people waiting and is gradually reducing the proportion of people who have been waiting over two years to be seen
- Community paediatric waiting times and numbers waiting remain significantly high owing to ongoing pathway issues and high levels of demand, which will be exacerbated by the loss of five of the team, including three experienced Consultants. A service transformation programme will aim to review roles, skill mix and service specification to mitigate the loss of the medical posts. A recovery action plan is in development
- Inappropriate out of area placements and inpatient bed occupancy levels –high-level of need for inpatient treatment. The inappropriate out of area position for adult acute has increased significantly recently. Actions are being implemented to address patient flow issues across the pathway in both inpatients and community, in order to reduce the need for admission, reduce length of stay of admissions, and thereby free up bed capacity within the Trust
- Early intervention waiting time to be seen has fallen below target for the first time in years, as a result of significant staffing pressures. Action is in progress to address this.

Most improved areas:

- The number of completed adult ASD assessments per month has remained significantly high and after 10 months, the full year contracted activity target has been exceeded by 260%
- The Psychological services waiting lists continue to reduce significantly
- The Child and Adolescent Mental Health service (CAMHS) Triage and Assessment team continues to manage the waiting lists very effectively, with numbers waiting and waiting times both now being sustained at a reasonable and manageable level.

Areas of success:

- NHS Talking Therapies 18-week and six-week referral to treatment, three day follow-up of discharged inpatients and the data quality maturity index have been consistently achieved
- The individual placement and support service, Work Your Way, continues to support ever-increasing numbers of people with finding permanent employment. The team received a positive review from the national body that oversees it, IPS Grow, following a fidelity review, involving two days of observations and meetings
- The rate of dementia diagnosis remains high – third highest in the region and 12th highest in the country
- Community Perinatal services continue to see increasing numbers of people, flexing to meet the ongoing high level of demand
- Adult and Children and Young People's Community Mental Health services continue to exceed their respective target activity levels for patient contacts.

Regional comparison

NHS Derby and Derbyshire Integrated Care Board (ICB) continues to perform favourably against a number of long-term plan targets, to which the Trust contributes, when compared with other ICBs in the region: dementia diagnosis, children and young people contacts, adult community mental health contacts and perinatal access. Inappropriate out of area placements remain challenging, with the number of inappropriate bed days at the second highest level in the region.

Finance

At the end of January, the year to date (YTD) position is a deficit of £5.4m which is better than plan by £0.4m.

The forecast position remains in line with the plan submission of £6.4m deficit.

Current financial risks to deliver the planned deficit:

- Delivery of the £12.5m efficiency programme in full, with a significant proportion delivered recurrently
- Management of Adult Acute out of area expenditure in line with the reducing trajectory
- Management of in-patient expenditure to a reduced run rate
- Management of agency expenditure within budget
- Management of any new emerging cost pressures
- Additional costs related to supporting a patient with complex needs ended at the beginning of September.

The Board Assurance Framework (BAF) risk that the *Trust fails to deliver its revenue and capital financial plans*, remains rated as **Extreme** for 2024/25 due to the inherent risks that are built into the financial plan.

Efficiencies

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

At the end of January, savings to the value of £10.1m have been realised against a plan of £10.1m, therefore, are on plan. These schemes have a full year effect of £12.1m against the plan of £12.5m.

The forecast assumes full delivery of the £12.5m, of which 65% is delivered recurrently.

Agency

Agency expenditure YTD totals £4.5m which is below plan by £0.9m. This includes £1.2m of additional costs to support a patient with complex needs (which ceased at the beginning of September).

Excluding this additional support, agency expenditure would be below plan by £2.0m.

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

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

The agency expenditure as a proportion of total pay for January has significantly reduced during the year to 1.8%. NHSE use of resources includes an action to improve workforce productivity and reduce agency spend to a maximum of 3.2% of the total pay bill across 2024/25.

The full year plan for agency expenditure totals £6.3m and expenditure levels for 2024/25 are forecast to be below plan by £1.2m.

Out of area placements

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

At the end of January total expenditure is £8.6m which is £4.0m above plan. The forecast assumes that the levels for January continue for the remainder of the financial year, which generates total expenditure of £11.1m which is above plan by £6.3m.

Capital expenditure

At the end of January, we are £2.9m above plan against the system capital allocation and forecasting to be significantly above plan by the end of the financial year by £3.4m. This is due to the residual Making Room for Dignity (MRfD) cost pressure after the original business as usual capital schemes have been scaled back to help provide some mitigation.

Additional capital allocation of £1.0m has been received, some of the allocation has come with some central funding and is cash back, and some of the allocation is through an increase in the system capital limit and is not cash backed.

Cash

Cash at the end of January is at £26.4m (£31.6 last month) which is £6.9m above plan. The increase in cash in November related to timing of receipts and payments in relation to the MRfD programme.

The cash levels are forecast to reduce to £14.7m by the end of the financial year which is £4.4m below plan. This forecast adverse variance to plan is related to the additional capital expenditure for MR4D programme which is now included in the forecast.

People

Annual appraisals

Appraisal compliance continues to remain high at 88% against a target of 90%. Low compliance continues to remain a particular challenge within Corporate services and efforts continue to address both appraisals that are out of date and those coming up for renewal.

Annual turnover

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

Compulsory training

Overall, the 85% target has been achieved for well over 24 months and has now achieved its highest level this month at 92%. Operational services are currently 93% compliant and Corporate services are at 87%.

Staff absence

The annual sickness absence rate is running at 6.12% and compared to the same period last year, it is 0.13% higher. Anxiety, stress or depression related illness remains the highest reason for sickness absence, followed by Cold, Cough, Flu – Influenza. Compared to the same period last year, long term sickness rates are 0.16% lower and short term sickness absence are 0.35% higher.

Proportion of posts filled

At the start of the financial year, new investment is released which creates brand new vacancies, initially increasing the overall vacancy rate. This year continues to see a staged release of investment funding throughout the year.

Bank and agency staff

Agency usage has reduced significantly over recent months and continues to fall following a temporary increase in agency usage due to clinical observations. The authorisation panel to oversee agency requests across the Trust continues to remain in place and work continues with the roster efficiency programme.

Supervision

Following an audit of supervision processes, the Trust continues to work on the recommendations. Overall compliance is seeing incremental improvement in both clinical supervision at 85% and management supervision at 87%.

Quality

Between October 2024 and January 2025, key quality performance metrics across patient experience, safety, and staffing levels have been closely monitored, revealing both progress and areas requiring improvement.

Patient experience and compliments

- Compliments have been increasing, reaching the upper process limit in December 2024, though the reasons remain unclear
- Complaints categorized as "quick resolution" remained below the mean of 22 due to staffing shortages over the holiday period, while "closer look" complaints followed expected trends.

Patient flow and delayed transfers of care/clinically ready for discharge (CRFD)

- Delays in patient discharge remain within expected limits, primarily due to housing, funding, and social care availability
- System-wide meetings and tracking tools are in place to address these delays and improve co-ordination.

Care programme approach (CPA) compliance

- CPA review compliance averaged 72%, with teams below 85% implementing action plans
- Efforts are focused on digital support and staff training to improve care planning and compliance.

Quality and safety metrics

- **Medication Incidents:** Below the mean of 82 since September 2024, with most being low harm. Clear guidelines and monitoring in place
- **Serious Incidents & Restraints:**
  - Moderate to catastrophic incidents declined but spiked in January due to self-harm and patient assault
  - Physical restraints remained above the Trust margin but showed a downward trend
  - Prone restraints remained below the Trust threshold, with October's spike linked to few high-acuity cases
  - Seclusions decreased and stayed below target, with an upcoming peer support review expected to further reduce incidents
- **Falls:** Within expected variation, with 93% categorized as minor or insignificant. Additional physiotherapy support is planned.

Staffing and Care Hours per Patient Day (CHPPD)

The Trust's CHPPD was 9.72, below the national average (11.4), with Nursing and Healthcare Support hours also lower than average.

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

Risks and Assurances

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

- This report reflects performance related to all of the Trust's service portfolio. Therefore, any decisions that are taken as a result of the information provided in this report is likely to affect members of those populations with protected characteristics in the REGARDS groups
- Any specific action will need to be relevant to each service and considered accordingly, so for example, as parts of the report relate specifically to access to Trust services; we will need to ensure that any changes or agreed improvements take account of the evidence that shows variable access to services from different population groups.

Recommendations

The Board of Directors is requested to:

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

Report presented by: **Arun Chidambaram**
Medical Director

James Sabin
Director of Finance

Rebecca Oakley
Director of People, Organisational Development and Inclusion

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

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

Rachel Leyland
Deputy Director of Finance

Liam Carrier
Assistant Director of Workforce Transformation

Joseph Thompson
Assistant Director of Clinical Professional Practice

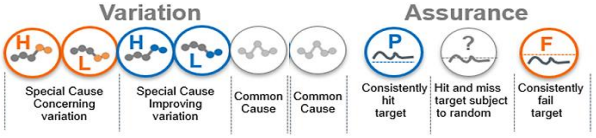
Performance Summary	
Areas of Improvement	**Areas of Challenge**
Operations	
• A high level of adult ASD assessments has been completed for the last 13 months, positively impacting on the number of people waiting • CAMHS waiting list is being maintained at a reasonable level • NHS Talking Therapies waiting times from first to second treatment have reduced significantly • The proportion of adult community mental health caseloads that are long term offer continue to reduce in line with the living well model • Psychological services waiting times continue to reduce and the number of people waiting has dropped significantly.	• Adult ASD assessment waiting times remain high • Community paediatric waiting times continue to prove extremely challenging • Early intervention waiting time to be seen has fallen below target for the first time in years • Inappropriate out of area placements • Inpatient bed occupancy levels remain high.
Finance	
• Agency expenditure usage continues to reduce, and December was at the lowest level for the year. • Efficiency delivery has caught up this month and is on plan year to date, and the gap continues to reduce.	• Financial deficit and achievement of the financial plan • Adult acute out of area expenditure is significantly higher than planned • Effective management/mitigation of cost pressures including those CQC driven aspects • Capital expenditure now forecast to significantly overspend against plan due to Making Room for Dignity cost pressures • Long-term plans to progress back to financial sustainability and balance.
People	
• Compulsory and role specific training • Annual turnover • Agency staff use	• Staff absence • Bank staff use • Annual appraisals • Supervision.
Quality	
• Complaint Handling: quick resolution complaints are expected to stabilise, with ongoing monitoring and reporting • Medication Safety: incidents remain below the mean, with improved guidelines, training, and monitoring • Seclusion and Prone Restraints: both have decreased and remained within acceptable limits, with further reductions expected through targeted interventions • Falls Prevention: most falls were minor or insignificant, and additional physiotherapy support is planned to enhance fall prevention efforts.	• Staffing & CHPPD: care hours per patient day remain below national averages, indicating workforce constraints • Physical Restraints: despite a downward trend, incidents remain above the Trust margin, primarily due to self-harm interventions • Delayed Discharges (CRFD): persistent challenges in housing, funding, and social care placements continue to impact patient flow • CPA Compliance: rates remain below target, with ongoing training and digital support required to improve documentation.

Assurance Summary

A. Operations

	Metric Name	Performance	Assurance	Latest Value	Target	Lower process limit	Upper process limit	Mean
1a	Waiting list - adult CMHT - average wait to be seen			5	4	7	9	8
1b	Waiting list - older adult CMHT - average wait to be seen			1	4	1	2	1
2a	Waiting list - adult CMHT SPOA - number waiting			660		683	921	802
2b	Waiting list - older people CMHT SPOA - number waiting			57		19	118	68
2c	Older people mental health 4 week referral to treatment			96%		10%	95%	52%
2d	Adult mental health 4 week referral to treatment			99%		2%	92%	47%
2e	Waiting list - ASD assessment - average wait to be seen			64		61	70	66
2f	Waiting list - ASD assessment - number waiting at month end			1,444		1940	2291	2116
2g	ASD assessments			75	26	28	90	59
3a	Waiting list - psychology - average wait to be seen			25		10	45	27
3b	Waiting list - psychology - number waiting at month end			533		614	771	692
4a	Waiting list - CAMHS - average wait to be seen			11		11	18	14
4b	Waiting list - CAMHS - number waiting at month end			284		269	411	340
5a	Waiting list - community paediatrics - average wait to be seen			58		36	43	39
5b	Waiting list - community paediatrics - no. waiting at month end			2,618		2617	2940	2779
B1	3 day follow-up			90%	80%	77%	98%	87%
D1	Community Mental Health Access (2 plus contacts)			12,920	11,899	10845	11702	11274
E1	Children & Young People Mental Health Access (1 plus contact)			3,425		3139	3310	3225
E4	Children & Young People Eating Disorder Waiting Time - Routine			100%	95%			
E5	Children & Young People Eating Disorder Waiting Time - Urgent			100%	95%			
G3	Early intervention 14 day referral to treatment - complete			50%	60%	57%	107%	82%
G3	Early intervention 14 day referral to treatment - incomplete			78%	60%	42%	123%	83%
H0	IAPT 6 week referral to treatment			95%	75%	60%	78%	69%
H1	IAPT 18 week referral to treatment			100%	95%	98%	101%	99%
H2	IAPT 1st to 2nd Treatment over 90 Days			32%	10%	15%	43%	29%
H7	IAPT patients completing treatment who move to recovery			54%	50%	43%	60%	52%
I1	Individual Placement and Support Access			545	343	167	498	332
K2	Average patients out of area per day - adult acute			28	0	3	24	14
K2	Patients placed out of area - adult acute			38	0	8	36	22
K2	Average patients out of area per day - PICU			20	0	12	23	18
K2	Patients placed out of area - PICU			30	0	20	36	28
L1	Perinatal Rolling 12 Months Access			12.0%	10%	7%	8%	8%
L2	Perinatal Access Year to Date			1,005	1,070	299	856	578
N4	Data quality maturity index			98%	95%	98%	98%	98%

Key to symbols[1]:



Blue dots indicate special cause variation, better than expected.

Orange dots indicate special cause variation, worse than expected.

[1]The rating symbols were designed by NHS Improvement

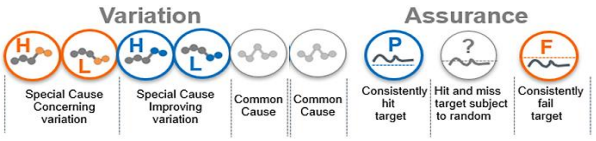
B. People

	Metric Name	Variation	Assurance	Latest Value	Target	Lower process limit	Upper process limit	Mean
1	Annual appraisals			88%	90%	82%	88%	85%
2	Annual turnover			11%	8-12%	11%	13%	12%
3	Compulsory training			92%	85%	89%	91%	90%
4	Staff absence			7%	5%	5%	7%	6%
5	Clinical supervision			87%	95%	79%	84%	81%
6	Management supervision			85%	95%	76%	82%	79%
7	Filled posts			90%	100%	88%	95%	91%
8	Bank staff use			4%	5%	4%	7%	6%

C. Quality

	Metric Name	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	No. of compliments received			136	119	68	207	137
2	No. of formal complaints received ("quick resolution")			7		3	40	21
3	No. of formal complaints received ("closer look")			13		0	31	16
4	Proportion of patients clinically ready for discharge			10%	4%	6%	14%	10%
5	Proportion of patients on CPA >12 months who have had their care plan reviewed			72%	95%	60%	69%	64%
6	Patients who have their employment status recorded as "in employment"			12%		12%	13%	12%
7	Patients who have their accommodation status recorded as "settled"			48%		38%	46%	42%
8	Number of medication incidents			58		48	115	82
9	No. of incidents of moderate to catastrophic actual harm			101	48	34	84	59
10	No. of incidents requiring Duty of Candour			0	1	0	2	1
11	No. of incidents involving prone restraint			4	12	0	24	11
12	No. of incidents involving physical restraint			51	46	26	130	78
13	No. of new episodes of patients held in seclusion			8	14	2	33	18
14	No. of falls on inpatient wards			22	30	8	59	34

Key to symbols[1]:



Blue dots indicate special cause variation, better than expected.

Orange dots indicate special cause variation, worse than expected.

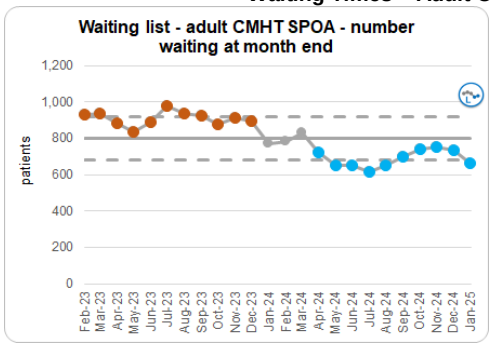
[1]The rating symbols were designed by NHS Improvement

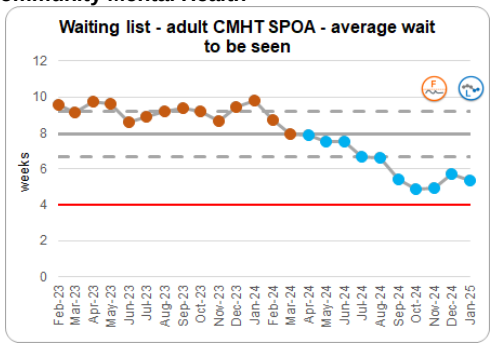
Derbyshire Healthcare
NHS Foundation Trust

Operational Performance

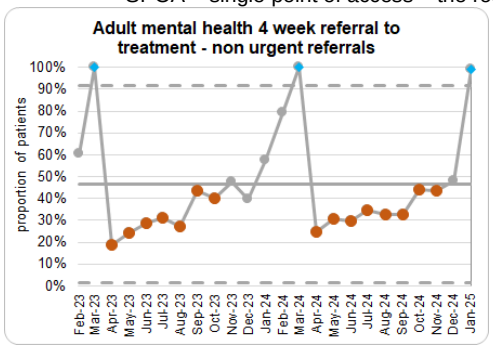
Operational Performance

Waiting Times – Adult Community Mental Health





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



Currently this is an internal measure:

- 4-week referral to treatment performance is based on referral to second contact. The data does not show patients who are currently waiting for their second contact.
- Showing phase 1 compliance and does not take into account SNOMED codes or specific interventions.
- All data is for episodes referred within the selected years.

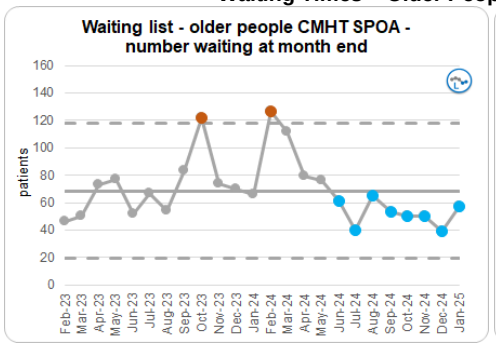
Summary
Although services are seeing an increase in referrals, the average wait to be seen continues to reduce and is currently just under 6 weeks.

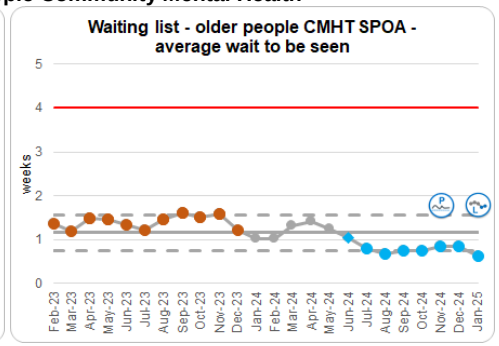
Referrals versus discharges
From April 2024 to Jan 2025 the overall number of referrals into SPOA was higher than the number of discharges by 137, which can be attributed to the increasing referrals into SPOA since the mobilisation of Living Well. Of concern, onward referrals from SPOA for intervention/treatment into different parts of the Living Well service, both short and long-term offers such as STO health, LTO community (excluding IPS and outpatients), have outweighed the number of discharges from these parts of the pathway with 417 more referrals than discharges between April 2024 and Jan 2025. If this increase in referrals for both assessment and intervention continues and remains higher than the number of monthly discharges, there is a high risk that waiting lists will increase and people will not get timely access to services when they require it owing to limited flow.

Recovery action plan
To reduce numbers waiting and length of time waiting, there continues to be an ongoing focus on productivity within all parts of the service pathway to ensure we increase flow, reduce unwarranted variation, and get best value for money. This includes targeted messaging; setting expectations – number of contacts, caseload numbers vs productivity; consistent use of the Employee Improvement Policy and Procedure; quality improvement approach to outpatient caseload management; optimised caseloads within the long-term offer; positive impact of the Living Well transformation once complete – see the following 2 pages.

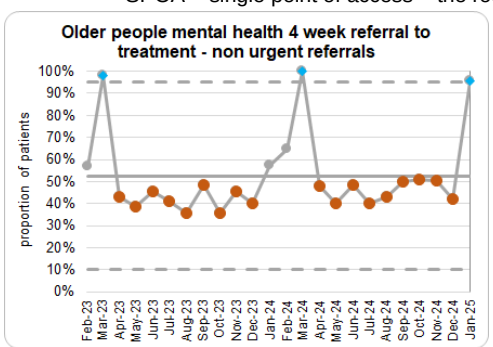
By when we will have recovered the position
The plan is positively impacting on waiting times and this can be seen in the consistently below average wait times over the last 9 months, which is a statistically significant reduction.

Waiting Times – Older People Community Mental Health





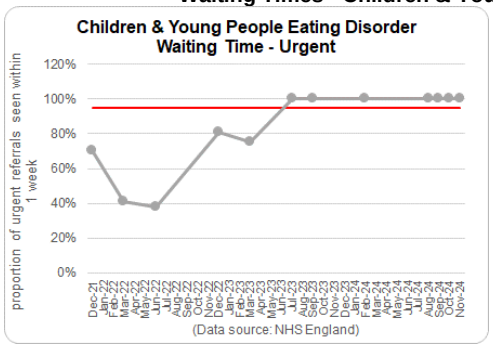
SPOA = single point of access – the route for external referrals into the services

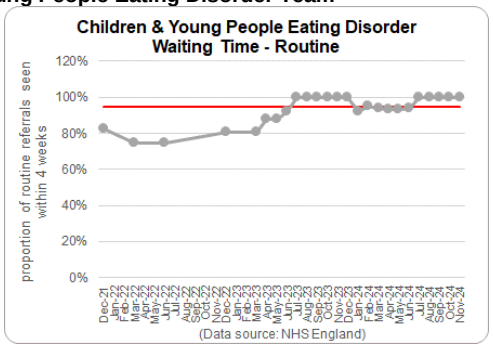


Summary
There has been a positive impact in terms of the work undertaken around triage, ensuring that patients enter the right pathway. Leadership There has also been a drive from Clinical Directors and Service Managers regarding expectations of productivity. Waiting times in MAS are stable and there has been an overall reduction in the number of patients waiting to be seen within the OA CMHT's. The waiting times in South Derbyshire have significantly reduced. Bolsover is the current hotspot due to vacancy factor, sickness, and complex employee relation issues.

Next steps – further engagement work with primary care around relationships and required referral information. The dementia assessment pathway work, will commence a review of the CMHT to DRRT element of the dementia pathway.

Waiting Times - Children & Young People Eating Disorder Team





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

Days	Qtr1	Qtr2	Qtr3	Qtr4	
2023/24	11	4	4	8	
2024/25	2	3	4	1	

Operational Performance

https://livingwellderbyshire.org.uk/

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

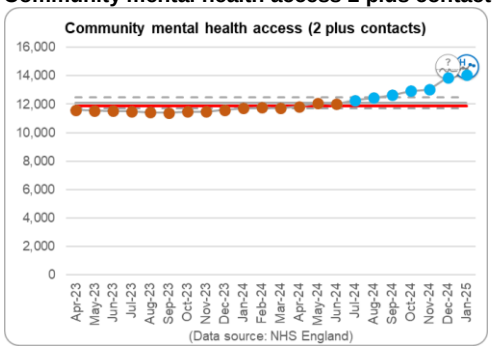
The new services went live during 2023/24:

- August 2023: High Peak
- September 2023: Derby City
- October 2023: Chesterfield
- January 2024: North East Derbyshire/ Bolsover
- February 2024: Amber Valley, and Erewash
- March 2024: Derbyshire Dales, and South Derbyshire

Community Mental Health Framework/Living Well Programme

DHCFT is a partner in the programme alongside the voluntary, community or social enterprise sector and the local authorities. Go live of the Living Well sites commenced in 2023/24 (August to March) so it is early days to yet understand true impact, however we can already see positive impact in terms of case load sizes (long term caseloads reducing whilst short term caseloads have increased). In addition, there are early indications of reducing referrals to MH Liaison Teams which frees up capacity to provide greater support to complex cases in the community and therefore to reduce presentations at A&E.

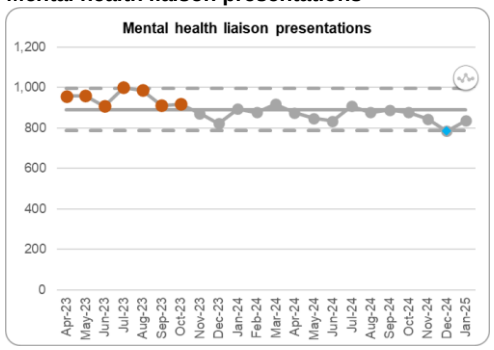
Community mental health access 2 plus contacts (NHS long term plan target)



Summary

The system was set a target to increase the number of adults and older adults receiving 2 or more contacts in a year from community mental health services to 10,044 by the end of March 2023, which was an increase of 14% on current performance. The target was achieved. For financial year 2023/24 the year-end target was increased to 11,899 and for the last 4 months the target was exceeded. For financial year 2024/25 NHSE have published data up to November, which demonstrates that year to date the target level of activity has been sustained each month. Data for December 24 and January 25 is unofficial, using internal measurement, and awaiting final validation.

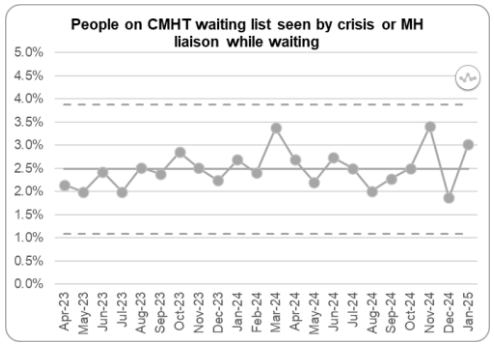
Mental health liaison presentations



Summary

One aim of living well is to free up capacity within secondary care mental health community teams to be able to provide support to more acutely unwell patients in the community. This approach should result in fewer presentations at acute trust emergency departments and support admission avoidance. The data indicates that the number of presentations has been below average in 10 of the last 12 months.

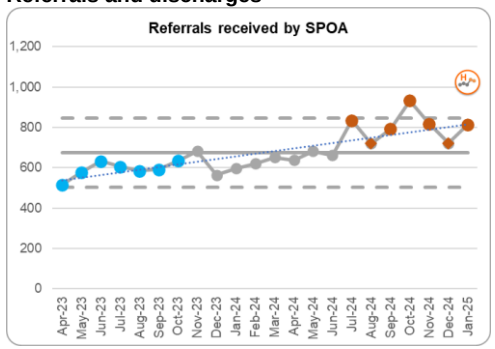
People on the community mental health team waiting list who have been seen by crisis services or mental health liaison while waiting

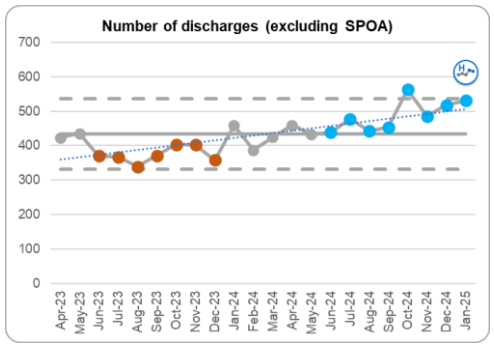


Summary

People who are waiting to be seen by community mental health teams should be seen sooner, therefore we would be expect the number of people needing to access crisis services whilst waiting for community mental health services to decrease, reducing demand on secondary services. However, to date there is no evidence of any reduction. There is a specific piece of work through the enabler MaST (Management and Supervision Tool) to review those patients in high escalation on CMHT caseloads to increase activity to prevent them from further health escalation/deterioration.

Referrals and discharges





Summary

The volume of referrals received has been steadily increasing since December 2023, with a significant increase experienced in recent months, this is attributed to the Living Well mobilisation. The volume of discharges has also been increasing over time since December 23.

Operational Performance

https://livingwellderbyshire.org.uk/

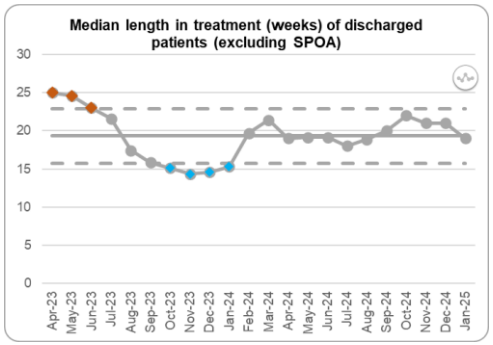
Caseload sizes

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

STO & LTO caseloads	Proportion of caseload that is long term offer											
Team	Oct-23	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Movement
CHESTERFIELD	96%	75%	72%	79%	73%	75%	75%	73%	72%	74%	71%	
HIGH PEAK	71%	54%	54%	53%	53%	54%	49%	46%	47%	46%	45%	
AMBER VALLEY	100%	100%	100%	100%	100%	100%	80%	73%	73%	69%	67%	
EREWASH	100%	91%	89%	90%	88%	89%	79%	75%	75%	73%	73%	
SOUTH DERBYSHIRE	100%	93%	89%	85%	80%	81%	73%	69%	69%	67%	66%	
DERBY CITY B	72%	57%	58%	66%	60%	65%	63%	67%	69%	66%	65%	
DERBY CITY C	74%	61%	60%	67%	58%	60%	59%	63%	68%	67%	66%	
Grand Total	**89%**	**77%**	**76%**	**80%**	**75%**	**77%**	**70%**	**69%**	**69%**	**68%**	**67%**	

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

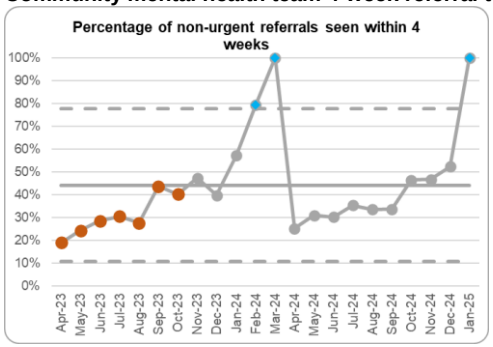
Length of time in treatment



Summary

Discharges would be expected to increase and length in treatment to reduce, owing to the short-term offer throughput offering a 12-week service. The flow of people through the service would ensure there is capacity to support people in a timely manner.

Community mental health team 4-week referral to treatment

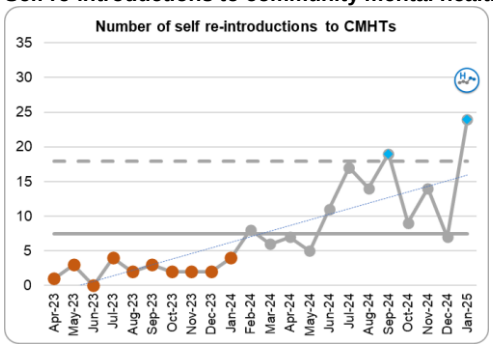


Summary

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

A significant piece of work is ongoing to correct multiple patient contacts that have been recorded incorrectly on SystmOne. Once complete this will positively impact on reported waiting times and the true picture will be more accurately reflected.

Self re-introductions to community mental health services



Summary

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

Operational Performance

Adult Neurodevelopmental Division (ND)

Inpatient/Flow/Avoiding Inappropriate Admissions

- The Short-Term Intervention Team (STIT) SDF funded has preliminary been extended until September 2025, however, confirmation required before March 31st 25. Further funding is pending QOF review.
- Deep dive into long-stay out-of-area patients has been conducted with planned changes to oversight and assurance to improve discharge rates.

Transforming care programme	Target	Completed
Number of adults in ICB commissioned inpatient care	16	17
Number of adults in secure inpatient care	15	20
CTR - Post admission Adult	75%	100%
CTR – 6 month follow up - ICB Commissioned	75%	100%
CTR - 12 month follow up - Secure Inpatient	75%	95%

Actions

A recovery action plan is in place, and at the time of writing the number of adults in ICB commissioned inpatient care has been recovered to below target level, currently standing at 15 placements. Work is in progress to reduce secure inpatient care placements and anticipated to fall below target by May 2025. The objective to improve bed flow/discharges for learning disability & autism (LDA) patients is shared across the system as a top priority. Improvements have already been made to avoiding admissions and attention is firmly focused on getting patients out of hospital back into the community safely and effectively. To date there are approximately 17 planned discharges this year, which coupled with the ongoing work to avoid admission will see an overall reduction in bedded care for LDA patients. The whole service review of the clinical care pathway will work toward ensuring community care is flexible, responsive and proactive so that it can meet the needs of those who need services.

Actions completed to date:

1. Evaluation and consolidation of admission avoidance initiatives specifically targeted at ASC people and people with LD, including, relaunched dynamic support pathway, Specialist Autism Team; Short Term Intervention Team, CYP Key working.
2. Evaluation and consolidation of preventative services in the community, including operational – continued improvement in autism diagnostic assessment throughput; strategic commissioning – investments in ND diagnostic pathway support.
   Establishment of new operational oversight structures as part of the ND programme including Joint Solutions Group (community) and two Discharge Delivery Groups (one per local authority area).
3. Progression of two LD NHS Major Service Change programmes – 1) Short Breaks 2) Inpatients. This includes consideration of initiatives which can enhance the local LD care pathway such as Step Up/Down.
4. Continuation of work to ensure diverse and high-quality care and accommodation in the community, with a strong focus on delivering against planned schemes. Also includes progression of NHS England Capital Bid
5. Deep dive into all patients who have been inpatient for 3 years + to inform actions and escalations across the system

Future Actions to improve discharges/flow:

- Review of Enhanced Case Manager role
- Roll out of new system-wide delivery plan will focus on care and accommodation which will support flow/discharge as some of the hotspots for discharge are related to ASC

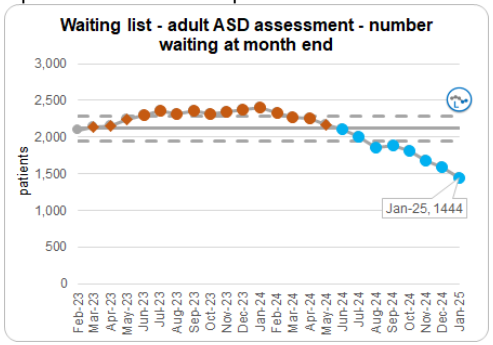
Risks

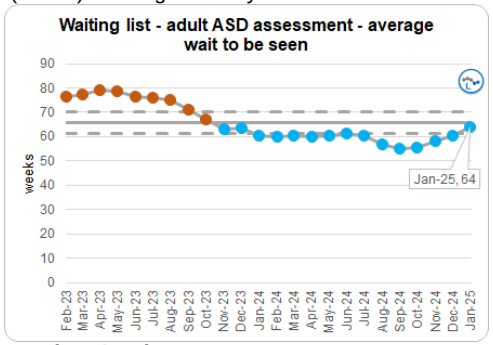
ND Patient Assurance Team: Recovery action plan in place and continued progress with infrastructure and processes. Vacancies imminent which need resolving to continue to drive progress.

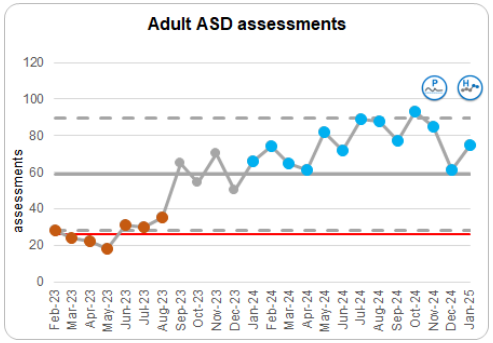
Risks

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

Training and Risk Screen Compliance: New reporting format has significantly lowered risk screen compliance. Working group addressing this with ND Head of People is leading this. To be reviewed in Operational & Clinical Operational Assurance Team (COAT) meetings monthly.







Autism Services

Adult Diagnostic Service

The number of completed assessments per month has remained high and after 10 months the full year contracted target has been exceeded by 260%. The number of people waiting continues to reduce significantly. Continued discussions with the ICB are taking place regarding extending the Autism diagnostic service (16 year +) following on from the closure of Sheffield diagnostic service.

Attention deficit hyperactive disorder (ADHD)

Ongoing gap in adult ADHD services. The Trust are continuing to build an agreed service specification and the resource needed to fulfil the potential commissioned service. Led by the Trust Managing Director for Planned Care and Chief Psychologist, ongoing discussions are progressing with the ICB and ND division.

Challenges

- Capturing patient experience: barrier to using the electronic patient survey as requires additional investment.
- Experts by experience coproduction and engagement- forming part of system delivery plan

Successes

- Annual health check completion has improved compared to last year's position YTD. Ongoing work however no longer national priority who access ND services. The findings of this to be shared with Trust Leadership Team.
- Phase two of Clinical Care Pathways has begun, focus on embedding the pathways and working through coproduced toolkits and resources.

Quality Improvement/Research

Community and Inreach both looking at new pilot model of service delivery which targets larger community provision and working differently to be more proactive and responsive in a trauma-informed manner. This work will be formatted into a QI project.

Operational Performance

Psychology & Psychological Therapies

The Division has maintained its excellent reputation in the region for being a fantastic place for psychologists to work and remains the employer of choice in the region. The Division currently have around 8% vacancy, with a head count of 275 staff (229.2 WTE).

Trainees and research: The next intake of funded trainees will be September 2025. Those who started in September 2024 have settled in well.

Talking Mental Health Derbyshire (TMHD): 6-week treatment target achieved and being maintained. Over delivered completed treatments within this contract. The service and staff will TUPE on 1st July 2025 to the new provider, Vita Health. There is a workplan in situ for the next 4 months to manage the transition of patients and staff. We are in constant discussion with ICB partners to understand the best ways for the system to manage the change.

Flow: The psychology teams have been working to specifically support the development of formulations for those with EUPD presentations within the inpatient areas. The EUPD pathway teams are also supporting with trying to maintain those in the community with a specific focus to avoid hospital admissions.

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

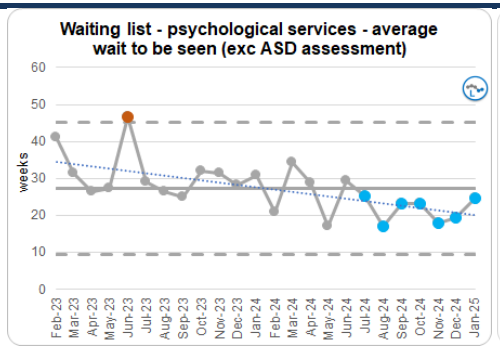
- Adults of working age psychology received 39 returns showing 82% positive feedback. The less positive feedback was owing to waiting times.
- Cognitive Behavioural Therapy & psychodynamic therapy received 15 responses and 100% were positive
- NHS Talking Therapies received 1,441 responses and 99% were positive.
- South & Dales Older Adult Psychology received 2 responses and 100% were positive.
- Learning disability psychology received 1 response which was positive.

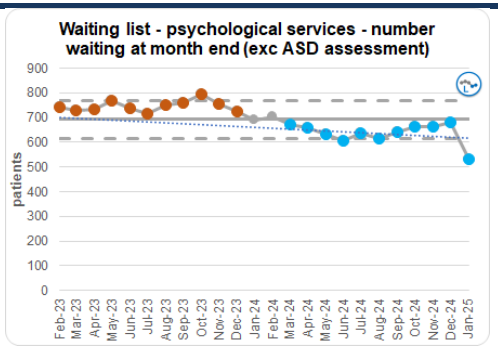
We are working to increase the numbers of friends and family completed feedback.

Trust wide staff wellbeing: Wellbeing remains a priority for all teams. Divisional staff receive continued requests to support individuals and teams which remains challenging. We are trying to consider ways across the system (JUCD) to improve the psychological support offered to colleagues. There remains a lack of appropriate psychological support for staff internally and across the system.

System support and contracts: We currently provide reflective practice for system partners (the police and rough sleeping teams) and are developing further system offers to the child death review team. The CBT team continues to provide training to other agencies. These are small income generator which we aim to grow over the coming years.

Increasing psychological awareness: Bite size psychological teaching sessions continue to have good attendance with a range of topics being delivered. Psychologists and psychotherapists are working across teams and services to provide support, formulation and build resilience.





Waiting lists and referrals: Overall, there continues to be a sustained reduction in the number of people waiting for psychological input to around 24 weeks. This has taken much work and sustaining this remains a focus in all areas. There are some areas (such as MAS psychology assessment) where the reduction has not been sustainable, and we are focusing on those. The other pressure point remains ASD assessment where the average wait is 64 weeks (as recorded in January 2025).

ASD and ADHD services: The Trust are currently in discussion with the ICB to provide an ADHD service and to extend the ASD assessment service to meet the needs of the population.

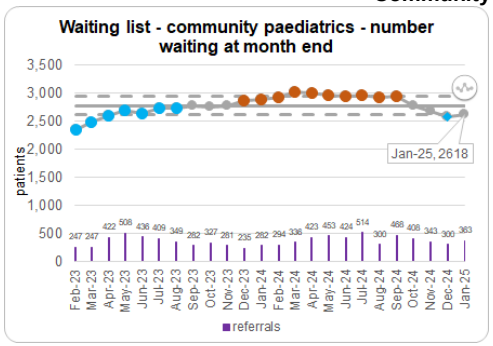
Key performance indicators: Clinical and managerial supervision remain high at 95.5% and 93.6% respectively, although there is still work to be done to improve this. Annual appraisal completion stands at 90.8%, but still needs to improve further. Return to work interviews remain low at 36% for January, though this related to just 11 returns to work in total. These have been followed up individually and will be corrected for the next update.

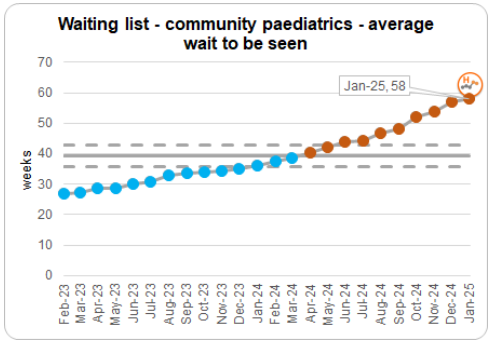
Productivity: Productivity remains a focus for all teams. The leadership team have shared expectations around job planning and delivery with managers. Accurate data is still a challenge, and we don't have this available for many of the teams. Digitisation of assessment tools is one of the next steps needed to improve the efficiency of the division and increase patient facing work.

Data: Over the last 6 months we have worked with the Training & Development team and ESR colleagues to improve the data and reporting. This is happening slowly, and role specific training data remains incorrect. Gaps remain in the broader access to accurate data.

Operational Performance

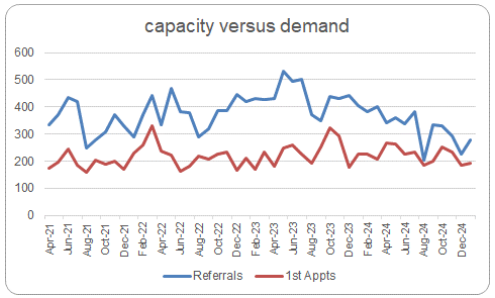
Community Paediatrics





Summary

At the end of January 2025 there were 2,618 children waiting to be seen and the average wait time was 58 weeks. Whilst referrals continue to rise, the positive impact of the internal review of processes, job plans etc. which enabled increasing the number of assessments in 2023/24 by 34% compared to 2022/23, has continued into the current financial year to date. However, demand continues to outstrip capacity by 38%, resulting in lengthening waits. Over the next 3 months there are likely to be over 300 patients in the Community Health Services Data Set who have been waiting over 104 weeks to be seen. The service will also lose 5 of the community paediatrician team through retirement and/or voluntary resignation. This includes the loss of 3 experienced consultants, including the clinical director, which will have a significant impact on service delivery.



Internal factors

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

External factors contributing to increased demand on Community Paediatricians

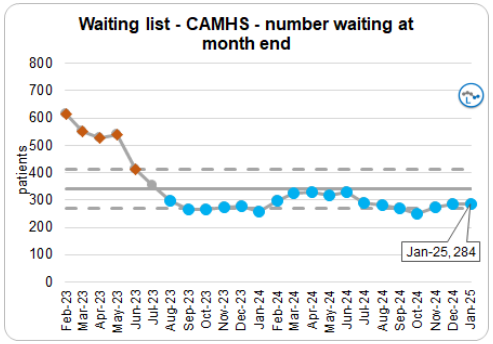
- Significant increase and enduring demand for ASD/ADHD specialist assessment. Demand for ASD and ADHD assessments is linked to an increase in SEND in schools, school pressures, cost of living crisis and reduced community support.
- Ongoing increased volume of referrals to community paediatricians owing to developmental delay, which has persisted since the pandemic.
- Increased complexity of children & young people's presenting needs post the pandemic, resulting in longer appointments, which reduces capacity to see more patients.
- Ongoing ADHD supply issues continue to impact on demand and management of cases needing to be expedited.

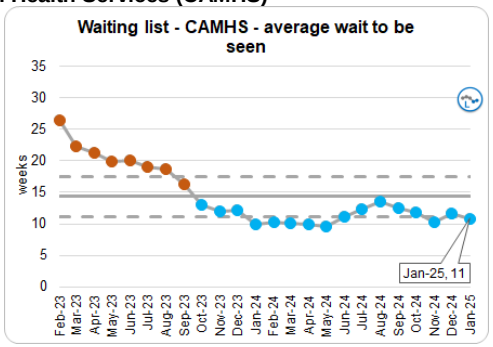
Actions

- Transformation work for the CYP neurodevelopmental pathway is ongoing.
- Ongoing senior leadership attendance at system neurodevelopmental meetings to highlight risks and increase local authority, education and primary care accountability for the increasing demand. Ongoing triage review of long waiters, with a system decision made to focus on education/schools in order to reduce referrals by offering advice, support and signposting as needed.
- Recovery action plan is in development.
- Mitigation measures to address the vacancies arising will form part of the service transformation programme, through a review of roles, skill mix, and service specification.
- Waiting times for community paediatrics are likely to continue to rise. The ongoing challenge is to reduce the growth and speed at which this takes place.

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

Child & Adolescent Mental Health Services (CAMHS)





Summary

At the end of January 2025, 284 children & young people were waiting to be seen and the average wait time was 11 weeks. The average wait is now more accurately reflected. Priority assessments remain to be seen within 4-6 weeks and routine assessments up to 20 weeks, however this is still a significant improvement from where we were in 2022.

Actions

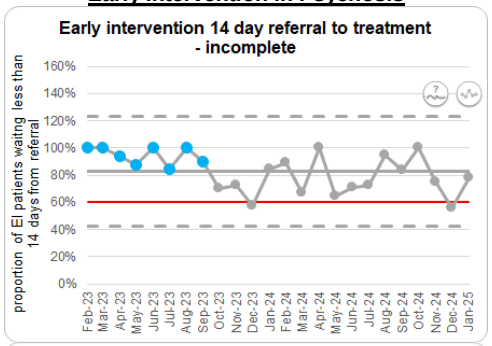
- The triage and assessment team are continuing to positively impact on external waiting times and are adhering to the Trust waiting well policy. Owing to the efficiency of the Triage and Assessment Team, it is necessary to limit and control the rate of assessments so that the teams further down the pathway do not become overwhelmed. It was planned to increase from 4 to 6 in January. However, owing to absences and vacancy, it has been increased to 8 per week which is maintaining a steady enough flow into the pathway and maintaining the average wait at around 16 weeks.
- The business case worked up with the ICB to access long term plan children & young people (CYP) services transformation money for 2024/25 is still a live proposal sitting with the senior commissioner.
- CAMHS Assessment Team clinicians continue to support with the quantitative behaviour clinic assessments to help reduce wait times. The team also continues to support with CAMHS ASD assessments, at the rate of 1-2 assessments per clinician per week. This results in young people, who were solely waiting for an ASD assessment potentially being discharged from service at a much faster rate than had they been waiting for the CAMHS specialist assessment team.
- Assessment Service Leads are closely monitoring the impact of the closure of national gender services, as referrals start to be sent through. As yet, there has not been a significant impact. A significant number of those referred in were already known to services/open to services, so the time spent triaging was minimal. The assessment of all CYP on the wait list for the gender clinics that have been closed was a mandated requirement from NHSE to mitigate the risks of having unknown CYP on their wait lists. The ongoing commissioning of gender services has not been resolved.

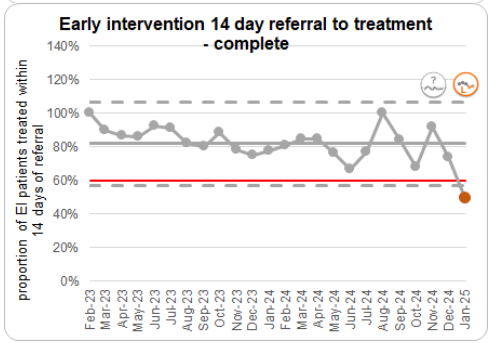
Recovery timescales:

Average wait is below 18 weeks however a national standard of 4 weeks was proposed by NHS England. If mandated, this would require new investment as outlined in the business case above, and would take 2-3 years to fully implement.

Operational Performance

Early Intervention in Psychosis





Summary

Patients with early onset psychosis are mainly continuing to receive very timely access to the treatment they need. In January 2025 the standard was not met for the first time in many months, with 12 patients waiting over 2 weeks to be seen.

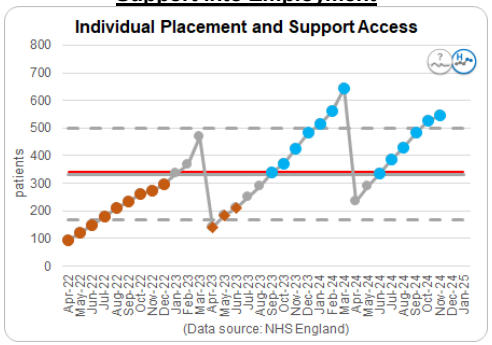
The key issues facing the service

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

Actions being undertaken

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

Support into Employment



Summary

Work Your Way is a team of employment specialists and peer support workers helping people using community mental health services in Derbyshire to find work and stay in work. The team is continuing to be extremely productive and in 2023/24 supported 645 people to access the service, and supported people to find permanent work in 176 jobs in roles of their choice. In the first 10 months of this financial year a significant number of people have been supported to access the service.

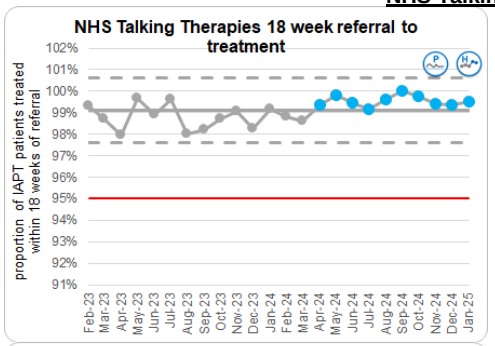
In January 2025 the team received a glowing review from the national body that oversees it, IPS Grow, following a 'fidelity review' involving two days of observations and meetings.

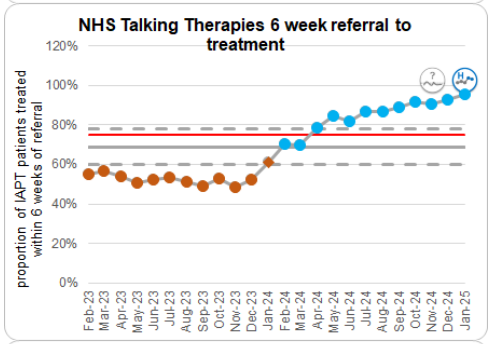
The fidelity review measured areas of good practice, including:

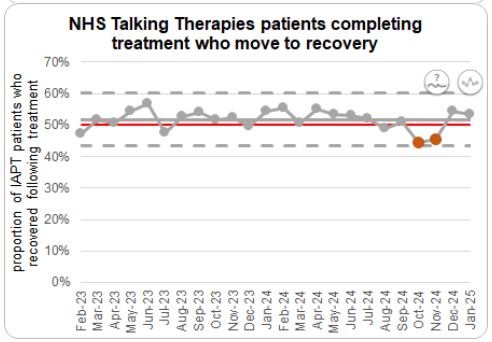
- Positive team culture
- Good communication
- Good employment support
- Focus on continuous learning and collaboration.

After the two days of observations and meetings, the team was given a score of 110 out of 125, which is an improvement of 10 points on the previous year and close to being the best score achievable. The service has been awarded a national quality mark.

NHS Talking Therapies

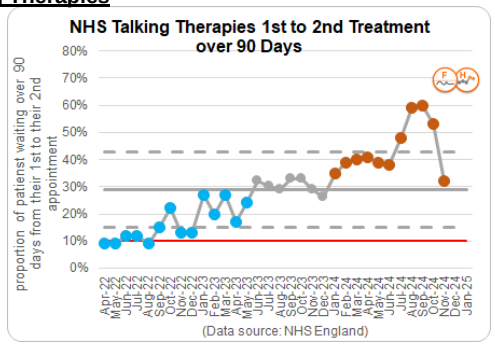






Summary

- 18-week referral to treatment performance and 6 6-week wait for referral to assessment/ 1st treatment entered continue to exceed target.
- Recovery Rate, Reliable Improvement and Reliable Recovery Rates are all on target in month and year to date following a couple of months of volatility.



Summary

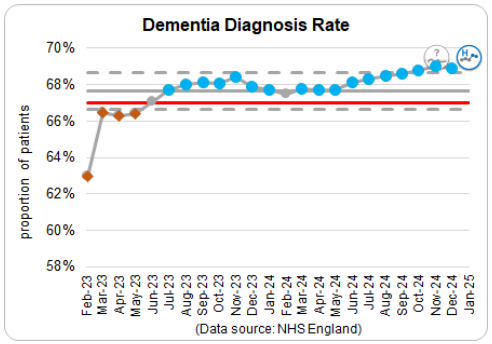
1st to 2nd treatment over 90 days has nearly halved across the 2 months to November making for a considerably improved picture.

Actions

- Negotiations with 3 of the 4 sub-contractors to carry on treating into quarter 1 of 25/26 to stabilise the counselling wait lists.
- Productivity of staff maintained despite the uncertainty of future service provision and model.
- Further losses in capacity for clinical staff with sub-contractors will reduce our capacity to manage wait lists. Loss of premises as leases are served notice reduces capacity for face to face treatments.
- Exit strategy continues to be worked upon, now meeting with the successful provider as confirmed on 6th Feb for handover of services and staff TUPE.
- Working with staff to maintain activity levels

Operational Performance

Dementia Diagnosis Rate



Summary

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

Regional Comparison December 24

Dementia diagnosis rate

Organisation Name	Measure Value STR
NHS STAFFORDSHIRE AND STOKE-ON-TRENT ICB	73.1%
NHS NOTTINGHAM AND NOTTINGHAMSHIRE ICB	70.9%
NHS DERBY AND DERBYSHIRE ICB	68.9%
NHS LINCOLNSHIRE ICB	68.3%
NHS NORTHAMPTONSHIRE ICB	66.1%
NHS BLACK COUNTRY ICB	65.8%
NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	64.8%
NHS BIRMINGHAM AND SOLIHULL ICB	62.6%
NHS SHROPSHIRE, TELFORD AND WREKIN ICB	62.0%
NHS COVENTRY AND WARWICKSHIRE ICB	58.0%
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICB	55.1%

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

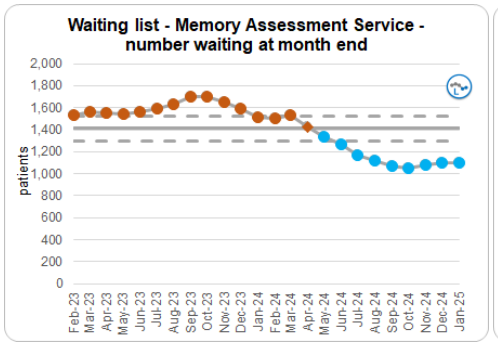
Dementia Diagnosis Benchmarking Data

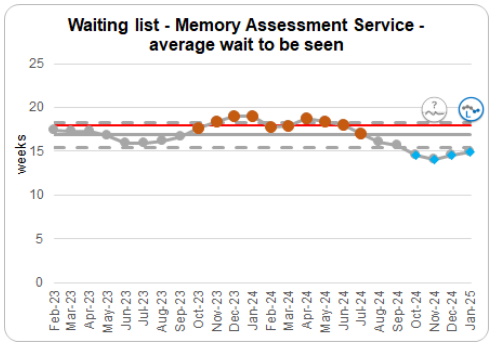
Type	Code	Diagnosis rate
ICB	QF7	75.9
ICB	QOP	74.6
ICB	QWE	73.2
ICB	QNC	73.1
ICB	QT1	70.9
ICB	QUY	70.7
ICB	QKK	70.2
ICB	QWO	70.2
ICB	QHG	69.6
ICB	QE1	69.3
ICB	QHM	69.1
ICB	QJ2	68.9
ICB	QJM	68.3
ICB	QH8	68.1
ICB	QXU	67.9
ICB	QNQ	67.7
ICB	QYG	67.3
ICB	QMJ	67.2
ICB	QPM	66.1
ICB	QUA	65.8
COUNTRY	ENG	65.6
ICB	QM7	65.3
ICB	QR1	65.2
ICB	QRV	65
ICB	QK1	64.8
ICB	QNX	63
ICB	QRL	62.7
ICB	QHL	62.6
ICB	QMM	62.3
ICB	QT6	62.3
ICB	QU9	62.3
ICB	QOC	62
ICB	QMF	61.9
ICB	QOX	61.9
ICB	QKS	60.5
ICB	QUE	60.5
ICB	QJG	60.4
ICB	QOQ	60.2
ICB	QJK	58.8
ICB	QWU	58
ICB	QVV	57.8
ICB	QSL	55.9
ICB	QGH	55.1

Primary Care Dementia Data - NHS England Digital

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

Dementia Diagnosis Waiting Times





Summary

At the end of January 2025 there were 1,097 people on the waiting list, with an average wait of 15 weeks, which includes people currently waiting as well as those who were assessed in month. Waiting times for initial assessment remain at approximately 24 weeks. Some progress has been made on assessment to diagnosis which is currently 8 weeks across the county.

Reasons for underperformance

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

Action plan

- Quality improvement project to maximise and make best use of current resource, to ensure maximum capacity and quality of current provision, with a focus on the medical workforce and diagnostic capacity. All elements have been completed apart from the medical workforce. Planning is underway for this, with a new speciality doctor now in post
- MAS 24 has been fully absorbed into the CMHT Care Homes Project.
- Reducing the DNA rate. There are still a number of cancellations, but the service are working to rebook people into suitable slots. A cancellation list is held and pull people are seen in the clinics where there are DNA's.
- Dementia assessment pathway work remains ongoing, with further engagement with Primary Care underway. Weekly emails to staff with individual performance data to ensure individual accountability for service provision.
- Regular monitoring of wait times and data cleansing.
- Complex case/under 55 pathway review completed.
- Medical workforce review. Partially complete: new Specialty Doctor now in post, with a plan around clinics and multidisciplinary meetings which will be reviewed 3 months post start date.

By when we will have recovered the position

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

Operational Performance

Summary
The national measure up to the end of 23/24 gave a combination of inappropriate out of area adult acute placements and psychiatric intensive care unit placements, calculated on a rolling 3 months' basis, at both ICB and sending provider level. From April 24 NHS England changed to measuring the number of placements at month end, at ICB level only. From internal data, at the end of November 24 there were 25 inappropriate out of area adult acute patients and 14 inappropriate out of area PICU patients. NB these figures exclude placements where continuity of care principles have been put in place, which are classed as appropriate placements.

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

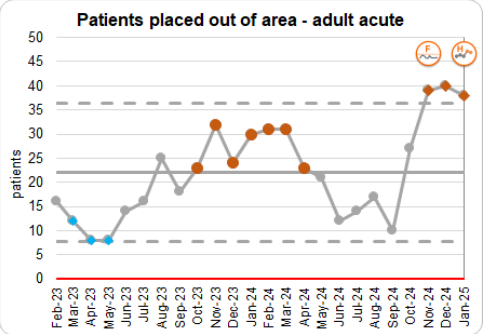
The level of acuity remains persistently high, resulting in the need for PICU beds and represented by the increase in adult acute admissions under the Mental Health Act, which account for 69% of all admissions. The level of acuity may also result in people taking longer to recover.

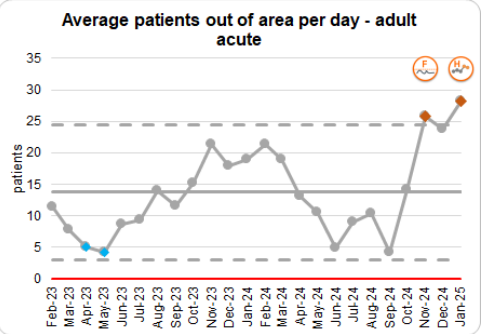
There are no PICU beds in Derbyshire at this time and therefore all patients placed in PICU are placed in out of area beds.

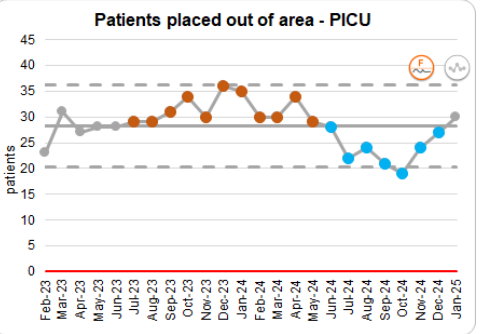
There is a need to ensure the number of inpatients who are clinically ready for discharge are kept at a minimum.

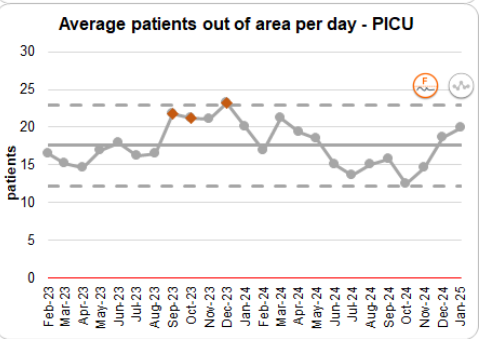
Regional comparison November 24
Inappropriate out of area placement bed days

Organisation Name	Measure Value STR
NHS BIRMINGHAM AND SOLIHULL ICB	1,535
NHS DERBY AND DERBYSHIRE ICB	1,235
NHS NOTTINGHAM AND NOTTINGHAMSHIRE ICB	1,045
NHS NORTHAMPTONSHIRE ICB	470
NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	410
NHS LINCOLNSHIRE ICB	395
NHS BLACK COUNTRY ICB	280
NHS COVENTRY AND WARWICKSHIRE ICB	185
NHS SHROPSHIRE, TELFORD AND WREKIN ICB	140
NHS STAFFORDSHIRE AND STOKE-ON-TRENT ICB	130
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICB	55









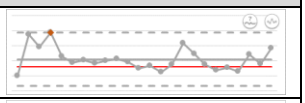
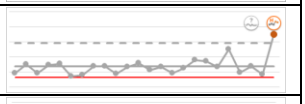
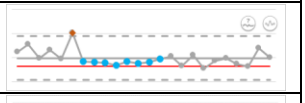
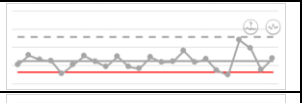
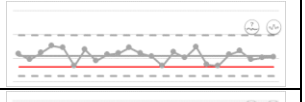
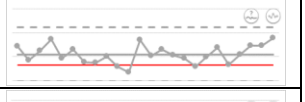
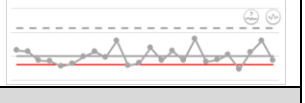
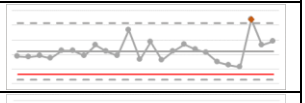
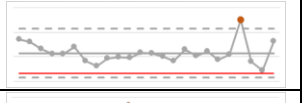
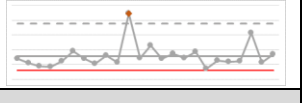
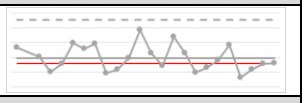
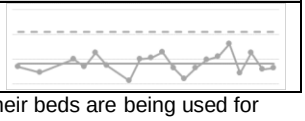
Recovery action plan
- A comprehensive recovery action plan has been developed and is being implemented.
- Step down beds to help with discharge flow and crisis house beds are being utilised to help avoid admissions where safe to do so.
- The crisis teams continue to work with higher than usual caseloads to avoid admissions to hospital wherever possible and appropriate.
- The Trust Strategic Integrated Flow Lead and Medical Lead for Clinical Transformation continue to support the improved flow of patients into and out of hospital.
- Changes to the learning disability & autism patient pathway to improve assessment and decision making have been implemented which have helped to manage this to ensure community alternatives are explored prior to admission.
- A twice weekly mini-MADE and MADE event is in place to ensure reduction in CRFD and able to escalate to Super-MADE where required.
- Gatekeeping has been implemented to provide a multi-agency response to the admission challenges.
- Implementation of community based Clozaril initiation, avoiding the need for admission to hospital.
- Enhanced impact of the emotional regulation pathway to support prevention of admission to hospital and/or facilitate early discharge.
- Derbyshire Mental Health Response Vehicle implemented in October 2024. This consists of one vehicle staffed by a paramedic and a mental health nurse.
- The establishment of MAST in CMHTs ensuring focused input to those of greatest need and at greatest risk of admission.
- Develop and implement criteria led discharge guidance.
- Challenge and confirm process incorporated into review of out of area patients.
- Challenge and confirm process incorporated into reviews for patients with LOS over 60 days.
- Daily dashboard generated providing breakdown of performance daily.
- Weekly multidisciplinary review of key performance data on the ward dashboard
- Estimated discharge date established during admission process and discharge planning to start at point of admission.
- Derbyshire ICB have agreed strategy to achieve maximum delayed discharge will be 24 hours. At the moment the average delayed discharge is 65 days with between 20 and 30 patients identified as "delayed discharge" at any one time.
- To engage with housing and clinical colleagues to ensure that homelessness pathway is robust as a discharge option.
- To generate improved flow and admission capacity in adult acute inpatients who are temporarily providing 7 day offer.
- Creating capacity to repatriate PICU patients when appropriate to do so and a reduction in requirement for psychiatric intensive care.

By when we will have recovered the position
- End of March 2025.

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

Operational Performance

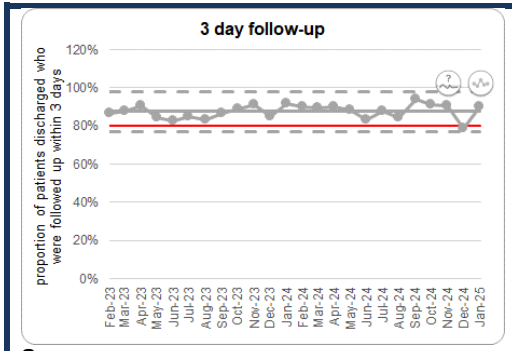
Occupancy & length of stay (days)

Clinical area	Beds	Bed occupancy Jan-2025	Average duration of stay to date of current patients		Average length of stay Jan-25 discharged		Change versus previous month discharged		Change over time – mean length of stay of discharged inpatients
Adult Acute			Mean	Median	Mean	Median	Mean	Median	
Morton	20	105%	42	28	57	30	↗	↗	
Pleasley	21	71%	78	30	175	63	↗	↗	
Tansley	21	102%	54	31	50	45	↘	↗	
Ward 33	20	96%	75	63	70	48	↗	↗	
Ward 34	20	103%	50	42	52	32	↗	↘	
Ward 35	20	106%	83	51	89	37	↗	↘	
Ward 36	21	96%	49	30	41	43	↘	↘	
Older People									
Bluebell – new ward	12	81%	96	46	38	39	n/a	n/a	
Cubley Female	18	70%	99	71	145	147	↗	→	
Cubley Male	18	86%	75	78	163	153	↗	↗	
Tissington	18	104%	92	61	85	49	↗	↘	
Perinatal									
The Beeches	6	87%	22	22	33	20	↗	↘	
Rehabilitation									
Cherry Tree Close	23	93%	342	301	322	322	↗	↗	

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

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

Operational Performance

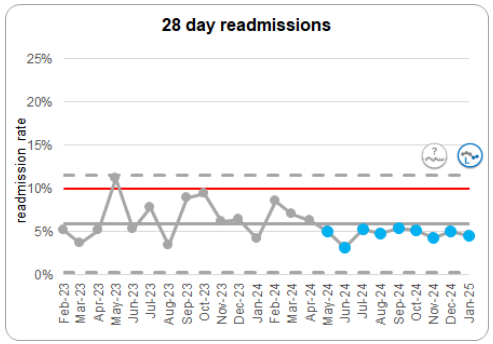


Summary

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

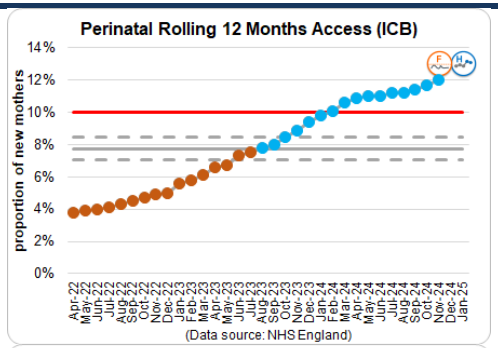
Actions

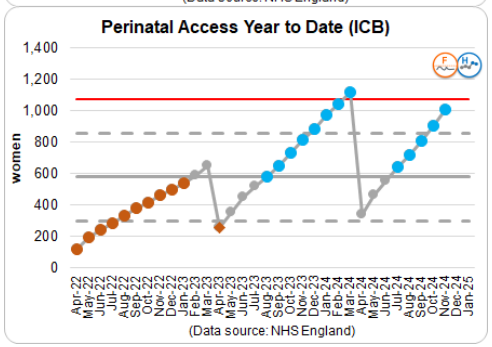
- Regular audit of follow-ups to ensure improved accuracy of reporting.
- Completion of breach reports for any follow-ups that were not achieved to enable learning from breaches.



Summary

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





Summary

The service continues to exceed the 10% access target, rolling access rate is currently 11.7%. The service is now fully recruited to and has specialist assessor roles in place. Accepting self-referrals and developing an outreach workstream is improving inclusive, parity of access. There is a consistently high demonstrable demand for the service. The service is currently refining clinical pathways to ensure that wait times are manged effectively. Completion of assessments within the maternal mental health service (MMHS) and psychology are lower than initially projected owing to length of stay on caseload and workforce challenges.

Actions needed to maintain target

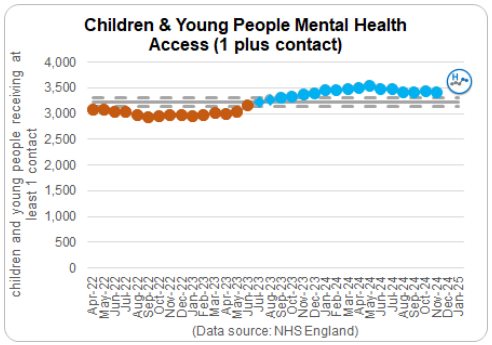
- Continued action plan to address DNA's.
- Service to continue strategic direction to address health inequalities and potential barriers to access.
- Waiting list to continue to be monitored by RAP and monthly exception report.
- Service to refine clinical pathways
- MMHS and psychology team to increase capacity to assess and manage wait times for the service.

Regional comparison November 24

Perinatal access – rolling 12 months

Organisation Name	Measure Value STR	LTP Trajectory STR	LTP Trajectory Percentag..
NHS SHROPSHIRE, TELFORD AND WREKIN ICB	745	501	149%
NHS DERBY AND DERBYSHIRE ICB	1,300	1111	117%
NHS NORTHAMPTONSHIRE ICB	995	905	110%
NHS BIRMINGHAM AND SOLIHULL ICB	1,925	1953	99%
NHS NOTTINGHAM AND NOTTINGHAMSHIRE ICB	1,280	1298	98%
NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	1,230	1259	98%
NHS LINCOLNSHIRE ICB	720	742	97%
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICB	760	781	97%
NHS BLACK COUNTRY ICB	1,505	1585	95%
NHS COVENTRY AND WARWICKSHIRE ICB	960	1045	92%
NHS STAFFORDSHIRE AND STOKE-ON-TRENT ICB	1,050	1215	86%

NHS Derby & Derbyshire ICB was the 2nd highest performing in the region, with activity exceeding long-term plan trajectory.



Summary

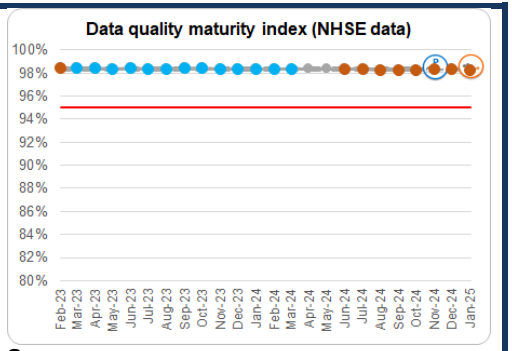
Performance has remained significantly high since August 2023.

Regional comparison November 24

C&YP access 1 plus contact

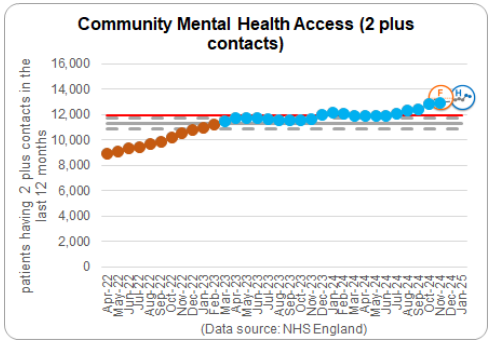
Organisation Name	Measure Value STR	LTP Trajectory STR	LTP Trajectory Percentag..
NHS NOTTINGHAM AND NOTTINGHAMSHIRE ICB	20,475	16124	127%
NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	17,730	14553	122%
NHS NORTHAMPTONSHIRE ICB	10,005	9600	104%
NHS DERBY AND DERBYSHIRE ICB	14,550	14463	101%
NHS COVENTRY AND WARWICKSHIRE ICB	12,550	12972	97%
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICB	10,460	11865	88%
NHS BLACK COUNTRY ICB	17,440	20240	86%
NHS STAFFORDSHIRE AND STOKE-ON-TRENT ICB	14,685	17273	85%
NHS SHROPSHIRE, TELFORD AND WREKIN ICB	6,370	8341	76%
NHS LINCOLNSHIRE ICB	8,610	11829	73%
NHS BIRMINGHAM AND SOLIHULL ICB	17,875	24834	72%

NHS Derby & Derbyshire ICB was the 4th highest performing in the region, with activity slightly above the long-term plan trajectory.



Summary

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



Summary

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

Regional comparison November 24

Community mental health 2 plus contacts t'formed

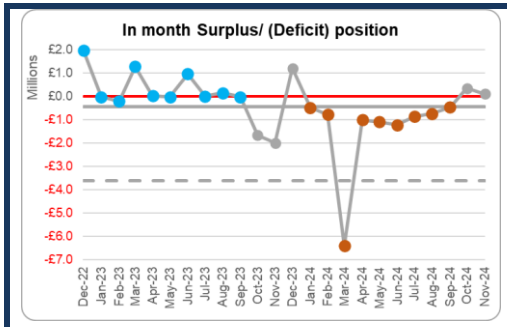
Organisation Name	Measure Value STR	LTP Trajectory STR	LTP Trajectory Percentag..
NHS BIRMINGHAM AND SOLIHULL ICB	25,360	10286	247%
NHS LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	14,410	6802	212%
NHS NOTTINGHAM AND NOTTINGHAMSHIRE ICB	15,865	7984	199%
NHS DERBY AND DERBYSHIRE ICB	13,030	7323	178%
NHS NORTHAMPTONSHIRE ICB	8,465	4932	172%
NHS BLACK COUNTRY ICB	14,460	8559	169%
NHS STAFFORDSHIRE AND STOKE-ON-TRENT ICB	11,830	7820	151%
NHS HEREFORDSHIRE AND WORCESTERSHIRE ICB	7,935	5260	151%
NHS LINCOLNSHIRE ICB	7,660	5407	142%
NHS COVENTRY AND WARWICKSHIRE ICB	7,975	6376	125%
NHS SHROPSHIRE, TELFORD AND WREKIN ICB	4,220	3394	124%

NHS Derby & Derbyshire ICB was the 4th highest performing in the region, with activity exceeding the long-term plan trajectory by 78%.

Derbyshire Healthcare
NHS Foundation Trust

Finance

Financial Performance



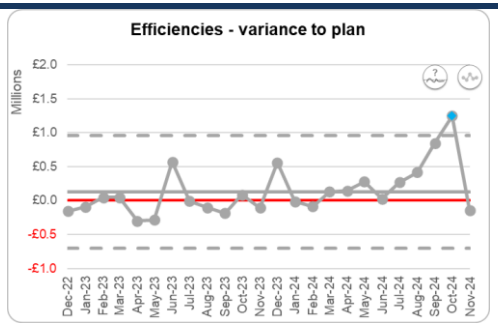
Summary
At the end of January, the financial position is a deficit of £5.4m which is better than plan by £0.4m.

The forecast position remains in line with the plan submission of £6.4m deficit.

Current risks to deliver the planned deficit:

- Delivery of efficiencies in full
- Management of Adult Acute out of area expenditure to reducing trajectory
- Management of in-patient expenditure to budget
- Additional costs of complex patient (now ceased)
- Management of agency expenditure within budget
- Management of any new cost pressures

The Board Assurance Framework (BAF) risk *that the Trust fails to deliver its revenue and capital financial plans for 2024/25,* remains rated as EXTREME due to the financial risks above.

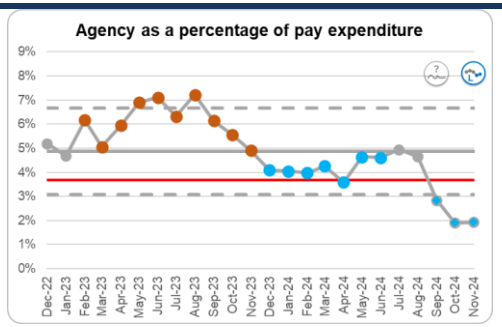


Summary
The plan includes an efficiency requirement of £12.5m with a proportion phased from quarter 2. The plan assumes 71% of the savings are delivered recurrently.

There has been a significant improvement in the position at the end of January and delivery is on plan year to date (YTD)

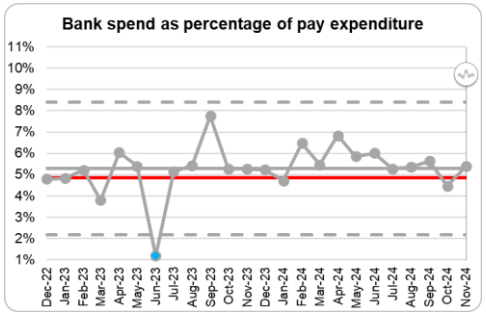
At the end of January £12.1m of the £12.5m planned efficiency delivery has been transacted in the ledger following the EQIA sign off process.

The Efficiency Programme Delivery Group, held fortnightly, continuous to oversee progress of the required savings.



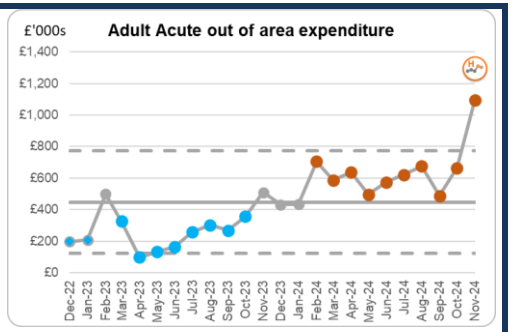
Summary
Agency expenditure YTD totals £4.5m which is below plan by £0.9m. This includes £1.2m of additional costs to support a patient with complex needs (ceased at the beginning of September). Excluding that cost the agency expenditure would be below plan by £2.0m. The agency expenditure as a proportion of total pay for January is 1.8%. The forecast agency expenditure of £6.3m is below plan by £1.2m

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



Summary
Bank expenditure YTD totals £7.6m, which is above plan by £0.4m.

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

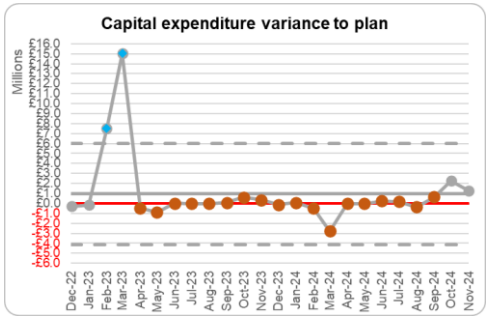


Summary
The plan for out of area expenditure is based on a reducing trajectory from twenty-two to zero beds by the end of the financial year. In addition to this the plan also included a further 6 block beds for part of the financial year.

At the end of January, the number out Adult Acute out of area placements are above the reducing trajectory which is generating an overspend of £4.0m.

The forecast does assume that the current level of placements continues for the remainder of the financial year, which generates an overspend of £6.3m at the end of the financial year.

Financial Performance

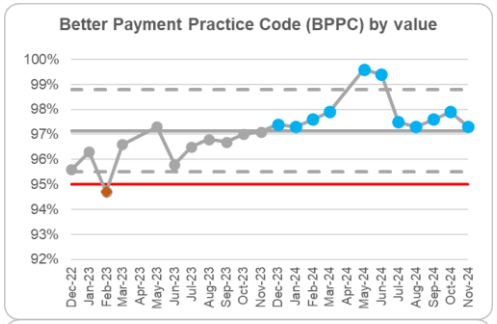


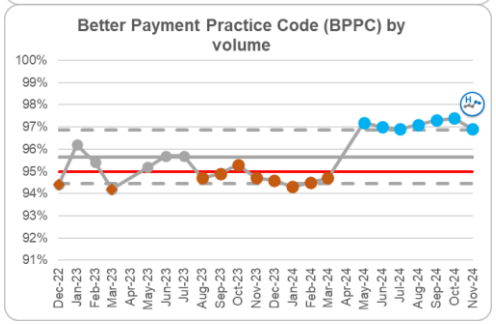
Summary
Capital expenditure against the system capital allocation at the end of January is above plan by £2.9m. This reflects the additional costs in relation to the Making Room for Dignity (MR4D) programme, of which some costs have been mitigated from pausing existing planned schemes.

Additional national funding for the MRFD programme has been confirmed (subject to certain conditions) and the costs are included in the forecast.

Any additional risks related to any new leases, which due to the changes in accounting treatment, will now need to be funded from the system capital allocation.

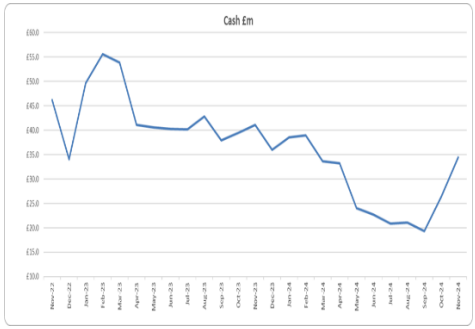
A new allocation of capital of £1.0m has been received and is reported within the forecast position this month.





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

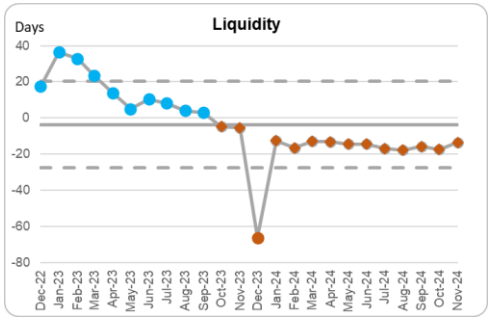
At the end of January, both the value and volume of invoices exceeded the target at 97.7% and 96.9% respectively.



Summary
Cash at the end of January is at £26.4m (£31.6m last month) which is £6.9m above plan.

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

The cash levels are forecast to reduce to £14.7m by the end of the financial year which is £4.4m below plan. This forecast adverse variance to plan is related to the additional capital expenditure for MR4D which is now in the forecast.



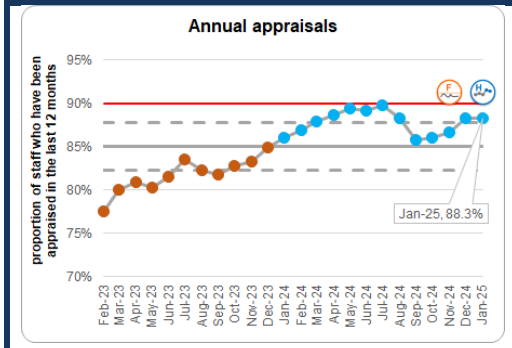
Summary
The chart above shows the liquidity levels over the last two years. Liquidity levels were high in 2021/22, however in 2022/23 the liquidity reduced due to the timing of cash receipts related to the centrally funded capital scheme for the MR4D programme. The Public Dividend Capital (PDC) drawdown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

Derbyshire Healthcare
NHS Foundation Trust

People

People Performance

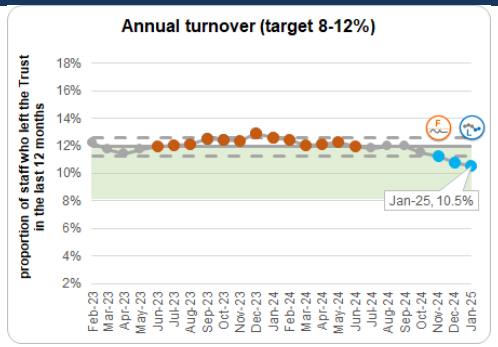
Annual appraisals



Summary
Overall, performance remains slightly below the 90% target at 88.3%. Operational Services are currently at 89% compliance and Corporate Services at 84%.

Actions
- Work has been undertaken to understand why there are challenges within corporate services to achieve full compliance. As a result, a shortened version of the appraisal has been developed for estates and facilities and team appraisals are being considered to support the division.
- New IT functionality has now been successfully tested which automatically sends calendar reminders to both the appraiser and appraisee regarding upcoming appraisals. The new functionality is planned to be rolled out Trust wide during March 2025.
- Appraisal data is being used with other key people performance metrics to identify hotspot areas and bespoke targeted OD work is being commissioned.

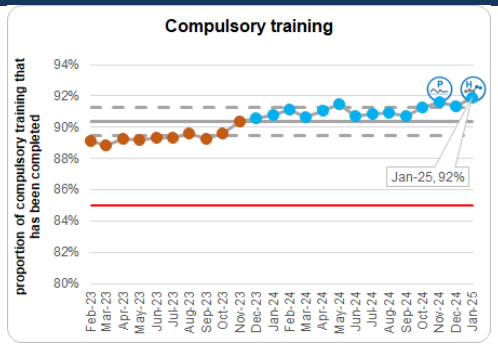
Annual turnover (target 8-12%)



Summary
Overall turnover has been within target for the last 7 months and remains in line with national and regional comparators.

Actions
- The staff benefits review to support engagement and retention, which included the Trusts salary sacrifice schemes, continues to remain extremely popular with our colleagues. The salary sacrifice schemes covers a wide range of products from everyday household appliances to lease cars.
- The Trust continues to run a robust vacancy control panel to monitor all recruitment activity.
- Stay surveys are now becoming embedded in a retention programme at 3, 6 and 9 months to ensure managers and colleagues are supported to address any early concerns and to support retention. The stay surveys and wider organisational development work is also playing a key role in the Trusts Making Room for Dignity programme.

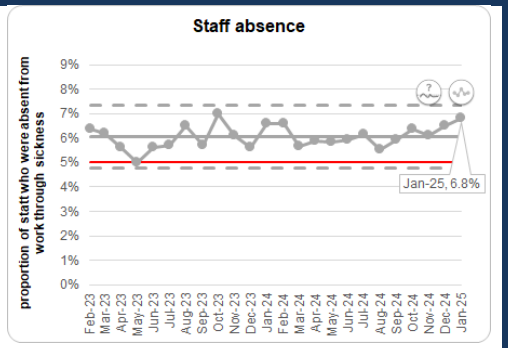
Compulsory training



Summary
Overall, the 85% compliance target has been achieved for well over 24 months and has now reached its highest compliance level this month at 92%. Operational Services are currently 93% compliant and Corporate Services are 87%.

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

Staff absence

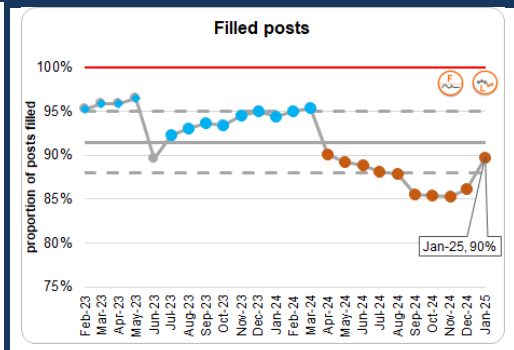


Summary
The monthly sickness absence rate is running at 6.8% and compared to the same period last year, long term sickness rates are 0.16% lower and short term sickness absence are 0.35% higher.

Anxiety, stress or depression related illness remains the highest reason for sickness absence, followed by Cold, Cough, Flu – Influenza.

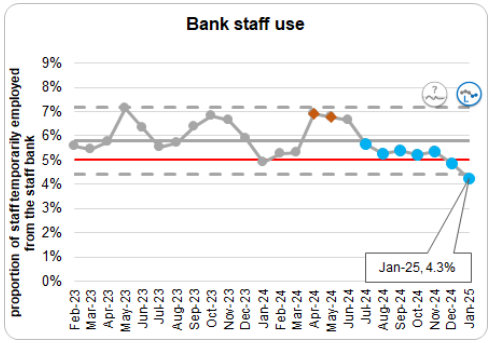
Actions:
- Work continues to ensure intervention with the management of sickness absence cases takes place at an earlier stage.
- All long-term absences are reviewed each month with the Director of People, Organisational Development & Inclusion and the Employee Relations Team to ensure a supportive and robust approach continues to be taken to managing all absences.

People Performance

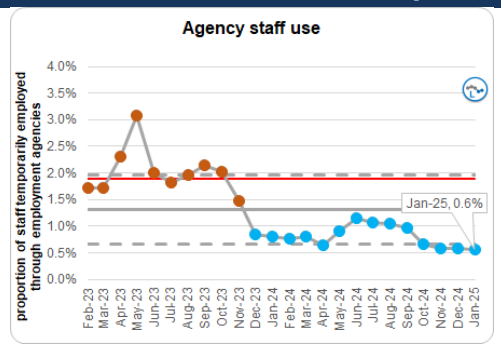


Summary
At the end of January 2025, 90% of posts overall where filled. This year continues to see a staged release of investment funding throughout the year.

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

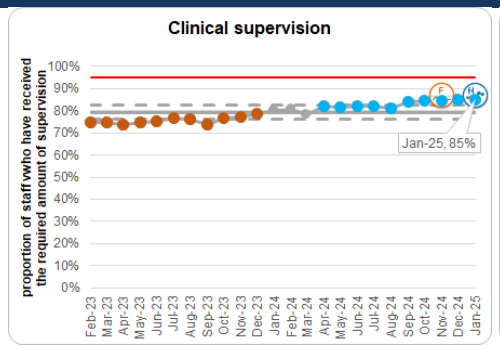


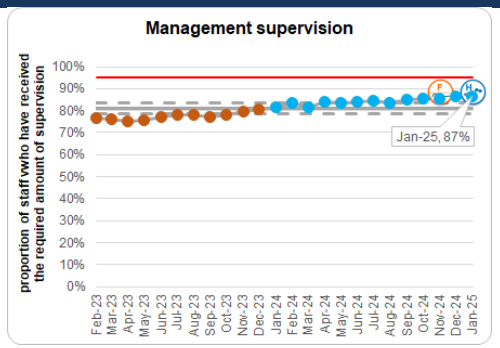
Summary
The proportion of staff used from the bank ranges from 4 to 7% per month. Bank staff are predominantly used on inpatient wards and reasons for temporary staffing use include cover for vacancies, sickness and for increased levels of observations.



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

Actions
The actions previously identified below, continue to remain in place and operate as business as usual.
- Weekly authorisation panel continues to oversee agency requests across the Trust.
- Agency usage continues to be monitored and remains within clinical staff groups.
- Clear protocols are in place to cover the circumstances where various levels of agency workforce relate to enhanced, safer and emergency staffing levels.
- Ongoing actions are taking place to support the reduction in medical agency usage, these include creative recruitment campaigns, alternative workforce roles where appropriate and continued increase of availability of temporary staffing through the Trust's medical bank function.
- Work continues with the roster efficiency programme.
- The Trust continues to work with Region and NHSE on the Agency Price Cap Compliance programme, which aims to bring all Trusts in line with the agency price cap from 1st April 2025 onwards.





Summary
Overall compliance is 85% for clinical and 87% for management supervision.

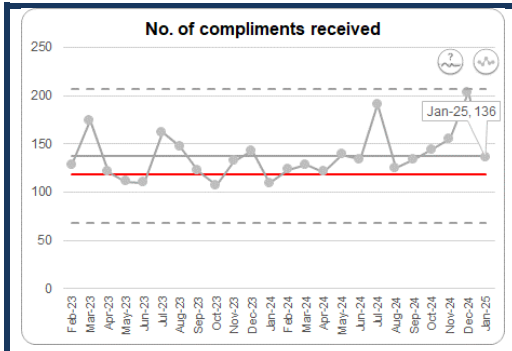
Actions
Following an audit of supervision processes, the Trust is nearing completion of the recommendations which will help towards achieving its target for both clinical and non-clinical supervision.

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

Derbyshire Healthcare
NHS Foundation Trust

Quality

Quality Performance

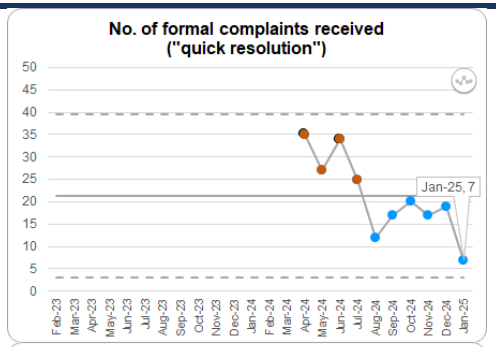


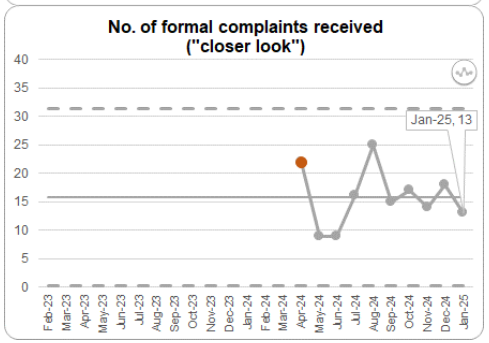
Summary
The number of compliments recorded between October 2024 and January 2025 is on an increasing trajectory and hit the upper process limit in December 2024. There is no clear reason why the number of compliments spiked in the period.

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

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

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



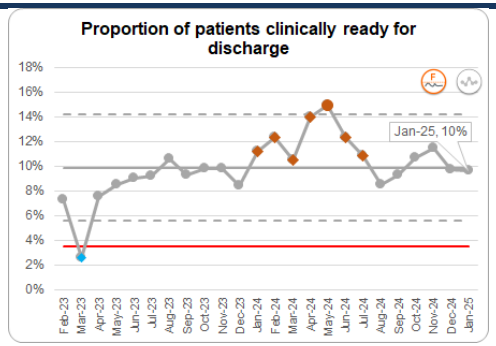


Summary
The number of complaints Identified as “quick resolution” has continued under the mean of 22 between October 2024 and January 2025 with a lower than anticipated number of quick resolution complaints being logged due to leave within the Patient Experience team over the Christmas period. In the next report, it is anticipated that the number of quick resolution complaints will continue between 15 and 20.

The complaints categorised as “closer look”, involve an investigation in line with how complaints are currently managed.

The number of closer look complaints has followed a common cause variation pattern and also stayed in line with the mean of 17.

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

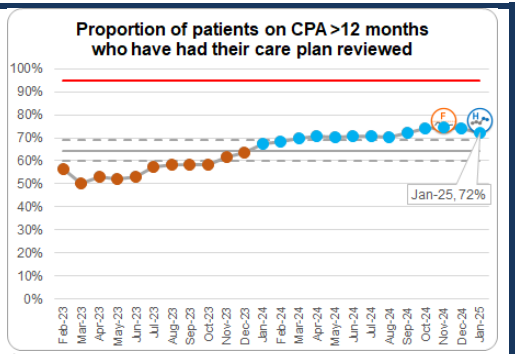


Summary
The number of service users meeting the criteria as CRFD (formally called Delayed Transfer of Care (DTOC), has consistently been between the mean and upper control limit between October 2024 and January 2025.

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

Escalation processes and partnership support

- An Adult CRD meeting continues to be held 3 times a week, which includes social care services.
- The Trust Strategic Integrated Flow Lead continues to attend the weekly system wide Pathways Operations Group, system wide, weekly Discharge Planning Implementation Group and monthly Strategic Discharge Group.
- A Discharge Tracking Tool as requested by NHS England has been in progress since July 2024, reviewing all adult admissions and onward referrals, allocations and barriers to discharge. This tool is used to monitor timescales, escalations and identify themes such as a lack of available, appropriate housing, establishing funding, and a lack of availability of social care placements.
- The System priorities identified from the Discharge Planning Implementation Group are expected to achieve continuity and coordination of care, reduce avoidable length of stay and improve flow and access to local beds over the next 3 months.



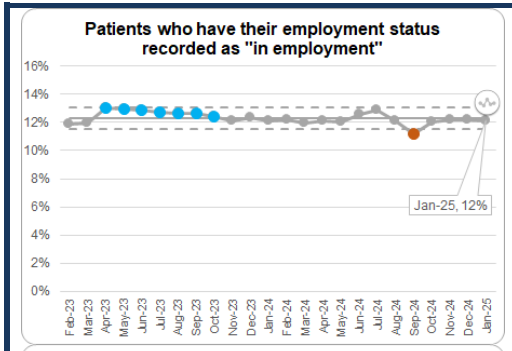
Summary
The current percentage of patients who had a CPA review in the past 12 months was 72% on average according to the Trust CPA review compliance report. However, due to the small numbers in some teams the percentage change is relatively large but the actual changes in compliance are minimal.

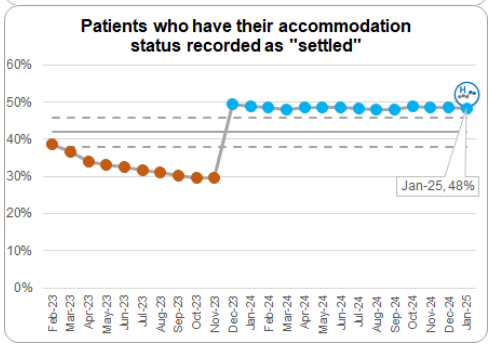
Actions

The Trust services with compliance lower than 85% have identified action plans to improve care plan, risk screen and CPA compliance as below:

- A process for monitoring compliance and quality has been implemented in each division and is monitored via the monthly Fundamentals of Care meeting, (in Inpatients, the Clinical Reference group) and the Divisional Clinical Operational Assurance Team (COAT) meetings.
- The Trust Digital practice team sent out “quick user guides” to services and offer drop-in sessions to support staff in inputting information correctly but have stated there is no way to prevent staff creating the care plans in an incorrect way which is not picked up by the algorithm.
- With improved care plan compliance, it is expected that more timely reviews of CPA will follow. There is also a working group in place which meets monthly to review the Trust approach to CPA led by NHS England and attended by the trust head of nursing for Community Services and the Practice lead for the Trust Living Well service.

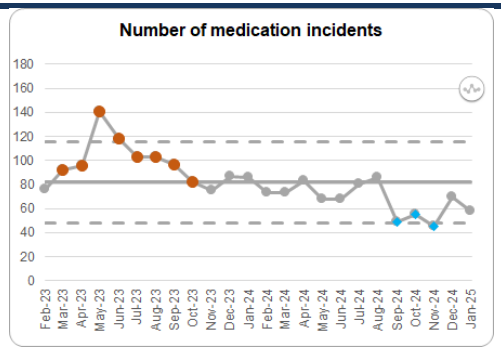
Quality Performance





Summary
Patients open to the Trust in settled accommodation has remained static between October and January 2025 and the number of patients open to employment has continued to remain between 11% and 13% since August 2022. This measure continues to be monitored by individual services.

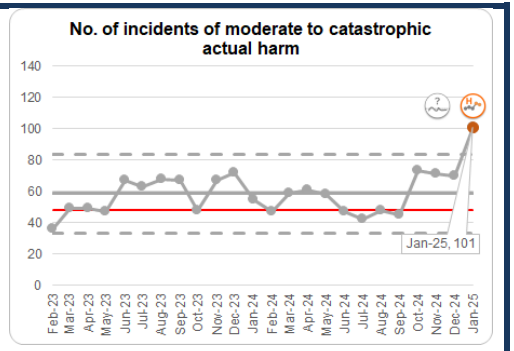
Actions
- A report has been developed which informs teams if there are gaps in the current Data Quality Maturity Index information recorded on referral and Ward and Service Managers have been asked to review this report weekly and action any gaps identified. This will be monitored via monthly service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



Summary
The number of medication incidents has been under the mean of 82 since September 2024. It should be noted that the medication incidents reported are largely of low-level harm.

Actions

- The “Quick medicine reference guide” relating to Controlled Drugs and measuring liquids is now available on FOCUS as part of Medicine Code and hard copies are available in all inpatient clinic rooms.
- To improve medicine temperature monitoring a task and finish group including Heads of Nursing, pharmacy and clinical leads started in January 2024 and is expected to reduce the number of incidents recorded following its conclusion. This could be influencing incidents not going over 90 since January 2024.
- DHCFT Pharmacy are feeding back to ward managers on a quarterly basis about shared learning from Monthly meetings with Chesterfield Royal Hospital pharmacy.
- The number of medication incidents is reviewed via the monthly medication management subgroup and is reported on within the quarterly thematic “Feedback Intelligence Group” (FIG) report by the Heads of Nursing/Practice and is included in the Serious Incidents Bi-monthly report. Any actions identified are reviewed via the medicines management subgroup and the Serious Incidents Bi-monthly report is taken quarterly to the Quality & Safety Committee (QSC) for assurance.



Summary
This data demonstrates the number of DATIX incidents recorded as moderate harm to catastrophic.

The number of incidents reduced between September and December 2024 with a spike between December 2024 and January 2025.

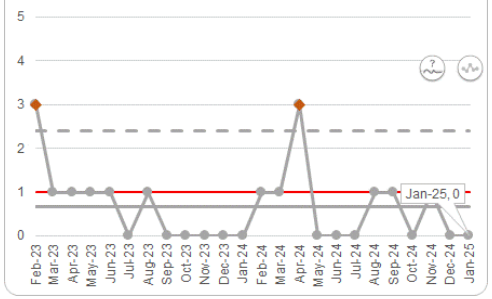
Analysis suggests that this is due to an increased number of Moderate incidents recorded as “self-harm” and physical assault from patients to staff and patient to patient.

A pattern of a high number of repeated incidents involving to a small group of patients continues to be seen and is consistent with anecdotal reports from staff that acuity on the inpatient wards is high and this is most prevalent on the female acute wards.

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

Quality Performance

No. of incidents requiring Duty of Candour



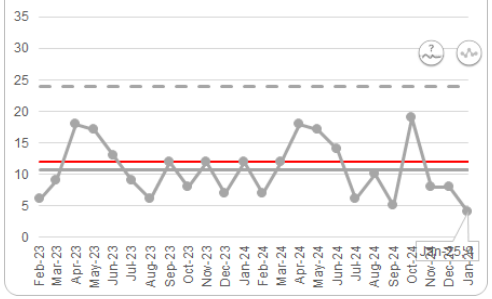
Summary
Duty of Candour remains within expected thresholds between October 2024 and January 2025

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

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

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

No. of incidents involving prone restraint

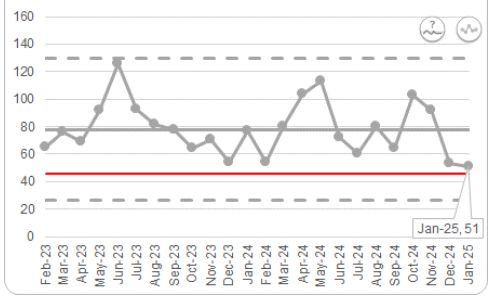


Summary
Incidents of prone restraint have continued within a common cause variation pattern between October 2024 and January 2025 and are currently below the Trust margin of 12 incidents.

The increase in October 2024 was attributed to a small number of unwell individuals who required multiple interventions and numbers have reduced in line with the recovery of these individuals.

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

No. of incidents involving physical restraint

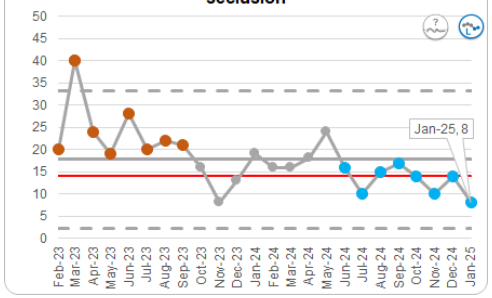


Summary
Physical restraints have decreased between October 2024 and January 2025 but continue above the Trust margin of 45 incidents. The number of episodes of physical restraint is linked to the number of self-harm incidents and a correlation in staff intervention required to prevent individuals harming themselves.

Action
The Trust Positive and Safe Support team continues to offer supplementary training sessions to improve training availability for staff and compliance with positive and safe training is currently at 78% for teamwork and 70% for breakaway training. The slower than anticipated increase in compliance is due to staff who were previously identified as medically exempt, now requiring training and an increase in staffing who require the training related to the making room for dignity programme Compliance with training is monitored in monthly divisional assurance review meetings and the monthly Reducing Restrictive Practise group. Compliance is expected to continue to increase monthly.

Any staff who do not have a training enrolment date all emailed weekly and a weekly report is sent to Ward Managers and General Managers outlying any staff who require training or have not attended.

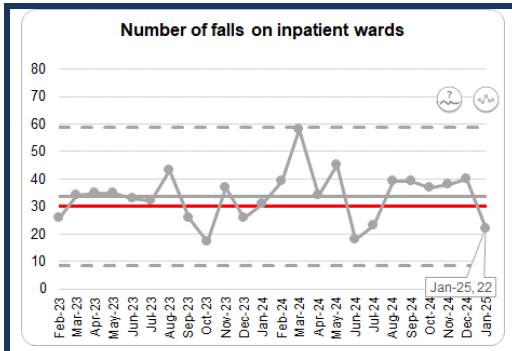
No. of new episodes of patients held in seclusion



Summary
Seclusions have decreased between October 2024 and January 2025. This is in line with common cause variation and below the Trust margin of 14 incidents.

Action
- Episodes of seclusion continue to be monitored via the monthly Reducing Restrictive Practice group.
- A review focused on peer support including debrief is expected to have an impact on reducing the number of seclusion incidents was expected to be complete by October 2024 however due to unexpected delays related to the working group capacity, this is now expected in March 2025
- This review will be presented, and progress monitored through the monthly Trust Reducing Restrictive Practice Group when completed.

Quality Performance



Summary

The number of falls recorded have followed a common cause variation pattern between October 2024 and January 2025 and is currently under the Trust threshold of 28 as expected. The Older persons service have also reported that from September 2024 there has been an increase in frail patients who have high levels of physical care needs.

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

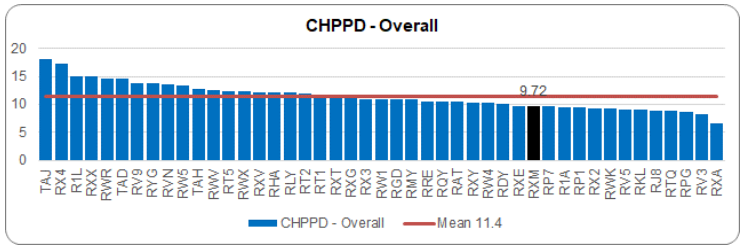
Actions

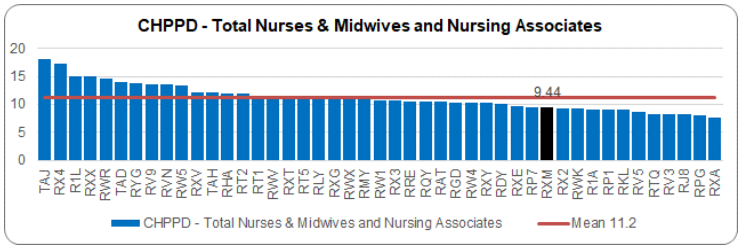
- All patients identified as high risk of falling are discussed in the bi-weekly falls prevention meeting and have fall prevention care plans in place.
- Support from a dedicated falls prevention Physiotherapist has not been embedded as expected and this has been escalated to a newly recruited Physiotherapy lead in January 2025.
- The number of falls reported is monitored via the Falls Lead Occupational Therapist, Head of Nursing and Clinical Matron and learning from the bi-weekly falls prevention meeting is reviewed in the monthly Divisional COAT meeting.

Care Hours per Patient Day (CHPPD)

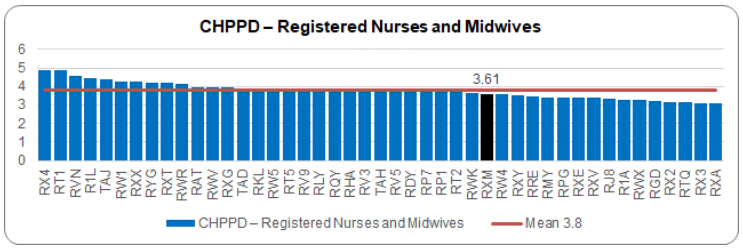
CHPPD is rolling data updated monthly, to show staffing levels in relation to patient numbers on an inpatient ward. Every month, the hours worked during day shifts and night shifts by registered nurses and midwives and by healthcare assistants are added together. Each day, the number of patients occupying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

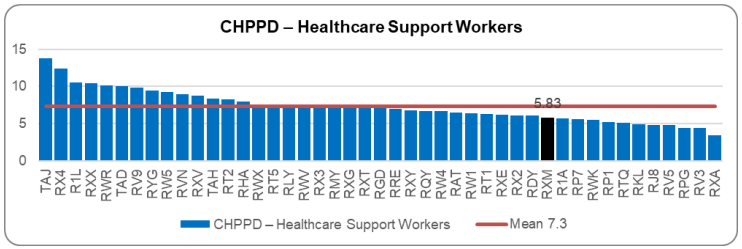
The charts below indicate that the Trust's CHPPD overall achieved 9.72 hours, which was below average when benchmarked against other mental health trusts in the country (11.4). For total nurses and nursing associates the Trust achieved 9.44 hours against the national average of 11.2 hours:





For registered nurses the Trust achieved 3.61 hours against the national average of 3.8 hours. For healthcare support workers the Trust achieved 5.83 hours against the national average of 7.3 hours:



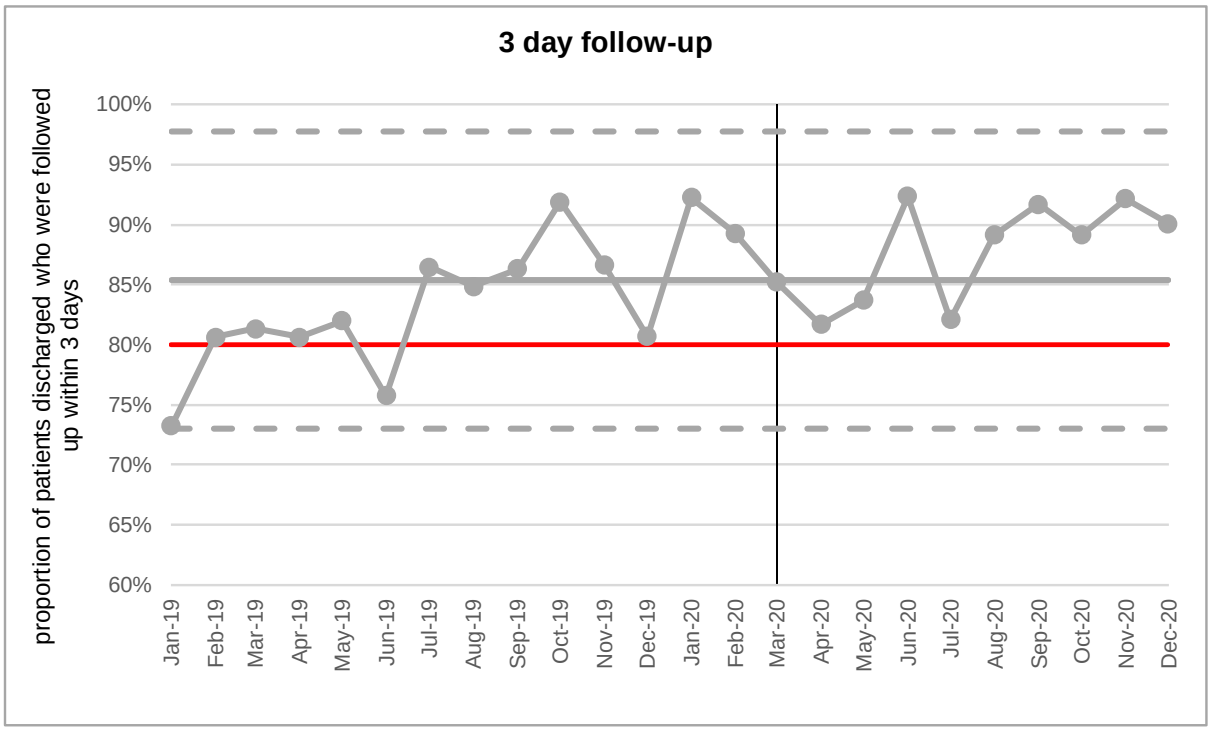


https://www.england.nhs.uk/publication/care-hours-per-patient-day-chppd-data/

Appendix 1

Statistical Process Control Chart (SPC) Guidance

Example SPC chart:



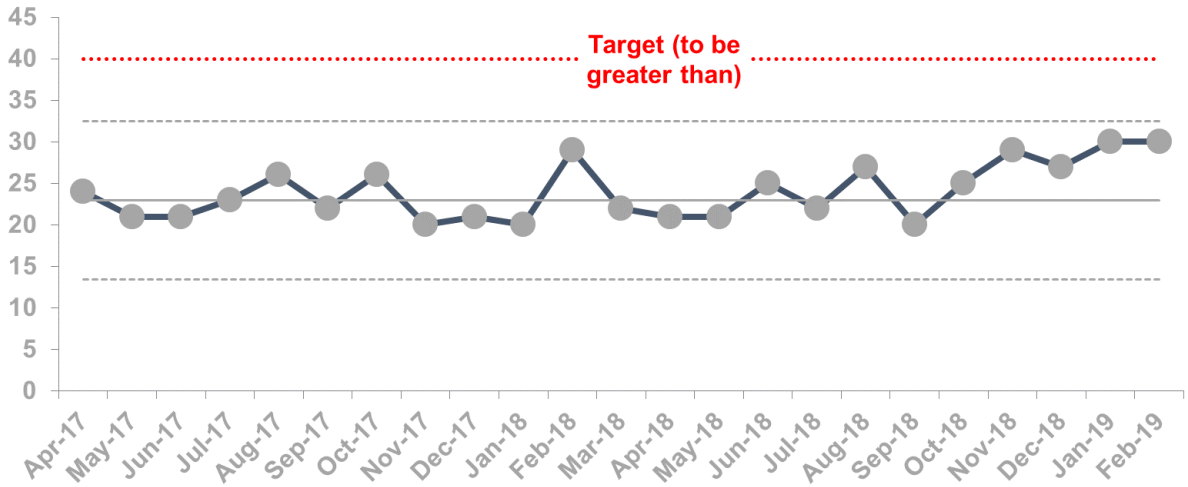
- The red line is the target
- The grey dots are the actual performance each month. They are coloured grey as performance each month is normal in this example
- The solid grey line is the average (mean) of all the grey dots
- The grey dotted lines are called process limits, or control limits.

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

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

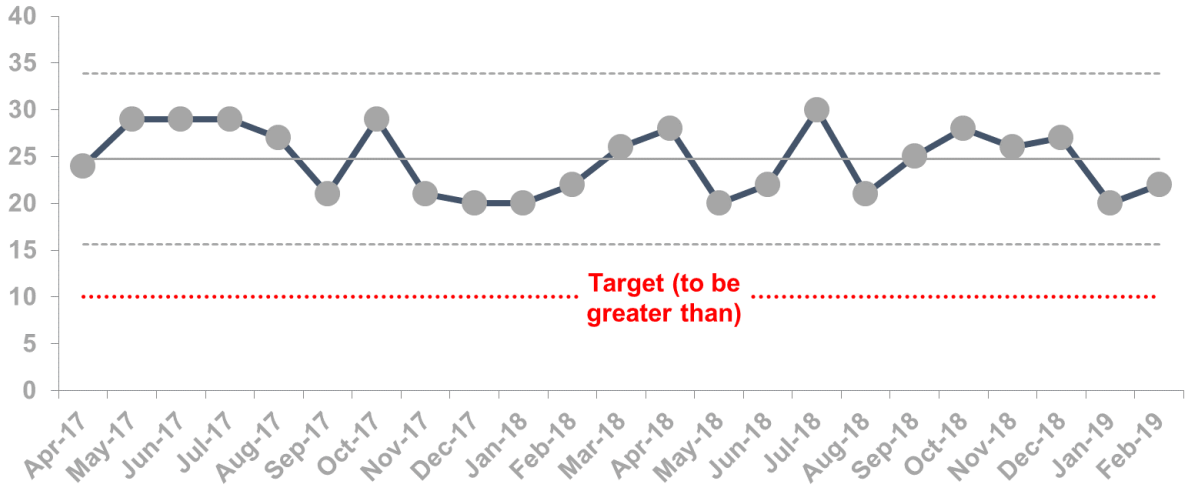
Things to look out for:

1. A process that is not working:



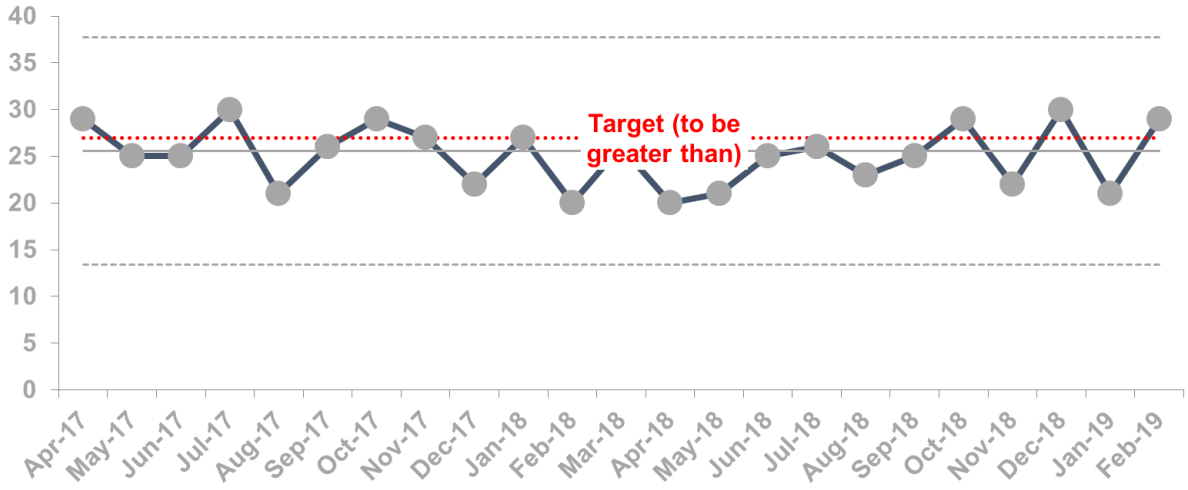
In this example the target is higher than the upper dotted grey line. This means that the target will never be achieved. To achieve the target, we need to change how we do things.

2. A capable process:



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

3. An unreliable system:

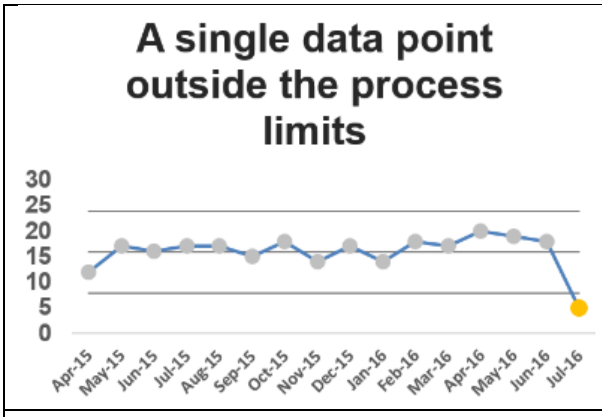
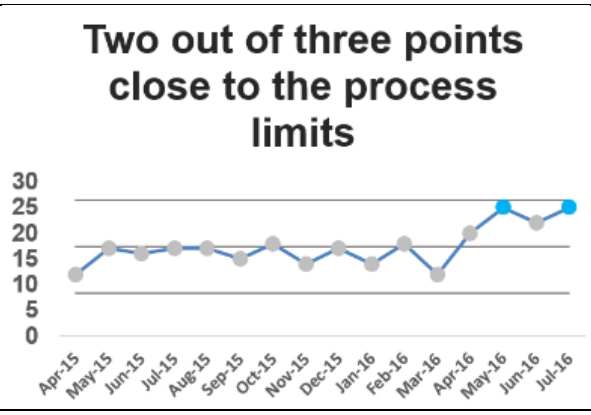
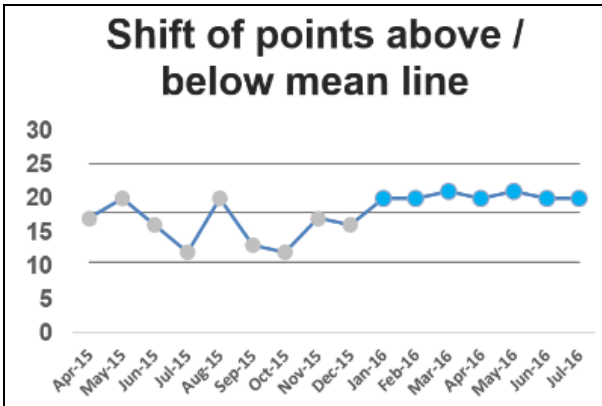
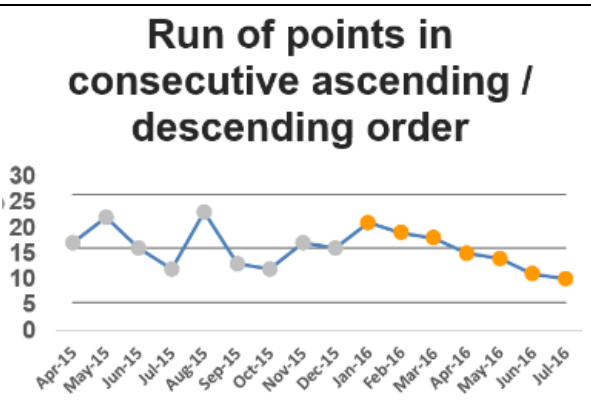


In this example, the target line sits between the two grey dotted lines. As it is normal for the grey dots to fall anywhere between the two dotted grey lines, this means that it is entirely random as to whether or not the target will be achieved. So, this system is unreliable and needs to be redesigned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

4. Unusual patterns in the data

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

There are four scenarios where this can happen:

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

Frequently seen in the NHS:

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

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

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

Appendix 2

Assurance Ratings

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 4 March 2025

Strategic Plan 2025-2028

Purpose of Report
To present the final draft version of the Strategic Plan 2025-2028 for approval by the Board.

Executive Summary
The new Trust Strategy was launched in October 2024 and action has since been progressed in developing an associated Strategic Plan to enact the ambitions described within this. A draft Strategic Plan for 2025-2028 was initially compiled based on the outputs of the board development session on 18 October 2024, and the dialogue on transformational opportunities hosted at the staff conference on 23 October 2024. The first draft Strategic Plan content was reviewed and developed through a further, full day workshop-style Board Development Session on 18 December 2024. The leadership forum on 20 January 2025 was harnessed as an opportunity to socialise the Strategic Plan content with leaders across the organisation. Outputs of the above sessions were applied to refine plan content, and a further draft was produced in February for validation and development by the Executive team. On 25 February 2025, the draft Strategic Plan 2025-2028 was presented to the Executive Leadership Team, and then presented for discussion at the Board Development Session on 26 February 2025. A number of minor edits agreed via the latter discussion are reflected in the enclosed final draft version. Action is in progress to map the assurance section of the plan to the Trust governance framework and committee work schedules, ensuring completeness of assurance across all priorities to relevant oversight forum. Content is also being mapped to Executive Director objectives with subsequent cascade to be enacted through teams and personal development plans across the organisation. Further activities will be planned to cascade plan content within the organisation once the final version is approved and published.

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 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 has been developed through engagement and consultation through two Board Development Sessions, the Staff Conference, and the Leadership Forum.

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

Recommendations

The Board of Directors is requested to approve the final draft Strategic Plan 2025-2028 for implementation.

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

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

Derbyshire Healthcare
NHS Foundation Trust

DRAFT

Strategic Plan

2025 - 2028

1. Patient focused

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

NHS Derbyshire Healthcare NHS Foundation Trust

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

'Breakthrough' Continuous Improvement Priority: To promote timely, high quality and personalised care

2. 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			Strategy into action metrics	Executive lead and forum for delivery management	Assurance source and forum
	2025-26	2026-27	2027-28			
2.1 Be recognised for attracting and retaining the best people	Improve our recruitment and retention processes and systems to provide assurance on the experience of our people Support managers to support our people to fulfil their potential and deliver new roles Further mature and embed our workforce planning approach and develop multi-year Trust strategic workforce plan which reflects our role as system partner.	Evaluate recruitment and retention outcomes and deliver year 2 development plan with focus on delivering to top of professional standards Refresh workforce plan and implement agreed developments for year 2	Evaluate recruitment and retention outcomes and deliver year 3 development plan with a focus on career progression pathways Refresh workforce plan and implement agreed developments for year 3	Targeted improvement across the following in identified teams/ areas: - Improved recruitment KPI's - Reduction in vacancies - Reduction in turnover Application of diverse recruitment approaches	Director of People, Organisational Development & Inclusion Divisional Performance Reviews	People Performance Report People and Culture Committee
2.2 Be recognised for supporting and developing our people to work confidently in their roles	Launch roadmap for leadership development and roll out year 1 plan including senior leadership programme Embed talent management and succession planning framework Develop standards and governance for advanced professional practice across roles Develop learning culture for all staff including regular career conversations	Evaluate leadership development roadmap progress and deliver year 2 plan based on intelligence from talent management Embed effective CPD programme across all disciplines with development plan focus on delivering to top of professional standards	Evaluate leadership development roadmap progress and deliver year 3 plan based on intelligence from talent management Evaluate CPD programme and establish plan for ongoing development towards all staff delivering to the top of professional standards	Growth of talent pools across all roles by 2028 Demonstrated improvement in people development measures	Director of People, Organisational Development & Inclusion Training and Education Group	People Performance Report People and Culture Committee
2.3 Be recognised by our people for our values driven and inclusive culture	Embed personal accountability charter within the people management and appraisal framework and develop competence of managers in restorative just culture 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 Refresh and deliver improvement plans for Workforce Race Equality and Disability Equality Standards	Evaluate impact of personal accountability charter and deliver action plan for ongoing development Establish plan to develop earned autonomy culture Promote cultural awareness aligned to national frameworks Refresh and deliver improvement action plans for improvement Workforce Race Equality and Disability Equality Standards	Evaluate impact of personal accountability charter and deliver action plan for ongoing development Embed processes to develop earned autonomy culture Evaluate cultural awareness aligned to relevant national frameworks Refresh and deliver improvement action plans for Workforce Race Equality and Disability Equality Standards	Assurance on impact of personal accountability charter and development of earned autonomy culture Increased diversity of workforce aligned to WRES and WDES Diversity of workforce that aligns with our local population	Director of People, Organisational Development & Inclusion EDI Steering Group	People Performance Report People and Culture Committee
2.4 Be recognised as a Trust that supports and promotes the wellbeing of our people	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 Continue to embed annual health and wellbeing assessment and deliver year 1 development plan Develop psychology support and offer for staff Review and refine attendance management policy and approaches to support colleagues and managers	Refresh health and wellbeing assessment and deliver action plan for ongoing development Benchmark and further develop competitive staff benefits and wellbeing offer	Refresh health and wellbeing assessment and deliver action plan for ongoing improvement Benchmark and further develop competitive staff benefits and wellbeing offer	Improvement against baseline health and wellbeing assessment Targeted improvement in sickness absence across identified teams/ areas	Director of People, Organisational Development & Inclusion Divisional Performance Reviews	People Performance Report People and Culture Committee
			Measure cross cutting 2.1 to 24 above:	Top quartile performance in national staff survey response rates and across all outcomes by 2028	Director of People, Organisational Development & Inclusion Executive Leadership Team	Staff Survey Report People and Culture Committee

3. 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			Strategy into action metrics	Executive lead and forum for delivery management	Assurance source and forum
	2025-26	2026-27	2027-28			
3.1 Achieve financial sustainability through improved clinical and operational productivity	Agree core priorities and deliverables for 25-26, to include reduction of OOA and premium spend Deliver agreed financial plan on pathway towards financial balance and sustainability Deliver year 1 plan for international medical recruitment on path to eradicate medical agency spend Understand productivity and sustainability across all services and plan for optimisation or consider exit Implement data flow for new national currency model Develop literacy of our people in financial, capacity and activity planning	Agree core priorities and deliverables for 26-27 Deliver agreed financial plan on pathway towards financial balance and sustainability Deliver year 2 plan for international medical recruitment on path to eradicate medical agency spend Implement demand and capacity planning Undertake annual productivity evaluation based on business modelling and benchmarking and implement year 2 plan	Agree core priorities and deliverables for 27-28 Deliver agreed financial plan on pathway towards financial balance and sustainability Deliver year 3 plan for international medical recruitment and eradicate medical agency spend in 2028 Embed demand and capacity planning Undertake annual productivity evaluation based on business modelling and benchmarking and implement year 3 plan	Delivery of agreed financial plan Delivery of efficiency plan Annual reduction of premium spend aligned to national targets Year on year increase on baseline productivity	Director of Finance Executive Leadership Team	Finance Report Transformation and Improvement Report Finance and Performance Committee
3.2 Transform our clinical pathways and operating model	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 Design and implement new operating model and accountability framework for delivery of services Design and launch transformation plan for corporate services Implement year 1 of agreed transformation programme Implement transformation and improvement framework Develop population health approach within the clinical transformation programme	Undertake annual evaluation and transformation portfolio refresh Implement year 2 of agreed clinical and corporate transformation programme Embed transformation and improvement framework . Evaluate effectiveness of operating model and consider need for further development Embed population health approach within the clinical transformation programme	Undertake annual evaluation and transformation portfolio refresh Implement year 3 of agreed clinical and corporate transformation programme Evaluate impact of and refresh transformation and improvement framework	Shift in budget from acute to community care by 2028 Achievement of waiting times standards, reduced ward length of stay and zero inappropriate OOA placements Year on year reduction of corporate cost base Growth of new services and income by 2028	Chief Delivery Officer and Deputy CEO Strategic Portfolio Oversight Group	Transformation and Improvement Report Finance and Performance Committee
3.3 Optimise our assets and enabling resources to improve services and care	Deliver and track realisation of intended benefits from the Making Room for Dignity programme Launch and deliver year 1 of agreed Estates Plan 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	Track and optimise realisation of benefits from the Making Room for Dignity programme. Deliver year 2 of agreed Estates Plan Deliver year 2 of agreed Digital Plan with focus on optimising 'end to end' digital workflow to release capacity and time to care	Track and optimise realisation of benefits from the Making Room for Dignity programme. Deliver year 3 of agreed Estates Plan Deliver year 3 of agreed Digital Plan with a focus on achieving recognition as exemplar site	Year on year reduction in estates cost Optimised utilisation of all estate by 2028 Digital maturity Optimisation of EPR	Director of Finance Estates Strategy Group Clinical Digital Board	Estates Report Digital Report Finance and Performance Committee
3.4 Reduce emissions we control directly (the NHS Carbon Footprint)	Deliver year 1 of agreed Sustainability Plan and achieve a reduction on emissions in 2025-26 on course for 80% long term target	Deliver year 2 of agreed Sustainability Plan and achieve a reduction on emissions in 2026-27 on course for 80% long term target	Deliver year 3 of agreed Sustainability Plan and achieve a reduction on emissions in 2027-28 on course for 80% long term target	80% reduction on the emissions we control directly by 2028 to 2032	Director of Finance Estates Strategy Group	Sustainability Report Finance and Performance Committee

'Breakthrough' Continuous Improvement Priority: Promoting value adding activities and releasing time to care across all services and clinical pathways

4. 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			Strategy into action metrics	Executive lead and forum for delivery management	Assurance source and forum
	2025-26	2026-27	2027-28			
4.1 Build partnerships that deliver on the needs of our communities	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 Develop our role as Perinatal Lead Provider and in leading Gambling Harm services within the East Midlands. Develop our strategic partnership with University of Derby and associated implementation plan Develop partnerships within the JUCD Provider Collaborative with a year one focus on collaboration across services for Children and Young People Deliver Community and Stakeholder Engagement Plan with year 1 priority focus on the deaf community, black communities and new migrant families Proactively engage with regional and national learning collaboratives Work in partnership to develop financial model and full business case for income generating business unit	Continue to develop our partnership within the East Midlands Alliance and define year 2 priorities for partnership collaboration Continue to develop our role as Perinatal Lead Provider and in leading Gambling Harm services within the East Midlands. Further develop strategic partnership with University of Derby and agree year 2 priorities Review opportunities and agree year 2 priorities for further collaboration within the JUCD Provider Collaborative Review progress, agree and deliver priorities for year 2 Community and Stakeholder Engagement Plan Proactively engage with regional and national learning collaboratives Operationalise and embed income generating business unit	Continue to develop our partnership within the East Midlands Alliance and define year 2 priorities for partnership collaboration Continue to develop our role as Perinatal Lead Provider and in leading Gambling Harm services within the East Midlands. Further develop strategic partnership with University of Derby and agree year 3 priorities Review opportunities and agree year 2 priorities for further collaboration within the JUCD Provider Collaborative Review progress, agree and deliver priorities for year 3 Community and Stakeholder Engagement Plan Proactively engage with regional and national learning collaboratives Deliver plan for development of income generating business unit and service offer	Growth of services delivered in collaboration and partnership by 2028 Improvement on baseline feedback from communities by 2028	Chief Executive Strategic Portfolio Oversight Group	Business Environment Reporting Integrated Performance Report Finance and Performance Committee
4.2 Excel in our role as an anchor organisation	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	Deliver action plan priorities with a focus on prioritising employability and engaging and enabling local suppliers Actively collaborate with our partners to deliver an inclusive wellbeing economy	Deliver action plan priorities with a focus on further developing how communities benefit from our property and assets, and our role in sustainability Actively collaborate with our partners to deliver an inclusive wellbeing economy	Improvement on baseline metrics across all five anchor development priorities by 2028	Chief Delivery Officer and Deputy CEO Strategic Portfolio Oversight Group	Strategic Progress Report Board of Directors
4.3 Achieve University Hospital Trust status	Develop our strategic partnerships with academic institutions and deliver year 1 plan to develop research capability Design and implement year 1 of action plan to be a centre for education across disciplines and achieve University Hospital Trust status	Continue to develop our strategic partnerships with academic institutions and deliver year 2 plan to develop research capability Review progress and implement year 2 of action plan to be centre of education and achieve University Hospital Trust status	Establish formal partnership agreements with academic institutions Achieve Centre for Education and University Hospital Trust status	Achievement of University Hospital Trust status in 2028	Medical Director Strategic Portfolio Oversight Group	Strategic Progress Report Board of Directors

‘Breakthrough’ Continuous Improvement Priority: Working together with communities and partners to deliver what is needed, when it is needed

In 2028 we will….

Derbyshire Healthcare NHS Foundation Trust

- Achieve national top quartile performance across all safety, effectiveness and experience measures
- Be recognised by patients and carers for empowering and supporting autonomy
- Have improved access to our services and achieve all target wait times
- Achieve an outstanding rating from the Care Quality Commission

- Meet the needs of our communities through seamless and integrated pathways
- Have grown our services delivered in collaboration and partnership
- Be recognised by our communities as excelling in action as an anchor organisation
- Achieve University Hospital Trust status as reflected in growth of our education, training and research capabilities

- Achieve top quartile performance in national staff survey response rates and across all outcomes
- Be recognised by our people for our values driven and inclusive culture
- Have a happy and healthy workforce that is reflected within turnover and absence rates
- Have diversity of workforce that aligns with our local population

- Be in financial balance and have a five year plan to maintain financial sustainability
- Have reduced our cost base and grown our services
- Have delivered a shift in budget from acute to community care
- Be on track to achieve an 80% reduction in the emissions we control directly

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 4 March 2025

Joined Up Care Derbyshire Provider Collaborative - governance arrangements, work programme and Memorandum of Understanding

Purpose of Report

The purpose of this agenda item is to bring to the Board a compendium of a number of different documents relating to the JUCD provider collaborative, some of which are for approval and support, and some are for information and assurance. The specific purposes of the paper are to:

- Update the Board on some changes to the ways of working and meeting arrangements for the provider collaborative, and to seek Board approval to the revised Terms of Reference and the Partnership Document for the Collaborative
- Update the Board on the priorities and 2024/25 work programme for the Collaborative, to appraise the Board about the potential impacts and consequences of shared working and secure Board support for the direction of travel particularly in relation to enabling services
- Seek Board approval to the risk and gain share agreement (Memorandum of Understanding) for the Provider Collaborative.

Executive Summary

The body of the paper which follows summarises the recent development of the collaborative, including refreshed priorities, proposals to amend the governance and meeting structure. The paper describes the development of the collaborative's workprogramme and the risk and gain share memorandum of understanding that has been drawn up to regulate how the collaborative partners handle the costs and benefits of shared working. There are a number of attached documents in addition to the body report. The additional documents are:

1. Provider Collaborative Partnership Agreement
2. Provider Collaboration Board Terms of Reference
3. Provider Collaborative Executive Leadership Group Terms of Reference
4. Memorandum of Understanding and Risk and Gain Share Agreement
5. Provider Collaborative Workprogramme, (Power Point slides).

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

Risks and Assurances

As detailed in the individual documents.

Consultation

Shared with all JUCD Provider Collaborative partners.

Governance or Legal Issues

The paper deals with the governance of the collaborative and its relationship to Trust boards, noting that at this stage no formal delegation is being made to the Collaboration Board.

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:

EDI impact assessment falls within the relevant service specifications.

Recommendations

The Board of Directors is requested to:

1. Note the update on the provider collaborative's development, working arrangements and work programme, and support the commitment to collaborative working and shared services that is envisaged, with particular note to the enabling services work
2. Approve the Partnership document and Terms of Reference for the Provider Collaboration Board
3. Approve the Memorandum of Understanding and risk and gain share agreements and agree that minor future amendments to this may be made with the agreement of the Provider Collaboration Board.

Report presented and prepared by: **Tamsin Hooton**
Programme Director, JUCD Provider Collaborative

Joined Up Care Derbyshire Provider Collaborative: Governance arrangements, Work programme and Memorandum of Understanding

1. Background

The Joined Up Care Derbyshire (JUCD) Provider Collaborative is a partnership of the NHS Foundation Trusts and other main NHS providers in Derby and Derbyshire, which has been in place since 2022 as part of the Integrated Care System (ICS) architecture. In March 2023 the Partnership Agreement and Terms of Reference for the Collaborative were approved by Trust Boards.

Since that time the Collaborative has continued to develop and progress its working arrangements, including reviewing its priorities and developing a structured workplan to reflect these.

The collaborative's three priorities are:

- Working together to **improve productivity and efficiency**, supported by a strong system continuous improvement approach
- Developing **at scale integrated care models** and pathways that improve sustainability and outcomes, including addressing fragile services
- Standardisation, harmonisation and consolidation of **corporate and back-office functions**.

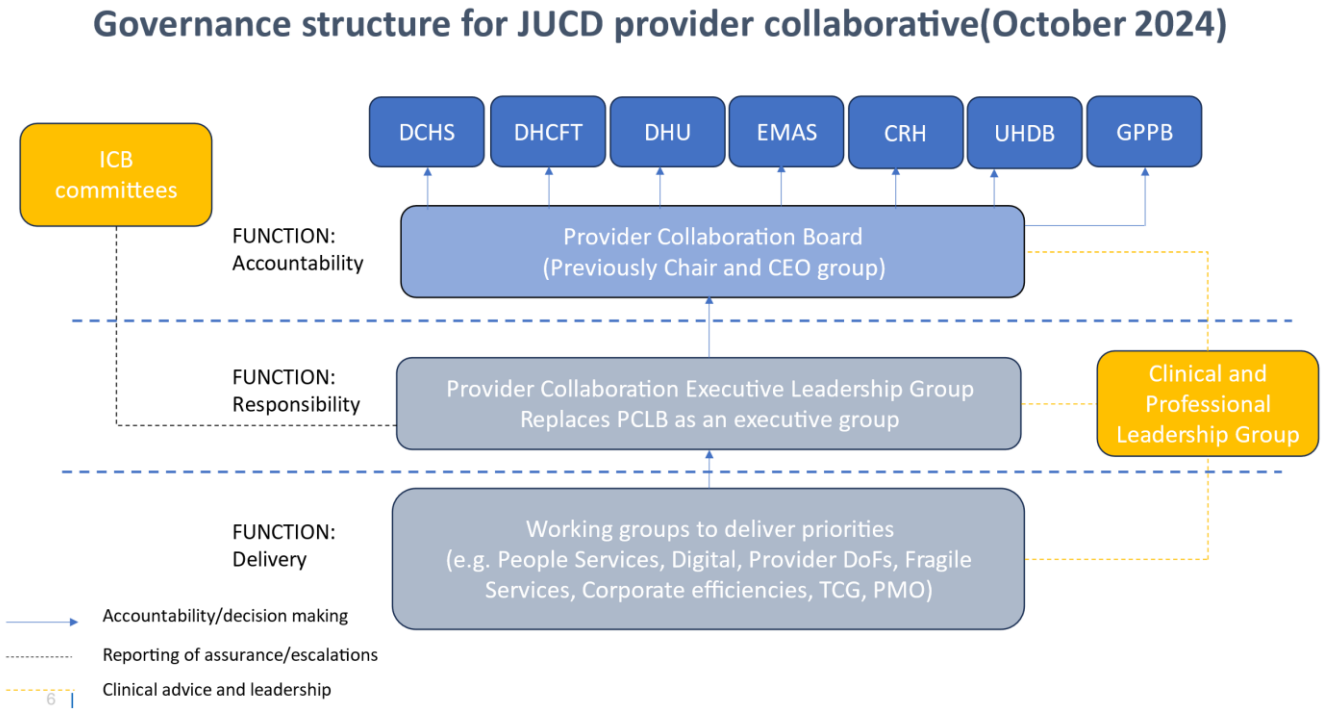
As an 'all in' collaborative we have recognised that there are many different scales and variations of collaboration and partnership working to address different problems, and not all providers need to be involved in every collaborative scheme. The collaborative acts as an umbrella for multiple different partnerships and alliances to solve different problems, supporting collaborations rather than being a homogenous entity. Examples of bi-lateral collaboration that are supported by the collaborative and respond to our shared priorities include the neurodivergence alliance between DHCS and DHCFT, CAMHs partnership work between DHCFT and CRH, CRH and UHDB working towards a partnership model of ophthalmology and the integration of urgent and emergency care provision between EMAS and DHU.

The past twelve months have seen the collaborative reappraise its focus and hone down our priorities, concluding that we must focus on doing a small number of things well at this stage of our maturity. We have undertaken a self-assessment using the national maturity matrix for collaboratives and are using this to help guide our development plan. We are 'developing' in relation to the national expectations of collaboratives, and have some areas of development, including programme delivery and impact on health inequalities among other things. Our focus is on the 'value added' through partnership working or integrated care, rather than having oversight of the combined responsibilities of existing statutory organisations.

2. Collaborative Governance and meeting structures

The collaborative was previously overseen by a Provider Collaborative Leadership Group, which was a CEO level group. As the collaborative has matured we have reviewed our ways of working, in response to an appreciation of our challenges and learning from other collaboratives and it is proposed to change the meeting structures for the Collaborative.

This will involve making the current informal Chairs and CEO group into a formal Provider Collaboration Board, which will provide the strategic leadership for the collaborative, and reframing the current PCLB into a Provider Executive Leadership Group, which will be responsible for our workplan delivery and will include a wider cross-section of Executives and programme SROs. The diagram below shows the future structure, which is operative from October 2024 but subject to formal sign-off by provider Boards.



Terms of Reference for the new leadership groups as well as an updated collaborative partnership agreement are attached to this report for approval by the Board.

3. Risk and Gain Share Memorandum of Understanding

As the provider collaborative matures and our collective work programme develops the Provider Collaborative Leadership Board concluded that it would be helpful to set out the key principles to support active partnership working and document our approach to the sharing of the risks and gains as a consequence.

The Joined-Up Care Derbyshire Provider Collaborative MoU establishes an agreed framework for managing risks and gains arising from collective endeavours and formalises the commitment made between the named parties to manage the costs and benefits of shared working, particularly where these may otherwise fall inequitably across partners. The MoU is attached as Appendix 4 and has a front section which sets out the principles that will govern our collaborative working, with a number of specific schedules setting out the details of how individual projects and financial commitments will be handled. The document has been agreed by the PCLB and PCB.

This document will be added to during our development through the addition of schemes as agreed with the mutual written consent of all parties. Individual collaborative schemes may set out further detailed arrangements for that specific area of collaboration in line with the high-level principles and objectives set out in this agreement. The Board is asked to agree that additional scheme schedules or minor changes to the risk and gain share may be agreed though the Provider Collaboration Board (PCB) without the need for individual Board approval, as long as the PCB members agree these do not constitute a material change to the principles and intent of the original document.

This MoU is not a legal document. It is not intended to be legally binding, and no legal obligations or legal rights shall arise between the partners from this memorandum. It is a shared understanding and commitment to a way of working between all the partners who have each entered it and does not replace or override the legal and regulatory frameworks that apply to our constituent organisations,. Instead, it sits alongside and complements these frameworks, creating the foundations for closer and more formal collaboration.

4. Provider Collaborative Workprogramme

The collaborative has developed a structured workplan of improvement projects which respond to our three priorities. There are 11 individual projects within the programme, which are summarised in more detail in Appendix 4. A more rigorous approach to defining programme benefits and impact is a current focus of our work. The PCELG will oversee delivery of the programme.

One of the greatest challenges for the collaborative, which affects progress and impact, is identifying sufficient resources to deliver our workprogramme and progress the opportunities that we have identified. The Collaborative is supported by a very small team consisting of two dedicated roles, a Programme Director and a Strategic Finance lead. The SRO for the collaborative, CEO of UHDB, as well as the SROs for the individual collaborative programmes of work, are all substantive provider executives from across the partner organisations. This time is given voluntarily, but releasing sufficient time to progress delivery of our objectives at pace in addition to existing responsibilities and operational pressures within statutory organisations remains an ongoing challenge. The collaborative leadership will need to help with identifying and releasing people to lead on agreed priorities. A discussion with the ICB about the potential for their staff to be aligned to transformation has also been raised.

There are similar constraints in releasing project management time. In some cases, we have been able to create new dedicated project roles, e.g. in ophthalmology, but workforce and financial constraints mean that doing this across all our programmes is unrealistic at this time.

4.1 Enabling Services

In addition to ongoing work to drive efficiency and better value for money through shared work on procurement, estates, workforce and digital, the Collaborative has agreed to consider the strategic and financial benefits of collaborating at greater scale across the range of enabling or 'back office' functions. Earlier this year the PCLB made a commitment in principle to move towards 'at-scale' delivery of enabling functions across the collaborative partners, to maximise the benefits of working together.

This programme of work is being led by Darren Tidmarsh as SRO, and a Steering Group representing organisational and functional leads for corporate services is in place. The intention is to look at opportunities for greater efficiency through harmonising, automating or consolidating services, doing this more consistently across multiple different functions rather than service by service.

We are seeking to bring in external support to help with understanding the value proposition and appraising the merits of different potential operating models, looking at best practice within the NHS and further afield. This work will include scoping the potential for greater use of AI and automation as well as the organisational model. The intention is to develop a business case for the optimum model which will come to provider Boards in due course. In doing this work, we will be looking at all potential models including in house, hosted, outsourced and wholly owned subsidiary models. The PCB has discussed this and agreed that there are no organisational 'red-lines' in relation to potential future delivery models, but that the options appraisal will need to be clear on risks and benefits, which will be looked at a system/collaborative level rather than from the perspective of individual organisations.

Any business case will need to set out a clear case for transformation and change, and it may be that benefits are not felt equally across the different collaborative partners, in which case we will need to test out the application of our MOU and risk and gain share.

Experience of partnership work on enabling services has been that while relationships are good and there is a willingness to work together, managers are often reluctant to consider making radical changes to how their functions are currently delivered. Strong leadership and a strategic drive towards being bold in the pursuit of best value, as well as a clear understanding of the benefits and costs of changing how we deliver services will be needed if this work is to genuinely help us to transform and innovate at scale. The Board is asked to support the direction of travel on enabling services and note that we will be seeking consensus decision making on any future business case.

5. Conclusion

The provider collaborative has made some good progress over the past twelve months in relation to clarity of focus, priorities and the development of a structured programme of work to deliver improvements to the way care is delivered and drive best value. The next phase of work will concentrate on delivery, whilst recognising the constraints in relation to capacity. Strong relationships, trust and a willingness to make decisions together in the interests of our population and the system will be needed to help us realise our ambition.

6. Recommendations

The Board is asked to:

1. NOTE the update on the provider collaborative's development, working arrangements and work programme, and SUPPORT the commitment to collaborative working and shared services that is envisaged, with particular note to the enabling services work
2. APPROVE the Partnership document and Terms of Reference for the Provider Collaboration Board
3. APPROVE the Memorandum of Understanding and risk and gain share agreements and agree that minor future amendments to this may be made with the agreement of the Provider Collaboration Board.

Joined Up Care Derbyshire (JUCD)
Provider Collaboration Partnership Working Arrangements
27th November 2024 v 1.2

Development / Changes from the previous version

Updated to reflect the change in the meeting structure and governance, and update some of the language to reflect the Collaborative Leadership Compact. This document sits alongside the Memorandum of Understanding agreed between the parties and the Terms of Reference of the collaborative leadership groups.

1. Background

1.1 National guidance on the role and function of the Provider Collaboratives[1] published in 2021 set out three key aims to deliver by working together at scale:

- Reduce unwarranted variation and inequality in health outcomes, access to services and experience
- Improve resilience by, for example, providing mutual aid
- Ensure that specialisation and consolidation occur where this will provide better outcomes and value.

Provider collaboratives are the vehicle for joining up the delivery of health care and vary in scale and scope. They are essential in the development of strong Integrated Care Systems (ICSs) as they can support and enable vertical integration (e.g., primary, community, local acute services) and horizontal integration (e.g. across multiple places or across multiple ICSs).

Provider collaboratives support improved decision making and delivery across multiple organisations. Through collaborating at scale, they can effectively align strategic decision making and make quicker and more effective decisions including standardisation of approaches and delivery where variation is unwarranted. Through working together providers can make the best use of the resources available and support the strategic aim of reducing health inequalities.

This can be over local areas known as being ‘at Place’ but sometimes, many people will have more complex or acute needs, requiring specialist expertise which can only be planned and organised effectively over a larger area than Place. This may be because concentrating skills and resources in bigger sites improves quality or reduces waiting times; because it is harder to predict what smaller populations will need; or because scale working can make better use of public resources. Because of this, some services such as hospital, specialist mental health and ambulance needs to be organised through provider collaboration that operates at a whole ICS area (or sometimes more widely).

The JUCD Provider Collaborative is an integral part of the ICS operating model and it has been agreed that provider collaboration at scale will comprise:

- Hospital Services (secondary, tertiary, networks)
- Mental Health
- Community Services
- Ambulance (999 & 111 / Urgent and Emergency Care)
- General Practice (In & Out of Hours Primary Care).

[1] B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf (england.nhs.uk)

The ICB membership includes the SRO for the provider collaborative, the CEO of the Community Trust and CEO of the Mental Health Trust as well as the GP Provider Board, and this ensures a link between the ICB and the Provider Collaboration Board.

This document does not seek to be binding but instead sets out the principles and approach to working together to deliver services for the people of Derby and Derbyshire which meet the quadruple aim of JUCD of:

- Improving experience of care (quality & satisfaction)
- Improving the health of the population
- Improving staff experience and resilience, and
- Reducing the per-capita cost of healthcare.

2. The providers

- Chesterfield Royal Hospital NHS FT
- Derbyshire Community Health Services NHS FT
- Derbyshire Healthcare NHS FT
- DHU Health Care CIC
- East Midlands Ambulance Service NHS Trust
- GP practices are represented by the GP Provider Board
- University Hospitals of Derby and Burton NHS FT.

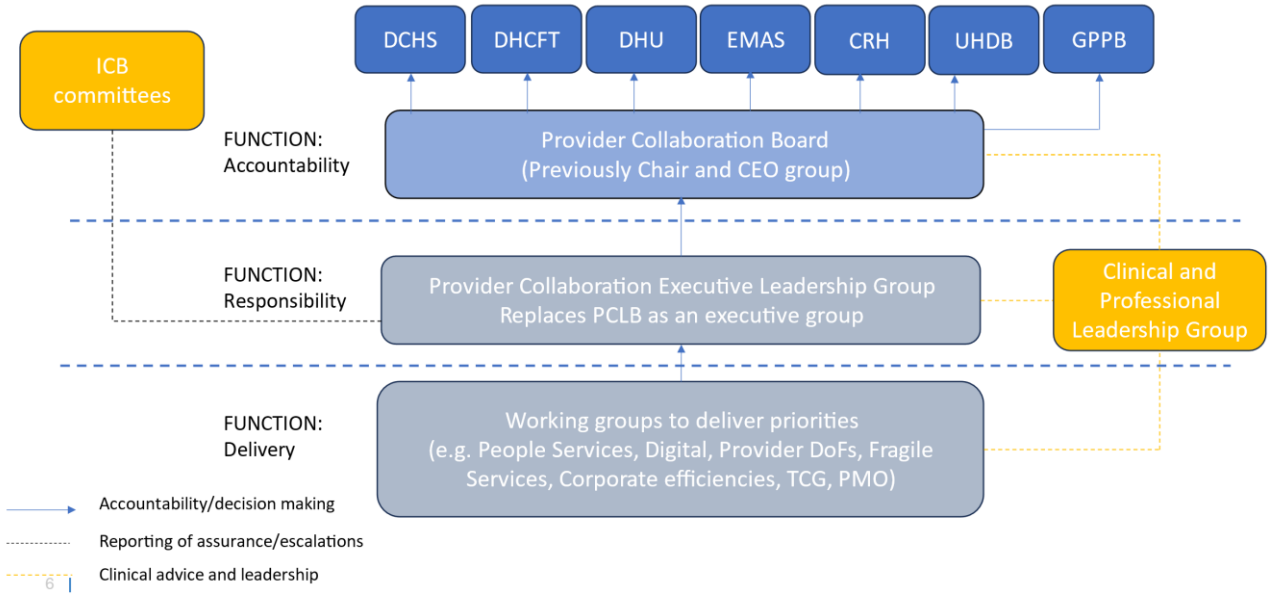
3. Governance Approach for provider collaboration

The governance of the provider collaborative consists of two main groups, a Provider Collaboration Board and Provider Collaboration Executive Leadership Group. The Provider Collaboration Board has been formed by the NHS and partner provider organisations in the JUCD ICS as a Board to provide strategic leadership to direct and maintain accountability for the collective work programme of the Derbyshire NHS Providers. Direct accountability is to provider Boards. The approach is in line with the requirements of the ICS Design Framework and the opportunities for different ways of working identified in the Health and Care Act.

The Provider Collaboration Executive Leadership Group is an executive group dedicated to developing the collaborative's workprogramme in order to deliver its priorities and objectives and driving delivery of the work plan.

The diagram below shows the governance structure of the Collaborative.

Governance structure for JUCD provider collaborative (Sep. 2024)



Whilst not accountable to the ICB Board, the Provider Collaborative is an important part of the ICS architecture, and the work of the collaborative contributes to the delivery of the ICS Strategy and JUCD Forward Plan. As such the Provider Collaboration Board will ensure that the collaborative's priorities and workprogramme are aligned to and support delivery of local strategies and objectives. Through the Chair of the PCB and the Provider Collaborative SRO (Chair of the PCELG) reports will be made to the ICB Board and sub-committees as required to give assurance that the collaborative is fulfilling its role within the ICS.

The providers acknowledge that arrangements will evolve and agree that the key to all collaboration is working together to build trust, and to begin with a streamlined governance structure and build as situations or emerging regulation require.

It is envisaged that in time the Provider Collaboration Board may take the form of a joint committee made up of the constituent organisations with delegations from these bodies to enable it to make appropriate decisions on their behalf. The Board is established by the providers, each of which remains a separate legal entity accountable for the services they provide, to ensure a governance framework for the further development of collaborative working between the providers.

The Provider Collaboration Board will determine the areas of which the provider collaborative will concentrate on and in doing this, clarity regarding any delegations required to enable effective delivery of agreed priorities will be determined.

The actions of the participants and bodies represented will:

- be driven by the interests of the people and communities served
- Support each other to address barriers to system transformation
- Design health, care and wellbeing services to meet the needs and wants of the people who use them, not the organisations who provide them
- Ensure services are provided as close as possible to the places people live.

To ensure these aims the Provider Collaborative Board and Executive Leadership Group will adopt the principles and behaviours set out in the Collaborative Compact which is attached as an Appendix to this document. In addition, the members of the PCB will:

- Function through engagement and discussion between its members. Any agreements reached at the Board will be enacted through the decision-making processes of the organisations involved
- Seek to reach consensus in deciding its recommendations and making decisions on system matters. The Chair will actively seek to reach decisions by consensus. If consensus cannot be reached, views which oppose the majority view will be recorded and presented with the report/advice ensure transparency.

The Board is made up of willing partners and as such, any of the member organisations can withdraw from the Board. This should be done in writing from the CEO and Chair of the organisation to the other Provider Collaborative Leadership Board members giving at least one months' notice. It should be noted that the legislation requires Acute and Mental Health providers (as a minimum) to be part of one or more provider collaboratives.

The work of the JUCD Provider Collaborative will be supported by a Programme Director who will work across the constituent bodies and be hosted by one of the provider organisations.

4. Membership and Business

Membership and quoracy arrangements for both the Provider Collaboration Board and the Provider Collaborative Executive Leadership Group are set out in their terms of reference. Membership of the two groups will reflect the need for senior leadership driving collaborations and the need to bring in a wide range of expertise.

Members of both groups are expected to:

- Accountable for contributing and taking personal responsibility for achieving the purposes set out in the Terms of Reference and taking forward relevant decisions to or on behalf of their organisations
- Expected to act as facilitators, providing effective communication for the programme to engage their respective organisations in the developments, modelling collective leadership
- Expected to provide information as necessary to support the undertaking of accurate analysis to inform developments
- Responsible for keeping their organisational board or equivalent updated on the progress of the ICS and the provider collaborative and will take key items for approval ensuring timely decision making does not delay the work of the ICS development and delivery
- Will confirm to all provisions regarding conflicts of interest detailed in the terms of reference. The approach to conflicts of Interest will be guided by the approach set out in NHS England » Managing conflicts of interest in the NHS and by the approach identified in Section G of the document *'Interim Guidance on the functions and governance of the integrated Care Board'* (NHS August 2021) or any updated versions.

Principles/ways for JUCD collaborative working	We will put the interests of our population and the **system first**, and be driven by the needs of our communities rather than our organisations We will design and deliver services that **improve people's experience** and outcomes from care and **address health inequalities** We will develop solutions that **improve the working lives**, health and wellbeing of our people We will take **joint ownership of our shared resources**/Derbyshire pound, and drive improvements to **productivity and efficiency** We will deliver care as **close to home** as possible

National leadership principles	Compassionate	Curious	Collaborative
Our leadership behaviours	Be inclusive, actively listening to one another and valuing different partners' perspectives Be open and honest about our challenges and what we cannot do Challenge each other respectfully and with compassion Support each other and seek to solve problems collectively Behave with kindness	Aim for the highest standards Support innovation and creativity Make decisions based on data and the evidence base Look forward, being prepared to challenge the status quo Be ambitious, and willing to make difficult decisions together Drive a culture of continuous improvement	Positively promote partnership and collaborative working across our organisations Support each other to remove barriers to transformation Act with integrity and do what we say we will Where there is conflict, be prepared to concede to reach consensus

Provider Collaboration Board

Terms of Reference

Draft 1.1 November 2024

1. Purpose

The Board provides the formal joint strategic leadership for the JUCD provider collaboration to enable the delivery of a shared agenda. It provides oversight for the development of clear strategic direction and accountability for the delivery of a robust, viable and deliverable and approach to collaboration and partnership working which meet the healthcare needs of the citizens of Derby and Derbyshire

The Board will be responsible for the following key functions:

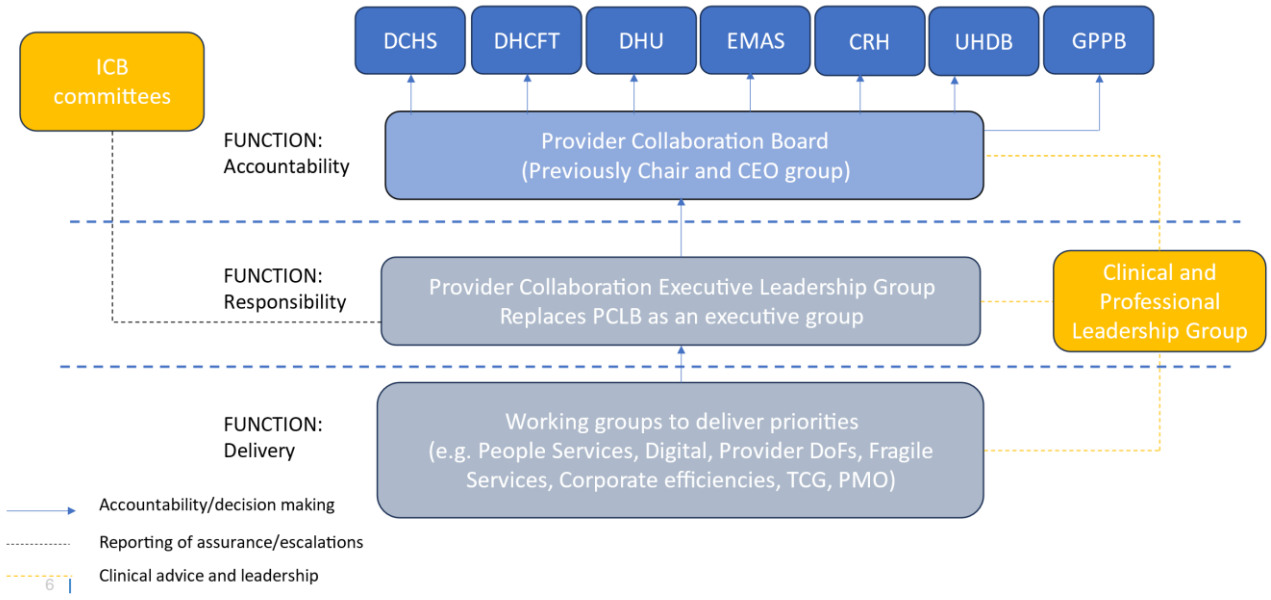
- Providing joint system leadership for partnership and collaborative working between providers
- Setting strategic direction and ambition in relation to collaboration to transform and address provider quality and efficiency,
- Establishing and maintaining the conditions for working together at scale with a shared purpose and effective decision-making arrangements
- Agreeing the strategic priorities for the collaborative, and approving the collaborative's work programme and annual plans
- Setting collaborative behaviours and ensuring that providers collectively resource agreed projects and programmes, and manage risks and gains resulting from this
- Providing shared accountability for the delivery of the agreed workprogramme, addressing any barriers or constraints that arise
- Agreeing the deployment of local assets and resources to deliver the collaborative's agreed objectives
- Overseeing the management of risks and agreeing actions to mitigate identified risks including resolving any issues that have not been resolved through the Executive Leadership Group
- Agreeing the strategic plan for collaboration for recommendation to Provider Boards and the ICB Board to contribute to delivery of the Joint Forward Plan

2. Accountability

The Provider Collaboration Board is directly accountable to the member provider Boards. The Chair represents the voice of the Provider Collaboration Board and will provide regular reports to Boards (including but not limited to, risk management and delivery).

The diagram below demonstrates the accountability and reporting arrangements for the provider collaborative.

Governance structure for JUCD provider collaborative (Sep. 2024)



Whilst not accountable to the ICB Board, the Provider Collaborative is an important part of the ICS architecture, and the work of the collaborative contributes to the delivery of the ICS Strategy and JUCD Forward Plan. As such the Provider Collaboration Board will ensure that the collaborative's priorities and workprogramme are aligned to and support delivery of local strategies and objectives. Through the Chair of the PCB and the Provider Collaborative SRO (Chair of the PCELG) reports will be made to the ICB Board and sub-committees as required to give assurance that the collaborative is fulfilling its role within the ICS.

3. Membership, attendance and responsibilities

The members of the Board will include the Chair and CEO of the respective JUCD provider collaborative partners, which are:

- Chesterfield Royal Hospital NHS FT
- Derbyshire Community Health Services NHS FT
- Derbyshire Healthcare NHS FT
- DHU Health Care C.I.C
- East Midlands Ambulance Service NHS Trust
- University Hospitals of Derby and Burton NHS FT
- JUCD GP Provider Board

In attendance

- Provider Collaborative Programme Director
- Specific individuals/roles supporting the development of the Provider Collaboration Board will also be invited to attend.

It is expected that members will prioritise meetings and make themselves available. Members, through notifying the Chair in advance of the meeting, may identify a deputy of sufficient seniority who will have delegated authority to make decisions on behalf of their organisation in accordance with the objectives set out in the Terms of Reference for this Board and relevant agenda items.

Members are expected to attend at least 75% of meetings held each calendar year to ensure consistency.

4. Quorum

The meeting will be quorate when each of the partners is represented by at least one person and there is at least one chair and one CEO present.

If any member of the Board has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum for that part of the meeting.

See section 8 for the provisions in relation to urgent meetings.

5. Chairing arrangements

The meeting will be chaired by one of the Chairs of the collaborative partner organisations, chosen through the agreement of the Chairs. The term of office will be for 12 months unless otherwise agreed by a quorate meeting of the Board.

Should the Chair or vice not be present at a meeting the core members present will agree which of their number will take the chair for that meeting.

6. Meeting Process

The group will meet formally bi-monthly as a minimum. The Chair may arrange extraordinary meetings at their discretion and if required to consider matters in a timely manner.

The meeting may be held, and meeting papers distributed, through electronic means. Where necessary, members will be required to respond to virtual electronic communications to consider issues.

The Chair will be responsible for agreeing the agenda; ensuring matters discussed meet the objectives as set out in these Terms of Reference and sent to members and attendees, unless by prior agreement, a minimum of two working days before the meeting. Additional items for the agenda will be taken by exception with the knowledge and agreement of the Chair in advance of the meeting commencing. Brief minutes of the meeting and a note of actions will be taken at the meeting.

The preparation and distribution of the agenda and meeting records will be supported by the provider organisation which takes the chair. The brief minutes and action notes will be circulated to members in a timely way and will be taken for approval at the next meeting.

There will be a standing agenda item at the end of each meeting to check the objectives have been met and review effectiveness of the discussions.

7. Delegated Authority

At this stage the Board has no formally delegated authority from the Boards of statutory organisations.

The seniority of individual members means that they are committing their respective organisations and making decisions within the scope of their own authority in tandem with other members of the group. Members will define and alert partners where they feel issues require reference to their Board.

As the collaborative matures, it may be appropriate for the Collaboration Board to take on more delegated authority, for instance becoming a joint committee of providers, as described in the Partnership Agreement. The Collaboration Board will be responsible for reviewing the governance arrangements for collaboration and for making recommendations for any changes to the constituent provider Boards.

8. Urgent Decisions

The Board may be required to take urgent decisions. An urgent decision is one where the requirement for the decision to be made arises between meetings and in relation to which a decision must be made prior to the next scheduled meeting. Where an urgent decision is required, a supporting paper will be circulated to all members. To reach a consensus view or make a decision the members may meet either in person, via video / telephone conference or (where meeting in person or remotely is not possible) communicate by email to take an urgent decision. Requests for all urgent decision will be made by the chair (or in the chair's absence the vice chair) and administered through the provider organisation which takes the chair.

The quorum will be as described in section 4. In such circumstances, a minute of the discussion and decision will be taken by the secretary and will be reported to the next meeting for formal ratification.

9. Conflicts of interest

As a Provider Collaborative Leadership Board not yet taking delegated decisions the requirements in relation to conflicts are less onerous, however it is felt important that good practice should be followed and therefore Members should adopt the following approach:

- That they continue to comply with relevant organisational policies/governance framework for probity and decision making.
- A register of interests will be recorded and maintained. This will be reviewed annually to ensure accuracy, in the intervening periods members should declare any unregistered interests pertinent to the agenda on an on-going basis. Members will be responsible for notifying the Chair of any changes to their respective declarations as and when they occur.
- In advance of any meeting, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals
- The Chair will take overall responsibility for managing conflicts of interest pertinent to agenda items as they arise; any such declarations will be formally recorded in the minutes of the meeting

- The Chair will determine how declared interests should be managed, which is likely to involve one the following actions:
    I. Allowing the individual to participate in the discussion, but not the decision-making process.
    II. Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the decision-making arrangements.
    III. Requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the discussions

In considering the approach to Conflicts of interest the Chair will take account of the guidance set out in NHS England » Managing conflicts of interest in the NHS and by the approach identified in Section G of the document Interim Guidance on the functions and governance of the integrated Care Board (NHS August 2021) or any updated versions including the advice that:

- It should not be assumed that members are personally or professionally conflicted just by virtue of being an employee, director, partner or otherwise holding a position with one of these organisations.
- Actions to mitigate Conflicts of Interest should be proportionate and should seek to preserve the spirit of collective decision-making wherever possible.
- ICBs should clearly distinguish between those individuals who should be involved in formal decision taking, and those whose input informs decisions, including shaping the ICB's understanding of how best to meet patients' needs and deliver care for their populations.

10. Review

The Board will review its effectiveness and approach to full status at every meeting and will periodically review progress of the collaborative against the provider collaboration maturity matrix.

In reviewing its effectiveness, the Board may amend its Partnership Document and Terms of Reference by resolution. The meeting will confirm whether the changes are substantive enough to require consideration by the provider Boards. Where this is indicated the changes will not take effect until the consultation has been undertaken. The revised Partnership Document and Terms of Reference will be shared with the ICB once confirmed.

These Terms of Reference will be reviewed at least annually to ensure good governance practice.

Provider Collaborative Executive Leadership Group

Terms of Reference

Draft 1.1 November 2024

1. Purpose

The Executive Leadership Group provides executive and senior leadership to develop, drive and deliver the workprogramme of the provider collaborative in order to deliver our shared ambition and strategic objectives. It is responsible for the development and delivery of a robust, viable and deliverable programme of transformation and improvement to deliver the agreed objectives of the provider collaborative, and meet the healthcare needs of the citizens of Derby and Derbyshire

The Provider Collaborative Executive Leadership Group (PCELG) will be responsible for the following key functions:

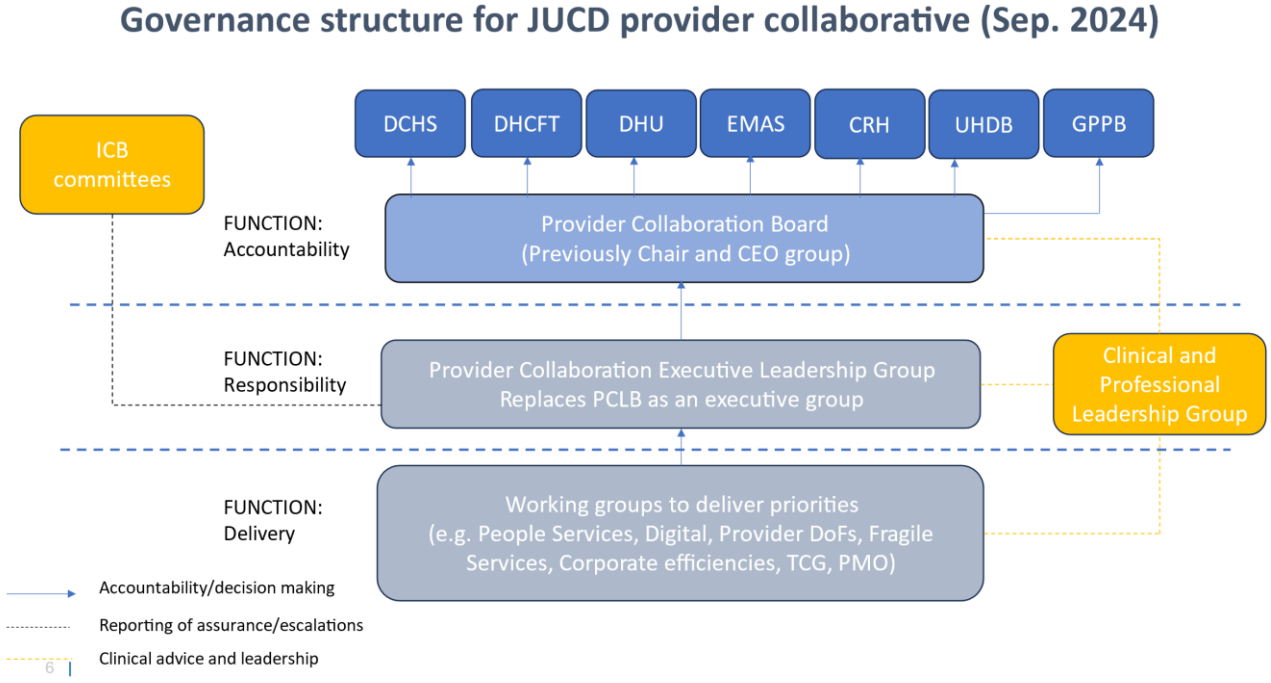
- Identifying and agreeing opportunities and priorities for collaboration in line with strategic objectives
- Leading the development and delivery of the collaborative workprogramme
- Providing joint system leadership to transform and address provider quality and efficiency, working together at scale
- Leading the development of solutions to improve the resilience and sustainability of services, ensuring that specialisation, integration or consolidation occur where this will provide better outcomes and value
- Agreeing the deployment of local assets and resources to deliver the collaborative's agreed objectives and workprogramme
- Managing risks and gains relating to the workprogramme in the first instance, in line with the agreed collaborative MOU
- Effective reporting on progress against the collaborative's workplan to the Provider Collaboration Board and other system leadership groups

2. Accountability and Reporting

The PCELG is accountable to the Provider Collaboration Board, and through that to Provider Boards. The Chair is the SRO for the Provider Collaborative and will provide regular reports including (but not limited to) programme delivery and risk management. In addition, an annual report will be provided to the ICB to include progress and a summary of key achievements.

The Chair is responsible for ensuring that relevant reports are made to the ICB or sub-committees and for proactively notifying the Chief Executive of the ICB of any matters pertinent to the business of the Collaborative including any key escalations that require ICB decision making. The PCELG will work closely with the Integrated Place Executive processes and individual organisations' lead officers within the ICS.

The diagram below shows the governance and reporting structure of the collaborative including the role of the PCELG.



3. Membership, attendance and responsibilities

The membership of the Group will consist of provider Chief Executive Officers, system executive SROs for the main Collaborative programmes, with additional Executive Directors or enabling function representatives to ensure a balanced representation across the provider members to enable effective discharge of the Group's responsibilities and oversight of delivery of the collaborative workprogramme. This will include executive directors responsible for key provider functions including finance, estates, procurement, digital and workforce along with a Medical Director and a chief operating officer.

The membership may change over time as the workprogramme develops, or to ensure a balance between provider, programme and functional representation overall. The Chair will be responsible for ensuring that the membership is reviewed and changes proposed to the CPELG as appropriate.

The membership at November 2024 will include:

- Chief Executive Officer UHDB, Chair of CPELG and SRO for the Provider Collaborative
- Chief Executive Officer of DHCFT (vice chair)
- Chief Executive officers from CRH NHS FT, DCHS NHS FT, DHU CiC,
- The Deputy Director of Strategy from EMAS will represent EMAS
- Chair of the GP Provider Board (or deputy)
- Chair of the Clinical and Professional Leadership Group
- Provider Collaborative Programme Director
- Medical Director UHDB & SRO for MSK
- Deputy CEO DCHS (Enabling Functions SRO)
- Chief People Officer UHDB (workforce SRO)
- Chief Financial Officer DHCFT (Estates SRO)
- Programme Director Digital and Data programme
- SRO for Collaborative Procurement work
- System lead for Allied Health Professionals & SLT SRO

- Strategic Finance Lead, Provider Collaborative
- Chief Nurse DCHS NHS FT
- Deputy COO CRH NHS FT & UHDB

In attendance

- By invitation – other partners / links from other systems or ICB
- Public Health and Health Inequalities Lead
- Governance and communications support (as needed)
- Specific individuals/roles supporting the development of the Provider Collaborative Leadership Board will also be invited to attend.
- Administrative support

It is expected that members will prioritise meetings and make themselves available. Members, through notifying the Chair in advance of the meeting, may identify a deputy of sufficient seniority who will have delegated authority to make decisions on behalf of their organisation in accordance with the objectives set out in the Terms of Reference for this Group and relevant agenda items.

Members are expected to attend at least 75% of meetings held each calendar year to ensure consistency.

4. Quorum

The meeting will be quorate when four of the provider Chief Executives or their deputies are present.

If any member of the Group has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum for that part of the meeting.

5. Chairing arrangements

The meeting will be chaired by a NHS Provider CEO and will be chosen through the agreement of the core members. The term of office will be for 12 months unless otherwise agreed by a quorate meeting of the Board.

Should the Chair or vice chair not be present at a meeting the core members present will agree which of their number will take the chair for that meeting.

6. Meeting Process

The group will meet on a monthly basis unless otherwise agreed. The Chair may arrange extraordinary meetings at their discretion and if required to consider matters in a timely manner.

The meeting may be held, and meeting papers distributed, through electronic means. Where necessary, members will be required to respond to virtual electronic communications to consider issues.

The Chair will be responsible for agreeing the agenda; ensuring matters discussed meet the objectives as set out in these Terms of Reference and sent to members and attendees, unless by prior agreement, a minimum of two working days before the meeting. Additional items for the agenda will be taken by exception with the knowledge and agreement of the Chair in advance of the meeting commencing. Brief minutes of the meeting and a note of actions will be taken at the meeting.

The preparation and distribution of the agenda and meeting records will be supported by the Programme Director of the provider collaborative and their team. The brief minutes and action notes will be circulated to members in a timely way and taken for approval at the next meeting.

There will be a standing agenda item at the end of each meeting to check the objectives have been met and review effectiveness of the discussions.

7. Delegated Authority

At this stage the Group has no formally delegated authority from the Boards of statutory organisations.

The seniority of individual members means that they are committing their respective organisations and making decisions within the scope of their own authority in tandem with other members of the group.

8. Urgent Decisions

The Group may be required to take urgent decisions. An urgent decision is one where the requirement for the decision to be made arises between meetings and in relation to which a decision must be made prior to the next scheduled meeting. Where an urgent decision is required, a supporting paper will be circulated to all members. To reach a consensus view or make a decision the members may meet either in person, via video / telephone conference or (where meeting in person or remotely is not possible) communicate by email to take an urgent decision. Requests for all urgent decisions will be made by the chair (or in the chair's absence the vice chair) and administered through the provider organisation which takes the chair.

The quorum will be as described in section 4 and will require the participation of four of the Provider Chief Executives or their deputies. In such circumstances, a minute of the discussion and decision will be taken by the secretary and will be reported to the next meeting for formal ratification.

9. Conflicts of interest

As the PCELG is not yet taking delegated decisions the requirements in relation to conflicts are less onerous, however it is felt important that good practice should be followed and therefore Members should adopt the following approach:

- That they continue to comply with relevant organisational policies/governance framework for probity and decision making.

- A register of interests will be recorded and maintained. This will be reviewed annually to ensure accuracy, in the intervening periods members should declare any unregistered interests pertinent to the agenda on an on-going basis. Members will be responsible for notifying the Chair of any changes to their respective declarations as and when they occur.
- In advance of any meeting, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed. This may include steps to be taken prior to the meeting, such as ensuring that supporting papers for a particular agenda item are not sent to conflicted individuals
- The Chair will take overall responsibility for managing conflicts of interest pertinent to agenda items as they arise; any such declarations will be formally recorded in the minutes of the meeting
- The Chair will determine how declared interests should be managed, which is likely to involve one the following actions:
    I. Allowing the individual to participate in the discussion, but not the decision-making process.
    II. Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to the decision-making arrangements.
    III. Requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to the discussions

In considering the approach to Conflicts of interest the Chair will take account of the guidance set out in NHS England » Managing conflicts of interest in the NHS and by the approach identified in Section G of the document Interim Guidance on the functions and governance of the integrated Care Board (NHS August 2021) or any updated versions including the advice that:

- It should not be assumed that members are personally or professionally conflicted just by virtue of being an employee, director, partner or otherwise holding a position with one of these organisations.
- Actions to mitigate Conflicts of Interest should be proportionate and should seek to preserve the spirit of collective decision-making wherever possible.
- ICBs should clearly distinguish between those individuals who should be involved in formal decision taking, and those whose input informs decisions, including shaping the ICB's understanding of how best to meet patients' needs and deliver care for their populations.

10. Review

The Group will review its effectiveness and approach to full status at every meeting and will periodically contribute to a review of progress against the provider collaboration maturity matrix, to be submitted to the Provider Collaboration Board.

In reviewing its effectiveness, the Group may amend its Terms of Reference by resolution. The meeting will confirm whether the changes are substantive enough to require consideration by the Provider Collaboration Board or and approval by provider Boards.

These Terms of Reference will be reviewed at least annually to ensure good governance practice.

` JOINED UP CARE DERBYSHIRE PROVIDER COLLABORATIVE

Memorandum of Understanding

Document History

Version Number	Revision date	Approved By	Approval Date	Description of Change
1.0	**19/08/2024**			**First Draft**
1.1	**17/09/2024**			**Second draft with comments by John Thorpe/Tamsin Hooton**
1.3	**19/09/2024**			**Third draft with comments by Tamsin Hooton**
1.4	**18/11/2024**			**Fourth draft with updates to Procurement scheme and inclusion of GP Provider Board as a party to this agreement**
1.5	**25/11/2024**			**Fifth draft with revision to align with revised governance arrangements and agreed Terms of Reference for new groups established**

1. Purpose

A Memorandum of Understanding (MoU) is a formal business document used to outline an agreement made between two or more separate entities, groups or individuals. The main purpose of the Joined-Up Care Derbyshire Provider Collaborative MoU is to establish an agreed framework and a written understanding of the commitment made between the named parties. This document serves as a MoU between the parties which sets out some key principles and approaches to handling partnership working, risks and gain sharing and will be added to during our development through the addition of schemes as agreed with the mutual written consent of all parties. Individual collaborative schemes may set out further detailed arrangements for that specific area of collaboration in line with the high-level principles and objectives set out in this agreement.

This MoU sits alongside the wider partnership agreement and Terms of Reference of the Provider Collaboration Board and Provider Collaborative Executive Group. It is not intended to be legally binding, and no legal obligations or legal rights shall arise between the partners from this memorandum. It is a shared understanding and commitment to a way of working between all the partners who have each entered it intending to honour all their obligations under it. It does not replace or override the legal and regulatory frameworks that apply to our constituent organisations,

which will have priority in the event of any conflict between those frameworks and this MoU. Instead, it sits alongside and complements these frameworks, creating the foundations for closer and more formal collaboration.

2. The parties to which this MoU applies.

Members of the Joined-Up Care Derbyshire Provider Collaborative and parties to this Memorandum are:

- Chesterfield Royal Hospital NHS Foundation Trust
- Derbyshire Community Health Services NHS Foundation Trust
- Derbyshire Healthcare NHS Foundation Trust
- DHU Healthcare CIC
- Derby and Derbyshire GP Provider Board
- East Midlands Ambulance NHS Trust
- University Hospitals of Derby and Burton NHS Foundation Trust

Additional partners may be added to individual specific schemes with the express agreement of all relevant parties. This may include Derby and Derbyshire Integrated Care Board where appropriate and where the collaboration will deliver maximum benefit from a system wide approach. Where this is the case the ICB will operate in line with the principles outlined in this agreement.

Partners all subscribe to the vision, principles, values and behaviours stated below, and agree to participate in the governance and accountability arrangements set out in this Memorandum.

3. Terms of this MoU

The MoU will commence on the date of signature of all the parties and will expire when superseded by another agreement by the parties. It will be subject to formal annual review and additions in-year in the form of schedules to the agreement as agreed by all parties. Any partner may exit the MoU by giving 6 months' notice in writing to the other parties at any time.

The annual review of this memorandum will be undertaken by the Provider Collaborative Executive Leadership Group (PCELG). If changes are proposed which are considered substantial by collaborative, then the revised memorandum will be taken through the Provider Collaboration Board (PCB) and sovereign boards , with the outcome reported back to thePCB.

4. Objectives of this agreement

- To set out our high-level principles which will underpin the collaborative's work programme.
- To ensure we align individual organisation's incentives with delivering the right outcomes for the collaborative and system.

- To set out a transparent and robust approach to risk / gain shares arising from collaboration on a scheme-by-scheme basis
- To facilitate a fair distribution of the financial consequences from collaborative working which is agreed and understood upfront.
- Provide partners with protection from a disproportionate loss or gain sitting with any one partner to the agreement.
- Protect all partners from a “loss of organisational memory” by having an agreement in place which supports the delivery of our collective priorities.

5. Principles, values and behaviours

- We agree that it is our collective responsibility to work together to ensure our services are sustainable, fit for purpose and provide good value for money for the population of Derby and Derbyshire.

- We will always act in good faith and in the best interests of the wider collaborative and the Derbyshire system.

- We agree to treat each other with respect and that no one provider is more important than another.

- We have mutual accountability for the delivery of the desired benefits for our collaborative activities

- We will promote a culture of collaboration within our organisations and empower our staff to work together across organisational boundaries in support of our collective objectives and priorities.

- We have shared ownership and management of the risks and opportunities that arise because of our collaborative work programme.

- We will make available sufficient resources to fulfil the objectives of the collaborative as set out in this agreement and the associated schemes.

- We commit to the principle of open book” accounting in respect of any service(scheme) which we agree to pool resources and collaborate on

- We will hold each to account, scrutinise and challenge each other constructively and be open ourselves to challenge from other parties to this agreement.

- We agree that all partners in the JUCD Provider Collaborative will be required to be participants in this over-arching agreement. For each associated scheme we will detail the parties involved in that specific activity and each partner retains the right " opt out " of a

particular scheme at the point of establishment. Details on how any partner withdrawing from a scheme once it has been established will be covered in the scheme specific detail.

- We will ensure that for each scheme we will be clear upfront regarding the key risks and opportunities, not just limited to financial, and each partners contribution to mitigating those risks and maximising the opportunities to drive out the desired benefits e.g. via a scheme level risks and benefits register.

- We recognise that the success of our collaborative will depend on each partner's ability to effectively co-ordinate and combine expertise, workforce and resources to deliver on our priorities.

- Further details of the agreed working arrangements are set out in appendix 1.

6. Responsibilities of all parties

Responsibilities of each of the parties are to:

- Work within the principles, behaviours and ways of working identified within this MoU.
- Contribute fully to our development into a mature and high functioning collaborative.
- Provide direction on key issues and areas of focus for the development of the collaborative.
- Use all reasonable endeavours to avoid unnecessary disputes and claims against any other partner
- Disclose to each other the full particulars of any real or apparent conflicts of interest in connection with this MoU.

7. Scope (addition of specific schemes)

As described in Section 1 schedules may be added to this MoU as we develop our work programme of collaborative activities. The schedules will include a scheme specification which will set out the bespoke arrangements for an individual scheme as agreed by the parties to this MoU to be included under this agreement via a variation agreed by all parties.

The scheme detail will include as appropriate financial arrangements, expected service levels, management of risks and how any variations in cost and performance will be managed and the circumstances under which the dispute and escalation process would be enacted.

Examples of relevant schemes include:-

Scheme 1 - Collaborative Procurement

Scheme 2- Provider Collaborative Resourcing/staffing arrangements

Scheme 3 - System PMO team

Scheme 4 - System Innovation Lead

8. Governance

The Provider Collaborative Leadership Board provides the over-arching formal leadership for the collaborative. It is responsible for setting the strategic direction for the collaborative, and agreeing the vision, outcomes, and objectives. It provides leadership and oversight for all collaborative business and a forum to seek collective support for decision making to progress the delivery of the vision for the collaborative. The PCELG will also act as the initial dispute resolution route for specific risk sharing arrangements where these have not been resolved at programme level (see section 11.)

The governance arrangements will vary by scheme and as part of the development of the supporting schedules to this MoU. For each scheme we will determine the relevant group that will have oversight of the delivery of the overall programme, make decisions and have responsibility for seeking assurance that risks and opportunities are being effectively managed on behalf of the collaborative. In addition, this group will be responsible for determining when any risk / gain share agreement is to be enacted.

9. Financials (scheme specific)

All partners will bear their own costs incurred in complying with this agreement save for the specific financial arrangements detailed in the scheme specific schedules which will form part of this agreement.

10. Risk and Gain Share arrangements

All partners are committed to the general principles of collective ownership of all risks and opportunities as a direct consequence of our collaborative activities, and the principles set out in section 4 and 5 of this agreement. Each scheme will detail the specific risk and gain share arrangements applicable to that area of our work programme.

Any disputes in relation to the application of the risk and gain share arrangements will be subject to resolution and escalation process detailed below.

11.Dispute Resolution and Escalation

All parties commit to working co-operatively to identify and resolve issues to mutual satisfaction to avoid as far as possible dispute or conflict in performing their obligations under this agreement.

If a problem, issue or dispute in relation to this agreement or any of its supporting schedules, comes to the attention of any party, then that party will notify other parties to the agreement.

The parties to this agreement agree to adopt a systematic approach to dispute resolution on matters pertaining to this agreement in accordance with the process outlined in the relevant schedule.

In the unlikely event that a resolution cannot be reached, the SRO and the relevant provider lead for the area in question will attempt to resolve the dispute, applying the principles in this agreement and any specifics relevant to the scheme. Where a resolution cannot be reached, there will be a formal escalation to PCELG.

The PCELG shall deal proactively with any dispute in accordance with the principles underpinning this agreement so as to reach a consensus decision. If the PCELG reaches a decision that resolves or otherwise concludes a dispute, it will advise all parties involved of its decision by writing.

All parties agree that if PCELG cannot resolve a dispute then the escalation route is to PCB. In the event that PCB are unable to resolve the dispute it may select an independent facilitator to assist. The process to appoint an independent facilitator will be overseen by PCB and the costs shared between the relevant parties agreed upfront.

12.Monitoring and Review

There will be a process for monitoring and review of this MOU in-year through the addition of schedules as agreed by all parties, with a formal review at least annually . The annual review process will be undertaken by the relevant group with oversight from PCELG, prior to formal approval by sovereign boards.

Where there is a significant change to the risk or benefit profile of a particular scheme in year, then the change will require approval by PCB and sovereign boards. The level at which this approval process will be initiated will be determined upfront as part of the development of the individual scheme details.

The addition of further schemes will be informed by the work plan of the Provider collaborative and as the case for change is developed. All schemes added to this agreement will be subject to the approval process outlined above.

13.Notice and Termination

All parties reserve the right to withdraw from this MoU or any of the underpinning schemes at any point by informing the other parties of their intention to do so in writing and with a minimum of six months' notice.

The scheme specific schedules will detail any further obligations on any party wishing to withdraw from this agreement early.

The PCB may resolve to terminate this agreement in whole where: -

- a dispute cannot be resolved pursuant to the dispute resolution procedure.
- automatically and immediately where there exists just one partner that remains a party to this agreement
- where all partners agree for this agreement to be replaced by a formal legally binding agreement between them.

Exclusion of a party to this agreement

- In the event of a material or a persistent breach of the terms of this Agreement by one or more parties, then the remaining parties will issue a formal notification of the dispute which will require resolution within 30 calendar days , which if not rectified will result in the partial termination of this agreement in respect of that partner(s)

Voluntary withdrawal of a party to this agreement

- Any party may withdraw from this Agreement by giving at least 60 calendar days' notice in writing to the other parties

14 INTRODUCING NEW PROVIDERS

Additional providers may become parties to this Agreement on such terms as all parties will jointly agree, acting at all times in accordance with the Collaborative Principles. Any new provider will be required to agree to the terms of this Agreement before admission.

15 Information Sharing and Confidential Information

It is essential to ensure full collaboration that relationships are built on mutual trust. Key to this is confidence that all parties will share all information that is required in order to achieve the best outcome for the citizens of Derbyshire and that the information that is shared is treated appropriately.

As such whilst nothing in this document impacts on providers' regulatory or statutory obligations it is anticipated / expected that:

- Providers will make sure that they share information, and in particular competition sensitive information, in such a way that is compliant with competition and data protection law. The approach will be in compliance with the Provider Selection Regime which it is anticipated will be included within the Health and Care Act.
- All providers will keep in strict confidence all confidential Information it receives from another provider.
- Providers will only use confidential information received from another provider for the purpose of collaboration and not for any other purpose.

16. INTELLECTUAL PROPERTY

In order to meet the objectives of the collaborative, each party grants to each of the other parties a fully paid-up non-exclusive licence to use its existing Intellectual Property provided under this

Agreement insofar as is reasonably required for the sole purpose of the fulfilment of that party's respective obligations under this Agreement.

If any party creates any new Intellectual Property through the operation of the Collaborative, the party which creates the new Intellectual Property will grant to the other parties a fully paid-up non-exclusive licence to use the new Intellectual Property for the sole purpose of the fulfilment of that party's obligations under this Agreement.

17. FREEDOM OF INFORMATION

If any party receives a request for information relating to this Agreement or the Integrated Services under the Freedom of Information Act 2000 or the Environmental Information Regulations 2004, it shall consult with the other parties before responding to such request and, in particular, shall have due regard to any claim by any other party to this Agreement that the exemptions relating to commercial confidence and/or confidentiality apply to the information sought.

18 Signatories

• Parties sign the agreement

Scheme 1 – Collaborative Procurement

Purpose of our collaboration

The Collaborative Procurement scheme has been established to take forward the development and oversee the delivery of a rolling joint work programme which maximises the system's opportunities for financial improvement through a collaborative procurement approach whilst ensuring that safety and quality standards are maintained.

Scope of the scheme

The default position is that this scheme covers all non-pay expenditure / contracts where it makes sense to collaborate across the JUCD Providers due to materiality and or opportunity to drive significant financial savings.

However, all partners retain the right to " opt out" of a particular contract or " line of expenditure" if better value can be obtained by collaboration outside of JUCD or there are significant quality and safety concerns which can be demonstrated to outweigh any financial gain. All partners agree to be open and transparent about any individual decision to " opt out" and share information and rationale accordingly.

Parties covered by the scheme (default all parties to MOU)

Excludes East Midlands Ambulance Service NHS Trust

SRO if applicable

Stuart Ellis

Responsibilities of each party

As detailed in the over-arching MoU

Each partner is required to actively engage and contribute to the agreed work programme, promoting and fostering a culture of collaboration in respect of procurement activities within each sovereign organisation.

Honour any financial or resourcing requirements agreed as part of the development of this scheme.

Reporting and Governance

Collaborative Procurement Steering Committee - responsibility for the delivery of the work programme, making shared decisions on key contracts ensuring system alignment and maximisation of value for money. Provide assurance into key system wide groups , escalating matters as necessary. Terms of reference for this group have been signed off by the Provider DOFs group.

Provider DOFs group - oversight of the overall work plan and provide a forum for decision, escalation and discussion on progress. Forum that considers and agrees any resourcing implications. This forum will also act as the first point of escalation for any disputes that cannot be satisfactorily resolved by the steering committee.

Provider Collaborative Leadership Board - will receive regular update and progress reports for assurance. This forum will act as the second escalation point for dispute resolution purposes.

Resourcing requirements

Dedicated staffing resource will be required to drive the work programme at the scale and pace required and will require investment from all parties which will be approved by the Directors of Finance

At a system level the expectation is that the " cost" of this will be offset by savings achieved in year because of participation in this scheme.

It is agreed to "share" the costs of resourcing amongst partners to the scheme on the basis of non pay budgets within the scope of this scheme. The work programme will be reviewed at the start of each financial year and where there is a material difference between the expected savings to be realised and the proportionate shares of in-scope non pay spend then an adjustment to the recharging arrangements will be agreed for that year only.

In any event , organisational shares will be actioned via the ICB allocation process and funding transferred to Chesterfield Royal NHS Foundation Trust as the agreed host employer for the central team.

Risk and Gain Share implications.

Each partner agrees to contribute to the central system resourcing requirements as agreed by the Provider DOFs to ensure the work programme progresses with necessary scale and pace.

Each partner will enjoy the savings realised through it's participation in this scheme as they fall and in relation to it's own contracts and non-pay expenditure.

To ensure this scheme drives the right behaviours, where a significant system financial benefit can be realised but this would cause a financial detriment to one or more partners, then all partners agree to adopt a net benefit position which will then be shared across all partners to the scheme based on proportion of relevant expenditure. The Strategic Finance Lead will support the SRO and programme lead in identifying opportunities where this principle is to be applied and to ensuring it is implemented in line with the agreement. This arrangement will be enacted and agreed by the Provider DOFs group on a case-by-case basis.

Review date

To be reviewed at least annually or when there is a significant change to the detail and or risk and benefit profile of the scheme.

Scheme 2 - Provider Collaborative Central Team Resourcing

Purpose of our collaboration

Ensure there is adequate resource of sufficient capability to help the collaborative function effectively across the spectrum of the work programme and our broader responsibilities with regards to system transformation and improvement

Scope of the scheme

The staff who make up the central team that supports the Provider Collaborative to deliver on it's priorities

Parties covered by the scheme (default all parties to MOU)

As per the MOU

SRO if applicable

Not applicable

Responsibilities of each party

Each partner is required to actively engage and support the provider collaborative central team in the discharge of their responsibilities.

Honour the financial commitment as detailed in this scheme.

Reporting and Governance

The Managing Director and the Strategic Finance lead will have lines of accountability to UHDB's chief executive officer and chief finance officer respectively acting as the host employing organisation.

Both postholders are accountable to the Provider Collaborative Leadership Board for the discharge of their responsibilities in progressing the priorities of the collaborative.

Resourcing requirements

Funding has been agreed to support the collaborative's central team structure which is made up of 2 full time posts of the Managing Director and the Strategic Finance Lead. It has been agreed that these posts will be hosted by UHDB acting as the host employer.

Funding adjustments will be actioned via the ICB allocation process to ensure that adequate funding is given to UHDB to cover the costs of employment in any given financial year.

Risk and Gain Share implications.

Each partner will contribute to the team costs in line with the agreed recharging schedule on an annual basis.

In the event that these posts are dis-established as part of a management of change process, each partner to this scheme agrees to endeavour to identify opportunities for re-deployment within their establishment. Where there are no suitable alternative employment opportunities identified, each partner will bear a share, in line with the agreed splits at that time , of any associated redundancy costs.

Review date

To be reviewed at least annually or when there is a significant change to the detail and or risk and benefit profile of the scheme.

Scheme 3 - System PMO Central Team Resourcing

Purpose of our collaboration

Ensure there is adequate resource of sufficient capability to help the JUCD e PMO system to function effectively across the spectrum of collaborative's work programme and the broader system transformation and improvement programme, and to support it's ongoing development.

Scope of the scheme

The staff who make up the central team that supports the e PMO and system wide Transformation programme.

Parties covered by the scheme (default all parties to MOU)

As per the MOU with the addition of the Derby and Derbyshire ICB

SRO if applicable

Not applicable

Responsibilities of each party

Each partner is required to actively engage and support the central team in the discharge of their responsibilities.

Honour the financial commitment as detailed in this scheme.

Reporting and Governance

The Director of PMO and Transformation will have accountability to the Provider Collaborative Managing Director.

The team will be responsible for the production of timely reports into system wide committees on the progress of the cost improvement plans as detailed in the e PMO alongside providing leadership, confirm and challenge and general support across the system's Transformation and Improvement programme.

Resourcing requirements

Funding has been agreed to support the agreed central team structure. It has been agreed that these posts will be hosted by UHDB acting as the host employer.

Funding adjustments will be actioned via the ICB allocation process to ensure that adequate funding is given to UHDB to cover the costs of employment in any given financial year.

Risk and Gain Share implications.

Each partner will contribute to the team costs in line with the agreed recharging schedule on an annual basis.

In the event that these posts are dis-established as part of a management of change process, each partner to this scheme agrees to endeavour to identify opportunities for re-deployment within their establishment. Where there are no suitable alternative employment opportunities identified, each partner will bear a share, in line with the agreed splits at that time , of any associated redundancy costs.

Review date

To be reviewed at least annually or when there is a significant change to the detail and or risk and benefit profile of the scheme.

Scheme 4 - System Innovation Lead

Purpose of our collaboration

An ICS Lead Innovation Lead post was established in JUCD, initially hosted by Derbyshire Healthcare from January 2023.

The role was established, in common with all other East Midlands ICSs, with the support of Health Innovation (HIEM) East Midlands to identify, test and spread new technologies and better ways of working whilst assisting the Integrated Care Board to meet their statutory obligations associated with research and innovation.

Scope of the scheme

The post holder will be hosted by Derby and Derbyshire ICB, the scheme covers the pay, non-pay costs for the innovation lead and any associated employment liabilities.

Parties covered by the scheme (default all parties to MOU)

As per the MOU with the addition of the Derby and Derbyshire ICB

SRO if applicable

Chris Weiner

Responsibilities of each party

Each partner is required to actively engage and support the innovation lead in the discharge of their responsibilities.

Honour the financial commitment as detailed in this scheme.

Reporting and Governance

The Innovation Lead has accountability to the ICB Medical Director.

The post holder will provide regular reports to system partners which detail the monies secured, the initiatives supported and the benefits generated.

Resourcing requirements

The post should be self-financing through a top slice (10%) of new innovation monies secured into the system by the postholder. The Derby and Derbyshire ICB is the host employer and therefore the ICB will retain the top slice monies to cover the costs of the post in any given year.

All partners agree to under-write any shortfall in funding in any given year in line with the established percentage shares used to apportion costs for other system wide roles

Risk and Gain Share implications.

Each partner will contribute monies to offset a funding shortfall in any given year in line with the established percentage shares.

Where a material surplus of funds in generated through the top-slice mechanism then there will be a system wide discussion on whether this funding to be invested to support agreed system priorities,

In the event that this post is dis-established as part of a management of change process, each partner to this scheme agrees to endeavour to identify opportunities for re-deployment within their establishment. Where there are no suitable alternative employment opportunities identified, each partner will bear a share, in line with the agreed splits at that time, of any associated redundancy costs.

Review date

To be reviewed at least annually or when there is a significant change to the detail and or risk and benefit profile of the scheme.

Joined Up Care Derbyshire

Provider Collaborative Work Programme Progress Update

November 2024

NHS

The Derbyshire VCSE sector Alliance

Derby City Council

DERBYSHIRE County Council

Contents

Provider Collaborative Priority	Workstream	SRO	Programme Lead
Productivity and efficiency, supported by continuous improvement approach	NHS Impact/continuous improvement	Tamsin Hooton Provider Collaborative Programme Director	Susan Whale, Director of PMO and Improvement
	System programme management and ePMO function	Tamsin Hooton Provider Collaborative Programme Director	Susan Whale, Director of PMO and Improvement
	Primary/Secondary Care interface	PC SRO TBC	Tamsin Hooton Provider Collaborative Programme Director
Sustainable, integrated care models including fragile services	Fragile Services	Tamsin Hooton Provider Collaborative Programme Director	Tamsin Hooton/various
	MSK	Gis Robinson, Executive MD, UHDB	Trish Bailey , DCHS
	SLT	Lucy Smith, Head of Therapies, CRH	Kate Cook/Lucy Smith
At scale corporate and enabling functions	At scale enabling functions model	Darren Tidmarsh, Deputy CEO DCHS Simon Crowther Deputy CEO UHDB	Tamsin Hooton Provider Collaborative Programme Director
	Estates	Simon Crowther Deputy CEO UHDB/ James Sabin CFO DHCFT	Cath Benfield, Strategic Finance Lead,, Matt Scarborough, ICS estates lead
	Procurement	Stuart Ellis, Commercial and Strategy Director DSFS	Programme Lead to be appointed
	People Services	Amanda Rawlings , Executive	Lyndsey Beardsley (Academy?)

Collaborative Work programme benefits map

Workstream	Benefit Type							
	Finance CRE	Finance VFM	Activity and Productivity	Performance	Quality	Safety	Staff Experience	Patient Experience
NHS IMPACT/ Continuous Improvement					●			
System Programme Management and EPMO Function		● (indirect)			●			
Primary/ Secondary care interface			●		●		●	
Ophthalmology			●	●	●		●	
MSK			●	●	●			
Children's Speech and Language Therapy			●		●		●	●
Enabling Services	● range £10m - £47m	●	●		●		●	
Estates	● £10m	● £6 - £7.5m				●		●
Procurement	● £675K in first phase £5m ambition	●					●	
Digital programmes			●		●		●	●
Workforce - Derbyshire Academy		● £10K to date		● 3,000 ANPs	●		●	
Workforce - Recruitment								
Workforce - Project Digital								

Delivery Board Workstreams / Programmes: Latest Status Report: Headlines. 15 Nov 2024

Workstream: Provider Collaborative **ID:** 25 **SYSTEM** **Del/Des:** DEL

Programme	Ben	Inis	Risks	Mits	Prog. Lead	Month	Previous	Current	Forecast	Timeline	Resources	Outcomes	Efficiencies	Partners:
CORPSER001 At Scale Enabling Functions Model		1		6	Tamsin Hooton (TH)	Oct-24 954		AMBER	GREEN	AMBER	GREEN	AMBER		DDICB-0 * UHDB-0 * CRH-0 * EMAS-0 * DCHS-0 * DHcFT-0
ESTRA001 Estates		1	5	1	Cath Benfield (CB)	Oct-24 944		AMBER	AMBER	RED	AMBER	RED		DDICB-0 * UHDB-0 * CRH-0 * EMAS-0 * DCHS-0 * DHcFT-0
FS-205 Integrated Clinical Pathways		1		4	Tamsin Hooton (TH)	Oct-24 956		RED	AMBER	RED	GREEN	AMBER		CRH-0 * DCHS-0 * DHcFT-0 * UHDB-0 * DDICB-0 * EMAS-0
CI-202 NHS Impact/Continuous Improvement		3	1	11	Susan Whale (SW)	Oct-24 948		AMBER	GREEN	AMBER	GREEN	AMBER		DCHS-0 * DHcFT-0 * EMAS-0 * UHDB-0 * CRH-0 * DDICB-0
PSI-204 Primary & Secondary Interface		1		1	Tamsin Hooton (TH)	Oct-24 955		GREEN	GREEN	AMBER	GREEN	AMBER		CRH-0 * GP-D-0 * UHDB-0
JPROC001 Procurement					Stuart Ellis (SE)	Oct-24 945		RED	AMBER	RED	AMBER	RED		DDICB-0 * UHDB-0 * CRH-0 * EMAS-0 * DCHS-0 * DHcFT-0
SPM-203 System Programme Management		2	3	12	Susan Whale (SW)	Oct-24 949		GREEN	GREEN	GREEN	GREEN	GREEN		CRH-0 * DCHS-0 * DHcFT-0 * UHDB-0 * DDICB-0 * EMAS-0

Provider Collaborative Work Programme - update on progress month 7 (1 of 2)

Plan	Baseline	Target 2024-25	Progress
NHS IMPACT / Continuous Improvement	To further develop the capacity and capability to deliver improved care across the collaborative and wider JUCD System.	System self assessment against NHS IMPACT NHS IMPACT development plan Training and Development plan for delivery (including QI methodology for system teams, change management/ system leadership, using data for improvement). Develop Joined Up Improvement	System self assessment completed in June 2024. First stage of IMPACT Action Plan developed with further workshop planned in November 2025 to develop next stages. Approach agreed to deliver training to agreed priority groups by March 2025. Relaunch of Joined Up Improvement planned for November 2025
System Programme Management and ePMO Function	To further develop the programme management function and ensure there is a consistent approach to programme management and benefits realisation across system improvement and transformation work.	Production of reliable monthly CIP / Efficiency Reports Produce a benefits realisation plan for 2024-25 Review of current ePMO system	Monthly reports have been produced. Benefits realisation plan is still under development- training offer will support moving this forwards further Review of current ePMO is underway. Executive interviews have been conducted and high level feedback was presented to NHS Exec on 1/11/24. Analysis of ePMO users surveys is underway.
Primary / Secondary Care Interface	To make improvements in productivity and reduce wasted clinical and patient time	Pilot single points of contact in each main provider	Providers are currently developing plans aiming to have models in place (pilots/PDSAs) by December
Integrated Clinical Pathways	Working in partnership to stabilise and sustain clinical services where possible. Develop plans to address fragility in agreed priority areas.	Develop case for a single Derbyshire Ophthalmology Service Provision of mutual aid to haematology services Reduction on locum spend on CAMHS service through partnership working Neurodivergence partnership and transformation Develop a single model for stroke rehabilitation across JUCD Review of MSK service model to strengthen pathways and increase out of hospital management of cases / develop CATS model further. Standardise Children's SLT to become a single provider	Progress is being made within CAMHs and ND- update report due Ophthalmology project is delayed due to lack of project team- shared post now agreed with project restart expected in November Haematology mutual aid has not demonstrated significant impact- recommend reinforcing referral guidance. Work now looking at 'left shift' opportunities, Some progress made in MSK pathways around primary care capabilities, joint injections etc. MSK programme is being reviewed with the ICB, to be clear on objectives, key change projects, roles and responsibilities. SLT single provider model agreed Business case finalised service transfer to DCHS planned for Jan 2025

Provider Collaborative Work Programme 2of 2

Plan	Baseline	Target 2024-25	Progress
Procurement		Developing and overseeing a work programmes across partners to drive financial improvement through maximising opportunities for collaboration on material procurement activities.	Shared procurement group has been established, some work done to identify the procurements that can be done together and a number of shared procurements are underway, Estimated benefit £695K this year. The longer term workplan and roadmap for benefits has not yet been developed. Agreement in principle to a shared system post. Recruitment has not yet commenced pending funding confirmation although a job description has been drafted. Expectation is that once funding has been confirmed the process can commence , although unlikely to have anyone in post until the new calendar year. This is compromising our ability to develop a shared work programme and benefits plan.
At scale enabling functions	£123m spend on functions with the scope of the Corporate Benchmarking returns (2022/23) :- Finance £13.6m, Gov & Risk £23.65m, HR £26.37m , D&T £47.6m, Legal £6.44m , Payroll £1.73m Procurement £3.74m	To improve productivity and efficiency of services through collaboration at scale. To ensure that the JUCD enabling services model adopts innovation and best practice and is fit for the future. Benchmarked £47m of spend above median in areas where we benchmark as above average (note also some areas where we benchmark below)	Steering group established and local benchmarking comparison has been undertaken using 23/24 data. Project external resource not yet identified, need to confirm which trust will procure using current frameworks .. KLOEs and summaries of opportunities in response to benchmarking and known best practice being developed.
Estates	£200n running cost of JUCD provider estate.	Drive better utilisation and deliver on rationalisation and consolidation opportunities Understand condition and cost of current estate footprint to create a baseline to inform strategic estates planning and support prioritisation of capital resources Ensure progress is made towards net zero carbon objectives Ambition is £10m running cost by 2026/2027.	New SRO for programme has been confirmed. Infrastructure strategy with NHSE for approval with detailed work plan developed Estates and efficiency subgroup has been established to take forwards the work on identifying opportunities for rationalisation and consolidation. System wide property sharing charter in progress. ADEPT process has restarted.

Digital and Data Transformation Plans

Plan	Baseline	Target 2024-25	Progress
Electronic Patient Record (ePR) - Introduction of ePR system at sites	Single EPR solution selected and ordered EPR full business case developed and national funding has been approved to progress procurement Implementation plan and deployment plan agreed	Roll out of EPR with significant productivity and cost savings by 2025-26 detailed in business case Removal of paper records, optimisation of system and legacy record management Improved patient safety impact	Implementation planning and training is underway at both sites
Derbyshire Shared Care Record	The Derbyshire Shared Care Records (DSCR) implementation continues involving other partner providers in submitting data to the DCSR- communication and engagement plan to increase usage of the DSCR is in progress. • 73% of care providers are reporting using a digital care record from a starting position in 22/23 of 44%. • On average care providers report • saving 20 minutes per day on record activity • Saving 24 hours per year on audit • Saving 20 minutes per day at handover • Saving over £2000 per year on stationery and storage costs	Key priorities for 24/25: - Increase user base and usage of the DSCR - Derbyshire County Council – connections to be achieve (City Council already achieved) - East Midlands Ambulance Service pilot completed and roll out to EMAS workforce on-going - Development of the RESPECT form completed with read and write capability, clinically led roll out plan in development	Connectivity with provider organisations, primary care and one local authority (Derby City) User base now over 5,000 Uses cases developed to promote usage of the DSCR
Technically Enabled Care and Efficiency - Supporting the delivery of services and clinical pathways to improve care and efficiency:	• Virtual wards • Urgent Community Response – "Team Up" • Care Co-ordination Solution – Theatre utilisation • Optica – discharge and patient flow and bed tracking • NHS App – Digital Patient Front – patient portal integration • SHREWD – ICB led project, not part of the ICS Digital Programme • ESR Project Derbyshire – support to this project is on pause	Detail in UEC slide Detail in Community and Team up slide TBC March 2025 acute implementation completed TBC	Virtual Wards – value for money review has been undertaken, awaiting final report to inform future direction. CCS – theatre utilisation module is being implemented at UHDB and CRH. Early indication of improved utilisation at both acutes. Optica – implementation in progress with a target date of March 2025 full implementation at both acutes NHS App – patient portal (national Wayfinder project) integration is being progressed at both acutes.

People Services Collaborative Transformation Plan (1 of 2)

Plan	Baseline	Target 2024-25	Progress
The Derbyshire Academy	Developing the Derbyshire Academy, enabling engagement with more educational stakeholders within the faculties to deliver flexible and timely education programmes for now and the future.	Business case proposal for pooling resources across the system in progress. Development of training alignment within the Derbyshire Academy, to maximise efficiencies and resources.	Positive impact of faculties and academy activities on workforce priorities for the system. Funding secured for remainder of financial year to continue vital work. Discussions to develop Social care, Healthcare Science and Psychological faculties continue. Progress is being made in the development of a workforce development implementation plan.
	Nursing and midwifery faculty are reviewing the workforce data and how they can use this information within their faculties to develop a system workforce plan.	#Derbyshire Nurse: making nursing in Derbyshire attractive. Newly Qualified Nurse rotational programme.	Programme proven successful, finalist entry into the Nursing Times Awards.
	Agreed priority areas for NHSE Next generation NHS initiative.	Improved future pipeline by scaling up engagement with schools, local HEI's/Colleges. Standardise assessment and procurement process of apprenticeship providers.	Development of Apprenticeship Strategy and steering group, with the ambition to increase clinical apprenticeships in line with the LTWP target of 22%.
	Programmes in place to provide statutory and continuing professional development at organisational and system level to discharge duty in relation to education and training. Standardisation of training and development.	NHS LTWP of 27% Target for placement expansion 28/29 and continue to increase capacity.	27% Placement expansion achieved. Further development of PARE system to monitor placement activity. Multi-professional education and training investment plan (METP) reductions across the system and inability to release staff for training is leading to a reduction in staff skills in the future.

People Services Collaborative Transformation Plan (1 of 2)

Plan	Baseline	Target 2024-25	Progress
People Digital Derbyshire	Theory of Change Logic Model workshops held in June, followed by further workshop in July to define outcomes and actions to resolve. This work will underpin the People Digital agenda going forward.	TBC	NHSBSA have recommended a level of continued support for Derbyshire. Short, medium and long term options on future development discussed which will enable a road map to be developed once resources and support from NHSBSA are agreed.
Recruitment Scaling	Discovery phase of recruitment scaling is complete. System level actions identified and pending discussion regarding alignment with data Functional Implementation Group.	TBC	Not updated

Derbyshire Healthcare NHS Foundation Trust
Report to the Trust Board – 4 March 2025

Board Assurance Framework (BAF) Report
Issue 4, version 4.3, 2024/25

Purpose of Report

To meet the requirement for Boards to produce an Assurance Framework. This report details the current BAF, Issue 4, version 4.3 for 2024/25.

Executive Summary

Director Leads, Deputy Directors, Operational Leads and Trust Senior Managers have reviewed the risks and provided comprehensive updates.

The previous issue of the BAF was based on the previous Trust strategic objectives. In this round of Director updates the risks have been mapped to the new strategic objectives and a thorough review of the associated risks, root causes and key gaps in control has been undertaken to ensure that:

- Any new risks to meeting the new objectives are captured in the BAF report
- The key controls and internal assurances of those controls still correct
- Any of the measures under the new objectives have been added to the controls, assurances, or to the narrative against the actions
- Action deadline dates and review dates (shown in brackets) have been reviewed
- The wording of the BAF risks descriptions has been updated to ensure it is current and clear
- Any duplications have been removed and content has been streamlined
- All risks are to the Trust strategic directives.

Summary of Updates

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

Risk 1A: The title has been updated to include patient experience and outcomes and the root causes have been updated to map to this and to reference learning from internal incidents, complaints and other sources of feedback.

Duplication of key gaps in control have been removed, including those that relate to investment in autism assessment and treatment services as they are referenced under the partnership section.

Risk 1D: An action has been added to monitor delivery of same sex guidance through the Quality and Safeguarding Committee.

People - Derbyshire Healthcare is a great place to work

Risks 2A and 2B: Root causes and key controls have been thoroughly reviewed and updated to link directly to the current risk. Duplications and risks to previous strategies and plans have been removed and new, current and relevant key gaps to controls have been added with associated actions. The status and progress on the new actions is under review and updates will be provided in the first issue of the 2025/26 BAF report.

The title of Risk 2B has been updated to include the risk of adequate supply of the right people being recruited and retained.

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

The title has been updated to include corrective action required to control the risk and root causes have been updated to ensure they directly link to the current risk. Additional key gaps in control have been identified and new actions to close them have been logged with progress updates.

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

Risk MS1 was previously included in the BAF report as a system-wide risk that did not directly link to Trust objectives. This has been removed and the risk and actions linked to it have been moved to the partnership section, now showing as Risk 1C. The entire non-Trust section has then been stricken through to remove any duplications and anything that is outside the remit of the Trust, but without losing any content that is linked to the Trust strategic objectives. Risk titles, all root causes, key gaps in control and associated actions to close those gaps have been updated and added to.

Operational Risks

The linked operational risks (high/extreme, Trust-wide) have been updated in Issue 4 of the BAF report by the Risk and Assurance Manager – Updates are taken from the progress summaries recorded in Datix by the Risk Handlers, the main changes are:

Risk 3009 – Demand for Autism Spectrum Disorder (ASD) assessment service far outstrips contracted activity

This has been removed from the BAF report as the Risk Hander has re-assessed the current rating as moderate.

Risk 23314 – Interpretation of data submitted within NHSE datasets risks erroneous views on the Trust

This is a new Trust-wide risk rated as high by the Risk Handler and has been included in the BAF report under the partnership section.

Risk 23372 – Risk to patient and staff safety due to parking issues - Kingsway site

Logged 29 January 2025 after being raised at the Health and Safety Committee and escalated to Director level. Initially rated extreme and re-assessed as high, it is listed below Risk 1A but also links to the people section as the risks are to patients and staff.

BAF Reporting Cycle/Format

Presented is a tracked changes version and a ‘clean’ version of the current BAF report with the headers updated to reflect the new strategic objectives – This is for ease of review.

All changes/updates to this issue of the BAF, compared with Issue 3 2024/25, are indicated in blue. All text that has been stricken through will be removed from the next issue (Issue 1 2025/26).

Version 4.1 of this issue was submitted for review by ELT on 7 January 2025 (no further updates were received) and version 4.2 was approved by the Audit and Risk Committee on 23 January 2025.

Board Committees also receive extracts from the current version of the BAF report to review the risks they are responsible for at all of their meetings – All updates received from the Board Committees are incorporated into the BAF for Board.

This **Issue 4 cycle** was:

ELT for all of the above	3 December 2024
Updates from ELT	3 December 2024
Director Lead updates	13 December 2024 – Deadline for submission
ELT for **review**: Version 4.1	7 January 2025
Updates from ELT	10 January 2025 – Deadline for submission
ARC for **approval**: Version 4.2	23 January 2025
Board for **review and approval**: Version 4.3	4 March 2025

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

Risks and Assurances

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

Consultation

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

Formal Reviews

- Executive Leadership Team, Issue 4.1: 7 January 2025
- Audit and Risk Committee, Issue 4.2: 23 January 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 lead Executive Director in taking forward.

Recommendations

The Board of Directors is requested to:

1. Review and approve this final issue of the BAF for 2024/25 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. Agree to receive updates in line with the forward plan for the Trust Board.

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

Report prepared by: **Kel Sims**
Risk and Assurance Manager

Board Assurance Framework 2024/25 – Issue 4.3 Board March 2025

~~PART ONE – RISKS TO DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST'S STRATEGIC OBJECTIVES~~

Ref	Risk	Director Lead	Risk Rating	Responsible Committee
Patient Focused - Our services will deliver safe and high-quality care ~~Strategic Objective 1 – To Provide GREAT Care in all Our Services~~				
24-25 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	Executive Director of Nursing, AHPs and Patient Experience (DON) / Medical Director (MD)	**HIGH**	Quality and Safeguarding Committee
24-25 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)	**HIGH**	Finance and Performance Committee
24-25 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)	**MODERATE**	Finance and Performance Committee
24-25 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	Executive Director of Nursing, AHPs and Patient Experience (DON) / Chief Delivery Officer (CDO)	**MODERATE**	Quality and Safeguarding Committee
People - Derbyshire Healthcare is a great place to work ~~Strategic objective 2 – To be a GREAT Place to Work~~				
24-25 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
24-25 2B	There is a risk that we do not have an adequate supply of a diverse workforce with the right ~~number of~~ 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 ~~Strategic Objective 3 – To Make BEST Use of Our Resources~~				
24-25 3A	There is a risk that the Trust fails to deliver its revenue and capital financial plans 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	Executive Director of Finance (DOF)	**EXTREME**	Finance and Performance Committee

Board Assurance Framework 2024/25 – Issue 4.3 Board March 2025

Partnerships - Our organisation will identify new ways of working, through new collaborative approaches ~~**Strategic Objective 4 – To be a GREAT Partner**~~				
24-25 4A	~~Whilst there are significant benefits from the creation of the Integrated Care System (ICS) as an NHS body, there is a risk that the effects of the change may impact negatively on the cohesiveness of the Derbyshire health and care system~~ There is a risk that the effects of both nationally and locally driven changes to roles and responsibilities within the Integrated Care Board (ICB), and with its partners may impact negatively on the cohesiveness of the Derbyshire health and care system	Chief Delivery Officer (CDO)	**MODERATE**	Trust Board
24-25 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
24-25 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 2024/25 – Issue 4.3 Board March 2025

Patient Focused - Our services will deliver safe and high-quality care
~~**Strategic Objective 1 – To Provide GREAT Care in all Our Services**~~

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

Impact: May lead to avoidable harm including increased morbidity and mortality; delays in recovery; and longer episodes of treatment; affecting patients, their family members, staff or the public

Root causes:

a) Workforce supply and lack of capacity to deliver effective care across hotspot areas, increasing risks in the clinical and medical workforce
b) Risk of substantial increase in clinical demand in some services
c) Intermittent lack of compliance with Care Quality Commission (CQC) standards, specifically the safety domain
d) National Oversight Framework (NOF) Level 3 quality issues
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) ~~Due to the move in Electronic Patient Record (EPR) system there is potential that data quality could adversely affect clinical standards~~ Data quality could be adversely affected due to the need to embed the new 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
~~n)~~p) Safety and learning culture, learning from internal incidents, complaints and other sources of feedback is not developing and needs to be further embedded

BAF Ref: 24-25 1A	**Director Lead**: ~~Dave Mason~~Tumi Banda (~~Interim~~ DON) / Dr Arun Chidambaram (MD)	**Responsible Committee**: Quality and Safeguarding Committee

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Appetite**		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Board Assurance Framework 2024/25 – Issue 4.3 Board March 2025

Preventative – Quality governance structures, teams and processes to identify quality related issues; mandatory training; Duty of Candour processes; clinical audits and research; health and safety audits; risk assessments; physical health care screening and monitoring; monitoring and effective responses to infection and control guidance, EQUAL unannounced visits to services and anonymised bright ideas service improvement ideas. Feedback intelligence from independent advocacy, Director visits in and out of hours and Board visits

Detective – Quality dashboard reporting; Board visits virtual clinical service contact visits; incident, complaints and risk investigation; clinical audit; Fire Safety Regulations (FSR) compliance checks; mortality review process; physical health care monitoring clinics pilots; safety check log; Head of Nursing and Matron compliance visits, reviewed model of announced and unannounced visits to service throughout the 24-hour period

Directive – Trust Strategy, ~~and commitments; Quality Improvement 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 (QSC); Continuous Improvement Plan – Confirmed launch date is 01.04.25

Assurances on controls – Internal	Assurances on controls – External
Trust quality and performance dashboards Scrutiny of Quality Account by committees Programme of physical healthcare and other clinical audits and associated plans Infection Control Board Assurance Framework reported to NHS England Positive and Safe self-assessment Head of Nursing and Matron compliance visits Board visits and out of hours visits CQC action plan in place (April 2024) ~~in response to high level inspection feedback, Section 31 requirements and review of Trust data by CQC~~	National enquiry into suicide and homicide NHS Litigation Authority (NHSLA) scorecard demonstrating low levels of claims Safety Thermometer identifies positive position against national benchmark Mental Health Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards CQC comprehensive review 2020 Trust is rated Good Trust fully compliant with National Quality Board Learning from Deaths guidance Relationship Meetings with CQC taking place Patient Safety Incident Response Framework (PSIRF) implementation CQC inspection (April 2024) ~~– Report pending~~ Regular NOF Level 3 meetings with NHS England (NHSE) and Integrated Care Board (ICB) ICB local review to ensure there are clear policies in place to meet the needs of people in Derbyshire with severe mental health illness NHSE guidance on intensive and assertive community mental health treatment Lord Darzi report and anticipated 10 year plan for the NHS

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Summary of progress	Action rating
Implementation of revised priority actions for '~~Good~~ High Quality Patient Focused Care' which support the Trust strategy and patient outcomes and guidance and standards for quality care ~~and in response to CQC inspections and recommendations~~	~~Redesign improvement plans to align to revised building blocks which support the Trust Strategy~~ To ensure adherence with guidance and standards of care, to measure improvements in patient outcomes	Compliance with suite of metrics and reporting schedule detailed in quality dashboard Internal reporting against self-assessment	31.03.25	Quality Surveillance Dashboard revised (programme of ward visits which are assessed against the CQC's single assessment framework)	AMBER

	To develop and implement a Quality Plan and a Continuous Improvement Plan To develop an improved learning culture within the Trust [ACTION OWNER: DON]	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, which scrutinises progress of actions arising from regulatory inspections and Mental Health Act visits and provides sign-off of completed actions CQC Executive Oversight Group in place – ~~Weekly~~ Fortnightly scrutiny of actions and updates reviewed Divisional Performance Reviews (DPRs) now embedded. We are now using the scorecard report with a data informed approach in the DPRs ~~and the Trust Leadership Team (TLT) group has been reviewed~~ A new Trust Strategy has been launched which sets out a clear direction for patient focussed improvements New Quality Plan and Continuous Improvement Plans are planned for development in 2025	
~~Insufficient investment in autism assessment and treatment services to meet demand. No commissioned treatment services~~	~~Investment required by ICS to meet assessment and treatment demands [ACTION OWNER: CDO]~~	~~Agreed funding allocation has occurred, recruitment to posts is active~~	~~(31.12.24)~~	~~Commissioned target of 26 assessments per month now being sustainably exceeded. Discussions underway~~	~~AMBER~~

				~~with ICB commissioners and executives on next steps to bolster ASD investment through contractual changes. Positive engagement session with GPs on their role in future pathways including need to include ADHD~~	
Gap in operating standards for acute and community mental health services	~~Enhanced monitoring of acute and community mental health services by the Nursing and Quality Directorate~~ Compile outcome measures for acute and community services and create relevant dashboards for the services to inform areas for improvement Improvement of both inpatient and community care settings – Environments need to be improved [ACTIONS OWNER: DON]	Improvement in operating standards compliance to be overseen by Quality and Safeguarding Committee ~~the Trust's CQC oversight group. To be confirmed by internal assessments against the new self-assessment framework and ultimately via external CQC inspection and assessment~~	31.03.25	Increased performance management scrutiny and unannounced site visits undertaken with compliance checks ~~Mock CQC inspections continue~~Monitoring Fundamental Standards of Care and the quality measures through the Quality Dashboard	AMBER
	~~Implement~~ Set out improvement plans to achieve Royal College of Psychiatrists (RCP) ~~Standards across Acute Services~~accreditation across services [ACTION OWNERS: MD/DON/CDO] Implement Community Mental Health Framework [ACTION OWNER: CDO]	Implemented Acute Inpatient Mental Health Service Accreditation (RCP Standards) reported in Divisional Achievement Reviews and Quality Account Implemented Mental Health Community Framework to Quality and Safeguarding Committee	31.03.25	~~Policy and Standard Operating Procedure (SOP) for Derbyshire Living Well and Derby Wellbeing Services is published.~~ Internal Trust programme Board in place to strengthen contribution and involvement in system-wide programme and delivery Mobilisation underway in High Peak, Derby City, Chesterfield and North-East Derbyshire System	

				Programme Team now established Final stage of mobilisation now completed in Amber Valley, Erewash, South Derbyshire and Derbyshire Dales Viability of the model may be at risk due to possibility of the social worker component not being funded by the ICB	
~~Implementation of clinical governance improvements with respect to:~~ ~~Outcome measures~~ - ~~Clinical service reviews including reduction in excess waiting times~~	~~Develop and implement an improvement plan~~ ~~[ACTION OWNERS: MD/DON/CDO]~~	~~Compliance with suite of metrics and reporting schedule~~	~~(31.12.24)~~	~~The re-launched Divisional Performance Reviews commenced in April. The DON is working on the development of a new clinical quality dashboard – A prototype has been developed and a paper was submitted to ELT in August re second phase deployment~~	~~AMBER~~
Implementation of new quality priorities for: - Sexual safety - Implementing CQUINS and Clinical outcome measures - Recovering services – equally well - New Trust strategy and priorities - Dormitory eradication programme	Develop and implement an improvement plan to enable all quality priorities to be implemented [ACTION OWNER: DON]	Compliance with suite of metrics and reporting schedule	31.03.25	The Trust has developed a sexual safety plan and has signed up to the sexual safety charter Sexual safety – Improvement work (dashboard, preceptorship training and protocols) commenced. Sexual safety on professional standards video launched with new training ~~Sexual safety checklist for services in design and~~	GREEN

				~~was submitted to QSC Committee in July~~ Dormitory eradication programme in construction: Making Room for Dignity is making progress with the units planned for opening between February and June 2025 ~~Trauma informed practice conference and work programme commenced in May 2023. Trauma lead appointed and developed training and strategy~~ The Trust is participating in the Culture of Care Collaborative Implementation of the Models of Care is progressing well ~~Plan for existing dormitory stock and to maintain and improve dignity for active bed stock assessed and presented to the ICB~~	
Learning from ~~other~~ independent and national forums on current issues affecting patient safety outcomes and experience ~~exposures of abuse presents the challenge that we need to have in place to identify poor or concerning behaviour~~	Participate in collaborative local and regional forums to gather learning Revisit all assurances and scrutinise practice, gathering intelligence and implement an improvement plan to enable all services to provide the highest standard of care which would be expected [ACTIONS OWNERS: DON/MD]	~~Communication and effectively responding to learning from recent exposes~~ ~~Mobilise and emphasise expectations of standards of care and Freedom to Speak Up~~ E~~e~~nsuring that staff are aware of how to raise concerns and speak up	~~(31.12.24)~~ (31.03.25)	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	AMBER

		Implement the Accountability Framework ~~Facilitate conversations on the risks of harm and closed cultures. Reset the culture and the tone of the requirement for professional scrutiny and all employee requirements to prevent harm and report poor care/ abuse~~ 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 Timely investigation and response to concerns and complaints ~~To work in accordance with the multi-agency policy relating to PIPOT~~		Increased visibility of senior staff through Board visits~~, mock CQC inspections~~ and out of hours visits Robust oversight of patient safety incidents, concerns, complaints, and compliments with scrutiny from independent partners, e.g. Healthwatch and experts by experience being core members of Patient and Carer Experience Committee External partnership working including Healthwatch and advocacy services within safeguarding and secure services. The Trust provides assurance and participates in external reviews alongside the ICB and Adult Safeguarding Board Trust-wide Learning, Culture and Safety Group established, providing oversight of teams/services with repeating patterns for improvements to be made	
Clinical improvement in the current use and transformation of Care Programme Approach	Identify the Trust's preferred alternative model to replace CPA	Review of changes to national policy to replace CPA	31.03.25	Ongoing oversight of CPA continues with focus on care planning and risk assessment	AMBER

(CPA), to support safe community practice	Establish transition plan which includes communications and training strategy and clear timeline for go live of the new system and detailing when use of CPA will cease Implement an improvement plan to enable all services to provide the highest standard of care [ACTIONS OWNERS: DON/MD]	Safe and effective practice is in place		Planning discussion has taken place in relation to the transition from CPA to the preferred alternative model, Dialogue Plus CPA training continues at present until alternative identified	
~~Clinical improvement in the current practice standards for new mental health in-patient standards released by NHS England~~	~~Scrutinise new practice standards and develop a new improvement plan, which establishes the Trust's baseline position against the standards, identifies the gaps in compliance and details specific actions needed to achieve the standard, to enable all services to provide the highest standard of care [ACTION OWNERS: DON/MD]~~	~~Review new standards and new reporting requirements with the clinical improvement team~~	~~(31.12.24)~~	~~Commencement of the implementation of the national inpatient standards from January 2024. National lead has presented to the executive team and operational leads and the Trust has joined the Culture of Care national programme. Pilot areas identified and programme commenced with good engagement~~ ~~The Trust has commenced a national quality improvement programme around good practice in Mental Health Act. These two programmes will be shared across all the inpatient units~~	~~AMBER~~
Review of the new Major Conditions Strategy and Suicide Prevention Strategy for England: To be considered ~~a reset of the Trust clinical strategy~~as Trust Clinical Plan developed	Scrutinise new policy direction and develop new plans Routinely review incidents for learning in suicide prevention including cluster analysis and benchmarking [ACTIONS OWNERS: DON/MD]	Adjust strategy and policy to meet requirements Undertake a cluster analysis of in-patient and acute care pathway deaths	~~(31.12.24)~~ (31.03.25)	Review of new strategy for Major Conditions and Suicide Prevention PSIRF priorities for 2024/25 focusing on prevention and oversight, linked to new strategies	AMBER

				Trust ~~clinical strategy~~Clinical Plan in development ~~and in line with the timeline for completion of the Trust Strategy (to include relevant national strategies)~~ ~~Suicide prevention lead appointed in September 2024~~ ~~Risk assessment, formulation, safety planning and suicide prevention training module developed. Will be rolled out to staff in November 2024~~	
Review of Patient Carer Race and Equality Framework (PCREF) and develop implementation plan	Revisit new policy direction and develop new plans [ACTION OWNER: MD]	Review framework and develop implementation plan	~~(31.12.24)~~ (31.03.25)	New Patient and Carer Strategy has gone through QSG and will be launched in line with the wider Trust Strategy EDI lead will be responsible for workforce elements of PCREF - Recruitment process underway Central oversight and resource to be identified	AMBER

Board Assurance Framework 2024/25 – Issue 4.3 Board March 2025

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	28.02.22	27.03.25	HIGH
23251	Forensic and Mental Health Rehabilitation Services	Risk to public due to management of Section 37/41	01.08.24: Following a recent Section 37/41 audit it has highlighted that clinical documentation is not of the standard and completion that is felt to effectively support and manage this group of patients - Risks posed to members of the public. Action logged to discuss next steps, which will outline risks and benefits associated with current process of management of S37/41s and risk and benefits of all S37/41s being managed under the Forensic CMHT 18.11.24: Audit highlighted concerns around the clinical documentation and management of 37/41's in local CMHTs – Continue to look at hybrid working within CMHTs Update requested from Risk Handler	02.10.24	18.02.25	HIGH

23372	Corporate Services – Estates and Facilities	Risk to patient and staff safety due to parking issues - Kingsway site	29.01.25: Parking is extremely dangerous on Kingsway site, this is presenting possible life threatening issues, and the potential for a repeat of previous occasions where a 999 vehicle couldn't access the site. We have responsibilities under the Health and Safety at Work etc. Act 1974 and the Regulatory Reform (fire safety) Order 2005 to ensure that we do not contribute or cause anyone's death. This would carry a corporate manslaughter charge should this happen. Requests have been made by the Head of H&S and staffside that: We tell non-patient facing staff, where there isn't a risk at home, to work from home, to bring many of the meetings back to online, including training where at all possible 11.02.25: There are a number of actions underway to manage this issue in the short terms, some communicated to all staff. In addition, there is an options paper for a more sustainable response going to the next ELT meeting	29.01.25	11.05.25	**HIGH**

Board Assurance Framework 2024/25 – Issue 4.3 Board March 2025

Patient Focused - Our services will deliver safe and high-quality care
~~Strategic Objective 1 – To Provide GREAT Care in all Services~~

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

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

BAF Ref: 24-25 1B	**Director Lead**: Vikki Ashton Taylor (CDO)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Appetite**		
High	Likelihood 4	Impact 4	High	Likelihood 3	Impact 5	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Routine environmental assessments for statutory health and safety requirements; environmental risk assessments reported through Datix; Infection, Prevention Control (IPC) risk assessments
Detective – Reporting progress against Premises Assurance Model (PAM) to the Executive Leadership Team (ELT); Dormitory Eradication Board reports into Trust Board
Directive – Capital Action Team (CAT) role in scrutiny of capital projects; IPC policy and procedure; Continuous Improvement Plan – Confirmed launch date is 01.04.25; Estates Plan – In development

Assurances on controls – Internal	**Assurances on controls – External**
IPC risk assessments Health and safety audits Premises Assurance Model System (PAMS) reporting ~~Estates Strategy~~	Mental Health Capital Expenditure bidding process External authorised reports for statutory health and safety requirements Estates and facilities management internal audit

Board Assurance Framework 2024/25 – Issue 4.3 Board March 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 adherence to emerging national guidance and policy requiring the elimination of mixed sex wards and dormitory style inpatient facilities	Deliver two new adult acute 54-bed units with ~~a~~ single room en-suite with additional staffing and new model of care [ACTION OWNER: CDO]	Delivery of approved business cases	~~31.12.24~~ 31.03.25	Two new build adult acute unit FBCs nationally approved September 2022, funded by £80m national PDC and £18.6m CDEL. ICS supported and approved revenue funding Delay in national approval and redesign of foundations. Planned to go live ~~November 2024~~February/March 2025	AMBER
	Older Adult service relocation to refurbished ward with single room en-suite and gender segregation, with additional staffing and new model of care, by September 2024 to eradicate dormitories in Northern Derbyshire and avoid the 12-bed service being isolated in otherwise vacated wards National PDC capital funding approval [ACTIONS OWNER: CDO]	Delivery of approved business case	~~30.11.24~~ 31.01.25	Older Adult service relocation FBC and revenue funding approved by ICS. National PDC capital funding approved by NHSE Scheme re-tendered due to affordability, refurbishment started on site December 2023. ~~This aspect of the project is on track to open~~ Bluebell Ward ~~in October 2024~~to open in January 2025	GREEN
	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	Delivery of approved business case	~~(30.11.24)~~ 31.12.25	FBC and revenue funding approved by ICS. National PDC capital funding approved by NHSE Radbourne Ward 32 refurb commenced November 2023. Due to go live autumn 2025	RED

	[ACTIONS OWNER: CDO]			Ward 35 refurb scheduled January 2025 – for mid-2026, subject to funding live summer 2026	
Lack of an accessible Derbyshire wide Psychiatric Intensive Care Unit (PICU)	Delivery of local PICU arrangements (new build and associated projects taking into account gender considerations) National PDC capital funding approval [ACTIONS OWNER: CDO]	Agreed programme of work with capital funding to support it	~~31.03.25~~ 31.05.25	FBC approved by ICS PICU fully funded by national and Trust capital – ~~. On track and E~~expected to be operational ~~March~~ April/May 2025	AMBER

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

Board Assurance Framework 2024/25 – Issue 4.3 Board March 2025

Patient Focused - Our services will deliver safe and high-quality care
~~Strategic Objective 1 – To Provide GREAT Care in all Our Services~~

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

Impact: This could lead to the disruption in the provision of services with risk to patient safety

Root causes:

a. Increasing reliance on a single electronic patient record
b. Increasing use of video software for the direct provision of care and operational purposes
c. Increased staff home working
d. Increasing electronic collaboration across health and social care partners
e. Increasing global instability and risk from state supported cyber attacks
f. Increase in locally developed system solutions to support DHCFT and partner operations and performance, i.e., flu vaccination, health risk assessments

BAF Ref: 24-25 1C	**Director Lead**: Vikki Ashton Taylor (CDO)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Appetite**		
Moderate	Likelihood 3	Impact 4	Moderate	Likelihood 3	Impact 4	Moderate	Likelihood 2	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Trust utilises NHS provided solutions as widely as possible, i.e., Office 365, NHS Mail to ensure compliance with mandated requirements. Use of the secure Health and Social Care Network (HSCN) specified by NHS Digital. Staff training on data security and protection. Regular all staff communications regarding safe ways of working and phishing emails. Contract with NHS Arden and Greater East Midlands Commissioning Support Unit provides information governance and security services, includes review of risks and addressing of vulnerabilities. Subscription with NHS Digital Care Certification Programme highlights cyber vulnerabilities and monitors Trust's compliance against them
Detective – Cyber essentials framework: NHS Digital encourage all organisations to comply. Advanced Threat Protection (ATP) monitors every server and device to highlight threats and software vulnerabilities
Directive – Compliance with NHS Digital requirements. Monthly rigor review meeting with NHS Arden and Greater East Midlands Commissioning Support Unit. Security and Protection Policies and Procedures. Business continuity policy and procedure; Digital Plan – In development

Board Assurance Framework 2024/25 – Issue 4.3 Board March 2025

Assurances on controls – Internal	Assurances on controls – External
IM&T Strategy delivery update to F&P – Annual Embedded programme of software and hardware upgrades Live testing of business continuity plans Digital Plan – In development	Templar Cyber Organisational Readiness Report (CORS) Annual external cyber review by Dynac (vulnerability scan) Data Security and Protection (DSP) annual review by Internal Audit Compliance with DSP Toolkit; high levels of training compliance

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Business continuity plans reflect changes to service delivery such as increased phone and video contacts	All services to review business continuity plans to ensure they take account of the increased use of phone and video contacts for care provision and also use of video conferencing for operational delivery [ACTION OWNER: CDO]	Reporting to the Divisional Performance Reviews (DPRs)	~~(31.12.24)~~ (31.03.25)	~~Business impact assessments collected.~~ Business continuity training for Trust L~~l~~eads started March 2024. Revised business continuity policy was ratified April 2024. Wider business continuity work (e.g. audit) ~~has taken~~took place in Quarter 2 as part of the EPRR Core Standards Recovery Action Plan – This is on track and expecting to be substantially compliant in the regional assessment	GREEN

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

Board Assurance Framework 2024/25 – Issue 4.3 Board March 2025

Patient Focused - Our services will deliver safe and high-quality care
~~Strategic Objective 1 – To Provide GREAT Care in all Our Services~~

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

Impact: May adversely impact on regulatory requirements to provide safe and quality care. Patients' dignity and privacy may be impacted. Enforcement regulatory notices may issued against the Trust that may impact on Trust reputation and restrictions to capital could be applied.

Root causes:

a) There was commitment across mental health services to eradicate dormitories by 2022 – Although the Trust has active plans for Making Room for Dignity with a fully funded programme, with the building and infrastructure commencing, the Trust has not delivered in the set timeframes
b) Infrastructure does not comply with current standards
c) Outdated approach of delivering mental health care in dormitories does not comply with current guidance
d) Dormitories compromise patient privacy and dignity due to the dormitory layout
e) Dormitories do not comply with Infection, Prevention and Control (IPC) guidance
f) Dormitories could compromise Health and Safety regulations and increase risks, e.g. fire safety
g) Dormitories are not therapeutic spaces to provide mental health care in

BAF Ref: 24-25 1D	**Director Lead**: ~~Dave Mason~~Tumi Banda (~~Interim~~ 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~~. Mock CQC inspections~~

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; ~~and commitments; Quality Improvement Strategy;~~ Physical Health Care Strategy; Safeguarding Strategy; Suicide Reduction Strategy; clinical strategies; policies and procedures available via Trust intranet; Central Alerting System (CAS) alerts; Risk Management Strategy; clinical sub committees of the Quality and Safeguarding Committee, Making Room for Dignity programme (MRfD); Continuous Improvement Plan – Confirmed launch date is 01.04.25

Board Assurance Framework 2024/25 – Issue 4.3 Board March 2025

Assurances on controls – Internal	Assurances on controls – External
Trust quality and performance dashboards Bed Management processes Scrutiny of Quality Account by committees Programme of physical healthcare and other clinical audits Infection Control Board Assurance Framework reported to NHSE Positive and Safe self-assessment Head of Nursing/Matron compliance visits Cleaning and maintenance schedules IPC training Level 1 and 2 Trust targets of 85% compliance minimum Continuous Improvement Plan – Confirmed launch date is 01.04.25	Delivery of Same Sex Accommodation Guidance Safety Thermometer identifies positive position against national benchmark Mental Health Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards CQC comprehensive review 2020 Trust is rated Good Estates and Facilities Management internal audit ~~Transitional Monitoring Meetings with CQC (bimonthly)~~ CQC inspection (April 2024) Patient Safety Incident Response Framework (PSIRF) implementation Monitoring of IPC standards compliance and reporting – ICS IPC Team

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Inpatients care is delivered in wards with dormitories, that compromise on patient dignity, privacy and effective IPC practice	Implement bed management process that ensure that admissions are screened to comply to gender, safety and IPC requirements Ensure that the environments are routinely check by clinicians, estates, and domestic staff Infection Prevention and Control monitoring, and training compliance Effective monitoring of the clinical environments by clinical, estates and domestic staff Monitor delivery of same sex guidance through Quality and Safeguarding Committee [ACTIONS OWNERS: DON/CDO]	Monitor and report breaches of same sex admission ~~breaches~~ 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 ~~Individual screening of admissions to appropriate ward environments to ensure gender needs, safety needs and IPC needs are met~~ Provision of other rooms for privacy and confidentiality across the estate	31.03.25	Level 1 and level 2 IPC training are above compliance target There is improved IPC governance and monitoring Fully funded programme of work in place. Construction started in Chesterfield and Derby~~. Designs have been co-produced with construction experts, clinicians, carers, patients and people with lived experience~~ – Making Room for Dignity programme is progressing Amended gatekeeping and purposeful admission process was launched in April 2024. This is having a positive impact on robust bed management processes ~~Ward Health Check forums relaunched to monitor range of~~	AMBER

				~~metrics including training compliance~~ ~~NHSE review of Trust's IPC approach (August 2024) resulted in actions to take, e.g. stand-alone IPC group, review of IPC strategy and select policies~~	

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

Board Assurance Framework 2024/25 – Issue 4.3 Board March 2025

People - Derbyshire Healthcare is a great place to work
~~**Strategic Objective 2 – To be 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 changes being made to national terms and conditions and pensions in the current economic climate, create additional pressures for people~~
b) ~~The staffing and work challenges lead to unhealthy working practices and hours of work~~
c) ~~The levels and pace of change and transformation are unprecedented~~
d) The growth of and~~,~~ increasing complexity of demand on our services and therefore our workforce~~and sometimes unconnected national and regional ask in the People and Inclusion directorate~~
~~e) The cost-of-living crisis is not matched by compensatory solutions in national terms and conditions~~
~~f) The capacity of leaders to focus on supporting, engaging and developing people~~
~~g)~~e) Lack of consistency and expectations of managers and leaders ~~people leaders~~
f) Lack of strategic development pathway for leaders
g) The number of leadership layers we have
h) Lack of accountability across the leadership levels
i) The volatile work environments where staff can be exposed to harm and trauma
~~j) The delivery of wellbeing, leadership, occupational health and engagement is led at arms-length with delivery through joint arrangements with DCHS and UHDB~~
~~k) Legacy team issues exist in areas across the Trust~~
~~l)~~j) 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
~~m) The long-term lack of investment in Organisational Development and Equality Diversity and Inclusion (EDI) teams, practices and solutions~~
~~n) Historical dual approach to bank staff which leads to differential treatment~~
~~o) The potential erosion of benefits and differentiation enjoyed by Trust staff, for example car parking~~
~~p) Limited representation of staff within networks and no clear and consistent operating framework~~
Employee Relations service sits outside of the trust in a shared joint venture which impacts on quality of service and accountability of responsiveness

BAF Ref: 24-25 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

Board Assurance Framework 2024/25 – Issue 4.3 Board March 2025

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~~annual review of people development plan commissioned through People and Inclusion directorate; provision of information through induction processes for new staff; staff engagement sessions; Equality, Diversity and Inclusion (EDI) Delivery Group meeting; supported networks for diverse staff groups and allies; Health and Well-being Network; workforce planning design meeting; Culture and Leadership Delivery Group~~

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; ~~People building blocks and priorities;~~ Strategic people priorities, ~~Communications Strategy, ICS People 5x7 plan~~

Assurances on controls – Internal	Assurances on controls – External
National staff survey and reporting into board, ELT and divisions Quarterly pulse check and action planning process Exit interview analysis and reporting	Benchmarking in mental health Trusts and at system level Staff survey analysis and reporting

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Lack of planned leadership development growth, stretch programmes and opportunities including coaching and mentoring	Leadership section of the People Plan ~~Strategy developed~~ to align to organisational leadership needs Review and development of Trust leadership offer and impact ~~Re-establish leadership forum~~ ~~Development of coaching access at local, system and national~~ [ACTIONS OWNER: DPOI]	Percentage of leaders with development plan as part of objectives Percentage of employees accessing leadership development programmes	~~(31.01.25)~~ (31.03.25)	Third cohort of Aspiring-2-Be leadership course launched Leadership Strategic Approach finalised and signed off at ELT and PCC in June 2024 Senior leadership programme ~~commissioned~~ agreed and dates being finalised Leadership forum now embedded and running regularly	AMBER
~~Fully embedded person-centred culture of leadership and management~~	~~Review of policies to support a person-centred approach to leadership~~ ~~Introduce just and restorative culture approach~~ ~~Review of leadership development offer~~	~~Reduced number of formal staff relations issues/cases reported in monthly people assurance report to ELT~~ ~~Staff survey results~~	~~(31.01.25)~~	~~Review of cases and case management reported to ELT bi-monthly with reasons for delays identified~~ ~~Civility, Respect and Resolution Policy to be launched January 2025 – Organisational Development~~	~~RED~~

	Re-establish line manager development sessions Scrutiny of people data at divisional level [ACTIONS OWNER: DPOI]			plan being developed to support	
No operating framework through which to maximise the impact of staff networks	Collaboratively develop and Implement Staff Network Framework to provide consistency across the networks with clear framework, clarity of roles and objectives to increase engagement with under-represented staff Support to Bi-monthly network Chairs meetings through DPI, Head of EDI and EDI Manager [ACTIONS OWNER: DPOI]	Engagement and buy-in by network Chairs Clarify on role and function of staff network chairs and objectives for each network – reviewed twice a year Sign up to the framework by network Chairs and Executive Directors Annual updates by network Chairs of engagement undertaken to be included in annual reports	(31.01.25)	Collaborative staff network actions agreed and regular meetings with chairs and vice chairs taking place to align power of staff networks Staff network guidance/framework developed and co-designed with networks	AMBER
The current capacity and structure of the People and Inclusion directorate is not able to meet the Trust, system, regional and national demands alongside challenges from outsourcing key services via People Services in DCHS and UHDB	Review of current People and Inclusion structure to align to needs and priorities of Trust, identify gaps and develop plan to mitigate Review of gaps in services delivered by People Services or UHDB and develop accountability framework Formalise existing governance meetings to ensure clear processes in place for People and Inclusion Services contract and UHDB key service contracts Review of current communications and engagement and people priorities across the Trust and system [ACTIONS OWNER: DPOI]	A People and Inclusion structure that can support the Trust to deliver against the people priorities Accountability dashboard presented to ELT quarterly Terms of reference in place and regular meetings A People and Inclusion structure that can support system-wide priorities People and Inclusion staff survey results	(31.01.25)	Contract review meetings established for Occupational Health and Payroll Services (UHDB) Monthly payroll contract meetings in place - Improvement Manager appointed by UHDB for six months to support contract, data and system standardisation Quarterly governance meeting structure in place and meetings commenced for joint venture performance	AMBER

~~Lack of maturity of EDI framework~~ Lack of progress across EDI including staff networks and reporting (WRES/WDES/gender pay gap)	~~Produce and implement EDI framework with clear legislative, and mandated NHS national regional and local deliverables required for the EDI function and structure to deliver~~ Staff networks have an embedded operating framework through which to maximise the impact of staff networks Clear measurable EDI plan that includes all national reporting and Trust level actions Support to bi-monthly network Chairs meetings through DPI, Head of EDI and EDI Manager [ACTIONS OWNER: DPOI]	~~Agree framework and capacity requirements to deliver~~ ~~Regular wider engagement with EDI Delivery Group, and divisional leads taking place~~ ~~Roll out of framework~~ ~~Delivery against the People Performance Dashboard~~ Clarify on role and function of staff network chairs and objectives for each network – Reviewed twice a year Annual updates by network Chairs of engagement undertaken to be included in annual reports Year on year change WRES/WDES, staff surveys and lived experience of staff through staff networks	~~(31.01.25)~~ (31.03.25)	Framework, including clear actions to progress and signed off at PCC	AMBER
~~We have not engaged with our Bank staff to develop a strong sense of belonging, engagement and psychological contract with the Trust~~	~~Regular monthly engagement sessions~~ ~~Staff survey participation~~ ~~Clinical supervision and appraisal participation~~ ~~Alignment to Agenda for Change for pay and conditions~~ ~~[ACTIONS OWNER: DPOI]~~	~~Staff survey engagement scores~~ ~~Attendance at engagement sessions~~	~~(31.01.25)~~	~~Aligned all bank staff bands 2, 3, 4 and 7 to Agenda for Change pay scales~~ ~~Band 5/6 bank pay approved for alignment to Agenda for Change~~ ~~Review of bands 2 and 3 roles on bank versus substantive roles and agreement on transition into band 3 with training - Complete~~	~~AMBER~~

				~~Review of training competences for bank and agency commenced and nearing completion~~ ~~Service level agreement developed for temporary staffing with clear expectations on annual reviews, clinical supervision and regular engagement~~	
~~Lack of visible and differential staff benefits and responsive support for staff that reflects current working conditions, e.g., cost of living crisis~~	~~Review of gaps in benefits to realign to staff needs~~ ~~Review of current reward and recognition framework~~ ~~Develop range of staff benefits that align to Trust values and 'people first' approach~~ ~~Develop the salary sacrifice offer to support colleagues with cost of living crisis~~ ~~[ACTIONS OWNER: DPOI]~~	~~Staff survey engagement score~~ ~~Staff turnover~~ ~~Pulse check scores~~	~~(31.01.25)~~	~~New staff benefits programme launched for staff including increased salary sacrifice options such as home electronics and gym membership~~	~~AMBER~~
~~Inconsistency in application of an inclusive approach impacting on developing and sustaining a sense of belonging~~	~~Embed an inclusive approach, promoting equality and ensuring diversity at all levels through learning and development, Schwartz Rounds, personal development reviews, mid-year reviews, rewards and awards, objective settings~~ ~~[ACTION OWNER: DPOI]~~	~~Year on year change WRES/WDES, staff surveys and lived experience of staff through staff networks~~ ~~Data drawn from all engagement activities to identify impacts on staff experience and any inequalities that need to be closed~~	~~(31.01.25)~~	~~Work commenced - Divisional level EDI staff survey data shared with divisions. Divisional People Leads are leading discussions on actions on improvements and achievements~~	~~AMBER~~

Board Assurance Framework 2024/25 – Issue 4.3 Board March 2025

Lack of ownership and embedded models of care and cultures across MRfD workforce resulting in retention and turnover challenges and inconsistency of approach across MRfD programme	Review of all commissioned and in house owned programmes both clinical and non-clinical to be clear of the 'ask' and the 'why' Clear framework to ensure alignment across all programmes Comprehensive plan of delivery and outcome measures [ACTIONS OWNER: DPOI]	Delivery against plan including attendance on programmes Staff survey measures Bespoke MRfD surveys to measure awareness and impact of programmes	(01.04.25)	Revised programme board and workstreams to ensure alignment and learning from gateway review Progress on measures is phasing to the opening of the new wards	RED
Not yet embedded the Trust personal accountability framework and inconsistent support for Employee Relations (ER) informal and formal cases	Fully embed Trust personal accountability framework across all teams and individuals to have ownership of their own behaviours Development and delivery of ER training for managers on cases and investigations Establish new ER services in Trust (currently in a shared service) [ACTIONS OWNER: DPOI]	Reduction in length of cases Reduction in formal cases Attendance at training by managers on cases and investigations Establishment of new ER in-house team	(30.06.25)	Progress under review – Updates to follow in next BAF issue	TBC
Inconsistent approach to flexible working impacting on staff morale	Develop and embed a clear approach to flexible working that supports service delivery and staff Develop a clear and consistent way of recording and reviewing flexible working that supports both managers and staff [ACTIONS OWNER: DPOI]	Ability to record and track number of flexible working arrangements in place Staff engagement measures via staff survey and pulse check	(30.06.25)	Progress under review – Updates to follow in next BAF issue	TBC
Lack of robust absence management policy and processes that support both managers and staff	Review and relaunch a new absence management policy Review support provided to managers to review and move forward long term sickness absence cases Review Occupational Health access, support and usage to ensure maximising service and being used to [ACTIONS OWNER: DPOI]	Reduction in absence management across both long and short term absences Reduction in Occupational Health DNAs	(30.06.25)	Progress under review – Updates to follow in next BAF issue	TBC

Board Assurance Framework 2024/25 – Issue 4.3 Board March 2025

People - Derbyshire Healthcare is a great place to work
~~Strategic Objective 2 – To be a GREAT place to work~~

There is a risk that we do not have an adequate supply of a diverse workforce with the right ~~number 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 ~~staff is limited~~some professions create long term vacancies and a lack of workforce planning in solutions to fill the gaps
~~b. There is fierce competition for professions between NHS providers for a limited number of people~~
~~c. People want to work more flexibly and a different approach to employment in 'generation z'~~
~~d. There is no embedded workforce planning across the NHS informing the supply chain~~
~~e. There is no connection between people and finance systems impacting on the ability to do real time effective planning~~
~~f. The long-term pandemic response and recovery and resultant pressures for staff has impacted on the attractiveness of careers in the NHS~~
~~g.~~b. ~~The delivery of people services is led at arms-length through the joint venture with DCHS, with limited direct ability to manage demand~~
~~h. The transformation plans require the largest scaling of services and therefore workforce growth~~
~~i. Workforce models are not in place across the organisation~~
~~j. Lack of certainty of the final workforce requirements of Making Room for Dignity~~
~~k. A large proportion of the workforce is within 10 years of possible retirement~~
~~l. The demand and usage of bank staff has doubled in the last two years~~
~~m.~~c. Pressures on workforce development and Continued Professional Development (CPD) funding may risk ability to develop skills and expertise
~~n. Funding pressures not aligned with workforce demand~~
~~o. Inherent bias in processes, policy and approach which have led to disparity in the workforce~~
~~p. Historic challenges in attracting, retaining and progressing people from diverse backgrounds, with lived experiences and with disabilities into the NHS~~
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: 24-25 2B	**Director Lead**: Rebecca Oakley (DPOI)	**Responsible Committee**: People and Culture Committee

Board Assurance Framework 2024/25 – Issue 4.3 Board March 2025

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 – ~~People building blocks; strategic priorities; 5x7 System People Priorities;~~ JUCD Careers Team; JUCD and People and Inclusion meeting; recruitment policy and procedure; TRAC recruitment system; safe staffing plans

Assurances on controls – Internal	Assurances on controls – External
People Performance Report at ELT and PCC People Dashboard in PCC PCC forward plan and deep dive plan Workforce plan Embedded recruitment and retention scheme	Healthcare Support Workers (HCSW) submissions System operational planning process Safe staffing report Regular NOF Level 3 meetings with NHSE and ICB (in relation to Making Room for Dignity (MRfD) recruitment)

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 ~~Establish a workforce transformation group to develop workforce development plans and ownership at divisional level~~ [ACTIONS OWNER: DPOI]	Vacancy rates Time taken to fill vacant posts Transformational posts, e.g. apprenticeships all identified Reduction in agency costs	~~(30.01.25)~~ (31.03.25)	Work commenced to map apprenticeship plan and resources required Agency reduction plan in place and having impact ~~Further agency summit planned for October 2024 to review ongoing spend~~ Agency summit took place October and November 2024 to focus on medical and acute agency spend (highest areas) Executive-led vacancy control meeting takes place every week for approval of all vacancies and workforce	AMBER

				expenditure increases, i.e., job evaluation ~~Vacancy control process strengthened and ongoing~~	
We do not have an effective and embedded succession talent management processes	Develop a Talent Management Strategy Pilot career conversations for senior leaders and roll out career conversations for all colleagues Work as a system to develop system-wide approach to talent management and align where best for the Trusts [ACTIONS OWNER: DPOI]	Career conversations taking place Internal appointments/promotions Turnover rate Key staff survey measures	~~(30.01.25)~~ (31.03.25)	Talent Strategy finalised Talent programme relaunched following learning from previous pilot with clear engagement timescales and expectations Talent and succession planning part of every executive director objectives	RED
~~Lack of capacity, experience and plans for recruiting overseas~~	~~Develop International Recruitment (IR) plan and programme~~ ~~Appoint IR team to lead programme~~ ~~Engage with national IR support~~ ~~Access national IR funding~~ ~~Support Trust teams to prepare for IR arrivals~~ ~~[ACTIONS OWNER: DPOI]~~	~~Number of IR appointments~~ ~~Retention rate of IR~~	~~(30.01.25)~~	~~Successfully recruited and objective structured clinical examination (OSCE) conversion completed for six IR candidates~~ ~~A further cohort of IR candidates will now be taking place~~	~~AMBER~~
Onboarding and retention process and planning needs to be embedded (this includes MRfD and challenges on retention of high numbers of newly qualified nurses)	Understand the key retention issues for posts/teams/professions with the highest turnover Ensure 'stay conversations' form part of regular 1:1s Develop NHS retention framework for nursing [ACTIONS OWNER: DPOI]	Improvements to turnover Staff survey engagement scores	~~(30.01.25)~~ (31.03.25)	Additional posts added to the preceptorship team to support retention of high numbers of newly qualified staff	RED
~~Medical staffing team and role not sufficiently developed~~	~~Review existing medical staffing team and workforce support and identify gaps~~	~~Engagement of medical workforce~~ ~~Reduction in agency spend~~	~~Complete~~ ~~(30.01.25)~~	~~Further discussions held as part of the agency summit –~~	~~AMBER~~

~~Workforce plan for medical staff not in place~~	~~Develop new model to support and maximise the medical workforce~~ ~~Develop medical agency model to ensure efficient usage~~ ~~Develop a medical staff workforce plan [ACTIONS OWNER: DPOI]~~			~~Agreed action to support agency reduction~~	
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 ~~of culturally competent recruitment processes~~	~~Completion and implementation of recommendations of the Above Difference recruitment and retention system pilot~~ ~~Wider engagement with recruiting managers, staff networks, clinical leads and operational leads~~ All chairs of recruitment panels have undergone inclusive chairs recruitment training Data driven recruitment practices ~~Quartile monitoring of utilisation of Above Difference recruitment and retention tools~~ ~~Continuous improvement approach to implementing learning~~ [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	~~(30.01.25)~~ (31.03.25)	~~Recruitment leads across the system all trained through Above Difference programme~~ Inclusive recruitment for chairs training commenced	RED
Effectiveness of recruitment policy, practice and processes	Review and develop existing recruitment Key Performance Indicators (KPIs) to ensure fit for purpose Where appropriate move away from TRAC to advertise jobs and use fast track processes, e.g. Indeed/MSforms Develop cohort recruitment for key posts Improve the multidisciplinary working (HR, communications and recruiting	Time to recruit Number of applicants applying and successfully shortlisted Campaign impact and reach Financial savings through cohort recruitment	~~(30.01.25)~~ (31.03.25)	Trust Strategic Recruitment and Retention Lead appointed Successful recruitment events in place including attendance at universities A range of recruitment methods are ~~being~~ deployed to ensure we attract a diverse range of applicants	AMBER

	managers) to enable better planned and executed campaigns [ACTIONS OWNER: DPOI]			On track with MRfD recruitment posts and plans in place for hard to recruit posts	
Agency and bank usage control measures and reduction	Ensure bank and agency usage is controlled by clear processes and measures with accountability at team level on spend Agency off framework usage is managed with clear expectations Plan in place to reduce and align to agency price cap for all posts Bank staff are recognised and rewarded appropriately [ACTIONS OWNER: DPOI]	Agency and bank usage reduction Agency off framework nil return Agency price cap achieved Bank usage is appropriate and available to support where needed	(30.06.25)	Progress under review – Updates to follow in next BAF issue	TBC

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

Board Assurance Framework 2024/25 – Issue 4.3 Board March 2025

Productive - Our services will be productive, demonstrate best value for our population and be cost effective ~~**Strategic Objective 3 – To Make BEST use of Our Resources**~~			
There is a risk that the Trust fails to deliver its revenue and capital financial plans 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 ~~is at risk of deteriorating~~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 **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 ~~i)~~k) Inability to manage increasing demand and acuity in our inpatient settings		
BAF Ref: 24-25 3A	**Director Lead**: James Sabin (DOF)	**Responsible Committee**: Finance and Performance Committee	
Key Controls			
Initial Risk Rating	**Current Risk Rating**	**Target Risk Rating**	**Risk Appetite**

Board Assurance Framework 2024/25 – Issue 4.3 Board March 2025

Moderate	Likelihood 2	Impact 5	Extreme	Likelihood 4	Impact 5	Moderate	Likelihood 2	Impact 5	Accepted	Tolerated	Not Accepted

Preventative – Operating plan and financial plan agreed for 24/25 in line with ICB requirement. Integrated Care System (ICS) signed off and fully support the dormitory eradication programme. 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 ~~Local Operating Procedure for Acute~~ 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 Vacancy control process in place with Executive oversight Performance management processes in place and being refreshed to add to assurance levels Dormitory eradication and PICU programme monitoring and reporting Appropriate monitoring and reporting of financial delivery – Trust overall and programme-specific including 'Use of Resources' reporting updates Assurance levels gained at Finance and Performance Committee (F&P) Delivery of Counter fraud and audit work programme with completed and embedded actions for all recommendations Independent assurance via internal auditors including HFMA checklist, external auditors and counter fraud specialist that the figures reported are valid and systems and processes for financial governance are adequate New governance process in place for the Making Room for Dignity programme and action plan in place in relation to the gateway review findings ~~Local Operating Procedure in operation for Acute Capital Programme Board and F&P oversight of Acute Capital Programme delivery~~	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

Board Assurance Framework 2024/25 – Issue 4.3 Board March 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
Trust cash and capital risks related to national funded acute capital programme: - Inflation cost risk - Risk-share - Cashflow timings and variability - Guaranteed Maximum Price exceeds national funding envelope (due to hyperinflation and other factors) Increased cost pressure now aligned to final refurbishment project. ~~Without national support, proceeding to contract in October is a challenge~~	Risk share arrangements with PSCP Programme approach and engagement with all stakeholders. Close involvement with NHSE Discussions ongoing with ICB and NHSE around the Making Room for Dignity cost pressure. ~~of~~ Although initial ask was supported, the cost pressure has grown materially in relation to the adult acute units, We are also not in a position to meet the conditions as now the pressure has grown and we will not have a Guaranteed Maximum Price (GMP) for Radbourne Until late Quarter 4 ~~c£7.5m~~ ~~Recent discussions held with NHSE and region around latest pressure. Decision pending and overdue~~ Further discussions are ongoing with NHSE Also progressing another VAT claim to part fund final stage [ACTIONS OWNER: DOF]	Cash and capital reporting as part of finance reporting into F&P and Board forecasting evidence of plan delivery and/or indicates areas of required management action New governance process will report formally into ELT and F&P then upwards to Board	31.03.25	Regular oversight of capital and cash position. Reporting to Trust Programme meetings and Committees on risks and mitigations Hyper-inflation cost risk is reducing Significant cost pressures on Radbourne Unit Refurb. - Options being revisited in light of growing pressure. Additional funding earmarked from national team is insufficient. Options and review needs to conclude in Quarter 4 to enable reinstatement of original plans with Kier in April or to move to a plan B ~~and Older Adults ward refurb requiring ongoing action~~ VAT rebate continues to flow to Trust. Still ongoing and reducing current/ongoing payments	~~AMBER~~ RED
System capital programme funding shortfall for self-funded Trust capital programme: System Capital Departmental Expenditure Limit (CDEL) inadequacy	Access any new national funding streams (e.g. digital or cyber) in year to maximise system capital plan in order to redirect CDEL capital for this cost pressure and other needed schemes [ACTIONS OWNER: DOF]	There remains a risk we will overcommit our CDEL allocation in 2024/25 (likely by £4M). ~~.~~ Ward 35 decision is a key risk later this year and would have wider impact on the strategic objective to eradicate all dorms	31.03.25	System capital plan has been submitted as part of planning process. We have also fed in the 10 year capital plan as part of a wider ICB system wide return Risk remains in relation to the Making Room for Dignity cost	~~AMBER~~ RED

for system capital requirements		Although national funding has been confirmed, it is now known this is not sufficient ~~If not nationally funded and confirmed by October~~, we will have an issue to address with the ICB~~.~~ To proceed at risk (affordability, cashflow and CDEL breach concerns) or pause/stop/abandon which would not deliver dormitory eradication and reduce bed capacity. Alternative more cost effective options to be explored but overall pressure remains		pressure and discussions with ICB and NHSE remain ongoing	
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. National funding for PDC revenue costs included in allocations for 2023/24 plan Early recruitment to staffing built into revenue plan of the Trust and funded by the system (both income and expenditure in the plan) as part of operating plan for 2024/25 [ACTIONS OWNER: DOF]	Monitoring and reporting of income allocations and expenditure in year Transparent reporting of position shared with ICB to reduce challenge and ensure joint understanding and support	31.03.25	~~Funding for PDC revenue from NHSE included in financial plan submission. Guidance change has removed £2.5m of income. Key driver of our underlying deficit~~ MHLDA DB agreed to oversee revenue delivery contained within programme spend Capital delay has led to reduced revenue risk and slippage Supporting non-recurrent revenue costs associated with dormitories and wider system	~~RED~~ AMBER
Insufficient substantive staffing into vacancies and temporary staffing costs for bank and agency staff do not reduce	Additional management action and oversight Agency progress monitored and strengthened links to CIP oversight group Direct engagement solution being implemented re medics	Enhanced bank and agency costs reported as part of wider financial and workforce reporting Continued workforce strategies progressed to reduce agency and increase bank reducing risk	31.03.25	Reports to ELT and F&P outlining current areas of pressure and required actions to be taken in year in order to remain on plan Funding contribution agreed with Eating Disorder Provider Collaborative for exceptional agency costs re 2023/24. ~~, further~~	~~RED~~ AMBER

	[ACTIONS OWNER: DPOI/DOF]			~~costs are being recharged but are in dispute.~~ Discussions ongoing re 2025/26 costs. Transfer of patient was concluded in September and non longer a concern ~~is on track for September and we are expected to cover future costs~~	
Non-delivery of required recurrent cost reduction and improved efficiency and Quality Improvement	Compilation and delivery of planned Trust efficiencies and quality improvements to deliver 2024/25 plan including recurrent long term cost reductions to return to breakeven Planning for 2024/25 has led to a recent ask for directorates to develop plans of 4% cost improvement in addition to various transformation schemes CIP governance and reporting processes strengthened. Close links to wider work re agency reduction, effective rostering and vacancy control [ACTIONS OWNERS: DOF/DPOI]	Efficiency and QI reporting to executives and F&P	31.03.25	CIP gap continues to reduce. The percentage which has been identified recurrently continues to increase Executive vacancy panel established in December 2023 Performance meetings are in place for clinical directorates and plans are being put in place in future for corporate areas Performance related additional controls are being developed to help close the CIP gap and ensure mitigation is in place Risk reducing due to continued progress Out of area risk, rather than CIP risk is now the primary factor in our plan delivery	~~RED~~ AMBER
Financial cost pressures created both internally and by system first decisions leading to the requirement for mitigations to close both the internal gap and the system financial gap	Additional 'stretch' management action required to reduce other cost and mitigate impact to achieve overall financial position Long list of unpalatable options drawn up and supported in principle by Board for further review. These are for consideration post planning nationally due to potential to impact patients and core Trust NHS offer. Need to develop		31.03.25	The financial position for Derbyshire is a risk to the statutory duties for DHCFT to manage its financial position Financial plan for 2024/25 is concluded but we need to continue to work on reducing the deficit as part of our longer term financial sustainability	RED

	these into costed and prioritised plans with clarity of patient and wider staff impact [ACTIONS OWNER: DOF]			All new investments to follow governance processes with business cases via ELT, F&P and Board where appropriate	

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

Board Assurance Framework 2024/25 – Issue 4.3 Board March 2025

Partnerships - Our organisation will identify new ways of working, through new collaborative approaches
~~**Strategic Objective 4 – To be a GREAT Partner**~~

Principal risk: **There is a risk that the effects of both nationally and locally driven changes to roles and responsibilities within the Integrated Care Board (ICB), and with its partners may impact negatively on the cohesiveness of the Derbyshire health and care system** ~~**Whilst there are significant benefits from the creation of the Integrated Care System (ICS) as an NHS body, there is a risk that the effects of the change may impact negatively on the cohesiveness of the Derbyshire health and care system**~~

Impact: Quality of services and patient experience may deteriorate. Financial position of the Derbyshire Health and Care system worsens; working relationships across the system deteriorates; loss of confidence from regulators in the Derbyshire system

Root causes:

a) S~~New s~~enior management relationships across organisations ~~, with potential new appointments in system leadership roles~~ and organisational expectations of role and responsibilities ~~the creation of provider collaboratives~~
b) Creation of mental health, learning disability and autism provider collaborative may destabilise some of the established relationships in place across Derbyshire
c) Creation of system level governance structures, for example Provider Collaborative Leadership Board, may impact on provider Foundation Trust governance arrangements and decision-making processes
d) Staff impacted by change, may lead to increased staff turnover in teams supporting the delivery of the Mental Health Long-Term Plan and subsequent loss of organisational memory
e) The Trust taking on additional lead-provider responsibilities at an ICS or regional level could impact on the quality, performance and financial risks faced by the organisation

BAF Ref: 24-25 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

Board Assurance Framework 2024/25 – Issue 4.3 Board March 2025

Assurances on controls – Internal	Assurances on controls – External
Regular reporting of position to Board by CEO Regular ELT updates and discussions NED Board members on JUCD committees and Board Board agreement required prior to undertaking of lead-provider responsibilities	Mental Health and Learning Disability assurance meetings with NHSE and ICB Gateway process run by NHSE prior to agreement to establish a Trust as lead-provider in regional collaboratives Representation on system-wide governance groups

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Increased governance at ICB and system level may create delays to decision making and cause increased governance burden ~~Increased decision-making at a system and/or provider alliance level may create conflicting accountabilities with the Trust-level governance structures which could result in an 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 [ACTION OWNERS: CEO/DCA]	Board level assurance that the Trust's corporate governance systems are compatible with the new ways of working that would allow both Trust and system objectives to be achieved Board level assurance that the Trust's risks have been fully articulated and understood within the wider integrated care system	~~(31.12.24)~~ (31/03/25)	~~Ongoing review of Trust governance to ensure operational performance delivery of MHLDA constitutional standards that DHCFT is a lead or main provider of the performance~~. 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	AMBER

				Trust's risks reported to the ICB monthly for cross-reference with other providers for the ICB BAF	

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

Board Assurance Framework 2024/25 – Issue 4.3 Board March 2025

Partnerships - Our organisation will identify new ways of working, through new collaborative approaches
~~**Strategic Objective 4 - To be a GREAT Partner**~~ ~~**Strategic Objective 4 – To be a GREAT partner**~~

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 ~~lead to poor~~have detrimental impact on patient experience and quality of care provided for people accessing services ~~within Place and communities~~.
~~Possible organisational ability to influence developments within the ICS~~

Root causes:
a) Silo working within the o~~O~~rganisation ~~historically too internally focused – Provider responsibilities impacting on executive and operational capacity~~
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: 24-25 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
~~System partners report that~~ S~~s~~ome ~~of its~~ core constitutional targets ~~were~~ not being met and ~~was failing to~~risk to mak~~ing~~e progress, at pace and scale, resulting in some patients being cared for outside of Derby and Derbyshire	New internal performance improvement group ~~and clarity to Trust Board on which DHCFT constitutional standards are not being met and whether the DHCFT contribution is the lead or material and how performance will improve~~ Recovery action plans for areas where Trust constitutional standards are not being met Improvement plan for joint autism service (with system partners) [ACTIONS OWNERS: CDO]	Improvement in performance in constitutional standards Recovery action plans in place in all required areas Feedback from social care on awareness of the Autism Strategy and reduction in autism waiting times ~~reduce across the interagency investment plan~~	~~(31.12.24)~~ (31.03.25)	~~Integrated performance report allows insight on key areas of improvement, with actions and narrative around next steps~~ In-year ~~p~~Progress delivering ~~with~~ recovery action plans: Performance improvement in dementia diagnosis and perinatal access has resulted in DHCFT now delivering the core constitutional targets in this area and others Ongoing work to reduce inappropriate Out of Area Placements, underpinned by a Recovery Action Plan continues including a twice weekly Multi-Agency Discharge Event, roll out of home treatment service, and piloting weekend working for community mental health teams. ~~and planned opening of~~ local PICU, will support improved patient flow and improved quality of care as the above will enable patients to be treated locally. ~~however inappropriate Out of Area placements remain above trajectory~~ ~~Autism waiting times continue to be achieved for the 26~~	RED

Formatted: Not Highlight

				~~contracted assessments per month.~~ ~~Internal quality improvement work has resulted in significant improvement in waiting times for assessment and reduction of wait lists~~	
System partners report that DHCFT is inward looking and not easy to work with ~~does not fully support PLACE developments~~	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 ~~Managing Directors to design a communication and improvement plan, with 360 feedback that PLACE partners feel DHCFT support, data is provided and their support named Managing Director is accessible~~ [ACTION OWNER: CDO]	~~PLACE / PCN and GP Directors provide direct feedback to Managing Directors on their relationship, knowledge and impact of the additional leadership support. This includes examples of collaboration and the impact of this support~~ ~~Confirmation of frequency of contact, joint action / achievement log of issues raised and achieved~~ ~~Managing Directors reports to TLT with summary of impact to ELT~~ Increased delivery of integrated services	~~(31.12.24)~~ (31.03.25)	~~Managing Directors (MDs) actively engaging with Primary Care Networks (PCNs)~~ Active membership of~~MDs are members~~ of Derby City PLACE Board, ~~and~~ PLACE County Partnership Board, and the integrated PLACE executive ~~Senior representation at the Integrated Place Executive.~~ Senior management representation named for all PLACE Alliance groups.~~ City and County Partnership Board currently developing purpose, MDs are actively involved in. MDs are also linking in with local GP forums within the City and County~~ ~~CEO meeting with GP network monthly~~ Collaborative development of community mental health 24/7 pilot alongside general practice partners	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	Reduction in inpatient absent and missing cases Training sessions offered to Police partners:	~~(31.12.24)~~ (31.03.25)	Police are a formal member of the MHLDA DB ~~and attending and contributing~~ ~~Street triage pilot was established between Police~~	AMBER

	To streamline process and timeline for 136 suite admissions and handover ~~support, communication and improved partnership working~~ [ACTION OWNER: CDO]	• Police mental health awareness training sessions • Suicide prevention work • Joint working with Trust safeguarding teams • Collaborative response to Right care Right Person (RCRP) Increased handovers completed within one hour		~~and Trust. This ceased on 31.03.24 and will be replaced by Right Care Right Person (RCRP)~~ Mental Health Response Vehicle (MHRV) to be implemented during 2024/25, to jointly provide a Trust and Police response to mental ill health calls ~~reduce pressure on Police to respond to mental ill health calls~~ Crisis café have opened in Buxton, Ripley and Swadlincote – This reduces demand on Police call-outs Trust is a member of the RCRP implementation executive group covering the Derbyshire system ~~with Police stakeholders and system colleagues~~	
Patient and carers groups report that they would like to see more progress in service user and carer involvement and moving from engagement to decision making	Peer support strategy and objectives for EQUAL and the Mental Health Engagement Group [ACTION OWNERS: DON/MD]	Peer support strategy Co-production in Patient and Carer Race Equality Framework (PCREF) requirements	~~(31.12.24)~~ (31.03.25)	EQUAL group established to support service user and carer engagement~~. EQUAL has created several sub committees~~ 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

				~~and effectively use action logs to reflect improvements made in service developments and patient care~~	

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

Board Assurance Framework 2024/25 – Issue 4.3 Board March 2025

~~PART TWO – SYSTEM BASED RISK IMPACTING ON AND MITIGATED BY MULTIPLE SYSTEM ORGANISATIONS~~

Partnerships - Our organisation will identify new ways of working, through new collaborative approaches
~~Multiple System Strategic Risk~~

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 ~~and in ICS in-patient LD bedded care~~

Impact: Poor partnership and system working could impact on the experience and quality of care provided for people with a ND disorder in Derbyshire ~~May lead to avoidable harm and delays in accessing appropriate services, affecting patients, their family members and staff~~

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) Inpatient bedded facilities do not meet safer staffing levels due to vacancies~~
~~e) Derbyshire bedded facilities do not meet current standards, e.g., en-suite accommodation, safety and environmental standards and the seclusion room does not meet the required standards as outlined in the Mental Health Act Code of Practice~~
~~f) The current LD bedded care facilities do not meet the national specifications for the Royal College of Psychiatrists Learning Disability recommended standards and are not in line with future clinical model for the LD&A pathway for Derbyshire~~
~~g) Derbyshire bedded care facilities for LD services had not had a full CQC inspection since 2016 as a core service~~
~~h)~~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

BAF Ref: 24-25 ~~MS1~~ 4C	**Director Lead**: Vikki Ashton Taylor (CDO)	**Responsible Committee**: Quality and Safeguarding Committee ~~– within~~ DHCFT Quality and Performance Committee ~~– within the~~ 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

Board Assurance Framework 2024/25 – Issue 4.3 Board March 2025

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; ~~and commitments; Quality Improvement 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 ~~improved models of support~~improvement	Review all models of support offered by the Intensive Support Team (IST) [ACTION OWNERS: CDO/DON/MD]	Outcome of review – Improved models of support	~~(31.12.24)~~ (31.03.25)	ICB have presented ~~work~~ to both providers ~~which looks at~~on how to ensure community offers ~~like IST~~ are enhanced further through the review of pathway offers where resource is disproportionately allocated Ongoing discussions to commit more resources to community pathways ~~including IST is interdependent on the future bedded model which is being explored by the ICB~~ The Trust is ~~now~~ working alongside DCHS and has established an integrated service provision for neurodevelopmental services across both organisations ~~for the system~~	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 ~~their lives~~ in the least restrictive manner, ~~-~~as close to home as possible	Continue to work on developed delivery improvement plan, owned by system partners~~, to improve position.~~. This includes new cohort stratification. ~~approach that has been developed –~~ Kk~~ey~~ action to implement ~~and fully~~ 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 ~~working across partner systems~~ Enhancing and reviewing Listening and Engagement Active Partnerships (LEAP) procedures Improvement plans in admission avoidance, crisis alternatives to admission ~~and market stimulation and development~~, including improvement in the use of Dynamic Support Registers as a means of admission avoidance ~~Make significant impacts on the number of stranded patients who have~~Reduction in delayed discharges in units across the country resulting in ~~the~~ NHSE escalations	~~(31.12.24)~~ (31.03.25)	Derbyshire is no-longer in national escalation regarding performance with inpatient services after demonstrating ~~significant progress and~~ improvement against plans. ~~and clear grip~~. New Dynamic Support Pathway (DSP) launched following cross-agency redesign work Cross-system delivery plan continues to be monitored through Neurodevelopmental Delivery group Board – Includes action plan in response to inflow, flow and outflow as discussed with NHSE and ICB leaders	AMBER
~~Current substantial staff vacancies are negatively impacting on safer staffing levels in a non-DHCFT Derbyshire bedded care facility~~	~~Compliance with NHS Improvement (NHSI) Workforce Safeguards requirements~~ ~~[ACTIONS OWNERS: CDO/DON]~~	~~Full compliance with safer staffing levels in line with the NHSI Workforce Safeguards~~	~~(31.12.24)~~	~~Reviews of safer staffing and stabilisation in non-DHCFT Derbyshire bedded LD facility - New period of service stabilisation underway with a focus on expediting discharge of current inpatients, and not accepting further admissions~~ ~~Workforce issues including recruitment and retention, staff wellbeing and mitigations against use of agency staff being addressed with rapidly~~	~~AMBER~~

				~~mobilised short-term leadership from DHCFT into the unit~~ ~~Improved engagement with universities and final year student nurses.~~ ~~The non-DHCFT bedded unit has now temporarily closed (August 2024); as agreed by the system whilst future models are evaluated~~	
~~Clinical care standards in a non-DHCFT Derbyshire bedded care facility including care plans, levels of incidents, restrictive practices including the use of long-term segregation are not compliant with clinical care standards~~	~~Develop an improvement plan for all Derbyshire in-patient LD&A services [ACTION OWNERS: CDO/DON]~~	~~Full compliance with required care standards~~ ~~External review of Long-Term Segregation and review to end restrictive practices~~	~~(31.12.24)~~	~~Joint paper from Trusts to ICB regarding overall bedded offer and inpatient review discussed with ICB executives March 2024~~ ~~Overall quality plan for improvement for LD&A inpatients in place following review by ICB - This includes trying to reduce the level of out of area care~~	~~AMBER~~
~~Lack of adherence to national guidance and policy on in-patient care in a non-DHCFT Derbyshire bedded care facility~~	~~Deliver a single room en-suite delivery plan and programme of work [ACTION OWNER: CDO/DON]~~	~~Delivery of approved business cases for development of single en-suite facilities, seclusion suite at specification standards and other improving the therapeutic and healing environment requirements~~ ~~Implementation of programme of work~~	~~(31.12.24)~~	~~Partnership working with DCHS and ICB to agree future plans and direction of travel for bedded offer for Derbyshire patients continues. Executive level discussions are underway for the long term goal, whilst providers work together to stabilise position in current unit and expedite discharges~~ ~~Broad expectations on model of care (bed 'type')~~	~~AMBER~~

				~~agreed across partners, including offering community house step up/step down options – Large scale ongoing work.~~	

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 fedback 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	30.10.24	30.01.25	HIGH

Board Assurance Framework 2024/25 – Issue 4.3 Board March 2025

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

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

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

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

Action Owners

CEO	Chief Executive Officer
DOF	Director of Finance
MD	Medical Director
CDO	Deputy Chief Executive / Chief Delivery Officer
DON	Director of Nursing, AHPs and Patient Experience
DPOI	Director of People, Organisational Development and Inclusion
DCA	Director of Corporate Affairs and Trust Secretary

Definitions

Preventative	A control that limits the possibility of an undesirable outcome
Detective	A control that identifies errors after the event
Directive	A control designed to cause or encourage a desirable event to occur

Board Assurance Framework 2024/25 – Issue 4.3 Board March 2025

Ref	Risk	Director Lead	Risk Rating	Responsible Committee
Patient Focused - Our services will deliver safe and high-quality care				
24-25 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	Executive Director of Nursing, AHPs and Patient Experience (DON) / Medical Director (MD)	**HIGH**	Quality and Safeguarding Committee
24-25 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)	**HIGH**	Finance and Performance Committee
24-25 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)	**MODERATE**	Finance and Performance Committee
24-25 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	Executive Director of Nursing, AHPs and Patient Experience (DON) / Chief Delivery Officer (CDO)	**MODERATE**	Quality and Safeguarding Committee
People - Derbyshire Healthcare is a great place to work				
24-25 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
24-25 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				
24-25 3A	There is a risk that the Trust fails to deliver its revenue and capital financial plans 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	Executive Director of Finance (DOF)	**EXTREME**	Finance and Performance Committee

Partnerships - Our organisation will identify new ways of working, through new collaborative approaches				
24-25 4A	There is a risk that the effects of both nationally and locally driven changes to roles and responsibilities within the Integrated Care Board (ICB), and with its partners may impact negatively on the cohesiveness of the Derbyshire health and care system	Chief Delivery Officer (CDO)	**MODERATE**	Trust Board
24-25 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
24-25 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 2024/25 – Issue 4.3 Board March 2025

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

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

Impact: May lead to avoidable harm including increased morbidity and mortality; delays in recovery; and longer episodes of treatment; affecting patients, their family members, staff or the public

Root causes:

a) Workforce supply and lack of capacity to deliver effective care across hotspot areas, increasing risks in the clinical and medical workforce
b) Risk of substantial increase in clinical demand in some services
c) Intermittent lack of compliance with Care Quality Commission (CQC) standards, specifically the safety domain
d) National Oversight Framework (NOF) Level 3 quality issues
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 need to embed the new 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) Safety and learning culture, learning from internal incidents, complaints and other sources of feedback is not developing and needs to be further embedded

BAF Ref: 24-25 1A	**Director Lead**: Tumi Banda (DON) / Dr Arun Chidambaram (MD)	**Responsible Committee**: Quality and Safeguarding Committee

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Appetite**		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Quality governance structures, teams and processes to identify quality related issues; mandatory training; Duty of Candour processes; clinical audits and research; health and safety audits; risk assessments; physical health care screening and monitoring; monitoring and effective responses

to infection and control guidance, EQUAL unannounced visits to services and anonymised bright ideas service improvement ideas. Feedback intelligence from independent advocacy, Director visits in and out of hours and Board visits

Detective – Quality dashboard reporting; Board visits virtual clinical service contact visits; incident, complaints and risk investigation; clinical audit; Fire Safety Regulations (FSR) compliance checks; mortality review process; physical health care monitoring clinics pilots; safety check log; Head of Nursing and Matron compliance visits, reviewed model of announced and unannounced visits to service throughout the 24-hour period

Directive – Trust Strategy; Physical Health Care Strategy; 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 (QSC); Continuous Improvement Plan – Confirmed launch date is 01.04.25

Assurances on controls – Internal	Assurances on controls – External
Trust quality and performance dashboards Scrutiny of Quality Account by committees Programme of physical healthcare and other clinical audits and associated plans Infection Control Board Assurance Framework reported to NHS England Positive and Safe self-assessment Head of Nursing and Matron compliance visits Board visits and out of hours visits CQC action plan in place (April 2024)	National enquiry into suicide and homicide NHS Litigation Authority (NHSLA) scorecard demonstrating low levels of claims Safety Thermometer identifies positive position against national benchmark Mental Health Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards CQC comprehensive review 2020 Trust is rated Good Trust fully compliant with National Quality Board Learning from Deaths guidance Relationship Meetings with CQC taking place Patient Safety Incident Response Framework (PSIRF) implementation CQC inspection (April 2024) Regular NOF Level 3 meetings with NHS England (NHSE) and Integrated Care Board (ICB) ICB local review to ensure there are clear policies in place to meet the needs of people in Derbyshire with severe mental health illness NHSE guidance on intensive and assertive community mental health treatment Lord Darzi report and anticipated 10 year plan for the NHS

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Summary of progress	Action rating
Implementation of revised priority actions for 'High Quality Patient Focused Care' which support the Trust strategy and patient outcomes and guidance and standards for quality care	To ensure adherence with guidance and standards of care, to measure improvements in patient outcomes To develop and implement a Quality Plan and a Continuous Improvement Plan To develop an improved learning culture within the Trust [ACTIONS OWNER: DON]	Compliance with suite of metrics and reporting schedule detailed in quality dashboard Internal reporting against self-assessment CQC inspection and assessment as a measurement tool Fundamental standards of care	31.03.25	Quality Surveillance Dashboard revised (programme of ward visits which are assessed against the CQC's single assessment framework) A CQC/Fundamental Standards Trust Oversight Group has been established, which	AMBER

		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		scrutinises progress of actions arising from regulatory inspections and Mental Health Act visits and provides sign-off of completed actions CQC Executive Oversight Group in place – Fortnightly scrutiny of actions and updates reviewed Divisional Performance Reviews (DPRs) now embedded. We are now using the scorecard report with a data informed approach in the DPRs A new Trust Strategy has been launched which sets out a clear direction for patient focussed improvements New Quality Plan and Continuous Improvement Plans are planned for development in 2025	
Gap in operating standards for acute and community mental health services	Compile outcome measures for acute and community services and create relevant dashboards for the services to inform areas for improvement Improvement of both inpatient and community care settings – Environments need to be improved [ACTIONS OWNER: DON]	Improvement in operating standards compliance to be overseen by Quality and Safeguarding Committee Implemented Acute Inpatient Mental Health Service Accreditation (RCP Standards) reported in Divisional Achievement Reviews and Quality Account	31.03.25	Increased performance management scrutiny and unannounced site visits undertaken with compliance checks Monitoring Fundamental Standards of Care and the quality measures through the Quality Dashboard	AMBER

	Set out improvement plans to achieve Royal College of Psychiatrists (RCP) accreditation across services [ACTION OWNERS: MD/DON/CDO] Implement Community Mental Health Framework [ACTION OWNER: CDO]	Implemented Mental Health Community Framework to Quality and Safeguarding Committee	31.03.25	Internal Trust programme Board in place to strengthen contribution and involvement in system-wide programme and delivery Mobilisation underway in High Peak, Derby City, Chesterfield and North-East Derbyshire System Programme Team now established Final stage of mobilisation now completed in Amber Valley, Erewash, South Derbyshire and Derbyshire Dales Viability of the model may be at risk due to possibility of the social worker component not being funded by the ICB	
Implementation of new quality priorities for: - Sexual safety - Implementing CQUINS and Clinical outcome measures - Recovering services – equally well - New Trust strategy and priorities - Dormitory eradication programme	Develop and implement an improvement plan to enable all quality priorities to be implemented [ACTION OWNER: DON]	Compliance with suite of metrics and reporting schedule	31.03.25	The Trust has developed a sexual safety plan and has signed up to the sexual safety charter Sexual safety – Improvement work (dashboard, preceptorship training and protocols) commenced. Sexual safety on professional standards video launched with new training Dormitory eradication programme in construction: Making	GREEN

				Room for Dignity is making progress with the units planned for opening between February and June 2025 The Trust is participating in the Culture of Care Collaborative Implementation of the Models of Care is progressing well	
Learning from independent and national forums on current issues affecting patient safety outcomes and experience	Participate in collaborative local and regional forums to gather learning Revisit all assurances and scrutinise practice, gathering intelligence and implement an improvement plan to enable all services to provide the highest standard of care which would be expected [ACTIONS OWNERS: DON/MD]	Ensuring that staff are aware of how to raise concerns and speak up Implement the Accountability Framework Strengthen out of hours, weekends and night announced and unannounced visits. To promote access to multiple managers, relationships, so colleagues feel empowered to report any concerns Professional leads are in place and supported by Employee Relations to ensure that registered professional staff are aware of the requirements to practice in line with their professional codes Uphold safeguarding standards including PIPOT Timely investigation and response to concerns and complaints	(31.03.25)	Options for staff to have conversations about care delivery and raise concerns available include Trust-wide and divisional engagements, Freedom to Speak Up, Schwartz Rounds Improvements in engagement of temporary staff identified Increased visibility of senior staff through Board visits and out of hours visits Robust oversight of patient safety incidents, concerns, complaints, and compliments with scrutiny from independent partners, e.g. Healthwatch and experts by experience being core members of Patient and Carer Experience Committee	AMBER

				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	
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	31.03.25	Ongoing oversight of CPA continues with focus on care planning and risk assessment Planning discussion has taken place in relation to the transition from CPA to the preferred alternative model, Dialogue Plus CPA training continues at present until alternative identified	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	(31.03.25)	Review of new strategy for Major Conditions and Suicide Prevention PSIRF priorities for 2024/25 focusing on prevention and oversight, linked to new strategies	AMBER

				Trust Clinical Plan in development	
Review of Patient Carer Race and Equality Framework (PCREF) and develop implementation plan	Revisit new policy direction and develop new plans [ACTION OWNER: MD]	Review framework and develop implementation plan	(31.03.25)	New Patient and Carer Strategy has gone through QSG and will be launched in line with the wider Trust Strategy EDI lead will be responsible for workforce elements of PCREF - Recruitment process underway Central oversight and resource to be identified	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
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	28.02.22	27.03.25	HIGH
23251	Forensic and Mental Health Rehabilitation Services	Risk to public due to management of Section 37/41	01.08.24: Following a recent Section 37/41 audit it has highlighted that clinical documentation is not of the standard and completion that is felt to effectively support and manage this group of patients - Risks posed to members of the public. Action logged to discuss next steps, which will outline risks and benefits associated with current process of management of S37/41s and risk and benefits of all S37/41s being managed under the Forensic CMHT 18.11.24: Audit highlighted concerns around the clinical documentation and management of 37/41's in local CMHTs – Continue to look at hybrid working within CMHTs Update requested from Risk Handler	02.10.24	18.02.25	HIGH

23372	Corporate Services – Estates and Facilities	Risk to patient and staff safety due to parking issues - Kingsway site	29.01.25: Parking is extremely dangerous on Kingsway site, this is presenting possible life-threatening issues, and the potential for a repeat of previous occasions where a 999 vehicle couldn't access the site. We have responsibilities under the Health and Safety at Work etc. Act 1974 and the Regulatory Reform (fire safety) Order 2005 to ensure that we do not contribute or cause anyone's death. This would carry a corporate manslaughter charge should this happen. Requests have been made by the Head of H&S and staffside that: We tell non-patient facing staff, where there isn't a risk at home, to work from home, to bring many of the meetings back to online, including training where at all possible 11.02.25: There are a number of actions underway to manage this issue in the short terms, some communicated to all staff. In addition, there is an options paper for a more sustainable response going to the next ELT meeting	29.01.25	11.05.25	**HIGH**

Board Assurance Framework 2024/25 – Issue 4.3 Board March 2025

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

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

BAF Ref: 24-25 1B	**Director Lead**: Vikki Ashton Taylor (CDO)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Appetite**		
High	Likelihood 4	Impact 4	High	Likelihood 3	Impact 5	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Routine environmental assessments for statutory health and safety requirements; environmental risk assessments reported through Datix; Infection, Prevention Control (IPC) risk assessments
Detective – Reporting progress against Premises Assurance Model (PAM) to the Executive Leadership Team (ELT); Dormitory Eradication Board reports into Trust Board
Directive – Capital Action Team (CAT) role in scrutiny of capital projects; IPC policy and procedure; Continuous Improvement Plan – Confirmed launch date is 01.04.25; Estates Plan – In development

Assurances on controls – Internal	**Assurances on controls – External**
IPC risk assessments Health and safety audits Premises Assurance Model System (PAMS) reporting	Mental Health Capital Expenditure bidding process External authorised reports for statutory health and safety requirements Estates and facilities management internal 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
Lack of adherence to emerging national guidance and policy requiring the elimination of mixed sex wards and dormitory style inpatient facilities	Deliver two new adult acute 54-bed units with ~~a~~ single room en-suite with additional staffing and new model of care [ACTION OWNER: CDO]	Delivery of approved business cases	31.03.25	Two new build adult acute unit FBCs nationally approved September 2022, funded by £80m national PDC and £18.6m CDEL. ICS supported and approved revenue funding Delay in national approval and redesign of foundations. Planned to go live February/March 2025	AMBER
	Older Adult service relocation to refurbished ward with single room en-suite and gender segregation, with additional staffing and new model of care, by September 2024 to eradicate dormitories in Northern Derbyshire and avoid the 12-bed service being isolated in otherwise vacated wards National PDC capital funding approval [ACTIONS OWNER: CDO]	Delivery of approved business case	31.01.25	Older Adult service relocation FBC and revenue funding approved by ICS. National PDC capital funding approved by NHSE Scheme re-tendered due to affordability, refurbishment started on site December 2023. Bluebell Ward to open in January 2025	GREEN
	Radbourne Unit dormitory eradication refurbishment to provide two 17-bed wards with single room en-suite, with additional staffing and new model of care, to complete dormitory eradication in Southern Derbyshire. Service users continue to receive care in non-compliant wards until this refurbishment is completed National PDC capital funding approval [ACTIONS OWNER: CDO]	Delivery of approved business case	31.12.25	FBC and revenue funding approved by ICS. National PDC capital funding approved by NHSE Radbourne Ward 32 refurb commenced November 2023. Due to go live autumn 2025 Ward 35 refurb scheduled January 2025 – for mid-2026, subject to funding live summer 2026	RED

Lack of an accessible Derbyshire wide Psychiatric Intensive Care Unit (PICU)	Delivery of local PICU arrangements (new build and associated projects taking into account gender considerations) National PDC capital funding approval [ACTIONS OWNER: CDO]	Agreed programme of work with capital funding to support it	31.05.25	FBC approved by ICS PICU fully funded by national and Trust capital – Expected to be operational April/May 2025	AMBER

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

Board Assurance Framework 2024/25 – Issue 4.3 Board March 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: This could lead to the disruption in the provision of services with risk to patient safety

Root causes:

a. Increasing reliance on a single electronic patient record
b. Increasing use of video software for the direct provision of care and operational purposes
c. Increased staff home working
d. Increasing electronic collaboration across health and social care partners
e. Increasing global instability and risk from state supported cyber attacks
f. Increase in locally developed system solutions to support DHCFT and partner operations and performance, i.e., flu vaccination, health risk assessments

BAF Ref: 24-25 1C	**Director Lead**: Vikki Ashton Taylor (CDO)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Appetite**		
Moderate	Likelihood 3	Impact 4	Moderate	Likelihood 3	Impact 4	Moderate	Likelihood 2	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Trust utilises NHS provided solutions as widely as possible, i.e., Office 365, NHS Mail to ensure compliance with mandated requirements. Use of the secure Health and Social Care Network (HSCN) specified by NHS Digital. Staff training on data security and protection. Regular all staff communications regarding safe ways of working and phishing emails. Contract with NHS Arden and Greater East Midlands Commissioning Support Unit provides information governance and security services, includes review of risks and addressing of vulnerabilities. Subscription with NHS Digital Care Certification Programme highlights cyber vulnerabilities and monitors Trust's compliance against them
Detective – Cyber essentials framework: NHS Digital encourage all organisations to comply. Advanced Threat Protection (ATP) monitors every server and device to highlight threats and software vulnerabilities
Directive – Compliance with NHS Digital requirements. Monthly rigor review meeting with NHS Arden and Greater East Midlands Commissioning Support Unit. Security and Protection Policies and Procedures. Business continuity policy and procedure; Digital Plan – In development

Board Assurance Framework 2024/25 – Issue 4.3 Board March 2025

Assurances on controls – Internal	Assurances on controls – External
IM&T Strategy delivery update to F&P – Annual Embedded programme of software and hardware upgrades Live testing of business continuity plans Digital Plan – In development	Templar Cyber Organisational Readiness Report (CORS) Annual external cyber review by Dynac (vulnerability scan) Data Security and Protection (DSP) annual review by Internal Audit Compliance with DSP Toolkit; high levels of training compliance

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Business continuity plans reflect changes to service delivery such as increased phone and video contacts	All services to review business continuity plans to ensure they take account of the increased use of phone and video contacts for care provision and also use of video conferencing for operational delivery [ACTION OWNER: CDO]	Reporting to the Divisional Performance Reviews (DPRs)	(31.03.25)	Business continuity training for Trust Leads started March 2024. Revised business continuity policy was ratified April 2024. Wider business continuity work (e.g. audit) took place in Quarter 2 as part of the EPRR Core Standards Recovery Action Plan – This is on track and expecting to be substantially compliant in the regional assessment	GREEN

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

Board Assurance Framework 2024/25 – Issue 4.3 Board March 2025

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

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

Impact: May adversely impact on regulatory requirements to provide safe and quality care. Patients' dignity and privacy may be impacted. Enforcement regulatory notices may issued against the Trust that may impact on Trust reputation and restrictions to capital could be applied.

Root causes:

a) There was commitment across mental health services to eradicate dormitories by 2022 – Although the Trust has active plans for Making Room for Dignity with a fully funded programme, with the building and infrastructure commencing, the Trust has not delivered in the set timeframes
b) Infrastructure does not comply with current standards
c) Outdated approach of delivering mental health care in dormitories does not comply with current guidance
d) Dormitories compromise patient privacy and dignity due to the dormitory layout
e) Dormitories do not comply with Infection, Prevention and Control (IPC) guidance
f) Dormitories could compromise Health and Safety regulations and increase risks, e.g. fire safety
g) Dormitories are not therapeutic spaces to provide mental health care in

BAF Ref: 24-25 1D	**Director Lead**: Tumi Banda (DON) / Vikki Ashton Taylor (CDO)	**Responsible Committee**: Quality and Safeguarding Committee

Key Controls

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

Preventative – Screening of each admission considering safety, care and infection control needs supported by the infection control team, health and safety audits; risk assessments; physical health care screening and monitoring; Maintaining environments and cleaning, Director and senior leader visits. Board visits. Quality governance structures, teams and processes to identify quality related issues. EQUAL unannounced visits to services and anonymised bright ideas service improvement ideas

Detective – Quality dashboard reporting; Board visits virtual clinical service contact visits; incident, complaints, and risk investigation; Fire Safety Regulations (FSR) compliance checks; mortality review process; physical health care monitoring clinics pilots; safety check log; Head of Nursing and Matron compliance visits, reviewed model of announced and unannounced visits to service throughout the 24 hour period, cleaning schedules and maintenance logs. Compliance to Delivering Same Sex Accommodation requirements

Directive – Trust Strategy; Physical Health Care Strategy; Safeguarding Strategy; Suicide Reduction Strategy; clinical strategies; policies and procedures available via Trust intranet; Central Alerting System (CAS) alerts; Risk Management Strategy; clinical sub committees of the Quality and Safeguarding Committee, Making Room for Dignity programme (MRfD); Continuous Improvement Plan – Confirmed launch date is 01.04.25

Board Assurance Framework 2024/25 – Issue 4.3 Board March 2025

Assurances on controls – Internal	Assurances on controls – External
Trust quality and performance dashboards Bed Management processes Scrutiny of Quality Account by committees Programme of physical healthcare and other clinical audits Infection Control Board Assurance Framework reported to NHSE Positive and Safe self-assessment Head of Nursing/Matron compliance visits Cleaning and maintenance schedules IPC training Level 1 and 2 Trust targets of 85% compliance minimum Continuous Improvement Plan – Confirmed launch date is 01.04.25	Delivery of Same Sex Accommodation Guidance Safety Thermometer identifies positive position against national benchmark Mental Health Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards CQC comprehensive review 2020 Trust is rated Good Estates and Facilities Management internal audit CQC inspection (April 2024) Patient Safety Incident Response Framework (PSIRF) implementation Monitoring of IPC standards compliance and reporting – ICS IPC Team

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Inpatients care is delivered in wards with dormitories, that compromise on patient dignity, privacy and effective IPC practice	Implement bed management process that ensure that admissions are screened to comply to gender, safety and IPC requirements Ensure that the environments are routinely check by clinicians, estates, and domestic staff Infection Prevention and Control monitoring, and training compliance Effective monitoring of the clinical environments by clinical, estates and domestic staff Monitor delivery of same sex guidance through Quality and Safeguarding Committee [ACTIONS OWNERS: DON/CDO]	Monitor and report breaches of same sex admission Monitoring of maintenance and cleaning schedules Head of Nursing and Matron environmental walkabouts Infection and Prevention and Control reports and monitoring of infections – To comply with the Infection Control Handbook and complete the required level of auditing Provision of other rooms for privacy and confidentiality across the estate	31.03.25	Level 1 and level 2 IPC training are above compliance target There is improved IPC governance and monitoring Fully funded programme of work in place. Construction started in Chesterfield and Derby – Making Room for Dignity programme is progressing Amended gatekeeping and purposeful admission process was launched in April 2024. This is having a positive impact on robust bed management processes	AMBER

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

Board Assurance Framework 2024/25 – Issue 4.3 Board March 2025

People - Derbyshire Healthcare is a great place to work

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

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

Root causes:

a) The growth of and increasing complexity of demand on our services and therefore our workforce
b) Lack of consistency and expectations of managers and leaders
c) Lack of strategic development pathway for leaders
d) The number of leadership layers we have
e) Lack of accountability across the leadership levels
f) The volatile work environments where staff can be exposed to harm and trauma
g) The need to develop cultural competence and confidence that is needed to value and create a sense of belonging for people of all backgrounds, ethnicities and with lived experience
Employee Relations service sits outside of the trust in a shared joint venture which impacts on quality of service and accountability of responsiveness

BAF Ref: 24-25 2A	**Director Lead**: Rebecca Oakley (DPOI)	**Responsible Committee**: People and Culture Committee

Key Controls

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

Preventative – Freedom to Speak Up Guardian (FTSUG) self-assessment and six monthly reports; actions taken from staff survey results, people performance reviews and actions, training and education meeting, Equality, Diversion and Inclusion (EDI) steering group, staff networks, health and wellbeing network
Detective – National staff survey, Quarterly Pulse Checks, FTSUG log and escalations; staff network engagement; WRES, WDES, wellbeing champion network, executive led engagement sessions; non-executive, executive and deputy visits to teams
Directive – Joined Up Care Derbyshire (JUCD) People Strategy, National People Plan; strategic people priorities

Assurances on controls – Internal	**Assurances on controls – External**
National staff survey and reporting into board, ELT and divisions Quarterly pulse check and action planning process Exit interview analysis and reporting	Benchmarking in mental health Trusts and at system level Staff survey analysis and reporting

Board Assurance Framework 2024/25 – Issue 4.3 Board March 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 Review and development of Trust leadership offer and impact [ACTIONS OWNER: DPOI]	Percentage of leaders with development plan as part of objectives Percentage of employees accessing leadership development programmes	(31.03.25)	Third cohort of Aspiring-2-Be leadership course launched Leadership Strategic Approach finalised and signed off at ELT and PCC in June 2024 Senior leadership programme agreed and dates being finalised Leadership forum now embedded and running regularly	AMBER
Lack of progress across EDI including staff networks and reporting (WRES/WDES/gender pay gap)	Staff networks have an embedded operating framework through which to maximise the impact of staff networks Clear measurable EDI plan that includes all national reporting and Trust level actions Support to bi-monthly network Chairs meetings through DPI, Head of EDI and EDI Manager [ACTIONS OWNER: DPOI]	Clarify on role and function of staff network chairs and objectives for each network – Reviewed twice a year Annual updates by network Chairs of engagement undertaken to be included in annual reports Year on year change WRES/WDES, staff surveys and lived experience of staff through staff networks	(31.03.25)	Framework, including clear actions to progress and signed off at PCC	AMBER
Lack of ownership and embedded models of care and cultures across MRfD workforce resulting in retention and turnover challenges and inconsistency of approach across MRfD programme	Review of all commissioned and in house owned programmes both clinical and non-clinical to be clear of the 'ask' and the 'why' Clear framework to ensure alignment across all programmes Comprehensive plan of delivery and outcome measures [ACTIONS OWNER: DPOI]	Delivery against plan including attendance on programmes Staff survey measures Bespoke MRfD surveys to measure awareness and impact of programmes	(01.04.25)	Revised programme board and workstreams to ensure alignment and learning from gateway review Progress on measures is phasing to the opening of the new wards	RED

Not yet embedded the Trust personal accountability framework and inconsistent support for Employee Relations (ER) informal and formal cases	Fully embed Trust personal accountability framework across all teams and individuals to have ownership of their own behaviours Development and delivery of ER training for managers on cases and investigations Establish new ER services in Trust (currently in a shared service) [ACTIONS OWNER: DPOI]	Reduction in length of cases Reduction in formal cases Attendance at training by managers on cases and investigations Establishment of new ER in-house team	(30.06.25)	Progress under review – Updates to follow in next BAF issue	TBC
Inconsistent approach to flexible working impacting on staff morale	Develop and embed a clear approach to flexible working that supports service delivery and staff Develop a clear and consistent way of recording and reviewing flexible working that supports both managers and staff [ACTIONS OWNER: DPOI]	Ability to record and track number of flexible working arrangements in place Staff engagement measures via staff survey and pulse check	(30.06.25)	Progress under review – Updates to follow in next BAF issue	TBC
Lack of robust absence management policy and processes that support both managers and staff	Review and relaunch a new absence management policy Review support provided to managers to review and move forward long term sickness absence cases Review Occupational Health access, support and usage to ensure maximising service and being used to [ACTIONS OWNER: DPOI]	Reduction in absence management across both long and short term absences Reduction in Occupational Health DNAs	(30.06.25)	Progress under review – Updates to follow in next BAF issue	TBC

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

People - Derbyshire Healthcare is a great place to work

There is a risk that we do not have an adequate supply of a diverse workforce with the right opeople 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: 24-25 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	Healthcare Support Workers (HCSW) submissions System operational planning process Safe staffing report

Embedded recruitment and retention scheme	Regular NOF Level 3 meetings with NHSE and ICB (in relation to Making Room for Dignity (MRfD) recruitment)

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
An integrated workforce plan and planning process that feeds into pipeline plans and ensures we have the right people in the right place with the right skills	Develop a Trust Workforce Plan linking demand and capacity, workforce redesign to ensure a fully funded workforce Develop vacancy rate data and breakdown variances in vacancy data [ACTIONS OWNER: DPOI]	Vacancy rates Time taken to fill vacant posts Transformational posts, e.g. apprenticeships all identified Reduction in agency costs	(31.03.25)	Work commenced to map apprenticeship plan and resources required Agency reduction plan in place and having impact Agency summit took place October and November 2024 to focus on medical and acute agency spend (highest areas) Executive-led vacancy control meeting takes place every week for approval of all vacancies and workforce expenditure increases, i.e., job evaluation	AMBER
We do not have an effective and embedded succession talent management processes	Develop a Talent Management Strategy Pilot career conversations for senior leaders and roll out career conversations for all colleagues Work as a system to develop system-wide approach to talent management and align where best for the Trusts [ACTIONS OWNER: DPOI]	Career conversations taking place Internal appointments/promotions Turnover rate Key staff survey measures	(31.03.25)	Talent Strategy finalised Talent programme relaunched following learning from previous pilot with clear engagement timescales and expectations Talent and succession planning part of every Executive Director objectives	RED
Onboarding and retention process and planning needs to be embedded (this includes MRfD and challenges on retention of high numbers of newly qualified nurses)	Understand the key retention issues for posts/teams/professions with the highest turnover Ensure ‘stay conversations’ form part of regular 1:1s	Improvements to turnover Staff survey engagement scores	(31.03.25)	Additional posts added to the preceptorship team to support retention of high numbers of newly qualified staff	RED

	Develop NHS retention framework for nursing [ACTIONS OWNER: DPOI]				
Lack of inclusive recruitment practices and actions to consider the needs of people from different backgrounds, to support our commitment to embedding an inclusive culture	All chairs of recruitment panels have undergone inclusive chairs recruitment training Data driven recruitment practices [ACTIONS OWNER: DPOI]	WRES and WDES data shows year on year improvement, staff survey and lived experience of staff Increase the proportion of applications from ethnic minority groups, increase likelihood of shortlisting and reduce disparity in all areas	(31.03.25)	Inclusive recruitment for chairs training commenced	RED
Effectiveness of recruitment policy, practice and processes	Review and develop existing recruitment Key Performance Indicators (KPIs) to ensure fit for purpose Where appropriate move away from TRAC to advertise jobs and use fast track processes, e.g. Indeed/MSforms Develop cohort recruitment for key posts Improve the multidisciplinary working (HR, communications and recruiting managers) to enable better planned and executed campaigns [ACTIONS OWNER: DPOI]	Time to recruit Number of applicants applying and successfully shortlisted Campaign impact and reach Financial savings through cohort recruitment	(31.03.25)	Trust Strategic Recruitment and Retention Lead appointed Successful recruitment events in place including attendance at universities A range of recruitment methods are deployed to ensure we attract a diverse range of applicants On track with MRfD recruitment posts and plans in place for hard to recruit posts	AMBER
Agency and bank usage control measures and reduction	Ensure bank and agency usage is controlled by clear processes and measures with accountability at team level on spend Agency off framework usage is managed with clear expectations Plan in place to reduce and align to agency price cap for all posts Bank staff are recognised and rewarded appropriately	Agency and bank usage reduction Agency off framework nil return Agency price cap achieved Bank usage is appropriate and available to support where needed	(30.06.25)	Progress under review – Updates to follow in next BAF issue	TBC

	[ACTIONS OWNER: DPOI]				

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

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

There is a risk that the Trust fails to deliver its revenue and capital financial plans 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

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

Board Assurance Framework 2024/25 – Issue 4.3 Board March 2025

BAF Ref: 24-25 3A	**Director Lead**: James Sabin (DOF)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Initial Risk Rating			Current Risk Rating			Target Risk Rating			Risk Appetite		
Moderate	Likelihood 2	Impact 5	Extreme	Likelihood 4	Impact 5	Moderate	Likelihood 2	Impact 5	Accepted	Tolerated	Not Accepted

Preventative – Operating plan and financial plan agreed for 24/25 in line with ICB requirement. Integrated Care System (ICS) signed off and fully support the dormitory eradication programme. 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 Vacancy control process in place with Executive oversight Performance management processes in place and being refreshed to add to assurance levels Dormitory eradication and PICU programme monitoring and reporting Appropriate monitoring and reporting of financial delivery – Trust overall and programme-specific including 'Use of Resources' reporting updates 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

New governance process in place for the Making Room for Dignity programme and action plan in place in relation to the gateway review findings	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
Trust cash and capital risks related to national funded acute capital programme: - Inflation cost risk - Risk-share - Cashflow timings and variability - Guaranteed Maximum Price exceeds national funding envelope (due to hyperinflation and other factors) Increased cost pressure now aligned to final refurbishment project	Risk share arrangements with PSCP Programme approach and engagement with all stakeholders. Close involvement with NHSE Discussions ongoing with ICB and NHSE around the Making Room for Dignity cost pressure. Although initial ask was supported, the cost pressure has grown materially in relation to the adult acute units, We are also not in a position to meet the conditions as now the pressure has grown and we will not have a Guaranteed Maximum Price (GMP) for Radbourne Until late Quarter 4 Further discussions are ongoing with NHSE Also progressing another VAT claim to part fund final stage [ACTIONS OWNER: DOF]	Cash and capital reporting as part of finance reporting into F&P and Board forecasting evidence of plan delivery and/or indicates areas of required management action New governance process will report formally into ELT and F&P then upwards to Board	31.03.25	Regular oversight of capital and cash position. Reporting to Trust Programme meetings and Committees on risks and mitigations Hyper-inflation cost risk is reducing Significant cost pressures on Radbourne Unit Refurb. Options being revisited in light of growing pressure. Additional funding earmarked from national team is insufficient. Options and review needs to conclude in Quarter 4 to enable reinstatement of original plans with Kier in April or to move to a plan B VAT rebate continues to flow to Trust. Still ongoing and reducing current/ongoing payments	RED
System capital programme funding shortfall for self-funded Trust capital programme System Capital Departmental Expenditure	Access any new national funding streams (e.g. digital or cyber) in year to maximise system capital plan in order to redirect CDEL capital for this cost pressure and other needed schemes [ACTION OWNER: DOF]	There remains a risk we will overcommit our CDEL allocation in 2024/25 (likely by £4M) Ward 35 decision is a key risk later this year and would have	31.03.25	System capital plan has been submitted as part of planning process. We have also fed in the 10 year capital plan as part of a wider ICB system wide return	RED

Limit (CDEL) inadequacy for system capital requirements		wider impact on the strategic objective to eradicate all dorms Although national funding has been confirmed, it is now known this is not sufficient, we will have an issue to address with the ICB To proceed at risk (affordability, cashflow and CDEL breach concerns) or pause/stop/abandon which would not deliver dormitory eradication and reduce bed capacity. Alternative more cost effective options to be explored but overall pressure remains		Risk remains in relation to the Making Room for Dignity cost pressure and discussions with ICB and NHSE remain ongoing	
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. National funding for PDC revenue costs included in allocations for 2023/24 plan Early recruitment to staffing built into revenue plan of the Trust and funded by the system (both income and expenditure in the plan) as part of operating plan for 2024/25 [ACTIONS OWNER: DOF]	Monitoring and reporting of income allocations and expenditure in year Transparent reporting of position shared with ICB to reduce challenge and ensure joint understanding and support	31.03.25	MHLDA DB agreed to oversee revenue delivery contained within programme spend Capital delay has led to reduced revenue risk and slippage Supporting non-recurrent revenue costs associated with dormitories and wider system	AMBER
Insufficient substantive staffing into vacancies and temporary staffing costs for bank and agency staff do not reduce	Additional management action and oversight Agency progress monitored and strengthened links to CIP oversight group Direct engagement solution being implemented re medics [ACTIONS OWNER: DPOI/DOF]	Enhanced bank and agency costs reported as part of wider financial and workforce reporting Continued workforce strategies progressed to reduce agency and increase bank reducing risk	31.03.25	Reports to ELT and F&P outlining current areas of pressure and required actions to be taken in year in order to remain on plan Funding contribution agreed with Eating Disorder Provider Collaborative for exceptional agency costs re 2023/24. Discussions ongoing re 2025/26 costs. Transfer of patient was	AMBER

				concluded in September and no-longer a concern	
Non-delivery of required recurrent cost reduction and improved efficiency and Quality Improvement	Compilation and delivery of planned Trust efficiencies and quality improvements to deliver 2024/25 plan including recurrent long term cost reductions to return to breakeven Planning for 2024/25 has led to a recent ask for directorates to develop plans of 4% cost improvement in addition to various transformation schemes CIP governance and reporting processes strengthened. Close links to wider work re agency reduction, effective rostering and vacancy control [ACTIONS OWNERS: DOF/DPOI]	Efficiency and QI reporting to executives and F&P	31.03.25	CIP gap continues to reduce. The percentage which has been identified recurrently continues to increase Executive vacancy panel established in December 2023 Performance meetings are in place for clinical directorates and plans are being put in place in future for corporate areas Performance related additional controls are being developed to help close the CIP gap and ensure mitigation is in place Risk reducing due to continued progress Out of area risk, rather than CIP risk is now the primary factor in our plan delivery	AMBER
Financial cost pressures created both internally and by system first decisions leading to the requirement for mitigations to close both the internal gap and the system financial gap	Additional 'stretch' management action required to reduce other cost and mitigate impact to achieve overall financial position Long list of unpalatable options drawn up and supported in principle by Board for further review. These are for consideration post planning nationally due to potential to impact patients and core Trust NHS offer. Need to develop these into costed and prioritised plans with clarity of patient and wider staff impact [ACTIONS OWNER: DOF]		31.03.25	The financial position for Derbyshire is a risk to the statutory duties for DHCFT to manage its financial position Financial plan for 2024/25 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	RED

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

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

Principal risk: There is a risk that the effects of both nationally and locally driven changes to roles and responsibilities within the Integrated Care Board (ICB), and with its partners may impact negatively on the cohesiveness of the Derbyshire health and care system
Impact: Quality of services and patient experience may deteriorate. Financial position of the Derbyshire Health and Care system worsens; working relationships across the system deteriorates; loss of confidence from regulators in the Derbyshire system

Root causes:

a) Senior management relationships across organisations and organisational expectations of role and responsibilities
b) Creation of mental health, learning disability and autism provider collaborative may destabilise some of the established relationships in place across Derbyshire
c) Creation of system level governance structures, for example Provider Collaborative Leadership Board, may impact on provider Foundation Trust governance arrangements and decision-making processes
d) Staff impacted by change, may lead to increased staff turnover in teams supporting the delivery of the Mental Health Long-Term Plan and subsequent loss of organisational memory
e) The Trust taking on additional lead-provider responsibilities at an ICS or regional level could impact on the quality, performance and financial risks faced by the organisation

BAF Ref: 24-25 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

Board Assurance Framework 2024/25 – Issue 4.3 Board March 2025

Assurances on controls – Internal	Assurances on controls – External
Regular reporting of position to Board by CEO Regular ELT updates and discussions NED Board members on JUCD committees and Board Board agreement required prior to undertaking of lead-provider responsibilities	Mental Health and Learning Disability assurance meetings with NHSE and ICB Gateway process run by NHSE prior to agreement to establish a Trust as lead-provider in regional collaboratives Representation on system-wide governance groups

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Increased governance at ICB and system level may create delays to decision making and cause increased governance burden	Keep Trust structures under continuous review against the wider governance landscape, including the provider collaboratives and alliance arrangements – This in turn may lead to a formal change of DHCFT governance arrangements Continue to influence within the system to ensure Lean and safe decision making and governance arrangements [ACTIONS OWNERS: CEO/DCA]	Board level assurance that the Trust's corporate governance systems are compatible with the new ways of working that would allow both Trust and system objectives to be achieved Board level assurance that the Trust's risks have been fully articulated and understood within the wider integrated care system	(31.03.25)	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

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: 24-25 4B	**Director Lead**: Vikki Ashton Taylor (DSPT)	**Responsible Committee**: Trust Board

Key Controls

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

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

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

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Some core constitutional targets not being met and risk to making progress, at pace and scale, resulting in some patients being cared for outside of Derby and Derbyshire	New internal performance improvement group Recovery action plans for areas where Trust constitutional standards are not being met Improvement plan for joint autism service (with system partners) [ACTIONS OWNERS: CDO]	Improvement in performance in constitutional standards Recovery action plans in place in all required areas Feedback from social care on awareness of the Autism Strategy and reduction in autism waiting times	(31.03.25)	In-year progress delivering recovery action plans: Performance improvement in dementia diagnosis and perinatal access has resulted in DHCFT now delivering the core constitutional targets in this area and others Ongoing work to reduce inappropriate Out of Area Placements, underpinned by a Recovery Action Plan continues including a twice weekly Multi-Agency Discharge Event, roll out of home treatment service, and piloting weekend working for community mental health teams. New build facilities including a local PICU, will support improved patient flow and improved quality of care as the above will enable patients to be treated locally	RED
System partners report that DHCFT is inward looking and not easy to work with	To build stronger working relations and build stronger integrated ways of working and be more accessible, both from an organisational and service perspective To deliver more integrated care [ACTIONS OWNER: CDO]	Increased delivery of integrated services	(31.03.25)	Active membership of Derby City PLACE Board, PLACE County Partnership Board, and the integrated PLACE executive	GREEN

				Senior management representation named for all PLACE Alliance groups. Collaborative development of community mental health 24/7 pilot alongside general practice partners	
Police partners report they do not always feel supported by mental health services and are under pressure to respond to mental health crisis	To reduce inpatient absent and missing cases To support Police with education and training where appropriate To streamline process and timeline for 136 suite admissions and handover [ACTIONS OWNER: CDO]	Reduction in inpatient absent and missing cases Training sessions offered to Police partners: • Police mental health awareness training sessions • Suicide prevention work • Joint working with Trust safeguarding teams • Collaborative response to Right care Right Person (RCRP) Increased handovers completed within one hour	(31.03.25)	Police are a formal member of the MHLDA DB Mental Health Response Vehicle (MHRV) to be implemented during 2024/25, to jointly provide a Trust and Police response to mental ill health calls Crisis café have opened in Buxton, Ripley and Swadlincote – This reduces demand on Police call-outs Trust is a member of the RCRP implementation executive group covering the Derbyshire system	AMBER
Patient and carers groups report that they would like to see more progress in service user and carer involvement and moving from engagement to decision making	Peer support strategy and objectives for EQUAL and the Mental Health Engagement Group [ACTION OWNERS: DON/MD]	Peer support strategy Co-production in Patient and Carer Race Equality Framework (PCREF) requirements	(31.03.25)	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

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

BAF Ref: 24-25 4C	**Director Lead**: Vikki Ashton Taylor (CDO)	**Responsible Committee**: Quality and Safeguarding Committee – DHCFT Quality and Performance Committee – Derbyshire ICS Mental Health, LD and Autism Board in terms of system operational delivery

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Appetite**		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 3	Accepted	Tolerated	Not Accepted

Preventative – Health and safety audits; risk assessments; investment in estates development; workforce plan covering recruitment and retention. Mental Health Act Code of Practice
Detective – CQC inspection reports; Board visits virtual clinical service contact visits; incident, complaints and risk investigations; safety check log; Head of Nursing and Matron compliance visits
Directive – Trust Strategy; Physical Health Care Strategy; Safeguarding Strategy; Trust Policy Dashboard

Assurances on controls – Internal	**Assurances on controls – External**
Regional and national escalation process – Internal preparation	Advisory support provided by DHCFT to the system on bedded care standards for Learning Disability in-patient services Involvement of Local Government Association to deliver a peer review Involvement of external consultants

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Summary of progress on action	Action rating
The community Intensive Support Team and Learning Disability models require improvement	Review all models of support offered by the Intensive Support Team (IST) [ACTION OWNERS: CDO/DON/MD]	Outcome of review – Improved models of support	(31.03.25)	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	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 improvement in the use of Dynamic Support Registers as a means of admission avoidance	(31.03.25)	Derbyshire is no-longer in national escalation regarding performance with inpatient services after demonstrating improvement against plans New Dynamic Support Pathway (DSP) launched following cross-agency redesign work Cross-system delivery plan continues to be monitored through Neurodevelopmental	AMBER

		Reduction in delayed discharges in units across the country resulting in NHSE escalations		Delivery group Board – Includes action plan in response to inflow, flow and outflow as discussed with NHSE and ICB leaders	

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 fedback 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	30.10.24	30.01.25	HIGH

Board Assurance Framework 2024/25 – Issue 4.3 Board March 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	DON	Director of Nursing, AHPs and Patient Experience
MD	Medical Director	DPOI	Director of People, Organisational Development and Inclusion
CDO	Deputy Chief Executive / Chief Delivery Officer	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 – 4 March 2025

Revised Trust Constitution

Purpose of Report

To seek approval for amendments to the Trust Constitution as detailed in the report.

Executive Summary

The Trust's Constitution sets out the powers and functions of the Trust and has recently been reviewed by a small working group of Governors and Board members.

Key components/content of the constitution are:

- Membership arrangements, for example categories of membership (public, staff and appointed) and geographical boundaries for each constituency
- Composition, election, tenure, disqualification and removal for the Council of Governors (including model election rules)
- Composition, appointment, disqualification, removal and voting arrangements for the Board of Directors
- Standing Orders (the form and function of the Council of Governor meetings). **Note:** the Standing Orders for the Board of Directors are set out in a separate document
- Maintenance of registers such as members, Governors and declarations of interest
- Requirement to have internal and external auditors and requirements for the annual report and accounts
- Process to follow for significant transactions (linked to income, assets and capital).

The amendments are set out in the table at Appendix A and, in summary, comprise of:

- Updating statutory references, specifically reflecting integrated care system (ICS) and acute provider collaborative (APC) arrangements
- Updated Code of Governance requirements and reference to the Fit and Proper Test framework
- Reflecting of the duty of the Council of Governors to represent the 'public at large'
- Inclusion of the use of e-governance, voting and hybrid/online meetings
- Various non-material changes, for example, change of job titles, document formatting and addition of points of clarification.

A full copy of the updated Constitution detailing all proposed amendments is available on request.

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

Benchmarking has been carried out against other Trust Constitutions to reflect any areas of good practise and NHS England (NHSE) guidance has been followed.

Consultation

With the working group.

Governance or Legal Issues

The content of a Foundation Trust's constitution is legally mandated and is also influenced by the code of governance for NHS provider trusts (the code). A national model core constitution sets out the template, with elements that can be tailored to meet the requirements of individual organisations.

The Trust's Constitution should be updated periodically to reflect new requirements and improvements. Changes to the Constitution can take effect only if the amendments are approved by both the Trust Board and the Council of Governors. Where there are amendments to the Constitution which relate to the powers, duties or roles of the Council of Governors, at least one Governor must attend the next annual members' meeting/annual general meeting and present the amendment(s) to members. Members have the right to vote on and veto these types of constitutional amendments.

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:

Changes reflect inclusive language across the Constitution (replacing gender specific pronouns with generic pronouns).

Recommendations

The Board of Directors is requested to agree the proposed changes to the Constitution.

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

Appendix A - Constitution Table of Amendments

Page	Section	Current version	Amendment	Rationale
4	2 – Principal Purpose	2.3 The Trust may provide goods and services for any purposes related to: 2.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness; and 2.3.2 the promotion and protection of public health (and)	**In addition** 2.3.3 the delivery of safe, effective care and the effective use of resources; and 2.3.4 the contribution to the objectives of the integrated care system (ICS); and 2.3.5 the collective responsibility with partners for delivery of high quality and sustainable services across system (ICS) and place based footprints.	Statutory guidance from the Health and Social Care Act 2022.
4	2 – Principal Purpose	N/A	**New sections** 2.5 The Trust is required to comply with the triple aim duty of better health and wellbeing for everyone, better quality of health services for all and sustainable use of NHS resources; 2.6 The Trust will also be required to engage consistently and constructively in shared planning and decision making with partners in system, place based partnerships, provider collaboratives and any other relevant forum; 2.7 The Trust will consistently take responsibility for delivery of improvements and decisions agreed through system and place based partnerships, provider collaboratives or any other relevant forums.	Statutory guidance from the Health and Social Care Act 2022.
4-5	3 – Powers		New sections 3.5 The Trust may arrange for any functions exercisable by it to be exercised by or jointly with any one or more of the bodies set out in section S 65Z5(i) of the 2006 Act. Where such a function is exercisable jointly the bodies may arrange for the functions to be exercised by joint committees as set out in S 65Z6 of the 2006 Act. 3.6 In exercising its powers, the Trust will have regard to:	To recognise joint committees and the 2006 Act (as amended by the Health and Social Care Act 2022).

			3.6.1 S.63B of the 2006 Act (revised 2022) (duty to have regard to the wider effect of discussions), also referred to as the "Triple Aim"; 3.6.2 S.63B of the 2006 Act (revised 2022) (duties in relation to climate change).	
5	7 – Staff Constituency	7.5 The minimum number of Members in each class of the Staff Constituency is 100 in the Nursing Staff class and Allied Health Professions Staff class, 20 in the Medical and Dental Staff class and 50 in the Administration and Allied Support Staff class.	7.5 The minimum number of Members in each class of the Staff Constituency is 100 in the Nursing Staff class and Allied **Healthcare** Professionals Staff class, 20 in the Medical and Dental Staff class and 50 in the Administration and Allied Support Staff class.	Changing the term to Allied Healthcare Professionals (AHP) **Note** – all other references in the constitution have been changed to this.
6	7 – Staff Constituency	N/A	**New section** 7.7 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.	For clarification.
7	12 – Council of Governors - tenure	12.5 An Appointed Governor shall cease to hold office if the appointing organisation withdraws its sponsorship of them.	12.5 An Appointed Governor shall cease to hold office if the appointing organisation withdraws its sponsorship of them, **the organisation ceases to exist or the individual leaves the organisation**;	For clarification.
7	13A – Council of Governors – duties of Governors	13A.1 The general duties of the Council of Governors are: 13A.1.1 to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors; and 13A.1.2 to represent the interests of the Members as a whole and the interests of the public at large.	13A.1 The general duties of the Council of Governors are: 13A.1.1 to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors; and 13A.1.2 to represent the interests of the Members as a whole and the interests of the public at large **to support collaboration and system working**.	Updated by - Addendum to your statutory duties – reference guide for NHS Foundation Trust Governors, NHSE 2022 Guidance on good governance and collaboration.
9	19A – Board of Directors – general duty	19A.1 The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the Members as a whole and for the public.	**In addition** 19A.2 The Board of Directors should promote the long-term sustainability of the Trust as part of the ICS and wider healthcare system.	

9	24 – Board of Directors – appointment and removal of the Chief Executive and other Executive Directors	24.1 The Non-Executive Directors shall appoint or remove the Chief Executive. 24.2 The appointment of the Chief Executive shall require the approval of the Council of Governors. 24.3 Not used. 24.4 A committee consisting of the Chair, the Chief Executive and the other Non- Executive Directors shall appoint or remove the other Executive Directors.	**In addition** 24.5 The process for the appointment to (and dismissal from) the post fulfilling the function of Secretary is a matter for the whole Board of Directors.	Code of Governance update.
10	27 – Board of Directors – standing orders	27.1 The Board of Directors shall adopt standing orders from time to time for the practice and procedure of the Board of Directors and in particular for its procedure at meetings. These shall include setting a quorum for meetings, both of Executive and Non-Executive Directors.	**In addition** 27.2 The standing orders can be found in a separate Trust controlled document.	For clarification.
13	34 – Audit Committee	The Trust shall establish a committee of Non-Executive Directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.	The Trust shall establish a committee of Non-Executive Directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate. **The Audit Committee should not be chaired by the Chair, Deputy Chair or Senior Independent Director.**	Code of Governance update.
15	40 – interpretations and definitions	40.1 Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this Constitution shall bear the same meaning as in the 2006 Act and the 2012 Act.	40.1 Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this Constitution shall bear the same meaning as in the 2006 Act, 2012 Act **and the 2022 Act.** **New definitions added:** **"Code of Governance for NHS Provider Trusts"** - means the Code of Governance by NHS England or such similar or further guidance as NHS England may publish from time to time; **"Integrated Care System"** means a statutory partnership of organisations who plan, buy and provide health and care services in their geographical area. The organisations involved include the NHS, local authorities,	To include reference to the Health and Social Care Act 2022.

			voluntary and charity groups, and independent care providers.	
	Annex 1 – The Public Constituency	Includes all electoral wards or Council areas.	To be updated with any changes to electoral wards or Council areas as defined by Derby City Council or Derbyshire County Council.	To ensure we are working to the latest electoral boundaries.
	Annex 5 – Additional Provisions - Council of Governors 3 - Council of Governors: **Removal and Disqualification**	3.1 A Governor shall not be eligible to become or continue in office as a Governor if: 3.1.1 they cease to be eligible to be a Member save in the case of Appointed Governors; 3.1.2 in the case of an Appointed Governor, the appointing organisation withdraws its appointment of them;	3.1 A Governor shall not be eligible to become or continue in office as a Governor if: 3.1.1 they cease to be eligible to be a Member **or a Member of the constituency (or class of constituency**) which they represent, save in the case of Appointed Governors; 3.1.2 in the case of an Appointed Governor, the appointing organisation withdraws its appointment of them, **the organisation ceases to exist or the individual leaves the organisation;** **New sections:** 3.1.14 They are a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986); 3.1.15 A staff Governor who is suspended from staff duties for any reason will also be suspended from their role as a governor for the duration of their suspension. Whilst a staff Governor is under investigation, they cannot attend meetings of the Council of Governors in any capacity, but missing any meetings of the Council of Governors will not count as failure to attend for the purpose of 4.1.3 below.	For clarification/and or considered best practise.
	Annex 5 – 4- Council of Governors: **Termination of Tenure**	4.1.4 If the Council of Governors resolves to terminate their term of office for reasonable cause on the grounds that in the reasonable opinion of 70% of the Governors present and voting at a meeting of the Council of Governors convened for that purpose that their continuing as a Governor would or would be likely to:	**New sub-section** (i) they have failed or refused to undertake and/or satisfactorily complete any training which the Council of Governors has required them to undertake in their capacity as a Governor; **(ii) they have failed to confirm acceptance of the code of conduct applicable to Governors**;	For clarification/and or considered best practise.

		(e) it would not be in the best interests of the Trust for that person to continue in office as a Governor, eg: (i) they have failed or refused to undertake and/or satisfactorily complete any training which the Council of Governors has required them to undertake in their capacity as a Governor; (ii) they have, in their conduct as a Governor failed to comply in a material way with the values and principles of the National Health Service or the Trust; or (iii) they have committed a material breach of any code of conduct applicable to Governors of the Trust.	(iii) they have, in their conduct as a Governor failed to comply in a material way with the values and principles of the National Health Service or the Trust; or (iv) they have committed a material breach of any code of conduct applicable to Governors of the Trust.	
	Annex 5 – 7 - Council of Governors: Meetings	7.1 Meetings of the Council of Governors shall be held at such times and places as the Council of Governors may determine and held not less than four general meetings each Financial Year. 7.2 All such meetings shall be open to the public unless the Council of Governors resolves that before each meeting public be excluded from the meeting, whether for the whole or part of the proceedings on the grounds that publicity would be prejudicial to the public interest or the interests of the Trust by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of the business to be transacted or the proceedings.	**7**.1 Meetings of the Council of Governors shall be held at such times and places **and of such format including in person, by using virtual media communication or hybrid** as the Council of Governors may determine and held not less than four general meetings each Financial Year; 7.2 All such meetings shall be open to the public unless the Council of Governors resolves that before each meeting public **and media** be excluded from the meeting, whether for the whole or part of the proceedings on the grounds that publicity would be prejudicial to the public interest or the interests of the Trust by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of the business to be transacted or the proceedings.	For clarification that this includes the media as well as the public.
	Annex 6 – Standing Orders for the Practice and Procedure of the Council of Governors	2.1.1 Appointment and removal of the Chair and Non-Executive Directors (Constitution Paragraph 21)	2.1.1 Appointment and removal of the Chair and Non-Executive Directors (Constitution Paragraph 21). **New sub sections** 2.1.1.1 The Council of Governors should raise issues to the Chair or in the case of the Chair to the Senior	For clarification/and or considered best practise.

	2.1 Roles and Responsibilities of Governors:		Independent Director prior to any formal action to remove a Non-Executive Director or the Chair. 2.1.1.2 Any proposal for removal must be proposed by a Governor and seconded by not less than ten Governors. 2.1.1.3 Written reasons for the proposal shall be provided to the Chair or Non-Executive Director in question, who shall be given the opportunity to respond to such reasons. 2.1.1.4 In making any decision to remove the Chair or a Non-Executive Director, the Council of Governors shall take into account the annual appraisal carried out by the Chair or Senior Independent Director, respectively. 2.1.1.5 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.	
	Annex 6 – 3.1 Calling meetings	3.1.1 Meetings of the Council of Governors shall be held at such times and places as determined by the Trust. Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give at least fourteen days written notice of the date and place of every meeting of the Council of Governors to all Governors. Notice will also be published on the Foundation Trust's website. The notice will be issued to Governors and published on the Trust's website at least fourteen days before the meeting.	3.1.1 Meetings of the Council of Governors shall be held at such times and places as determined by the Trust. **Meetings may be held virtually by digital means.** Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give at least fourteen days written notice of the date and place of every meeting of the Council of Governors to all Governors. Notice will also be published on the Foundation Trust's website. The **agenda pack** will be issued to Governors and published on the Trust's website at least **three clear days** before the meeting.	For clarification/and or considered best practise.
	Annex 6 – 3.2 - Admission of the Public	The provisions for the admission of the public to meetings of the Council of Governors are detailed at Paragraph 14 and Annex 5 of the Constitution.	The provisions for the admission of the public **and media** to meetings of the Council of Governors are detailed at Paragraph 14 and Annex 5 of the Constitution. **The public and representatives of the media shall be afforded facilities to attend all formal meetings of the Council of Governors but shall be required to withdraw upon the Council of Governors resolving as follows:**	For clarification/and or considered best practise.

			"That representatives of the media and other members of the public be excluded from the remainder of this meeting because the confidential nature of the business to be transacted is such that publicity would be prejudicial to the public interest". **New sub-section** 3.2.1 Managing disruption – The Chair shall give such directions as they think fit in regard to the arrangements for meetings and accommodation of the public and representatives of the media such as to ensure that the Council of Governors' business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Council of Governors resolving as follows. "That in the interests of public order the public withdraw from the meeting for (the period to be specified) to enable the Council of Governors to complete business without the presence of the public and media".	
	Annex 6 – Voting at meetings	3.13 All questions put to the vote shall, at the discretion of the person presiding, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request. 3.16 A Governor may only vote if present (either in person, by telephone or by electronic communication) at the time of the vote on which the question is to be decided. In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.	3.13 All questions put to the vote shall, at the discretion of the person presiding, be determined by oral expression or by a show of hands **or by appropriate electronic mean**s. A paper ballot may also be used if a majority of the Governors present so request. **In the event of a meeting being held by virtual media, an electronic voting facility will be made available, including when appropriate, the facility for holding a secret ballot.** 3.16 A Governor may only vote if present (either in person, by telephone **or by electronic communication)** at the time of the vote on which the question is to be decided. In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.	For clarification/and or considered best practise.
	Annex 6 – Minutes	3.17 The Minutes of the proceedings of a matter shall be drawn up and submitted for	3.17 The Minutes of the proceedings of a matter shall be drawn up and submitted for agreement at the next	To mirror practise.

		agreement at the next ensuing meeting where they will be signed by the person presiding at it. 3.18 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.	ensuing meeting where they will be **ratified as the correct record** ~~signed~~ by the person presiding at it. 3.18 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting. **The ratified minutes will be conclusive evidence of the events of the meeting and retained by the Secretary**.	
	Annex 6 – Standing Orders	3.21 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.	3.21 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting **and shall apply only for the duration of the meeting in question**.	For clarification/and or considered best practise.
	Annex 6 – record of attendance and quoracy	3.25 Record of Attendance – the names of the Governors present at the meeting shall be recorded in the minutes. 3.26 Quorum – no business shall be transacted at a meeting of the Council of Governors unless at least one third of the Council of Governors are present, with a minimum of six, a majority of whom must be Governors elected by the Public Constituencies, and one staff governor.	3.25 Record of Attendance – the names of the Governors present at the meeting shall be recorded in the minutes. **Governors who are unable to attend a meeting shall notify the Secretary in advance of the meeting so that their apologies may be recorded. For the avoidance of doubt, attendance may include through virtual media.** 3.26 Quorum – no business shall be transacted at a meeting of the Council of Governors unless at least one third of the Council of Governors are present, with a minimum of six, a majority of whom must be Governors elected by the Public Constituencies, and one staff governor. **At the start of each meeting, the Chair shall be responsible for determining that the meeting is quorate.**	For clarification/and or considered best practise.
	Annex 6 – Committees	4.1 Except as required by paragraph 9.2 of Annex 5, the Council of Governors shall exercise its functions in general meeting and shall not delegate the exercise of any function or any power in relation to any function to a Committee.	4.1 Except as required by paragraph 9.2 of Annex 5, the Council of Governors shall exercise its functions in general meeting and shall not delegate the exercise of any function or any power in relation to any function to a Committee**, but it may appoint Committees to assist the Council of Governors in carrying out its roles.**	For clarification/and or considered best practise.
	Annex 6 – Resolution Dispute	5.1 Dispute Resolution between Board of Directors and Council of Governors 5.1.1 The Council of Governors and the Board of Directors shall be committed to developing and maintaining a constructive and positive	5.1 Dispute Resolution between Board of Directors and Council of Governors 5.1.1 The Council of Governors and the Board of Directors shall be committed to developing and maintaining a constructive and positive relationship. The	For clarification/and or considered best practise.

		relationship. The aim at all times is to resolve any potential or actual differences of opinion quickly, through discussion and negotiation. 5.1.2 If the 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. 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, will notify NHS England of the specific issue of non-compliance.	aim at all times is to resolve any potential or actual differences of opinion quickly, through discussion and negotiation. **5.1.1.1 Governors can raise concerns with the Secretary who may in the first instance be able to resolve the matter informally.** **5.1.1.2 Where the 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).** 5.1.2 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.	
	Annex 8 – Further Provisions	5.3.4 Communications between the Council of Governors and the Board of Directors may occur with regard to, but shall not be limited to: 5.3.4.1 the Board of Directors proposals for the Strategic Direction and the Annual Business Plan; 5.3.6 The following formal methods of communication may also be used as appropriate with the consent of both the Council of Governors and the Board of Directors: 5.3.6.1 attendance by Board Directors at a meeting of the Council of Governors; 5.3.6.2 provision of formal reports or presentations by executive directors to a meeting of the Council of Governors; 5.3.6.3 inclusion of appropriate minutes for information on the agenda of a meeting of the Council of Governors; 5.3.6.4 reporting the views of the Council of Governors to the Board of Directors though the Chair or, Deputy Chair	5.3.4 Communications between the Council of Governors and the Board of Directors may occur with regard to, but shall not be limited to: 5.3.4.1 the Board of Directors proposals for the Strategic Direction and the Annual Business Plan, **including information on the ICS plans, decisions and delivery that directly affects the organisation and its patients and service users**; 5.3.6 The following formal methods of communication may also be used as appropriate with the consent of both the Council of Governors and the Board of Directors: 5.3.6.1 attendance by Board Directors at a meeting of the Council of Governors; 5.3.6.2 provision of formal reports or presentations by executive directors to a meeting of the Council of Governors; 5.3.6.3 inclusion of appropriate minutes for information on the agenda of a meeting of the Council of Governors; 5.3.6.4 reporting the views of the Council of Governors to the Board of Directors though the Chair, Deputy Chair **or Senior Independent Director.** **5.3.6.5 The Senior Independent Director (SID) can act as an alternative source of advice to Governors from the Chair** **5.3.6.6 The SID shall be available to Governors if they have concerns that contact through normal channels has failed to resolve any issues which**	Updated by - Addendum to your statutory duties – reference guide for NHS foundation trust governors, NHSE 2022 Guidance on good governance and collaboration.

			been raised or for which such contact is inappropriate.	
Various	Access to (and exclusion from) Board and Governor meetings	Just the reference to the public.	Includes reference to public **and media**.	For clarification/and or considered best practise.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 4 March 2025

NHS Staff Survey 2024 – National Results

Purpose of Report

The purpose of this presentation is to update the Public Trust Board on the 2024 National NHS Staff Survey, presented alongside NHS England benchmarking data. This analysis provides a comprehensive assessment of the Trust's current position in comparison to other NHS trusts in the same benchmarking group, identifying key trends, strengths, and areas requiring improvement. The presentation aims to inform strategic discussions, support evidence-based decision-making, and guide workforce initiatives to enhance staff experience and organisational effectiveness.

Executive Summary

This presentation presents a comprehensive summary of the results from the National NHS Staff Survey 2024, conducted between September and November 2024. The survey results are benchmarked against 50 peer organisations within our designated comparison group, which includes **Mental Health and Learning Disability Trusts** as well as **Mental Health, Learning Disability and Community Trusts**. Where relevant, the results are contextualised by comparing them to the best, average, and lowest-performing organisations within this group.

To ensure fairness in comparisons, most of the data presented in this presentation has been weighted. However, a small number of questions—primarily those related to demographic or factual information—are not weighted or benchmarked. The results are structured according to the People Promise themes, which represent key aspects of staff experience. This approach provides a clear and consistent framework for analysing the findings. Each theme is scored on a 0-10 scale, where a higher score indicates a more positive outcome. These theme scores are derived by aggregating individual survey question responses into grouped categories.

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

Risks and Assurances

- Lack of engagement in some areas – we acknowledge that 36% of the workforce did not take part in the 2024 staff survey
- Implementation Challenges – Some actions may require significant time and/or resources
- Assurance that response rates have increased, and we are hearing from more colleagues each year.

Consultation

- Picker (Host)
- NHS England
- People, Organisational Development and Inclusion team
- All eligible staff are invited to participate in the National NHS Staff Survey.

Governance or Legal Issues

- CQC analyse the NHS Staff Survey results
- NHS England will publish these results publicly on 13 March
- The People and Culture Committee will receive and discuss the results in March.

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:

Our NHS Staff Survey results are be broken down by protected characteristics and further analysis is done by the Equality, Diversity and Inclusion Team in conjunction with all Staff Network Groups.

Recommendations

The Board of Directors is requested to receive the National 2024 Staff Survey results and note a full discussion will take place at the People and Culture Committee in March.

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

Report prepared by: **Lucy Moorcroft**
Organisational Development Lead

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 4 March 2025

Freedom to Speak Up Guardian (FTSUG) report

Purpose of Report

This paper is a half-yearly report to ensure the Derbyshire Healthcare Foundation Trust (DHcFT) Board is aware of Freedom to Speak Up (FTSU) cases within the Trust; an analysis of trends within the organisation and actions being taken to improve speaking up culture.

Executive Summary

The FTSU report to Board sets out the number of cases and themes raised in the last six months from July to December 2024 at DHcFT.

Total case numbers: 121 cases seen in this report to Board for the period are a 47.5% percentage increase on the 82 cases reported in the October 2024 FTSU report to Board for the period January to June 2024.

Emerging, or ongoing, themes include:

- **Inclusion/Discrimination:** Concerns from Black and Minority Ethnic (BME) staff regarding inclusion in various different areas. This included concerns about racism from patients and the understanding of these behaviours and support for BME staff experiencing them, further concerns around banter, the support from, and relationship with, non BME managers including a lack of understanding of discrimination and racism and racial trauma
- **Policy/Process and Procedure/Worker Wellbeing and Safety:** concerns raised from some colleagues around the impact of disciplinary processes and/or performance management processes on staff wellbeing particularly those staff with existing mental health conditions.

The report also contains a list of actions taken to enhance visibility and promote FTSU to ensure that speaking up culture is continuously improved.

The Speaking Up Champions' network also supports workers to raise their concerns at the earliest opportunity and signposts workers to the FTSUG for advice and guidance.

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

Risks and assurances

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

- Reporting on speaking up is presented to the Trust Board and the Audit and Risk Committee (ARC) every six months to provide assurance on progress made. The People and Culture Committee (PCC) also receives FTSU information as part of the wider staff feedback dashboard
- The Audit and Risk Committee continues to monitor the progress of the FTSU action plan
- There are risks to having a culture where workers do not feel able to safely voice their concerns. There are potential impacts on patient safety, clinical effectiveness and patient and staff experience, as well as possible reputational risks and regulatory impact.

Consultation

Executive Leadership Team.

Governance or Legal Issues

Trusts are required to have a FTSUG as part of the NHS standard contract terms and conditions.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

- Assurance is sought by the FTSUG, that concerns logged from staff with protected characteristics are supported by employee relations/EDI processes; and that any wider issues are being considered by senior Trust leadership
- This report highlights some areas of good practice, including having FTSU Champions from a diverse range of backgrounds, as well as numbers of BME colleagues speaking up.

Recommendations

The Board of Directors is requested to:

1. Support the current mechanisms and activities in place for raising awareness of the FTSU agenda
2. Discuss the report and determine whether it sufficiently assures the Board of the FTSU agenda at the Trust and that those proposals made by the FTSUG promote a culture of open and honest communication to support staff to speak up.

Report presented and: **Tamera Howard**
prepared by: **Freedom to Speak Up Guardian**

Freedom to Speak Up Guardian (FTSUG) – half-yearly report

1. Introduction

1.1 The Freedom to Speak Up Guardian (FTSUG) is part of a culture of speaking up and acts to enable patient safety concerns to be identified and addressed at an early stage. Freedom to Speak Up (FTSU) has three components: improving and protecting patient safety, improving and supporting worker experience and visibly promoting learning cultures that embrace continual development. The Care Quality Commission (CQC) assesses an NHS trust's speaking up culture under the Well-Led domain of its inspections.

1.2 The FTSU report covers the period from July to December 2024: Quarter 2 and 3 2024/25. Reporting to Board is on a six-monthly basis.

2. Aim

2.1 This report aims to provide the Board with:

- Information on the number of cases being dealt with by the FTSUG and themes identified from July to December 2024
- Information on what the Trust has learnt and what improvements have been made as a result of workers speaking up
- Actions taken to improve FTSU culture in the Trust, including progress in the promotion of the FTSUG role and addressing barriers to speaking up
- Updates from the National Guardians Office (NGO)
- Key recommendations to Board.

3. Summary of Freedom to Speak Up Concerns

3.1 Concerns are categorised in accordance with NGO guidance. The NGO requires concerns relating to Patient Safety, Bullying and Harassment, Inappropriate Attitudes and Behaviours, Worker Safety and Wellbeing, Public Interest Disclosure Act (PIDA) concerns, anonymous concerns and those suffering detriment or demeaning treatment, as a result of speaking up, to be reported on a quarterly basis.

3.2 **Table 1** show the FTSU case data comparison for DHcFT in 2023 and 2024 and the average for Mental Health Trusts in 2023/24. This shows a 45% increase in number of FTSU cases from 2023 to 2024.

Table 1

DHcFT FTSU Cases 2023	DHcFT FTSU Cases 2024	Average annual cases for MH Trusts in 2023/24 (Speaking Up to FTSUGs: 2023/24)
140	203	110

Table 2 shows that the FTSUG logged 37 cases in Q2 2024/25 and 84 cases in Q3 2024/25. In Quarter 4 2024/25, 40 cases have been logged. In 2024, DHcFT averaged 50.75 cases per quarter (12 months).

3.3 **Patient Safety and Quality:** During Q2 and Q3 2024/25, patient safety and quality concerns represented 9.1% of cases. From January to June 2024, they represented 8.5% of cases. Patient safety and quality concerns are directed to the Director of Nursing, AHPs, Quality and Patient Experience and to the Medical Director.

According to the Summary of Speaking Up to FTSUGs: 2023/24, patient safety concerns represented 18.7% of all concerns nationally.

Table 2: FTSU Data Q1 2024/25 and Q4 2023/24

Types of Concerns	Q2 2024/25	Q3 2024/25
Patient Safety & Quality (NGO/PIDA)	3	8
Bullying & Harassment (NGO/PIDA)	5	15
Inappropriate Attitudes & Behaviours (NGO)	13	23
Worker Safety & Wellbeing (NGO)	17	42
Potential Fraud or Criminal Offence (PIDA)	0	0
Total Cases (individuals) reported to FTSUG*	**37**	**84**
Public Interest Disclosure Act (PIDA) concerns	8	23
Reportable to NGO: Bullying and Harassment / Patient Safety / Worker Safety / Inappropriate Attitudes & Behaviours	38	88
Anonymous / Not known / Other	4	3
Person indicates suffering detriment as a result of speaking up	0	1
Number of cases that have received feedback	**33**	**68**

***Individuals (cases) approaching FTSUG may log more than one concern.**

3.4 **Bullying and Harassment concerns** represented 16.5% of cases raised to the FTSUG from July to December 2024, which is lower than the 19.8% raised nationally to FTSUGs during 2023/24. (Summary of Speaking Up to FTSUGs: 2023/24). This is a decrease on the 21.9% of cases raised from January to June 2024. Bullying and harassment FTSU cases levels for DHcFT for 12 months from January to December 2024 were at 20.3%.

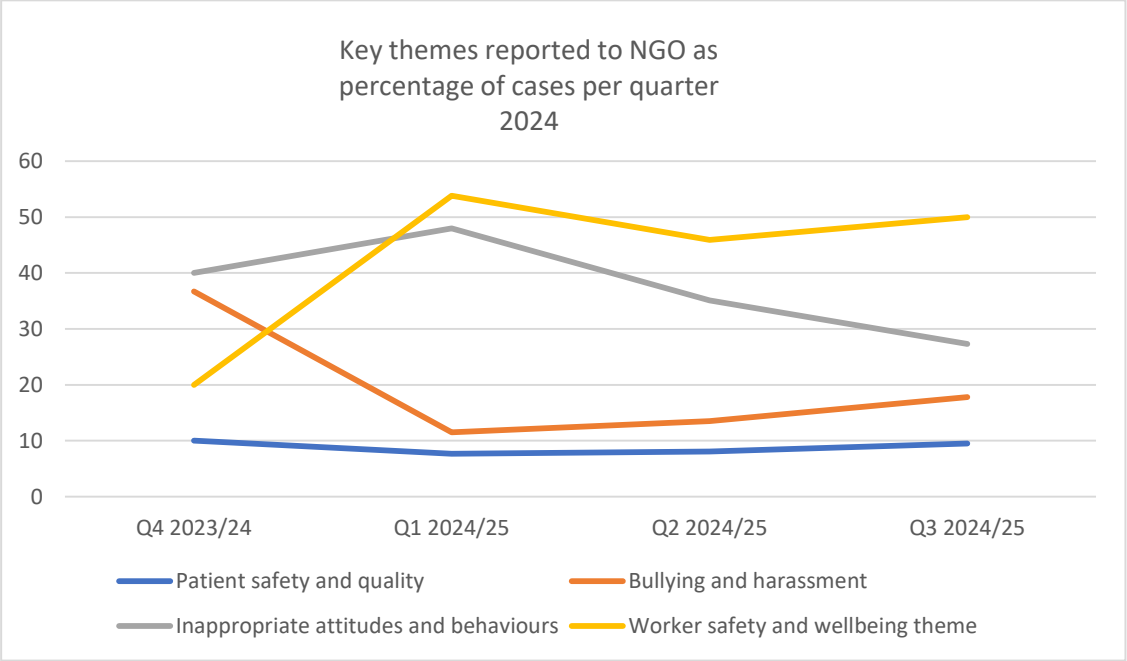
The FTSUG promotes the Trust's Dignity at Work policy, Trust Wellbeing offers, staff-side/union support and Employee Relations where staff require information and support around bullying and harassment matters.

3.5 **Inappropriate Attitudes and Behaviours concerns** represented of 29.7% cases raised to the FTSUG from July to December 2024. This is a decrease on the 45.1% of cases raised from January to June 2024. The NGO figure for 2023/24 is 38.5% (Summary of Speaking Up to FTSUGs: 2023/24).

3.6 **Worker Safety and Wellbeing theme:** 48.8% of cases involved an element of worker safety and wellbeing in Q2 and Q3 2024/25. This is a significant increase on the 20.3% of cases seen in Q1 2024/25 and Q4 2023/24. Nationally in 2023/24, the average for worker safety and wellbeing was 32.3%. (Summary of Speaking Up to FTSUGs: 2023/24).

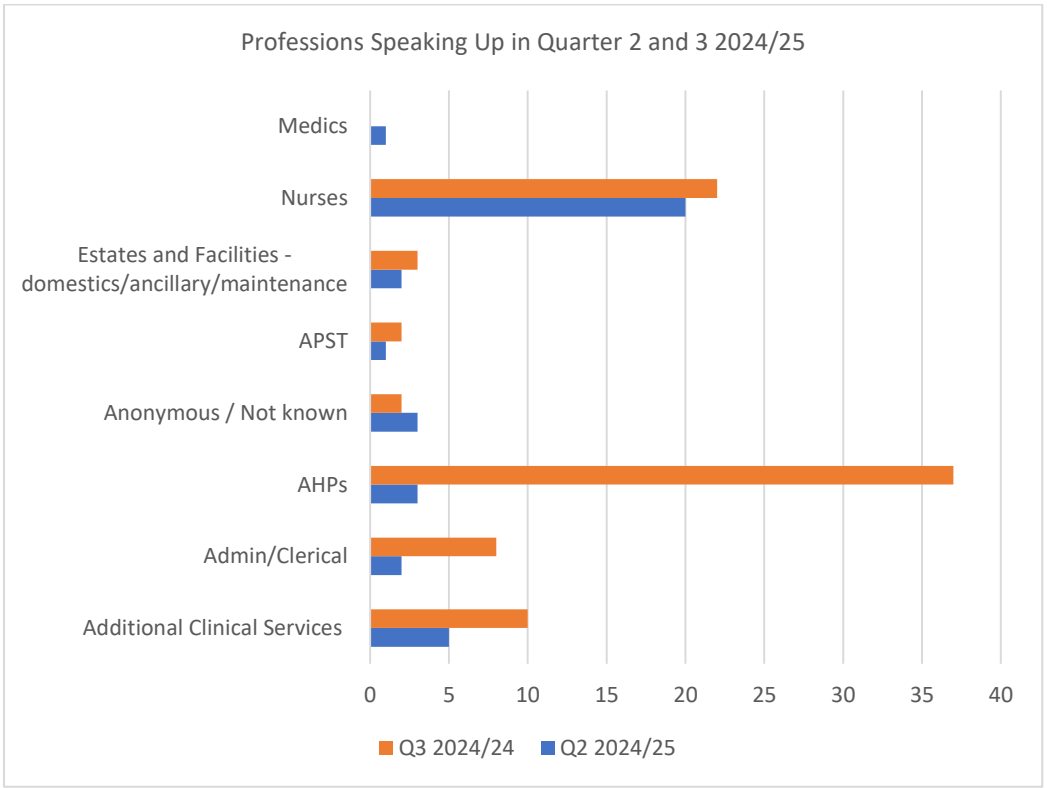
Figure 1 shows Bullying and Harassment, Inappropriate Attitudes and Behaviours, Patient Safety and Quality and Worker Safety and Wellbeing cases as percentage of number of cases per quarter as reported by the FTSUG to the NGO over the January to December 2024 period (12 months).

Figure 1



3.7 **Professional groups**: In Q2 and Q3 2024/25, 33.8% of staff approaching the FTSUG were Nurses. This is similar to Nurses approaching in Q1 2024/25 and Q4 2023/24 at 36.6% of staff. It is also higher than the national average reported by the NGO at 28.3%. (Summary of Speaking Up to FTSUGs: 2023/24). There were higher numbers of Allied Healthcare Professionals (AHPs) logged in Quarter 3 2024/25 due to 23 staff speaking up from one department. See Figure 2.

Figure 2: Professional groups speaking up in Q2 and Q3 2024/25 as percentage of total cases per quarter in comparison to NGO 2023/24 data



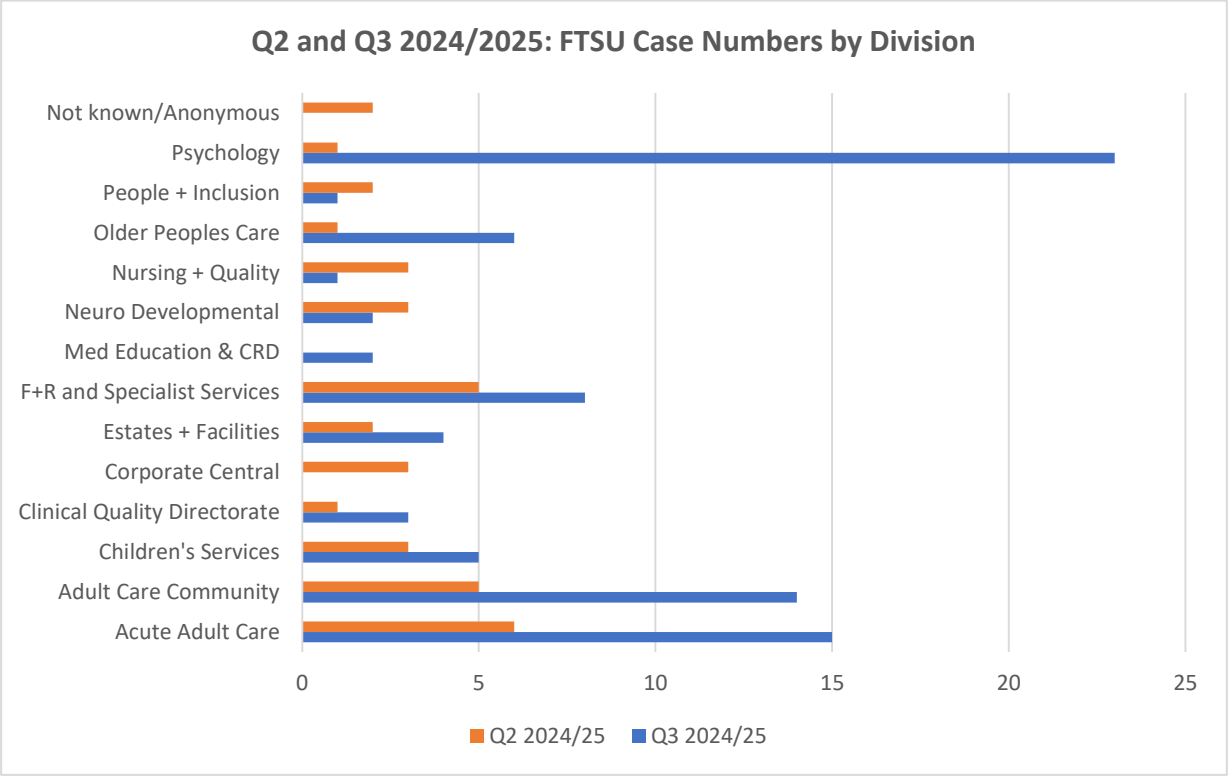
3.8 **Experiencing Detriment or Demeaning treatment:** In Q2 and Q3 2024/25, 0.8% of workers reported that they had experienced a detriment or demeaning treatment as a result of speaking up. In Q1 2024/25 and Q4 2023/24 this was 3.6%. NGO average for detriment in 2023/24 was 4% (Summary of Speaking Up to FTSUGs: 2023/24).

3.9 **Ethnicity of Workers:** In Q2 and Q3 2024/25, 25.6% of colleagues speaking up identified as Black and Minority Ethnic (BME). This is an increase on Q1 2024/25 and Q4 2023/24, where 19.5% of staff speaking up identified as BME. 18.95% of DHcFT staff are from BME communities (Equality and Diversity Dashboard June 2024).

3.10 **Anonymous, Confidential or Open concerns:** Anonymous concerns were 5.8% of concerns. This is lower than anonymous concerns reported nationally in 2023/24, which were 9.5% (Summary of Speaking Up to FTSUGs: 2023/24). In Q1 2024/25 and Q4 2023/24, anonymous concerns represented 9.7% of cases.

3.11 **Concerns raised by Division:** Figure 3 shows the number of cases from Divisions across the Trust. There are high numbers of concerns from Psychology due to 23 workers from a team in this Division speaking up during Q3. Numbers in some areas are higher during Q3 as more staff spoke up.

Figure 3



4. Emerging or ongoing themes with learning/action points

4.1 **Worker Safety and Wellbeing / Policy, Process and Procedure (including Management of Change), Patient Safety and Quality / Patient Experience:** 23 staff from a service in the Trust have spoken with the FTSUG about a forthcoming TUPE process (June 2025) about the loss of their NHS roles. They were concerned that following the TUPE process they would lose their NHS Terms and Conditions because the new provider will restructure and there will be redundancies. Colleagues were also concerned about accessing their NHS contracts via Employee Relations. Colleagues spoke up about the quality of the tender process which they have challenged with the ICB. Staff also talked about the impact on patient safety and the risk to patients who they can no longer continue to support - or have to stop seeing when the clinical need is still there for the patient.

They were concerned about the lack of response from the Trust around some of their concerns. A provider has now been chosen for these staff to move to and further concerns have been raised about the quality and capabilities of the new provider.

Learning and improvement

- Concerns around accessing contracts were escalated and were addressed via employee relations and a comms message to all the staff involved
- Some individual concerns were escalated around wellbeing and impact of the process on staff. These were responded to with signposting to the Service Manager and the Head of the Service as well as in-house wellbeing services. Staff are also being supported by their unions
- The group have escalated concerns to the ICB through the ICB FTSUG and also to other relevant organisations including NHSE
- Executive Leaders and Services Leaders are aware of the impact of the TUPE process and are supporting with some listening events for staff.

4.2 **Inclusion/Discrimination:** Concerns from BME staff working in one specific area regarding inclusion in various different areas. This included concerns about racism from patients and the understanding of this and its impact on quality of care that can be provided by the BME worker for the patient who is being discriminatory – and the lack of understanding of the impact at times by non-BME managers. Two colleagues also raised concerns about the lack of access to progression and development routes including a Band 5 to Band 6 nursing opportunity. There was feeling that non BME colleagues were accessing these opportunities more easily and sooner than they were. Concerns were also raised about the wider culture of the leadership on one specific ward and a lack of inclusion. There are also other concerns from BME staff across the Trust in relation to banter, support from and relationship with non-BME manager, including a lack of understanding of discrimination and racism and racial trauma.

Learning and improvement

- Improvement and support will now involve bespoke training and development around inclusion for staff working in specific service areas where concerns are raised and a more generic training and development approach across the wider Trust. The Trust has just commissioned from NHS elect and another provider to deliver around inclusion and discrimination
- There is a working group for one of the areas around racism and inclusion that the FTSUG is attending
- A new Equality, Diversity and Inclusion (EDI) lead commences on the 31 March 2025, which will link to a Trust-wide and Divisional approach across the Trust
- Comparisons to the recent staff survey will also be made to link any feedback from these areas to FTSU concerns raised.

4.3 **Policy/Process and Procedure / Worker Wellbeing and Safety:** Disciplinary processes/ HR processes and impact on staff with mental health issues. A number of our staff have mental health conditions/issues which have been adversely impacted on by being involved in an HR process, for example, receiving a disciplinary-type letter or being performance managed. (Nine staff have spoken up regarding these types of concerns). Some staff spoke of receiving a disciplinary process HR letter and the shock associated with this. Some staff were concerned about performance management policies and whether they were being utilised and/or adhered to.

Learning and improvement

- Raised with the Director, and Deputy Director, of People and Inclusion in relation to concerns around whether a Just Culture and compassionate leadership approach is being taken or whether this is not happening at times
- The importance of a Just Culture and making sure that staff with protected characteristics are treated fairly is also an important further consideration. Further improvement work to be carried out within this area.

5. Improving Speaking Up Culture

5.1 **Improving visibility and networking:** The FTSUG presents at monthly Trust Inductions. The FTSUG attends team meetings on request. The FTSUG is now holding regular face-to-face drop-ins in some acute settings including at the Radbourne Unit and at Cubley Court. The FTSU is involved in listening events in specific areas of the Trust in relation to concerns. Speaking Up Month October 2024 involved the promotion of speaking up champions from across the Trust.

5.2 **Supporting communities who face barriers to speaking up:** The FTSUG engaged with the Equality, Diversity and Inclusion (EDI) team to address inclusion issues and share themes for diverse groups until September 2024. Since that time, the FTSUG has been able to speak with the Director of People, Organisational Development and Inclusion whilst the EDI team is being recruited to. The FTSU has attended the EDI steering group regularly and has reached out to the staff network leads. The FTSUG also attends the Junior Doctors Forum on a regular basis and presents training on FTSUG at north and south Junior Doctors training sessions.

5.3 **Triangulation of data and FTSU:** the FTSUG meets regularly with senior leaders, including the Director of People, Organisational Development and Inclusion, to discuss triangulation of data. The FTSUG produces a report for the People and Culture Committee to support the triangulation of data from FTSU.

5.4 **Network of FTSU Champions:** The FTSUG holds monthly catch-up meetings with Speaking Up Champions to share good practice, support any speaking up matters and to share NGO information. Champions referred in 22% of concerns during July to December 2024. DHcFT currently has 35 FTSU Champions who come from a range of Divisions across the Trust. Children's services and Adult Community Care have created their own network of Divisional champions and the FTSUG meets bi-monthly with the Children's services group.

5.5 **Non-Executive Directors:** the FTSUG is supported by Geoff Lewins, Non-Executive Director (NED) lead for Speaking Up. The FTSUG holds monthly meetings with the NED to share FTSUG practice and areas for support and development.

6. Learning, Improvement and Development in relation to Speaking Up Culture within the Trust

6.1 **Evaluation feedback on Speaking Up:** An evaluation form for individuals who have spoken up is sent out following contact with the FTSUG using an online link. 88% (22 of 25 responses) of those responding from July to December said 'yes' they would speak up again. These questions are required by the NGO.

6.2 **Derbyshire Integrated Care System (ICS):** the FTSUG meets monthly with other ICS FTSUGs to discuss system arrangements around FTSU.

6.3 **Speak Up e-learning training launch:** Speak Up e-learning training launched for all staff on 1 April 2024. Currently at 85% compliance across organisation (3 February 2025). Completion was due by 1 October 2024.

6.4 **Staff Survey 2024: Raising Concerns:** There are four questions linked to the staff survey on raising concerns. At the time of writing, the results have not been officially released. Three responses have increased very slightly since the preceding survey in 2023 and are higher than comparator organisations. However, question 25f: Feel organisation would address any concerns I raised has shown a decrease of 1.7% since the 2023 survey.

7 National Guardian's Office and related National Changes

7.1 **FTSU Action and Improvement plan** was created and monitoring of compliance of the actions is through the six-monthly reporting by the FTSUG to the Audit and Risk Committee.

7.2 **NGO Detriment Guidance:** The National Guardian's Office produced Detriment Guidance for Guardians in January 2025. The report says (page 1) that 'Many people who speak up fear nothing will be done or that they will suffer retaliation for having spoken up. Individual barriers to speaking up may vary from person to person, depending on factors including their status in their organisation, their background, and personal characteristics. Recent high-profile cases of workers suffering detriment for speaking up are troubling reminders that it is not always easy to speak up in the health or care sectors. Workers speaking up can find themselves bullied or threatened – there is a worrying trend of being reported for misconduct to their professional body.' The report also explains that an organisation has a responsibility to:

- Protect workers who speak up from detriment, disadvantageous or demeaning treatment
- Ensure the working environment is a safe one
- Respond to concerns of disadvantageous or demeaning treatment by examining the facts, reviewing outcomes, providing feedback, and reflecting and learning
- Act – and be seen to act - when detriment, disadvantageous or demeaning treatment does occur
- Communicate that detriment from speaking up will not be tolerated
- Include any reports of detriment following speaking up in regular reporting and review as a whole and not just on an individual basis.

The FTSUG will be reviewing the detriment section of the FTSU policy and updating accordingly in line with this guidance.

8. Conclusion

8.1 Feeling free to speak up represents a significant cultural change across the NHS. Success is not only the responsibility of the FTSUG. It is important that the Trust continues to learn from concerns that workers raise and to build an environment where workers know their concerns, and feedback, are taken seriously and welcomed as an opportunity to guide service improvement and development.

8.2 The Board will continue to use the positive culture around speaking up to drive recommendations from the report forward and to deliver meaningful and visible responses to Trust-wide concerns.

Board Committee Assurance Summary Reports to Trust Board – 4 March 2025

The following summaries cover the meetings that have been held since the last public Board meeting held on 14 January 2025 and are received for information.

- Audit and Risk Committee 23 January
- People and Culture Committee 28 January
- Finance and Performance Committee 13 January and 19 February (3 March verbal update)
- Quality and Safeguarding Committee 28 January and 11 February

Key:

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

Audit and Risk Committee – key assurance levels agreed – 23 January 2025	
	BAF Deep Dive - Finance In line with the Trust's Risk Policy all extreme risks are subject to a deep dive requirement through the Audit and Risk Committee. The component elements within BAF Risk 3A – '*There is a risk that the Trust fails to deliver its revenue and capital financial plans 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'* were reviewed in a presentation provided by Director of Finance. The 'Extreme' risk level was confirmed and the Committee received **significant assurance** on the current approach of Finance and Performance Committee oversight and reporting.
	Operational Risk Management The Committee received assurance on the work undertaken to comply with the risk management strategy, and the status of Datix record keeping standards in reference to the internal audit recommendations. The latest compliance levels on risk reviews and actions showed an increase in overdue status. This would be escalated to Executive Leads. **Significant assurance** was noted on the efforts to drive the risk management process and the escalate address non-compliance but **limited assurance** was obtained from the report due to the lack of improvement in reviewing overdue risks and actions.
	Risk Management Strategy The Committee was appraised of changes to the management of the ligature risks, assessments and associated actions. The ligature risk assessments would now be managed outside of the Datix system under a bespoke system that has been designed around the CQC Ligature Risk Assessment Tool. The Ligature Risk Reduction Policy and Procedure had been ratified and the Chair agreed to discuss the matter with the Chair of the Quality and Safeguarding Committee to ensure the robustness of the transition between the two systems and future oversight. (Post-meeting note: discussion since held).

	Board Assurance Framework (BAF) Issue 4 (version 4.2) of the BAF for 2024/25 was reviewed and the Committee agreed **significant assurance** that the paper provided of the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives. The BAF was now mapped to the new strategic objectives and a thorough review of the associated risks, root causes and key gaps in control has been undertaken.
	Well Led Action Plan The Committee noted the latest progress against the recommendations. There has been excellent progress and only two actions remain outstanding. The Medical Director has requested an extension on the Clinical Plan work and the report on the review of the Constitution would be submitted to the Board and Council of Governors in March 2025 for approval. **Limited assurance** was allocated until all of the recommendations were completed.
	Supervision of Staff Audit The Committee noted that the majority of the actions had been linked to approval of a revised Supervision policy, but this had been delayed. Limited assurance was allocated until all of the actions had been closed.
	Conflicts of Interest and Declarations of Interest Report The Trust's returns for Decision Making Staff had seen a marginal decrease from the previous year and reminders would be sent in quarter 1 of 2025/26. The continued increase of reporting of both private clinical practice and secondary employment demonstrated that the declaration of interest process is embedded into established Trust processes and is generating appropriate declarations. There would be additional communications around gifts, followed by an audit of declarations. **Significant assurance** was agreed that the requirement to make declarations is embedded into Trust processes.
	Commercial/Top-up Insurances This report gave an overview of insured risks the Trust has covered. Appropriate property insurance was being procured for the hospital new builds. The Committee requested that the Data Protection and Security Committee (DS&P) continues to keep the possible procurement of cyber insurance under review. **Significant assurance** was accepted that the Trust is actively monitoring and taking a commercially informed decision regarding the risks it insures.
	SFI Waiver Report (six-monthly) The Waiver Register for quarters 1, 2 and 3 for the financial year 2024/25 provided **significant assurance** that tendering and contracting processes are conducted in accordance with the Trust's Standing Financial Instructions and any waivers and non-competitive quotations have been logged and are presented for regular review by the Audit and Risk Committee.
	Data Quality update (six-monthly The Committee agreed **significant assurance** on the report which outlined the activities which have been undertaken over the last six months to ensure the Trust maintains good data quality. Support was given on the ambition to keep the amount of manual data processing to a minimum to reduce the potential for errors and also for operational teams to follow Standard Operating Procedures to ensure that electronic records are complete, accurate and up to date. The Committee was pleased to note that there is now a group from operations, nursing quality and governance and medical who are focused on Data Quality across the Trust.
	Annual Report Planning - Year End Timetable Planning The year-end timetable and key dates associated with the approval of the annual report and accounts provided **significant assurance** that year-end planning in relation this element is under control, noting the issues that were currently being work through on the operational plan submission.

	Approve Accounting Standards/Policies for Annual Accounts The Committee agreed the Trust's accounting policies for the 2024/25 Annual Accounts and took **significant assurance** these were in line with the Department of Health's Group Accounting Manual (GAM) and would reflect any future changes in the GAM before final accounts submission.
	Debtor Write-Off Report In line with a recommendation from an Internal Audit review of the Trust's debtor processes, a report covering 2022/23 to 2024/25 debtor write-offs was presented. This would be scheduled annually.
	Internal Audit Progress Report The Internal Auditor (360 Assurance) report identified progress made in relation to completion of work from the Trust's 2024/25 Internal Audit Plan. Planning for 2024/25 was in progress. The follow up rate for actions had deteriorated and this was being monitored closely.
	Counter Fraud, Bribery and Corruption Progress Report The Committee received an update on activity undertaken in accordance with the Counter Fraud Plan and included the current position in relation to continued compliance with the Government Functional Standard and submission of the Trust's Counter Fraud Functional Standard Return. International Fraud Awareness Week was used as a promotional opportunity through visits to teams and surveys. The suite of training modules continues to be used to emphasise the responsibility of all staff to bring fraud concerns to the team's attention.
	External Audit Progress Report The External Auditor, Forvis Mazars, confirmed that the scope of the audit and timetable is consistent with the previous year and will be completed in June in line with reporting deadlines and set out the emerging areas for the financial statement audit.
	Escalations to Board or other Committees: The Chair would escalate the issues around the changes to the ligature risk assessment process to the Chair of the Quality and Safeguarding Committee. **Items added to the Board Assurance Framework**: None. **Next scheduled meeting:** 24 April 2025.
Committee Chair: Geoff Lewins	**Executive Leads: Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary and James Sabin, Director of Finance**

People and Culture Committee – key assurance levels agreed – 28 January 2025
People and Inclusion Assurance Dashboard The Committee reviewed current performance. The main points were: Mandatory Training: plans for a deep dive of Resus ILS Level 3 compliance were highlighted and as overall compliance has remained above target, it was agreed to review this at the next meeting. Vacancies and Recruitment: there had been a decline in Recruitment key performance indicators (KPIs), which was attributed to the recent bank holidays and a team restructure. Clear expectations are being reiterated. It was noted that a breakdown of Vacancy Control Panel (VCP) decisions is to be prepared and there is a pause on approval of non-clinical, Band 7 and above posts, unless there is an exception. Freedom to Speak Up (FTSU): the Committee was notified that the Chief Executive and Deputy Chief Executive are helping the FTSU Guardian in supporting raised concerns from the Improving Access to Psychological Therapies (IAPT) team, in relation to a TUPE process. **Significant assurance** was accepted on progress shown for mandatory training, staff turnover, vacancies and recruitment, bank usage and Freedom to Speak Up.

Attendance and Absence: a refreshed policy and approach is to be promoted to improve assurance around support available for long term absences.

Annual Appraisals: the overall improvement over the last year was noted, along with the trialling of an automated notification system, whereby the appraiser and appraisee receive calendar reminders.

Limited assurance was accepted on attendance and absence, Employee Relations, clinical supervision and annual appraisals.

Making Room for Dignity (MRfD)

It was noted that 66% of the additional staff have either already commenced or are due to, with robust plans in place for the remaining gaps. Discussions focussed on safe staffing and the required balance of experienced and newly-qualified staff. It was emphasised that teams will be mapped in terms of ability and practice.

In relation to the significant numbers of 'hard-to-recruit' and 'national workforce shortage' posts required, the Committee accepted **limited assurance**.

A simplified Model of Care, focusing on the three main areas, was well received by the Committee.

Limited assurance was accepted on the development of, and progress with, the service and cultural transformation work and implementation.

System Developments

The Committee was presented with a slide show to summarise local and national updates, which included:

National Statutory and Mandatory Training: a Memorandum of Understanding will facilitate portability of training records for staff movements between any of the 266 NHS organisations in England.

Future NHS Workforce Solution Transformation Programme: it was noted that workforce surveys are to be completed in relation to trusts' readiness for the new ESR system.

Leadership and Management Code of Practice: attention was drawn to the huge document and the expectation for online engagement through the Citizen Space platform.

System: it was reported that potential efficiencies of combining some transactional processes with other NHS providers is in the early stages of discussion.

Trust: news of the successful appointment of a Head of Equality, Diversity and Inclusion (EDI) and an EDI Officer were welcomed, along with the transition of Employee Relations from the joint venture into the Trust.

36 mutually agreed resignation scheme (MARS) applications were under review and it was noted that those approved will leave the Trust by 15 March.

Deep Dive – Health and Wellbeing

The Committee received **significant assurance** that the Health and Wellbeing Service provides a range of services for Derbyshire Healthcare colleagues, across the three priority areas:

- Championing wellbeing
- Helping people to help themselves and others.
- Supporting colleagues

However, **limited assurance** was received on the impact of these services due to the lack of measurable outcomes or performance targets. It was noted that the corrective actions will be in place by the end of May.

2024 NHS Staff Survey Fieldwork Update

It was noted that the biggest challenge over the last three years has been around engaging teams and encouraging their participation, which cross-referenced to the KPI data. The potential barriers included:

- Leadership engagement
- Culture barriers
- Capacity.

	In order to overcome these barriers, the Committee noted the suggested actions: • Staff Survey Champions • Myth-busting sessions • Pre-fieldwork culture sessions • Weekly catchups with Divisional People Leads (DPLs) and Staff Survey Champions during fieldwork • Accountability at all levels. The important role of the Communications and Engagement team to explain and report on actions was emphasised.
	2024 NHS Staff Survey First Look The Committee was advised that the Trust's response rate of 64% is highest within the mental health benchmarking group. The top improved and most reduced areas were noted.
	Update on Communications Strategy and Plans to Support Staff Engagement The Committee discussed the two plans to support delivery of the new Trust Strategy, which were shared for information: • Communications Plan • Community and Stakeholder Engagement Plan. It was noted that the drivers to move to an Engagement Plan now relate to partnership priority. The positive and authentic work was praised. A Board Development session in February with Community Action Derby will take some of those conversations forward.
	Supervision of Staff – update on Policy Review and Impact on Actions It was highlighted that the policy is to be used as both a performance metric and clinical compliance indicator. A key change noted was that compliance is that supervision takes place every eight weeks, as opposed to the duration; quality is time, satisfaction, experience, etc, and can be picked up in different ways.
	Board Assurance Framework (BAF) – key risks identified: The Committee was advised that an in-depth review has ensured alignment with the new Trust Strategy. The thorough scrutiny was welcomed and it was noted that none of the ratings have changed.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework**: the limited assurance for Absence and Attendance and the need for ongoing Committee oversight had been noted. The leadership risks are also to be recorded. It was recommended, that clarification of safe staffing/skills mix should be clarified within the Workforce section of the BAF. **Next scheduled meeting:** 25 March 2025.
Committee Chair: Ralph Knibbs	**Executive Lead: Rebecca Oakley, Director of People, Organisational Development and Inclusion**

Finance and Performance Committee – key assurance levels for items – 13 January 2025	
	Making Room for Dignity (MRfD) Programme Update The positive feedback received from service users and staff for the newly opened Bluebell Ward was highlighted. It was reported that The Radbourne Unit refurbishment should reconvene in April 2025.

	Substantial issues with the foundations around Wards 35 and 36 block, along with a recommendation to demolish and rebuild were noted. Potential costings are being investigated. A new, more robust governance structure was explained. This is now in place and working with six operational workstreams to strengthen oversight of the programme.
	Financial Performance – Month 8 Finance Report A year-to-date surplus of £2.1m ahead of plan was reported, with slippage on the MRfD programme as the key driver. The Committee noted the key pressure remains the overspend for 'out of area' placements, which appears to be deteriorating in quarter 3. Cost improvement programme (CIP) performance is in a better position and an additional c£1m of capital secured linked to critical infrastructure was acknowledged and welcomed.
	Review and Approval of Treasury Management Policy and Procedures The minor changes were noted and the policy ratified.
	Operational and Financial Planning Pending receipt of national guidance, a brief overview of the 2025/26 planning approach was shared. It was noted that the high-level, System submission is due mid- February, with out of area spend and inpatient staffing levels as the key drivers. A transformation approach to CIPs was supported.
	Safer Staffing/Establishment Review update Inpatient staffing establishment and proposed changes to improve safer staffing were accepted and welcomed. However, the remaining challenges with Band 6 over-recruitment were noted.
	Collaborations and other Alliances The Committee received an update on the work of the East Midlands Provider Collaborative and **significant assurance** was received on the quality and safety of the East Midlands Perinatal Mental Health Provider Collaborative.
	Operational Performance The update on Trust performance to the end of November 2024 highlighted some issues around inappropriate out of area placements. The associated recovery action plan was noted, along with a successful capital bid for a mental health hub. The Committee accepted **significant assurance** and the report was considered a fair reflection of the key issues and performance. Whilst there are pockets of deteriorated or poor performance being monitored and risks flagged accordingly, the progress and positive trajectories were welcomed.
	Procurement update No concerns were raised. It was noted that limited resources have led to minimal developmental progress and recruitment is ongoing for Head of Procurement and Deputy roles, which will provide increased resilience. The workplan will progress into 2025/26, with tri-annual updates.
	System Update: Integrated Care Board (ICB) Finance Committee/System Directors of Finance (DoFs) Any points to note are covered within the Finance report and planning sections.
	Emergency Preparedness, Resilience and Response (EPRR) Report The update and progress report were well received, and the encouraging progress noted.
	Board Assurance Framework (BAF) 2024/25 Risks Overview It was confirmed that the risks have been updated to align to the new strategy, with a particular focus on Finance and MRfD.

	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework:** None. **Next scheduled meeting:** 19 February 2025.
Committee Chair: Tony Edwards	**Executive Lead: James Sabin, Director of Finance**

Extra-ordinary Finance and Performance Committee – key assurance levels for items – 19 February 2025. Note: invites were extended to the full Board for this meeting.	
	Operational Plan 2025/26 The Committee received an update of the draft plan position paper and the core basis for the initial draft submission due on 26 February. In the absence of additional funding from the commissioners, cost pressures related to out of area placements, inpatient acuity/observations and pay award pressures were noted as the key drivers of the continued deficit. It was recognised that the investments are minimal and workforce growth is not expected beyond the Making Room for Dignity (MRfD) programme. Development of the Cost Improvement Programme plans will be the main focus. Further prioritisation and scaling back of capital plans may be required. The Committee noted the movement in the figures during the draft plan process, with the final figure being c£5.8m deficit. A request was made to track future movements to understand the plan composition. A further update will be given at the scheduled Committee meeting on 3 March and at the Extra-ordinary Confidential Board the next day, which will provide a post submission update and system-wide position statement.
	Making Room for Dignity (MRfD) Agreement It was noted that the revised contractual arrangement with IHP had been formally signed. As the projects had progressed to practical completion, the variation risks and additional works (as instructed and requested by us the client) have been reduced and/or robustly costed and agreed. The Committee noted that no further material risk is expected.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework:** None although the MRfD risk is reviewed and updated monthly. **Next scheduled meeting:** 3 March 2025.
Committee Chair: Tony Edwards	**Executive Lead: James Sabin, Director of Finance**

Extra-ordinary Quality and Safeguarding Committee – key assurance levels for items – 28 January 2025	
	Review of Making Room for Dignity (MRfD) Policies and Standard Operating Procedures (SoPs) The Committee noted that 130 policies had been reviewed with some minor amendments made to include the new sites and buildings, to align with the model of care and that all comply with the Care Quality Commission and Health and Safety requirements. It was reported that any further, major changes to the amended policies will be reviewed via the standard route. The plan to reiterate the policies as and when required was welcomed.

	Significant assurance was accepted that on opening, the effectiveness of the new facilities will be evidenced by the MRfD Programme Oversight and Delivery Group (PODG).
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework:** None. **Next scheduled meeting:** 13 February 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 – 11 February 2025
Regulation 28 – Admissions and Handover Audit The Committee received the results of an audit undertaken to provide assurance that the Trust was following policy subsequent to a Regulation 28. The audit was undertaken across all Trust inpatient settings, which covered the period November 2024 to January 2025. It was noted that 90% of patients within Adult services had been admitted outside of the handover period. There was one incidence recorded on Datix, as 'no harm'. Of the remainder, some were relating to admissions through the collaborative for patients transferring from another destination, and some were deemed to have been a greater risk if the admission was not taken. It was agreed that there is an effective process in place. The Committee received and reviewed the evidence and accepted **significant assurance**.
Director of Nursing Update The Director of Nursing (DoN) update included that the ligature policy has now been published on the Trust's intranet. It was emphasised that environmental ligature risk assessments are to be reported on a different platform, which is not yet available and these will remain on Datix in the meantime. However, any clinical incident relating to ligature will always remain on Datix. It was noted that successful appointments within the Safeguarding team has eliminated interim staffing. However, recruitment is ongoing for a Named Doctor/Paediatric Consultant. Other areas covered included a Safeguarding Adult Review by the Derbyshire Safeguarding Adults Board and the associated learning.
Fundamental Standards of Care Report The Committee discussed and acknowledged the summarised reports and the action plan from April/May and December 2024 and acknowledged the Care Quality Commission (CQC) revised ratings for the Acute wards as 'good' across all domains. It was agreed to monitor and receive assurance regularly on the progress of the actions as they are completed across the inpatient settings in the Trust. The reports show that there have been improvements, however, due to wider spread of actions across all inpatient areas and effective leadership to ensure sustained improvements, **limited assurance** was accepted.
Making Room for Dignity (MRfD) Programme update The report provided **limited assurance** on the mobilisation and operationalisation planning for the remaining units and **limited assurance** on plans to deliver clinical model of care training, flow plan, Standard Operating Procedures/clinical policies and quality assurance framework. The progress on the actions being implemented was however noted with regular follow to continue. The key points raised included the successful mobilisation for Bluebell Ward and it was noted that risks are mitigated as and when they are identified. It was highlighted that a Benefits Realisation report is being prepared, along with a post-project evaluation to illustrate achievements as a result of the investment.

	Making Room for Dignity (MRfD) Outcome Measures The paper described the outcomes that were submitted as part of the NHSE business case, which then align the MRfD model of care with the Trust Strategy and the four 'P's, Patient Focused; People; Productivity and Partnerships. The Committee received **significant assurance** that the MRfD programme has outcomes that will contribute to the delivery of the Trust Strategy, outcomes set out in the Business Case and outcomes that will improve Quality and Safety.
	Medicines and Pharmacy update A delay with updating Trust policies and lack of robust consideration around key medicine safety issues was raised. Due to quoracy challenges at the relevant sub-committee meetings, it was highlighted that representation is being agreed with Pharmacy, Medical and Nursing colleagues. It was noted that a task and finish group is to develop an action plan based on recommendations from a medicine administration thematic review of Datix incidents. The Committee supported and valued the role of the Medicine Management Committee and sub-committees at reviewing and taking appropriate action around medicine safety and governance within the Trust.
	Patient Safety Report The report provided the Committee with **limited assurance** relating to all Patient Safety process incidents occurring between 1 April 2024 and 31 December 2024. It was noted that the team has been effectively managing the workflow, notwithstanding the capacity issues, which are now resolving. Attention was drawn to the good improvements around phased implementation of training. Due to notable delays for external investigations to be processed, the Committee requested a report on the potential outcomes and how learning is demonstrated.
	Reducing Restrictive Intervention Report The challenges through staff vacancies and medical exceptions were noted in relation to training and Quality Improvement compliance. Attention was drawn to risk assessment and management compliance and it was noted that a working group is addressing data quality and ensuring accurate completion. A reduction in absconsions was welcomed and it was noted that prone restraint is being actively monitored and reduced through new training and interventions. The Committee received **limited assurance** on Reducing Restrictive Interventions and the progress made, noting there are still areas to improve on.
	Physical Healthcare update (six-monthly) The paper advised that overdue policies will be completed by the end of March. Highlights noted by the Committee included: a national initiative to promote health equality for those with severe mental health illness (SMI); approval of a business case which facilitates pathology results to transfer direct to SystmOne; the Trust's commitment to smoking cessation and improvement plans to monitor venous thrombo-embolism (VTE) assessments. **Limited assurance** was accepted.
	Medical Devices Assurance Report The Committee received a position paper outlining the current findings in relation to medical devices. It was reported that the servicing contract is outdated and responsibilities for procurement, servicing and assurance are fragmented. In addition, there are risks associated with devices that have not received an annual service.

	The Committee noted and supported the recommended actions, which included plans to improve procurement oversight and maintenance co-ordination; strengthening of asset register management and renegotiation of the contract.
	Quality Dashboard The majority of clinical performance indicators between October and December illustrated a continued pattern of common cause variation. The dashboard evidenced the areas of improving variation, which included: • Seclusion • Number of outstanding actions following serious incidents • Concerns recorded • Compliments recorded • Policy compliance • Settled accommodation. And the areas of concerning variation: • Inpatient incidents where staffing is a contributory factor • Percentage of GP summary sent out within 24 hour • Average length of stay (LoS) Acute Inpatient • Risk Screening/Assessment compliance. The Committee received **limited assurance** on progress towards clinical performance targets.
	Board and Quality Visits The Committee received a progress report in relation to Board Visits undertaken in the last six months. The recurring themes with the organisation/co-ordination of some Board visits were noted, for example, wheelchair access, parking, cancellations and lack of Reception services. Options for resolution were considered and will be overseen by the Deputy Director of Nursing and Heads of Nursing. It was highlighted that a positive impression had been made when the ICB visited the new units ahead of completion. **Limited assurance** was accepted due to the requirement for a more focused process and improved capture of feedback.
	Care Planning/Person-Centred Care (Monthly Update) It was noted that there has been ongoing challenge, particularly within the Community team, due to the number of vacancies and sickness absence, which is being monitored. However, there has been continued progress overall. The Committee accepted the proposed level of **limited assurance** due to the non-achievement of the target compliance level by some services.
	Divisional Performance Review (DPRs) The Committee received **significant assurance** from the performance review process. It was noted that an 'inform, challenge and confirm' process covers a range of quality, operational, workforce and performance measures and the review panel holds Divisions to account for the progress of recovery action plans for areas of under-performance. The process will now be considered for corporate areas.
	Learning from Deaths/Mortality Report The Committee received information for the period 1 October to 31 December 2024 and it was noted that future reporting will reflect equality, protected characteristics and other variables more effectively. **Limited assurance** was accepted due to further work required to fully implement the national guidance, along with approval for the report to be published on the Trust's website.

	Deep Dive – Adult Care Acute Medication Assurance Audits A review of the administration of medicines: low level and moderate harm incidents, was undertaken to support improvement in patient safety within the organisation. The medicine safety improvement programme and learning from a thematic review will now be implemented. It was noted that a total of 34% of all medicine incidents reported via Datix were Trust-related, with the main contributing variables being human, system, environmental and external factors. Recommendations from the review will be overseen by the Trust's Medicine Management Safety and Practice Committee (MMaSP) and focus on, fix, improve and change to improve safety.
	Policy Review The Committee reviewed and ratified the following policies: • Incident Policy and Procedures • Duty of Candour Policy and Procedures • Inpatient Therapeutic Observations and Engagement Policy and Procedure • Electronic Programme Management Office (ePMO) Policy and Procedure, including Quality Impact Assessment (QEIA) • Risk Assessment Policy and Procedure
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework:** It was recommended to consider: • The risks around medical devices and the resources available to deliver safe clinical care • Detail around the different platform for recording ligature risk assessments. **Next scheduled meeting:** 11 March 2025.
Committee Chair: Lynn Andrews	**Executive Lead: Tumi Banda, Director of Nursing, AHPs, Quality and Patient Experience**

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 4 March 2025

Learning from Deaths/Mortality Report – 1 October to 31 December 2024

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 October 2024 to 31 December 2024.

Executive Summary

- The Trust received 582 death notifications of patients who had been in contact with our services in the last three months. There is very little variation between male and female deaths; 319 male deaths were reported compared to 263 females
- The Trust has reported five Learning Disability deaths in the reporting timeframe and no deaths of patients with a diagnosis of autism
- Medical Examiner Officers have been established at all Acute Trusts in England and their role will be extended to include deaths occurring in the community, including at NHS Mental Health and Community trusts. The implementation of this process came into force on 9 September 2024. Nationally for community-based services. The Patient Safety team will continue to work with Medical Examiners to ensure the Trust maintains momentum in this area
- Good practice identified through case note reviews is fed back to clinicians involved as part of our appreciative learning
- A process has been implemented within the patient Electronic 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. These forms are audited.

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

This report provides limited assurance 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, Deputy Director of Nursing and the Director of Nursing, AHPs, Quality and Patient Experience
- Executive Incident Group
- Quality and Safeguarding Committee, 11 February 2025.

Governance or Legal Issues

There are no legal issues arising from this report.

The Care Quality Commission Regulations - this report provides assurance as follows:

- Outcome 4 (Regulation 9) Care and welfare of people who use services
- Outcome 14 (Regulation 23) Supporting staff
- Outcome 16 (Regulation 10) Assessing and monitoring the quality of service provision
- Duty of Candour (Regulation 20).

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

- During 1 October to 31 December 2024, there was very little variation between male and female deaths; 319 male deaths were reported compared to 263 female deaths
- No unexpected trends were identified according to ethnic origin or religion.

Recommendations

The Board of Directors is requested to accept this Mortality Report with limited assurance from the Quality and Safeguarding Committee and agree for the report to be published on the Trust's website as per national guidance.

Report presented by: **Arun Chidambaram**
Medical Director

Report prepared by: **Louise Hamilton**
Safer Care Co-ordinator

Rachel Williams
Lead Patient Safety/Experience, Patient Safety Specialist

Learning from Deaths - Mortality Report

1. Background

In line with the Care Quality Commission's (CQC) recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a framework for NHS Trusts - 'National Guidance on Learning from Deaths'. The purpose of the framework is to introduce a more standardised approach to the way NHS trusts report, investigate, and learn from patient deaths, which should lead to better quality investigations and improved embedded learning. To date, the Trust has met all of the required guidelines.

The report presents the data for 1 October to 31 December 2024.

2. Current Position and Progress (including COVID-19 related reviews)

- Cause of death information is currently being sought through the Coroner offices in Chesterfield and Derby but only a very small number of cause of deaths have been made available. This will improve now that the Medical Examiners process of reviewing the Trust's non-coronial deaths is in place. The Trust continues to meet with the Medical Examiners on a regular basis however feedback on cause of deaths has been minimal
- 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 21 January 2025
- A process has been implemented within the patient Electronic 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
- The Mortality Case Record review panel process has been evaluated and plans are in place to re-design this to act as an assurance and audit panel over incidents closed through the Operational Incident Review group. This is currently on hold due to capacity within the Patient Safety team
- The Trust Mortality Committee has been evaluated and developed into a Learning the Lessons Oversight Committee which will improve governance around learning and drive quality improvement.

3. Data Summary of all Deaths

Note that inpatients and learning disability (LD) data is based upon whether the patient has an open inpatient or LD referral at time of death. The table below outlines information from 1 October 2024 to 31 December 2024.

	October	November	December
Total Deaths Per Month	200	177	205
LD Referral Deaths	1	2	2

From 1 October to 31 December 2024, the Trust received 582 death notifications of patients who have been in contact with our services. Of these deaths, 319 patients were male, 263 female, 435 were white British and 13 Asian British. The youngest age was 0 years, the oldest age recorded was 104. The Trust has reported five Learning Disability deaths in the reporting timeframe and no deaths of patients with a diagnosis of autism.

4. Review of Deaths

Total number of Deaths from 1 October 2024 to 31 December 2024 reported on Datix.	64 “Unexpected deaths” Zero COVID deaths Five “Suspected deaths” Nine “Expected - end of life pathway” NB some expected deaths have been declined so these incidents are not included in the above figure. Four inpatient deaths, two expected – end of life, one inpatient death (overdose in the community prior to admission) died following transfer to the acute hospital for further treatment and one unexpected death on section 17 leave. *(W102211, W102539, W102579 and W100765)*
Incidents assigned for a review.	72 incidents assigned to the operational incident group.

Only deaths which meet the criteria below are reported through the Trust incident reporting system (Datix) and these are also reviewed using the process of the *Untoward Incident Reporting and Investigation Policy and Procedure.*

Any patient, open to services within the last six months, who has died, and meets the following:

- Homicide – perpetrator or victim
- Domestic homicide - perpetrator or victim
- Suicide/self-inflicted death, or suspected suicide
- Death following overdose
- Death whilst an inpatient
- Death of an inpatient who died within 30 days of discharge from a DHcFT hospital
- Death following an inpatient transfer to acute hospital
- Death of patient on a Section of the Mental Health Act or Deprivation of Liberty Safeguards (DoLs) authorisation
- Death of patient following absconsion from an inpatient unit
- Death following a physical restraint
- Death of a patient with a learning disability
- Death of a patient where there has been a complaint by family/carer the Ombudsman, or where staff have raised a significant concern about the quality-of-care provision.
- Death of a child (this will also be subject to scrutiny by the Child Death Overview Panel)
- Death of a patient open to safeguarding procedures at the time of death, which could be related to the death
- Death of a patient with historical safeguarding concerns, which could be related to the death
- Death where a previous Coroners Regulation 28 has been issued
- Death of a staff member whilst on duty
- Death of a child under the age of 18 of a current or previous service user who has died in suspicious circumstances
- Where an external organisation has highlighted concerns following the death of a patient whether they were open to the Trust at time of death or not
- Death of a patient with Autism
- Death of a patients who had a diagnosis of psychosis within the last episode of care.

5. Learning from Deaths Procedure

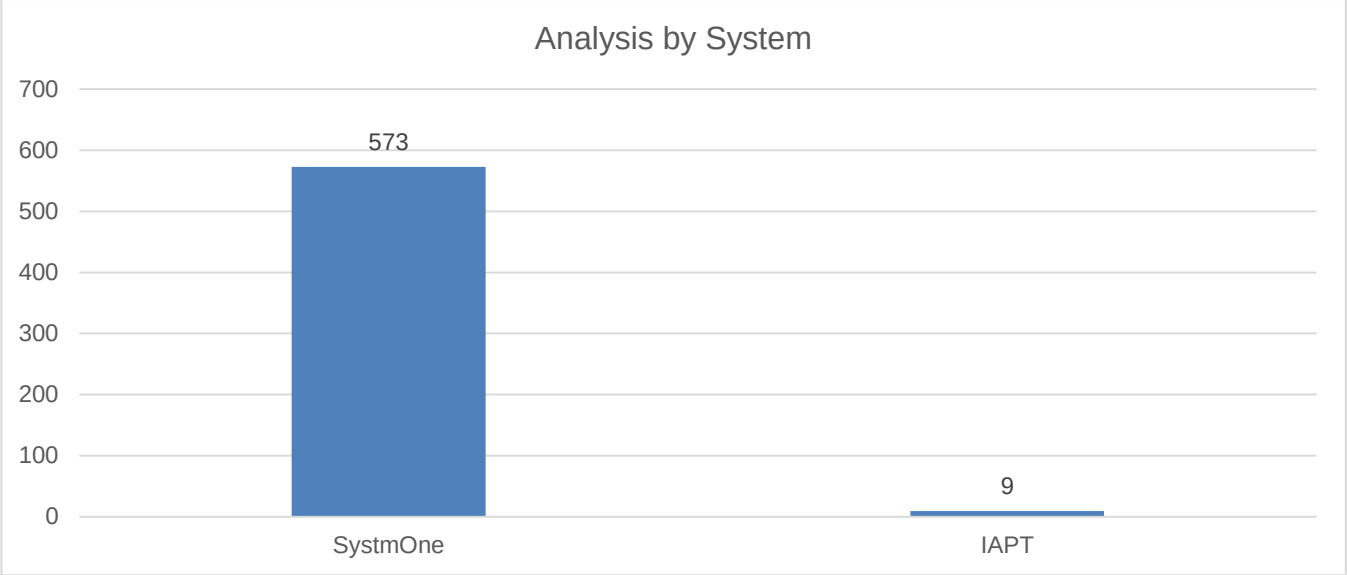
The Trust has now completed a move in terms of its mortality process, a process has been implemented within the patient Electronic Record which aids staff in identifying deaths which meet the threshold for DATIX reporting. This process fulfils stage one of the Learning from Deaths in that all deaths 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. However, this has been impacted by long term sickness over recent weeks however a plan is in place to address this.

6. Analysis of Data

6.1 Analysis per notification system since 1 October 2024 to 31 December 2024

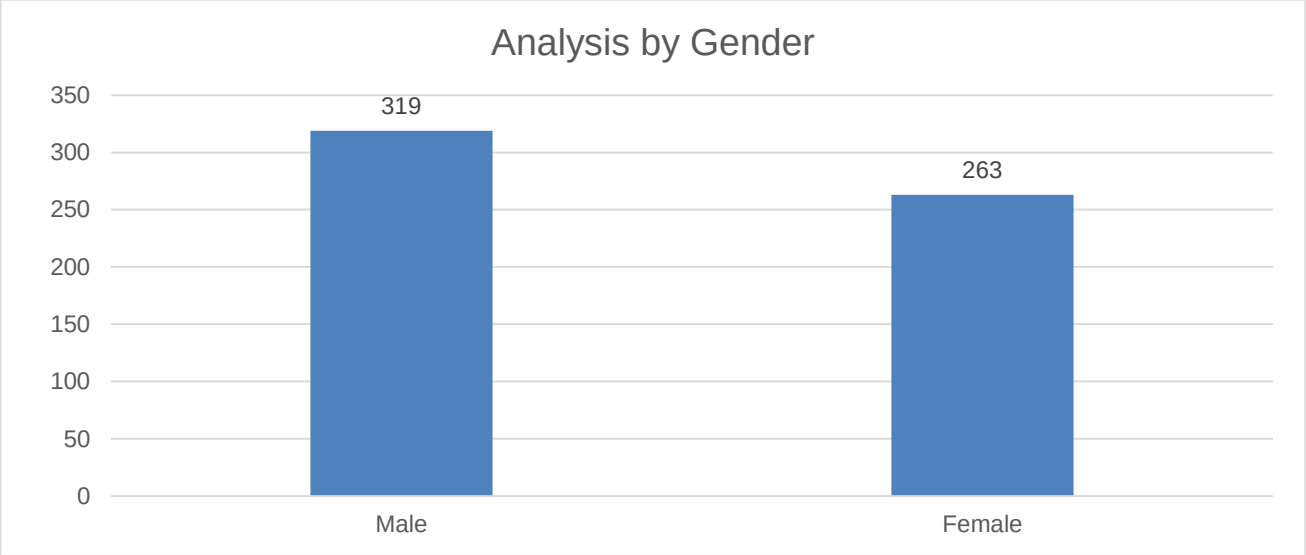


System	Number of Deaths
SystmOne	573
IAPT	9
Grand Total	**582**

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.

6.2 Analysis by Gender

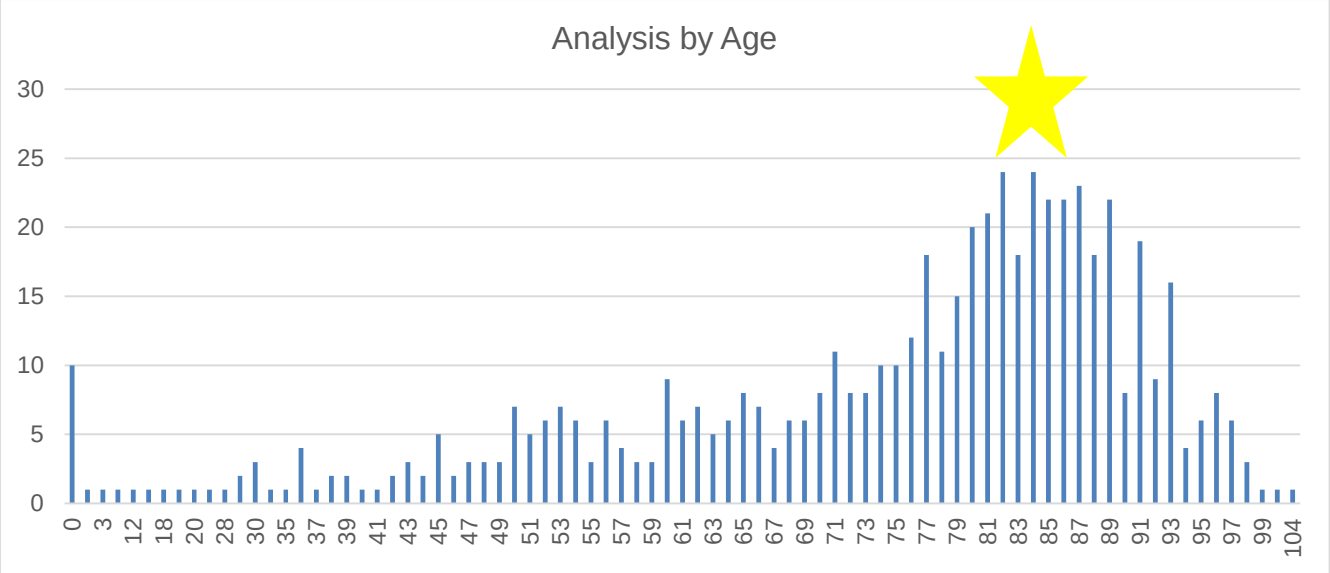
The following data shows the total number of deaths by gender 1 October 2024 to 31 December 2024. There is very little variation between male and female deaths; 263 female deaths were reported compared to 319 males:



Gender	Number of Deaths
Male	319
Female	263
Grand Total	**582**

6.3 Analysis by Age Group

The youngest age was classed as zero, and the oldest age was 104 years. Most deaths occurred within the 80 to 89 age groups (indicated by the star):



6.4 Learning Disability Deaths (LD)

	October	November	December
LD Deaths	1	2	2
Autism	0	0	0

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.

From 1 January 2022, the Trust has been required to report any death of a patient with autism. To date, 12 patients have been referred.

During 1 October 2024 to 31 December 2024, the Trust has recorded five 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.

6.5 Analysis by Ethnicity

White British is the highest recorded ethnicity group with 435 recorded deaths, 46 deaths had no recorded ethnicity assigned. The chart below outlines all ethnicity groups:

Ethnicity	Number of Deaths
White – British	435
Other Ethnic Groups - Any other ethnic group	64
Not Known	38
White - Any other White background	14
Asian or Asian British - Indian	9
Not stated	8
White – Irish	5
Asian or Asian British - Pakistani	3
Black or Black British - Caribbean	2
Asian or Asian British - Any other Asian background	1
Black or Black British - African	1
Mixed - Any other mixed background	1
Mixed - White and Black Caribbean	1
Grand Total	**582**

6.6 Analysis by Religion

Christianity is the highest recorded religion group with 238 recorded deaths, 141 deaths had no recorded religion assigned. The chart below outlines all religion groups:

Religion	Number of Deaths
Christian	230
Not religious	166
(blank)	139
Church of England, follower of	13
Church of England	6
Christian religion	4
Christian, follower of religion	4
Methodist	3
Religion NOS	2
Roman Catholic	2
Sikh	2
Catholic religion	2
Catholic: non Roman Catholic	2
Hindu	1
Jewish	1
Anglican	1
Buddhist	1
Agnostic movement	1
Pagan	1
Islam	1
Grand Total	**582**

6.7 Analysis by Sexual Orientation

Heterosexual or straight is the highest recorded sexual orientation group with 402 recorded deaths. 159 have no recorded information available. The chart below outlines all sexual orientation groups:

Sexual Orientation	Number of Deaths
Heterosexual	402
(blank)	154
Sexual orientation not given - patient refused	15
Sexual orientation unknown	5
Not stated (person asked but declined to provide a response about their sexual orientation)	4
Female homosexual	1
Unknown	1
Grand Total	**582**

6.8 Analysis by Disability

The table below details the top eight categories by disability. Gross motor disability was the highest recorded disability group with 117 recorded deaths:

Disability	Number of Deaths
Gross motor disability	117
Disability	41
Intellectual functioning disability	39
Emotional behaviour disability	25
Hearing disability	14
Disability Questionnaire - Behavioural and Emotional	6
Disability Questionnaire - Progressive Conditions and Physical Health	6
Disability Questionnaire - Mobility and Gross Motor	4

There were a total of 268 deaths with a disability assigned and the remainder were blank or had no assigned disability.

7. Recommendations and Learning

Improvement issue	Improvement plan
Transfer, Leave and Discharge.	**Transfer of the deteriorating patient** Internal investigations highlighted themes around the transfer and return of patients between inpatient services for the Trust and Acute providers. This includes handover of information, and the way patients are conveyed. A quality improvement project has been undertaken between Derby Hospital and DHcFT to develop a transfer and handover proforma which is now in place. **Self-harm of patients whilst on leave from inpatient services and Section 17 leave arrangements** Several investigations have highlighted 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. The works will include review of the pathway of communication and documentation (including risk assessments and care plan) between Crisis Resolution and Home Treatment/ Community teams and Inpatient Services when a patient is due to be on s17 leave/ discharged. This will be reviewed within the Adult Acute Learning the Lessons Subgroup.
Suicide Prevention.	**Suicide Prevention training** The Trust has identified the need to re-establish Suicide Prevention training across services, this is being led by the Trust Medical Director. A Trust Suicide Prevention Lead has now been appointed and this links into current training development in relation to Safety Planning, Risk Assessment and Suicide Prevention expected for March 2025.
Training and awareness of Emotionally Unstable Personality Disorder (EUPD).	The Trust will develop a training and awareness package for all services in relation to EUPD which is being led by the Trust Medical Director.
Multi-agency engagement following incidents.	It is known that patients are often known to multiple services both internally and externally. Works have been commissioned to consider agreements needed to enhance multi-agency working with partner agencies when an incident investigation has been commissioned to improve shared learning and enhance family liaison and support.
Physical Health management within inpatient environments.	Quality improvement work in relation to improving physical healthcare management, observation, and care planning within Older People's services. Enhancement of wound care management and infection prevention and control investigation and follow up within inpatient services. Introduction of RESTORE2 into ILS training framework including review of current ILS provision. Transition agreed to Level 2 and Level 3 resuscitation training and adoption of more recognition of Deteriorating Patient scenarios in training to aid clinicians (Bluebell ward first adopter). Establish a physical health reporting working group to establish the new system one reporting frameworks to improve reports for assurance. Introduction of RESTORE2 into ILS / Level 2 and level 3 training framework including review of current ILS provision.
MDT process improvements within CMHTs.	Investigations have highlighted themes in relation to MDT processes within CMHTs and works are currently underway to review the EPR and recording documentation and MDT process to ensure this is fit for purpose and being adhered to.
Self-harm within inpatient environments including management of contraband.	Adoption of the CQC/MHLD Nurse Directors forum guidance for ligature risk assessment processes. Risk assessment has new section on the risk assessment tool in the EPR

Improvement issue	Improvement plan
	Quality Improvement programme in relation to self-harm via sharps of females within inpatient services (local priority)- currently on hold Improvement to environment – now using convex mirrors and zonal observations on female wards, changed ligature environment risk assessment Improvement to therapeutic engagements Improvement to risk assessment and management including observation levels - observation booklet in place To continue commissioned working group to review handheld clinical devices and compliance with observations including physical health observations Ligature training package in place and is currently being rolled out including competency assessment Green zone – within inpatient areas there is an area painted green which holds emergency equipment such as ligature knife, resuscitation equipment so is easily identifiable Ligature risk reduction working group.
Dissemination of learning and service improvements following incidents including assurance and governance.	Work is underway to improve the way in which the trust learning and improves from incidents, this will include a revision to the processes in place in relation to internal investigation recommendations, Case Record Review learning, Incident Review Tool learning and the revised Trust Mortality process. Develop pathway to offer clear governance processes. Develop service line learning briefings specific to service learning. Trust-wide learning the lessons to share high level responses and learning. Develop better ways for monitoring and reporting emerging themes. Joined up working between services. Improved monitoring of high-profile cases and joined up working between services involved. Development of more collaborative Learning Responses.
Application of red flags and flow of incidents resulting in death.	Improvement in the application and identification of red flags for reporting death. Revision of current red flags for relevance given changes both nationally and locally. Redesign the function of the ‘Mortality’ process within structures through the Learning the Lessons subgroups. Review the purpose and function of the Mortality Case Record Review panel and redesign this to one of audit and assurance.
Interface between Mental Health and Substance Misuse service.	Suspected Suicide of a patient who has a dual diagnosis of substance misuse and mental health but has been declined 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. Currently several actions in place. Improvement plan to be developed and managed through the services Learning the Lessons subgroup.
Risk assessment, management, and care planning.	This is an area which repeatedly shows need for improvement and the Trust is currently finalising a Safety Planning training package which will consist of 4 modules and incorporate suicide prevention.

FORWARD PLAN - BOARD - 2024/25		07-May-2024	02-Jul-2024	01-Oct-2024	05-Nov-2024	14-Jan-2025	04-Mar-2025
	Deadline for Approved Papers	**25-Apr-2024**	**21-Jun-2024**	**18-Sep-2024**	**24-Oct-2024**	**02-Jan-2025**	**20-Feb-2025**
DOCA/TS	Declarations of Interest	X	X	X	X	X	X
DON	Patient/Staff Story	X		X	X	X	X
CHAIR	Minutes/Matters Arising/Action Matrix	X	X	X	X	X	X
CHAIR	Board Review of Effectiveness of Meeting	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	X
CHAIR	Chair's Update	X	X	X	X	X	X
CEO	Chief Executive's Update	X	X	X	X	X	X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE							
DCEO/CDO	Trust Strategy Progress update (on approval, launch Nov-2024) / New Strategy Delivery Plan Mar-2025)	X		X	X	X	X
DPODI	Staff Survey Results						X
DPODI	Annual Gender Pay Gap Report for approval (on assurance at People and Culture Committee)	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					X	
DPODI	Annual Approval of Modern Slavery Statement (on assurance at People and Culture Committee - Mar. To be published on Trust website on approval)	X					
DPODI	2024/25 Flu Campaign	Summary of 2023/24 campaign		X			
DOCA/TS	Corporate Governance Report	X					
DOCA/TS	Year-end Governance Reporting from Board Committees and Approval of ToRs (within Corp Gov report) (on assurance at Audit and Risk Committee Apr)	X					
DOCA/TS	Trust Sealings (six monthly - for information - also within May Corp Gov report)	X			X		
DOCA/TS	Annual Review of Register of Interests	X					
DOCA/TS	Board Assurance Framework Update	X		X	X		X
DOCA/TS	Review of Trust Constitution						X
FTSUG	Freedom to Speak Up Guardian Report (six monthly)			X			X
CHAIR	Fit and Proper Person Declaration		X				
DOF/DCEO/CDO/ DPODI	Planning Update	X (Finances)		X (Ops)			
Committee Chairs	Board Committee Assurance Summaries	X	X	X	X	X	X
DoF	Standing Financial Instructions (on assurance at Audit and Risk Committee)			X			
OPERATIONAL PERFORMANCE							
DCEO/CDO/DON/ DOF/DPODI	Integrated Performance and Activity Report to include Finance, People performance and Quality	X	X	X		X	X
DCEO/CDO/DON	Focused Performance Report (in lieu of Integrated Performance and Activity Report)				X		
DCEO/CDO	ICB Joint Forward Plan (included in CEO Update)			Deferred to Jan-2025		X	
CEO	East Midlands Collaborative					X	
DCEO/CDO	Emergency Preparedness, Resilience and Response (EPRR) Core Standards			X			
CEO	Joined-up Care Derbyshire (JUCD) Provider Collaborative - governance arrangements, work programme and Memorandum of Understanding						X
Prog Director	Making Room for Dignity progress	X			Included with CEO's update		
DON/MD	Safer Staffing Annual Review (on assurance at Quality and Safeguarding Committee Jul)			X			
DPODI	Workforce Plan Annual Review (on assurance at People and Culture Committee Jul)			X			
QUALITY GOVERNANCE							
DON	Fundamental Standards of Care Report					X	
MD	Learning from Deaths Mortality Report (on assurance at Quality and Safeguarding Committee)		AR		X	X	X
MD	Guardian of Safe Working Report (on assurance at Quality and Safeguarding Committee		AR		X	X	
MD	Improving the Working Lives of Doctors in Training		X				
DON	Receipt of Annual Reports (on assurance at Quality and Safeguarding Committee): - Annual Looked After Children (QSC Sep) - Annual Safeguarding Children and Adults at Risk (QSC Sep) - Annual Special Educational Needs and Disabilities (SEND) (QSC May/Jun) - Quality Account (Jul)		X		X		
DCEO/CDO	Transformation and Continuous Improvement (sign-off of Strategy/Plan Mar-2025)						Deferred to Jun-2025
DON	Infection Prevention and Control Annual Report and IPC BAF (on assurance at Quality and Safeguarding Committee Oct)				AR		
MD	Re-validation of Doctors Compliance Statement (following assurance at People and Culture Committee May)		X				
DON	Outcome of Patient Stories - every two years - due Mar-2026						
POLICY REVIEW							
DOF	Standing Financial Instructions Policy and Procedures (Jul-2024)		Deferred to Oct-2024	X			

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/Staff Story	X	X	X	X	X	X
CHAIR	Minutes/Matters Arising/Action Matrix	X	X	X	X	X	X
CHAIR	Board Review of Effectiveness of Meeting	X	X	X	X	X	X
CHAIR	Board Forward Plan (for information)	X	X	X	X	X	X
CHAIR	Summary of Council of Governors Meeting (for information)	X	X		X	X	
CHAIR	Chair's Update	X	X	X	X	X	X
CEO	Chief Executive's Update	X	X	X	X	X	X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE							
DCEO/CDO	Trust Strategy Progress update	X			X		
DPODI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) *request for Board delegated authority for People and Culture Committee meeting Sep to approve the October submissions*			X			
DPODI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Strategic implications (retrospective sign-off on assurance at People and Culture Committee - Sep)				X		
MD	Patient and Carers Race Equality Framework *scheduling tbc*						
DOCA/TS	Receipt of Reports (on assurance from Audit and Risk Committee (ARC)):						
	Year-end Governance Reporting from Board Committees and Approval of ToRs (ARC - Apr)	X					
DPODI	Receipt of Reports (on assurance from People and Culture Committee (PCC)):						
	Annual Approval of Modern Slavery Statement (PCC - Mar, to be published on Trust website on approval)	X					
	Staff Survey Results (PCC - Mar)						X
	Annual Gender Pay Gap Report for approval (PCC - May)	X					
	2025/26 Flu Campaign Annual Report (PCC - Jul)			X			
DOCA/TS	Continuation of Services Condition 7 - Provider Licence	X					
DOCA/TS	Trust Sealings (six-monthly - for information)	X			X		
DOCA/TS	Annual Review of Register of Interests	X					
DOCA/TS	Board Assurance Framework Update	X		X	X		X
FTSUG	Freedom to Speak Up Guardian Report (six monthly)			X			X
CHAIR	Fit and Proper Person Declaration		X				
DOF/DCEO/CDO/ DPODI	Planning Update	X					
Committee Chairs	Board Committee Assurance Summaries	X	X	X	X	X	X
OPERATIONAL PERFORMANCE							
DCEO/CDO/DON/ DOF/DPODI	Integrated Performance and Activity Report (Operations, Finance, People and Quality)	X	X	X	X	X	X
DCEO/CDO	ICB Joint Forward Plan (ad hoc inclusion with CEO Update)						
DCEO/CDO	Emergency Preparedness, Resilience and Response (EPRR) Core Standards			X			
Prog Director	Making Room for Dignity progress	X	X				
DPODI	Receipt of Reports (on assurance from People and Culture Committee (PCC)):						
	Workforce Plan Annual Review (PCC - Jul)			X			
DON/MD	Receipt of Reports (on assurance from Quality and Safeguarding Committee (QSC)):						
	Safer Staffing Annual Review (QSC - Jul)			X			
QUALITY GOVERNANCE							
DON	Fundamental Standards of Care Report (CQC Domains)		X			X	
DON	Receipt of Reports (on assurance from Quality and Safeguarding Committee (QSC)):						
	Guardian of Safe Working Report (QSC - quarterly)		AR		X	X	
	Annual Special Educational Needs and Disabilities (SEND) (QSC - May/Jun)		X				
	Quality Account (QSC - Jul)			X			
	Annual Looked After Children (QSC - Sep)				X		
	Infection Prevention and Control Annual Report and IPC BAF (QSC - Oct)				X		
	Annual Safeguarding Children and Adults at Risk (QSC - Sep)				X		
	Delivery of Same Sex Accommodation (QSC - Oct)				X		
MD	Learning from Deaths/Mortality Report (QSC - quarterly)		AR		X	X	X
MD	Receipt of Reports (on assurance from People and Culture Committee (PCC)):						
	Re-validation of Doctors Compliance Statement (PCC - May)		X				
DCEO/CDO	Transformation and Continuous Improvement (bi-annual)	X			X		
DON	Outcome of Patient Stories (every two years, due Mar-2026)						
POLICY REVIEW							
DOCA/TS	Fit and Proper Person Policy (31-Mar-2026)				X		
DOCA/TS	Policy for Engagement Between the Board of Directors and the Council of Governors (30-Nov-2025)				X		
DOF	Standing Financial Instructions Policy and Procedures (31-Oct-2025)			X			

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
A	
A&E	Accident & Emergency
ACCT	Assessment, Care in Custody & Teamwork
ACE	Adverse Childhood Experiences
AC/RC	Approved Clinician/Responsible Clinician
ADHD	Attention Deficit Hyperactivity Disorder
ADI-R	Autism Diagnostic Interview-Revised
ADOS	Autism Diagnostic Observation Schedule (assessment)
AED	Automated External Defibrillator
AfC	Agenda for Change
AHP	Allied Health Professional
AI	Artificial Intelligence
AIMS	Royal College of Psychiatrists Accreditation for Inpatient Mental Health Services Standards
ALB	Arms-length body such as NHS Improvement (NHSI) and NHS England (NHSE)
AMM	Annual Members' Meeting
AMHP	Approved Mental Health Professional
ANP	Advanced Nurse Practitioner
AO	Accountable Officer
AOVPN	AlwaysOn VPD (secure network access)
APC	Annual Physical Health
APOM	Activity Participation Outcome Measure
ASD	Autism Spectrum Disorder
ASM	Area Service Manager
ATR	Alcohol Treatment Requirement
ATU	Acute Treatment Unit
B	
BAF	Board Assurance Framework
BCF	Better Care Fund
BCO	Building Control Officer
BCP	Business Continuity Plan
BIA	Business Impact Analysis
BLS	Basic Life Support (ILS Immediate Life Support)
BMA	British Medical Association
BAME	Black, Asian and Minority Ethnic
BME	Black and Minority Ethnic group
BoD	Board of Directors
BPD	Borderline Personality Disorder
BPPC	Better Payment Practice Code
C	
CAMHS	Child and Adolescent Mental Health Services
CASSH	Care and Support Specialised Housing
CBT	Cognitive Behavioural Therapy
CBRN	Chemical, Biological, Radiological and Nuclear
CCG	Clinical Commissioning Group (defunct from 1 July 2022)
CCQI	College Centre for Quality Improvement
CCT	Community Care Team
CDEL	Capital Departmental Expenditure Limit
CD-LIN	Controlled Drug Local Intelligence Network
CDM	Construction Design and Management

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
CDMI	Clinical Digital Maturity Index
CE	Chief Executive
CEO	Chief Executive Officer
CER	Clinical Establishment Review
CESR	Certificate of Eligibility for Specialist Registration
CGA	Comprehensive Geriatric Assessment
CHANNEL	Confidential, voluntary, multi-agency safeguarding programme that provides early intervention to protect vulnerable children and adults who might be susceptible to being radicalised
CHPPD	Care Hours Per Patient Day
CIC	Children in Care
CIN	Children in Need
CIP	Cost Improvement Programme
CMDG	Contract Management Delivery Group
CMHF	Community Mental Health Framework
CMHT	Community Mental Health Team
CNST	Clinical Negligence Scheme for Trusts
COAT	Clinical Operational Assurance Team
COF	Commissioning Outcomes Framework
CoG	Council of Governors
COO	Chief Operating Officer
CP	Child Protection
CPA	Care Programme Approach
CPD	Continuing Professional Development
CPN	Community Psychiatric Nurse
CPR	Child Protection Register
CPRG	Clinical Professional Reference Group
CQC	Care Quality Commission
CQI	Clinical Quality Indicator
CQRG	Care Quality Review Group
CQUIN	Commissioning for Quality and Innovation
CRD	Clinically Ready for Discharge
CRG	Clinical Reference Group
CRH	Chesterfield Royal Hospital
CRHT	Crisis Resolution and Home Treatment
CROMS	Clinician Reported Outcome Measures
CRR	Case Record Reviews
CRS	(NHS) Care Records Service
CRS	Commissioner Requested Services
CSC	Commonwealth Scholarship Commission
CSDS	Community Services Data Set
CSF	Commissioner Sustainability Fund
CSPR	Child Safeguarding Practice Review
CTO	Community Treatment Order
CTR	Care and Treatment Review
CUF	Cost Uplift Factor
CYP	Children and Young People
D	
DAR	Divisional Assurance Review
DASP	Drug and Alcohol Strategic Partnership
DAT	Drug Action Team

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
Datix	Trust's electronic incident reporting system of an event that causes a loss, injury or a near miss to a patient, staff or others
DBS	Disclosure and Barring Service
DBT	Dialectical Behavioural Therapy
DfE	Department for Education
DCHS	Derbyshire Community Health Services NHS Foundation Trust
DDCCG	Derby and Derbyshire Clinical Commissioning Group
DEED	Delivering Excellence Every Day
DHCFT	Derbyshire Healthcare NHS Foundation Trust
DHR	Domestic Homicide Review
DISCO	Diagnostic Interview for Social and Communication Disorders (assessment)
DIT	Dynamic Interpersonal Therapy
DME	Director of Medical Education
DNA	Did Not Attend
DoC	Duty of Candour
DOF	Director of Finance
DoH	Department of Health
DOL	Deprivation of Liberty
DoLS	Deprivation of Liberty Safeguards
DON	Director of Nursing
DPA	Data Protection Act
DPI	Director of People and Inclusion
DPR	Divisional Performance Review
DPS	Date Protection and Security
DQMI	Data Quality Maturity Index
DRR	Drug Rehabilitation Requirement
DRRT	Dementia Rapid Response Team
DSAB	Derby and Derbyshire Safeguarding Adult Board
DSP	Data Security and Protection
DSCB	Derby and Derbyshire Safeguarding children Board
DSPT	Director of Strategy, Partnerships and Transformation
DTOC	Delayed Transfer of Care
DV	Domestic Violence
DVA	Derbyshire Voluntary Action (formerly North Derbyshire Voluntary Action)
DWP	Department for Work and Pensions
E	
EbE	Expert by Experience
ECT	Enhanced Care Team
ECT	Electroconvulsive Therapy
ECW	Enhanced Care Ward
ED	Emergency Department
EDS2	Equality Delivery System 2
EHA	Early Help Assessment
EHCP	Education, Health and Care Plan
EHIC	European Health Insurance Card
EHR	Electronic Health Record
EI	Early Intervention
EIA	Equality Impact Assessment
EIP	Early Intervention In Psychosis
EIS	Early Intervention Service
ELT	Executive Leadership Team
EMDR	Eye Movement Desensitising and Reprocessing Therapy

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
EMR	Electronic Medical Record
EPC	Energy Performance Certificate
EPMA	Electronic Prescribing and Medicine Administration
ePMO	Electronic Programme Management Office
EPR	Electronic Patient Record
EPRR	Emergency Preparedness, Resilience and Response
ERIC	Estates Return Information Collection
ESR	Electronic Staff Record
EUPD	Emotionally Unstable Personality Disorder
EWTD	European Working Time Directive
F	
FBC	Full Business Case
FFT	Friends and Family Test
FGM	Female Genital Mutilation
FOI	Freedom of Information
FOT	Forecast Out-Turn
FSR	Full Service Record
FT	Foundation Trust
FTE	Full-time Equivalent
FTN	Foundation Trust Network
FTSU	Freedom to Speak Up
FTSUG	Freedom to Speak Up Guardian
F&P	Finance and Performance
FYE	Full Year Effect or Financial Year End
5YFV	Five Year Forward View
G	
GAM	Group Accounting Manual
GDPR	General Data Protection Regulation
GGI	Good Governance Institute
GIRFT	Getting it Right First Time
GMC	General Medical Council
GMP	Guaranteed Maximum Price
GoSWH	Guardian of Safe Working Hours
GP	General Practitioner
GPFV	General Practice Forward View
H	
HCA	Healthcare Assistant
HCP	Healthy Child Programme
H1	First half of a fiscal year (April through September)
H2	Second half of a fiscal year (October through the following March)
HEE	Health Education England
HES	Hospital Episode Statistics
HFMA	Healthcare Financial Management Association
HoNOS	Health of the Nation Outcome Scores
HoP	Head of Practice
HOPE(s)	The HOPE(s) model is an ambitious human rights-based approach to working with individuals in segregation, developed from research and clinical practice
HSCIC	Health and Social Care Information Centre
HSE	Health and Safety Executive
HSSC	Health and Safety Security Committee
HV	Health Visitor

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
HWB	Health and Wellbeing Board
I	
I&E	Income and Expenditure
IAPT	Improving Access to Psychological Therapies
Icare	Increase Confidence, Attract, Retain, Educate
ICB	Integrated Care Board
iCIMS	Internet Collaborative Information Management System
ICM	Insertable Cardiac Monitor
ICO	Information Commissioner's Office
ICS	Integrated Care System
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IDVAs	Independent Domestic Violence Advisors
IFRS	International Financial Reporting Standards
IG	Information Governance
ILS	Immediate Life Support (BLS – Basic Life Support)
IMST	Information Management Systems and Technology
IMT	Incident Management Team
IMT&R	Information Management, Technology and Records
INQUEST	
IPP	Imprisonment for Public Protection
IPR	Integrated Performance Report
IPS	Individual Placement and Support
IPT	Interpersonal Psychotherapy
IRHTT	In-reach Home Treatment Team
IRT	Incident Review Tool
J	
JCVI	Joint Committee on Vaccination and Immunisation
JDF	Junior Doctor Forum
JLNC	Joint Local Negotiating Committee
JNCC	Joint Negotiating Consultative Committee
JTAI	Joint Targeted Area Inspections
JUCB	Joined Up Care Board
JUCD	Joined Up Care Derbyshire
K	
KLOE	Key Lines of Enquiry (CQC)
KPI	Key Performance Indicator
KSF	Knowledge and Skills Framework
L	
LA	Local Authority
LAC	Looked After Children
LCFS	Local Counter Fraud Specialist
LA – CYPD	Local Authority – Children and Young People Divisions
LADO	Local Authority Designated Officer
LD	Learning Disabilities
LD/A	Learning Disability and Autism
LeDeR	Learning Disabilities Mortality Review
LFPSE	Learn from Patient Safety Events
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender and Queer or Questioning, Intersex, Asexual
LHP	Local Health Plan

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
LHRP	Local Health Resilience Partnership
LHWB	Local Health and Wellbeing Board
LNC	Local Negotiating Committee
LOS	Length of Stay
LPS	Liberty Protection Safeguards
LSU	Long-Term Service Use
LTP	Long Term Plan
LTS	Long Term Segregation
LWSTO	Living Well Short-Term Offer
M	
MADE	Multi-agency Discharge Event
MAPPA	Multi-agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference (meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors
MARS	Mutually Agreed Resignation Scheme
MAS	Memory Assessment Service
MASH	Multi-Agency Safeguarding Hub
MAST	Management and Supervision Tool
MAU	Medical Assessment Unit
MBU	Mother and Baby Unit
MCA	Mental Capacity Act
MCC	Medicine Clinical Committee
MD	Medical Director
MDA	Medical Device Alert
MDM	Multi-Disciplinary Meeting
MDR	Medical Device Regulation
MDSO	Medical Device Safety Officer
MDT	Multi-Disciplinary Team
M&E	Mechanical and Electrical
MFA	Multi-Factor Authentication
MFF	Market Forces Factor
MHA	Mental Health Act
MHAC	Mental Health Act Committee
MHIN	Mental Health Intelligence Network
MHIS	Mental Health Investment Standard
MHLDA	Mental Health, Learning Disabilities and Autism
MHLT	Mental Health Liaison Team
MHOST	Mental Health Optimal Staffing Tool
MHRA	Medical and Healthcare products Regulatory Agency
MHRT	Mental Health Review Tribunal
MHRV	Mental Health Response Vehicle
MHSDS	Mental Health Services Data Set
MMaSP	Medicine Management Safety and Practice
MMC	Medicines Management Committee
MoU	Memorandum of Understanding
MPAC	Multi-Professional Approved Clinician
MSC	Medical Staff Committee
MSK	Musculoskeletal (conditions)
MSP	Medicines Safety and Practice

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
MST	Multisystemic Therapy
MSU	Medium Secure Unit
MTFP	Medium Term Financial Plan
N	
NAI	Non-Accidental Injury
NCRS	National Cancer Registration Service
ND	Neuro-development
NED	Non-Executive Director
NETS	National Educational Training Survey
NHS	National Health Service
NHSCFA	NHS Counter Fraud Authority
NHSE	National Health Service England
NHSI	National Health Service Improvement
NHSEI	NHS England and NHS Improvement
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NIMS	National Incident Management System
NIVS	National Immunisation and Vaccination System
NPS	National Probation Service
NQB	National Quality Board
NR	Non-Recurrent
NROC	Non-Resident On-Call
O	
OBC	Outline Business Case
ODG	Operational Delivery Group
OOA	Outside of Area
OPMO	Older People's Mental Health Services
OP	Outpatient
OSC	Overview and Scrutiny Committee
OSCE	Objective Structured Clinical Examination
OT	Occupational Therapy
P	
PAB	Programme Assurance Board
PAG	Programme Advisory Group
PALS	Patient Advice and Liaison Service
PAM	Payment Activity Matrix
PARC	Psychosis and the reduction of cannabis (and other drugs)
PARIS	This is an electronic patient record system
PbR	Payment by Results
PCC	Police & Crime Commissioner
PCC	People and Culture Committee
PCLB	Provider Collaborative Leadership Board
PCN	Primary Care Networks
PCOG	Patient and Carer Operational Group
PCREF	Patient and Carers Race Equality Framework
PDC	Public Dividend Capital
PDF	Portable Document Format
PDSA	Plan, Do, Study, Act
PFI	Private Finance Initiative
PFF	Probation Feedback Form
PFR	Provider Finance Return

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
PHC	Public Health Commissioners
PHCIC	Physical Healthcare and Infection Control Committee
PHE	Public Health England
PHSCC	Population Health and Strategic Commissioning Committee
PHSMI	Physical Health Serious Mental Illness
ECW	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PiPoT	Persons in a Position of Trust
PJF	Professional Judgement Framework
PLACE	Patient-Led Assessments of the Care Environment
PLIC	Patient Level Information Costs
PMF	Performance Management Framework
PMH	Perinatal Mental Health
PMLD	Profound and Multiple Disability
PMO	Project Management Office
PODG	Programme Oversight and Delivery Group
PPE	Personal Protection Equipment
PPI	Patient and Public Involvement
PPN	Public Protection Notice
PPT	Partnership and Pathway Team
PQN	Perinatal Quality Network
PREM	Patient Reported Experience Measure
PROMS	Patient Reported Outcome Measures
PSF	Provider Sustainability Fund
PSII	Patient Safety Incident Investigations
PSIRF	Patient Safety Incident Review Framework
PSQG	Patient Safety and Quality Group
PYE	Part Year Effect
Q	
QAG	Quality Assurance Group
QASI	Quality Assurance Serious Incidents
Q&SC	Quality and Safeguarding Committee
QEIA	Quality and Equality Impact Assessment
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity Programme
QOF	Quality and Outcomes Framework
R	
RAID	Rapid Assessment, Interface and Discharge
RAP	Recovery Action Plan
RCGP	Royal College of General Practitioners
RCI	Reference Cost Index
REGARDS	Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation
ReQoL	Recovering Quality of Life
ROM	Reported Outcome Measure
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
	practicable at that time. If this is the case, it must be documented in the patient's electronic care record
s136	Section 136 of the Mental Health Act: Police can use emergency powers if they think you have a mental disorder, you're in a public place and need immediate help. They can take you or keep you in a place of safety, where your mental health will be assessed.
SAAF	Safeguarding Adults Assurance Framework
SAR	Safeguarding Adult Review
SAS Doctor	Specialist, Associate Specialist and Specialty Doctor
SBARD	Situation, Background, Assessment, Recommendation and Decision (SBARD) tool
SBS	Shared Business Services
SCPHN	Specialist Community Public Health Nurse
SEIPS	Systems Engineering Initiative for Patient Safety
SEND	Special Educational Needs and Disabilities
SFI	Standing Financial Instructions
SI	Serious Incidents
SIG	Serious Incident Group
SID	Senior Independent Director
SIDS	Sudden Infant Death Syndrome
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement
SLaM	South London and Maudsley NHS Trust
SLR	Service Line Reporting
SMI	Severe Mental Illness
SNOMED CT	Systemised Nomenclature of Medicine – Clinical Terms
SOC	Strategic Options Case
SOF	Single Operating Framework
SOP	Standard Operating Procedure
SPOA or SPA	Single Point of Access
SPOE	Single Point of Entry
SPOR	Single Point of Referral
SSQD	Specialised Services Quality Dashboards
STEIS	Strategic Executive Information System
STF	Sustainability and Transformation Fund
STOMP/STAMP	Stopping The Over-Medication of children and young People with a learning disability, autism or both / Supporting Treatment and Appropriate Medication in Paediatrics
STP	Sustainability and Transformation Partnership
SUI	Serious (Untoward) Incident
SW	Social Worker
SystmOne	Electronic patient record system
T	
TAV	Team Around the Family
TARN	Trauma Audit and Research Network
TBT	Tobacco Dependence Team
TCP	Transforming Care Partnerships
TCS	Transforming Community Services
TDA	Trust Development Authority
TDT	Tobacco Dependence Team
TIC	Trauma Informed Care
TLT	Trust Leadership Team
TMAC	Trust Medical Advisory Committee (now Medical Senate)

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
TMT	Trust Management Team
TMTC	Trust Medical Training Committee
TOIL	Time Off In Lieu
TOOL	Trust Operational Oversight Leadership
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
U	
UHDB	University Hospitals of Derby and Burton
UEC	Urgent and Emergency Care
V	
VARM	Vulnerable Adult Risk Management
VCOD	Vaccination as a Condition of Deployment
VCP	Vacancy Control Panel
VdTMoCA	Vona du Toit Model of Creative Ability *(a practical guide for Acute Mental Health Occupational Therapy Practice)*
VFM	Value For Money
VO	Vertical Observatory
VTE	Venous Thromboembolism
W	
WAP	Wireless Application Protocol
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent
Y	
YTD	Year to Date

February 2025