Derbyshire Healthcare
NHS Foundation Trust

Public Trust Board Meeting

19 May 2026

Conference Rooms A and B

Research and Development Centre, Kingsway, Derby, DE22 3LZ

Meeting Book - Public Trust Board Meeting

Contents and Page Numbers

Derbyshire Healthcare
NHS Foundation Trust

Public Board Meeting

Agenda

Date: Tuesday, 19 May 2026

Time: 9.30am

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

Item	Time	Topic	Lead
1	9.30	Chair's welcome, opening remarks, apologies and declarations of interest 1.1 Trust Vision and Values 1.2 Register of Interests 2026/27 1.3 Annual review of 2025/26 Declarations of Interest	Selina Ullah
2	9.35	Board Story: *'How our people and their values support everything we do'*	Tumi Banda
3	10.00	Minutes of the Board of Directors meeting held on 24 March 2026	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
PARTNERSHIPS			
8	10.25	Joined Up Care Derbyshire Provider Collaborative annual report 2025/26	Mark Powell/Tamsin Hooton
OPERATIONAL PERFORMANCE			
9	10.35	Integrated Performance report, including Quality, Operations, People and Finance 9.1 Committee Board Assurance Summaries	Tumi Banda/Rebecca Oakley/James Sabin Committee Chairs
BREAK 11.10am			
10	11.20	Year-end Financial Position – 2025/26	James Sabin
11		Medium-term Plan response 11.1 Compliant with conditions 11.2 Linked to activity and performance, Year 3 Length of Stay	
STRATEGY DEEP DIVE			
12	11.25	People	Rebecca Oakley
QUALITY GOVERNANCE			
13	11.40	Assertive Outreach Treatment – Community Mental Health Action Plan update	Tumi Banda
14	11.50	Transformation and Continuous Improvement (bi-annual)	Maria Riley

STRATEGIC PLANNING AND CORPORATE GOVERNANCE			
15	11.55	Board Assurance Framework (BAF) update	Justine Fitzjohn
16	12.05	Trust Strategic Plan (Quarter 4 update, to include 4 Ps Delivery Plans)	Maria Riley
17		Trust Strategic Delivery Pan – 2026/27	
18	12.15	Corporate Governance report, including: 18.1 Appendix 1 - Board Committee Terms of Reference 18.2 Appendix 2 - Audit and Risk Committee year-end Effectiveness report 18.3 Appendix 3 - Trust Sealings 18.4 Appendix 4 - Continuation of Services Condition 7 – Provider Licence	Justine Fitzjohn
REPORTS FOR NOTING FOLLOWING ASSURANCE AT BOARD COMMITTEES			
19	12.20	<u>People and Culture Committee</u> 19.1 Annual Gender Pay Gap and Public Sector Equality Duty report (for approval) 19.2 Guardian of Safe Working Hours 19.3 Medical Appraisal and Revalidation – annual report 19.4 Modern Slavery Statement – annual review (for approval)	Ralph Knibbs
		<u>Quality and Safeguarding Committee</u> 19.5 Special Educational Needs and Disabilities (SEND) annual report	Lynn Andrews
CLOSING BUSINESS			
20	12.25	Consideration of any items affecting the Board Assurance Framework (BAF)	Selina Ullah
21		Meeting effectiveness	
FOR INFORMATION			
Forward Plan 2026/27 Glossary of NHS Acronyms Summary of Council of Governors meeting held 24 March 2026			

Next meeting:

Date:	**Time:**	**Location:**
Tuesday, 21 July 2026	9.30am	Conference Rooms A&B, Research and Development Centre, Kingsway, Derby, DE55 3LZ. Arrangements will be notified on the Trust website seven days in advance of the meeting.

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

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

Should assistance be required (eg due to mobility, hearing, vision, or other needs), please let us know so we can put a Personal Emergency Evacuation Plan (PEEP) in place. Thank you.

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

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

Strategy on a page

NHS
Derbyshire Healthcare
NHS Foundation Trust

Our vision

We make a positive difference in everything we do

Our strategic priorities

Patient focus

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

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 and include everyone in all we do.

Ambitious

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

Belonging

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

Collaborative

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

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 2026/27

NAME	INTEREST DISCLOSED	TYPE
Selina Ullah Trust Chair	• Non-Executive Director, General Pharmaceutical Council • Non-Executive Director, Locala Community Partnerships CIC • Director, Muslim Women's Council • Trustee – NHS Alliance	(e) (e) (e) (e)
Chioma Akpom Non-Executive Director	• Director, Narini Limited	(a)
Deborah Good Non-Executive Director	• Trustee of Artcore – Derby • Director of Craftcore Derby	(e) (e)
Jo Hanley Non-Executive Director	• Remediation Unit Director, Post Office Limited	(e)
Andrew Harkness Non-Executive Director	• Spouse, Nicola Harkness, works at Staffordshire and Stoke-on-Trent Integrated Care Board *until 31-Jul-2026*	(e)
Ralph Knibbs Senior Independent Director	• Trustee of the charity called Star* Scheme	(d)
Mark Powell Chief Executive	• Treasurer, Derby Athletic Club	(d)
Vikki Ashton Taylor Deputy Chief Executive and Chief Delivery Officer	• Justice of the Peace, covering Derbyshire and Nottinghamshire Magistrates	(d)
Girish Kunigiri Medical Director	• Trustee for the Bridge, Homelessness to Hope, Leicester • Vice Chair, ECT and Related Treatments Committee, Royal College of Psychiatry	(d) (e)
James Sabin Director of Finance	• Spouse works at Sheffield Health & Social Care NHS Foundation Trust as Head of Capital and Therapeutic Environment	(e)
All other members of the Board of Directors have submitted a nil return, meaning they have no interests to declare.		

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

Annual review of Register of Directors' Interests – 2025/26

Purpose of Report

This report provides the Trust Board with the year-end 2025/26 Register of Directors' interests. This register will be published in the Annual Report for 2025/26. The register is updated with each new interest declared/removed and the revised version is then reported to each Public Board.

Executive Summary

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

Strategic Considerations		**BAF Risk (eg 1A)**	**Strategic Delivery Plan Reference**
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	N/A	N/A
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X		
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X		
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X		

Risks and Assurances

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

Consultation

None.

Governance or Legal Issues

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

Net Zero Duty Implications

In compliance with the NHS move towards net zero carbon emissions, the Trust must consider statutory emissions and environmental targets in their decisions. Reports should identify related impacts on workforce and system leadership; sustainable models of care; digital transformation; travel and transport estates and facilities (including capital projects, asset management and utilities, green space and biodiversity); medicines; supply chain and procurement; food and nutrition and adaptation.

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

Nothing specific for this report.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

Recommendations

The Board of Directors is requested to approve and record the declarations of interest as disclosed. These are recorded in the Register of Interests which is accessible to the public at the Trust Head Office and will be listed in the Trust's Annual Report for 2025/26.

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

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

DECLARATION OF INTERESTS REGISTER 2025/26		
NAME	**INTEREST DISCLOSED**	**TYPE**
Selina Ullah Trust Chair	• Non-Executive Director, General Pharmaceutical Council • Non-Executive Director, Locala Community Partnerships CIC • Director, Muslim Women's Council • Trustee – NHS Alliance	(e) (e) (e) (e)
Chioma Akpom *Designate from 06-Oct-2025 to 30--Nov-2025* Non-Executive Director *from 01-Dec-2025*	• Director, Narini Limited	(a)
Tony Edwards *until 31-Jul-2025* Deputy Trust Chair	• Independent Member of Governing Council, University of Derby	(a)
Deborah Good Non-Executive Director	• Trustee of Artcore – Derby • Director of Craftcore Derby	(d) (d)
Jo Hanley *from 4-Aug-2025* Non-Executive Director	• Non-Executive Director, Dudley NHS Foundation Trust (ceased 31-Mar-2026) • Remediation Unit Director, Post Office Limited	(e) (e)
Andrew Harkness Non-Executive Director	• Spouse, Nicola Harkness, works at Staffordshire and Stoke-on-Trent Integrated Care Board	(e)
Ralph Knibbs Senior Independent Director	• Trustee of the charity called Star* Scheme	(d)
Geoff Lewins *until 30-Nov-2025* Non-Executive Director	• Director, Arkwright Society Ltd • Director, Cromford Mill Limited (wholly owned trading subsidiary of Arkwright Society)	(a) (a)
Mark Powell Chief Executive	• Treasurer, Derby Athletic Club	(d)
Vikki Ashton Taylor Deputy Chief Executive and Chief Delivery Officer	• Justice of the Peace, covering Derbyshire and Nottinghamshire Magistrates	(d)
Mark Broadhurst *from 22-Sep-2025 to 30-Nov-2025* Interim Medical Director	• Conduct independent psychiatric clinic as a "sole trader". Does not compete for NHS patients	(b)
Girish Kunigiri *from 29-Oct-2025* Medical Director	• Trustee for the Bridge, Homelessness to Hope, Leicester • Vice Chair, ECT and Related Committee, Royal College of Psychiatry • Clinical Director, Mental Health team, Midlands NHSE	(d) (e) (e)
James Sabin Director of Finance	• Spouse works at Sheffield Health & Social Care NHS Foundation Trust as Head of Capital and Therapeutic Environment	(e)
All other members of the Board of Directors have submitted a nil return, meaning they have no interests to declare.		

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

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, 24 March 2026

MEETING HELD IN PUBLIC

Commenced: 9.30am Closed: 12.52pm

PRESENT	Selina Ullah	Trust Chair
	Lynn Andrews	Non-Executive Director
	Ralph Knibbs	Senior Independent Director
	Chioma Akpom	Non-Executive Director
	Deborah Good	Non-Executive Director
	Jo Hanley	Non-Executive Director
	Andrew Harkness	Non-Executive Director
	Mark Powell	Chief Executive
	Vikki Ashton Taylor	Deputy Chief Executive and Chief Delivery Officer
	Tumi Banda	Director of Nursing, Allied Health Professions (AHP), Quality and Patient Experience
	Justine Fitzjohn	Director of Corporate Affairs and Trust Secretary
	Dr Girish Kunigiri	Medical Director
	Rebecca Oakley	Director of People, Organisational Development and Inclusion
	James Sabin	Director of Finance
IN ATTENDANCE	Anna Shaw	Associate Director of Communications and Engagement*
DHCFT/2026/017	Becki Priest	Chief Allied Health Professional (AHP) and Deputy Director of Patient Experience
DHCFT/2026/017	Anna Moss	Head of Clinical Practice, Older Adults and Community (guest for patient story)
DHCFT/2026/027	Tam Howard	Freedom to Speak Up Guardian
	Jo Bradbury	Corporate Governance Officer
OBSERVERS	Angela Kerry	Public Governor, Amber Valley
	Lai Mei Li	Public Governor, Amber Valley
	Christopher Williams	Public Governor, Erewash
	Joanne Foster	Staff Governor*
	Sophie Speed	Lead Nurse, Hartington Unit, Crisis Team – working Age Adults
	Hayley Turner	Older Adult Acute and Community Care Group Operational Manager

* denotes on-line attendance

DHCFT/ 2026/016	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** Selina Ullah, Trust Chair, welcomed Board colleagues, Governors and observers to the meeting. There were no apologies for absence and no declarations of interest raised with any of the day's agenda items. The current Declarations of Interest Register was noted.

	Selina communicated the housekeeping and fire safety information.
DHCFT/ 2026/017	**PATIENT STORY – 'GRANDAD'** Anna Moss, Head of Clinical Practice for Older People's services, shared a powerful story about her late grandfather, Ralph. The story focused on Ralph's journey following a diagnosis of dementia during the Covid pandemic. The Board noted that It had taken just four minutes for Ralph to be diagnosed with vascular dementia. Following the appointment in the Memory Assessment service of Tameside and Glossop Integrated Care NHS Foundation Trust, Anna explained the family were given a bag of leaflets and left alone to self-navigate care, which she referred to as, 'diagnosed and dumped'. Reflecting on her grandad's condition, Anna advised his increasing confusion, paranoia, wandering at night, calling her up to 25 times each day and suffering with multiple infections, resulted in a move to respite care. Within 18 hours of admission, the police had been called due to Ralph showing aggressive behaviours that had not been expressed previously. Anna, who has worked in Older People's Mental Health services for the last ten years (both within and outside of Derbyshire), tried hard to support and educate her family on how best to support Ralph, acknowledging the difficulty of this role as a daughter and granddaughter, whilst also continuing to work in the same field. With knowledge of the Derbyshire based Dementia Rapid Response team (DRRT), Anna suggested Ralph relocate to Derbyshire. She was successful in finding a bed for him in a New Mills care home, where Ralph and his family were warmly welcomed. Ralph lived here for a further two and a half years, where the DRRT and the home reviewed his diagnosis and medication and allowed him to have a purpose. There was no further aggression or hospital admissions. Anna commended the multi-disciplinary team approach the family experienced, mentioning that there was great collaboration between mental and physical health and that her family was astounded by the difference in care and experience received. The conversation detailed significant challenges during Ralph's care: inadequate information at diagnosis, lack of service guidance, repeated A&E visits and difficulties accessing respite care, compounded by Covid restrictions. Attention was also drawn to the absence of practical advice for managing new aggressive behaviours and the complexities of family dynamics. Anna praised Derbyshire's ethos of treating patients at home and the holistic, family-oriented approach of the New Mills team. The Derbyshire services had provided meaningful engagement for Ralph, resulting in improved behaviour and wellbeing, avoiding hospital admissions. However, the end-of-life care was marred by disagreement between the GP and District Nurse regarding pain management. Selina emphasised the importance of reviewing the Trust's impact on service users, drawing attention to the need for personalised care and the importance of the patient being at the centre of service delivery. Tumi Banda, Director of Nursing, AHPs, Quality and Patient Experience, noted that some staff are also carers. He suggested that future staff surveys should consider questions about the quality of care provided by the Trust. Identifying that the Trust currently lacks a Staff Carers Network, Becki Priest, Chief AHP and Deputy Director of Patient Experience, suggested this could be explored, provided an Executive sponsor is in place. Deborah Good, Non-Executive Director and Board Care Champion, expressed a desire to see lessons from this story implemented Trust-wide and offered her support to develop a Staff Carers Network. **Action**. The contrast between services in Tameside and Derbyshire was raised, noting that opportunities available in Tameside's Memory Assessment service are not mirrored in Derbyshire, with consideration given to how the Board might address disparities in access and speed of diagnosis.

	The story was described as heartwarming by Selina and she commended the teams for their excellent, patient-centred care, highlighting the value of a personalised care package. She asked for the Board thanks to be passed to the team. The importance of integrated working was recognised by Dr Girish Kunigiri, Medical Director. He asked Anna to reflect on the support she received. Anna responded positively regarding GP support and communication, though she reiterated the challenge at end of life. Expressing gratitude for the collaborative approach in Derbyshire, Anna noted that her family was kept well informed and supported. She did, however, acknowledge the emotional and practical difficulties of balancing work and caring responsibilities, especially during the pandemic. **RESOLVED: The Board of Directors was greatly inspired by Anna's story and was keen to support the establishment of a Staff Carers Network.**
DHCFT/ 2026/018	**MINUTES OF THE LAST BOARD OF DIRECTORS MEETING** The draft minutes of the last meeting held on 27 January 2026 were accepted as a correct record of the meeting.
DHCFT/ 2026/019	**ACTION MATRIX AND MATTERS ARISING** The relevant Executives gave updates on the completed actions: DHCFT/2026/008, Integrated Performance Report (IPR): Vikki Ashton Taylor, Deputy Chief Executive and Chief Delivery Officer, explained that today's report incorporates greater triangulation to strengthen assurance and facilitate connected discussion across Operations delivery, Workforce and Finance. DHCFT/2026/010, Patient and Carers Race Equality Framework (PCREF): Girish confirmed that PCREF is now a standing item for discussion at different forums, with oversight at the Mental Health Act Committee on a quarterly basis and submission to Board six-monthly. DHCFT/2026/015, Meeting Effectiveness: Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary, highlighted the Board agenda has been adjusted to combine the Board Committee Assurance Summaries with the IPR for improved triangulation and discussion. There were no outstanding actions and no matters arising.
DHCFT/ 2026/020	**QUESTIONS FROM MEMBERS OF THE PUBLIC** No questions had been received.
DHCFT/ 2026/021	**CHAIR'S UPDATE** Selina provided the Board with her reflections on activity since the previous Board meeting on 27 January 2026 and drew attention to the below points: Selina reported that, together with Board and staff colleagues, she had been to a sign language taster session as part of Deaf Awareness Week. The event had proved eye-opening, especially for those who are hearing, reminding the Board of the privileges often taken for granted. She reminded the Board that engagement with Deaf and Black communities were the two areas of focus within the Trust's strategic priorities. In February, Selina had welcomed the newly appointed Governors and welcomed back re-elected Governors, the election results being listed in her report. All had been invited to the Governor induction and Selina added that the new governors would add to the Council of Governors' diverse skills and experiences. Angela Kerry and Neil Baker were the new joint Chairs of the Governance Committee and Brian Edwards had been confirmed as Interim Lead Governor.

	A recent meeting with Staff Governors was mentioned, where discussions had centred on data quality and evidence-based practice. The suggestion to provide hard copies of the staff survey, along with engagement sessions was raised as a practical measure enhanced involvement. In terms of System collaboration, Selina outlined her activities including being on the appointment panel for the Chief Executive at Derbyshire Community Health Services NHS Foundation Trust (DCHS). She gave an overview of discussions at Provider Collaborative and wider system meetings, particularly the opportunities neighbourhood working continues to present for collaborative delivery and the reorganisation of resources from Acute to Community settings. Selina underscored the need to remain focused on organisational priorities particularly on health inequalities and mentioned the evolving work on this by the Integrated Care Board cluster. The risk associated with financial plans continues to be a key focus in System discussions, noting the Trust's compliance contrasted with non-compliance among other providers, which may impact future funding prospects, prompting a call for diligence and focus, while acknowledging both intended and unintended consequences. Lynn Andrews, Non-Executive Director, reflected on the recent Trust engagement sessions, noting that staff have been proactive in voicing concerns, particularly on the organisational changes. Mark Powell, CEO, reiterated the importance of creating an environment where individuals feel comfortable raising issues in a respectful and professional manner, a point that had been actively discussed. Emphasising that no additional funding is forthcoming, Jo Hanley, Non-Executive Director, raised questions about partnership working and the potential for closer collaboration with local authorities. Selina responded affirmatively, linking this to neighbourhood working and the presence of elected members on the Council of Governors. Vikki echoed agreement, referencing a review meeting of the Mental Health, Learning Disabilities and Autism Delivery Board. She noted the challenge of reviewing the effectiveness of the group, which comprises voluntary sector representatives, the East Midlands Ambulance Service and the police. She had been encouraged by the discussions and anticipated a shift in approach from the Integrated Care Board (ICB), with the Trust maintaining a strong voice in strategic meetings. Jo's suggestion to formalise joint leadership was optimistically responded to. Mark cited the emergence of a new cluster and ongoing discussions with Nottinghamshire and Leicester colleagues. He stressed the importance of collaborative learning and observed that local authorities are undergoing significant changes due to government reform, with substantial shifts anticipated over the next 18–24 months. It was noted that Mark's report includes an addendum expressing a genuine desire for joint efforts to improve patient care, referencing the upcoming Derbyshire collaboration session in April as a forum to determine future objectives and partnerships. **RESOLVED: The Board of Directors noted the content of this report.**
DHCFT/ 2026/022	**<u>CHIEF EXECUTIVE'S UPDATE</u>** The report provided an update on current local issues and national policy developments and also reflected a wider view of the Trust's operating environment, serving to horizon scan for risks and opportunities that may affect the organisation. Mark announced the appointment of Dr Nick Broughton's as the new national Programme Director for mental health, learning disability and autism services at NHS England, engaging with mental health Chief Executives about national priorities. Optimism was expressed that Dr Broughton's increased visibility would strengthen mental health representation at the national level. Mark also reported on the Provider Capability Assessment (part of the NHS Oversight Framework), which had been given an amber/green rating, mirroring the Trust's own evaluation. Mark acknowledged several outstanding concerns identified within the assessment and assured the Board that these key issues would be addressed proactively.

	Service changes in Derby and Derbyshire were noted, with Mark confirming that dialogue with DCHS continues regarding the ongoing transition of Older People's Mental Health (OPMH) and Neurodevelopmental (ND) services. The recent activity of the Care Quality Commission (CQC) within the Trust was discussed. Mark reported that the draft inspection report for Cherry Tree Close rated the service as 'good' and summarised that all services inspected over the past 12–18 months have been rated 'good', attributing this success to the teams' hard work. Vikki elaborated on the Mental Health Urgent Assessment Centre, which has received capital funding. She explained that individuals experiencing mental health deterioration would be transferred to this facility at the Radbourne Unit, where the environment is more suitable for mental health care compared to an Accident & Emergency (A&E) setting. She highlighted the potential for short interventions enabling support at home rather than admission to an Inpatient bed. Vikki noted the absence of funding for staffing, emphasising that this should not impede service delivery for the population, and proposed a review of working practices as a response to this challenge. Observing that the Community services CQC inspection report was much longer in comparison to previous reports, Tumi added this was due to it encompassing several services and teams, including crisis care, reflecting a comprehensive inspection. Tumi commended the level of detail in the report, viewing it as a testament to the teams' consistently high standards. **RESOLVED: The Board of Directors noted the update.**
DHCFT/ 2026/023	**INTEGRATED PERFORMANCE REPORT (IPR) AND BOARD COMMITTEE ASSURANCE SUMMARIES** The IPR provided a high-level view of performance against a number of Operational, Financial, People and Quality metrics, and assurance regarding actions being taken to improve performance up to the end of January 2026 for internal measures and to the end of December 2025 where the data source is NHS England. Points to note were brought to the attention of the Board by Executive Directors and Committee Chairs during the IPR discussions. The Board Committee Assurance Summaries from recent meetings were considered alongside the IPR. Quality Tumi emphasised the focus by the Patient Experience team to ensure timely resolution of complaints, he also outlined the work with System partners to alleviate increasing challenges around housing needs and specialist packages of support for those clinically ready for discharge. It was noted that a Violence and Aggression Group has been formed to address high incident levels, including those marked as major due to race and other protected characteristics. The challenges of reducing prone restraint were acknowledged, with staff-led initiatives and intervention cited as key responses. As Chair of the Quality and Safeguarding Committee, Lynn informed that the last two meetings had concentrated on key areas of risk. It was noted that the Committee had praised staff for meeting the assurance requirements of the CQC and fundamental standards of care. Outlining policy interventions and shared insights gained from Learning from Deaths and Health Inequalities, Lynn referenced compliance with the Patient and Carers Equality Framework (PCREF) and Duty of Candour responsibilities. Tumi and Vikki detailed the increasing challenges related to housing and specialist placements, which impacted negatively on discharges. The necessity of identifying appropriate placements within 72 hours to ensure a downward trend was stressed, with the Trust working with partners to ensure community preparedness.

Noting a prevalence of limited/amber assurance levels, Mark questioned the aspiration for full or significant assurance and pace of improvement. This challenge was posed to all committees, warning against complacency and urging clarity on what constitutes 'good'.

The Board debated this challenge and Tumi confirmed the ambition for full assurance, acknowledging the evolving nature of processes and outputs. He highlighted the importance of reflective practice within the Quality and Safeguarding Committee and ongoing improvements, though admitted that further work remained.

Lynn echoed Mark's sentiments, describing the difficulty of providing assurance based solely on individual papers. Referring to the multiple red indicators presented in the IPR, she reasoned that receipt of limited assurance ratings were not off-kilter. The efforts to include necessary information despite confines in available assurance categories was noted.

Clarity on what areas committees are able to assure was questioned by Andrew Harkness, Non-Executive Director, who highlighted the subtlety of overarching assessments and the importance of distinguishing controllable factors.

Jo observed that categorisation of assurance levels was not always helpful and cautioned against expecting full assurance in all areas.

Mark reiterated the importance of public accountability, stressing that clarity, accuracy and detail in papers were crucial. He tasked committees with reviewing assurance levels and the infrequent escalations to the Board. **Action**.

Describing ongoing discussions within the Quality and Safeguarding and People and Culture Committees regarding escalation, Ralph Knibbs, Senior Independent Director, attributed the lack of Board escalation to strong working relationships that enabled negotiation and resolution at Committee-level. He characterised these relationships as trusting, open, collaborative and respectful. However, he acknowledged the need for further assurance.

The increase in matters being referred to the Trust Delivery Group (TDG) was observed by Deborah Good, Non-Executive Director, viewing this as a positive step towards resolution and identifying the appropriate point for escalation to the Board.

The need for clarity regarding long-term targets and progress against stated objectives was highlighted. It was recognised that many targets lacked clear timelines and assurance would be strengthened by establishing explicit trajectories. The importance of evidence, pace of change and ambition was stressed.

Chioma Akpom, Non-Executive Director, proposed trend analysis for assurance; if amber status persisted for six to 12 months, escalation should be considered, subject to risk appetite. Girish emphasised the need for clarity in escalation decisions and confidence in leadership to avoid detrimental organisational impacts.

The openness and transparency of the discussion was praised by Selina, who recommended further attention in committees and governance processes.

<u>Operations</u>

Vikki informed that 70 people continue to wait over 52 weeks to access care, with ongoing programmes continuing to improve this position.

It was noted that the Trust and System have set a goal to reduce the number of patients with a learning disability or autism in beds to no more than 32 by the end of March 2026, which has been agreed with NHS England. Altogether, there are 37 patients in beds. To help reach the target, there is a performance improvement plan focusing on preventing unnecessary admissions and supporting patients to leave hospital.

Due to the significant increase in demand, not balanced by funding, Vikki reported that the Mental Health Helpline continues to underperform. She added that discussions are underway with the ICB

to review the service, which had not been updated since early 2021. It was noted that 80% of calls are now in receipt of professional advice/guidance.

As Chair of the Finance and Performance Committee, Jo confirmed that these matters had been discussed, receiving limited assurance relative to targets. She highlighted interventions for the Mental Health Helpline and mentioned the temporary closure of the East Midlands Perinatal Collaborative, viewing this as an opportunity for piloting improvements.

In response to a query from Girish about the escalation process within local authority governance for those clinically ready for discharge, Vikki advised that the local authority Executive Board and Social Care were aware of the challenges, though internal escalation processes remained unclear. Girish recommended the Board seek clarification on these processes.

The increasing average wait times were noted, prompting further discussion. Vikki explained that significant transformational work was underway, but the service was commissioned for a limited number of assessments, which was consistently exceeded. Ongoing discussions with the ICB had not yielded resolution, and waiting lists continued to grow. Reporting processes were being refined to better reflect escalating demand.

<u>People</u>

Rebecca presented positive outcomes in training and appraisal rates. Staff turnover was within tolerance, though varied across roles, Registered Mental Health Nurses, 6–7%, Allied Health Professionals, 13% and Administration, 12%, with a recent spike noted. Absence rates had improved, supported by ongoing review of the Wellbeing offer and increased psychological support. Cleansing of supervision data continued, with policy updates and system improvements addressing inconsistencies in recording.

Rebecca reported the conclusion of the second phase of organisational change, with outcomes delivered to colleagues. The resulting high anxiety of staff was acknowledged. Full conclusion was anticipated within two weeks, with lessons learned to inform future changes.

As Chair of the People and Culture Committee, Ralph drew attention to a recent increase in Freedom to Speak Up cases and the development of EDI related initiatives. He stressed the importance of forward planning, defining success at year-end and balancing quantitative performance indicators with qualitative measures. He cautioned that constant change made full assurance difficult to achieve.

A limited impact from the ban on the use of Band 2 and 3 Healthcare Support Workers was noted, with the Agency Oversight Group expanding to strengthen temporary staffing arrangements.

<u>Finance</u>

James Sabin, Director of Finance, delivered a positive financial update, reporting an adjusted position of £0.7m deficit, which is ahead of plan by £0.5m.

Risks to delivering the financial plan were noted to include delivery of efficiencies in full, Adult Acute Out of Area (OoA) placements and bank and agency usage.

Jo confirmed the Committee had no indication of future issues. She cited the refresh of the Committee's BAF risks, advocating for a longer-term perspective and ongoing conversations about next year's financial plan.

James confirmed national acceptance of the Trust's financial submission, though noted last-minute changes by the ICB. He described a shift towards month-on-month stretching rather than year-end goals and noted the lack of investment to achieve this.

Highlighting discrepancies in numbers and assumptions, Vikki reported the ICB had increased the Perinatal target by 42. This was described as unfair, noting the Trust had not signed up to these targets. Mark recommended formalising the query. **Action**.

	Mental Health Act (MHA) Committee Deborah, Committee Chair, reported improved communication and focus on compliance, noting escalation of rights reading to the TDG to ensure alignment across the different Care Groups. She observed clearer delineation between committees and highlighted the MHA link with the People and Culture Committee. She added that oversight of PCREF was now monthly, with Girish providing dedicated leadership. Selina recognised the critical role of the MHA Committee, acknowledging the progress and grip on legal issues, suggesting that limited assurance was appropriate overall. **RESOLVED: The Board of Directors:** **1. Obtained limited assurance current performance across the areas presented** **2. Noted the Board Assurance Summaries.**
DHCFT/ 2026/024	**MAKING ROOM FOR DIGNITY (MRFD) – FORMAL APPROVAL OF POST-PROJECT EVALUATION AND BENEFITS EVALUATION REPORTS** The item was introduced with particular attention to the comprehensive nature of the evaluations, which had been reviewed by three committees, Quality and Safeguarding, Finance and Performance and People and Culture. This collaborative nature of the review process, ensured that the reports were robustly scrutinised and broadly supported prior to being presented for formal approval. **RESOLVED: The Board of Directors:** **1. Considered and discussed the post-project evaluation and benefits reports** **2. Approved submission of the reports to NHS England.**
DHCFT/ 2026/025	**BOARD ASSURANCE FRAMEWORK (BAF) UPDATE** The report detailed the current BAF risks, Issue 4, version 4.3 for 2025/26 and the position at the end of 2025/26. Justine highlighted that intense scrutiny of the BAF had been undertaken in February, highlighting that the version under review represented the year-end iteration for 2025/26. She drew attention to Risk 1A, relating to Patient Safety and Experience, referencing the Quality Delivery Plan. It was noted this risk level remained high, due to the remaining dormitories at the Radbourne Unit. It was advised that the new version of the BAF will be presented at the May Board. Mark pointed out the predominance of red scoring for updates and queried if there was a timing issue for updates, noting that there had been numerous changes in risk ratings and frequent day-to-day adjustments by various contributors. Reviewing the action ratings for the framework's component parts, he observed that only one had achieved a green rating, which he deemed unacceptable for a year-end review of delivery against strategic risks. In relation to the key gaps in control, James reasoned that risks are removed from the framework as soon as they have been mitigated and the rating turned to green. He suggested that tracking risk ratings over time would be beneficial to provide a clearer historical perspective. Selina acknowledged the importance of reflecting the Trust's actual position, suggesting that the BAF did not fully capture the complexity of the issues faced. She encouraged the Board to challenge itself further at the next BAF review. **RESOLVED: The Board of Directors:** **1. Reviewed Issue 4 of the BAF for 2025/26** **2. Requested further clarification and reassurance be presented at the next Board meeting** **3. Agreed to continue to receive updates in line with the forward plan for the Trust Board.**
DHCFT/	**FREEDOM TO SPEAK UP GUARDIAN (FTSUG) REPORT (SIX-MONTHLY)**

2026/026	This half-yearly report informed the Board on Freedom to Speak Up (FTSU) cases within the Trust; an analysis of trends and actions being taken to improve the speaking up culture. Tam Howard, FTSUG, reported that 170 staff members had spoken up in the last six months, with a significant proportion related to the same night shift concerns, which was noted as a potential skew in the data. This had also equated to an increase in patient safety and quality concerns, the number of clinical colleagues speaking up and the representation of BME staff. The increase in reporting was highlighted as a positive reflection of staff willingness to raise issues. However, the remaining challenges were recognised, as 40% of cases involved bullying or harassment and 16% were related to discrimination. The report also noted the highest ever proportion of BME staff (40.6%) speaking up, however this could possibly be explained as part of the night shift issue. Despite the Trust being among the highest nationally for reporting numbers, Lynn observed this was not reflected in the staff survey results, with reasons for the gap discussed recently with Tam. Rebecca echoed these concerns, noting inconsistencies between the staff survey and the report, particularly regarding the sharing of outcomes from raised concerns. Mark suggested that phrasing of the staff survey questions may not clearly relate to FTSU, potentially causing confusion among staff. The Board acknowledged the challenge of managing staff expectations; while positive that many are speaking up, there is a need to respectfully and clearly communicate when certain issues cannot be resolved. Andrew emphasised the importance of leaders picking up on themes and that the FTSU process should be for non-managerial issues. Respectfully disagreeing, Tam argued that FTSU is for any issues, which prompted further debate on how to change the narrative and ensure meaningful action. Highlighting those concerns around breaks, particularly during night shifts, Tumi recognised negotiation could have resolved the matter. Selina concurred, querying why escalation to FTSUG was needed when so many people had raised the concern. She advocated for local resolution wherever possible. It was agreed that some colleagues misconceive the authority of the FTSUG. **RESOLVED: The Board of Directors:** **1. Noted the contents of the report and the themes arising from FTSU activity during the reporting period** **2. Supported the ongoing mechanisms and activities in place to promote the FTSU agenda across the Trust** **3. Provided assurance that the actions and proposals outlined by the FTSUG continue to support an open and transparent culture where staff feel safe to raise concerns.**
DHCFT/ 2026/027	**<u>STAFF SURVEY</u>** Rebecca presented the 2025 NHS Staff Survey benchmarking results, along with an overview of how the Trust performs in comparison with the national benchmarking group of Mental Health and Learning Disability trusts. The Trust's response rate was described as very positive, exceeding the national average of 52%. Results were analysed according to the seven elements of the NHS People Promise, with further detail provided. Drawing attention to the Friends and Family questions, the results of which have fallen: • *I would recommend my organisation as a place to work* • *If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.*

	Rebecca highlighted that, nationally, staff engagement and motivation have also dropped, with fewer staff raising concerns, although the changes were not statistically different from the previous year. She expressed disappointment at these trends and emphasised the need to focus on the two questions, noting that Divisions have their own reports and will be confirming at least one action each. It was noted that the team-level results were delayed and that oversight would be maintained through the People and Culture Committee, with ongoing engagement recognised as essential, acknowledging that the survey represents only a snapshot in time. Regarding the question addressing the standard of care, and the static nature of responses, Chioma queried whether actions taken had been sufficient, and if not, what gaps remained. Acknowledging the challenge, Rebecca explained that while interventions had been implemented, there had been insufficient focus on sharing outcomes at Trust-level, particularly regarding patient care, due to the recent, concentrated engagement around the consultation process. It was agreed that incorporating a patient story into the communications was a golden opportunity to enhance messaging. Ralph commented on the large-scale transformation programmes, the new facilities and Phases 1 and 2 of the operating model, which may have resulted in the perception these developments were externally imposed rather than as initiatives in which staff could participate. He stressed the importance of acknowledging the silent majority and advocated for visible leadership to clearly explain the rationale behind changes. Selina concurred with this useful reminder. Disappointed with the survey results, Mark recognised the challenges and ongoing changes being faced. He reaffirmed the intention to continue focus on the Friends and Family questions, maintaining attention to these issues on a daily basis. Rebecca concluded by stating that a communications plan would be developed following discussions at the Trust Delivery Group. **RESOLVED: The Board of Directors:** **1. Noted the NHS Staff Survey 2025 benchmarking results and the key themes identified within the benchmarking analysis** **2. Supported the continued development of targeted workforce improvement actions aligned to the Trust's People Plan priorities.**
DHCFT/ 2026/028	**<u>DIGITAL DELIVERY PLAN</u>** Girish presented the Digital Delivery Plan 2026-28 for approval by the Board of Directors. Jo expressed strong confidence in the process undertaken, highlighting the effective socialisation of the plan with colleagues and partners. She recognised the plan as integral to the organisation's broader strategic aspirations and, while endorsing the plan, acknowledged the significant challenges and workload ahead. Lynn, acknowledging the plan's depth and alignment with the 10-Year Health Plan, raised questions about the transformational programme and the prioritisation of actions. She noted that these considerations would benefit from further clarity, particularly in relation to the Clinical Plan, which had not yet been finalised. Emphasising that the plan is closely aligned with the transformational programme currently in place, Girish stated the importance of synchronisation with national and local priorities. He confirmed the Clinical Plan is scheduled for presentation at the Quality and Safeguarding Committee and Board within the next four months. Commending the plan's ambition, Chioma recommended a thorough analysis of organisational capacity and capability regarding the plan's objectives. She expressed a keen interest in joining the Delivery Group and stressed the necessity of ongoing conversations about data quality and optimisation to drive improvement.

	Addressing the issue of capability and capacity, Andrew challenged the Board to reflect on the previous year's performance, advocating for granular reporting to demonstrate progress. He also questioned the breadth of IT systems listed in the plan, suggesting that prioritisation and rationalisation may be required to focus efforts on the most impactful areas. Referencing the imminent promotion of the plan and the challenges anticipated in the coming year, Vikki cautioned around the timing of recruitment efforts. The significance of this concern was acknowledged by Selina. **RESOLVED: The Board of Directors approved the Digital Delivery Plan - 2026-28.**
DHCFT/ 2026/029	**PEOPLE PLAN** This report set out how the People Plan for 2025-28 will support, develop and value Trust people over the next three years, aligning with the national NHS Long Term Plan, the Trust Strategy and the People element of the Four Ps (Patients, People, Productive and Partnerships). Rebecca advised that the plan provides a framework for attracting and retaining the best colleagues, supporting professional development and leadership, embedding an inclusive and values-driven culture and promoting staff wellbeing. It was noted that following presentation of the draft format to the People and Culture Committee in September, the plan has been socialised with key stakeholders, revised following comments received and approved thereafter, in November 2025. Ralph advocated the sequencing of actions and added that in terms of implementation, the Delivery Plan is to be submitted to the People and Culture Committee. **RESOLVED: The Board of Directors:** **1. Received the final People Plan, noting the scrutiny undertaken by the People and Culture Committee** **2. Approved the Plan and the proposed quarterly updates to the People and Culture Committee on progress against the plan.**
DHCFT/ 2026/030	**REPORTS FOR NOTING ON ASSURANCE** These reports were received for information and noting having previously provided assurance to the Quality and Safeguarding Committee. Guardian of Safe Working Hours (GoSWH) report: This quarterly report from the Trust's GoSWH provides data about the number of Resident Doctors in training in the Trust, full transition to the 2016 Resident Doctor contract and any issues arising therefrom. The report details arrangements made to ensure safe working within the new contract and arrangements in place to identify, quantify and remedy any risks to the organisation. **RESOLVED: The Board of Directors:** **1. Noted the contents of the report** **2. Welcomed Dr Praveena Peddireddi as the new GoSWH.** Learning from Deaths/Mortality report: The report covered the period 1 October 2025 to 31 December 2025. Following scrutiny at the Quality and Safeguarding Committee in February, it had been agreed for the report to be considered by the Trust Board of Directors. **RESOLVED: The Board of Directors accepted this report with limited assurance of the Trust's approach and agreed for the report to be published on the Trust's website as per national guidance.**
DHCFT/ 2026/031	**FIT AND PROPER PERSON POLICY** The refreshed Fit and Proper Person Policy and Procedure was presented for approval.

	Justine politely reminded Board members to ensure completion of their self-attestation forms. **RESOLVED: The Board of Directors approved the revisions to the Policy.**
DHCFT/ 2026/032	**CONSIDERATION OF ANY ITEMS AFFECTING THE BOARD ASSURANCE FRAMEWORK (BAF)** Selina reflected on the day's full agenda and the useful and challenging discussions. There were no items affecting the BAF.
DHCFT/ 2026/033	**MEETING EFFECTIVENESS** Comments on the day's discussions were invited from attendees and observers: • Lai Mei Li, Public Governor, Amber Valley, expressed appreciation for the openness of the meeting, particularly welcoming challenge. She noted the importance of developing relevant measures to achieve optimal outcomes and commended the transparency, especially given the public nature of the proceedings. • Angela Kerry, Public Governor, Amber Valley, highlighted the value of seeing new Non-Executive Directors (NEDs) actively participating. She acknowledged the complexity of the agenda and the limited time to focus on all issues, describing the process as 'a tough call'. • Sophie Speed, Lead Nurse, Hartington Unit, Crisis Team – working Age Adult, Chesterfield Royal Hospital, commented on the multi-layered connectivity within the discussions. She emphasised that colleagues are sceptical of the confidentiality of the online staff survey, suggesting that paper-based surveys might be preferable. • Hayley Turner, Older Adult Acute and Community Care Group Operational Manager, expressed gratitude for the opportunity to attend and had enjoyed the level of challenge and interesting subject matter. She emphasised the impact of patient and carer stories, observing that staff on the ground were more influenced by such narratives than by performance metrics. Hayley also noted ongoing struggles with Inpatient flow and suggested sharing insights from this journey more widely. • Referring to the BAF risks, specifically regarding digital and technical vulnerabilities that could result in a major outage, Andrew recommended a repositioning of emphasis and suggested further review of digital plans as part of the annual process to ensure effective implementation. In agreement, Selina pointed out that cyber security risks are noted but not overly-mentioned. She advocated for their explicit inclusion in future risk assessments and reminded the Board to maintain oversight, particularly through the Finance and Performance Committee. • Justine observed that the Executive Leads and Committees had contributed to a productive and dynamic review of the BAF. However, Ralph felt that the scope of the digital discussion was too narrow, arguing for a broader focus on enhancements and efficiency. He expected each area to have a defined plan for improvement. The Board agreed to clarify where responsibility for data quality would reside going forward. **Action**.
The next meeting to be held in public session will be held in person on Tuesday, 19 May 2026 at 9.30am in Conference Rooms A and B, Centre for Research and Development, Kingsway, Derby.	

ACTION MATRIX - BOARD OF DIRECTORS - MAY 2026							
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
24-Mar-2026	DHCFT/2026/017	Patient Story - 'Grandad'	Deborah Good/ Becki Priest	Consider establishing a Trust Staff Carers Network.	TBA	Will be included for consideration in the new Wellbeing Offer, as support for carers is included as one of the six core strands.	Green
24-Mar-2026	DHCFT/2026/023	IPR	Committee Chairs/ Executive Leads	Committee Chairs and Executive Leads to consider assurance levels being received and review the parameters for escalation to Board.	31-Jul-2026	Discussions held with the Deputy Chair and the Director of Corporate Affairs on assurance ratings and reporting as part of wider improvements. Board will be discussing this in conjunction with the Well-Led review work.	Yellow
24-Mar-2026	DHCFT/2026/023	IPR - Finance	Vikki Ashton Taylor	Formalise challenge to the ICB in relation to the Perinatal targets.	01-Apr-2026	Response received from the ICB clarifying the differences. Note: important to ensure NHSE and the ICB monitor performance against Trust component of their target only, as some targets include other providers.	Green
24-Mar-2026	DHCFT/2026/026	Board Assurance Framework (BAF) update (Issue 4)	Executive Directors and Comm	Board to receive further clarification and reassurance in relation to the identification and mitigation of risks to achieving the Trust's strategic objectives at the year-end position.	Quarter 1, 2026/27	Full review of BAF report completed, ensuring the risks, assurances, controls and linked actions map to the current Trust strategic objectives; summarised in the executive summary, Board 19-May-2026, agenda item 15.	Green
24-Mar-2026	DHCFT/2026/033	Meeting Effectiveness	Vikki Ashton Taylor	Clarification of responsibility for data quality.	12-May-2026	Responsibility sits with Vikki Ashton Taylor, Deputy Chief Executive and Chief Delivery Officer.	Green

Key:					
	Action Overdue	RED		**0**	**0%**
	Action Ongoing/Update Required	AMBER		**0**	**0%**
	Resolved	GREEN		**4**	**80%**
	Agenda item for future meeting	YELLOW		**1**	**20%**
				5	**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 24 March 2026. The structure of this report reflects the role that I have as Trust Chair.

Executive Summary

Our Trust and Staff

1. On 31 March I hosted Philip Ross, Chair and Charlotte Burrows, CEO of Design in Mental Health Network with Mark Powell, Trust CEO. We had the opportunity to showcase our new Carsington Unit facility from a design perspective. They were particularly impressed by the role of lived experience in shaping the Making Room for Dignity programme from the programme submission, design, execution and ongoing involvement of individuals with lived experience through various forums and designated roles. Philip wrote a piece about the visit and the positive impact of thoughtful design on patient, carers and staff colleagues alike. He highlighted the impact on their experience, recovery and wellbeing. The piece in LinkedIn attracted significant interest and comments which reaffirmed to me that our facilities are exceptional and leading the way in patient centred therapeutic environments.
2. I attended the Chief Executive Officer (CEO) Engagement Hour on 13 April, which provided an opportunity to hear from our colleagues followed by a Focused Engagement hour on 29 April on two difficult topics, violence and aggression and sexual safety. The session and the topics were handled with sensitivity. Substantial work was underway through the violence, abuse and aggression collaborative by engaging colleagues across services to co-create and co-produce a compassionate, trauma-informed set of actions drawing upon staff experience and data. The actions are outcome focussed and builds on previous work, ie 'It's not Okay' initiative. The sexual safety presentation informed of the Trust's adoption of the Sexual Safety Charter in the workplace which sets clear standards of acceptable behaviour and a culture where staff feel safe to report any incidents, however minor it may be. A working group is in place and a sexual safety policy will be launched soon.
3. I have begun to shadow the Executive team to understand the day-to-day issues they are grappling with and to understand the challenges Directors are facing. On 14 April, I began 'A day in the life of an Executive Director' by shadowing James Sabin, Executive Director of Finance. We started by a visit to the Contracting team, which was very insightful as they shared the challenges of ensuring the contract renewal process was smooth and covered what the Trust had agreed with commissioners, which can at times be different in the actual contract. I also met the members of the Finance team, Karl, Phil, Dave and Alex and I was able to sit on a cost improvement programme (CIP) update meeting. The CIP target 2025/26 year position was achieved and the cost reduction programme was delivered in full. The 2026/27 position for Derbyshire Healthcare was positive, and we are in the upper quartile for plans developed with projection initiation documents in place. I was able to see the alignment of the CIP tracker, Quality Improvement Assessment tracker and the Project Initiation Documents (PIDs) with the assistance of Joe Wileman, Head of Programme Delivery and Karl Faulkner, Finance Manager – Reporting, which demonstrated the amount of work, co-ordination and grip required to achieve the performance and outcomes the Board expects. My visit to the Estates and Facilities service was equally informative. Andy Donoghue, Associate Director of Estates and Facilities and Jordan Yates, Head of Estates, talked about some of the developments and innovative practice that has been introduced.

We met with a number of the team members working in Estates and Facilities including members of the Electric and Gas Engineering team, the workshops, health and safety, stores and medical devices. We also saw the electric vehicles and how the team was contributing to the Trust's sustainability agenda. Jordan showed us some of the workplace culture work that had been undertaken with a focus on colleague wellbeing. Walking around the services, I saw lots of evidence of this which was resulting in positive outcomes, such as improved staff survey results and supervision.

4. On 22 April, Mark Powell and I visited the Psychology service and we had the privilege of sitting in on a Therapeutic Community meeting. We observed the community which consists of staff and patients membership. The referral criteria includes those who have long-standing mental health issues exhibiting high risk and it is assessed that they will benefit from an intensive structured therapeutic counselling and self-reflective learning programme lasting 12 to 18 months.

Council of Governors

5. On 1 April, I held a virtual coffee session with the governors. These meetings are informal and a means for us to get to know each other and the Trust. I was pleased some of our new governors, Jean Johnson, Public Governor, Bolsover and North East Derbyshire and Lai Mei Li, Public Governor, Amber Valley, were able to join, along with Angela Kerry, Public Governor, Amber Valley. We spoke about some of the developments and also about the organisational restructure.
6. On 21 April, the Governance Committee was held, chaired by Neil Baker, Public Governor, Bolsover and North East Derbyshire. Ralph Knibbs, Senior Independent Director, attended on my behalf as I had to attend a regional meeting.
7. On 5 May, the Governors Nominations and Remunerations Committee met to receive the annual appraisals outcomes for the Non-Executive Directors (NEDs). It also included the process for my annual appraisal as Trust Chair, which is led by Ralph Knibbs, in his capacity as Senior Independent Director. The Committee provides assurance to the Council of Governors that we have a robust appraisal process in place.
8. I would like to thank all of the governors for their support to the Trust, leadership and their counsel to me. It is very much appreciated and I look forward to continuing to work with the governors as we await to receive more clarity about the future role of governors.
9. On 18 May, I met with Brian Edwards in his capacity as Interim Lead Governor and Hazel Parkyn, Deputy Lead Governor. I briefed them on some of the key issues and developments concerning the Trust.
10. I also met with the Staff Governors on 18 May. This provided useful feedback from colleagues and a sense check of how it feels in the organisation. It also 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.
11. There is a Council of Governors meeting this afternoon and then the next meeting will be on 21 July, following the Public Board meeting on that day. The next Governance Committee takes place on 25 August.

Board of Directors

12. I continue to meet with my Non-Executive Director (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.
13. The Board has undertaken the annual cycle of appraisals of the NEDs and the Executive Directors. The appraisals and objective setting for the NEDs has concluded and will be reported back to the Council of Governors. I have also concluded light touch reviews with Jo Hanley and Chioma Akpom who have both joined the Trust within the last six months and agreed their objectives for 2026/27.
14. On 15 April the Board held its Strategy and Development Session, which focused on the Care Quality Commission Well-Led that Boards are assessed against. We heard from Sarah Duncanson, Lead Inspector for the East Midlands. The session was very informative and provided an opportunity to also share our collective understanding of the Well-Led and where we thought we were against the framework. This also provided our newer Board colleagues with an opportunity to learn more about the Trust.
15. On 28 April, a Confidential Trust Board meeting took place where the Board was appraised of a number of matters linked to service transformation.
16. An Extra-ordinary Remuneration and Appointments Committee meeting was held on 29 April to discuss the outcome of the annual benchmarking of Executive Directors, as per the terms of reference of the Committee, and NHSE guidance on annual benchmarking of Executive Director pay.
17. I am pleased to share that Lynn Andrews, NED, was successful in her application to join the NHS Aspirant Chairs Programme. Congratulations to Lynn as it was a very competitive process. A total of 15 applicants from the Midlands were interviewed, of which only three NEDs were successful.

System Collaboration and Working

18. The Provider Collaboration Board met on 22 April to discuss the future of provider collaboration and whether there is any value in continuing given the national policy directives emphasis on individual provider performance and accountability. It was helpful to hear the different candid perspectives from system colleagues. It was agreed a further face-to-face meeting was necessary to explore the tensions of collaboration at a Derbyshire System-level from the individual provider position and league tables which is driving certain behaviours not conducive to collaboration.
19. The regular meeting (18 April) of the Midlands Chairs and Chief Executives with Dale Bywater, NHSE Regional Director, was cancelled as it was close to a mandated national NHSE meeting.
20. On 27 March, Mark Powell and I were involved in the recruitment of the substantive CEO of Derbyshire Community Health Services (DCHS) NHS Foundation Trust. The interim CEO, Jim Austin, was successful in his application to become the permanent CEO of DCHS. Mark and I look forward to continuing to work with him and his Chair, Julie Houlder.

Regulators, NHS Providers, NHS Confederation and others

21. On 21 April, Mark and I attended the Midlands NHS Leadership meeting in Birmingham. We heard from Sir Jim Mackey, CEO of NHS England and the new regional Chair, Russell Hardy MBE. The opportunity to hear from both Sir Jim and Russell was insightful and disappointing; in that Mental Health and collaboration were barely mentioned, the focus being on Acute trusts once again.

22. I am now on the Board of the NHS Alliance; this is the new membership organisation that has formed following the merger of NHS Providers and NHS Confederation. Lord Victor Adebawole, the Chair of the new entity has requested that I undertake a review of the NHS Alliance in relation to race equality and inclusion and to propose recommendations for the Alliance. I attended the last 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 2026/27.

23. I have continued to attend regular briefings from NHSE for the Midlands region.

Strategic Considerations		**BAF Risk(s)**	**Strategic Delivery Plan Reference**
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	1A, 1E	1.1 – 1.4
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X	2A, 2B	2.1 – 2.4
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X	3A	3.1, 3.2
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	4B	4.1

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.

Net Zero Duty Implications

In compliance with the NHS move towards net zero carbon emissions, the Trust must consider statutory emissions and environmental targets in their decisions. Reports should identify related impacts on workforce and system leadership; sustainable models of care; digital transformation; travel and transport estates and facilities (including capital projects, asset management and utilities, green space and biodiversity); medicines; supply chain and procurement; food and nutrition and adaptation.

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

None.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

This report reflects 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 – 19 May 2026

Chief Executive's update

Purpose of Report

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

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

National and regional context

Neighbourhood Health Framework

In March the Government published the Neighbourhood Health Framework, which outlines a neighbourhood health model that puts people at the centre of how their health and care is delivered; by organising services so they can work together to serve a defined population. The aims of this approach are to:

- Improve people's health and care outcomes, reduce health inequalities and help them stay well at home
- Organise services around the person with more convenient, personalised and joined-up care
- Reduce pressure on Acute services, including hospitals and care homes
- Cut waste and duplication
- Help the NHS deliver against core targets.

National Oversight Framework

Quarter 3 results from the National Oversight Framework (NOF) have now been published. Our position in segment three has remained the same since the quarter two results were announced in December. Thank you to colleagues who have worked hard to improve and maintain our performance and appropriately record all the activities we undertake.

As a reminder, NHS England (NHSE) publishes their assessment of trusts' performance through the NOF, which places all NHS trusts into one of four segments (segment one being the highest performing). The framework is being reviewed for 2026/27, with revised metrics aligned with the Medium-Term Planning Framework ambitions as well as wider integration with the strategic direction as set out in the 10-Year Health Plan.

We are carrying out some modelling work against the proposed metrics, the number of which have increased from the previous year. NHSE have indicated that Provider Capability Assessments will need to be refreshed and we are expecting the technical guidance on this and the new NOF this month.

National workforce expansion and challenges

Recently the Government announced the NHS had met its target to recruit 8,500 additional mental health staff early, alongside continued investment and progress towards Community-based care. However, in common with other providers, we are experiencing very high levels of demand for our services as well as some workforce pressures. Overall, the direction of travel is clear; towards Community, Prevention and Integrated Care, but delivery risks remain significant in the short- to medium-term.

Integrated Care Board (ICB) changes

The implementation of ICB mergers and cost reductions from April 2026 introduces further System change. We are working closely with the ICB cluster leadership to manage any impact on commissioning arrangements and service delivery. The new shift is for ICBs to operate as strategic commissioners across Mental Health, Learning Disabilities (LD) and Autism services, with a strong emphasis on population health, outcomes and partnership with providers.

Independent review into Mental Health conditions, Attention Deficit Hyperactivity Disorder (ADHD) and Autism: interim report

The interim report of the Independent review into mental health conditions, ADHD, and autism has been published by the government. The review aims to understand how common these conditions are, identify key patterns, and explore inequalities experienced by people with mental health conditions, ADHD and autism among children, young people, and adults. It examines why prevalence is changing, the risks and benefits of medication, and considers how to prevent mental ill-health. It also focuses on building resilience, improving early support and developing better access to a range of NHS and Community-based services for timely, appropriate care.

Mental Health Act 2025

In my last report, I mentioned the transitional implementation of the Mental Health Act 2025. Section 51 came into effect on 6 April 2026 and addresses a gap in the application of the Human Rights Act to some mental health patients. The Board's Mental Health Act Committee is overseeing the Trust's implementation of the 2025 Act.

Local context

Care Quality Commission (CQC) activity

The CQC has now published a report following the inspection of our Mental Health Crisis and Home Treatment services and health-based places of safety, which took place earlier this year. I am pleased to confirm the report outlines an overall good rating, with good ratings also being achieved against each of the key lines of enquiry (demonstrating that the services are Safe, Caring, Responsive, Effective and Well-Led).

This is a great achievement for our teams and is another example of Trust services receiving a good rating from the CQC. We continue to wait for feedback following the CQC's inspection of our Community-based Mental Health services, which took place in January 2026.

Substance Misuse service changes

On 1 April 2026 the Derby City Substance Misuse service transferred to new providers. The Adult service (Derby Drug and Alcohol Recovery service) has moved to Cranstoun and the Children and Young People's service (Breakout), to Change Grow Live (CGL). This followed a procurement exercise undertaken by our commissioners at Derby City Council.

I wanted to place in public my thanks to a long list of colleagues who delivered these services for Derbyshire Healthcare over many years. Whilst I was very sad to see the team move outside of the Trust, I look forward to building new relationships with Cranstoun and CGL moving forward.

Helpline's contact number moves to 111

Since April 2024, our Derbyshire Mental Health Helpline and Support service have been offering local people two ways to call the team: via an 0800 number and via NHS 111. From 1 July 2026, the only way to contact the helpline will be by calling NHS 111 and then selecting the 'Mental Health' option (option 2). The 0800 number (0800 028 0077) will be switched off on this date.

Using only NHS 111 is the approach recommended by NHS England. When people dial 111 and select 'Mental Health', they are put through to their local helpline team, who can tell them about local support services nearby. Having one number for the Derbyshire Helpline also simplifies the call handling process and means the team can respond to calls more effectively.

Digitisation of the Mental Health Act

The Trust has recently invested in a specialist digital solution to administer the Mental Health Act (MHA). The Trust currently leads MHA offices across the Joined-Up Care Derbyshire System and has identified several patient-focused and quality benefits to this approach, including:

- Reduced incidents and unlawful detentions
- Empowering patient rights and improved patient experience
- Freeing up clinical and corporate time
- Improved patient flow.

This progress will also support the aims of the Trust Strategy, to progress digital technologies and new ways of working to provide better care for the people of Derby and Derbyshire. It will improve productivity and provide data to improve clinical decision making.

Industrial action

Since the Board last met, the Trust has experienced a further stage of industrial action, with Resident Doctors participating in strike action after Easter. I am pleased to confirm that any disruption to our services was carefully managed by the Incident Management team (IMT).

Recent achievements

The Trust continues to receive positive recognition across our staff and services. Highlights from recent weeks include:

- The In-Reach and Home Treatment team in Derby were March's DEED of the month winners. A service user nomination described compassionate, empathetic care at a moment of profound crisis, with support that "saved my relationship and my life". This reflects life-changing impact, delivered through collaborative, compassionate team working and strongly embodies all the Trust values. Congratulations to the team!
- Colleagues working at the Bluebell Ward at Walton Hospital were the DEED winners for April. Congratulations to Emily Ulyatt, Registered Mental Health Nurse; Charlotte Cooling, Housekeeper; Natalie Nickson, Nursing Associate and Healthcare Assistants, Rebecca Redfern and Isabel Maseva, who received serval nominations describing their professionalism, co-ordination and dedication to ensure positive outcomes for people in our care!
- At the end of March I presented Anthony Newman, Nursing Assistant at the Kedleston Unit, with an award for 40 years' service. Similarly, at the end of April, I also presented Julian Bannister, Community Lead Nurse at Bolsover Community Mental Health team (CMHT), with his award for 40 years' service, both of which are a tremendous achievement
- Selina Ullah, Trust Chair, was announced as a finalist in the Social Leader category of the British Muslim Awards 2026 in May. Although she wasn't the final winner, she was 'recognised for excellence'
- I would like to extend my congratulations to Professor Subodh Dave, who has been elected the new President of the Royal College of Psychiatry (RC Psych). Subodh will take up this post, which is the most senior member role in the RC Psych, from 16 June. This is a great achievement for Subodh and very positive for Derbyshire Healthcare
- Members of our Forensic Community Mental Health team attended a forensic trauma-informed care event hosted in Nottingham by the University of Lincoln last week. The team was asked to send representatives along to this invite-only event, to contribute to conversations about national guidelines and standards. This is great recognition of the team's influence and positive reputation
- Congratulations to Joan Scourfield, Nursing Assistant at Tissington House, for her involvement in creating the play, Punch, which recently won two Olivier Awards. Joan has used her personal experience to help young people understand restorative justice, forgiveness and the impact that positive role models can have.

Through the emotive play Punch, Joan's experience is highlighted on stage ensuring her message reaches people across the country

- We recently supported a national conference held at the University of Derby about an important emerging topic for mental health services: dissociation. This is a term that has grown in popularity and become common in everyday language, but myths and misconceptions remain, some of which are potentially harmful. We're fortunate to have an expert within the Trust on dissociation: clinical psychologist Dr Paul Langthorne, who has co-edited a new book about the topic and was a presenter at the Derby conference. At the conference, Paul and the other speakers discussed the benefits – both human and economic – of identifying and addressing complex dissociation and the importance of mental health professionals becoming more dissociation-informed in their work, so they can recognise and respond to dissociation effectively and reduce the long-term harm. Effective treatments for dissociation are based on a trauma-phased approach and a range of adapted psychological therapies, and they offer hope for recovery.

Staff engagement

New arrangements for staff engagement

At the start of May, I shared a message with all colleagues focused on staff engagement, our culture and behaviours, particularly thinking about colleagues' feedback in the most recent NHS Staff Survey and importantly, how I would like to build on various suggestions that have been put forward. This outlined a number of different themes that have emerged across the Trust, including the level of positive messages we share and the reasons we talk about the Trust's financial position.

From this month we are going to try a couple of new ideas to provide colleagues with the opportunity to engage and receive/share information in a different way. These include the introduction of a new Leadership Cascade and a change to the focus of the all-staff engagement hour. Our principles will remain consistent – to share open and honest news and information and to encourage effective two-way communication.

Staff collaborative – tackling violence, abuse and aggression

Our new staff collaborative continues to meet to shape how the Trust can prevent and respond to violence, abuse and aggression at work. This is a very important and concerning issue for the Trust and one that does not appear to be abating, despite our best efforts. The collaborative is including examples of racist and sexual safety incidents in this work.

In memory of Richard Day

In March we shared the very sad news confirming the loss of our well-respected colleague, Richard Day. I know many colleagues remain deeply affected by Richard's sudden loss.

Colleagues from across the Trust came together to support the team at Kingfisher House in an online memorial where we shared memories and tributes to Richard. We will make arrangements to include a lasting tribute to Richard in our memorial garden at Kingsway Hospital later this year.

NHS birthday parkrun

The NHS turns 78 on Sunday, 5 July. To celebrate, and as part of our wider focus on staff wellbeing, colleagues, partners and communities are invited to take part in a special parkrun at Markeaton Park in Derby at 9.00am on Saturday, 4 July.

Team visits

I have continued to get out across our different sites:

- I visited the Perinatal Support team at the Hope Centre on Curzon Street in Derby on 17 March
- On 22 April I attended the Therapeutic Community meeting at the Resource Centre on London Road in Derby

- I visited the Derbyshire Recovery Partnership, Amber Valley Working Age Adult CMHT and Amber Valley Older People CMHT at Ripley Town Hall on 8 May

- On 13 May I held a CEO's Engagement Hour for colleagues and then joined the Carers Support Group at Cubley Court, Kingsway
- On 14 May, I visited the Erewash Older Adults CMHT, Erewash Living Well team and Working Age Adults CMHT at Ilkeston Resource Centre.

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

- On 25 March, Vikki Ashton Taylor, Deputy CEO and Chief Delivery Officer, visited the Safeguarding team at Kingsway House. She spent time with the Child and Adolescent Mental Health services team at Temple House on 30 March and visited the Derwent Unit in Chesterfield on 10 April. On 13 April, Vikki went to see colleagues in our Psychology services at Dovedale Day Services based at London Road Community Hospital. She also joined a Board visit on 16 April to the CMHT Early Intervention South Team at St Andrew's House and on 23 April, she visited the Amber Valley Living Well team at Ripley Town Hall
- Tumi Banda, Director of Nursing, AHPs, Quality and Patient Experience, visited the Patients' Bank at Kingsway on 1 April. On 8 April, he spent time on Dove Ward and Wren Ward, here at the recently opened Carsington Unit and on 9 April he went to see the Mental Health Liaison team and the Royal Derby Hospital. Tumi spent time with our Estates colleagues in Kingsway House on 22 April and then visited the Liaison North Assessment services in Chesterfield on 23 April
- Dr Girish Kunigiri, Executive Medical Director, visited the Derwent Unit on 26 March, the Carsington Unit on 27 March and also went to see the Crisis Team on 21 April
- Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary, visited two teams at Kingsway; Pharmacy (30 April) and Catering (8 May) and also two Board visits; Domestic/Hotel services, South team (21 April) and North team (13 May)
- James Sabin, Director of Finance, joined a Board visit to the Community Paediatric team on 1 April. He also visited the Contracting team, Estates team and Catering team with Selina Ullah, Trust Chair, on 14 April
- Rebecca Oakley, Director of People, Organisational Development and Inclusion, visited the Derwent Unit, Carsington Unit and Audrey House on 9 April and also the Radbourne Unit on 21 April.

Raising awareness and community engagement

Community engagement update

At a recent Board Strategy and Development Session, we focused on our Community and Stakeholder Engagement Plan, one of the plans that underpins the Trust Strategy.

Significant progress has been made with our relationships with our local Deaf communities, and we now have an active Deaf Focus Group. A review of Deaf service offers and Deaf accessibility on the Trust website is underway, to improve access routes. We are also working with partners to increase workplace opportunities for the Deaf community and developing training materials for colleagues.

In line with our priorities for the second year of the plan, we are working closely with Community Action Derby (CAD) to gain a better understanding of the needs of Black communities in Derby, with a particular focus on access and experience of our services. We will work with CAD to build on existing networks of community organisations to co-produce interventions that are culturally appropriate and responsive to community needs.

Awareness events

The Trust has recognised several awareness raising events over recent weeks. This includes Maternal Mental Health Awareness Week (4-10 May) where our Perinatal (mother and baby) Mental Health team went out into the community, hosting a stall in Derby Market Hall for the day

and sharing information with families. This is just part of the outreach work the team delivers in partnership with organisations like the charity Connected.

The theme of Mental Health Awareness Week (11-17 May) is 'action' and the Trust will be encouraging people to join us in taking action to support good mental health. While awareness is vital, real change comes when we take action too.

International Nurses Day (12 May) is a global celebration that acknowledges and celebrates the commitment of Nurses around the world, and we will be celebrating Nursing colleagues throughout the week, sharing their experiences and why they have dedicated their lives to making a positive difference to others.

Service user and carer feedback

Community Mental Health survey

The results of the annual CQC Community Mental Health survey were recently published. The Trust's results show meaningful improvements across core areas of service user experience, particularly around respect and dignity, compassion, therapy privacy, involvement in care planning, family engagement and clarity of medication discussions. These represent positive shifts in relational care and person-centred practice.

The survey also highlights concerns related to declines in care review frequency, support while waiting, physical health support, employment support and proactive inquiry about access needs. These trends align with areas we have identified internally as needing stronger processes and assurance, which form part of the structured improvement plan, including:

- Development and implementation of minimum physical health assessment standards and staff training
- A quality improvement programme to raise care plan compliance to 90%, supported by audits and examples of good practice
- Reinforcement of annual care reviews, monitored through a monthly audit cycle
- Ensuring Support While Waiting (SWW) reviews are completed consistently in line with policy
- Embedding continuous case note audits focusing on employment and individual placement and support referral pathways.

Strategic Considerations		**BAF Risk(s)**	**Strategic Delivery Plan Reference**
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	1A, 1E	1.1–1.4
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X	2A, 2B	2.1–2.4
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X	3A	3.1, 3.2
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	4B	4.1

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.

Net Zero Duty Implications

In compliance with the NHS move towards net zero carbon emissions, the Trust must consider statutory emissions and environmental targets in their decisions. Reports should identify related impacts on workforce and system leadership; sustainable models of care; digital transformation; travel and transport estates and facilities (including capital projects, asset management and utilities, green space and biodiversity); medicines; supply chain and procurement; food and nutrition and adaptation.

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

None.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

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

Recommendations

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

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

Joined Up Care Derbyshire (JUCD) Provider Collaborative annual report - 2025/2026

Purpose of Report

The JUCD Provider Collaborative is a partnership vehicle of the main NHS providers in Derbyshire which exists to support shared working between organisations. The Collaborative is accountable to the Boards of Derbyshire NHS provider organisations including Derbyshire Healthcare NHS Foundation Trust.

The Provider Collaborative Board has agreed to strengthen the way that individual provider Boards have oversight of the work of the collaborative, and formal reports will be made to Board bi-annually in future. This is the first time the collaborative has produced an annual report, in addition to regular programme reporting.

The annual report describes the work of the collaborative over the past financial year and reflects on successes and challenges as well as pointing to the future direction of partnership working.

Executive Summary

The Collaborative works alongside neighbourhood structures as a key forum for partnership working in Derby and Derbyshire, focussing on things that are of shared importance to NHS provides, including enabling and corporate services as well as clinical pathways. One of the core purposes of the Collaborative is to support effective and efficient service delivery and to increase the sustainability of services.

The Collaborative has well-established governance, led by a Provider Collaborative Board and oversees a shared programme of work which is described in the attached annual report and appendices. The scope of the programme reflects the collaborative's priorities which include; enhancing efficiency in enabling corporate services, clinical pathway improvement and strengthening the operational and financial sustainability of clinical services.

Strategic Considerations		**BAF Risk (eg 1A)**	**Strategic Delivery Plan Reference**
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

See attached report.

Consultation

Not applicable.

Governance or Legal Issues

Note that the Collaborative is accountable to the Boards of the member organisations.

Net Zero Duty Implications

In compliance with the NHS move towards net zero carbon emissions, the Trust must consider statutory emissions and environmental targets in their decisions. Reports should identify related impacts on workforce and system leadership; sustainable models of care; digital transformation; travel and transport estates and facilities (including capital projects, asset management and utilities, green space and biodiversity); medicines; supply chain and procurement; food and nutrition and adaptation.

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

The enabling services workstreams of Procurement, Estates and Digital have implications for net zero duties. Detailed implications are addressed within the relevant workstream governance and decision making, eg within the Strategic Estates Group in relation to how providers are meeting targets to reduce carbon emissions. In relation to clinical pathways, provider leads consider how to enable care closer to home as one of our priority objectives and the digital transformation of care to avoid the need for attendances at hospital is a key theme.

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 clinical pathway priorities for the collaborative have a clear objective to reduce health inequalities, including those related to protected characteristics. See attached report for details. Any specific proposals to change service delivery will undertake EQIAs.

Recommendations

The Board of Directors is requested to:

1. Receive the annual report
2. Note the implications for Derbyshire Healthcare.

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

Report prepared by: **Tamsin Hooton**
Provider Collaborative Programme Director

Joined Up Care Derbyshire Provider Collaborative - Annual Report 2025/2026

Executive Summary and Foreword

The Provider Collaborative has played an important role during 2025/26 in supporting system-wide improvement across Derby and Derbyshire. Through collaborative working across NHS providers, the programme aims to address shared challenges and add tangible value to individual providers and system delivery. Over the last year we have improved system capability and laid the foundations for future transformation across clinical services and enabling functions.

Overall performance across the programme reflects a mixed position, as summarised in the Annual Programme Report (Appendix 1). Several programmes made good progress including digital transformation, improvement capability and some clinical redesign programmes. However, some of our programmes have experienced significant challenges in delivering their ambition, due to a range of factors including data quality limitations, capacity constraints and external dependencies such as commissioning alignment. In some cases, programmes were paused or slowed because of competing operational priorities or to ensure alignment with national policy direction.

Much of our work has focused on building the evidence base for future change and undertaking the design phase for future models of care and left-shift in 2025/2026 rather than immediate implementation and delivery. The Children and Young People's service collaboration and Women's Health Hub programmes made significant progress in mapping services, understanding demand and capacity, and developing robust cases for change and proposals for moving services to the right place, positioning the system for decision-making and implementation in future years.

The collaborative has played a role in strengthening system capability for improvement across providers. This has included developing an improved understanding of provider costs, performance variation, undertaking benchmarking and developing consistent data sources to support comparisons and identification of opportunities for improvement. The Joined Up Improvement work is an area where the collaborative is successfully supporting capability and developing a shared approach to improving across organisational boundaries.

However, the year has also highlighted some systemic challenges. Data quality and analytical capacity are consistent constraints across the programme, limiting the ability to quantify benefits and move at pace. In clinical pathways, despite strong provider engagement and shared work to develop models of care that will deliver better outcomes, lack of alignment with commissioning and contracting decision making has

sometimes delayed delivery. Capacity and leadership constraints have also limited the pace at which we have achieved our ambition.

In summary, 2025/26 was a year of continued foundation building, moving to an increasingly robust programme approach, being realistic with one another and prioritising areas where we can deliver the most tangible benefits. The Provider Collaborative has strengthened relationships and governance, and developed an increasingly strong shared evidence base to support improvement, while also clearly identifying the barriers that must be addressed to move from design to collective delivery. The key challenge for 2026/27 will be converting this groundwork into implementation and delivery. To do this we will need to learn from and address some of the thematic challenges and barriers to improvement highlighted in the programme report.

Our ambition is that this way of working continues to mature and deliver tangible improvements that patients can see and feel - shorter waits, simpler access to services and more consistent, high-quality care - while also creating a more resilient, sustainable NHS for the future.

Julie Houlder

Chair of the Provider Collaborative

Chair, DCHS NHS FT

Stephen Posey

Senior Responsible Officer and Chair of Executive Leadership Group

Chief Executive Officer, UHDB NHS FT

Joined Up Care Derbyshire Provider Collaborative Annual Report 2025/2026

1. Introduction and Background

The Joined Up Care Derbyshire (JUCD) Provider Collaborative is a partnership between the main NHS providers in Derby and Derbyshire, namely:

- Chesterfield Royal Hospital NHS Foundation Trust
- Derbyshire Community Services NHS Foundation Trust
- Derbyshire Healthcare NHS Foundation Trust
- Derby and Derbyshire GP Provider Board
- DHU Healthcare CIC
- East Midland Ambulance Service
- University Hospitals or Derby and Burton NHS Foundation Trust

The collaborative has been in place since 2022 as a formal partnership and over the years of its existence has been developing into a robust programme of work.

The collaborative is accountable to provider Boards and is governed by a Provider Collaborative Board, chaired by Julie Houlder, and an Executive Leadership Group, which has responsibility for shaping and delivering the work programme. The senior responsible officer for the Collaborative is Stephen Posey. Reports on the work of the collaborative, seeking approval off the annual work programme and governance arrangements including a formal risk and gain share agreement have been brought to previous meetings of UHDB Board.

The collaborative has a very small central team, consisting of a Programme Director and Strategic Finance lead. A priority for 2025/2026 has been to strengthen our capacity to deliver. Dedicated project leads have been recruited to support two of our most important priorities; estates and procurement, and recently we have agreed to create two programme manager posts which will be recruited to support delivery of specific projects in 2026/2027.

2. Collaborative Work Programme and Priorities

The structure of the provider collaborative work programme in 2025/2026 is shown below.

Enabling Services Priorities

- Enabling Services at Scale
- Estates
- Procurement
- Digital and Data
- People Services

Clinical pathways and Fragile services

- Children and Young Peoples' Services
- Musculo-skeletal services
- Gynaecology and Women's Health
- Ophthalmology

Enabler – Joined Up Improvement
QI methodology, training and NHS IMPACT

Over 2025/2026 the collaborative has strengthened programme management and reporting arrangements with a stronger focus on benefits realisation which, whilst still developing, is driving an increased focus on identifying and tracking the impact of collaborative work in our leadership conversations.

A report summarising the objectives, achievements, challenges and potential for future delivery for each programme area within the collaborative is attached as Appendix 1. Some key reflections about our progress and learning are considered in the executive summary and explored in more detail in the following sections.

3. Prioritising our efforts and focusing on delivering benefits

Early in the financial year it became clear that, given the very limited amount of dedicated resource to support the collaborative and the level of operational pressures and organisational internal commitments for provider leaders who were involved in leading individual projects within the collaborative programme, we needed to prioritise fewer things. The collaborative leadership agreed to hone down the breadth of the programme and whilst we did not stop work on other areas in our ambitious programme, there was agreement to focus our attention on two areas of work in 2025/2026: estates and procurement. These areas were identified as our highest priorities due to the potential to deliver real improvements and efficiencies within a relatively short time frame, compared to some of the more challenging strategic change areas where benefits were expected to take much longer to deliver and would require significant investment to achieve.

We have strengthened capacity in these two priority areas and now have dedicated system leads for estates and procurement who are supporting the respective executive SROs and programme groups to develop detailed workplans and enable delivery of projects. This is starting to show impact as can be seen in the highlight reports.

4. Highlights and Successes

Key areas of success and progress made during the last year include:

Children and young people's services collaborative - work has taken place successfully to co-produce the case for change, map resources and key performance issues across providers and generate proposals for changes to operational delivery models which are now with commissioners for consideration.

Women's Health Hubs/Gynaecology 'left shift' - this project has seen a collaboration between General Practice and acute providers to develop clinical pathways to reduce acute outpatient referrals and deliver care closer to home for a range of high-volume conditions. Following pilot work with UHDB which demonstrated that 25% of patients did not need to be on the secondary care waiting list, a model of community-based clinics is now ready for mobilisation through PCNs across Derbyshire.

Strategic Estates workstream - has completed an analysis of premises data across all providers to support improving utilisation and inform collaborative decisions about disposals and shared premises. Other benefits have included adopting memorandums for cross provider occupancy of premises rather than incurring lease costs, and supporting neighbourhood groups to identify options for estates to deliver integrated care at local level.

Shared procurement workstream - provider leads have developed a shared database of contracts and are developing a pipeline for shared procurements. In a limited way, some contracts for non-clinical services have begun to be procured once across providers, and this has demonstrated financial savings for providers. The level of savings will increase into 2026/2027 as more contracts are re-procured at scale by providers.

We have also agreed to hold contracts for IT and other services in subsidiaries where this enables best value and efficient contract management and work has taken place to novate relevant contracts to realise efficiencies.

Digital workstream - has delivered enhancements to the Derbyshire shared care record and implementation of solutions to support cross provider patient management such as the Optica discharge co-ordination software. The programme has evidenced productivity gains achieved through system pilot of co-pilot which has now been extended and is supporting teams across JUCD to change the way they work harnessing AI.

Joined Up Improvement - is a community of practice developing a shared approach to improvement which is successfully growing system capability and capacity through developing, sharing and embedding improvement training and adoption of tools and methodologies. Through this network we are trialling offering improvement coaching to system projects and have delivered masterclasses in measuring the impact of improvement.

5. Challenges and Learning

In many instances, dedicated leadership capacity has been a constraint, as has the ability of providers to release resource to drive delivery of collaborative projects has been lacking and this has impacted both clinical redesign as well as enabling services projects. There is a inevitable pull for providers to prioritise internal priorities and delivery responsibilities, particularly when expectations of financial and performance improvement are so high and this often undermines the ability to progress shared work at pace, where this requires input from different provider teams. Despite trying to prioritise areas where there is a clear potential for benefits from shared working, in many cases these benefits are hard to realise quickly without significant collective effort and often involve people 'giving up' control or changing their ways of working. The cultural and regulatory environment for the NHS is not always supportive of effective collaborative delivery. A number of the systemic challenges are summarised in the Executive summary, with greater detail in the programme report in in Appendix 1. Areas of specific note for Boards include:

Enabling Services: we began the year with cross-provider agreement to work towards a strategic case for a shared services model. Following commissioning an initial scoping review of opportunities which identified that there were significant opportunities to deliver savings (in the range of £11m-£14m) commitment to move towards tangible proposals for an at scale model of enabling functions was reviewed, in part due to challenges experienced by other systems in achieving benefits as well as competing focus on delivering in-year efficiencies within each partner organisation. This programme of work has not progressed towards the original vision, however it is acknowledged that there are still opportunities for sharing services at scale, both across Derbyshire and with other providers and we will continue to work together to develop proposals for change.

Musculo-skeletal services: providers within the collaborative worked together to set out an integrated model of care which would strengthen community physiotherapy productivity and capacity, building a single point of access, integrated clinical assessment and pathways into both community and acute care. We were confident that this model would deliver tangible benefits, and the proposal was well received by commissioners, who were initially supportive of a lead provider model to deliver an integrated community physiotherapy model. However, contracting and procurement discussions with commissioners now mean that the proposed changes will not be commissioned in 2026/2027 and providers are now taking stock of what we can do alternatively to achieve benefits for patients.

6. Changing Context for the Collaborative - Adapting to address Providers' key risks

The Provider Collaborative Board is a valuable forum bringing together Chairs and CEOs from each of the provider partners to steer the work of the partnership. In recent months there have been some important discussions which recognise that the benefits of the collaborative go beyond being able to deliver a programme of work and that there is strength in having a single voice and mechanism to engage with and influence the ICB Cluster Executive as well as other stakeholders. In recent months, the collaborative leaders have reconfirmed their commitment to work together but have also noted the challenges that we have experienced in achieving change and improvement at the level that we aspire to.

The increasingly challenging operational context for NHS providers and the reducing role of the ICB in managing system finances and operational delivery means that we are starting to have important conversations within the Collaborative about how providers might share risk and work together more closely to manage system expectations and accelerate delivery of change. The collaborative has a formal risk and gain sharing agreement which underpins our shared delivery and has been instrumental in working through the risk sharing arrangements for the community transformation programme. Whilst this has been inherently challenging it also demonstrates our maturity as a group of providers and this is something that we will continue to work together on as we expand our shared delivery to other areas of transformation.

7. Forward Look and Future Board Oversight

The Provider Collaborative enters 2026/27 with stronger foundations, clearer learning, and a more robust evidence base. Boards can be assured that the programme is well-placed to move from planning to delivery, provided that key risks including data quality, capacity, leadership, and commissioning alignment are actively addressed and supported at system and organisational level.

There is increasing alignment between the Provider Collaborative at scale and Neighbourhood working within Derbyshire. As the ICB cluster working arrangements begin to take shape and the ICB moves into more of a strategic commissioning mode, Derbyshire providers are increasingly working together to shape and deliver key our response to the 10-year Plan at a Derbyshire level and this cements the value of the collaborative as a vehicle. To truly achieve the potential of the collaborative a stronger franchise from individual organisations and greater alignment with and active input of providers' core activities will be needed.

To improve provider Boards' oversight of the collaborative, twice-yearly formal reports will be brought to Boards. Oversight by the Provider Collaborative Board and Executive Leadership Group will continue as will regular communications on progress for cascade through the year.

8. Summary and conclusion

The collaborative continues to mature and has begun to demonstrate benefits over the last year, generating some real changes to the way we deliver care and support services and providing a forum for providers to come to develop shared plans for how services should be organised and delivered and take decisions in the interests of patients and the wider system. As we move into 2026/2027 our programme continues to be iterated and strengthened as an important part of the overall approach to transformation and improvement and our response to the NHS 10 year plan.

Joined Up Care Derbyshire

Provider Collaborative

Provider Collaborative Programme 2025/26 Annual Report

NHS

The Derbyshire VCSE sector Alliance

Derby City Council

DERBYSHIRE County Council

Year-end programme summary:

Joined Up Care Derbyshire

Provider Collaborative

Programme:	Year-end status:	Programme Lead:	SRO:
CYP Collaboration	AMBER/GREEN	Tamsin Hooton	Mark Powell
Digital	AMBER/GREEN	Dawn Atkinson	Jim Austin
Enabling Services at scale	RED/AMBER	Tamsin Hooton	Darren Tidmarsh
Estates	AMBER	Carole Fuller	James Sabin
Joined Up Improvement	GREEN	Abi Ingram	Tamsin Hooton
MSK	RED	Trish Bailey	Gis Robinson
Ophthalmology	RED	Vacant	Vacant
People Services	AMBER	Various	Caroline Wade
Procurement	AMBER	Michael King	Stuart Ellis
Women's Health Hub	AMBER/GREEN	Dr Heidi Smith-Scott	Ian Potter

Programme:	CYP Collaboration	Programme Lead:	Tamsin Hooton
Year-end status:	AMBER/GREEN	SRO:	Mark Powell

PROGRAMME OBJECTIVES:

- Improve access to care for children, make services more sustainable/address fragility, and reduce fragmentation and inequities in the provision of care.
- The programme was set up to articulate the case for change in CYP services in Derbyshire and identify some options for different ways of organising and delivering care that would address the case for change.

MILESTONES ACHIEVED:

- Programme initiated and supported by the Provider Collaborative, with SRO leadership.
- Working group established to bring provider leads together.
- Case for change articulated, initial service priorities agreed.
- PCELG and PCB support for direction of travel secured, support for lead or single provider models in a number of fragile and fragmented services.
- Information gathering exercise completed, mapping provider costs, workforce, waiting times etc.
- Options for change in priority areas were generated and discussed by working group.
- Preferred options identified for ND, continence, therapies.
- Discussions initiated with commissioners about moving to preferred option(s) in the priority areas.

PROGRAMME CHALLENGES:

- Lack of consistent and reliable data to compare different providers and assess the overall costs and performance of CYP services.
- Challenges in releasing leadership to support collaborative improvement and shared working across providers.
- Although overall the programme has made good progress towards its objectives, this has taken more time than envisaged, as a result of competing priorities and the time taken to obtain data and convene relevant leads in the working group

LESSONS LEARNED:

- It isn't always easy to evaluate how well different models are delivering and performing in the absence of clear standards, reliable data sets or consistent measures and feedback from staff and patients.
- The work has demonstrated the importance of evidence to objectively demonstrate 'what needs to be fixed' and assess whether different options would address the case for change or not.
- Provider teams sometimes struggle to access the required data and there are insufficient resources to support programmes from an analytical perspective, so programme staff are required to be self-reliant in making the best use of available data sources.

PROGRAMME BENEFITS:

The programme did not set any targets for financial savings or other efficiencies in 2025/2026 as the programme was at the planning stage, generating proposals for change rather than delivering them.

The programmes benefits have included:

- Giving CYP services more profile in change programme.
- Bringing staff together from different services to articulate their challenges, aspirations for improvement, and ideas about potential for change.
- Developing a more robust understanding of the provider landscape for CYP including mapping costs, workforce, waiting times and other key metrics.
- Increasing shared understanding of service utilisation and our use of resources to underpin proposal for change.
- Facilitating and developing a consensus about the changes that we could make to provider models to achieve our stated objectives.
- Agreed proposals for changes to how specific services are delivered which will strengthen workforce sustainability and reduce service fragmentation, variability and interface issues.

PROGRAMME FUTURE:

- Move towards the formal agreement of lead/single provider models for the services we have developed preferred options in, noting that provider board approval as well as commissioner support to transfer contracts will be needed.
- Operational transfer of services can then take place; it is hoped this will be within 2026/2027.
- The programme leads will continue to work on options for improvement to how children's therapies and community paediatrics is delivered across providers.
- The provider collaborative should continue to consider other opportunities for strategic change in CYP services, going beyond the initial 'quick wins' identified in 2025/2026. This should include close discussion with commissioners to ensure that providers' thinking is aligned with strategic commissioning strategy.

Programme:	Digital	Programme Lead:	Dawn Atkinson
Year-end status:	AMBER/GREEN	SRO:	Jim Austin

PROGRAMME OBJECTIVES:

Supporting JUCD partners to optimise technology and digital innovation to support the delivery of services for staff and patients through digital enablement.

MILESTONES ACHIEVED:

- Derbyshire Shared Care Record: implementation of the ReSPECT form, read and write capability, accessible to health and social care to support direct care.
- Optica: implementation of Optica in both acute organisations to support patient discharge through the tracking of essential tasks to reduce/remove unnecessary delays.
- Neighbourhood working: supported the development of hub working, delivered a service specification to inform digital solution to support operation delivery.

PROGRAMME CHALLENGES:

Working with providers when priorities are not completely aligned and resources are limited – service change and technical support expertise.

LESSONS LEARNED:

- Digital enablement requires both change management and technical skills resource to support operation service change.
- Measuring the impact of digital enablement is challenging.

PROGRAMME BENEFITS:

Limited benefits realisation has been achieved except for work undertaken to determine time released because of using Co-pilot. We were able to calculate 'time saved' estimated through survey results and then monetise the value.

Benefit measure:	Plan start:	Plan value:	Actual value:
Co-Pilot: time saved on tasks using Co-Pilot (accumulative minutes).	Apr-25	0	1,087
Co-Pilot: increased consistency in work output.	Apr-25	0	414
Co-Pilot: support of staff understanding day-to-day roles or tasks.	Apr-25	0	459

PROGRAMME FUTURE:

- Federated Data Platform: optimisation of the FDP digital solutions and data management platform capability.
- Optica: adoption of the One Optica product for Community and Mental Health when improved functionality available to roll out.
- Digitally enabled Integrated Neighbourhood working model: continue to support the development of the integrated model of service delivery.
- Ambient Voice Technology (AVT): wider adoption and benefits framework development.
- Frontline Productivity: the outcome of the regional/national funding prioritisation process will not be known until late summer.
- Artificial Intelligence/Robotic Process Automation: scope the opportunities to use AI/RPI to support productivity and efficiency.

Programme:	Enabling Services at scale	Programme Lead:	Tamsin Hooton
Year-end status:	RED / AMBER	SRO:	Darren Tidmarsh

PROGRAMME OBJECTIVES:

- This programme was established in 2024 to look at the opportunity for an 'at scale' model of enabling services for Derbyshire NHS providers.
- The objective of this programme is to identify and deliver efficiencies and better value in the way that corporate and enabling services are delivered.
- The 2025/2026 deliverables were to undertake a review and scoping of the opportunities to inform the production of proposals to providers and leading to an eventual business case for a shared business model.

MILESTONES ACHIEVED:

- Deloitte commissioned to undertake a review of our enabling services to support the collaborative in developing concrete proposals.
- This work was envisaged in two phases, the first was to scope and quantify opportunities for savings given our context. The first phase concluded in May 2025 with the delivery of a report identifying savings in a range of £11m - £14m with estates, digital, and people services identified as the areas with the greatest opportunities for efficiencies through collaboration.
- The Collaborative Executive did not agree to commission a second phase of external consultancy to support building a business case for a shared services model. Subsequently, work has focussed on estates and procurement work through existing collaborative programmes - see separate reports on these areas.
- We have also been exploring maximising use of existing wholly owned subsidiaries in the procurement, digital, and pharmacy areas.

PROGRAMME CHALLENGES:

- Pressure to deliver savings within individual organisations to achieve CIP in 2025/2026 led to a focus on short term deliverability and areas that individual providers could control and drive at pace. Longer term strategic collaboration and consolidation of functions into a single vehicle is seen as more difficult to pull off and this lack of confidence in achievability has held us back from moving ahead with a business case as planned .
- Senior resource to lead on this work has been limited and this, combined with some scepticism about the achievability of modelled changes, has contributed to providers focussing on alternative areas to release savings.
- In People Services, the national work to move to single systems and operating models for ESR etc meant that designing a Derbyshire approach to shared functions was paused to ensure that anything we did was compatible with national programme. See separate report.

LESSONS LEARNED:

- There was some reluctance amongst providers to utilise wholly owned subsidiaries for delivery of core enabling services where this would mean the transfer of staff into another, non-NHS organisation. We need to consider how 'at-scale' functions can be delivered in a way that does not lead to loss of control or ownership of key functions.
- It has been difficult to gain the level of ownership and commitment to harmonise and consolidate different provider functions given existing pressures and the lack of collaborative leadership in individual functions.
- To move towards our original vision of an at scale shared services model will require significant disruption to current ways of working and team structures. Without strong senior commitment to this and belief that the benefit/effort ratio is favourable t is unlikely that the programme will achieve what was originally envisaged.

PROGRAMME BENEFITS:

- We now have a detailed mapping of our enabling services operating model, benchmarked opportunities, and a detailed and documented understanding of the areas where providers in Derbyshire are willing to collaborate.
- We have established collaborative governance and a steering group for enabling services which provides a forum for senior colleagues to explore future opportunities for efficiency and improvement through shared working.
- We have identified and are progressing some areas of 'quick wins' in relation to using our existing wholly owned subsidiaries.
- We have a single voice in discussing with other collaboratives/systems and the cluster ICB in relation to enabling services opportunities.
- See separate reports for benefits relating to Estates, Procurement, and People Services.

PROGRAMME FUTURE:

It should be noted that there are ongoing workstreams relating to people services, digital, estates and procurement within the collaborative work programme, and work will continue to deliver identified improvements and efficiencies in these separate workstreams.

We are reviewing the learning from some other areas that have pursued 'at scale' delivery of corporate services, such as Lancashire and Devon to understand what really works in helping to deliver tangible savings.

The future of the strategic enabling services model programme will rely on functional corporate services leads and Chief Finance Officers continuing to work together to explore those areas where we agreed as part of the first phase work that there is an ambition and willingness to collaborate in specific functions/sub-functions. There is potential to go beyond our current BAU improvement plans but this will require functional SROs to be enabled to drive these ideas through to delivery which will require organisational commitment and resourcing.

Programme:	Estates	Programme Lead:	Carole Fuller
Year-end status:	AMBER	SRO:	James Sabin

PROGRAMME OBJECTIVES:

- To understand the condition and the cost of our current estate footprint and create a baseline to inform our strategic estates planning and support the prioritisation of limited capital resources.
- Drive better utilisation and deliver on rationalisation and consolidation opportunities which are clinically informed and aligned to system strategy.
- Ensure progress is made towards our agreed net zero carbon objectives.
- Develop a system plan to support, retain, and develop our facilities management and estates workforce.
- Measures of success: reduced cost of estate including reduction in void space and number of sites.
- Reduction in directly controlled CO2 emissions.

MILESTONES ACHIEVED:

- Recruitment of Estates Programme Manager – in post from Q3 onwards.
- Reclassification of core, flex, and tail sites to inform future disposal pipeline.
- Initial work with neighbourhood teams including providing underpinning data on current estate, utilisation, etc.
- Development and system agreement to an Estate protocol which sets out ways of working and principles to support financial flows to enable better utilisation of our collective estate.
- Agreement to implement Memorandum of Terms of Occupation (MoTOs) to replace the need for formal leases where sites/space is shared between system partners.
- Identified key priority sites for utilisation reviews in 26/27.
- Clarity on cost and size of current void and bookable space to identify future opportunities.
- Expressions of interest submitted for potential transfer of NHSPS sites.
- Sharing agreement/charter approved and in use.

PROGRAMME CHALLENGES:

- Lack of dedicated resource to drive the work programme initially
- Robust data to support decision making/identification of opportunities.
- Lack of funding to pump prime initiatives and or support feasibility studies.
- Balancing estate efficiencies with Neighbourhood and place-based service models.
- Maintaining a single, high-quality estates dataset to support strategic estates planning and investment decisions.
- Translating emerging opportunities from NHSP and CHP into deliverable neighbourhood and disposal plans.
- Releasing financial value from under-utilised and void estate space.

LESSONS LEARNED:

- Clarity on governance around estate rationalisation verses neighbourhood agenda is required.
- Sharing of specialist skills to create capacity between Trust estates teams - process to be agreed and implemented.
- Data for ADEPT provided the system with updated view of the estate but didn't cover 100% of the footprint.
- Dedicated resource is needed to provide the capacity to drive the work programme.

PROGRAMME BENEFITS:

Progress in 2025/26 has focused on ensuring there are the right enablers in place to support future benefits realisation:

- System consensus on core, flex, and tail sites - crucial to informing the future disposal pipeline.
- Agreement on new ways of working and how to manage financial implications to incentivise sharing of space.
- Implementation of MoTOs to mitigate need for formal leases and associated legal costs.
- Better transparency of costs of void and bookable space and where opportunities to improve are.
- Sharing of data between partner organisations and improved quality of underpinning estate data.

PROGRAMME FUTURE:

- To optimise value from the collective estate – reduce backlog maintenance and improve utilisation.
- Estate rationalisation – consolidation of under-utilised sites to reduce costs and improve value for money and make a meaningful contribution to the financial sustainability of the Derbyshire system.
- To use estates as an enabler for service transformation and development of the neighbourhood model of care.
- To strengthen governance and planning, enable shared use of space, and improve data quality to support quicker decision making.
- Drive cost efficiencies through better collaboration with regards to all estate-related non pay spend.
- Better support the estate and facilities management workforce, supporting retention and resilience.

Programme:	Joined Up Improvement	Programme Lead:	Abi Ingram
Year-end status:	GREEN	SRO:	Tamsin Hooton

PROGRAMME OBJECTIVES:

- To develop capacity and capability to deliver improved care across Derby and Derbyshire, including providing a sustainable quality improvement training offer available system-wide.
- To develop a shared system approach to continuous improvement, including use of shared methodologies and approaches.
- To fully utilise Joined Up Improvement to share best practice and support a cultural shift towards continuous improvement.
- To increase communication and engagement around continuous improvement, including sharing of best practice, training, and tools.

MILESTONES ACHIEVED:

- QI Directory launched to improve access to locally delivered Quality Improvement training and boost capability to deliver improved care. All opportunities included in the directory are available to all JUCD staff, including colleagues from Primary Care, VCFSE, and Local Authorities. 786 locally delivered courses completed in 25/26, which is significantly over target.
- Improvement Futures workspace launched as a one-stop-shop for all things improvement, including locally branded improvement tools, templates, and resources.
- Hosted a system-wide improvement event around High Intensity Users in September 2025, kicking off a programme of work to address frequent service users.
- Developed proposal for System Improvement Coaches which is being piloted in the High Intensity User programme.
- Completed digital PMO tool procurement exercise incl. market scanning and appraisal of existing tools. Recommendation made to cluster but ICB decision to not re-procure a digital PMO tool.
- Developed project management approach for Neighbourhoods & Provider Collaborative.
- Monthly Joined Up Improvement Exchange continues to build momentum thanks to topical presentations around the Community Transformation Programme, Empowering General Practice Programme, and Benefits Masterclass.

PROGRAMME CHALLENGES:

- Lack of resource to deliver a consistent, system-wide improvement training offer to build capability. QI Directory mitigated this by extending access to in-house QI training to all JUCD staff; giving all staff the opportunity to upskill in improvement tools and techniques.
- Inconsistency in engagement across system programmes – lack of visibility of improvement projects/programmes being delivered and their impact.
- De-commissioning current digital PMO tool presents a risk to assurance of delivery. Alternative arrangements in development for Neighbourhoods & Provider Collaborative to mitigate this.

LESSONS LEARNED:

- More work to do around improvement being embedded as business as usual, and not an extra ask – cultural shift required.
- Benefits identification, tracking, and reporting is challenging – more support required to identify impact in project planning phases.
- Importance of creating space for showcasing improvement projects and sharing learning; lots of expertise in the system to tap into.

PROGRAMME BENEFITS:

Benefit measure:	Plan start:	Plan value:	Actual value:
Number of staff trained in QI per year	Apr-25	500	786

PROGRAMME FUTURE:

- Build on existing improvement forums to develop an Improvement Community of Practice to share expertise, learning, and support the cultural shift towards continuous improvement.
- Develop consistent Derbyshire PMO reporting approach working with Neighbourhood & programme teams to provide assurance on the delivery of improved care, incl. impact.
- Coordinate continuous quality improvement training & development, particularly for providers who do not have an in-house offer.
- Engage with ICB about how Derbyshire provider work sits alongside cluster approach

Programme:	MSK	Programme Lead:	Trish Bailey
Year-end status:	RED	SRO:	Gis Robinson

PROGRAMME OBJECTIVES:

- To ensure that MSK services are configured to meet our population's needs in an effective way targeting resources to deliver the greatest impact and addressing the current inequity in access, experience, and outcomes .
- To better co-ordinate delivery promoting consistency of data collection, evidence-based practice, service evaluation, and governance.
- To support management of workload in all providers including primary care.
- To make best use of clinical skills across system providers – right person, right setting, right time.
- To support delivery of financial and efficiency targets across the system.
- To maximise the opportunity for digital enablement/enhancement across the pathway to support ease of referral, data collection, and patient self-management/activation.

MILESTONES ACHIEVED:

- Proposed new Integrated model for Community Services was developed through provider collaboration with clear articulation of benefits and deliverables.
- Proposal submitted to the ICB and supported in principle by ICB Cluster Executives (noting that ultimately ICB decided not to commission a lead provider model and intend commission status quo for a 12-month period followed by a procurement exercise across Notts and Derbyshire).
- Elements of pathway redesign progressed (linked to GiRFT recommendations).
- Piloted Community Appointment Days/Super Clinics.
- GP led review of FCP delivery/data collection.
- Report completed by system digital team giving insight and recommendations for better interoperability across whole pathway.
- Links made to JUCD obesity programmes.

PROGRAMME CHALLENGES:

- Lack of robust data.
- Barriers linked to commissioning frameworks and compliance/risk of challenge.
- Delays in decision making within the ICB and a lack of clear commissioning direction.
- Maintaining engagement across the pathway - linked to delays, lack of visible progress and competing priorities.
- Complex multi-provider landscape.

LESSONS LEARNED:

- At the point of receiving ICB sign off to proceed, the expectations on implementation within the length of contract offered were prohibitive. Earlier risk-based decision making may have led to a different outcome.
- Clinical engagement via dedicated GP Provider Board and ICB GP leads has been of great value in taking a whole pathway approach and ensuring that the development of the model aligned with emergent thinking around Neighbourhoods.
- Focus on provider and contracting models may detract from making progress on practical, front line improvement work

PROGRAMME BENEFITS:

Note that no planned financial or activity reduction benefits were included in programme targets for 2025/2026 as work was in progress to develop the proposed pathway and model benefits.

Significant benefits were identified in the model submitted to the ICB, including reductions in acute OP referrals, reductions in physiotherapy follow up rates, and the achievement of community physio waiting times standard.

Benefits of the programme in 2025/2026:

- An improved understanding of data and work to model benefits from pathway redesign was undertaken collaboratively.
- Work to understand FCP activity and referral rates.
- Community clinic days piloted successfully in DCHS and PCNs.
- Preparatory work on digital to support the development of a single point of access (SPA) has been undertaken, this can be used to progress a SPA in 2026/2027 if providers commit to doing so.

PROGRAMME FUTURE:

- The case for change remains strong and without provider-led improvement issues relating to long waiting lists, rising demand for physiotherapy and orthopaedic care, and health inequalities remain.
- The potential benefits that were modelled as part of the work in 2025/2026 would be considerable, and these will not be achieved without co-ordinated effort on the part of providers.
- Provider discussion about future approach to collaborative improvement to be arranged.
- Likely to need to identify new programme lead and active input from all providers if work is to be revived.
- Clarity needed on ICB intentions for future commissioning/timelines/priorities to mitigate risk of undertaking further provider-led discussions that are not compatible with future ICB specification or procurement intentions.

Programme:	Ophthalmology	Programme Lead:	Rachel Millard (now vacant)
Year-end status:	RED *(note project paused)*	SRO:	Vacant

PROGRAMME OBJECTIVES:

The programme aimed to address fragility in acute ophthalmology services, particularly in CRH.

A PID was developed and agreed by the collaborative in 2024/2025 which involved moving to a single acute ophthalmology model for Derbyshire, with CRH and UHDB working in collaboration. The objectives of this were to:

- Address demand and capacity imbalance in acute settings.
- Improve workforce sustainability.
- Reduce waiting times by adopting best practice pathways and providing mutual aid.

MILESTONES ACHIEVED:

- Needs assessment document completed, identifying a range of improvement opportunities for providers.
- Demand and capacity position mapped.
- CRH recruitment has reduced acute fragility.
- Project was paused in autumn 2025 – UHDB identified an operational risk relating to outpatient waiting list backlog and redeployed the integration project manager to address internal improvement.

PROGRAMME CHALLENGES:

- Delay in identifying project lead led to a waning in commitment to original vision.
- Changes in leadership in the project team and within provider divisions led to loss of history of the project development and a change in commitment to working together towards a single service.
- Lack of good data to understand demand and capacity and identify opportunities to change.
- Internal provider operational priorities competing with focus on working together and strategic change.

LESSONS LEARNED:

- Importance of sustaining senior clinical and operational leadership of programme in order to deliver on agreed model. The SRO for the project changed.
- Collaborative project leads need to be 'owned' by the provider teams they are working with – perception of people coming from one organisation can undermine sense of shared ownership.
- Genuine commitment to change/working together is needed at the level of clinical teams as well as senior leadership.

PROGRAMME BENEFITS:

- Progress has been made on understanding provider demand and capacity and identifying opportunities for improvement at provider level.

PROGRAMME FUTURE:

- Provider leads have met to consider what next for this project. There is consensus that there is still an imbalance in demand and capacity within acute ophthalmology services and a need to address strategic sustainability for both providers. Ophthalmology is one of the highest volume elective specialties with significant waiting lists and poor access to care in some sub-specialties. Activity is increasingly flowing to independent sector providers, creating a further risk to NHS provider sustainability.
- Discussions with the ICB have taken place re: their commissioning priorities and the expected impact of optometrist treat and triage model on acute demand.
- It is proposed that work on ophthalmology continues as a 'system programme', with a mix of individual provider transformation and shared work on left-shift and right sizing acute services. It is proposed this forms part of the collaborative 'left-shift' programme.

Programme:	People Services	Programme Lead:	Various
Year-end status:	AMBER	SRO:	Caroline Wade

PROGRAMME OBJECTIVES:

- Achieve collaboration in the delivery of People Services at scale across the four NHS providers in Derby and Derbyshire.
- Identify and deliver opportunities for transformation in the delivery of People Services to improve the quality of outcomes, improve compliance, and reduce cost.
- Mature the Derbyshire Academy to place education, training, and workforce development on a sustainable footing.
- Payroll harmonisation project to improve payroll processes and create efficiency savings across UHDB, DCHS, DHCFT, and DDICB.
- Fully optimise ESR to improve efficiency and enable a smoother transition to the future NHS workforce solution.

MILESTONES ACHIEVED:

- Successful collaborative bid for early adopter status of the Future Workforce Solution.
- Agreed funding to support improvements in data quality and ESR maturity to set conditions for FWS.
- Maturity of Derbyshire Academy.
- Commissioned review of education and training delivery including apprenticeships and placement learning.
- Collaborative delivery of Oliver McGowan training achieving 31 March 26 compliance target.
- UHDB utilising ESR self-service for bank account changes.
- DHCFT transfer from Goodshape absence system to ESR completed (benefit being released in 26/27).
- Draft Derbyshire overpayments/underpayments policy developed.

PROGRAMME CHALLENGES:

- Sustainable resourcing: people, finance, and data.
- Consistent leadership.
- Competing priorities/collaborations.

LESSONS LEARNED:

- Requirement to embed a more formalised approach to governance.
- Clarity of purpose for operational leads.

PROGRAMME BENEFITS:

- Credible collaboration across providers on delivery of Oliver McGowan, education, and training review and preparation for Forward Workforce Solution.
- Improved governance of People Services through Enabling Services programme.

Benefit measure:	Plan start:	Plan value:	Actual value:
ESR Project Derbyshire: number of duplicated details in ESR	Oct-25	500	3,287
ESR Project Derbyshire: number of details validated in ESR	Oct-25	500	1,638
ESR Project Derbyshire: consistent ESR reporting - difference in headcount across both systems (number)	Oct-25	500	1,638

PROGRAMME FUTURE:

- 2026 focus will be collaborative delivery of Future Workforce Solution which presents generational opportunity for providers to move forward together, at pace, and achieve digital transformation in the delivery of People Services.
- Benefits expected from payroll harmonisation project, including UHDB capacity being released from timesheet automation and review/consolidation of the management of staff benefits.
- Outstanding ESR Project Derbyshire detail validation expected to be completed in 26/27.

Programme:	Procurement	Programme Lead:	Michael King
Year-end status:	AMBER	SRO:	Stuart Ellis

PROGRAMME OBJECTIVES:

- Establish a consistent, system-wide procurement approach across JUCD providers.
- Improve collaboration and visibility of spend and forward planning.
- Identify and deliver system procurement savings and cost avoidance.
- Build foundations for category strategies and aligned contract renewal planning.

MILESTONES ACHIEVED:

- Hub & Spoke collaborative procurement model implemented.
- Terms of Reference agreed across all system partners.
- First consistent view of JUCD system spend established despite data gaps.
- JUCD procurement workplan produced using AP, PO, Atamis and comparative spend data.
- NHSSC fully engaged, with additional resource allocated to support JUCD.
- Access secured to NHSSC Beta Data Visualisation Tool.
- Initial savings delivered across water, surgical sutures, and workforce systems.

PROGRAMME CHALLENGES:

- Data quality and inconsistency across partners remains the principal constraint.
- Variable maturity and coverage of Atamis across organisations.
- Limited dedicated resource for project delivery and data analytics.
- Some opportunities absorbed by national programmes or not viable at this stage.
- Further strengthening required in partner contract and expiry data.

LESSONS LEARNED:

- Data quality underpins all system-level opportunity identification and delivery.
- Early NHSSC engagement is critical to system-level impact.
- A “collaborate first” approach improves pace and consistency.
- Clear governance and resourcing are required to convert opportunities into savings.
- Estates and Digital categories require early strategic planning rather than reactive renewal.

PROGRAMME BENEFITS:

Benefit measure:	Plan start:	Plan value:	Actual value:
Contracts Management: reduction in non-pay spend	2025/26	£70k	£33k - water aggregation (CRH)

PROGRAMME FUTURE:

Start:
- System Estates Procurement Strategy development.
- Category strategies across major spend areas (Clinical, Digital, Estates).
- Further NHSSC system challenge and opportunity development.

Continue:
- Execute the agreed 26/27 work plan.
- Hub & Spoke collaborative delivery model.
- Data-led opportunity identification and aligned work planning.
- Atamis adoption and data improvement programme.

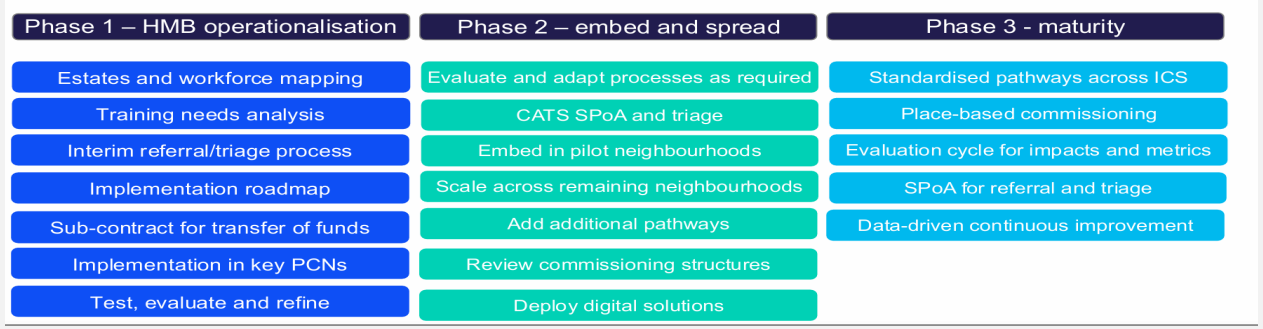
Stop:
- Isolated, single-organisation procurement approaches for influenceable spend.

Benefit measure:	Plan start:	Plan value:
Contracts Management: reduction in non-pay spend (surgical sutures - UHDB)	Mar-26	£125k p.a. (4 yrs) UHDB committed to £52K
Contracts Management: reduction in non-pay spend (RLDatix/Allocate)	2026/27	£547K over 3 years

Programme:	Women's Health Hub	Project Lead:	Dr Heidi Scott-Smith
Year-end status:	AMBER/GREEN	SRO:	Ian Potter

PROGRAMME OBJECTIVES:

Overall objective to create a women's health pathway to deliver secondary care activity in primary care. Undertake waiting list validation to identify services most frequently referred to gynaecology services in secondary care. This programme of work is being delivered in 3 phases:



MILESTONES ACHIEVED:

- Waiting list validation project completed across Derby and Derbyshire in conjunction with UHDB and CRH. The results across Derby and Derbyshire were similar in that 25% of referrals could be removed as a result of the validation, and that coil and pessary management are amongst the highest reasons for referral to secondary care that could be seen in primary care.
- The waiting list validation work in North and South Derbyshire provides robust, evidence-based insights for the project and fostered positive connections among the initial project team, GPs, and hospital consultants. These relationships are being further reinforced as the project progresses to co-produce the pathway transformation.
- Successful bid for CLEAR to support this project with a focus on HMB including pessary management. This increased the resource and provided national experience and insight to this project.
- Most of Phase 1 for this project is complete. Clinical Standard Operating Procedure is being reviewed by clinicians and UHDB are in the process of drafting the sub-contractual arrangements for review and agreement.

PROGRAMME CHALLENGES:

- Red risks relate to funding arrangements to support pathway transformation and short timescales to implement transformative pathways. This risk is likely to remain in the long term but, in the short term, we expect this to be addressed via subcontract arrangements.
- Funding the pathway transformation, i.e. phase 2, will require further exploration as the overall aim is to prevent referrals being submitted to secondary care and being managed in primary care which will require additional infrastructure to ensure success.
- Timescales have been extended as part of the national CLEAR programme.

LESSONS LEARNED:

- Time – realistic timescales are essential otherwise projects are at risk of failure if not able to complete properly. During the waiting list validation project there were several 'unforeseen circumstances' that could not have been planned for that caused delays.
- Strong working relationships – this is essential to transform services. Time needs to be taken on building these as transformation can only happen together.
- Data/information – a clear and shared purpose when requesting and reviewing data/information is essential to ensure the correct information is available to inform decisions.

PROGRAMME BENEFITS:

2025/26 has focused on the development of phase 1 to ensure readiness for implementation from May 2026 in South Derbyshire and to replicate this project in North Derbyshire from April 2026 onwards. The development of positive working relationships with the acute trusts and primary care has been essential to reaching the final stages of phase 1.

The waiting list validation exercise confirmed that 25% of outpatient referrals could be seen in a different way, thus providing a robust evidence base for the development of future pathways and avoided acute activity.

See 'programme future' section for expected benefits in 26/27.

PROGRAMME FUTURE:

Phase 1 of the project will be operationalised across Derby and Derbyshire with UHDB and CRH, while preparatory work to transition into Phase 2 will commence.

Projected impact on acute capacity and demand through implementation of place-based gynaecology pathways are:

- **Avoided secondary care activity** (cost avoidance).
- **Reduction in follow-ups and outpatient demand.**
- **Release of acute capacity for higher-value activity.**

Indicative modelling shows a reduction in weekly activity demand on acute services over phase 1 - diversion of approx. 1,927 routine referrals into primary care with 1,029 associated FUs. Phase 2: diversions of approx. 6,347 routine referrals into primary care with 3,390 associated FUs. Potential income/productivity opportunity (£573k–£1.8m depending on scale).

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 19 May 2026

Integrated Performance Report

Purpose of Report

The purpose of the report is to provide a high level view of performance against a number of Operational, Financial, People and Quality metrics and to provide assurance regarding actions being taken to improve performance. The data period is up to the end of March 2026 for internal measures and to the end of February 2026 where the data source is NHS England.

Executive Summary

The report provides oversight of performance against a number of key long term plan, NHS Oversight Framework (NOF), and internal operational measures.

Quality

This section summarises performance across key Quality, Safety, Patient Experience and Access metrics. Updated improvement ambitions align to the Trust strategy and Quality Delivery Plan, including a 10% reduction across several high-risk safety indicators over the next 12 months. While there is evidence of stable performance and emerging improvement in a number of areas, significant risks remain relating to access, flow and patient experience that require continued Board oversight.

Areas of Assurance

- **Clear improvement ambitions and targets** aligned to Trust priorities and increased demand from the Making Room for Dignity (MRfD) Programme
- **Robust governance arrangements** for restrictive practice and safety incidents, including Reducing Restrictive Practice (RRP), Positive and Safe and specialist oversight groups
- **Improving or stable trends** in medication incidents, falls, and some restrictive practice metrics, largely within common cause variation
- **100% Duty of Candour compliance**, with systematic Serious Incident review processes in place
- **Clear plan to eliminate prone restraint** by September 2026, supported by incident review and staff training.

Areas of Risk

- **Complaints response times** remains below target, posing ongoing experience and regulatory risk despite recent improvement actions
- **Patients not seen for over 12 months** remains consistently high, representing a access, safety and compliance risk
- **Length of stay (LoS) and delayed discharges** remain above national thresholds, driven by System-wide placement and housing constraints
- **Clinically Ready for Discharge (CRfD) levels** remain above the national benchmark, indicating continued flow and pressure risks
- **High-acuity inpatient cohorts** continue to drive restraint, violence and ligature risks, requiring sustained intensive intervention.

Operational performance

Notable changes since the last report:

- **Inappropriate out of area (OoA) placements:** placements have significantly reduced from a high of 28 back in January 2025. However, the Trust continues to require some external placements owing to demand exceeding bed capacity and there being no Psychiatric Intensive

Care Unit (PICU) provision for females in Derbyshire. At the time of writing there are five patients in inappropriate OoA placements – five female PICU, with the appropriate additional three patients in continuity of care female PICU placements. The Acute team is working on repatriation of these female PICU patients once clinically ready

- **Early intervention in psychosis:** the performance improvement plan has been successfully implemented and has achieved the desired effect, resulting in the two-week referral to treatment target being exceeded for the last two months
- **Memory Assessment Service (MAS):** the MAS team has been working hard to reduce waiting times and for the second quarter in a row have seen a slight improvement in comparison to other local systems. In the first quarter of this year, Derby and Derbyshire had the highest waits of any of the 11 Midlands systems, but for the last two quarters have ranked eighth, with a significant reduction in the number of people waiting over 18 weeks – down from approximately 70% to 42%. This is at a time when demand for MAS, despite rigorous pathway work, has increased
- **Transforming Care Programme:** the final position at the end of March 2026 was 19 Learning Disability (LD) and Learning Disability or Autism (LDA) patients in beds versus a trajectory of 18 (+1), and 18 Autistic Spectrum Disorder (ASD) patients in beds against a trajectory of 10 (+8), a total of 37 Adult Inpatients which was nine over trajectory. A performance improvement plan is in place with an emphasis on admission avoidance and an outflow plan in terms of supporting discharges. Deep dives have taken place specifically around autism - those within the Ministry of Justice cohort and also children and young people (CYP). In terms of CYP, at the end of March there were five Inpatients against a trajectory of three, making two over trajectory. The current position mid-April for LD/LDA is 18 versus a trajectory of 16 (+two) and for ASD is 17 versus a trajectory of 16 (+one), so overall adult is +three over trajectory. CYP has seen a recent discharge so there are currently four Inpatients versus a trajectory of 3 (+one), with another discharge expected before the end of April.

Top three things to note from this report:

1. **NOF challenges**

   Performance improvement plans are in progress for all the challenging areas of the framework and are summarised in the main body of the report. The Q3 results have now been published by NHS England. The Trust positioned exactly the same as in Q2, ranking 41st out of 61 NHS providers and remaining in segment 3.

   Proportion of people waiting over 52 weeks for Community services: As forecast, the Trust ranked fourth highest (worst) in the country for waits over 52 weeks, at 66%. The national median was just 0.42% (mean 8%). From internal data, the March position has improved to 51%. This is largely a result of the ongoing transition of the records relating to Community Paediatric ASD assessment waits, and Attention Deficit Hyperactive Disorder (ADHD) assessment waits, from community to mental health. The planned transfer of these waits into the mental health services dataset in line with other providers, as advised by NHSE, will improve the position to around 14% once complete, presenting a more accurate picture. However, this would still place well within quartile 4. Further phased improvement through backlog reduction commenced in April 2026. A performance improvement plan has been updated and implemented with the aim of eliminating physiotherapy waits over 52 weeks by the end of August 2026, and for children aged 0-4 years waiting over 52 weeks by the end of November 2026.

   Crisis response: this is a NOF measure of the proportion of urgent referrals made to Crisis teams and Mental Health Single Points of Access who were seen face-to-face within 24 hours. In the Q3 NOF ratings, the Trust placed 12th best provider in the country for performance against this metric, climbing 12 places since Q2 and achieving the top quartile, for which the teams are to be commended. The teams continue to perform strongly and ranked 11th best in January 2026.

Proportion of Acute Inpatients discharged with a LoS of 60 plus days: in the Q3 NOF rankings the Trust placed fifth highest of all providers and in quartile 4 (the worst quartile) at 32.5% versus the national average of 23.3%. If people had been discharged when clinically ready, the Trust would have placed 14th highest, and in quartile 3. Delays to discharge are inflating average LoS by nine days overall. Of the current Inpatients, 10% of adults are CRfD, totalling 612 delayed bed days to date. The main reason for delay is awaiting supported accommodation across both Working Age Adults (WAA) and Older Age Adult (OAA) wards – on average this equates to 35%. The Trust continues to work with System partners via multi-agency discharge events (MADEs) and targeted working group to reduce CRfD delays and is actively engaged with the Midlands Learning and Improvement Network, which is supporting shared learning as an enabler to improving LoS. To further support this work a bid for Derbyshire, Lincolnshire and Nottinghamshire (DLN) transformation funds has been submitted for a Housing Lead and Housing Officers to strengthen the health and housing pathway across the System and support in particular delays due to care and accommodation. A revised performance improvement plan across WAA and OAA wards is in progress, with targeted improvements due by Q2.

CYP accessing Mental Health services: with a 0.9% increase in access, as forecast the Trust placed in the second worst quartile of NHS providers once more in Q3. The provider median was an increase of 6.8%. The service improvement programme recruitment process has now finished, and 11.7 whole time equivalent (WTE) additional posts have been recruited to and 12 of the 13 recruits have started in post. The aim of the additional posts is to reduce waiting times to four weeks over the course of the improvement programme and will positively impact on this access metric.

2. **High performing areas**

The areas where a consistently high level of performance can be seen continue to be access to Perinatal Mental Health services, individual work placement support access, CYP eating disorder referral to treatment waiting times, Inpatient discharges followed up within 72 hours, dementia diagnosis and adult ASD assessments completed per month.

3. **Challenging areas**

Other areas where standards are not currently being achieved include the adult ASD assessment waiting list and waiting times to be seen.

Regarding the Mental Health Helpline there continues to be challenges relating to demand and capacity, with the increasing demand on the helpline, professional line and mental health response vehicle, outstripping the commissioned funding. The Integrated Care Board (ICB) and Trust are finalising the roll-out of the new text message service which is forecast for implementation from 1 July 2026 with funding of £117k to support the roll-out of this new service. The Trust has explicitly requested formal review points at three, six, nine and 12 months, with a caveat that if funding becomes a shortfall the ICB considers further investment, with an option also for the Trust to serve notice. Performance improvement plans have been formulated for the most challenging areas and are summarised in the main body of the report.

Living Well: Derbyshire County Council have started a formal process in terms of adult social care withdrawal from the Living Well programme. Their decision is based on year-on-year decisions rather than mid- to long-term commitments. With expected changes from August 2026, the Trust is pulling together a group to manage the route into statutory Adult Social Care services to support the Living Well offer going forward. This change may also affect/stop the Trust's ability to support neighbourhood developments. The risk associated will be reflected and reported through to the Board Assurance Framework (BAF).

Triangulation

Delays to discharge are inflating LoS, which then impacts on capacity to admit patients and results in people being placed OoA, at significant cost. In financial year 2025/26, if there had been zero delayed discharges in Adult Acute and the maximum three days of home leave policy had been adhered to, average LoS would have reduced by seven days, and 19 beds would have been freed up. Guiding principles are in development by the Divisional Medical Director for minimising leave periods to an average of three days.

In Older Adults, if patients were discharged when clinically ready to do so, all four Older Adult wards would be achieving the 2026/27 medium-term plan year-end target for LoS.

People

High Performing Areas

The Trust continues to demonstrate strong performance across several key workforce metrics. Annual appraisal compliance remains consistently high at 92%, exceeding the 90% target for eleven consecutive months, providing assurance of effective performance management and staff development. Given this sustained performance, there is confidence to increase the target to 95% to drive further improvement.

Similarly, compulsory training compliance is robust at 94.8%, well above the 85% target, with plans to further strengthen standards through a 5% increase in both mandatory and role-specific training targets.

Annual turnover remains stable at 11%, in line with national and regional benchmarks and below the Trust's 12% tolerance, indicating a relatively stable workforce.

Supervision arrangements have also improved, with clinical supervision exceeding the revised 95% target at 96%, and the successful implementation of an updated supervision system aligned to policy, representing a significant organisational achievement.

Challenging Areas

Sickness absence remains a key area of concern. While the annual rate has slightly reduced to 5.84%, monthly absence for March 2026 has increased to 6.13%, with a notable rise compared to the same period last year. Long-term absence (3.5%) continues to be a significant contributor, with mental health-related conditions (anxiety, stress, depression) remaining the leading cause. This highlights the need for sustained focus on wellbeing, early intervention, and management capability.

Management supervision compliance, at 94.8%, is marginally below the revised 95% target, indicating a need for continued focus to achieve consistent compliance across all staff groups.

Financial

At the end of the financial year, there is an overall deficit of £6.5m, which has been adjusted for the Private Finance Initiative (PFI) adjustment related to the International Financial Reporting Standards (IFRS) 16 accounting change and impairments, bringing the adjusted financial position to a small surplus of £11k, which is slightly better than the breakeven plan.

The required efficiencies of £14.8m have been delivered in full. However, the split between recurrent and non-recurrent schemes was different to the original plan due to the reduced savings from the operating model in year which has been mitigated by non-recurrent one-off benefits.

Expenditure on Adult Acute OoA placements totalled £8.3m, which was above plan by £4.4m.

Bank and agency expenditure continued to be below plan by £0.3m and £0.9m respectively.

In relation to capital expenditure, in total this was below plan by £0.4m. Self-funded schemes were below plan by £1.5m. However, during the year we received additional national funding of £1.1m which related to Estate and Digital schemes. This in turn led to capital expenditure of £18.2m in-year, £0.4m less than originally planned.

Strategic Considerations		Board Assurance Framework Risks	Strategic Delivery Plan Reference
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	25-26 1A	1.2-1.4
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X	25-26 2A	2.1–2.4
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X	25-26 3A	3.1–3.3
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	25-26 4A-C	4.1

Risks and Assurances

This report should be considered in relation to the relevant risks in the Board Assurance Framework (BAF): 25-26 2A,2B; 25-26 3A; 25-16 4A-C. The content provides assurance across several BAF risks related to workforce, operational performance and regulatory compliance. The use of run charts provides a more detailed view of performance over time as it enables the differentiation between common cause and special cause variation.

Consultation

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

Governance or Legal Issues

This report reflects a range of activities that fall under the statutory requirements of the Health and Safety at Work, etc, Act 1974 and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) (as amended).

Net Zero Duty Implications

In compliance with the NHS move towards net zero carbon emissions, the Trust must consider statutory emissions and environmental targets in their decisions. Reports should identify related impacts on workforce and system leadership; sustainable models of care; digital transformation; travel and transport estates and facilities (including capital projects, asset management and utilities, green space and biodiversity); medicines; supply chain and procurement; food and nutrition and adaptation.

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

No meaningful impact identified.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

Recommendations

The Board of Directors is requested to:

1. Confirm the level of assurance obtained on current performance across the areas presented. The recommended level is limited assurance: weaknesses in the design or inconsistent application of controls put the achievement of the system's objectives at risk in the areas reviewed. (see Appendix 2)
2. Determine whether any further assurance is required.

Report presented by:

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

Vikki Ashton-Taylor
Deputy Chief Executive and Chief Delivery Officer

Rebecca Oakley
Director of People, Organisational Development and Inclusion

James Sabin
Director of Finance

Report prepared by:

Peter Henson
Head of Performance and Delivery

Rachel Leyland
Deputy Director of Finance

Liam Carrier
Assistant Director of Workforce Transformation

Joseph Thompson
Associate Director of Physical Health and Quality

Derbyshire Healthcare
NHS Foundation Trust

Integrated Performance Report

January 2026

www.derbyshirehealthcareft.nhs.uk
DHCFT DERBYSHCFT NHS_DERBYSHIREHEALTHCARE

WE MAKE A POSITIVE DIFFERENCE IN EVERYTHING WE DO

QUALITY PERFORMANCE

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

Responsible Committee: **Quality and Safety Committee**

Executive Summary

The Quality metrics in green in the table below have been updated to reflect the improvement ambition related to Metrics including Medication incidents per month, Falls on Inpatient wards per month, Abscond, escape and fail to return incidents, Seclusion episodes per month, Physical restraint incidents per month, Incidents of violence and aggression between patients per month, Assaults on staff by patients per month and Ligature incidents per month involving fixed points by reducing the average by 10% over the next 12 months based on a reduction on the mean over the past 24 months. Metrics including Duty of Candour incidents, Care Programme Approach (CPA) annual reviews, Proportion of patients clinically ready for discharge (CRfD), Inpatient discharges aged 18-64 with a length of stay (LoS) over 60 days, Inpatient discharges aged 65 plus with a LoS over 90 days, Patients open to Mental Health services but not seen for over 12 months, Complaints responded to within 90 working days (rolling 24 months) and prone restraint incidents per month have individual targets to identified in blue in the table below. These updated improvement measures reflect the Trust improvement priorities identified in the Trust Strategy and Quality Delivery Plan and account for the increase in patient numbers linked to the Making Room for Dignity (MRfD) Programme.

Overview

Complaints responded to within 90 working days (Target: 100%)

- Performance remains below target, with only 44–50% of complaints responded to within 90 working days between January and March but it should be noted that performance is improving each month. To improve this further, bank investigators are being employed by the Patient Experience team and the establishment of the service is being reviewed to ensure it can meet the needs of the organisation.

Seclusion episodes per month (Target: ≤18)

- Seclusion episodes were within target in January and February but increased to 25 in March. Analysis suggests this is due to an increase in localised acuity in the Psychiatric Intensive Care Unit (PICU) and the male wards at the Radbourne Unit. In response to this, the Positive and Safe team is doing individualised work with these teams to review their practice and explore less restrictive alternatives to support the reduction of 10% over the next 12 months.

Physical restraint incidents per month (Target: ≤88)

- Physical restraints increased between December 2025 and February 2026 but have started to reduce in March 2026. This is linked to small number of patients requiring repeated interventions and Individualised care plans in place to support these individuals Is expected to sustain the reduction in incidents.

Physical restraint by prone position (Target: 0)

- The Trust has an ambition to reduce restraint by the prone position only to 0 by September 2026. To achieve this every pronoun only restraint will be individually reviewed and staff involved will be provided with support and education using alternative positions when safe to do so. The majority of prone restraint is linked to the use of rapid tranquilization so work around utilising alternate injection sites is included in this intervention.

Incidents of violence and aggression between patients (Target: ≤19.

- The majority of these incidents occur within Organic Older Adult Inpatient services and the PICU and as of March 2026 are on target to meet a 10% reduction over the next 12 months. Work around supporting staff to reduce violence and aggression between patients is led by the Trust Positive and Safe team and is monitored by the monthly Reducing Restrictive Practice Group.

Assaults on staff by patients (Target: ≤24)

Incidents of assault from patients to staff have followed a common cause variation pattern. The Trust Reducing Restrictive Practice Group has oversight of this data, and it is a focus of the staff collaborative on violence and aggression which launched in January 2026 with a second session that took place in April 2026. This work will focus on reducing violence and aggression towards staff and contribute towards a 10% reduction over the next 12 months.

Ligature incidents per month (Target: ≤55) and Ligature incidents involving fixed points (Target: ≤3)

- The number of ligature incidents reported each month continues to follow a pattern of common cause variation and the numbers reflect the acuity of the female Inpatient wards with a small number of individuals accounting for multiple incidents. This has also been impacted by the opening of the Enhanced Care Unit (ECU) and the higher proportion of female patients within Inpatient services. Interventions to reduce use of ligatures are being explored via the monthly Ligature risk Reduction Group.

Medication incidents per month (Target: ≤122)

- From November 2025, medication incident reporting has been on a downward trajectory and is below the mean of 122. The main incident type reported continues to be storage-related issues and temperature monitoring.

Falls on Inpatient wards (Target: ≤39)

- Falls remain within common cause variation. The majority of incidents are reported as low or no harm. Preventative measures include high training compliance and the introduction of contactless patient monitoring in Older People's Inpatient services is expected to support further reductions to achieve the ambition of reducing the number of falls by 10% over the next 12 months.

Absconds/escapes/failures to return (Target: ≤21)

- The number of incidents has continued to follow a pattern of common cause variation the data will continue to be monitored for any patterns or themes. The higher on average numbers in March relate to acuity within the Inpatient service but do not relate to any increase in patient harm.

Duty of Candour incidents (DoC) (Target: 0)

- In 100% of cases the DoC was discharged, and any DoC incident is reviewed within the twice weekly Trust Serious Incident Groups.

Care Programme Approach (CPA) annual reviews (Target: ≥95%)

- The reduction in CPA reviews being completed is due to staff incorrectly reporting on the electronic patient record, staff sickness and acuity within the Community services. To support an improvement in compliance, any service under 85% compliant has a bespoke action plan in place monitored via the Divisional cross check meeting or Care Group equivalent

Proportion of patients CRfD (Target: ≤3.5%)

- The proportion of service users meeting the criteria of CRfD has remained below the mean of 11% since November 2025 but remains above the national threshold of 3.5%. Twice-weekly, multi-agency discharge event (MADE) meetings with the Integrated Care Board (ICB), Trust Directors, the Head of Social Care, Continuing Health (funding panel members) and Housing take place to discuss any barriers to discharge and support resolution.

Long length of stay (LoS) – discharges aged 18–64 (Target: ≤24%) Discharges aged 65+ (Target: ≤40%)

- LoS within both Adult and Older Adult services are over the respective national targets. This is linked to the impact of the difficulty in identifying placements for patients and care homes requesting periods of leave before they will accept patients and patients not having suitable housing following admission to the Inpatient wards. This is explored as part of the twice-weekly, MADE meetings.

Patients open to Mental Health services not seen for over 12 months (Target: 0)

- Numbers remain consistently high with no improvement between February and March 2026. This represents an access, safety and regulatory concern and is part of the Trust Strategy and Improvement Plan.

QUALITY KEY PERFORMANCE INDICATORS

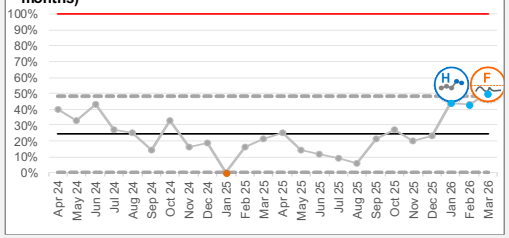
Measure	Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	
No. of complaints responded to within 90 working days (rolling 24 months)	100%	25%	14%	12%	9%	6%	21%	27%	20%	23%	44%	43%	50%	
Seclusion episodes per month	18	14	21	8	21	42	21	28	15	26	17	16	25	
Physical restraint incidents per month	88	49	62	60	99	145	102	89	72	75	112	146	135	
Prone restraint incidents per month	0	3	3	5	3	13	9	14	14	14	10	19	3	
Incidents of violence and aggression between patients per month	19	23	11	16	18	29	21	34	27	19	18	19	12	
Assaults on staff by patients per month	24	17	34	18	30	32	29	26	24	22	23	25	27	
Ligature incidents per month	55	103	55	70	108	96	100	47	65	35	77	31	73	
Ligature incidents per month involving fixed points	3	2	2	3	15	12	10	4	5	4	4	0	4	
Medication incidents per month	122	102	99	113	143	125	127	162	179	163	161	129	121	
Falls per month	39	46	36	57	45	46	58	33	33	40	43	45	40	
Abscond, escape and fail to return incidents	21	13	17	15	24	22	13	18	23	21	24	20	28	
Duty of candour incidents	0	0	1	2	1	1	5	4	0	1	3	4	4	
Care programme approach (CPA) annual reviews	95%	79%	80%	79%	80%	79%	80%	79%	79%	82%	82%	80%	76%	
Proportion of patients clinically ready for discharge	3.5%	12%	13%	13%	12%	12%	13%	12%	11%	11%	11%	9%	12%	
Inpatient discharges aged 18-64 with a length of stay over 60 days[1]	24%	29%	27%	31%	32%	28%	29%	31%	32%	33%	32%			
Inpatient discharges aged 65 plus with a length of stay over 90 days[1]	40%	53%	45%	42%	32%	33%	36%	46%	45%	41%	42%			
Patients open to mental health services but not seen for over 12 months	0	786	749	661	575	587	503	460	433	399	408	401	401	

[1]NHS England data

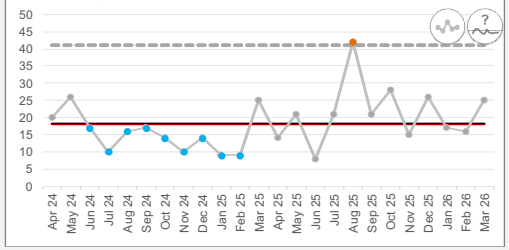
Target
Mean over the past 24 months

Quality Key Performance Indicators – Statistical Process Control Charts

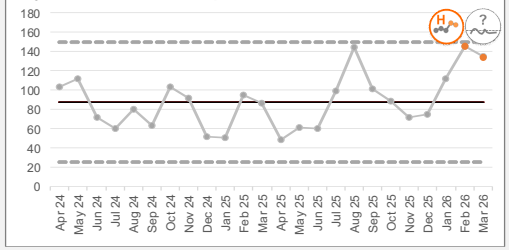
Complaints responded to within 90 working days (rolling 24 months)



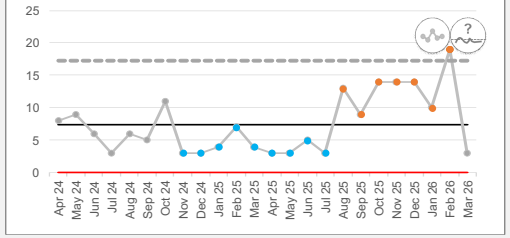
Seclusion episodes per month



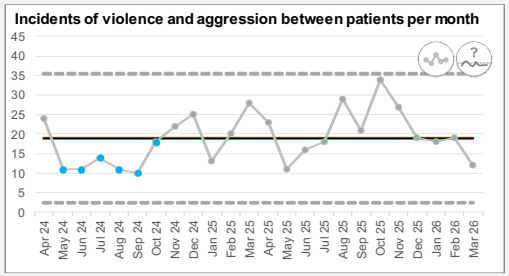
Physical restraint incidents per month



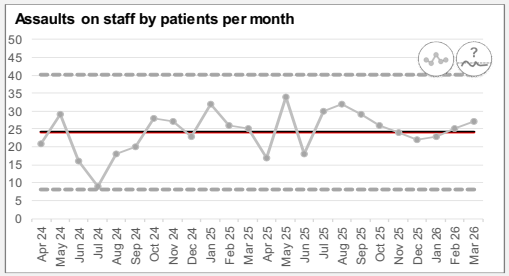
Physical restraint by prone only position per month



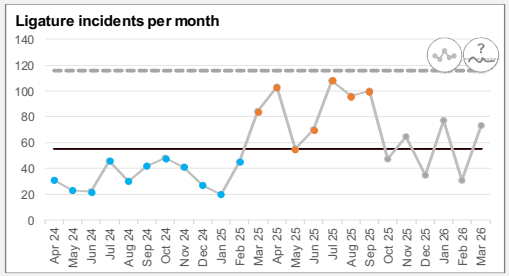
Incidents of violence and aggression between patients per month



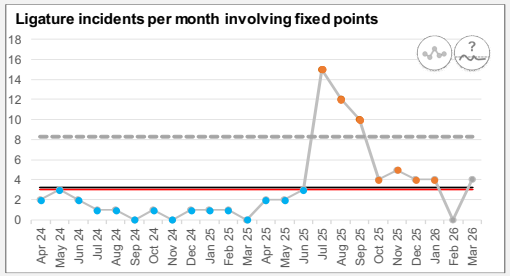
Assaults on staff by patients per month



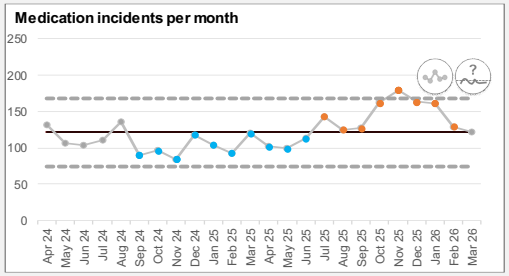
Ligature incidents per month



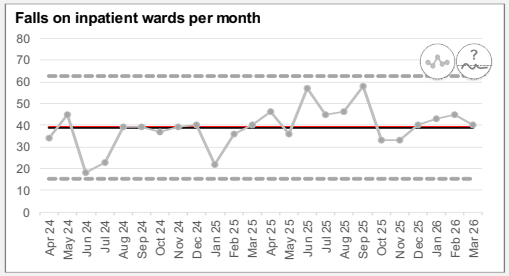
Ligature incidents per month involving fixed points



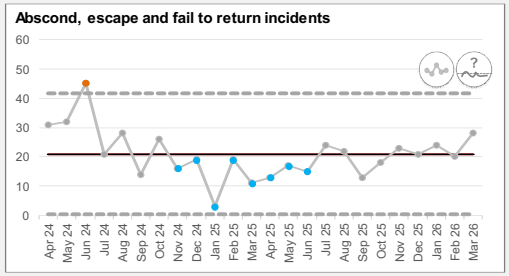
Medication incidents per month



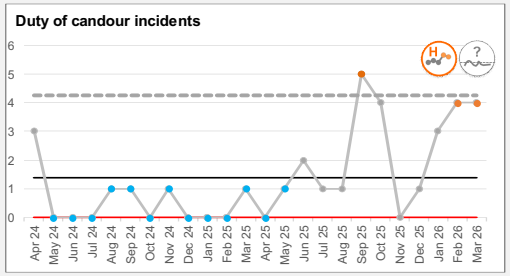
Falls on inpatient wards per month



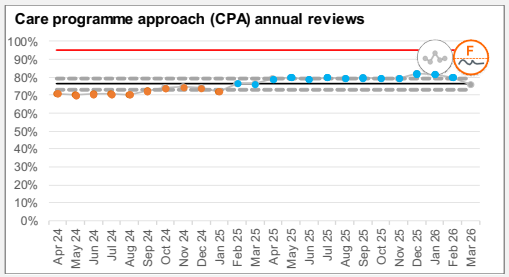
Abscond, escape and fail to return incidents



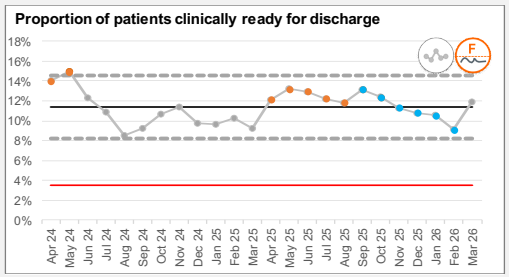
Duty of candour incidents



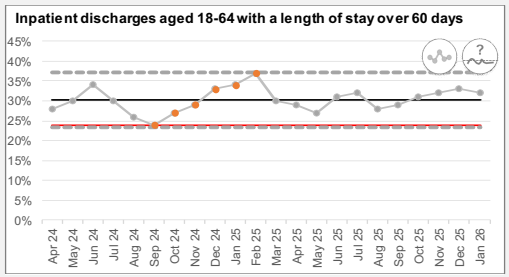
Care programme approach (CPA) annual reviews



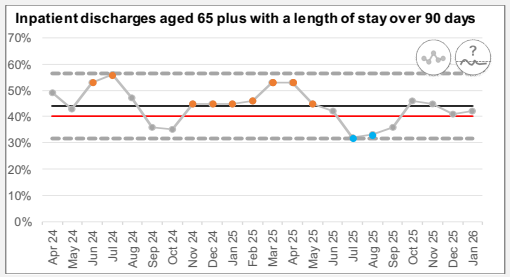
Proportion of patients clinically ready for discharge



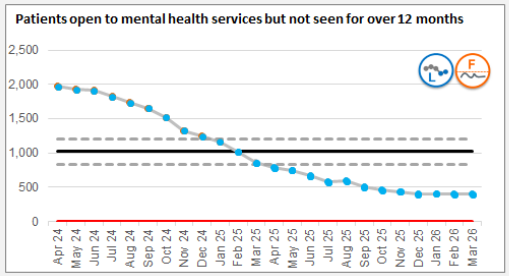
Inpatient discharges aged 18-64 with a length of stay over 60 days



Inpatient discharges aged 65 plus with a length of stay over 90 days

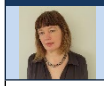


Quality Key Performance Indicators – Statistical Process Control Charts (2)



A reduction of 10% from a benchmark mean based on the period between 1 April 2024 and 31 March 2026 has been agreed as a patient focused priority for improvement in relation to the trust strategy in 2026/27 in restrictive practices, violence and aggression between patients and towards staff, absconding, falls and ligatures.

OPERATIONAL PERFORMANCE



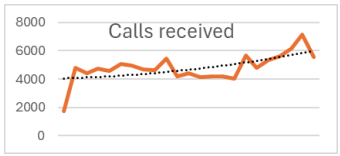
Deputy Chief Executive/ Chief Delivery Officer:
Vikki Ashton Taylor

Responsible Committee: **Finance and Performance Committee**

Executive Summary

Inflow

- **Percentage of patients in crisis to receive face-to-face contact within 24 hours:** this is an NHS Oversight Framework (NOF) measure of the proportion of urgent referrals made to Crisis teams and Mental Health Single Points of Access who were seen face to face within 24 hours. In the Q3 NOF ratings the Trust placed 12th best provider in the country for performance against this metric, climbing 12 places since Q2 and achieving the top quartile, for which the teams are to be commended. The teams continue to perform strongly and ranked 11th best in January 2026
- **Mental Health Helpline:** From the latest official statistics in development published by NHS England (February 2026), the proportion of calls to the helpline which were abandoned (callers hung up) after interactive voice response call steering remained high at 49%. In comparison, the national average for calls abandoned was 28.4%. The Trust's speed to answer calls has remained the third quickest in the Midlands. Demand for the Trust's service continues to increase, reaching a high of 7.1k calls received in January 2026. Over the last month the performance improvement plan has been central to supporting the actions undertaken by the triumvirate. Weekly cross-check meetings review performance against the plan, and there are fortnightly performance delivery and assurance meetings with the divisional lead to ensure progression. Some key actions include:



    - The ICB and Trust are finalising the roll-out of the new text message service which is forecast for implementation from 1 July 2026 with funding of £117k to support the roll out of this new service. The Trust has explicitly requested formal review points at three, six, nine and 12 months, with a caveat that if funding becomes a shortfall the ICB consider further investment, with an option also for the Trust to serve notice
    - The 0800 number will cease on 1 July. Over the next 12 weeks the project team will work through a communication and clinical/operational project plan to ensure that the population who currently use the 0800 route to mental health support know how to continue to access telephone services (111#2 and the new text message service)
    - To ensure greater data accuracy, the professional line will move over to Ignite this week. This is the same telephony system used for 111#2 and will be used for text messaging also. Continued work on securing a new service specification is being worked through with the ICB which is reflective of the service for 2026
    - Recruitment remains a challenge- with only 1.6 whole time equivalent (WTE) recruited out of a possible four WTE
    - Work is ongoing with recruitment around opportunities for skill mix and recruitment drives. The team are also increasing bank opportunities to support the performance. Demand still outstrips capacity even with baseline recruitment filled and this continues to be a risk to performance and service delivery.

Outflow

- **Inappropriate OoA Adult Acute placements:** placements have significantly reduced from a high of 28 back in January 2025. However, the Trust continues to require some external placements owing to demand exceeding bed capacity and no PICU provision for females in Derbyshire. At the time of writing there are five patients in inappropriate OoA placements. The male PICU for Derbyshire which opened in July 2025 has enabled male patients to be cared for close to their family and local support networks. At the time of writing there are no male PICU patients OoA. There are currently eight females in PICU placements in total – three continuity of care and five inappropriate. The Acute team is working on repatriation of these female patients once clinically ready. There are also 19 Adult continuity of care Acute placements in total
- **Proportion of Adult Acute Inpatients aged 18-64 discharged with 60 days plus LoS:** In the Q3 NOF rankings, the Trust placed fifth highest of all providers and in quartile 4 (the worst quartile) at 32.5% versus the national average of 23.3%.

If people had been discharged when clinically ready, the Trust would have placed 14th highest, and in quartile 3. Delays to discharge are inflating average LoS by nine days overall. Of the current Inpatients, 10% of adults are currently ready for discharge, totalling 612 delayed bed days to date. The main reason for delay is awaiting supported accommodation (35%). The Trust continues to work with System partners to reduce CRfD delays and is actively engaged with the Midlands Learning and Improvement Network which is supporting shared learning as an enabler to improving LoS. A revised performance improvement plan is in progress, with all actions due to be completed by September 2026

- **Average LoS for Adult Acute, Older Adult and PICU mental health beds:** the latest monthly Mental Health services dataset data published by NHS England (January 2026) placed the Trust 16th highest of all NHS providers for average LoS, at 63 days. However, if patients had been discharged when CRfD the Trust's Q3 average LoS would have been 55 days, which would place below the national average of 58 days. Currently there are a total of 21 Adults and Older Adults who are CRfD, who have been delayed for a total of just under 2,000 days to date. This creates a very poor patient experience and has a significant financial impact on the health system as it results in other patients having to be placed with private providers, at cost. Revised performance improvement plans for Adult and Older Adult LoS reduction and improved flow have been developed and are currently in the implementation phase
- **Three-day follow-up:** the national standard for follow-up after Inpatient discharge continues to be consistently exceeded, ensuring patients get support at the time they are most vulnerable. This process is tightly monitored by the Trust's Performance Analyst to ensure the safety of patients.

Elective/access

- **Women accessing specialist Perinatal Mental Health service**: the service continues to support increasing numbers of women before and after the birth of their children, placing NHS Derby and Derbyshire ICB in the top 10 nationally
- **Adult Autistic Spectrum Disorder assessment (ASD):** activity levels continue to exceed the commissioned target for assessments, with the full year target exceeded by 81%. Waiting times remain very high at around 54 weeks, with demand far exceeding commissioned capacity. The waiting list has reduced over the last four months but more than 1,100 people are currently waiting
- **Community waits over 52 weeks:** In the latest NOF ratings (Q3) the Trust ranked fourth highest (worst) in the country for waits over 52 weeks, at 66%. The national median was just 0.42%. From internal data, the March position has improved to 51%. This is largely a result of the ongoing transition of records from Community to Mental Health. The majority of the long waits are for Community Paediatric ASD assessment or ADHD assessment. The planned transfer of these waits into the Mental Health services dataset in line with other providers, as advised by NHSE, will improve the position to around 14% once complete, presenting a more accurate picture. However, this would still place well within quartile 4. Demand over the past six years has been as high as 450% above capacity and remains to date at 250% above. There has been limited System ownership to prevent flow into health services. There has been no increase in funding to match increased demand or population increase of 10% over the past 15 years. A performance improvement plan has been devised and implemented and further phased improvement through backlog reduction commenced in April 2026. Actions include:
    - Improved System ownership and prioritisation of early intervention strategy to reduce flow - Neurodevelopmental Hubs
    - Successful multi-disciplinary early years programme reduced improved access and wait times for 0-4 pathway
    - Workforce – revised skill mix and fast track of vacancies
    - Upskilling of Band 5 and 6 to take on increased acuity in Physiotherapy caseload
    - Band 7 Physiotherapist from Adult LD team providing additional support to address code 5 (medium priority, ie cerebral palsy/musculoskeletal (MSK) waits – agreed extension for three months to work on Code 6 waits
    - Community Paediatrician extended hours and weekend clinics

Planned date for recovery/compliance: end of August 2026 – seen all Physiotherapy waiting over 52 weeks. End of November 2026 – projected delivery to have seen all children aged 0-4 years who had been waiting over 52 weeks

Early intervention in psychosis: the early intervention services and At Risk Mental State (ARMS) services assess people who are suspected of experiencing a first episode of psychosis. The national standard is to undertake an assessment and assign a care coordinator within two weeks of people being referred into the service (target 60%). The issues impacting on performance last time have been addressed through implementation of the performance improvement plan, normal service has resumed, and for the last two months the target has been exceeded

- **Children and young people (CYP) Mental Health access:** with a 0.9% increase in access, as forecast the Trust placed in the second worst quartile of NHS providers once more in Q3. The provider median was an increase of 6.8%. The service improvement programme recruitment process has now finished, and 11.7 WTE additional posts have been recruited to and 12 of the 13 recruits have started in post. The aim of the additional posts is to reduce waiting times to four weeks over the course of the improvement programme and will positively impact on this access metric
- **Memory Assessment Service (MAS):** the MAS team has been working hard to reduce waiting times, and for the second quarter in a row have seen a slight improvement in comparison to other local systems. In the first quarter of this year, Derby and Derbyshire had the highest waits of any of the 11 Midlands systems, but for the last two quarters have ranked eighth, with a significant reduction in the number of people waiting over 18 weeks – down from approximately. 70% to 42%. This is at a time when demand for MAS, despite rigorous pathway work, has increased.

Collaboratives

Transforming care programme: the Trust and System reset a trajectory to achieve a total of no more than 32 adult patients in beds by the end of Q4, 2025/26. This trajectory, including the planning for 2026/27 and 2027/28, has been discussed and agreed with NHSE. The final position at the end of March was 19 LD and LDA patients in beds versus a trajectory of 18 (+one), and 18 ASD patients in beds against a trajectory of 10 (+eight) a total of 37 Adult Inpatients which was nine over trajectory. A performance improvement plan is in place with an emphasis on admission avoidance and an outflow plan in terms of supporting discharges. Deep dives have taken place specifically around autism - those within the Ministry of Justice cohort - and also CYP. The reviews have supported effective discharge planning and have given assurance around case management. There is also a separate opportunity to look at housing (accommodation) strategies. In terms of CYP, at the end of March there were five Inpatients against a trajectory of three, making two over trajectory. The Trust and System will continue to meet with NHSE regional team in order to monitor performance and progress. The current position mid-April for LD/LDA is 18 versus a trajectory of 16 (+two), and for ASD is 17 versus a trajectory of 16 (+one), so overall Adult is +three over trajectory. CYP has seen a recent discharge so there are currently four Inpatients versus a trajectory of 3 (+one), with another discharge expected before the end of April.

Living Well: Derbyshire County Council have started a formal process in terms of adult social care withdrawal from the Living Well programme. Their decision is based on year-on-year decisions rather than mid- to long-term commitments. With expected changes from August 2026, the Trust is pulling together a group to manage the route into statutory Adult Social Care services to support the Living Well offer going forward. This change may also affect/stop the Trust's ability to support neighbourhood developments. The risk associated will be reflected and reported through to the Board Assurance Framework (BAF).

OPERATIONAL KEY PERFORMANCE INDICATORS

Measure	Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	
Long term plan 2025/26														
Inappropriate adult acute & PICU mental health out of area placements at month end^	5	13	8	13	4	11	10	4	7	4	7	3	6	
Women accessing specialist perinatal mental health services (rolling 12 months)* ^^	1242	1390	1390	1395	1400	1395	1365	1360	1365	1360	1355			
Perinatal access rate (ICB)*	10%	12.8%	12.9%	12.9%	13.0%	12.6%	12.4%	12.3%	12.4%	12.3%	12.2%			
Individual work placement support access (rolling 12 months)*	690	745	765	760	755	780	810	805	810	805	845			
Average length of stay for adult acute, older adult & PICU mental health beds**	55	64	61	60	59	61	63	62	63	62	63	63	60	
NHS oversight framework 2025/26														
Proportion of people waiting over 52-weeks for community services*	0%	65%	64%	65%	68%	65%	65%	66%	62%	66%	62%	63%	51%	
Children and young people accessing NHS-funded MH services - annual change*	15.9%	0.6%	0.7%	1.8%	0.1%	0.4%	0.4%	1.0%	0.4%	1.0%	1.7%			
Proportion of acute inpatients aged 18-64 discharged with 60 days plus length of stay**	20.6%	31%	33%	27%	27%	33%	31%	31%	31%	31%	31%	34%	29%	
Percentage of patients in crisis to receive face-to-face contact within 24 hours*	65.4%	47%	52%	53%	65%	76%	75%	76%	75%	76%	78%			
Key operational measures														
Children & young people eating disorder routine referrals seen within 4 weeks*	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Children & young people eating disorder urgent referrals seen within 1 week*	95%	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	100%	#N/A	#N/A	
Inpatient discharges followed up within 72 hours	80%	90%	87%	88%	92%	85%	89%	86%	91%	86%	91%	92%	89%	
Dementia diagnosis rate (ICB)*	68%	69.2%	68.9%	68.6%	68.7%	68.9%	68.8%	68.9%	68.8%	68.9%	68.7%	68.7%		
Early intervention in psychosis 2 week waits from referral to treatment - complete	60%	43%	37%	39%	52%	85%	56%	78%	41%	78%	41%	67%	73%	
Early intervention in psychosis 2 week waits from referral to treatment - incomplete	60%	46%	50%	58%	75%	92%	88%	63%	73%	63%	73%	72%	92%	
Adult ASD assessment – number of people waiting at month end	219	1492	1429	1401	1370	1388	1366	1390	1432	1371	1357	1286	1154	
Adult ASD assessment – average wait (weeks)	18	55	56	54	52	53	55	55	54	56	53	50	54	
Adult ASD assessment – number of assessments completed per month	26	61	64	29	36	44	47	34	53	34	53	54	56	

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

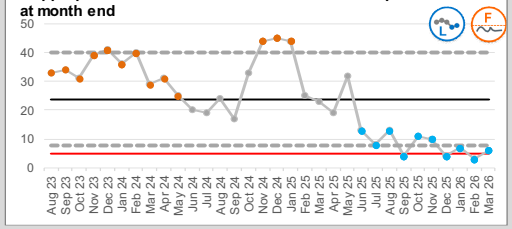
* Data source = NHS England

^^ Perinatal and maternal mental health services

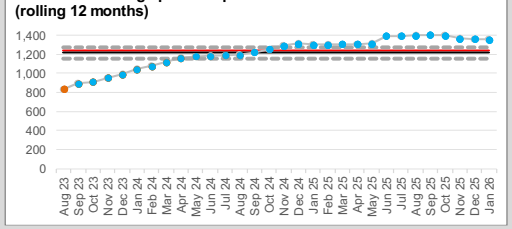
** Rolling 3 months, length of inpatient spell of patients discharged

Operational Key Performance Indicators – Statistical Process Control Charts

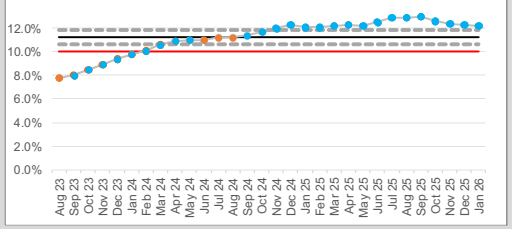
Inappropriate adult acute mental health out of area placements at month end



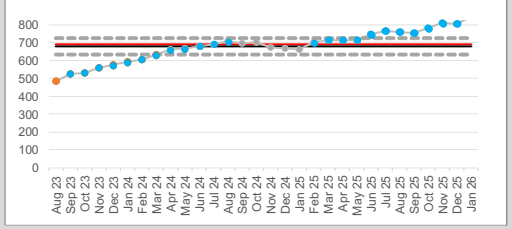
Women accessing specialist perinatal mental health services (rolling 12 months)



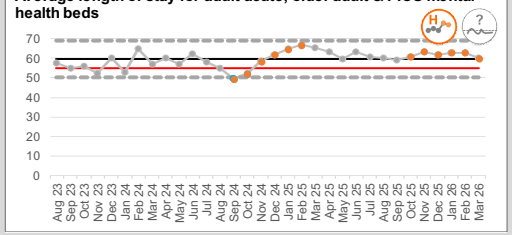
Perinatal access rate (ICB)



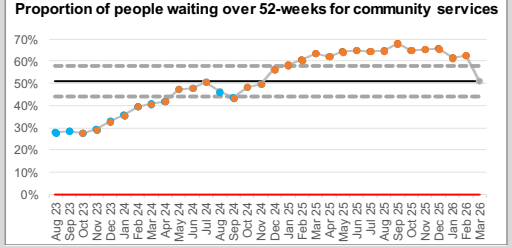
Individual work placement support access (rolling 12 months)



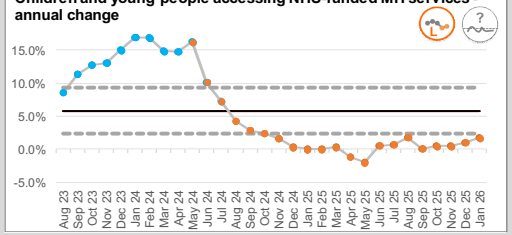
Average length of stay for adult acute, older adult & PICU mental health beds



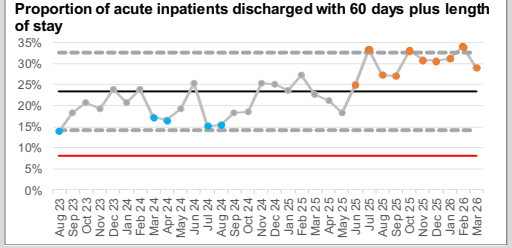
Proportion of people waiting over 52-weeks for community services



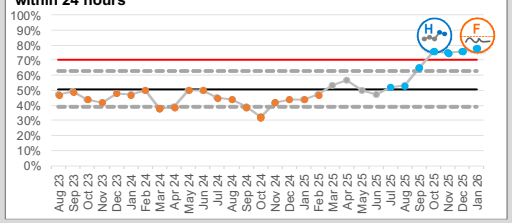
Children and young people accessing NHS-funded MH services - annual change



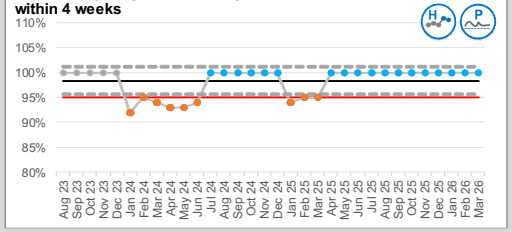
Proportion of acute inpatients discharged with 60 days plus length of stay



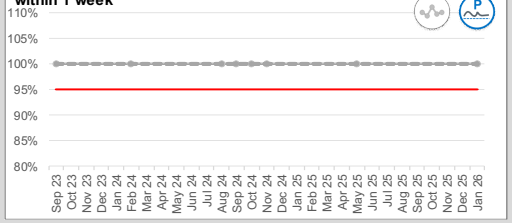
Percentage of patients in crisis to receive face-to-face contact within 24 hours



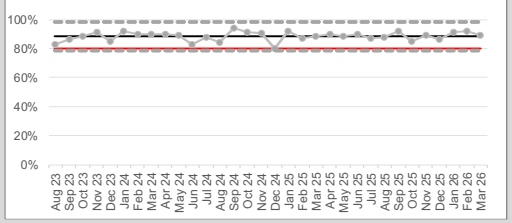
Children & young people eating disorder routine referrals seen within 4 weeks



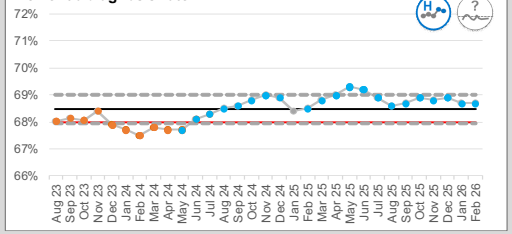
Children & young people eating disorder urgent referrals seen within 1 week



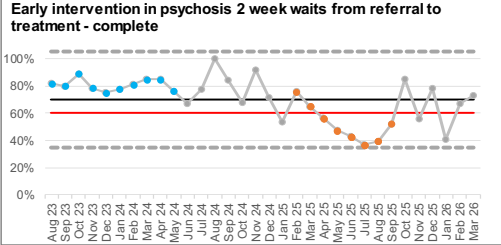
Inpatient discharges followed up within 72 hours



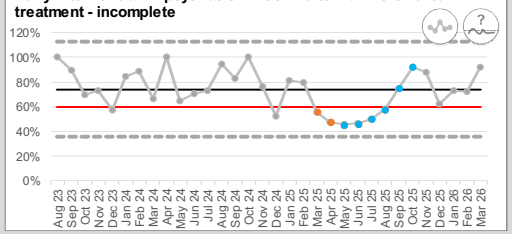
Dementia diagnosis rate



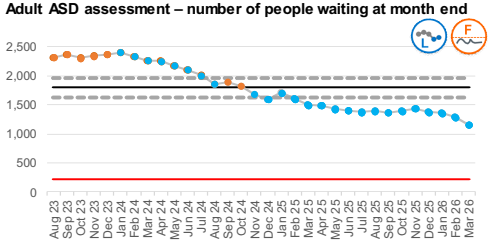
Early intervention in psychosis 2 week waits from referral to treatment - complete



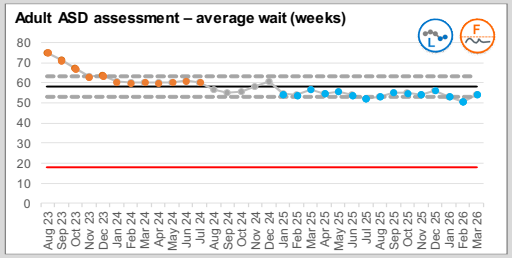
Early intervention in psychosis 2 week waits from referral to treatment - incomplete



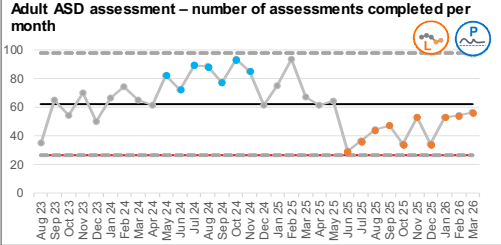
Adult ASD assessment – number of people waiting at month end



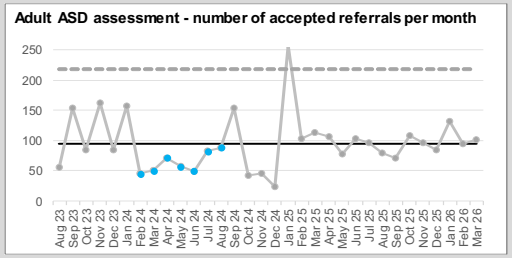
Adult ASD assessment – average wait (weeks)



Adult ASD assessment – number of assessments completed per month



Adult ASD assessment - number of accepted referrals per month



TRANSFORMATION AND IMPROVEMENT

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

FLOW PATHWAY

National Planning Priority 2025/26: Reduction of adult acute mental health inappropriate out of area placements

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

Interventions:

A comprehensive improvement and transformation plan remains in delivery for the Flow Pathway applying 30/60/90 day improvement methodology to assess, implement and scale improvements in a measurable and sustainable way with interventions across the 'end to end' pathway, alongside strategic interventions to support sustainable change:

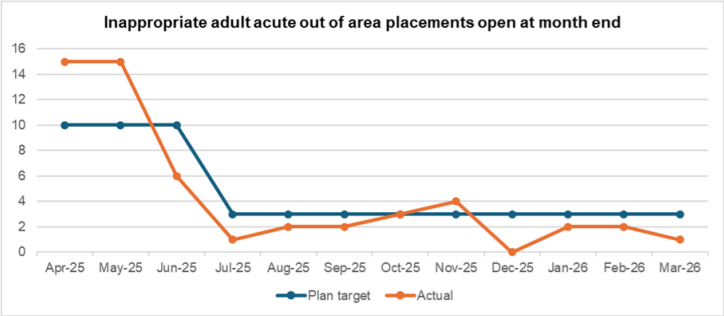
Pathway	Work stream
Inflow	1. Admission review form and process
	2. Safety Huddles and MaST (Digital tool) application
Inflow and Flow	3. Operational management and controls
Flow	4. Purposeful admission and 72 hour review
	5. Rapid review (Red2Green) evaluation
	6. Inpatient leave protocol
Outflow	7.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

Opportunities identified through the JUCD Men-SAT review supported by the NHSE Mental Health Improvement Support team have been incorporated to the action plan. We are also fully engaged with the Midlands Learning and Improvement Network, through which there is a focus on shared learning to deliver improved LoS.

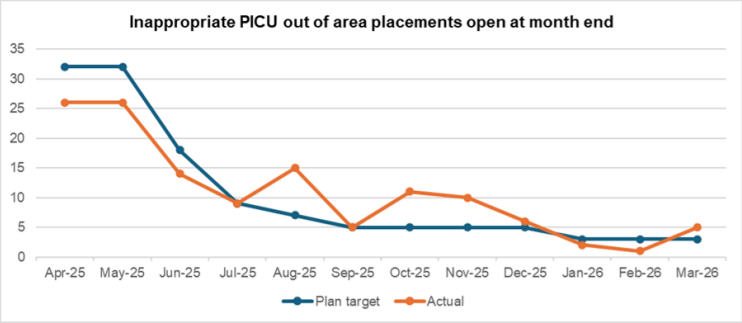
The final work stream above is supporting the development of a strategic programme to improve our 'end to end' care pathways and processes across Inflow, Flow and Outflow ensuring every person who needs Acute Mental Health care receives timely access in, or close to, home.

Impact:

The inappropriate Adult Acute OoA placement position achieved at 31 March 2026 was one, below the operational plan trajectory of three.



The inappropriate PICU OoA placement achieved at 31 March 2026 was five, above the operational plan trajectory of three.



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

The Operational Plan ambition for 2026/27 is focused on phased withdrawal from the privately commissioned beds with an agreed trajectory for delivery in place.

A workshop approach has been implemented with frontline teams, applying intelligence and insights in development of the model, pathway and strategic Inflow implementation plan for delivery in 2026/27. Outputs from the third workshop have been applied to inform a draft plan that has been consulted upon with the 120+ colleagues who have engaged with the process. This has been presented to the Trust Delivery Group (TDG) and is currently under consideration to inform the final 2026/27 plan through the Patient Flow Delivery Group. Action also remains focused on the approach for integration and localisation of services in alignment with the 10-Year Health Plan and recently published Neighbourhood Health Framework with a Board Strategy and Development Session hosted 15 April to further define strategic intent and next steps for action in delivery.	

TRANSFORMATION AND IMPROVEMENT

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

COMMUNITY AND CRISIS

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

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

Interventions:	**Impact**
Metric: Access standards for Mental Health Helpline An improvement plan is in place comprising operational, improvement, and transformational solutions over 10 workstreams that include: One access point though 111 mental health option and closure of the 0800 number; Addressing technical telephony system issues; Demand and capacity modelling; Developing the professional line; Enhanced data reporting through SystmOne; Resolution of NHSE data reporting; Resourcing of helpline and Mental health response vehicle; Triage process; High intensity users: and design of the strategic service model. The plan has recently been reviewed for 2026/27 and presented to the TDG.	**Metric: Access standards for Mental Health Helpline** Phased recovery has not been delivered in 2025/26 aligned to originally agreed trajectory A revised trajectory for 2026/27 is currently in design aligned to review and refresh of the performance improvement plan and conversation with the ICB regarding the service offer that can be delivered within funded resources given the significant imbalance in demand vs capacity demonstrated through modelling.

Metric: People in Mental Health Crisis seen face to face within 24 hours For Crisis services, an improvement plan has been delivered comprising operational, improvement and transformational solutions over eight workstreams that include: Accurate triage and logging; Consistent overnight staffing; Review of triage functions; Modelling of demand and capacity; Streamlining administrative tasks; Weekly cross-check meetings; Development of data reporting for emergency duty; Digital pilot for use of ambient voice technology. For Community services, a plan has been delivered to include Revision of the standard operating procedure for response to urgent referrals; and development processes for review and correction of referral urgency level to drive accurate data capture.	**Metric: People in mental health crisis seen face to face within 24 hours** Recovery fully delivered aligned to Performance Improvement Plan with action in delivery to sustain performance into 2026/27.
Metric: Early intervention in psychosis two-week referral to treatment An improvement plan has been delivered comprising operational, improvement and transformational solutions over eight workstreams that include: Enhanced operational controls and breach analysis to inform learning and improvement action; Demand and capacity modelling; Workforce review; Pathway development in partnership with Crisis service with potential prescribing before assessment and diagnoses; Review of assessment and allocation processes; and Review of flow along the pathways with the aim of ensuring effective deployment of all available capacity within the service.	**Metric: Early intervention in psychosis two-week referral to treatment** Recovery fully delivered aligned to Performance Improvement Plan with action in delivery to sustain performance into 2026/27.

TRANSFORMATION AND IMPROVEMENT

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

ELECTIVE ACCESS

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

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

Interventions:	**Impact:**
Metric: Waits over 52 weeks for Community services Neurodevelopmental hubs have been established working with Community services for earlier upstream triage. This is delivering positive impact, reducing the average number of new referrals received to around 250 in recent months. An improvement and transformation plan is in design to further address the imbalance to include: 1. Addressing the referral pathway and reviewing processes with all partners 2. Enhancing internal efficiency and productivity through optimisation of assessment processes and workflows 3. Exploring options to increase capacity through recruitment, partnership and alternative workforce/ service models.	**Metric: Waits over 52 weeks for Community services** Neurodevelopmental waits are not expected to be recoverable without significant additional investment. However, the data quality improvement work should result in a significant reduction in the proportion waiting over 52 weeks. Advice from NHSE on application of the national dataset standards for neurodevelopmental activity and waits has supported a shift in data submission from the Community services dataset towards the Mental Health services dataset. This will offer published data within a reporting route that is more consistently applied by peer providers. A plan has been delivered for transition of records with further phased improvement through backlog reduction commenced from April 2026.
Metric: CYP accessing Community Mental Health services Performance against the new oversight framework metric measuring contacts vs 12 months prior has been impacted a time limited waiting list initiative in 2024/25 which successfully reduced the backlog through additional capacity that was not subject to recurrent funding. Current performance is being measured against waiting list initiative performance and this will correct from August 2025. Following submission of a business case to expand capacity in routine Child and Adolescent Mental Health services (CAMHS) through reducing wait times, enhancing timely access, improving service flow and increasing participation, the ICB has recently committed £0.986k in recurrent System development funding to DHcFT in order to expand capacity within routine CAMHS.	**Metric: People in Mental Health Crisis seen face to face within 24 hours** Annual issue with comparative capacity corrected from August 2025. Agreed investment will support achievement of a four to six week waiting period for comprehensive assessment and an additional four to six weeks to access care co-ordination or treatment by February 2027.
Metric: Adult ASD Assessment service The service is commissioned to deliver 26 assessments per month but receives around 95 referrals with demand outstripping capacity. A new model has been implemented to increase productivity and volume of assessments that can be completed within commissioned resources. For the last 19 months, the waiting list has been reducing month on month. Digital solutions to further improve productivity and the volume of assessments that can be delivered within current capacity are currently being explored.	**Metric: Adult ASD Assessment service** Trajectory is on track to achieve national standard for referral to assessment within three months (13 weeks) by June 2027.

TRANSFORMATION AND IMPROVEMENT

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

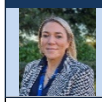
JOINED UP PATHWAYS AND SERVICES: EAST MIDLANDS ALLIANCE

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

Interventions:	**Impact:**
East Midlands IMPACT Collaborative St Andrews (STAH) beds remain closed with continued support from the collaborative to the Intensive Oversight and Assurance Group and Recovery Support Programme action plan. Detailed analysis has been completed of occupied bed days over the last five years with this demonstrating the success of interventions in maintaining a very slight upward trend. Financial stability for providers and reconfiguration of services to balance demand and capacity is an ongoing priority with financial recovery plans presented for consideration by EMA Board.	**East Midlands IMPACT Collaborative** Transformation project underway between IMPACT and Nottinghamshire Healthcare to create a new “Blended” service provision (medium to low patient journey) in one unit setting replicating the service in place at STAH. The model will support the collaborative in readiness for the anticipated new national specifications for Women’s Secure Care that will make blended pathways that are all inclusive to all women a new standard.
East Midlands CAMHS Collaborative St Andrews remains on Intensive Quality Assurance and Improvement level in response to the systemic quality and safety concerns. An action plan is in delivery for recommendations from the Nottinghamshire Healthcare CAMHS Inpatients’ Independent Closed Culture Review. Concerns being addressed for the Chesterfield Enhanced Community service (tier 3.5) which has been significantly impacted by staff sickness and vacancies over Q3. Recurrent funding has been supported following evaluation of the Enhanced Care Referral team. Financial forecast of £4m carry forward for investment in 2026/27.	**East Midlands CAMHS Collaborative** Recruitment of the Co-Production and Involvement Lead is progressing. Family Ambassador Programme expansion into the CAMHS Enhanced Community services is progressing for the three pilot sites. Leicestershire and Lincolnshire have been agreed as the Day service pilot sites with an implementation plan in development.
East Midlands Adult Eating Disorder Collaborative Nova Ward remains on enhanced quality assurance and improvement level of oversight due to systemic quality concerns across Cygnet Elowen Hospital. A Quality Improvement Plan is in place with clear governance to oversee progress. Activity levels have increased following the significant reduction earlier in the year. Due to ongoing funding pressures no additional transformational projects can be supported at this time with this position to be reviewed each quarter.	**East Midlands Adult Eating Disorder Collaborative** Projections now indicate a sufficient surplus to fully fund the Waterlily programme into 2026/27. AED commissioning intentions have been agreed through the EMPC governance including the Strategic Partnership Board.

East Midlands Perinatal Provider Collaborative Both Mother and Baby Units remain on routine quality assurance and improvement level with no escalations this quarter. Margaret Oates continues to have high room temperatures as an item on their risk register with mitigations in place. Admissions increased in the quarter although average LoS for discharged patients has decreased. Due to acuity, two patients were initially admitted to beds outside of the East Midlands with repatriation as soon as beds available. A drop in appraisal and clinical supervision rates has been addressed at the Beeches.	**East Midlands Perinatal Provider Collaborative** Air conditioning now installed at The Beeches with full resolution of ongoing issues over recent years with high room temperatures. Learning being reviewed from redeployment of teams to Community-based support over the period of closure for the unit. A focus on patient and carer experience, learning and improvement within the quarterly report demonstrates the positive breadth and depth of work across both units along with the strong focus on co-production with experts by experience.
East Midlands Gambling Harm service Significant additional funding allocation for 2026/27 is enabling service expansion planning with a focus on strengthening clinical capacity and exploring new partnerships for broader reach and recovery support. Service continues to improve referral numbers with quarter on track to exceed upper target. Service demand is driving challenges in wait times for late evening clinics with waiting well arrangements in place. Demand also driving need for resources to support awareness-raising, gambling harms training and input into strategic planning for service expansion.	**East Midlands Gambling Harm service** Lived experience partners have been engaged to support a project with Leicestershire County Council to develop messaging and raise awareness among local authority staff about gambling harm, available services, and support for affected others. A funding bid has been submitted to NHSE to support data-led service improvement and reduce inequalities.

PEOPLE PERFORMANCE



Director of People, Organisational Development and Inclusion:
Rebecca Oakley

Responsible Committee: **People and Culture Committee**

Executive Summary

Update

Annual appraisals: continue to remain high at 92% and has surpassed the 90% Trust target for the last 11 consecutive months. Efforts continue to address appraisals that are out of date and approaching renewal, to both maintain and increase compliance further. In light of our sustained success in meeting the compliance target, it is now proposed to raise this threshold from 90% to 95%.

Annual turnover: remains in line with national and regional comparators running at 11% and has remained below the Trust's 12% upper tolerance limit for the last year.

Compulsory training: compliance continues to remain high at 94.8% and has surpassing the 85% target. Efforts continue to address training that is out of date and approaching renewal, to both maintain and increase compliance further. Mandatory training target and role specific training targets will now increase by 5%.

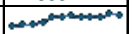
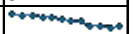
Sickness absence: for the month of March 2026 is running at 6.13%, an increase of 1.05% compared to the same period last year. Short-term sickness absence represents 2.6% and long-term absence represents 3.5%. The annual sickness absence rate is running at 5.84%, a reduction of 0.17% compared to the same period last year. Anxiety, stress or depression related illness remains the highest reason for sickness absence, followed by cough, cold, flu. The Absence Oversight Group continues to focus on development of its delivery plan, covering absence monitoring, policy compliance, hot spot areas, support for managers and support for our people. A Quality Improvement approach will continue to be taken to assist with reducing absence levels.

Vacancy rate: for the month of March 2026 is running at 6% of funded posts. The rate is derived from taking the number of funded full time equivalent (FTE) posts, less staff in post fte at month end. At the start of the financial year new investment is released which creates brand new vacancies, initially increasing the vacancy percentage. This year continues to see a staged adjustment to vacancies throughout the year as service developments and cost improvement programmes are delivered.

Agency usage: has reduced significantly compared to the previous year and continues to remain low. Agency staff continue to be used among Medics, Registered Mental Health Nurses (RMNs) and some Healthcare Assistants (HCAs). The Agency Reduction Panel now meets fortnightly to oversee a new plan, focusing on filling vacancies and ensuring proper approval processes.

Supervision: The Trust target has been reviewed against other mental health trusts and reset at 95%, reflecting a more sustainable and realistic benchmark for ongoing compliance. The Trust's supervision system was successfully aligned to the revised Supervision Policy for the end of March 2026. This was a long-awaited, complex, technical system development which took several months to plan, develop, test and deploy. Compliance for clinical supervision has surpassed the target at 96% and management supervision remains just slightly below target at 94.8%.

PEOPLE KEY PERFORMANCE INDICATORS

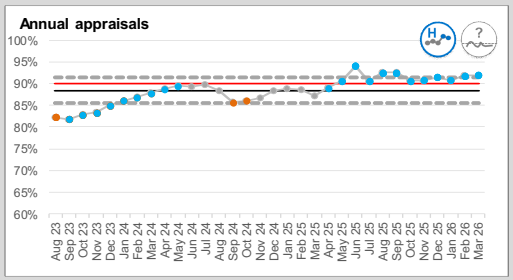
Measure	Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	
People Performance														
Annual appraisals	90%	89%	91%	94%	91%	93%	93%	91%	91%	91%	91%	92%	92%	
Annual turnover (target 8-12%)	12%	10.7%	10.6%	10.2%	10.0%	10.1%	10.1%	10.4%	10.7%	10.8%	10.7%	10.8%	11%	
Compulsory training	85%	93.2%	93.6%	93.7%	94.0%	94.6%	94.6%	94.8%	94.5%	94.6%	94.5%	95.0%	94.8%	
Vacancy	5%	11.6%	11.2%	10.9%	10.2%	10.4%	9.1%	8.9%	8.5%	6.7%	6.4%	5.8%	6%	
Bank staff use	5%	4.5%	4.0%	4.1%	3.9%	4.5%	5.1%	4.5%	5.2%	4.7%	4.2%	4.7%	5.2%	
Agency staff use	1.9%	0.3%	0.4%	0.3%	0.4%	0.5%	0.4%	0.5%	0.4%	0.5%	0.4%	0.5%	0.7%	
Management supervision - staff compliant with supervision policy[3]	95%	84%	85%	86%	86%	85%	87%	88%	86%	89%	88%	85%	94.8%	
Clinical supervision - staff compliant with supervision policy[3]	95%	81%	83%	82%	82%	82%	83%	85%	86%	88%	88%	89%	96%	
NHS oversight framework 2025/26														
Sickness absence rate	5%	5.4%	4.9%	5.3%	5.8%	5.5%	5.8%	6.6%	6.6%	6.3%	6.0%	6.2%	6.1%	
Long term sickness (28 days plus)	n/a	2.8%	2.6%	2.6%	2.9%	2.8%	3.5%	3.6%	3.9%	3.7%	3.2%	3.2%	3.5%	
Short term sickness (<28 days)	n/a	2.6%	2.3%	2.7%	2.9%	2.7%	2.3%	2.9%	2.6%	2.6%	2.8%	2.9%	2.6%	
Annual NHS staff survey - raising concerns sub-score[1]	6.64	6.76	6.76	6.76	6.76	6.76	6.76	6.76	6.76	6.76	6.76	6.76	6.64	
Annual NHS staff survey engagement theme score[1]	7.02	7.07	7.07	7.07	7.07	7.07	7.07	7.07	7.07	7.07	7.07	7.07	7.02	
National Education and Training Survey overall satisfaction score (C.)[2]	77.4%	78.9%	78.9%	78.9%	78.9%	78.9%	78.9%	78.9%	78.9%	78.9%	78.9%	78.9%	79.4%	

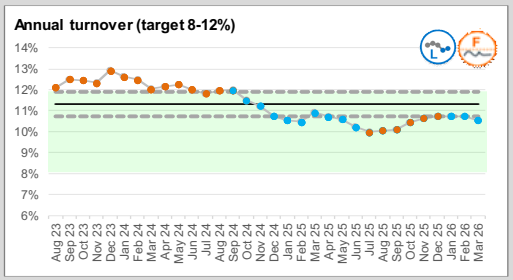
[1]2025 survey results were published in March 2026. Target = national average (2024 raising concerns = 6.74, and 2024 engagement = 7.07).

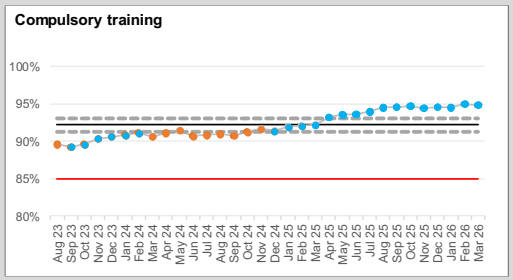
[2]2025 survey results were published in March 2026. Target = national average.

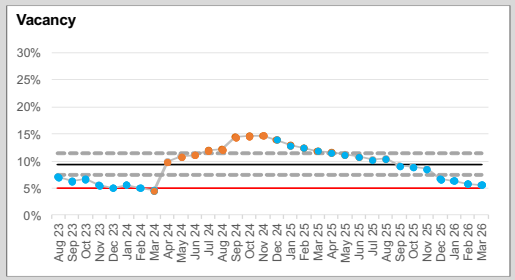
[3]System changes implemented from March 2026

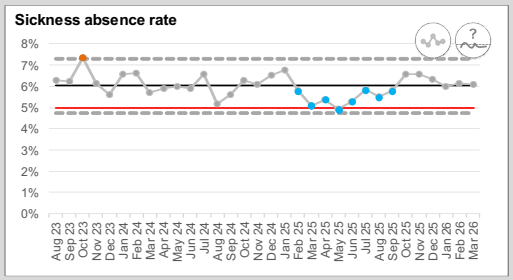
People Key Performance Indicators – Statistical Process Control Charts

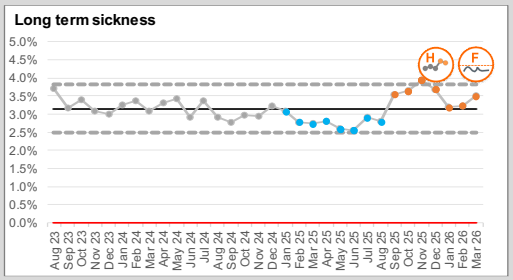


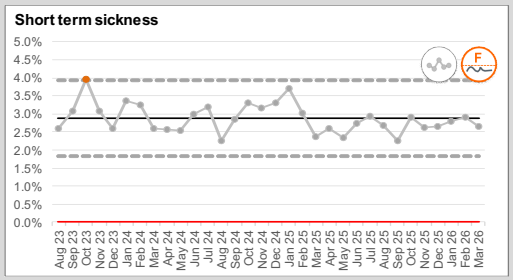


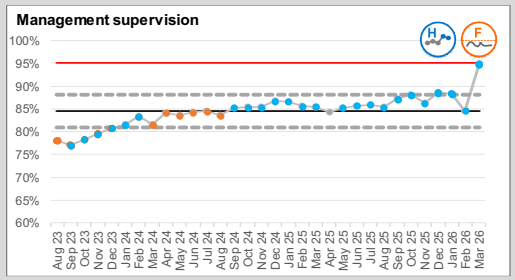


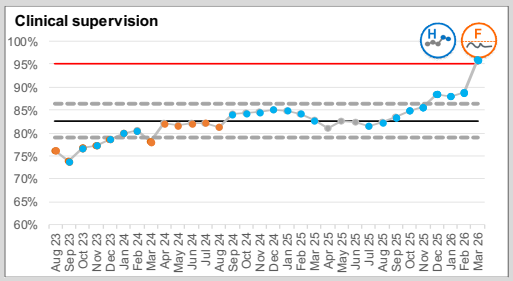


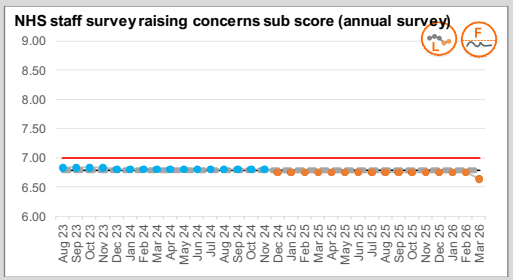


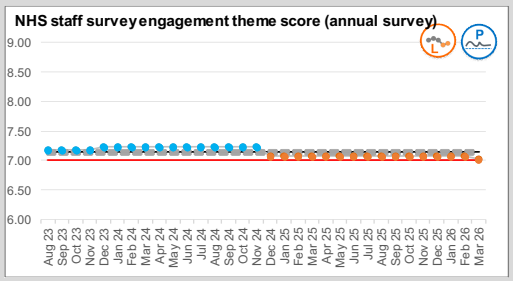


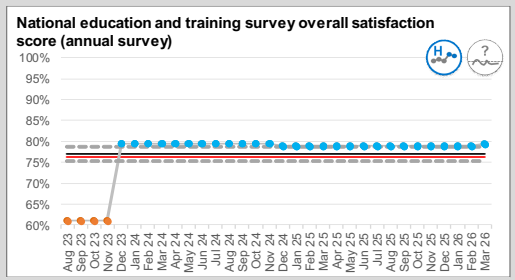


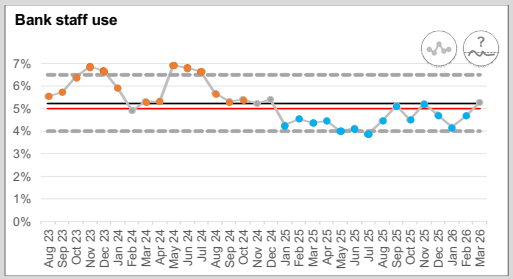


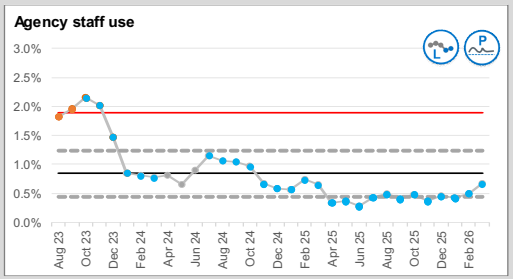












FINANCIAL PERFORMANCE

Director of Finance:
James Sabin

Responsible Committee: **Finance and Performance Committee**

Executive Summary

Overall

At the end of the financial year, there is an overall deficit of £6.5m, which has been adjusted for the Private Finance Initiative (PFI) adjustment related to the International Financial Reporting Standards (IFRS) 16 accounting change and impairments, bringing the adjusted financial position to a small surplus of £11k which is slightly is better than the plan of breakeven.

Efficiencies

The plan includes an efficiency requirement of £14.8m with the plan assuming 82% is delivered recurrently. At the end of the financial year efficiencies were delivered in full. However, the split between recurrent and non-recurrent schemes was different to the original plan due to the reduced savings from the operating model in year which has been mitigated by non-recurrent one-off benefits.

Agency

Agency expenditure at the end of the financial year is £2.5m, which equates to 1.3% of the total pay expenditure and is below plan by £0.9m as per the previous forecast. The two highest areas of agency usage continue to relate to Consultants and Nursing staff.

Adult Acute OoA Placements

The biggest area of risk all year has been in relation to adult acute out of area placements, with expenditure being above plan by £4.5m which is slightly worse than last month's forecast.

Capital Expenditure

Capital is below plan at the end of the financial year by £0.4m. The plan included a 5% over planning assumption of £105k which all organisations agreed to remove that expenditure. As a System, there were several cost pressures that emerged that need to be mitigated. Therefore, all organisations were asked to consider contributing a further underspend on their capital plans to help mitigate the System capital position. Therefore, business as usual (BAU) capital is forecast to be under plan by £1.0m. Additional national monies for Estate and Digital schemes have been secured totalling £1.3m.

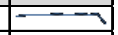
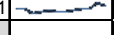
Cash

Cash at the end of March is at £26.9m which is higher than plan by £1.5m due to the timing of receipts. There are no concerns in relation to debt recovery.

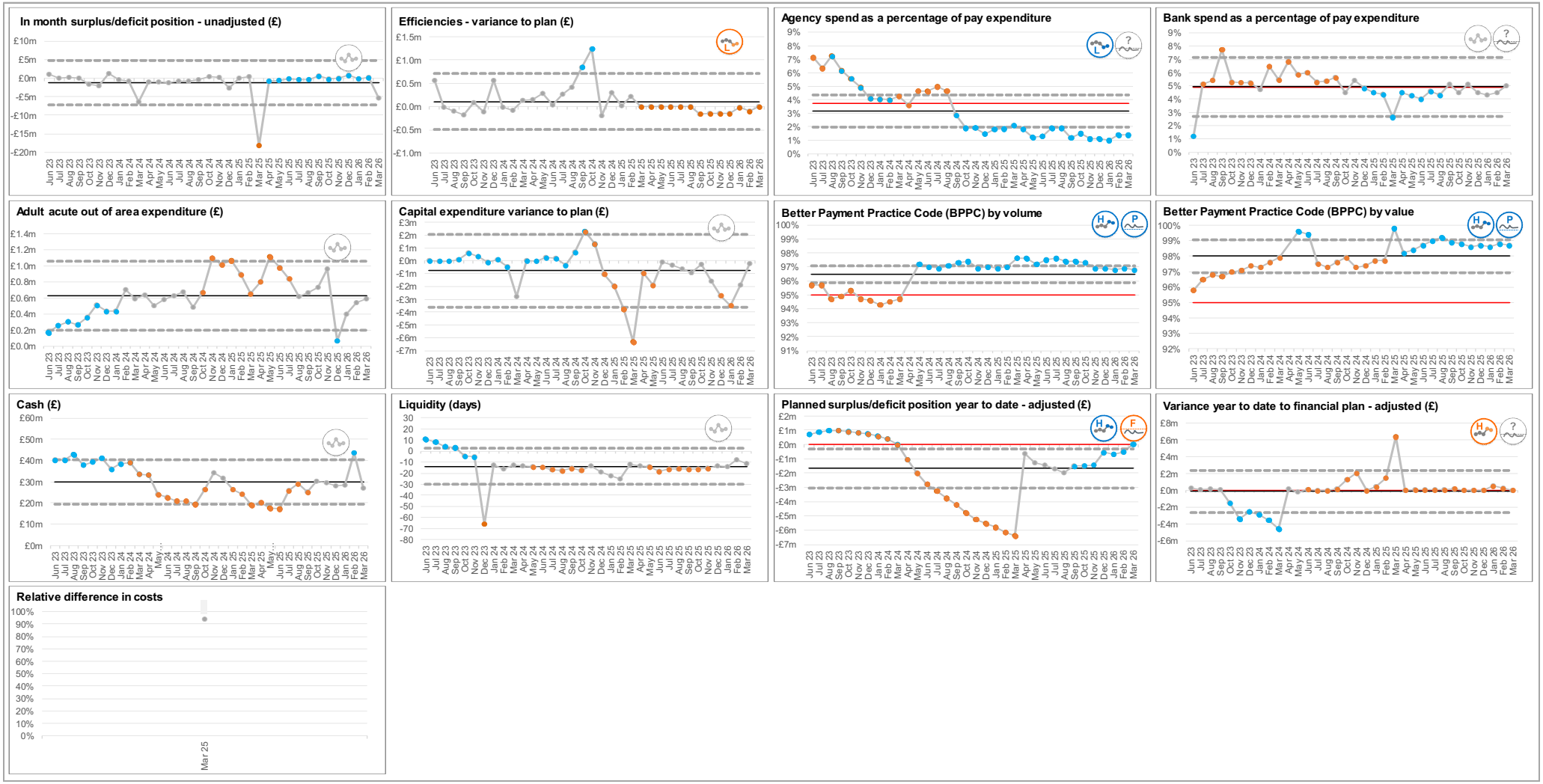
Better Payment Practice Code

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

FINANCIAL KEY PERFORMANCE INDICATORS

Measure	Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	
Financial Performance														
In month surplus/deficit position - unadjusted (£)	-	-£ 759,497	-£ 618,647	-£ 181,431	-£ 356,503	-£ 340,743	£ 546,298	-£ 224,055	-£ 16,211	£ 792,384	-£ 181,752	£ 105,378	-£ 5,302,531	
Efficiencies - variance to plan (£)	-	£ -	£ -	£ -	£ -	£ -	-£ 153,000	£ 2,000	£ 1,000	-£ 150,000	-£ 17,000	-£ 96,000	£ -	
Agency spend as a percentage of pay expenditure	3.7%	1.8%	1.2%	1.3%	1.9%	1.9%	1.2%	1.5%	1.0%	1.1%	1.0%	1.4%	1.4%	
Bank spend as a percentage of pay expenditure	4.9%	4.5%	4.3%	4.0%	4.6%	4.3%	5.1%	4.5%	4.9%	4.5%	4.3%	4.5%	5.0%	
Adult acute out of area expenditure (£000)	-	£ 799	£ 1,110	£ 977	£ 839	£ 618	£ 660	£ 727	£ 956	£ 60	£ 399	£ 543	£ 592	
Capital expenditure variance to plan (£)	-	-£ 953,000	-£ 1,907,000	-£ 107,000	-£ 333,000	-£ 640,000	-£ 917,000	-£ 274,000	-£ 1,606,000	-£ 2,719,000	-£ 3,479,000	-£ 1,905,000	-£ 244,000	
Better Payment Practice Code (BPPC) by volume	95%	97.6%	97.2%	97.5%	97.6%	97.4%	97.4%	97.3%	96.9%	96.9%	96.8%	96.9%	96.8%	
Better Payment Practice Code (BPPC) by value	95%	98.2%	98.4%	98.7%	99.0%	99.2%	98.9%	98.8%	98.6%	98.7%	98.6%	98.8%	98.7%	
Cash (£000)	-	£ 20,204	£ 17,589	£ 17,175	£ 25,805	£ 29,130	£ 25,167	£ 30,338	£ 29,717	£ 27,969	£ 28,403	£ 43,653	£ 26,925	
Liquidity (days)	-	-13	-14	-19	-16	-16	-16	-16	-16	-13	-14	-8	-11	
NHS oversight framework 2025/26														
Planned surplus/deficit year to date - adjusted (£)	£ -	-£ 643,118	-£ 1,289,243	-£ 1,442,742	-£ 1,714,677	-£ 1,986,468	-£ 1,521,049	-£ 1,472,000	-£ 1,421,000	-£ 557,000	-£ 669,000	-£ 521,000	£ 11,000	
Variance year to date to financial plan - adjusted (£)	tbc	£ 26,588	£ 43,183	£ 76,791	£ 63,671	£ 65,060	£ 207,015	£ 5,116	£ 6,456	£ 33,609	£ 496,585	£ 240,026	£ 11,000	
Relative difference in costs	<100%	93.76%												

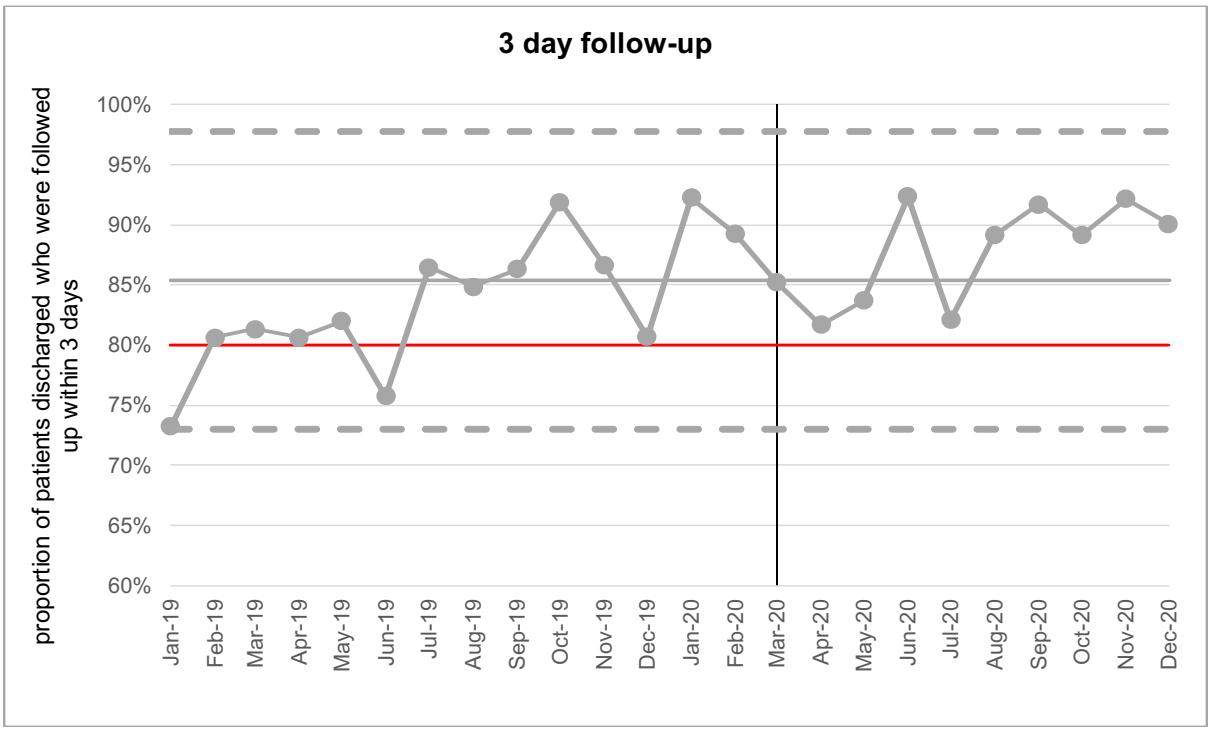
Financial Key Performance Indicators – Statistical Process Control Charts



Appendix 1

Statistical Process Control Chart (SPC) Guidance

Example SPC chart:



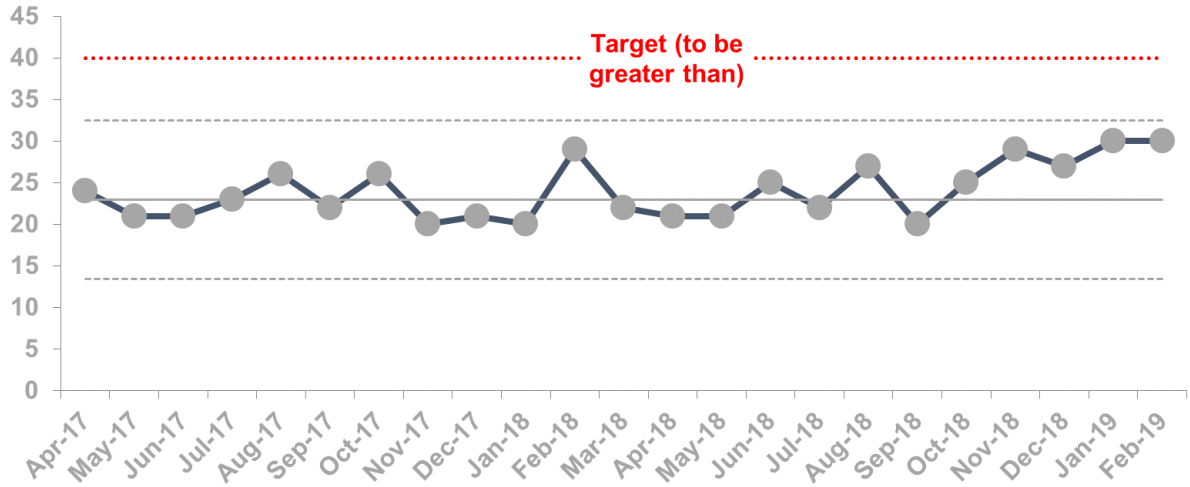
- The red line is the target
- The grey dots are the actual performance each month. They are coloured grey as performance each month is normal in this example
- The solid grey line is the average (mean) of all the grey dots
- The grey dotted lines are called process limits, or control limits.

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

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

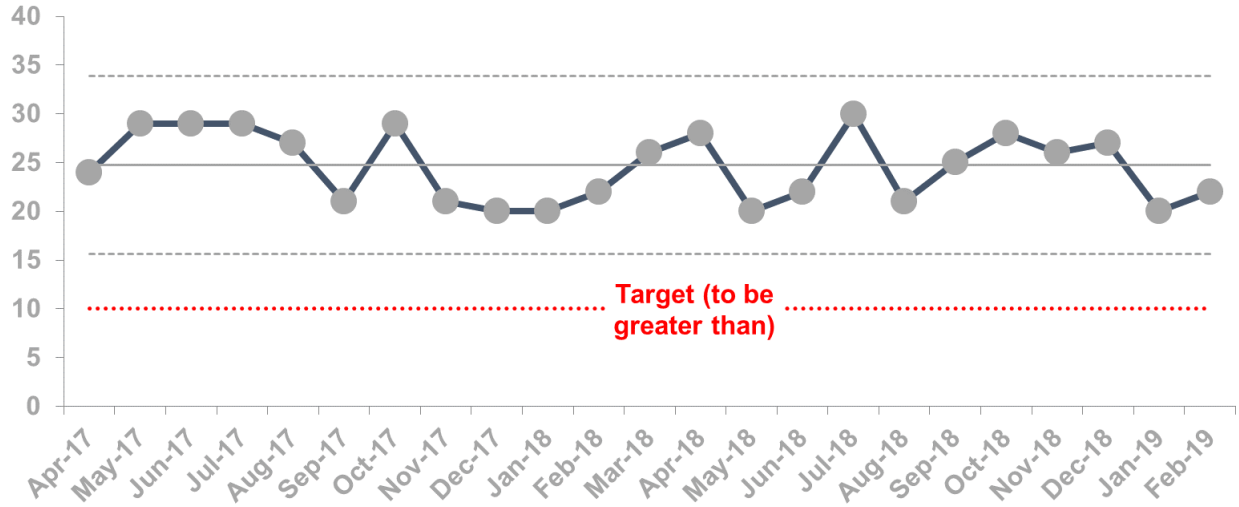
Things to look out for:

1. A process that is not working:



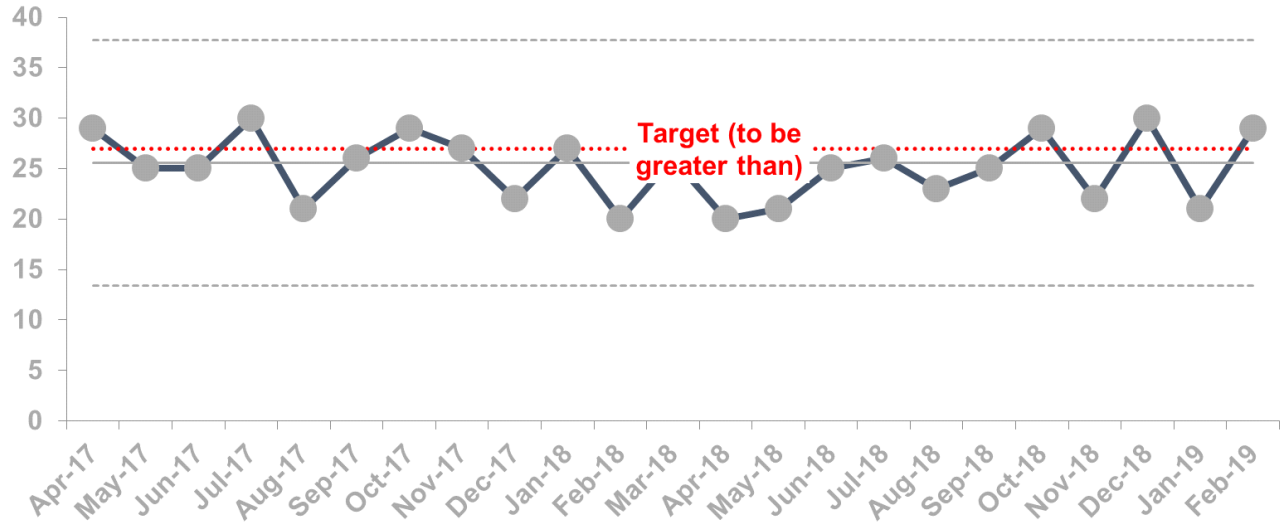
In this example the target is higher than the upper dotted grey line. This means that the target will never be achieved. To achieve the target, we need to change how we do things.

2. A capable process:



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

3. An unreliable system:

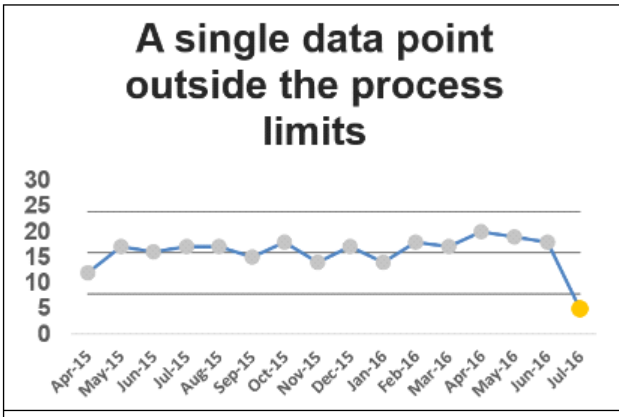
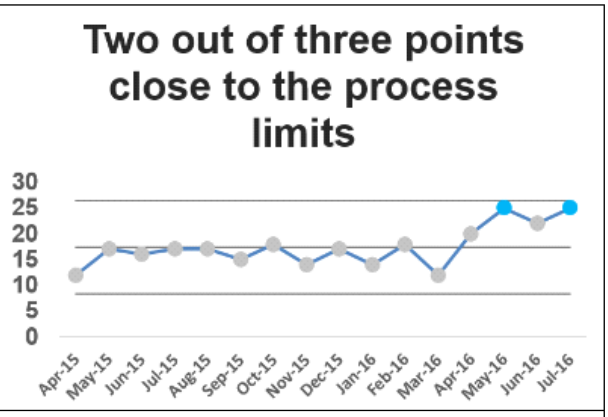
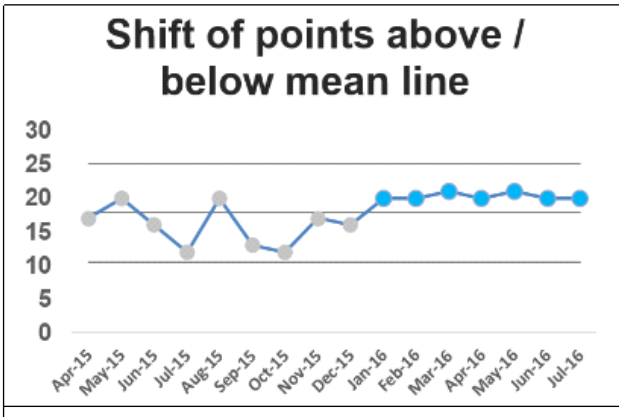
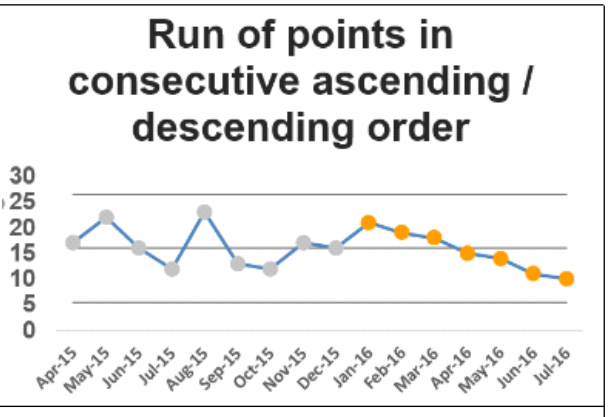


In this example, the target line sits between the two grey dotted lines. As it is normal for the grey dots to fall anywhere between the two dotted grey lines, this means that it is entirely random as to whether or not the target will be achieved. So, this system is unreliable and needs to be redesigned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

4. Unusual patterns in the data

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

There are four scenarios where this can happen:

<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.

Board Committee Assurance Summary Reports to Trust Board – 19 May 2026

The following summaries cover key items discussed at the meetings that have been held since the last public Board meeting held on 24 March 2026 and are received for information.

- Finance and Performance Committee – 20 March 2026 and 6 May 2026 (verbal)
- Quality and Safeguarding Committee – 14 April 2026 and 7 May 2026
- Audit and Risk Committee – 23 April 2026
- People and Culture Committee – 29 April 2026

Key:

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

Finance and Performance Committee – key assurance levels for items – 20 March 2026	
	Making Room for Dignity (MRfD) programme **Benefits Evaluation reports for Audrey House and Kingfisher Unit** The Committee approved the Benefits Evaluation reports for Audrey House and Kingfisher Psychiatric Intensive Care Unit (PICU) as part of the MRfD programme. Incorporating feedback from patients, staff, System partners and Board members, the evaluation assessed outcomes against the four strategic priorities (Patient; People; Productivity; Partnership). Overall, progress was positive with most metrics improving. Bank staff costs were the main exception, linked to recruitment delays for Kingfisher and the acuity of the environment. Additional work has been commissioned with WSP to capture learning through internal reviews and stakeholder sessions. The reports, which provided **significant assurance**, will be formally endorsed at Trust Board and shared with NHS England. The next reviews are planned at 12 months and two years.
	Clinical Digital Plan The Committee supported the draft Digital Delivery Plan for presentation to Trust Board. The plan has been developed through an extensive consultation phase (including Digital Futures Day and CEO engagement) and is aligned to the Clinical Delivery Plan and organisational priorities. It is structured around four programme areas (digitise, optimise, connect and enable) with defined deliverables and a two-year roadmap. Key risks and dependencies were highlighted. Accepting **significant assurance**, the Committee emphasised prioritisation of deliverables and pausing lower-priority work if capacity becomes constrained, alongside ongoing staff feedback and engagement mechanisms.
	Financial Governance and Performance – Month 10 Finance report A £0.7m deficit at month 10 was reported, £0.5m better than plan, with strong Cost Improvement Programme (CIP) delivery, positive cash and payment positions and capital now on track to recover by year-end. The Trust is on track to meet year-end financial objectives, with remaining savings expected to be achieved.

	The Derbyshire system was £33m year-to-date in deficit (primarily Acute trusts) with a forecast £51m year-end deficit; withdrawal of deficit support for Acutes and national funding redistribution policies meaning balanced providers will not benefit while the System remains in deficit. The report provided the Committee with **significant assurance**.
	Continuous Improvement Progress and next steps for implementing the Transformation and Continuous Improvement Framework and associated delivery plans were noted. Updates included broad coverage of continuous improvement training, increasing numbers of local team-led projects registered on the live QI system and tracked through governance routes and the distinction between strategic programmes (eg patient flow improvements and development of a mental health urgent assessment centre) and local initiatives. The Committee received **significant assurance** regarding this item.
	Contracts update **Limited assurance** was provided by the update. Risks to income in a post-Covid commissioning landscape were acknowledged. Key issues included delays in receiving the draft 2026/27 ICB contract, ongoing checks of the 2025/26 contract and a backlog of contract variations awaiting signature. Late confirmations were linked to funding cycles across local authorities and other organisations. Risks around additional roles reimbursement scheme contracts were highlighted, where the Trust acts as host employer for roles funded by both primary care networks and the ICB; mitigations include redeployment of staff. A reflection on the Derby City Substance Misuse tender outcome was received, including external analysis and planned training to strengthen commissioner relationships and bid writing. Organisational learning and relationship management were emphasised.
	Operational Performance report The Committee received **limited assurance** from the report. Improvements in inappropriate out of area placements, early intervention in psychosis and crisis response times were highlighted. Discussions focused on the transforming care programme: a change in counting methodology for people with learning disabilities/autism in inpatient beds increased reported numbers, triggering weekly assurance meetings with NHS England and the ICB; identifying the need for a multi-year strategy and local authority engagement. Due to expanded scope without additional funding, internal redesign was described to improve response rates. Further actions include closure of the 0800 number, managing high-intensity callers and continued discussions with the ICB on scope and funding. Community waits over 52 weeks were largely attributed to rising demand for ADHD/Autism assessments and lack of local commissioning; the ICB Executive Team has committed to developing a commissioning plan and separating waiting lists to target improvement activity within the Trust's control.
	Operational and Financial Planning The Committee received **significant assurance** from the update on operational and financial planning. It was noted that regional engagement has focused on financial outturn and CIP planning, with positive feedback. A potential year-two capital non-compliance risk was flagged due to the need to complete MRfD works. Discrepancies between the Trust's submitted activity numbers and those submitted by the ICB to the national team with no explanation were discussed with the Committee agreeing this should be documented and clarified for Board awareness.

East Midlands Perinatal Mental Health Provider Collaborative

As lead provider for this collaborative, the Trust allocates funding and provides provider oversight, with commissioning oversight undertaken via an external hub to avoid conflicts of interest.

The temporary closure of the Derby Mother and Baby Unit, was noted, during which admissions to Nottingham's unit as required is being piloted.

The Committee accepted **significant assurance** from the paper.

Committee year-end Effectiveness report and annual review of Terms of Reference (ToRs)

The Committee considered the year-end report on its activity and effectiveness and confirmed that it had fulfilled its terms of reference during 2025/26, with **full assurance.** Minor amendments to the ToRs were agreed.

Board Assurance Framework 2025/26 risks overview (and consider forward plan of deep dives)

The Committee noted the completion of a light-touch refresh with no material changes.

Escalations to Board or other Committees: None.

Items added to the Board Assurance Framework: None.

Next scheduled meeting: 6 May 2026.

Committee Chair: Jo Hanley	**Executive Lead: James Sabin, Director of Finance**

Quality and Safeguarding Committee – key assurance levels for items – 14 April 2026

Director of Nursing update

The introduction and alignment of the new Quality Dashboard, provided the Committee with **limited assurance** while it was still in the development stages. The focus was on ensuring metrics reflect strategic priorities, the process for updating targets, and the assurance mechanisms for reporting to the Board and Committee.

It was noted that some metrics have been removed or added to ensure comprehensive assurance to the Integrated Care Board and NHS England under the NOF framework, with some metrics not yet available, to be included as data becomes ready.

It was further noted that the dashboard for the Board will be a streamlined version of the Committee dashboard.

Fundamental Standards of Care report

It was reported that 91 service reviews had been completed, with all recent inspections rated 'good' across all domains, including Cherry Tree and Crisis services. The Committee noted that the Quality Assurance Framework is seen as effective, with ongoing support for areas of concern.

The rationale for maintaining a limited assurance rating was discussed, noting that while progress is evident, some recent actions are not fully implemented. The Committee agreed on the need for clearer articulation of what is required to move to significant assurance and suggested including expected timeframes for improvement.

Participants debated how to balance recognising progress with the inherent uncertainties in service delivery. It was suggested to specify areas where assurance is limited and detailing mitigation plans, while acknowledging the challenge of predicting when full assurance can be achieved due to factors outside the Trust's control.

Limited assurance was received, with evidence of strong performance across services and a clear trajectory of improvement, alongside identified risks which are being actively managed.

Assertive Outreach (AO) Community Mental Health Treatment (quarterly)

	The Committee discussed the ongoing AO self-assessment, which evidenced progress, though work remains in areas such as working with relatives and implementing the Personalised Care Framework, which is still in draft. It was clarified that while clinical practice is not affected, assurance reporting is limited by system integration challenges. Carers' engagement is improving but remains inconsistent, with efforts underway to enhance identification and feedback mechanisms. Concerns were raised about team capacity and resource allocation, noting disparities between city and rural areas. It was clarified that capacity is not easily transferable due to service structure and discussions with the ICB are ongoing to establish a county-wide team for better resource flexibility. The Midlands Intensive and AO Self-Assessment tool was approved for submission. **Significant assurance** was received for the update of ongoing Trust work around AO and with System partners.
	Infection Prevention and Control (IPC) update and Board Assurance Framework (BAF) Changes to infection control structures and reporting were noted, which ensure all statutory requirements are met and audits are systematically conducted. The high number of audits and the need to balance assurance with time for care was recognised. The roll-out of Level 3 training was highlighted, with matrons and new structures included. The Committee accepted **significant assurance** from the ongoing monitoring through routine IPC reporting arrangements.
	Quality Account (draft) It was noted that the document covers performance against Trust ambitions, CQC ratings, patient safety, effectiveness, experience and digital initiatives, aligning with statutory requirements and Trust Strategy. Whilst comprehensive, it was acknowledged that the document is not user-friendly for the public due to national directives on what should be included. Suggestions to address this included a one-page visual summary, clearer articulation of ambitions versus achievements and transparency about areas still in progress. The Committee advocated for better showcasing of the transformational changes and that consideration be given to using video or summaries to enhance engagement.
	Quality Dashboard (bi-monthly) The report provided **limited assurance** on progress towards clinical performance targets. Increases in physical and prone restraint were reported, mainly due to a small number of high-acuity patients, with targeted improvement plans in place. The Committee discussed ongoing efforts to reduce restrictive interventions, including a collaborative and self-assessment against national standards. The new metrics on complaints were welcomed and reviewed, noting improved response times. Discrepancies between complaints received and responded to, due to withdrawals and referrals to other bodies, were explained. Persistent high averages in Length of Stay and Discharge metrics were attributed to increased patient acuity and reduced out-of-area placements. A spike in medication incidents was attributed to increased reporting following electronic prescribing implementation and more vigilant practice, particularly among newly qualified Nurses.
	Patient-Led Assessments of the Care Environment (PLACE) (annual) The PLACE results were presented, noting lower organisational food scores compared to previous years and disparities between adjacent wards assessed by different teams (same building different organisations' services). The subjectivity of scoring and the use of external patient advocates were discussed. Mitigations include a deep dive into food scores, developing an action plan by May and considering the use of Trust service users for more contextual feedback. The Committee agreed to revisit the action plan in July and ensure integration with infection control and patient experience.

Committee year-end Effectiveness report and annual review of Terms of Reference (ToRs)

The Committee considered the year-end report on its activity and effectiveness and confirmed that it had fulfilled its terms of reference during 2025/26. The report demonstrated the extensive matters covered and evidenced that the Committee had worked effectively. Minor amendments to the ToRs were reviewed and agreed.

Suicide and Self-Harm Prevention Plan (six-monthly)

The Plan's alignment with national guidelines was outlined to include local adaptations for high-risk groups and actions for Derbyshire, including targeted support, reducing barriers and addressing online safety and access to means.

High compliance rates for online modules were reported, along with plans for face-to-face training, and the establishment of Learning from Lessons Groups to ensure recommendations are implemented and cascaded.

The need for formalised post-incident support for staff, with a working group established to develop policy was discussed. Opportunities for community outreach and training for large employers were identified as future actions.

The need for ICB-level governance of suicide prevention, with plans for executive discussions to clarify accountability and ensure strategic alignment was highlighted.

Summary of Board Assurance Framework (BAF) Risks

The Committee noted that the quality risk rating has been reduced from high to moderate, supported by improved CQC oversight and external assurance. Progress in areas such as suicide prevention and dormitory elimination was noted.

Gaps in assurance were identified for Learning Disabilities, Autism and Children's services and more explicit reporting and Divisional updates to the Committee were suggested.

Policy Review

The Chaperone Policy and Procedure was ratified.

Board Assurance Framework (BAF) – key risks identified: None.

Items for discussion at Board or other Board Committees: A legacy outstanding action raised at the Finance and Performance Committee was noted, regarding low volumes of responses for the Friends and Family test. It was agreed to close the loop and ensure regular review through the Quality and Safeguarding Committee.

Items added to the Board Assurance Framework: None.

Next scheduled meeting: 7 May 2026.

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

Quality and Safeguarding Committee – key assurance levels for items – 7 May 2026

Director of Nursing update

The main points noted by the Committee were:

- The formation of the Violence and Aggression Collaborative to address violence, aggression and abuse against staff was described, incorporating involvement with the police around anti-racism; sexual safety and physical violence with integration into broader incident and racism reporting
- The Trust Delivery Group's approval and timeline to explore Community safer staffing was highlighted, including case load management and multi-disciplinary involvement, despite the lack of statutory guidance, with benchmarking efforts underway against similar organisations

	• Changes within the Integrated Care Board (ICB) were explained, including the appointment of two deputies to the Director of Quality, clarifying oversight responsibilities for infection prevention and safeguarding, and noting ongoing review and alignment with new governance structures • Efforts to learn from regional organisations and ensure alignment with population health needs and care pathways were explained • An outline of the NHSE Flu Vaccine programme dates for delivery.
	Fundamental Standards of Care It was reported that the Trust has retained a 'good' rating across all domains, with improvements in the safe and responsive domains following factual accuracy submissions, and no outstanding regulatory actions. Recent inspections of health-based places of safety (HBPoS) have highlighted environmental and staffing concerns, with actions in place and thematic analysis of visits being presented to relevant groups. The structured improvement plan and leadership oversight for Dove Ward was noted, along with the appointment of a new Interim Ward Manager and ongoing staff engagement to address inconsistent frontline practice. The effectiveness of the Quality Assurance Framework was highlighted, with a one-page summary and booklet developed to promote staff engagement and Band 5 Nurses participating in visiting panels. The embedment of the new triumvirate structure to strengthen operational leadership, visibility and collective accountability was discussed, with emphasis on the Board's patient-focused strategy and its impact on cascading leadership. Evidence of strong regulatory compliance and governance across services, managed risks and a clear trajectory to support improvements with consistency of clinical practice, provided **significant assurance.**
	Ligature Risk Reduction Report The Committee was informed that a dedicated ligature minimisation and management group reviews trends, data and policies, with a focus on fixed point ligatures and targeted interventions with a specific focus in female wards. It was noted that an in-house training package on ligature management is being delivered by the Suicide Prevention Lead, with uptake progressing above trajectory. The report highlighted that incident analysis has revealed reductions in fixed point ligatures, attributed to staff awareness and environmental controls, with ongoing monitoring and adaptation to changing patient behaviours. A significant amount of evidence was offered to consider a high level of assurance. However, the Committee accepted the **limited assurance** offered noting the current levels of training and the importance of clinical scrutiny in restrictive practices.
	Patient Safety report It was reported that deaths, often related to addiction, constitute the largest category of catastrophic incidents, with major self-harm incidents increasing and abuse/aggression incidents showing clustered patterns linked to individual patients. The paper identified disproportionate representation of certain ethnic groups in major incidents, aligning with national research, and noted over-representation of younger people in major incidents linked to social media risks. It was noted that 13 learning responses were commissioned, with progress made in reducing overdue incident reviews, but minimal progress in addressing outstanding patient safety actions, prompting plans for clearer ownership and escalation. Delay in development of automated reports was attributed to limited capacity and it was agreed the Executives will consider the implications of this further, factoring in scrutiny of the overall pace of improvement works for the Patient Safety team.

The Committee noted the progress made and the opportunities for improvement the new governance structures are providing**. Limited assurance** was accepted acknowledging that plans to improve upon this throughout the next quarter are in place.

Quality Account – sign-off

The final draft of the document was received, noting the incorporation of feedback from the Committee and wider stakeholders, accessibility improvements and the pending inclusion of the ICB quality statement.

It was agreed that the final version clearly reflects the Trust's progress since the foundation year of the Strategy, the achievements in 2025/26 and the plans represent a clear and logical progression from building capability to measurable improvement.

Approval for Board submission was granted.

Special Educational Needs and Disabilities (SEND) annual report

The Trust's high compliance rates in audits and health advice key performance indicators were noted, with improvements in Oliver McGowan training and transition processes for patients across services.

Attention was drawn to remaining challenges in System partnership working, particularly in data sharing and health inequalities, with Ofsted and Care Quality Commission reviews highlighting areas for improvement and ongoing efforts to address data gaps. The Executives committed to address the concerns in relation to data gaps and strengthening partnership working.

Due to the new nature of the requirements, **limited assurance** was provided by the report.

Clinical Governance for Quality and Safety

The revised framework detailed pictograms and hierarchies for governance, outlining board-to-floor and floor-to-board reporting for quality and safety, with clear alignment.

It was noted that a continuous improvement approach using 'Plan, Do, Study, Act' cycles is planned to monitor and adapt governance structures, ensuring ongoing grip and control over quality, safety, and effectiveness.

The Committee accepted **significant assurance** in the structure and clarity of the framework, noting the need for evidence of outcome and potential simplification of meeting structures as implementation matures.

Clinical Audit – annual report on Effectiveness and Clinical Audit Plan

Progress in embedding quality improvement (QI) methods was reported, aligning audits with organisational priorities and increasing QI-trained leadership in priority audits.

The Introduction of The Hierarchy of Interventional Effectiveness has enabled a greater understanding of where the greatest improvement interventions can take place. Plans to leverage published research to shift towards more effective system interventions was noted.

Audit completion challenges were attributed to staff turnover and reliance on Medics for delivery and it was noted that the Clinical Effectiveness Group aims to improve prioritisation and resource allocation.

Efforts to broaden audit participation across disciplines, with increased involvement from non-medical professions were discussed to further enhance multi-disciplinary review.

Limited assurance was accepted due to inconsistent application of otherwise sound design controls.

Quality and Equality Impact Assessment (QEIA) Assurance (annual update)

The QEIA process applied to transformation projects was presented, noting Executive review and alignment to system standards, with many QEIA submissions revised until approved, noting no outright rejections in the past year.

The inclusion of continuous improvement projects was questioned, along with the need for policy clarification on process scope beyond transformation projects.

	It was noted that while the process is robust and provided **significant assurance**, the report lacked evidence of ongoing monitoring, mitigation and impact evaluation; specifically in relation to quality and safety resulting in **limited assurance** and a request for an interim report addressing these gaps.
	Policy Review The Privacy and Dignity (including Same Sex Accommodation guidance) Policy and Procedures was ratified.
	Items for discussion at Board or other Board committees: It was noted that the Quality Governance Framework will be discussed at the People and Culture Committee. **Items added to the Board Assurance Framework:** It was suggested that the backlog on PSIRF actions and investigations impacting on learning from incidents should be articulated as a risk if not captured adequately within the BAF. **Next scheduled meeting:** 16 June 2026.

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

Audit and Risk Committee – key assurance levels for items – 23 April 2026	
	Board Assurance Framework (BAF) – Issue 1, 2026/27 The Committee was informed that a comprehensive review had been undertaken, including individual Director assessments, two sessions with the Executive Leadership Team and an AI mapping exercise to ensure alignment with the Trust Strategy. The inclusion of risk appetite scores and wording around risk tolerance was highlighted. In order to improve cross-committee understanding of risks, it was noted that all committees now receive the full BAF report, rather than purely their relevant sections. A downgrade of Risk 1A from high to moderate was reported. The BAF was approved with **significant assurance** around the review process.
	Operational Risk Management (quarterly update) to include the new Corporate and Divisional Governance Structure The report highlighted that review completion rates were initially low due to annual leave and staffing changes but had improved as risk owners caught up. Changes in ward and Care Group management required additional training and support for new staff. The Committee noted the new governance structure, with updated risk assessment policies and quarterly reporting to Care Group performance review meetings and Divisional Board meetings. Explanation was received of an overdue Fire and Safety risk review, for which sign-off was pending following completion of an Estates action. It was agreed that a review of reporting frequency would be considered in six months' time. **Significant assurance** was provided regarding efforts to drive the risk management process.
	Draft Annual Report and Accounts – 2025/26 The Committee received the first draft of the Annual Report, Annual Accounts and Annual Governance Statement (AGS), noting that missing sections due to data cut-off would be included with the final version in May. On presentation of the draft Accounts, a headline deficit adjustment to a small surplus after technical adjustments was highlighted and the standard annual pension contribution adjustment and desktop revaluation was clarified. It was noted that the AGS included input from professional leads and oversight by the Director of Corporate Affairs and Trust Secretary.
	Going Concern Assessment – 2025/26

	The Committee received the going concern assessment and approved the following statements for inclusion in the Annual Report – 2025/26: • The Directors have a reasonable expectation that the services provided by the NHS foundation trust will continue to be provided by the public sector for the foreseeable future, and • For this reason, the Directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.
	Audit and Risk Committee year-end Effectiveness report and review of Terms of Reference (ToR) The Committee considered the year-end report on its activity and effectiveness for 2025/26 and the comprehensive, self-assessment process, using the HMFA Audit Committee handbook template. Members supported the view that the Committee's objectives had been achieved and noted the **significant assurance** provided regarding the discharging of its remit as outlined in the Committee's ToRs. The Committee approved minor revisions to its ToRs, including a new Counter Fraud standard.
	Board Committees' year-end Effectiveness reports and review of their ToRs The Committee agreed **significant assurance** on the year-end effectiveness reports from the Board Committees concerning their activity and effectiveness for 2025/26, comparing the work of the Committees to their ToRs. The need to refine survey questions for relevance was highlighted and it was noted this was to be reviewed to improve the process for next year. A summary of the year-end reporting will be presented to the Trust Board in May.
	Patient Safety Incident Review Framework (PSIRF) Learning from Patient Safety Incidents (Limited Assurance report, 360 Assurance) In line with process for limited assurance reports, the Committee had invited the Lead Director to attend the meeting to outline the management response. The Trust's Executive Medical Director advised the Committee of the detailed progress on updating policies, improving public access to plans, establishing review cycles and enhancing oversight through new reporting structures and learning forums at Care Group and Trust-wide levels. Mechanisms for ongoing monitoring, escalation and reporting were described which will ensure sustained improvement. It was noted that this report had also been presented to the Quality and Safeguarding Committee, who would be monitoring improvements. The Committee noted the report actions are on track for delivery by August 2026.
	Implementation of the Freedom to Speak Up (FTSU) Policy Framework (six-monthly update) and request for approval of the refreshed FTSU Plan 2026-2029 and FTSU Policy and Procedure The Committee monitors compliance with the FTSU policy and processes and received a six monthly update which also gave an overview of the main themes, which are reported in detail and for triangulation to other sources of feedback at the People and Culture Committee. Staff confidence and responsiveness FTSU metrics were positive. It was noted that action plans include cultural improvement initiatives, strengthened leadership support, anti-racism statements and improved escalation processes. It was clarified that the updated policy aligns with national guidance and strengthens management of detriment. The improved alignment between cultural and FTSU initiatives was recognised. **Significant assurance** was received that the Trust's arrangements enable staff to speak up confidently and safely about concerns relating to their working environment. The Committee approved the FTSU Policy and FTSU Plan for 2026-2029.
	Salary Overpayments update

	The collaborative work with payroll providers and other trusts to strengthen overpayment policies and service level agreements was described, aiming for completion and sign-off by the end of May. The Committee noted efforts to address late notifications by contacting line managers and promoting use of the notice system. It was emphasised that overpayments are now a standing item at the Trust Delivery Group. The Committee confirmed **Limited Assurance** on the update on the basis that overpayments had still not been reduced to an acceptable level and requested that future updates include data on the impact of actions, such as reductions in overpayments and improved recovery rates.
	Internal Audit Progress Report The Committee noted the issue of the two final audit reports, high action tracking rates and the imminent finalisation of a Care Planning report. Benchmarking on losses and single tender waivers was also provided for information. The Interim Head of Internal Audit Opinion was delivered as significant assurance, noting that the Care Planning report would be finalised and included in the final opinion. The Committee was assured by the progress compared to the previous year. The development of the 2026/27 plan, which was risk-based and aligned with strategic risks was outlined and approved by the Committee. It was suggested additional focus be placed on restricted practice, the digital agenda and change management, subject to resource limitations and plans to revisit these topics in future years.
	Counter Fraud, Bribery and Corruption progress report The Committee approved the 46-day work plan for 2026/27, which includes reviews of controlled drugs management, National Fraud Initiative preparation and conflicts of interest declarations. Recent activities were noted to include training sessions, completion of a review of estates and fleet vehicles with seven recommendations and closure of several fraud cases. All actions from the mid-year counter fraud functional standard return were complete.
	External Audit – Audit Strategy Memorandum Forvis Mazars presented the external audit plan, outlining key financial reporting risks, audit approach and timelines. It was noted that the plan is consistent with previous years, focusing on management override of controls, valuation of land and buildings and revenue recognition. A slight reduction in risk was noted, along with the use of data analytics and standard risk assessments. It was reported that materiality thresholds were set at the higher end due to strong controls. The value for money assessment remains ongoing, with no significant weaknesses identified so far. Access to data and information for field work was noted as satisfactory with the audit on track for timely completion.
	Conflicts of Interest Policy The Committee scrutinised and endorsed the approach to e-Commerce and ratified the policy.
	Board Assurance Framework (BAF) – key risks identified: None.
	Items for discussion at Board or other Board Committees: None. **Items added to the Board Assurance Framework**: None. **Next scheduled meeting:** 2 June 2026.
Committee Chair: Chioma Akpom	**Executive Lead: Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary**
People and Culture Committee – key assurance levels for items – 29 April 2026	
	Director of People update

The Committee noted the slide presentation, which covered the below areas:

- Staff Standards: it was highlighted that the launch of national management and leadership standards are awaited, emphasising that local initiatives and ongoing work will continue, regardless of the national timeline and will be integrated rather than the creation of additional workstreams
- 10-Year Workforce Plan: this is expected with initial references anticipated in May
- Violence and Aggression Collaboration: two recent sessions, attended primarily by frontline staff, were described to include a focus on violence and aggression, sexual safety, racism and police engagement. The positive reception of the Green Lane Counselling Support service during the workshops to enhance staff wellbeing was highlighted.

  It was noted that staff networks have expressed interest in supporting the initiatives by facilitating and offering drop-in sessions.

People and Inclusion Assurance Dashboard

The main points reviewed by the Committee were:

Long-term absence reduction: the implementation of a new process and policy was described, which includes those cases exceeding 12 months. It was noted that meetings with affected staff, often involving unions, are ongoing with gradual progress made. Analysis of data across professions and Directorates with high sickness rates is identifying the hot spots of focus for Task and Finish Groups and Organisational Development culture plans.

Annual Appraisal: the continued position above compliance was highlighted, noting that the target is to move to 95%.

Supervision and Appraisal compliance: it was reported that Supervision recording now aligns with policy and the compliance target is to be adjusted to 95%, already met by Clinical Supervision.

Temporary Staffing: in response to persisting inappropriate agency usage and high bank staffing, a fortnightly agency group and monthly strategy group focus on recruitment and reducing last minute requests.

Freedom to Speak Up (FTSU): the Committee identified gaps in demonstrating impact and agreed to receive more concrete examples of resolution and outcomes for staff assurance.

Significant assurance was received on the progress shown for mandatory training, staff turnover and annual appraisals and **limited assurance** for vacancies and recruitment, attendance and absence, Temporary Staffing usage, supervision and FTSU.

Medical Appraisal and Revalidation (annual)

The Committee noted that the move to the electronic L2P platform has highlighted doctors who are significantly behind with their appraisals, which is being closely monitored with active support to bring in line with requirements.

A number of areas of improvement highlighted by internal audit have been accepted and are being implemented.

Significant assurance was accepted.

Modern Slavery Statement

The Committee approved the revised Statement, subject to the inclusion of strengthened narrative around assurance measures and staff training compliance.

Equality, Diversity and Inclusion – Gender Pay Gap report and Public Sector Equality Duty (PSED) report

Improvements in organisational culture, the role of staff networks and the integration of the Patient and Carer Race Equality Framework were outlined, noting increased confidence in meeting PSED and capturing good practice.

Inconsistencies around the effectiveness of Recruitment Inclusion Guardians was acknowledged, with the need for more data and consistent weighting of their input at recruitment panels.

	The Committee agreed to take **significant assurance** on progress to reduce the gender pay gap and EDI achievements and **limited assurance** on long-term pay gap reduction due to the need for sustained action.
	Staff Survey – Trust Actions 2025 The Committee was presented with data on teams with low or no survey responses, identifying these as priority areas for engagement and listening events to understand barriers and concerns. Proposed Trust-level actions aligned with organisational values and ongoing initiatives were reviewed, with a working group established to drive progress and report through governance structures. The need to learn from positive feedback and to ensure staff feel valued was emphasised. The importance of involving staff at all levels in action planning and communicating both successes and areas for improvement was discussed. It was agreed that while the action plan is well-developed, there is **limited assurance** on its effectiveness until outcomes can be measured. The need for clear expected outcomes, targeted focus and ongoing evaluation was recognised.
	Recruitment– improvement action plan Implementation of escalation processes for delays, improved reporting and reduced 'time-to-hire' metrics were explained, with some targets, such as 'time to shortlist' unmet. The need for real-time vacancy data and predictive pipeline management to ensure seamless recruitment, particularly for newly qualified Nurses was emphasised, with work towards integrating Finance and HR data for better forecasting. The focus on minimising reliance on agency staff and improving retention was highlighted.
	Guardian of Safe Working Hours (GoSWH) The report detailed a significant increase in exception reports, attributed to the increased workload from new builds and greater anonymity in the reporting process, which encourages transparency. The shift towards payment instead of time off in lieu for exception reports has financial implications and it was confirmed that Finance is monitoring these costs and mechanisms are in place to track and manage the impact. It was highlighted that data is being collected and triangulated to assess workload changes, with further analysis expected and vacancies in higher trainee posts are under review to determine if trends require intervention.
	Deep Dive – Health and Wellbeing The Committee noted the exit of Leadership and Wellbeing services from the Joint Venture, with transition to 'Health Assured' for independent counselling and enhanced support, with a focus on cost-effectiveness and quality. It was informed that the new model includes team support, mediation, trauma support and GP access via 'Perkbox', with simple and meaningful metrics established to assess the impact of the new Wellbeing offer, focusing on absence rates, staff survey results and service satisfaction. The inclusion of students and bank workers in the Wellbeing offer was confirmed. The Committee received **significant assurance** in the development of the 2026 Wellbeing Offer and its structured six-pillar framework. **Limited assurance** was received on the impact of the new offer and model at this point.
	Review of People and Culture Committee Board Assurance Framework (BAF) Risks Discussions related to staff morale following the recent organisational changes, the potential for increased turnover among newly-recruited Nurses and the importance of monitoring retention trends and age profiles. The need for more specific risk descriptions in relation to diversity at leadership level was highlighted, noting under-representation of ethnic minorities in senior roles, despite overall workforce diversity.

	The importance of linking Workforce, Finance and Patient Safety risks within the BAF was emphasised, ensuring that actions and impacts are clearly articulated and connected across domains.
	Items for discussion at Board or other committees: None. **Items added to the Board Assurance Framework**: The inclusion of Bank effectiveness was suggested. **Next scheduled meeting:** 2 July 2026.

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

Year-end Financial Position – 2025/26

Purpose of Report

This paper provides a short update on the financial position for 2025/26. It is recognised a much more detailed finance paper is provided and discussed at Finance and Performance on a monthly basis and at Audit and Risk Committee as part of the year end account review and sign off process.

Executive Summary

The overall financial outturn for 2025/26 was a deficit of £6.5m against a planned deficit of £5.7m. After technical adjustments the outturn position is a small surplus of £11k.

Adjusted financial performance	**Current Plan 31/03/2026 YTD £000**	**Actual 31/03/2026 YTD £000**	**Variance 31/03/2026 YTD £000**
Surplus/(deficit) for the period/year	(5,711)	(6,537)	(826)
Add back all I&E impairments/(reversals)	4,200	5,510	1,310
Surplus/(deficit) before impairments and transfers	**(1,511)**	**(1,027)**	**484**
Retain impact of DEL I&E (impairments)/reversals	(200)	(262)	(62)
Remove PFI revenue costs on an IFRS 16 basis	6,521	6,470	(51)
Add back PFI revenue costs on a UK GAAP basis	(4,810)	(5,170)	(360)
Adjusted financial performance surplus/(deficit)	**0**	**11**	**11**

Efficiencies of £14.8m were delivered in full, although the split between recurrent and non-recurrent delivery was different to the original plan.

Agency and bank expenditure were both below planned levels by £0.9m and £0.3m respectively.

Adult Acute out of area expenditure was above plan all year but has been mitigated by other underspends.

Draft annual accounts were presented to Audit and Risk Committee on 23 April and submitted to NHS England on 27 April and are subject to audit review with final accounts due on 26 June.

Strategic Considerations		**BAF Risk (eg 1A)**	**Strategic Delivery Plan Reference**
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	3A	3.1
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.			

Risks and Assurances

The key risks relate to the Board Assurance Framework Risk on delivery of the Financial Plan which was currently at Moderate but was achieved for 2025/26. This has been refreshed as part of the Board review of the Board Assurance Framework following the 2026/27 planning round.

Consultation

- The financial position is discussed and signed off internally and reported to the Derbyshire System Derbyshire, Lincolnshire, Nottinghamshire (DLN) cluster and NHSE
- A detailed finance report is provided to the Finance and Performance Committee
- The draft accounts have been presented to the Audit and Risk Committee.

Governance or Legal Issues

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

Net Zero Duty Implications

In compliance with the NHS move towards net zero carbon emissions, the Trust must consider statutory emissions and environmental targets in their decisions. Reports should identify related impacts on workforce and system leadership; sustainable models of care; digital transformation; travel and transport estates and facilities (including capital projects, asset management and utilities, green space and biodiversity); medicines; supply chain and procurement; food and nutrition and adaptation.

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

Some of the efficiency schemes such as travel and estate rationalisation may have a positive impact on reducing carbon emissions.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

Recommendations

The Board of Directors is requested to note the financial position for 2025/26 and successful delivery of the required financial objectives of breakeven.

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

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

2025/26 Outturn

At the end of March, the unadjusted financial position before technical adjustments was a deficit of £6.5m against a deficit plan of £5.7m.

Statement of comprehensive income	Current Plan 31/03/2026 YTD £'000	Actual 31/03/2026 YTD £'000	Variance 31/03/2026 YTD £'000
Operating income from patient care activities	247,449	248,312	863
Other operating income	9,745	14,153	4,408
Employee expenses	(197,880)	(195,227)	2,653
Operating expenses excluding employee expenses	(56,984)	(67,578)	(10,594)
OPERATING SURPLUS/(DEFICIT)	**2,330**	**(340)**	**(2,670)**
FINANCE COSTS			
Finance income	601	1,473	872
Finance expense	(3,209)	(3,210)	(1)
PDC dividend expense	(5,433)	(4,460)	973
NET FINANCE COSTS	**(8,041)**	**(6,197)**	**1,844**
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(5,711)**	**(6,537)**	**(826)**

Adjusted financial performance	Current Plan 31/03/2026 YTD £'000	Actual 31/03/2026 YTD £'000	Variance 31/03/2026 YTD £'000
Surplus/(deficit) for the period/year	(5,711)	(6,537)	(826)
Add back all I&E impairments/(reversals)	4,200	5,510	1,310
Surplus/(deficit) before impairments and transfers	**(1,511)**	**(1,027)**	**484**
Retain impact of DEL I&E (impairments)/reversals	(200)	(262)	(62)
Remove PFI revenue costs on an IFRS 16 basis	6,521	6,470	(51)
Add back PFI revenue costs on a UK GAAP basis	(4,810)	(5,170)	(360)
Adjusted financial performance surplus/(deficit)	**0**	**11**	**11**

The following technical adjustments have been taken into account when reporting the adjusted financial position against the breakeven plan:

- Impairments, where the value of a building has been reduced by £5.5m which £5.2m related to the Making Room for Dignity (MRfD) programme, with the remainder related to over specification of works in progress or obsolescence for normal operations
- Public Finance Initiative (PFI) adjustment related to the International Financial Reporting Standards (IFRS) 16 accounting change.

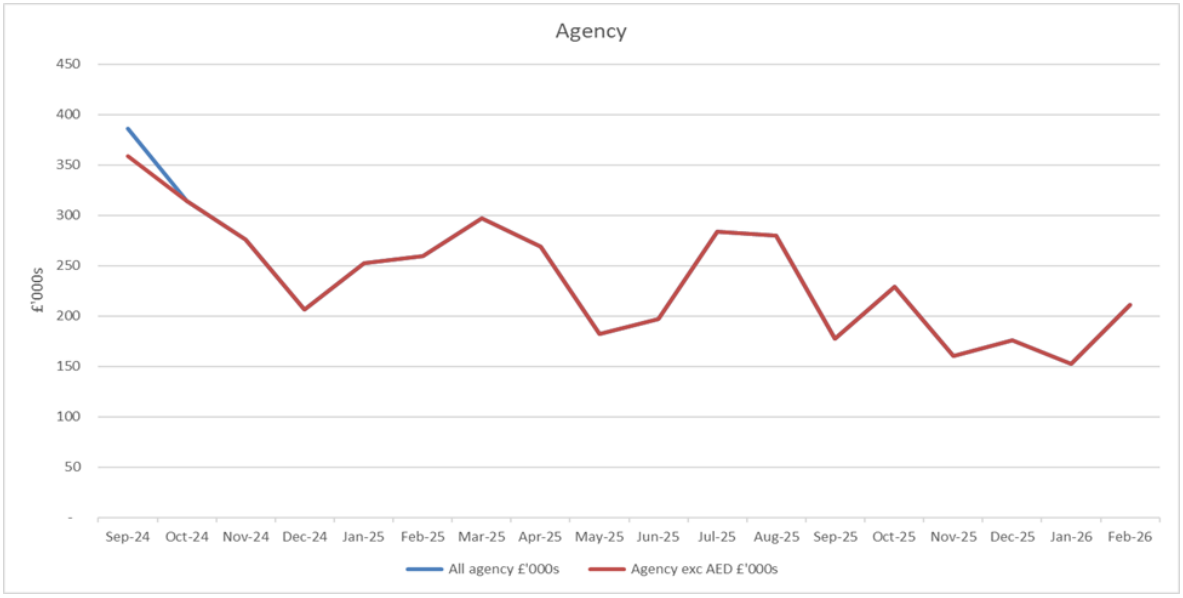
Temporary Staffing

At the end of March, agency expenditure was £2.5m, which was below plan by £1.2m. The main area of agency expenditure was on Consultants at £2.1m and £0.3m on qualified Nursing. There has been a reduction on agency expenditure throughout the financial year and is significantly lower than the expenditure in previous years.

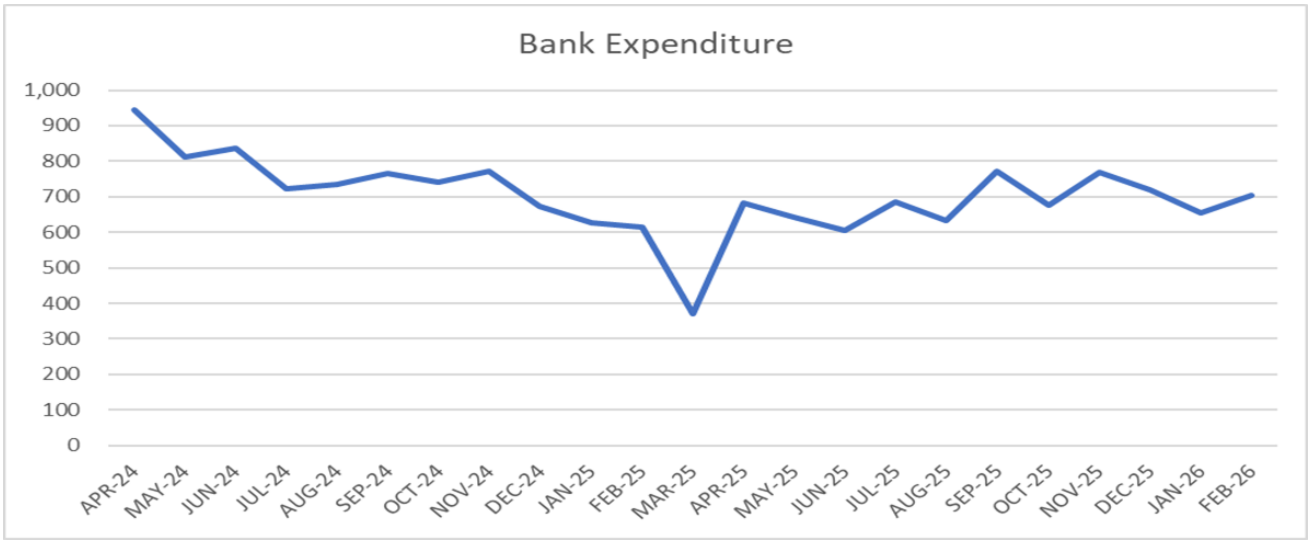
Agency spend by NHSI Staff Group
Mar-26

	% of spend	2025-26 Forecast	2024-25 Actual	Change
Consultants, agency	83%	£2,114,882	£2,808,986	-£694,104
Career/staff grades, agency	0%	£0	£0	£0
Trainee grades, agency	0%	£0	£0	£0
Qualified nursing, midwifery and health visiting staff, agency	12%	£308,855	£1,110,010	-£801,156
Support to nursing staff	4%	£111,017	£1,112,541	-£1,001,524
Qualified scientific, therapeutic and technical staff, agency	0%	£0	£0	£0
Managers and infrastructure support, agency	0%	£2,346	£57,702	-£55,356
Support to clinical staff, excluding support to nursing staff, agency	0%	£0	£0	£0
	100%	**£2,537,100**	**£5,089,240**	**-£2,552,140**
Contingency		£0	£0	£0
		£2,537,100	**£5,089,240**	**-£2,552,140**

2025-26 Plan	**£3,416,000**
Expenditure below plan	**-£878,900**
Expenditure % below plan	**-25.7%**



Bank staff expenditure totalled £8.3m in 2025/26 which was £0.3m under plan. The main area of bank usage relates nursing staff on the Inpatient wards.



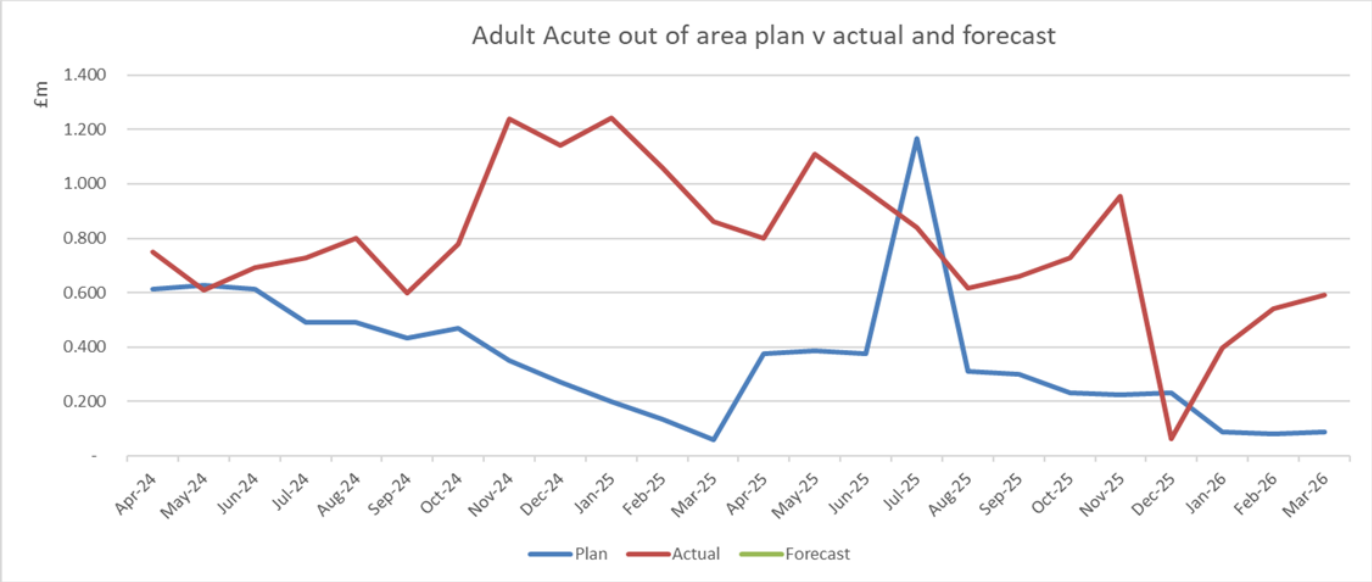
Efficiencies

At the end of the financial year, the efficiency programme of £14.8m has been delivered in full, with 66% delivered recurrently. The delay on the operational restructure reduced the in-year recurrent savings. However, this has been mitigated by other in year non-recurrent benefits.

Efficiency Savings	Plan 31/03/2026 YTD £'000	Actual 31/03/2026 YTD £'000	Variance 31/03/2026 YTD £'000
Recurrent			
Pay - Recurrent	9,303	5,642	(3,661)
Non-pay - Recurrent	2,708	3,401	693
Income - Recurrent	100	699	599
Total recurrent efficiencies	**12,111**	**9,742**	**(2,369)**
Non recurrent			
Pay - Non-recurrent	163	2,459	2,296
Non-pay - Non-recurrent	2,477	778	(1,699)
Income - Non-recurrent	34	1,806	1,772
Total non-recurrent efficiencies	**2,674**	**5,043**	**2,369**
Total Efficiencies	**14,785**	**14,785**	**0**

Adult Acute out of area

During 2025/26, £8.3m has been spent on out of area placements, which is £4.5m above plan. There was a reduction in expenditure during the financial year until January when expenditure started to increase.



Capital

The capital plan was resubmitted at the end of April 2025. The plan is made up of Capital Departmental Expenditure Limit allocation of £5.9m (including leases) along with national funding of £11.8m for the MRfD programme.

The plan included a 5% over planning assumption of £105k. It has been agreed for all organisations to remove the over planning assumption from the forecast at month 6.

As a System, there are several cost pressures that emerged that need to be mitigated. Therefore, all organisations were asked to consider contributing a further underspend on their capital plans to help mitigate the System capital position. We have paused expenditure by £200k and offered a further £850k by deferring expenditure on the self-funded MRfD project, of which the £850k is expected to be returned next financial year.

Therefore, business as usual (BAU) capital is forecast to be under plan by £1.0m.

Additional national monies for estate and digital schemes have been secured totalling £1.3m. At the end of the financial year, we were £3.7m above plan against the System capital allocation, which is due to the residual MRfD cost pressure after the original BAU schemes have been scaled back to help provide some mitigation, agreed by the System.

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

Capital Scheme Desc	Full Year Plan 31/03/2030 Year ending £'000	Actual Outturn 31/03/2030 Year ending £'000	Variance Variance 31/03/2030 Year ending £'000
Self Funded schemes			
MR4D Radbourne Unit	1,840	0	1,840
Fire compartmentation works	400	720	(320)
Estate Staffing	240	270	(30)
IT Equipment	772	872	(100)
Backlog maintenance	1,500	2,150	(650)
Anti-Ligature works	25	25	0
Urgent Estate requests	200	200	0
The Beeches air conditioning	50	187	(137)
Hartington Unit works to retained space	100	123	(23)
Medical equipment rolling programme	50	76	(26)
EV Charging - infrastructure upgrades	50	50	0
EV Charging - charging points roll out	50	50	0
Backlog Maintenance - Moderate and low risk	876	403	473
Total CDEL (befroe IFRS16)	**6,153**	**5,126**	**1,027**
Centrally funded schemes PDC			
MR4D Radbourne Unit	11,810	11,810	**0**
ROU Additons	0	614	**(614)**
Alfreton Programme	0	162	**(162)**
Patient Knows Best	0	70	**(70)**
MH reducing OOA placements	0	425	**(425)**
Total central funding	**11,810**	**13,081**	**(1,271)**
Total capital plan submitted	**17,963**	**18,207**	**(244)**
Operating Leases			
CHP and Prop Co leases	300	139	161
Non-NHS leases	300	0	300
HU	0	0	0
Leasetermination/Peartree Clinic		(148)	148
Total Leases	**600**	**(9)**	**609**
Total Capital	**18,563**	**18,198**	**365**

Trust's Medium-Term Plan - 2026/27 to 2028/29 and five-year integrated delivery plan - NHSE feedback letter

Purpose of Report

The purpose of this report is to share the NHSE feedback letter in relation to the Trust's Medium-Term Plan for 2026/27 to 2028/29 and five-year integrated delivery plan.

Executive Summary

We received the response for the Trust plan from NHSE on 2 April (attached as it includes a requirement for the full response to be shared with the Board). **Accepted Status – Compliant with conditions** due to non-compliance in your activity submissions. The detail of which relates to Year 3 Length of Stay (LoS) metrics.

Strategic Considerations		BAF Risk (eg 1A)	Strategic Delivery Plan Reference
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	3A	3.1
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.			

Risks and Assurances

- The risks predominantly remain in relation to 1) inpatient overspends driven by acuity and additional observations, 2) Out of Area (OoA) demand, impacted by flow and clinically ready for discharge (CRfD) patients. 3) identification and delivery of Cost Improvement Programmes (CIPs) whilst managing timing delays and potential exit cost risk
- These are managed and monitored via the Board Assurance Framework (BAF) and Corporate and Directorate risk registers.

Consultation

- The Plan was developed via Trust governance including, the Trust Delivery Group (TDG), Finance and Performance Committee (FPC), People and Culture Committee and Board. In addition, a series of workshops helped develop the CIP plans, themes in addition to transformation projects which are overseen via the Strategic Portfolio Oversight Group and other digital groups
- The financial position is discussed and signed off internally and reported to the Derbyshire System (Derbyshire, Lincolnshire, Nottinghamshire) cluster and NHSE. Regular Provider NHS Oversight Framework (NOF) meetings take place with NHSE
- A detailed finance report is provided to the FPC and is covered with the wider Integrated Performance Report that is discussed at Board.

Governance or Legal Issues

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

Net Zero Duty Implications

In compliance with the NHS move towards net zero carbon emissions, the Trust must consider statutory emissions and environmental targets in their decisions. Reports should identify related impacts on workforce and system leadership; sustainable models of care; digital transformation; travel and transport estates and facilities (including capital projects, asset management and utilities, green space and biodiversity); medicines; supply chain and procurement; food and nutrition and adaptation.

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

- In delivery of our financial objectives, we continue to make progress with regards to net zero. Rationalise estate, modernise and reduced emissions and reduce waste
- Some of the efficiency schemes such as travel and estate rationalisation may have a positive impact on reducing carbon emissions.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

All associated CIP plans which form part of our plans go via a formal Quality and Equality Impact Assessment (QEIA) process.

Recommendations

The Board of Directors is requested to:

1. Note the NHSE feedback and required conditions
2. Note the non-compliance re year 3 LoS submission. This was known and agreed as unrealistic at the time, due to progress already committed to re years 1 and 2
3. Note the asks, including the continued development of CIPs plans through the full QEIA process by the end of May and plans for 2027/28 onwards to be developed by 31 August 2026.

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

To: Mark Powell, Chief Executive Officer
Selina Ullah, Chair
Derbyshire Healthcare NHS FT

Dale Bywater
Regional Director
NHS England – Midlands
Cardinal Square
10 Nottingham Road
Derby
DE1 3QT

2 April 2026

Dear Mark,

ORGANISATION NAME: Derbyshire Healthcare NHS FT

Acceptance Status: Compliant with Conditions

I am writing in response to the submission **of your final medium-term plan for 2026/27–2028/29** and your **five-year Integrated Delivery Plan**, and to set out next steps. Thank you for the extensive work across the organisation that has contributed to the development of these plans.

As we move into implementing the plans our shared focus moves firmly toward delivering the strategic shifts and long-term transformation required to reset NHS performance and build a sustainable, modern health and care service. The Medium-Term Planning Framework set a clear expectation that organisations will work over multiple years, to restore constitutional standards, strengthen community-based care, and accelerate prevention and digital transformation. Planning over multiple years means that planning does not end with the agreement of the plan; the focus on delivery will also be accompanied by ongoing foundational work as you continue to work on understanding any changes in the demand and capacity of your services and population health needs.

Transforming our services remains essential to achieving the required outcomes for patients as well as productivity and efficiency improvements to ensure sustainability. We will continue to work with you to ensure your organisation has access to the development and improvement support needed to strengthen capability and capacity.

Your submitted plan has been reviewed against the expectations set out in the national guidance and has been assessed as **Compliant with Conditions due to non-compliance in your activity submissions.**

Oversight

Effective oversight of the delivery of these plans will be important to ensure that the ambitious trajectories are met. We will review progress against these plans with you through our regional oversight arrangements, which include routine provider review meetings (PRMs), ICB cluster review meetings and other forums e.g. tiering calls, finance oversight meetings. This will ensure that there is continuous assurance, alignment across organisations, and transparent governance.

Finance

Delivering financial balance remains a key requirement for all NHS organisations and systems. We are pleased to see that you have submitted a balanced plan and note the risks described in your submission.

Please refer to appendix 2 to this letter which outlines the ongoing financial conditions expected to be adhered to.

Quality considerations for the delivery of Medium-Term Plans

The Medium-Term Planning framework sets out the key approach to transforming quality across the NHS with reference to the National Quality Board NQB) Quality Strategy, the introduction of modern service frameworks and a focus on patient and staff experience alongside outcomes. ICBs and providers must continue to implement the NHS Patient Safety Strategy and implement guidance from April 2026 as it is published. It is important that Equality and Quality Impact Assessments are undertaken for any proposed service changes and should be fully reflected in the management of identified risks.

Next steps

Please can you ensure that your Board has approved your medium-term plan submission and fully understands any risks, actions and mitigations required to deliver the finance, activity and workforce plans. Your submitted activity plans including key commitments (including any areas of non-compliance) are found in appendix 1 and will form part of our ongoing performance management processes.

Please let me know if you wish to discuss any of the above. I would be grateful if you could share this letter with your full Board.

Yours sincerely

Dale Bywater
Regional Director – Midlands

CC:
Simon Evans, Chief Operating Officer, NHS England (Midlands)
Nicola Hollins, Regional Director of Finance, NHS England (Midlands)
Kay Fradley, Director of Strategic Development, NHS England (Midlands)
Rebecca Farmer, Director of System Coordination and Oversight (Midlands)

Appendix 1 – Full plan submission

Headline Targets - the targets/baselines specified in tables in the MTP Framework

					2026/27				2027/28				2028/29			
Document Section	Statement in guidance	Planning Metric	Activity and Performance Template Metric ID	ICB or Provider Based	Time point	Baseline /Target	Plan	Variance	Time point	Baseline /Target	Plan	Variance	Time point	Baseline /Target	Plan	Variance
3.5 Mental Health	Eliminating inappropriate out of area placements	Number of active inappropriate adult acute out of areas placements (OAPs) at the end of the reporting period	E.A.5	Provider	Mar-27	0	0	0	Mar-28	0	0	0	Mar-29	0	0	0

Supporting Metrics - these are wider targets/baselines mentioned through the text in the MTP Framework

					2026/27				2027/28				2028/29			
Document Section	Statement in guidance	Planning Metric	Activity and Performance Template Metric ID	ICB or Provider Based	Time point	Baseline/Target	Plan	Variance	Time point	Baseline/Target	Plan	Variance	Time point	Baseline/Target	Plan	Variance
3.5 Mental Health	Reduce longest waits for CYP community mental health services by improving productivity, reducing local inequalities and unwarranted variation	Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period	E.A.7	Provider	Mar-27	0	0	0.0								
	Reduce the average length of stay in adult acute mental health beds	Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds (3 month rolling metric)	E.H.38	Provider	Mar-27	52.5	46.5	-6.0	Mar-28	46.5	41.9	-4.7	Mar-29	41.9	41.9	0.0
		Average Length of Stay for Patients in Older Adult Acute Mental Health Beds (3 month rolling metric)	E.H.39	Provider	Mar-27	86.8	78.1	-8.7	Mar-28	78.1	74.0	-4.1	Mar-29	74.0	74.0	0.0

Appendix 2 – Financial Conditions

The following ongoing financial conditions are expected to be adhered to:

- We note your final submitted plans show compliance in years 2027/28 and 2028/29. We expect you to continue to develop these medium term plans so as to ensure sufficient substance to describe the practical means by which break even will be achieved in those years by no later than 31 August 2026 (see also efficiencies below).

- The timescale for the finalisation of commissioners and providers contracts was 31 March 2026. In the event you are yet to be compliant with this deadline please ensure all contracts are agreed with formal signature by no later than 15 April 2026.

- Your financial plan submitted on 12 February 2026 shows planned efficiency and productivity totalling £14.5m (5.9%); of which only 28.7% has been categorised by your organisation as being fully developed. Triangulated organisational plans should demonstrate a credible trajectory for delivery with an expectation that at least 75% of efficiencies are fully developed and quality impact assessed by 31 March, rising to 90% by 30 April and 100% by 29 May. Improvement will be monitored as part of the regional weekly contract tracker process. In-year progress against achievement of recurrent efficiencies and productivity will remain a key area of attention throughout 2026/27.

- In line with best practice, you are encouraged to ensure development of a three-year rolling programme of efficiencies. Whilst year 1 (2026/27) ought to now be well defined (see above) the region expects you to be progressing outline plans to include key transformation programmes and trajectories which will deliver recurrent cost base reductions in years 2027/28 and 2028/29. In line with the deadline for defined three-year plans outlined above we would expect firm efficiency plans for 2027/28 to be in place by 31 August 2026 with outline high level plans (describing the main areas of saving and the likely “route to cash”) for 2028/29 by the same date.

- Your 2026/27 financial plan shows proposed workforce reductions of 36 WTE. It is anticipated that clear and credible workforce plans will be available for regional review and assurance accompanied by any appropriate self-funded redundancy programmes. Organisations should expect to deliver the financial means for their redundancy programmes whilst achieving the overarching requirements for financial balance outlined above.

- Fully engage in national pay and non-pay savings initiatives, in particular around national agreements for medicines and other non-pay purchasing.

- Monitoring of agency usage and compliance with usage and rate limits, with compliance with a similar set of conditions in relation to bank staff.

- Any consultancy expenditure above £50,000 requires prior approval from the NHS England regional team based on the agreed regional process.

Please also note the following points of general best practice:

- Improve the quality of, and be assured on, activity data, counting and coding. This is critical to underpin the continuing work on deconstructing block contracts, setting future contract baselines, improving cost information and enabling productivity tracking. Good quality data is also essential for operational performance, quality and safety (e.g. mortality), population health and strategic commissioning decisions.

- Driving through improvements in productivity remains a priority. Alongside developing efficiency programmes, organisations should engage with and use the various analysis and benchmarking information available to identify the local improvement actions to advance productivity. This should include engagement with national programmes and initiatives, such UEC transition to digital-first and clinically prioritised access and outpatients shift to a digital-first, patient led model.

- Continue to drive down unwarranted excess corporate and overhead costs. For ICBs, this means delivery of the Model ICB against the revised running cost allocation envelopes. For providers, this means continued delivery of savings against the 40% growth since 2018/19. We encourage all organisations to develop options for shared and at-scale functions, alongside adopting best practice initiatives across target operating models and service delivery.

Trust Strategy 4Ps (People; Productive; Patient; Partnerships)
Deep Dive – People

Purpose of Report

To provide the Board of Directors with a deep dive across the strategic people pillar of People, and specifically an overview of progress against delivery of the Derbyshire Healthcare People Plan 2025–28.

The report includes achievements to date across the four People Plan themes, key challenges and risks and the priorities and planned areas of focus for Years 2 and 3 of the programme.

Executive Summary

This report presents the first Strategic Deep Dive into People - one of the four pillars of the Trust Strategy and provides an opportunity to give the Board greater visibility and assurance regarding delivery of the People agenda and associated priorities, as well some of the areas we are less assured about and the risks associated with this. As this is the first deep dive of this nature, feedback on the format, level of detail and overall presentation of the report would be welcomed to help inform and strengthen future strategic deep dive reports to the Board.

The paper provides an overview of progress over the first 18 months of the Trust Strategy and during Year 1 of the People Plan. The People Plan is aligned to the Trust's four strategic priorities and focuses on attracting and retaining talented colleagues, developing compassionate and inclusive leadership, strengthening organisational culture and improving wellbeing and workforce experience.

Achievements We Are Proud of as a People team

Over the past year, the People team has continued to make meaningful progress in supporting colleagues, strengthening culture and delivering key workforce priorities across the Trust. The People team has played a central role in supporting the delivery of large scale organisational change through the operating model restructure. This has included providing specialist HR advice and guidance to leaders and colleagues, developing and implementing robust and fair assessment and selection processes, maintaining constructive and positive partnership working with Staff Side colleagues, and commissioning bespoke wellbeing and psychological support arrangements for teams impacted by change. The team has also successfully supported the delivery of two mutually agreed resignation schemes (MARS) and voluntary redundancy processes with compassion, professionalism and a strong focus on colleague wellbeing and support throughout the process.

One of the areas we are particularly proud of has been the continued development of our equality, diversity and inclusion (EDI) agenda. This has included leading the development of the Trust's Race Equality Plan and EDI Plan, helping to strengthen the Trust's strategic focus on inclusion and ensuring this remains closely aligned to our wider organisational priorities. We have also successfully relaunched the Black and Minority Ethnic Groups (BME) and the Lesbian, Gay, Bisexual, Transgender and Queer or Questioning (LGBTQ+) Staff Networks, creating stronger opportunities for staff voice, engagement and visibility across the organisation and helping colleagues feel more connected and represented.

We have continued to strengthen fairness and consistency within our people processes by providing specialist advice and support during panels and grievance processes. This has helped to reinforce inclusive practice and ensure our approaches remain aligned to our values and expected behaviours.

Supporting the Trust's wider culture change journey has been another important focus for the team. Through visible engagement, relationship building, ward visits and collaborative working with leaders, Trade Union colleagues and staff groups, we have continued to support the development of a more compassionate, respectful and psychologically safe culture. We are also pleased to have started embedding restorative just culture principles more consistently within leadership and people practices, helping to encourage supportive resolution approaches and constructive conversations.

There has also been significant progress across employee relations and workforce governance. This includes the successful transfer of the Employee Relations service back into Derbyshire Healthcare, alongside the recruitment and development of a dedicated pool of investigators to strengthen the quality, consistency and timeliness of ER support. The establishment of the Absence Oversight Group has also created stronger organisational oversight and a more supportive focus on attendance management, although we recognise there is further work to continue developing this area.

The team has played an active role in supporting several key organisational priorities and transformation programmes. This has included helping to progress the Trust's Sexual Safety agenda and leading work to strengthen job evaluation arrangements and processes.

Collectively, these achievements reflect the commitment, professionalism and compassion of colleagues across the People team and the important contribution they continue to make in supporting both our workforce and the wider organisation.

Risks and Challenges

There are several key areas that it is important to highlight to the Board in relation to emerging risks, ongoing challenges and the planned actions being taken to support delivery and maintain progress across the People agenda.

As new leadership structures and teams become established following organisational change, there is a risk of inconsistency in leadership capability, team effectiveness and cultural alignment. Newly formed teams and leaders will require clear frameworks, support and development to successfully lead services through change and embed positive team cultures. To support this, the Trust is strengthening leadership development arrangements, leadership frameworks and organisational development (OD) support. The transition of leadership and wellbeing functions back into the Trust also provides an opportunity to deliver more aligned, responsive and locally tailored support for leaders and teams.

Although the Personal Accountability Charter has now been introduced across a range of people processes, leadership approaches and OD activity, embedding consistent accountability, behaviours and cultural expectations across all teams and services will take sustained focus and time. The 2026 NHS Staff Survey results indicate an overall decline across a number of survey indicators, reinforcing the scale of the cultural and organisational challenges currently being experienced and highlighting the need for continued, long-term investment in workforce experience and culture change.

There remains a risk of inconsistency in how approaches are adopted and embedded across different services and leadership groups, particularly during a period of significant organisational change and operational pressure. Rebuilding engagement, trust and workforce experience will require visible leadership, consistent behaviours and sustained action over the next two years to deliver meaningful and sustainable improvement.

To support this, the Trust will continue to reinforce the Personal Accountability Charter through appraisal processes, leadership development, OD interventions and workforce policies. Staff Survey findings, Pulse Surveys, engagement feedback, culture reviews and wider workforce indicators will continue to be used to monitor progress, identify areas requiring targeted support and ensure improvement activity remains focused on the areas of greatest need.

The pace of digital transformation across workforce services continues to present both opportunities and challenges.

There is a risk that limited capacity, capability or pace of adoption could impact the Trust's ability to fully utilise digital workforce solutions and maximise workforce insight and efficiency. The Trust recognises the importance of being an early adopter of the Future Workforce System and will continue to strengthen digital capability, workforce systems development and data-driven approaches. This will support improved workforce planning, reporting, automation and operational decision-making.

Sickness absence and attendance management remain ongoing workforce challenges. Whilst progress has been made in strengthening oversight arrangements, there remains a need to improve consistency, data quality, accountability and early intervention approaches across services. The development of improved workforce reporting, strengthened governance through the Absence Oversight Group and refreshed attendance management approaches will support more proactive management and clearer accountability across both Operational and People teams. A continued focus on wellbeing and compassionate management approaches will also remain important.

Maintaining timely and efficient recruitment processes continues to be a key organisational priority, particularly within hard-to-recruit workforce groups. Variability in recruitment processes and accountability can impact time-to-hire, candidate experience and workforce pressures across services. To address this, the Trust will continue strengthening recruitment key performance indicators (KPIs), Divisional reporting and governance arrangements to improve accountability across both People and Operational teams. Continued benchmarking, workforce insight and recruitment performance monitoring will support ongoing improvement.

Overall, the report highlights that progress has been made in establishing the foundations required to deliver the Trust's People ambitions and wider cultural transformation priorities. Whilst a number of risks and challenges remain, clear actions and improvement plans are in place to support delivery over the next two years and strengthen assurance across the People agenda.

Strategic Considerations		**BAF Risk (eg 1A)**	**Strategic Delivery Plan Reference**
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	2a and 2b	2.1–2.4
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

Risks

- The scale and pace of organisational change activity across the Trust, including management of change processes and wider transformation programmes present a risk to workforce capacity, engagement and the timely delivery of People Plan priorities
- The ongoing national risk of industrial action across parts of the NHS workforce continues to create uncertainty and operational pressure
- The introduction of new and evolving leadership teams across a number of areas of the Trust presents both opportunities and risks. There is a continued need to invest in leadership capability, team development and OD support to ensure leaders are equipped to lead through change, embed compassionate and inclusive cultures, and deliver sustainable workforce and service improvement.

Assurances

- Delivery is monitored through established governance arrangements and Board oversight
- RAG ratings and KPI measures are in place to provide oversight of progress, delivery and emerging risks across all four themes
- Staff feedback mechanisms, including the NHS Staff Survey, Pulse Surveys and Stay Surveys, continue to inform improvement priorities and workforce interventions
- Strengthened leadership, OD, wellbeing and EDI governance arrangements provide assurance regarding delivery and oversight of key people priorities.

Consultation

- Development and delivery of the People Plan has been informed through extensive staff engagement, NHS Staff Survey feedback, Pulse Surveys, Stay Surveys and ongoing engagement with leaders, staff networks and Staff Side colleagues
- Several workstreams, including attendance management, wellbeing and organisational change programmes, have involved ongoing consultation and engagement with Staff Side representatives, operational leaders and frontline colleagues.

Governance or Legal Issues

- The People Plan supports delivery of statutory workforce responsibilities, NHS People Promise priorities and national NHS workforce standards
- Organisational change, TUPE, employee relations matters and workforce policy developments continue to be managed in line with employment legislation, NHS Terms and Conditions and national guidance
- Delivery of Workforce Race Equality Standards (WRES), Workforce Disability Equality Standards (WDES) and Sexual Safety standards support compliance with national workforce and equality requirements.

Net Zero Duty Implications

In compliance with the NHS move towards net zero carbon emissions, the Trust must consider statutory emissions and environmental targets in their decisions. Reports should identify related impacts on workforce and system leadership; sustainable models of care; digital transformation; travel and transport estates and facilities (including capital projects, asset management and utilities, green space and biodiversity); medicines; supply chain and procurement; food and nutrition and adaptation.

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

Workforce and OD programmes increasingly utilise virtual and blended delivery methods to support sustainability objectives.

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 remains central to the People Plan, with continued focus on delivery of WRES and WDES improvement plans, anti-racism actions, inclusive recruitment approaches and strengthening staff network involvement in governance and improvement activity
- The report recognises the importance of creating psychologically safe, inclusive and compassionate workplaces where all colleagues feel valued and supported
- Equality impacts and workforce risks continue to be monitored through established governance arrangements, EDI oversight groups and staff engagement mechanisms.

Recommendations

The Board of Directors is requested to:

1. Take assurance that the achievements and progress outlined in the paper support the delivery of the Trust Strategy and People Plan
2. Note the challenges, risks and dependencies impacting delivery across some workstreams and the planned actions being taken to support delivery and maintain progress across the People agenda.

Report presented and prepared by: **Rebecca Oakley**
Director of People, Organisational Development and Inclusion

Trust Strategy 4Ps (People; Productive; Patient; Partnerships)
Deep Dive – People

Last year, we developed and launched the Derbyshire Healthcare People Plan (2025–28), which underpins and enables delivery of the wider Trust Strategy and is closely aligned to our four strategic priorities: Patient Focused, People, Productive and Partnerships. Sitting beneath the People priority, the Plan reflects our commitment to attracting, developing and retaining talented colleagues, while fostering a compassionate, inclusive culture where everyone feels valued and has a strong sense of belonging.

The Plan was shaped through extensive engagement with colleagues across the Trust and insights gathered through the NHS Staff Survey and ongoing staff engagement, which provide a clear understanding of what matters most to our workforce and where we need to focus our efforts over the coming years.

The People Plan is also aligned to the ambitions set out within the NHS 10-Year Health Plan, recognising that our people are fundamental to delivering sustainable, high-quality care and meeting the challenges facing the NHS over the next decade. The priorities within this Plan reflect key national themes, including workforce growth and retention, leadership and career development, inclusion and equality, staff health and wellbeing, and the use of digital innovation to modernise how we work and deliver services.

This paper provides an update on progress against the four themes within the People Plan. As this is a three-year programme of work, it is recognised that some priorities are scheduled for development and delivery later within the lifespan of the plan.

The RAG ratings included within the report provide an overview of progress to date, highlighting areas that have been successfully delivered or are progressing well through Year 1 and into Year 2. They also identify those areas that have not yet commenced, reflecting the phased approach to delivery across the three-year period. Whilst some actions remain in the early stages of development, the Trust remains committed to delivering all priorities within Years 2 and 3 of the People Plan.

Theme One: Attract and Retain the best people

1	Strengthen our recruitment and retention processes and strategic plan as a System partner	
2	Support managers to support our people	
3	Embed our workforce plan and build confidence	
4	Drive digital transformation	
5	Utilise staff voice to inform all that we do	
6	Offer a supportive benefits package	

This theme focuses on strengthening the Trust's ability to attract, recruit and retain a skilled, compassionate and diverse workforce. During Year 1, work has focused on improving recruitment governance, strengthening workforce planning, enhancing onboarding and retention approaches and ensuring staff voice continues to shape workforce improvement activity. Several larger transformation programmes remain in development and will continue to progress over future phases of delivery.

Achievements and Progress

- Recruitment governance and KPI oversight strengthened through regular operational KPI meetings and development of divisional recruitment reporting
- Continued benchmarking with Midlands partners in relation to recruitment performance and time-to-hire metrics

- Stay Surveys at three, six and 18 months embedded to strengthen retention insight and workforce experience intelligence. Every new staff member is sent the Stay Survey and results utilised to inform our actions. We have seen a decrease in turnover rates in our Acute Inpatient wards. In these areas Healthcare Assistant (HCA) turnover is 4.48% and Registered Mental Health Nurse (RMN) turnover is 6.70%
- Development of revised induction, onboarding resources and welcome materials for new starters, embedding the Personal Accountability Charter and 'A Kind Life' approach
- Strengthened job design and job evaluation capability through bespoke training and additional panel capacity leading to improvements in job evaluation timelines. 11 new people have been trained in the national job evaluation framework along with three attendees at consistency checking training and seven people who attended refresher training. Further training is planned for later this year. The national Nursing profiles work is well under way with a clear plan developed in partnership with Staff Side
- Redeployment process reviewed and updated to improve efficiency, communication and staff experience
- Development of the staff benefits and recognition offer through ongoing work with Perkbox, including wellbeing and virtual GP support
- Launch of new sickness reporting system to improve workforce reporting and oversight, with plans for further development being designed
- Continued utilisation of NHS Staff Survey, Pulse Surveys and Stay Surveys to inform Divisional and Trust-wide improvement actions
- Development of Divisional and team-level "You Said, We Did" feedback approaches linked to the 2025 NHS Staff Survey

- Implementation of Patchwork Rota system to strengthen medical workforce planning and rota management. The rota management element of Patchwork is due to be implemented imminently and Patchwork has indicated that through the implementation of the medical workforce planning system, financial grip around medical workforce spend has improved realising £287.2k in savings by transitioning to 100% Direct Engagement, achieving £69.5k in cost avoidance with shifts being filled by bank against agency, reducing rate escalation from 6% to 3%.

Challenges

- Workforce planning timescales and progress impacted by alignment to the emerging NHS 10-Year workforce plan and organisational operating model changes
- Capacity limitations impacting pace of digital transformation and workforce systems development
- Further work required to strengthen automation, workforce intelligence and data-informed decision making
- Medical recruitment strategy and workforce pipeline development remain in early stages and require further System alignment
- Sustaining engagement and visible action following the 2025 NHS Staff Survey remains a key priority.

Years 2 and 3 Developments

- Development of recruitment systems and digital transformation such as the introduction of AI as a supportive tool to further strengthen recruitment processes
- Introduction of the new workforce solution (replacement for ESR) to support recruitment, retention and workforce planning
- Further embed Perkbox as the Trust's benefits package to enhance retention, recognition and reward
- Further development of the absence manager software to support managers in using digital transformation to manage sickness absence.

Theme Two: Support and Develop our people

1	Deliver a roadmap for leadership development to enable success	
2	Implement effective talent management and succession planning	
3	Set standards for advanced professional practice	
4	Foster a learning culture for career and personal development for all	
5	Advance Organisational Development (OD) initiatives	
6	Promote career mobility and opportunities across the System	

This theme focuses on strengthening leadership development, talent management, OD and career opportunities across the Trust. During Year 1, work has focused on building the foundations for a more structured and sustainable approach to leadership, talent and workforce development, recognising that a number of larger transformation programmes will continue to develop over the lifetime of the three-year People Plan.

Achievements and Progress

- Development of a leadership roadmap is underway as part of the transition of leadership development arrangements from Derbyshire Community Health Services (DCHS) to DHcFT in July 2026
- Progression of the STRIVE senior leadership programme in partnership with The King's Fund and CMI, supporting leadership capability and development across senior roles. 46 senior leaders are currently going through the programme with initial positive feedback received
- Initial work commenced to align leadership development approaches to the emerging national Management and Leadership Development (MALD) framework
- Executive talent management pilot programme completed, with learning being used to inform development of a future Trust-wide talent and succession planning approach
- OD commissioning framework refreshed to strengthen how OD and change support is embedded across services, with a stronger focus on impact and continuous improvement
- Continued delivery of culture reviews, team development activity and tailored OD interventions to support teams in understanding strengths, challenges and improvement priorities. Three full, formal culture reviews were started in 2025 with greater leadership ownership evidenced

- OD consultancy support increasingly focused on bespoke, needs-led interventions aligned to workforce challenges and service requirements
- Strengthened OD insight and triangulation through engagement activity, culture reviews, collaboratives and improved survey participation, supporting earlier identification of workforce risks and support needs
- Enhanced appraisal documentation introduced with recognition for further work required to support career development conversations and link to talent management.

Challenges

- National delays in the rollout of the MALD framework have impacted full alignment of leadership development planning, although preparatory mapping work has commenced locally
- Engagement in career development sessions during the autumn period was lower than anticipated, with learning being used to inform future approaches and increased local team-based delivery
- Talent management and succession planning work has been intentionally paced to align with wider organisational operating model developments and leadership transition arrangements
- Several areas within this theme remain in earlier stages of development, including advanced professional practice standards, career mobility pathways and wider learning culture programmes.

Years 2 and 3 Developments

- Full transition of the leadership offer into DHcFT with a strengthened OD, Leadership and Wellbeing team. Funding for a three-person team has come from the exit of the joint venture with DCHS
- Talent management and succession planning programme planned for delivery in Years 2 and 3
- Further development of appraisal processes to enhance career conversations, working with NHS Elect to develop an approach.

Theme Three: Inclusive and Value Drive Culture

1	Embed our Personal Accountability Charter	
2	Develop an EDI framework for inclusive recruitment and development	
3	Deliver WRES and WDES improvement plans	
4	Uphold LGBTQ+ equality standards	
5	Ensure EDI accountability at all levels	
6	Implement 'A Kind Life' culture change programme	
7	Launch and embed an anti-racism strategy and actions	
8	Strengthening Staff Networks in governance	
9	Focus on embedding psychologically-safe teams	

This theme focuses on strengthening inclusion, psychological safety, accountability and compassionate culture across the Trust. During Year 1, work has focused on embedding the Personal Accountability Charter, progressing EDI governance, strengthening staff networks, launching key culture change programmes and developing approaches which support fairness, kindness and respectful resolution across teams.

Achievements and Progress

- The Personal Accountability Charter has been embedded across appraisal and performance processes, people policies, culture change programmes and leadership development activity to strengthen accountability, behaviour expectations and professional standards
- Restorative just culture approaches and accountability principles have been incorporated into the way in which we respond to ER concerns, leadership development and learning approaches to support fair, supportive and values-led leadership behaviours
- The EDI framework and governance arrangements continue to strengthen, with oversight provided through established governance structures and Board assurance processes
- WRES and WDES submissions have been routinely completed, with delivery monitored through the EDI Working Group to support accountability and improvement activity
- Staff Networks continue to strengthen and play an increasingly active role in engagement, governance and shaping improvement priorities across the Trust

- Progression of the Trust's Anti-Racism Plan and supporting actions to strengthen awareness, accountability and inclusion across the organisation
- Trust-wide rollout of the 'A Kind Life' programme, including Kindness Masterclasses, Active Bystander training and facilitated conversations to strengthen compassionate leadership, wellbeing and respectful team cultures
- Development of tailored kindness and respectful resolution approaches within ER processes, including use of 'A Kind Life' materials and training for ER colleagues
- Continued development of restorative just culture approaches and psychological safety resources to support leaders and teams
- Reduction in formal ER activity through increased focus on respectful resolution and early intervention approaches.

Challenges

- Embedding long-term cultural change programmes, including the Personal Accountability Charter and 'A Kind Life', will require sustained leadership engagement and reinforcement over time
- Capacity for leaders to fully engage in kindness and culture development activity remains variable across some areas and services
- Further work is required to continue embedding psychological safety consistently across teams and leadership levels
- Several EDI and inclusion workstreams remain in earlier stages of development, including LGBTQ+ Equality Standards, inclusive career pathways and broader EDI accountability frameworks.

Years 2 and 3 Developments

- Embedding our kindness, restorative and just culture work so that this becomes the organisational cultural norm. This will be evidenced through further reductions in formal casework
- Work to address psychological safety in all teams to reduce the varying experiences of our staff through leadership development, promotion of kind life resources and further embedding the Anti-Racism Plan.

Theme Four: Wellbeing and Support for our People

1	Embed a flexible working culture	
2	Strengthen our health and wellbeing offer	
3	Develop a psychological support offer	
4	Refine attendance management policies and processes	
5	Support leaders during formal processes	
6	Refresh our health and well-being assessment	
7	Ensure Team-Based Wellbeing	
8	Deliver Sexual Safety & Violence Prevention Standards	
9	Introduce Menopause Policy and Accreditation	

This theme focuses on strengthening staff wellbeing, psychological support, flexible working and compassionate people management approaches across the Trust. During Year 1, work has focused on reviewing and strengthening the wellbeing offer, embedding national safety standards, developing psychological support pathways and progressing compassionate attendance and people management approaches.

Achievements and Progress

- Review and redesign of the Trust's Health and Wellbeing Offer commenced as part of the transition of wellbeing services from DCHS to DHcFT in July 2026
- Strengthened Wellbeing Support Offer through increased promotion of Employee Assistance Programme (EAP) services, wellbeing resources and staff wellbeing communication channels
- Introduction of additional psychotherapy support for specific complex or high-level wellbeing cases, strengthening the Trust's psychological support offer
- Development of psychologically informed support pathways and integration of psychological support within wider wellbeing transition plans

- Implementation of the national Sexual Safety Charter and NHS Violence Prevention Standards
- Strengthened governance and reporting arrangements for sexual safety and violence prevention through People and Culture Committee, Trust Delivery Group, Executive Leadership Team and Joint Negotiating Consultative Committee oversight
- Continued rollout of 'A Kind Life' and Active Bystander approaches to support compassionate leadership, respectful resolution and staff wellbeing
- Progression of attendance management policy review to strengthen consistency, compassionate support and accountability approaches
- Training and support arrangements progressing for panel chairs, investigators and medical leaders managing formal processes, including Maintaining High Professional Standards (MHPS)-related development
- Initial exploration of peer support approaches for leaders managing complex formal processes.

Challenges

- Flexible working implementation has commenced; however, capacity limitations have delayed wider roll-out and system development
- Attendance management policy development required significant engagement with leaders and Staff Side colleagues, impacting timescales for implementation
- Embedding a longer-term cultural shift in attendance management and wellbeing approaches will take time and continued reinforcement
- Several wellbeing workstreams, including team-based wellbeing approaches and refreshed wellbeing assessments, remain paused pending wider organisational transition and Joint Venture discussions
- Organisational change activity, including management of change processes and TUPE arrangements, continues to place additional pressure on workforce wellbeing and support services.

Years 2 and 3 Developments

- Team-based wellbeing will link to the development of psychologically-safe teams and the introduction of the new OD, Leadership and Wellbeing team
- Focussed effort in meeting the needs of our workforce through the introduction of a Menopause Policy and accreditation will commence in Year 2.

National landscape

NHS Staff Standards

The NHS Staff Standards were first announced within the NHS 10-Year Health Plan and represent a significant national development aimed at improving workforce experience across the NHS. The standards are being developed jointly by the Department of Health and Social Care (DHSC) and NHS England (NHSE), in partnership with the Social Partnership Forum (SPF), with implementation anticipated within the next eight weeks.

The purpose of the Staff Standards is to establish a clear and consistent baseline for staff experience across NHS organisations. The standards are intended to ensure that improving staff experience becomes a core organisational priority and that all NHS staff experience a consistent minimum standard of support, inclusion, safety and wellbeing, regardless of employer. The standards are expected to evolve over time, with future refinement supporting continuous improvement across the NHS workforce.

The Staff Standards will be mandatory and linked directly into the NHS Oversight Framework (NOF) and wider accountability arrangements. Compliance and progress against the standards will contribute to organisational oversight and assurance processes, including segmentation within the NOF. Importantly, the standards are not intended to replace existing initiatives such as the NHS People Promise; instead, they are designed to strengthen and build upon current workforce commitments by providing a more formalised framework for measuring and improving staff experience.

The standards once implemented will be reviewed and assessed against the current People Plan with links being identified to ensure our People Plan reflects the requirements in the standards.

NHS 10-Year Workforce Plan

The NHS 10-Year Workforce Plan is expected to be published within the next four weeks and will provide the national workforce framework to support delivery of the NHS 10-Year Health Plan. Early national messaging indicates that the plan will set out a clear, robust and more directive approach to workforce transformation across the NHS, with a strong emphasis on long-term sustainability, productivity and workforce modernisation.

A key principle underpinning the emerging plan is a move away from the historic assumption that increasing workforce numbers alone will automatically result in improved patient care and organisational performance. Instead, there will be a greater focus on ensuring staff are empowered, equipped, trained and supported to work differently and more effectively. Whilst workforce growth will continue to form part of the national approach, the emphasis is expected to shift towards sustainable workforce growth, improved workforce utilisation and strengthening domestic workforce supply and development.

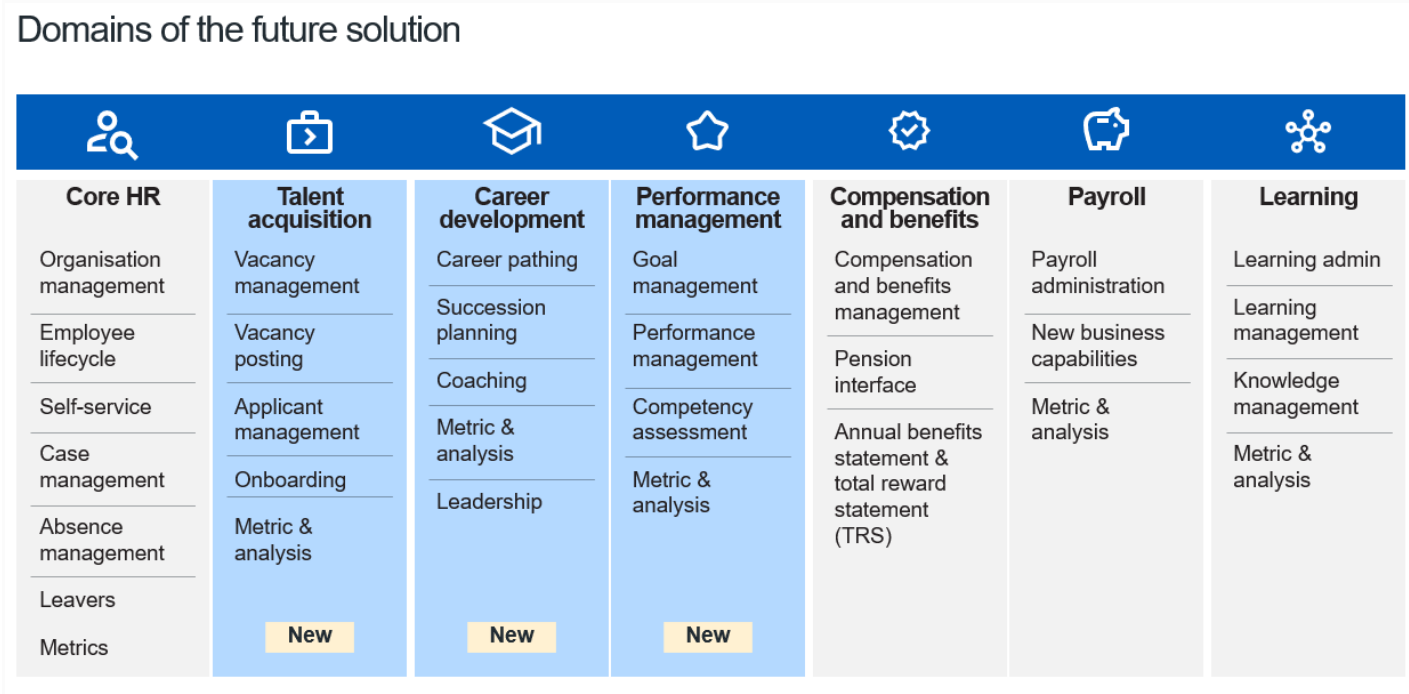
The Plan is also expected to align closely with broader NHS reform programmes, including neighbourhood health models, digital transformation, leadership reform and the emerging NHS Staff Standards. These developments are likely to have significant implications for workforce planning, OD, leadership development and future people priorities across NHS organisations.

Many of the anticipated themes within the emerging 10-Year Workforce Plan are already reflected within the Derbyshire Healthcare People Plan 2025–28, particularly around leadership development, workforce wellbeing, inclusion, digital transformation, compassionate culture and workforce sustainability. As further national detail emerges, the Trust will continue to review and align local workforce priorities to ensure continued alignment with national expectations and future workforce reform.

Future Workforce System

The Future NHS Workforce Solution (FWS) is a new and enhanced workforce management solution for the NHS that will succeed the Electronic Staff Record (ESR).

ESR processes £55b in payroll each year to over 1.9m NHS employees across England and Wales, which accounts for around 5% of the UK workforce. The future solution is expected to be fully implemented by 2030 and will support NHS organisations and their employees by providing a complete employment lifecycle platform. It will support everything from recruitment and onboarding to career development, workforce management, payroll and retirement. Derbyshire Healthcare has been successful in becoming an early adopter for the new FWS and work has already begun in scoping the foundational readiness for the new solution.



Summary

During the first year of delivery of the Derbyshire Healthcare People Plan 2025–28, significant progress has been made across all four People Plan themes. The Plan continues to provide a strong framework for delivering the Trust's strategic People priority and aligns closely with emerging national workforce, leadership and OD agendas.

A number of important foundations have now been established to support longer-term workforce improvement and cultural development. This includes strengthened recruitment governance and workforce insight, the roll-out of Stay Surveys, progression of leadership and OD programmes, implementation of the Personal Accountability Charter and 'A Kind Life' approaches, strengthened respectful resolution approaches within ER processes and continued development of wellbeing and psychological support offers. Encouraging early progress is also being seen in leadership development, inclusion activity and wellbeing support arrangements, although many of these programmes remain in the early stages of embedding and cultural maturity.

The report also recognises the significant organisational change activity that has taken place across the Trust, including management of change processes, TUPE arrangements and wider operating model developments. These changes have inevitably impacted the pace at which some People Plan priorities have progressed. Nevertheless, substantial progress has continued across a broad range of workstreams, reflecting the commitment and resilience of colleagues across the organisation.

The paper acknowledges that meaningful cultural change takes time and requires sustained leadership visibility, consistency and reinforcement. As the Trust moves into Years 2 and 3 of the People Plan, there will be an increasing focus on targeted, team-based interventions, strengthening leadership capability, embedding psychologically-safe and inclusive cultures and ensuring workforce support arrangements continue to evolve in response to organisational and national change. National developments across NHS People, including the emerging Leadership College, Management and Leadership Development Framework and wider workforce reforms, also present significant opportunities to further strengthen leadership, talent and workforce development approaches across the Trust.

Assertive Outreach (AO) Community Mental Health Treatment

Purpose of Report

To inform and request retrospective sign-off from the Board of Directors about the outcome of the Midlands Intensive and Assertive Outreach (AO) Self-Assessment Tool, which will be submitted to Midlands Mental Health team, NHS England on 6 May 2026.

Executive Summary

The primary aim of the Midlands Intensive and AO Self-Assessment Tool, was for the trusts in the region to use it to capture their progression towards assurance in our ability to identify, maintain contact, and meet the needs of people who may require Intensive and Assertive community care and follow-up. The self-assessment focused on the areas from the most recent review that systems continue to grapple with. It also includes the wide range of improving practice interventions that have emerged from the last national-level review.

The Self-Assessment Tool guides services to reflect the core elements of delivery of partnership working, workforce, community-based care, key working, out of hours provision, care planning, information sharing, carer involvement and impact measurement, and to rate the level of progression toward full assurance using a standardised Likert scale.

From the feedback of the self-assessment, strengths include well established governance structures and comprehensive coverage across core domains; however, variation in delivery remains evident between some teams.

Key gaps include limited access to Psychology and Housing input, inconsistent General Practitioner (GP) support for AO cases, poor carer engagement despite a pro-active approach to reach out to families for this cohort, pressures on caseloads size due to increasing demand and consultant capacity for this cohost and insufficient use of patient-reported outcome measures (PROMS). Persistent Information Technology interoperability issues continue to hinder seamless information sharing and coordination of care despite local workarounds.

Addressing these gaps through targeted workforce planning, improved partnership working, and enhanced data integration will be essential to achieving consistent, safe, and equitable service delivery across Derby and Derbyshire in supporting Intensive and AO service users.

Top three priorities

1. To enhance capacity within the Intensive and AO service
2. Strengthen engagement with carers and families by reviewing current feedback processes and ensuring systematic collection and analysis of carer input
3. Interoperability and timeliness of information sharing with partners.

Strategic Considerations		**BAF Risk (eg 1A)**	**Strategic Delivery Plan Reference**
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	1a	1.1, 1.2, 1.4
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X		2.4

Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X		3.2
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		4.1

Risks and Assurances

- Risks identified are supported by an action plan under review by the chairs of the Group with escalation as required
- Due to the projection of more referrals that will require AO offer, the current resources will not be adequate
- Staff are likely to be overwhelmed which will have a negative impact on service users due to staff sickness or staff managing high AO caseloads.

Consultation

- A Task and Finish Group comprising of Adults of Working Age (AWA) Care Group Head of Clinical Practice, AWA Care Group Head of Operations, Service Manager for Early intervention and Governance and Compliance Manager, met on 9, 16 and 23 March 2026, feedback from AO workers and also feedback from Integrated Care Board (ICB) representatives was requested
- Intensive and AO System meeting on 24 March 2026
- Executive Leadership Team; Quality and Safeguarding Committee, April 2026.

Governance or Legal Issues

The work is being carried out in line with direction from NHS England to all ICBs and mental health trusts.

Net Zero Duty Implications

In compliance with the NHS move towards net zero carbon emissions, the Trust must consider statutory emissions and environmental targets in their decisions. Reports should identify related impacts on workforce and system leadership; sustainable models of care; digital transformation; travel and transport estates and facilities (including capital projects, asset management and utilities, green space and biodiversity); medicines; supply chain and procurement; food and nutrition and adaptation.

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

N/A.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Access to services and health inequalities consideration.

Recommendations

The Board of Directors is requested to:

1. Discuss the report and retrospectively approve the Midlands Intensive and AO Self-Assessment Tool, which was submitted by 1 May 2026
2. Note the progress on-going work about Assertive Outreach with System partners set out in the self-assessment tool.

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

Report prepared by: **Toby Marandure**
AWA Care Group Head of Clinical Practice

Julie Pickford
AWA Care Group Head of Operations

Midlands Intensive and Assertive Outreach (AO) Self-Assessment Tool

Purpose of the report

To inform the Board about the outcome of the completion of the Midlands Intensive and AO Self-Assessment Tool, which was submitted on 6 May 2026 the submission was reviewed in the division, Executive Leadership Team and The Quality Safeguarding Committee before submission to the ICB.

The Self-Assessment Tool guides services to reflect on core elements of delivery on partnership working, workforce, community-based care, key working, out of hours provision, care planning, information sharing, carer involvement and impact measurement and to rate the level of progression toward full assurance using a standardised Likert scale.

Scoring Criteria progression to assurance				
1	2	3	4	5
Not in place/ significant gaps	Making forward progress but significant gaps still exist	Some aspects in place but incomplete	80% in place	In place and functional

Attached is the domain-by-domain summary synthesising the scoring choices.

Areas of Improvement

Partnership Working:

Partnerships are in place but constrained by capacity and consistency, particularly in housing and social care (S117 aftercare) where delays persist.

Primary care engagement is variable, with limited uptake of shared care and inconsistent physical health follow-through.

Access to voluntary, community and social enterprise organisations exists but is underutilised due to service user complexity and engagement barriers.

Multi-agency working with police is inconsistent, varying by individual response.

Information sharing remains a significant systemic barrier, with 24–72 hour delays and lack of real-time interoperability across the system.

Workforce:

Significant gaps in psychological therapy provision are evident once service users transition into Community Mental Health teams or long-term care pathways have been mitigated by psychology formulation sessions to meet therapeutic needs.

Community-Based Care:

The Management and Supervision Tool (MaST) is well embedded within services. AO identification processes remain robust, though Consultant availability is inconsistent, leading to variability in clinical oversight. The reliance on locum Psychiatrists has had a negative effect on the consistency and quality of AO medicine management. Family engagement demonstrates good practice in some localities but remains uneven across the service.

Key Workers and Caseload Management:

MaST and internal reporting systems provide robust oversight and support effective monitoring of practice. However, some staff continue to manage caseloads that remain higher than ideal levels, affecting capacity and continuity.

Out-of-Hours Provision:

AO worker availability remains restricted to Monday–Friday, 9.00am–5.00pm, which continues to limit continuity of care outside core hours. Engagement between the Crisis team and AO patients also remains inconsistent, often constrained by consent requirements and the complex nature of the client group. Work is underway to strengthen collaboration with Police by improving data sharing.

Care Delivery:

Audit processes are well established and provide strong assurance. The Serious Incident (SI) process is well-structured, supported by a weekly review group that ensures oversight and learning. Monthly supervision sessions incorporate AO case reviews, promoting shared learning and reflective practice across teams.

Information Sharing:

Electronic Patient Record (EPR) systems across partner organisations remain fragmented, with ongoing delays and data gaps affecting information sharing and continuity. Regular risk strategy meetings help mitigate some of these limitations by enabling joint discussion and decision-making.

Families and Carers:

Carer support groups are established in some areas, though provision is not consistent across all localities. Carer involvement remains highly dependent on patient consent, which continues to limit consistency and engagement opportunities. The use of carer dashboards and Friends and Family Test (FFT) feedback mechanisms is currently under-developed, reducing the availability of actionable insights. Additionally, a significant number of AO clients have limited or no family involvement, further constraining data collection and opportunities for co-production.

Demonstrating Impact:

There is need to develop and implement AO-specific outcomes tools, such as the Bexley Engagement Measure, are needed to strengthen evaluation and demonstrate impact, the working group is working to have a specific dashboard for the service.

Governance and Oversight:

There is clear floor-to-Board reporting structure is in place, ensuring effective escalation and oversight. The Quality and Safeguarding Committee receives quarterly assurance on the AO quality reporting and improvements. The Operational meeting structure has been recently redesigned to strengthen assurance processes and enhance alignment between Clinical, Operational, Strategic priorities and the new operating model.

Top three priorities

The self-assessment shows strong overall progress, with most areas rated as either ‘80% in place’ or ‘in place and functional’. However, significant operational gaps remain in Psychology, Housing, GP engagement and out-of-hours continuity. IT interoperability continues to be a major System barrier despite local workarounds. Rising caseloads, limited Consultant availability and engagement with Adult Outreach service users continue to create pressure points. Family and carer involvement, as well as the use of Patient-Reported Outcome Measures (PROMs), remain inconsistent, largely due to low service user participation. While robust governance structures are in place across the service, the quality and consistency of delivery vary between teams.

1. To enhance capacity within the Intensive and AO service, there is a need to increase staffing resources to manage the current and potential caseload demand. At present, 145 service users are supported under the AO caseload. However, through the MaST system, an additional 108 service users have been identified as meeting the criteria for AO input. The Board escalated the need for investment to meet service gaps to the Derby and Derbyshire ICB in June 2025, there have been significant changes with the ICBs, the next follow up on this will be with the Director of Quality on 13 May 2026.
2. Strengthen engagement with carers and families by reviewing current feedback processes and ensuring systematic collection and analysis of carer input. The Trust will be deploying Patient Knows best in 2026.
3. Interoperability and timeliness of information sharing. The aim is to reduce the 72-hour export lag of data in uploading information for reporting between SystmOne and MaST.

Self-Assessment

Scoring Criteria				
progression to assurance				
1	2	3	4	5
Not in place/ significant gaps	Making forward progress but significant gaps still exist	Some aspects in place but incomplete	80% in place	In place and functional

Partnership Working

Identified challenges (September 2025 Review Summary)	Systems face persistent challenges in developing effective partnership approaches. •Engagement remains inconsistent engagement across key across some partners, particularly social care and Primary Care Networks. •Fragmented, non-interoperable information systems hinder real-time data sharing. •Workforce pressures, including unstable Section 75 agreements, affect multi-agency continuity. Sustainable funding for VCSE contributions remains uncertain despite their recognized value.

Areas of Focus	We have no clear partnership working or governance structure in place for this patient group		We have some elements of partnership and governance in place, but they are inconsistent, informal or still developing		We have strong and embedded partnership and governance arrangements in place to support this patient group	Additional Comments
Access to housing/ relationships across housing stakeholders includes this cohort.			YES			HACT review completed, this is ongoing and a housing workstream is in place across system partners. Some housing providers have representation within MDT meetings. There is limited housing availability in Derby City area, AO patients regularly use hostels, sometimes long term. We do have good links with housing providers, however we reach out to them. Ongoing lack of S117 aftercare follow up from social care.
Primary Care are engaged and involved			YES			Ongoing challenges with GP's accepting shared care arrangements, lack of physical health assessments within primary care. This is a particular issue for people open to EIP services and people with assertive and intensive care needs where GP's will not continue prescribing on discharge from the service - datixes being completed each incident. This is variable across the county and some GP practices and PCN's where we are working in partnership well. GP's provide repeat prescriptions in the main and review physical health needs when patients supported. Can be difficult to get appointments for AO patients at some surgeries, however some are helpful. (AO patients routinely not online, some don't have access to a phone or will not attend without CPN taking)

VCFSE are incorporated into our support offer				YES		Within community services we work jointly with VCSE, some areas where this is limited accessibility for those with assertive outreach needs primarily linked to how these people present and limited engagement.
We actively engage with social care and other partners (eg) Police				YES		Overall there are good working relationship with the police and social care. Limited engagement with the police regarding information sharing and links with the police to be able to proactively work together for people disengaging and deteriorating mental state increasing risk to others and self. We do have the professional line which the police and Emas can make contact with to link in with services, often finding that the response is limited when MH services contact the police with concerns re risk to others. Relies on care co to liaise. Police tend to get in touch with helpline/ out of hours services or send a PPN. Social care less engaging.
We have real time data sharing across our key partnerships			YES			Our EPR provider does not provide live integrated data and can often be 24-72 hours delay for data exports. Patient detail info - We do have access to Derbyshire Shared Care records however minimal information is shared and the Trust and most GP's use the same EPR with some delay in data sharing. National Spine again with limited information. Still waiting for the reasonable adjustments digital flag in EPR's nationally. Data shared on system 1 , however no access to that from social care, housing, police
Are we looking at our response /interventions as part of a whole pathway? For example,						
1. Looking at those people with first episode psychosis (first three years of care) and				YES		CBTp and family therapy available, limited physical health assessment and interventions. IPS, psychosocial interventions, psychoeducation.
2. Those people with long-term psychosis.				YES		Access to psychology however long delays, people with assertive outreach needs clinicians are able to meet with psychology colleagues to develop a formulation, AO clinicians encouraged to complete training in Motivational Interviewing. No access to CBTp for people with long term psychosis.IPS, psychosocial interventions, psychoeducation. AOT is considered with people with long term psychosis and additional complexities
Additional Areas of Focus (Please enter here)						

Workforce

Identified challenges (September 2025 Review Summary)	· Fragile workforce capacity · Recruitment and retention difficulties across psychology, advanced practitioner, and peer support roles. Training and competency development. · Gaps in carer support, autism/LD awareness, and engagement skills. · Caseload expectations (e.g., ≤15 patients per worker) are frequently unachievable without additional resources.

Areas of Focus	We have significant gaps in assurance processes relating to staffing for this patient group		We have some systems in place, but they are incomplete, inconsistently applied, or under development		We have robust systems in place and embedded to ensure safe and competent staffing for this patient group	Additional Comments
We have sufficient access to:						
Psychological therapy for this cohort and are aware of the length of waits to access		YES				EIP have access to psychological interventions and have recruited into relevant posts with small waiting times, once a person transitions to the Long Term Offer/CMHT there is a gap in psychological provision for people with long term psychosis and assertive and intensive support needs. Psychology formulation sessions have been set up for clinicians to have psychological support with managing their caseloads.
Peer support			YES			EIP have a good peer support network and roles in place to support people accessing the service. Staff have regular peer support as clinicians. For AO clinicians a peer supervision group occurring monthly is in place and embedded whilst acknowledging limited dedicated peer support worker roles in the teams.
Our staff are able to access the knowledge and skills to support people in this cohort along the pathway.				YES		Staff have good peer support, training has been identified but challenges with training availability and staff accessing this to upskill. Variable access to other professionals.
We are providing training and development for staff to support our AO community (this includes our autism & LD community)		YES				CAARMS training - staff booked and facilitator has not attended on a number of occasions. Requests for in-house training regarding people with LD/ASD. CBTp training for people providing AO approaches due to lack of supervisors If time could allow we do feel other teams would benefit from training around AO capabilities particularly social care
Our training and development input supports staff to be culturally competent and aware (PCREF)			YES			Workstream specifically relating to PCREF in place. All staff cultural sentivity training. Care plans have section called my care plan that enables us to document their needs including cultural and spiritual needs.
Additional Areas of Focus (Please enter here)						
Community-based Care						
Identified challenges (September 2025 Review Summary)	· Workforce shortages, funding gaps. · Difficulties sustaining small, intensive caseloads limit consistent implementation. · Fragmented IT systems and poor interoperability hinder real-time monitoring and cohort tracking. Variations in service models, governance, and resource availability across localities create inequities in care					

Areas of Focus	We have no formal local policies or governance arrangements in place to support access to community services.		We have some policies and governance arrangements but they are inconsistently applied, under development, or lack full alignment with best practice		We have comprehensive, embedded, and routinely monitored policies and governance arrangements in place to ensure access, support, and safe transitions.	Additional Comments
We understand /know the individuals within our current caseload who require IAO					YES	We embedded MaST, gives an overview of AO Caseload and support in identifying people who require an AO approach. We do monthly supervision with all AO Workers in that they report their caseload size. MaST can identify people who are eligible for AO, those people will be discussed in MDM for appropriate allocation. If time could allow we do feel other teams would benefit from training around AO capabilities particularly social care
Have we integrated / utilised the findings from the Special Review of MH Services at Nottinghamshire NHSFT to consider our service provision in the context of:						The Trust have proactively worked with System Partners to continuously review their special review of mental health services at Nottingham and implemented an action plan which was approved at Board Level. Risk strategy meeting held prior to any discharge planning. MDT is within wider CMHT and not specific to AO. Repeated use of locum psychiatrist and CMHT psychiatrists not always understand of AO patient's needs can create issues with medicine management and rapid response.
· joint discharge planning				YES		
· multidisciplinary team working				YES		
· dynamic risk management					YES	
· Medicines management					YES	
Our data dashboard sights staff to where people are accessing or not engaging with our services along the pathway					YES	MaSt supports us to have a robust oversight.
We are able to track our interventions to support individuals once identified by our data management tool (eg) MaST					YES	
Interoperability of our IT is not a barrier to track this cohort				YES		There is a slight delay of reporting data to MaST which can be up to 72 hours.
We create opportunities for friends and families to engage and input to plans and interventions				YES		Carers Group set up in different parts of the county, but not everywhere, done lots of work with Teams re our ability to listen to carers and family. Carers Dashboard in place, need to ensure everyone is using this. Have a project with Clinical Leads around how to engage with families. Monthly casenote audits around family engagement.
Additional Areas of Focus (Please enter here)						

Key Workers and Caseload Management

Identified challenges (September 2025 Review Summary)	· Most key workers continue to carry caseloads of 25–40 patients per key worker, limiting the ability to provide personalised, proactive support. · High caseloads compromising contact frequency and personalised engagement. · Potential increase to risk of disengagement and missed early intervention in relapse.

	· Additionally, ongoing community transformation, organisational change, and contractual shifts, such as Section 75 arrangements, place further pressure on services, creating uncertainty in workforce models and risking increased demand without corresponding resources.					
Areas of Focus	We have no oversight or monitoring mechanisms in place to ensure key worker allocation or to monitor caseload appropriateness		We have some oversight in place, but we are not able to fully monitor key worker allocation or caseload appropriateness		We have robust and embedded oversight and monitoring systems in place, giving us clear oversight and assurance of key worker allocation and caseload management	Additional Comments
Our organisation is sighted to current caseload size and frequency of contact on an ongoing basis					YES	We have MaST in place and internal reporting around conducts and 365 Reports that help us to have robust oversight of all intensive AO caseload, however, we still have some areas where staff are working to higher caseloads and EI Teams does not use MaST. Reduced caseloads for AO workers - get emails weekly regarding contact figures
We have a clear understanding of the proportion / number of people requiring assertive outreach input within our CMHTs					YES	Please include: approx. IAO numbers per CMHT, proportion of people with IAO needs per CMHT AO functionality is ringfenced. We have AO standard Operation Policies and EI Teams in place.
we are able to monitor/review our assertive outreach prevalence numbers for our local population					YES	Through the use of MaST in population health data and regular reviews in MDMs.
We are applying the principles set out in the Personalised Care Framework for our IAO population	YES					Personalised Care Framework is not embedded in the Trust as the Trust is still working to CPA.
Additional Areas of Focus (Please enter here)						
Out of Hours Provision						
Identified challenges (September 2025 Review Summary)	· Workforce and funding pressures restrict proactive support. · Cohort may not present via ED or 999, they risk being deprioritized · Out-of-hours responses are often reactive rather than proactive. · Role clarity - external partners, including ambulance, police, and voluntary sector staff, uncertain about responsibilities during out-of-hours episodes.					
Areas of Focus	We have no formal arrangements in place for multi-agency coordination outside of core hours		We have some arrangements in place, but they are inconsistently applied, informal, or lack full system engagement		We have clear, formalised, and embedded arrangements in place to enable effective multi-agency coordination outside of core hours	Additional Comments

External partners coming into contact with people harder to engage have been supported to understand their responsibilities during out of hours episodes			YES			Some aspects are in place, eg we are reaching out to the Police. There is always variation due to how the Police work but we are currently waiting for them to set up an intelligent database which we can contribute to, We are currently using the Reasonable Adjustment Tab in System One to highlight to the GPs that the person is on AO needs. The Trust also works with the Ambulance Services to man the ambulance response vehicle with EMAS. In the event that the current conduct with the AO patient, the MH Workers in the response vehicle will be able to access System One for the most up to date plan of care for that service user.
Our out of hours provision enables a focus beyond ED and 999				YES		Notes added previously. There is currently work to implement the MH Unit Assessment Centre due to go live in July 2026. This will be able to divert people who do not need to be seen in ED but they are in a crisis that can be supported for the person to go back into the community. The turnaround of the MH Assessment Centre is 4 hours. We have the MH Helpline in place.
We are able to make provision for continuity of care at weekends/evenings?				YES		We have the Crisis and Home Treatment Teams which the AO Workers can refer onto if they need the service users to be supported during weekends and evenings. However they need to meet the Crisis and Home Treatment criteria. AO workers are Monday to Friday 9-5. Patients can call helpline out of hours however unlikely to do so and wouldn't be continuity of care as would depend on who is on shift as to whether they have any knowledge of the patient. Crisis team rarely support AO patients again due to lack of engagement and them requiring consent to refer. Recently added on front page of system 1 reasonable adjustments - this has had a positive response with a GP surgery.
Additional Areas of Focus (Please enter here)						
Care Delivery						
Identified challenges (September 2025 Review Summary)	· Care plan quality is variable, with updates and co-production inconsistent. · Limited PROMs use hinders measurement of impact and experience. · Workforce skills gaps in psychosis, risk formulation, and family interventions · Engagement challenges - some service users struggle to participate in co-production or outcome measures, while assertive approaches to engagement remain resource-dependent and inconsistently applied.					
Areas of Focus	We have no consistent oversight to ensure that our care delivery for this cohort indicates that their needs are comprehensively assessed / have care plans		We have some oversight mechanisms in place, but they are inconsistently applied or not fully embedded across services		We have robust and embedded oversight arrangements in place to ensure care plans are in place and holistic needs are assessed and addressed	Additional Comments
Our review of care delivery includes:						

whether care is delivered as planned					YES	We regularly audit AO caseloads and use of MaST. Care delivered depends on patients response at that time which fluctuates
Medication concordance					YES	We have MaST in place and also work closely with our Community Pharmacists. Concordance regularly reviewed
How frequently people were reviewed when risks increased					YES	Increased visits from Care Co-coordinators, regular discussions in MDT and Safety Huddles. However, we do not have dedicated AO Consultant time which can cause a slight delay in review in some areas.
If our care plans have been developed, delivered and reviewed by a MDT?				YES		Inconsistent depending on which other members of MDT are involved with patient as we currently do not have an AO team
We are able to demonstrate that our response to serious incidents for our IAO cohort incorporates the principles set out in the Patient Safety Incident Response Framework (PSIRF)					YES	Thematic analysis conducted alongside SI investigations.
Our Serious Incident Review Process:						Please include: (eg) Frequency of any routine review / the number of people flagged in the last quarter. We have got the SI Group Meeting that takes place on a weekly basis to review all Serious incidents reported in the Trust. Cases will be allocated accordingly for further investigation or full investigation in line with PSIRF Guidelines. In the event that there is an AO reported case, this will be further discussed in our monthly supervisions with AO Workers for shared learning and support for AO Workers with a Risk Management Formulation.
We review our serious incidents (SIs) involving people with psychosis as part of our continuous improvement plan for Intensive and Assertive Outreach					YES	
We have a process in place that flags any of our SI reviews with potential learning/missed opportunities regarding people with IAO needs.					YES	
We monitor the number of SIs that we flag where people have AO needs to support a true understanding of our current service for this cohort					YES	
Additional Areas of Focus (Please enter here)						

Information Sharing

Identified challenges (September 2025 Review Summary)	· Fragmentation of IT systems and lack of interoperability between platforms - preventing different agencies from accessing and contributing to a single, coherent patient record. · Inconsistent application of GDPR and wider information governance rules, leaving many staff uncertain about what can be legally shared. · Despite strong safeguarding frameworks, there are still gaps in information exchange with primary care, education, and VCSE providers, which means some partners remain disconnected from crucial aspects of patient care. · Reliance on information sharing via personal contacts and informal processes, rather than being embedded in robust, system-wide mechanisms. · Timeliness of information exchange particularly during crisis episodes or care transitions, when delays can have the most serious consequences for patient safety and outcomes.

Areas of Focus	We have no formal information sharing protocols in place, or existing protocols are not used in practice.		We have some protocols or agreements but they are inconsistently applied or not embedded across all partners		We have clear, formalised, and consistently applied information sharing protocols in place across all relevant partner organisations	Additional Comments
Strategic partners are engaged and focused to resolve the interoperability challenges between different platforms				YES		Systematic systems are different. Operational Policies in services are not always in sync. However, there is still ongoing work to see how we can work with the Police and also teams are promoting setting up Risk Strategy Meetings that will facilitate information sharing where IT systems may not be able to support us, eg if we are dealing with a complex housing issue, we would need to invite Housing Association Teams to support those MDMs. Some have more understanding than others, can be inconsistencies
Our review of SI's gives an indication of where the lack of information sharing has contributed and the causes.					YES	Picked up as part of the PSIRF process and any actions will be part of a Safety Action Plan.
Additional Areas of Focus (Please enter here)						

Families and Carers

Identified challenges (September 2025 Review Summary)	· Systematic monitoring is limited: · Some providers lack formal procedures to audit family and carer contact · Feedback is not consistently used to inform service change. · Consent and confidentiality barriers restrict meaningful involvement, as families are often excluded when patients withhold consent. · Staff approaches to balancing confidentiality and engagement vary. · The quality of engagement is uneven - involvement not always proactive or meaningful · Carers feeling underheard, particularly around discharge planning and crisis pathways.

Areas of Focus	We have no formal mechanisms in place to gather, monitor, or respond to family and carer feedback		We have some arrangements in place but they are inconsistently applied, informal, or lack clear governance		We have clear, embedded arrangements and processes in place to routinely capture and respond to family and carer feedback	Additional Comments

We provide a flexible range of opportunities for families and carers to contribute and tell us what works for them and what doesn't					YES	We have got the Friends and Family Questionnaire in place and also the Electronic Patient Records Survey. The plan is to be sent every 6 months and at the point of discharge. AO System Meetings we have invited people with lived experience, although engagement is low for them, we are keen to get feedback from them. We have got a representative from the Carers Engagement Meeting in our AO Meetings (Equal). We have got carers groups in most of the teams which will help us to proactively engage with families and we have Carers Champions in teams which attend Carers Engagement Meetings. Individual care co-ordinators maintain links with family where patient has consented. Carer support groups/ assessment are external to the trust and we can signpost there but wouldn't get feedback.
We are learning more about what works and what doesn't in engaging with families and carers and in capturing their feedback			YES			Karen Billyard to provide feedback. Teams have been informed to increase use of carers dashboard and friends and families test, however can be difficult with AO patients who often do not have family or friends or they are not involved
Additional Areas of Focus (Please enter here)						
Demonstrating Impact						
Identified challenges (September 2025 Review Summary)	· Absence of cohort-specific KPIs. · PROMs - not consistently used to drive improvement. · Wide variation across ICBs and Trusts in metrics, reporting quality, and co-production.					
Areas of Focus	We have no formal processes to measure or monitor the effectiveness of local services		We have some processes in place but they are inconsistent, incomplete, or lack full integration across services		We have comprehensive and embedded processes in place to systematically measure, monitor, and demonstrate service effectiveness	Additional Comments
Our data capture helps us to measure how well we identify, maintain contact with, and meet the needs of our IAO population ?					YES	MaST in place and we have the supportive Policies.
We make use of evidence based tools (eg) DACT to benchmark our delivery and progression to meeting the needs of this cohort					YES	The AO Policy is based around the DACT Model.
Our patient reported outcomes are utilised to adapt and improve our service provision for this cohort.				YES		The AO Workers have reported the challenges of engagement by AO patients. Patients reported outcome measures. They are asking for the use of dedicated AO outcomes such as Bexley Engagement Measure.

Our review informs our understanding of how accessible the service is to different elements of our local population				YES		The Trust is advocating for having dedicated AO Teams and an AO Option Paper was submitted to the Board which is advocated for dedicated AO Teams.
Additional Areas of Focus (Please enter here)						
Governance and Oversight						
Our executive teams are satisfied that effective processes are in place to provide them with robust assurance that the needs of this cohort are met.					YES	Regular reporting to Board and Committees. There is Exec oversight. The Execs have oversight of the MaST Dashboards. Our new Operational Meeting Structure have clear pathways of reporting floor to Board.
Additional Areas of Focus (Please enter here)						

Transformation and Continuous Improvement report

Purpose of Report

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

Executive Summary

Action supporting development of continuous improvement and transformation arrangements at the Trust remains in delivery, aligned to the agreed Transformation and Continuous Improvement Framework, which is a key enabler of the Trust Strategy.

The Strategic Portfolio Oversight Group (SPOG) oversees assurance that all aspects of the Strategic Plan are on track for implementation according to agreed timescales and oversees the design and delivery of a portfolio of transformation and improvement that is aligned to achieve organisational strategic intent. SPOG receives quarterly reporting on delivery which has been continuously developed over 2025/26 to enhance reporting and assurances.

SPOG discussion on 22 April 2026 focused on the status, assurances and risks across detailed Quarter 4 highlight reports for each programme that consist of the Trust transformation portfolio, along with highlights from the system and regional portfolio. SPOG further received proposals on the review and reset of the portfolio for 2026/27 and detailed planning documentation for each component programme.

Focus has been maintained on development of the Continuous Improvement Framework within the Trust and the content at Section 4 of the enclosed report provides an overview of activities in delivering improvement education and the current projects under design and delivery within the LiveQI platform. Attention remains focused on the development of arrangements for supporting improvement practice beyond the classroom education and on fostering the network and community of improvement practitioners across the Trust.

Aligned to the NHS IMPACT framework, design has been progressed for the launch of an enhanced organisational approach to continuous improvement in 2026/27. This will offer an opportunity to accelerate progress in creating the conditions for successful continuous improvement into action. Work is in progress to design the associated web content with a focus on learning from, sharing and celebrating success; to include a new monthly forum for exchange and conversation, a shared library for short-form case studies of improvement initiatives and a network for development of peer communication and support.

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

Concurrently, with the rapid improvement plan, we have been progressing development of our longer term plan for transformation of the ‘end to end’ pathway and define how the Trust care pathways and service will be redesigned in alignment with the Neighbourhood Mental Health model of care and delivery of this through 24/7 Neighbourhood Mental Health Hubs and the Mental Health Urgent Care Assessment Centre. Status of plans and the next steps for action were considered via the Board Development Session on 15 April 2026.

Strategic Considerations		BAF Risk(s)	Strategic Delivery Plan Reference
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	All	All
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:

- The Transformation and Improvement Framework and associated portfolio are aligned to achieve organisational strategic intent with risks to delivery of the Strategic Plan recognised and managed via the Board Assurance Framework
- The Transformation and Improvement Framework sets out the approach for management of risk and assurance over delivery of transformational and continuous improvement activities at the Trust

Assurances include that:

- The Transformation and Improvement Framework has been designed to support delivery of Trust Strategy
- The Strategic Portfolio Oversight Group oversees the design and delivery of the portfolio of transformation and improvement that is aligned to achieve organisational strategic intent
- The enclosed report demonstrates significant assurance on successful delivery of the transformation and improvement portfolio with detailed highlights, assurances and escalations considered by the Strategic Portfolio Oversight Group.

Consultation

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

Governance or Legal Issues

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

Net Zero Duty Implications

In compliance with the NHS move towards net zero carbon emissions, the Trust must consider statutory emissions and environmental targets in their decisions. Reports should identify related impacts on workforce and system leadership; sustainable models of care; digital transformation; travel and transport estates and facilities (including capital projects, asset management and utilities, green space and biodiversity); medicines; supply chain and procurement; food and nutrition and adaptation.

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

The Transformation and Improvement Framework and associated portfolio directly support statutory commitments to achieve net zero by reducing carbon output associated with care delivery, estates, travel, supply chains, and operational processes.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

Recommendations

The Board of Directors is requested to confirm the level of assurance secured in delivery of the agreed Transformation and Improvement Framework. 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 put the achievement of particular objectives at risk.

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

NHS
Derbyshire Healthcare
NHS Foundation Trust

Transformation and Improvement Delivery Report

Q4 2025-26

Report Contents

Derbyshire Healthcare NHS Foundation Trust

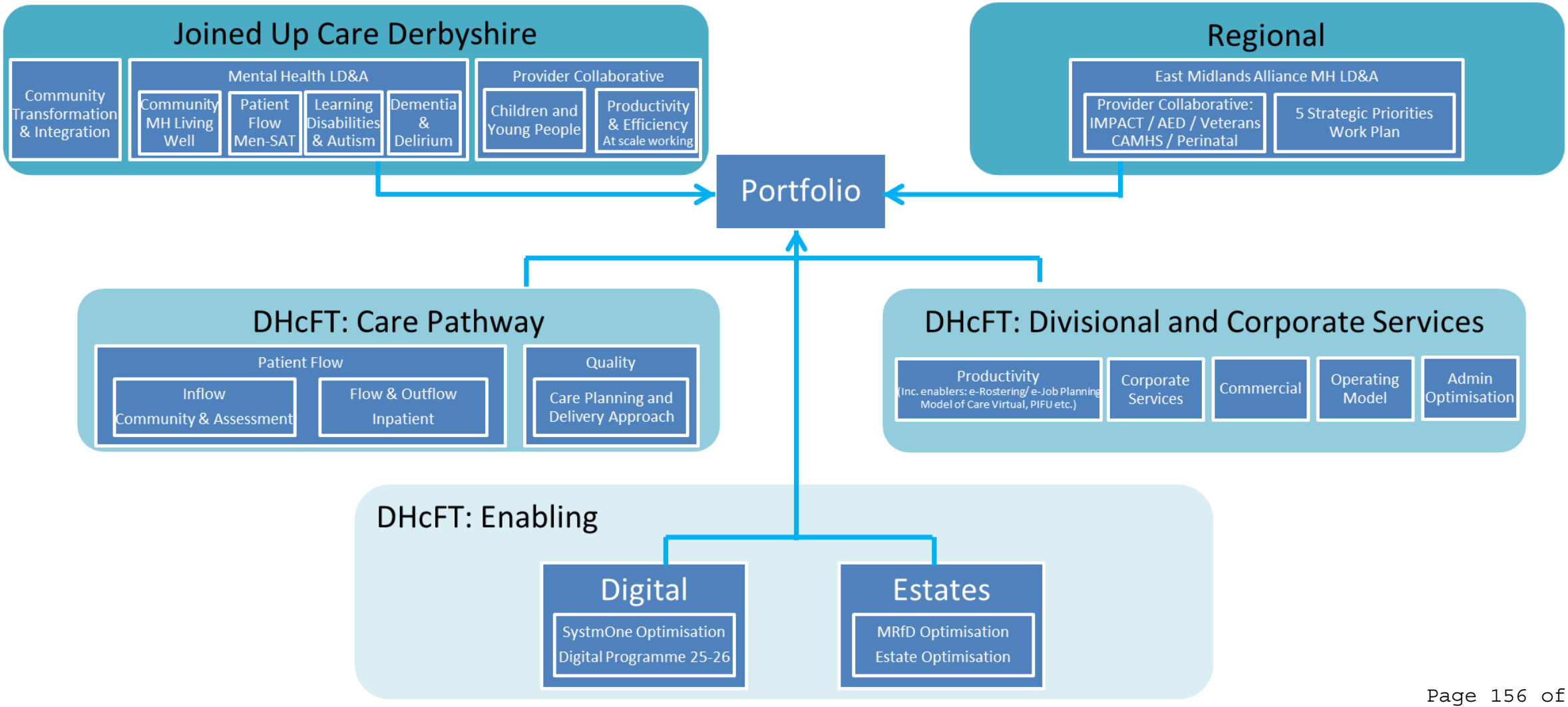
Derbyshire Healthcare
NHS Foundation Trust

Section 1: Transformation and Continuous Improvement Framework Assurance

1.1 Portfolio 2025-26

Derbyshire Healthcare NHS Foundation Trust

The portfolio approved by Strategic Portfolio Oversight Group (SPOG) on 24 June 2025 is set out below, with programme management arrangements implemented and overseen by SPOG to assure success in delivery.



1.2 Framework Assurance

Derbyshire Healthcare NHS Foundation Trust

A status overview is offered below across the requirements of the approved Transformation and Improvement Framework.

A refresh of the transformation portfolio is underway for 2026-27 with this fully aligned to framework requirements.

A review and refresh of the Trust framework document is scheduled for Q1 of 2026-27.

Framework	Section	Status Update
Transformation	3.1 Portfolio	The 2025-26 transformation portfolio approved by SPOG has been aligned to framework requirements.
	3.2 Design Management	The 2025-26 transformation portfolio has been designed in alignment with framework requirements.
	3.3 Design Process	A transition is underway from the decommissioned JUCD digital ePMO to an in-house designed solution with action to ensure robust PMO processes are retained aligned to framework requirements.
	3.4 Governance	Governance arrangements have been further developed across the portfolio over Q4 with action to refresh TOR and arrangements across a number of Delivery Groups.
	3.5 Leadership	Leadership arrangements have now been established across the portfolio aligned to framework requirements.
	3.6 Outcomes and benefits	Development of our approach on outcomes and benefits remains a focus with this under active consideration for 2026-27 programme planning.
Continuous Improvement	4.1 Aim	The continuous improvement framework has been continually developed aligned to agreed aims.
	4.2 Methodology	Improvement activities have been designed and delivered in alignment with agreed methodology.
	4.3 Process	Improvement activities have been designed and delivered in alignment with agreed process.
	4.4 Management	All continuous improvement activities continue to be captured and managed via the LIVEQI platform.
	4.5 Programmes	Further development is planned for 2026-27 in application of the NHS IMPACT improvement guide.

Derbyshire Healthcare
NHS Foundation Trust

Section 2: DHcFT Transformation Portfolio Status Report

2.1 DHcFT Programme Status

Derbyshire Healthcare NHS Foundation Trust

An overview of delivery status at Q4 2025-26 across the programmes that consist the DHcFT transformation portfolio is set out below:

Programme	Overall Status	Timeframe	Quality/ Aims	Finance/ Resources
Patient Flow	Partial Delivery			
Quality	Programme ambitions undelivered due to late publication of national Personalised Care Framework			
Corporate Services	Partial Delivery			
Productivity	Partial Delivery			
Commercial	Full Delivery			
Admin Optimisation	Partial Delivery			
Operating Model	Full Delivery			
Estates	Full Delivery			
Digital	Partial Delivery			

2.2 DHcFT Programme Risk

Derbyshire Healthcare NHS Foundation Trust

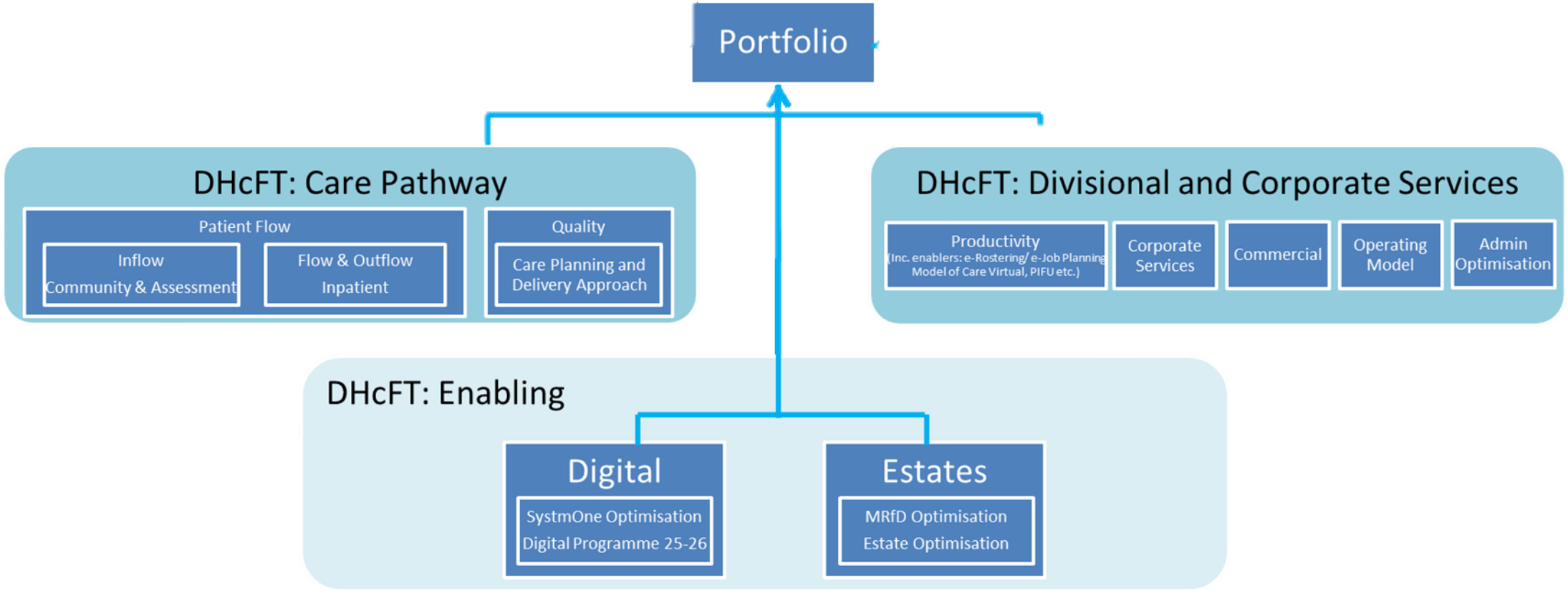
Key risks at Q4 2025-26 across programmes that consist the DHcFT transformation portfolio are set out below:

Programme	Risk	Description	Mitigation
Patient Flow	Delivery of ambitious trajectory for improvement of LoS and LLoS	Accelerated progress required in action to reduce LoS and LLoS	Performance improvement plans in place and being overseen by Patient Flow Delivery Group and Trust Delivery Group. Flow and discharge action plan agreed with ICB and ASC partners. Engagement with Midlands Learning and Improvement Network with learning being applied from bespoke Derbyshire follow up event hosted in January and further cross system event in February 2026.
	Delivery of MH Helpline Improvement Plan	Risk to delivery of improvement due to significant imbalance in capacity vs demand with ongoing rise in demand and no additional resources or investment available.	Performance improvement plan and capacity vs demand planning refreshed and presented for consideration through appropriate governance oversight Groups. Meeting scheduled with ICB 20 April 2026 to consider service specification.
	Delivery of new models	No recurrent revenue funding stream available to support new service models for the MHUAC or development of Neighbourhood through Living Well.	Bid to be submitted for DLN transformation funding.
	Collapse of integrated Living Well offer due to staff leaving	Lack of long-term commitment to funding from ICB for ASC workforce. Retention and recruitment of staff is limited.	Issue escalated to and being managed at CEO level across partner organisations.
Quality	Delivery of plan to implement new national Personalised Care Framework.	Delay in publication of new national framework and guidance is impacting the expected timeline to develop and deliver aligned implementation plan.	Limited ability to influence national timescales with achievement in 2025-26 now undeliverable and plan for 2026-27 under design.
Commercial	Care package progression	There is insufficient available capacity for staff to support the development of the care packages during their substantive hours.	Consider option to front load the project with a financial envelope that will enable staff remuneration to identify and develop the required care packages outside of contracted hours.
Digital	Resources required to deliver Digital Delivery Plan 2026-28.	Availability of Digital and enabling IM&T resources to deliver ambitious programme defined in the Digital Delivery Plan 2026-28, alongside action on the Arden and GEM Commissioning Support Unit contract and need to develop proposals to deliver required corporate efficiency savings in 2026-27.	Evaluation of Digital and enabling IM&T resources underway with reporting and escalation to be considered via Digital Delivery Group and Trust Delivery Group as appropriate. Recruitment in progress for Programme Lead for Digital Transformation and Chief Clinical Information Officer.

2.3 DHcFT Programme Highlight Reports

Derbyshire Healthcare NHS Foundation Trust

Highlight reports for each programme consisting the 2025-26 DHcFT transformation portfolio were included within the detailed version of this report and considered by the Strategic Portfolio Oversight Group on 22 April 2026.



Derbyshire Healthcare
NHS Foundation Trust

Section 3: Partnership Transformation Portfolio Status Report

3.1 Partnership Programme

Programme highlight reporting for the JUCD and regional portfolio is managed according to various system PMO arrangements and there is therefore inconsistency of formatting.

An overview of key highlights across this portfolio for consideration by DHcFT is set out at the following Section 3.2.

Detailed highlight reports across the portfolio were included within the detailed version of this report and considered by the Strategic Portfolio Oversight Group on 22 April 2026.

3.2 Partnership Programme Highlights

Derbyshire Healthcare NHS Foundation Trust

An overview of key highlights at Q4 2025-26 across the programmes that consist the partnership transformation portfolio is set out below:

Programme	Issue Highlighted
JUCD: Living Well	Escalations in place regarding Local Authority and VCSE resourcing and contracting which risk stability and delivery of programme and current model of care. Action escalated to CEO level and under active management and mitigation across system partners.
JUCD: Men-SAT	Limited progress to date in system level action plan response to Men-SAT report with escalation made via JUCD MHLD&A Delivery Board. Six month NHSE MHIST team revisit is scheduled for 23 April 2026 to stocktake progress and agree next steps for action.
JUCD Provider Collaborative: Enabling Services	Work continues to advance, most successfully within procurement and estates, but progress has not been made at the scale or pace envisaged at the start of the year. The forward approach for 2026-27 is under active consideration at CEO level through the Provider Collaborative Leadership Group.
East Midlands Alliance: Gambling Harm	Continued positive progress made in increasing referrals and conversion to treatment. Significant additional funding stream expected to be received for 2026-27 via gambling levy with service specification due to support development of plans.

Derbyshire Healthcare
NHS Foundation Trust

Section 4: Continuous Improvement Approach Update

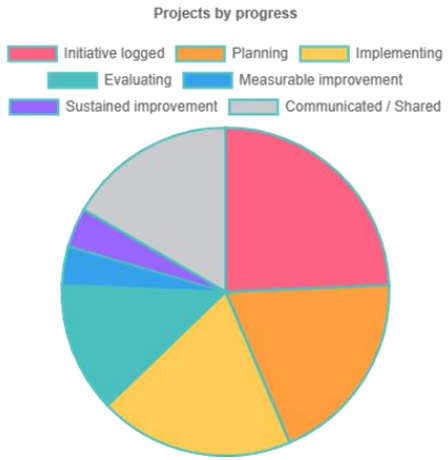
4.1 Improvement Portfolio

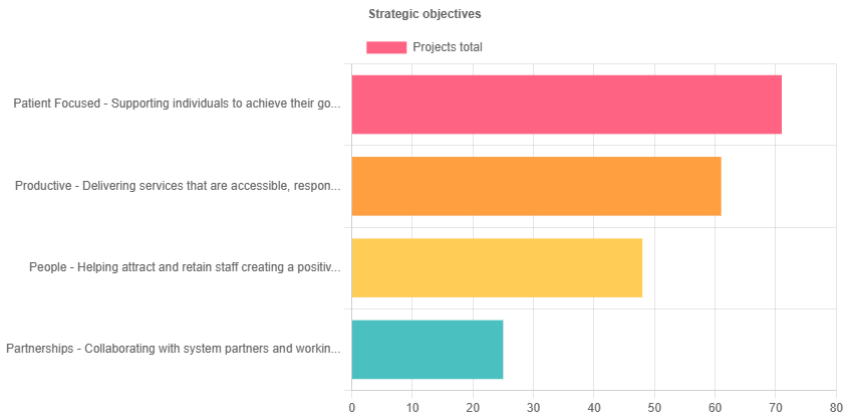
Derbyshire Healthcare NHS Foundation Trust

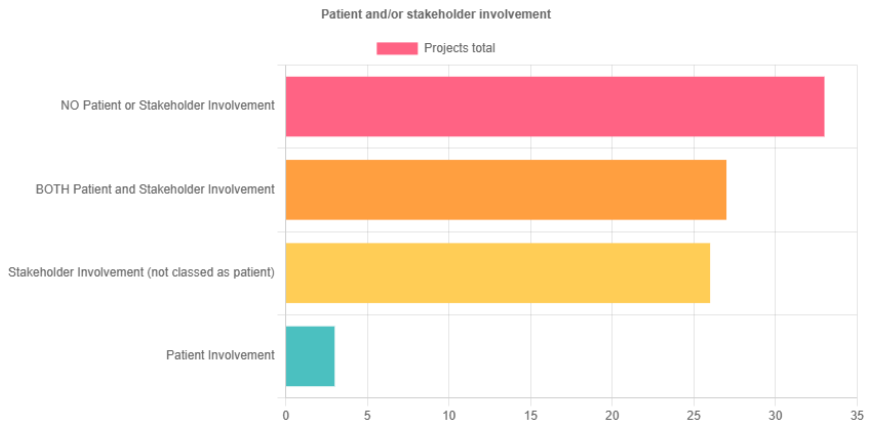
LIVEQI has been maintained as the in-house designed workspace and repository for continuous improvement projects. Over recent months it has been further developed to incorporate transformation projects which were previously managed via the JUCD digital ePMO solution that is shortly to be decommissioned.

LIVEQI currently hosts 98 improvement and transformation projects which all trust staff can access and view. Alongside digital functionality in the platform, this offers templates for planning and delivering projects that can be downloaded and uploaded by project leads and teams. It also contains analytical content to support evaluation of data, and there is ongoing work to develop reporting further functionality. The platform supports the identification of project stage, enabling the improvement team to offer support and guidance to those colleagues that are currently working on, or looking to get involved in a new improvement project.

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







4.2 Current Improvement Activities

Derbyshire Healthcare NHS Foundation Trust

Improvement projects currently active in the LIVEQI platform are focused on the following aims:

Current Portfolio
• LIO Oxehealth: Oxevision contactless monitoring medical device as enabler for patient care, safety and experience
• Culture of Care programme aimed at compassionate and inclusive care and improved patient and staff experience
• Culture of Care projects: Bluebell Older Adults; Kedleston Unit; Cubley Court
• Children's physio bookable clinics
• Occupational Therapy Referral Process
• Community Mental Health Team carer involvement
• Compliance with MHRA guidelines for our patients on valproate
• QI predictability tool for risk and reduce harm in Substance Misuse population
• Experience Based Co-design of Psychosis Cantered Integrated Care Services for Ethnically Diverse People with Multimorbidity (CoPICS)
• Purposeful admission, Trauma informed care and sensory interventions. New Model of Care delivery, as part of the Making room for Dignity programme
• Development of Resident Doctors' Handbook
• On call monitoring
• Improving patient and staff experience of ward rounds on The Beeches
• Diversion and Wellbeing Hub
• Enhancing completion rates of occupational therapy assessments: An older adult community mental health team
• Induction for HST Doctors
• Improve collaborative working between inpatient wards and OT

Where the above continuous improvement projects have opportunity for scale and spread and / or deliver efficiency benefits, these will be recognised through transfer to the formal annual programme and financial tracking via the PMO functionality of the LIVEQI platform

4.3 Sharing and Celebrating Success

Derbyshire Healthcare NHS Foundation Trust

A summary one page case study poster is in development to enhance sharing and celebration of improvement success with the first draft below. Over future reporting periods all projects completed in the prior quarter will be documented for inclusion within this report, alongside new arrangements for sharing with our people and teams.

Making Positive Improvements: A Success Story

Reducing Falls in Older Adults Inpatient North Acute Wards (Pleasley/Bluebell)

Project Lead: Scarlett Williams ACP

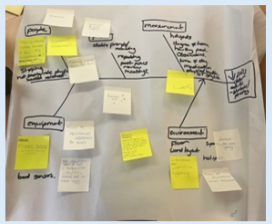
Aim:

To reduce the number of falls and harm from falls, on the Older Adult inpatient Bluebell ward, from 110 (2023-2024) to 55 (50% reduction) by December 2025. In relation to harm, to also reduce the degree of harm from falls. Between 2023-2024 there were 5 moderate harm outcomes, 39 low harm outcomes and 66 no harm outcomes.

Methodology and Process:

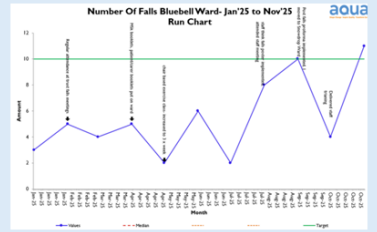
Improvement methodology and tools were employed during the project:

1. Analysis of data from falls incidents via Datix reporting (number and time of falls).
2. A fishbone, root cause analysis tool was applied to explore multifactorial aspects of falls with the team as part of the diagnosis.
3. Hot spot observations were collaboratively secured via process mapping and spaghetti diagram.
4. A driver diagram was developed to confirm aim, identify drivers and ideas for tests of change, mapping outcome, process and balancing measures.
5. Multiple change ideas were tested collating data, study, adapt, adopt, abandon then cycle PDSA.
6. Intervention impact was evaluated, documented and implemented for scale and spread.
7. At project closure learning was documented and shared.



Impact:

- Reduced falls (falls on Bluebell ward reduced by 45%, which is below the target but remains a great success)
- Reduced harm number of falls incidents improved patient experience,
- Improved staff morale,
- Better holistic care,
- Embed on ward culture

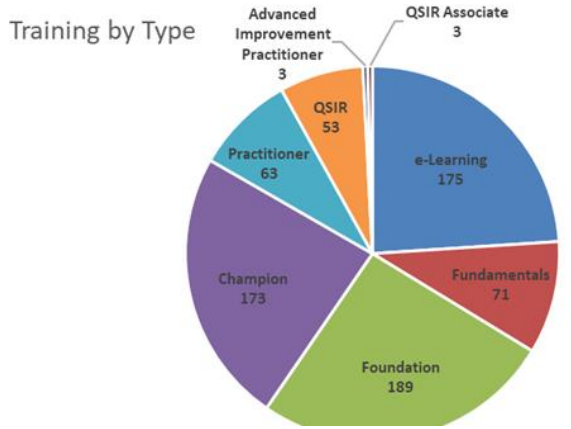


Learning:

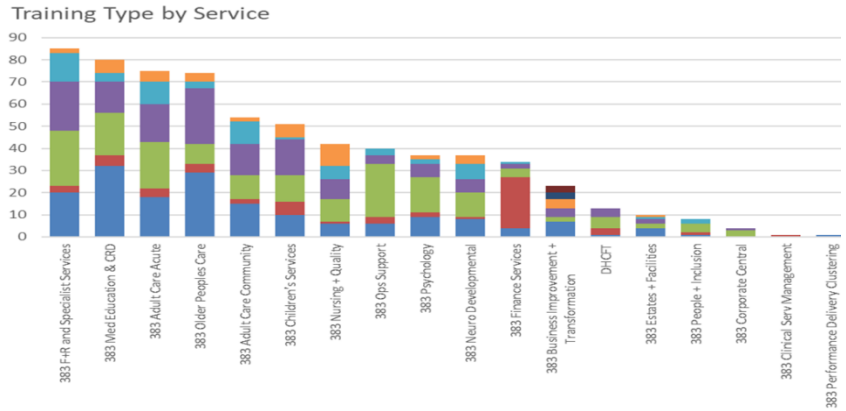
- Leadership is important for a project to run well
- Completing a project takes time, and following methodology is important.
- Involving others in the project is a must for success and sustainability
- There will be bumps along the way, not all will go to plan and that's ok. It's about reviewing and learning from what didn't work or go so well and why.
- Not everyone in the team will feel as passionate as you about the project, educate the team, take them on the journey and celebrate the small wins,

4.4 Improvement Education

730 staff and system partners have completed or are currently participating within an improvement education offer, with a further 49 booked in to upcoming sessions. This does not include induction and leadership development which incorporate an integrated improvement component. There continues to be a good level of more advanced methodology uptake with 36% of Trust staff having attained the higher level of Champion (two-day) improvement education and above.



There remains good spread of education across service areas, but education has also been targeted to areas where there is improvement and transformation work planned or underway. There has been focus on identified senior and leadership roles where it is important to demonstrate commitment to our improvement approach and establish this in practice within leadership behaviours. Mapping is currently underway of new operating model structures to identify further targeted opportunities for development.



*Note these are numbers of trained individuals so smaller teams may have smaller numbers.

Aligned to the change in direction of system partners on improvement education we no longer deliver education in collaboration and our offer of access to Trust education for system colleagues has been adapted to allow access only to our unused capacity. We will continue to proactively engage with discussions regarding the restoration of a collaborative education programme, recognising the benefits this offers.

4.5 Improvement Approach and Community

With valued support from the Communications and Engagement Team a new ‘identity’ has been drafted for the Trust continuous improvement approach. Development of this is ongoing with work underway to translate the NHS IMPACT five domains from corporate language to meaningful ambition statements for our people and teams. A final draft will be consulted upon and agreed in Q1, ahead of application to support launch of a new enhanced approach to continuous improvement in 2026-27.

Derbyshire Healthcare NHS Foundation Trust
Report to the Trust Board – May 2026

Board Assurance Framework (BAF), Issue 1, 2026/27 – for review

Purpose of Report

To meet the requirement for Boards to produce an Assurance Framework. This report details the current BAF risks, Issue 1, version 1.3 for 2026/27.

Executive Summary

Director Leads, Deputy Directors, Directors of Operations, Operational Leads and Trust Senior Managers have reviewed the risks to the Trust's strategic priorities for 2026/27.

The BAF report has undergone extensive review and overhaul in preparation for the first issue of the new fiscal year. Each Director has reviewed the risks, root causes and key gaps in control to ensure that:

- The risks are relevant to the Trust's 2026/27 priorities and directly linked to the Trust Strategic Delivery Plan
- The current risk ratings are appropriate for the position of the start of 2026/27
- Key controls and internal assurances of those controls are correct for 2026/27
- Progress summaries against continued risks (carried forward from 2025/26) are updated to ensure they reflect the current status and are relevant to the 2026/27 status. Any updates relating to previous versions are held on the archived BAF reports.

Reminder: If action target dates are in brackets they indicate the next review date. If there are no brackets it is a set completion date that cannot be changed.

Summary of updates

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

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

The risk rating has been reduced by the Director of Nursing, AHPs, Quality and Patient Experience, from high to moderate – Improvements have been made over the last year, actions have progressed and the Care Quality Commission results map to the overall improved position across Inpatient services.

Actions have been removed from the 'gaps in Acute and Community operating standards' section – Measures are in place and compliance standards are being met. Out of area rates are now also reduced and risks relating to that are controlled/mitigated.

The key gap in control relating to Patient Carer Race and Equality Framework (PCREF) has been updated by the Suicide Prevention Lead who has identified several more actions to close the gap.

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

The Director of Finance has added to the root causes, identifying the barriers limiting our ability to invest in capital.

People - Derbyshire Healthcare is a great place to work

The Director of People, Organisational Development and Inclusion has thoroughly reviewed risks 2A and 2B and has updated the titles of each. Updates have been provided against the key gaps in control. Progress to close several gaps has been made, specifically around the development of an Equality, Diversity and Inclusion plan and also leadership development.

The next review date for all actions has been set for six months' time to allow for progress to be made.

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

Risk 3A: There is a risk that the Trust fails to deliver its revenue and capital financial plans for 2026/27 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. There is also the added risk of a Capital Departmental Expenditure Limits (CDEL) breach linked to following through on the Making Room for Dignity dormitory eradication programme and our associated capital commitments

The title has been added to and now maps to the financial risk linked to Risk 1B (and root causes added to by the Director of Finance).

The Director of Finance has thoroughly reviewed Risk 3A and provided updates on actions to close key gaps in control and further measures to ensure they are relevant to the position at the start of 2026/27.

The internal and external assurances have also been updated to ensure they are current.

The overall risk rating has been increased, from moderate to high.

Risk 3B: 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

This was previously logged under the Patient Focused section but as the residing risk is more relevant to productivity it has been moved and updated.

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

Risk 4A: 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

The Chief Delivery Officer has removed the action relating to working with the police (in agreement with the Director of Nursing, AHPs, Quality and Patient Experience) as there are no gaps in control relating to partnership working with the police identified for 2026/27. All actions to close previous gaps have been completed and improved partnership working is now business as usual.

The Director of Nursing, AHPs, Quality and Patient Experience has changed the status of the action to close the key gap in controls that relates to working with patient and carer groups as the actions are complete and there is a method of sustainability (as noted in the progress summary).

Previous Partnership Risks (2025/26):

There is a risk that the effects of both nationally and locally driven changes to roles and responsibilities across the Integrated Care Boards (ICB), and with its partners may impact negatively on the cohesiveness of the Derbyshire Health and Care System in our organisation

The Chief Delivery Officer has removed this risk – Working arrangements are business as usual and the major changes have been overcome. Ongoing change is standard.

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

The risk has been removed from the Partnership section. The remaining gap in operating standards and clinical risks for Learning Disabilities and Autism (LD&A) services is now included in the key gaps in control under Risk 1A.

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

This has been moved to the Productivity section as the most relevant for the remaining risk. There are emergency preparedness plans and controls in place to control the overarching risk and possible reduced productivity in the event of a major outage. There remain two key gas in control to manage the dependency on digital technology.

Operational Risks

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

REMOVED - Risk 23465: Clinical Risks to Children Due To Lack of Wheelchair Services – This has re-categorised as a Divisional risk.

MOVED - Risk 23314: Interpretation of data submitted within NHSE datasets risks erroneous views on the Trust – This has been moved to sit beneath Risk 4A as the remaining BAF risk in the Partnership section.

Risk 23650: Lack of Resources to Support Trust Projects – This remains in version 1.3 for reference but going forward updates will be captured in the key gaps in control in Risk 3B as the operational risk record has been closed to avoid duplication.

Risk 21620: IT system collapse due to cyber-attack – The Interim Head of Information Management, Technology and Records is reviewing this risk to consider if updates can be recorded in the key gaps in control under Risk 3B, or if it needs to remain in the operational risk register. The outcome will be apparent in the next issue of the BAF report.

BAF Reporting Cycle/Format

All changes/updates to this issue of the BAF, compared with Issue 4 2025/26, are shown in tracked changes. All text that has been stricken through will be removed from the next issue (Issue 2 2026/27).

The references for each risk have been updated, as they are each year. The status/references at year-end 2025/26 and the new 2026/27 versions are included in the Annual Governance Statement along with a summary of all changes that have occurred throughout the last year and any that effect the revised version for the new fiscal year.

Following the Board BAF Development session in February the format of the report has been updated:

- Risk tolerance scores have been updated in-line with the key at the end of the report and the title has been corrected in each risk header
- A new risk appetite section has been added to each risk and the key for rating has been added in the report to align with the Risk Management Strategy.

The **Issue 1 cycle** is:

Executive Leadership Team (ELT) for **full collective review**: Version 1.1	13 April 2026
ARC for **approval**: Version 1.2	23 April 2026
Board for **review and approval**: Version 1.3	19 May 2026

Board committees also receive the current version of the BAF report to review the risks they are responsible for – All updates received from the Board committees, approved by the director leads, are incorporated into the BAF report.

Strategic Considerations		BAF Risk(s)	Strategic Delivery Plan Reference
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	All	All
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 report in seeking to identify and mitigate risks to achieving the Trust's strategic priorities.

Consultation

The BAF report is reviewed and updated by:

- Executive Directors
- Deputy Directors
- Managing Director
- Professional Leads
- Operational Risk Handlers.

The BAF is presented quarterly to ELT for full collective review, the Audit and Risk Committee for approval and Board for review and approval.

Governance or Legal Issues

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

Net Zero Duty Implications

In compliance with the NHS move towards net zero carbon emissions, the Trust must consider statutory emissions and environmental targets in their decisions. Reports should identify related impacts on workforce and system leadership; sustainable models of care; digital transformation; travel and transport estates and facilities (including capital projects, asset management and utilities, green space and biodiversity); medicines; supply chain and procurement; food and nutrition and adaptation.

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

Any possible net zero implications are included in the detail of the BAF report.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Specific elements within each BAF risk and associated actions are addressed by the relevant lead director in taking forward.

Recommendations

The Trust Board is requested to:

1. Review and approve Issue 1 of the BAF for 2026/27 and the assurance the paper provides of the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives
2. Continue to receive updates in line with the forward plan for the Trust Board.

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

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

Board Assurance Framework Report 2026/27 – Issue 1.3 Board May 2026

Trust Strategic Priorities	
Patient Focused - Our services will deliver safe and high-quality care	Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers
People - Derbyshire Healthcare is a great place to work	We will attract, involve and retain staff creating a positive culture and sense of belonging
Productive - Our services will be productive, demonstrate best value for our population and be cost effective	We will improve our productivity and design and deliver services that are financially sustainable
Partnerships - Our organisation will identify new ways of working, through new collaborative approaches	We will collaborate with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities

Risks to Trust Strategic Priorities ~~2025/26~~2026/27

Ref	Risk	Director Lead	Risk Rating	Responsible Committee
Patient Focused - Our services will deliver safe and high-quality care				
~~25-26 1A~~ 26/27 1A	There is a risk that the Trust will fail to provide standards for safety, and effectiveness as required by our patients, regulators, partners and our Board, There is also a risk of poor patient experience and outcomes	Director of Nursing, AHPs, Quality and Patient Experience (DON) / Medical Director (MD)	~~HIGH~~ MODERATE	Quality and Safeguarding Committee
~~25-26 1C~~	~~There is a risk that the Trusts increasing dependence on digital technology for the delivery of care and operations increases the Trusts exposure to the impact of a major outage~~	~~Medical Director (MD)~~	~~MODERATE~~	~~Finance and Performance Committee~~
~~25-26 1E~~ 26/27 1B	There is a risk that the Trust does not deliver key regulatory and strategic requirements related to dormitory eradication and that the Trust estate is not maintained sufficiently well to comply with regulatory and legislative requirements	Director of Nursing, AHPs, Quality and Patient Experience (DON)	MODERATE	Quality and Safeguarding Committee
People - Derbyshire Healthcare is a great place to work				
~~25-26 2A~~ 26/27 2A	There is a risk that we are unable to sustain a positive, inclusive and compassionate ~~create the right~~ culture with high levels of staff morale and engagement while delivering multiple, concurrent change and efficiency programmes, leading to increased sickness absence, employee relations cases, loss of discretionary effort and reduced capacity to deliver strategic priorities safely	Director of People, Organisational Development and Inclusion (DPOI)	HIGH	People and Culture Committee

~~25-26 2B~~ 26/27 2B	There is a risk that we do not have an adequate supply of a skilled and diverse workforce in critical clinical roles, including inpatient nursing and support staff, limiting the Trust's ability to deliver safe staffing, reduce reliance on temporary workforce solutions, and meet safety, quality and financial priorities~~with the right people with the right skills to support and deliver safe high-quality care~~	Director of People, Organisational Development and Inclusion (DPOI)	**HIGH**	People and Culture Committee
Productive - Our services will be productive, demonstrate best value for our population and be cost effective				
~~25-26 3A~~ 26/27 3A	There is a risk that the Trust fails to deliver its revenue and capital financial plans for ~~2025/26~~2026/27 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. There is also the added risk of a Capital Departmental Expenditure Limits (CDEL) breach linked to following through on the Making Room for Dignity dormitory eradication programme and our associated capital commitments	Director of Finance (DOF)	~~MODERATE~~ HIGH	Finance and Performance Committee
26/27 3B	There is a risk that the Trusts increasing dependence on digital technology to deliver safe, timely and integrated care increases exposure to major system outages or cyber incidents, impacting patient safety, service continuity and strategic delivery	Chief Delivery Officer (CDO)	**MODERATE**	Finance and Performance Committee
Partnerships - Our organisation will identify new ways of working, through new collaborative approaches				
~~25-26 4A~~	~~There is a risk that the effects of both nationally and locally driven changes to roles and responsibilities across the Integrated Care Boards (ICB), and with its partners may impact negatively on the cohesiveness of the Derbyshire health and care system in our organisation~~	~~Chief Delivery Officer (CDO)~~	~~**MODERATE**~~	~~Trust Board~~
~~25-26 4B~~ 26/27 4A	There is a risk of reputational damage if the Trust is not viewed as a strong partner both within the Derby and Derbyshire Integrated Care System (ICS) and more broadly within the East Midlands Mental Health Provider Alliance	Chief Delivery Officer (CDO)	**MODERATE**	Trust Board
~~25-26 4C~~	~~There is a risk to safe, effective clinical care across Derbyshire impacting upon patients, due to not achieving national standards and variation of clinical practice and service commissioning in the Learning Disability (LD) Transforming Care Partnership~~	~~Chief Delivery Officer (CDO)~~	~~**MODERATE**~~	~~Trust Board~~

Patient Focused - Our services will deliver safe and high-quality care
There is a risk that the Trust will fail to provide standards for safety and effectiveness as required by our patients and our Board **Impact:** May lead to avoidable harm including increased morbidity and mortality; delays in recovery; and longer episodes of treatment; affecting patients, their family members, carers, staff or the public **Root causes:** a) Workforce supply and lack of capacity to deliver effective care across hotspot areas, increasing risks in the clinical and medical workforce b) Risk of substantial increase in clinical demand in some services, including high caseloads and wait lists in some community services c) Intermittent lack of compliance with Care Quality Commission (CQC) standards d) National Oversight Framework (NOF) Level 3 - Financial position and out of area placements and continued monitoring of quality standards across all Trust services e) Lack of embedded outcome measures at service level f) Lack of compliance with physical healthcare monitoring in primary and secondary care, not at the required level for reductions in mortality g) Restoration and recovery of access standards in autism and memory assessment services h) Lack of appropriate environment to support high quality care, i.e. single gender dormitories i) Local NHS Trusts will offer Recruitment and Retention Premium to Consultant Psychiatrists in specialist services and other clinical staff due to competitive practices that destabilises Trust clinical services and leads to a deterioration in waiting time and potentially in safety j) Data quality could be adversely affected due to the Electronic Patient Record (EPR) and its application k) Health inequalities across Derbyshire. Initial insights show gaps in access to service, case load and worsening patient outcomes for our patients l) Sustained pressure in the crisis and acute care pathway with bed occupancy over 85% and increased waiting time for patients to access bedded care from the community m) Gaps in Advocacy for Children who are under 18 ~~m)~~n) The community Intensive Support Team and Learning Disability models have non-standardised operating models and require more capacity ~~n)~~o) Capacity to learn from other organisations in their ability to maintain adequate mortality, serious incidents and learning reviews to respond to improve practice and to also comply with the coroner's formal requirements ~~o)~~p) Lack of systematic capture of patient experience and feedback in our services ~~p)~~q) Lack of learning from patient or carer feedback from complaints and concerns due to delayed investigations and responses ~~q)~~r) Safety and learning culture, learning from internal incidents, complaints and other sources of feedback is not developing and needs to be further embedded s) Inconsistent approach to working with families and carers, involving the care of family members ~~r)~~t) Increased violence and aggression within the inpatient settings towards staff and other patients

BAF Ref: ~~25-26~~ ~~1A~~26/27 1A	**Director Lead**: Tumi Banda (DON) / Girish Kunigiri (MD)	**Responsible Committee**: Quality and Safeguarding Committee

Board Assurance Framework Report 2026/27 – Issue 1.3 Board May 2026

Key Controls										
Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Tolerance**	**Risk Appetite**
High	Likelihood 4	Impact 4	~~High~~ Moderate	Likelihood ~~3~~4	Impact 4	Moderate	Likelihood 3	Impact 4	Not Accepted	Low

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. Adherence to the Trust's Quality Assurance Framework
Detective – Quality dashboard reporting; Board visits virtual clinical service contact visits; incident, complaints and risk investigation; clinical audit; Fire Safety Regulations (FSR) compliance checks; mortality review process; physical health care monitoring clinics pilots; safety check log; Head of Nursing and Matron compliance visits, reviewed model of announced and unannounced visits to service throughout the 24-hour period; Fundamental Standards of Care visits; quality cross-checks: Inpatient and Community; 15 Steps challenge commencing in inpatient services; patient survey; friends and family test
Directive – Trust Strategy; Quality Delivery Plan; Joint Child Adult and Family Safeguarding Strategy; Patient and Carer Experience pledges and associated workplans; Patient Safety Incident Response Plan (PSIRP); clinical strategies; policies and procedures available via Trust intranet; Central Alerting System (CAS) alerts; Risk Management Strategy; clinical sub committees of the Quality and Safeguarding Committee

Assurances on controls – Internal	Assurances on controls – External
Trust quality and performance dashboards Scrutiny of Quality Account by committees Programme of physical healthcare and other clinical audits and associated plans Infection Control Board Assurance Framework reported to NHS England Positive and Safe self-assessment ~~Head of Nursing and Matron compliance visits~~ Quality Assurance Framework Board visits and out of hours visits Fundamental Standards of Care visits Clinical audits Incident reporting and monitoring systems through Datix Quality and safeguarding workplan Patient, family and carer feedback Trust risk registers and scrutiny of the Risk Management Strategy by Board committees	National enquiry into suicide and homicide NHS Litigation Authority (NHSLA) scorecard demonstrating low levels of claims Safety Thermometer identifies positive position against national benchmark Trust fully compliant with National Quality Board Learning from Deaths guidance Engagement meetings with CQC taking place Patient Safety Incident Response Framework (PSIRF) implementation CQC comprehensive review 2020 Trust rated Good CQC inspections: Acute and PICU December 2024 rated Good; Wards for older people with mental health problems, July 2025 rated Good; Forensic inpatient or secure wards, September 2025 rated Good; Rehab and long stay unit, January 2026 rated Good, Crisis and Health Based Place of Safety, January 2026 Rated Good Quarterly CQC regulation oversight Regular NOF Level 3 meetings with NHS England (NHSE) and Integrated Care Board (ICB) ICB local review to ensure there are clear policies in place to meet the needs of people in Derbyshire with severe mental health illness Adult and Children Safeguarding Boards (Derby City and Derbyshire County) ICB Quality System Group for Integrated Care System (ICS) quality system monitoring

		Advisory support provided by the Trust to the system on bedded care standards for Learning Disability in-patient services			
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**
Gap in operating standards and clinical risks for acute and community mental health services	~~Improve the assessment interventions and risk management of patients requiring enhanced input or assertive outreach services~~ ~~Compile outcome measures for acute and community services and create relevant dashboards for the services to inform areas for improvement~~ Improvement of both inpatient and community care settings – Environments need to be improved [ACTIONS OWNER: DON] Set out improvement plans to achieve Royal College of Psychiatrists (RCP) accreditation across services [ACTION OWNERS: MD/DON/CDO] Implement Community Mental Health Framework (CMHF) Improve the out of area (OOA) placements and facilitate care closer to home Improve access to services ~~Improve access~~ [ACTIONS OWNER: CDO/DON]	Improve working with carers and families Improving risk assessment and care planning for patients in community settings Deliver the assertive outreach pathway to support patients with complex care needs. Provision is part of the CMHT with a specialist service Improvement in operating standards compliance to be overseen by Quality and Safeguarding Committee Adherence to the Trust Assurance Framework across all the services to review and monitor quality of care ~~Implemented Acute Inpatient Mental Health Service Accreditation (RCP Standards) reported in Divisional Performance Reviews and Quality Account~~ Implemented Mental Health Community Framework to Quality and Safeguarding Committee ~~Aim for no inappropriate out of area placements~~	~~(31.03.26)~~ (30.06.26)	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 Quality Assurance Framework in place to monitor quality and safety Triumvirate leadership in the place across divisions and care groups to take collective responsibility for quality and safety Governance structure to review, monitor, improve quality and give assurance to the Board is in place following implementation of the new operating model ~~Internal Trust programme Board in place to strengthen contribution and involvement in system-wide programme and delivery~~	AMBER

		Achieving waiting time access targets		~~Living Well transformation mobilisation completed March 2025~~ ~~Viability of the model may be at risk due to possibility of the social worker component not being funded by the ICB~~ ~~The funding has now been agreed for 2025/26 for social care and the voluntary sector to support the CMHF. The programme team supporting the delivery has been reduced and is committed for a further two years to support transformation~~ ~~Dashboard has been generated for inpatient acute services. DON leads a fortnightly forum around achieving compliance~~ ~~CQC have reinspected acute inpatients areas and adjusted the rating of older adults and forensic inpatient services to good~~ Implement and monitor the ten High Impact Actions including MADE events and working with system partners. Inappropriate OOA bed	

				use has significantly reduced Performance Improvement Plans in place and monitored Ongoing conversations with ICB cluster regarding appropriate funding to meet increased demand	
Gap in operating standards and clinical risks for Learning Disabilities and Autism (LD&A) services	The community Intensive Support Team and Learning Disability models require improvement 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 [ACTIONS OWNERS: CDO/DON/MD]	Review all models of support offered by the Intensive Support Team (IST) completed and improvement made Implement and embed delivery improvement plan to ensure focussed system action on existing inpatients who are placed inappropriately and out of area Enhancing and reviewing Listening and Engagement Active Partnerships (LEAP) procedures Improvement plans in admission avoidance, crisis alternatives to admission, including improvement in the use of Dynamic Support Registers as a means of admission avoidance Reduction in delayed discharges in units across the country resulting in NHSE escalations	(30.06.26)	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 Following agreement at each respective Trust Board: Plans in place to TUPE LD services from DCHS to the Trust during Quarter 1 2026/27 New Dynamic Support Pathway (DSP) launched following cross-agency redesign work The Trust with the ICB continues to meet with NHSE on a quarterly basis to monitor performance, focussing on those patients with a long length of stay and who are Clinically Ready for Discharge	AMBER

Learning from independent and national forums on current issues affecting patient safety outcomes and experience	Participate in collaborative local and regional forums to gather learning Revisit all assurances and scrutinise practice, gathering intelligence and implement an improvement plan to enable all services to provide the highest standard of care which would be expected Monitor and implement the lessons from CQC Section 48 from other providers Patient safety incidents and patient experience and effectiveness to be triangulated in providing assurance on quality as set out in the Quality Delivery Plan [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 Patient safety team and patient safety lead working collaboratively to effectively evaluate risk and quality and identify learning and improvement Quarterly self-assessment of Assertive Outreach of quality and safety matrix as reported to Quality and Safeguarding Committee	~~(31.03.26)~~ (30.06.26)	Options for staff to have conversations about care delivery and raise concerns available include Trust-wide and divisional engagements, Freedom to Speak Up, Schwartz Rounds Improvements in engagement of temporary staff identified ~~Increased visibility of senior staff through Board visits and out of hours visits – New programme/dates launched September 2025~~ Robust oversight of patient safety incidents, concerns, complaints, and compliments with scrutiny from independent partners, e.g. Healthwatch and experts by experience being core members of Patient and Carer Experience Committee ~~15 Steps is being launched through Patient Experience, underway from October 2025, led by experts by lived experience~~ External partnership working including Healthwatch and	AMBER

				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 Culture of Care Programme ended March 2026. The Trust will continue with Models of Care ~~All older adult wards are currently actively participating in Culture of Care quality collaborative from September 2025~~ ~~Review underway to improve response times to closer look complaints~~ ~~Working Group for Independent Mental Health Homicide Review in place~~ Action plan in place to improve responses to complaints and patient feedback	

				Significant Level of assurance received in 2025 from ICB on the Safeguarding Accountability and Assurance Framework review and Section 11 compliance	
Clinical improvement in the current use and transformation of Care Programme Approach (CPA), to support safe community practice	Identify the Trust's preferred alternative model to replace CPA Establish transition plan which includes communications and training strategy and clear timeline for go live of the new system and detailing when use of CPA will cease Implement an improvement plan to enable all services to provide the highest standard of care [ACTIONS OWNERS: DON/MD]	Review of changes to national policy to replace CPA Safe and effective practice is in place Improve patient safety risk assessment, care planning and CPA review compliance in community services	~~(31.03.26)~~ (30.06.26)	Ongoing oversight of CPA continues with focus on care planning and risk assessment CPA training continues at present until alternative identified – Not yet confirmed National consultation underway on a personalised care framework~~, latest draft was published in September 2025~~	AMBER
Review of the new Major Conditions Strategy and Suicide Prevention Strategy for England: To be considered as Trust Clinical Plan developed	Scrutinise new policy direction and develop new plans Routinely review incidents for learning in suicide prevention including cluster analysis and benchmarking [ACTIONS OWNERS: DON/MD]	Adjust strategy and policy to meet requirements Undertake a cluster analysis of in-patient and acute care pathway deaths	~~(31.03.26)~~ (30.06.26)	Review of new strategy for Major Conditions and Suicide Prevention PSIRF priorities focusing on prevention and oversight~~, linked to new strategies~~/. Incorporated into the Trust's updated Suicide and Self Harm Prevention Strategy Suicide Prevention Lead ~~recruited~~in post New r~~R~~isk assessment, safety planning and suicide awareness training now ~~rolled out~~	~~AMBER~~ GREEN

				~~with plan to extend to module 2 in October 2025~~in place, mandatory for all clinical staff ~~Trust Suicide Plan was ratified at Board in November 2025~~Trust Suicide and Prevention Strategy published March 2026	
Review of Patient Carer Race and Equality Framework (PCREF) and develop implementation plan	Establish PCREF Steering Group Complete Self-assessment on PCREF Development of PCREF Champions – Scope to identify relevant service user and carer representative Improving data quality to ensure it reflects the community we serve Develop an annual report and project plan for the next three years ~~Revisit new policy direction and develop new plans~~ [ACTIONS OWNER: MD]	~~Review framework and develop~~ Complete action plan on PCREF implementation ~~plan~~ PCREF Champions in place Involvement of service users and carers in developments Validation of data quality Annual report production	~~(31.03.26)~~ (30.06.26) (30.09.26) 31.03.27	~~New Patient and Carer Strategy has gone through QSG and will be launched in line with the wider Trust Strategy~~ Trust PCREF self-assessment has been completed PCREF Steering Group established February 2026 ~~EDI lead is in position for PCREF~~ PCREF Lead recruitment process started Central oversight ~~and resource to be identified~~in place by Mental Health Act Committee	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 02.03.26: Awaiting go-live of questionnaire on SystmOne to allow consultants to record their valproate caseload. This is intended to give more transparent oversight of our level of assurance of adherence to safety guidance and will allow the level of risk to be reassessed	28.02.22	02.06.26	HIGH
23501	Corporate Services – Clinical Quality	Risk to Service Delivery - Patient Safety Team	There are currently several learning responses that require allocation with further investigations overdue. Coroners, staff, patients and families are waiting for the outcome of these learning responses. Risks include: • Distress to families/carers who are waiting for the outcome of learning responses - Risk of further harm • Reputation damage for the Trust • Possible increased distress for staff who are involved in the process Trust timeframes not being met, lack of training for new starters. No further training scheduled or designed for full patient safety incident investigations 11.02.26: Interim Patient Safety Lead now in situ to support the activity of the Patient Safety Team and with line management to Operational Patient Safety Manager (OPSM). Two investigators remain temporarily redeployed. Bank colleagues have been supporting with completion of assurance reviews to manage backlog of learning responses. This has been discussed and agreed through the Executive Incident Group	08.05.25	11.05.26	HIGH

23681	Corporate Services – Clinical Quality	Nutritional Risks - No Clinical (Nutrition) Oversight Within the Catering Department	Multiple catering related nutritional risks having the potential to result in patient harm from choke, malnutrition, allergic reaction, delays in discharge, regulatory non-compliance, reputational impact, poor patient experience. DHCFT is non-compliant with the following national legislation and recommendations: • CQC regulation 14 'Meeting Nutritional and Hydration Needs' • NHS England National Standards for Healthcare Food and Drink (standards 1-4 out of 8 standards) • Report of the Independent Review of NHS Hospital Food recommendation 2b 'Ensure there is a named food service dietitian in every Trust responsible for overseeing patient, staff and visitor catering, with appropriate funding to support this role outside of clinical responsibilities' • PLACE (patient led assessment of care environment) - Food questionnaire BDA (British Dietetic Association) Nutrition & Hydration Digest (legal compliment to NHS England National Standards for Healthcare Food)	18.02.26	18.05.26	**HIGH**

Board Assurance Framework Report 2026/27 – Issue 1.3 Board May 2026

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

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

Impact:
Low quality care environment specifically related to dormitory wards at the Radbourne Unit
Crowded staff environment
Patient safety and dignity risks associated with dormitory in-patient bedded care at the Radbourne Unit
Non-compliance with statutory care environments at the Radbourne Unit
Non-compliance with statutory health and safety requirements at the Radbourne Unit
Final ward refurbishment cost unknown until we receive the final Guaranteed Maximum Price (GMP) in late Quarter ~~3~~4
Completion of the full Dormitory eradication programme has been delayed until ~~early~~ mid 2027/28

Root causes:

a. Long term under investment in NHS capital projects and estate
b. Limited opportunity for Trust large scale capital investment
c. Increasing expectations in care and working environments as national capital strategy and surrounding legislative and regulatory requirements evolve
d. National capital funding restrictions for business-as-usual capital programme for Trusts and Integrated Care Systems
e. Cost creep in the development has added pressure to the Making Room for Dignity programme and the ability to complete the Radbourne Unit refurbishments. Whilst funding is secured in relation to the first ward, issues with the foundations are driving up costs and delaying the completion of the programme
~~e.~~f. k.l. CDEL restrictions limiting our ability to invest in capital even where we have the funds to proceed. Priority remains completion of the Making Room for Dignity and dormitory eradication programme thus less opportunity to invest in other areas in the short term

BAF Ref: ~~25-26~~ ~~1E~~26/27 1B	**Director Lead**: Tumi Banda (DON)	**Responsible Committee**: Quality and Safeguarding Committee

Key Controls

Initial Risk Rating			Current Risk Rating			Target Risk Rating			Risk Tolerance	Risk Appetite
High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 3	Moderate	Likelihood 3	Impact 4	Tolerated	Moderate

Preventative – Routine environmental assessments for statutory health and safety requirements; environmental risk assessments reported through Datix; Infection, Prevention Control (IPC) risk assessments
Detective – Reporting progress against Premises Assurance Model (PAM) to the Executive Leadership Team (ELT); Dormitory Eradication Board reports into Trust Board; Quality dashboard reporting; Board visits virtual clinical service contact visits; incident, complaints, and risk investigation
Directive – Capital Action Team (CAT) role in scrutiny of capital projects; IPC policy and procedure; Continuous Improvement Plan ~~– Launch date to be confirmed~~; Estates Plan ~~– In final stages with early draft having been through governance~~; Trust Strategy; Physical Health Care Strategy; Safeguarding Strategy; Suicide Reduction Strategy; clinical strategies; policies and procedures available via Trust intranet; Central Alerting System (CAS) alerts; Risk Management Strategy

Assurances on controls – Internal	Assurances on controls – External
IPC risk assessments Health and safety audits Premises Assurance Model System (PAMS) reporting Making Room for Dignity Programme Committee structure and working groups Trust quality and performance dashboards Bed Management processes Scrutiny of Quality Account by committees Programme of physical healthcare and other clinical audits Infection Control Board Assurance Framework reported to NHSE Positive and Safe self-assessment ~~Head of Nursing/Matron compliance visits~~ Quality Assurance Framework Cleaning and maintenance schedules Continuous Improvement Plan ~~– Launch date to be confirmed~~ Estates and facilities management internal audit	Mental Health Capital funding secured External authorised reports for statutory health and safety requirements Regional reporting and NHSE oversight Gateway review process – Positive feedback from first stages Safety Thermometer identifies positive position against national benchmark Mental Health Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards CQC comprehensive review 2020 Trust rated Good CQC inspections: Acute and PICU December 2024 rated Good; Wards for older people with mental health problems, July 2025 rated Good; Forensic inpatient or secure wards, September 2025 rated Good; Rehab and long stay unit, January 2026 rated Good Patient Safety Incident Response Framework (PSIRF) implementation Monitoring of IPC standards compliance and reporting – ICS IPC Team

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Lack of adherence to ~~emerging~~ national guidance and policy requiring the elimination of ~~mixed sex wards and~~ dormitory style inpatient facilities	Radbourne Unit dormitory eradication refurbishment to provide two 17-bed wards with single room en-suite, with additional staffing and new model of care, to complete dormitory eradication in Southern Derbyshire [ACTIONS OWNER: DON/CDO] ~~National PDC capital funding approval [ACTION OWNER: DOF]~~	Delivery of approved business case Completion of the units at the Radbourne Unit CQC approval and sign off ~~Successful transition and opening of the units~~	30.06.28	FBC and revenue funding approved by ICS. National PDC capital funding approved by NHSE ~~Carsington Unit and Derwent Unit are now open~~ Continuation of the Making Room for Dignity Programme to refurbish Radbourne Unit ~~Refurbishment of the Radbourne Unit can recommence.~~ Expected completion early 2027/28	AMBER

				~~Radbourne Unit will progress with one ward due for completion early 2026/27 and one in 2027/28 – Expected completion date updated~~ Annual review of the delivery of same sex accommodation was completed and published by the Board in November 2025; The Trust is compliant with the guidance	

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

People - Derbyshire Healthcare is a great place to work

There is a risk that we are unable to sustain a positive, inclusive and compassionate ~~create the right~~ **culture with high levels of staff morale** and engagement while delivering multiple, concurrent change and efficiency programmes, leading to increased sickness absence, employee relations cases, loss of discretionary effort and reduced capacity to deliver strategic priorities safely

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
~~g)~~h) Level and pace of organisational change
~~h)~~i) National, system and provider mandated changes connected to financial position of the NHS

BAF Ref: ~~25-26 2A~~26/27 2A	**Director Lead**: Rebecca Oakley (DPOI)	**Responsible Committee**: People and Culture Committee

Key Controls

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

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~~ working group, staff networks, health and wellbeing network, operating model structure
Detective – National staff survey, Quarterly Pulse Checks, FTSUG log and escalations; staff network engagement; WRES, WDES, wellbeing champion network, executive led engagement sessions; non-executive, executive and deputy visits to teams
Directive – ~~Joined Up Care Derbyshire (JUCD) People Strategy,~~ National People Plan; strategic people priorities

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

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Lack of planned leadership development growth, stretch programmes and opportunities including coaching and mentoring	Leadership section of the People Plan to align to organisational leadership needs Delivery of the People Plan priority: To be recognised for supporting and developing our people to work confidently in their roles Review and development of Trust leadership offer and impact [ACTIONS OWNER: DPOI]	Percentage of leaders with development plan as part of objectives Percentage of employees accessing leadership development programmes	~~(31.03.26)~~ (30.09.26)	STRIVE – Senior leadership programme currently being delivered in partnership with Kings Fund, Chartered Management Institute and Derby university Leadership development (delivered via an service level agreement with DCHS) notice served on contract, from July a new team and service will be situated within DHCFT. As part of the transition a full review of the current offer and any gaps taking place will be completed People Plan presented and signed off at People and Culture Committee (PCC) November 2025 – Includes clear direction on leadership development ~~Leadership Service Level Agreement developed with joint venture delivery team~~	AMBER
Lack of progress across EDI including staff networks and reporting (WRES/WDES/gender pay gap)	Staff networks have an embedded operating framework through which to maximise the impact of staff networks Clear measurable EDI plan that includes all national reporting and Trust level actions Support to bi-monthly network Chairs meetings through DPI, Head of EDI and EDI Manager	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	~~(31.03.26)~~ (30.09.26)	Framework, including clear actions to progress and signed off at PCC Race equality plan developed in conjunction with BME network and supports key actions in WRES	AMBER

	Delivery of People Plan priority: To be recognised by our people for our values driven and inclusive culture [ACTIONS OWNER: DPOI]	lived experience of staff through staff networks		Staff network conference planned to take place in May 2026 EDI plan developed and presented at PCC in March 2026 – Combines all WRES/WDES/gender pay gap actions EDI working group in place	
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	~~(31.03.26)~~ (30.09.26)	Revised programme board and workstreams to ensure alignment and learning from gateway review Wider organisational plan for acute wards in development, where appropriate cultural reviews are being commissioned All wards completed the programme, six month follow-up with each ward now planned ~~Bluebell ward and Sycamore ward organisational development culture programme completed~~ ~~Remaining wards planned for November and December 2025~~	RED

Not yet embedded the Trust personal accountability framework and inconsistent support for Employee Relations (ER) informal and formal cases	Fully embed Trust personal accountability framework across all teams and individuals to have ownership of their own behaviours Development and delivery of ER training for managers on cases and investigations Establish new ER services in Trust (currently in a shared service) [ACTIONS OWNER: DPOI]	Reduction in length of cases Reduction in formal cases Attendance at training by managers on cases and investigations Establishment of new ER in-house team	~~(31.03.26)~~ (30.09.26)	ER team transitioned out of DCHS Joint Venture into DHCFT June 2025 A kind life just culture training programme commenced, incorporating personal accountability framework – 150 colleagues have already attended Active Bystander training being rolled out New Respect and Resolution policy launched	RED
Inconsistent approach to flexible working impacting on staff morale	Develop and embed a clear approach to flexible working that supports service delivery and staff Develop a clear and consistent way of recording and reviewing flexible working that supports both managers and staff [ACTIONS OWNER: DPOI]	Ability to record and track number of flexible working arrangements in place Staff engagement measures via staff survey and pulse check	~~(31.03.26)~~ (30.09.26)	Design of flexible working system linked to ESR to record requests for flexible working and approved requests in progress Flexible working group in place and currently designing training for the roll out of the system	RED
Lack of robust absence management policy and processes that support both managers and staff	Review and relaunch a new absence management policy Review support provided to managers to review and move forward long term sickness absence cases Review Occupational Health access, support and usage to ensure maximising service and being used to Delivery of People Plan priority: To be recognised as a Trust that supports and promotes the wellbeing of our people [ACTIONS OWNER: DPOI]	Reduction in absence management across both long and short term absences Reduction in Occupational Health DNAs Staff survey and pulse check Improvements as part of NOF segment data	~~(31.03.26)~~ (30.09.26)	Absence plan developed and presented to PCC and ongoing scrutiny with further deep dive planned for January 2026 Oversight working group established	RED

Lack of a stable positive culture due to high levels of organisational change impacting on morale	Review and develop organisational change policy to ensure clear and supportive approach for managers and staff Clear wellbeing processes for occupational health and other support mechanisms Effective, clear and open communication channels	Staff survey and pulse check engagement scores Financial balance	~~(31.03.26)~~ (30.09.26)	Fast track process for Occupational Health in organisational change Phase 1a operating model programme completed Phase 1b ~~planned to commence January 2026~~consultation concluded – Interviews taking place April 2026	RED

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

People - Derbyshire Healthcare is a great place to work

There is a risk that we do not have an adequate supply of ~~a~~ skilled and diverse workforce in critical clinical roles, including inpatient nursing and support staff, limiting the Trust's ability to deliver safe staffing, reduce reliance on temporary workforce solutions, and meet safety, quality and financial priorities ~~with the right of people with the right skills to support and deliver safe high-quality care~~

Impact: May lead to reduced staffing levels and skill gaps which impact on safe staffing levels and addressing health inequalities in patient facing services and the ability of our supporting and corporate teams to support front line services

Root causes:

a. There are occupational shortages nationally which mean that the supply of some professions creates long term vacancies and a lack of workforce planning in solutions to fill the gaps
b. Pressures on workforce development and Continued Professional Development (CPD) funding may risk ability to develop skills and expertise
c. ~~D~~Historical disproportionate growth in senior leadership posts in correlation with frontline clinical posts
~~d. Lack of triangulation of workforce and finance data~~
~~National and regional Recruitment Retention Premium (RRP) applications to hard to recruit posts impacting on Trust recruitment and retention~~

BAF Ref: ~~25-26 2B~~26/27 2B	**Director Lead**: Rebecca Oakley (DPOI)	**Responsible Committee**: People and Culture Committee

Key Controls

Initial Risk Rating			Current Risk Rating			Target Risk Rating			Risk Tolerance	Risk Appetite
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 4	Not Accepted	Low

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 and Agency Improvement Group; Combined Delivery Group with multi-disciplinary team (MDT) input; Medical Staffing Group, Sustainability Meeting; FTSU culture; exit interview process stay interview process
Directive –JUCD Careers Team; JUCD and People and Inclusion meeting; recruitment policy and procedure; TRAC recruitment system; safe staffing plans

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

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
An integrated workforce plan and planning process that feeds into pipeline plans and ensures we have the right people in the right place with the right skills	Develop a Trust Workforce Plan linking demand and capacity, workforce redesign to ensure a fully funded workforce Develop vacancy rate data and breakdown variances in vacancy data Delivery of all People Plan priorities: Attracting a high skilled and diverse range of applicants to our roles Retaining our diverse talent through growth and development Staff are delivering at the top of their professional standards Opportunities for professional and career development [ACTIONS OWNER: DPOI]	Reduced vacancy rates Time taken to fill vacant posts Transformational posts, e.g. apprenticeships all identified Reduction in agency costs Improved retention rates	~~(31.03.26)~~ (30.09.26)	Executive-led vacancy control meeting takes place every week for approval of all vacancies and workforce expenditure increases, i.e., job evaluation Divisional workforce planning session taking place in July 2026 Finance led workforce plans triangulated and signed off at regional level Revised agency control group in place	AMBER
We do not have an effective and embedded succession talent management processes	Develop a Talent Management Strategy Pilot career conversations for senior leaders and roll out career conversations for all colleagues Work as a system to develop system-wide approach to talent management and align where best for the Trusts Delivery of all People Plan priorities: Attracting a high skilled and diverse range of applicants to our roles Retaining our diverse talent through growth and development [ACTIONS OWNER: DPOI]	Career conversations taking place Internal appointments/promotions Reduction in turnover rate Key staff survey measures	~~(31.03.26)~~ (30.09.26)	Talent Strategy finalised Talent programme for senior executive leadership completed – to be run for senior leadership team following finalised operating model Talent and succession planning part of every Executive Director's objectives	RED

Onboarding and retention process and planning needs to be embedded (this includes MRfD and challenges on retention of high numbers of newly qualified nurses)	Understand the key retention issues for posts/teams/professions with the highest turnover to deliver People Plan priorities to attract and retain newly qualified nurses Ensure 'stay conversations' form part of regular 1:1s Develop NHS retention framework for nursing [ACTIONS OWNER: DPOI]	Improvements to turnover Staff survey engagement scores	~~(31.03.26)~~ (30.09.26)	Additional posts added to the preceptorship team to support retention of high numbers of newly qualified staff Stay Surveys launched at months 3, 6 and 12 Revised induction commencing from May 2026	AMBER
Lack of inclusive recruitment practices and actions to consider the needs of people from different backgrounds, to support our commitment to embedding an inclusive culture	All chairs of recruitment panels have undergone inclusive chairs recruitment training Data driven recruitment practices Delivery of People Plan priority: To be recognised by our people for our values driven and inclusive culture [ACTIONS OWNER: DPOI]	WRES and WDES data shows year on year improvement, staff survey and lived experience of staff Increase the proportion of applications from ethnic minority groups, increase likelihood of shortlisting and reduce disparity in all areas	~~(31.03.26)~~ (30.09.26)	Job evaluation national assessment completed and work programme to improve efficiency of the process in place and presented to PCC National nursing profiles review – Working group in place with staffside representation Inclusive recruitment for chairs training: Ongoing roll out Cultural competence training commissioned rolled out, initially focusing on acute wards and now expanding wider. Board have also completed the training	RED
Effectiveness of recruitment policy, practice and processes	Review and develop existing recruitment Key Performance Indicators (KPIs) to ensure fit for purpose Where appropriate move away from TRAC to advertise jobs and use fast track processes, e.g. Indeed/MSforms Develop cohort recruitment for key posts	Time to recruit Number of applicants applying and successfully shortlisted Campaign impact and reach Financial savings through cohort recruitment	~~(31.03.26)~~ (30.09.26)	A range of recruitment methods are deployed to ensure we attract a diverse range of applicants Revised Service Level Agreement and KPIs in place for recruitment service	AMBER

	Improve the multidisciplinary working (HR, communications and recruiting managers) to enable better planned and executed campaigns [ACTIONS OWNER: DPOI]				
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	~~(31.03.26)~~ (30.09.26)	Ongoing weekly agency approval in place for approval of all agency requests Assistant Director of Workforce is co-chair of national regional agency reduction group Consistent agency reduction demonstrated	AMBER

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

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

There is a risk that the Trust fails to deliver its revenue and capital financial plans for ~~2025/26~~2026/27 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. There is also the added risk of a Capital Departmental Expenditure Limits (CDEL) breach linked to following through on the Making Room for Dignity dormitory eradication programme and our associated capital commitments

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. In addition, we have an ambitious CIP requirement approaching 6% due to ~~cost~~ ongoing pressures. Further mitigations will be required if we don't control inpatient ward overspends and deliver on our out of area reduction programme

Root causes:

a) Financial detriment (revenue, cash and/or capital) resulting from large capital development programme, in particular dormitory eradication and associated capital schemes
b) Organisational financial detriment created by commissioning decisions or wider 'system-first' decisions including enactment of risk-sharing agreement in partnership arrangements or changes in NHS financial arrangements. System financial position resulting in required additional financial savings to support the System position from Mental Health funds
b) Non-delivery of expected financial benefits from transformational activities
c) Non-delivery of required levels of efficiency improvement
d) Lack of sufficient cash and working capital
e) Loss due to material fraud or criminal activity
f) Unexpected income loss or non-receipt of expected transformation income (e.g. long-term plan (LTP) and Mental Health Investment Standard (MHIS) without removal of associated costs
g) Costs to deliver services exceed programmes the Trust financial resources available
h) Lack of cultural shift/behaviours to return to financial cost control regime. Areas of non-compliance with Standing Financial Instructions (SFIs) and financial duties. Ineffective grip and control measures to control inappropriate spending
i) Inability to reduce temporary staffing expenditure
j) Inability to reduce inappropriate out of area placements and effectively manage flow
k) Inability to manage increasing demand and acuity in our inpatient settings
l) Inability to provide safe care within funded staffing levels due to acuity and additional observation requirements
~~k)~~m)
~~l)~~n) Trust reluctance to remove costs in line with non-recurring income removal due to wider system impact (financial and Equality Impact Assessment concerns)
~~m)~~o) Inability to timely respond due to the volume and bottlenecks associated with large levels of organisational change and transformation simultaneously ongoing. Delays caused by the level of organisational change and limited capacity

~~n)~~p) Level and pace of organisational change may result in extended timelines due to capacity across a range of services including People Services teams, staffside and wellbeing support

~~o)~~q) Exit costs will impact on our financial sustainability. We do not necessarily have the financial flexibility to enact exits without putting at risk our financial obligation to breakeven

BAF Ref: ~~25-26 3A~~26/27 3A	**Director Lead**: James Sabin (DOF)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Initial Risk Rating			Current Risk Rating			Target Risk Rating			Risk Tolerance	Risk Appetite
Moderate	Likelihood 2	Impact 5	~~Moderate High~~	Likelihood ~~23~~	Impact 5	Moderate	Likelihood 2	Impact 5	Tolerated	Low

Preventative – Operating plan and financial plan agreed for ~~2025/26~~2026/27 in line with ~~ICB~~ national requirement. Integrated Care Board (ICB) signed off and fully support the dormitory eradication programme and are supporting this through to completion as a pre-commitment. ~~Devoted and adequate team for Programme delivery.~~ High quality business cases. Regular meetings with NHSE on programme progress. Meaningful stakeholder engagement (internal and external). Robust cash flow forecasting and delivery. Multi-disciplinary development of financial plans for new of work. System sign-off and appropriate governance arrangements for new programmes of work: Budget training, segregation of duties, management of commissioning risk through system engagement and leadership, mandatory counter fraud training and annual counter fraud work programme: Enhanced cash management and forecasting aligned to large capital and transformational programmes. Action plans in place and recovery plans for areas of focus. Deep dives commissioned via F&P Committee

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; strengthened governance processes around the Making Room for Dignity Capital Programme

Assurances on controls – Internal	Assurances on controls – External
Operational plan; financial planning including CIP planning, processes and delivery monitoring CIP programme group established to strengthen oversight. Further work and governance changes planned to drive the transformational plans and monitor progress Vacancy control process in place with Executive oversight Performance management processes in place and being refreshed to add to assurance levels. Now also established and in place ~~for 2025/26~~ for corporate functions ~~Dormitory eradication and PICU programme monitoring and reporting~~	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~~Performance meetings~~/System Project Management Office/system~~System DOF meetings Internal Audits – Financial integrity and key financial systems audits

Board Assurance Framework Report 2026/27 – Issue 1.3 Board May 2026

Appropriate monitoring and reporting of financial delivery – Trust overall and programme-specific Assurance levels gained at Finance and Performance Committee (F&P) Delivery of Counter fraud and audit work programme with completed and embedded actions for all recommendations Independent assurance via internal auditors including HFMA checklist, external auditors and counter fraud specialist that the figures reported are valid and systems and processes for financial governance are adequate Governance process in place for the Making Room for Dignity programme Strategic Portfolio Oversight Group	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 Regular NOF meetings with NHSE and ICB A clean year-end position and clean Value for Money (VFM) assessment as part of our year end audit

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Trust cash and capital risks related to national funded acute capital programme: Increased cost pressure now aligned to final refurbishment project	We will not have a Guaranteed Maximum Price (GMP) for Radbourne Until late Quarter 4 ~~Progressing another VAT claim to part fund final stage~~ [ACTION~~S~~ 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	~~(31.03.26)~~ (30.06.26)	Regular oversight of capital and cash position. Reporting to Trust Programme meetings and Committees on risks and mitigations Significant cost pressures on Radbourne Unit Refurb. The decision and affordability question of the second ward will be worked up in Q~~q~~uarter 4 aligned to receipt of the GMP	AMBER
~~Additional revenue related to new builds, refurbishments and PICU not fully funded by system~~ Some partners moving away from business case assumptions and previous agreements Re-costing service provision, increasing Service Level Agreements	Close partnership working with ICB and system partners. [ACTIONOWNER: DOF]	Monitoring and reporting of income allocations and expenditure in year Transparent reporting of position shared with ICB to reduce challenge and ensure joint understanding and support	~~(31.03.26)~~ (30.06.26)	MHLDA DB agreed to oversee revenue delivery contained within programme spend Still working through inter-Trust charges with Chesterfield Royal Hospital. ~~No major~~Some concerns flagged to date as costs have risen well above baseline inflation	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 taken re medics~~ Continued workforce strategies progressed to reduce agency and increase bank reducing risk Enhanced bank and agency costs reported as part of wider financial and workforce reporting Agency actions and controls are working and costs continue to reduce [ACTIONS OWNER: DPOI/DOF]	~~Enhanced bank and agency costs reported as part of wider financial and workforce reporting~~ ~~Continued workforce strategies progressed to reduce agency and increase bank reducing risk~~ Continued reduced run rates evidence in spend Continued reduction in breaches in rates and framework providers	~~(31.03.26)~~ (30.06.26)	~~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~~ ~~Medical actions taken leading to reduced locum agency expenditure~~ Further work underway to comply with new mandate to ban use of band 2/3 agency use	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 OWNERS: DOF/MD/DON/CDO]	Alignment with our financial plan we are as an organisation Reduction of pay run rate in line with delivering on a planned headcount reduction	~~(31.03.26)~~ (30.06.26)	Financial plan for ~~2025/26~~2026/27 is concluded but we need to continue to work on reducing the deficit as part of our longer term financial sustainability All new investments to follow governance processes with business cases via ELT, F&P and Board where appropriate and will require wider system support. All investments need a clear source of funding as increased CIPs beyond 6% is not credible Currently reviewing national toolkit and areas of further opportunities to strengthen grip and control~~.~~	AMBER

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

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

There is a risk that the Trust's increasing dependence on digital technology- to deliver safe, timely and integrated care increases exposure to major system outages or cyber incidents, impacting patient safety, service continuity and strategic delivery.~~for the delivery of care and operations increases the Trust's exposure to the impact of a major outage~~

Impact:
There is a risk that the Trust's digital infrastructure, systems, or data may be compromised due to an outage or failure to maintain adequate cybersecurity measures. This could lead to significant disruption to clinical services, compromise of sensitive patient or staff data, reputational damage, regulatory breaches, and potential harm to patients

Root causes:

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

BAF Ref: ~~25-26 1C~~26/27 3B	**Director Lead**: Vikki Ashton Taylor (CDO)~~Girish Kunigiri (MD)~~	**Responsible Committee**: Finance and Performance Committee

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Tolerance**	**Risk Appetite**
Moderate	Likelihood 3	Impact 4	Moderate	Likelihood 3	Impact 4	Moderate	Likelihood 2	Impact 4	Tolerated	Moderate

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

Board Assurance Framework Report 2026/27 – Issue 1.3 Board May 2026

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

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
NHS 10 year plan to abolish Commissioning Support Units (CSU). By Spring 2027 Arden GEM CSU is likely to be abolished and DHCFT no longer and to benefit from respective cyber, network and technical services and support	~~Added to Trust risk register and tracked~~Tracked by IMT&R senior team. National changes tracked via regional forum and Technical Design Authority. Alternative options – Plan in progress leading to options appraisal. Options may include: Some services provided in-house by DHCFT, contract with another supplier (NHS or private), wait for possible rebrand / merger of Arden Gem CSU and contract with new entity [ACTION OWNER: ~~MD~~CDO]	Transfer of support services to a new entity	~~(31.03.26)~~ (30.06.26)	~~Initial fact finding and options document prepared for F&P~~ Quarterly review leading to deadline in spring 2027 Due to significant links and sharing with DCHS across all levels of infrastructure, process, network, domain, DHCFT is looking to be in lockstep with DCHS in terms of joint approach to new ICT supplier Updated options appraisal and position statement provided for December ELT. DHCFT Internal CSU Transition task and finish group meeting every other week to ensure Trust requirements are met	AMBER
Unsupported IT devices are a potential security risk	Routine review and update of Trust assets. Ongoing cycle to refresh kit and update assets to comply with security updates [ACTION OWNER: ~~MD~~CDO]	Compliance with monthly rigour and service reviews Removal of any unsupported devices/assets with each wave of security updates	~~(31.03.26)~~ (30.06.26)	DHCFT the first Trust in the midlands to be fully compliant and phase out Windows 10 devices. Cycle will repeat with next wave of security updates Ongoing - Monthly rigour and service review meetings with IT service supplier	AMBER

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

ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating
21620	IT, IM and Patient Records	IT system collapse due to cyber attack	06.01.26: Cyber Security Operations Centre (CSOC) released high severity alert for need to update network switches nationally. Nationally organisations unable to comply within 14 days due to scale of task. DHCFT has plan in place with Arden GEM and near completion for security updates 27.04.26: Latest CSOC Cyber Security Operations Centre alert now complete. Risk reviewed where consequence remains Major, likelihood remains likely. Transition plan from Arden GEM CSU to NHIS will pose significant change and need to ensure DHCFT has correct levels of security in place. Capital plan to be used to support updates for support and replacement for network switches and Firewalls. Work to be split into business as usual before the transfer	08.02.19	27.07.26	HIGH
23650	IT, IM and Patient Records	Lack of Resources to Support Trust Projects	Increased demand on IMT&R to support projects during end of financial year 2025 and start of 2026: • ND transformation project - Support for community paediactric services and alignment with mental health services for child cohort 5-16 • DCHS service realignment and transfer of services to DHCFT • Derby city - Substance misuse contract end and offboarding • Arden GEM CSU transition planning • Patient Engagement Portal (PEP) project support • Support for new private health service No dedicated project team within IMT&R and no additional resources provided currently to support the above projects.	17.12.25	Closed on Datix as included above – Future updates will be recorded against the BAF risk	HIGH

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 across the Integrated Care Boards (ICB), and with its partners may impact negatively on the cohesiveness of the Derbyshire health and care system in our organisation

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

Root causes:

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

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

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Tolerance**	**Risk Appetite**
High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 3	Moderate	Likelihood 3	Impact 4	Tolerated	TBC

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
Detective – Continuing engagement in all Joined up Care Derbyshire governance from DHCFT representatives. Due diligence processes undertaken prior to accepting any lead provider responsibilities
Directive – Mental Health, Learning Disability and Autism System Delivery Board to engage widely across membership on the development of any provider collaborative with agreed plans and processes. Gateway process run by NHSE prior to agreement to establish the Trust as lead-provider in any regional collaborative

Assurances on controls – Internal	**Assurances on controls – External**
Regular reporting of position to Board by CEO Regular ELT updates and discussions	Mental Health and Learning Disability assurance meetings with NHSE and ICB Gateway process run by NHSE prior to agreement to establish a Trust as

NED Board members on JUCD committees and Board Board agreement required prior to undertaking of lead-provider responsibilities	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
Changes to governance at ICB and system level may create delays to decision making and cause increased governance burden	Keep Trust structures under continuous review against the wider governance landscape, including the provider collaboratives and alliance arrangements – This in turn may lead to a formal change of DHCFT governance arrangements Continue to influence within the system to ensure Lean and safe decision making and governance arrangements [ACTIONS OWNERS: CEO/DCA]	Board level assurance that the Trust's corporate governance systems are compatible with the new ways of working that would allow both Trust and system objectives to be achieved Board level assurance that the Trust's risks have been fully articulated and understood within the wider integrated care system	(31.03.26)	We have implemented a new divisional performance review process, underpinned by balanced scorecards. To ensure operational performance delivery of MHLDA constitutional standards that DHCFT is a lead or main provider Derbyshire Provider Collaborative Leadership Board have an agreed work programme as approved by ICB The Trust is an active member of and provides regular assurance to system-wide governance groups, e.g. their quality and safety group Memorandums of understanding and alliance agreements are in place where appropriate, i.e. LD Alliance Trust's risks reported to the ICB monthly for cross-reference with other providers for the ICB BAF.	AMBER

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

Board Assurance Framework Report 2026/27 – Issue 1.3 Board May 2026

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

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

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

Root causes:

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

BAF Ref: ~~25-26 4B~~26/27 4A	**Director Lead**: Vikki Ashton Taylor (~~DSPT~~CDO)	**Responsible Committee**: Trust Board

Key Controls

Initial Risk Rating			Current Risk Rating			Target Risk Rating			Risk Tolerance	Risk Appetite
High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 3	Moderate	Likelihood 3	Impact 3	Tolerated	Moderate

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~~ Trust Delivery Group (TDG) 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, for example, resulting in some patients being cared for outside of Derby and Derbyshire	New internal performance improvement process and oversight in place ~~Recovery action~~Performance Improvement P~~p~~lans for areas where Trust constitutional standards are not being met ~~Improvement plan for joint autism service (with system partners)~~ Work with ICB cluster to agree commissioning intentions and future funding for specific services where demand outstrips capacity [ACTIONS OWNER~~S~~: CDO]	Improvement in performance of constitutional standards and NHS Oversight Framework (NOF) metrics Recovery action plans in place in all required areas Agreed commissioning intentions and funding	~~(31.03.26)~~ (30.06.26)	~~In-year progress delivering recovery action plans: Performance improvement in dementia diagnosis and perinatal access has resulted in DHCFT now delivering the core constitutional targets in this area and others~~ Significant reduction in number of inappropriate Out of Area Placements, underpinned by a ~~Recovery Action~~ Performance Improvement Plan continues including a twice weekly Multi-Agency Discharge Event, roll out of home treatment service. New build facilities including a local PICU support improved patient flow and improved quality of care as the above will enable patients to be treated locally ~~Flow improvement plan is impacting and out of area bed numbers and acute length of stay are reducing~~ ~~Recovery Action~~Performance Improvement Plans in place in relation to key access targets, measured in the NOF performance reviews~~, for example crisis 24 hour face to face appointments~~. for example, length of stay for	AMBER

				acute and older adults, MH Helpline, crisis team responses (adult and children) and 104 week waits. NOF improvement in Quarter 2 to segment 3 from segment 4 Joint review underway for Mental Health Helpline. Awaiting confirmation of commissioning intentions for ADHD and ASD. Awaiting confirmation of recurrent funding for the social care element of the Living Well service	
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 and neighbourhood model of care [ACTIONS OWNER: CDO]	Increased delivery of integrated services Established mental health 24/7 neighbourhood hub Expand Living Well service offer to meet national requirements	~~(31.03.26)~~ (30.09.26)	Collaborative development of community mental health 24/7 pilot alongside general practice partners ~~Twice weekly mini MADE and weekly~~Regular system partner meetings to increase collaborative working to improve access to services, for example, MADE events~~ taking place. This is helping to develop our working relationship with social care and ICB colleagues whilst focusing on reducing~~ to reduce length of stay and Clinically Ready For Discharge numbers Active membership of all Neighbourhood (Place) Alliance Groups ~~Engagement with partners continues~~	GREEN

~~Police partners report they do not always feel supported by mental health services and are under pressure to respond to mental health crisis~~	~~To reduce inpatient absent and missing cases~~ ~~To support Police with education and training where appropriate~~ ~~To streamline process and timeline for 136 suite admissions and handover [ACTIONS OWNER: CDO]~~	~~Reduction in inpatient absent and missing cases~~ ~~Training sessions offered to Police partners:~~ ~~• Police mental health awareness training sessions~~ ~~• Suicide prevention work~~ ~~• Joint working with Trust safeguarding teams~~ ~~• Collaborative response to Right care Right Person (RCRP)~~ ~~Increased handovers completed within one hour~~	~~(31.03.26)~~	~~Police are a formal member of the MHLDA DB~~ ~~Mental Health Response Vehicle (MHRV) to be implemented during 2024/25, to jointly provide a Trust and Police response to mental ill health calls~~ ~~Crisis cafés have opened in Buxton, Ripley and Swadlincote – This reduces demand on Police call-outs~~ ~~Trust is an active member alongside the Police as a member of the RCRP implementation executive group covering the Derbyshire system~~ ~~With the opening of the Carsington we now have a third Section 136 Suite. The three units are supported with additional resources enabling a more responsive 136 provision within Derbyshire, harnessing effective working relationships with Police which has resulted in a reduction in time that Police are required to stay at the 136 suite~~	~~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 element will be included in the Quality Plan, to be launched in July 2025 Co-production in Patient and Carer Race Equality Framework (PCREF) requirements	~~(31.03.26)~~	EQUAL group established to support service user and carer engagement and informs future service improvements across the East Midlands Perinatal Mental Health Provider Collaborative	~~AMBER~~ BLUE

				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 Key gap in control closed as all measures met. Sustainability is within the Quality Delivery Plan	

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

ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating
23314	Corporate Services – IM&T	Interpretation of data submitted within NHSE datasets risks erroneous views on the Trust	30.10.24: NHSE interpret and analyse data submitted within mandated NHSE submissions. This analysis is not fed back to the Trust to allow them to validate and comment on before being published to the wider NHSE community, ICBs and others. This may also include historical analysis where the Trust has no way of rectifying any issues that might be raised. With this there is a risk that external organisations to the Trust are forming views on the Trust based on erroneous information Risk still resides and will remain so until NHSE, regional sections of NHSE and ICB's communicate and coordinate methodologies prior to publishing analysis – Situation unchanged	30.10.24	10.05.26	HIGH

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: 25-26 4C	**Director Lead**: Vikki Ashton Taylor (CDO)	**Responsible Committee**: Quality and Safeguarding Committee – DHCFT Quality and Performance Committee – Derbyshire ICS Mental Health, LD and Autism Board in terms of system operational delivery

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Tolerance**	**Risk Appetite**
High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 3	Moderate	Likelihood 3	Impact 3	Tolerated	TBC

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	(31.03.26)	ICB have presented to both providers on how to ensure community offers are enhanced further through the review of pathway offers where resource is disproportionately allocated Ongoing discussions to commit more resources to community pathways The Trust is working alongside DCHS and has established an integrated service provision for neurodevelopmental services across both organisations The integrated model continues with a governance structure aligned. 09.03.26; Following agreement at each respective Trust Board; Plans in place to TUPE LD services from DCHS to the Trust during Q1 26-27.	AMBER
Improvements are required in rapidly returning patients who access Learning Disabilities and Autism (LD&A) services to local	Continue to work on developed delivery improvement plan, owned by system partners. This includes new cohort stratification– Key action to implement	Improvement plans developed and implemented resulting in a stabilised service and positive outcomes for patients	(31.03.26)	Derbyshire is no-longer in national escalation regarding performance with inpatient services	AMBER

~~care to enable them to live in the least restrictive manner, as close to home as possible~~	~~embed approach to ensure focussed system action on existing inpatients who are placed inappropriately and out of area~~ ~~[ACTION OWNER: CDO]~~	~~Enhancing and reviewing Listening and Engagement Active Partnerships (LEAP) procedures~~ ~~Improvement plans in admission avoidance, crisis alternatives to admission, including improvement in the use of Dynamic Support Registers as a means of admission avoidance~~ ~~Reduction in delayed discharges in units across the country resulting in NHSE escalations~~		~~after demonstrating improvement against plans. There has been a recent Standard operating Procedure (SOP) realignment request from NHSE which has resulted in a small number of additional patients being added~~ ~~New Dynamic Support Pathway (DSP) launched following cross-agency redesign work~~ ~~Cross-system delivery plan continues to be monitored through Neurodevelopmental Delivery group Board – Includes action plan in response to inflow, flow and outflow as discussed with NHSE and ICB leaders~~ ~~The Trust with the ICB continues to meet with NHSE on a quarterly basis to monitor performance and transformation, focussing on those patients with a long length of stay and who are Clinically Ready for Discharge.~~ ~~09.03.26; A reset in Q3 of the LD&A & ASD Policy (counting, DSR management/escalation);~~	

				this has led to a marginal increase in cases within beds (local, IMPACT); a PIP in place with weekly monitoring – the Trust & ICB, and monthly performance monitoring with NHSE. Planning submission around numbers submitted to the end of 27-28.	

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

ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating
23314	Corporate Services – IM&T	Interpretation of data submitted within NHSE datasets risks erroneous views on the Trust	30.10.24: NHSE interpret and analyse data submitted within mandated NHSE submissions. This analysis is not fed back to the Trust to allow them to validate and comment on before being published to the wider NHSE community, ICBs and others. This may also include historical analysis where the Trust has no way of rectifying any issues that might be raised. With this there is a risk that external organisations to the Trust are forming views on the Trust based on erroneous information Risk still resides and will remain so until NHSE, regional sections of NHSE and ICB's communicate and coordinate methodologies prior to publishing analysis – Situation unchanged	30.10.24	10.03.26	HIGH

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

Board Assurance Framework Report 2026/27 – Issue 1.3 Board May 2026

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 TOLERANCE
Very Low	Accepted
Low	
Moderate	Tolerated
High	Not Accepted
Extreme	

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

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

Action Owners

CEO	Chief Executive Officer
DOF	Director of Finance
MD	Medical Director
CDO	Deputy Chief Executive / Chief Delivery Officer
DON	Director of Nursing, AHPs, Quality and Patient Experience
DPOI	Director of People, Organisational Development and Inclusion
DCA	Director of Corporate Affairs and Trust Secretary

Definitions

Preventative	A control that limits the possibility of an undesirable outcome
Directive	A control designed to cause or encourage a desirable event to occur
Detective	A control that identifies errors after the event

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 19 May 2026

Trust Strategic Plan 2025-28: Quarter 4 (Q4) Progress update

Purpose of Report

To update the Board of Directors on progress in delivery of the Strategic Plan at the end of Q4, 2025/26.

Executive Summary

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

The enclosed report provides an update at the end of Q4, 2025/26 on delivery of priorities and deliverables within the year one roadmap. The format of this version is slightly adjusted to reflect only the actual year end position rather than the mid-year reporting of current quarter and expected position at the year end. The report further offers a view on completeness of intended assurances, which have been mapped to the papers received by agreed oversight forum.

The attached report evidences the delivery of a number of the key priority actions to enable delivery of the Trust Strategy in Q4, with 12 of the 15 key priorities for delivery being fully achieved by the end of Q4. This has resulted in improved access to a number of services for the Derby and Derbyshire population, the development of an income generating business unit, strong partnership working to improve services offered to patients as part of the East Midlands Provider Collaborative and the Trust financial plan being on track in Q4 including delivery of required Cost Improvement Programme (CIP) and achievement of agency and bank staff usage targets.

The three remaining deliverables that have not been fully achieved are as follows:

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

Delay in publication of the new national Personalised Care Framework has impacted the expected timeline to design and deliver an aligned implementation plan with next steps being considered via the refresh of 2026/27 deliverables presented under separate cover.

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

The Clinical Delivery plan remains in development with forward approach refreshed by the new Medical Director and a draft due to be consulted upon and presented for approval in Q1 of 2026/27.

Achievement in-year of a number of targets including perinatal access, dementia diagnoses, children and young people eating disorder access and individual work placement support access. Improvement action plans to reduce out of area placements and increase crisis 24-hour face-to-face response resulted in Q4 achievement of Operational Plan trajectories. Focus retained on other challenged access targets including length of stay and Community waiting times with improvement plans being overseen by the Trust Delivery Group and Finance and Performance Committee.

3.3: Optimise our assets and enabling resources to improve services and care

Publication of the Digital Delivery Plan was delayed to Q4 in order to allow reset of ambitions and alignment with outputs of the Digital Futures Day.

Strategic Considerations		BAF Risk(s)	Strategic Delivery Plan Reference
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	All	All
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:

- Risks to delivery of the Strategic Plan are recognised and managed via the Board Assurance Framework.

Assurances include that:

- The Strategic Plan aligns with and seeks to enact the Trust's Strategy
- The source and forum for assurance is defined for each Strategic Plan priority
- The enclosed report demonstrates significant assurance on successful delivery of year one Strategic Plan ambitions with specific areas of under delivery recognised and discussed through prior quarterly reports and overseen by respective sub committees.

Consultation

- The Strategic Plan was developed through engagement and consultation through two Board Strategy and Development Sessions, the Staff Conference and the Leadership Forum
- The quarterly delivery report has been received by the Strategic Portfolio Oversight Group with assurances considered and adjustments agreed.

Governance or Legal Issues

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

Net Zero Duty Implications

In compliance with the NHS move towards net zero carbon emissions, the Trust must consider statutory emissions and environmental targets in their decisions. Reports should identify related impacts on workforce and system leadership; sustainable models of care; digital transformation; travel and transport estates and facilities (including capital projects, asset management and utilities, green space and biodiversity); medicines; supply chain and procurement; food and nutrition and adaptation.

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

The Strategic Plan directly supports statutory commitments to achieve net zero by reducing carbon output associated with care delivery, estates, travel, supply chains and operational processes.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

Recommendations

The Board of Directors is requested to confirm the level of assurance secured in delivery of year one Strategic Plan ambitions. 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 put the achievement of particular objectives at risk.

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

NHS
Derbyshire Healthcare
NHS Foundation Trust

Strategic Plan 2025 - 2028

Progress Update: Q4 2025 – 2026

Patient focused

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

NHS
Derbyshire Healthcare
NHS Foundation Trust

Priorities for delivery of success	Roadmap to delivery of success 2025-26	Q4 Progress Update	Status Q4 Position	Assurance mapped to Q4 papers
1.1 Improve safety and effectiveness in line with our quality ambitions	1.1.1 Develop and implement Quality Delivery Plan, agree improvement ambitions and measures, and establish associated governance 1.1.2 Monitor performance and implement action plans to address any identified improvement opportunities 1.1.3 Implement national initiatives including Culture of Care inpatient quality improvement programme and Patient Carer Race and Equality Framework	1.1.1 Quality Delivery Plan approved and published in Q2 including roadmap to delivery and measures of success. 1.1.2 Quality monitoring continuously developed over Q4 with mechanisms fully embedded, action plans delivered as appropriate to address identified areas of improvement and assurance overseen by QSC. Impact demonstrated through reduction in bank and agency reliance leading to more consistent care, improved CQC inspection outcomes published across four services, and proposed reduction in BAF risk rating for Q1 of 2026-27. 1.1.3 Progress maintained in Culture of Care programme with self assessment completed Q4. Forward approach for 2026-27 defined with local ward ambitions to be supported through continuous improvement projects. PCREF lead commenced in post and self assessment workshop hosted in Q4 with outputs informing forward action plan.	Delivery on plan at Q4	Agreed assurances considered by Quality and Safeguarding Committee (QSC)
1.2 Improve experience for, and empower, service users patients and carers	1.2.1 Define and agree experience measures across all services 1.2.2 Review and refine feedback mechanisms across all services 1.2.3 Monitor feedback and implement plan to address any identified improvement aligned to transformation and continuous improvement portfolio 1.2.4 Develop and agree framework for empowerment 1.2.5 Design and launch education programme 1.2.6 Develop and implement engagement through to co-production framework	1.2.1 Measures of experience defined through Quality Delivery Plan with dashboard developed and operationalised to track and assure delivery aligned to year 1 ambitions and roadmap. 1.2.2 Feedback mechanisms further developed over Q4 with focus on standardisation and effective co-ordination and escalation across all services. 1.2.3 Feedback monitoring maintained over Q4 with identified need to accelerate improvement in responsiveness to feedback and complaints and action plan progress overseen by QSC. 1.2.4 Approach defined within Quality Delivery Plan and action plans in delivery aligned to newly appointed remunerated lived experience roles across all services and renewed patient and carer experience meeting. 1.2.5 Education programme now focused on addressing identified need in physical health with delivery phase of CPD programme launched Q4 in partnership with DCHS. 1.2.6 Work plan for advancing coproduction and participation delivered with lived experience partners now fully embedded within evaluation of quality of care through fundamental care standards and '15 Steps' quality visits.	Delivery on plan at Q4	Agreed assurances considered by QSC
1.3 Develop effective quality governance systems and processes that facilitate shared learning and support a positive safety culture	1.3.1 Review, refresh and embed quality governance systems aligned to new Quality Delivery Plan 1.3.2 Refine Learning Culture and Safety Group as a mechanism to develop and assure a positive safety culture 1.3.3. Agree preferred model and design plan for transition from Care Programme Approach to support safe care co-ordination	1.3.1 Quality Assurance Framework developed aligned to year 1 Quality Delivery Plan ambitions and roadmap. Enhanced governance arrangements operationalised and embedded aligned to new operating model. Impact demonstrated through tested alignment with Well Led framework over Q4. 1.3.2 Development plan for learning and safety culture in delivery aligned to Quality Delivery Plan with Q4 focus on alignment and connection of approach and learning mechanisms under new operating model. 1.3.3 Decision agreed to implement new NHSE Personalised Care Framework. Delayed final framework and guidance now expected to be published in 2026-27 with risk based decision not to proceed on current draft guidance.	Delivery behind plan at Q4 due to delay in NHSE Framework	Agreed assurances considered by QSC
1.4 Improve access to our services and achieve all target wait times	1.4.1 Launch and deliver year 1 Clinical Services Delivery Plan with a focus on improving access and on understanding and addressing health inequalities 1.4.2 Design framework for disproportionate allocation of resources based on needs of our population 1.4.3 Agree and monitor achievement of target waiting times across all services with a year 1 priority focus on eradication of inappropriate out of area (OOA) placements through 'end to end' pathway optimisation	1.4.1 Clinical Services Delivery plan remains in development with forward approach refreshed by new Medical Director and a draft due to be consulted upon and presented for approval in Q1 of 2026-27 1.4.2 Framework for disproportionate allocation of resources in development aligned to 1.4.1 above. 1.4.3 Achievement in year of a number of targets including perinatal access, dementia diagnoses, children and young people eating disorder access, and individual work placement support access. Improvement action plans to reduce out of area placements and increase crisis 24 hour face to face response resulted in Q4 achievement of Operational Plan trajectories. Continued focus on other challenged access targets including LoS and Community waiting times.	Publication due Q1 26-27 Access recovery in specific services beyond 25-26	Due once final draft plan agreed IPR assurance considered by Finance and Performance Committee (FPC)

Delivery concerns at Q4 to be managed via management oversight forum and escalated to Quality and Safety Committee as required

1.2.3 Action plan in place and being overseen by QSC to improve responsiveness to feedback and complaints

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

People

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

NHS Derbyshire Healthcare NHS Foundation Trust

Priorities for delivery of success	Roadmap to delivery of success 2025-26	Q4 Progress Update	Status Q4 Position	Assurance mapped to Q4 Papers
2.1 Be recognised for attracting and retaining the best people	2.1.1 Improve our recruitment and retention processes and systems to provide assurance on the experience of our people 2.1.2 Support managers to support our people to fulfil their potential and deliver new roles 2.1.3 Further mature and embed our workforce planning approach and develop multi-year Trust strategic workforce plan which reflects our role as system partner.	2.1.1 Work is continuing to embed and build on the triangulated approach to retention intelligence, with ongoing monitoring of Stay Survey insights, exit interview themes and NHS Staff Survey data. Focus remains on applying intelligence to inform targeted actions and maintain oversight through the PCC dashboard to support improvements in recruitment and retention experience. 2.1.2 Manager capability development continues to be embedded through inclusive communication training, Chairs' Training and learning from the Violence, Abuse & Aggression Collaborative. Feedback from collaborative sessions to be translated into practical actions, including clearer expectations for leadership visibility, improved post-incident support and strengthened consistency. 2.1.3 National planning submissions completed Q4, incorporating triangulated data across workforce FTE, finance and activity. Local workforce planning remains an ongoing and iterative process with continued work to embed systematic and sustainable approach.	Delivery on plan at Q4	Agreed assurances considered by People and Culture Committee (PCC)
2.2 Be recognised for supporting and developing our people to work confidently in their roles	2.2.1 Launch roadmap for leadership development and roll out year 1 plan including senior leadership programme 2.2.2 Embed talent management and succession planning framework 2.2.3 Develop standards and governance for advanced professional practice across roles 2.2.4 Develop learning culture for all staff including regular career conversations	2.2.1 STRIVE senior leadership programme successfully commenced in Q4, with Module 1 delivered to the first cohort and strong engagement from participants. Accreditation with Chartered Management Institute is progressing recognising programme status. 2.2.2 Learning from talent and succession pilot is shaping next phase of implementation, with a senior-level review scheduled for 2026. Work in progress to refresh the talent model, map career pathways, and strengthen apprenticeship and development routes. 2.2.3 Progress continues to strengthen the advanced professional practice framework, with clearer alignment between clinical leadership expectations, professional standards and service needs. Insights are informing more consistent and structured approach. 2.2.4 Learning culture continues to be strengthened through integration with the 'A Kind Life' programme and Personal Accountability Charter. Increased uptake of masterclasses, training and conversations is supporting a more open, reflective culture.	Delivery on plan at Q4	Agreed assurances considered by PCC
2.3 Be recognised by our people for our values driven and inclusive culture	2.3.1 Embed personal accountability charter within the people management and appraisal framework and develop competence of managers in restorative just culture 2.3.2 Deliver year 1 plan to develop EDI framework with a focus on diversity in recruitment and development offer, and equipping leaders with skills and data to improve 2.3.3 Refresh and deliver improvement plans for Workforce Race Equality and Disability Equality Standards	2.3.1 Embedding of Personal Accountability Charter continues to progress through 'A Kind Life' programme, with wide engagement. Learning from Violence, Abuse & Aggression Collaborative has further strengthened approach. highlighting the importance of consistent leadership behaviours, clear boundaries and visible follow-through. Charter and Trust values being consistently threaded through the design of our future wellbeing and leadership development offer, supporting a more aligned and values-driven approach. 2.3.2 and 2.3.3 EDI, WRES and WDES plans approved by PCC, with delivery of the Year 1 EDI framework underway. Anti-Racism Strategy in place and with first phase of delivery in progress, alongside refreshed WRES and WDES improvement plans. Staff networks established and actively engaged, with strengthened governance and oversight through the EDI Working Group.	Delivery on plan at Q4	Agreed assurances considered by PCC
2.4 Be recognised as a Trust that supports and promotes the wellbeing of our people	2.4.1 Embed a flexible working culture, supporting colleagues to balance home and work life and support delivery of services ,with clear action plans for delivery within one year 2.4.2 Continue to embed annual health and wellbeing assessment and deliver year 1 development plan 2.4.3 Develop psychology support and offer for staff 2.4.4 Review and refine attendance management policy and approaches to support colleagues and managers	2.4.1 Work is continuing to embed a consistent and transparent approach to flexible working. Implementation of new system and supporting processes remains ongoing, alongside manager training to support confident and equitable application of the policy. 2.4.2 Planning underway in preparation for end of the Joint Venture agreement, with a focus on transitioning wellbeing services and shaping the future in-house offer. Work is ongoing to align the refreshed Health and Wellbeing assessment with this transition. 2.4.3 Planning also focused on shaping a future in-house psychological support offer with work ongoing to review current provision and develop a more responsive, accessible and needs-led model aligned to the wider wellbeing transition with external support. 2.4.4 Attendance management continues to be strengthened through improved data visibility enabled by the new sickness monitoring system. Annual sickness absence rate offers a clear baseline for ongoing improvement with plans in place for Phase 2 development of the Absence Manager system, introducing enhanced automation and monitoring functionality.	Delivery on plan at Q4	Agreed assurances considered by PCC

Delivery concerns at Q4 to be managed via management oversight forum and escalated to People and Culture Committee as required

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

Productive

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

NHS Derbyshire Healthcare NHS Foundation Trust

Priorities for delivery of success	Roadmap to delivery of success 2025-26	Q4 Progress Update	Status Q4 Position	Assurance mapped to Q4 papers
3.1 Achieve financial sustainability through improved clinical and operational productivity	3.1.1 Agree core priorities and deliverables for 25-26, to include reduction of OOA and premium spend 3.1.2 Deliver agreed financial plan on pathway towards financial balance and sustainability 3.1.3 Deliver year 1 plan for international medical recruitment on path to eradicate medical agency spend 3.1.4 Understand productivity and sustainability across all services and plan for optimisation or consider exit 3.1.5 Implement data flow for new national currency model 3.1.6 Develop literacy of our people in financial, capacity and activity planning	3.1.1 Financial plan agreed by ICB and NHSE with system deficit support of £45m enabling break even position across partners. Medium term financial planning progressed Q4 with final submission aligned to national timetable. 3.1.2 Financial plan remains on track at end of Q4, including CIP delivery and achievement of agency and bank targets. 3.1.3 International medical recruitment plan progressed aligned to agreed plan and timeline over Q4. 3.1.4 Engagement maintained with NHSE pilot and recruitment by end Q4 for lead to develop productivity approach over 2026-27. Governance of productivity, efficiency and wider enablers reviewed, developed and launched in Q4. 3.1.5 National currency model now delayed beyond 2025-26. National cost collection submission made in Q1 with outputs published in Q4 and action underway to analyse opportunities develop associated action plans for 2026-27. 3.1.6 HFMA e-learning platform procured with access to 50 modules. Plan for launch and roll out aligned to second phase of operating model in Q1 of next year following completion of restructure.	Delivery on plan at Q4	Agreed assurances considered by Finance and Performance Committee (FPC)
3.2 Transform our clinical pathways and operating model	3.2.1 Establish vision and ambitious transformation plan for integrated 'end to end' pathway and model of care across community and acute services and align to partnership development approach 3.2.2 Design and implement new operating model and accountability framework for delivery of services 3.2.3 Design and launch transformation plan for corporate services 3.2.4 Implement year 1 of agreed transformation programme 3.2.5 Implement transformation and improvement framework 3.2.6 Develop population health approach within the clinical transformation programme	3.2.1 NHSE Men-Sat recommendations progressed aligned to urgent care transformation plan. Community and crisis workshop series concluded in Q4 to support development of vision and strategic plan. Progress made over Q4 in developing strategic intent for neighbourhood mental health model with further Board conversation in April. 3.2.2 Phase one operating model successfully operationalised in Q4 through new Triumvirate Leadership Teams. Phase two launched and to be concluded to expected timeline in Q4. 3.2.3 JUCD Provider Collaborative work programme and benefits realisation plan in delivery comprising five enabling corporate services with co-ordinated Trust plans accelerated over Q4 to enable delivery from 2026-27. 3.2.4 Assurance over design and delivery of transformation portfolio developed over Q4 overseen by the Strategic Portfolio Group and FPC. Deep dive process implemented with action agreed for areas of focus or concern. 3.2.5 Continued progress over Q4 in implementation of framework with key actions being enhancement of programme management and oversight arrangements and development of approach for continuous improvement with enhanced arrangements for capturing, sharing and celebrating improvement success to be launched in 2026-27. 3.2.6 Population health intelligence being actively considered through development of the neighbourhood and urgent models of care to ensure these are aligned to local need. Approach to be further developed over 2026-27.	Delivery on plan at Q4	Agreed assurances considered by Finance and Performance Committee (FPC) and People and Culture Committee (PCC)
3.3 Optimise our assets and enabling resources to improve services and care	3.3.1 Deliver and track realisation of intended benefits from the Making Room for Dignity (MRfD) programme 3.3.2 Launch and deliver year 1 of agreed Estates Plan 3.3.3 Launch and deliver year 1 of agreed Digital Plan with a focus on consolidating gains from existing assets including EPR and design of 'end to end' digital workflow	3.3.1 MRfD programme fully operationalised with formal post project evaluation and benefits realisation reports for PICU/ECU completed aligned to agreed timeline in Q4. 12 month review of data scheduled for 2026-27. 3.3.2 Estates Plan approved by FPC in Q2 with all key deliverables on track at Q4. 3.3.3 Digital Delivery Plan and roadmap developed, consulted upon and published in Q4 aligned to outputs of the Digital Futures Day. Review and refresh of programme, work plan and arrangements to oversee and assure delivery underway.	Delivery on plan at Q4 Delivery behind plan at Q4	Agreed assurances considered by FPC
3.4 Reduce emissions we control directly (the NHS Carbon Footprint)	3.4.1 Deliver year 1 of agreed Sustainability Plan and achieve a reduction on emissions in 2025-26 on course for 80% long term target	3.4.1 Sustainability Plan approved by FPC in Q2 with all key deliverable on track at Q4. Development of an associated Travel Plan a defined priority with ongoing work on this into 2026-27.	Delivery on plan at Q4	Agreed assurances considered by FPC

Delivery concerns at Q4 to be managed via management oversight forum and escalated to Finance and Performance Committee as required

3.1.4: Acceleration of productivity approach planned in 2026-27 aligned to recruitment of dedicated resource.

3.1.5 National currency model was on hold and has now been delayed for implementation beyond 2025-26.

Partnerships

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

NHS Derbyshire Healthcare NHS Foundation Trust

Priorities for delivery of success	Roadmap to delivery of success 2025-26	Q4 Progress Update	Status Q4 Position	Assurance mapped to Q4 papers
4.1 Build partnerships that deliver on the needs of our communities	4.1.1 Develop our partnership within the East Midlands Alliance, to enable the best mental health, learning disability and autism care and support for the people of the East Midlands and deliver year 1 plan across the priorities for: 1. Quality improvement and productivity 2. Enabling safe care 3. Developing our workforce 4. Improving population health 5.Reducing inequalities 4.1.2 Develop our role as Perinatal Lead Provider and in leading Gambling Harm services within the East Midlands. 4.1.3 Develop our strategic partnership with University of Derby and associated implementation plan 4.1.4 Develop partnerships within the JUCD Provider Collaborative with a year one focus on collaboration across services for Children and Young People 4.1.5 Deliver Community and Stakeholder Engagement Plan with year 1 priority focus on the deaf community, black communities and new migrant families 4.1.6 Proactively engage with regional and national learning collaboratives 4.1.7 Work in partnership to develop financial model and full business case for income generating business unit	4.1.1 East Midlands Alliance development plan for 2025-26 agreed and in delivery over the five agreed priorities with progress overseen through the Alliance Board and updates via Chief Executive Report to Board of Directors. Alliance event hosted to share progress across the programme and collaboratives. Current focus on review and agreement of ambitions and priorities for 2026-27 and beyond. 4.1.2 Action in developing East Midlands collaboratives reported to and overseen by Finance and Performance Committee. Highlights in Q4 include focus on continuous improvement and clinical learning into action for Perinatal, and continued progress made for Gambling Harm in increasing referrals and overall service activity. 4.1.3 Strategic partnership agreement signed with University of Derby with associated plan agreed and in delivery aligned to 4.3 below. 4.1.4 JUCD Provider Collaborative detailed work programme and benefits realisation plan in delivery comprising five enabling corporate services and four clinical pathways, including Children and Young People. System partners have collaborated over Q4 to oversee progress to date and agree next steps for collaborative action into 2026-27. 4.1.5 Continued progress made in delivery of the Community and Stakeholder Engagement plan with focus on the action plans for Deaf and Black communities. Outcomes to date and strategic intent on year 2 priorities agreed via a Board Development Session in February 2026. 4.1.6 Active engagement maintained in learning collaboratives with highlights in Q4 being progress on the Culture of Care programme learning events supported by the National Collaborating Centre for Mental Health, along with collaboration through the Midlands Learning and Improvement Network with a priority focus on application of learning to improve inpatient length of stay. 4.1.7 Action delivered to further develop the model for an income generating business unit aligned to strategic intent defined via Q2 Board development session. Timeline and milestone plan to mobilisation in 2026-27 approved and being overseen by Trust Delivery Group.	Delivery on plan at Q4	Agreed assurances considered by the Finance and Performance Committee and the Board of Directors
4.2 Excel in our role as an anchor organisation	4.2.1 Apply datasets alongside local demographics to establish baseline position and inform actions to develop our role across five domains: as an employer, a procurer, as a holder of property and assets, as a partner, and in sustainability	4.2.1 Action progressed over Q4 to develop co-ordinated view of the anchor ambitions that are embedded throughout our organisational strategy, along with the work being progressed at scale with JUCD system. Stocktake position discussed via Board Development Session in February with approach taken to develop a documented overview of anchor ambitions and deliverables, along with high level metrics that demonstrate impact over the five anchor ambition domains by 2028 as an employer, a procurer, as a holder of property and assets, as a partner, and in sustainability.	Delivery on plan at Q4	Considered via Board Development Session February 2026
4.3 Achieve University Hospital Trust status	4.3.1 Develop our strategic partnerships with academic institutions and deliver year 1 plan to develop research capability 4.3.2 Design and implement year 1 of action plan to be a centre for education across disciplines and achieve University Hospital Trust status	4.3.1 Strategic partnership agreement signed with University of Derby with associated plan agreed and in delivery to develop and strengthen research capability, and support ambition to achieve University Hospital status. Progress reported to and overseen by Board of Directors. 4.3.2 Action plan defined with support from University of Derby and launched in Q4.	Delivery on plan at Q4	Agreed assurances considered by the Board of Directors

Delivery concerns at Q4 to be managed via management oversight forum and escalated to Finance and Performance Committee as required

4.2.1: Progress on Derbyshire anchor organisation ambitions via the system anchor group lacks pace, however action via mechanisms such as Joined up Derbyshire Careers Derbyshire is ongoing and delivering measurable outcomes.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 19 May 2026

Trust Strategic Delivery Plan - 2026/27

Purpose of Report

To present the proposed 2026/27 Strategic Plan deliverables for approval.

Executive Summary

The Trust Strategy was launched in October 2024 and action was subsequently progressed in developing an associated Strategic Plan for 2025-2028 to define the priorities, deliverables and associated roadmap for delivery of strategic ambitions.

Priorities and deliverables for the lifecycle of the 2025-2028 Strategy were originally defined within the three-year Strategic Plan document approved by the Board on 4 March 2025.

Recognising the constant evolution of the operating environment over the last 12 months, deliverables for 2026/27 have been reviewed in alignment with 'Must have, Should have, Could have and Won't have' (MoSCoW) methodology, a recognised framework for categorising tasks to guide focus and resource allocation.

A first draft was discussed by the Board via a development session conversation on 15 April 2026, with further action agreed to support final consideration and agreement of 2026/27 deliverables. The further developed framework was considered and supported by the Strategic Portfolio Oversight Groupon 22 April 2026. The outputs of the above provide the proposed 2026/27 Strategic Plan deliverables presented for approval.

Strategic Considerations		**BAF Risk(s)**	**Strategic Delivery Plan Reference**
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	All	All
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:

- Risks to delivery of the Strategic Plan are recognised and managed via the Board Assurance Framework.

Assurances include that:

- The Strategic Plan aligns with and seeks to enact the Trust Strategy
- The source and forum for assurance is defined for each Strategic Plan priority.

Consultation

- The Strategic Plan was developed through engagement and consultation through two Board Strategy and Development Sessions, the Staff Conference and the Leadership Forum
- The refresh of priorities has been discussed and agreed by the Executive Leadership Team and through a Board Strategy and Development Session conversation on 15 April 2026, with further action agreed to support final consideration and agreement of 2026/27 deliverables
- The further developed framework was considered and supported by the Strategic Portfolio Oversight Group on 22 April 2026.

Governance or Legal Issues

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

Net Zero Duty Implications

In compliance with the NHS move towards net zero carbon emissions, the Trust must consider statutory emissions and environmental targets in their decisions. Reports should identify related impacts on workforce and system leadership; sustainable models of care; digital transformation; travel and transport estates and facilities (including capital projects, asset management and utilities, green space and biodiversity); medicines; supply chain and procurement; food and nutrition and adaptation.

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

The Strategic Plan directly supports statutory commitments to achieve net zero by reducing carbon output associated with care delivery, estates, travel, supply chains and operational processes.

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 proposed 2026/27 Strategic Plan deliverables.

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

NHS
Derbyshire Healthcare
NHS Foundation Trust

Strategic Delivery Plan 2025-2028

2026/27 Review and Refresh

2025-28 Strategic Plan Content

Patient focused

Proposal based on prioritisation process

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	Improve safety and reduce harm: timely learning from incident, review of Datix, PISRF reviews in line with Trust Policy Reduce restrictive practices incidents (seclusion, restraint, rapid tranquilisation) by 10% through targeted clinical interventions Learning from Incidents - all SI learning themes reported to ELT and QSC with action tracking Reduce incidents of violence and aggression towards staff by 10%	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	Patient and Carer Race Equality Framework- coproduction of an action plan and having 3 pilot sites for implementation Improve participation and improve scores in Community Mental Health Feedback Deliver engagement and co-production plan (in continuous improvement and care delivery) Closer Look Complaints to be responded within 90 days Improve participation and improve scores in Community Mental Health Feedback	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	Deliver a minimum of 3 operational NOF performance standards Develop and deliver Clinical Plan with set deliverables to be delivered in year 1 Develop and deliver community safer staffing models in community services Provide assurance and oversight of nursing and AHP roster, safer staffing and associated budgetary spend meet the national agency and bank usage targets	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	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	Deliver the Trust's OOA bed reduction plan	Deliver year 3 of Clinical Services Delivery Plan with a focus on improving outcomes aligned to the new model for safe community practice	Improved access for underserved communities by 2028 Shift in resource by 2028	Medical Director	Strategic Progress Report Board of Directors Integrated

2025-28 Strategic Plan Content

People

Proposal based on prioritisation process

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.	Improve recommendation as a place to work and staff engagement scores (Pulse check ins to assess progress) Reduction in medical and key clinical vacancies (focus on remaining 39.72 TE HCSW inpatient vacancy and 26.69 FTE RMN inpatient vacancy) Improvement in general recruitment processes Improvement in teams with turnover above 10% to reduce variance and bring in line with trust thresholds Improvement in eRoster efficiency to support overall reduction in 10% bank usage and 30% agency usage (alongside elimination of all HCSW agency usage)	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	Reduction in length of time for formal ER cases (measurement through regular reporting via TDG) Reduction in inappropriate formal ER cases (utilising the respectful resolution policy to reduce formal ER cases) Continue to deliver Leadership Development Programme Deliver organisational change aligned to efficiency plan and organisational priorities	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	Deliver all elements of EDI Plan for 2026-27	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	Assurance on impact of personal accountability charter and development of earned autonomy culture Increased diversity of workforce aligned to WRES and WDES	Director of People, Organisational Development & Inclusion EDI Steering Group	People Performance Report People and Culture Committee

2025-28 Strategic Plan Content

Productive

Proposal based on prioritisation process

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	Deliver the Trust's agreed financial breakeven position by year end Achieve £14.5 million in CIP with at least 66% recurrent savings by Q4 Establish innovation panel for colleagues to seek funding to deliver service and transformational change - focusing on delivering improved measurable patient outcomes	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	Agree and implement the CMH 24/7 neighbourhood model Agree and implement the MH Urgent Care Assessment clinical model	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	Deliver year 1 priorities Digital Delivery Plan (Psyomics, Patient Knows Best, eMHA by Thalamos, SystmOne Optimisation) Operationalise and deliver first treatments in Positive Health Difference services	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 priorities Estates Plan. This includes progress and disposal of tail estates aligned to Estates plan; Deliver 15% reduction on back log maintenance where sites being retained; Implement solutions for managed car park to improve health and safety across various sites)	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

2025-28 Strategic Plan Content

Partnerships

Proposal based on prioritisation process

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	Develop relationship with ICB Executive team to keep DHcFT positioned positively as a key partner in the new cluster Become a lead provider for mental health services in Derby and Derbyshire Deliver priorities for Community and Stakeholder Engagement Plan – Deaf, Black and New Migrant communities EM Provider Collaborative: Move from 2 to 1 Commissioning Hub, expand Gambling Harm service by 10% Optimise DLN cluster opportunities: Integrate Living Well in Neighbourhoods offer, undertake system wide strategic review of Children's services, embed Right Care Right Person (RCRP) ways of working	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	Collaborate with our partners to deliver an inclusive wellbeing economy - business as usual	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 – business as usual	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

Corporate Governance report

Purpose of Report

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

Executive Summary

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

- All Board Committees participated in a Microsoft Forms effectiveness survey which invited members (and other core attendees, where appropriate) to deliver feedback on the meetings held over the year and how the Committee could be improved, including identifying any training or support needs. The Healthcare Financial Management Association (HFMA) Audit Committee checklists in paper form were used for ARC.

The year-end report for the ARC is also presented (Appendix 2) and summarises how the Committee has discharged its remit during 2025/26.

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

The Board is asked to approve the 2025/26 Continuation of Services Condition 7 – availability of resources self-declaration for signature of the Chair and Chief Executive (Appendix 4).

Strategic Considerations		**BAF Risk (eg 1A)**	**Strategic Delivery Plan Reference**
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	N/A.	N/A.
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X	N/A.	N/A.
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X	N/A.	N/A.
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	N/A.	N/A.

Risks and Assurances

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

Consultation

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

Governance or Legal Issues

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

Net Zero Duty Implications

In compliance with the NHS move towards net zero carbon emissions, the Trust must consider statutory emissions and environmental targets in their decisions. Reports should identify related impacts on workforce and system leadership; sustainable models of care; digital transformation; travel and transport estates and facilities (including capital projects, asset management and utilities, green space and biodiversity); medicines; supply chain and procurement; food and nutrition and adaptation.

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

Picked up in individual reports, of note is all Committee meet virtually, reducing the travel impact.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

Recommendations

The Board of Directors is requested to:

1. Approve the suite of ToRs for Board Committees (Appendix 1)
2. Note the assurance received by the Audit and Risk Committee that all Board Committees have effectively carried out their role and responsibilities as defined by their ToRs during 2025/26 and receive the year-end report of the Audit and Risk Committee (Appendix 2)
3. Note the Trust seal report (Appendix 3)
4. Approve the Continuation of Services Condition 7 self-declaration (Appendix 4).

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

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

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

At its meeting on 23 April 2026, the Audit and Risk Committee received the year-end effectiveness summaries for all the Board Committees as well as their Terms of Reference (ToRs).

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

The Audit and Risk Committee received assurance from the summary reports and effectiveness surveys, that the Committees have effectively carried out their role and responsibilities during 2025/26. All the Board Committees have developed a full future year's forward plan.

The suite of ToRs is included as Appendix 1.

The year-end report for the Audit and Risk Committee is also presented to the Board at Appendix 2. This summarises how the Committee has discharged its remit during 2025/26.

For next year, the surveys will be more tailored for individual committees.

Recommendation:

The Board of Directors is requested to:

- approve the suite of ToRs for the Board Committees and note the assurance received by the Audit and Risk Committee that all Board Committees have effectively carried out their role and responsibilities as defined by their ToRs during 2025/26
- receive the year-end report for the Audit and Risk Committee.

2. Register of Trust Sealings

The six-monthly update on the authorised use of the Trust Seal since the last report to the Board on 25 November 2025 is attached for information at Appendix 3.

Recommendation:

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

3. 2025/26 Continuation of Services Condition 7 – availability of resources

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

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

a) After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions

which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate

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

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

It is recommended that statement (a) is made to align with the going concern assessment which had been approved by the Audit and Risk Committee and will be reported within the Trust's 2025/26 Annual Report. Other sources of assurance/evidence to support this statement are listed in Appendix 4.

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

Recommendation:

The Board of Directors is asked to approve the 2025/26 Continuation of Services Condition 7 – availability of resources for signature of the Chair and Chief Executive.

Appendix 1

NO CHANGES

Remuneration and Appointments Committee Terms of Reference

Purpose

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

1. Authority

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

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

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

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

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

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

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

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

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

2. Membership

2.1 The membership of the Committee shall consist of:

- Trust Chair
- All Non-Executive Directors.

2.2 The Trust Chair will chair the Committee.

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

3. Attendance

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

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

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

4. Quorum

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

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

5. Frequency of Meetings

Meetings shall be held quarterly or as required.

6. Duties and Responsibilities

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

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

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

[1] Code of governance for NHS provider trusts.

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

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

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

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

6.1 Appointments (and removal) Role

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

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

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

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

6.1.5 Ensure that a proposed Executive Director's other significant commitments (if applicable) are disclosed before appointment and approve requests from individual Executive Directors to take on external appointments, including, but not limited to, additional paid employment, non-executive directorships, or trusteeships that any changes to their commitments are reported to the Board as they arise. Full-time Executive Directors should not take on more than one non-executive directorship of another Trust or organisation of comparable size and complexity, and not the chairship of such an organisation.

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

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

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

6.1.9 Ensure all Executive Director appointments meet the Fit and Proper Persons Test (FPPT) on commencement and will oversee ongoing compliance.

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

6.2 Remuneration Role

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

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

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

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

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

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

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

7. Minutes and Reporting

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

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

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

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

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

8. Terms of Reference Review

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

Approved by Remuneration and Appointments Committee	17 March 2026
Approved by Audit and Risk Committee	23 April 2026
Approved by Board of Directors	19 May 2026

DRAFT

Finance and Performance Committee Terms of Reference

Purpose

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

1. Authority

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

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

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

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

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

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

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

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

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

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

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

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

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

1.9 To receive assurance in relation to the fulfilment of the financial and performance aspects of the Trust's roles and responsibilities within all collaboratives and alliances, where the Trust is Lead Provider or partner, including the effective operation of Commissioning Hub support.

2. Membership

2.1 The membership of the Committee shall comprise:

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

Standing attendees comprise of:

~~Clinical Operational Managing Director leads~~
Deputy Director of Finance
Deputies as required

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

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

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

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

3. Attendance

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

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

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

4. Quorum

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

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

5. Frequency

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

6. Duties and Responsibilities

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

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

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

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

6.4 To receive reports on business and commercial matters.

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

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

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

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

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

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

7. Minutes and Reporting

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

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

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

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

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

8. Terms of Reference Review

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

Approved by Finance and Performance Committee	20 March 2026
Approved by Audit and Risk Committee	23 April 2026
Approved by Board of Directors	19 May 2026

DRAFT

Quality and Safeguarding Committee Terms of Reference

Purpose

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

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

1. Authority

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

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

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

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

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

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

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

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

1.8~~9~~ To receive assurance in relation to the fulfilment of the quality aspects of the Trust's roles and responsibilities within ~~in~~ all collaboratives and alliances where the Trust is Lead Provider or partner, including the effective operation of Commissioning Hub support~~it is a partner~~.

2. Membership

2.1 The membership of the Committee shall comprise:

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

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

3. Attendance

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

- Deputy Chief Executive and Chief Delivery Officer or a nominated deputy.
- Deputy Director of Nursing and Quality Governance
- Lead professional for Patient Safety
- Chief Pharmacist
- Research and Clinical Audit Manager
- Risk and Assurance Manager
- Assistant Director of Clinical Professional Practice
- Assistant Director of Legal, Governance and Mental Health Legislation
- Health and Safety Manager
- Safeguarding Children Lead
- Safeguarding Adults Lead.

3.2 The following may also attend:

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

Any other attendees will be invited upon request.

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

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

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

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

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

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

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

4. Quorum

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

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

5. Frequency

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

6. Duties and Responsibilities

In respect of general governance arrangements:

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

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

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

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

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

6.6 Receive assurance on Quality Performance from the Divisional Boards, ~~and~~ Care ~~delivery~~ ~~g~~Groups and other delivery groups on the subject matter such as ligatures, restrictive practice, IPC, Physical Health.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6.26.7 **A formal link to the area Safeguarding Children and Adults Boards** and provide systems leadership to our wider geographical and community safeguarding responsibilities and be the conduit for linking the community Safeguarding Board strategies with the Trust strategy.

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

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

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

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

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

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

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

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

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

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

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

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

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

6.27 Safeguarding Adults Key Responsibilities:

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

Therefore, the Trust should annually:

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

6.28 Safeguarding Children Key Responsibilities:

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

7. Minutes and Reporting

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

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

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

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

8. Terms of Reference Review

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

Approved by Quality and Safeguarding Committee	14 April 2026
Approved by Audit and Risk Committee	23 April 2026
Approved by Trust Board	19 May 2026

DRAFT

People and Culture Committee Terms of Reference

Purpose

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

1. Authority

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

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

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

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

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

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

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

2. Membership

2.1 The membership of the Committee will comprise:

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

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

In attendance as core attendees:

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

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

3. Attendance

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

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

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

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

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

4. Quorum

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

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

5. Frequency

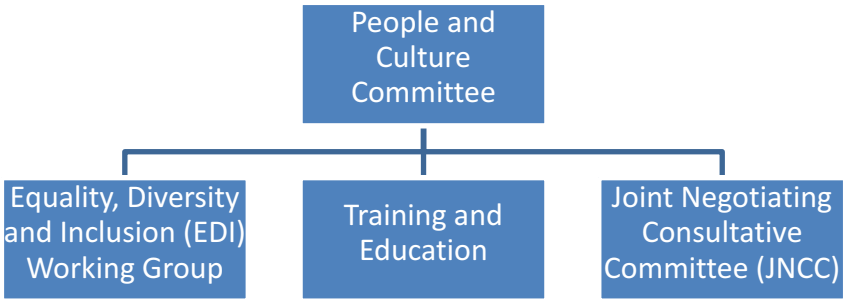
5.1 The Committee will meet on a bi-monthly basis with additional meetings being called when necessary.

6. Duties and Responsibilities

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

6.2 The Committee will monitor the implementation of the People Plan and report progress to the Board by exception.

6.3 A number of supporting groups/forums will be accountable to the People and Culture Committee whilst not exhaustive; it is anticipated that the following groups will have a direct or indirect relationship and will be agreed within the Committee:



6.4 The Committee will oversee and monitor workforce performance.

6.5 The Committee reviews and monitors the Workforce metrics and Board Assurance Framework and ensures the Board is kept informed of any significant workforce risks.

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

6.7 The Committee is to be assured that mechanisms are in place to review and monitor the effectiveness and capability of the workforce across the whole Trust and that appropriate actions are taken to address issues of poor performance and bring about continuous quality improvement.

6.8 The Committee is to be assured that the Trust identifies lessons for improvement and implements these in all relevant areas.

6.9 The Committee is to be assured that national standards, guidance and best practice are systematically reviewed and embedded within the Trust.

6.10 The Committee is to be assured that the views of staff and appropriate others are systematically and effectively engaged in organisational development activities.

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

6.12 The Committee will oversee the leadership, training and education framework and monitor progress.

6.13 The Committee will oversee staff health and wellbeing including Trust and Divisional level health and wellbeing initiatives and health and wellbeing support aligned to staff absence

6.13 The Committee will monitor the implementation of agreed action plans in relation to organisational interventions and measure the effectiveness of change.

6.14 The Committee will review its effectiveness by self-assessment on an annual basis and at the end of each meeting. The annual review will be presented to the Audit and Risk Committee.

7. Minutes and Reporting

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

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

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

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

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

8. Terms of Reference Review

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

Approved by People and Culture Committee	3 March 2026
Approved by Audit and Risk Committee	23 April 2026
Approved by Trust Board	19 May 2026

DRAFT

Mental Health Act Committee Terms of Reference

Purpose

The Committee monitors and obtains assurance on behalf of the Hospital Managers and the Trust as the detaining authority that the safeguards of the Mental Health Act are appropriately applied. It also monitors related statute and guidance and reviews the reports following Mental Health Act inspections by the Care Quality Commission.

1. Authority

1.1 The Board of Directors has approved the establishment of a Mental Health Act Committee as a Committee of the Board. The purpose of the Committee is to obtain assurance, on behalf of the "Hospital Managers" and the Trust as the detaining authority, that the safeguards and provisions of the Mental Health Act are appropriately applied; to take account of the provisions of related statute and guidance, such as Mental Capacity Act, Deprivation of Liberty Safeguards (DOLS) and Human Rights Act.

1.2 The Committee will exercise its responsibilities by fulfilling a scrutiny and monitoring role from receipt of regular activity data and inspection reports from an Operational Group; by obtaining assurance that best practice is deployed across the Trust.

1.3 As a Committee of the Board, the Mental Health Act Committee has an important role to provide assurance on the progress and risks arising relating to the delivery of the Trust's Strategic objectives which fall within the Committee's remit. It will consider any exceptions or risks escalating these to the Trust Board or referring to the Executive Leadership Team as necessary.

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

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

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

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

1.8 As a designated policy ratification group, (see 'Policy on Policy Documents) the Mental Health Act Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. These include policies in relation to the Mental Health Act and Code of Practice requirements, and the duties of Associate Hospital Managers, including the protocols for the hearing of appeals and reviews. It also includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality

Impact Assessment (EIA) which forms part of the current policy template. All policy documents are allocated a policy ratification group as they are published on Focus.

1.9 An operational subgroup will meet approximately one month before the full Committee to prepare assurances and highlight exceptions.

2. Membership

2.1 The membership of the Committee shall comprise:

- Non-Executive Directors x three (one will be appointed as Chair of the Committee)
- Medical Director or Director of Nursing, AHPs, Quality and Patient Experience
- Director of Corporate Affairs and Trust Secretary.

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

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

3. Attendance

3.1 Additional attendees shall comprise:

- Assistant Director of Legal, Governance and Mental Health Legislation
- Mental Health Act Manager
- ~~Managing~~ Director of Operations
- ~~Representative of Associate Hospital Managers~~
- Director of Nursing, Allied Health Professionals, Quality and Patient Experience, when required (refer to quorum at 4.1 below)
- Other senior management/professional leads may be invited at the discretion of the Committee Chair.

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

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

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

4. Quorum

4.1 A quorum shall be a minimum of three members including at least two Non-Executive Directors and one Executive Director. If the Medical Director is unable to attend the Director of Nursing, Allied Health Professionals and Patient Experience will be required to attend instead in order to meet the quorum requirements. Non-quorate meetings may go ahead unless the chair decides not to proceed. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

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

5. Frequency

5.1 Meetings will be held quarterly.

6. Duties and Responsibilities

6.1 To receive compliance and assurance reports from the Operational Group regarding the number of patients subject to detention under each section of the Mental Health Act for the previous quarter as part of a rolling twelve-month review to identify any variation or trends (including diversity data) and provide interpretation of data including an outline of actions arising as appropriate.

6.2 To consider matters of recommended good practice, and in particular the requirements of the Code of Practice (Revised): Mental Health Act (1983) and its Code of Practice as amended and approve policy changes to receive assurance on the steps taken to implement and embed recommended good practice relating to the requirements of the Mental Health Act, Mental Capacity Act and related legislation.

6.3 To receive assurance reports and scrutinise, as required, other activity reports from the Operational Group, eg the use of seclusion, noting any exceptions and escalating concerns as necessary.

6.4 To receive assurance reports relating to the Mental Health Act and related legislation which arise from the Care Quality Commission Inspection Reports and the implementation of the management response as defined by the Operational Group, providing scrutiny and challenge and noting exceptions and risks escalated by the operational group. With regard to Section 136, to oversee and receive assurance on the use of this section through the multi-agency Section 136 sub-committee.

6.5 To oversee the implications of related legislation, principally the Mental Capacity Act, (including Deprivation of Liberty), Human Rights Act guidance and other related legislation as appropriate, receiving assurance on impact, risk and effective implementation throughout the Trust.

6.6 To oversee that training needs are satisfactorily met to ensure compliance with legislative and best practice requirements, through assurance reporting and in general help promote awareness of the requirements of the Mental Health Act, Mental Capacity Act and associated legislation.

6.7 When receiving information and scrutinising good practice on Mental Health Act activity and reports, the Committee will pay due regard ~~to the Trust's Equality and Diversity Agenda~~ to inequalities (specifically Patient and Carer Race Equality Framework) and how the Operational Group intends to monitor and action plan for the same.

6.8. As the responsible Committee for PCREF, the Committee will receive regular updates on implementation within the Trust via the PCREF Steering Group.

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

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

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

6.12 To maintain a forward plan of regular agenda items to encompass the role and remit of the Committee as outlined in the Terms of Reference.

6.13 To oversee the development of an annual review of performance of the Committee against key areas as outlined within the Terms of Reference and confirm that all areas of governance and responsibility have been monitored.

6.14 Receive feedback, via the Operational Group overview report, from Associate Hospital Managers and review any performance issues arising from mental health tribunals.

6.15 To receive assurance from the Operational Group of their actions (actual or intended) regarding the implementation of Mental Health Legislation and/or significant case law changes.

7. Minutes and Reporting

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

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

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

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

8. Terms of Reference Review

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

Approved by Mental Health Act Committee	15 April 2026
Approved by Audit and Risk Committee	23 April 2026
Approved by Trust Board	19 May 2026

Appendix 2

Derbyshire Healthcare NHS Foundation Trust
Report to the Audit and Risk Committee – 23 April 2026

2025/26 year-end Effectiveness review of the Audit and Risk Committee and annual review of the Terms of Reference (ToRs)

Purpose of Report

The 2025/26 report is to be reviewed by the Audit and Risk Committee to be finalised and agreed for submission to the Trust Board. The report summarises how the Committee has discharged its remit during 2025/26 and is in addition to the assurance summary reports which have been presented to Board meetings throughout the year.

Executive Summary

This paper provides a report to the Audit and Risk Committee on its activity and effectiveness of the Committee for 2025/26, comparing the work of the Committee to its ToRs.

The review contained in this paper takes into account the Committee's meetings held from April 2025 to January 2026.

The Committee met six times throughout the year: 24 April 2025, 22 May 2025, 18 June 2025, 24 July 20254, 23 October 2025 and 16 January 2026. In addition, two Extra-ordinary, Confidential meetings were held on 24 April 2025 and 16 January 2026.

An evaluation process was conducted via Microsoft Forms, inviting members of the Committee to assess the Committee's effectiveness over the year and capturing feedback on how the Committee could be improved going forward, including identifying any training or support needs. An analysis of the evaluation is included (Appendix A) and the full results (Appendix B).

This assessment highlights the assurances provided over the past year on the structure and content of the agenda, the quality of the chairing, the engagement and participation of Committee members and the importance of reviewing the focus and membership going forward. Members need to be satisfied that items in the Forward Plan will maintain the Committee's oversight of all aspects of financial and operational performance.

Following this year-end review by the Committee, members' feedback will be captured in the minutes of the meeting to be held on 23 April.

Year-end review (Appendix C) and revised ToRs (Appendix D) are presented for approval.

Strategic Considerations		BAF Risk (eg 1A)	Strategic Delivery Plan Reference
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	ALL*	N/A
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		

* On the basis ARC approves versions of the BAF

Board Assurances

The purpose of the Audit and Risk Committee is to establish and maintain an effective system of integrated governance, risk management and internal control across the organisation, in a way that supports the organisation's objectives.

Consultation

This paper has not been considered by any other group.

Governance or Legal Issues

The NHS Audit Committee Handbook advises that an Audit Committee, in line with best practice in other sectors, should prepare a report to the Board that sets out how the Committee has met its Terms of Reference.

Satisfactory governance performance underpins many aspects of statutory, regulatory and legal compliance for foundation trusts. The Audit and Risk Committee forms part of the Trust's Corporate Governance Framework as a Committee of the Board.

Net Zero Duty Implications

In compliance with the NHS move towards net zero carbon emissions, the Trust must consider statutory emissions and environmental targets in their decisions. Reports should identify related impacts on workforce and system leadership; sustainable models of care; digital transformation; travel and transport estates and facilities (including capital projects, asset management and utilities, green space and biodiversity); medicines; supply chain and procurement; food and nutrition and adaptation.

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

ARC continues to meet effectively virtually reducing environmental impacts of travel to face to face meetings.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

There are no identified impacts arising from this report. All business considered by the Committee is subject to consideration of any impact and this is outlined on report cover sheets which have made relevant reference to equality, diversity and inclusion matters.

Recommendations

The Audit and Risk Committee is requested to:

1. Consider and agree the report for onward review by the Trust Board
2. Consider the level of assurance provided regarding the discharging of its remit as outlined in the Committee's Terms of Reference
3. Approve the highlighted changes to the ToRs.

Report presented by: **Chioma Akpom**
Chair, Audit and Risk Committee

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

APPENDIX A

Analysis of Year-end Effectiveness Evaluation 2025/26

The Committee is perceived as functioning effectively, with most questions showing a strong majority of 'Agree' or 'Strongly Agree' responses. For example, 86% agreed or strongly agreed that agenda items are appropriately closed off, and 86% agreed that members hold assurance providers to account for late or missing assurances.

Committee engagement and environment are highly rated, with 100% of respondents agreeing or strongly agreeing that members contribute regularly and that the environment enables open expression of views. Additionally, 86% felt debate is allowed to flow and conclusions are reached without being cut short.

A few areas show less consensus, such as the visibility and approachability of the Committee Chair, where responses were split evenly between 'Unable to answer,' 'Agree,' and 'Other.' Some questions also had notable 'Unable to answer' or 'Other' responses, indicating uncertainty or room for improvement in communication and clarity.

APPENDIX B

This document is extracted from the HFMA *NHS Audit Committee Handbook* (Appendix B)

Check List 2: Committee Effectiveness Check List

Statement	Strongly agree	Agree	Disagree	Strongly Disagree	Unable to answer	Comments
1. Committee Focus						
1.1. The Committee has set itself a series of objectives for the year.	1	5	0	0	2	The objectives are presented in the ToRs for each Committee. In addition, the Chair and NEDs have personal objectives.
1.2. The Committee has made a conscious decision about information it would like to receive.	2	6	0	0	0	There is scope for improvement on the clarity and brevity of the information produced.
1.3. Committee members contribute regularly to the issues discussed.	5	3	0	0	0	
1.4. The Committee is aware of the key sources of assurance and who provides them.	4	3	0	0	1	
1.5. The Committee receives assurances from third parties who deliver key functions – eg NHS Shared Business Services or private contractors.	1	6	0	0	1	Taking into account 360 Assurance as third party. Assurance from NHSE via DSP Toolkit.
1.6. Equal prominence is given to both quality and financial assurance.	2	5	0	0	1	Quality and Finance are considered in depth in the QSC and FPC. The ARC does receive assurance over Financial control areas more regularly and Quality issues when necessary.
2. Committee Team Working						
2.1. The Committee has the right balance of experience, knowledge and skills to fulfil its role.	4	3	0	0	1	
2.2. The Committee has structured its agenda to cover, quality, data quality, performance targets and financial control.	2	6	0	0	0	To an extent.
2.3. The Committee ensures that the relevant executive director/ attends its meetings to enable it to secure the required level of understanding the reports and information it receives.	6	2	0	0	0	
2.4. Management fully briefs the Committee on key risks and any gaps in control.	3	5	0	0	0	

2.5. Other Committees provide timely and clear information in support of the Audit Committee.	3	4	0	0	1	Consideration around the skew and quarter shift of the DSP toolkit year, 01-Jul through to 30-Jun.
2.6. The Committee environment enables people to express their views, doubts and opinions.	5	3	0	0	0	
2.7. Internal audit contributes to the debate across the range of the agenda.	2	5	0	0	1	
2.8. Members hold their assurance providers to account for late or missing assurances.	1	6	0	0	1	
2.9. Decision and action are implemented in line with timescale set down.	2	5	0	0	1	Committee actions are captured and tracked. Where there are delays, these are discussed and agreed.
3. Committee Effectiveness						
3.1. The quality of Committee papers received allows members to perform their roles effectively.	3	4	0	0	1	Potential improvements could be made with availability of papers via MS Sharepoint/Teams. There is scope for improvement.
3.2. Members provide real and genuine challenge – they do not just seek clarification and/or reassurance.	3	4	0	0	1	
3.3. Debate is allowed to flow and conclusions reached without being cut short or stifled.	4	4	0	0	0	
3.4. Each agenda item is 'closed off' appropriately so that the Committee is clear what the conclusion is; who is doing what, when and how etc and how it is being monitored.	2	6	0	0	0	
3.5. At the end of each meeting the Committee discuss the outcomes and reflect on decisions made and what worked well, not so well etc.	2	4	0	0	2	
3.6. The Committee provides a written summary report of its meetings to the Board.	4	2	0	0	2	
3.7. The Board challenges and understands the reporting from this Committee.	2	5	0	0	1	
3.8. There is a formal appraisal the Committee's effectiveness each year.	5	2	0	0	1	

4. Committee Engagement						
4.1. The Committee challenges management and other assurance providers during the year to gain a clear understanding of their findings.	3	4	0	0	1	
4.2. The Committee is clear about its role in relationship to other Board Committees that play a role in relation to clinical governance, quality and risk management.	3	4	0	0	1	
4.3. The Committee receives clear and timely reports from other Board Committees which set out the assurances they have received and their impact (either positive or not) on the organisation's assurance framework.	2	5	0	0	1	
4.4. We can provide two examples of where we as a Committee have focused on improvements to the system of internal control as a result of assurance gaps identified.	2	4	0	0	2	
5. Committee Leadership						
5.1. The Committee Chair has a positive impact on the performance of the Committee.	3	5	0	0	0	Only chaired one meeting which went well. Early indications are that Chioma will have positive impact on the performance of the Committee.
5.2. Committee meetings are chaired effectively.	2	6	0	0	0	Early indications are that Chioma will have positive impact on the performance of the Committee.
5.3. The Committee Chair is visible within the organisation and is considered approachable.	3	4	0	0	1	New and not had time as yet to evidence New Chair.
5.4. The Committee Chair allows debate to flow freely and does not assert their own views too strongly.	3	4	0	0	1	Too early to form a view.
5.5. The Committee Chair provides clear and concise information to the Board on the activities of the Committee and implications of all identified gaps in assurance control.	3	3	0	0	2	Unable to answer

APPENDIX C

Board Committee Meeting Year-End Review 2025/26

Audit and Risk Committee

1. Purpose

The Audit and Risk Committee is the principal Committee for seeking independent assurance on the general effectiveness of the Trust's internal control and risk management systems and for reviewing the structures and processes for identifying and managing key risks. It is responsible for reviewing the adequacy of all risk and control related statements prior to approval by the Board of Directors and for seeking assurances on these controls. In discharging its responsibilities, the Committee takes independent advice from the Internal Auditor or seeks any other legal or professional advice as required to discharge its responsibilities.

It achieves this by:

- Ensuring there is an effective internal audit function that provides appropriate independent assurance to the Committee, the Chief Executive and the Board of Directors
- Reviewing the work and findings of the Trust's External Auditor
- Reviewing the findings of other significant assurance functions, both internally and externally
- Reviewing the work of other committees within the organisation
- Requesting and reviewing reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control
- Reviewing and by delegated authority, approving the annual report and financial statements
- Ensuring that the systems for financial reporting to the Board, including those around budgetary control, are subject to review in order to be sure that they are complete and accurate.

Throughout the year, the Committee considers external audit reports, internal audit reports, and counter-fraud progress reports. All audit outcomes are overseen by monitoring the delivery of internal and external audit report recommendations.

The Committee considers the Board Assurance Framework, Annual Report and Annual Governance Statement and progress with internal and external audit plans. It also receives updates on losses and compensation payments, exit payments, conflicts of interest, tenders and waivers, debtors and clinical audit. The Committee also considers governance and compliance documents as well as oversight of the Trust's commercial insurances.

The Committee assesses the effectiveness of the external audit process by undertaking a self-assessment each year and by meeting with auditors in private. Auditors attend every meeting of the Committee, and the Trust's compliance with the audit plan approved by the Committee is monitored.

2. Authority

The Audit and Risk Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's strategic objectives. This includes identification, review and scrutiny of all relevant risks on the Board Assurance Framework (BAF) and reviewing of BAF management and reporting prior to formal reporting to the Trust Board. The Committee is authorised by the Board of Directors to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

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

The Committee did not identify the need to seek external legal advice or other independent professional advice during the year.

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

As a designated policy ratification group, (see Policy on Policy document) the Audit and Risk Committee is operationally responsible for monitoring that the policy documents for which it is responsible comply with the policy. This includes monitoring that the style, content and format of the policy are compliant, including completion of the Equality Impact Assessment (EIA) which forms part of the current policy template.

In 2025/26 the Committee approved the following:

- Claims Handling Policy and Procedures.

The Committee agreed a revised set of Standing Financial Instructions (SFIs) during the annual review of SFIs at its July meeting.

3. Membership of Audit and Risk Committee

The Audit and Risk Committee comprises independent Non-Executive Directors. The Committee members in 2025/26 are listed below:

Name	Title
Chioma Akpom (from 1 December 2025)	Committee Chair, Non-Executive Director
Geoff Lewins (until 30 November -2025)	Committee Chair, Non-Executive Director
Deborah Good	Non-Executive Director
Andrew Harkness	Non-Executive Director

4. Attendance

An attendance log reflects attendance by members of the Committee, as well as the Director of Corporate Affairs and Trust Secretary and Director of Finance who are required to attend routine meetings of the Committee to support the Chair and Committee members. The Director of Corporate Affairs and Trust Secretary is the nominated Lead Executive for the Committee. Other Executive Directors have attended by invitation to consider areas of risk or operation that are their responsibility.

The Chief Executive as Accountable Officer attends the annual sign of meeting at which the Annual Report and Accounts including the Annual Governance Statement were considered, as well as the opinion of the Head of Internal Audit which supports the conclusion within the Annual Governance Statement. The Trust Chair also attended the meeting to consider and approve the Annual Report and Accounts. The Lead Governor is invited to attend the meeting to observe the final approval of the Annual Report and Accounts, where they cannot attend the Committee Chair offers a follow up meeting.

The External Auditor was represented at all meetings. Internal Auditors attended all meetings of the Committee. A representative of the Counter Fraud Service attended the meetings when counter fraud reporting was scheduled. Both the Internal and External Auditors had the opportunity to meet with the Audit and Risk Committee Chair in private (without Executives present) prior to Committee meetings.

5. Access

The Head of Internal Audit, representatives of External Audit and Counter Fraud Specialist have a right of direct access to the Chair of the Committee and are aware of the channels through which this can be achieved. In practice, this has been undertaken through the private meetings held prior to each Committee meeting.

6. Frequency of Meetings

The Committee met six times throughout the year: 24 April 2025, 22 May 2025, 18 June 2025, 24 July 2025, 23 October 2025 and 23 January 2025 discharging its responsibilities as set out in the Terms of Reference. In addition, two Extra-ordinary, Confidential meetings took place on 24 April 2025 and 16 January 2026 in relation to re-appointment of the internal and external auditors.

7. Required frequency of attendance by members

According to the Committee's Terms of Reference, members should attend at least 80% of all meetings each financial year but should aim to attend all scheduled meetings. In 2025/26, the majority of members achieved in excess of 80% attendance at the meetings of the Committee. All meetings have been quorate. Below is the 2025/26 attendance log:

Audit & Risk Committee - 2025/26									
Attendance Record	**24-Apr-2025**	**22-May-2025**	**18-Jun-2025**	**24-Jul-2025**	**23-Oct-2025**	**16-Jan-2026**	**Number of meetings attended**	**Total number of meetings eligible to attend**	**%**
MEMBERS									
Chioma Akpom					1*	1	2	2	100%
Geoff Lewins	1	1	1	1	1		5	5	100%
Deborah Good	0**	0**	0**	1	1	1	3	6	50%
Andrew Harkness	1	1	1	1	1	1	6	6	100%
Ralph Knibbs	1	1	0	1	1	0	4	4	100%
EXECUTIVE ATTENDEES									
Justine Fitzjohn	1	1	1	1	1	0	5	6	83%
James Sabin	1	1	1	1	1	1	6	6	100%
* Designate member ** Authorised absence									

8. Duties and Responsibilities

The Audit and Risk Committee has an annual plan of scheduled agenda topics, along with a range of specific issues which are subject to review. A rolling programme of actions is maintained and monitored. The following subheadings, shown in italics, are copied from the Duties and Responsibilities section of the Terms of Reference of the Audit and Risk Committee (attached). The commentary underneath each subheading is drawn from a review by the Director of Corporate Affairs and Trust Secretary of the minutes of all meetings and other relevant information.

The Committee's duties and responsibilities can be categorised as follows:

9. Integrated governance, risk management and internal control

9.1 To review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities, clinical and non-clinical, that supports the achievement of the Trust's objectives.

The Committee has a forward plan that maps out the periodic review of governance, risk and controls, internally and externally (via the audit plan and programmes).

The management of risk underpins the achievement of the Trust's Strategy and related objectives. The Trust's approach to Risk Management is set out in the Risk Management Strategy 2026-2028 which comprehensively brings together the Trust's risk management approach. The Committee received an annual summary of progress against the Risk Management Strategy in October 2025.

It was agreed that annual updates will continue to be received in order to measure progress against the Risk Management Strategy. The Committee accepted the inclusion of the system-based risk impacting on and mitigated by multiple system organisations as a stand-alone risk that is now included in the BAF report for scrutiny but presented apart from risks specific to the Trust's strategic objectives. This was changed with the launch of the new Strategy in November 2024 and is now included in the Partnerships BAF risk.

The Committee receives quarterly Operational Risk Management reports.

9.2 To consider the Board Assurance Framework and high-level risks, and to comply with any request for assurance in relation to the Board Assurance Framework and the Risk Register including deep dives of risks as appropriate.

The Committee has reviewed the format and content of the Board Assurance Framework four times during 2025/26 and has challenged the adequacy of the assurances that have been received. The BAF includes risks and mitigations developed in line with the objectives which support delivery of the Trust Strategy.

The Committee was assured that the Board Assurance Framework process was reviewed, scrutinised and updated in seeking to identify and mitigate risks to achieving the Trust's strategic objectives. There were no deep dives in 2025/26.

9.3 In particular to review the adequacy and effectiveness of:

- ***all risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances.***

The Annual Governance Statement was subject to scrutiny and challenge by the Audit and Risk Committee to ensure it met the requirements as set out for the report. The Committee was assured that the report was balanced and fair.

- ***the underlying assurance processes that indicate the degree of achievement of the Trust's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.***

- ***arrangements for the effective management of clinical and corporate risk to underpin the delivery of the Trust's principal objectives.***

The Committee has a process for receiving 'Deep Dives' which provides assurance over controls and gaps in assurance with a focus on action plans to manage risks. This approach informs and supports the overall review of the BAF prior to regular submission to the Trust Board. All high and extreme clinical and corporate risks are identified and linked to the BAF risks as part of routine reporting. A six-monthly report links corporate/operational risks to BAF risks.

- ***arrangements in place for preventing and countering fraud, bribery and corruption and managing security in compliance with the related NHS Counter Fraud Authority standards.***

The Trust's Counter Fraud service was provided by 360 Assurance to the year-end. Plans were designed to provide counter-fraud, bribery and corruption work across generic areas of activity in compliance with the latest guidance and standards.

The counter fraud annual report includes the NHS Counter Fraud Authority Functional Return. 360 Assurance assured the Committee that the Trust's counter fraud, bribery and corruption arrangements are embedded. There is a strong anti-fraud, bribery and corruption culture within the Trust and the counter fraud service delivered by 360 Assurance is efficient.

The Committee receives progress reports against delivery of the work plan including compliance against the comprehensive fraud risk assessment. This assessment is also recorded and managed in line with the organisation's risk management policy and included on the appropriate risk registers.

The Committee's Executive Lead and Director of Corporate Affairs and Trust Secretary has an additional role as the Trust's Counter Champion.

- ***The Committee shall maintain an oversight of the Trust's general material control and risk management systems, including processes and responsibilities, the production and issue of any risk and control-related disclosure statements. The key record to guide the Committee's work will be the Board Assurance Framework (BAF).***

The BAF is a 'live' document and as such is regularly reviewed and updated. The Committee is responsible for reviewing the BAF to assure itself that the BAF appropriately addresses objectives and risks and also to ensure that newly arising risks are identified. The Committee has confirmed that it is satisfied that the BAF shows a clear mapping across all risks identified by the Board of Directors and that good engagement has taken place with the Executive Directors in managing the overarching Risk Register.

9.4 As part of its integrated approach, the Committee will ensure appropriate information flows, to the Committee from executive management and from and between other Board Committees, in relation to the Trust's overall internal control and risk management position.

The Audit and Risk Committee secures its oversight on assurance of effectiveness of other committees via each Committee's year-end report. Annual Effectiveness reports relating to 2024/25 were received by the Committee in April 2025. For 2025/26 they are planned for review by the Committee in April 2026. Ongoing oversight was secured from the Committee assurance summaries presented to the Trust Board. There have been escalations between Board Committees during the year.

9.5 To monitor corporate governance (eg compliance with terms of the licence, constitution, codes of conduct, standing orders, standing financial instructions, maintenance of registers of interests).

The Corporate Governance Framework was presented to the Committee at its May 2025 meeting. The Waiver of Standing Financial Instructions Register reports are received by the Committee every six months. An annual review of Standing Financial Instructions (SFIs) is built into the Forward Plan.

An external assessment under the Well Led Framework was undertaken in 2023 by the Office of Modern Governance. The assessment of the Trust's governance arrangements was a positive one. During the course of the review the Office of Modern Governance indicated they observed many elements of good or leading-edge leadership and governance practice. This was balanced by the highlighting of areas where a sharpening or subtle refocusing of the Trust approach will accelerate the journey of improvement the Trust is on. These areas were reflected in the recommendations and were built into the action plan, delivery of which was monitored by the Audit and Risk Committee. All actions are now completed.

The Trust has commissioned its next external assessment against the revised Well Led Single Assessment Framework, with preliminary work starting in March 2026. The action plan from this will be submitted to the Committee for monitoring delivery.

9.6 To develop and use an effective assurance framework to guide the Committee's work. This will include utilising and reviewing the work of the internal audit, external audit and other assurance functions as well as reports and assurances sought from directors and managers and other investigatory outcomes so as fulfil its functions in connection with these Terms of Reference.

See items 9.2-9.3 above.

10. Internal audit

10.1 To review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation.

The Trust takes a risk-based approach to developing the internal audit. The Committee has received assurance that sufficient work has been undertaken for the Head of Internal Audit opinion.

10.2 To oversee on an on-going basis the effective operation of internal audit in respect of:

- ***Adequate resourcing***
- ***Co-ordination with external audit***
- ***Meeting the Public Sector Internal Audit Standards***
- ***Providing adequate independent assurances***
- ***Having appropriate standing within the Trust***
- ***Reviewing and approving the internal audit plan ensuring that this meets the internal audit needs of the organisation.***

The Committee has a standing item on its agenda to receive a progress report from the Internal Auditors. The internal audit programme was regularly reviewed in-year to ensure that it continued to meet the internal audit needs of the organisation.

10.3 To consider the major findings of internal audit investigations and management's response and their implications and monitor progress on the implementation of recommendations.

Much of the work of the Committee is supported by the programme of work for internal audit services, provided by 360 Assurance. Services have been within an agreed work plan, prepared in consultation with the Executive Leadership Team and approved by the Committee, which seeks to ensure that reviews focus on areas of risk identified by the Trust.

The Internal Auditors progress report lists the outcomes of the completed reviews. Any Limited Assurance report is presented in full to the Committee, the Executive Director Lead is invited to attend the meeting to set out the management response and approach towards the agreed actions. Compliance against actions is monitored through the 'Pentana' system and reported in the Internal Audit Progress Report.

10.4 To consider the provision of the internal audit service, the cost of the audit.

The two year contract extension option for 360 Assurance was renewed in 2025/26 commencing on 1 April 2026.

10.5 To monitor the effectiveness of internal audit and to conduct an annual review of the internal audit function.

Reviewed as part of the annual report presented to the Committee, 360 Assurance issues client satisfaction questionnaires.

11. External audit

11.1 To make a recommendation to the Council of Governors in respect of the appointment, re-appointment and removal of an external auditor and related fees as applicable. To the extent that the recommendation is not adopted by the Council of Governors, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

The Forvis Mazars' contract was procured via direct award for three years (with a two year option for extension) commencing on 1 September 2025 and was approved by the Council of Governors.

11.2 To discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy.

Regular reporting to the Committee by the External Auditor as a standing agenda item encompasses updates on the nature and scope of the annual audit to be undertaken.

11.3 To assess the External Auditor's work and fees each year and based on this assessment, to make the recommendation above to the Council of Governors with respect to the re-appointment or removal of the Auditor. This assessment should include the review and monitoring of the External Auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.

A report is presented annually to the Council of Governors on the work of the External Auditors. A positive response was received from the Trust on the annual client satisfaction survey performed issued by Forvis Mazars.

11.4 To oversee the conduct of a market testing exercise for the appointment of an auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors with respect to the appointment of the Auditor.

See 11.1 and 11.2

11.5 To review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations.

Implementation of recommendations has been overseen as part of reporting to the Committee on internal and external audit review recommendations.

11.6 To develop and implement a policy on the engagement of the External Auditor to supply non-audit services.

This policy is in place with the External Auditors.

11.7 To consider the provision of the external audit service, the cost of the audit and any questions of resignation and dismissal of the auditors.

See items above (11.2, 11.3 11.4) relating to the provision of the External Audit service.

12. Annual accounts review

12.1 To approve the Annual Report and Accounts and Annual Governance Statement on behalf of the Trust Board. In doing so the Committee will determine their completeness, objectivity, integrity and accuracy.

In preparation for approval of the Annual Report and Accounts, the Committee reviewed the relevant disclosure statements, in particular the Annual Governance Statement, together with the Head of Internal Audit Opinion, External Audit Opinion and considered that the Annual Governance Statement was consistent with its views on the Trust's systems of internal control.

12.2 To review all accounting and reporting systems for reporting to the Board of Directors, including in respect of budgetary control.

The Committee agreed the draft accounting policies for annual accounts 2025/26 in January 2026.

13. Speaking Up

To review the adequacy of the Trust's arrangements by which Trust staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.

The Committee receives updates on the implementation of the Freedom to Speak Up (FTSU) Policy within the Trust twice a year, in October and April. The reports enable the Committee to review the robustness of policy and procedures.

The Committee agreed significant assurance in 2025/26 with the adequacy of the Trust's arrangements by which Trust staff may, in confidence, speak up about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.

14. Standing orders, standing financial instructions and standards of business conduct

14.1 To review on behalf of the Board of Directors the operation of, and proposed changes to, the standing orders and standing financial instructions, the constitution, codes of conduct and standards of business conduct; including maintenance of registers.

Apart from SFI, this requirement is covered by the Corporate Governance Framework which is reported and approved by the Committee. The Framework is comprehensively reviewed every three years but elements of it are revised more frequently, for example the annual review and approval of Committee Terms of Reference.

14.2 To examine the circumstances of any significant departure from the requirements of any of the foregoing, and whether those departures relate to a failing, an overruling or a suspension.

No significant issues were reported during the 2025/26 year. Reports of waiving of the Standing Financial Instructions and Standing Orders (where these have occurred) have been routinely reported to the Committee.

14.3 To review the scheme of delegation.

This forms part of the Corporate Governance Framework of the Trust and is reviewed periodically.

Other

14.4 To review performance indicators relevant to the remit of the Committee.

Through reporting from the auditors, the Audit and Risk Committee remained appraised of the Trust's performance in financial indicators as benchmarked against other mental health foundation trusts and the wider NHS.

14.5 To examine any other matter referred to the Committee by the Board of Directors and to initiate investigation as determined by the Committee.

The Committee asked for specific assurance around the processes for managing a risk around valproate, the Committee referred the issue to the Quality and Safeguarding Committee to consider patient safety impacts. No actions were referred to the Committee by the Board of Directors during the year.

14.6 To consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health sector and professional bodies with responsibilities that relate to staff performance and functions.

Direct oversight of regulatory reviews carried out during the year, such as those undertaken by the CQC, have remained within the remit of the Trust Board itself, with assurance for CQC reporting through the Quality and Safeguarding Committee.

14.7 To review the work of all other Trust committees in connection with the Committee's assurance function.
See 9.4 above.

14.8 The Committee may also request specific reports from individual functions within the Trust (for example, clinical audit).

Reports have been requested during the year including on-going updates on salary overpayments and processes for the supervision of staff. The Committee also received assurance on the overall 2024/25 Clinical Audit programme, its fitness for purpose and its delivery; and provided an initial view of the Clinical Audit Programme for 2025/26.

14.9 The Committee may refer specific issues to the Board, Finance and Performance Committee and other Committees and make recommendations as appropriate.

At the conclusion of every meeting the Committee discussed and agreed any necessary referrals to other Committees. These are noted on the assurance summary of the meeting presented to the Public Board meeting. Referrals are noted on the Committee's actions matrix and archived once evidence and assurance has been received that these are complete.

14.10 The Committee will receive assurance reports on Information Governance arrangements, particularly in respect to compliance with the Information Governance Toolkit and legislative compliance including the Data Protection Act and General Data Protection Regulation (GDPR).

An update on Data Security and Protection including cyber security and compliance with the Data Security and Protection Toolkit was received in May 2025 in line with the revised national reporting timetable. Significant assurance was confirmed. Reporting will continue on bi- annual basis.

14.11 Audit and Risk Committee has a specific responsibility for overseeing the management of conflicts of interest and evaluating the Trust's response to implementing the Trust's Conflict of Interest Policy. The Committee is specifically cited in the national guidance in respect of consideration of any breaches.

The Committee receives updates on compliance against the Conflicts of Interest Policy twice a year. This also includes reporting on gifts, hospitality, sponsorship and secondary employment in line with the Policy.

15. Feedback from Audit Committee Handbook survey

The Director of Corporate Affairs and Trust Secretary and Committee Chair have completed Checklist 1 from the HFMA Audit Committee handbook and this year, Members (and regular attendees) have also been invited to complete the Checklist 2 questionnaire individually. This questionnaire covers Committee processes and effectiveness. The significant majority of responses were either 'strongly agree' or 'agree' in terms of positive response. The analysis is set out in Appendices A and B.

Suggested areas for development are:

- Scope for improvement on the clarity and brevity of the information produced
- Potential improvements could be made with availability of papers via MS Sharepoint/Teams.

16. Objectives

These are now embedded in the Terms of Reference and assessed as part of the year-end effectiveness report which will be prepared for the Committee in April 2026.

The key objectives are:

- **To ensure the internal audit programme is effectively implemented and reports signed off in a timely manner.**

Measured by adherence to agreed timelines for internal audit processes as reported through internal audit plan progress reports as standing item at all Committee meetings.

- **To promote best practice across all Board Committees, building upon embedded practice and seeking continuous improvement.**

Evaluated through end of year reports and ongoing discussion at Board Committee chairs meetings during the year. Best practice across all Board Committees is a core item of business at the Board Committee Chairs meetings.

- **Ensure continued engagement/governor involvement in external audit and related Committee matters.**

See 4. The Lead Governor is invited to observe the year end account sign off meeting. The Annual Report and Accounts and report from the External Auditors is reported to the Council of Governors in September every year. Approval of the External Audit Contract is a duty of the Council of Governors, which is assisted by the Audit and Risk Committee.

- **To further embed oversight of risk within the Board Committee structure.**

The Committee has led focus on the BAF, including Deep Dives on any Extreme-rated BAF risks where required, to drive Board and Committee business to focus work on the successful delivery of the Trust's strategic objectives.

This is measured through the year-end review of Committees (April annually) to confirm embeddedness of established process in this area. Assurance summaries from Committees to the Board operated well during the year to date in their role to provide the Board with assurance on key areas of Committee business and also to escalate risk issues.

- **To ensure that robust governance processes are in place, including oversight of effective implementation of any revised governance structure arising from Trust strategy review.**

Evidenced through implementation of the framework of established activity in internal audit, external audit, assurance reporting on risk management and other internal/external reports which have given assurance to allow sign off of annual report and accounts including the Annual Governance Statement.

The Annual Governance Statement brings together all the detail on systems, controls and processes. A draft will be presented to the Committee in April 2026. The Committee has received staged reporting on the Head of Internal Audit Opinion.

- **To identify training needs of Audit and Risk Committee members and deliver appropriate training/support to enable members to be effective in their Committee role.**

The Committee Chair has attended networking events relating to their roles during the year and he also attends the JUCD Audit Committee Chairs group. Additional training and support is provided to the newest members of the Committee. The latest HMFA Audit Committee Handbook has been circulated to the Committee. Internal and External Audit circulate regular briefing relevant to the audit environment.

- **To review results from the annual Committee effectiveness report and develop actions (not covered by above) for delivery by the Committee to agreed timeframes.**

See 10 above.

- **To clarify and implement effective reporting and oversight of Data Quality**

The Committee has continued to seek periodic assurance from the IMT&R Lead that data continues to follow the rules of validation. An update report is presented every six months.

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

Although the Committee has not undertaken a specific review in 2025/26, report authors continue to complete the equality, diversity and inclusion section of the cover sheets.

- **To ensure any gaps in assurance identified in the internal audit programme are adequately covered via alternative methods such as self-effectiveness or external review.**

This will be evaluated as part of the response to the 2025/26 Head of Internal Audit Opinion and will be considered as part of approval of the 2026/27 Internal Audit Plan.

17. Freedom to Speak Up

The Audit and Risk Committee is committed to the principles of Speaking Up and actively shaping the speaking up culture. To this end the Committee has considered in carrying out this review, that it has robustly challenged itself to improve patient safety, develop a culture of continuous improvement, openness and honesty. This can be specifically evidenced through the update reports on Freedom to Speak Up received by the Committee.

18. Ongoing Assurance – Governance Best Practice

The Committee has embedded the principles of the good governance best practice and continues to follow the process contained in its annual forward planning and review of effectiveness.

19. Minutes and Reporting

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

Each meeting is formally recorded and available to all Board members.

19.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed. This will include details of any evidence of potentially ultra vires, otherwise unlawful or improper transactions, acts, omissions or practices or any other important matters. To the extent that such matters arise, the Chair of the Committee shall present details to a meeting of the Board of Directors in addition to the assurance summary.

An assurance summary is reported to the public meeting of the Board of Directors after each meeting, which summarises discussions, details assurance and actions required, as well as decisions made and identification of any key risks. Items for escalation to the Board or for referral to other Board Committees are also contained within the assurance summary.

19.3 The Committee will report annually to the Board of Directors and the Council of Governors in respect of its work in support of the annual governance statement (AGS) specifically commenting on:

- ***The assurance framework and its fitness for purpose***
- ***The effectiveness of risk management within the Trust***
- ***The integration of and adherence to governance arrangements***
- ***The appropriateness if the evidence that shows the organisation is fulfilling its regulatory requirements relating to its existence as a functioning business***
- ***The robustness of the processes behind the quality accounts; and***
- ***Any pertinent matters in respect of which the Committee has been engaged.***

The Board of Directors receives regular updates on the progress of compiling the AGS as part of the Board Committee Assurance Reports. The Committee has delegated authority from the Board to sign off the Annual Report and Accounts including the AGS Report and the sign off meeting is attended by the Chair and Chief Executive. The Committee Chair presented a summary of the Committee's Annual Report for 2024/25 to the Council of Governors in September 2025. The Trust's Annual Report and Accounts for 2024/25 were presented to the Council of Governors by Forvis Mazars, the Trust's External Auditors, in September 2025.

19.4 The Committee's annual report should also describe how the Committee has fulfilled its Terms of Reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed. The Trust's annual report shall include a section describing the work of the Committee in discharging its responsibilities.

This report outlines how the Committee has addressed all elements of its Terms of Reference during the year. The work of the Committee is included within the Annual Report. The Board takes significant assurance regarding the contents of the Annual Report and Accounts for the as overseen by the Committee.

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

The Committee reflected upon its effectiveness at the end of each meeting, the appropriateness of papers and received suggestions for improvement. Overall, members have been satisfied with the way the Committee operates and have commented on good level of debate, challenge and participation of members and attendees and chairing effectiveness. Papers have continued to improve with well-structured recommendations, contributing to holding Executive Directors to account. The Committee has continued to receive good levels of assurance and has been responsive to demand and priorities.

Board Committee Chairs discussed Committee effectiveness at their meetings held in year and were assured of key elements of governance, consistency and intelligence sharing across Committees.

20. Administrative Support

The Director of Corporate Affairs and Trust Secretary discharged her duties in support of the Audit and Risk Committee throughout the year.

21. Review of Terms of Reference

The Terms of Reference will be reviewed in April 2026 as part of the end of year reporting process and are appended to this report for further review.

22. Conclusion

The Audit and Risk Committee has continued to be a well-functioning effective Board Committee throughout 2025/26 and has provided appropriate assurance to the Board.

APPENDIX D

DRAFT

Audit and Risk Committee Terms of Reference

Purpose

This is the principal Committee for seeking independent assurance on the general effectiveness of the Trust's internal control and risk management systems and for reviewing the structures and processes for identifying and managing key risks. It is responsible for reviewing the adequacy of all risk and control related statements prior to approval by the Board and for seeking assurances on these controls. In discharging its responsibilities, the Committee takes independent advice from the Internal Auditor or seeks any other legal or professional advice as required to discharge its responsibilities.

1. Authority

1.1 The Audit and Risk Committee (the Committee) is constituted as a Committee of the Trust's Board of Directors. Its constitution and Terms of Reference are set out below and are subject to amendment at future Board of Directors meetings. The Committee shall not have executive powers in addition to those delegated in these Terms of Reference.

1.2 As a Committee of the Board, the Audit and Risk Committee has an important role to provide assurance on the progress and risks relating to the delivery of the Trust's strategic objectives which fall within the Committee's remit. This includes identification, review and scrutiny of all relevant risks on the Board Assurance Framework.

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

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

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

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

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

2. Membership

2.1 The Committee shall be composed of at least three independent Non-Executive Directors, at least one of whom should have recent and relevant financial experience.

2.2 One of the members shall be appointed Chair of the Committee by the Board of Directors.

2.3 The Trust Chair shall not be a member of the Committee (but may attend by invitation as appropriate).

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

3. Attendance

3.1 Only members of the Committee have the right to attend meetings, but the Director of Finance and Director of Corporate Affairs and Trust Secretary shall generally be invited to attend routine meetings of the Committee. Other Executive Directors and/or staff and executives shall be invited to attend those meetings in which the Committee will consider areas of risk or operation that are their responsibility and will be expected to attend as requested.

3.2 The Chief Executive, as Accountable Officer, may be invited to attend meetings and should discuss at least annually with the Committee the process for assurance that supports the governance statement. They should attend when the Committee considers the Annual Governance Statement and the annual report and accounts.

3.3 The External Auditor or their representative should normally attend meetings.

3.4 The Head of Internal Audit or their representative should also attend routine meetings.

3.5 A representative of the local Counter Fraud Service will attend at least two meetings of the Committee per year.

3.6 A governor representative may be invited to attend meetings of the Committee as an observer when the Committee considers the Annual Governance Statement and the Annual Report and Accounts.

3.7 The Director of Corporate Affairs and Trust Secretary shall be the secretary to the Committee and will provide appropriate support and advice to the Chair and the Committee members.

3.8 At least once per year the Committee Chair should meet privately with the external and Internal Auditors.

Access

3.9 The Head of Internal Audit or their representatives, representatives of External Audit and Counter Fraud Specialist have a right of direct access to the Chair of the Committee.

4. Quorum

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

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

5. Frequency of meetings

5.1 Meetings shall be held at least four times per year, the total number of meetings being determined by the assurance required by the Committee to discharge its responsibilities. The Board of Directors, Chief Executive, External Auditors or Head of Internal Audit may request an additional meeting if they consider that one is necessary.

6. Duties and Responsibilities

6.1 The Committee's duties and responsibilities can be categorised as follows:

Integrated governance, risk management and internal control

6.2 To review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities, clinical and non-clinical, that supports the achievement of the Trust's objectives.

6.3 To consider the Board Assurance Framework and high-level risks, including Deep Dives of risks as appropriate.

6.4 In particular to review the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances
- the underlying assurance processes that indicate the degree of achievement of the Trust's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- arrangements for the effective management of clinical and corporate risk to underpin the delivery of the Trust's strategic objectives
- arrangements in place for preventing and countering fraud, bribery and corruption and managing security in compliance with the related NHS Protect Standards
- the Committee has taken on the role of reviewing efforts to meet the Counter Fraud Functional Standard, and the identification and management of fraud risks
- The Committee shall maintain an oversight of the Trust's general material control and risk management systems, including processes and responsibilities, the production and issue of any risk and control-related disclosure statements. The key record to guide the Committee's work will be the Board Assurance Framework (BAF).

6.5 As part of its integrated approach, the Committee will ensure appropriate information flows, to the Committee from executive management and from and between other Board Committees, in relation to the Trust's overall internal control and risk management position.

6.6 To monitor corporate governance (eg compliance with terms of the licence, constitution, codes of conduct, standing orders, standing financial instructions, maintenance of registers of interests and adequacy of commercial insurance cover).

6.7 To develop and use an effective assurance framework to guide the Committee's work. This will include utilising and reviewing the work of the internal audit, external audit and other assurance functions as well as reports and assurances sought from directors and managers and other investigatory outcomes so as fulfil its functions in connection with these Terms of Reference.

Internal audit

6.8 To review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation.

6.9 To oversee on an ongoing basis the effective operation of internal audit in respect of:

- Adequate resourcing
- Co-ordination with external audit
- Meeting the Public Sector Internal Audit Standards
- Providing adequate independent assurances
- Having appropriate standing within the Trust
- Reviewing and approving the internal audit plan ensuring that this meets the internal audit needs of the organisation.

6.10 To consider the major findings of internal audit investigations and management's response and their implications and monitor progress on the implementation of recommendations.

6.11 To consider the provision of the internal audit service and the cost of the audit.

6.12 To monitor the effectiveness of internal audit and to conduct an annual review of the internal audit function.

External audit

6.13 To make a recommendation to the Council of Governors in respect of the appointment, re-appointment and removal of an External Auditor and related fees as applicable. To the extent that the recommendation is not adopted by the Council of Governors, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

6.14 To discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy.

6.15 To assess the External Auditor's work and fees each year and based on this assessment, to make the recommendation above to the Council of Governors with respect to the re-appointment or removal of the Auditor. This assessment should include the review and monitoring of the External Auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.

6.16 To oversee the conduct of a market testing exercise for the appointment of an auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors with respect to the appointment of the Auditor.

6.17 To review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations.

6.18 To develop and implement a policy on the engagement of the External Auditor to supply non-audit services.

6.19 To consider the provision of the external audit service, the cost of the audit and any questions of resignation and dismissal of the auditors.

Annual accounts review

6.20 To approve the Annual Report and Accounts and Annual Governance Statement on behalf of the Trust Board. In doing so the Committee will determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

- The meaning and significance of the figures, notes and significant changes
- Changes in, and compliance with the accounting policies, practices and estimation techniques
- Areas where judgment has been exercised
- Explanation of estimates or provisions having material effect
- Explanations for significant variances
- The schedule of losses and special payments
- Significant adjustments in the preparation of the financial statements and any unadjusted statements
- Any reservations and disagreements between the External Auditors and management which have not been satisfactorily resolved
- Compliance with the Annual Reporting Manual requirements for the content of the annual report as published by NHS England.

6.21 To review all accounting and reporting systems for reporting to the Board of Directors, including in respect of budgetary control.

Freedom to Speak Up (Raising Concerns including Protected Disclosures)

6.22 To review the adequacy of the Trust's arrangements by which Trust staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.

Standing orders, standing financial instructions and standards of business conduct

6.23 To review on behalf of the Board of Directors the operation of, and proposed changes to, the standing orders and standing financial instructions, the constitution, codes of conduct and standards of business conduct; including maintenance of registers.

6.24 To examine the circumstances of any significant departure from the requirements of any of the foregoing, and whether those departures relate to a failing, an overruling or a suspension.

6.25 To review the scheme of delegation.

Other

6.26 To review performance indicators relevant to the remit of the Committee.

6.27 To examine any other matter referred to the Committee by the Board of Directors and to initiate investigation as determined by the Committee.

6.28 To consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health sector and professional bodies with responsibilities that relate to staff performance and functions.

6.29 To review the work of all other Trust committees in connection with the Committee's assurance function.

6.30 The Committee may also request specific reports from individual functions within the Trust (for example, clinical audit).

6.31 The Committee may refer specific issues to the Board, Finance and Performance Committee and other Committees and make recommendations as appropriate.

6.32 The Committee will receive assurance reports on Data Security and Protection arrangements, particularly in respect to compliance with the Data Security and Protection Toolkit and legislative compliance including the Data Protection Act and General Data Protection Regulations.

6.33 Audit and Risk Committee has a specific responsibility for overseeing the management of conflicts of interest and evaluating the Trust's response to implementing the Trust's Conflict of Interest Policy. The Committee is specifically cited in the national guidance in respect of consideration of any breaches.

6.34 Responsibility for the oversight of data quality assurance.

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

7. Minutes and Reporting

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

7.2 An assurance summary will be prepared and submitted to the Board of Directors and shall include details of any matters to be escalated in respect of which actions or improvements are needed. This will include details of any evidence of potentially *ultra vires*, otherwise unlawful or improper transactions, acts, omissions or practices or any other important matters. To the extent that such matters arise, the Chair of the Committee shall present details to a meeting of the Board of Directors in addition to the assurance summary.

7.3 The Committee will report annually to the Board of Directors and the Council of Governors in respect of its work in support of the Annual Governance Statement, specifically commenting on:

- The assurance framework and its fitness for purpose
- The effectiveness of risk management within the Trust
- The integration of and adherence to governance arrangements
- The appropriateness of the evidence that shows the organisation is fulfilling its regulatory requirements relating to its existence as a functioning business
- The robustness of the processes behind the quality accounts
- Any pertinent matters in respect of which the Committee has been engaged.

7.4 The Committee's annual report should also describe how the Committee has fulfilled its Terms of Reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed. The Trust's annual report shall include a section describing the work of the Committee in discharging its responsibilities.

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

8. Administrative Support

8.1 The Committee shall be supported by the Director of Corporate Affairs and Trust Secretary whose duties in this regard include, but are not limited to:

- Agreement of the agenda with the Chair of the Committee and attendees
- Agendas and papers will be distributed in accordance with deadlines agreed with the Committee Chair. Ideally, this should be no less than three working days, although flexibility will be maintained for extra-ordinary circumstances
- Ensuring that those required to attend are invited to the meeting in good time
- Ensuring that the minutes are taken and keeping a record of matters arising and issues to be carried forward
- Manage the forward plan of the Committee's work
- Arranging meetings for the Chair with directors and advisers as necessary

- Advising the Committee as appropriate on pertinent issues/areas of interest/policy developments
- Enabling training and development of Committee members as appropriate
- Reviewing every decision to suspend the standing orders.

9. Review of Terms of Reference

The Terms of Reference of the Committee shall be reviewed at least annually.

Approved by Audit and Risk Committee	23 April 2026
Approved by the Board of Directors	19 May 2026

Appendix 3

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 19 May 2026

Trust Sealings

Purpose of Report

This report provides the Trust Board with a six-month update of the authorised use of the Trust Seal since the last report to the Board on 25 November 2025.

Executive Summary

The Trust's Standing Financial requires deeds and contracts relating to the disposal, acquisition or leasing of land or property to be executed under the Common Seal of the Trust.

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

A report on use of the seal was last made to the Board on 25 November 2025. Since the last report, the Trust Seal was used as follows:

- DHCFT/137 – (16 December 2025) – Transfer of deed of grant relating to Site 2, manor Kingsway Hospital, Derby DE22 3LZ between 1) Homes and Communities Agency, 2) Tilia Partnership Homes Ltd, 3) Derbyshire Healthcare NHS Foundation Trust
- DHCFT/138 – (16 December 2025) – Licence to use Suite 4 at the property Cromwell Business Centre, High Street, Chapel-en-le-Frith between1) Trustees of the Frith Estates Pension Scheme, 2) Derbyshire Healthcare NHS Foundation Trust
- DHCFT/139 – (16 December 2025) – Minor works contract for re-instatement of existing contractors car park at Chesterfield Royal Hospital S44 5BL between 1) Derbyshire Healthcare NHS Foundation Trust, 2) Peak Surveying & Engineering Ltd
- DHCFT/140 – 27/1/26 – Disposal of strip of land at Kingsway Hospital between 1) Homes and Communities Agency, 2) Tilia Partnership Homes Ltd., 3) Derbyshire Healthcare NHS Foundation Trust.

Strategic Considerations		**BAF Risk (eg 1A)**	**Strategic Delivery Plan Reference**
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	N/A	N/A
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X	N/A	N/A
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X	N/A	N/A
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	N/A	N/A

Risks and Assurances

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

Consultation

N/A.

Governance or Legal Issues

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

Net Zero Duty Implications

In compliance with the NHS move towards net zero carbon emissions, the Trust must consider statutory emissions and environmental targets in their decisions. Reports should identify related impacts on workforce and system leadership; sustainable models of care; digital transformation; travel and transport estates and facilities (including capital projects, asset management and utilities, green space and biodiversity); medicines; supply chain and procurement; food and nutrition and adaptation.

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

The Trust amended its standing financial instructions to reduce the number of documents requiring sealing which reduced printing and postage requirements.

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

Recommendations

The Board of Directors is requested to note the authorised use of the Trust Seal since the last report to the Board on 25 November 2025 and receive full assurance that this has been undertaken in accordance with the Standing Financial Instructions and Standing Orders of the Board of Directors.

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

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

Emma Warrilow
Personal Assistant

Continuation of Services Condition 7 – availability of resources – 2025/26

Declaration:

After making enquiries, the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months (2025/26).

Rationale for above declaration:

Primary evidence is contained in the Going Concern assessment which has been considered by the Audit and Risk Committee. This assessment is based solely on the anticipated future provision of our services in the public sector in line with current guidance. This decision will be reviewed each year in order to ensure that accounts are prepared on an appropriate basis given prevailing circumstances at the time. The Trust's financial management arrangements, overseen by Finance and Performance Committee. This is described in full along with mitigating actions in the Board Assurance Framework.

Selina Ulla
Trust Chair

Mark Powell
Chief Executive

Public Sector Equality Duty (PSED) Annual Report 2025/26
Gender, Ethnicity and Disability Pay Gap Report (March 2025)

Purpose of Report

This report provides the Board of Directors with an overview of the Trust's statutory equality reporting, including the Public Sector Equality Duty (PSED) Annual Report 2025/26 and the Gender, Ethnicity and Disability Pay Gap Report (March 2025). It outlines how the Trust is meeting its obligations under the Equality Act 2010 and improving workforce equality outcomes.

Executive Summary

Gender Pay Gap Report

This report presents the Trust's Gender Pay Gap (GPG) position at 31 March 2025, in line with statutory reporting requirements. It also includes voluntary reporting on ethnicity and disability pay gaps to support the organisation's wider commitment to equality, diversity and inclusion (EDI).

The Trust continues to demonstrate a **narrowing median gender pay gap**, which has reduced from 7.81% in 2024 to **5.28% in 2025**, indicating improved pay equity across the workforce. However, the **mean gender pay gap has marginally increased** to **15.99% (from 15.51%)**, reflecting the continued impact of workforce composition, particularly the concentration of women in lower pay quartiles.

The workforce remains predominantly female (79%) and this structural imbalance continues to be the primary driver of the pay gap. Women are over-represented in lower pay bands and under-represented in the highest pay quartile, highlighting the ongoing need to support progression into senior roles while also improving gender balance across all levels.

The **bonus pay gap remains significant (mean 85.78%)**, largely driven by historic clinical excellence awards, which disproportionately benefit a small number of senior male medical staff. While improvements have been made to ensure fairer allocation processes, legacy impacts continue to influence the current position.

The report on ethnicity pay gap shows a **mixed picture for ethnicity pay**, with a median gap of **7.25% favouring White staff**, but a mean gap of **-7.23% favouring BME staff**, largely influenced by the Medical workforce. When excluding Medical roles, the gap reverses, indicating underlying disparities that require further analysis.

For disability, there is **no median pay gap**, which is positive; however, a **mean gap of 4.9% persists** and data completeness remains a key limitation due to underreporting.

The Trust recognises that **data quality, workforce composition and progression opportunities** are key factors influencing pay gaps. A targeted action plan is in place focusing on:

- equitable recruitment and starting salaries
- improving diversity data completeness
- strengthening inclusive recruitment practices
- supporting progression of underrepresented groups
- expanding flexible working opportunities
- enhancing staff engagement and inclusive culture.

Overall, while progress is evident, particularly in reducing the median gender pay gap, **sustained and targeted action is required** to address structural inequalities, improve representation at senior levels and ensure long-term reduction across all pay gap measures.

Public Sector Equality Duty (PSED) Annual Report 2025/26

This report outlines the Trust's progress in meeting its statutory obligations under the Equality Act 2010 and demonstrates its commitment to embedding EDI across all aspects of service delivery and employment. The Trust has made clear and visible progress in strengthening its EDI infrastructure, with a strong focus on anti-racism, inclusive culture, and improving workforce equality. Governance arrangements are established and oversight is provided through Board committees and Executive leadership.

Key Achievements

- **Strengthened anti-racism approach**, including a Board statement, dedicated leadership and implementation of a new racist incident response process
- **Improved staff voice and engagement** through active staff networks, safe spaces and lived experience reporting
- **Enhanced recruitment and workforce practices**, including EDI checks in recruitment panels and ongoing review of Recruitment Inclusion Guardians
- **Targeted action on career progression** for ethnic minority and disabled staff
- **Investment in training and culture**, including Inclusive Intercultural Communication and Active Bystander programmes
- **Progress in creating psychologically-safe environments**, supported by Freedom to Speak Up and anonymous reporting mechanisms.

Workforce Insights

- Workforce is predominantly female (79%) and White (74%), with 25% from ethnic minority backgrounds
- Recruitment data shows strong diversity in applications (81% from ethnic minority groups) but lower conversion to appointments (30%), indicating ongoing inequality in outcomes
- Disability declaration remains relatively low (12%), with a notable proportion of undeclared data, limiting insight
- Training compliance is high overall (93.7%) but slightly lower for some minority groups.

Key Risks and Challenges

- Persistent inequalities in recruitment outcomes and career progression for under-represented groups
- Incomplete workforce data (eg disability, protected characteristics) limiting full analysis and targeted action
- Need to further embed EDI into core operational and leadership accountability frameworks.

Governance and Assurance

- Robust reporting mechanisms in place (WRES, WDES, Gender Pay Gap, PSED)
- Oversight provided through the Trust Delivery Group, People and Culture Committee and Executive Leadership Team
- Regular feedback loops via staff networks and engagement forums.

Conclusion

The Trust is moving beyond compliance toward a more proactive and embedded EDI approach. While strong foundations are in place, continued focus is required on addressing workforce inequalities, improving data quality, and ensuring measurable impact on both staff experience and patient outcome.

Strategic Considerations		BAF Risk (eg 1A)	Strategic Delivery Plan Reference
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	2a	2.3
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

There is a continued risk of persistent pay gaps and inequities in career progression across the workforce. This is compounded by incomplete workforce data, which limits the organisation's ability to generate insight and take targeted, evidence-based action.

Assurance is provided through strengthened EDI governance arrangements and enhanced Board oversight. Targeted action plans linked to pay gap findings are being actively delivered, alongside ongoing staff engagement through networks and forums to inform and shape improvements.

Consultation

This PSED has been informed by engagement with Staff Networks, EDI working groups and stakeholders. The gender pay gap report and actions will be held at the EDI working group and have engagement through the staff networks.

The paper was shared with the People and Culture Committee on 29 April 2026.

Governance or Legal Issues

This report ensures compliance with the Equality Act 2010 and the Public Sector Equality Duty. It supports the Trust's statutory requirement to publish equality information and demonstrate progress against equality objectives.

Net Zero Duty Implications

In compliance with the NHS move towards net zero carbon emissions, the Trust must consider statutory emissions and environmental targets in their decisions. Reports should identify related impacts on workforce and system leadership; sustainable models of care; digital transformation; travel and transport estates and facilities (including capital projects, asset management and utilities, green space and biodiversity); medicines; supply chain and procurement; food and nutrition and adaptation.

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

N/A.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

The Trust has identified areas where further improvement is required, particularly in relation to workforce data, inclusion, and equitable outcomes. These risks will be managed through the delivery of targeted action plans, ongoing monitoring, and strengthened governance arrangements. Overall, the report demonstrates a clear commitment to reducing inequalities, improving staff experience, and ensuring fair and inclusive practices across the organisation.

Recommendations

The Board of Directors is requested to:

1. Take significant assurance in the progress that has been made in reducing the median gender pay gap and the key achievements across EDI as highlighted in the PSED report
2. Take limited assurance on the long term reduction across all pay gap measures due to the need for sustained and targeted action.

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

Report prepared by: **Shaminder Uppal**
Head of EDI

Alex Wright
EDI Officer

Derbyshire Healthcare
NHS Foundation Trust

Gender Pay Gap report

2025/26 (data extract as at 31 March 2025)

www.derbyshirehealthcareft.nhs.uk

DHCFT DERBYSHCFT NHS_DERBYSHIREHEALTHCARE

Background

Since the Equality Act 2010 (Specific Duties) Regulations 2011 (SDR) came into force on 10 September 2011, there has been a duty for public bodies with 150 or more employees to publish information on the diversity of their workforce. Although the SDR did not require mandatory gender pay gap (GPG) reporting, the Government Equalities Office (GEO) and the Equality and Human Rights Commission (EHRC) provided guidance that made it clear that employers should consider including GPG information in the data they already publish. It was evident that not all employers did this, so the government made GPG reporting mandatory by amending the SDR so that all public sector employers with more than 250 employees have to measure and publish their gender pay gaps.

Employers with 250 employees and over need to publish the following information annually for all employees who are employed under a contract of employment, a contract of apprenticeship or a contract personally to do work. This will include those under Agenda for Change terms and conditions, Medical staff and very senior managers. All calculations are made relating to the pay period in which the snapshot day falls. For this seventh year of publication, it will be the pay period including 31 March 2025.

Employers will need to:

- calculate the hourly rate of ordinary pay relating to the pay period in which the snapshot day falls
- calculate the difference between the mean hourly rate of ordinary pay of male and female employees, and the difference between the median hourly rate of ordinary pay of male and female employees
- calculate the difference between the mean (and median) bonus pay paid to male and female employees
- calculate the proportions of male and female employees who were paid bonus pay
- calculate the proportions of male and female employees in the lower, lower middle, upper middle and upper quartile pay bands by number of employees rather than rate of pay.

Ordinary pay includes:

- basic pay
- paid leave, including annual, sick, maternity, paternity, adoption or parental leave (except where an employee is paid less than usual or nothing because of being on leave)
- area and other allowances
- shift premium pay, defined as the difference between basic pay and any higher rate paid for work during different times of the day or night
- pay for piecework.

It does not include:

- remuneration referable to overtime
- remuneration referable to redundancy or termination of employment
- remuneration in lieu of leave
- remuneration provided otherwise than in money.

The relevant pay period means the pay period within which the snapshot date falls, which for monthly-paid staff would be the month in which the date is included.

Bonus pay relates to performance, productivity, incentive, commission or profit-sharing, but excludes:

- remuneration referable to overtime
- remuneration referable to redundancy
- remuneration referable to termination of employment.

Doctors' clinical distinction/excellence awards will be regarded as bonus pay, as well as any other payments above the level of ordinary for performance or expertise such as performance related pay for very senior managers, long service awards and others. The relevant period means the period of 12 months ending with the snapshot date.

Calculating the quartiles

Determine the hourly rate of pay and then rank the relevant employees in rank order from the lowest to the highest.

Divide those employees into four sections, each comprising an equal number of employees to determine the lower, lower middle, upper middle and upper quartile pay bands.

Show the proportion of male and female employees in each band as a percentage of the total employees in each band.

What employers need to publish

The information outlined above will need to be published within one year of the date for the 2025 snapshot (publishing deadline of 30 March 2026 for data at 31 March 2025).

The information must be published on a website that is accessible to employees and the public free of charge. The information should remain on the website for a period of at least three years beginning with the date of publication.

In addition, employers have the option to provide narrative that will help people to understand why a gender pay gap is present and what the organisation intends to do to close it.

During the first publication employers will have already registered with the government online reporting service to submit their GPG results.

Colleagues from the Electronic Staff Record (ESR) continue to refine the tool that helps organisations nationally to calculate their GPG data.

The 2025 Gender Pay Gap (GPG) results for Derbyshire Healthcare NHS FT are detailed below:

GPG results as at 31 March 2025:

Gender	Average Hourly Rate	Median Hourly Rate
Male	£24.46	£20.16
Female	£20.55	£19.09
Difference	£3.91	£1.06
Pay Gap %	**15.99%**	**5.28%**

The mean pay gap indicates that for every £1.00 a man makes, a woman makes £0.84 pence.

The median pay gap indicates that for every £1.00 a man makes, a woman makes £0.95 pence.

The median pay gap has decreased to 5.28% in 2025 from 7.81% in 2024.

The mean pay gap has increased slightly from 15.51% in 2024 to 15.99% in 2025.

There is a £3.91 mean pay gap between men and women and a £1.06 median pay gap which shows the importance of continuing to try to ensure proportionate representation of gender across the Trust.

It is positive that the median pay gap has continued to decrease further, following the first decrease in three years in 2024. It is worth noting that both the median and mean can change depending on fluctuations in the workforce. The mean can be influenced by high and low salaries as this is the average hourly rate of pay.

As of March 2025, the organisation is made up of 3,474 staff, 2,753 females and 721 males. As the organisation is made up of 79.24% females, there is still a high percentage of women in the lower quartiles (see tables below) where pay is lower and outliers in high pay can impact on this mean. The median is a good judge of distribution of pay so it is positive that this has decreased further in the past 12 months. The median is not impacted by high salary outliers.

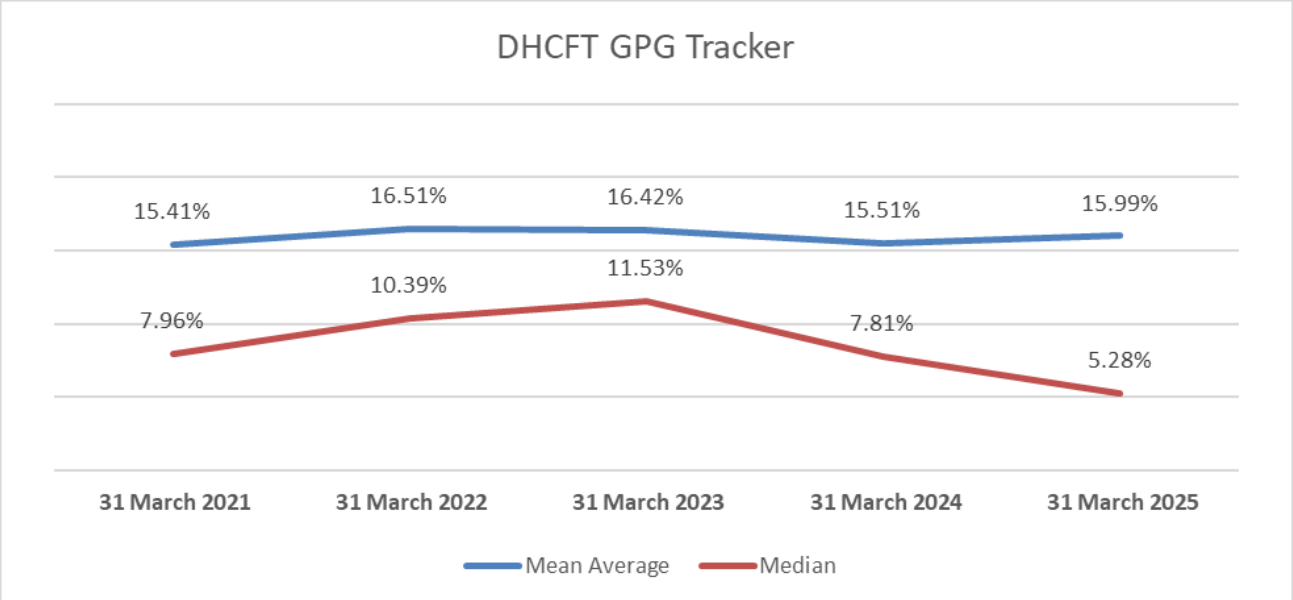
A comparison of 2024 v 2025 Gender Pay Gap results for Derbyshire Healthcare NHS FT is detailed below:

31 March 2024		
Gender	Average Mean Hourly Rate	Median Hourly Rate
Male	£22.91	£19.63
Female	£19.35	£18.10
Difference	£3.55	£1.53
Pay Gap %	15.51%	7.81%

31 March 2025		
Gender	Average Mean Hourly Rate	Median Hourly Rate
Male	£24.46	£20.16
Female	£20.55	£19.09
Difference	£3.91	£1.06
Pay Gap %	15.99%	5.28%

Variation	
Average Mean Hourly Rate	Median Hourly Rate
£1.55	£0.53
£1.20	£1.00
£0.36	-£0.47
0.48%	-2.54%

Annual tracker



Quartiles

Quartile	Female	Male	Female %	Male %	Totals
1	722	136	84.15	15.85	858.00
2	631	165	79.27	20.73	796.00
3	776	174	81.68	18.32	950.00
4	624	246	71.72	28.28	870.00

Q1 = Lowest, Q4 = Highest

31 March 2024

Quartile	Female	Male	Female %	Male %
1	716	131	84.53	15.47
2	699	165	80.90	19.10
3	700	158	81.59	18.41
4	617	241	71.91	28.09

31 March 2025

Quartile	Female	Male	Female %	Male %
1	722	136	84.15	15.85
2	631	165	79.27	20.73
3	776	174	81.68	18.32
4	624	246	71.72	28.28

Variation

Female %	Male %
-0.38	0.38
-1.63	1.63
0.10	-0.10
-0.19	0.19

The tables above highlight the proportion of women across the organisation, and this distribution has a direct impact on the gender pay gap. By creating a more equal distribution this is likely to reduce the gender pay gap.

Since 2024, the number of males and females has increased across three out of four quartiles, demonstrating the growth of the organisation as a whole. The proportion of men has increased in the lower quartiles since 2024 but slightly reduced in the third. This shows that more males have been appointed in the under-represented lower pay bands since last year. The proportion of women in the upper quartile has very slightly decreased from 71.91% in 2024 to 71.72%.

Proportion of females and males in each quartile over a period of five years

	31/03/2021		31/03/2022		31/03/2023		31/03/2024		31/03/2025	
Quartile	Female %	Male %	Female %	Male %	Female %	Male %	Female %	Male %	Female %	Male %
1	83.75	16.25	84.35	15.65	85.71	14.29	84.53	15.47	84.15	15.85
2	80.84	19.16	79.89	20.11	79.34	20.66	80.9	19.1	79.27	20.73
3	79.54	20.46	81.86	18.14	81.64	18.36	81.59	18.41	81.68	18.32
4	71.21	28.79	71.94	28.06	71.02	28.98	71.91	28.09	71.72	28.28

In order to improve the gap, more work must be done to ensure women progress through the pay bands and to continue to attract males into roles where they are under-represented in the lower quartiles. The highest pay band still has the highest proportion of male employees compared to the lower bands. Women remain under-represented in this quartile and over-represented in the lower quartile.

Bonus Gap

There are currently two types of bonus payments at Derbyshire Healthcare, the clinical excellence and long service awards. The variation of the bonus pay gaps can depend on who is eligible for each award and is not linked to previous year's payments.

The bonus pay gap mean was 85.78% and there is no median gap.

GPG Bonus results as of 31 March 2025:

Gender	Total Avgerage Bonus Pay	Total Median Bonus Pay
Male	£3,907.16	£200.00
Female	£555.56	£200.00
Difference	£3,351.60	£0.00
Pay Gap %	**85.78%**	**0.00%**

To gain a clearer understanding, bonuses have then broken down to illustrate the difference in Doctors' clinical excellence awards and long service awards.

Clinical Excellence Awards

Gender	Avgerage Bonus Pay	Median Bonus Pay
Male	£12,940.17	£6,032.04
Female	£3,622.24	£3,317.59
Difference	£9,317.93	£2,714.46
Pay Gap %	**72.01%**	**45.00%**

Long Service Awards

Gender	Avgerage Bonus Pay	Median Bonus Pay
Male	£237.50	£200.00
Female	£254.90	£200.00
Difference	-£17.40	£0.00
Pay Gap %	**-7.33%**	**0.00%**

Gender Pay Gap Bonus

31 March 2024

Gender	Average Mean Bonus Pay	Median Bonus Pay
Male	£3,553.28	£300.00
Female	£762.58	£200.00
Difference	£2,790.70	£100.00
Pay Gap %	**78.54%**	**33.33%**

31 March 2025

Gender	Average Mean Bonus Pay	Median Bonus Pay
Male	£3,907.16	£200.00
Female	£555.56	£200.00
Difference	£3,351.60	£0.00
Pay Gap %	**85.78%**	**0.00%**

Variation

Average Mean Bonus Pay	Median Bonus Pay
£353.88	-£100.00
-£207.02	£0.00
£560.90	-£100.00
7.24%	**-33.33%**

Clinical Excellence Awards

31 March 2024

Gender	Average Mean Bonus Pay	Median Bonus Pay
Male	£8,770.57	£3,546.03
Female	£4,433.84	£3,546.03
Difference	£4,336.74	£0.00
Pay Gap %	**49.45%**	**0.00%**

31 March 2025

Gender	Average Mean Bonus Pay	Median Bonus Pay
Male	£12,940.17	£6,032.04
Female	£3,622.24	£3,317.59
Difference	£9,317.93	£2,714.46
Pay Gap %	**72.01%**	**45.00%**

Variation

Average Mean Bonus Pay	Median Bonus Pay
£4,169.60	£2,486.01
-£811.60	-£228.45
£4,981.20	£2,714.46
22.56%	**45.00%**

Long Service Awards

31 March 2024

Gender	Average Mean Bonus Pay	Median Bonus Pay
Male	£242.00	£200.00
Female	£241.00	£200.00
Difference	£1.00	£0.00
Pay Gap %	**0.41%**	**0.00%**

31 March 2025

Gender	Average Mean Bonus Pay	Median Bonus Pay
Male	£237.50	£200.00
Female	£254.90	£200.00
Difference	-£17.40	£0.00
Pay Gap %	**-7.33%**	**0.00%**

Variation

Average Mean Bonus Pay	Median Bonus Pay
-£4.50	£0.00
£13.90	£0.00
-£18.40	£0.00
-7.74%	0.00%

The table shows a variation due to the clinical excellence awards and long service awards. The Trust has worked on reducing the gap by applying these awards consistently now. The gaps, in the main, are caused by legacy payments.

The bonus pay gap was mainly due to the clinical excellence awards and this can be associated with some large outlier payments to males based on honouring historic entitlements which increase this gap. During Covid in 2020, the Clinical Excellence Awards started being divided equally between eligible consultants at DHcFT, the existing gap is mainly due to a number of consultants receiving the award based on the historical process.

The bonus gap for long service awards is -7.33% and there is no median gap so this indicates that the scheme is administered consistently.

We will continue to monitor bonus payments and how these are paid to ensure fairness particularly in our clinical excellence awards which tends to cause the bigger gap.

DHcFT overall mean and median bonus gap based on hourly rates of pay

	2021	2022	2023	2024	2025
Mean bonus gender pay gap	89.54%	87.62%	68.93%	78.54%	85.78%
Median bonus gender pay gap	88.93%	50.00%	95.71%	33.33%	0.00%

NB: Bonuses paid relate to clinical excellence awards (including long service?) which are for applicable consultants only rather than all employees (even though the calculation includes all staff)

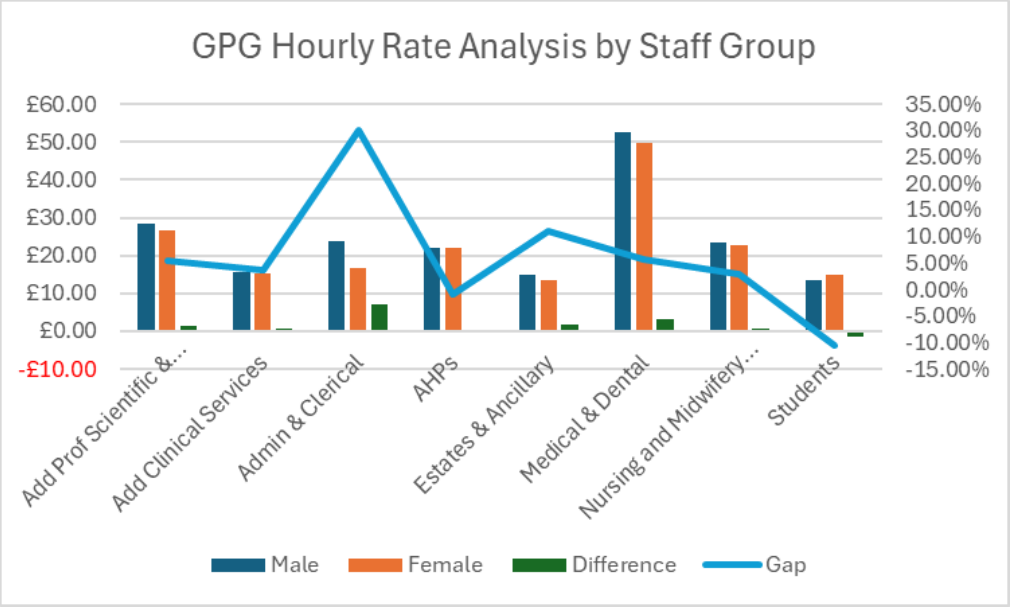
Further GPG Hourly Rate analysis as at 31 March 2025

By Staff Group

Staff Group	Male	Female	Diff	Gap
Add Prof Scientific and Technic	£28.31	£26.80	£1.51	5.34%
Additional Clinical Services	£15.69	£15.13	£0.56	3.56%
Administrative and Clerical	£23.75	£16.62	£7.12	30.00%
Allied Health Professionals	£21.86	£22.03	-£0.17	-0.79%
Estates and Ancillary	£15.07	£13.42	£1.65	10.98%
Medical and Dental	£52.65	£49.59	£3.06	5.81%
Nursing and Midwifery Registered	£23.27	£22.57	£0.70	3.00%
Students	£13.38	£14.79	-£1.41	-10.55%

By Service Line

Service Area	Male	Female	Diff	Gap
Adult Care Acute	£27.39	£20.49	£6.90	25.18%
Adult Care Community	£25.91	£21.06	£4.85	18.72%
Central (L3)	£35.66	£25.30	£10.36	29.05%
Children's Services	£23.18	£20.82	£2.35	10.16%
Clinical Quality Directorate	£29.28	£26.91	£2.37	8.10%
Clinical Serv Management	£14.65	£14.59	£0.06	0.43%
Corporate Central	£18.81	£18.92	-£0.11	-0.58%
Delivery, Strategy, Performance & Transformation	£43.30	£33.77	£9.53	22.01%
Estates + Facilities	£16.56	£13.83	£2.73	16.47%
F+R and Specialist Services	£23.71	£20.94	£2.77	11.70%
Finance, Contracting & Procurement	£24.47	£21.28	£3.19	13.02%
Med Education & CRD	£30.12	£22.32	£7.81	25.92%
Neuro Developmental	£21.55	£21.40	£0.15	0.70%
Older Peoples Care	£26.53	£19.47	£7.05	26.58%
Ops Support	£23.02	£19.39	£3.63	15.77%
People + Inclusion	£22.22	£25.01	-£2.79	-12.58%
Psychology	£29.43	£25.46	£3.98	13.51%
Training	£13.38	£15.47	-£2.09	-15.62%
Trust Directorate	£46.87	£32.24	£14.63	31.22%



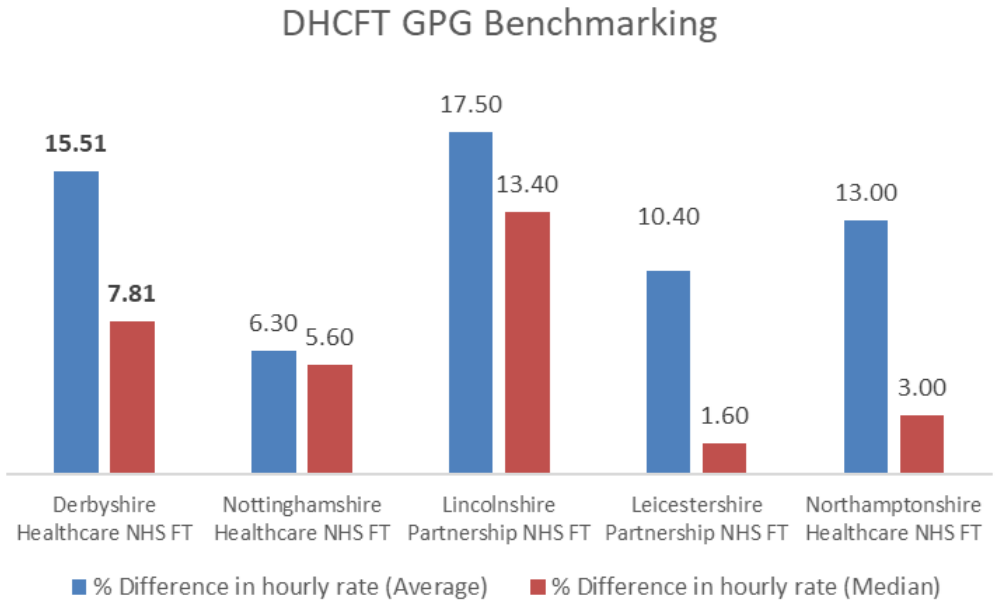
We plan to further analyse the gap by staff group by performing further “deep dive” analyses to understand why the gap is more significant among certain staff groups.

Benchmarking (latest available benchmarking data 31 March 2024):

The following table shows the Trust compares compared to similar NHS provider trusts from data published in 2024 as at the time of publishing 2025 data is unavailable.

Employer	% Difference in hourly rate (Average)	% Difference in hourly rate (Median)	% Women in lower pay quartile	% Women in lower middle pay quartile	% Women in upper middle pay quartile	% Women in top pay quartile	% Who received bonus pay (Women)	% Who received bonus pay (Men)	% Difference in bonus pay (Mean)	% Difference in bonus pay (Median)
Derbyshire Healthcare NHS FT	**15.51**	**7.81**	84.53	80.90	81.59	71.91	6.80	2.50	78.54	33.33
Nottinghamshire Healthcare NHS FT	**6.30**	**5.60**	75.40	69.40	76.90	72.30	100.00	100.00	11.81	0.00
Lincolnshire Partnership NHS FT	**17.50**	**13.40**	88.40	82.40	80.20	75.40	0.50	4.60	55.61	0.00
Leicestershire Partnership NHS FT	**10.40**	**1.60**	82.00	80.40	84.10	75.30	8.90	12.60	70.90	25.90
Northamptonshire Healthcare NHS FT	**13.00**	**3.00**	87.00	82.00	84.00	77.00	18.00	27.00	46.00	60.00

Source: *GOV.UK*



Compared with neighbouring organisations, Derbyshire Healthcare NHS Foundation Trust shows a relatively higher mean hourly pay difference (15.51%), which is greater than that reported by Nottinghamshire Healthcare NHS Foundation Trust (6.3%), Leicestershire Partnership NHS Trust (10.4%), and Northamptonshire Healthcare NHS Foundation Trust (13%), but slightly lower than Lincolnshire Partnership NHS Foundation Trust (17.5%).

However, Derbyshire's median difference (7.81%) sits mid-range, being higher than Nottinghamshire (5.6%), Leicestershire (1.6%) and Northamptonshire (3%), but lower than Lincolnshire (13.4%). This suggests Derbyshire's typical pay gap is moderate relative to peer organisations, even though the mean difference is comparatively higher.

Ethnicity and Disability Pay Reporting

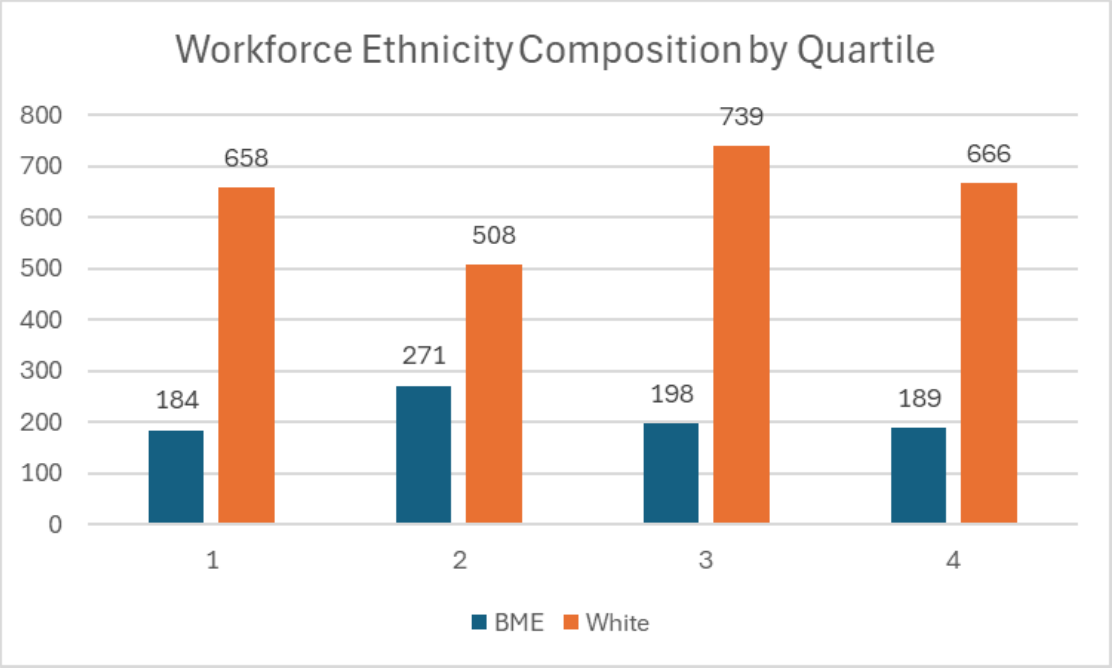
In the absence of legislation, the trust has voluntarily compiled the below ethnicity and disability pay gap reporting, as part of the organisation's approach to improve inclusion and tackle inequality in the workplace.

With more year-on-year data, the Trust will be in a better position to explore the ethnicity and disability pay gap trends and subsequently address it through impactful interventions.

EPG results as at 31 March 2025:

Ethnicity	Average Hourly Rate	Median Hourly Rate
White	£20.99	£19.91
BME	£22.50	£18.46
Difference	-£1.52	£1.44
Pay Gap %	-7.23%	7.25%

Quartile	BME	White	BME %	White %	Totals
1	184	658	21.85	78.15	842.00
2	271	508	34.79	65.21	779.00
3	198	739	21.13	78.87	937.00
4	189	666	22.11	77.89	855.00



Ethnicity Pay Gap Results

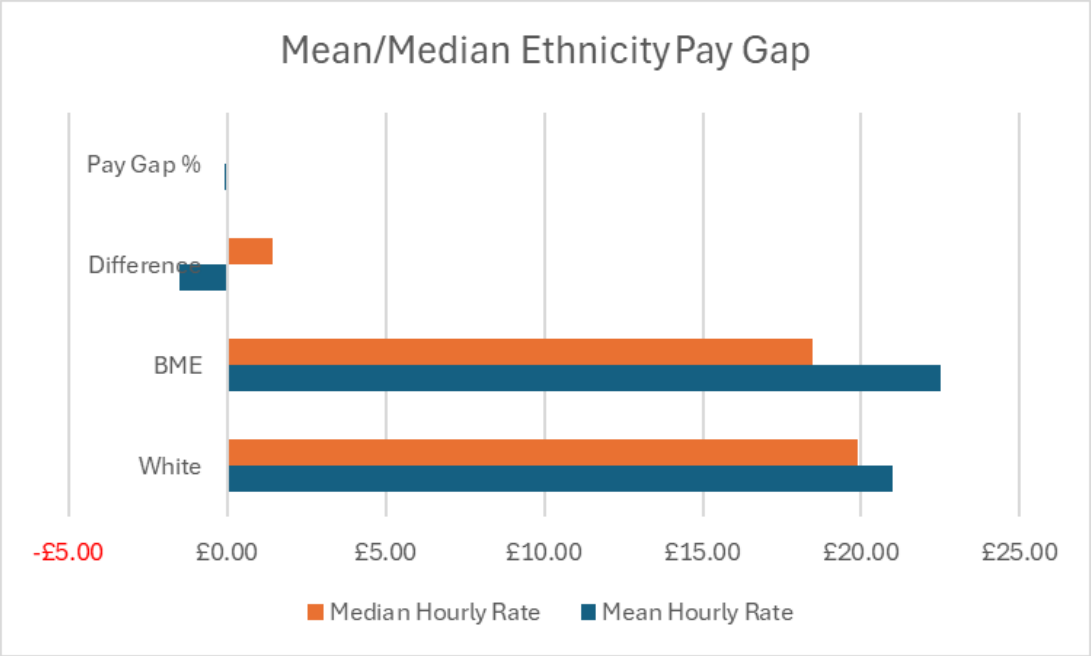
Median pay gap 7.25%: For every £1.00 a white colleague makes, a BME colleague makes £0.93 pence.

Mean pay gap -7.23%: For every £1.00 a white colleague makes, a BME colleague makes £1.07 pence.

(Please be advised that ethnicity data has not been provided by 61 colleagues during this reporting period).

The Trust workforce consists of 2,571 staff (75.3%) (as last year) from White background, and 842 (24.7%) from BME background. This is an increase of 3% from 2024. The breakdown will fluctuate throughout the year due to staff starters and leavers. Subsequently, all our quartiles are made up of predominantly White colleagues. The highest concentration of colleagues from BME background remains in the lower middle quartile.

The overall picture indicates that BME staff across the Trust on average earn more than White colleagues, as the mean pay gap is 7.25% in favour of BME staff. However, further analysis of this indicates that the medical workforce contributes to this where rates of pay are higher than other roles. **When removing the Medical workforce, the mean and median is pay gaps change in favour of white employees (please see "Ethnicity Pay Gap Excluding Medical and Dental Colleagues" table below)**. This shows the importance of undertaking more detailed analysis across the Trust and between professional groupings.



Ethnicity Pay Gap Excluding Medical and Dental Colleagues for Comparison:

Ethnicity Excluding M&D	Average Hourly Rate	Median Hourly Rate
White	£20.33	£19.10
BME	£18.72	£17.61
Difference	£1.62	£1.48
Pay Gap %	7.95%	7.78%

The mean pay gap (7.95%) indicates that for every £1.00 a white colleague makes, a BME colleague makes £0.92 pence.

The median pay gap (7.78%) indicates that for every £1.00 a white colleague makes, a BME colleague makes £0.92 pence.

Excluding Medical and Dental staff from this analysis causes the median pay gap to change in favour of white colleagues.

DHcFT Overall mean and median ethnicity pay gap based on hourly rates of pay over a four-year period:

	2022	2023	2024	2025
Mean Hourly Rate Pay Gap %	-10.94	-9.44	-9.04	-7.23
Median Hourly Rate Pay Gap %	6.53	3.3	2.56	7.25

These have stayed relatively consistent over the past four years, with a steady decrease in the mean hourly pay gap.

NB: bonuses paid relate to clinical excellence awards which are for applicable Consultants only rather than all employees (even though the calculation includes all staff).

Disability Pay Gap Results

This is the third year that DHcFT is reporting on the Disability pay gap in line with the NHS national aspiration.

As per our Workforce Disability Equality Standards report, the Trust employs 415 members of staff that have declared they have a disability which equates to 13.66% (up from 11.6**%** in 2024) of the overall workforce.

It is crucial to note that this figure might not be representative of the actual number of colleagues who have a disability since it depends on the declaration rates.

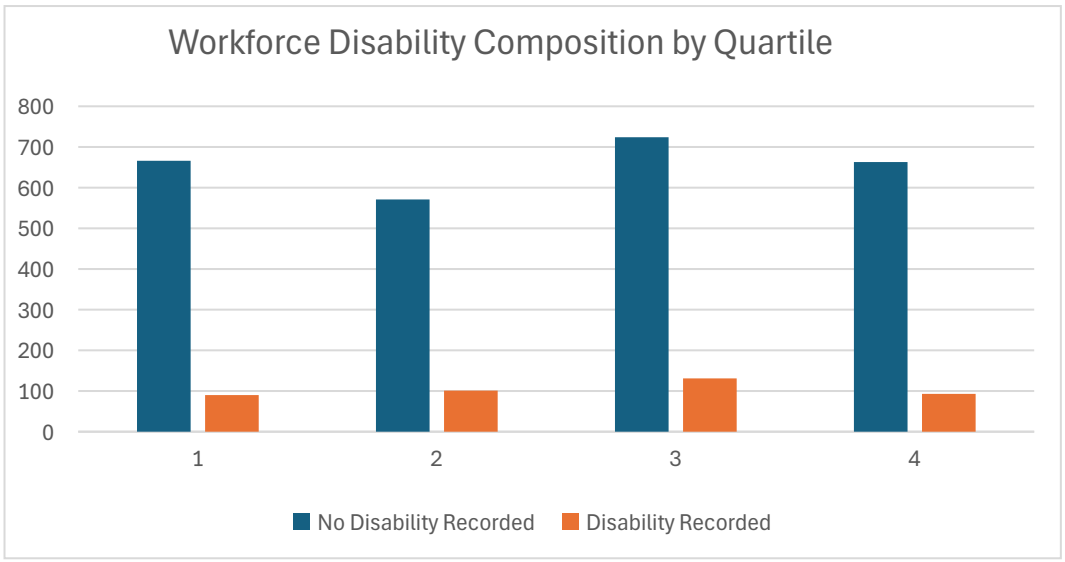
As per the below data, the Trust does not have a median hourly rate gap between staff who declared a disability and those who stated they do not have a disability. However, the mean hourly rate shows a gap of 4.9% in pay between colleagues who declared a disability and those who did not. The mean though can be impacted by any outliers in pay. It is positive there is no median pay gap. However, more work will be done to encourage staff to disclose their diversity information.

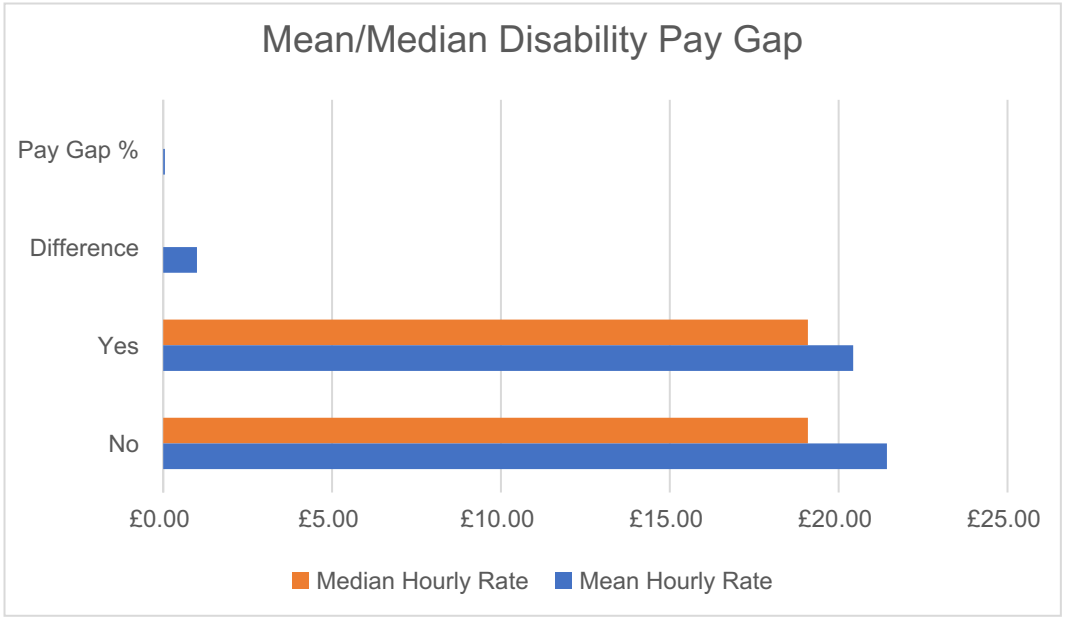
The tables below shows distribution of colleagues who stated that they have a disability and those who stated that they do not across the four quartiles.

DPG results at 31 March 2025:

Disability	Average Hourly Rate	Median Hourly Rate
No	£21.43	£19.09
Yes	£20.43	£19.09
Difference	£1.00	£0.00
Pay Gap %	4.90%	0.00%

Quartile	No	Yes	No %	Yes %	Totals
1	666	90	88.10	11.90	756
2	571	101	84.97	15.03	672
3	724	131	84.68	15.32	855
4	663	93	87.70	12.30	756





(Please be advised that disability data has not been provided by 435 colleagues during this reporting period).

What we are doing to narrow the pay gap:

Some of the measures the Trust is committing to over the next 12 months:

ACTION	ACTIVITY	WHO
Ensure fair and consistent starting salaries	Analyse gender differences in starting salaries, review findings, and provide guidance to recruiting managers to ensure equity	Strategic Recruitment Lead
Improve workforce diversity data	Encourage staff to complete diversity information and deliver a communications campaign to improve data completeness for robust analysis	Equality, Diversity and Inclusion (EDI) team, DAWN Network
Strengthen inclusive recruitment practices and attract a diverse range of applicants	Deliver Chairs of Recruitment training; relaunch the Recruitment Inclusion Guardian (RIG) process, and provide updated training and refresher sessions; Work with community partners and external organisations to broaden access to employment opportunities	Strategic Recruitment Lead, EDI team
Promote flexible and inclusive ways of working	Update the flexible working policy, promote job share and part-time opportunities in senior roles, and implement ESR monitoring to identify barriers	Director of People and Inclusion
Strengthen Staff Networks and inclusive culture	Support Staff Networks to increase visibility, engagement and impact; deliver an All-Staff-Networks Conference; provide safe spaces for discussion via the EDI team and drop-in sessions	EDI team
Support progression and retention of under-represented groups	Review the Trust development offer to support progression of women and under-represented groups; identify and support staff with caring responsibilities; explore flexible leadership roles	People and Inclusion, including EDI team, Staff Networks
Promote a safe and respectful workplace and intersectional understanding	Monitor the effectiveness of the Sexual Safety Charter through the Sexual Safety Working Group; undertake intersectional analysis of pay gaps via the EDI Working Group to inform future actions	Deputy Director of People and Inclusion, Strategic Recruitment Lead, OD Lead, Workforce Transformation

Derbyshire Healthcare
NHS Foundation Trust

Public Sector Equality Duty Annual Report

2025/26

WE MAKE A POSITIVE DIFFERENCE IN EVERYTHING WE DO

www.derbyshirehealthcareft.nhs.uk

DHCFT DERBYSHCFT NHS_DERBYSHIREHEALTHCARE

Introduction: Understanding the Public Sector Equality Duty

The Public Sector Equality Duty (PSED) was introduced in April 2011, under section 149 of the Equality Act 2010. It requires public authorities to have due regard to the need to:

- Eliminate discrimination, harassment, victimisation, and other conduct prohibited under the Act
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not.

To promote transparency and accountability, the Equality Act 2010 (Specific Duties) Regulations 2011 require public authorities to:

- Publish equality objectives at least every four years
- Provide information to demonstrate compliance with the duty.

Our Trust Commitment to Equality, Diversity, and Inclusion

We are committed to embedding equality, diversity, and inclusion (EDI) in every aspect of our operations. We strive to create a compassionate and inclusive environment for both care delivery and employment.

Our vision:

"We make a positive difference in everything we do"

This Strategy outlines our new, bold vision for the future, and the ways we will work in order to achieve our ambitions. We are committed to making positive changes that, in turn, have a positive impact on the people we support.

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

Strategic Objectives:

Our EDI efforts align with the Trust's four strategic priorities:

We are 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.

We value our people:

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

We are productive:

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

We work in 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.

How We Are Meeting the PSED Duties:

Stopping Discrimination and Harassment

- The Trust has a clear Anti-Racism Board Statement
- A Senior Anti-Racism Lead is in place
- A new Racist Incident Response Process will be used across the Trust
- Anonymous reporting for discrimination is being introduced
- EDI checks are now part of HR panels to improve fairness
- Reasonable Adjustments for disabled staff are being improved
- Recruitment Inclusion Guardians are being reviewed to improve fair recruitment
- Learning from racism cases is being strengthened through the Patient and Carer Race Equality Framework (PCREF).

Improving Equality of Opportunity

- The BME Network has been relaunched and the Lesbian, Gay, Bisexual, Transexual, Queer or Questioning+ (LGBTQ+) Network re-established
- A new Trust EDI Policy will be written in early 2026
- New EDI and Race Equality Working Groups will track progress
- Action is being taken to improve career progression for ethnic minority and disabled staff
- The Trust is working to improve equality data and staff declaration rates
- Recruitment processes are being improved to make them fairer
- Inclusive Intercultural Communication training continues
- The EDI Drop-In Clinic will offer staff advice and support

Building Good Relationships

- The Anti-Racist Journey Model will support learning and open discussion
- Safe Spaces and staff listening sessions continue
- A Staff Network Conference will take place in 2026
- Lived experience reports will be shared twice a year with senior leaders
- PCREF is being led by the Medical Director to improve culturally safe mental health care.

What This Means for Our Staff

- Safer and fairer workplaces
- Better support when discrimination or racism happens
- Fairer access to jobs, training and promotion
- Better support for disabled staff
- Stronger staff voice through Networks and Safe Spaces
- More confidence to speak up.

What This Means for Our Patients and Communities

- More culturally safe care, especially in mental health
- Better understanding of different needs and backgrounds
- Fairer access to services
- Stronger trust in the Trust
- More respectful and person-centred care.

Governance and Accountability

The Trust will publish:

- Workforce Race Equality Standard (WRES)
- Workforce Disability Equality Standard (WDES)
- Equality Delivery System 2 (EDS2)
- Public Sector Equality Duty (PSED) Report
- Gender Pay Gap Report
- Modern Slavery Statement.

Progress is monitored through:

- Trust Delivery Group (TDG)
- People and Culture Committee
- Executive leadership
- Staff Network feedback.

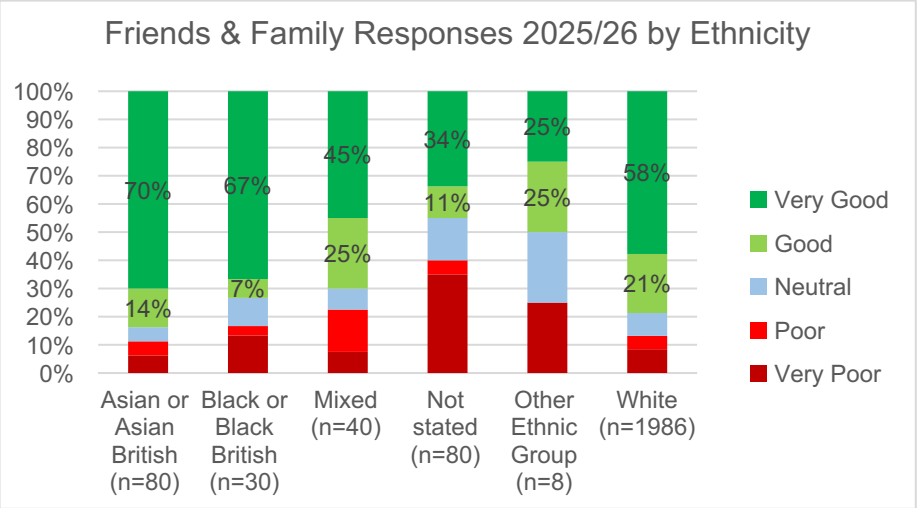
A new Trust EDI Plan for 2027–2029 will also be published.

Promoting equality in service delivery

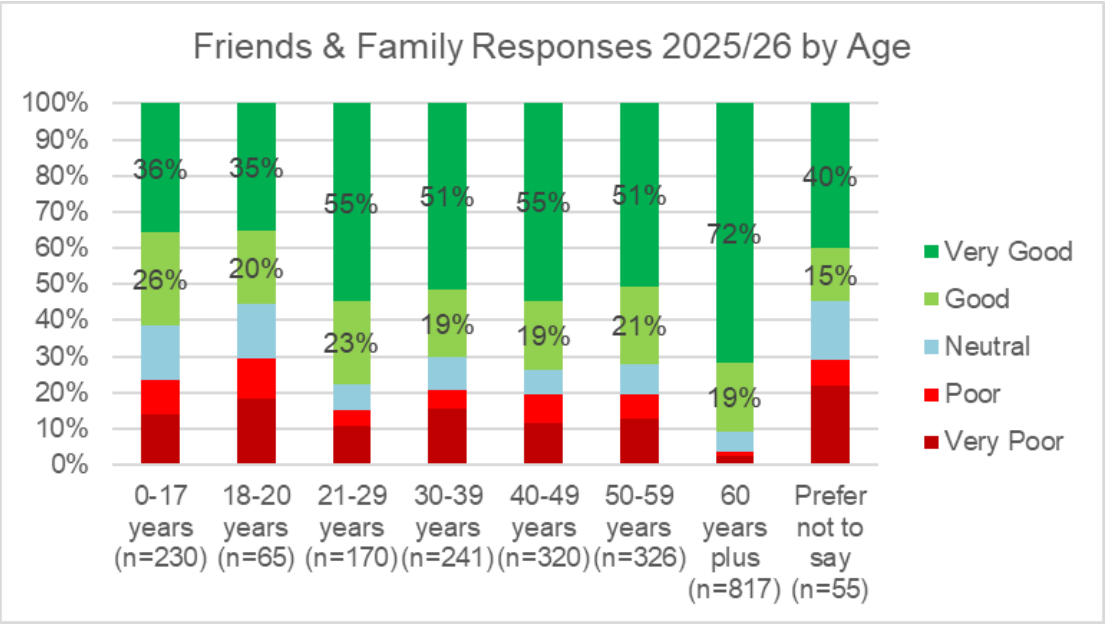
NHS providers are mandated to capture data from patient's Friends and Family Test (FFT) results to ascertain patient experience. To measure customer satisfaction the Trust promotes the Friends and Family Test survey, and respondents are asked to provide their ethnicity, age, and gender in answering whether they would be happy for friends and family to receive treatment at the Trust.

Friends and Family satisfaction ratings 2025/26

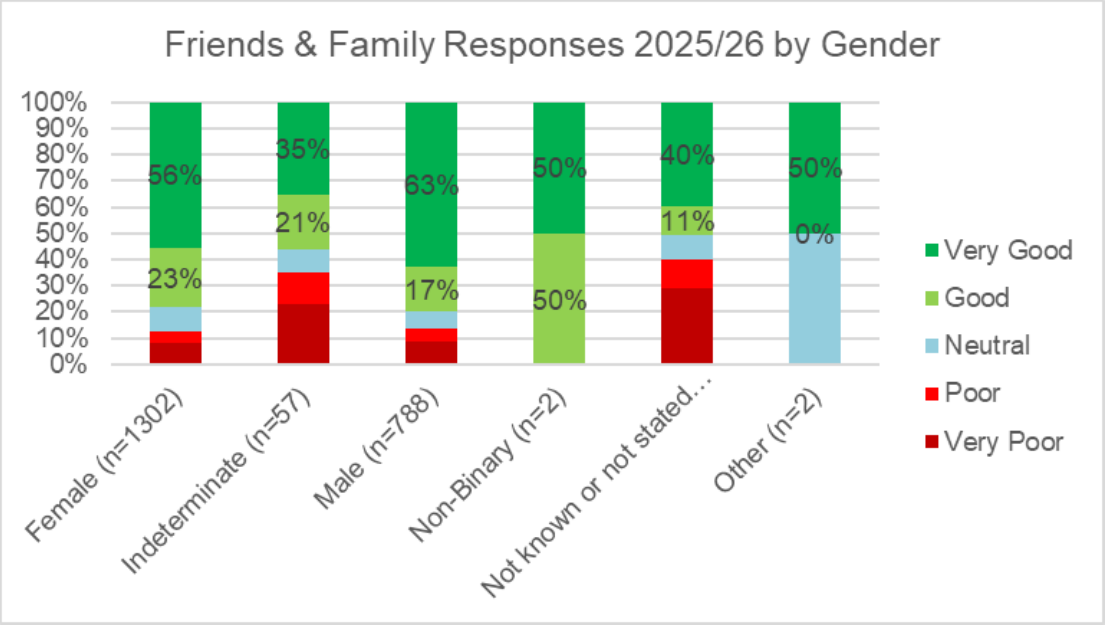
By Ethnicity:



By Age:



By Gender:



Person-centred care planning to promote equality in service delivery:

The Trust operates on a person-centred care planning basis. Each person is treated as an individual and their care plan considers all their individual needs, which by default encapsulates equality of service delivery.

Through the use of person-centred care planning, the Trust ensures that all patients are informed and supported to be as involved as they wish to be in decisions about their care.

A care plan is devised jointly with the patient unless they are unwilling or unable to be involved. The principle of devising the care plan in conjunction with the patient, where possible, is consistently applied. In addition, for patients with a learning disability an accessible care plan has been devised which uses symbols to aid understanding and to enable participation in the production of the care plan.

Staff Networks Overview

Our staff networks play a crucial role in advancing inclusion, offering support, and driving change across the Trust.

Christian Network

- Weekly informal meetings (Wednesday mornings, 8.30am-9.00am)
- Some lunch-time sessions
- Celebratory events such as Easter and Christmas
- Cross-Trust collaboration and city-wide event.

Armed Forces Community Network

- Safe environment for veterans, reservists, families and allies
- Major events: Month of the Military Child, Armed Forces Day, VE Day, Army Insight and Leadership Day
- Active commitment to the Armed Forces Covenant and recognition schemes
- Charity events raising money for military charities
- Attending Breakfast Clubs jointly with Burton Network
- Contact: **dhcft.armedforcesinfo@nhs.net**

BME (Black and Minority Ethnic) Network

- Aims to ensure parity in career outcomes and progression
- Virtual meetings with built-in peer support (closed Group)
- Face-to-face drop in on inpatient wards to be rolled out first session April 2026
- Chairs are part of wider work in the organisation Patient and Carer Race Equality Framework (PCREF) and Violence and Aggression workshop
- BME network now have and open space where allies are invited
- We celebrated race equality week with an extraordinary BME meeting which was attended by out exec sponsors
- We are getting more new members attending the meeting and members are being encouraged to cascade the Network email to promote the network
- Contact: **dhcft.bmeinfo@nhs.net**

DAWN (Disability and Wellbeing Network)

- Safe space for discussion, peer support and advocacy
- Achievements: Adjustment Passport, MindView rollout, centralised budget, Disability Leave Policy, two recorded Podcasts
- Goals-Disability Confident Leader status, reviewing access to our estate and working with Accessible to produce a virtual map of the facilities we have
- Attending team meetings to talk about the network and the work it does
- Contacts: **dhcft.dwinfo@nhs.net** **april.saunders@nhs.net** **barbara.chilvers@nhs.net**

Women's Network

- Inclusive space for individuals identifying as female
- Topics: Gender pay gap, career pathways, hormone health, flexible work
- Advocating for systemic policy change and equity
- Plans for Reciprocal Mentoring Scheme
- Contact: **dhcft.womensnetwork@nhs.net**

Multifaith Network:

- Delivery of inter-faith group sessions discussing relevant themes to the healthcare setting
- Enabling participants to express faith values that inform their day-to-day care as well as what inspires them to care
- Enabling participants to appreciate other people's values, broadening outlooks on life and practice
- Highlighting key faith-based festivals/events
- Regularly meeting with other forums to improve engagement in the community, especially in terms of bringing a greater awareness of mental health issues in local faith communities.

LGBT+ Network:

- Reinstated in 2025 with renewed energy
- Virtual meetings with built-in peer support (closed Group)
- Increased visibility, looking to relaunch officially in 2026
- Linking with Derbyshire Community Health Services NHS Foundation Trust to consider joint support and joint working
- Consultation on policy development
- **Contact:** dhcft.lgbtinfo@nhs.net

The Trust is also currently exploring the development of a Carer's Network to support staff with carer responsibilities following a scoping exercise.

Please scan the QR codes below to visit further information on Focus.

Armed Forces Community Network	Black and Minority Ethnic (BME) Staff Network	Christian Network	Disability and Wellness Network (DAWN)	LGBT+ (Lesbian, Gay, Bisexual, Transgender +) Network	Multi-Faith Forum	Women's Network

Sexual Safety Charter

A new charter on sexual safety at work has been published and a policy has been developed in collaboration with key stakeholders and Staff Networks. The work of the Sexual Safety Working Group is ongoing.

EDI Training

Inclusive Intercultural Communication (IIC) Training

Objectives

- Recognise communication barriers in diverse teams
- Promote empathetic and inclusive language
- Address linguistic and cultural identity challenges
- Facilitate clearer digital and face-to-face communication.

Participant Feedback

- “This course should be mandatory for all NHS staff”
- “As an international member of staff, I feel heard and understood”
- “It helped me adapt my communication style immediately”
- “Important session for onboarding and future training frameworks”.

Active Bystander Training

DHcFT has commissioned ‘A Kind Life’ to develop an Active Bystander ‘Train the Trainer’ programme, which will be rolled out organisation-wide beginning in January 2026. A Kind Life, which aims to embed the principles of a just and restorative culture in line with the operational priority to improve staff experience.

Bespoke Training

While we cannot guarantee the elimination of all discrimination that our staff may face, we can improve the way that our staff our supported as a result of such experiences. The EDI team is working with patient-facing areas to develop a training package to improve collaboration and support within teams.

Race Equality Strategy and Action Plan (draft for co-production with BME Staff Network and key stakeholders)

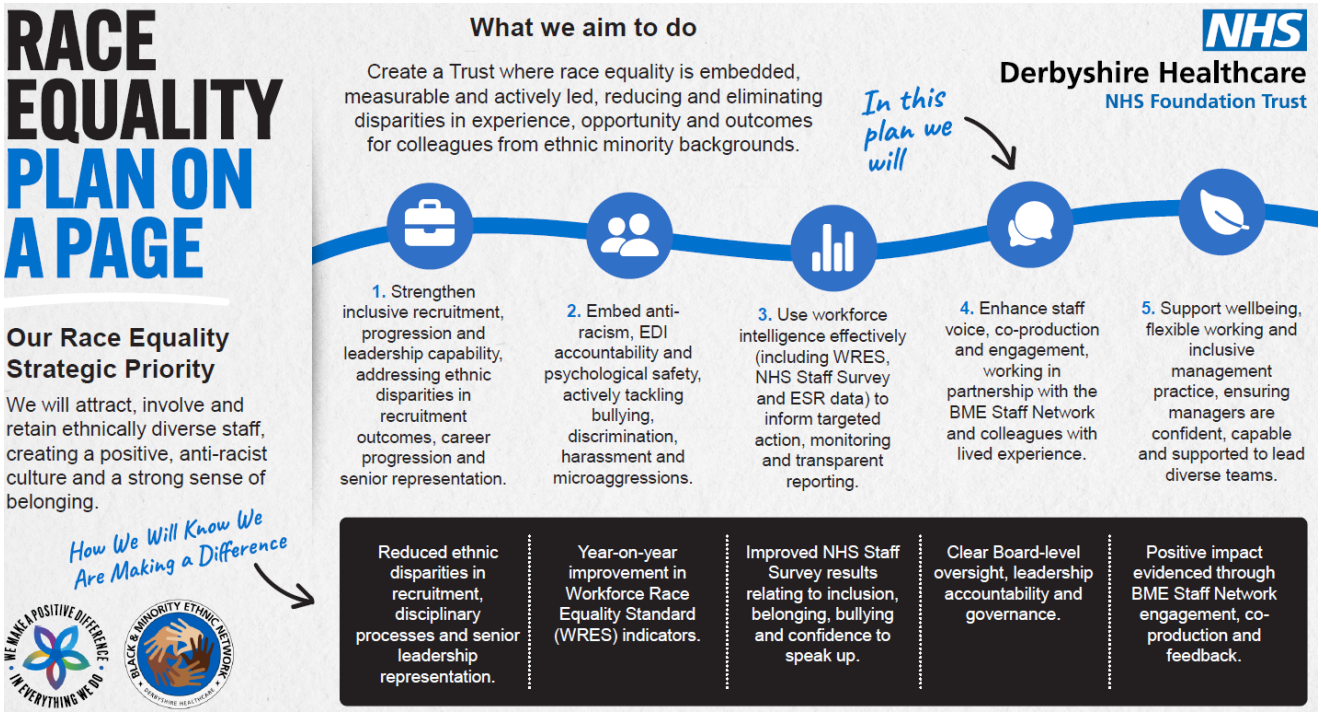
In 2025 the Trust signed up to an over-arching anti-racism statement to include the following:

“Racism - whether overt or subtle, individual or systemic - has no place in our organisation. It breaks trust, harms lives and deepens health inequalities. We recognise the damage it causes, and we refuse to be bystanders. At Derbyshire Healthcare, we believe in the power of compassion, inclusion and dignity for all. Every person deserves to feel safe, valued and respected - in our services, our teams, and our communities.”
A new Race Equality Strategy and Action Plan has been developed.

Vision: To create an equitable, inclusive, and safe workplace where all those from minoritised communities feel valued, respected, and empowered.

Mission: To combat racism and intersectional discrimination within DHcFT through leadership, accountability, inclusive engagement and a sustained commitment to education, culture and structural change.

The Strategy and Action Plan has been developed in collaboration with the BME Staff Network and key stakeholders.



Freedom to Speak Up Guardian

Derbyshire Healthcare NHS Foundation Trust is committed to creating an inclusive culture where all colleagues feel safe, respected and confident to speak up about any aspect of their working life. The Freedom to Speak Up Guardian provides an independent and confidential route for staff to raise concerns or share experiences relating to patient safety, quality of care, behaviours, culture or workplace practices, when they feel unable to do so through other channels.

The role supports the Trust's commitment to equality, diversity and inclusion by helping to ensure that every colleague's voice is heard and valued. Particular attention is given to understanding and reducing barriers that may prevent staff from different backgrounds or those with protected characteristics from speaking up. Promoting psychological safety and inclusive working environments is central to this work. The Freedom to Speak Up Guardian works in partnership with the EDI team to ensure that concerns relating to equality, inclusion and protected characteristics are understood and responded to appropriately.

Themes and learning from Freedom to Speak Up cases are reviewed to identify opportunities for organisational learning and improvement. This helps the Trust to address cultural or systemic issues, strengthen inclusive practices and ensure that concerns raised by colleagues lead to meaningful change.

Through this work, DHcFT continues to promote a culture of openness, fairness and continuous improvement where speaking up is encouraged and supported for everyone.

Recruitment Inclusion Guardians

The Recruitment Inclusion Guardians were introduced across the Trust in February 2020 to support panels for Band 7 and above roles, which was subsequently extended to cover recruitment panels for all Band 6 and above roles.

Recruitment Inclusion Guardians are one of other measures DHcFT is taking to ensure our recruitment processes are inclusive.

The main objectives of the Recruitment Inclusion Guardians are to:

- ensure that the Trust places a high value on diversity and fairness, treating all applicants with dignity and respect
- support all hiring managers to achieve good equalities practice at all stages of the recruitment process
- advocate for equality and promote the interests of all protected groups.

The process has recently been undergoing a review that aims to assess the existing resources and the demand which will enable us to standardise the process, increase its impact and introduce measures to regularly assess impact effectively.

Future Plans/Considerations

To include:

- Embed EDI objectives into executive and senior manager appraisal frameworks
- Refresh inclusive recruitment guidance and processes
- Deliver inclusive recruitment training for senior appointment panels
- Deliver mentoring and sponsorship schemes for under-represented staff
- Review and strengthen reporting routes and staff support pathways
- Relaunch centralised reasonable adjustment process
- Provide manager guidance and training on reasonable adjustments
- Strengthen governance and executive sponsorship for staff networks
- Explore menopause-friendly accreditation
- Deliver Trust-wide inclusion and engagement events.

Our ongoing work in equality, diversity, and inclusion reflects our commitment to not just meet statutory obligations but to exceed them. By embracing and supporting the diverse identities of our staff, patients, and communities, we are building a Trust that is inclusive, respectful and resilient.

Workforce Data Snapshot (as of December 2025)

Data compiled from DHcFT's ESR system:

- **Table 1**: Overall Workforce Composition
- **Table 2**: Recruitment Trends
- **Table 3**: Working Patterns
- **Table 4**: CPD Training Access
- **Table 5**: Employee Relations Casework
- **Table 6**: Leavers Breakdown.

Table 1: Overall Workforce Composition

Breakdown of employees 31 Dec 2025

	Headcount	FTE	Workforce %
Trust			
Employees	**3474**	**3032.41**	**100.00%**
Race			
White	**2559**	**2199.11**	**73.66%**
White - British	2441	2100.29	70.26%
White - Any other White background	69	61.29	1.99%
White - Irish	25	19.38	0.72%
White English	10	7.65	0.29%
White Unspecified	7	4.49	0.20%
White Other European	2	1.40	0.06%
White Cornish	1	1.00	0.03%
White Mixed	1	1.00	0.03%
White Northern Irish	1	1.00	0.03%
White Scottish	1	0.80	0.03%
White Turkish	1	0.80	0.03%
Mixed Race	**79**	**71.21**	**2.27%**
Mixed - White & Asian	27	23.97	0.78%
Mixed - White & Black Caribbean	27	24.81	0.78%
Mixed - Any other mixed background	12	10.93	0.35%
Mixed - White & Black African	12	11.10	0.35%
Mixed - Black & White	1	0.40	0.03%
Asian or Asian British	**325**	**282.79**	**9.36%**
Asian or Asian British - Indian	200	173.38	5.76%
Asian or Asian British - Pakistani	99	85.13	2.85%
Asian or Asian British - Any other Asian background	13	12.40	0.37%
Asian or Asian British - Bangladeshi	5	4.59	0.14%
Asian Punjabi	2	1.67	0.06%
Asian Tami	2	1.80	0.06%
Asian British	1	0.83	0.03%
Asian Sinhalese	1	1.00	0.03%
Asian Sri Lankan	1	1.00	0.03%
Asian Unspecified	1	1.00	0.03%
Black or Black British	**426**	**405.17**	**12.26%**
Black or Black British - African	341	329.29	9.82%
Black or Black British - Caribbean	60	52.92	1.73%
Black or Black British - Any other Black background	13	11.56	0.37%
Black Nigerian	7	6.80	0.20%
Black British	4	3.60	0.12%
Black Mixed	1	1.00	0.03%
Other Ethnic Backgrounds	**35**	**31.80**	**1.01%**
Any Other Ethnic Group	22	20.00	0.63%
Chinese	10	8.80	0.29%
Filipino	2	2.00	0.06%
Other Specified	1	1.00	0.03%
Not Stated	**50**	**42.33**	**1.44%**
Total BME			**24.90%**
Gender			

	Female	2759	2373.45	79.42%
	Male	715	658.96	20.58%
Religious Belief				
	Christianity	1492	1307.07	42.95%
	Atheism	696	619.49	20.03%
	Do not wish to disclose	507	423.28	14.59%
	Other	390	343.54	11.23%
	Islam	135	119.59	3.89%
	Unspecified	95	78.82	2.73%
	Sikhism	71	58.73	2.04%
	Hinduism	58	54.08	1.67%
	Buddhism	22	19.81	0.63%
	Judaism	6	6.00	0.17%
	Jainism	2	2.00	0.06%
Sexual Orientation				
	Heterosexual or Straight	2937	2577.13	84.54%
	Not Stated	266	215.84	7.66%
	Gay or Lesbian	92	84.53	2.65%
	Other Unspecified	91	74.54	2.62%
	Bisexual	64	58.87	1.84%
	Not Listed	14	13.51	0.40%
	Undecided	10	8.00	0.29%
Disability				
	No	2680	2375.35	77.14%
	Yes	431	372.10	12.41%
	Not Declared	344	269.68	9.90%
	Prefer Not To Answer	19	15.28	0.55%
Age				
	16-20	15	11.85	0.43%
	21-30	466	439.07	13.41%
	31-40	888	788.23	25.56%
	41-50	921	822.40	26.51%
	51-60	859	737.13	24.73%
	61-70	311	225.67	8.95%
	71 & above	14	8.05	0.40%
Marriage & Civil Partnership				
	Married	1748	1485.59	50.32%
	Single	1190	1078.21	34.25%
	Divorced	242	208.25	6.97%
	Unknown	142	127.06	4.09%
	Civil Partnership	66	59.56	1.90%
	Widowed	47	37.55	1.35%
	Legally Separated	39	36.18	1.12%
Maternity				
	Maternity Leave	61	54.07	1.76%

Table 2: Recruitment Trends

Breakdown of Recruitment Data 01 Apr 2025 to 31 Dec 2025	Applications	%	Shortlisted	%	Interview Attended	%	Appointments	%
Trust								
Employees	16994	-	2645	-	1640	-	279	-
Race								
White	2985	17.57%	1161	43.89%	732	44.63%	155	55.5
BME	13780	81.09%	1398	52.85%	834	50.85%	83	29.7
Not Stated	229	1.35%	86	3.25%	74	4.51%	41	14.7
Gender								
Female	11673	68.69%	1894	71.61%	1161	70.79%	200	71.6
Male	5265	30.98%	733	27.71%	468	28.54%	75	26.8
Not stated	56	0.33%	18	0.68%	11	0.67%	4	1.4
Religious Belief								
Atheism	1243	7.31%	436	16.48%	280	17.07%	59	21.1
Buddhism	217	1.28%	21	0.79%	14	0.85%	4	1.4
Christianity	9723	57.21%	1309	49.49%	821	50.06%	101	36.2
Hinduism	1308	7.70%	97	3.67%	50	3.05%	7	2.5
Not stated	59	0.35%	59	2.23%	58	3.54%	37	13.2
Islam	2736	16.10%	237	8.96%	130	7.93%	15	5.3
Jainism	9	0.05%	1	0.04%	1	0.06%	0	0.0
Judaism	2	0.01%	2	0.08%	1	0.06%	0	0.0
Other	641	3.77%	220	8.32%	126	7.68%	23	8.2
Sikhism	248	1.46%	66	2.50%	38	2.32%	4	1.4
Do not wish to Disclose	808	4.75%	197	7.45%	121	7.38%	29	10.3
Sexual Orientation								
Bisexual	364	2.14%	91	3.44%	60	3.66%	6	2.1
Gay or Lesbian	175	1.03%	60	2.27%	43	2.62%	12	4.3
Heterosexual or Straight	15844	93.23%	2317	87.60%	1406	85.73%	216	77.4
Undecided	39	0.23%	11	0.42%	8	0.49%	1	0.3
Other not listed	51	0.30%	15	0.57%	7	0.43%	1	0.3
Not Stated	58	0.34%	58	2.19%	57	3.48%	38	13.6
Do not wish to Disclose	463	2.72%	93	3.52%	59	3.60%	5	1.7
Disability								
Yes	929	5.47%	325	12.29%	216	13.17%	35	12.5
No	15804	93.00%	2188	82.72%	1321	80.55%	196	70.2
Prefer not to Answer	192	1.13%	63	2.38%	35	2.13%	6	2.1
Not Declared	69	0.41%	69	2.61%	68	4.15%	42	15.0
Age								
Under 20	167	0.98%	25	0.95%	12	0.73%	2	0.7
20-24	1579	9.29%	245	9.26%	158	9.63%	33	11.8
25-29	4610	27.13%	497	18.79%	292	17.80%	58	20.7
30-34	3962	23.31%	504	19.05%	299	18.23%	39	13.9
35-39	2776	16.34%	398	15.05%	253	15.43%	45	16.1
40-44	1857	10.93%	347	13.12%	223	13.60%	31	11.1
45-49	1018	5.99%	240	9.07%	164	10.00%	30	10.7
50-54	593	3.49%	206	7.79%	129	7.87%	22	7.8
55-59	289	1.70%	113	4.27%	64	3.90%	11	3.9
60-64	127	0.75%	62	2.34%	42	2.56%	7	2.5
65+	16	0.09%	8	0.30%	4	0.24%	1	0.3
Not Stated	0	0.00%	0	0.00%	0	0.00%	0	0.0
Marriage & Civil Partnership								
Civil Partnership	285	1.68%	61	2.31%	34	2.07%	7	2.5
Divorced	290	1.71%	100	3.78%	64	3.90%	11	3.9
Legally Separated	76	0.45%	23	0.87%	16	0.98%	0	0.0
Married	8753	51.51%	1194	45.14%	742	45.24%	99	35.4
Single	6979	41.07%	1033	39.05%	615	37.50%	109	39.0
Unknown	55	0.32%	55	2.08%	54	3.29%	36	12.9
Widowed	47	0.28%	13	0.49%	10	0.61%	2	0.7
Other	322	1.89%	115	4.35%	74	4.51%	12	4.3
Do not wish to disclose	187	1.10%	51	1.93%	31	1.89%	3	1.0

Table 3: Working Patterns

Breakdown of Working Pattern 31 Dec 2025

		Full Time	Workforce %	Part Time	Workforc %
rust					
	Employees	2041	58.75%	1433	41.25%
ace					
	White	1393	54.44%	1166	45.56%
	BME	620	71.68%	245	28.32%
	Not Stated	28	56.00%	22	44.00%
ender					
	Female	1494	54.15%	1265	45.85%
	Male	547	76.50%	168	23.50%
eligious Belief					
	Christianity	892	59.79%	600	40.21%
	Atheism	428	61.49%	268	38.51%
	Do not wish to disclose	258	50.89%	249	49.11%
	Other	227	58.21%	163	41.79%
	Islam	86	63.70%	49	36.30%
	Unspecified	50	52.63%	45	47.37%
	Sikhism	34	47.89%	37	52.11%
	Hinduism	43	74.14%	15	25.86%
	Buddhism	15	68.18%	7	31.82%
	Judaism	6	100.00%	0	0.00%
	Jainism	2	100.00%	0	0.00%
exual Orientation					
	Heterosexual or Straight	1745	59.41%	1192	40.59%
	Not Stated	123	46.24%	143	53.76%
	Gay or Lesbian	64	69.57%	28	30.43%
	Unspecified	46	50.55%	45	49.45%
	Bisexual	49	76.56%	15	23.44%
	Not Listed	11	78.57%	3	21.43%
	Undecided	3	30.00%	7	70.00%
isability					
	No	1644	61.34%	1036	38.66%
	Yes	249	57.77%	182	42.23%
	Not Declared	137	39.83%	207	60.17%
	Prefer not to Answer	11	57.89%	8	42.11%
ge					
	16-20	10	66.67%	5	33.33%
	21-30	374	80.26%	92	19.74%
	31-40	536	60.36%	352	39.64%
	41-50	574	62.32%	347	37.68%
	51-60	454	52.85%	405	47.15%
	61-70	90	28.94%	221	71.06%
	71 & above	3	21.43%	11	78.57%

larriage & Civil Partnership					
	Married	922	52.75%	826	47.25%
	Single	817	68.66%	373	31.34%
	Divorced	131	54.13%	111	45.87%
	Unknown	86	60.56%	56	39.44%
	Civil Partnership	41	62.12%	25	37.88%
	Widowed	17	36.17%	30	63.83%
	Legally Separated	27	69.23%	12	30.77%
laternity					
	Maternity Leave	36	59.02%	25	40.98%

Table 4: CPD Training Access

Breakdown of Mandatory Training Compliance 31 Dec 2025

	%
Trust	
Employees	93.66%
Race	
White	94.63%
BME	91.32%
Not Stated	84.51%
Gender	
Female	94.21%
Male	91.62%
Religious Belief	
Atheism	95.12%
Buddhism	95.35%
Christianity	94.21%
Hinduism	88.54%
Not stated	87.04%
Islam	92.10%
Jainism	90.91%
Judaism	95.00%
Other	94.82%
Sikhism	89.92%
Do not wish to disclose	91.94%
Sexual Orientation	
Bisexual	95.53%
Gay or Lesbian	95.37%
Heterosexual or Straight	94.21%
Not stated	89.14%
Other sexual orientation not listed	99.31%
Undecided	96.81%
Unspecified	85.52%
Disability	
Yes	94.14%

No	94.43%
Pefer not to Answer	92.51%
Not Declared	87.33%

Age	
16-20	94.30%
21-30	94.32%
31-40	94.22%
41-50	95.24%
51-60	93.26%
61-70	88.53%
71 & above	73.61%

Marriage & Civil Partnership	
Civil Partnership	94.78%
Divorced	94.64%
Legally Separated	94.94%
Married	93.23%
Single	94.11%
Unknown	93.04%
Widowed	92.67%

Table 5: Employee Relations casework

Breakdown of ER Casework Data 01 Apr 2025 to 31 Dec 2025	Disciplinaries	%	Grievance	%	Dignity at Work	%
Trust						
Employees	21	-	11		10	
Race						
White	16	76.19%	10	90.91%	7	70.00%
BME	5	23.81%	1	9.09%	3	30.00%
Not Stated	0	0.00%	0	0.00%	0	0.00%
Gender						
Female	12	57.14%	7	63.64%	6	60.00%
Male	9	42.86%	4	36.36%	4	40.00%
Not stated	0	0.00%	0	0.00%	0	0.00%
Religious Belief						
Atheism	5	23.81%	2	18.18%	2	20.00%
Buddhism	0	0.00%	0	0.00%	0	0.00%
Christianity	9	42.86%	4	36.36%	6	60.00%
Hinduism	0	0.00%	1	9.09%	0	0.00%
Not stated	1	4.76%	3	27.27%	1	10.00%
Islam	2	9.52%	0	0.00%	1	10.00%
Jainism	0	0.00%	0	0.00%	0	0.00%
Judaism	0	0.00%	0	0.00%	0	0.00%
Other	4	19.05%	1	9.09%	0	0.00%
Sikhism	0	0.00%	0	0.00%	0	0.00%
Sexual Orientation						
Bisexual	1	4.76%	0	0.00%	0	0.00%
Gay or Lesbian	1	4.76%	1	9.09%	1	10.00%
Heterosexual or Straight	17	80.95%	10	90.91%	8	80.00%
Undecided	0	0.00%	0	0.00%	0	0.00%
Other not listed	0	0.00%	0	0.00%	0	0.00%
Not Stated	2	9.52%	0	0.00%	1	10.00%
Disability						
Yes	7	33.33%	8	72.73%	2	20.00%
No	13	61.90%	2	18.18%	7	70.00%
Not Declared	1	4.76%	1	9.09%	1	10.00%
Age						
16-20	0	0.00%	0	0.00%	0	0.00%
21-30	0	0.00%	0	0.00%	0	0.00%
31-40	6	28.57%	4	36.36%	0	0.00%
41-50	7	33.33%	3	27.27%	3	30.00%
51-60	5	23.81%	1	9.09%	5	50.00%
61-70	3	14.29%	3	27.27%	2	20.00%
71 & above	0	0.00%	0	0.00%	0	0.00%
Marriage & Civil Partnership						
Civil Partnership	1	4.76%	0	0.00%	0	0.00%
Divorced	4	19.05%	3	27.27%	3	30.00%
Legally Separated	2	9.52%	0	0.00%	0	0.00%
Married	4	19.05%	5	45.45%	5	50.00%
Single	8	38.10%	3	27.27%	2	20.00%
Unknown	2	9.52%	0	0.00%	0	0.00%
Widowed	0	0.00%	0	0.00%	0	0.00%
Other	0	0.00%	0	0.00%	0	0.00%

Table 6: Leavers Breakdown

Breakdown of Leavers 01 Apr 2025 to 31 Dec 2025

	Headcount	Workforce %
Trust		
Employees	371	-
Race		
White	**291**	**78.44%**
White - British	279	75.20%
White - Any other White background	6	1.62%
White Unspecified	3	0.81%
White - Irish	2	0.54%
White Other European	1	0.27%
Mixed Race	**14**	**3.77%**
Mixed - White & Black Caribbean	6	1.62%
Mixed - White & Black African	3	0.81%
Mixed - Any other mixed background	2	0.54%
Mixed - White & Asian	2	0.54%
Mixed - Other/Unspecified	1	0.27%
Asian or Asian British	**21**	**5.66%**
Asian or Asian British - Indian	15	4.04%
Asian or Asian British - Pakistani	5	1.35%
Asian or Asian British - Any other Asian background	1	0.27%
Black or Black British	**35**	**9.43%**
Black or Black British - African	24	6.47%
Black or Black British - Caribbean	9	2.43%
Black British	1	0.27%
Black or Black British - Any other Black background	1	0.27%
Other Ethnic Backgrounds	**4**	**1.08%**
Any Other Ethnic Group	2	**0.54%**
Chinese	1	**0.27%**
Vietnamese	1	**0.27%**
Not Stated	**6**	**1.62%**
Gender		
Female	295	79.51%
Male	76	20.49%
Religious Belief		
Christianity	157	42.32%
Atheism	77	20.75%
Do not wish to disclose	66	17.79%
Other	35	9.43%
Unspecified	11	2.96%
Islam	10	2.70%
Buddhism	6	1.62%
Sikhism	5	1.35%
Hinduism	4	1.08%
Sexual Orientation		
Heterosexual or Straight	293	78.98%
Not Stated	51	13.75%

	Bisexual	12	3.23%
	Gay or Lesbian	11	2.96%
	Other	3	0.81%
	Undecided	1	0.27%
Disability			
	No	275	74.12%
	Yes	56	15.09%
	Not Declared	38	10.24%
	Prefer Not To Answer	2	0.54%
Age			
	16-20	2	0.54%
	21-30	50	13.48%
	31-40	87	23.45%
	41-50	62	16.71%
	51-60	95	25.61%
	61-70	67	18.06%
	71 & above	8	2.16%
Marriage & Civil Partnership			
	Married	175	47.17%
	Single	140	37.74%
	Divorced	32	8.63%
	Unknown	12	3.23%
	Civil Partnership	7	1.89%
	Widowed	3	0.81%
	Legally Separated	2	0.54%
Maternity			
	Maternity Leave	2	0.54%

Guardian of Safe Working Hours (GoSWH) quarterly report - 1 January to 31 of March 2026

Purpose of Report

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

Executive Summary

The Board of Directors is requested to note:

1. Exception reports
    a. At the time of drafting total exception reports for the period are 22. There is a definite increase in numbers as compared to total reports in the last quarter; 14. This can be explained partly by increase in on-call workload after the new built wards on Kingsway became operational. Another reason might be the increase in uptake of reporting by trainees due to the additional anonymity provided by the new exception report reform. For rota workloads and possible mitigations, please refer to point 2 (a). Increase in uptake of exception reporting can be considered a positive outcome
    b. As the exception report reforms came into force in the middle of this period (4 February, and as the data points recorded on the software have changed, it was not possible to merge the data so it will be presented as two discrete sets of tables)
    2. Rota workloads
    a. A baselining, hours monitoring exercise was completed for the Foundation year 2 (FY2) to Core trainee year 3 (CT3) Doctors participating in the out of hours rotas in the south and has since been repeated with new builds at Kingsway open and operational. Information from this has fed into a costed options appraisal, where one option is to have two Doctors on site overnight. This is being led on by Medical Education. The Trust south Dr Machin, Deputy Director of Medical Education (DDME)will be leading on this.
3. Exception reporting reform
    a. Exception reporting reform became online from 4 February 2026
    b. Overall, the uptake of access and completion tests have increased but there is a lag in trainees ‘completing’ the reports they raised. This will be explored further in future Resident Doctor Forum (RDF) meetings.

Strategic Considerations		BAF Risk (eg 1A)	Strategic Delivery Plan Reference
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	2A	2.1
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 from the DHcFT GoSWH provides data about the number of Resident Doctors in training in the Trust, full transition to the 2016 Resident Doctor contract and any issues arising therefrom. The report details arrangements made to ensure safe working within the new contract and arrangements in place to identify, quantify and remedy any risks to the organisation.

Consultation

The GoSW has shared the previous quarterly and annual reports to the People and Culture Committee with the Joint Local Negotiating Committee (JLNC), the Trust Medical Training Committee (TMTC), the RDF and its constituent Resident Doctors. Following presentation to this Committee, this report will be shared at the next RDF meeting, its constituent Resident Doctors, the TMTC and the JLNC.

Governance or Legal Issues

None.

Net Zero Duty Implications

In compliance with the NHS move towards net zero carbon emissions, the Trust must consider statutory emissions and environmental targets in their decisions. Reports should identify related impacts on workforce and system leadership; sustainable models of care; digital transformation; travel and transport estates and facilities (including capital projects, asset management and utilities, green space and biodiversity); medicines; supply chain and procurement; food and nutrition and adaptation.

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

Not applicable.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

None.

Recommendations

The Board of Directors is requested to note the contents of the report and the mitigation planned or put in place to manage increase in exception reporting.

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

Report prepared by: **Dr Praveena Peddireddi**
Guardian of Safe Working Hours

Guardian of Safe Working Hours (GoSWH) quarterly report

1. Resident doctor data

For the period 1 January to 31 of March 2026.

Numbers in post for resident doctors in training

Numbers of doctors in post WTE	North	South
FY1	3	5
FY2	3	5
GP ST	4	7
CT	12	15
HSTs	8	12
Paediatrics ST	0	0

Key

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

2. Exception reports

Aggregated data, covering the period **10 December 2025 to 29 January 2026**:

Location	No of exceptions raised	No of exceptions closed	No of exceptions outstanding
North	3	2	1
South	3	0	3
Total	**6**	**2**	**4**

Grade	No of exceptions raised	No of exceptions closed	No of exceptions outstanding
CT1-3	2	0	2
ST4-7	4	2	2
GP	0	0	0
Foundation	0	0	0
Total	**6**	**2**	**4**

Action taken

Location	Payment	TOIL	Not agreed	No action required
North	0	13	0	0
South	1	3	0	1
Total	**1**	**16**	**0**	**1**

Response time

Grade	48 hours	7 days	Longer than 7 days	Open
CT1-3	0	5	1	0
Foundation	0	8	0	0
ST4-7	0	3	0	0
GP	0	1	0	0

Aggregated data, covering the period **29 January 2026 to 31 of March 2026**:

Grade	No of exceptions raised	No of exceptions closed	No of exceptions outstanding
CT1-3	5	2	3
ST4-7	6	6	0
GP	0	0	0
Foundation	5	5	0
Total	**16**	**13**	**3**

Action taken

Payment	12
TOIL	1
Not agreed (pending review)	3
No Action	0
Total	**16**

Response time

Grade	48 hours	14 Days	Longer than 14 days	Open
CT1-3		2		3
Foundation			5	
ST4-7	2	1	3	
GP	0	0	0	0

- Marked delay in closing exception reports is due to time taken by the trainees to respond
- Most exception reports had their typical response between two to three days from the relevant responders (Medical Education, DDME, etc)
- It appears as if trainees need more information about responding to queries through email and closing exceptions as needed.

3. Work schedule reviews

No formal work schedule reviews undertaken.

4. Fines

Current balance: £179.48

5. Locum/Bank Shifts covered (1 January to 31 March 2026)

	North	Cost	South	Cost
Locum/bank shifts covered	41	25585	55	33,420
Agency locum shifts covered	0	0	0	0

6. Agency Locum (1 January to 31 March 2026)

Nil.

7. Vacancies (1 January to 31 of March 2026)

	North	South
CT1-CT3	2	0
ST4-7	0.20	4
GP registrars	0.40	1
Foundation	0	0

8. Qualitative information

- Rota workloads

  - A baselining hours monitoring exercise was completed for the FY2 to CT3 doctors participating in the out of hours rotas in the south and has since been repeated with new builds at Kingsway open and operational. Information from this has fed into a costed options appraisal, where one option is to have two doctors on site overnight
  - Work ongoing with assessing on call work load for trainees. DDME is leading on his currently.

- Exception reporting reform

  - Exception reporting reform became online from 4 February 2026
  - Some initial glitches with trainees finishing test reports which look like they are sorted now
  - Ongoing issues with trainees not ‘closing’ their exception reports leading to increased response time depiction on the report. This needs to be addressed.

9. Compliance of rotas

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

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

None not already covered.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 19 May 2026

Medical Appraisal and Revalidation – 2025/26 – annual report

Purpose of Report

To provide the Board of Directors with an update on medical appraisal and revalidation activity within the Trust during the 2025/26 medical appraisal cycle.

Executive Summary

The purpose of medical revalidation and appraisal is to support and develop our medical workforce through reflection on clinical practice whilst complying with General Medical Council (GMC) frameworks to protect patients.

As at 31 March 2026, 134 doctors had a connection with the Trust for appraisal. Of these:

- 99 doctors have completed their appraisal within the required time
- 27 doctors have not completed an appraisal during this time frame
- 8 doctors joined the Trust in the last 12 months and are not due for the appraisal.
- Of the 27 remaining majority have completed their appraisal (127 in total ie 96% compliance) at the time of writing the report.
- All doctors without an appraisal have been contacted by the Medical Appraisal Lead and have a plan in place to support them to improve their compliance with appraisal.

The Trust continues to use the electronic platform L2P for medical appraisal which allows greater transparency of the appraisal data for individual doctors as well as for the Trust Revalidation team. It provides relatively intuitive means of recording and reviewing appraisal information. Built-in automatic reminders around time frames have helped to improve compliance with appraisal submission dates and are being enhanced to ensure further improvements in compliance.

Internal audit has identified a number of areas of improvement, all of which have been accepted and are being implemented.

The Responsible Officer Advisory Group (ROAG) remains the point of escalation for non-engagement with appraisal and agreement on revalidation decisions.

Strategic Considerations		**BAF Risk (eg 1A)**	**Strategic Delivery Plan Reference**
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	2A	2.1
Productive: We will improve our productivity and design and deliver services that are financially sustainable.			
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.			

Risks and Assurances

The move to L2P has highlighted doctors who are significantly behind with their appraisals. This situation is being closely monitored by the appraisal lead and the doctors are being actively supported to take action to bring themselves in line with requirements.

Consultation

The People and Culture Committee, 29 April 2026.

Governance or Legal Issues

N/A.

Net Zero Duty Implications

In compliance with the NHS move towards net zero carbon emissions, the Trust must consider statutory emissions and environmental targets in their decisions. Reports should identify related impacts on workforce and system leadership; sustainable models of care; digital transformation; travel and transport estates and facilities (including capital projects, asset management and utilities, green space and biodiversity); medicines; supply chain and procurement; food and nutrition and adaptation.

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

Not applicable.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

The above has been considered but no impact has been identified.

Recommendations

The Board of Directors is requested to note the contents of this report, which offers assurance as there is a sound system; process, governance and assurance to meet the Trust objectives. However, inconsistent application arises in terms of the engagement of individual clinicians and is managed by the Deputy Medical Director via the Clinical Directors.

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

Report prepared by: **Mark Broadhurst**
Medical Appraisal Lead

Medical Appraisal and Revalidation within DHcFT

1) Background to medical appraisal and revalidation

Every licensed doctor must revalidate every five years to show that they are up to date and fit to practice. This report relates to all doctors in non-training posts (Consultant Grade and SAS Grade) employed by the Trust. There is a separate process for doctors in training.

Evidence to support revalidation is collected through annual appraisal whereby information on learning, feedback from colleagues and patients, complaints and serious incidents is reflected on. This information is reviewed by the Responsible Officer who will make a recommendation to the General Medical Council (GMC). The recommendation options are:

- Revalidation to go ahead
- Deferral for three to six months due to insufficient evidence
- Non engagement with process.

2) Situation in DHcFT

At the end of the appraisal year, 1 April 2025 to 31 March 2026 (data as of 2 March 2026), the Trust had 137 doctors eligible for revalidation. These are doctors who are employed by the Trust in non- training posts. As such, they are a mix of Consultant grade, Staff and Specialty grade doctors.

The Trust currently has 30 doctors trained to carry out medical appraisals. Training for new appraisers is carried out on a two-yearly basis. Appraisers carry out a varying number of appraisals per year depending on their availability. This work is carried out as part of their Supporting Professional Activities (SPA).

The Trust's Deputy Medical Director has a medical appraisal portfolio, whose role includes supporting appraisers, carrying out appraisals, updating the medical workforce about appraisal and revalidation and working with the Responsible Officer to ensure standards are met for revalidation. This role is supported by Medical Staffing colleagues and by the Personal Assistant to the Medical Director who work collectively as the Revalidation team.

In August 2023, DHcFT moved from using the MAG form (a pdf proforma) to using the L2P electronic platform for the recording and management of medical appraisals. This has provided significant benefits to individual doctors, appraisers and the Revalidation team. Benefits include a clearer view of the status of each doctor with regards to appraisal and revalidation and easier to complete documentation for appraisal making it easier for doctors and their appraisers to complete. L2P allows reports to be run from the system which shows analysis of data by grade or workplace.

3) Revalidation Data

Doctors are revalidated every five years. Between 13 February 2025 and 28 Feb 2026, DHcFT had eight doctors due for revalidation. The outcome for these was:

- Number of doctors revalidated: seven
- Number of revalidation deferrals: two
- Reason for deferral: insufficient evidence – one doctor
- non engagement – one doctor.

Both doctors who had their revalidation deferred have now completed the necessary work and have been revalidated.

This is an improvement on the previous year (13 February 2024 - 13 February 2025) when 10 doctors had their revalidation deferred; nine due to insufficient evidence and one due to non-engagement.

Appraisal data overview

The appraisal year runs from 1 April to 31 March. For the appraisal year 1 April 2025 to 31 March 2026: (data up until 28 February 2026): Number of doctors: 137

Doctors with appropriate reasons to have appraisal delayed: Five doctors presently eligible to participate in appraisal: 132

Eligible doctors with up-to-date appraisal: 127 = 96%

The monthly compliance figures (%) for the past year are shown below:

2025										2026		
Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
80.33	95.90	91.06	90.32	89.43	87.80	77.27	81.82	77.37	75.91	92.59	96.21	96

4) Appraisal data by Directorate

Directorate	Number of doctors with late appraisals
Working Age Adult Acute and PICU	2
Working Aage Adult Community and Assessment	2
Forensic and Rehab and Substance Misuse	1
Perinatal, Children's and ED	1
Older Adults	1

5) Audit of revalidation and medical appraisal processes

An audit carried out by the Trust external auditors in September 2025, audit identified one medium priority action and six low priority actions. There were no high priority actions. All actions have now been completed.

Actions included:

Medium priority

a) evaluation of the quality assurance processes in place and update of these as needed.

Low priority

b) updating the appraisal policy
c) developing a job description for appraisers
d) formalising the schedule for training of appraisers
e) formalising the reporting of medical appraisal compliance to the People and Culture Committee
f) reviewing quoracy and if necessary Terms of Reference for ROAG
g) Triangulation of information about serious incidents and complaints.

6) Plans to continue to improve the robustness of the medical appraisal and revalidation processes with DHcFT

We have formalised the escalation process which will be implemented when doctors risk becoming out of date with appraisal.

This involves a series of reminders to the doctors and notifications escalating through the Medical management tiers. It is a stepped process, overseen by the Responsible Officer Advisory Group (ROAG) which follows NHSE guidance. Advice from the GMC Liaison Officer is sought by the Responsible Officer at the appropriate stage of escalation.

Regular updates have been provided to the medical workforce via the Medical Senate in the Executive Medical Director report to reinforce the importance of appraisal and revalidation and the need for prioritisation of this.

Classification: Official

Publication reference: PR1844

NHS England

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.2 Feb 2023

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – [*delete as applicable*] of [*insert official name of DB*] can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: The DHCFT Responsible Officer will continue to discharge the role and responsibilities on behalf of the medical staff and will provide appropriate support to the Medical Appraisal Lead
Comments: Dr Kunigiri is the recently appointed DHCFT Responsible Officer.
Action for next year: To continue.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes
Action from last year: Training for new and existing appraisers is scheduled for November 2025.
Comments: DHCFT has embedded the L2P electronic platform into its processes for appraisal. All doctors eligible for appraisal have access and receive an induction to the process from the appraisal lead. L2P is now the only platform used for medical appraisal.
Training for appraisers most recently occurred in November 2025.
Internal audit identified an opportunity to strengthen appraisal in DHCFT by implementing a documented, recurring training schedule for medical appraisers, specifying frequency and content areas. This will be implemented over the next year.
Action for next year: Continue to embed the use of L2P across the medical body.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: To continue to use current systems to maintain accurate information.
Comments: The medical appraisal lead ensures an accurate record is kept on the electronic system L2P. This happens through liaison with medical staffing colleagues and the workforce information team to highlight new starters and leavers to the Trust. This information is cross refenced with the GMC connect site which lists those medical practitioners with a prescribed connection to DHCFT.
Action for next year: To continue to use current systems to maintain accurate information.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: The policy will continue to be reviewed in line with DHCFT timeframes. It is due for review in September 2026.
Comments: Internal audit identified areas in the policy which could be improved to increase robustness of DHCFT medical revalidation processes. In particular, recommendations were to; include up to date links to external guidance, include responsibilities of committee/groups with oversight of medical appraisal, include responsibilities of individual appraisers and appraisees and include up to date information on the reminders process.
Action for next year: The policy has been updated and will be followed from this year.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: Consideration to be given to peer review during future appraisal cycles.
Comments: The DHCFT Medical Appraisal Lead has established regular contact with the Medical Appraisal Lead in a neighbouring Trust (Nottinghamshire). Quarterly meetings take place with a focus on national updates, comparison of local (anonymised) data and sharing of best practice.
Action for next year: To continue with and develop this link and widen across the region.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: To continue with current arrangements as detailed below.
Comments: Locums and short-term placement doctors are contacted by the medical appraisal lead and arrangements put in place for their appraisal as required. Agency locums may carry out their appraisal through their agency or can do this through DHCFT. All medical staff have access to CPD, appraisal, revalidation, and governance.
Action for next year: To continue with this arrangement.

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1]

Action from last year: To continue to use our electronic appraisal system to support all doctors to complete their appraisal in line with GMC standards with focused support for those who are not meeting required timescales.

Comments: Quality of appraisals continues to be good and appraisals are carried out to a high standard. Completion of appraisals within required timeframes is an ongoing challenge. L2P's electronic platform provides greater transparency about individual doctors appraisal status and allows targeted support to those doctors who are not in line with standards.

Internal audit suggested reinforcing the need for corroborative data by the compliments and complaints team to feed into appraisal.

Action for next year: To continue to utilise the electronic system to improve identification and support for those doctors who are delayed.

Ensure mechanism in place for complaints, compliments data.

7. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

Action from last year: To continue to improve compliance with appraisal timeframes.

Comments: Systems have been developed in DHCFT to formalise the escalation process when doctors are falling behind with appraisal. Involvement of operational managers and Clinical Directors forms part of this process and an individual meeting with the RO may take place. Escalation is co ordinated through the Responsible Officer Advisory Group (ROAG) which meets bi-monthly.

In September 2024 all doctors eligible for appraisal were sent a letter from the Responsible Officer clearly outlining the expectations for appraisal, requirements for revalidation and potential consequences of not complying with the process.

Escalation processes are in place for the other doctors falling behind with appraisal with the development of automated reminders through the L2P appraisal platform. The escalation process is monitored through the ROAG with feedback to individuals Clinical Director.

Action for next year: To continue to improve compliance with appraisal timeframes through the above processes.

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: The Policy will be reviewed according to DHCFT timeframes – next review September 2026.

Comments: The policy has been updated early in line with recommendations from internal audit carried out by 360 Assurance.

Action for next year: New policy to be followed in the upcoming appraisal year

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: To continue to maintain adequately trained appraisers through training new appraisers in order to account for retirements and resignations.
Comments: DHCFT has maintained appropriate numbers of appraisers. New doctors have joined the existing cohort following appropriate training. Further training is planned for November 2025.
Action for next year: To continue to maintain adequately trained appraisers through training new appraisers in order to account for retirements and resignations.

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: Further appraisal training planned in November 2025. This is for existing and new appraisers.
Comments: Medical appraisers receive support through informal group and individual discussion with peers and the appraisal lead. Internal audit has identified a need for a more robust mechanism to gain feedback on appraisers performance
Action for next year: More robust mechanism for collecting and monitoring feedback for appraisers

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

Action from last year: A quality assurance audit to be carried out
Comments: All annual appraisals are reviewed by the medical appraisal lead once they are submitted. Any issues raised by the appraiser or picked up by the appraisal lead at this stage will lead to further amendments by the doctor before the appraisal is signed off. Prior to revalidation, the appraisal lead and RO review all appraisals for that revalidation cycle for the individual doctor. Standards are measured against GMC requirements for revalidation. Any further information required will then be requested prior to revalidation.
Action for next year: To continue with this quality assurance process.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2026	134
Total number of appraisals undertaken between 1 April 2025 and 31 March 2026	99
Total number of appraisals not undertaken between 1 April 2025 and 31 March 2026	27
Total number of agreed exceptions	13

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: To continue with regular liaison meetings.
Comments: The Responsible Officer has regular, documented meetings with the GMC Employment Liaison officer. Fitness to practice issues and thresholds of referral are discussed and noted.
Action for next year: To continue with regular liaison meetings.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: To continue with high levels of compliance in this area.
Comments: All revalidation recommendations have been made within appropriate timeframes.
Action for next year: To continue with high levels of compliance in this area.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: To look further at the use of data to inform individual doctors practice and comparison amongst groups of doctors.
Comments: Quality Improvement activity is undertaken across services and by individuals to look at their own practice. Feedback is given about complaints and serious incidents. There is a drive within DHCFT to make data accessible to clinicians to support improved care and outcomes for example reviewing prescribing data.
Action for next year: To look further at the use of data to inform individual doctors practice and comparison amongst groups of doctors.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: To continue with and develop the approach below.
Comments: Individual doctors and the Appraisal Lead are able to link in with the Patient Experience Team for details of any complaints or serious incidents involving them. Internal audit has identified the need to increase the use of this facility in all appraisals
Action for next year: To improve the robustness of this occurring in all appraisals.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: To continue and develop the approach below.
Comments: Processes are in place involving the Patient Experience Team to review concerns. The RO is in regular contact with the GMC Liaison Officer to discuss any concerns. The Medical Disciplinary Policy has been extensively revised and ratified by the People and Culture Committee.
Action for next year: To continue and develop this approach.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: Formal disciplinary matters are reported to People and Culture Committee along with other professions. This report has narrative on numbers, type (conduct & capability) and breakdown of protected characteristics
Comments: We will continue to work with Deputy Director of Human Resources, who is now engaged with the governance of Responsible Officer Advisory Group and is familiar with the practice of medical disciplinary policy
Action for next year: This work is ongoing and will continue

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.
[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Action from last year: Continue with the plan to liaise with other ROs and stakeholders

Comments: Responsible Officer Advisory Group workflow will continue to support effective communication.

Action for next year: Continue with the plan to liaise with other ROs and stakeholders

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Continue to work with Deputy Director of HR in educating non-medical colleagues about disciplinary policy for medics

Comments: Medical Managers and Employee Relations Team work closely in the context of any concerns about doctors. Maintaining High Professional Standards policy is well embedded and understood. A Trust reorganisation has resulted in a new team of Medical Managers and Operational leads in our care groups and services. The Trust are supporting all managers to undertake development programme to ensure that such policies are understood and used

Action for next year: Ongoing support for all managers in the Trust (both Medical and operational) to gain/increase knowledge of disciplinary policy for medics.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: Pre-employment checks are completed by Medical HR team focussing on registration, qualifications, DBS checks. Section 12 status and Approved Clinician Status was included as part of pre-employment check. We have access to the national database for Section 12 status and Approved Clinician status.

Comments: Continue with current practice. This year we have done international recruitment and adhered to GMC guidelines for sponsor of international candidates.

Action for next year: This continues as previously

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- **General review of actions since last Board report**

Medical appraisal within DHCFT has been the subject of significant focus over the past few years. Investment into the electronic platform L2P has allowed greater transparency on individual doctors appraisal status as well as streamlining and simplifying the overall process both for the individual doctor and the appraisal team. Recent internal audit has highlighted areas for revision in order to increase the robustness of appraisal and revalidation processes within DCHFT. These actions are being implemented.

- **Actions still outstanding**

Many actions in this report are ongoing and build on the previous year's work. There has been significant progress in raising the profile of appraisal and revalidation through the efforts of the RO supported by the appraisal team. The recommendations of the internal audit process will continue to be embedded.

- **Current Issues**

At the end of the 25/26 appraisal cycle (31st March 2026) 1 doctor remained significantly out of date with their appraisal (more than 5 years of no appraisals) – compared with 4 in 24/25. The doctor works at Consultant Level within DHCFT. Escalation processes are in place for this doctor and progress is being made by the doctor and Clinical Director supporting them.

- **New Actions:**

Actions from internal audit have been accepted and are being implemented

Overall conclusion:

There has been ongoing progress in raising the profile of appraisal and revalidation through the efforts of the RO supported by the appraisal team. Continued work is necessary to ensure this progress is evidenced in our data and it is hoped that the actions identified and implemented by internal audit will assist with this.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief Executive or Chairman (or Executive if no Board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

NHS England
Skipton House
80 London Road
London
SE1 6LH

This publication can be made available in a number of other formats on request.

Publication reference: PR1844

Annual Compliance Report for NHS England (Annex C, Annual Organisational Audit)

Designated Body:	**Derbyshire Healthcare NHS Foundation Trust - Medics**
Start date of period:	1 April 2025
End date of period:	31 March 2026
Report generated on:	20 April 2026 12:45
Report generated by:	Mark Broadhurst
File name:	NHS England annual compliance report 01-04-2025 to 31-03-2026 (run 20-04-2026 12-45).xlsx

AOA Reference	Item	Number of prescribed connections	Completed appraisals (1)	Optional completed appraisals (1a)	Approved incomplete or missed appraisal (2)	Unapproved incomplete or missed appraisal (3)	Total
2.1.1	Consultants	81	66	41	8	11	85
2.1.2	Staff grade, associate specialist, specialty doctor	48	30	19	17	2	49
2.1.3	Doctors on Performers Lists	1	1	1	0	0	1
2.1.4	Doctors with practising privileges	0	0	0	0	0	0
2.1.5	Temporary or short term contract holders	3	2	1	1	0	3
2.1.6	Other clinicians with a prescribed connection	1	0	0	1	0	1
2.1.7	**Total of 2.1.1 - 2.1.6**	134	99	62	27	13	139

The NHS England rules have been applied as follows, based on a reasonable interpretation of the rules in terms of the L2P data.

For every clinician with a prescribed connection:

If the clinician had any appraisals with a meeting date in the reporting year, count those appraisals (see below).

Otherwise:

If the clinician had any appraisals with an appraisal month in the reporting year, count those appraisals (see below).

Otherwise the clinician had no appraisals in the reporting year or no appraisal dates set, so the clinician is counted in measure 2.

For every appraisal counted above:

If the meeting date was in the reporting year and the appraisal was signed off:

If the meeting was within the 3 months before the due date AND the submission was within 28 days of the meeting date AND the submission was in the reporting year, then both measure 1 and optional measure 1a.

Otherwise, just measure 1.

If the meeting date was in the reporting year and the appraisal was not signed off:

If the appraisal was on time, then measure 2.

If the appraisal was late and the reason was understood and accepted, then measure 2.

Otherwise, measure 3.

Otherwise, the meeting date was not in the reporting year:

If the meeting date was early (ie before the reporting year) and the appraisal was submitted early or on time, then measure 2.

If the appraisal was late and the reason was understood and accepted, then measure 2.

Otherwise, measure 3.

Note that if any clinicians had more than one appraisal in the reporting year, the total may be higher than the number of prescribed connections.

The data used to arrive at the figures above can be found in the 'Clinicians and appraisals' worksheet.

Modern Slavery Statement

Purpose of Report

To present the Trust's Annual Modern Slavery Statement for 2025/26 for approval.

Executive Summary

The Trust's Annual Modern Slavery Statement for 2025/26 is attached. This statement has been considered and supported by the People and Culture Committee to assess whether the Trust has met the criteria for the preceding financial year.

The statement has been reviewed by the Head of Strategic Procurement and Tendering, the Assistant Director, Safeguarding Adults, the Strategic Recruitment Lead and the Head of Equality, Diversity and Inclusion. Their amendments/additions are shown in highlighted text.

The Board is requested to approve the Statement, and this will be uploaded to the Trust's website, replacing the previous version.

Strategic Considerations		BAF Risk (eg 1A)	Strategic Delivery Plan Reference
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	1A	1.1
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X	2B	2.1,2.3
Productive: We will improve our productivity and design and deliver services that are financially sustainable.			
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.			

Risks and Assurances

The Board receives assurance that the Trust is discharging its statutory duties regarding the modern slavery statement through the statement which it approves on an annual basis.

Consultation

Head of Strategic Procurement and Tendering, the Assistant Director, Safeguarding Adults, the Strategic Recruitment Lead and the Head of Equality, Diversity and Inclusion, the People and Culture Committee

Governance or Legal Issues

The Trust has to publish an annual statement setting out the steps they take to prevent modern slavery in their business and their supply chains. This is a requirement under Section 54 (Transparency in Supply Chains) of the Modern Slavery Act 2015. The statement must be updated every year and published on the Trust website within six months of the financial year end.

Net Zero Duty Implications

In compliance with the NHS move towards net zero carbon emissions, the Trust must consider statutory emissions and environmental targets in their decisions. Reports should identify related impacts on workforce and system leadership; sustainable models of care; digital transformation; travel and transport estates and facilities (including capital projects, asset management and utilities, green space and biodiversity); medicines; supply chain and procurement; food and nutrition and adaptation.

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

Nothing specific for this report.

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 commits to the design and implementation of services, policies and measures that meet the diverse needs of services, the population and workforce, ensuring that none are placed at a disadvantage over others.

The Trust has to publish an annual statement setting out the steps they take to prevent modern slavery in their business and their supply chains. This is a requirement under Section 54 (Transparency in Supply Chains) of the Modern Slavery Act 2015. The Statement must be updated every year and published on the Trust website within six months of the financial year end.

Recommendations

The Board of Directors is requested to approve the revised Modern Slavery Statement for 2025/26 for publishing on the Trust's website, replacing the previous version.

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

Report prepared by: **Justine Fitzjohn**
Director of Corporate Affairs and Trust Secretary, assisted by Jo Bradbury, Corporate Governance Officer

MODERN SLAVERY STATEMENT – 2025/26

INTRODUCTION

This Statement is made pursuant to section 54 of the Modern Slavery Act 2015 and sets out the steps that Derbyshire Healthcare NHS Foundation Trust (the Trust) has taken, and is continuing to take, to make sure that modern slavery or human trafficking is not taking place within our business or supply chain.

Modern slavery encompasses slavery, servitude, human trafficking and forced labour. The Trust is committed to preventing all forms of modern slavery and human trafficking and to acting ethically, with integrity and transparency in all business dealings. The Trust has a zero-tolerance approach to any form of modern slavery. We are committed to acting ethically and with integrity and transparency in all business dealings and to put effective systems and controls in place to safeguard against any form of modern slavery taking place within our business or our supply chain, supported by safeguarding teams, Equality, Diversity and Inclusion (EDI) leads, and System partners.

The Trust recognises that modern slavery disproportionately affects individuals and groups experiencing inequality, including people from ethnic minority backgrounds, migrants, individuals with disabilities, and those facing socio-economic disadvantage. We are committed to addressing these risks through an inclusive, anti-discriminatory and trauma-informed approach.

AIM OF THIS STATEMENT

The aim of this statement is to demonstrate that the Trust follows good practice, and all reasonable steps are taken to prevent slavery and human trafficking.

All members of staff have a personal responsibility for the successful prevention of slavery and human trafficking, with the Procurement Department taking the lead responsibility for compliance in the supply chain.

ABOUT THE ORGANISATION

The Trust is a provider of mental health, learning disability and children's services across the city of Derby and wider county of Derbyshire. We provide a variety of inpatient and community-based services throughout the county. We also provide specialist services across the county including substance misuse and eating disorders services.

Successful partnership working is essential to the delivery of many of our services. The Trust works in close collaboration with our commissioners and fellow providers of local healthcare services, together with local authority colleagues at Derby City Council and Derbyshire County Council, and voluntary and community sector organisations. Derbyshire Healthcare is an active partner in Joined Up Care Derbyshire, an Integrated Care System of health and care organisations working collectively to address challenges and improve the level of joined up working within the local health and care economy.

The Trust provides services to a diverse population, including areas of wealth alongside significant deprivation. The Trust's catchment area includes both city and rural populations, with over 70 different languages being spoken. This diversity requires culturally competent approaches to identifying and responding to exploitation, including modern slavery and human trafficking.

We became a Foundation Trust in 2011 and we employ over 3,500 staff based in over 60 locations across the whole of Derbyshire. Across the county and the city, we serve a combined population of approximately one million people.

OUR POLICIES ON SLAVERY AND HUMAN TRAFFICKING

The Trust is aware of its responsibilities towards patients, service users, employees and the local community and expects all suppliers to the Trust to adhere to the same ethical principles. The Trust is committed to ensuring that there is no modern slavery or human trafficking in our supply chains or in any part of our business. Our internal policies replicate our commitment to acting ethically and with integrity in all our business relationships.

This approach is aligned with the Equality Act 2010 and the Public Sector Equality Duty, ensuring that individuals with protected characteristics are safeguarded from exploitation and discrimination.

Currently all awarded suppliers sign up to our terms and conditions of contract which contain a provision around Good Industry Practice to ensure each supplier's commitment to anti-slavery and human trafficking in their supply chains; and that they conduct their businesses in a manner that is consistent with the Trust's anti-slavery policy.

The Trust policies, procedures, governance and legal arrangements are robust, ensuring that proper checks and due diligence are applied in employment procedures to ensure compliance with this legislation. We also conform to the NHS employment check standards within our workforce recruitment and selection practices. This strategic approach incorporates analysis of the Trust's supply chains and its partners to assess risk exposure and management on modern slavery.

If required, the information may also be provided in other languages.

We operate several internal policies to ensure that we conduct business in an ethical and transparent manner. These include the following:

Recruitment and Selection policy and procedure: We operate a robust recruitment policy including conducting eligibility to work in the UK checks for all directly employed staff. Other checks include checks of identity, evidence of qualifications, health clearance, employment history and Disclosure Barring Service criminal records check for roles that meet the requirements. External agencies are sourced through the NHS England nationally approved frameworks and are audited to provide assurance that pre-employment clearance has been obtained for agency staff to safeguard against human trafficking or individuals being forced to work against their will.

The Trust recognises that certain workforce groups, including internationally recruited staff, agency workers, and those in lower-paid roles, may be at increased risk of exploitation. Safeguards are in place to support these staff and ensure fair and safe working conditions.

Equal Opportunities: We have a range of controls to protect staff from poor treatment and/or exploitation which comply with all respective laws and regulations. These include provision of fair pay rates, fair terms and conditions of employment, and access to training and development opportunities.

Safeguarding Policies: We adhere to the principles inherent within both our Safeguarding Children and Adults policies and procedures. These provide clear guidance so that our employees are aware as to how to raise safeguarding concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain.

Freedom to Speak Up Policy: We operate a Speak Up policy so that all employees know that they can raise concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain, without fear of reprisals.

Standards of Business Conduct (within Standing Orders): This policy explains the manner in which we behave as an organisation and how we expect our employees and suppliers to act.

PARTNERSHIP WORKING

The Trust works collaboratively with system partners including local authorities, safeguarding partnerships, voluntary and community sector organisations, and law enforcement partners to prevent and respond to modern slavery. This includes information sharing, joint safeguarding responses, and contribution to local strategic priorities.

WORKING WITH SUPPLIERS

The Procurement Team ensures that due diligence is undertaken for all new and ongoing suppliers of goods and services to the organisation and their associated Supply Chains by sourcing through the following compliant routes:

1. Competitive Procurement Act 2023 (Public Contract Regulations) procurements tendered in compliance with UK guidance which require suppliers to confirm they comply with the Modern Slavery Act. To support their response bidders are also required to state:

   a. the organisation's structure, its business and its supply chains;
   b. its policies in relation to slavery and human trafficking;
   c. its due diligence processes in relation to slavery and human trafficking in its business and supply chains;
   d. the parts of its business and supply chains where there is *a risk of slavery and human trafficking taking place, and the* steps *it* has *taken to* assess *and manage that risk;*
   e. its effectiveness in ensuring that slavery and human trafficking is *not taking place in its business or supply chains, measured against such performance indicators as it considers appropriate;*
   f. the training and capacity building about slavery and human trafficking available to its staff.

2. Procurement through compliant national government frameworks. The Trust purchases large amounts of products from third party distributors such as NHS Supply Chain and utilises framework agreements from national framework providers such as Crown Commercial Services (CCS) which include specific questions around the Modern Slavery in their procurement documentation and any breaches of labour laws which result in disqualification of unsuitable organisations.

3. All contracts and associated purchase orders are raised on the NHS Standard Terms and Conditions which suppliers are mandated to comply with. These conditions state:

   10.1.28 it shall: (i) comply with all relevant Law and Guidance and shall use Good Industry Practice to ensure that there is no slavery or human trafficking in its supply chains; and (ii) notify the Authority immediately if it becomes aware of any actual or suspected incidents of slavery or human trafficking in its supply chains;

   10.1.29 it shall at all times conduct its business in a manner that is consistent with any anti-slavery Policy of the Authority and shall provide to the Authority any reports or other information that the Authority may request as evidence of the Supplier's compliance with this Clause 10.1.29 and/or as may be requested or otherwise required by the Authority in accordance with its anti-slavery Policy.

TRAINING

Advice and training about Modern Slavery and human trafficking is available to staff through our mandatory Safeguarding Children and Adults training programmes, our Safeguarding policies and procedures, and our Safeguarding Leads. It is also discussed at our compulsory staff induction training.

The compliance target for mandatory Safeguarding training is 95%; as at May 2026 compliance is at 92% (Adult) and 95% (Children).

Awareness is also raised through information sharing on the Trust intranet and our public website.

Advice and training about Modern Slavery and human trafficking is available to staff through our Safeguarding Children and Adults training programme. The Trust is committed to and follow the Derbyshire and Derby Safeguarding Adults Policy and Procedures and the Derby and Derbyshire safeguarding Children Partnership Procedures.

Training also supports staff to recognise how exploitation may present across diverse communities, including cultural, language and socio-economic barriers to disclosure.

OUR PERFORMANCE INDICATORS

We will know the effectiveness of the steps that we are taking to ensure that slavery and/or human trafficking is not taking place within our business or supply chain if:

- No reports are received from our staff, the public, or law enforcement agencies to indicate that modern slavery practices have been identified
- Assurance is not derived solely from the absence of reported cases, it is triangulated through a range of indicators, including workforce training compliance, safeguarding activity and reporting and established escalation pathways
- The Trust also seeks assurance through the regular review of safeguarding data for potential indicators of exploitation, audit of workforce awareness and confidence in identifying and reporting modern slavery, monitoring of Freedom to Speak Up concerns and active engagement with multi-agency safeguarding partners
- In addition, the Trust will continue to strengthen assurance through improved data capture, targeted audits and enhanced workforce awareness to support the early identification of hidden harm.

BOARD OF DIRECTORS' APPROVAL

The Board of Directors has considered and approved this statement and will continue to support the requirements of the legislation.

This statement is made pursuant to Section 54(1) of the Modern Slavery Act 2015 and constitutes our organisation's modern slavery and human trafficking statement for the current financial year.

Signed on behalf of the Board of Directors:

Selina Ullah
Trust Chair

Mark Powell
Chief Executive

Special Education Needs and Disabilities (SEND) annual report

Purpose of Report

To meet the quality requirement in schedule from Derbyshire Integrated Care Board (ICB) to provide an annual report of SEND.

Executive Summary

The requirement from the ICB state that our current position and future plan of development in relate to SEND in the follow areas.

1. SEND self-assessment and action plan
2. Quality Assurance of health advice - audit
3. KPI performance- SEND Dashboard
4. Staff training
5. Children and Young People (CYP)/family's satisfaction, feedback and co-production
6. Governance - how does the SEND workstream fit within the organisation
7. Transition to Adult services.

This was a new requirement for 2022/23; therefore, this is the fourth annual report.

Strategic Considerations		BAF Risk (eg 1A)	Strategic Delivery Plan Reference
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	1a	1.1; 1.2; 1.3
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.			
Productive: We will improve our productivity and design and deliver services that are financially sustainable.			
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.			

Risks and Assurances

The Trust has limited assurance in some areas of the report due to the new nature of the requirements.

Consultation

- All service lines within the Children's Division have been consulted and some limited involvement from Adult Learning Disability and Neurodevelopmental services. Feedback from children/young people and their families has been included
- Quality and Safeguarding Committee, 7 May 2026

Governance or Legal Issues

- Children and Families Act 2014
- Ofsted and CQC SEND inspection framework.

Net Zero Duty Implications

In compliance with the NHS move towards net zero carbon emissions, the Trust must consider statutory emissions and environmental targets in their decisions. Reports should identify related impacts on workforce and system leadership; sustainable models of care; digital transformation; travel and transport estates and facilities (including capital projects, asset management and utilities, green space and biodiversity); medicines; supply chain and procurement; food and nutrition and adaptation.

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

Net Zero implications in the delivery SEND are accounted for in the Trust's Green Plan.

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:

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

The aim of the report is to improve access and outcomes for children with Special Educational Needs and Disabilities in Education and Health. No protected characteristics should be disadvantaged by this report, but it is limited under 25 years of age. This limit is set by legislation.

Recommendations

The Board of Directors is requested to note the limited assurance accepted by the Quality and Safeguarding Committee in some areas of the report due to the new nature of the requirements.

Report presented by: **Lynn Andrews**
Chair, Quality and Safeguarding Committee

Report prepared by: **Susan Walker**
SEND Clinical Co-ordinator

Louise Jenkins
Assistant Director of Children's Safeguarding and Head of Professional Practice

Derbyshire Healthcare
NHS Foundation Trust

Special Educational Needs and Disabilities (SEND) annual report

May 2026

www.derbyshirehealthcareft.nhs.uk

DHCFT DERBYSHCFT NHS_DERBYSHIREHEALTHCARE

Special Educational Needs and Disabilities (SEND) annual report

Introduction

This is the fourth annual report for Derbyshire Healthcare NHS Foundation Trust (DHcFT) regarding Special Educational Needs and Disabilities (SEND). The Children and Families Acts 2014 Section 3 first introduced significant responsibilities for health, social care and education to work closely together to improve outcomes for children and young people (CYP) (0-25 years old) who have special education needs or disabilities.

These reforms were monitored through the first round of local area SEND inspections (joint CQC and Ofsted) up to 2022. The current Framework of SEND inspection has been in place now for three years and all area are expected to be visited within five years. Derbyshire Local Area (Derbyshire County Council area) was inspected in September 2024 which found “widespread and/or systemic failings leading to significant concerns about the experiences and outcomes of CYP with special educational needs and/or disabilities (SEND), which the local area partnership must address urgently” (Ofsted/ CQC 2024). Focus has been on how the local area can demonstrate it makes a positive impact on outcomes for this group of people. Derbyshire is due to be reinspected in May 2026. Derby City are expecting their inspection.

In response to the current SEND inspection framework, the Integrated Care Board for Derbyshire (ICB) has updated some of its requirements as part of the quality assurance for services who see people up to the age of 25. This report has been completed to meet this requirement and will support the priority action plan in Derbyshire and planning for inspection in Derby City.

The requirements for this report are:

1. *SEND self-assessment and action plan*
2. *Quality Assurance of health advice - audit*
3. *KPI performance - SEND Dashboard*
4. *Staff training*
5. *CYP/family's satisfaction, feedback & co-production*
6. *Governance- how does the SEND workstream fit within the organisation*
7. *Transition to adult services*

SEND Self-assessment, Local offer and Action Plan

The Local Offer websites for both Derby City and Derbyshire have been audited to ensure that our services information is on the website and is up to date. Both areas local offer websites provide a brief description of the services and the appropriate link to the Trust website to ensure information is up to date. This was last audit by the SEND Clinical Co-ordinator in March 2026.

The SEND self-assessment for the last five years has been regularly completed by the Service Leads and SEND Clinical Co-ordinator and has been updated April 2026. This is reviewed by the Leadership team in Perinatal, Child and Adolescent Mental Health services (CAMHS), Eating Disorders and the Adult Neurodevelopmental Care Group and updates of progress reports are sent Quality and Safeguarding Committee.

Progress has been made on this self -assessment, particularly around staff training and awareness of processes to meet our statutory responsibilities regarding the Education, Health and Care Plan (EHCP) assessment process. We have a good working relationship with the Integrated Care Board (ICB) and both Derby City and Derbyshire Councils' SEND departments are supporting initial assessment. The SEND Clinical Co-ordinator works with the DCO (SEND) to support those which are going the SEND extend tribunal appeals. This year there has been a change in the profile of those who are requesting an extended appeal tribunal who those over 18 years old having a significant increase in numbers. This would fit with the Derbyshire SEND inspection finding lack of involvement and poor quality of annual reviews in post 16 settings and is involving a wider range of services within the Trust than previously.

Planned Development

The self-assessment shows that annual reviews remain an area of development. To be able to progress this, we need to engage the local authorities to ensure we are aware of all those with and EHCP on our caseloads. We are able to identify those on caseload and report on it (see SEND Dashboard data). We are currently working with the ICB to progress this.

Quality Assurance of Health Advice - Audit

The quality schedule from the ICB and the Children and Families Act 2014 states that we must provide good quality health advice for CYP who are receiving a service from the Trust within six weeks of request as part of the statutory assessment process for EHCP. An audit tool was developed in partnership with the ICB and other local health providers to meet the NHS standards for report. We have also completed random sample audits in each service and results have been fed back to services.

Service	Compliance in audit
Children's Occupational Therapy	99%
Children's Physiotherapy	100%
Community Paediatrician	99%
Attention Deficit Hyperactivity Disorder (ADHD) Nurses	98%
CAMHS	100%

Other services have not been randomly audited as they complete less than 10 reports per year.

Most services in the Trust are using the check list of NHS standards to have quality assurance by the clinical lead before every report is sent to the Local Authority. This is reflected in the results of the audit. These are very positive results. We are still getting the occasional abbreviation or unexplained diagnosis, but generally the reports are of a high standard, and we have received positive feedback from the ICB regarding the high quality.

There is a standard template for providing the initial advice has embedded this year. Services have developed some standards phased for the provision that will offered which can be tailored to the individual.

The number of SEND Extended Tribunal appeals (appeals which involve the health component of the EHCP) have increased over the last 12 months. The quality of the report writing has meant that no health professional from the Trust has had to attend a hearing in person. However, there has been an increase in the numbers involving over 18s which are open to our services.

Planned Development

To continue to audit initial EHC health needs reports to ensure to continued high standards are maintained. To consider if this audit process needs to be extended to cover annual review reports once an agreed system has been developed for notifications.

KPI Performance- SEND Dashboard

The only KPI we are currently being asked to report on is the compliance with the statutory six-week timescale for providing EHC health advice as part of the initial EHCP assessment.

Summary of KPI data across Derbyshire and Derby City

	2025									2026		
Letter Requests/Number of Plans	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Letter1	14	20	27	25	1	1	2	0	1	0	1	0
Letter2	186	120	118	202	131	102	216	142	228	153	199	173
EHCP Draft	15	43	8	5	3	23	53	61	69	79	57	111
EHCP	37	41	83	82	26	52	74	31	70	75	70	98
	2025									2026		
Response Times (by Month of Response) for Children Open in Reporting Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
No. Letter 2 Responses with Preceding Letter 2	168	143	108	189	148	115	191	141	163	165	243	170
No. Letter 2 Responses within 42 Days	168	143	108	189	148	115	191	141	163	165	243	170
Letter 2 %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
No. Letter 2s where Response Date Deadline Falls in Month (42 days after Letter 2 Request)	227	224	86	167	109	178	115	147	209	169	141	225
No. Letter 2s Due where Response Recorded and Within 42 Days	227	224	86	167	109	178	115	147	209	169	141	225
% Letter 2s Due where Response Recorded and Within 42 Days	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

This compliance is a significant achievement, particularly as the demand for EHC health report has again grown by 17% this year, having increased by 13% 24/25 and 41% 23/24. The majority of this growth has been from Derbyshire County Council, whereas Derby City's numbers of request have been consistent. The Trust has supported the SEND Clinical Co-ordinator with the support role of the SEND Process Co-ordinator (0.2wte) being made substantive.

There continues to be significant challenges within these processes this year with Derbyshire County Council's Derbyshire EHC Hub (by IDOX). The way the system was implemented alongside significant staffing changes within the council's SEND department has meant progress has been slow. Therefore, the Trust, alongside all other health providers with the support of the DCO (SEND) have agreed to continue to use the system in a limited way to reduce the risks involved. We have a health working group for the system and have had intermittent engagement from Derbyshire County Council. This has begun to improve with the stabilisation of the Derbyshire Council's workforce and the last couple of months we have begun to make progress.

The focus until this year has been about the initial health needs assessment. There has been previously less focus on the annual reviews. However, the introduction of the Derbyshire EHC Hub and the provider SEND self-assessments has highlight the inconsistencies around health professionals are being invites to either attend or provide a report. There is no current system in Derby City to monitor if health professionals are being invited to contribute to annual reviews.

We can report and give a wide picture to evidence we meet SEND requirements. This includes the statutory requirement to notify the local authority of children under statutory school age who have or may have SEND (however, it is not a formal KPI). This was an area that was pick up as lack in evidence in the Derbyshire SEND inspection, however we do not provide 0-19's in Derbyshire. The 0-19's service in Derby City can demonstrate they consistently notify the local authority when they refer an under 5 to a specialist service or receive correspondence to indicate they have a disability from a specialist service not within our organisation as part of the disability pathway in the 0-19 service. The Community Paediatricians also complete this notification if a child is diagnosed with a disability.

Local Authority	2025									2026			
Local Authority	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Derby City Council	28	34	35	56	30	25	48	27	21	32	31	28	395
Derbyshire County Council	1	0	3	1	1	2	2	2	1	2	0	0	15
Total	29	34	38	57	31	27	50	29	22	34	31	28	410

The other request for data is for waiting times for CYP who have SEND. There is significant difficulty in identifying this cohort of children and young people. We can identify CYP who have an EHCP, but it is significantly more difficult to identify children and young people who have a special educational need without disability or those who have SEND but being supported at SEND support/graduated response level. This is a national issue as the definition of SEND is that the health or social care need, needs to be having a significant impact on education which cannot be met through normal reasonable adjustments and it's not diagnosis-led. Therefore, without education data of which children are considered to have SEND we are unable to identify accurately which children we should be reporting on. The ICB has now agreed that our stance is that we can only reliable identify those with an EHCP. The quality assurance schedule for the contract is now requiring all health providers to have a visible flag on the health record for those who are known to have an EHCP. Our Trust has this in place for a number of years.

The number of CYP who have an active referral on SystmOne and an EHCP flag.

Unit	Distinct Patient Count
Unknown	88
Community Paediatrics	699
Community Therapy (Occupational Therapy)	205
Community Therapy (Physiotherapy)	274
Derby & South Derbyshire ID SPoE	3
Derbyshire South County SPoA	61
DHcFT - CAMHS	404
DHcFT - Central Services	127
DHcFT - Learning Disabilities	87
DHcFT - Mental Health Inpatients	4
DHcFT - Mental Health WAA Community	163
DHcFT - Urgent & Crisis	3
DHcFT Children's City SPoA	28
Health Visiting	35
School Nursing Service	1105
Senior Disability Health Visitors	2
Specialist Nursing (ADHD)	374
Specialist Nursing (Continence)	111
Specialist Nursing (Learning Disabilities)	84
Specialist Nursing Children in Care	52
Total	**2677**

The total number refers to the number of individuals as some individuals have more than one referral open.

This data is incomplete as we should be aware of all EHCPs in Derby City as we have the 0-19's Integrated Public Health Nurses and the total for them currently stands at 1,142, but Derby City currently have approximately 5000 plans and Derbyshire have approximately 9000 plans. We can only add the flag if the local authority informs us, they have issued an EHCP. This has been consistently raised with the local authorities over a number of years.

Our processes around EHCP initial assessments and data should be considered an area of strength and is recognised by the ICB, who have encouraged the other health providers to adopt the same processes.

Planned Development

The Trust alongside other health care providers and ICB will continue to work with Derbyshire County Council to improve the processes to embed the new Derbyshire EHC Hub (by IDOX). We are currently only using it for initial assessment in the SEND Single Point of Access (SPA) for the Trust. Derbyshire County Council would like for it to be also used for Annual reviews of EHCPs. There is no system in Derby City for notification of annual reviews. We do not have any data and the ability to report around annual reviews needs to be developed.

We know from the data we are not aware a significant number of CYP who have EHCPs. We have agreed to work with both local authorities and ICB to initial ensure health providers are aware of who has an EHCP. Then work on a system of notifications for annual reviews.

The Trust needs to be aware of the potential increased demand in reports that will be required once this is in place. Previously, the focus of report has been within Children's services, but in both Derby City and Derbyshire the number of over 18s now make up approximately a third of those who have an EHCP.

Staff training

We have extended SEND training from just the Children's Care Group to all services which see those under 25 years' old in November 2024. We are using the recommended Council of Disabled Children's e-learning Level 1 and 2. Currently compliance for the Children's Division is 94%, with the Trust as a whole it 81.7%.

We have also begun to roll-out Level 3 training for those who have to write reports and are regularly involved with those CYP with SEND. The first session was held face to face in March with 34 people attending. The feedback was a significant improvement in confidence from 3.29/5 to 4.58/5 in practitioners ability to support CYP with SEND and the EHCP process. The plan is to continue this as a rolling programme.

There is other training available in training passports which support the SEND and reasonable adjustments agenda. This across the whole of the Trust (all ages):

Course	Not Completed	Completed	Total
The Oliver McGowan Mandatory Training on Learning Disability and Autism	313	2,957	3,270 90.43%

The Trust has also rolled out the NHS Oliver McGowan Tier 1 training which the Trust has now brought in house to ensure there are sufficient spaces for al staff to be trained.

We have now embedded SEND as part of the safeguarding information sharing document which goes out to all teams within the Trust, to improve awareness about our legal responsibilities and the events going on in the two local areas we cover.

Planned Development

To develop a paper for the Training Committee for the Level 3 training to be added to training passports as role specific training.

CYP/family's satisfaction, feedback and co-production

Feedback from CYP and families is collected at key stages of the care journey, typically at three months, six months and/or discharge, depending on service pathways and appointment frequency. Collection points vary by service and will be further standardised once the approach is fully embedded and aligned to service-specific requirements.

Feedback is captured through:

- Electronic patient surveys, collected via SystmOne, SMS links or QR codes
- QR codes embedded in appointment letters in some services
- Posters displayed in clinical settings
- Friends and Family Test (FFT).

Overall, feedback is predominantly positive and supportive, and where service change or transformation is underway, patient experience data often reflects these improvements.

Key themes from feedback

Across services, common themes identified include:

- Long waiting times, particularly for CAMHS support
- Young people being required to attend A&E for mental health assessments
- Suggestions for alternative assessment settings for young people experiencing mental health crisis.

Actions taken in response to feedback

Work is underway across multiple System partners to address these themes:

- Joint working with CAMHS Crisis and Liaison teams to reduce unnecessary waiting times, particularly overnight waits for young people at University Hospitals of Derby and Burton (UHDB)
- Ongoing collaboration with UHDB to improve triage processes for young people presenting in crisis and ensure more effective joint working
- Continued development of Crisis teams and work to improve professional awareness of crisis pathways, providing alternatives to A&E for urgent mental health assessments
- Service flow improvement work to reduce waiting times for CAMHS support
- Care plans and safety plans are sent to families following the seven and 14-day follow-up appointments with the CAMHS Liaison team
- Development of an MCM questionnaire to better understand the demographics of young people attending A&E, supporting targeted prevention and use of community pathways
- Introduction of a safety-netting information sheet provided to all families following assessment by the CAMHS Liaison team, including signposting to available support.

Evidence of impact – CAMHS Liaison

Recent feedback within CAMHS Liaison services demonstrates:

- A significant increase in care plans and safety plans being completed
- Clear evidence of young person and parent involvement in care documentation
- Five out of six respondents reported receiving good self-help advice
- 100% of parents reported feeling involved in care planning.

Complex Health, ADHD and Autism Spectrum Disorder (ASD) pathways

- Feedback within Complex Health services remains mixed, with ongoing requests for continued ASD support
- Parental expectations, particularly following longer waiting times, can present challenges
- Positive qualitative feedback highlights child-focused care, compassionate practice and relational approaches
- Increasing positive comments around communication, consistency of staffing and staff approachability
- Families value continuity and consistency in staff
- Ongoing service transformation continues across ADHD and ASD pathways.

CAMHS Triage and Assessment team

Feedback for the CAMHS Triage and Assessment Team is predominantly positive, with families reporting:

- Feeling comfortable in the care environment
- Feeling listened to and treated as equals
- Compassionate and understanding staff
- Clear explanations and effective signposting
- Confidence that they were directed to the correct services.

Co-production and involvement

The Trust undertakes a range of co-production activities, including:

- Active involvement of carers and families in service improvement projects, notably the neurodevelopmental pathway transformation
- Family feedback has directly influenced:
  - Support provided while awaiting assessment
  - Development and use of Neurodevelopmental Hubs.

Patient experience data across CYP's services demonstrates predominantly positive feedback, with clear themes informing service development. Ongoing System-wide work is addressing areas of concern, particularly crisis access, waiting times and alternatives to A&E, alongside strong evidence of co-production and responsive service improvement.

Public Health Nursing teams and Derby City has been working hard in embedding the offer for families who have children with SEND and also the preventative measures that can be put into place to support families before they hit crisis. The Family Hubs have a range of services based there, including Health Visiting and some specialist health services, alongside early years support from Derby City Council. The Family Hubs have a regular parent/carer panel where they discuss support needs and where the gaps/ improvements in service are needed. From these meetings the Hub has had significant investment in parenting courses covering helping to manage children's behaviour, sleep and toileting support. There is an offer for support with children who struggle to eat a balanced diet.

There has been investment in specific support for children whose development is outside the normal range to support them to understand if a single point of access (SPOA) referral would be beneficial and what the process is.

Response from text survey following group April 2025-March 2026:

Question	Outcome	Number of responses
Did you find the group useful?	Yes No	65 2
Were you clear about the next steps and plan for your child?	Yes No	64 2

There are also positive comments as part of the feedback,

“I would like to express my heartfelt appreciation to the entire health visiting team for the excellent care and support they have provided. Their professionalism, compassion and dedication were evident in every interaction. They communicated clearly listened attentively and went above and beyond to ensure that all our needs were met. The venue was also Immaculate which created a welcoming and comfortable environment their expertise and reassuring presence made tremendous difference, and we felt truly supportive throughout thank you for your outstanding service you're a fantastic team and we are very grateful for everything you do. The health centre was mint so much welcoming”

“I felt the process was quite quick and they explained that the next steps really well”

A significant project is currently being undertaken to understand what would benefit young people transitioning into Adult Learning Disability Health services. The Trust has held three engagement activities:

- In conjunction with the Derbyshire Community Health Services NHS Foundation Trust (DCHS) Quality Improvement team and Umbrella, a focus group was held with service users with a learning disability to gather feedback on experiences of transition and ideas for improvement. This focus group has now been completed, and its findings are feeding into improvements to the transition pathway, including enhancing the information available for service users and families. The outcomes have also been shared with a range of professionals across the system
- In conjunction with the same teams, a carer focus group was held with Umbrella to obtain feedback from carers on the transition process. This focus group has also been completed, and the findings are similarly contributing to improvements within the transition pathway and informing the work of a newly established working group focused on developing the transition process for service users referred into the service
- In conjunction with the DCHS Patient Experience team, a questionnaire was developed and distributed via health and social care partners to gather views from carers (and where applicable individuals with a learning disability) on what works well and what could be improved in transition. Unfortunately, no responses were received to this questionnaire. The barriers to engagement will be reviewed and further attempts will be made to capture this feedback.

The outcomes of these engagement activities are currently being reviewed and evaluated, with the aim of further improving current transition processes.

The project focusing on adults with learning disability from ethnic minority backgrounds funded by the East Midlands Clinical Research Network, National Institute of Health Research (NIHR) has now finished and now feeding into wider projects in the Trust around reasonable adjustments and the Patient and Carer Race Equality Framework (PCREF).

The Young People Peer Support Workers are heavily involved with the new CAMHS Groups Programme supporting the facilitation of groups and will also be providing individual support to CYP to enable them to access the groups where there are additional challenges/barriers. The Young People Peer Support Workers will also be supporting CYP with discharge processes following CAMHS group involvement offering transitions support.

The Young People Peer Support Workers host a weekly participation group which is available to all CYP open to CAMHS. The group is called Our Peer Space and combines social activities alongside direct participation work.

The Young People Peer Support Workers also oversee the successful running of the Summer Programme which offers CYP open to CAMHS a diverse range of social and creative activities over the long summer holidays; this includes adjustments being made to activities to ensure they are accessible to all the CYP open to CAMHS. Across summer 2025, the team facilitated seven sessions which reached 26 young people with excellent feedback received. There are plans to continue to grow this even more for summer 2026.

The Parent Carer Peer Support Workers continue to offer weekly groups to parents and carers of young people open to CAMHS, including specific guidance and support for families on waiting lists. The Parent Carer Peer Support Workers also offer bespoke support on a one-to-one basis to parent carers and have recently introduced pop in support sessions across all of our bases. They are continuing to grow their face-to-face offer although continue to offer sessions online too to increase accessibility.

In addition to facilitating specific spaces for children, young people, parents and carers, all members of the CAMHS Peer Support team offer lived experience consultancy within all service developments across CAMHS and the wider network, representing the voice of children, young people and families. Some examples of this are; being on interview panels, completing audits of clinical environments from a lived experience perspective, working with the complaints team to improve communications between systems and diverse families, and sitting within the working groups which are focussed upon the Quality Network for Community CAMHS (QNCC) accreditation.

There is also have a formal voice through the Patient and Carer Experience Committee which feeds into the Quality and Safeguarding Committee and Trust Board.

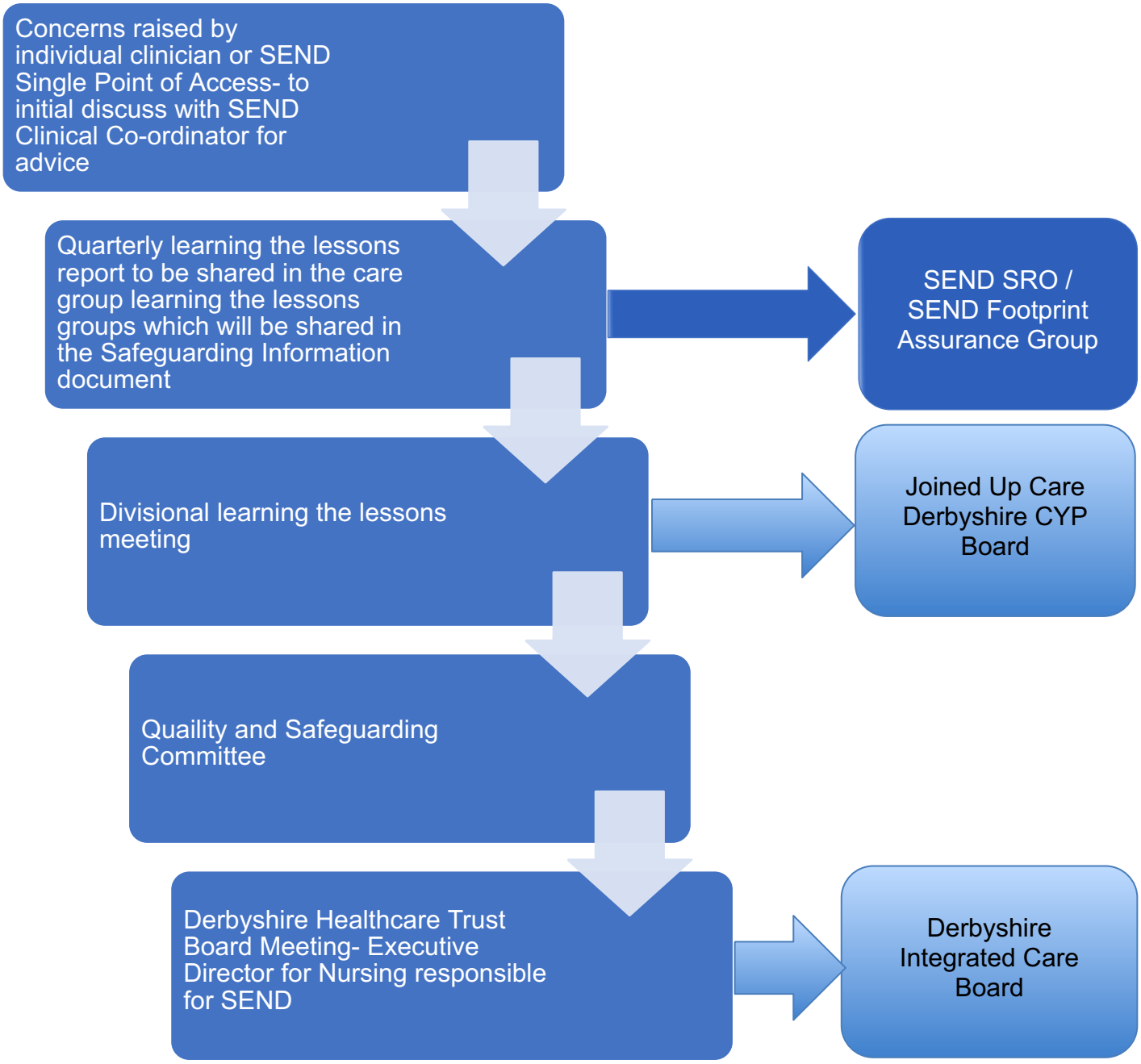
Planned development

The services will continue to receive feedback from the electronic patient survey. Themes from these surveys will continue be review by teams and the information will continue to be use as part of service development, this is then reported on in the Patient Experience Committee (PEC) through the PEC report. The proposal is to develop a “you said we did” section for each service on the Trust website to complete the circle of feedback to the local area. This will be managed by an identified within clinician the team for each team/service.

The development of the neurodevelopmental pathway will be continued in a co-produced manner. Supporting families while waiting with the new ND hubs is work that will be continued which will hopefully support the themes from the concerns/complaints around waiting times. Neurodevelopmental (ND) pathway transformation continues through a System-wide programme led by the ICB in partnership with NHS providers. The work focuses on improving experiences and outcomes for children, young people and families, addressing increasing demand, and strengthening support while waiting, with clear evidence of co-production through the development of ND Hubs. Priority is also being given to improving continuity into adulthood, including ADHD assessment and medication pathways for young people aged 16+, with System partners developing solutions to address current gaps and reduce future risk.

Governance- how does the SEND workstream fit within the organisation

Derbyshire Healthcare FT SEND Escalation Standard Operating Procedure



Transition to Adult services

We have updated the transition from CAMHS to Adult Mental Health service Policy. All services have locally held standard operating procedures or processes for transition to the equivalent Adult service where it exists normally in our partner health providers. Occupational Therapy and Physiotherapy have updated their standard operating procedures for transitions, aligning the transition age with other services at 18 years' old. The Transition Lead in the Learning Disabilities services will continue to develop service following the co-production around transition.

The numbers of young people who are needing to be transitioned from CAMHS to Adult Mental Health services is low. The Care Co-ordinator can develop an individual plan with the young person and Adult services to transition them across. Transition from Children's services to Adult Mental Health services for those who need a continuation of their ADHD medication now works well and there is good communication between the services.

There does remain a significant issue though for those wishing to start ADHD medication or are not on a stable dose as our Adult Mental Health teams are not commissioned to support this. The global shortage of ADHD medication has stabilised but still has intermittent supply issues this a more significant issue is impacting on more young people. The ADHD Nurses and Community Paediatricians are working hard to provide young people back onto alterative medication safely. However, medication supply can still sudden become not available. This continues to impact on the number of prescriptions to be provided by the Specialist services. The introduction of the "right to choose" providers has given a pathway for those who have not managed to be started on medication due to the length of waiting lists before their 18th birthday.

The Neurodevelopmental Transformation Pathway (led by the ICB with NHS Providers) is looking to develop a Young Person and Adult services to support the assessment and medication of those with ADHD to support young people from the age of 16. They are currently developing a business case.

We have developed a system which supports data reviews for clinicians if the young person they are working with is entitled to a learning disability annual health check, which is overdue. This is only operational in the Mental Health units of our SystmOne (not Children's Community units on S1). Whereas the responsibility for health check remains with the GP, the aim of this is to encourage young people to start accessing their GP services to support the transition to primary care from Specialist services.

Planned development

The most challenging areas around transition remain where there is no equivalent Adult service. Clinicians work with the young person and family to find the best available support on an individual basis. Predominantly, these are young people with an intellectual disability or neurodiversity which does not meet the criteria for Specialist services. The planned work around annual reviews for those with EHCP should help support this. We need to consider how we are using the flags around annual health check. There is further work needed to be done with universal services, predominately GP services, in how we support accessing primary services having been supported by Children's Specialist services, building on the work done around annual health checks.

Summary and Future Plans and Developments

The previous SEND Inspection framework focused on quantitative measures around timeliness of EHCP and quality of contributes from professionals. This we have completed successfully and received some positive feedback from the Designated Clinical Officer (DCO) (SEND).

The new inspection framework is more focused on outcomes and the experience of young people and their families. As a health provider we are seen as responsive to adapting to develop processes which support the SEND agenda. However, there is still a significant amount of work to do in maintaining the compliance and quality for the EHCP processes due to increase demand. The focus will be in the next 12 months on developing data around annual reviews and our compliance with completing annual review reports.

We have engaged with the local areas to provide feedback on the current SEND white paper and are supporting the ICB to provide the baseline data for this. The Experts at Hand model will be a significant shift in how services deliver support to CYP with SEND, which will need to be worked through.

We will continue to support Derbyshire with the upcoming re-inspection and Derby City with their expected SEND inspection.


WE MAKE A POSITIVE DIFFERENCE
IN EVERYTHING WE DO

FORWARD PLAN - BOARD - 2026/27		19-May-2026	21-Jul-2026	22-Sep-2026	24-Nov-2026	26-Jan-2027	23-Mar-2027
	Deadline for Approved Papers	**07-May-2026**	**09-Jul-2026**	**10-Sep-2026**	**12-Nov-2026**	**14-Jan-2027**	**11-Mar-2027**
DoCA/TS	Declarations of Interest	X	X	X	X	X	X
DoN	Patient/Board Story	X	X	X	X	X	X
CHAIR	Minutes/Matters Arising/Action Matrix	X	X	X	X	X	X
CHAIR	Board review of meeting effectiveness	X	X	X	X	X	X
CHAIR	Board Forward Plan (for information)	X	X	X	X	X	X
CHAIR	Summary of Council of Governors meeting (for information)	X	X		X	X	
CHAIR	Chair's update	X	X	X	X	X	X
CEO	Chief Executive's update	X	X	X	X	X	X
PD, PC, JUCD	Joined Up Care Derbyshire Provider Collaborative annual report - 2025/26	X			X		
OPERATIONAL PERFORMANCE							
DCEO/CDO/DoN/ DoF/DPODI	Integrated Performance report (Operations, Finance, People and Quality)	X	X	X	X	X	X
Committee Chairs	Board Committee Assurance Summaries	X	X	X	X	X	X
DCEO/CDO	Emergency Preparedness, Resilience and Response (EPRR) Core Standards			X			
DCEO/CDO	ICB Joint Forward Plan (ad hoc inclusion with CEO update)						
DoF	Year-end Financial Position 2025/26	X					
DoF	Medium-term Plan response (compliant with conditions; linked to activity and performance)	X					
Executive Lead	Deep Dive - 4Ps (Trust Strategy - People; Productive; Patient; Partnerships)	People	Productive	Patient	Partnership		
Receipt of Reports (for noting following assurance at Quality and Safeguarding Committee (QSC)):							
DoN/MD	Safer Staffing annual review (QSC Jul)			X			
QUALITY GOVERNANCE							
DoN	Assertive Outreach Treatment - Community Mental Health Action Plan update	X			X		
DoN	Fundamental Standards of Care report (CQC Domains) (six-monthly)		X			X	
MD	Medical Job Planning (annual) (PCC Jul/Jan)		X				
DoN	Outcome of Board stories (annual, Jun)		X				
DCEO/CDO	Transformation and Continuous Improvement (bi-annual)	X			X		
DCEO/CDO/MD/DoN	Winter Plan		X	X			
Receipt of Reports (for noting following assurance at People and Culture Committee (PCC)):							
MD	10 Point Plan to Improve the Lives of Resident Doctors (PCC - Nov)				X		
MD	Guardian of Safe Working Hours report (QSC quarterly / annual report Jun)	X	AR		X	X	
MD	Medical Appraisal and Revalidation - annual report (PCC Apr)	X					
Receipt of Reports (for noting following assurance at Quality and Safeguarding Committee (QSC)):							
DoN	Infection Prevention and Control annual report and IPC BAF (QSC Oct)				X		
MD	Learning from Deaths/Mortality report for approval (QSC quarterly)		AR		X	X	X
DoN	Looked After Children - annual report (QSC Sep)				X		
DoN	Delivery of Same Sex Accommodation (QSC Oct)				X		
DoN	Quality Account (QSC - May)		X				
MD	Research and Development (QSC Jun (AR) and Dec)		AR			X	
DoN	Safeguarding Children and Adults at Risk - annual report (QSC AR Sep)				X		
DoN	SEND - Special Educational Needs and Disabilities annual report (QSC May/Jun)	X					
STRATEGIC PLANNING AND CORPORATE GOVERNANCE							
DoF/DCEO/CDO/DPODI	2026/27 Plan (annual)	NHSE Feedback to Medium-Term Plan					
DoCA/TS	Annual Review of Register of Directors' Interests	X					
DoCA/TS	Board Assurance Framework update	X		X	X		X
DCEO/DCO	Clinical Digital Plan update (six-monthly)				X		
DoCA/TS	Continuation of Services Condition 7 - Provider Licence	X					
DoCA/TS	Council of Governors - Composition and Elections			X			
CHAIR	Fit and Proper Person Declaration		X				
FTSUG	Freedom to Speak Up Guardian report (six-monthly)			X			X
MD	Patient and Carers Race Equality Framework (six-monthly)		X			X	
DoCA/TS	Trust Sealings (six-monthly - for information)	X			X		
DCEO/CDO	Trust Strategic Plan (quarterly update, to include 4 Ps Delivery Plans)	X	X	X		X	
DPODI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) *request for Board delegated authority for People and Culture Committee meeting Sep to approve the October submissions*			X			
DPODI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Strategic implications (retrospective sign-off on assurance at People and Culture Committee Sep)			X			
Receipt of Reports (for noting following assurance at Audit and Risk Committee (ARC)):							
DoCA/TS	Year-end Governance reporting from Board Committees and approval of Terms of Reference (ToRs) (ARC Apr)	X					
Receipt of Reports (for noting following assurance at People and Culture Committee (PCC)):							
DPODI	2025/26 Flu Campaign annual report (PCC Jul)			X			
DPODI	Annual Approval of Modern Slavery Statement (PCC Apr/May, to be published on Trust website on approval)	X					
DPODI	Annual Gender Pay Gap report for approval (data for previous year reporting deadline Mar - PCC Jul)	X					
DPODI	People Plan (PCC - Sep)				X		
DPODI	Staff Survey results (PCC Mar)						X
POLICY REVIEW							
DoF	Standing Financial Instructions Policy and Procedures (31-Oct-2026)			X			

KEY

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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
A	
A&E	Accident and Emergency
ABPI	Association of British Pharmaceutical Industry
ACCT	Assessment, Care in Custody & Teamwork
ACE	Adverse Childhood Experiences
AC/RC	Approved Clinician/Responsible Clinician
ADHD	Attention Deficit Hyperactivity Disorder
ADI-R	Autism Diagnostic Interview-Revised
ADOS	Autism Diagnostic Observation Schedule (assessment)
AED	Adult Eating Disorder
AED	Automated External Defibrillator
AfC	Agenda for Change
AFT	Advanced Foundation Trust
AHP	Allied Health Professional
AI	Artificial Intelligence
AIMS	Royal College of Psychiatrists Accreditation for Inpatient Mental Health Services programme
ALB	Arms-length body such as NHS Improvement (NHSI) and NHS England (NHSE)
AMM	Annual Members' Meeting
AMHP	Approved Mental Health Professional
ANP	Advanced Nurse Practitioner
AO	Accountable Officer
AO	Assertive Outreach
AOVPN	AlwaysOn VPD (secure network access)
APC	Annual Physical Health
APNA NHS	Asican Professionals' National Alliance
APOM	Activity Participation Outcome Measure
ARMS	At Risk Mental State
ARRS	Additional Roles Reimbursement Scheme
ASD	Autism Spectrum Disorder
ASM	Area Service Manager
ATR	Alcohol Treatment Requirement
ATU	Acute Treatment Unit
B	
BAF	Board Assurance Framework
BCF	Better Care Fund
BCO	Building Control Officer
BCP	Business Continuity Plan
BI	Business Intelligence
BIA	Business Impact Analysis
BLS	Basic Life Support (ILS Immediate Life Support)
BMA	British Medical Association
BAME	Black, Asian and Minority Ethnic
BILD	British Institute of Learning Disabilities
BME	Black and Minority Ethnic group
BoD	Board of Directors
BPD	Borderline Personality Disorder
BPPC	Better Payment Practice Code
C	

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
CAARMS	Comprehensive Assessment of At-Risk Mental States
CAD	Community Action Derby
CANSAS	Camberwell Assessment of Need Short Appraisal Schedule
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)
CCCG	Collaborative Commissioning and Contracting Group (East Midlands Alliance)
CCQI	College Centre for Quality Improvement
CCT	Community Care Team
CDEL	Capital Departmental Expenditure Limit
CD-LIN	Controlled Drug Local Intelligence Network
C.DIFF	Clostridioides difficile
CDM	Construction Design and Management
CDMI	Clinical Digital Maturity Index
CE	Chief Executive
CEO	Chief Executive Officer
CER	Clinical Establishment Review
CERT	Community Enhanced Rehabilitation team
CESR	Certificate of Eligibility for Specialist Registration
CFFSR	Counter Fraud Functional Standard Return
CGA	Comprehensive Geriatric Assessment
CGL	Change Grow Live
CHANNEL	Confidential, voluntary, multi-agency safeguarding programme that provides early intervention to protect vulnerable children and adults who might be susceptible to being radicalised
CHIME	Connectedness, Hope, Identity, Meaning, Empowerment recovery
CHPPD	Care Hours Per Patient Day
CIC	Children in Care
CIN	Children in Need
CIP	Cost Improvement Programme
CMDG	Contract Management Delivery Group
CMHF	Community Mental Health Framework
CMHT	Community Mental Health Team
CMO	Chief Medical Officer
CNST	Clinical Negligence Scheme for Trusts
COAT	Clinical Operational Assurance Team
COD	Cause of Death
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	Clinical Quality Review Group
CQUIN	Commissioning for Quality and Innovation

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
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
CSTF	Core Skills Training Framework
CSU	Commissioning Support Unit
CTO	Community Treatment Order
CTR	Care and Treatment Review
CUF	Cost Uplift Factor
CYP	Children and Young People
D	
DAG	Divisional Assurance Group
DAR	Divisional Assurance Review
DARD	Drugs and Alcohol Related Deaths
DASP	Drug and Alcohol Strategic Partnership
DAT	Drug Action Team
Datix	Trust's electronic incident reporting system of an event that causes a loss, injury or a near miss to a patient, staff or others
DBS	Disclosure and Barring Service
DBT	Dialectical Behavioural Therapy
DDME	Deputy Director of Medical Education
DfE	Department for Education
DCHS	Derbyshire Community Health Services NHS Foundation Trust
DCO	Designated Clinical Officer
DDCCG	Derby and Derbyshire Clinical Commissioning Group
DDSAB	Derby and Derbyshire Safeguarding Adult Board
DDSC	Designated Doctor Safeguarding Children
DDSCB	Derby and Derbyshire Safeguarding Children Board
DDSCP	Derby and Derbyshire Safeguarding Children Partnership
DEED	Delivering Excellence Every Day
DHcFT	Derbyshire Healthcare NHS Foundation Trust
DHR	Domestic Homicide Review
DHSC	Department of Health and Social Care
DISCO	Diagnostic Interview for Social and Communication Disorders (assessment)
DIT	Dynamic Interpersonal Therapy
DLN Cluster	Derbyshire, Lincolnshire, Nottinghamshire Cluster
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
DPA	Data Protection Act
DPI	Director of People and Inclusion
DPIA	Data Protection Impact Assessment
DPR	Divisional Performance Review
DPS	Date Protection and Security
DQMI	Data Quality Maturity Index
DRR	Drug Rehabilitation Requirement
DRRT	Dementia Rapid Response Team
DSCRO	Data Services for Commissioners Regional Offices
DSFS	Derbyshire Support and Facilities Services
DS&P	Data Security and Protection
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	
EAP	Employee Assistance Programme
EbE	Expert by Experience
ECT	Enhanced Care Team
ECT	Electroconvulsive Therapy
ECW	Enhanced Care Ward
ED	Emergency Department
EDS2	Equality Delivery System 2
EHA	Early Help Assessment
EHCP	Education, Health and Care Plan
EHIC	European Health Insurance Card
EHR	Electronic Health Record
EI	Early Intervention
EIA	Equality Impact Assessment
EIP	Early Intervention In Psychosis
EIS	Early Intervention Service
e-LfH	e-Learning for Healthcare
ELT	Executive Leadership Team
EMDR	Eye Movement Desensitising and Reprocessing Therapy
EMPH	East Midlands Provider Collaborative
EMR	Electronic Medical Record
EPC	Energy Performance Certificate
EPMA	Electronic Prescribing and Medicine Administration
ePMO	Electronic Programme Management Office
EQIA	Equality Impact Assessment
EPR	Electronic Patient Record
EPRR	Emergency Preparedness, Resilience and Response
ERIC	Estates Return Information Collection
ESR	Electronic Staff Record
ETOC	Enhanced Therapeutic Observation and Care
EUPD	Emotionally Unstable Personality Disorder
EWTD	European Working Time Directive
F	
FBC	Full Business Case
FCMHT	Forensic Community Mental Health

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
FDP	Federated Data Platform
FFT	Friends and Family Test
FGM	Female Genital Mutilation
FIG	Feedback Intelligence Group
FOI	Freedom of Information
FOT	Forecast Out-Turn
F&P	Finance and Performance
FReM	Government Financial Reporting Manual
FSR	Full Service Record
FT	Foundation Trust
FT ARM	Foundation Trust Annual Reporting Manual
FTE	Full-time Equivalent
FTN	Foundation Trust Network
FTSU	Freedom to Speak Up
FTSUG	Freedom to Speak Up Guardian
FWS	Future NHS Workforce Solution
FYE	Full Year Effect or Financial Year End
5YFV	Five Year Forward View
G	
GAM	Group Accounting Manual
GBO	Goal Based Outcome
GDPR	General Data Protection Regulation
GGI	Good Governance Institute
GIRFT	Getting it Right First Time
GMC	General Medical Council
GMP	Guaranteed Maximum Price
GoSWH	Guardian of Safe Working Hours
GP	General Practitioner
GPFV	General Practice Forward View
H	
HACT	Housing Association Charitable Trust
HBPoS	Health Based Places of Safety
HCA	Healthcare Assistant
HCAI	Healthcare Associated Infection
HCHS	Hospital and Community Health Services (NHS)
HCP	Healthy Child Programme
H1	First half of a fiscal year (April through September)
H2	Second half of a fiscal year (October through the following March)
HEE	Health Education England
HES	Hospital Episode Statistics
HFMA	Healthcare Financial Management Association
HoNOS	Health of the Nation Outcome Scores
HoP	Head of Practice
HOPE(s)	The HOPE(s) model is an ambitious human rights-based approach to working with individuals in segregation, developed from research and clinical practice
HSCIC	Health and Social Care Information Centre
HSE	Health and Safety Executive
HSSC	Health and Safety Security Committee
HST	Higher Specialty Training
HV	Health Visitor
HWB	Health and Wellbeing Board

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
I	
I&E	Income and Expenditure
IAPT	Improving Access to Psychological Therapies
Icare	Increase Confidence, Attract, Retain, Educate
ICB	Integrated Care Board
iCIMS	Internet Collaborative Information Management System
ICM	Insertable Cardiac Monitor
ICO	Information Commissioner's Office
ICS	Integrated Care System
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IDVAs	Independent Domestic Violence Advisors
IFRS	International Financial Reporting Standards
IIC	Inclusive Inter-cultural Communication
IG	Information Governance
ILS	Immediate Life Support (BLS – Basic Life Support)
IMHA	Independent Mental Health Advocacy
ImmForm	UKHSA ImmForm system – used to order medical products and collect vaccine uptake data
IMST	Information Management Systems and Technology
IMT	Incident Management Team
IMT&R	Information Management, Technology and Records
INQUEST	Official, public inquiry to discover the facts about a death. An inquest is conducted by a coroner to determine who the deceased was, and how, when, and where they died, especially in cases of sudden, violent, or unexplained deaths
IPC SAG	Infection Prevention and Control Strategic Action Group
IPP	Imprisonment for Public Protection
IPR	Integrated Performance Report
IPS	Individual Placement and Support
IPT	Interpersonal Psychotherapy
IQVIA	I (for IMS Health), Q (for Quintiles) and VIA (meaning 'by way of')
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
LADO	Local Authority Designated Officer
LCSPR	Local Child Safeguarding Practice Review
LD	Learning Disabilities
LD/A	Learning Disability and Autism
LeDeR	Learning Disabilities Mortality Review
LFPSE	Learning from Patient Safety Events
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender and Queer or Questioning, Intersex, Asexual
LHP	Local Health Plan
LHRP	Local Health Resilience Partnership
LHWB	Local Health and Wellbeing Board
LNC	Local Negotiating Committee
LOS	Length of Stay
LPS	Liberty Protection Safeguards
LSU	Long-Term Service Use
LTFT	Less Than Full-Time
LTP	Long Term Plan
LTS	Long Term Segregation
LTWP	Long Term Workforce Plan
LWSTO	Living Well Short-Term Offer
M	
M&E	Mechanical and Electrical
MADE	Multi-agency Discharge Event
MAPPA	Multi-agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference (meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors
MARS	Mutually Agreed Resignation Scheme
MAS	Memory Assessment Service
MASH	Multi-Agency Safeguarding Hub
MaST	Management and Supervision Tool
MAU	Medical Assessment Unit
MBRACCE	Mothers and Babies: Reducing Risk through Audits and confidential Enquiries
MBU	Mother and Baby Unit
MCA	Mental Capacity Act
MCC	Medicine Clinical Committee
MCCD	Medical Certificate of Cause of Death
MD	Medical Director
MDA	Medical Device Alert
MDM	Multi-Disciplinary Meeting
MDR	Medical Device Regulation
MDSO	Medical Device Safety Officer
MDT	Multi-Disciplinary Team
Men-SAT	Mental Health Services Assessment Tool
MFA	Multi-Factor Authentication
MFF	Market Forces Factor
MHA	Mental Health Act
MHAC	Mental Health Act Committee
MHIN	Mental Health Intelligence Network
MHIS	Mental Health Investment Standard
MHLDA	Mental Health, Learning Disabilities and Autism

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
MHLT	Mental Health Liaison Team
MHOST	Mental Health Optimal Staffing Tool
MHPS	Maintaining High Professional Standards
MHRA	Medical and Healthcare products Regulatory Agency
MHRT	Mental Health Review Tribunal
MHRV	Mental Health Response Vehicle
MHSDS	Mental Health Services Data Set
MiCAD	Reporting system for medical device service and repair
MMaSP	Medicine Management Safety and Practice
MMC	Medicine Management Committee
MOC	Medicine Optimisation Committee
MoSCoW	Must have, Should have, Could have and Won't have (methodology)
MoU	Memorandum of Understanding
MPAC	Multi-Professional Approved Clinician
MRSA	Methicillin-resistant Staphylococcus aureus
MSC	Medical Staff Committee
MSK	Musculoskeletal (conditions)
MSP	Medicines Safety and Practice
MST	Multisystemic Therapy
MSU	Medium Secure Unit
MTFP	Medium-Term Financial Plan
N	
NAI	Non-Accidental Injury
NCISH	National Confidential Inquiry into Suicide and Safety
NCRS	National Cancer Registration Service
ND	Neuro-development
ND	Neurodiversity
NECS	North of England Care System Support
NED	Non-Executive Director
NETS	National Educational Training Survey
NFI	National Fraud Initiative
NGO	National Guardian's Office
NHIS	Nottingham Health Informatics Service
NHS	National Health Service
NHSC	NHS Confederation
NHSCFA	NHS Counter Fraud Authority
NHSE	National Health Service England
NHSI	National Health Service Improvement
NHSEI	NHS England and NHS Improvement
NHSP	NHS Providers
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NIMS	National Immunisation Management System
NIMS	National Incident Management System
NIVS	National Immunisation and Vaccination System
NOF	NHS Oversight Framework
NPS	National Probation Service
NPSA	National Patient Safety Alert
NQB	National Quality Board
NR	Non-Recurrent
NROC	Non-Resident On-Call

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
O	
OBC	Outline Business Case
ODG	Operational Delivery Group
OoA	Outside of Area
OPMO	Older People's Mental Health Services
OP	Outpatient
OSC	Overview and Scrutiny Committee
OSCE	Objective Structured Clinical Examination
OT	Occupational Therapy
P	
PAB	Programme Assurance Board
PAG	Programme Advisory Group
PALS	Patient Advice and Liaison Service
PAM	Payment Activity Matrix
PARC	Psychosis and the reduction of cannabis (and other drugs)
PARIS	This is an electronic patient record system
PbR	Payment by Results
PCC	Police & Crime Commissioner
PCC	People and Culture Committee
PCLB	Provider Collaborative Leadership Board
PCN	Primary Care Networks
PCOG	Patient and Carer Operational Group
PCREF	Patient and Carers Race Equality Framework
PDC	Public Dividend Capital
PDF	Portable Document Format
PDSA	Plan, Do, Study, Act
PET	Psychiatric Emergency Team
PFI	Private Finance Initiative
PFF	Probation Feedback Form
PFR	Provider Finance Return
PHC	Public Health Commissioners
PHCIC	Physical Healthcare and Infection Control Committee
PHE	Public Health England
PHE	Physical Health Equipment
PHSCC	Population Health and Strategic Commissioning Committee
PHSMI	Physical Health Serious Mental Illness
PHSO	Parliamentary and Health Service Ombudsman
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PiPoT	Persons in a Position of Trust
PJF	Professional Judgement Framework
PLACE	Patient-Led Assessments of the Care Environment
PLIC	Patient Level Information Costs
PMF	Performance Management Framework
PMH	Perinatal Mental Health
PMLD	Profound and Multiple Disability
PMO	Project Management Office
PNA	Professional Nurse Advocate
PODG	Programme Oversight and Delivery Group
PPE	Personal Protection Equipment
PPI	Patient and Public Involvement

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
PPN	Public Protection Notice
PPT	Partnership and Pathway Team
PQN	Perinatal Quality Network
PREM	Patient Reported Experience Measure
PRN	Prescribed as necessary
PROMS	Patient Reported Outcome Measures
PSED	Public Sector Equality Duty
PSF	Provider Sustainability Fund
PSII	Patient Safety Incident Investigations
PSIRF	Patient Safety Incident Review Framework
PSIRP	Patient Safety Incident Review Plan
PSQG	Patient Safety and Quality Group
PSR	Provider Selection Regime
PTU	Psychiatry Teaching Unit
PYE	Part Year Effect
Q	
QAG	Quality Assurance Group
QASI	Quality Assurance Serious Incidents
Q&SC	Quality and Safeguarding Committee
QEIA	Quality and Equality Impact Assessment
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity Programme
QNCC	Quality Network for Community CAMHS
QOF	Quality and Outcomes Framework
QSIR	Quality, Service Improvement and Redesign
R	
RAID	Rapid Assessment, Interface and Discharge
RAP	Recovery Action Plan
RAVS	Record a Vaccination Service
RCGP	Royal College of General Practitioners
RCI	Reference Cost Index
RDF	Resident Doctor Forum
RDOG	Research and Development Operational Group
REGARDS	Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation
ReQoL	Recovering Quality of Life
RFI	Request for Information
ROAG	Responsible Officer Advisory Group
RoDP	Recognition of Deteriorating Patient
ROM	Reported Outcome Measure
RPOG	Restrictive Practice Oversight Group
RRN	Restraint Reduction Network
RRP	Recruitment Retention Proposal
RSV	Respiratory Syncytial Virus
RTS	Real Time Surveillance
RTT	Referral to Treatment
S	
s132	Section 132 of the Mental Health Act: As soon as a patient is detained under the Act the patient must be given their rights orally and in writing unless it is not practicable at that time. If this is the case, it must be documented in the patient's electronic care record

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
s136	Section 136 of the Mental Health Act: Police can use emergency powers if they think you have a mental disorder, you're in a public place and need immediate help. They can take you or keep you in a place of safety, where your mental health will be assessed.
SAAF	Safeguarding Adults Assurance Framework
SAB	Safeguarding Adults Board
SAF	Single Assessment Framework
SAR	Safeguarding Adult Review
SAS Doctor	Specialist, Associate Specialist and Specialty Doctor
SAT	Specialist Autism Team
SBARD	Situation, Background, Assessment, Recommendation and Decision (SBARD) tool
SBS	Shared Business Services
SCPHN	Specialist Community Public Health Nurse
SEIPS	Systems Engineering Initiative for Patient Safety
SEND	Special Educational Needs and Disabilities
SFI	Standing Financial Instructions
SI	Serious Incidents
SIG	Serious Incident Group
SID	Senior Independent Director
SIDS	Sudden Infant Death Syndrome
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement
SLaM	South London and Maudsley NHS Trust
SLR	Service Line Reporting
SLRDE	Senior Lead for Resident Doctor Experience
SMI	Severe Mental Illness
SNOMED CT	Systemised Nomenclature of Medicine – Clinical Terms
SOAD	Second Opinion Appointed Doctor
SoBS	Survivors of Bereaved by Suicide
SOC	Strategic Options Case
SOF	Single Operating Framework
SoCI	Statement of Comprehensive Income
SO	Standing Order
SOP	Standard Operating Procedure
SPF	Social Partnership Forum
SPOA or SPA	Single Point of Access
SPOE	Single Point of Entry
SPOG	Strategic Portfolio Oversight Group
SPOR	Single Point of Referral
SSQD	Specialised Services Quality Dashboards
SSRB	Senior Salaries Review Board
STEIS	Strategic Executive Information System
STAH	St Andrew's House
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
SWW	Support While Waiting
SystmOne	Electronic patient record system

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
T	
10YHP	10-Year Health Plan
TAV	Team Around the Family
TARN	Trauma Audit and Research Network
TBT	Tobacco Dependence Team
TCP	Transforming Care Partnerships
TCS	Transforming Community Services
TDA	Trust Development Authority
TDG	Trust Delivery Group
TDT	Tobacco Dependence Team
TIC	Trauma Informed Care
TLT	Trust Leadership Team
TMAC	Trust Medical Advisory Committee (now Medical Senate)
TMT	Trust Management Team
TMTC	Trust Medical Training Committee
TOIL	Time Off In Lieu
TOOL	Trust Operational Oversight Leadership
ToRs	Terms of Reference
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
U	
UHDB	University Hospitals of Derby and Burton
UEC	Urgent and Emergency Care
V	
VARM	Vulnerable Adult Risk Management
VCOD	Vaccination as a Condition of Deployment
VCP	Vacancy Control Panel
VCSE	Voluntary, Community and Social Enterprise organisations
VdTMoCA	Vona du Toit Model of Creative Ability *(a practical guide for Acute Mental Health Occupational Therapy Practice)*
VFM	Value For Money
VO	Vertical Observatory
VTE	Venous Thromboembolism
VUCA	Volatility, Uncertainty, Complexity, Ambiguity
W	
WAP	Wireless Application Protocol
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent
Y	
YTD	Year to Date

12 May 2026

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 19 May 2026

Report from the Council of Governors meeting

The Council of Governors has met once since the last report, on 24 March 2026. The meeting was conducted as a hybrid meeting.

Chief Executive's update

The Chief Executive presented his update which focused on the:

- Three year medium term plan
- Recent Care Quality Commission (CQC) inspections of several of our community based mental health services and our mental health rehabilitation inpatient service Cherry Tree Court
- Development of the mental health urgent assessment centre which will be at the Radbourne Unit in Derby.

Well-Led update

The Director of Corporate Affairs and Trust Secretary gave an update on preparation for CQC's Well-Led inspection and outlined the governors' role in this.

Non-Executive Directors report

Jo Hanley, Non-Executive Director and Chair of the Finance and Performance Committee presented an overview of her roles and activities at the Trust.

Verbal summary of Integrated Performance Report (IPR)

Non-Executive Directors gave a verbal summary of the IPR focusing on key finance, performance, and workforce measures.

Report from the Governors' Nominations and Remuneration Committee

The Trust Chair presented an overview of the matters discussed at the last Governors' Nominations and Remuneration Committee on 10 December 2025, which covered the following business:

- Fit and Proper Person Test (FPPT) compliance for the most recently appointed Non-Executive Directors (NEDs)
- The appraisal process for the Chair and the NEDs for 2025/26.

Update on governor elections

The Membership and Involvement Manager presented a summary report on the 2025/26 elections. Inductions have been completed for the new governors. There are three vacancies for seats in Chesterfield, Erewash and High Peak and Derbyshire Dales.

Report from the Governance Committee

The Co-Chair of the Governance Committee presented a report of the meetings held on 17 December 2025 and 17 February 2026.

Review Governor Membership Engagement Action Plan

The Membership and Involvement Manager provided an update on the Governor Membership Engagement Action Plan which was developed to increase engagement with members and to promote the governor role.

Governor training and development

The Membership and Involvement Manager confirmed that sessions on Risk Management, Finance and Medium-Term Planning and an overview of Freedom To Speak Up have taken place. Reference was also made to the free of charge mental health awareness training sessions provided by Derbyshire County Council.

Any other business: Lead Governor arrangements

The Membership and Involvement Manager confirmed that the process for Lead Governor arrangements had taken place. No public governors had responded to the formal notice; and with governors' approval Brian Edwards has volunteered to take on the role on a temporary basis.

Any other business: Annual Members Meeting – 30 September 2026

The Governance Committee had agreed to change the time of the Annual Members Meeting from 4-6pm to 6-8pm. It is hoped that more people will be able to attend.

RECOMMENDATION

The Trust Board is asked to note the summary report from the Council of Governors meeting held on 24 March 2026.