2025/26 Annual Report & Accounts

NHS
Derbyshire Healthcare
NHS Foundation Trust

Derbyshire Healthcare NHS Foundation Trust
Annual Report and Accounts 2025/26

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Chair's Foreword

Dear all

Welcome to the Annual Report and Accounts for 2025/26.

This has been a pivotal year for the Trust as we opened many of the new units that formed our Making Room for Dignity (MRFD) programme. The developments form a once-in-a-lifetime opportunity to transform inpatient mental health services, improving the experiences of local people who use our services. The programme is not yet fully complete, and I look forward to seeing the continuation of improvements being made to the Radbourne Unit in Derby over the coming years.

Significant progress has been made in achieving the first-year priorities outlined in the Trust Strategy that was developed in 2024/25. I was pleased to support the approval and implementation of many of our plans that underpin the Trust's strategic priorities, including a new Digital Plan.

We have celebrated many achievements throughout the year, which are highlighted in this Annual Report. I was particularly pleased to enter a strategic partnership agreement with the University of Derby, to strengthen workforce development, research collaboration and student learning opportunities.

Our staff and services have been recognised through many awards, and I was delighted to see so many colleagues at the latest Asian Professionals' National Alliance (APNA) awards, where eight colleagues were celebrated for visibly making a difference to the NHS and its diverse workforce.

The Trust's annual HEARTS awards were a highlight of 2025, recognising colleagues such as Angela Rafferty, Lead Nurse for the Electroconvulsive Therapy (ECT) Suite team for her 48 years of service to the NHS. Dr Saladi Sudhakar, a consultant psychiatrist with the Erewash Community Mental Health Team received the Outstanding Care and Compassion award after being praised by a patient for his consistent and compassionate care.

I was pleased to welcome new members to the Board of Directors this year. Dr Girish Kunigiri joined the Trust as Executive Medical Director in October 2025. Jo Hanley and Chioma Akpom also commenced in post as Non-Executive Directors in August and December 2025 respectively. Thank you to Dr Arun Chidambaram, Tony Edwards and Geoff Lewins, who left the Board of Directors this year, for all their efforts whilst in post.

In February 2026 we welcomed newly elected members of the Council of Governors, and I am pleased to introduce Lai Mei Li, Jean Johnson, Sarah Tupling and Stephen Handsley. Tom Bladen and Brian Edwards were also re-elected for a further term of office. Thank you to those who retired from their governor roles in 2025/26.

Sadly, we lost several current and much valued colleagues this year. Kevin Bagshaw, Emma Thomson and Richard Day will each be remembered in our memorial garden at Kingsway Hospital.

Selina Ullah
Trust Chair

Chief Executive's Introduction

2025/26 has been a hugely significant year for the Trust, with important changes shaping the services we offer to local people. I was delighted to see the new facilities that form our Making Room for Dignity (MRFD) programme open throughout the year, and to join the official opening events that celebrated these achievements. This is a significant milestone for the Trust, but more importantly for the people who live in Derby and Derbyshire, who, after many years of sub-standard facilities, can now receive their care in facilities that are dignified and private. I am grateful to everyone who worked hard to ensure that we were able to open these throughout the year.

We continue to focus on seeking to be innovative and delivering improvements that will enhance people's care and their experiences of our services. The Trust is committed to progressing national priorities including the development of a new Mental Health Urgent Assessment Unit to add further support for people experiencing a mental health crisis, and to enhance our community mental health services, with our partners as part of the national policy focusing on neighbourhood health.

The Care Quality Commission (CQC) has reflected positively on our progress and achievements throughout the year with all core service inspections they have undertaken receiving a good overall rating. In July 2025 the Trust's wards for older people with mental health problems were rated good across all the CQC domains, in September 2025 the secure inpatient service, at the Kedleston Unit, was rated good across all the CQC's domains and in February 2026 the Trust's rehabilitation unit, Cherry Tree Close, also received a good rating across all domains. In March we received confirmation the CQC were also awarding a good rating to the Trust's mental health crisis and home treatment services and health-based places of safety.

This feedback is testament to the dedication, professionalism, and teamwork that is consistently demonstrated by the Kedleston and Cherry Tree teams and all our crisis and home treatment services and places of safety. The CQC also visited our community mental health services this year and, as the financial year ends, we are awaiting a draft report following this inspection.

Significant changes have taken place to the way our services are structured this year, with the creation of two new divisions that host our clinical care groups. This has led to changes in our senior management leadership structures, to better align our ways of working, reduce silo working, and enable us to work within the financial constraints that have been placed upon us. This has been a particularly challenging year financially and we have worked hard to deliver savings and efficiencies across our services, reaching our planned break-even position.

Our results from the national NHS Staff Survey (page 138) remained higher than the national average in each of the seven elements that form the NHS People Promise. Whilst there is a lot to be proud of, particularly when looking at our results in comparison to other organisations, I recognise that many of our scores are lower than they were last year and in previous years. This is a trend that is reflected nationally, and no doubt reflects the significant financial challenges that all parts of the NHS have experienced in the last year. Our improvement plans this year will focus on two key areas – making the Trust a better place to receive care and making the Trust a better place to work.

Disappointingly, the Trust was not successful in a bid to continue providing the Derby City Substance Misuse Service and we transferred the service and colleagues to new providers on 1 April 2026. We continue to work with system partners to align services to the best possible

provider across Derby and Derbyshire, ensuring equitable services are available across the county.

I am proud of the progress that has been made in achieving digital transformation this year, including the creation of a new Digital Plan following our Digital Futures Day in November 2025. This is a significant area of development in healthcare and something that we continue to understand and embrace. I'm looking forward to seeing the outcomes for our patients and service users as we implement the new plan in the coming year.

Thank you to everyone who has supported the Trust over the last year.

Mark Powell
Chief Executive

HSJ Digital Awards: Double national win

These dual national awards demonstrated the strength and ambition of the Trust's digital transformation programme.

In June 2025, the Digital Organisation of the Year award recognised the Trust's successful rollout of an integrated, future-proof Electronic Patient Record (EPR) system, which enabled seamless information sharing across clinical services and with primary care. The judges also recognised the introduction of electronic prescribing, which improved the consistency and safety of medicines management.

The second award, Generating Impact in Population Health through Digital, celebrated the innovative work of the School Nursing Team, who transformed the way children's health needs are identified through a digitised Health Needs Assessment. Working in partnership with The Lancaster Model (TLM) and Aire Innovate, the team gathered vital wellbeing insights from thousands of young people – including 85% of Year 6 pupils and 70% of Year 9 pupils. This shift from reactive safeguarding to proactive, data driven public health has already delivered meaningful improvements for more than 15,000 young people across Derby.

Performance report

This overview of performance provides a short summary of the organisation, its purpose, the key risks to achievement of organisational objectives and performance throughout the year. It is supported by further detail outlined in the 2025/26 Performance section that follows on page 23.

Overview of performance
2025/26 has been another busy and challenging year for the Trust, with a number of significant changes made to operational structures. Performance across all services has generally remained strong throughout the year and proactive steps have been taken to reduce the number of people who have had to be cared for in out of area inpatient units.

Nationally the NHS has once more experienced a number of financial challenges this financial year, with a national mandate to prioritise and achieve financial balance, while maintaining quality. As a result, the Trust has again made significant cost savings.

Meeting increasing demand for our services
Throughout 2025/26 the Trust has experienced an ongoing high level of demand for community and inpatient services, with inpatient wards fully occupied much of the time. A significant amount of work has been undertaken to improve flow.

A large proportion of admissions under the Mental Health Act has persisted since the COVID-19 pandemic, with people presenting with a higher level of acuity. The new inpatient units were designed for a therapeutic model of care which aims to support people's recovery, reducing their length of stay in our ward environments, however delays to discharge when patients are clinically ready to be discharged have persisted. To achieve a sustainable outcome, the Trust is collaborating with system partners to develop a unified, long-term solution.

Demand for services in the community also remains high, and the community mental health teams have increased the number of patient and patient proxy contacts by 4% compared with the previous year. The Trust has continued to work in partnership with other local agencies, including the voluntary sector and social care sector to provide easy access to a wide range of mental health and wellbeing support across our communities.

There are long waits to access some services, specifically; autistic spectrum disorder assessment for adults and children, and children's community services, with pro-active work to reduce these as much as possible. Additional information and guidance is provided to people who are waiting to access our services to ensure they are supported while waiting.

Successes
There have been many achievements and positive developments throughout the year, many of which are included throughout this Annual Report.

Psychiatric intensive care
This year saw the opening of a male Psychiatric Intensive Care Unit (PICU) for Derbyshire. Kingfisher House, a 14-bed new build PICU on the Kingsway Hospital site is now making a positive difference to male patients requiring an increased level of support, as they receive the care and treatment that they need close to their family and support networks, instead of having to be cared for outside Derbyshire. There is no PICU provision for females in Derbyshire, however a female Enhanced Care Unit, Audrey House, is now open to provide a more intensive level of treatment than is provided on an acute ward.

Help in mental health crisis
The Trust is in the process of establishing a Mental Health Urgent Assessment Centre, converting existing Trust estate next to the Radbourne Unit, adjacent to the Royal Derby Hospital. The Centre will enable clinical decision making in a more therapeutic environment external to the Acute Trust

Emergency Department (ED) setting. The purpose of the Centre is to assess and manage the needs of patients, providing an easy to access service for people suffering from a mental health crisis. The service will see people over the age of 18 who self-present, who are referred by the police or ambulance service, or who are diverted from the Acute Trust Emergency Department.

Staff feedback – survey results
The national 2025 Staff Survey response rate of 64% remained higher than average, and the results were above average for all elements of NHS People Promise. It was disappointing to see some scores decline since 2024 and this year's plan will focus on improving the Trust as a place to work and as a place to receive care and treatment.

Signed

Mark Powell
Chief Executive
18 June 2026

Snapshot of activity 2025/26

About us

Purpose and activities of Derbyshire Healthcare NHS Foundation Trust
Derbyshire Healthcare NHS Foundation Trust (DHCFT) is a provider of mental health, learning disability and children's services across the city of Derby and wider county of Derbyshire. We run 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, and we run the East Midlands Gambling Harms service.

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 seventy different languages being spoken.

Successful partnership working is essential to the delivery of many of our services and central to our values. The Trust has continued to be an active partner in the Derby and Derbyshire Integrated Care System (ICS), made up of NHS providers, Local Authorities and the local Integrated Care Board (ICB) working together to improve the health of Derby and Derbyshire citizens, and to further the transformative change needed to tackle system health and care challenges. Following the reconfiguration of ICBs this year, we are working with the newly appointed executive team within the newly established Derbyshire, Lincolnshire and Nottinghamshire ICB Cluster.

The Trust is also a member of the East Midlands Mental Health, Learning Disabilities and Autism Alliance and is a key partner in several provider collaboratives. For more information, please go to the Stakeholder Relations section on page 104.

History of the Trust
Previously Derbyshire Mental Health Services NHS Trust, was granted Foundation Trust status on 1 February 2011. Universal children and family services for Derby transferred to the Trust in 2011, following the dissolution of Derby City Primary Care Trust.

Our services
Derbyshire Healthcare has a broad range of services that are structured within two clinical divisions:

- Community and acute mental health services
- Older adults mental health services, specialist and children's services.

Community and acute mental health services
This division includes the following services:

- **Working age adult acute services:** our adult acute hospital services, including Audrey House, Carsington Unit, Derwent Unit, Kingfisher House (our Psychiatric Intensive Care Unit), and Radbourne Unit; and our urgent assessment and home treatment services, including our crisis services and liaison teams, and helpline.

- **Community mental health services for working age adults:** our community mental health services, locally based across Derbyshire, for people experiencing significant mental health difficulties requiring specialist interventions, including Consultant Psychiatric outpatients services and Early Intervention services. It also includes Living Well services, Physical Health Monitoring for people commencing on antipsychotic medication or having this titrated, and an Individual Placement Support team called Work Your Way helping people return to work and stay in work.

Older adults mental health services, specialist and children's services
This division includes the following services:

- **Older adults acute and community mental health services:** an inpatient service for people experiencing severe dementia on the Cubley Court wards and an inpatient service for older people experiencing functional illness, such as severe depression or psychosis, based at Tissington House in Derby and Bluebell Ward in Chesterfield. This division also delivers services locally across Derbyshire within the Community Mental Health Teams (CMHT) and Memory Assessments Service (MAS) and provides an intensive alternative to hospital admission through the Dementia Rapid Response Teams (DRRT) and the In-reach and Home Treatment Team.

- **Forensic and mental health rehabilitation, substance misuse and psychology:** Forensic and rehabilitation services include a Community Forensic Team, a Criminal Justice Liaison and Diversion Team and a Placement Review Team, as well as a Low Secure Inpatient Unit provided at the Kedleston Unit. Currently there is a rehabilitation inpatient service at Cherry Tree Close and there is an ongoing transformation to extend the rehabilitation pathway including a community rehabilitation team.

- **Perinatal services:** mother and baby mental health services, provided both in the community and in an inpatient setting at The Beeches, which is located within the Radbourne Unit building.

- **Eating disorders services:** for adults.

- **Substance misuse services:** through Derby Drug and Alcohol Recovery Service and Derbyshire Recovery Partnership, Physiotherapy and Dietetics services, up to 31 March 2026.

  From 1 April 2026:

  - The Derby City Drug and Alcohol Service for Adults is provided by the national charity Cranstoun
  - The Derby City Children and Young People's Drug and Alcohol Service is provided by the national charity Change Grow Live.

- **Children's health and care services:** Child and Adolescent Mental Health Services (CAMHS) including a liaison team based within Royal Derby Hospital and a CAMHS eating disorders service for young people. It also includes 0 to 19 Universal Children's Services, with public health teams including health visitors and school nurses and specialist children's services providing therapy and complex needs services, and a service for looked after children in care.

- **Neurodevelopmental services:** providing Autistic Spectrum Disorder (ASD) assessment and learning disabilities services including an intensive learning disabilities (LD) support team to help prevent hospital admission.

- **Psychology and psychological therapies:** providing psychological assessment and interventions for patients across the Trust. Interventions are delivered in 1:1 or group format and use a range of psychological models. Psychological therapy is delivered by a range of therapists and clinical psychologists for all age groups and presentations in the community and in patient services. They are embedded in teams across the Trust.

Further details on the above services can be found on the Trust website:
https://www.derbyshirehealthcareft.nhs.uk/

The Green Plan

Climate and sustainability summary (Task Force on Climate-related Financial Disclosures (TFCD))
We have summarised our approach using four headings that are commonly used in climate reporting: governance, strategy, risk management, and metrics and targets.

TCFD compliance statement
This section is structured in line with the TCFD framework, as adopted for NHS Foundation Trusts through the NHS Foundation Trust Annual Reporting Manual (FT ARM) on a phased "comply or explain" basis. It explains our governance, strategy, risk management, and metrics and targets for climate and sustainability under the headings of:

1. Governance: covered below (Section 1), including Board/committee oversight and management responsibilities.
2. Strategy: covered below (Section 2), including our main climate-related risks and opportunities over short-, medium- and long-term horizons. Further work is required to quantify financial impacts and to complete formal climate scenario analysis for our services and estate; we will develop this in line with national guidance and available capacity.
3. Risk management: covered below (Section 3), including how climate risks are identified, assessed, escalated and managed through Trust-wide processes.
4. Metrics and Targets: covered below (Section 4). Our main commitment is an 80% reduction in emissions we control directly by 2032, supported by a rolling three-year Green Plan. Detailed operational metrics sit within the Green Plan and its annual progress updates.

1. Governance (who oversees this work)

- Board-level oversight: the Green Plan is one of the enabling plans to the Trust's Strategy. It is monitored by the Finance and Performance Committee (FPC), with updates provided twice a year.
- Executive oversight: the Senior Responsible Owner (Director of Finance) line-manages the Sustainability Manager, providing regular (monthly) oversight.
- System-wide oversight: the Integrated Care Board (ICB) Chief of Staff chairs a quarterly Greener Delivery Group for Joined Up Care Derbyshire (JUCD), attended by local NHS Trusts and the NHS England's (NHSE) Regional Net Zero Team. Governance arrangements may change as regional structures change, but ICB oversight is expected to continue.
- Purpose: the Greener Delivery Group provides system-level accountability for meeting carbon reduction targets and supports delivery of the Green Plan.

How climate issues are considered in decisions

- The Trust's Strategic Delivery Plan includes a target to reduce carbon emissions (carbon dioxide equivalent) from 1990 levels by 80% by 2032.
- We are improving reporting so decision-makers can understand the likely carbon impact of major plans and projects.
- The FPC reviews the Green Plan targets each year and monitors progress. Climate-related risks are handled through the Trust's normal risk management processes and legal duties (including adaptation reporting).

Management responsibilities (how the work is delivered)

- Main reporting route: Finance and Performance Committee (FPC).
- Sustainability lead: an interim 0.4 WTE Sustainability Manager (Band 8a) was appointed in February 2025 to co-produce and coordinate the Green Plan, based on NHS guidance.
- Leads across the organisation: each of the nine Green Plan areas has a named lead who is responsible for delivery within their operational area.
- External assurance: sustainability is reviewed by the Care Quality Commission (CQC) as part of the "Well Led" domain; the CQC Compliance and Responsibility Manager supports

this work with the Sustainability Manager. The work is also overseen by our ICB Sustainability Manager, and the NHSE Regional Sustainability Lead who are updated and support via a quarterly ICB quality meeting.

- Patient safety and resilience: the Emergency Preparedness, Resilience and Response (EPRR) lead works with the Sustainability Manager on risks from extreme weather and business continuity.

How we stay informed and coordinate actions

The Sustainability Manager works with the Integrated Care Board (ICB) sustainability team and wider partners (including NHSE, local government and regional bodies) to understand risks and opportunities that affect the Trust.

- Leads for each Green Plan area meet with the Sustainability Manager regularly (typically every two months) and use shared online space to exchange updates and documents.

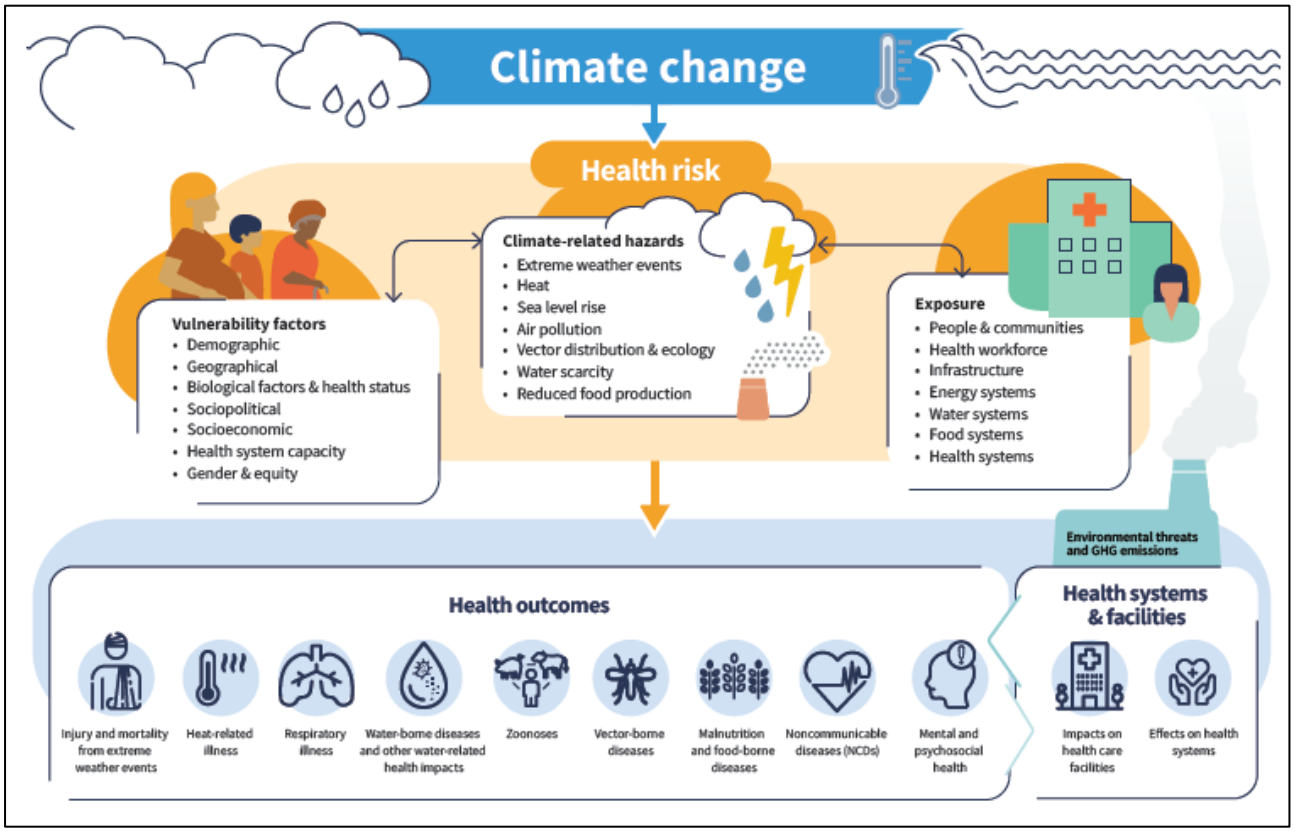


Figure 1: COP29 special report on climate change and health: Health is the argument for climate action. Geneva: World Health Organization; 2024.

2. Strategy (our main climate risks and opportunities)

We consider climate risks and opportunities over three time horizons: short term (0-3 years), medium term (3-10 years), and long term (10-25 years).

We are developing our approach to assessing the resilience of our services and estate under different climate scenarios, in line with national guidance and proportional to the Trust's size, risks and available data.

Short term (0–three years)
Risks:

- More frequent extreme weather (storms, snow, heatwaves, flooding)
- Disruption to staff travel, supplies, and buildings
- Rising costs for essentials such as food, energy, and construction materials.

Opportunities:

- Energy and heat decarbonisation (for example, LED lighting, heat pumps, and electric vehicles) can cut energy use and improve long term costs
- New ways of delivering care (for example, remote consultations and better use of community buildings) can reduce travel and make services more resilient.

Medium term (three–10 years)
Risks:

- Unstable energy prices make it harder to plan budgets and contracts, which can affect spending on direct patient care
- Higher demand for services as extreme heat and cold affect health, including increased risk for people with severe mental illness
- Buildings and equipment may become outdated faster if they cannot cope with hotter summers (meaning more retrofitting and resilience investment)
- Ongoing disruption to projects and the workforce from repeated climate events.

Opportunities:

- Upgrade buildings using both passive measures (for example, shading and ventilation) and active technology (for example, efficient heating and cooling)
- Move to a lower-carbon fleet (reducing reliance on petrol and diesel)
- Work with partners on shared procurement, joint estates planning, and system-wide carbon reduction.

Long term (10–25 years)
Risks:

- Without adaptation, the health impacts of heat, cold, and flooding are expected to worsen over time
- Climate change can worsen health inequalities and interact with deprivation, long term conditions, and mental illness, driving higher demand for services
- Some buildings and assets may need replacing earlier than planned, leading to unexpected capital costs
- Rising costs (for example, insurance, energy, and resilience measures), alongside higher demand, could put pressure on long term financial plans.

Opportunities:

- Many climate risks require action beyond the Trust alone but coordinated national and international action can reduce future impacts
- Opportunity to be a leader in sustainable mental health care
- Use and protect local “green and blue spaces” (parks, countryside, rivers and waterways) as part of wellbeing and mental health pathways, where appropriate. Evidence suggests these can support mental health and can be low cost and lower carbon
- More assistive technology, remote consultations, and data-led tools (including artificial intelligence (AI)) may support a “digital first” approach and reduce waste, travel and estate pressure

- Build climate-aware practice into staff training, wellbeing support, and professional development.

3. Risk management (how we identify and manage climate risks)

We manage climate-related risks through the same governance and assurance processes we use for other Trust-wide risks.

- How risks are identified: in line with the Trust's Risk Management Policy and Green Plan priorities
- How patient safety risks are managed: through Emergency Preparedness, Resilience and Response (EPRR) planning for extreme weather and business continuity; through planning and procurement processes; through training and health improvement programmes
- How this links to wider risk management: through the Board Assurance Framework (BAF), Datix risk assessments, the Finance and Performance Committee (FPC), and the Audit and Risk Committee (ARC).

Main climate risks we track

We group climate-related risks into the categories below and manage them through our normal risk and assurance processes.

Transition risks (moving to Net Zero): reaching Net Zero requires investment and can reduce flexibility (for example, greater reliance on electricity when we do not generate our own). Costs may rise due to new regulation and earlier replacement of assets. If we do not meet requirements, there could be financial, legal, or regulatory consequences. We reduce this risk using proven procurement and planning processes, and prioritising actions that bring the most benefit.

Technology risks: new technology may not perform as expected or last as long as planned. We reduce this risk by prioritising proven technologies where possible.

Market risks: energy prices and wider global events can affect costs and availability. Repeated climate disruption may also affect recruitment and retention. Limited public transport at some sites can increase vulnerability when fuel costs rise, although moving to electric vehicles can help. We minimise this risk using contact management, investment in fleet technology, and via partnership working with system partners.

Reputational risks: our staff and communities expect us to take climate change seriously. If we do not show progress, it could affect morale, recruitment and retention, and wider trust in us as an "anchor institution". We moderate this risk using forward planning and clear actions.

Physical risks: climate projections for Derbyshire indicate hotter summers, warmer winters, and more extreme weather (including intense rainfall and flooding). Heat can increase mental health-related illness and emergencies, which affects demand, patient safety and service continuity. We limit the impact of this via risk assessment and management in all our places of work.

Chronic risks (long term pressures): climate change can worsen the wider factors that affect health (such as housing, income and inequality). Communities with fewer resources can be hit hardest. This can increase demand for services, including anxiety linked to climate change and impacts following extreme weather events. We work with our system partners and NHS processes to reduce the impact of climate change on the people who use our services. Examples include investment in new facilities, maintaining green spaces for inpatient groups, and constant review of the environmental conditions that affect our work.

How we assess and prioritise these risks

- Assessment and prioritisation: we use our Risk Management Policy to judge likelihood and impact, and we record and track actions through the BAF and Datix

- Business continuity: we use EPRR methods for planning and response to extreme weather and other events that could disrupt care
- Evidence and assumptions: we use climate projections and guidance from partners and national agencies (for example, NHS England, the Environment Agency and local authorities)
- Decision making: risks are mitigated, accepted, transferred or controlled in line with our standard governance processes and the resources available.

4. Metrics and targets (how we measure progress)

We track progress using the NHS Green Plan framework. This focuses action in nine practical areas, supported by technical metrics and nationally set targets.

The nine areas of focus in our Green Plan are:

Nine areas of focus in our Green Plan		
1. Sustainable models of care	4. Estates and facilities	7. Food and nutrition
2. Digital transformation	5. Medicines	8. Climate adaptation
3. Travel and transport	6. Supply chain and procurement	9. Workforce

What we measure: each area has measures (metrics) that help us track actions and outcomes. Some emissions reporting and targets are set nationally for NHS organisations and are reported at national level for the NHS. We use national data and dashboards where available, alongside our local Green Plan measures.

In line with national guidance, Trusts are not expected to disclose scope 1, 2 or 3 emissions as these are calculated nationally. Figure 2 below shows what falls into scopes 1 to 3.

Trend information: where available, we use historical data (for example, through the Greener NHS Dashboard) to understand trends and to compare with similar organisations.

How figures are calculated: we use supplier certification data where relevant and nationally provided NHSE data where it is supplied centrally.

Where we use centrally provided figures, they are supplied through NHSE tools and use nationally recognised methodologies; where we use local figures, they are calculated from supplier and operational data.

Carbon pricing: we do not use internal carbon pricing.

Our targets

- Main commitment: reach net zero by 2040 for the emissions we control directly (the “NHS Carbon Footprint”) and achieve net zero by 2045 for the emissions we don’t control but can influence, with a total 80% reduction by 2028-2032 against 1990 levels
- How we plan delivery: a rolling three-year Green Plan (most recently reviewed in 2025) covering the nine focus areas. This plan is available on our website
- How we track performance: progress is reviewed through our governance arrangements, supported by NHS guidance and dashboards.

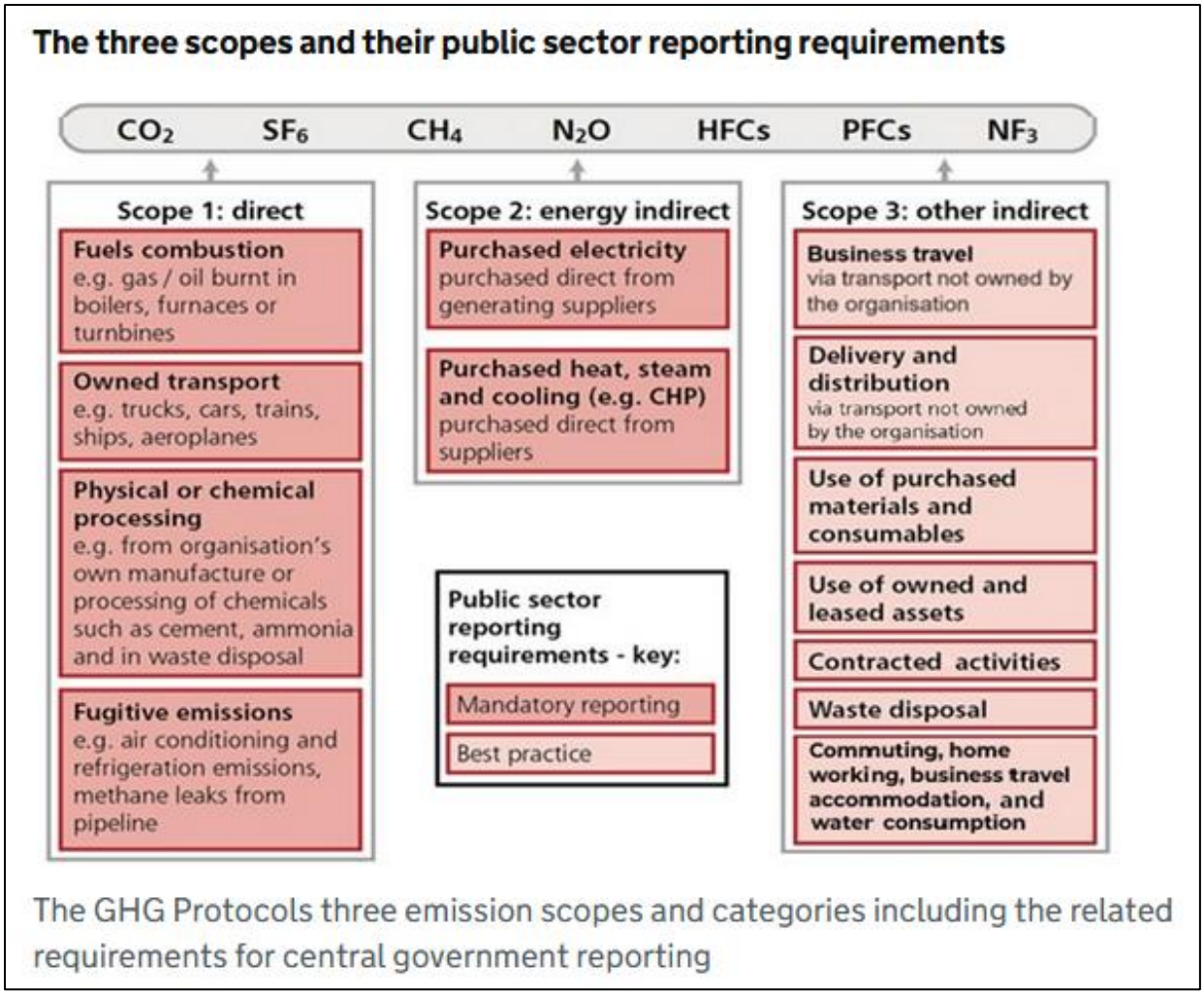


Figure 2: Scope 1-3 emissions. (C) National Grid
Source: Sustainability Reporting Guidance 2025-26 - GOV.UK

Local golf club raising money for Trust's mental health unit

One of Derbyshire's premier golf clubs has chosen the Trust's charitable fund as its nominated charity for 2026 and will be raising money during 2026 for the Radbourne Unit.

Kedleston Park Golf Club selects a new charity each year to support through raffles and other fundraising events. This year, the club captain Martin Allen picked the Radbourne Unit, which is one of the Trust's mental health units supporting people with acute mental health needs.

Trust Strategy

The Trust Strategy (2024-2028) was approved by the Board of Directors and launched in November 2024. This followed a period of extensive engagement with colleagues, partners, carers and people who use our services with engagement session feedback directly shaping the content and format of the Trust Strategy. It was important to co-create the new Trust Strategy, as it outlines a shared direction of travel for the coming years.

The Trust Strategy outlines our Trust vision, values and strategic priorities.

Trust vision and values
The Trust's vision was also updated in 2024 to 'We make a positive difference in everything we do'.

Our values were developed in partnership with staff, partners, patients, service users and carers.

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 priorities – the Four P's

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

The priorities are all of equal focus and importance. Each has a set of key deliverables which sit under each priority. These are reviewed on an annual basis to monitor progress, completion and to identify any new deliverables that reflect the changing environment in which we work.

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.

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.

Personal Accountability Charter
A consistent message shared during the Strategy engagement was the need to develop a framework that provided more detail on behaviours that aligned to the new Trust values and how these could be expressed in our day-to-day interactions. Our Personal Accountability Charter outlines these behaviours and supports the ongoing development of a positive culture in all our teams. This charter was developed alongside colleagues as part of the engagement to develop the Trust Strategy.

Strategy on a page
We have created a single page summary of the Trust Strategy that brings together the new vision, values and strategic priorities. This has formed the basis of our engagement. It is published within the strategy and also as a standalone document.

The Trust Strategic Plan 2025-28, that sits under the Trust Strategy, was subsequently developed in collaboration with Trust Board members, staff, service users and partners. This plan defined the priorities, deliverables and roadmap for successful delivery of Trust Strategy. The Trust Board approved the Strategic Plan in March 2025 and progress against this has been reviewed and considered by the Board on a quarterly basis over 2025/26.

Over the course of the last year the Trust has sought to develop and publish a series of Delivery (Enabling) Plans that will enact the Strategic Plan. These include our Quality Delivery Plan, People Plan, Estates Plan, Green Plan and Digital Delivery Plan. Our Clinical Delivery Plan is in the final stages of development and will be published in the first quarter of 2026/27.

Read more on the Trust's website page Our strategy, vision and values :: Derbyshire Healthcare NHS Foundation Trust

"I always wanted to be a nurse… After 40 years, that passion has never left me." – local nurse marks four decades of NHS care with long service award

A specialist nurse from the Mental Health Liaison Team in North Derbyshire was recognised for 40 years of dedicated NHS service.

Angela Richardson, who works within the Trust, was presented with her 40 Years' Service Award by Chief Executive, Mark Powell, acknowledging her longstanding commitment to patient care and to the Trust.

Clinical ambition
The Clinical Delivery Plan builds on our clinical ambition, illustrated in the image below to support the delivery of the Trust Strategy. It is currently being developed and will be consulted with stakeholders and is expected to be completed by the summer 2026.

Our Clinical Delivery Plan will be a blueprint for prioritising and transforming the way we deliver our services focused on the pursuit of excellence, delivering high quality services and meeting the changing needs of our patients. The delivery of this will be supported by other enabling plans such as the Quality Delivery Plan, the Digital Delivery Plan, People Plan and Estates Plan.

Our Clinical Delivery Plan will focus on having robust care models and pathways that are patient and family centred, trauma informed, evidence based and outcome focussed. The plan also highlights the need for our organisation to be more proactive by working with partner organisations to improve the population health and tackling health inequalities across our communities. The plan will be clinically led, coproduced with our patients and their carers, data driven and will rightly focus on better access, experience and outcome to our patients.

The Clinical Delivery Plan is shaped by the many voices of staff, patients and their carers who told us what makes Derbyshire Healthcare special for them as well as where we must improve, tackling cultural challenges, reducing bureaucracy and empowering our front-line staff. This Plan is developed for action, built on what we've heard, and to be delivered together by building multidisciplinary teams that are ambitious and enabled to deliver outstanding care.

It will be used by our clinical services as guidance in their annual cycle of service planning and as the principles that must drive longer-term clinical transformation. We will measure success in terms of our progress towards achieving our strategic aims to support safe, high quality, person focused care, and to meet the needs and improve the health of the communities we serve, in a way that is fit for now and the future.

Significant governance and regulatory events during the year

Changes to the Board of Directors
The Executive Medical Director post was substantively recruited in 2025/26 with Girish Kunigiri starting in September 2025. There were two new Non-Executive Director appointments, Joanne Hanley and Chioma Akpom after Non-Executive Directors Geoff Lewins and Tony Edwards left after their terms of office ended. Further details of the changes to the Board membership are given in the Directors' report starting on page 69.

National Oversight Framework (NOF) changes to segmentation
NHS England (NHSE) revised the NOF in 2025/26 but delayed confirming provider segmentation positions to allow additional data testing. The Trust's back-dated position for Quarter 1 was confirmed as Segment 4. Following the publication of Quarter 2 NOF data, the Trust was moved into Segment 3, acknowledging progress in improving performance. The ongoing focus of NOF meetings with NHSE and the ICB during 2025/26 has been on improving:

- Waiting times to access our Community Paediatric services
- People's length of stay in our Adult and Older Adult ward environments
- Access to services for children and young people
- Availability of our 24-hour, face to face crisis response.

The introduction of enhanced benchmarking tools, such as the NOF, provides valuable opportunities to gain experience from peers and share best practice. For further details please read the NOF update on page 149.

Provider capability assessment
During 2025/26, as part of the NOF, the Trust participated in NHSE's Provider Capability Assessment, which provides an external, evidence-based view of the Trust's capability across leadership, governance, performance oversight and improvement. The outcomes of this assessment have been considered by the Board and have directly informed Board development priorities and governance improvement actions. NHSE have allocated an Amber-Green Provider Capability rating to the Trust.

Care Quality Commission (CQC) oversight
During 2025/26, the Trust received positive assurance from CQC planned inspections and Mental Health Act monitoring visits, all of which resulted in 'good' ratings. For more information, please read the Compliance with CQC Registration section of the Annual Governance Statement on page 152.

Assessment against the NHSE/CQC Well Led Framework
On the basis that the last Trust-wide well led CQC inspection was in 2020, the Trust has developed internal preparation plans against the eight quality statements within the Single Assessment Framework (SAF). To assist with this, and following NHSE guidance that expects an external well led development review to be carried out every three to five years, the Trust has commissioned its next external assessment with preliminary work starting in March 2026.

New Trust operating model
January 2025 saw the introduction of a new governance structure, developed in line with the new operating model that was introduced in November. Its aim is to reduce layers of decision making and clarify roles and responsibilities, with consistent terms of reference, agendas, and action logs in place across the divisions. The new structure intends to promote collaborative working by emphasising multi-disciplinary and partnership working, with mechanisms for learning from incidents and sharing best practice. The Trust will also embrace a digital focus to support transformation of service models. The second phase of the operating model is expected to conclude in Quarter 1 of 2026/27.

Going concern disclosure
The Trust accounts, starting at page 166, have been prepared on a going concern basis. 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 to ensure that accounts are prepared on an appropriate basis given prevailing circumstances at the time. The Audit and Risk Committee considered the basis for adopting the going concern approach for 2025/26 accounts and were able to make the following statement:

"*After making enquiries, 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. 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*."

"No matter your age, starting a conversation about mental health can be the first step to feeling understood. A small chat can change a life"

The Trust promoted the message "A small chat can change a life" to encourage people of all ages to talk openly about mental health. The awareness piece promoted the importance of everyday conversations in supporting community wellbeing. Through encouraging people to start simple, judgement free discussions, the Trust aimed to normalise mental health dialogue and signposted support options across Derbyshire. This initiative aligned with wider regional prevention priorities and highlighted the value of early, informal support in improving long-term outcomes.

Performance Analysis – 2025/26

Measuring performance
Performance is monitored using a comprehensive range of online reports and dashboards. Data is extracted daily overnight from the electronic patient records, electronic staff records, and Datix risk management database, and used to inform the reports and dashboards, giving a very timely view of performance. The dashboards developed using PowerBI include caseloads, waiting lists, inpatients, children's services and substance misuse. These are very powerful tools to support the provision of effective care and treatment, the management of waiting lists, and the use of patient demographic data for monitoring of access equality.

The Trust Board meets every two months and is presented with an integrated performance report. The report provides a wide-ranging view of performance areas relating to quality, people services, operational services, and finance. Data is presented in statistical process control format which enables measurement for improvement and provides assurance. The report summarises actions from performance improvement plans developed to mitigate any identified issues, which further provides assurance to the Board. In addition, each operational division has been subject to regular reviews of performance at a divisional level, chaired by the Deputy Chief Executive/Chief Delivery Officer.

For benchmarking performance, the Trust makes use of a variety of data sources, such as the Model Hospital, NHS England official statistics, mental health services dataset reports, community services datasets, and NHS Futures.

Performance monitoring
The Trust's performance is monitored against a wide range of national and local targets and standards including:

- Financial plans
- Local Integrated Care System contractual targets
- Locally agreed performance measures
- NHS England Specialised Services contractual targets
- NHS Oversight Framework standards
- Quality priorities.

Performance management structures are in place in Operational Services to enable performance monitoring at all levels of the organisation. Operational performance is overseen by the Trust Delivery Group (TDG) at monthly meetings. The remit of the TDG is to lead on quality and performance improvement and to oversee quality and performance in the five Care Groups.

Each Care Group has a regular performance review at which a comprehensive overview of operational performance and quality is presented by clinical and operational staff to senior management, with membership of the review committee including the Deputy Chief Executive/ Chief Delivery Officer, the Director of Nursing, Allied Health Professionals, Quality and Patient Experience, the Medical Director, and the Director of Finance. This forum enables positive challenge and confirmation by senior management and provides an opportunity for the divisions to escalate issues that are outside their remit to resolve.

The Trust Board receives patient stories, which provide direct feedback of patient experience of services and allows Board members to identify any areas for improvement, and areas of exemplary practice.

Public Health commissioned contracts are monitored via quarterly performance review meetings with the Derby and Derbyshire Integrated Care Board (ICB).

Performance against the specialised services contractual targets and standards, which cover low secure inpatients and perinatal inpatients, has been monitored by each provider collaborative lead provider at quarterly Derbyshire contract review meetings.

The Care Quality Commission (CQC) continue to monitor performance through inspections.

NHSE continues to monitor performance against national priority measures. The Annual Governance Statement, on page 152 of this Annual Report outlines how the Trust manages its key risks.

Performance overview and key themes in Trust performance 2025/26
There have been a number of challenges faced by the Trust this financial year. The key areas of challenge were as follows:

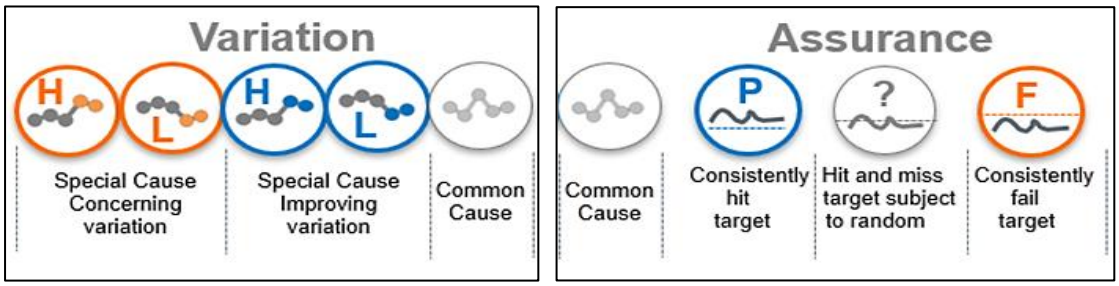
Waiting times for adult autistic spectrum disorder (ASD) assessment:
Activity levels continue to exceed the commissioned target for assessments, with the full year target for assessments exceeded by 81%, however demand for the service continues to significantly outstrip commissioned capacity. As a result, waiting times remain very high at around 54 weeks. The waiting list has reduced over the last four months of the year, but more than 1,100 people are currently waiting.

Community waits over 52 weeks:
This is a new national metric introduced by NHSE in the NHS Oversight Framework 2025/26. In the latest ratings (Quarter 3) the Trust ranked 4th highest (i.e. among the worst) in the country for waits over 52 weeks, at 66%. The national median was just 0.42%. From internal data the year end 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 autistic spectrum disorder assessment or attention deficit hyperactive disorder 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 the Trust within the lowest-performing quartile of NHS providers. Further phased improvement through backlog reduction commenced in April 2026.

Inappropriate out of area placements in adult acute and psychiatric intensive care unit (PICU) beds:
The Trust continues to require some external placements owing to demand exceeding bed capacity, and PICU provision for females in Derbyshire. 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. Placements have significantly reduced from a high of 28 back in January 2025, to six patients at financial year end in inappropriate out of area placements in total: one adult acute and five female PICU patients.

Length of stay in inpatient care:
Length of stay is high when compared with other NHS providers. This is largely a result of patients clinically ready for discharge whose discharge has been delayed. Delays to discharge are inflating average length of stay quite significantly, which impacts on capacity to admit more patients. The Trust continues to work with system partners to reduce clinically ready for discharge delays and is actively engaged with the Midlands Learning and Improvement Network which is supporting shared learning as an enabler to improving length of stay. A revised performance improvement plan is in progress, with all actions due to be completed by September 2026.

Key to the symbols on the charts below:



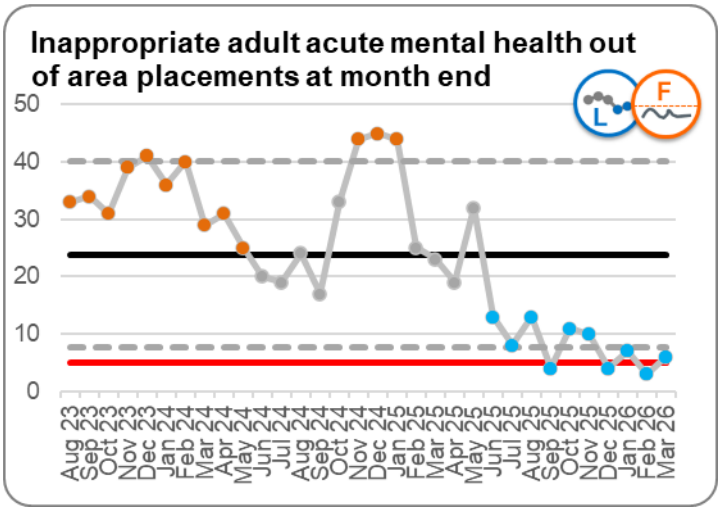
Blue dots indicate special cause variation – performing better than expected. Orange dots indicate special cause variation – performing worse than expected. Grey dots indicate common cause variation – performing as expected.

Data reported to the end of March 2026 if internal, or January 2026 if official NHSE data, as this is the latest published national data.

NHS long term plan metrics:

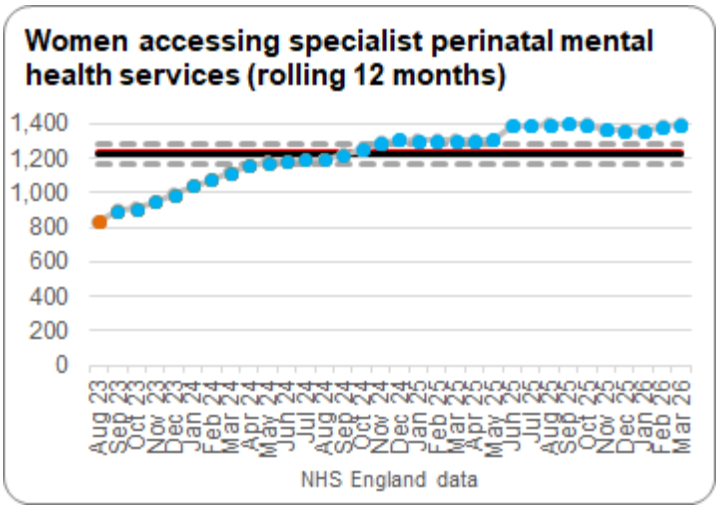
Inappropriate out of area placements

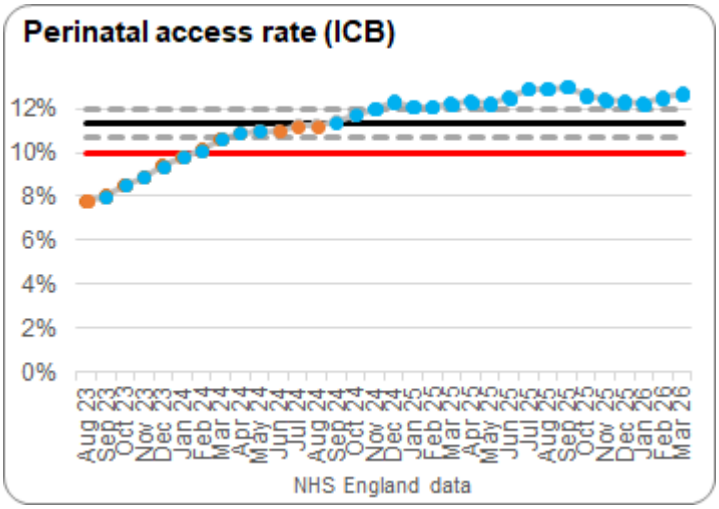
Placements have significantly reduced from a peak of 28 back in January 25, however the Trust continues to require some external placements owing to acute demand exceeding bed capacity, and there being no PICU provision for females in Derbyshire. The male PICU for Derbyshire which opened in July 2025 has enabled male patients to be cared for close to their family and local support networks. During financial year 2025/26, seven beds have been needed per day to meet the demand for female PICU care most of the time. This is a similar level of demand as seen in previous years.



Women accessing specialist perinatal mental health services

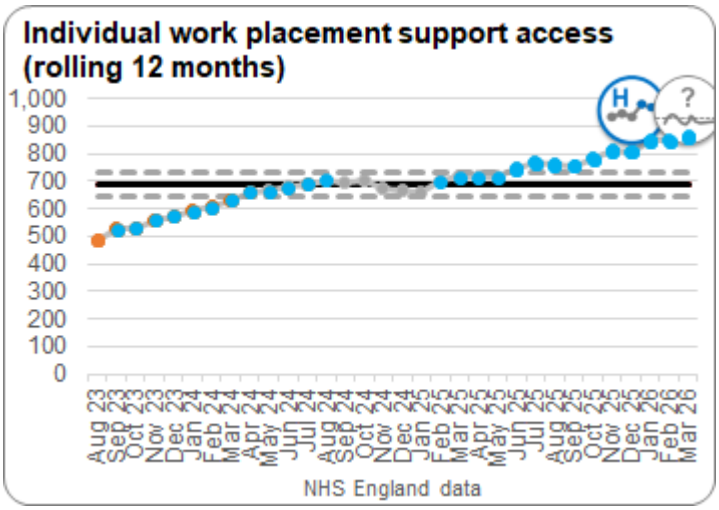
The service continues to support increasing numbers of women before and after the birth of their children, with the target level of contacts exceeded throughout the year, placing NHS Derby and Derbyshire ICB in the top 10 performers nationally.





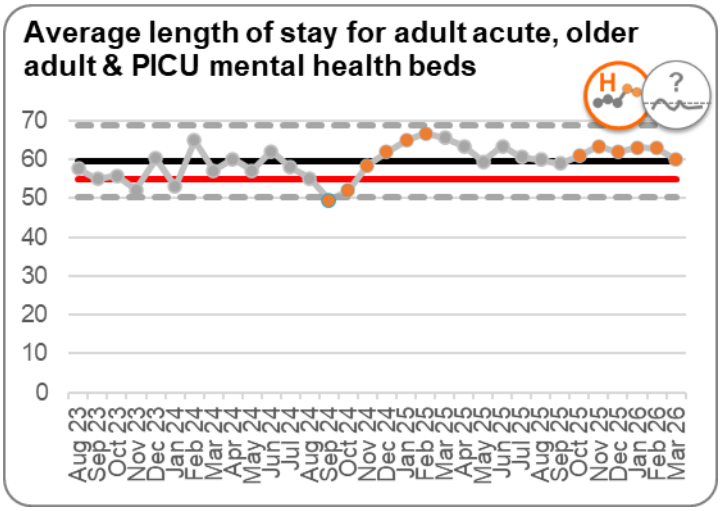
Individual work placement support access (rolling 12 months)

Work your Way, the Derbyshire NHS employment service, is a team of employment specialists and job coaches who help people using community mental health services in Derbyshire to find work and stay in work, because having a job can help people get well and stay well. The team's aim is to help people find the right job, one that suits their ambitions, their talents and their needs. The number of people supported to find employment has been increasing each month and has exceeded target throughout the year.



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

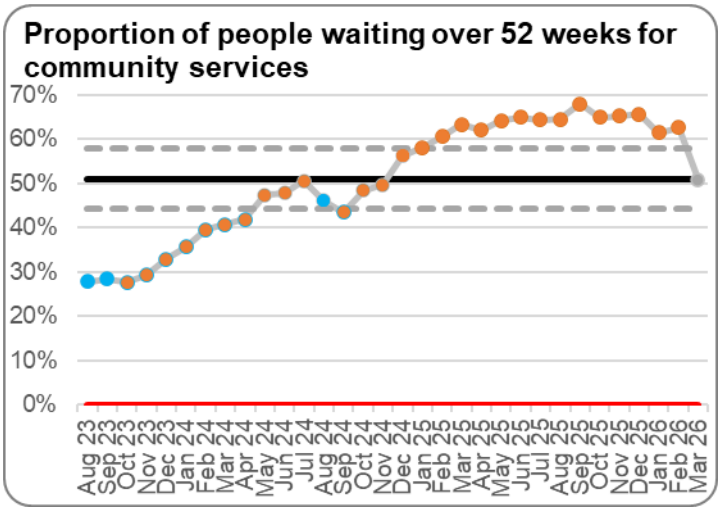
The latest monthly mental health services dataset data published by NHSE (January 2026) placed the Trust 16th highest of all NHS providers for average length of stay, at 63 days. However, if patients had been discharged when clinically ready to be discharged the Trust's Quarter 3 average length of stay would have been 55 days, which would place below the national average of 58 days. The average was 21 adults or older adults clinically ready for discharge. The Trust continues to work with system



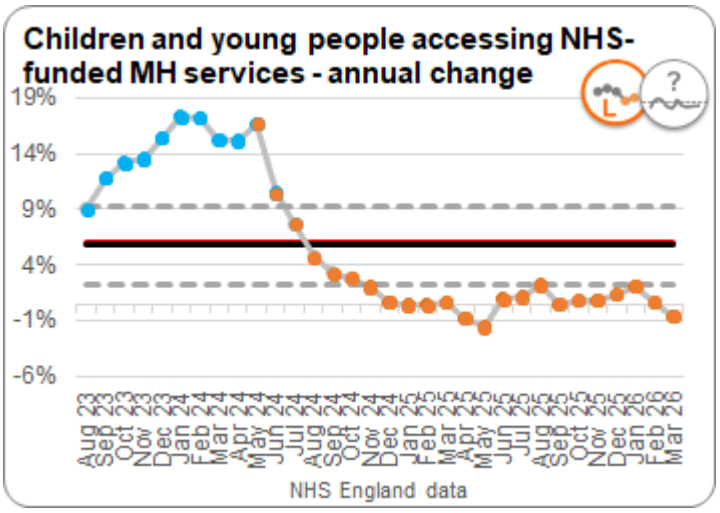
partners to reduce clinically ready for discharge delays.

NHS Oversight Framework 2025/26 targets:

Proportion of people waiting over 52 weeks for community services
In the latest NHS oversight framework ratings the Trust ranked 4th highest in the country for waits over 52 weeks. The majority of the waits are for community paediatric autistic spectrum disorder assessment or attention deficit hyperactive disorder 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. Further phased improvement through backlog reduction commenced in April 2026.

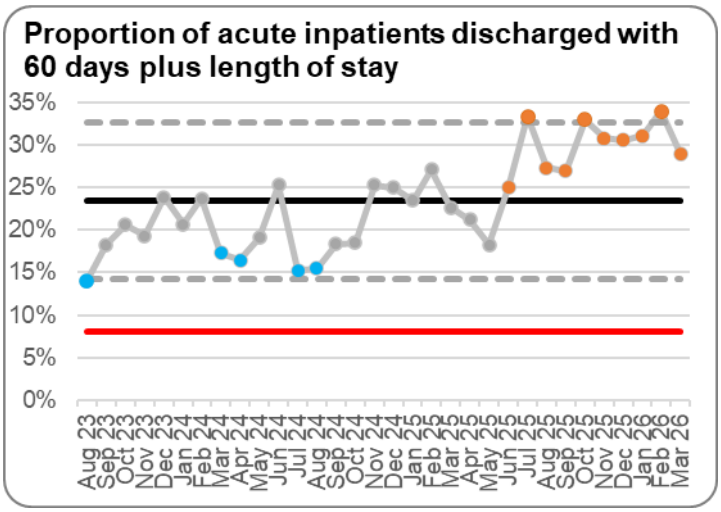


Children and young people accessing NHS-funded mental health services – annual change
The Trust placed in the 2nd worst quartile in Quarter 3. In order to cut waiting times, the ICB has invested in Child and Adolescent Mental Health Services (CAMHS). The recruitment process finished at the end of March 26, and 11.7 wte additional posts have been recruited to with 12 of the 13 recruits now in post. The aim of the additional posts is to reduce waiting times to four weeks over the course of the three year improvement programme and will positively impact on this access metric.



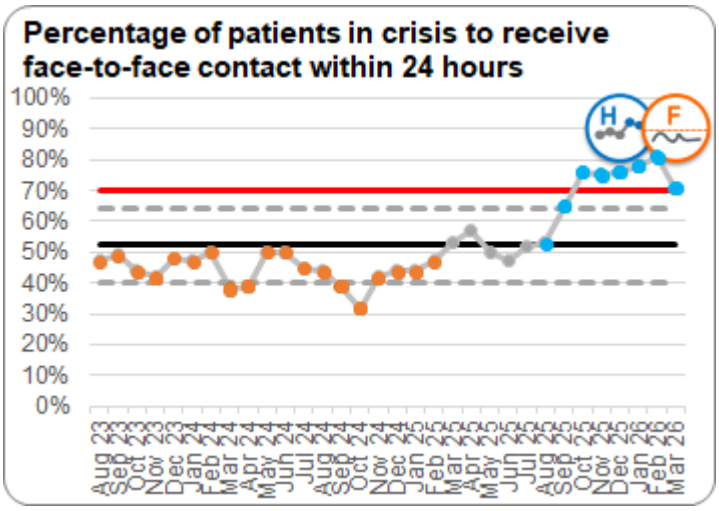
Proportion of acute inpatients aged 18-64 discharged with 60 days plus length of stay
In the Quarter 3 NOF rankings the Trust placed 5th highest of all providers at 32.5% versus the national average of 23.3%. Delays to discharge are inflating average length of stay by nine days overall. Of the current 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 clinically ready for discharge delays and is actively engaged with the Midlands Learning and Improvement Network which is supporting shared learning as an enabler to improving length of stay.



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

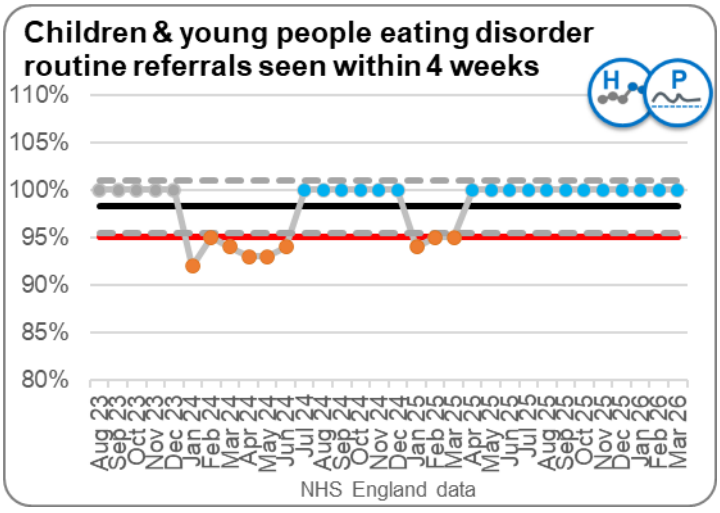
This is a measure of the proportion of urgent referrals made to crisis teams and mental health single points of access who were seen face to face within 24 hours. In the Quarter 3 NOF ratings the Trust placed 12th best provider in the country for performance against this metric, climbing 12 places since Quarter 2 and achieving the top quartile, for which the teams are to be commended.



Key Operational Measures:

Children and young people eating disorder routine referrals seen within four weeks

Throughout the financial year 100% of children and young people have been seen within four weeks of a routine referral.

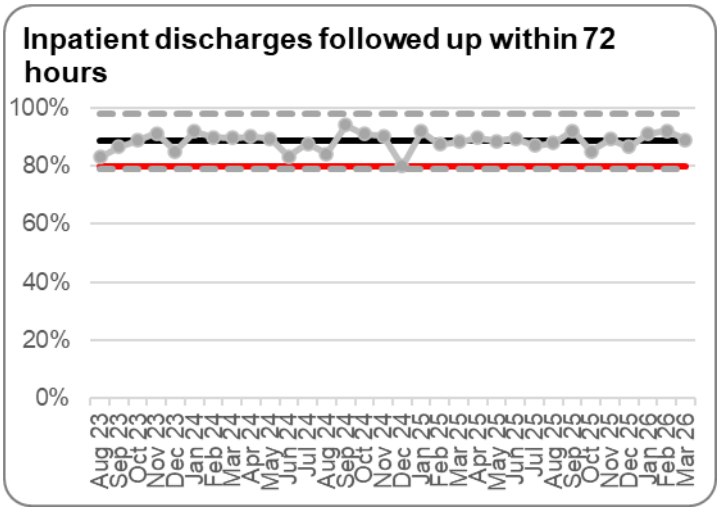


Children and young people eating disorder urgent referrals seen within one week

Very few urgent referrals have been received. However, each child or young person was seen within one week of being referred. No urgent referrals were received in February or March 2026.

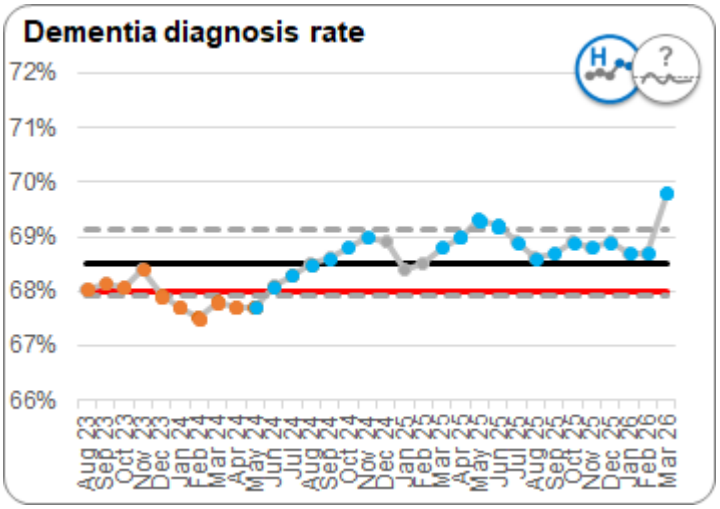
Inpatient discharges followed up within 72 hours

The national standard for follow-up of patients discharged from inpatient wards within three days of discharge, in order to provide support when people are potentially at their most vulnerable, has consistently been exceeded.



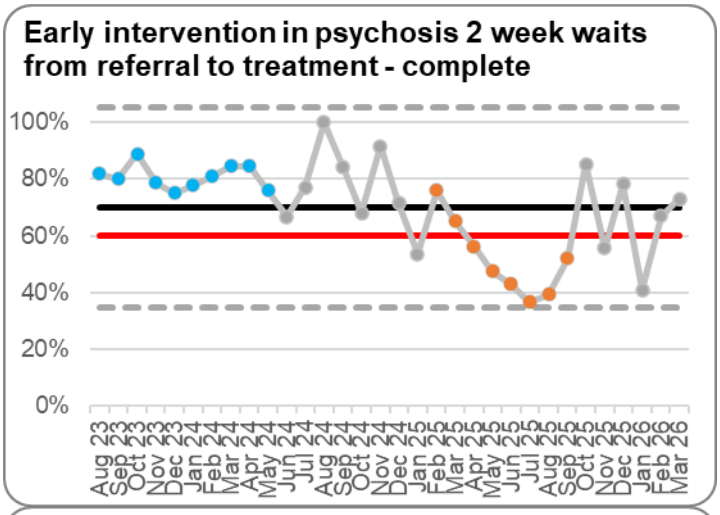
Dementia diagnosis rate

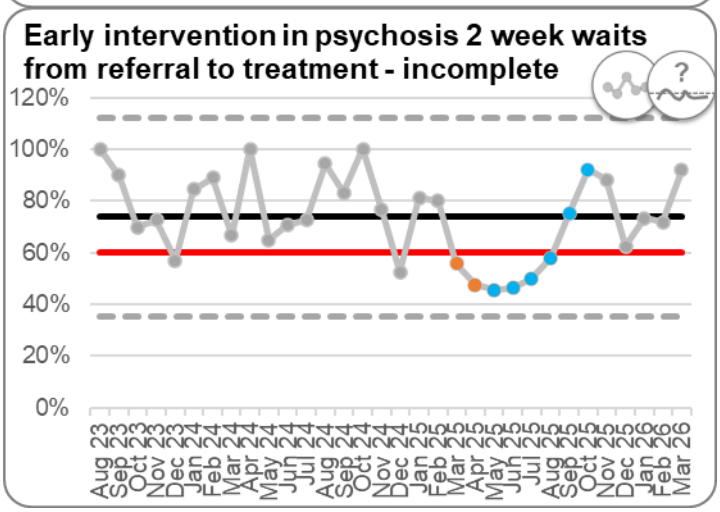
Dementia diagnosis of people in Derby and Derbyshire has exceeded target for the full financial year. The Memory Assessment Service (MAS) has been working hard to reduce waiting times, with a significant reduction in the number of people waiting over 18 weeks, down from 70% to 42%. This is at a time when demand for MAS, despite rigorous pathway work, has increased.



Early intervention in psychosis two week waits from referral to treatment – complete

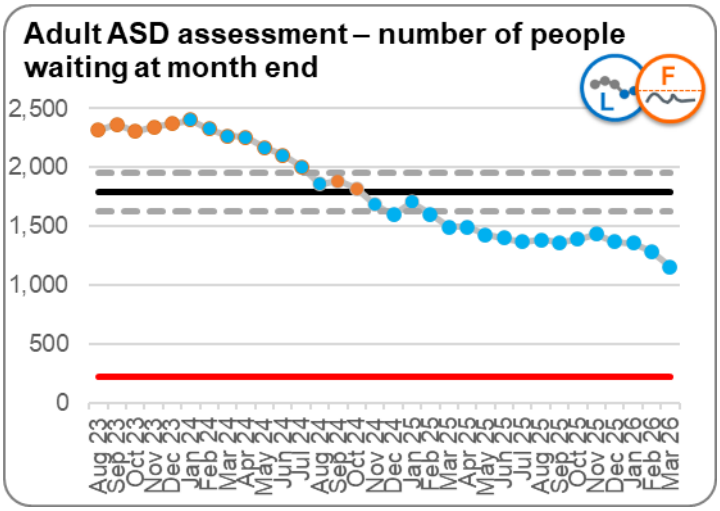
The Early Intervention and at Risk Mental State (ARMS) services assess people who are suspected of experiencing a first episode of psychosis. The national standard is to undertake an assessment and assign a Care Coordinator within two weeks of people being referred into the service (target 60%). During the year the service has experienced a significant increase in demand at the same time as a significant level of staff turnover (25%), vacancies peaking at 16%, and periods of high levels of sickness absence which all inevitably impacted on waiting times. A performance improvement plan was put in place and proved effective, with the position recovering in February 2026.

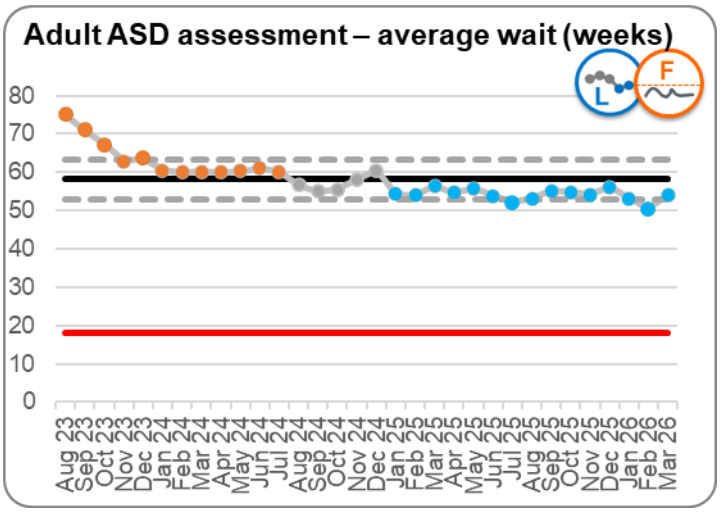


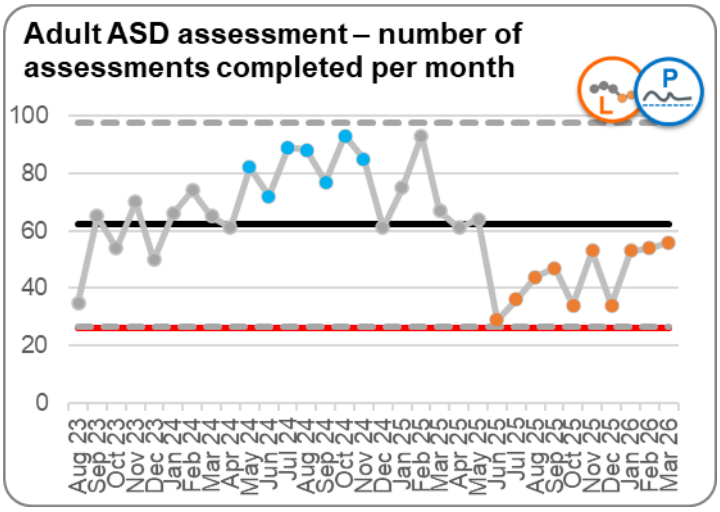


Adult autistic spectrum disorder assessment

Activity levels continue to exceed the commissioned target for assessments, with the full year target for assessments exceeded by 81%. However, demand for the service continues to significantly outstrip commissioned capacity. As a result, waiting times remain very high at around 54 weeks. The waiting list has reduced over the last four months of the year, but more than 1,100 people are currently waiting.







Tackling Health Inequalities

Reducing health inequalities remains a strategic priority for the Trust and is integral to the delivery of high-quality, equitable and person-centred care. The Trust recognises that significant variation persists in health outcomes, experiences and access to services across the population, often associated with ethnicity, disability, deprivation, age, sex, sexual orientation, religion and the wider determinants of health. Addressing these inequalities is essential to improving outcomes, reducing unwarranted variation and ensuring that all individuals have equitable opportunities to achieve the best possible health and wellbeing.

During 2025/26, the Trust further strengthened its approach to reducing health inequalities through closer integration of Equality, Diversity and Inclusion, quality improvement, service transformation, population health management and patient experience. Consideration of health inequalities is increasingly embedded within strategic decision-making, service redesign, quality improvement programmes and governance arrangements, supporting the recognition of equity as a core component of service delivery rather than a standalone activity. The Trust has also improved the completeness of demographic data collection, including ethnicity and wider socio-economic information, with ethnicity recording now exceeding 95%, thereby strengthening the evidence base for identifying and addressing inequity.

The tables below show that patient and service data continues to identify areas in which inequalities persist. For example, the NHS Talking Therapies data (Table 1) shows this is generally equitable across most groups, but the more pronounced inequalities are evident in clinical outcomes, restrictive interventions (Table 2), Mental Health Act detentions (Table 3) and physical health outcomes (Table 4). These findings demonstrate that equitable access alone is insufficient and that targeted action remains necessary to improve experience and outcomes for underserved groups.

Ethnic inequalities remain a significant concern. Mental Health Act data (Table 3 below) demonstrates disproportionate rates of detention amongst ethnically diverse communities, with markedly higher crude detention rates reported for Black, mixed, Asian and other ethnic groups when compared with White populations. Wider service data also indicates poorer Talking Therapies outcomes for Black and minority ethnic groups overall, alongside disproportionate representation in some restrictive interventions, including seclusion and rapid tranquillisation. These findings are consistent with the priorities of the Patient and Carer Race Equality Framework (PCREF) and reinforce the importance of sustained focus on anti-racism, culturally responsive care, co-production and service redesign informed by community insight.

Inequalities are also evident for disabled people and for some faith and sexual orientation groups. Within Talking Therapies, people reporting a disability experience poorer recovery and reliable recovery outcomes than those without a disability, despite comparable access times. Some religious groups, particularly Muslim patients, also demonstrate poorer outcomes, although small numbers for some communities necessitate cautious interpretation. Differences are also present by sexual orientation, with bisexual patients showing poorer outcomes overall than heterosexual patients. These findings reinforce the importance of maintaining an intersectional approach to service improvement and continuing to strengthen both the quality and completeness of recorded equality data.

Demand for services remains highest within communities experiencing the greatest levels of deprivation across Derbyshire and Derby City. Deprivation is strongly associated with poorer outcomes and higher rates of Mental Health Act detention, with the most deprived communities experiencing substantially higher detention rates than the least deprived. These findings reflect the continuing impact of the wider determinants of health and reinforce the

importance of partnership working across the Integrated Care System, local authorities and the voluntary and community sector to address inequity at population level.

Improving physical health outcomes for people living with Severe Mental Illness remains a key priority. Completion of physical health checks is improving, although variation persists across demographic groups. More broadly, premature mortality, excess under-75 mortality and suicide rates for people with Severe Mental Illness remain worse locally than national benchmarks, particularly in Derby. This underlines the need for sustained focus on prevention, annual physical health checks, improved access to screening and treatment, and stronger integration between mental and physical healthcare services.

In response to these challenges, the Trust has continued to strengthen governance, accountability and improvement activity through implementation of the PCREF, development of the Trust's Race Equality Strategy and Action Plan, and establishment of the Race Equality Working Group. A significant area of focus throughout the year has also been engagement and co-production with patients, carers, community organisations and people with lived experience, helping to ensure that service improvements are informed by the voices of those most affected by inequality.

During 2025/26, the Trust further strengthened its approach to accessible communication and equitable access to care. Interpretation and translation services, accessible information formats and support provided through the Accessible Information Standard continue to help ensure that patients receive information in ways that meet their individual needs. Enhanced reporting through Power BI dashboards, demographic analysis and EDI performance monitoring is also enabling services to better understand variation in access, waiting times, patient experience and outcomes across different population groups, thereby supporting a more evidence-based approach to identifying inequalities, targeting improvement activity and monitoring progress over time.

Alongside this work, the Trust has continued to invest in developing an inclusive organisational culture that supports equitable care delivery. Inclusive Intercultural Communication training, Active Bystander programmes, strengthened Equality Impact Assessment processes and anti-racism initiatives have contributed to building organisational capability to recognise and address inequalities. Priorities for 2026/27 include further embedding of the Patient and Carer Race Equality Framework, strengthening community engagement and co-production, improving the completeness and quality of equality data, enhancing the use of Equality Impact Assessments within service redesign, and ensuring that health inequalities are routinely considered through governance, quality improvement and performance management processes.

Promotion of equality of service delivery:

Due regard to the aims of the public sector equality duty
To meet the requirements of the Public Sector Equality Duties (PSED) Equality Act 2010, the Trust has published data on equality and diversity on its website www.derbyshirehealthcareft.nhs.uk/about-us/equality-and-diversity and shared it with the Derbyshire Integrated Care Board (ICB).

Performance against equality of service delivery key performance indicators (KPIs) and metrics
Patients continue to be given a choice of the method of contact for their appointments, either by using video, by telephone or in person. This flexible approach has continued to have a positive impact. Clinically the Trust's mental health, substance misuse, and neurodevelopmental services have delivered a high volume of care and treatment contacts throughout the year. The Trust's child health services (health visiting, safeguarding, school

nursing and child protection) have also experienced a high level of demand and provided a comprehensive universal children's service throughout the year.

Explanation of activities the Trust is undertaking to promote equality of service delivery

The Trust continues to take a holistic, person-centred approach to care planning. Each person is treated as an individual and their care plan considers all of their individual needs, which ensures 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. In addition, for service users with a learning disability an accessible care plan is utilised which contains symbols to aid understanding and so enables the service user to participate in the production of the care plan.

Inequalities data - core measures

Table 1 - Inequalities in people achieving access and outcomes for NHS Talking Therapies:

The Trust ceased to provide NHS talking therapies from July 2025 therefore the data covers the period April to June 2025 only:

Characteristic	Six week referral to treatment	18 week referral to treatment	Recovery rate	Reliable improvement rate	Reliable recovery rate	Average sessions
Age group						
Under 18	94%	100%	28%	72%	28%	7.7
18 to 25	98%	100%	43%	67%	38%	10
26 to 64	94%	99%	48%	70%	45%	9.8
65 to 74	99%	99%	61%	78%	57%	8.9
75 to 89	100%	100%	63%	70%	53%	8.2
BME group						
BME	94%	99%	41%	70%	38%	10.5
Not stated	91%	100%	30%	53%	30%	9.1
White British	96%	99%	49%	70%	46%	9.7
Disability						
Disability	95%	100%	38%	70%	35%	10.4
No disability	96%	99%	51%	71%	48%	9.7
Not stated	95%	99%	48%	70%	45%	9.8
Religion						
Christian	96%	99%	52%	70%	48%	9.9
Hindu	100%	100%	n/a	100%	n/a	7.6
Muslim	100%	100%	33%	58%	29%	8.8
None	96%	99%	48%	71%	46%	9.7
Other	96%	96%	25%	64%	25%	9.2
Pagan	88%	88%	31%	75%	31%	10.7
Sikh	83%	100%	n/a	n/a	n/a	14.2
Gender						
Female	95%	99%	47%	70%	44%	10
Male	97%	99%	50%	69%	48%	9.1
Non-binary	86%	86%	n/a	n/a	n/a	9.8
Sexual orientation						
Bisexual	95%	96%	39%	65%	35%	9.2
Gay/lesbian	94%	97%	48%	64%	45%	11.2
Heterosexual	96%	99%	50%	72%	47%	9.7
Not stated	92%	100%	39%	60%	34%	10.1

Microsoft Power BI

Table 2 - Inequalities in rates of restrictive interventions in inpatient services:

Chemical restraint – rapid tranquilisation	No:	%
Black African	9	3.2%
Black Caribbean	7	4.4%
Indian	7	2.2%
Not stated	56	21.9%
Other Black	1	0.6%
Other ethnic category	4	1.6%
Other White	4	2.5%
White British	148	63.2%
White Irish	1	0.3%
Physical restraint – prone	**No:**	**%**
Black African	7	3.6%
Black Caribbean	3	1.5%
Indian	8	4.1%
Not stated	41	20.8%
Other ethnic category	5	2.5%
Other Mixed	1	0.5%
Other White	3	1.5%
White British	127	64.5%
White Irish	2	1.0%
Physical restraint – kneeling	**No:**	**%**
Black African	3	7.1%
Black Caribbean	1	2.4%
Indian	1	2.4%
Not stated	8	19.0%
Other White	2	4.8%
White British	25	59.5%
White Irish	2	4.8%
Physical restraint – seated	**No:**	**%**
Black African	1	0.4%
Black Caribbean	8	2.8%
Indian	4	1.4%
Not stated	52	18.3%
Other Asian	2	0.7%
Other Black	1	0.4%
Other ethnic category	5	1.8%
Other Mixed	2	0.7%
Other White	2	0.7%
Pakistani	1	0.4%
White British	206	72.5%
Physical restraint – side	**No:**	**%**
Black African	1	0.7%
Black Caribbean	2	1.4%
Indian	9	6.3%
Mixed White and Asian	3	2.1%

Not stated	20	13.9%
Other Black	1	0.7%
Other ethnic category	4	2.8%
Other White	2	1.4%
White British	102	70.8%
Physical restraint – standing	**No:**	**%**
Black African	7	1.1%
Black Caribbean	28	4.4%
Indian	9	1.4%
Mixed White and Asian	2	0.3%
Mixed White and Black African	4	0.6%
Mixed White and Black Caribbean	2	0.3%
Not stated	120	18.9%
Other Asian	4	0.6%
Other Black	5	0.8%
Other ethnic category	11	1.7%
Other Mixed	11	1.7%
Other White	17	2.7%
Pakistani	6	0.9%
White British	409	64.3%
White Irish	1	0.2%
Seclusion	**No:**	**%**
Black African	8	3.1%
Black Caribbean	23	9.0%
Indian	2	0.8%
Mixed White and Asian	3	1.2%
Not stated	42	16.5%
Other Asian	5	2.0%
Other Black	6	2.4%
Other ethnic category	5	2.0%
Other Mixed	6	2.4%
Other White	16	6.3%
White British	137	53.7%
White Irish	2	0.8%

Table 3 - Inequalities in use of the Mental Health Act:

Statistics are available at ICB level, published annually. The most recent publication relates to financial year 2024/25.

Detentions by gender 2024/25 – NHS Derby and Derbyshire ICB:

	Male	Female
Number of detentions	455	425
Base population	524,926	542,028
Crude rate per 100,000	87	78

Detentions by age group 2024/25 – NHS Derby and Derbyshire ICB:

	15 and under	16 to 17	18 to 34	35 to 49	50 to 64	65 and over
Number of detentions	5	5	250	220	195	205
Base population	188,900	23,627	209,144	194,369	228,005	222,909
Crude rate per 100,000	3	21	120	113	86	92

Detentions by ethnicity 2024/25 – NHS Derby and Derbyshire ICB:

	White	Mixed	Asian	Black	Other
Number of detentions	605	30	55	45	80
Base population	958,165	20,414	52,573	14,569	10,311
Crude rate per 100,000	63	147	105	309	776

Detentions by index of multiple deprivation 2024/25 – NHS Derby and Derbyshire ICB:

01 most deprived	02 more deprived	03 more deprived	04 more deprived	05 more deprived
130	150	90	95	115
80,775	114,436	101,931	90,753	124,853
161	131	88	105	92

06 less deprived	07 less deprived	08 less deprived	09 less deprived	10 least deprived
60	50	50	65	40
92,684	91,603	111,919	119,920	107,457
65	55	45	54	37

Mental Health Act Statistics, Annual Figures, 2024-25 - NHS England Digital

Table 4 - Rates of eligible patients with severe mental illness (SMI) receiving an annual physical health check and action plan.

Statistics are available at ICB level, published quarterly. The most recent publication relates to financial year 2025/26 Quarter 3:

Category	Demographic breakdown – NHS Derby and Derbyshire ICB	Number on PHSMI Register	People on PHSMI register who had a full physical health check	
			Patients	%
Sex	Male	3,940	2,300	58
	Female	3,935	2,400	61
	Not known/not specified	*	*	*
Age Band	Under 18	10	*	*
	18-19	20	*	*
	20-24	200	95	48
	25-29	370	180	49
	30-34	660	320	48
	35-39	780	405	52
	40-44	790	425	54
	45-49	765	420	55
	50-54	875	540	62
	55-59	820	555	68

	60-64	795	535	67
	65-69	620	440	71
	70-74	450	310	69
	75-79	355	240	68
	80-84	220	145	66
	85-89	105	65	62
	90+	50	25	50
	Missing/invalid	*	*	*
Ethnicity	A: British	6,380	3,895	61
	B: Irish	50	30	60
	C: Any other White background	280	155	55
	D: White and Black Caribbean	65	30	46
	E: White and Black African	20	10	50
	F: White and Asian	25	15	60
	G: Any other mixed background	65	30	46
	H: Indian	160	95	59
	J: Pakistani	195	115	59
	K: Bangladeshi	10	10	100
	L: Any other Asian background	85	50	59
	M: Caribbean	100	60	60
	N: African	90	45	50
	P: Any other Black background	55	30	55
	R: Chinese	15	*	*
	S: Any other ethnic group	70	45	64
	Z: Not stated	95	40	42
	99: Not known	*	*	*
	Missing/invalid	110	50	45
IMD Decile	1	1,090	600	55
	2	1,245	770	62
	3	955	590	62
	4	875	495	57
	5	940	575	61
	6	615	375	61
	7	485	295	61
	8	585	350	60
	9	610	380	62
	10	445	270	61
	Missing/invalid	25	10	40

*no data published online for those at Midland level.

Physical Health Checks for People with Severe Mental Illness, Q3 2025/26 - NHS England Digital

1. Supporting measures

Inequalities in access to mental health services, including NHS Talking Therapies and other adult community mental health services

1. Patients open to mental health services

Age cohort

<19	2436	9%
19-23	1902	7%
24-28	1934	7%
29-33	2268	8%
34-38	2309	9%
39-43	2035	7%
44-48	1906	7%
49-53	1867	7%
54-58	2100	8%
59-64	2167	8%
>64	6236	23%
Total caseload	**27160**	

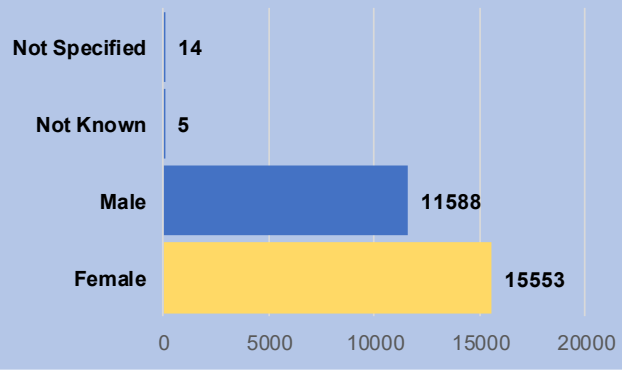
Top 10 reasons for referral

Adjustment to health issues	8555	31%
Anxiety	4093	15%
Organic brain disorder	3538	13%
Advice/Consultation	2197	8%
Depression	1841	7%
Ongoing or Recurrent Psychosis	1069	4%
Neurodevelopmental conditions	863	3%
Neurodevelopmental Conditions, exclu	685	3%
(Suspected) First Episode Psychosis	658	2%
Personality disorders	569	2%

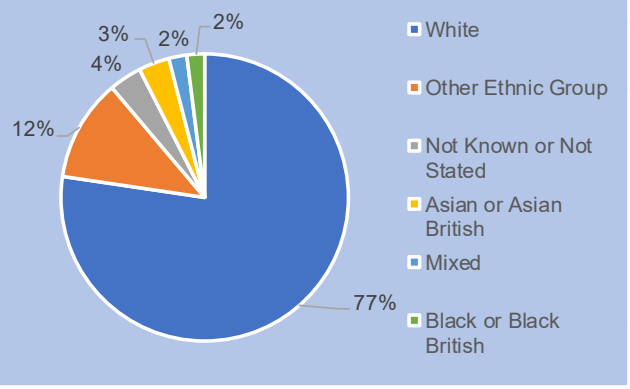
Deprivation index (1= most deprived)

1	3024	11%
2	4159	15%
3	2273	8%
4	5410	20%
5	3600	13%
6	2046	8%
7	2473	9%
8	1162	4%
9	1997	7%
10	1011	4%

Gender



Ethnicity



2. Patients currently waiting for mental health services

Age cohort

<19	3153	46%
19-23	351	5%
24-28	320	5%
29-33	341	5%
34-38	304	4%
39-43	266	4%
44-48	212	3%
49-53	191	3%
54-58	198	3%
59-64	210	3%
>64	1248	18%
Total waiting	**6794**	

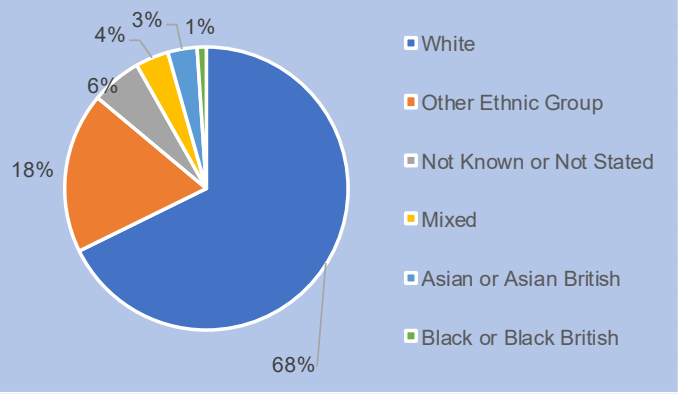
Top 10 reasons for referral

Neurodevelopmental Conditions, exc. ASD	1193	18%
Organic brain disorder	994	15%
Adjustment to health issues	810	12%
Anxiety	563	8%
Drug and alcohol difficulties	283	4%
Depression	178	3%
Neurodevelopmental conditions	169	2%
In crisis	66	1%
Self harm behaviours	40	1%
Post Traumatic Stress Disorder	34	1%

Deprivation index (1= most deprived)

1	776	11%
2	1104	16%
3	502	7%
4	1067	16%
5	1018	15%
6	542	8%
7	584	9%
8	366	5%
9	571	8%
10	258	4%

Ethnicity



Inequalities in rates of premature mortality for people with severe mental illness. High level statistics are available at local authority level:

1. Derby City

Indicator Name	Area Name	Time period	Value
E09a – Premature mortality in adults with severe mental illness (SMI)	England	2021-23	110.8
E09a – Premature mortality in adults with severe mental illness (SMI)	Derby	2021-23	164.9
E09b – Excess under 75 mortality rate in adults with severe mental illness (SMI)	England	2021-23	383.7
E09b – Excess under 75 mortality rate in adults with severe mental illness (SMI)	Derby	2021-23	514
E10 – Suicide rate	England	2022-24	10.9
E10 – Suicide rate	Derby	2022-24	12.2

Public Health Outcomes Framework - Data | Fingertips | Department of Health and Social Care

2. Derbyshire

Indicator name	Area name	Time period	Value
E09a – Premature mortality in adults with severe mental illness (SMI)	England	2021-23	110.8
E09a – Premature mortality in adults with severe mental illness (SMI)	Derbyshire	2021-23	113.1
E09b – Excess under 75 mortality rate in adults with severe mental illness (SMI)	England	2021-23	383.7
E09b – Excess under 75 mortality rate in adults with severe mental illness (SMI)	Derbyshire	2021-23	439.6
E10 – Suicide rate	England	2022-24	10.9
E10 – Suicide rate	Derbyshire	2022-24	12.5

Public Health Outcomes Framework - Data | Fingertips | Department of Health and Social Care

Inequalities in rates of diagnosed mental health conditions:
A formal diagnosis is generally only recorded on discharge from inpatients. The table relates to all discharges over the last three financial years. The percentages show what proportion of patients in each column had a particular diagnosis. For example, 25% of Asian or Asian British discharged inpatients had a diagnosis of schizophrenia:

Diagnosis	Asian or Asian British	Black or Black British	Mixed	Other Ethnic Group	White British	White Other	Grand total
F20 – Schizophrenia	25.0%	24.1%	14.1%	33.3%	14.1%	28.0%	15.6%
F60 – Specific personality disorders	2.9%	9.3%	9.2%	0.0%	14.1%	12.0%	12.3%
F31 – Bipolar disorder	19.1%	5.6%	5.9%	8.3%	9.6%	16.0%	9.5%
F43 – Reaction to severe stress, and adjustment disorders	1.5%	0.0%	9.7%	16.7%	8.7%	0.0%	8.0%
F32 – Major depressive disorder, single episode	7.4%	0.0%	7.6%	0.0%	7.9%	4.0%	7.3%
F25 – Schizoaffective disorders	7.4%	20.4%	5.9%	0.0%	5.1%	0.0%	5.8%
G30 – Alzheimer disease	4.4%	0.0%	4.9%	8.3%	5.4%	4.0%	5.0%
F23 – Brief psychotic disorder	7.4%	7.4%	4.9%	8.3%	3.2%	4.0%	3.9%
F29 – Unspecified psychosis not due to a substance or known physiological condition	5.9%	9.3%	5.4%	8.3%	3.2%	0.0%	3.9%
F41 – Other anxiety disorders	0.0%	0.0%	5.4%	0.0%	3.9%	4.0%	3.7%
F19 – Other psychoactive substance related disorders	0.0%	7.4%	3.8%	8.3%	3.2%	16.0%	3.6%
F33 – Major depressive disorder, recurrent	4.4%	1.9%	2.7%	0.0%	3.0%	0.0%	2.9%
F22 – Delusional disorders	2.9%	1.9%	1.6%	8.3%	2.5%	0.0%	2.4%

F84 – Pervasive developmental disorders	1.5%	1.9%	1.6%	0.0%	2.6%	0.0%	2.3%
F01 – Vascular dementia	0.0%	0.0%	2.2%	0.0%	1.6%	0.0%	1.5%
R45.4 – Irritability and anger	0.0%	1.9%	2.2%	0.0%	1.2%	0.0%	1.3%
F30 – Manic episode	0.0%	0.0%	0.5%	0.0%	1.4%	0.0%	1.1%
G31 – Other degenerative diseases of nervous system, not elsewhere classified	0.0%	0.0%	2.7%	0.0%	0.8%	0.0%	1.0%
F10 – Alcohol related disorders	0.0%	0.0%	0.5%	0.0%	0.9%	4.0%	0.8%
F53 – Puerperal psychosis	1.5%	1.9%	1.1%	0.0%	0.7%	0.0%	0.8%
F61 – Mixed and other personality disorders	1.5%	1.9%	0.0%	0.0%	0.7%	0.0%	0.6%
F05 – Delirium due to known physiological condition	0.0%	0.0%	1.1%	0.0%	0.7%	0.0%	0.6%
F12 – Cannabis related disorders	0.0%	1.9%	0.5%	0.0%	0.6%	0.0%	0.6%
Z03 – Encounter for medical observation for suspected diseases and conditions ruled out	2.9%	1.9%	0.5%	0.0%	0.3%	0.0%	0.6%
F42 – Obsessive-compulsive disorder	0.0%	0.0%	0.0%	0.0%	0.7%	0.0%	0.5%
O99 – Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium	1.5%	0.0%	0.5%	0.0%	0.5%	0.0%	0.5%
F44 – Dissociative and conversion disorders	0.0%	0.0%	0.5%	0.0%	0.6%	0.0%	0.5%
F90 – Attention-deficit hyperactivity disorders	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.4%
F14 – Cocaine related disorders	1.5%	0.0%	0.0%	0.0%	0.2%	4.0%	0.3%
F50 – Eating disorders	0.0%	0.0%	0.0%	0.0%	0.3%	4.0%	0.3%
R41 – Other symptoms and signs involving cognitive functions and awareness	0.0%	1.9%	0.0%	0.0%	0.2%	0.0%	0.2%
G20 Parkinson disease	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.2%
F68 – Other disorders of adult personality and behaviour	0.0%	0.0%	0.5%	0.0%	0.2%	0.0%	0.2%
F06 – Other mental disorders due to known physiological condition	0.0%	0.0%	0.5%	0.0%	0.1%	0.0%	0.2%
F03 – Unspecified dementia	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.2%

F70 – Mild intellectual disabilities	0.0%	0.0%	0.5%	0.0%	0.1%	0.0%	0.2%
F34 – Persistent mood [affective] disorders	0.0%	0.0%	0.5%	0.0%	0.1%	0.0%	0.2%
F64 – Gender identity disorders	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%
F11 – Opioid related disorders	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%
G23 – Other degenerative diseases of basal ganglia	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%
F24 – Shared psychotic disorder	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%
R46.2 – Strange and inexplicable behaviour	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%
F21 – Schizotypal disorder	0.0%	0.0%	0.5%	0.0%	0.0%	0.0%	0.1%
F07 – Personality and behavioural disorders due to known physiological condition	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
F45 – Somatoform disorders	0.0%	0.0%	0.5%	0.0%	0.0%	0.0%	0.1%
F09 – Unspecified mental disorder due to known physiological condition	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%
G10 – Huntington's disease	0.0%	0.0%	0.5%	0.0%	0.0%	0.0%	0.1%
F38 – Other mood (affective) disorders	0.0%	0.0%	0.5%	0.0%	0.0%	0.0%	0.1%
F40 – Phobic anxiety disorders	0.0%	0.0%	0.5%	0.0%	0.0%	0.0%	0.1%
Grand total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Discharged inpatients	**68**	**54**	**185**	**12**	**887**	**25**	**1,231**

Inequalities in the social determinants of health that impact on the prevalence of, acuity and recovery from mental health conditions.

Data is available at ICB level, as follows:

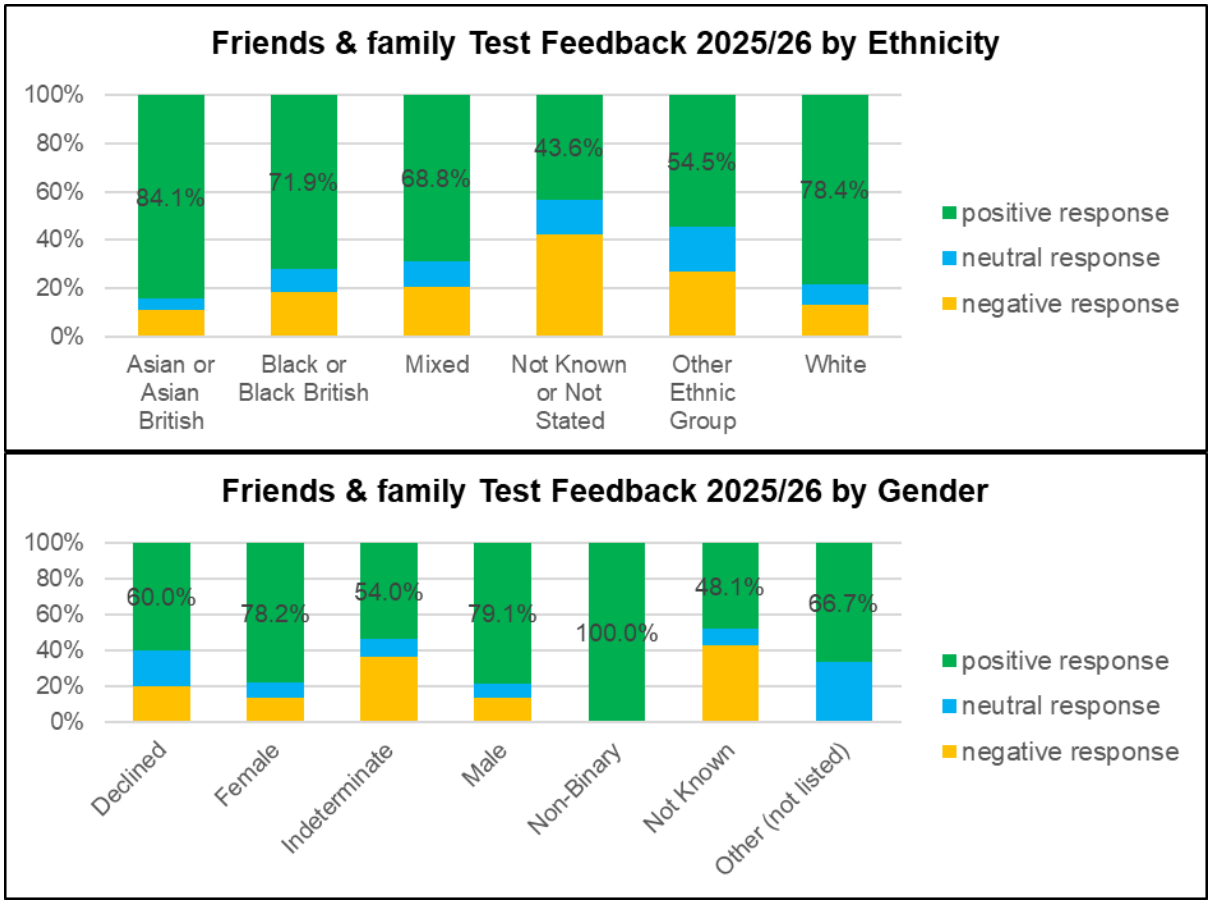
Indicator	Period	NHS Derby and Derbyshire ICB	Midlands	England
Common mental health conditions				
Depression – QOF prevalence	2024/25	15.9%	14.9%	14.3%
Depression – QOF incidence (new diagnosis)	2024/25	1.1%	1.4%	1.4%
Newly diagnosed patients with depression reviewed 10-56 days after diagnosis	2024/25	62.7%	60.8%	64.7%
Severe mental illness				
Model-based estimated prevalence of severe mental illness	2023	1.16%	1.18%	1.16%
Model-based estimated prevalence of schizophrenia	2023	0.36%	0.39%	0.38%

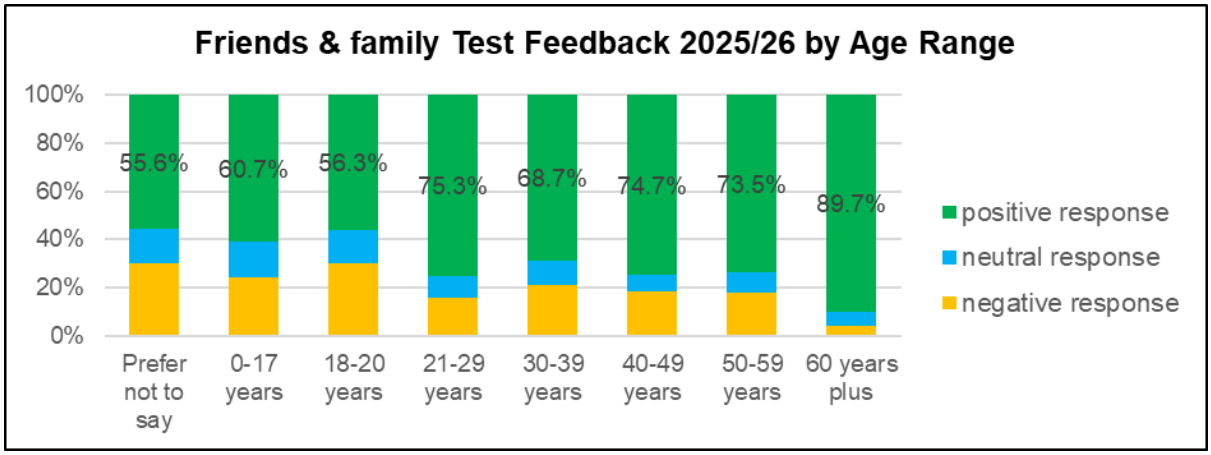
Model-based estimated prevalence of bipolar disorder	2023	0.44%	0.43%	0.42%
Model-based estimated prevalence of other psychosis	2023	0.36%	0.37%	0.36%
New referrals to secondary mental health services per 100k (all ages)	2022/23	7,836	-	8,117
Attended contacts with community and outpatient mental health services per 100k (all ages)	2022/23	35,468	31,717	32,170
Inpatients stays in secondary mental health services per 100k (all ages)	2022/23	186	194	204
Deprivation score (Index of Multiple Deprivation 2025)	2025	21.6	-	21.8

Adult mental health and wellbeing - Data | Fingertips | Department of Health and Social Care

Inequalities surfaced in patient reported outcome and experience measures recorded in local and national tools.

The Trust continues to promote the Friends and Family Test, and respondents are asked to provide their ethnicity, age and gender. Results for the 2025/26 financial year were as follows:





New artwork created by patients for patients displayed at new mental health unit in Chesterfield

A stunning art display was created by patients with acute mental health needs to help enhance mental health and wellbeing to support with social connection.

Located at 'The Hive' – a communal space, located at the Derwent Unit in Chesterfield, the hand-crafted art display of a mosaic tree and tiled wall was co-created by patients on the unit, the Recreational Activity Team, and designed by Rosanna Scrase, Artist and Recreation Worker. The artwork was created at the Hartington Unit, also at the Chesterfield site, before patients relocated to the Derwent Unit in March 2025.

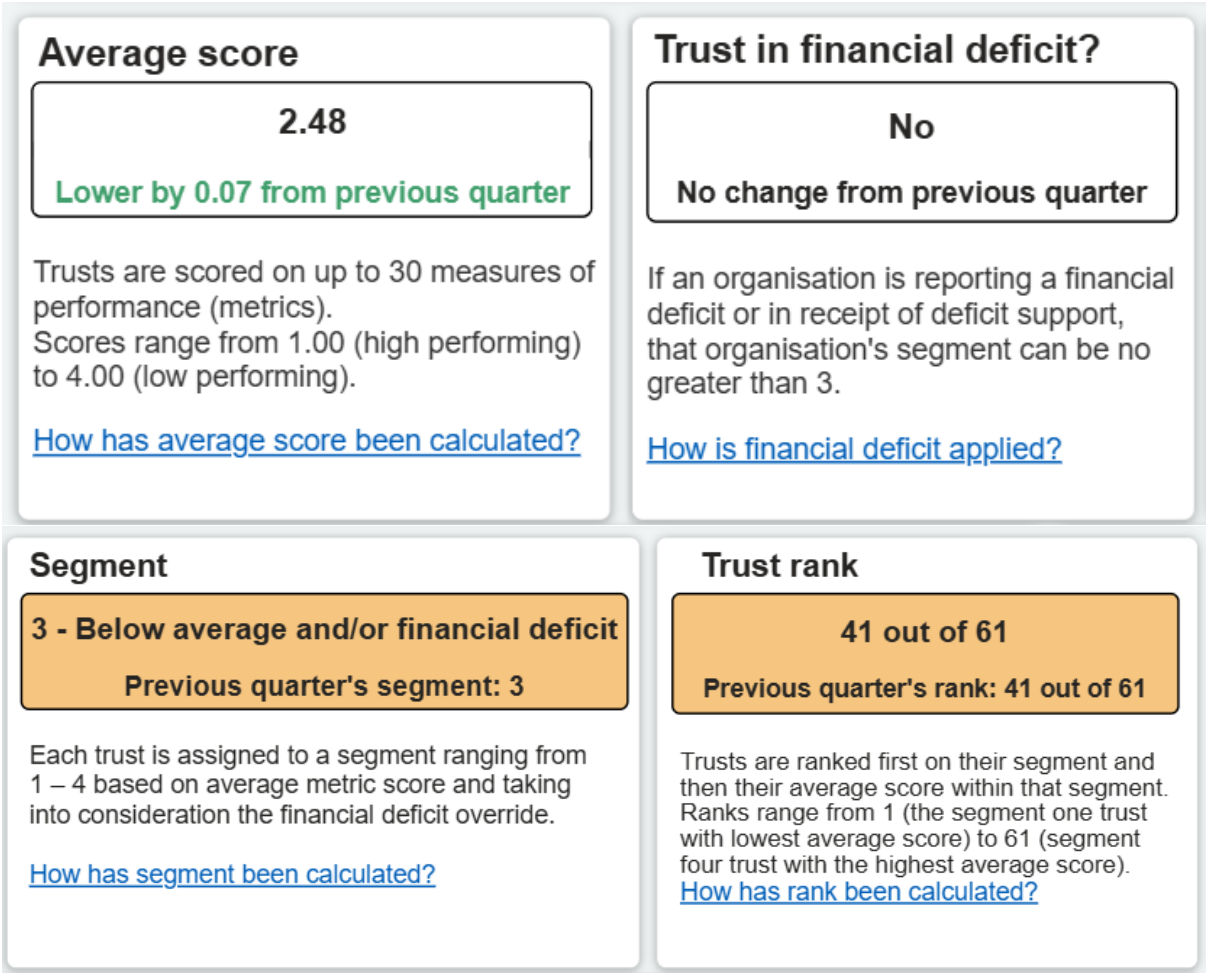
The mosaic is composed of hundreds of hand-crafted clay tiles. Each tile was made by patients at various stages of their recovery, with the Recreation Team offering guidance and support throughout the process. Embedded within the bark of the tree are positive words and phrases chosen by the patients.

Operational performance summary

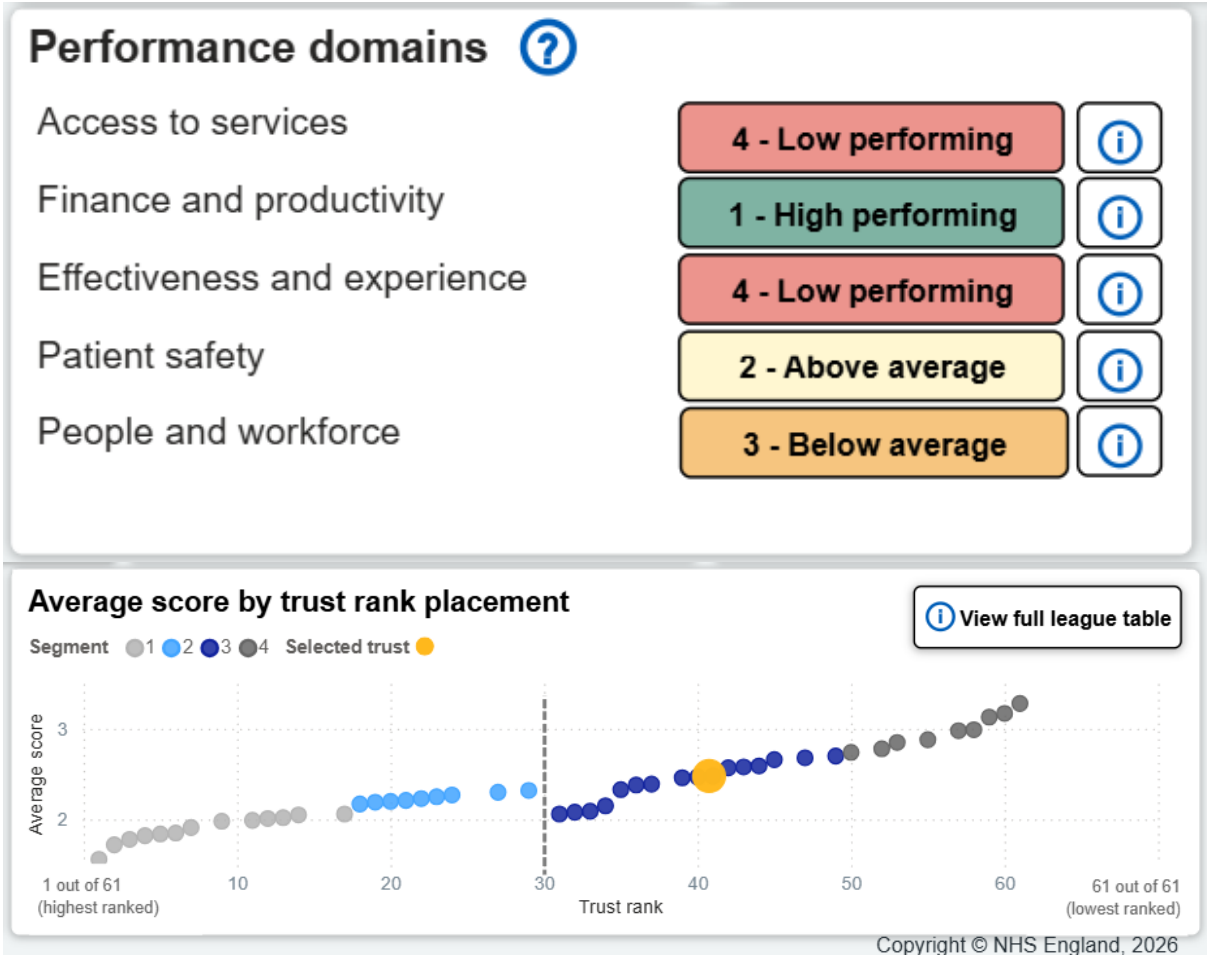
Trust performance is measured against a number of national and local indicators and standards. The performance measures considered key by the organisation are summarised below:

a) NHS Oversight Framework 2025/26

This financial year NHS England introduced a new NHS oversight framework and scoring methodology based on 5 performance domains, which ranks NHS providers from best to worst. The framework is used by NHS England's regional teams to guide oversight of integrated care systems and NHS providers. In Quarter 3 of 2025/26 the Trust ranked 41 out of 61 NHS providers, placing in Segment 3:



The Trust finished the financial year ranked 40 out of 61 NHS providers, placing in Segment 3:



View NHS Oversight Framework - Model Mental Health

Performance domain and metrics	Target	Apr-25	May-25	Jun-25
Access to Services				
Proportion of people waiting over 52-weeks for community services	0%	65%	64%	65%
Children and young people accessing NHS-funded MH services – annual change	15.9%	0.6%	0.7%	1.8%
Effectiveness and experience of care				
CQC community mental health survey satisfaction rate score	6.8	6.5		
Proportion of acute inpatients aged 18-64 discharged with 60 days plus length of stay	20.6%	31%	33%	27%
Patient safety				
Annual NHS staff survey – raising concerns sub-score[1]	6.64	6.76		
Percentage of patients in crisis to receive face to face contact within 24 hours	65%	47%	52%	53%
People and workforce				
Sickness absence rate	5%	5.4%	4.9%	5.3%
Annual NHS staff survey engagement theme score[1]	7.02	7.07		
Finance and productivity				

Planned surplus/deficit year to date – adjusted (£)	£ -	-£ 643,118	- £1,289,243	- £1,442,742
Variance year to date to financial plan – adjusted (£)	0	£ 26,588	£ 43,183	£ 76,791
Relative difference in costs	<100%	93.76%		

Performance domain and metrics	Target	Jul-25	Aug-25	Sep-25
Access to Services				
Proportion of people waiting over 52-weeks for community services	0%	68%	65%	65%
Children and young people accessing NHS-funded MH services – annual change	15.9%	0.1%	0.4%	0.4%
Effectiveness and experience of care				
CQC community mental health survey satisfaction rate score	6.8			
Proportion of acute inpatients aged 18-64 discharged with 60 days plus length of stay	20.6%	27%	33%	31%
Patient safety				
Annual NHS staff survey – raising concerns sub-score[1]	6.64			
Percentage of patients in crisis to receive face to face contact within 24 hours	65%	65%	76%	75%
People and workforce				
Sickness absence rate	5%	5.8%	5.5%	5.8%
Annual NHS staff survey engagement theme score[1]	7.02			
Finance and productivity				
Planned surplus/deficit year to date – adjusted (£)	£ -	- £1,714,677	- £1,986,468	- £1,521,049
Variance year to date to financial plan – adjusted (£)	0	£ 63,671	£ 65,060	£ 207,015
Relative difference in costs	<100%			

Performance domain and metrics	Target	Oct-25	Nov-25	Dec-25
Access to Services				
Proportion of people waiting over 52-weeks for community services	0%	66%	62%	66%
Children and young people accessing NHS-funded MH services – annual change	15.9%	1.0%	0.4%	1.0%
Effectiveness and experience of care				
CQC community mental health survey satisfaction rate score	6.8			
Proportion of acute inpatients aged 18-64 discharged with 60 days plus length of stay	20.6%	31%	31%	31%
Patient safety				
Annual NHS staff survey – raising concerns sub-score[1]	6.64			
Percentage of patients in crisis to receive face to face contact within 24 hours	65%	76%	75%	76%
People and workforce				
Sickness absence rate	5%	6.6%	6.6%	6.3%

Annual NHS staff survey engagement theme score[1]	7.02			
Finance and productivity				
Planned surplus/deficit year to date – adjusted (£)	£ -	-£1,472,000	-£1,421,000	-£557,000
Variance year to date to financial plan – adjusted (£)	0	£5,116	£6,456	£33,609
Relative difference in costs	<100%			

Performance domain and metrics	Target	Jan-26	Feb-26	Mar-26
Access to Services				
Proportion of people waiting over 52-weeks for community services	0%	62%	63%	51%
Children and young people accessing NHS-funded MH services – annual change	15.9%	1.7%		
Effectiveness and experience of care				
CQC community mental health survey satisfaction rate score	6.8			7.3
Proportion of acute inpatients aged 18-64 discharged with 60 days plus length of stay	20.6%	31%	34%	29%
Patient safety				
Annual NHS staff survey – raising concerns sub-score[1]	6.64			6.64
Percentage of patients in crisis to receive face to face contact within 24 hours	65%	78%		
People and workforce				
Sickness absence rate	5%	6.0%	6.2%	6.1%
Annual NHS staff survey engagement theme score[1]	7.02			7.02
Finance and productivity				
Planned surplus/deficit year to date – adjusted (£)	£ -	-£669,000	-£521,000	£11,000
Variance year to date to financial plan – adjusted (£)	0	£496,585	£240,026	£11,000
Relative difference in costs	<100%			

Internally the Trust has continued to value the importance of and to monitor its performance against an additional suite of Trust level performance indicators, as follows:

Performance indicator	Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
CPA three day follow up	80%	89%	88%	90%	88%	88%	92%
Data quality maturity index	95%	96%	96%	96%	96%	96%	96%
EIP RTT within 14 days – complete	60%	53%	52%	43%	38%	41%	52%
EIP RTT within 14 days – incomplete	60%	48%	43%	46%	52%	61%	75%
Performance indicator	**Target**	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**
CPA three day follow up	80%	85%	89%	86%	91%	92%	89%
Data quality maturity index	95%	97%	97%	97%	97%	98%	98%
EIP RTT within 14 days – complete	60%	85%	56%	78%	41%	67%	73%
EIP RTT within 14 days – incomplete	60%	92%	88%	63%	69%	72%	92%

The Trust performed highly against the majority of indicators for most of the time. Out of area placements remained a challenge but were significantly reduced at year end.

b) Contractual targets

Main Contract
The following measures form part of the Trust's main contract with the Derbyshire ICB:

Performance indicator	Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Outpatient appts did not attends	15%	12%	13%	13%	13%	13%	13%
Outpatient appts Trust cancellations	5%	9%	10%	9%	11%	13%	7%
Delayed transfers of care	4%	12%	13%	13%	12%	12%	13%
Discharge email sent in 24 hours	90%	80%	89%	83%	83%	82%	87%
Inpatient 28 day readmissions	10%	3%	11%	7%	8%	12%	9%
Mixed sex accommodation breaches	0	0	0	0	0	0	0
MRSA – blood stream infection	0	0		0	0	0	0
Under 18s admitted to adult wards	0	0	0	1	0	0	0
Performance indicator	**Target**	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**
Outpatient appts did not attends	15%	13%	12%	12%	13%	13%	12%
Outpatient appts Trust cancellations	5%	7%	11%	9%	9%	6%	10%
Delayed transfers of care	4%	12%	11%	11%	11%	9%	10%
Discharge email sent in 24 hours	90%	83%	83%	80%	79%	78%	84%
Inpatient 28 day readmissions	10%	8%	5%	3%	7%	8%	10%
Mixed sex accommodation breaches	0	0	0	0	0	0	0
MRSA – blood stream infection	0	0	0	0	0	0	0
Under 18s admitted to adult wards	0	0	0	1	0	0	0

There have been ongoing delayed discharges of people clinically ready for discharge from the inpatient wards, mainly as a result of care home or housing issues.

Performance indicator	Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Three day follow up – all inpatients	80%	90%	88%	90%	88%	88%	92%
Clostridium difficile incidents	7	0	0	0	0	0	0
CPA employment status	90%	95%	96%	95%	94%	95%	94%
CPA review in last 12 months	95%	79%	80%	79%	80%	80%	80%
CPA settled accommodation	90%	95%	95%	95%	94%	94%	94%
Ethnicity coding	90%	96%	96%	96%	96%	96%	96%
NHS number	99%	100%	100%	100%	100%	100%	100%
Performance indicator	**Target**	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**
Three day follow up – all inpatients	80%	85%	89%	86%	91%	92%	89%
Clostridium difficile incidents	7	0	0	0	0	0	0
CPA employment status	90%	94%	94%	94%	94%	93%	93%
CPA review in last 12 months	95%	79%	79%	82%	82%	80%	77%
CPA settled accommodation	90%	94%	95%	94%	94%	94%	93%
Ethnicity coding	90%	96%	96%	96%	96%	96%	96%
NHS number	99%	100%	100%	100%	100%	100%	100%

The Trust has continued to ensure that patients are followed up in the first three days following discharge from mental health inpatient wards to provide support and ensure their wellbeing during

the period when they are potentially at their most vulnerable. The level of patients who have their ethnicity and NHS number recorded on their record remains high.

c) School Nursing

Category	Spec URN	Metric	Qtr1	Qtr2	Qtr3	Qtr4
School-age universal touchpoints – via The Lancaster Model	10	Number of health promotion sessions delivered in schools	85	34	52	50
	11	Number of CYP that have received a support session (workbook) from the school nursing team	27	1	2	31
	12	Number of home-educated children and young people (CYP) that have received a support session (workbook) from the school nursing team	0	0	0	0
	13	Number of health promotion sessions delivered in special schools	0	0	1	0
Children not brought	21	Proportion of appointments where CYP/families were not brought	200/611 (32.73%)	141/450 (31.33%)	169/624 (27.08%)	184/626 (29.39%)
Safeguarding (across 0-19 pathway)	22	Number of Early Help Assessments (EHA) completed	34	18	30	33
	23	% of children recorded as children in care (CIC)	4/611 (0.65%)	8/450 (1.78%)	3/624 (0.48%)	2/626 (0.32%)
	24	% of children recorded as children in need (CIN)	6/611 (0.98%)	14/450 (3.11%)	15/624 (2.40%)	16/626 (2.56%)
	25	% of children recorded as child protection (CP)	20/611 (3.27%)	16/450 (3.56%)	19/624 (3.04%)	15/626 (2.40%)
	26	Attendance at safeguarding related meetings where 0-19s service has been actively involved in care of the child: over 5	82	90	76	104

d) Health Visiting

Category	Ref	Metric	Target	Qtr1	Qtr2	Qtr3	Qtr4
Best start in life touch points (universal and targeted)	1	% of antenatal reviews delivered	60%	356/360 (98.89%)	370/360 (102.78%)	240/360 (66.67%)	243/360 (67.50%)
	2	% coverage of new birth visit (NBV) within 14 days	92%	750/758 (98.94%)	710/716 (99.16%)	717/722 (99.31%)	679/688 (98.69%)
	3	% of children receiving a 6-8 week review	92%	737/747 (98.66%)	738/746 (98.93%)	719/724 (99.31%)	692/697 (99.28%)
	4	% of children receiving a 3/4 month contact via text messaging		593/767 (77.31%)	692/750 (92.27%)	639/725 (88.14%)	642/707 (90.81%)

	5	% of children receiving a 3/4 month contact via group setting or individually		27		35		3		26	
	6	% of children receiving a 6 month contact via text messaging		342/752 (45.48%)		557/763 (73.00%)		746/749 (99.60%)		729/733 (99.45%)	
	7	% of children receiving a 12-month review	92%	689/708 (97.32%)		766/795 (96.35%)		739/758 (97.49%)		711/759 (93.68%)	
	8	% of children receiving a 2/2.5-year review	90%	715/752 (95.08%)		690/718 (96.10%)		701/735 (95.37%)		732/777 (94.21%)	
	9	% of children receiving a 3/3.5-year contact via text messaging		707/716 (98.74%)		557/808 (68.94%)		751/753 (99.73%)		754/754 (100.00%)	
	10	Number of Early Help Assessments (EHA) completed		52		48		58		65	
Breast-feeding	11	10-14 Days - Coverage	98%	750/758 (98.94%)		709/716 (99.02%)		717/722 (99.31%)		679/687 (98.84%)	
	12	10-14 Days - Prevalence	65%	522/758 (68.87%)		519/716 (72.49%)		504/722 (69.81%)		499/687 (72.63%)	
	13	6-8 Weeks - Coverage	98%	738/745 (99.06%)		737/746 (98.79%)		718/722 (99.45%)		691/694 (99.57%)	
	14	6-8 Weeks - Prevalence	43%	402/745 (53.96%)		421/746 (56.43%)		435/722 (60.25%)		393/694 (56.63%)	
SEND (Ages and stages questionnaire (ASQ) / speech and language)	15	2.5 year review – % of children with one or more delay as a result of concerns with ASQ3		16/715 (2.24%)		21/690 (3.04%)		25/701 (3.57%)		18/732 (2.46%)	
	16	2.5 year review – % of children referred on as a result of concerns with ASQ3		16/16 (100.00%)		21/21 (100.00%)		25/25 (100.00%)		18/18 (100.00%)	

	17	% of children identified with speech, language and communication (SLC) needs via early language identification measure (ELIM)		79/715 (11.05%)		104/690 (15.07%)		98/701 (13.98%)		85/732 (11.61%)	
	18	% of children with identified SLC needs referred on for additional support		71/79 (89.87%)		85/104 (81.73%)		92/98 (93.88%)		73/85 (85.88%)	
Healthy weight	19	% of brief interventions around healthy weight and nutrition with parent/carers of children at/above 91st centile		4/12 (33.33%)		0/11 (0.00%)		1/27 (3.70%)		8/19 (42.11%)	
	20	% of healthy weight resource packs provided via the 2/2.5 year development review		200/715 (27.97%)		202/690 (29.28%)		252/701 (35.95%)		309/732 (42.21%)	
	21	% referrals made into Tier 2 child weight management intervention for children at/above the 91st centile		Not in place yet		Not in place yet		Not in place yet		Not in place yet	
Oral health	23	% of tooth brushing packs and advice given at 6–8-week check	80%	336/755 (44.50%)		635/742 (85.58%)		587/719 (81.64%)		589/693 (84.99%)	

School nursing
The service continues to deliver The Lancaster Model (TLM) for contacts at reception and year nine. Owing to staffing issues it has not been possible to deliver the questionnaire to year six pupils. However, health promotion presentations have been offered and delivered in most primary schools based on information from the previous TLM questionnaires.

In 2025 the School Nursing service won the Health Service Journal digital award for generating impact in population health through digital (TLM).

Recruitment into Health Visiting and School Nursing posts remains a challenge for the service and is a national issue. The teams have been skill mixed to try and support the service delivery to some extent, but recruitment remains an issue for the service.

Health visiting
The 0-5 service continues to meet its key performance indicator standards in relation to the Healthy Child Programme.

The key performance indicators for the 0-19 contract have been met throughout the last 12 months. The service also exceeded the regional and national average for all contacts (0-5).

Area name: Derby	New birth visits within 14 days	New birth visits after 14 days	New birth visits within and after 14 days	6 to 8 week review
England	85.2%	12.8%	98%	85.1%
East Midlands region	90.1%	8.5%	98.6%	90.8%
Derby	98.4%	0.2%	98.7%	97%

Area name: Derby	12 month review by 12 months	12 month review by 15 months	2 to 2½ year reviews	2 to 2½ year reviews using ASQ-3
England	79.7%	88.4%	80.8%	93.9%
East Midlands region	86.3%	92%	82.2%	90.4%
Derby	95.3%	95.6%	93.3%	95.3%

Produced by: Office for Health Improvement and Disparities, Department of Health and Social Care 9/2/2026

The service is continually flexed to ensure that the mandated touch points are completed within relevant time scales. There are currently 198 families within the 0-5 service who are receiving enhanced support owing to being on plan for child protection, children in need or children in care.

The 0-19 service holds a UNICEF Baby Friendly Initiative (BFI) accreditation.

Quality performance

During 2025/26, the Trust maintained a clear and sustained focus on the quality, safety and experience of care, despite continued system pressures arising from increasing demand, workforce challenges and rising governance e.g. patient acuity. The Board is satisfied that this section provides a fair, balanced and understandable assessment of quality performance, reflecting both areas of progress and those requiring continued improvement.

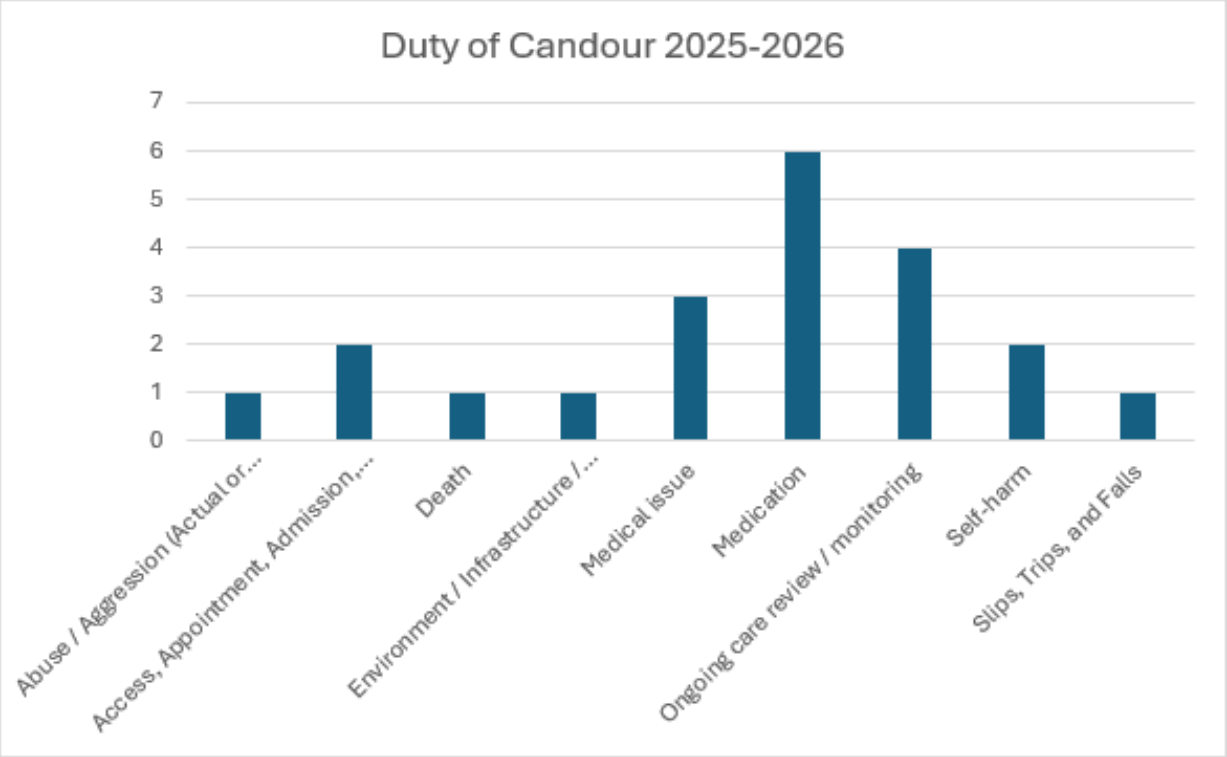
The Trust continued to deliver against its Quality Ambition and Quality Delivery Plan, aligned to the Trust Strategy 2024–2028, with improvements across patient safety, clinical effectiveness and experience. Performance was monitored through an integrated quality performance framework, using quantitative and qualitative indicators, trend analysis and triangulated intelligence from data, lived experience feedback, direct observation and external oversight. Further detail can be seen in the Trust Quality Account 2025/26, which is published on the Trust's website.

Patient safety and harm reduction
Patient safety remained a core organisational priority. The Trust maintained an overall Care Quality Commission (CQC) rating of 'Good', with all inspected services rated 'Good'.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Mental health crisis services and health-based places of safety	Good	Good	Good	Good	Good	Good
Forensic inpatient or secure wards	Good	Good	Good	Good	Good	Good
Long stay or rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Good	Good
Wards for older people with mental health problems	Good	Good	Good	Good	Good	Good
Acute wards for adults of working age and psychiatric intensive care units	Good	Good	Good	Good	Good	Good

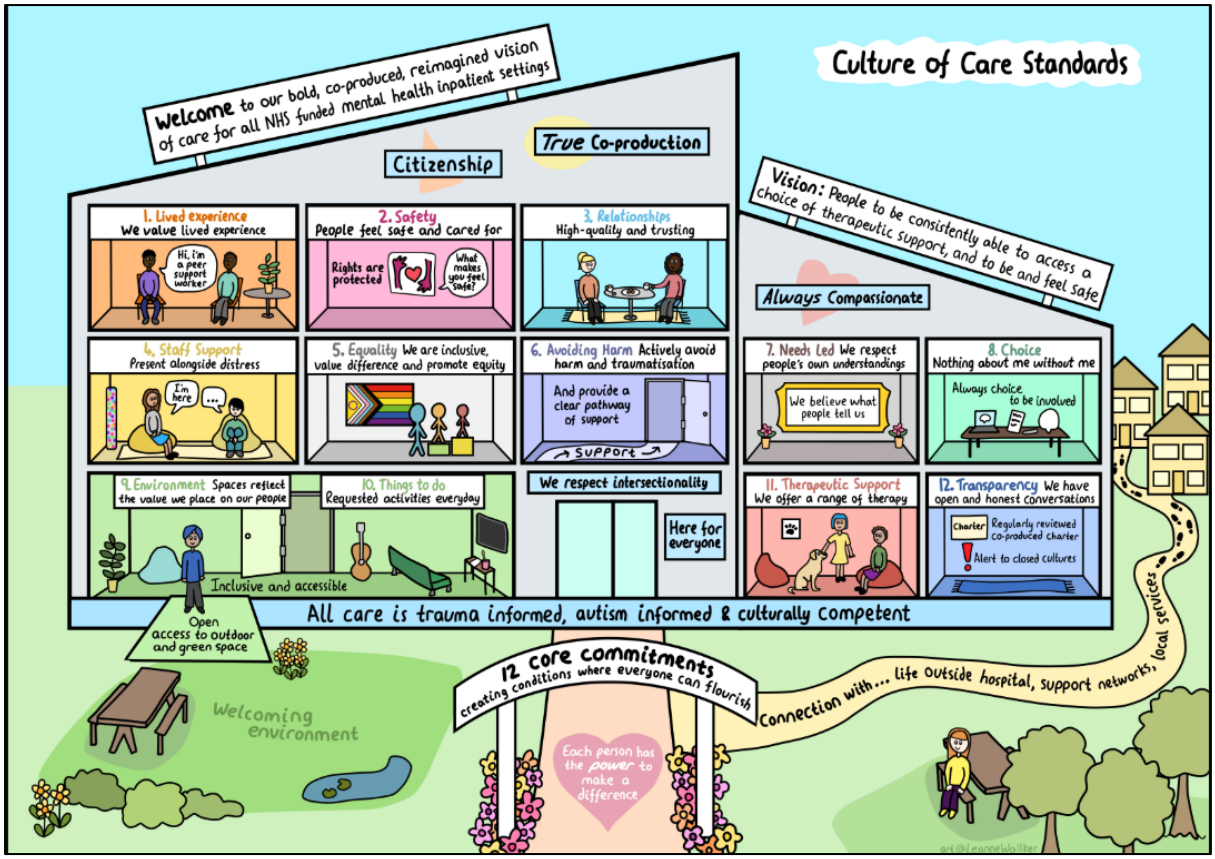
Progress was made in embedding the Patient Safety Incident Response Framework (PSIRF), strengthening learning from incidents and deaths, improving involvement of patients and families, and supporting a culture focused on system learning rather than individual blame. During 2025/26, the Trust saw improved timeliness and consistency in incident learning responses under PSIRF, with increased involvement of patients and families and clearer organisational oversight of learning themes and actions.

The Board received assurance that learning from incidents was being translated into service-level improvement and the Trust achieved 100% Duty of Candour compliance for incidents occurring within 2025/26.



Restrictive practices continued to be rigorously overseen, supported by improved risk screening, strengthened observation practice and trauma-informed approaches. Safeguarding assurance remained strong, underpinned by high training compliance, robust governance arrangements and positive external validation. Targeted work was progressed to strengthen sexual safety and professional boundaries, supported by clear executive oversight.

Clinical effectiveness, outcomes and environment
Clinical effectiveness was enhanced through continued investment in modern, therapeutic environments and evidence-based practice. Delivery of the Making Room for Dignity (MRFD) programme improved privacy, safety and therapeutic care while reducing reliance on inappropriate out of area placements. The Culture of Care programme strengthened inpatient culture and ward-level leadership, contributing to improved patient experience and staff engagement.



Effectiveness was further supported by research, audit and accreditation activity, including participation in over 35 National Institute for Health Research (NIHR) studies and achievement or maintenance of multiple Royal College of Psychiatrists accreditations, demonstrating alignment with nationally recognised quality standards. During 2025/26, Research and Development (R&D) remained central to improving quality, safety and effectiveness of care at the Trust. A growing culture of embedded research is enabling staff capacity and capability, expanding patient and carer involvement, and improving knowledge and use of the evidence base.

Research activity is aligned to strategic priorities and strengthened through partnerships with academic and system colleagues and communities. Findings are applied to clinical pathways, decision making and service redesign, supported by robust governance and assurance processes, contributing to continuous improvement and delivery of high-quality evidence based care. A Research and Development Strategic 'Plan on a page' for 2025-2028 is in place, with outcomes measures.

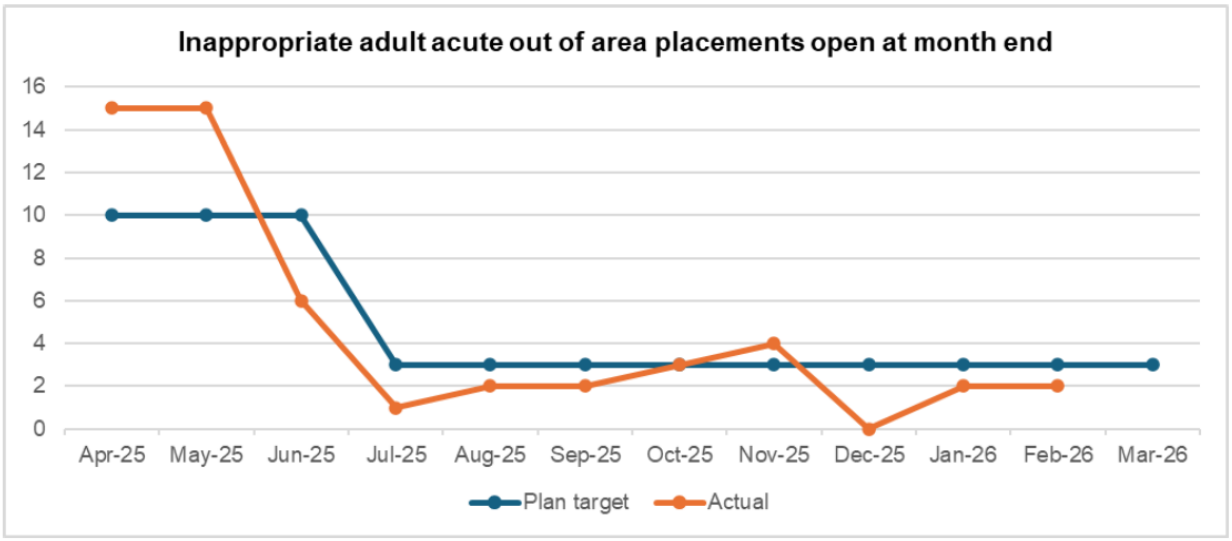
Experience, involvement and equity

The Trust strengthened its organisational approach to patient, carer and lived experience involvement, with clearer governance, improved coproduction and sustained Triangle of Care compliance. Complaints and concerns processes were improved, including responsiveness, transparency and systematic use of learning to inform service improvement.

Health inequalities considerations were embedded across quality improvement work, including early implementation of the Patient and Carer Race Equality Framework (PCREF), autism-informed and trauma-informed care, and a continued focus on inclusive and culturally safe services.

Access, flow and system performance

Performance in access and flow remains a key challenge across mental health services nationally. During 2025/26, the Trust made progress through a comprehensive Patient Flow Programme, reducing inappropriate out of area placements and improving oversight of admissions, length of stay and discharge processes.



Above: The inappropriate out of area position achieved at the end of February 2026 month end was two, below the Operational Plan trajectory of three.

Development of the Mental Health Urgent Assessment Centre and continued delivery of the Mental Health Helpline supported system priorities to strengthen urgent and crisis mental health

pathways and reduce avoidable pressure on emergency departments. Despite progress, the Board recognises that sustained pressure on access, flow and workforce capacity continues to present a risk to quality and patient experience, and this remains a key focus for improvement planning in 2026/27.

Digital enablement and productivity
Digital transformation continued to support quality improvement, including optimisation of the electronic patient record, electronic prescribing and deployment of contactless patient monitoring in inpatient areas to strengthen physical health monitoring and night-time safety. Digital delivery is governed through established arrangements with a clear focus on quality impact, patient safety and staff experience.

System working and alignment with Integrated Care Board (ICB) plans
The Board has reviewed the extent to which the Trust has exercised its functions in line with the relevant plans of NHS Derby and Derbyshire ICB. Quality priorities and improvement activity during 2025/26 were aligned with ICB forward plans, including reducing inappropriate out of area placements, strengthening crisis care, safeguarding, children's services and addressing health inequalities. Delivery was supported through partnership working and agreed system governance arrangements.

Strategic partnership with the University of Derby

A three-year partnership agreement was launched to strengthen workforce development, research collaboration- and student learning opportunities.

This strategic partnership reinforced the Trust's commitment to developing a skilled, future ready workforce. Through combining academic expertise with frontline healthcare insight, the collaboration is helping to expand research capability, enhance student placements and embed innovative approaches that support high quality, evidence-based care across Derbyshire.

Meet the Dalek that is helping doctors – by raising funds for our Trust
A Dalek named Dusty, was created to help raise money for local NHS mental health services.
Dusty is the creation of Samantha and Adrian Kennedy, from Oakwood, who travel to events up and down the country, entertaining people for free and raising money for the Trust's charitable fund.

Workforce performance

In support of our Great Place to Work strategic intent we have maintained a strong focus on reducing sickness absence and improving staff wellbeing. We have also delivered an enhanced development programme for our leaders and managers.

At year end the Trust employed 3,508 contracted staff and 459 bank staff.

Recruitment and retention

- Turnover – our annual staff turnover rate for 2025/26 was 10.53%. This is lower than last year, falling within the target of 10-12%.
- Vacancies – reflecting the picture nationally, we have had some challenges in recruitment of Band 5 and 6 mental health nurses and some consultant posts. During 2025/26 we recruited 455 new starters and by the year end we had an overall increase of 55 staff. Our vacancy rate at the end of March was 5.63%.

Staff attendance and wellbeing

Our annual sickness rate for 2025/26 was 5.84% which is 0.17% lower than the previous year. In line with experiences across other NHS trusts nationally, anxiety, stress, depression and/or other psychiatric illnesses remains the Trust's highest reason for sickness absence and accounted for 36.08% during 2025/26. Anxiety, stress, depression and/or other psychiatric illnesses; accounted for 39.48% of sickness absence during March 2026, followed by cold, cough, flu (influenza) at 7.43% and gastrointestinal problems at 7.40%.

Our enhanced wellbeing offers had good take up during the year; however, we have not yet seen an associated downturn in sickness absence rates. We expect a timing difference between the receipt of the wellbeing support and the return to work or the avoidance of absence; however, this expectation will be explored at the People and Culture Committee.

Appraisals

The Trust appraisal target rate is 90% and at the end of March 2026 the completion rate was 91.98%.

Compulsory training

The Trust has a compliance target rate of 85% and at the end of March 2026 the compliance rate was 95%.

Leadership development

There is a range of leadership development support available designed to help the wellbeing, engagement and development of managers and their teams including masterclasses, bite-sized resources, tools, and webinars.

This year saw the introduction of a Mid-level Leaders programme aimed at colleagues who directly manage people who manage others. Whilst the Trust offers a range of leadership and management development our longer-term programmes tended to focus on supporting aspirant and newly appointed managers. As a result, there was a noticeable gap in targeted support for more experienced, mid-level managers, those operating one step removed from the front line, who play a critical role in translating strategy into practice. The programme included six core face to face sessions along with a minimum of three optional online sessions. The programme evaluated well with the participants valuing the practical tools and techniques they could immediately apply with their teams.

Following the operational restructure, the Trust also introduced STRIVE, a values-based senior leadership development programme designed to support leaders operating at system and organisational level through a period of significant change. STRIVE articulates the core expectations of senior leadership practice through a consistent leadership framework: Strategic, Transformational, Resilient, Inclusive, Values-Led and Empowered. The programme has been

designed and delivered in partnership with external leadership and development organisations and is aligned to the Trust's strategic priorities, ensuring leadership development directly supports the future direction of the organisation.

STRIVE is delivered over a 12-month period and provides dedicated space for senior leaders to strengthen strategic leadership capability, collective accountability and effective partnership working, including within triumvirate leadership arrangements. The programme includes the option for participants to progress towards a formal Level 7 leadership qualification, supporting longer-term leadership development and succession planning at senior levels.

To further strengthen the leadership pipeline, future development plans include the extension of the STRIVE approach to Band 7 leaders, creating a more coherent and progressive leadership pathway across the organisation. This will provide targeted development for aspiring senior leaders, supporting readiness for increased responsibility and ensuring greater alignment and continuity between leadership levels.

"Being the first girl in my family to go to university was just the beginning" – a Trust nurse shared her experience of faith, family and the NHS as part of South Asian Heritage Month

As part of South Asian Heritage Month (18 July – 17 August), the Trust celebrated a range contributions from its south Asian communities and colleagues. This year's theme, 'Roots to Routes', invited us to learn about south Asian identity, culture and the rich diversity that strengthens our workforce and the care we provide.

To mark the awareness month, the Trust celebrated its diverse workforce by sharing colleagues' stories and shining a spotlight on their lives. Sabeeha Anisah, Health Protection Lead Nurse at the Trust, was one of three members of staff who wrote a personal piece sharing her own experiences and reflections on how cultural pride and professional achievements have shaped who she is today.

Trust celebrates NHS's 77th birthday

The 5 July 2025 marked the 77th birthday of the NHS, which has been supporting British families since 1948. To commemorate this milestone the Trust staff and patients celebrated the NHS's birthday with several events and activities leading up to the big day.

Colleagues came together from all services to recognise the NHS's success over the last 77 years. Bakers from wards and teams across the Trust held an NHS 'Big Tea' to raise money for the Trust's charitable funds and mark the special occasion.

10 Point Plan to improve resident doctors' working lives
In August 2025, NHS England launched a 10 Point Plan aimed at improving the working conditions of approximately 75,000 Resident Doctors. This initiative, incorporated into the NHS Oversight Framework, addresses long-standing issues like payroll errors, poor rota management, and inadequate rest facilities.

The 10 Point Plan for Resident Doctors cover the following areas:

1. Improve workplace wellbeing: trusts must take meaningful steps to improve the working environment, including providing designated on-call parking, 24/7 access to hot meals, rest areas, and lockers.

2. Rota and schedule transparency: trusts must provide work schedules at least eight weeks in advance and detailed rotas no later than six weeks before a rotation begins.

3. Fair annual leave: a review is underway to ensure annual leave is allocated in a fair, transparent, and consistent manner across all trusts to support doctor wellbeing.

4. Board-level leadership: every trust must appoint two named leads – one senior executive and one resident doctor peer representative who report directly to the board on resident doctor issues.

5. Eliminate payroll errors: trusts are required to join a national payroll improvement programme to reduce errors caused by rotations by at least 90% by March 2026.

6. End unnecessary training repetition: through a national Memorandum of Understanding (MoU), trusts must accept prior statutory and mandatory training to prevent doctors from repeating it when they rotate.

7. Reform exception reporting: a new national framework simplifies the process for doctors to report and receive fair compensation for working beyond their contracted hours.

8. Rapid expense reimbursement: trusts must transition to a system that reimburses course-related expenses within four to six weeks of submission, ideally as soon as the expense is incurred.

9. Reduce rotational impact: NHS England and the British Medical Association (BMA) are piloting new ways to manage medical rotations to reduce the administrative and personal burden on trainees.

10. Expand Lead Employer model: to eliminate the need for doctors to change employers with every rotation, the Lead Employer model will be expanded nationally to improve administrative continuity.

The Trust is compliant with points 1 to 8 with the remaining points 9 to 10 reliant on future National/Deanery intervention and steer.

Financial performance

Detailed financial performance
The Trust and its system partners in Joined Up Care Derbyshire (JUCD) regularly updated their financial forecasts as the year progressed. Financial performance has been reported regularly to the Trust Board as part of an integrated performance report and described both the current and forecast financial position and key matters of interest as the year progressed.

Detailed scrutiny and assurance discussions take place at the Trust's Finance and Performance Committee. In addition, the performance of all partners and the overall system position is reported through various JUCD's system meetings.

At the end of month 12 the outturn for the Trust was a deficit of £6.5m (breakeven after technical adjustments). The adjusted financial position, after technical adjustments for impairments and Public Finance Initiatives (PFI), of breakeven was as per the plan.

Our most important financial key performance measures are those that evidence achievement of the financial plan and any key variances to the plan. Ongoing and forecast achievement against these financial key performance measures is checked through a wide range of activities in the organisation; they range from meetings with individual budget holders to discuss performance against a single budget, to team and divisional reporting, culminating in reporting to Trust Board and the Finance and Performance Committee on the overall performance of the Trust.

The Board report in March 2025 summarised key risks to delivery of the financial position. Risks related to costs for adult acute out of area placements, delivery of efficiencies and temporary staffing costs. The Trust continued to enhance the reporting of both bank and agency expenditure which has continued to reduce during 2025/26 and are both below the plan that was set. Analysis of temporary staffing costs, for both bank and agency staffing, will continue, in order to inform and support decision making to deliver continued reductions that are planned for 2026/27.

Among the notable successes, the Trust delivered on its efficiency requirement for 2025/26 in full. However, a proportion of those savings were non-recurrent in nature, meaning they do not carry forward a recurrent saving into the next financial year.

Key technical financial components which contribute to the plan delivery also includes our liquidity, net current assets/liabilities and cash levels which can be found on the statement of financial position page 173. It is clearly important to ensure we are able to continue to service our debts, and our liabilities and these are included in the notes to the accounts.

Another important measure is our performance against our capital expenditure plan. At the start of the year our capital plan was for £18.6m, of which £11.8m was to be funded from national public dividend capital (PDC) allocations in relation to the Dormitory Eradication Programme. During the year we received additional PDC funding for capital expenditure of £1.1m which related to other estate and digital schemes. This in turn led to capital expenditure of £18.2m in year, £0.4m less than originally planned. The underspend was driven by the self-funded schemes of £31.5m which was agreed across the JUCD system in order to support the mitigation of system wide cost pressures, some of this funding will be returned to the organisation in 2026/27.

The Trust had previously received additional PDC capital funding for the earlier stages of the Dormitory Eradication Programme between 2021/22 and 2025/26.

The capital expenditure across estates and technology and their sources of funding is summarised in the table below:

Capital expenditure summary 2025/26	Plan £'000	Actual £'000
Self-funded capital schemes		
Information and technology	772	872
Estates (including leases)	5,981	4,407
Total self-funded schemes	**6,753**	**5,279**
PDC-funded capital schemes		
Information and technology	0	425
Estates (including dormitory eradication funding)	11,810	12,494
Total PDC-funded schemes	**11,810**	**12,919**
Total capital expenditure 2025/26	**18,563**	**18,198**

Although we are constrained by our share of JUCD's fixed capital limit we do review our priorities within the capital programme to enable us to seek to address 'People First' priorities, Care Quality Commission (CQC) requirements, urgent maintenance, and replacements.

As part of planning capital expenditure for the next financial year, organisations have been set capital expenditure limits by NHS England.

In terms of long term trends, we have performed well financially every year since becoming a Foundation Trust, demonstrating that our operating profitability is generally strong, and we built up our cash reserves in the years where a surplus was required to be generated. In more recent times financial measurement in the NHS has changed; with the expectation that Foundation Trusts such as our ourselves no longer seek to make a surplus. Instead, the NHS is asked to aim to deliver a balanced financial position called 'breakeven' where costs match income.

Looking forward, we will continue to work closely with health and social care partners to deliver the strategic priorities of JUCD and have submitted individual organisational plans for the next five years. The plan submission for 2026/27 was a breakeven plan.

With regard to future financial risks and activities; as well as being part of JUCD the Trust is also a partner in provider alliances in the East Midlands. Part of these wider partnership arrangements is to look at joint planning and analysis of key risks and mitigations with assumptions across partners informing delivery plans and forecasts.

The Trust has not undertaken any work overseas during 2025/26.

Countering fraud and corruption

The Trust's counter fraud service is provided by 360 Assurance who work with us to devise an operational counter fraud work plan for the year, which is agreed by the Trust's Audit and Risk Committee. The plan is designed to provide counter fraud, bribery and corruption work across generic areas of activity in compliance with NHS Counter Fraud Authority standards and our Local Counter Fraud Specialist provided 46 days of service for us across the year. The number of days of activity across the year is summarised below grouped by type of activity:

Area of activity in countering fraud	Days
Proactive work	39
Reactive work	12.5
Total days	**51.5**

Data security and protection

The Data Security and Protection (DS&P) toolkit is used by healthcare organisations to provide assurance around safe handling and protection of data, meeting legal requirements and maintain public trust in the NHS.

The Trust successfully completed the most recent 2024/25 toolkit and is certified until 30 June 2026. Local audit provided by 360 Assurance highlighted two recommendations. Action has completed for all of these in advance of planned deadline 30 September 2025.

The current version of the DS&P toolkit is work in progress with 360 Assurance again scheduled for local audit later in April to May 2026. The Trust is on track to complete the toolkit submission on time ahead of the 30 June 2026 deadline.

Policies
All Trust policies for DS&P group have been kept in date and no policy has expired or needed an extension for review during the previous year. The DS&P policy compliance has been consistently 100% on the Trust policy dashboard.

Mandatory training
Throughout April 2025 to March 2026 the Trust has consistently reported excellent compliance for mandatory Data Security Awareness training. Across the whole Trust the average has been 97%-98%. This is delivered at Trust induction and as part of refresher training via a range on online e-learning, traditional paper workbooks, pre-recorded and in person classroom sessions.

		Total	Corporate services	Operational services
April 2026	Total target group	3283	631	2652
	In date	3203	620	2583
	Out of date	80	11	69
	Performance threshold %	**97.56%**	**98.26%**	**97.40%**

All staff must complete Data Security Awareness training annually and are sent reminders along with line manager leading up to expiry, on anniversary and warnings after expiration date. Although a compassionate approach is in place for staff on long term absence, if action is not taken, computer and email access is disabled until training is completed.

Data Protection Act – subject access requests
Between April 2025 and March 2026 the Trust received 498 subject access requests (SARs) with a further two carried over from previous year. These are requests from service users or those acting on their behalf. All of which were completed within the legal deadline with no breaches. The average time for all requests including complex cases was 12 days.

April 2025 – March 2026	Standard (one month deadline)	Complex (three-month deadline)	Total
Total requests received	493	5	498
Number of closed requests	482	5	487
Average days to complete a request	12	38	12

SAR volumes continue to increase year on year, with 2025/26 being the busiest period to date. Despite this, the Trust has continued to meet its obligations under the Data Protection Act. This has been supported by a dedicated clinical team coordinating SARs through a centralised approach. Additionally, the team offers valuable redeployment opportunities for displaced clinical staff, allowing their knowledge and experience to support the process while keeping their skills current, maintaining mandatory training and supervision, and ensuring they are well prepared to return to their substantive roles.

Although 2025/26 was the busiest year to date for SARs, the Trust demonstrated exemplary compliance with the Data Protection Act. This achievement is largely due to a specialised clinical team responsible for centralising and managing requests. The team also provides support to displaced clinical staff requiring redeployment by identifying areas where their expertise can contribute value to the process. In return, these staff members are able to maintain and enhance their skills, fulfil mandatory training and supervision requirements, and remain well-prepared for reintegration into their original teams.

Incidents – data security breaches
Between April 2025 and March 2026 there has been two concerns reported to the Trust from the Information Commissioner's Office (ICO), references:

- IC-370838-Y8Q4: this relates to a staff subject access request which there was a delay in relation to responding to questions raised as part of staff investigation process. Although the core request was completed there were further additional queries which were not responded to promptly. Lessons learned in relation to making sure queries raised by staff as part of investigation process are responded to and or shared with the relevant team supporting subject access request process.

- IC-433722-Q7G1: this relates to another staff subject access request which the Trust needed to categorise as complex and needed an extension to complete. There was cross over where the subject access response was completed in advance of the ICO contacting the Trust. Lessons learned in relation to making sure timely communication with the requestor and coordination between People Services and team supporting subject access request process.

In addition to the above there have been a further two incidents reported locally on our Trust Datix system which in turn have been reported externally via the DS&P toolkit. Of these two incidents, neither met the threshold to be escalated further to the ICO. All incidents were investigated and lessons learnt were used to support improvements in processes and training.

Risks
DS&P risks are reviewed monthly as part of the Information Management, Technology and Records Department (IMT&R) senior team meeting and in turn reviewed as part of DS&P group. Our top three current DS&P related risks are:

- Cyber Risks:
    - IT system collapse due to cyber-attack (including artificial intelligence (AI) used inappropriately)
    - Data accuracy and cyber security relating to Microsoft Azure services
    - Risk of supplier of Trust services being involved in a cyber incident.
- Inappropriate access to records risks:
    - Inappropriate access by staff to service user records
    - Risk of unauthorised access to confidential information or inappropriate destruction of paper records
    - Inappropriate use of AI.
- Patient communication – incorrect recipients (includes email and SMS as well as traditional paper letters).

Cyber security
Cyber security continues to be one of the Trust's top three Data Security and Protection (DS&P) risks and remains recognised within the Board Assurance Framework (BAF). The risk profile reflects the wider NHS environment, where cyber threats remain persistent and increasingly sophisticated.

Building on progress made in previous years, the Trust has continued to work closely with partners across the regional Joined Up Care Derbyshire (JUCD) system. This collaboration has supported shared learning around cyber resilience and business continuity, and has helped strengthen links between technical, digital and information security teams across Derbyshire.

The ongoing development of the DS&P toolkit, now aligned with the National Cyber Security Centre's Cyber Assessment Framework, reflects the growing emphasis on cyber security assurance. The updated framework places greater focus on prevention, detection and response, requiring organisations to demonstrate sustained improvement rather than one-off compliance. The Trust remains on track with this approach.

Raising cyber awareness across the workforce continues to be a key priority. Strong compliance with mandatory data security training provides a solid foundation, but this is complemented by targeted support from Specialist Information Asset Owners, whose deeper understanding of Trust systems helps identify and manage risks closer to operational activity. This combined approach supports early identification of issues and strengthens the Trust's overall cyber resilience.

Freedom of information
The Trust's DS&P Committee is responsible for awareness and overseeing the Trust's compliance with the Freedom of Information Act 2000 and the implementation of an open culture to improve transparency.

During the 2025/26 financial year, the Trust received 485 requests for information and responded to 437 within the 20 working daytime limit. The Trust received eight requests for an internal review in respect of the information it provided to requesters. The Trust has been referred to the ICO twice in respect of the way it has applied exemptions to requests and is awaiting the ICO's decision notice.

Local NHS Psychology and Psychological Therapies division recognised nationally for inclusive employment

A Trust team was named a finalist at the National Learning Disabilities and Autism Awards for their commitment to inclusive employment practices.

The Division of Psychology and Psychological Therapies at the Trust was shortlisted for 'The Employer Award' category. This award celebrated organisations that have gone above and beyond to employ and support individuals with a learning disability or autism, creating inclusive workplaces where everyone can thrive.

Accountability report

The Trust's directors take responsibility for preparing the Annual Report and Accounts. We consider this information is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy.

This accountability report is signed in my capacity as accounting officer.

Mark Powell
Chief Executive
18 June 2026

Trust CEO donates prize to local NHS charity

In July 2025, the Chief Executive of the Trust generously donated a prize to the Trust's League of Friends charity, following a recent win at a national healthcare conference.

Mark Powell, Trust CEO, attended the NHS Confederation conference in June, where he was selected as the winner of a £1,000 prize draw sponsored by Flexzo AI – an Artificial Intelligence-powered healthcare staffing platform company designed to simplify recruitment for NHS Trusts.

Directors' report

Trust Board members on 31 March 2026:

Selina Ullah, Chair
Current term of office: 14 September 2024 – 13 September 2027

Selina joined the Trust as Chair on 14 September 2021 and has since been reappointed for a second three-year term of office. Her appointment and re-appointment was approved by the Trust's Council of Governors. Selina also chairs the Trust's Remuneration and Appointments Committee, the Council of Governors and the Governors' Nominations and Remuneration Committee.

She previously served as a Non-Executive Director at Bradford Teaching Hospitals NHS Foundation Trust for six years and was appointed Vice Chair and Senior Independent Director there in 2019. Prior to joining the NHS Alliance, she was the Vice Chair and Senior Independent Director of NHS Providers.

Selina brings extensive board-level experience across health and public sector organisations. She is a board member for the Muslim Women's Council, having previously served as its Chair for ten years, and holds a number of other non-executive roles, including Lay Council Member at the General Pharmaceutical Council and Senior Independent Director at Locala CIC, a social enterprise providing community healthcare. Selina is also a trustee and board member of NHS Alliance, where she represents mental health providers nationally.

Mark Powell, Chief Executive
Mark became Chief Executive of the Trust on 3 April 2023.

As Chief Executive, he provides strategic leadership focused on quality, inclusion, partnership working and continuous improvement in services for patients and local communities. Mark is intent on building a compassionate and high-performing organisational culture, improving access to healthcare services, and delivering major infrastructure developments such as the Trust's new inpatient facilities.

He is the executive sponsor of the Trust's Black and Minority Ethnic group (BME) Staff Network and is also an Ordinary Member of the Derby and Derbyshire Integrated Care Board, contributing mental health expertise to system wide planning and strategy.

Mark has over 20 years' experience working in the NHS and brings a wide range of senior leadership experience across mental health, community, acute and commissioning services, with a track record of operational excellence, service transformation and system-level leadership.

Prior to joining the Trust, he was Managing Director and Deputy Chief Executive at Leicestershire Partnership NHS Trust, where he oversaw large scale service delivery and contributed to the development of integrated care models. He has previously worked at Derbyshire Healthcare as Chief Operating Officer, when he led the Trust's initial response to the COVID-19 pandemic and strengthened service resilience across clinical pathways. His earlier roles include Executive Director of Operations at Burton Hospitals NHS Foundation Trust and positions in public health and commissioning, developing community health improvement programmes.

Mark lives in Derby and is a keen cyclist and golfer.

Lynn Andrews
Current term of office: 11 January 2026 – 10 January 2029

Lynn joined the Trust as a Non-Executive Director (NED) on 11 January 2023, following a short period in a designate role to support transition into the clinical NED position. She has since been re-appointed for a second three-year term.

She is the Chair of the Trust's Quality and Safeguarding Committee and was appointed Deputy Chair of the Trust in August 2025. She also became the Trust's Non-Executive Director link for Freedom to Speak Up in December 2025.

A registered nurse by background, Lynn qualified in Scotland and has worked in healthcare since 1987. She has held a wide range of senior clinical, executive and governance roles and holds a master's degree in health policy. Her last executive role was as Executive Director of Nursing and Patient Care at Chesterfield Royal Hospital NHS Foundation Trust, where she led on quality, patient experience and safety.

She brings a strong focus on quality, governance and regulation and is passionate about improving the experience of patients and staff. She has a thorough understanding of NHS regulation through her work with regional and national NHS teams.

Lynn has lived in Derbyshire for over 20 years and enjoys running in South Derbyshire and the Peak District.

Other Non-Executive Directors

Chioma Akpom
Current term of office: 1 December 2025 – 30 November 2028

Chioma joined the Trust as a NED on 1 December 2025 for a three-year term of office, having served a short period before that in a designate role.

She is also Chair of the Trust's Audit and Risk Committee.

Chioma brings 25 years of experience in digital transformation, audit, governance, risk and compliance, gained across a range of sectors.

She is a Fellow of the Association of Chartered Certified Accountants (ACCA) and a Certified Information Systems Auditor (CISA). Chioma is currently Managing Director and Global Head of Audit Systems, Data, Analytics and Innovation at HSBC, where she leads global digital strategy and transformation.

Deborah Good
Current term of office: 1 March 2025 – 29 February 2028

Deborah joined the Trust as a NED on 1 March 2022 and has since been reappointed for a second three-year term of office.

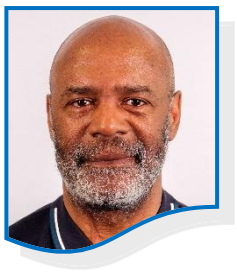
She is Chair of the Mental Health Act Committee and is the Non-Executive link and Board champion for Carers.

Deborah spent most of her career working in the social housing sector, where she held senior leadership roles focused on improving services and outcomes for local communities. A former

Housing Director, she holds a BA and a Postgraduate Diploma in Housing and brings extensive experience of customer experience, governance and partnership working.

She has served on a range of multiagency boards, including as Executive Director of Customer Experience and Business Support at Solihull Community Housing and as a NED at Derwent Living.

Deborah lives in Derbyshire and is a Trustee of Artcore, a visual arts organisation supporting diverse communities across the county.



Ralph Knibbs, Senior Independent Director
Current term of office: 1 July 2025 – 30 June 2028

Ralph joined the Trust as a NED on 1 July 2022 having served a month in a designate role. He has since been reappointed for a second three-year term.

He is Chair of the Trust's People and Culture Committee and the Trust's Senior Independent Director (SID). The SID serves as an alternative point of contact for governors and directors when they have concerns or when it would be inappropriate to contact the Chair or Chief Executive. He also acts as the Trust's Wellbeing Guardian.

Ralph brings over 20 years' experience as a senior strategic human resource professional, having worked across both the public and private sectors, including within complex organisations such as Rolls-Royce plc. He has extensive experience leading people-focused transformation and supporting effective team working and performance.

He is currently Head of Human Resources at UK Athletics. He is a passionate advocate for equality, diversity and inclusion and brings a strong focus on workforce culture, leadership and governance.

Andrew Harkness
Current term of office: 13 January 2025 – 12 January 2028

Andrew joined the Trust as a NED on 13 January 2025 for a three year term of office.

He brings a strong system-wide perspective to his Non-Executive role and is committed to supporting services that improve outcomes and wellbeing for local communities.

Andrew is the NED link to the Trust's Strategic Performance Oversight Group.

He is a pharmacist and Consultant in Public Health, with extensive experience leading public health programmes, tackling health inequalities and improving population health. He has worked in a range of senior roles across the NHS and local authorities and was most recently Chief Executive of St Giles Hospice, near Lichfield.

He lives in Staffordshire and enjoys participating in and coaching for triathlons.

Jo Hanley
Current term of office: 4 August 2025 – 3 August 2028

Jo joined the Trust as a NED on 4 August 2025, for a three-year term of office.

She is Chair of the Trust's Finance and Performance Committee.

Jo brings over 20 years' experience in the Financial Services industry from Lloyds Banking Group, where she worked in senior operational and financial management roles and led large-scale transformational change and more recently the Post Office. She has a strong track record in supporting effective oversight and financial governance and driving customer/patient centricity and organisational performance.

Alongside her Trust role, Jo is Co-Chair of the Midlands branch of Women in Banking and Finance, a social enterprise focused on increasing equality, diversity and inclusion. Up until March 2026, she was also a NED at Dudley Group NHS Foundation Trust, where she chaired the Audit and Risk Committee. She is committed to supporting the Trust's transformation journey, with a focus on continuous improvement, high quality services and inclusive leadership.

Other Executive Directors

Vikki Ashton Taylor, Deputy Chief Executive and Chief Delivery Officer
Vikki began in post as the Trust's Director of Strategy, Partnerships and Transformation on 1 June 2022 and was appointed Deputy Chief Executive in March 2024. She then also became Chief Delivery Officer in April 2024.

She is responsible for operational service delivery across the Trust, and is the executive lead for strategy, improvement and transformation including clinical digital transformation and partnership working. She chairs the organisational Trust Delivery Group and the Strategic Portfolio Oversight Group.

Vikki is the executive sponsor for the Trust's Disability and Wellness Staff Network. She is also the East Midlands Perinatal Services Lead Provider executive on behalf of the East Midlands Provider Alliance.

She has worked in the NHS for over 25 years, where she has provided strategic leadership to support effective delivery, partnership working and continuous improvement. Prior to joining the Trust, she was the Lead Director for Joined Up Care Derbyshire, where she worked closely with partners to support joined-up, system-wide approaches to improving health and care.

Vikki is committed to supporting a culture of openness, accountability and continuous improvement. She works closely with colleagues across the Trust and system partners to ensure strategic priorities translate into tangible improvements in services, staff experience and patient outcomes.

She lives in Derbyshire and volunteers as a Magistrate for the Ministry of Justice.

Tumi Banda, Director of Nursing, Allied Health Professionals, Quality and Patient Experience. Tumi joined the Trust in September 2024 as Director of Nursing, Allied Health Professionals, Quality and Patient Experience. In this executive role, he provides professional leadership across nursing and allied health professionals, leads the Trust's quality and patient experience agenda, and supports delivery of safe, effective and compassionate care. He holds key executive responsibilities on behalf of the Trust, including joint executive

leadership (with the Executive Medical Director) of the Quality and Safeguarding Committee and serving as the Trust's Director of Infection Prevention and Control. He is also the Trust's senior point of contact for the Care Quality Commission (CQC), providing leadership and assurance in relation to regulatory standards and inspections.

A registered mental health nurse, Tumi qualified in 2004 at City University London and has worked across a wide range of mental health settings. Prior to his current appointment, he was Interim Director of Nursing at Essex Partnership University NHS Foundation Trust and previously worked at Derbyshire Healthcare in 2022 as Interim Executive Director of Nursing and Patient Experience. He brings extensive experience of board-level quality governance, improvement, and regulatory assurance.

Tumi is particularly passionate about improving the care and experience of people during psychiatric emergencies and advancing approaches that improve outcomes for patients and staff.

He holds a master's degree in Transcultural Health Care from Queen Mary University of London and is a Florence Nightingale Foundation Scholar.

Dr Girish Kunigiri, Executive Medical Director. Girish joined the Trust as Executive Medical Director on 29 October 2025, providing clinical leadership across the Trust, with a strong focus on quality, safety, and continuous improvement in mental health services. He oversees medical education, pharmacy and research across the Trust, and supports the implementation of our suicide prevention strategy and the Mental Health Act.

He is the executive lead for the Mental Health Act Committee and the Patient and Carer Race Equality Framework (PCREF), supporting our journey to becoming an actively anti-racist organisation.

Girish is the Trust's Caldicott Guardian, responsible for protecting the confidentiality of people's health and care information and making sure it is used properly and is the executive sponsor for the Trust's Multi-Faith Staff Network and Christian Staff Network.

He is a consultant psychiatrist with many years' experience working across the East Midlands and is widely respected for his role in shaping and improving mental health services. He brings substantial clinical and strategic leadership experience to the role, having previously served as Chief Medical Officer at Lincolnshire Partnership NHS Foundation Trust. He is particularly committed to working collaboratively with clinicians, patients and partners to support safe, effective and compassionate care.

Alongside his Trust role, Girish is the Clinical Director for Midlands Mental Health Team, overseen by NHS England, where he has played a key role in supporting regional collaboration and implementing the NHS Long Term Plan. He is also Vice Chair of the Royal College of Psychiatrists' ECT and Related Treatments Committee, contributing to national standards, learning and best practice. He was also recently appointed as CQC Executive Reviewer.

Girish is passionate about fostering an open and inclusive culture where staff feel supported to speak up, learn and innovate, and where clinical leadership helps drive positive experiences and outcomes for patients and service users.

He is a Trustee for a homeless charity and enjoys running, having participated in many marathons over the years.

James Sabin, Executive Director of Finance. James joined the Trust as Director of Finance on 5 February 2024. He is responsible for the Trust's strategic financial planning, financial control and performance, and for ensuring the Trust meets its statutory and regulatory financial duties.

He leads the Trust's procurement, contracting and estates functions in addition to being the sustainability lead, supporting the sustainable delivery of high-quality services. He is the executive lead for the Finance and Performance Committee and the Trust's audit and counter fraud functions. He is also the executive sponsor for the Trust's LGBTQ+ Staff Network.

James brings extensive senior NHS finance and corporate leadership experience. Prior to joining the Trust, he spent over eight years at Sheffield Health and Social Care NHS Foundation Trust as Deputy Director of Finance, Procurement and Contracting. He also undertook a secondment as Director of Finance at South West Yorkshire Partnership NHS Foundation Trust, where he additionally led performance, informatics and digital teams and acted as the Trust's Senior Information Risk Owner.

He is the Derbyshire system Senior Responsible Office (SRO) Estates lead. He also sits on a number of national groups, He has a keen interest in continuous improvement, innovation and digital solutions, as enablers to drive value in supporting good quality patient care.

Other Directors who attend the Trust Board:

Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary. Justine joined the Trust as Trust Secretary in June 2019 and was appointed Director of Corporate Affairs and Trust Secretary in April 2024. In her role, Justine is responsible for supporting effective leadership and decision making through the Trust Board, Board Committees and Council of Governors.

Her portfolio includes Foundation Trust membership and governors, legal, Health and Safety, Risk Management, Board Secretariat, Freedom of Information and Freedom to Speak Up. Justine is an executive lead for the Trust's Audit and Risk Committee and is also executive sponsor for the Trust's Armed Forces Staff Network. She is also the Trust's Senior Independent Risk Owner (SIRO), and Counter Fraud Champion.

Justine joined the Trust from University Hospitals of Derby and Burton NHS Foundation Trust, where she was Deputy Director of Governance. She brings wide-ranging experience in regulation, governance and statutory and legal compliance across the NHS.

She is committed to public services, having had a career in Local Government before joining the NHS, she holds a law degree and is chartered secretary qualified.

Rebecca Oakley, Director of People, Organisational Development and Inclusion Rebecca was appointed Director of People, Organisational Development and Inclusion on 1 June 2024 having previously served as Deputy Director and then Interim Director of People and Inclusion.

She is the executive lead for the Trust's People and Culture Committee and the specialist HR advisor to the Remuneration and Appointments Committee. She is also the executive sponsor for the Trust's Women's Staff Network.

Rebecca has worked in the NHS in Derbyshire for over 20 years, with experience across HR and corporate functions including organisational development, service improvement and communications. Before joining the Trust in 2021, she worked at Derbyshire Community Health Services NHS Foundation Trust, where she led the Organisational Development function across both organisations.

She holds an Executive MBA and is a Chartered Fellow of the Chartered Institute of Personnel and Development (CIPD). Rebecca is committed to supporting an inclusive culture where people feel valued, supported and able to contribute to continuous improvement.

Others who had served as Board members in 2025/26

Arun Chidambaram – Executive Medical Director
Dr Chidambaram joined the Trust in October 2022 and left on 21 September 2025. A Forensic Consultant Psychiatrist by background, Arun was previously Deputy Chief Medical Officer and Locality Medical Director at Lancashire and South Cumbria NHS Foundation Trust. He has previously worked as a Deputy Medical Director across a number of organisations, including being the Interim Medical Director and Medical Director for Operations at Mersey Care NHS Foundation Trust. Arun holds two master's degrees in psychiatry and a postgraduate certificate in healthcare leadership. He has a wealth of clinical experience in addition to leadership expertise within a healthcare setting. Arun was the executive lead for safety. He is now Chief Medical Officer at Greater Manchester Mental Health NHS Foundation Trust.

Mark Broadhurst – Interim Medical Director
Mark acted in this interim role for the period 22 September to 23 November 2025. He had been Deputy Medical Director since 2017. Mark returned to his substantive post at the Trust.

Geoff Lewins – Non-Executive Director
Geoff left on 30 November 2025 having first joined the Trust on 1 December 2017. He was re-appointed to his second three-year term in 2020 and then re-appointed for two further one-year terms. A qualified accountant by background, Geoff has more than 30 years' experience in finance, IT and governance, having formerly worked as Director of Finance Strategy for Rolls-Royce plc. Geoff was the chair of the Trust's Audit and Risk Committee and also the NED Freedom to Speak Up lead.

Tony Edwards – Non-Executive Director
Tony left at the end of his first term on 31 July 2025, having first joined the Trust on 1 August 2022 and was appointed as Deputy Chair on 11 January 2023. He was Chair of the Trust's Finance and Performance Committee, holds a BA in Accounting and Finance and is a Chartered Accountant. Tony spent the first half of his career in senior finance roles in manufacturing and then a further 17 years in business unit leadership roles with Filtrona plc and Luxfer Holdings plc. He has been a governor at Nottingham Trent University and the University of Derby.

Appointments by the Council of Governors

During 2025/26 the Council of Governors re-appointed two Non-Executive Directors (NEDs) and appointed two new NEDs.

The balance of skills and expertise required by the Board is reviewed for each vacancy and this is then reflected in the recruitment and selection criteria. NEDs are members of the Board and Board Committees and therefore retain significant independence from the operational management of the Trust. There are no links or directorships that could materially interfere with the exercise of independent judgement. No individual or group of individuals dominates the Board's decision making. Considering the criteria set out in the Code of Governance, the Trust Board has determined that all of the Trust's NEDs are considered to be independent and provide an independent view on strategic issues, performance, key appointments and hold the Executive Directors to account. The role of Senior Independent Director is held by Ralph Knibbs.

Details of the skills, expertise and experience of the individual Executive Directors can be found in the biography section of the Directors' report see page 69. Throughout the year the Remuneration and Appointments Committee has sought to ensure the Board has a wide range of skills in order to fulfil its duties effectively.

Register of interests
It is a requirement that the Chair, Board members and Board level directors who have regularly attended the Board during 2025/26, and current members, should declare any conflict of interest that arises while conducting NHS business.

The Chair and Board members declare any business interests, positions of authority in a charity or voluntary bodies in the field of health and social care, and any connections with a voluntary or other body contracting for NHS services. These are formally recorded in the minutes of the Board, and entered into a register, which is available to the public. Directorships and other significant interests held by NHS Board members are declared on appointment, kept up to date and included in the Annual Report.

A register of interests is also maintained in relation to all governor members on the Council of Governors. This is available by application to the Trust's Membership office by emailing dhcft.membership@nhs.net

The disclosure and statements referenced within this report are subject to the NHS Codes of Conduct and Accountability which is binding upon Board Directors. Interests are disclosed as set out on the next page.

Declarations of interests register 2025/26 (as of 31 March 2026)

DECLARATION OF INTERESTS REGISTER 2025/26		
NAME	**INTEREST DISCLOSED**	**TYPE**
Selina Ullah Trust Chair	• Director/Trustee, Manchester Central Library Development Trust • Non-Executive Director, General Pharmaceutical Council • Non-Executive Director, Locala Community Partnerships CIC • Director, Muslim Women's Council • Trustee – NHS Confederation • Vice Chair/Senior Independent Director – NHS Providers Board of Trustees	(e) (e) (e) (e) (e) (e)
Chioma Akpom *Designate from 06-Oct-2025 to 30--Nov-2025* Non-Executive Director *from 01-Dec-2025*	• Director, Narini Limited • Director, Studio 4CCCC Ltd	(a)
Tony Edwards *until 31-Jul-2025* Deputy Trust Chair	• Independent Member of Governing Council, University of Derby	(a)
Deborah Good Non-Executive Director	• Trustee of Artcore – Derby • Director of Craftcore Derby	(e) (e)
Jo Hanley *from 4-Aug-2025* Non-Executive Director	• Non-Executive Director, Dudley NHS Foundation Trust • Remediation Unit Director, Post Office Limited	(e) (e)
Andrew Harkness Non-Executive Director	• Spouse, Nicola Harkness, works at Staffordshire and Stoke-on-Trent Integrated Care Board	(e)
Ralph Knibbs Senior Independent Director	• Trustee of the charity called Star* Scheme	(d)
Geoff Lewins *until 30-Nov-2025* Non-Executive Director	• Director, Arkwright Society Ltd • Director, Cromford Mill Limited (wholly owned trading subsidiary of Arkwright Society)	(a) (a)
Mark Powell Chief Executive	• Treasurer, Derby Athletic Club • Ordinary Member for Mental Health, NHS Derby and Derbyshire Integrated Care Board (ICB), NHS Lincolnshire ICB and NHS Nottingham and Nottinghamshire ICB cluster	(d) (e)
Vikki Ashton Taylor Deputy Chief Executive and Chief Delivery Officer	• Magistrate, covering mainly Derbyshire and Nottinghamshire Courts	(e)
Mark Broadhurst *from 22-Sep-2025 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 Treatments Committee, Royal College of Psychiatry	(d) (d)
James Sabin Director of Finance	• Spouse works at Sheffield Health and Social Care NHS Foundation Trust as Head of Capital and Therapeutic Environment • Spouse is Trustee of Sheffield Hospitals Charity	(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 (except for 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).

Details of any political donations
The Trust has made no political donations during 2025/26.

Better Payment Practice Code:

	31 March 2026				31 March 2025		
	Number		**£000**		Number		£000
Total non-NHS trade invoices paid in the year	**15,395**		**59,119**		16,728		86,558
Total non-NHS trade invoices paid within target	**14,963**		**58,650**		16,249		85,202
Percentage of non-NHS trade invoices paid within target	**97%**		**99%**		97%		98%
Total NHS trade invoices paid in the year	**713**		**13,772**		617		16,890
Total NHS trade invoices paid within target	**627**		**13,286**		587		16,105
Percentage of NHS trade invoices paid within target	**88%**		**96%**		95%		95%

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

Income disclosures
As an organisation we are required by the NHS Act 2006 (as amended by the Health and Social Care Act 2012) to state whether our income from the provision of goods and services for the purposes of healthcare in England is greater than our income from the provision of goods and services for any other purpose. We can confirm that this was the case, as evidenced by our accounts.

In addition, we are required by the same Act to provide information on the impact that other income has had on our provision of healthcare. We can confirm that our other operating income has had no adverse impact on our provision of goods and services for the purposes of the health service in England.

Disclosures relating to NHS Improvement's well led framework
See the Annual Governance Statement for further disclosures relating to NHS Improvement's (now NHS England) Well Led framework on page 93.

Disclosure to auditors
On the 18 June 2026 the Directors of DHCFT declare that, to their knowledge, there is no relevant information of which the Trust's auditor is unaware and the Directors have taken all the steps that they ought to have taken as a Director to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information.

Derbyshire Healthcare leaders recognised nationally for their impact on health and inclusion

The Trust is celebrating national recognition for two of its leaders.

Chair, Selina Ullah, has once again been named by the Health Service Journal (HSJ) as one of the 50 most influential Black, Asian and Minority Ethnic people in health.

Consultant Psychiatrist, Dr Subodh Dave, was also named a Rising Star for his work with the Royal College of Psychiatrists and Doctors in Distress.

How we are organised

The Trust Board of Directors
The Trust Board of Directors has a responsibility to make the best use of financial resources and deliver the services people need, to standards of safety and quality which are agreed nationally.

The role of the Board of Directors is to manage the Trust by:

- Setting the overall strategic direction of the Trust within the context of NHS priorities
- Regularly monitoring performance against objectives
- Providing effective financial stewardship through value for money, financial control and financial planning
- Ensuring that the Trust provides high quality, effective and patient focused services through clinical governance
- Ensuring high standards of corporate governance and personal conduct
- Promoting effective dialogue between the Trust and the local communities we serve
- Promote the Trusts' long-term sustainability as part of the Integrated Care System (ICS) and wider healthcare system in England, generating value for members, patients service users and the public.

In 2025/26 the Board of Directors met six times as a Public Board to discuss the business of the organisation. These meetings are held in public, and anyone is welcome to attend and hear about our latest developments and performance. Several Extraordinary Confidential Board meetings were also held.

Responsibilities of the Board of Directors
The Board of Directors ensures that good business practice is followed, and that the organisation is stable and able to respond to unexpected events, without jeopardising services, and confident enough to introduce changes where services need to be improved. Therefore, the Board of Directors carries the final overall corporate accountability for its strategies, policies and actions as set out in the codes of conduct and accountability issued by the Secretary of State. To discharge its responsibilities for the governance of the Trust, the Board has established a number of Committees of the Board as described on page 81.

The Board of Directors ensures compliance with the principles, systems and standards of good corporate governance and has regard to guidance issued by NHS England (NHSE) and appropriate codes of conduct, accountability and openness applicable to foundation trusts. It is responsible for maintaining committees of the Trust Board with delegated powers as prescribed by the Trust's standing orders, scheme of delegation and/or by the Trust Board from time to time.

Performance of the Board of Directors
The Trust recognises that the evaluation of the performance of the Board, Committees and individual Directors in the discharge of their responsibilities is essential to ensuring the Trust is effectively governed.

The individual Directors undertake a process of objective setting, personal support and development, and annual appraisals; for Executive Directors, this is overseen by the Remuneration and Appointments Committee, and the Nominations and Remuneration Committee of the Council of Governors for the Non-Executive Directors. Objectives are set within the context of the Trust's strategic plans and objectives and include measurable indicators to evaluate progress.

The Senior Independent Director leads the performance evaluation of the Chair using a process which is agreed by the Governors' Nominations and Remuneration Committee and in which the full Council of Governors are encouraged to participate. This feedback is discussed with the Lead Governor, shared with the Chair and was taken to the Governors' Nominations and Remuneration

Committee in May 2026 and reported on to the Council of Governors in May 2026. All Board member appraisals have been carried out in line with the NHSE Board Member Appraisal Framework, which includes the Leadership Competency Framework.

The Board is held to account, and its performance is evaluated on an ongoing basis, by the Council of Governors discharging its statutory responsibilities, and regularly feeds back to the Board through the Chair. The Board regularly reviews the performance of Committees and is assisted by the Audit and Risk Committee which reviews the work of the other Board Committees to ensure that they have appropriate control systems for supporting the Board's work and have appropriate mechanisms for managing and mitigating risks within their areas of responsibility. Members of the Board of Directors are outlined in the Directors' report on pages 69.

Meetings of the Board of Directors
The Board of Directors held six public meetings during 2025/26:

	Actual attendance	Possible attendance
Non-Executive Directors		
Selina Ullah	6	6
Tony Edwards *(left 31 Jul-2025)*	2	2
Lynn Andrews	6	6
Ralph Knibbs	5	6
Chioma Akpom *(started 1 Dec-2025)*	3	3
Deborah Good	5	6
Jo Hanley *(started4 Aug-2025)*	3	4
Andrew Harkness	5	6
Geoff Lewins *(left 30 Nov-2025)*	4	4
Executive Directors		
Mark Powell	3	6
Vikki Ashton Taylor	6	6
Tumi Banda	6	6
Arun Chidambaram *(left 21 Sep-2025)*	2	2
Justine Fitzjohn	6	6
Girish Kunigiri *(started 29 Oct-2025)*	3	3
Rebecca Oakley	6	6
James Sabin	6	6
Mark Broadhurst* *(interim Medical Director)*	1	1

Directors' expenses

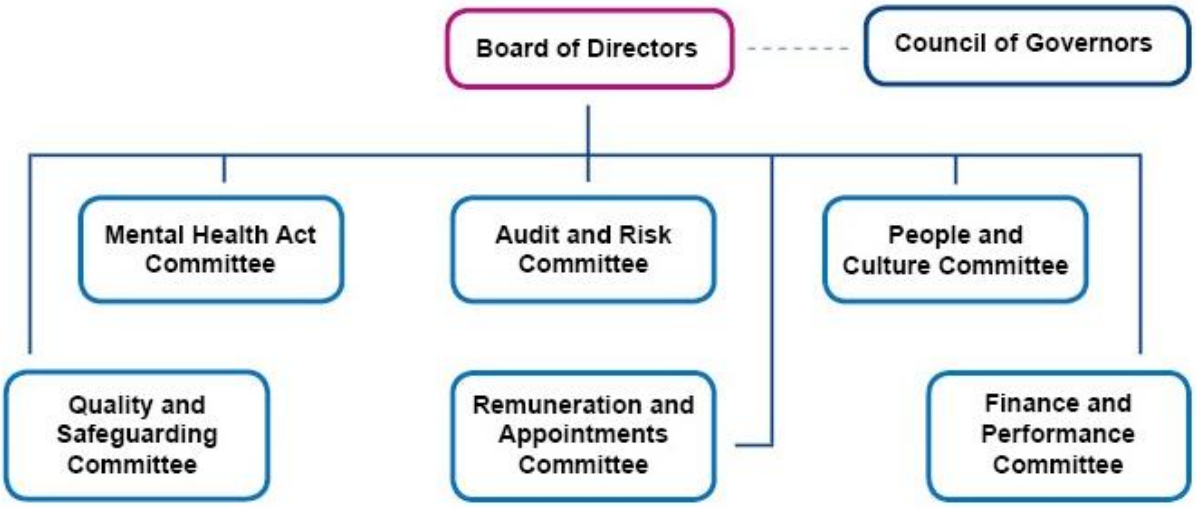
	2025/26	2024/25
Number of Directors	**18**	16
Number of Directors receiving expenses for the year	**13**	9
Aggregate sum of expenses paid to Directors in the year (£00)	**£26**	£54

Values shown in £00 – actual amount £2,648 (2024/25: £5,435)

Committees of the Board of Directors

Board governance structure

Non-Executive Directors are represented on all Board Committees.



Audit and Risk Committee
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.

The Audit and Risk Committee is responsible for ensuring the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities in support of the organisation's objectives. It achieves this by:

- Ensuring that there is an effective internal audit function providing appropriate independent assurance to the Audit and Risk Committee, Chief Executive and Board
- Reviewing the work and findings of the external auditor
- Reviewing the findings of other significant assurance functions, both internal and external to the organisation
- Reviewing the work of other committees within the organisation whose work can provide relevant assurance to the Audit and Risk Committee's own scope of work
- Requesting and reviewing reports and positive assurances from Directors and managers on the overall arrangements for governance, risk management and internal control
- Reviewing and approving the Annual Report and financial statements (as a delegated responsibility of the Board) and ensuring that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

The Audit and Risk Committee reports to the Board of Directors on an annual basis on its work in support of the Annual Governance Statement, specifically commenting on whether the Board Assurance Framework (BAF) is fit for purpose and governance arrangements are fully integrated. The Audit and Risk Committee throughout the year 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 Trust has an internal audit function which is referenced in the terms of reference of the Audit and Risk Committee. A review of

the effectiveness of internal and external audit took place during the year, alongside assurance on counter fraud.

The Committee considers the BAF, Annual Report and Accounts, Annual Governance Statement and progress with internal and external audit plans. It also receives reports on data security and protection, data quality, implementation of speaking up processes, impact of clinical audit and updates on losses and compensation payments, exit payments, conflicts of interest, tenders and waivers, debtors and commercial insurance.

The Audit and Risk Committee reports to the public Trust Board after each meeting under the Board Committee Assurance report and covers significant issues, including assurance received and any gaps in assurance.

The Committee assesses the effectiveness of the external audit process as part of the self-assessment undertaken each year and by meeting with auditors in private. Auditors attend every meeting of the Audit and Risk Committee, and the Trust's compliance with the audit plan approved by the Committee is monitored.

The Committee discussed but did not consider there to be any significant issues in relation to the financial statements that needed to be addressed.

In 2025/26 the Audit and Risk Committee comprised the following Non-Executive Director members:

- Geoff Lewins (Chair) *(left 30 Nov-2025) **
- Chioma Akpom *(Chair) (started 1 Dec-2025)*
- Deborah Good
- Andrew Harkness

Non-Executive Directors attendance at the Audit and Risk Committee during the year was as follows:

	Actual attendance	Possible attendance
Geoff Lewins *(left Nov-2025)*	5	5
Chioma Akpom (*started Dec-2025)*	3	3
Deborah Good	3	8
Andrew Harkness	8	8
Ralph Knibbs (for quoracy)	4	4

Finance and Performance Committee
This Committee oversees and gains assurance on all aspects of financial management and operational performance, including contract compliance, commercial decisions and cost improvement reporting. The Committee also oversees the Trust's business development, commercial strategies, Estate Plan, Digital Plan, Green Plan and workforce resource planning (prior to review by the People and Culture Committee). The Committee oversees emergency planning and health and safety. It 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.

Mental Health Act Committee
This 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 and Mental Capacity Act are upheld. This specifically includes the proactive and active management of the prevention of deprivation of liberty and ensuring Deprivation of Liberty Safeguards (DoLS) applications as a

managing authority are appropriately applied. It also monitors related statute and guidance and reviews the reports following Mental Health Act inspections by the Care Quality Commission (CQC).

Quality and Safeguarding Committee
This Committee seeks assurance that high standards of care are provided, and that adequate and appropriate governance structures, processes and controls are in place to promote safety and quality in patient care. The Committee monitors risks arising from clinical care and ensures the effective and efficient use of resources through evidence-based clinical practice. 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.

In terms of its safeguarding portfolio this Committee sets the Safeguarding Quality Strategy providing quality governance to all aspects of the safeguarding agenda. It provides assurance to the Board that the organisation is effectively discharging and fulfilling its statutory responsibility for safeguarding to ensure better outcomes for children and vulnerable adults. The Committee leads the assurance process on behalf of the Trust for the following areas: Children Act, Care Act (2014), counter-terrorism legislation; it provides a formal link to the Local Authority Safeguarding Children and Safeguarding Adults Boards and promotes a proactive and preventative approach to safeguarding.

People and Culture Committee
This Committee supports the organisation to achieve a well led, values driven positive culture. The Committee provides 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. This is achieved through ensuring the development and implementation of an effective People Plan; implementing a systematic approach to change management; ensuring workforce plans are fit for purpose and driving a positive culture with a high degree of staff engagement.

Remuneration and Appointments Committee
The role of the Committee is to ensure there is a formal and transparent procedure for developing policy on Executive Director remuneration and for agreeing the remuneration packages of individual Directors. It is also responsible for the appointment of the Chief Executive, with ratification from the Council of Governors. The Committee is responsible for identifying and appointing candidates to fill all the Executive Director positions on the Board. The Committee has met eight times throughout the year. Further details on the Remuneration and Appointments Committee can be found in the Annual Statement of Remuneration on page 113.

The attendance at the Remuneration and Appointments Committee is listed in the Remuneration Report on page 113.

Executive Leadership Team (ELT)
As the most senior executive decision-making body in the Trust, ELT is responsible for ensuring that strategies and performance targets, approved by the Board of Directors, are implemented effectively to timescale. The group shares a responsibility to provide strategic leadership to the organisation, consistent with its values and principles. It also ensures that a culture of empowerment, inclusivity and devolution of responsibility with accountability is strongly promoted.

Governance is also underpinned by the Trust Delivery Group and Divisional Governance processes. This was revised in year under the new operating model, with the creation of two Clinical Divisions and five Care Groups.

Council of Governors

The Council of Governors performs an important role and is responsible for representing the interests of Trust members, the public and partner organisations of the Trust.

The governors, the majority of whom must be elected from the Trust's membership, have several statutory responsibilities including representing the views and interests of members and the public and Non-Executive Director (NED) appointments. They are consulted on the Trust's forward planning and ensure that the Trust operates in a way that fits with its purpose and authorisation; this is done through the full Council of Governors meetings where they hold the NEDs to account for the performance of the Board and receive reports on Trust performance and services.

Governors are invited to attend Public Trust Board meetings in an observer capacity to witness the work of the NEDs, enabling governors to hold them effectively to account.

Governors alongside NEDs and Executive Directors also participate in the Trust's Board visits. They visit Trust services and provide vital feedback about services whilst learning about the services and engaging with staff.

The Trust's Council of Governors is made up of governors across three constituencies:

- Public governors, elected by members of the public constituency
- Staff governors, elected from the staff body
- Appointed governors representing our partner organisations.

The Trust's Council of Governors during 2025/26 are outlined on pages 87-88 of this report, alongside their attendance at the Council of Governors meetings. The Council of Governors has held hybrid meetings, giving governors the option of meeting virtually or in person depending on their personal circumstances. This has been successful, and meetings have retained the benefits of good attendance and networking.

Key developments during 2025/26
During 2025/26 governors approved and contributed to the following:

- Approved the appointment of two NEDs for a three-year term
- Approved the reappointment of the external auditors
- Had the opportunity to discuss the Trust's annual plan submission
- Participated in the appraisal process for the Trust Chair and NEDs
- Reviewed and updated the Governors Membership Engagement Action Plan
- Established a Governor Task and Finish Group focusing on plans for the Annual Members Meeting
- Received the staff survey results
- Received the report from the external auditors on the Annual Report
- Received reports from the Governance Committee and Governors' Nominations and Remuneration Committee
- Received reports from the NEDs on the work they carried out during the year.

Building on effective relationships with the Board has continued to be a priority for the year. The Council of Governors meets jointly with the full Board of Directors twice during the year on topics of common interest. These sessions take place in person giving the opportunity for governors and the Board to network and build on their relationships. This year topics included updates on the government's 10 Year Health Plan for England and the impact on the Trust, financial plans for this year and the next, Inquiries (including trust liabilities of failing), Freedom to Speak Up, Well Led review, and medium-term planning.

The Chief Executive attends Council of Governors meetings with the Trust Chair (who is also the Chair of the Council of Governors) and NEDs to share the Board's current agenda and performance and challenges. The NEDs provide a summary of the Trust's Integrated Performance Report and reports on their work. Executive Directors attend as required.

A governors annual effectiveness survey was conducted again this year which 60% of the Council of Governors participated in. Overall, the results were very positive with the majority of respondents agreeing that:

- The Trust's values, mission and priorities have been adequately explained to the Council
- The Council of Governors carries out its work in an open, transparent manner
- The Council of Governors meets at appropriate and regular intervals and receives adequate time and support to function well
- Governors ask relevant questions of the NEDs about challenge at Board meetings
- Governors can contribute positively to the work of the Council of Governors
- Governors feel supported by the Trust to carry out their responsibilities as a governor including the fulfilment of their statutory duties
- Governors are aware of risks to the quality, sustainability and delivery of current and future services
- The Council of Governors carries out its work with quality as its focus
- The Council communicates with, listens and responds to members and other stakeholders effectively
- Governors' views are taken into account as members of the Council of Governors.

The survey included sections for free text to enable governors to make suggestions and comments regarding governor training and development needs; suggestions for improvement or to raise specific issues; and comments on the effectiveness of the Council of Governors. In line with best practice the survey is undertaken annually.

The Trust produces a regular e-bulletin, '*Governor Connect*' that provides governors with regular information about the Trust; opportunities for governors to engage with members and the public; training and development opportunities to help them in their governor role; governor actions; information on Joined Up Care Derbyshire (JUCD).

The interests of patients and the local community are represented by the Council of Governors. Governors are encouraged to engage with local consultative forums, voluntary organisations, Patient Participation Groups and their members and the public to achieve this, and to feedback to the Board of Directors. Membership and public engagement continue to be a priority for governors and will continue to be so throughout 2026/27. They attend community meetings and events, particularly those organisations in the voluntary sector; and are encouraged to attend Joint Countywide Mental Health Forums and subscribe to Derbyshire Voluntary Action and Derbyshire Mental Health Forum e-newsletters to find out about local groups in their areas.

There is an established Governor Engagement Log which lists various events and meetings attended by governors throughout the County. The Engagement Log enables governors to list issues and feedback from Trust members and the public about matters relating to the Trust. The information helps governors to identify common themes/issues relating to the Trust to raise with NEDs and on which to hold them to account.

In 2025/26 governors were encouraged to engage with the activities of JUCD (for example Derbyshire Dialogue), so they could explore their role within the context of system working. They also received the link to JUCD's regular e-newsletter which included updates on the system and partner organisations. Throughout the year, the Chief Executive gave updates on the Integrated Care Board. The Council of Governors is also represented on the NHS Derby and Derbyshire Integrated Care Board Public Partnerships Committee and attends the Trust's Carers Forum.

Lead and Deputy Lead Governor arrangements
Susan Ryan was the Trust's Lead Governor until the end of her term of office on 31 January 2026. Brian Edwards is Susan's successor, he is supported by Hazel Parkyn, Deputy Lead Governor.

Electing new governors to the Council
The election process began in late 2025 with new governors' terms of office beginning on 1 February 2026. There were seven public governor vacancies and one staff governor vacancy. New governors attended a governor induction session in February 2026 with the Trust Chair, Director of Corporate Affairs and Trust Secretary, and the Membership and Involvement Manager.

Training and development
An induction for new governors is held when their term of office begins giving governors an opportunity to understand their role. They also receive information about the Trust, the services it provides, wider developments within the local health and care economy and the wider NHS. New governors are also given the opportunity to 'buddy up' with a more experienced governor to help them to familiarise themselves with the role.

Governors have been actively involved in developing their training and awareness programme, taking into account the statutory roles of governors, with the aim of ensuring governors are supported in effectively delivering their duties. This year training and development opportunities focused on understanding the annual plan, finance and procurement, trauma informed practice, and risk management. Governors are also encouraged to attend GovernWell sessions organised by NHS Providers and the NHS Providers conference and workshops which gave governors the opportunity to network with governors from other trusts and to share good practice. Mental health awareness training provided by Derbyshire County Council was also shared with governors.

Meetings of the Council of Governors 2025/26
The Council of Governors met five times during 2025/26, of which one was held confidentially. Individual attendance by governors is shown in the table on the next two pages. The Council of Governors has the right to request Directors to attend a Council meeting to discuss specific concerns regarding the Trust's performance. This power has not been exercised during 2025/26.

The Council of Governors and the Board of Directors are committed to maintaining their constructive and positive relationship. The aim is always to resolve any potential or actual differences of opinion quickly, through discussion and negotiation. If the Trust Chair cannot achieve resolution of a disagreement through informal efforts, then they will follow the dispute resolution as laid out in the Trust's Constitution and as outlined in the policy regarding engagement between the Council of Governors and the Board of Directors.

National policy – future of Councils of Governors
In July 2025, within the 10 Year Health Plan for England the government announced its intention to remove the statutory requirement for Foundation Trusts to have Governors. In this absence of legislative change and national guidance, the Trust is taking a business-as-usual approach supporting and valuing its Governors in their roles. We are committed to keeping Governors updated on a transitional plan and are inviting our Governors to help us shape ongoing community connections to ensure robust local accountability, whatever the future model looks like.

Register of interests
The Register of Interests of the Council of Governors is available through the Membership office. Please email: dhcft.membership@nhs.net.

The Trust would like to thank all individuals who have volunteered their time as members of the Council of Governors during 2025/26.

Summary attendance by governors at meetings of the Council of Governors (CoG) 2025/26

	Title	First name	Surname	Number of CoG meetings attended (out of possible number of meetings) *	Term of office
Constituency – Public (elected)					
Amber Valley	Mrs Mrs	Susan Lai Mei	Ryan Li	4/4 1/1	01/02/20 – 31/01/23 01/02/23 – 31/01/26 01/02/26 – 31/01/29
Amber Valley	Mrs	Angela	Kerry	3/5	21/03/22 – 31/01/25 01/02/25 – 31/01/28
Bolsover and North East Derbyshire	 Mrs	Vacancy** Jean	 Johnson	 1/1	25/09/24 – 31/01/26 01/02/26 – 31/01/29
Bolsover and North East Derbyshire	Mr	Neil	Baker	5/5	01/02/25 – 31/01/28
Chesterfield	Mr	Dave	Allen	3/5	01/02/24 – 31/01/27
Chesterfield	Ms	Jill***	Ryalls	1/5	21/03/22 – 31/01/25 01/02/24 – 04/02/26
Derby City East	Mrs Ms	Jane Sarah	Chukwudi Tupling	2/3 0/1	01/02/25 – 03/10/25 01/02/26 – 31/01/29
Derby City East	Mr	Tom	Bladen	4/5	01/02/23 – 31/01/26 01/02/26 – 31/01/29
Derby City West	Mrs	Ruth	Day	5/5	01/02/25 – 31/01/28
Derby City West	Mrs Dr	Chris Stephen	Williamson Handsley	2/4 1/1	01/02/23 – 31/01/26 01/02/26 – 31/01/29
Erewash	Mr	Andrew Vacancy****	Beaumont	1/1	01/10/19 – 20/03/22 21/03/22 – 31/01/25 01/02/25 – 03/06/25
Erewash	Mr	Christopher	Williams	3/5	01/02/25 – 31/01/28
High Peak and Derbyshire Dales	Dr	Fiona Vacancy*****	Birkbeck	3/4	01/02/24 – 31/01/26
High Peak and Derbyshire Dales	Mr	Brian	Edwards	4/5	01/02/23 – 31/01/26
Rest of England	Mr	Anson	Clark	4/5	01/02/24 – 31/01/27
South Derbyshire	Mrs	Hazel	Parkyn	3/5	21/03/22 – 31/01/25 01/02/25 – 31/01/28
Constituency – Staff (elected)					
Administration and Allied Support Staff	Mrs	Claire	Durkin	5/5	01/02/24 – 31/01/27
Administration and Allied Support Staff	Mrs Mrs	Marie Nicole	Hickman Ellis	1/4 1/1	01/02/20 – 31/01/23 01/02/23 – 31/01/26 01/02/26 – 31/01/29
Allied Healthcare Professions	Mrs	Fiona	Rushbrook	3/5	01/02/24 – 31/01/27
Medical and Dental	Dr	Mathew	Joseph	4/5	01/02/25 – 31/01/28

Nursing	Mrs	Joanne	Foster	3/5	02/06/18 – 01/06/21 02/06/21 – 31/01/24 01/02/24 – 31/01/27
Nursing	Mr	Sifo	Dlamini	5/5	01/02/24 – 31/01/27
Constituency – Appointed					
Derby City Council	Cllr	Alison	Martin	1/5	24/05/23 – 23/05/26
Derbyshire County Council	Cllr Cllr	Garry Sam	Hickton Redfern	0/0 2/4	24/05/23 – 01/05/25 24/05/25 – 23/05/28
Derbyshire Voluntary Action	Ms	Rachel	Bounds	2/5	13/06/20 – 12/06/23 13/06/23 – 12/06/26
Derbyshire Mental Health Forum	Mrs	Debra	Dudley	2/5	19/08/24 – 18/08/27
University of Derby	Dr	David	Robertshaw	2/5	16/1/24 – 15/1/27
University of Nottingham	Dr	Vacancy****** Pippa	Hemingway	2/2	31/12/24 – 23/09/25 24/09/25 – 23/09/28

* Includes one extraordinary confidential meeting
** Vacancy due to governor resignation. The vacancy was included in the January 2025 elections, but no nomination was received.
*** Vacancy due to governor resignation.
**** Vacancy due to governor resignation. The vacancy was included in the January 2026 elections, but no nomination was received.
***** The vacancy was included in the January 2026 elections, but no nomination was received.
****** Vacancy due to delay in replacing previous appointed governor for this organisation.
Note staff governors may not have been able to attend CoG meetings due to the operational pressures.

Governors' expenses

	2025/26	2024/25
Number of governors	33	34
Number of governors receiving expenses for the year	9	11
Aggregate sum of expenses paid to governors in the year (£00)	10	11

Values shown in £'00 – actual amount paid £957 (2024/25: £1,110)

Trust's comms team shortlisted for award for promoting regional gambling service

The Trust's Communications and Engagement team were for a national award for its efforts to raise awareness of the new East Midlands Gambling Harms Service.

The team's campaign has focused on breaking down stigma and encouraging people to come forward and get support, from clinical professionals who have changed lives.

Membership review

Foundation Trusts have freedom to develop services that meet the needs of local communities. Local people are invited to become a member of the Trust, to work with the Trust to provide the most suitable services for the local population. Anyone aged 16 years and over who live in Derbyshire, or the Rest of England, is eligible to become a public member of the Trust (subject to certain exclusions, which are outlined in the Trust's Constitution).

Membership strengthens the links between healthcare services and the local community. It is voluntary and free of charge and obligation. Members can share their views on relevant issues for governors to act upon, as well as helping to reduce stigma and discrimination regarding the services offered by the Trust.

Members views are represented at the Council of Governors by governors who are elected for specific groups of members known as constituencies. Constituencies cover service users, carers, staff, partner organisations and public members.

Public governors are elected to represent their geographical area and have a duty to engage with local members. Staff governors represent the different staff groups that work for the Trust, and appointed governors sit on the Council of Governors to represent the views of their organisation.

Governors canvass the opinion of the Trust's members and the public and communicate their views to the Board of Directors. Appointed governors also canvass the opinion of the body they represent. The Trust takes steps to ensure that members of the Board of Directors develop an understanding of the views of members and governors through regular attendance at the Council of Governors and wider contact.

Members can contact governors by email: dhcft.governors@nhs.net or by calling the Membership Office on 01332 623723.

Member engagement
Governors have engaged with members and the public virtually and at face-to-face events. Governors continue to review the Governor Engagement Action Plan which is aligned to the aims and objectives of the Trust's Membership Plan (2025-2028). The Membership Plan outlines an intention to know more about the membership of the Trust and target communication and engagement appropriately.

This is supported using a membership database. During the year the Trust has updated information on the database, encouraging members to share their email addresses for more members to receive '*Members News'* the memberships e-newsletter which provided news about the Trust and wider developments.

The data we have available indicates that our membership is broadly representative. However, we intend to further target our activities over the forthcoming year to increase the diversity of our membership. Governors have been equipped with details about the membership so that they can focus engagement on these areas.

The Trust engages with its members through an e-newsletter called '*Members News*'. Members are invited to observe Council of Governors meetings and can submit questions in advance of each Council of Governors meeting. They are also invited to the Annual Members Meeting.

Membership recruitment
Governors are encouraged to be active in their local community acting as ambassadors and signposting people to contact the right person about Trust services. The insight into our members, achieved using demographic data, will focus our membership recruitment over the forthcoming year, to attract a greater diversity of members.

Membership figures at the end of 31 March 2026

Constituency	Number of members as at 31 March 2025	Number of members as at 31 March 2026
Public	5,622	5,682
Staff	3,412	3,460
Total	9,034	9,142

Members can contact governors via the Trust's website, www.derbyshirehealthcareft.nhs.uk, under the 'About us' section or by emailing dhcft.governors@nhs.net.

"A passion and drive of caring for others is what has kept me going for so many years" – Nurse of 50 years recognised for her 'dedication to patient care' over longstanding career

A Trust nurse who has dedicated five decades to caring for local communities was recognised for her extraordinary commitment to the NHS.

Lesley Newton Griffiths, who works as a Health Protection Unit Nurse within the Trust, was presented with her 50 Years' Service Award by Chief Executive Mark Powell, celebrating her longstanding contribution to patient care and her positive impact across the Trust.

Highlights from our governors…

I am now in my second term as a Governor and continue to find the role both interesting and challenging. It has given me a much greater understanding of how the NHS operates and the complexities it faces, supported by engagement with members, staff and Board activities. I remain passionate about improving mental health care and making sure individuals do not go through negative experiences. I am proud to represent my community, raise the issues affecting people in Derby City East and act as a constructive critical friend to support the Trust's ongoing improvement.
Tom Bladen, Public Governor for Derby City East

Being a governor has given me a broader understanding of how the Trust operates and the complexity of delivering high quality care. Alongside my MSc in Psychology and knowledge of health research I am able to bring both academic knowledge and lived experience into constructive discussions. The highlight of the role for me has been the Board visits and engagement with staff where I have gained valuable insight into services and the dedication of those working within them. I have found it rewarding to act as a critical friend and contribute to improvements that benefit patients, families, and staff.
Ruth Day, Public Governor, Derby City West

Being a Staff Governor has given me a different view of the Trust, away from operational detail and closer to how issues are tested, challenged, and assured. I have come to appreciate the responsibility governors carry in asking the right questions and supporting effective Board oversight. With a nursing background, I remain conscious of how this work affects patient care and plays out in practice. I approach the role carefully, aware of both its responsibility and its privilege, guided by the Trust's values.
Sifo Dlamini, Staff Governor, Nursing

As an Appointed Governor at the Trust, I am proud to represent the Voluntary, Community, Faith, and Social Enterprise (VCFSE) sector and ensure its voice is reflected in decision making. Through my contributions to governance and committee meetings, alongside engagement with frontline services such as the Early Intervention Team in Chesterfield, I help to bridge the gap between community insight and Trust priorities.
Debra Dudley, Appointed Governor, Derbyshire Mental Health Forum

As a newly elected Staff Governor, I am both delighted and excited to represent the Trust's Admin and Allied Support Staff, ensuring their voices are heard. With over 28 years' experience across financial services and corporate sectors, and my recent work mobilising programmes such as the Making Room for Dignity Programme as a Project Manager in the Trust, I bring a wealth of knowledge that I hope will be integral to our decision-making processes. My dual expertise in both corporate environments and Derbyshire Healthcare, combined with my strong commitment to Trust values and strategy, supports me to contribute meaningfully to the Council of Governors. I am dedicated to being caring, inclusive, ambitious, and fostering a sense of belonging, working collaboratively with colleagues to make a real difference.
Nicole Ellis, Staff Governor, Admin and Allied Support

I am now well into my third and final term of office as Staff Governor and I continue to feel that there was still more I want to achieve on behalf of my colleagues. I will always hold firm the belief that the most important Trust value is putting our colleagues/staff at the centre of all we do, and that by doing so this can only in turn enhance our patient's experience. Also, on a personal level having achieved 40 years in the NHS last year, I am aware that a lot of the public and indeed many colleagues are feeling as if the NHS is breaking; I want to continue to reassure them and work to address this and hopefully restore faith and confidence in us. I continue to feel more than fulfilled and happy in my current job role/position, but there is always more I can offer to the wider staff members of the Trust I hold so dear.

Jo Foster, Staff Governor, Nursing

As a recently elected Public Governor, I welcome the invaluable opportunity to serve in an ambassadorial role, one which both represents the interests of the Trust, whilst adhering to its mission and values. As a retired Associate Professor in the Sociology of Health and Illness, the delivery of mental healthcare formed a key part, both of my teaching and my research. Much of this provided me with a deep theoretical knowledge and understanding of the complexities associated with mental health. It also fostered an insight into the practices and practicalities associated with those whose professional roles help provide the type of compassionate care I would want for myself, my family and the wider community of Derby City West which I am both proud and privileged to serve. Finally, on a more personal level, prior to retirement, my wife spent her entire career as a senior RMN within the Trust; someone from whom I learned so much about the importance and value of the patient's experience.

Stephen Handsley, Public Governor, Derby City West

I am a newly appointed Public Governor for Bolsover and North East Derbyshire. During my term of office, I look forward to engaging with the local community and raising awareness of the Trust and the services it provides. I feel it's important that the public are confident and able to navigate the complex systems of the NHS. I consider that from working in the NHS for over 20 years I am in a privileged position to offer my support to people in this area and take back to the Trust any comments and suggestions that may be voiced.

Jean Johnson, Public Governor, Bolsover and North East Derbyshire

I really enjoy being a Governor. I especially enjoy engagement activities within my local community and having the opportunity to feedback to the Trust. I hope I am a critical friend and am able to flag issues and resolve these where possible. In the current climate it's not easy but I enjoy the challenge.

Hazel Parkyn, Public Governor, South Derbyshire

It's a privilege to serve as a Deaf Public Governor for Derby City East. Being a Governor means 'listening to' and 'making others vitally aware' of members of our Deaf community and ensuring that their 'voices/hands' are heard at the heart of decision making. It's about championing, building trust, and working together to support the best outcomes for patients and staff alike. I am proud to play a part in shaping our NHS for the better.

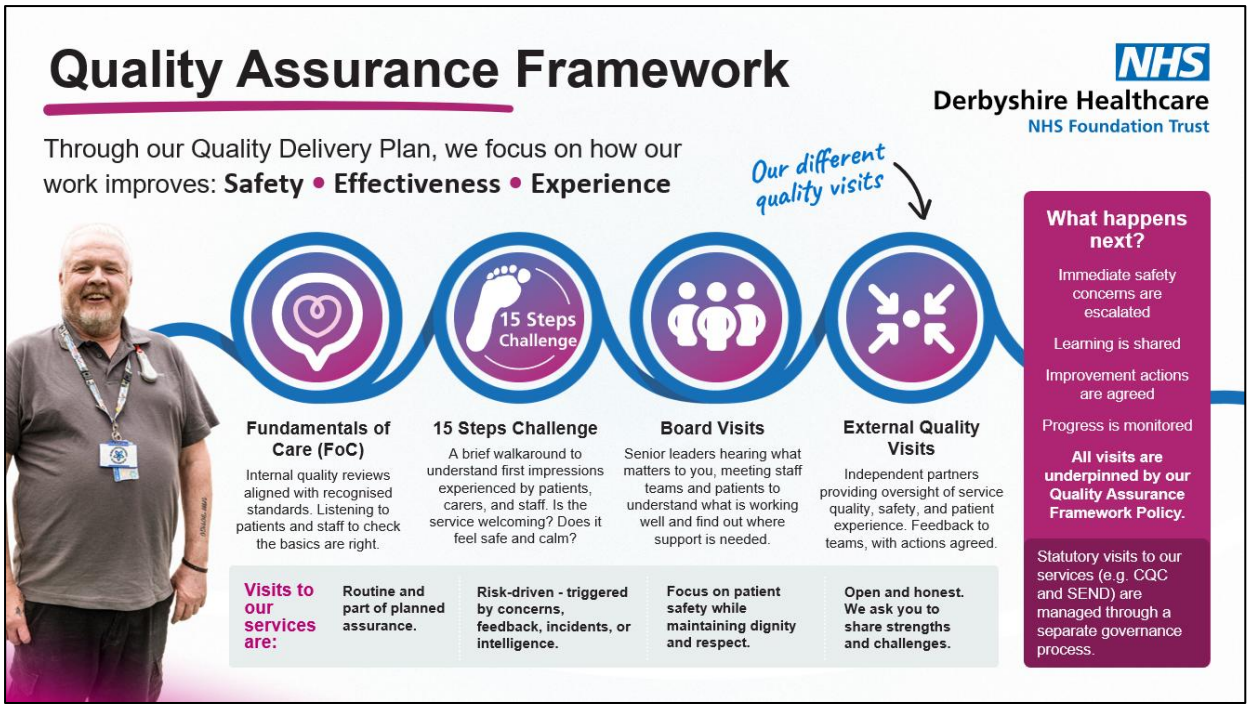
Sarah Tupling, Public Governor, Derby City East

Well Led requirements on quality 2025/26

Leadership and Governance of Quality
During 2025/26, the Board had explicit regard to the Care Quality Commission (CQC) Well Led Framework in its oversight of quality, organisational performance and internal control. Quality leadership is embedded within the Trust's strategic direction, Quality Delivery Plan and Board Assurance Framework.

Board Oversight and Assurance
Quality governance arrangements remained robust throughout the year. The Board and its committees maintained strong oversight of quality through:

- Regular review of integrated quality performance reports
- Triangulated assurance via the Quality Assurance Framework, combining data, feedback, lived experience and direct observation
- Sustained executive and non-executive visibility in services through Board visits and Fundamentals of Care reviews.



These arrangements strengthened the Board's understanding of quality at ward, service and organisational level, enabling early identification of risk and timely escalation where required.

Learning, culture and improvement
The Trust continued to invest in a positive safety and learning culture, supported by The Patient Safety Incident Response Framework (PSIRF), strengthened Freedom to Speak Up arrangements and targeted work to address violence, abuse and aggression towards staff. Speaking up intelligence and staff feedback were used alongside quality data to inform improvement priorities and leadership action.

Action plans to strengthen the governance of quality during and beyond 2025/26 included:

- Further embedding PSIRF and learning response governance
- Strengthening oversight of workforce wellbeing and leadership capability
- Expanding lived experience involvement within quality assurance and improvement
- Improving digital analytics and data quality to support consistent performance monitoring.

External Review and Consistency
During 2025/26, the Trust received positive assurance from CQC planned inspections and Mental Health Act monitoring visits, all of which resulted in 'Good' ratings. At the time of publication, the Board is not aware of any material inconsistencies between the information presented in this Annual Report and reports arising from CQC planned or responsive reviews. Where inspections remain underway, the Trust continues to engage openly with regulators and will respond through established governance arrangements.

Derbyshire NHS Mental Health Liaison Team earns gold standard for community psychiatric care

North Derbyshire's Mental Health Liaison Team, part of the Trust, has earned official recognition by the Psychiatric Liaison Accreditation Network (PLAN) for a third time in a row.

PLAN is a prestigious quality improvement and accreditation network for psychiatric liaison services across the UK. The accreditation focuses on facilitating quality improvement and development in liaison psychiatry services through a supportive peer-review model, enabling communication, and the sharing of best practices between services.

"It is important to talk because, if you don't, the problems can become bigger than you." – Trust employee explains the importance around raising awareness for services this Men's Health Week

Men's Health Week is an international event to raise awareness about men's physical and mental health, with the aim of giving boys and men access to the information, services and treatment they need to maintain their health. Local organisations including the Trust recognised the importance of men's mental health to support our overall health and wellbeing.
As part of this awareness day, David Mellors, ex-army veteran and current peer support worker at the Trust, shared his story. David, who has complex post-traumatic stress disorder as a veteran, has received support from local charities, NHS therapists and the Trust's early intervention service to better navigate his mental health in a healthier way.

New and/or revised services

There has been change, development and redesign across a number of services provided by the Trust during 2025/26.

Living Well
NHS England (NHSE) transformation funding has been applied continuously into 2025/26 to support the transformation of community mental health services. The service, known as Living Well, is accessed by a multiagency service single point of access (SPOA) with the aspiration of enabling an easy step up/step down approach. The local Living Well teams are made up of an integrated health, social care and voluntary, community and social enterprise (VCSE) sector workforce including Peer Support Workers, Wellbeing Coaches, Social Care Practitioners, Occupational Therapists and Community Psychiatric Nurses. Teams are now able to better meet a diverse range of needs under one umbrella as opposed to previous more siloed working which resulted in people experiencing multiple assessments and hand offs.

The focus is on early intervention, a preventative approach that is person-centred, removing unnecessary barriers, and ensuring people can access the support, care and treatment that they need in a timely manner from within the service or signposted to services in the community. This service offer is intended to increase community resilience, allowing carers to harness the support of local services. All eight of our localities across the county and city have worked to further develop this multiagency service over the last year, aiming to meet the needs of those who had previously experienced gaps between primary and secondary mental health care. The Living Well programme began in 2020 and as we reach the five-year milestone, those visionary new services have come to fruition across Derby and Derbyshire localities. The Trust is now seeing positive results and feedback from all localities, demonstrating the hard work, dedication and input from the multiagency teams.

In October 2025 the Trust Board committed to developing its neighbourhood mental health model of care on the strong foundations of the Living Well service transformation. Plans are currently being developed for 2026/27 aligned to the new national Neighbourhood Health Framework.

Talking Therapies
In the summer of 2024, we took the very difficult decision not to bid for a talking therapies contract for 2025 to 2030 for our Talking Mental Health Derbyshire service. This was a result of reviewing the tender process issued by the Integrated Care Board (ICB), outlining requirements for this service from 2025 to 2030. The reason for not bidding for a contract this time was due to the reduced financial envelope being offered, making it unworkable despite our best efforts. Several options were considered to explore a viable future service offer, including working in different ways with alternative partner organisations. As we were unable to find a workable solution, we confirmed that we were unable to enter a bid. When the contract expired in June 2025, the Trust worked closely with the new provider to support a smooth and successful transition for both service users and staff.

Making Room for Dignity (MRFD) programme
Following years of planning, buildings that form part the Trust's £150m MRFD programme were successfully opened in 2025/26. This momentous development programme comprising of six builds will eradicate the use of dormitory style accommodation across the county's mental health facilities. Early evaluation of benefits indicates we are on track to fully realise the benefits set out within the business case with a full evaluation of all buildings based on 12-month data scheduled for 2026/27. A full programme update is given on page 97.

Right Care, Right Person framework
Over 2025/26 the Trust has successfully worked in collaboration with system partners to develop its approach to the Right Care, Right Person (RCRP) framework. RCRP is an approach designed

to ensure that people of all ages, who have health and/or social care needs, are responded to by the right person, with the right skills, training, and experience to best meet their needs.

While some mental health related incidents may need the police, other services may be more appropriate. Health and social care staff have the experience and training to provide the relevant physical and mental health support. The aim of the approach is:

- To get the person or people involved the right help as soon as possible
- To prevent further distress to the person
- To allow the police to focus resources on preventing crime, protecting life and property and keeping public order.

The Trust has worked with colleagues across partner organisations including the Police Authority, Local Authorities, VCSE and the broader NHS family. Through a joint multiagency governance structure, policies and operational arrangements have been developed, agreed and implemented for an effective and seamless interface between policing and mental health services.

All of the initiatives described above have been fully supported by the local Derby and Derbyshire Integrated Care System and broader East Midlands provider partners.

Mental Health Urgent Assessment Centre
The Trust has been successful in securing national funding to develop a new Mental Health Urgent Assessment Centre in the Radbourne Unit in Derby, adjacent to the Royal Derby Hospital. The service aims to provide a more suitable environment for urgent mental health assessments for working age adults to reduce unnecessary attendances to the Emergency Department and support flow into inpatient services. It will provide a specialist environment for people in mental health crisis, offering an alternative to acute emergency departments. Through co-location in the new facilities, we will offer integrated care services which will aim to provide a multidisciplinary team to provide urgent assessment.

The new service is due to open in July 2026 and will be implemented through a phased approach over subsequent months.

24/7 Neighbourhood Mental Health Hub
Aligned to the recently published national Neighbourhood Health framework, some local areas have been piloting a neighbourhood approach for mental health through 24/7 neighbourhood mental health centres. These centres for people with severe mental illnesses are intended to improve care continuity, reduce crisis and provide an alternative to hospital for people experiencing a mental health crisis.

Following careful analysis of local needs and health inequalities, the Trust has been successful in securing funding to develop a new 24/7 Neighbourhood Mental Health Hub in Amber Valley. Outline plans are currently in development building on our existing Living Well service and learning from pilot sites across the country with the hub expected to open in 2027.

Making Room for Dignity (MRFD) programme
As outlined in previous Annual Reports, in 2020 the Government pledged more than £400m to eradicate dormitory accommodation from mental health facilities across the country to improve the safety, privacy and dignity of people experiencing mental illness. £80m of this was allocated to mental healthcare in Derbyshire, forming the backbone of a £150m development of new and refurbished facilities.

After years of planning, engagement and construction, the Trust is delighted to confirm that five new or newly refurbished healthcare facilities opened in Derbyshire in 2025, giving patients a more therapeutic environment to recover from acute mental ill health.

This consisted of:

- Bluebell Ward, Walton Hospital, Chesterfield – 12-bedded unit for older adults, opened in January, followed by an official opening ceremony in May.

Derbyshire Healthcare CEO, Mark Powell, Lord-Lieutenant of Derbyshire, Mrs Elizabeth Fothergill CBE and Trust Chair, Selina Ullah, at the official opening ceremony of Bluebell Ward.

- The Derwent Unit, Chesterfield Royal Hospital site – 54-bedded adult acute unit, opened in March, followed by an official opening ceremony in October.

Colleagues, patients and partners outside the Derwent Unit at the official opening ceremony

- The Carsington Unit, Kingsway Hospital, Derby – a 54-bedded adult acute unit, opened in May, followed by an official opening ceremony in November.

Colleagues, patients and partners outside the Carsington Unit at the official opening ceremony

- Kingfisher House, Kingsway Hospital, Derby – a 14-bedded psychiatric intensive care unit (PICU) opened in July, followed by an official opening ceremony in November. This is a new service for male patients, which will remove the need for people to travel outside of Derbyshire to receive this support.

Colleagues celebrating next to the plaque at the official opening ceremony of Kingfisher House.

- Audrey House, Kingsway Hospital, Derby Hospital – an eight-bedded enhanced care unit, opened in August, followed by an official opening ceremony in November. This is a new service for female patients, which will remove the need for people to travel outside of Derbyshire to receive this support.

Colleagues, patients and partners outside Audrey House at the official opening ceremony

The opening of each unit was celebrated with an official event, where the Lord-Lieutenant of Derbyshire, Mrs. Elizabeth Fothergill CBE was invited to cut the ribbon and formally open each unit. These celebrations were attended by Trust staff, patients, carers, partners and representatives who had supported the developments.

Each of the new units offer wards with ensuite single bedrooms, which allows people more privacy and dignity, alongside outdoor and indoor spaces that offer more opportunities for therapy-based care. The new units have been designed to make people feel comfortable, in control, and at their very best, which early indications show, is already helping with their recovery.

To compliment and further enhance the new facilities and patient experience, the Trust developed and implemented a new Model of Care. The new model was designed with input from experts by experience and focuses on purposeful admission, trauma-informed care and sensory intervention:

The refurbishment of two 17-bed mental health acute wards for patients at the Radbourne Unit, at Derby Royal Hospital, continues. This will complete the MRFD programme and eradicate all dormitory accommodation from the Trust's mental health inpatient facilities.

Once again, the Trust would like to highlight and acknowledge the invaluable input from patients, carers and staff into the programme, particularly those who were involved in, or supported with, the relocation of our patients and services.

Feedback

"The unit is a really good design and the grounds are fantastic. It's really good to be able to get outdoors, and I'm looking forward to using the outdoor gym."
Service user

"I've got my own room, with my own TV and remote, and my own bathroom. And I've enjoyed getting involved with the activities, including gardening and pottery. I'm now helping to grow more plants in the sky garden, from scented herbs to flowers which will add some extra colour. The best thing about it here is the staff, though. They are all wonderful."
Service user

"The unit is so much brighter, the patients are happier here and it makes you feel happy to come to work. With all the activities going on – that's when you form those bonds with the patients because you're doing an activity together and people open up. You learn more about each other and the techniques we can use to help people get better."
Staff member

"I feel so proud to work here. The environment is beautiful, and I have already noticed a difference in our patients. People are telling us it is so much nicer and brighter, and they love the sky garden. It's a lovely place to sit and chat outside."
Staff member

Local NHS Trust partners with charities to provide patients with food and clothing essentials

The Trust launched an initiative to ensure patients being discharged from its mental health inpatient units receive food and clothing parcels to support their transition home.

Working in collaboration with the charity Derby Food 4 Thought Alliance, the Trust provided three-day food parcels to patients at the Radbourne Unit and across the Kingsway Hospital site in Derby, helping to bridge the gap between inpatient care and home life. In addition, the charity Sharewear Clothing Scheme has been instrumental in supplying clothing to those requiring this support, ensuring dignity and comfort.

Compliments, complaints and concerns 2025/26

The Trust's Patient Experience team is the central point of contact for people to provide feedback and raise concerns about the services provided by the Trust. The team sits within the Clinical and Quality Directorate. The team's aim is to provide a swift response to concerns or queries raised and to ensure a thorough investigation takes place when required, with complainants receiving comprehensive written responses, including being informed of any actions taken.

2025/26 has been a challenging year for the Patient Experience team, particularly in regard to ongoing complaints and reports waiting to be drafted. Support to address this has been put in place and work is also ongoing with the Trust Transformation team to assess if further improvements can be made. Changes have been made to the expected timeframe for investigations to be completed from 40 or 60 working days to 90 working days to ensure that we are setting reasonable expectations and people are informed of achievable timelines from the outset.

The Patient Experience team work with operational teams to ensure that the best outcomes are achieved in a timely manner from local services. Our progress throughout the year is monitored and reported on in quarterly reports to the Patient and Carer Operational Group and to the Quality and Safeguarding Committee.

	2024/25	2025/26*
Complaint quick resolution	241	174
Complaint closer look	189	220
Compliment	1791	1575
Concern	86	88
Enquiry	1697	1816

*There may be further adjustment due to categorisation during the year.

- Complaints quick resolution are issues that can come through the Patient Experience Team, but which can be resolved locally by the ward or team. The issues are noted on a quick resolution form and sent to the team to act on and respond directly to the complainant.
- Complaints closer look are issues that need investigating and require a formal written response from the Trust. Investigations are coordinated through the Patient Experience team.
- Concerns are issues that are raised directly with staff, who log the information and any actions taken.
- An Enquiry is a general question raised that may, or may not, be relating to services provided by the Trust.

Of the 220 closer look complaints, seven were upheld in full, 33 upheld in part, 76 not upheld, one closed with local resolution and five closed no investigation required. 98 complaints are still being investigated or awaiting a response. Work is underway to reduce the length of time investigations are taking and to improve the timeliness of our responses.

The most common issue raised in complaints during 2025/26 was regarding issues in respect to care planning. Themes from complaints are shared with the operational teams via our quarterly reports.

Top three issues raised in concerns	
2024/25	
Unprofessionalism by staff	10
Availability of Services	7
Appointments	7
2025/26	
Unprofessionalism by staff	16
Breach of confidentiality	7
Information provided	6
Patient safety issues	6

Top three issues raised in Complaints	
2024/25	
Care planning	181
Unprofessionalism by staff	85
Availability of Services	72
2025/26	
Care planning	202
Engagement	102
Unprofessionalism by staff	89

Parliamentary and Health Service Ombudsman and Local Government Ombudsman
During the year, the Trust discussed 6 cases with the Parliamentary and Health Service Ombudsman. Of the six cases, one case was looked at by the PHSO, and the Local Government Ombudsman and is now being looked at again by the PHSO. All six cases are ongoing.

Compliments
Most of the 1,575 compliments received during 2025/26 reflected people's general gratitude for the care, support, and help that staff had provided.

Top three themes	2024/25
General gratitude	1380
Support/help	1269
Care	1065

Top three themes	2025/26
General gratitude	1187
Support/help	1103
Care	987

Local nurse recognised for bringing communities together to tackle perinatal mental health

A Community Nurse at the Trust was recognised for her exceptional contribution to community mental health outreach.

Michelle Trolley, Community Outreach Nursery Nurse with the Perinatal Community Team (North), was celebrated for her efforts in building a relationship with the Chesterfield Asian Association – a registered charity promoting the culture, education, health and welfare of Asian people residing in Chesterfield and North Derbyshire, and organising a vibrant community fun day aimed at promoting open conversations around perinatal mental health.

Stakeholder relations
The Trust has an extensive record of working well with partners across the health and social care economy and provides a broad range of services in partnership with other providers across the NHS and voluntary sector. As reflected within our new Trust Strategy, we are committed to building on the partnerships and collaborations we have in place and believe that that this approach to providing services brings benefits to patients through opportunities to integrate and develop services for our communities and local people. The increasingly challenging financial environment that the people of Derby and Derbyshire and the broader NHS experience means that partnership working is ever more important.

The Trust continues to be a member of the East Midlands Mental Health, Learning Disabilities and Autism Alliance, a partnership arrangement with the aim of providing strategic oversight to the creation of the regional lead provider arrangements. This collaboration provides a vehicle for working together across the region to improve services, coordinate approaches to challenges, and seek out opportunities to deliver the objectives of the NHS Long Term Plans for Mental Health and Learning Disabilities.

The Trust has continued to develop its role as lead provider for the East Midlands Perinatal Mental Health Provider Collaborative, offering high quality care for women and their babies with serious mental illnesses that require Mother and Baby Unit (MBU) admission, and seamless care between MBU and community perinatal mental health teams. Over 2025/26 we have implemented learning and developed ways of working that have improved case and outcomes across the two East Midlands perinatal units. Clinically led learning discussions have been hosted to support the development of plans for improving equity of patient access and reducing unwarranted variation. In addition, we have improved the ward environment by adding air conditioning to ensure an even temperature for mothers and babies during periods of hot weather.

The Trust continues to be an active partner in the East Midlands Child and Adolescent Mental Health Services (CAMHS) Provider Collaborative led by Northamptonshire Healthcare NHS Foundation Trust. The collaborative has been harnessed as a vehicle to redesign and further develop CAMHS Tier 4 inpatient services across the East Midlands. The Trust CAMHS Tier 3.5 service has been developed over the last year for young people who are experiencing complex mental health problems which may require a Tier 4 hospital admission. The service offers care to young people in the community and through a day programme provision, supporting young people facing emotional and mental health crisis seven days a week. The service continues to demonstrate positive impact, and recurrent funding has been approved by the Alliance, reflecting the significant impact this has had in preventing Tier 4 hospital admissions.

The Trust has continued to work under a regional partnership agreement for the delivery of inpatient forensic services, with eight other NHS, private and voluntary sector providers across the East Midlands. This partnership offer is an opportunity for collaboration in improving inpatient forensic services and includes the delegation of planning and contracting functions from NHS England to a lead provider, working within the collaborative framework led by Nottinghamshire Healthcare NHS Foundation Trust.

Through the regional Adult Eating Disorder partnership led by Leicester Partnership NHS Trust the Trust has supported the pilot, evaluation and identification of a recurrent funding stream for the Waterlily Inpatient Prevention programme. Evaluation demonstrates positive impact on patient outcomes and admission avoidance with the implementation of this as a mainstream service representing a significant positive transformation for our population.

The Trust has continued to lead the East Midlands Gambling Harm service providing specialist support based on a ‘hub and spoke’ model, with the central hub situated in Derby and wider spokes provided across the wider East Midlands region. The service is provided by a multi-disciplinary team of staff including a psychiatrist, psychologists, mental health nurses, specialist mental health practitioners including cognitive behavioural therapists and peer support worker

positions who deliver evidence-based interventions either in a group setting or one to one. Over 2025/26 the service has seen a significant increase in referrals following more focused service promotion and stakeholder engagement, along with a reduced attrition rate arising from a flexible approach to service user engagement. Interventions developed over the last year include an evening clinic and a condensed treatment programme.

In addition, the Trust has engaged in a number of other partnerships with organisations across the health and care system to deliver improved services to our communities which include:

- In partnership with East Midlands Ambulance Service (EMAS) development of the Mental Health Response Vehicle service which is delivering significant benefit in reducing avoidable conveyance to emergency departments
- We continued to provide drug and alcohol services across both the Derby city, and for the wider County of Derbyshire in collaboration with a range of partners from the charity sector
- The Trust continues to provide children's continence services in partnership with other providers across Derbyshire under Chesterfield Royal Hospital (CRH) NHS Foundation Trust as lead provider
- The Trust has continued to provide a successful Alcohol Care team service within University Hospitals of Derby and Burton (UHDB) NHS Foundation Trust supported by a dedicated funding stream for 2025/26
- The Trust continues to operate the Derbyshire 24/7 Mental Health, Learning Disability and Autism Helpline and Support Service in partnership with P3, who provide Peer Support Workers as the first point of access ahead of Trust clinicians
- The Trust has continued to strengthen its close working relationship with Derbyshire Community Health Services (DCHS) NHS Foundation Trust through the Derbyshire Integrated Adult Neurodevelopmental (ND) service. This arrangement has supported the ongoing development and improvement of neurodevelopmental services over the last year.

Joined Up Care Derbyshire (JUCD)
The Trust has continued to be an active partner in the Derby and Derbyshire Integrated Care System (ICS), made up of NHS providers, Local Authorities and the local Integrated Care Board (ICB) working together to improve the health of Derby and Derbyshire citizens, and to further the transformative change needed to tackle system health and care challenges. Following the reconfiguration of ICBs during the year, we are working with the newly appointed executive team within the newly established Derbyshire, Lincolnshire and Nottinghamshire ICB Cluster.

We have representation on the Provider Collaborative Leadership Board which is made up of Derbyshire NHS Provider Chief Executive Officers and has agreed a set of priority areas for joint working which focus around supporting fragile services and progressing joint areas of opportunity to achieve alignment, such as implementing a consistent appraisal framework, as well as progressing opportunities for improved services and efficiencies.

Through this, collaborative providers are working together to unlock opportunities to streamline and strengthen how a range of NHS services for children and young people are organised and delivered. During 2025/26 a working group has taken forwards actions that include:

- Mapping the current landscape to develop a clear shared picture of resources
- Challenges and opportunities to develop the case for change
- Scoping specific opportunities for improving service delivery in key challenged areas including neurodiversity, children's services, continence, audiology and therapies.

Mark Powell, the Trust Chief Executive, has led the children's services review on behalf of Derbyshire providers. The overall objective of the work is to make services more accessible for children and families and to strengthen how sustainable, integrated and effective children's services are in JUCD.

The Trust's Deputy Chief Executive is a key member of the JUCD Mental Health, Learning Disabilities and Autism Delivery Board. The Trust continues to take an active role in the design and delivery of the Mental Health, Learning Disability and Autism transformation programme, and has offered the Board assurance on key deliverables, including the improvement plan for reduction of inappropriate out of area placements for inpatient care.

In collaboration with national partners, a whole system programme of work has been delivered in 2025/26 which sought to further develop and improve acute mental health pathways and services for the benefit of the population of Derby and Derbyshire. The JUCD system engaged the Mental Health Improvement Support Team to support in application of the Mental Health Services Assessment Tool (Men-SAT) improvement tool. The Men-SAT application review comprised a series of virtual whole system workshops, concluding with a full day summit and series of site visits to services across the mental health pathway. The resulting report made eight recommendations that will support sustainable improvement of services and pathways. The majority of these require system led action and support in order to fully unlock the identified opportunity with the Trust supporting proactive action with system partners to implement the associated action plan.

The Trust continues to work closely with DCHS to improve services for people with learning disabilities through the development of a Derbyshire Adult Integrated Neurodevelopmental service which includes a single management structure across the two organisations.

Over 2025/26 there has been continued focus on improving our collaborative working with primary and community care partners in local communities, sometimes referred to as Local Place Alliances. Further development of these relationships remains a key objective for the forward year, aligned to the national ambitions for shift of care to community provision, and the development of neighbourhood services through Integrated Neighbourhood Teams.

Nurse with 48 years' service and 'life-saving' psychiatrist amongst those honoured at the Trust's Honouring Excellent and Really Terrific Staff (HEARTS) Awards

The Trust held its annual HEARTS staff awards ceremony today (22 October 2025) at the Trust's conference room at Kingsway Hospital, Derby. Among this year's award recipients were an employee with nearly five decades of dedicated long service, as well as a doctor recognised for his exceptional support to patients thanks to his practical expertise and compassionate approach.

The awards ceremony, hosted by members of the Trust's Board of Directors and sponsored by Hill Dickinson, Kier Construction and Arden Partnership, recognised individual Trust employees and teams who went above and beyond the call of duty and performed at a consistently high level to support patients, carers and fellow colleagues. Over 180 nominations were received for the awards from both inside and outside the organisation.

Thank you…

'Partnership' is central to the way the Trust operates and there are many groups and organisations that the Trust would like to thank for their support and involvement during the year. These include:

- All the **volunteers** who make such a positive difference to the work of the Trust, including volunteers in our services, our Mental Health Act office and those who have taken part in quality assessment visits at Trust sites.
- All our **governors** who give up their time to represent their communities and oversee the way that the Trust makes decisions, and all our **Trust members** for showing a continued interest in the work of the Trust.
- All those who attend our **EQUAL Forum** and its sub-groups, for their efforts in representing service users and carers and for the invaluable contribution they make to our Trust and our community. The launch of the 15 Steps Challenge has been a particularly welcome innovation this year, shining a light on first impressions on our inpatient units.
- All the **experts by experience** and **peer support workers** who guide and inform our services.
- The **League of Friends** for their continued commitment to our organisation and their charitable endeavours; the money they raise enables people using our services to benefit from a greater range of activities and support.
- The **service users** and **carers** who have attended Board meetings this year to tell their story.
- The **Staff Network** members, in particular the chairs of the networks, for creating spaces for colleagues to gain support and guidance from their peers and an opportunity to shape attitudes and ways of working across the Trust.
- **North Derbyshire Mental Health Carers Forum** and **South Derbyshire Mental Health Carers Forum**, for continuing to improve the Trust's understanding of how to support service users and their carers.
- All those who have donated to the **Trust charitable fund** over the past year and paid for extra activities and items for our patients, or for staff wellbeing schemes, that could not be provided through NHS funding. A special thank you to Kedleston Park Golf Club for choosing the Radbourne Unit as their charity for this year, and to Adrian and Samantha Kennedy and their Dalek, Dusty, for their fundraising efforts at fan conventions.
- The **University of Derby** for its strategic partnership with the Trust, which covers a range of areas including research, training and staff wellbeing.
- Our partners at **Phoenix Futures** and **Intuitive Thinking Skills** who worked with us to provide Derby Drug and Alcohol Recovery Service until its closure on 31 March 2026.
- Our partners who continue to work with us to provide Derbyshire Recovery Partnership, our county drug and alcohol support service: **Phoenix Futures**, **Intuitive Thinking Skills** and **Derbyshire Addictions Advice Service** (DAAS). DAAS also continue to play an important role in the delivery of our regional gambling service, East Midlands Gambling Harms service.
- **First Steps Derbyshire** for their continued and longstanding partnership in providing eating disorders services.
- The charity **Connected** for their close collaboration with our Perinatal mental health service.
- **P3** and **Derbyshire Federation for Mental Health** for their continued collaboration with us on the Derbyshire Mental Health Helpline and Support Service, which remains an essential service for Derbyshire people who are in mental health crisis.
- **Derbyshire Voluntary Action** and **Erewash CVS** for their continued support and partnership.

- To all our **third sector and VCSE partners** who continue to collaborate with us on the transformation of community mental health services through Living Well, as well as on our children's services and in our Place-based developments.
- The co-creators and members of our **Deaf Focus Group**, a key forum as we accelerate our community and stakeholder engagement. These include: Communication Unlimited, Deaf-initely Women, Derby City Council Deaf Services team, British Deaf Association, National Deaf Children's Society, SignVideo. Our thanks, too, to Derbyshire Constabulary's Police Link Officers for the Deaf (PLOD).
- Organisations supporting us as we seek to increase our engagement with Derby and Derbyshire's Black communities, including **Community Action Derby**, **Chesterfield and North East Derbyshire CVS** and the **University of Derby**.
- **Healthwatch Derby** and **Healthwatch Derbyshire** for being the voice of our community and providing invaluable feedback on how our care is experienced and could be improved.
- Our **Joined Up Care Derbyshire system partners** including NHS Derby and Derbyshire Integrated Care Board; Derbyshire Community Health Services NHS Foundation Trust, who collaborate closely with us on the development of neurodevelopmental services and older people's mental health services; and Chesterfield Royal Hospital and University Hospitals of Derby and Burton trusts who host our psychiatric liaison teams and have supported our MRFD programme.
- **His Majesty's Lord Lieutenant of Derbyshire**, Mrs Elizabeth Fothergill MBE, for her support of our MRFD programme and for being the guest of honour at the opening ceremonies of several of our new and refurbished inpatient units.
- Colleagues at **WSP** for helping to bring the MRFD programme to fruition.
- Our partners in **Public Health** at Derby City Council and Derbyshire County Council for their guidance and their collective leadership of our public health services.
- The members of the **Mental Health, Learning Disability and Autism System Delivery Board** for their dedication to the improvement of local health services.
- The **Coroners service** of Derbyshire for their ongoing partnership working and support to our colleagues and our families.
- The **Care Quality Commission (CQC**) for their guidance and direction, particularly regarding the openings of our new acute mental health inpatient facilities.
- The **Royal College of Psychiatrists** and its assessment teams for their oversight of standards of care in several of our mental health services.
- The **Carers Trust** for their leadership of the Triangle of Care scheme.
- **IPS Grow** for their oversight of our individual placement and support service, Work Your Way.
- The **Police** (Derbyshire Constabulary) and **Probation Service** for their leadership in public protection and safety, and their support of our Criminal Justice Liaison and Diversion service.
- **HM Prison Service** for their collaboration on our Reconnect service, which helps people leaving prison to get support from health services in their community.
- The **sponsors** of our 2025 staff conference and staff awards: Browne Jacobson, Patchwork and TPP SystmOne (staff conference) and Arden Partnership, Hill Dickinson and Kier (staff awards).
- Partners in the **East Midlands Alliance** for Mental Health, Learning Disabilities and Autism whose communities of practice are an opportunity for NHS Trust professionals to develop and share truly innovative thinking.
- Members of the East Midlands **provider collaboratives** including the IMPACT (secure inpatient services), CAMHS and Perinatal collaboratives – for working together to improve these important regional mental health services.

Our sincere thanks to these partners and to our **colleagues within Derbyshire Healthcare**, who make everything possible.

Engaging with our communities and wider patient and public Involvement activities

2025/26 saw the delivery of the year one priorities, as outlined in the Trust's Community and Stakeholder Engagement Plan, which supports the 'Partnerships' strategic priority of the Trust Strategy. The plan supports the Trust to better understand our communities' needs and health inequalities, in order to provide targeted support that improves people's access, experience and outcomes of our services. A system-wide identified focus for mental health engagement was Black and Deaf communities, which was also agreed by the Trust Board of Directors as the initial priority groups for local engagement.

In 2025 the Trust co-created a new focus group with Deaf representatives from across the city and county. This collaboration has proved valuable in working together to improve access, experience and outcomes of Trust services. The Trust is currently working with Deaf partners to explore workforce development opportunities for Deaf people, working with the University of Derby, and increasing the Deaf information available on the Trust webpage.

New relationships have been established with Derbyshire Constabulary's Police Link Officers for the Deaf (PLOD) scheme, Communication Unlimited and Derby City Council Deaf Services. The Trust is delighted that a recently elected public governor for Derby City East, is a member of the Deaf community and nominated herself as a direct result of the relationship with the Deaf Focus Group. The Trust is also liaising with health colleagues across the country to develop bespoke Deaf cultural awareness training for staff.

Trust colleagues attending Basic British Sign Language (BSL) Training at the Derby Deaf Club in March 2026

The Trust has also developed new relationships via the Chesterfield and North East Derbyshire Council for Voluntary Service (CVS), following the launch of the Tackling Mental Health Inequalities through Cultural Competence report. In agreement with the relevant Board members, mapping is taking place to identify the subcultures within the Black community. This work is taking place with support from Community Action Derby (CAD) and will be followed by appropriate engagement as a focus for our engagement work during 2026/27.

Working with the Deaf and Black communities will continue as the focus of the Community and Stakeholder Engagement Plan for year two, as agreed by the Trust Board in February 2026. Year two will expand to include Deaf pathways mapping with speech and language therapy (SALT) colleagues and the expansion of basic British Sign Language (BSL) training for staff. The Trust has also identified a Board-level representative to attend the Derby Health Inequalities Partnership (DHIP) to further enhance the partnership work with CAD.

The Trust has also progressed work with key stakeholders, including local Members of Parliament (MPs), with several opportunities focused on the opening of the new Trust facilities and the regular stakeholder bulletin (*Positive Dimensions*) has been reviewed and revamped which also allows for data capture and greater insight into the readership.

Direct engagement took place across our communities over the year, including the following events:

Caribbean Carnival, July 2025
Further strengthening our focus on engaging with Black communities, the Trust attended the Caribbean Carnival in July 2025. The aim was to gain initial feedback from this priority group about their access, experiences and outcomes of our services. This also provided the opportunity to engage with local partners and wider stakeholders and to provide our local communities with information about the services we offer.

Members of Team Derbyshire Healthcare at Derby's Caribbean Carnival, July 2025

Pride in Belper, August 2025
Colleagues from the Trust's Executive Leadership team and Communications and Engagement team attended the Pride in Belper event to establish new connections within the LGBTQ+ communities, as well as other voluntary and statutory organisations.

MP visits
The Trust continues to share quarterly MP briefings, providing regular updates about the Trust's work. During the year, MPs across the city and county visited the recently opened Carsington Unit at Kingsway Hospital in Derby and the Derwent Unit in Chesterfield. This provided an opportunity for MPs to view the new wards, meet with staff and it enabled them to ask questions about the facilities and gain greater insight into the services delivered to local people.

Catherine Atkinson, MP for Derby North, and Baggy Shanker, MP for Derby South, visited the Carsington Unit at Kingsway, Derby, in January 2026.

Communities in Derby Wellbeing
The Communications and Engagement team has attended the monthly Derby Wellbeing Collaborative meetings. The aim is to nurture and build existing and new community connections and work with local communities to tackle stigma and provide accessible information to improve access to Trust services.

Awareness days 2025
The Trust took part in the annual Derbyshire Baton of Hope, suicide prevention event on the 13 September 2025. It was the UK's largest Suicide Prevention Day initiative with other events taking place across the country. The aim of this initiative is to boost the national conversation to eliminate the stigma around this issue and to connect and collaborate with people and organisations that are already working to save lives. It was also to create better signposting for those who feel they need support. Colleagues from the Trust attended the event to raise awareness of the Trust's services that are available to the community and gathered at the final stop on the baton's route.

The Trust also supported and participated in awareness raising, information sharing and anti-stigma events throughout the year. This included supporting national and international awareness raising days and weeks. These included: Maternal Mental Health Week, Children's Mental Health Week, Time to Talk Day, World Suicide Prevention Day, Mental Health Awareness Week and World Mental Health Day, which was celebrated with the official opening ceremony of the new Derwent Unit at Chesterfield.

The Trust is fully committed to ensuring equality, diversity, inclusion and human rights and in conjunction with our staff networks, helped to recognise and promote awareness days, weeks and months throughout the year.

The Trust also supported and celebrated with staff, carers and those in our care with key faith dates throughout the year.

East Midlands Gambling Harms Service

The East Midlands Gambling Harms Service team engaged directly with students and staff at university Freshers' Fairs at the University of Northampton and Derby University, distributing leaflets and raising awareness. There was a dual purpose to choosing universities; many of our service users have said this is where their problem first took hold, and it is also a time when young people may have more freedom.

The question: "do you have a friend who may need help?", approach proved successful in generating conversations and breaking down barriers.

The team also posted weekly in over 100 regional Facebook groups across the East Midlands, adapting messages to different audiences and encouraging more self-referral. The messages have targeted football betting, casino, horse racing, bingo and even in-game purchases in children's games, which has been linked to problem gambling. The message was changed regularly to target anyone who may be struggling with their gambling, in whatever form. This sustained activity contributed to a 33% increase in website traffic over the past year.

Celebration of World Mental Health Day on Derwent Unit opening day

Remuneration report

This remuneration report is signed in my capacity as accounting officer.

Mark Powell
Chief Executive
18 June 2026

Annual statement on remuneration

Major decisions/substantial changes to senior managers' remuneration
On 15 September 2025 the Remuneration and Appointments Committee approved the pay award of 3.25% for very senior managers (VSM). This was applicable from 1 April 2025 and was based on the Senior Salaries Review Body (SSRB) recommendations accepted by the Government.

The 3.25% was awarded to all eligible substantive Executive Directors.

The Committee recognised that some VSMs will be earning less than staff at the top of Agenda for Change Band 9. The Remuneration and Appointments Committee noted the position on Band 9 salaries in the organisation against the VSM salaries and considered the updated VSM framework but took no further action.

As in previous years, medical directors employed on the consultant contract received the agreed pay award for their consultant pay, as per the Government's response to the Doctors and Dentists Review Body (DDRB) recommendations. Extra contractual payments pertaining to their role as a VSM were subject to the VSM pay framework and the application of the 3.25% increase.

The NHS England Chair remuneration framework was applied to the Chair upon appointment. The national framework for Non-Executive Director (NED) remuneration was considered during a review of NED remuneration carried out by the Governors' Nominations and Remuneration Committee in October 2022. The Council of Governors accepted all the recommendations of the Committee's review and approved a revised remuneration structure at its meeting in November 2022. The Council of Governors adopted the national basic pay for NEDs but agreed a local level of supplementary payments for those currently in the roles of Deputy Chair, Senior Independent Director and the Chair of Audit and Risk Committee with the intention of adjusting the future value of the supplementary payments for any new appointments to better align with the financial limits set out in the guidance. This is in line with the comply and explain principle.

Selina Ullah
Trust Chair and Chair of Remuneration and Appointments Committee and Chair of Governors' Nominations and Remuneration Committee

Senior managers' remuneration policy future policy table:

Executive Directors

Component	The Remuneration and Appointments Committee oversees the remuneration and terms and conditions of Executive Directors and senior managers. The Committee's approach to remuneration is guided by the Executive Director Remuneration Policy which outlines the approach the Trust takes to oversee the salaries and the provisions for other benefits as outlined in remuneration tables on pages 118-121.
How this operates	The Terms of Reference of the Remuneration and Appointments Committee outline their responsibility to decide on the level of remuneration for each appointment.
How this supports the short- and long-term strategic objectives of the Trust	The policy is against a key set of principles, including Board portfolios and composition, which together contribute to the short term and long-term delivery of the Trust Strategy.
Maximum that can be paid	Pay is outlined in the remuneration tables outlined on page 118. This remains constant unless there is specific reason for review, as agreed with the Remuneration and Appointments Committee, for example to reflect wider benchmarking, a change of portfolio or acting-up arrangements.
Framework used to assess performance measures that apply	Performance is measured using appraisal processes. Remuneration is not normally linked to the appraisal process.
Provisions for recovery or withholding of payments	Not applicable as we do not operate performance related pay so do not provide for the recovery of sums paid to a director or for withholding the payments of sums to senior managers.

Non-Executive Directors

Component	The Governors' Nominations and Remuneration Committee oversees the remuneration and expenses for Non-Executive Directors (NEDs), recommending any amendments to the Council of Governors. There is an annual flat rate non-pensionable fee, with a higher rate payable for the Chair of the Trust, the Senior Independent Director, Audit and Risk Committee Chair and Deputy Chair. The Committee's approach to remuneration in 2025/26 was considered against the NHSE remuneration structure for NHS provider Chairs and NEDs. The revised structure acknowledges that within Foundation Trusts it is for the Council of Governors to determine the remuneration of the Chair and NEDs and they retain the prerogative to operate outside of the framework on a 'comply or explain' basis.
Additional fees	Not applicable.
Other remuneration	Not applicable.

In terms of diversity and inclusion, the Remuneration and Appointments Committee regularly reviews 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 Governors' Nominations and Remuneration Committee of the Council of Governors, as applicable, with regard to any changes.

In line with all Board Committees, the Remuneration and Appointments Committee actively considers the equality impact and evidence relating to all items of Committee business as part of the Committees' contribution to equality, diversity and inclusion.

Service contract obligations
Executive Directors are employed on contracts of service and are substantive employees of the Trust. Executive Directors may participate in the Trust lease car scheme for which there is a Trust contribution. If appropriate, Directors may receive relocation payments or other such recompense in line with Trust policy.

The Remuneration and Appointments Committee's approach to setting periods of notice is to ensure that the Trust has sufficient flexibility to make changes required to promote the interests of the Trust, whilst giving both the Director and the Trust sufficient stability to promote their work. The Committee also has regard to recognised good practice across the NHS, and the demands of the market.

Payments for loss of office are determined by reference to the contractual arrangements in place with the relevant Executive Director, as detailed above. The various components would be calculated as follows:

Salary for period of notice
The Committee will usually require Executive Directors to serve their contractual notice period, in which case they will be paid base salary in the usual way. In the event that the Committee agreed to pay in lieu of notice, this would be calculated on the relevant base salary. If exercised, this would mean that the Executive Director received payment without providing service in return. All Executive Directors are contracted to serve six months' notice, with the exception of the contracts for the Interim Directors.

The Trust's Constitution sets out the grounds on which a NED appointment may be terminated by the Council of Governors. A NED may resign before completion of their term, by giving written notice to the Director of Corporate Affairs and Trust Secretary.

Policy on payment for loss of office
Any redundancy payment would be calculated in accordance with the relevant parts of Agenda for Change, which apply through the relevant contracts and would be subject to any statutory limits that may be imposed by the government or regulator.

Statement on consideration of employment conditions elsewhere in the Trust
The pay and consideration of employees was not taken into account when setting the Remuneration Policy for senior managers and the Trust did not consult with its employees on this issue.

The Remuneration and Appointments Committee considered the national VSM pay framework and benchmarking information to determine senior managers pay. The Trust participates annually in the NHS Providers Board remuneration survey and the Remuneration and Appointments Committee reviews the findings.

The latest VSM pay framework, effective from 1 April 2025 applies to all integrated care boards (ICBs) and NHS provider trusts and seeks to strengthen the link between reward and performance outcomes, increase transparency and offer flexibility to attract talented candidates to the most challenging roles.

Annual Report on remuneration

Directors' appointments and contracts

Executive Directors of the Trust Board have permanent contracts of employment, and are not subject to fixed term arrangements, except where indicated in the Directors' Report. Non-Executive Directors (NEDs) including the Trust Chair are subject to fixed term appointments. Details of NEDs terms of office are outlined in the Directors' Report on page 69.

Remuneration and Appointments Committee

The role of the Committee is to ensure there is a formal and transparent procedure for developing policy on Executive Director remuneration and agreeing remuneration packages of individual Directors. The Committee is also responsible for identifying and appointing candidates for Executive Director positions on the Trust Board. The Committee has met five times in 2025/26.

Attendance at the Remuneration and Appointments Committee by NEDs is outlined below:

	Actual attendance	Possible attendance
Selina Ullah (Chair)	5	5
Lynn Andrews	5	5
Tony Edwards (*left 31 Jul-2025)*	2	2
Ralph Knibbs	5	5
Chioma Akpom (*started 1 Dec-2025)*	2	2
Deborah Good	2	5
Jo Hanley *(started 1 Aug-2025)*	1	3
Andrew Harkness	5	5
Geoff Lewins *(left 30 Nov-2025)*	3	3

Governors' Nominations and Remuneration Committee

The role of the Committee is to recommend to the Council of Governors remuneration and terms of service policy for NEDs, taking into account the views of the Chair (except in respect of their own remuneration and terms of service) and the Chief Executive and any external advisers. The Committee has met three times in 2025/26.

Attendance at the Governors' Nominations and Remuneration Committee is outlined below:

	Actual attendance	Possible attendance
Selina Ullah (Chair)	3	3
Ralph Knibbs, Senior Independent Director	1	1*
Susan Ryan, Public Governor, Amber Valley (Lead Governor up to 31 Jan 2026)	3	3
Jill Ryalls, Public Governor, Chesterfield	0	3
Tom Bladen, Public Governor, Derby City East	1	3
Christine Williamson, Public Governor, Derby City West	0	0**
Brian Edwards, Public Governor, High Peak and Derbyshire Dales	3	3
Hazel Parkyn, Public Governor, South Derbyshire (Deputy Lead Governor)	3	3
Fiona Rushbrook, Staff Governor, Allied Healthcare Professions	2	3
Debra Dudley, Appointed Governor, Derbyshire Mental Health Forum	2	3

* Ralph Knibbs took over as Chair from the item Chair's appraisal, when Selina left the meeting

** Christine Williamson is a stand-in

Note: The Chair or any Non-Executive Director declares an interest and withdraws from any discussions at the Committee in relation to their own pay and conditions.

The details included in the Remuneration report (salary and allowances of Executive and NEDs for the year 2025/26 and pension benefits) plus the fair pay multiple, payment for loss of office and payments to past senior managers are subject to audit.

Seven impressive Derbyshire Healthcare NHS colleagues and one team shortlisted for national award championing equality, diversity and inclusion across healthcare

The Trust were finalists for a record eight times at a national awards scheme run by the Asian Professionals' National Alliance (APNA NHS). APNA champions equality, diversity and inclusion in the workplace, to visibly make a difference to the NHS and its diverse workforce.

Trust shortlisted for national health award for showcasing innovation within mental health services

The Trust was shortlisted for an innovative project which improves the efficiency and person-centredness of occupational therapy input into care plans in our forensic mental health and rehabilitation service, at the national Health Service Journal (HSJ) Awards.

The Trust's occupational therapy team at the Kedleston Unit and Cherry Tree Close were finalists in the Mental Health Innovation of the Year category, a category that recognises the work of healthcare organisations across the country who have provided excellent patient-centred care through strong engagement between clinicians within and outside of an organisation.

Trust mental health team shortlisted for national dementia award for providing transformative patient care to those with memory loss or cognitive decline

A Trust mental health team were shortlisted for a National Dementia Care Award for innovative approach to improve health outcomes for dementia patients.

The Mental Health Liaison Team, based at the Royal Derby Hospital, was shortlisted in the 'Outreach Category,' which recognises innovative outreach initiatives developed and implemented to support individuals affected by dementia.

Salary and allowances of Executive and Non-Executive Directors for the year 2025/26

Title	Name	2025/26				2024/25			
		Salary and Fees (in bands of £5,000)	All taxable benefits (to the nearest £100)	All pension-related benefits (in bands of £2,500)	Total (in bands of £5,000)	Salary and Fees (in bands of £5,000)	All taxable benefits (to the nearest £100)	All pension-related benefits (in bands of £2,500)	Total (in bands of £5,000)
Chief Executive	Mark Powell	195-200	800	57.5-60	255-260	190-195	800	112.5-115	305-310
Deputy Chief Executive and Chief Delivery Officer	Vikki Ashton Taylor [*1]	145-150		42.5-45	190-195	140-145		85-87.5	225-230
Director of Finance	James Sabin	130-135	800	0	130-135	125-130		145-147.5	270-275
Executive Medical Director	Girish Kunigiri [*2]	105-110		27.5-30	130-135				
Interim Medical Director	Mark Broadhurst [*3]	35-40		10-12.5	50-55				
Executive Medical Director	Arun Chidambaram [*4]	95-100		20-22.5	115-120	200-205		72.5-75	275-280
Director of People, Organisational Development and Inclusion	Rebecca Oakley [*5]	115-120	1,200	32.5-35	150-155	110-115	1,200	0	110-115
Director of Nursing, Allied Health Professionals, Quality and Patient Experience	Tumi Banda [*6]	125-130		27.5-30	155-160	65-70		5-7.5	70-75
Interim Director of Nursing and Patient Experience	David Mason [*7]					45-50		0	45-50
Director of Corporate Affairs and Trust Secretary	Justine Fitzjohn [*8]	105-110		35-37.5	140-145	100-105		17.5-20	120-125
Chair	Selina Ullah	45-50			45-50	45-50			45-50
Non-Executive Director	Lynn Andrews	10-15			10-15	10-15			10-15
Non-Executive Director	Deborah Good	10-15			10-15	10-15			10-15
Non-Executive Director	Ralph Knibbs	10-15			10-15	10-15			10-15
Non-Executive Director	Andrew Harkness [*9]	10-15			10-15	0-5			0-5
Non-Executive Director	Jo Hanley [*10]	5-10			5-10				
Non-Executive Director	Chioma Akpom [*11]	5-10			5-10				
Non-Executive Director	Geoff Lewins [*12]	10-15			10-15	15-20			15-20
Non-Executive Director	Antony Edwards [*13]	0-5			0-5	10-15			10-15
Non-Executive Director	Ashiedu Joel [*14]					0-5			0-5

(This disclosure is subject to audit)

NB. Annual performance related bonuses and Long-term performance related bonuses are nil for 2025/26 (2024/25: nil).

*1 Vikki Ashton Taylor – Director of Strategy, Partnerships and Transformation from 01.06.2022 and became Deputy Chief Executive/Chief Delivery Officer from 01.04.2024

*2 Girish Kunigiri – started in post 29.10.2025

*3 Mark Broadhurst – in post from 22.09.2025 to 23.11.2025

*4 Arun Chidambaram – left 21.09.2025

*5 Rebecca Oakley – Interim Director of People, Organisational Development and Inclusion from 30.05.2023, then appointed to role of Director on permanent basis from 01.06.2024

*6 Tumi Banda –started in post 16.09.2024

*7 David Mason – left 31.08.2024

*8 Justine Fitzjohn – Trust Secretary from 03.06.2019 and Director of Corporate Affairs added 01.04.2024

*9 Andrew Harkness – started in post 12.01.2025

*10 Jo Hanley – started in post 04.08.2025

*11 Chioma Akpom – started 06.10.2025

*12 Geoff Lewins – left 30.11.2025

*13 Anthony Edwards – left 31.07.2025

*14 Ashiedu Joel – left 31.08.2024

**The total taxable benefits reported in the table above of £2.8k all relate to lease car benefits.*

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in the organisation in the financial year 2025/26 was £195,000 - £200,000 (2024/25: £200,000 - £205,000). This is a change between years of 2.5%

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

For employees of the Trust as a whole, the range of remuneration in 2025/26 was from £23,875 to £231,213 (2024/25 £16,816 to £230,122). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 2.8%

There were nine employees that received remuneration in excess of the highest paid director in 2025/26 (2024/25: eight employees).

The highest paid director during 2025/26 was the Chief Executive (2024/25: Executive Medical Director).

On 15 May 2025, NHS England (NHSE) published the VSM pay framework and supporting documents, which has been jointly produced by NHSE and the Department of Health and Social Care (DHSC).

The framework states that it seeks to strengthen the link between reward and performance outcomes, increase transparency and offer flexibility to attract talented candidates to the most challenging roles.

The Trust adheres to the framework for all senior staff appointed or reviewed since 1 April 2025.

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce. This only includes permanent employees, not temporary staff as the ratio would be unfairly distorted by including them.

	2025/26			2024/25		
	25th percentile	**Median**	**75th percentile**	**25th percentile**	**Median**	**75th percentile**
Salary of component of pay	£30,196	£38,831	£49,185	£29,114	£38,898	£48,526
Total pay and benefits excluding pension benefits	£30,196	£38,831	£49,179	£29,114	£38,908	£48,526
Pay and benefits excluding pension: pay ratio for highest paid director	7	5	4	7	5	4

Pension Benefits – 1 April 2025 to 31 March 2026

Title	Name	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2026 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2026 (bands of £5,000)	Cash Equivalent Transfer Value at 01 April 2026	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2026	Employers Contribution to Stakeholder pension (£00)
		£000	£000	£000	£000	£000	£000	£000	£000
Chief Executive	Mark Powell	2.5-5	0-2.5	65-70	155-160	1284	82	1387	27
Deputy Chief Executive and Chief Delivery Officer	Vikki Ashton Taylor	2.5-5	0-2.5	55-60	135-140	1,149	66	1,235	21
Director of Finance	James Sabin	0-2.5	0	35-40	85-90	733	0	744	17
Executive Medical Director	Girish Kunigiri	0-2.5	0-2.5	45-50	110-115	973	38	1,078	10
Interim Medical Director	Mark Broadhurst	0-2.5	0-2.5	60-65	150-155	1313	17	1436	4
Executive Medical Director	Arun Chidambaram	0-2.5	0	55-60	120-125	1,101	32	1,187	13
Director of People, Organisational Development and Inclusion	Rebecca Oakley	0-2.5	0-2.5	30-35	70-75	575	42	627	15
Director of Nursing, Allied Health Professionals, Quality and Patient Experience	Tumi Banda	0-2.5	0	30-35	75-80	605	37	652	18
Director of Corporate Affairs and Trust Secretary	Justine Fitzjohn	0-2.5	0-2.5	25-30	55-60	532	52	593	15

Payments for loss of office
None in 2025/26

Payments to past senior managers
None in 2025/26

Staff report

Workforce profile: staff numbers *subject to audit

Average number of employees (WTE basis)	2025/26 Total Number	2025/26 Permanent Number	2025/26 Other Number	2024/25 Total Number	2024/25 Permanent Number	2024/25 Other Number
Medical and dental	**205**	197	8	**202**	192	10
Ambulance staff	**0**			**0**		
Administration and estates	**728**	728		**727**	726	1
Healthcare assistants and other support staff	**637**	634	3	**583**	576	7
Nursing, midwifery and health visiting staff	**1,168**	1,164	4	**1,150**	1,142	8
Nursing, midwifery and health visiting learners	**19**	19		**26**	26	
Scientific, therapeutic and technical staff	**415**	415		**431**	431	
Healthcare science staff	**0**			**0**		
Social care staff	**25**	25		**26**	26	
Other	**0**			**0**		
Total average numbers	**3,197**	**3,182**	**15**	**3,145**	**3,119**	**26**
Of which: number of employees (WTE) engaged on capital projects	**5**	5		**9**	9	

*Current year excludes Chair/Non-Executives, prior year includes

Workforce profile: staff costs *subject to audit

(Figures in £000)	2025/26			2024/25		
	Total	Permanently employed	Other	Total	Permanently employed	Other
Salaries and wages	**143,474**	**142,371**	**1,103**	**134,056**	**134,056**	
Social security costs	**17,914**	**17,914**	**-**	**13,220**	**13,220**	**-**
Apprenticeship levy	**694**	**694**	**-**	**657**	**657**	**-**
Employer contributions to NHS Pension Scheme	**18,086**	**18,086**	**-**	**16,946**	**16,946**	**-**
Employer contributions paid by NHSE on providers' behalf	**11,784**	**11,784**	**-**	**11,052**	**11,052**	**-**
Other pension costs	**-**	-	-	**-**	-	-
Other post-employment benefits	**-**	-	-	**-**	-	-
Temporary staffing (External Bank)	**-**	-	-	**-**	-	-
Temporary staffing (Agency/Contract)	**2,537**	-	**2,537**	**5,089**	-	**5,089**
Termination benefits	**1,135**	**1,135**	**-**	**-**	-	-
Total Gross Staff Costs	**195,624**	**191,984**	**3,640**	**181,020**	**175,931**	**5,089**
Of the total above:						
Charged to Capital	**397**	-	-	**532**	-	-
Employee benefits charged to revenue	**195,227**	-	-	**180,488**	-	-

Breakdown of employees by age, disability, gender and other characteristics

	Headcount	FTE	Workforce %
Trust			
Employees	3508	3064.61	-
Staff Group			
Add Prof Scientific and Technic	232	201.17	6.61%
Additional Clinical Services	678	603.61	19.33%
Administrative and Clerical	644	550.35	18.36%
Allied Health Professionals	255	219.62	7.27%
Estates and Ancillary	226	167.59	6.44%
Medical and Dental	184	165.17	5.25%
Nursing and Midwifery Registered	1277	1145.09	36.40%
Students	12	12.00	0.34%
Age			
16-20	14	10.85	0.40%
21-30	457	431.15	13.03%
31-40	916	817.13	26.11%
41-50	924	824.63	26.34%
51-60	869	744.14	24.77%
61-70	312	228.06	8.89%
71 and above	16	8.65	0.46%
Disability			
Declared Disability	445	383.39	12.69%
No Declared Disability	3063	2681.22	87.31%
Ethnicity			
White – British	2445	2106.20	69.70%
White – Irish	23	17.90	0.66%
White – any other White background	69	60.69	1.97%
White Northern Irish	1	1.00	0.03%
White unspecified	7	4.49	0.20%
White English	11	8.65	0.31%
White Scottish	1	0.80	0.03%
White Cornish	1	1.00	0.03%
White Turkish	1	0.80	0.03%
White Mixed	2	2.00	0.06%
White Other European	2	1.40	0.06%
Mixed – White and Black Caribbean	26	24.21	0.74%
Mixed – White and Black African	13	12.00	0.37%
Mixed – White and Asian	27	23.89	0.77%
Mixed – Any other mixed background	12	10.94	0.34%
Mixed – Black and White	1	0.40	0.03%
Asian or Asian British – Indian	204	175.87	5.82%
Asian or Asian British – Pakistani	98	82.24	2.79%
Asian or Asian British – Bangladeshi	6	5.59	0.17%
Asian or Asian British – any other Asian background	12	11.60	0.34%
Asian Punjabi	2	1.67	0.06%
Asian Sri Lankan	1	1.00	0.03%
Asian Tamil	2	1.80	0.06%
Asian Sinhalese	1	1.00	0.03%
Asian British	1	0.83	0.03%
Asian Unspecified	1	1.00	0.03%
Black or Black British – Caribbean	60	53.12	1.71%

	Headcount	FTE	Workforce %
Black or Black British – African	367	354.21	10.46%
Black or Black British – any other Black background	11	10.00	0.31%
Black Mixed	1	1.00	0.03%
Black Nigerian	9	8.80	0.26%
Black British	4	3.60	0.11%
Chinese	10	8.80	0.29%
Any Other Ethnic Group	23	20.89	0.66%
Filipino	2	2.00	0.6%
Not Stated	51	43.21	1.45%
Gender			
Female	2767	2383.11	78.88%
Male	741	681.50	21.12%
Gender breakdown			
Female Director/CEO	3	3.00	42.86%
Male Director/CEO	4	4.00	57.14%
Female Senior Manager Band 8c and above	28	25.88	65.12%
Male Senior Manager Band 8c and above	15	14.60	34.88%
Female Employee other	2736	2354.22	79.12%
Male Employee other	722	662.90	20.88%
Religious Belief			
Atheism	703	625.00	20.04%
Buddhism	24	22.01	0.68%
Christianity	1504	1320.73	42.87%
Hinduism	61	56.39	1.74%
Not stated	602	503.92	17.16%
Islam	136	118.28	3.88%
Jainism	2	2.00	0.06%
Judaism	6	6.00	0.17%
Other	397	350.07	11.32%
Sikhism	73	60.21	2.08%
Sexual Orientation			
Bisexual	69	64.09	1.97%
Gay or Lesbian	89	81.32	2.54%
Heterosexual or Straight	2972	2610.34	84.72%
Undecided	10	7.20	0.29%
Other not listed	14	13.37	0.40%
Not Stated	354	288.28	10.09%

Sickness absence data

Sickness absence data for 2025/26 is published by NHS Digital at this location:
NHS Sickness Absence Rates - NHS Digital

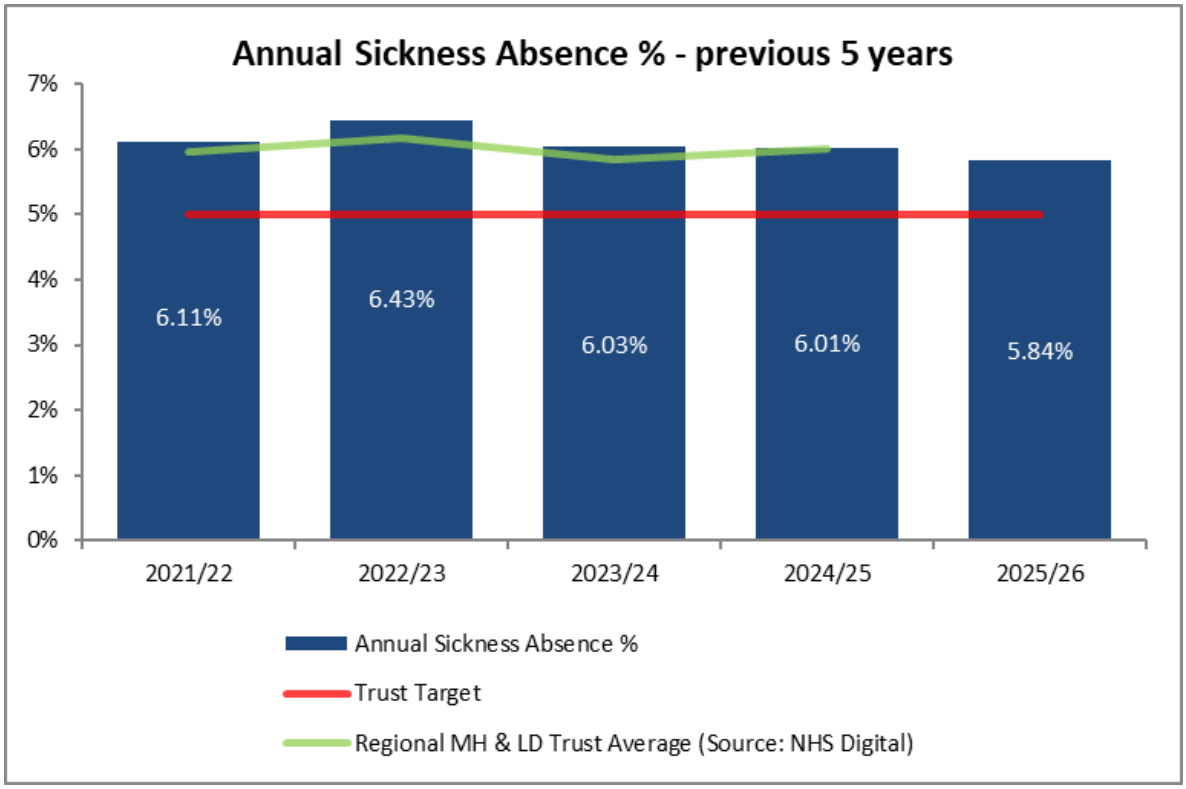
We continue to work with colleagues to support their health and attendance at work. The annual sickness rate for 2025/26 was 5.84% which is 0.17% lower than the previous year.

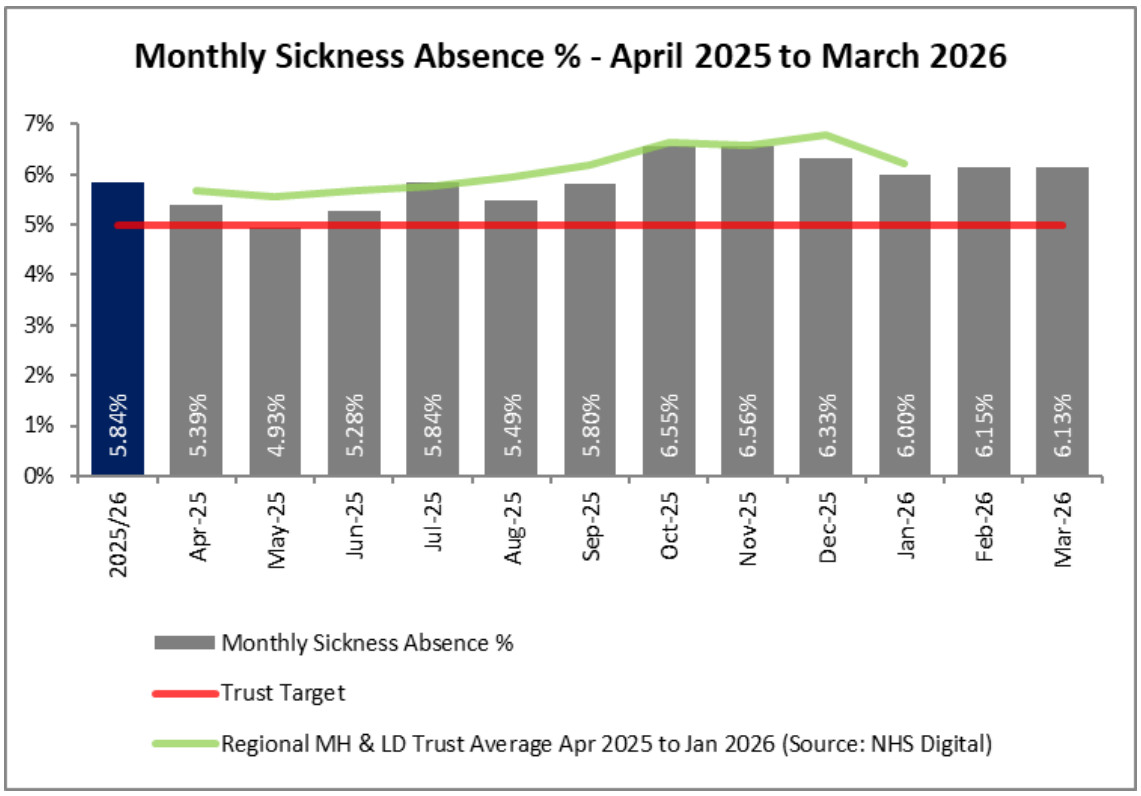
In line with experiences across other NHS trusts nationally, anxiety, stress, depression and/or other psychiatric illnesses remains the Trust's highest reason for sickness absence and accounted for 36.08% of all sickness absence during 2025/26, followed by cold, cough, flu-influenza at 9.08% and 'other known causes' not elsewhere classified (includes surgery) at 8.82%.

For colleagues who are unable to attend work we have a range of support, which we are reviewing to ensure it means the needs of both individual colleagues who are off work and managers supporting colleagues.

Average FTE for 2025	Adjusted FTE days lost to Cabinet Office definitions	Average sick days per WTE
3025	38,188	12.6

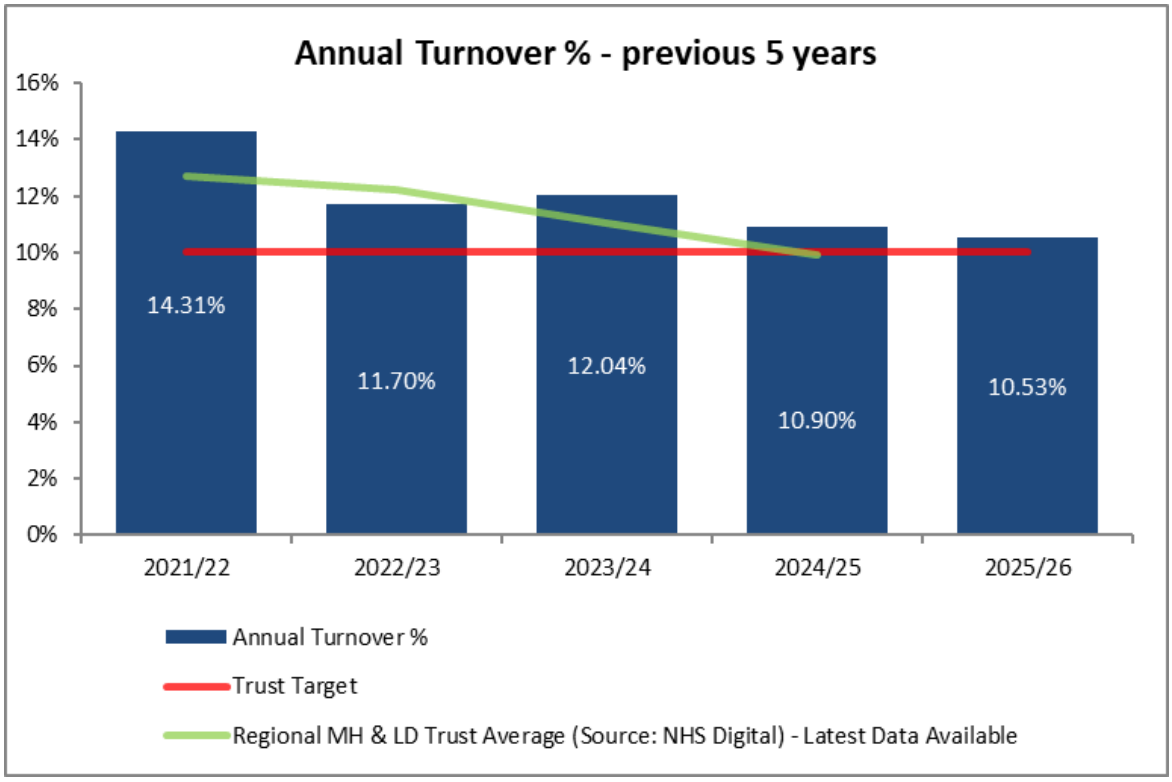
Table above: Source: NHS Digital – Sickness Absence Publication – based on data from the ESR Data Warehouse
Period covered: January to December 2025

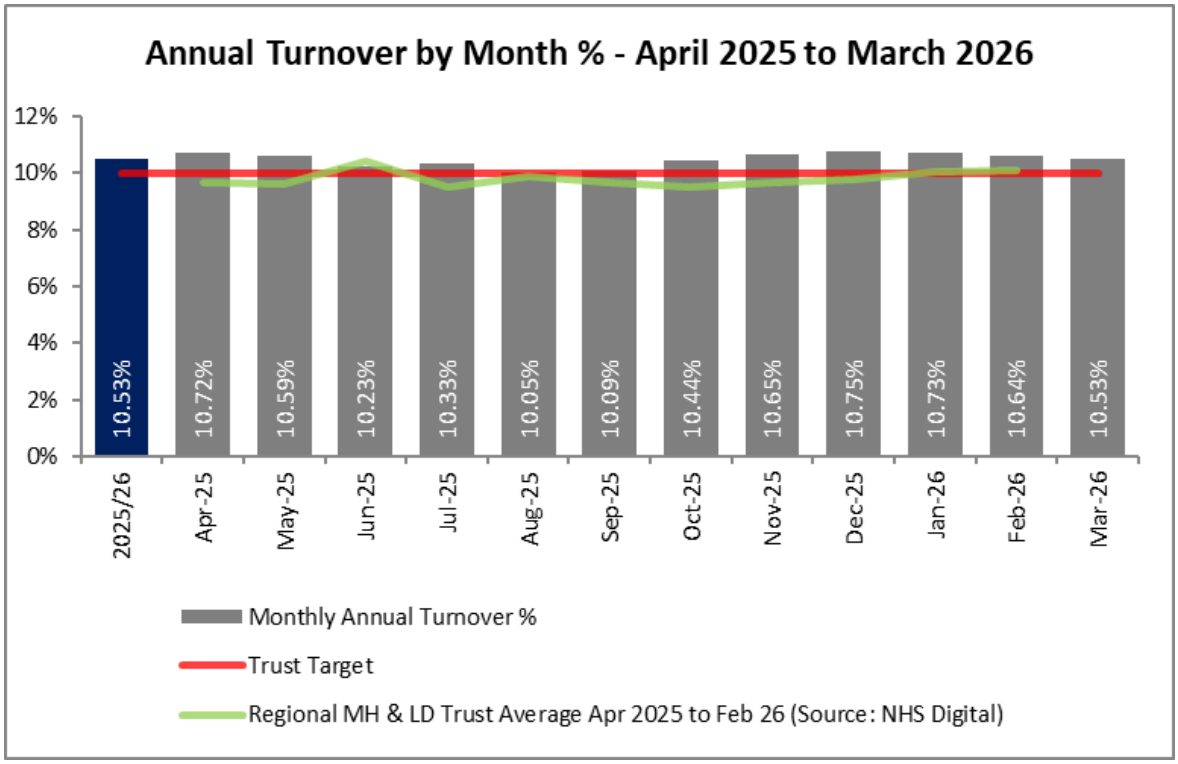




Turnover data

Turnover data for 2025/26 is published by NHS Digital at this location:
[NHS workforce statistics - NHS Digital]





Dedicated Occupational Therapists receive national award for 40+ years of outstanding contributions to the profession

Two NHS Occupational Therapists who work with local children across Derby and Derbyshire were presented with a Merit Award by the Royal College of Occupational Therapists (RCOT). The award recognises person's contribution to the profession on either a local or regional scale, in a specialist field of practice or in a diverse area of practice.

Elaine Rickett, a Community Paediatric Occupational Therapist, and Janet Taylor, Occupational Therapist for the Children and Young Adults Therapy Team at the Trust, have each showed leadership, innovation and a lasting impact on practice and service delivery throughout their longstanding careers, championing person-centred care, advancing inclusive practice, and mentoring the next generation of occupational therapists.

Staff Health and Wellbeing

The Trust is committed to supporting the health and wellbeing of its staff. We recognise that a healthy, engaged workforce is vital for delivering safe, high-quality care and fostering an inclusive, positive workplace culture. Our approach prioritises personalisation, continuous improvement, and collaboration, ensuring our staff have access to effective support and opportunities to thrive. This is our approach:

Staff wellbeing remains a key organisational priority, underpinning patient safety, service quality, and staff retention. National trends and local data indicated rising stress levels and the importance of proactive mental health interventions. In response, we have strengthened our wellbeing offer, ensuring it reflects staff voices, emerging best practice, and evolving needs.

This year, we hosted our first Wellbeing Champion's Conference, which brought together staff from across the Trust to share best practice and develop new skills. During the event, we launched a new champion's model, including mental health and women's health champions, with recruitment underway.

To improve mental health support, we introduced a dedicated suicide awareness intranet page providing guidance, training, and signposting for both managers and staff.

Recognising the importance of daily wellbeing, we developed a 'Pause, Play, Connect' resource to encourage everyday wellbeing and strengthen team connections. The resource offers a range of simple, accessible activities designed to help teams build in moments to pause, reconnect and look after their wellbeing during the working day. By promoting self-care, reflection and social connection, the resource supports a positive team culture and helps staff to prioritise wellbeing in a practical and sustainable way, even during periods of high demand.

The inclusion of wellbeing questions in the National Quarterly Pulse Survey has provided invaluable insights, allowing us to tailor our wellbeing initiatives with greater precision. Encouragingly, over 72% of staff have engaged in a wellbeing conversation within the past six months, and despite ongoing pressures, 79% report that they sometimes, often, or always take a break during their working day. Notably, the most common aspirational changes identified by staff were aimed at becoming healthier through weight management and increased physical activity. To support these aspirations, Body MOT clinics were

delivered across approximately ten Trust sites during the year, engaging around 100 members of staff. The Body MOTs provided colleagues with key health metrics, including blood pressure, percentage body fat and visceral fat levels, creating an opportunity for informed and meaningful conversations about lifestyle changes. This personalised approach enabled staff to better understand their physical health and facilitated timely signposting to appropriate support for physical activity, mental health and menopause, helping to promote early intervention, self-management and sustained wellbeing.

We commissioned and continued to deliver a wide range of training, including new sessions from Futureproof on neurodiversity, mental health awareness, menopause in the workplace, and more. Participants consistently rated the wellbeing workshops as excellent, finding the content highly relevant, engaging, and informative, with practical tools particularly helpful.

During the year, we continued to deliver wellbeing conversations training and stress workshops to support both managers and staff to recognise, discuss and respond to wellbeing concerns at an early stage. The training focused on building confidence to have open, supportive conversations about wellbeing, stress and mental health, alongside practical tools to help individuals manage pressure and maintain resilience at work.

In the summer of 2025, we proudly introduced our new men's health peer support group, 'Getting over the hump'. This initiative was designed to create a welcoming and confidential space where male colleagues could openly discuss their wellbeing, share experiences, and offer mutual encouragement. By fostering a supportive environment, the group aims to break down barriers surrounding men's health and ensure that everyone feels comfortable seeking and providing support when it's needed most.

Looking ahead, the Trust remains committed to the wellbeing of its colleagues and will continue to work with key stakeholders to shape and tailor wellbeing approaches that respond to the evolving needs of the organisation.

Policies and actions related to staff with impairments and/or long-term health conditions:
In 2025/26, significant improvements have been made to the support offered to managers of colleagues with long term health conditions, and to the colleagues themselves. The Trust intranet site now has a dedicated section explaining what reasonable adjustments are, makes suggestions as to the kinds of things that can be considered and signposts to external resources. This guidance was written in partnership with Staff Side colleagues and members of the Disability and Wellness Network group (DAWN), helping to ensure that the contents were representative of those with lived experience of long-term health conditions.

This year, we have also improved the processes to be followed when colleagues need something purchasing, as part of their reasonable adjustments. A centralised budget has been established, and this alone has significantly improved the responsiveness of the Trust in providing reasonable adjustments. Additionally, a single-sign-on portal has been developed by the DAWN group and our internal IT specialists. This creates a single point of access to request items, protects confidentiality in a far more robust manner that prior processes, facilitates communication between employees, line managers and the teams providing the equipment. It improves visibility of requests to those that need it, and clear lines of accountability. This system is currently being demonstrated to local trusts, with the potential for the system to be replicated by their own IT teams.

We were also pleased to launch an online channel for managers that focuses solely on the complexities of absence management. In this channel, Employee Relations colleagues post bite size training sessions on key topics, in order that they are accessible to all staff, inside and outside of core hours. This is starting to generate its own momentum and community, as

more experienced managers share experience and best practices with less experienced colleagues, with HR professionals providing oversight and assurance.

Last year's Annual Report stated that the Trust continues to review its current aspirations and commitments and are specifically reviewing work packages in relation to the development of a just and learning culture. This commitment is reaffirmed and significant progress has been made in 2025/26. Our Dignity at Work and Grievance Policies have been replaced by a single Respectful Resolution Policy. This places a far greater emphasis on the informal resolution of conflict, since data shows that whilst formal processes are essential in some cases, over-reliance on this approach rarely delivers positive outcomes for those involved, whereas skilful and genuine efforts at informal resolution are much more likely to lead to outcomes considered satisfactory to the individuals concerned. This process has been developed in conjunction with A Kind Life Ltd.

Linked to the implementation of the Respectful Resolution Policy, the Trust in 2025 launched a programme of Active Bystander training programmes, with the aspiration to roll this out across all teams, on an ongoing basis. This programme delivers the approaches that underpin the realisation of informal resolution to conflict. It empowers individuals to have their own voice and gives the tools to frame conversations about conflict to deliver win/win outcomes.

The Trust operates a Guaranteed Interview Scheme, which allows anyone with a disability to have a guaranteed invitation to interview if they meet the essential eligibility criteria as listed in the person specification. The Trust has achieved Disability Confident Employer Level 2 status as part of the Disability Confident Scheme which focuses on the key themes of getting the right people for our business and keeping and developing our people. The Trust is working towards achieving the Level 3 Disability Confident Leader to draw from the widest possible pool of talent, and ensuring we are securing, retaining and developing disabled staff.

Involving and engaging staff

Staff engagement and internal communications have continued to be a priority for the Trust this year, with staff having access to a wide range of channels and engagement opportunities.

Each month the Trust holds a virtual engagement hour, featuring updates and conversations on a range of different topics, proving a valuable opportunity to share best practice and innovations. All staff are invited to attend and attendance and participation at these events continues to grow.

The involvement of colleagues in key areas of work including the Making Room for Dignity (MRFD) programme has continued over the last year, ensuring that colleagues have the opportunity to shape and influence important projects that will shape the future delivery of Trust services.

A new operating model has been in development this year, with new divisional structures coming into effect from 24 November 2025. Consultation and engagement have taken place with affected colleagues, with the changes continuing to be reflected in wider services and the Trust's management structures.

Focused conversations take place on topics that colleagues have identified as being important, including violence, abuse and aggression experienced from people being supported by our services. This includes issues of sexual safety, racism and wider discrimination. During the year the Trust also undertook focused engagement with colleagues during times of community unrest, producing clear guidance to escalate any concerns that were racist or discriminatory.

Using the results of the 2025 NHS Staff Survey (page 138), we are working with colleagues to make improvements in response to the feedback received. This includes a focus on two key areas – making the Trust a better place to receive care and making the Trust a better place to work.

Engagement through our staff networks
The Trust's staff networks have continued to meet regularly throughout the year, offering guidance, support and an opportunity to increase wider understanding of inclusion across the Trust.

Our staff networks have an important role in sharing information and celebrating significant events and awareness days throughout the year, promoting positive inclusive messages to our staff and potential future workforce. Examples of awareness campaigns this year have included Black History Month, LGBTQ+ History Month, Neurodiversity Celebration Week, National Race Quality Week, Disability History Month, Armed Forces Day and International Women's Day. Important religious and spiritual events have also been celebrated, with information shared to raise awareness of different faiths and cultures.

To coincide with South Asian Heritage Month, the BME Staff Network was relaunched in a virtual celebration event. Over 50 colleagues attended to hear the network's story and how recent changes to the leadership of the group and a practical workplan have allowed the network to move forward.

Involving staff in the performance of the Trust
All Trust employees have access to information regarding the performance of the Trust. The public Trust Board papers are available on the Trust website and a summary of the discussions (including staff and patient experiences) are shared on the Trust's website and through internal communication mechanisms. Staff are also invited to observe Trust Board and Council of Governors meetings, which are held in public.

Remembering our colleagues
Sadly, the Trust lost a small number of colleagues throughout the year. Kevin Bagshaw, Emma Thomson and Richard Day will be remembered in the memorial garden at Kingsway Hospital.

Staff engagement events:

Annual staff conference
In 2025 the theme for our annual staff conference was 'adapting to a changing landscape'.

Jo Salter MBE was the event's guest speaker. Jo reflected on her experience as the UK's first female fast jet pilot, relating her experiences to the challenges currently faced in the NHS. Jo spoke about her career to date, the barriers she has faced and the lessons we can all learn about how to influence and adapt to changes that affect us personally and professionally. She also spoke about the importance of teams embracing and adapting to change together, with "no one being left behind, unless they choose to be".

A number of important conversations took place on the day as attendees discussed the changes that were important at the time, the many achievements collectively made since the last Staff Conference, and the digital initiatives we have in place across the Trust.

This year the staff conference was funded by sponsorship monies. Thank you to our sponsors Browne Jacobson, Patchwork and TPP.

Jo Salter MBE and Mark Powell CEO

Digital Futures Day
In November 2025, the Trust's first Digital Futures Day took place at Chesterfield Football Club, supported by several technology companies. The day followed a fictional patient pathway accessing mental health services and we followed their journey through our services from their

initial mental health needs and community-based support, through to inpatient admission and discharge. There were lots of innovative conversations and potential solutions explored, which could improve our processes and patient outcomes.

The highlights and priorities from the Digital Futures Day have shaped the development of a new Trust-wide Digital Plan. Further events are planned for 2026/27.

Honouring Exceptional and Really Terrific Staff (HEARTS) awards
October 2025 saw the return of the Trust's popular HEARTS awards, highlighting the fantastic work of colleagues over the last year. A record number of staff were nominated in each of the award categories, with members of the public nominating colleagues in the Making a Positive Difference award category, for making a positive difference to people's lives and embodying the Trust's values.

Congratulations to everyone who was nominated and recognised in the HEARTS awards.

Our 2025 winners included:

- Clinical Team of the Year Award – Bolsover Older Adult Community Mental Health Team (CMHT)
- Non-Clinical/Corporate Team of the Year Award – Capital Projects and MRFD programme team and Estates and Facilities department
- Making a Positive Difference Award – Amanda Alston, Forensic Community Mental Health Team.
- Patient Focus Award – Children in Care and Adoption team
- Productivity and Innovation Award – Erica Screaton and the Occupational Therapy team at the Derwent Unit
- Partnership and Collaboration Award – Lynn Dunham, Clinical and Quality Directorate
- Outstanding Care and Compassion Award – Dr Saladi Sudhakar, Erewash Community Mental Health Team – Outpatients
- Rising Star Award – Oluyomi Ladapo, Cubley Court Male
- Inclusive Leader Award – Nicole Ellis, MRFD programme team
- Lifetime Achievement Award – Angela Rafferty, Electroconvulsive Therapy (ECT) Suite team.

Thank you to Hill Dickinson, Kier Construction and Arden Partnership who sponsored the 2025 HEARTS awards.

In October 2026, the Trust will be holding the HEARTS Awards in an external venue, to allow more teams and colleagues to be invited and celebrated and widen the number of external guests. We will continue to seek sponsorship to cover the costs of the HEARTS Awards.

The Trust's Delivering Excellence Every Day (DEED) staff recognition scheme continues to be very popular and 2025/26 saw a record number of nominations from both colleagues and members of the public. We continue to have a monthly winner chosen by the Executive Leadership team and promoted on our internal channels.

Board visits
All members of the Trust's Board of Directors regularly visit teams to discuss current challenges and priorities, meeting colleagues and people using our services. Attendance from members of the Council of Governors and experts by experience are also welcomed.

In addition, regular informal staff engagement visits undertaken by the Chief Executive and Executive Directors, alongside wider visits for example including the annual Christmas decorations competition.

"Stress is the body's way of responding to challenges. It is not always a bad thing" – local Safe Haven shares tips on combatting stress as part of Stress Awareness Month

Stress Awareness Month (1-30 April) is an opportunity to raise awareness around stress management and combating the stigma of stress and mental health issues. Last year's theme was 'lead with love' campaigning to encourage kindness, compassion, and acceptance, no matter the challenges we face. Local organisations including the Trust recognise the importance of mental health to support residents' overall health and wellbeing. These local organisations worked together to ensure that local people are aware of simple ways to help reduce stress, and the sources of support available if stress becomes too much to manage.

As part of the awareness day, the Trust spoke with Derby Safe Haven, run by charity Waythrough (formerly known as Richmond Fellowship), who provide out-of-hours support on a self-referral basis every day of the week between 4.30pm to 12.30am for anyone struggling and needing a friendly face to talk to. Lucy Jantschenko, Team Manager at Waythrough, shared tips on ways to better manage stress.

Freedom to Speak Up

The Trust employs a Freedom to Speak Up Guardian (FTSUG) who provides a confidential and impartial source of support for staff to raise concerns safely and without fear of reprisal. The FTSUG is supported by a network of Speaking Up Champions located across the Trust who can offer guidance and support to colleagues wishing to raise concerns.

Staff are encouraged, in the first instance, to raise work related concerns with their line manager or someone within their management chain. However, concerns relating to any aspect of working life can also be raised directly with the FTSUG. Staff may also contact the Chief Executive, who is the executive lead for speaking up across the Trust, an Executive Director, or the designated Non-Executive Director (NED) with responsibility for Freedom to Speak Up.

Staff may also raise concerns with external organisations. Information on external bodies and how to contact them is available in the Trust's Freedom to Speak Up Policy and on the staff intranet.

The role of the FTSUG is promoted through a range of internal communication channels, including regular staff communications and the staff intranet. The Trust also supports Speak Up Week, held annually in October, to raise awareness of speaking up and promote the network of Speaking Up Champions. The FTSUG delivers training across the Trust and holds drop-in sessions at various sites to provide staff with opportunities to seek advice or raise concerns.

The Trust's commitment to speaking up is highlighted during corporate induction, where the FTSUG delivers a presentation to new starters outlining the support available and the routes for raising concerns.

For staff who may find it difficult to speak up directly, or who wish to raise concerns anonymously, alternative routes are available. Staff can access the Freedom to Speak Up raising concerns button on the staff intranet or contact the FTSUG in writing.

Feedback to those who speak up

The Trust aims to address concerns promptly and to ensure individuals who raise concerns are kept informed and supported throughout the process. While most concerns are managed within agreed timescales, the Trust recognises that in some circumstances timeframes may need to be extended and this will be communicated where possible.

The FTSUG aims to:

- Respond to individuals who raise concerns within five working days
- Ensure individuals receive feedback on the concerns they have raised.

Protecting staff who speak up

The Freedom to Speak Up Policy states that staff who raise concerns must not experience detriment or inappropriate treatment as a result of speaking up.

Where concerns about detriment or inappropriate behaviour are identified, the Trust will ensure allegations are investigated promptly and fairly and that appropriate action is taken. The Trust will not tolerate any attempt to coerce, intimidate or bully an employee into not speaking up. Such behaviour would represent a breach of Trust values and may result in disciplinary action.

The Trust is committed to fostering a positive speaking up culture by addressing barriers to raising concerns and promoting psychological safety so that staff feel supported and confident to speak up. Staff may raise concerns confidentially, and the Trust recognises that in some circumstances individuals may wish to remain anonymous.

Protecting staff
Work continues providing evidence of key standards being met in accordance with the Health and Safety at Work Act 1974, the Regulatory Reform (Fire Safety) Order 2005, and Security Management Standards.

Nine incidents occurred during 2025/26 which were reported to the Health and Safety Executive under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). Of the five incidents, four resulted in over seven days absence from work, four were specified major injury's, (fractured bone).

The Trust's Health and Safety Training Framework (detailing compliance with training that supports the achievement of the strategic objectives) continues to be delivered to a high standard, ensuring that training as a control measure is effective and adequately reduces risk.

Compliance is reported to the Trust's Health and Safety Committee on a quarterly basis. This Committee has continued to meet quarterly throughout the year and includes robust representation from recognised Trade Union bodies. The Committee demonstrates effectively the requirement to consult and communicate on all health and safety related matters. The Committee has a detailed documented work plan to ensure effective business is undertaken and completed.

Competency	Does not meet requirement	Meets requirement	Grand total	Compliance %
Fire warden (three yearly)	59	269	328	82%
Fire safety (two yearly)	149	3155	3304	95%
Health and safety awareness (three yearly)	163	3155	3304	85%

Occupational health
The Trust provides occupational health support to staff through a wider health wellbeing offer, as outlined in the Staff Report.

"When you get the help you need, you realise you are worth something": Leroy urged people to speak up when they're feeling down for Mental Health Awareness Week

Leroy, a patient at the Trust, has opened up about his battles with his mental health which stretch back nearly 40 years.

Diagnosed with bipolar disorder, he was admitted to inpatient units with the Trust many times during his life. Leroy shared his story as part of Mental Health Awareness Week.

Expenditure on consultancy
Consultancy fees incurred in 2025/26 were £0 (2024/25 £0).

Off-payroll arrangements
The Trust has had no off-payroll engagements since 2022/23.

Table 1: Highly paid off-payroll worker engagements as at 31 March 2026 earning £245 per day or greater

Number of existing engagements as of 31 March 2026	0
Of which:	
Number that have existed for less than one year at the time of reporting	0
Number that have existed for between one and two years at the time of reporting	0
Number that have existed for between two and three years at the time of reporting	0
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of reporting	0

Table 2: All highly paid off-payroll workers engaged at any point during the year ended 31 March 2026 earning £245 per day or greater

Number of off-payroll workers engaged, during the year ended 31 March 2025	0
Subject to off-payroll legislation and determined as out-of-scope of IR35	0
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: number of engagements that saw a change to IR35 status following review	0

Table 3: For any off-payroll engagements of Board members, and/ or senior officials with significant financial responsibility between 1 April 2025 and 31 March 2026

Number of off-payroll engagements of board members and/or senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure includes both off-payroll and on-payroll engagements.	18

Exit packages 2025/26*

Exit package cost band	No. of compulsory redundancies 2025/26	No. of other departures agreed 2025/26	Total no. of exit packages by cost band 2025/26	No. of compulsory redundancies 2024/25	No. of other departures agreed 2024/25	Total no. of exit packages by cost band 2024/25
<£10,000		9	9		15	15
£10,000 – £25,000		6	6		4	4
£25,001 – £50,000	1	3	4		6	6
£50,001 – £100,000		1	1			
£100,001 – £150,000		1	1			
£150,001 – £200,000		4	4			
>£200,000						
Total number of exit packages by type	1	24	25	0	25	25
Total resource cost (£000)	43	1092	1135	0	362	362

* Subject to audit

Exit packages: non-compulsory departure payments

	Agreements number 2025/26	Total value of agreements £000 2025/26	Agreements number 2024/25	Total value of agreements £000 2024/25
Voluntary redundancies including early retirement contractual costs	9	880	1	4
Mutually agreed resignations (MARS) contractual costs	9	180	12	271
Early retirements in the efficiency of the service contractual costs				
Contractual payments in lieu of notice	6	32	12	87
Exit payments following Employment Tribunals or court orders				
Non-contractual payments requiring HM Treasury (HMT) approval *				
Total	24	1092	25	362
Of which: non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

NHS Staff Survey 2025

Staff experience and engagement

The Trust is committed to creating a culture where all colleagues feel valued, heard, and supported. Our approach to staff engagement is underpinned by the NHS People Promise and focuses on continuous listening, meaningful engagement, and visible action in response to feedback.

We utilise a range of formal and informal listening mechanisms, including the annual NHS Staff Survey, National Quarterly Pulse Survey, engagement events, staff networks, Freedom to Speak Up, and direct engagement through leadership walkarounds and listening sessions. These mechanisms enable us to understand staff experience in real time and respond proactively to emerging themes.

To support engagement with the NHS Staff Survey, the Trust adopts a proactive and inclusive approach, including on-site engagement visits, virtual sessions, targeted communications, and weekly response rate updates to encourage participation. A prize draw was also done as an incentive to take part, alongside eye-catching visuals that highlighted the importance of staff feedback. These efforts contributed to a positive response rate and demonstrated our commitment to listening, learning, and acting on what matters most to our staff.

These activities are designed to ensure all colleagues have the opportunity to contribute and that feedback reflects the breadth of staff experience across the organisation.

NHS Staff Survey

The NHS Staff Survey is conducted annually. From 2022 onwards, the survey questions align to the seven elements of the NHS People Promise, alongside the two themes of staff engagement and morale. Indicator scores are reported on a scale of 0 to 10.

The response rate to the 2025 survey was 64% (2024: 64%, 2023: 62%, 2022: 48%), demonstrating sustained improvement in participation compared to previous years and continued strong engagement from colleagues across the Trust.

The Trust is benchmarked against organisations within the Mental Health and Learning Disability, and Mental Health, Learning Disability and Community Trusts benchmarking group.

Trust support worker of 30+ years receives prestigious Chief Nursing Officer Award for transforming care for patients with severe mental disorders

Only awarded exclusively to individuals who exemplify the highest standards of care, a Derbyshire-based NHS support worker was honoured with a national accolade from NHS England for demonstrating exceptional excellence within healthcare.

Anthony Newman, support worker at Kedleston Low Secure Unit at the Trust, was presented with a Chief Nursing Officer Award for demonstrating outstanding care and commitment to their work.

Summary of performance

Indicator	2025		2024		2023	
	Trust	Benchmark	Trust	Benchmark	Trust	Benchmark
We are compassionate and inclusive	7.68	7.61	7.75	7.63	7.80	7.65
We are recognised and rewarded	6.46	6.37	6.52	6.35	6.64	6.41
We each have a voice that counts	6.93	6.89	6.99	6.94	7.06	7.01
We are safe and healthy	6.44	6.34	6.52	6.40	6.55	6.40
We are always learning	5.90	5.83	5.93	5.93	6.02	5.93
We work flexibly	7.05	6.84	7.10	6.83	7.19	6.83
We are a team	7.33	7.17	7.32	7.15	7.32	7.18
Staff engagement	7.02	7.02	7.07	7.07	7.23	7.11
Morale	6.25	6.12	6.33	6.20	6.44	6.17

Commentary on key findings
The Trust continues to perform at or above the benchmarking group across all indicators, demonstrating a consistently positive staff experience relative to comparable organisations.

Response rates have remained strong at 64%, reflecting continued engagement with the survey and confidence that staff feedback will be heard and acted upon.

Strengths are evident in:

- We are a team (7.33) – indicating strong teamworking and collaboration across services
- We are compassionate and inclusive (7.68) – reflecting a positive and supportive organisational culture
- We work flexibly (7.05) – demonstrating continued progress in supporting flexible working arrangements

However, the survey shows a gradual decline over time in several indicators, particularly:

- Morale (6.25)
- We are safe and healthy (6.44)
- We each have a voice that counts (6.93)

While these scores remain above benchmark, the downward trend indicates areas requiring focused attention.

Actions to address areas of concern
In response to the survey findings and wider listening channels, the Trust has prioritised the following areas:

- Making the Trust a better place to receive care – making sure Derbyshire Healthcare is a place colleagues would recommend to their families and friends as a place to receive care, and that colleagues see patient care as our number one priority.
- Making the Trust a better place to work – making sure that colleagues feel supported, valued and safe while they are at work; that people want to stay working for the Trust and that the Trust is a place new colleagues want to come and work.

Future priorities and targets
The Trust has identified the following key priorities to improve staff experience:

- Improving morale and wellbeing, with a focus on psychological safety and workload pressures
- Enhancing staff voice and involvement, ensuring colleagues feel able to contribute to improvements
- Embedding a positive and inclusive culture, aligned to the NHS People Promise.

Monitoring and assurance
Progress against these priorities will be monitored through:

- Annual NHS Staff Survey results
- National Quarterly Pulse Survey data
- Workforce metrics (including turnover, sickness absence, and retention)
- Local team-level survey data and action plans
- Regular reporting through Trust governance structures.

The Trust will continue to use these insights to drive continuous improvement and ensure that staff experience remains a central priority.

UK first as Derbyshire psychiatry team visits House of Lords to launch toolkit on adding patient perspective to the teaching of student doctors

The Trust's team behind the largest 'expert patient' programme in medical education in the UK shared its secrets with the world, publishing a toolkit on how to improve the teaching of future psychiatrists by involving the real-world experiences of people with mental ill health in the curriculum.

The Derby Psychiatry Teaching Unit – part of the Trust – launched its Expert Patient Programme Toolkit at an event hosted by Lord Kamlesh Patel of Bradford at the House of Lords in June 2025.

2025 NHS Staff Survey
Results Summary

People Promise

NHS
Derbyshire Healthcare
NHS Foundation Trust

The national NHS Staff Survey presents feedback from colleagues aligned to the seven themes of the NHS People Promise. These themes are areas that are central to improving colleagues' experiences at work. Our Trust results are presented across these themes below, in addition to the Trust's overall scores for staff engagement and morale.

64%
Response rate
2024: 64%

We are compassionate and inclusive
7.7 ▼ LOWER THAN LAST YEAR
HIGHER THAN THE AVERAGE COMPARATOR SCORE: 7.6

We are recognised and rewarded
6.5 ▼ LOWER THAN LAST YEAR
HIGHER THAN THE AVERAGE COMPARATOR SCORE: 6.4

We each have a voice that counts
7.0 ▼ LOWER THAN LAST YEAR
HIGHER THAN THE AVERAGE COMPARATOR SCORE: 6.9

We are safe and healthy
6.4 ▼ LOWER THAN LAST YEAR
HIGHER THAN THE AVERAGE COMPARATOR SCORE: 6.3

We are always learning
5.9 ▼ LOWER THAN LAST YEAR
HIGHER THAN THE AVERAGE COMPARATOR SCORE: 5.8

We work flexibly
7.0 ▼ LOWER THAN LAST YEAR
HIGHER THAN THE AVERAGE COMPARATOR SCORE: 6.8

We are a team
7.3 THE SAME AS LAST YEAR
HIGHER THAN THE AVERAGE COMPARATOR SCORE: 7.2

Staff engagement
7.0 ▼ LOWER THAN LAST YEAR
EQUAL TO THE AVERAGE COMPARATOR SCORE: 7.0

Morale
6.3 ▼ LOWER THAN LAST YEAR
HIGHER THAN THE AVERAGE COMPARATOR SCORE: 6.0

Colleagues feedback

Thank you to everyone who completed the NHS Staff Survey in 2025.

The Trust is committed to making ongoing improvements in response to the feedback we have received from colleagues.

Your feedback continues to rate the Trust higher than average when benchmarked against other comparable organisations.

Team-level feedback has been shared, with a small number of local actions being identified that will make the most difference in your local areas of work.

This is in addition to Trust-wide actions, which include:

- **Making the Trust a better place to receive care**
- **Making the Trust a better place to work.**

Staff Friends and Family Test Scores

LAST YEAR 68% → 64%
Would recommend Derbyshire Healthcare as a place to work.

LAST YEAR 64% → 63%
Would be happy with the standard of care provided by this organisation If a friend or relative needed treatment.

We have been scored against each element compared to the average from the 48 other organisations in our benchmarking group

All elements are scored on a 0-10 scale, where a higher score is more positive than a lower score. The People Promise scores are generated by grouping the results from each question into sub-themes.

Equality Report – embedding equality, diversity and inclusion (EDI) (2025/26)

“Respect, dignity, compassion, and care should be at the core of how patients and staff are treated not only because that is the right thing to do, but because patient safety, experience and outcomes are all improved when staff are valued, empowered and supported.”

The Trust remains committed to embedding EDI across all aspects of its work. Our approach aligns with the NHS Constitution, the Equality Act 2010, and national priorities.

In line with the Public Sector Equality Duty (PSED), the Trust has had due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between different groups.

EDI is embedded within organisational governance, quality improvement, workforce strategy, and patient care, ensuring equality is central to both staff experience and service delivery.

Strategic framework and alignment
Our EDI work in 2025/26 is underpinned by national and local frameworks, including:

- NHS EDI Improvement Plan
- Workforce Race Equality Standard (WRES)
- Workforce Disability Equality Standard (WDES)
- Gender Pay Gap (GPG) Reporting
- Race Equality Action Plan
- Equality Impact Assessments (EIA).

These frameworks are embedded within governance structures and inform both strategic priorities and operational delivery.

Workforce equality and data driven improvement
The Trust continues to use WRES, WDES, and GPG data to identify inequalities, monitor trends, and drive targeted improvement.

Workforce Race Equality Standard (WRES)
The latest published 2024/25 WRES report demonstrates both progress and persistent inequalities:

- Workforce diversity has significantly increased, with 20.38% of staff from ethnically diverse backgrounds in 2025 (up from 12.6% in 2018)
- Despite this, only 4.9% of non-clinical staff at Band 8a+ are from ethnically diverse backgrounds, indicating underrepresentation at senior levels
- White candidates remain 1.81 times more likely to be appointed from shortlisting
- Ethnically diverse staff are 1.81 times more likely to enter formal disciplinary processes.

Staff survey data further highlights disparities:

- 19.3% of ethnically diverse staff report bullying from staff versus 14.9% of White staff
- Only 53.7% believe there are equal opportunities for progression versus 65.6% of White staff
- 14.8% report discrimination versus 5.1% of White staff.

At Board level, representation is more positive:

- 35.7% of Board members are from ethnically diverse backgrounds, compared to lower workforce representation.

These findings demonstrate progress in representation but ongoing inequalities in experience, progression, and processes.

Workforce Disability Equality Standard (WDES)
The 2024/25 WDES report highlights improvements alongside continued disparities:

- Disability declaration has increased to 11.53% in 2025 (from 4.5% in 2019), reflecting improved staff confidence
- Disabled staff remain underrepresented at Board level and senior leadership roles
- Staff experience data shows:
    - 43.4% of disabled staff feel valued versus 54.8% of non-disabled staff
    - 27.9% report bullying/harassment, higher than non-disabled colleagues
    - 13.6% feel pressure to work when unwell versus 9% of non-disabled staff
    - Lower confidence in equal opportunities for progression.

These findings highlight structural and cultural barriers impacting disabled staff experience and inclusion.

Gender Pay Gap (GPG)
The Trust's Gender Pay Gap (2024/25) reflects ongoing inequalities in pay distribution linked to workforce composition and representation at senior levels. Targeted actions are in place to improve progression and address occupational segregation.

Key barriers identified
Analysis across WRES, WDES and staff survey data identifies key organisational barriers:

- Underrepresentation of ethnically diverse and disabled staff at senior levels
- Disparities in recruitment and career progression
- Higher likelihood of disciplinary action for ethnically diverse staff
- Lower levels of inclusion, belonging and perceived fairness
- Higher rates of bullying, harassment and discrimination
- Cultural and structural barriers affecting workforce experience.

These barriers are being addressed through the Race Equality Action Plan and EDI Action Plan.

Equality of service delivery
In line with the Annual Reporting Manual (Section 2.24), the Trust promotes equality of service delivery through:

- Embedding EDI within service redesign and transformation programmes
- Applying Equality Impact Assessments (EIA) to identify and mitigate risks
- Improving culturally competent care and access for diverse communities
- Using patient feedback, complaints, and experience data to identify inequalities.

This ensures that equality is embedded across both workforce and patient outcomes.

Embedding equality in decision making (EIA)
Equality Impact Assessments (EIAs) are central to ensuring equitable decision making.

During 2025/26:

- EIAs are applied to all major service, workforce and policy decisions
- Findings are used to mitigate risks and shape service design
- EIAs are aligned with Quality Impact Assessments (QIA).

This ensures that equality considerations directly influence organisational decisions.

Staff experience and engagement
Staff survey data continues to inform priorities:

- Persistent disparities in bullying, discrimination and progression
- Targeted work to improve response rates in underrepresented groups
- Analysis by protected characteristics, team and site
- Use of qualitative feedback to inform local action plans.

Local EDI action plans are being developed with Divisional People Leads to address inequalities at team level.

EDI Action Plan delivery
The Trust's EDI Action Plan brings together national requirements and local priorities, including:

- Delivery of the Anti-Racism Strategy (launched October 2025)
- Implementation of inclusive recruitment practices
- Active bystander training and culture change initiatives
- Strengthening staff network engagement and coproduction
- Monitoring recruitment, progression and disciplinary data.

Actions are monitored through governance structures and the EDI Working Group.

Conclusion
The Trust acknowledges both progress made and areas requiring further improvement. Evidence from WRES and WDES demonstrates:

- Sustained improvement in workforce diversity and disability disclosure
- Persistent inequalities in staff experience, progression, and representation.

While representation at Board level has improved, disparities remain across career progression, disciplinary processes, and staff experience.

By embedding EDI within governance, decision making, and service delivery, and aligning with national frameworks and local action plans, the Trust is taking a structured and accountable approach to advancing equality.

We remain committed to fostering an inclusive culture where all staff feel valued and supported, and where all patients receive equitable, high-quality care. This work directly supports delivery of the Trust's People Plan, ensuring that equality, diversity and inclusion are embedded across workforce priorities including recruitment, retention, leadership development and staff experience, and that all improvement activity is aligned to creating a compassionate, inclusive and high performing organisation.

The Modern Slavery and Human Trafficking Act 2015
The Trust's Modern Slavery statement is published on the Trust website:
Modern_Slavery_Statement_-_2025-26.pdf

Disclosures set out in the Code of Governance for NHS Provider Trusts

The Trust has applied the principles of the Code of Governance for NHS Provider Trusts on a 'comply or explain' basis. The Code of Governance for NHS Provider Trusts was published in October 2022 and has been applicable since 1 April 2023. It replaced the NHS Foundation Trust Code of Governance.

The information in this report about our compliance or explanations for non-compliance with the Code of Governance is subject to review by the Trust's external auditors.

Requirements under the code for disclosure
The Trust discloses compliance with the Code of Governance where annual disclosure in the Annual Report is required. Those marked 'additional' are not in the Code but are added by the Annual Reporting Manual to supplement the requirements. Additional information has also been included as appropriate, to provide further detail on the Trust's compliance with the Code.

Reference	Summary of requirement	Disclosure/ additional information
A 2.1	The Board of Directors should assess the basis on which the Trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships.	Within the Annual Governance Statement and the Performance Section.
A 2.3	The Board of Directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the Trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the Trust's approach to investing in rewarding and promoting the wellbeing of its workforce.	Assurance through Well Led report and covered within the Staff Report. Accountability Framework.
A 2.8	The Board of Directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision making, and set out the key partnerships for collaboration with other providers into which the Trust has entered.	Within the Performance Section and Annual Governance Report.
B 2.6	The Board of Directors should identify in the annual report each Non-Executive Director considers to be independent.	Within the Directors' report.
B 2.13	The annual report should give the number of times the Board and its committees met, and individual director attendance.	Within the Directors' report.
B 2.17	Clear statement detailing the roles and responsibilities of the Council of Governors. The annual report should include this schedule of matters or a summary statement of how the Board of Directors and the Council of Governors operate.	Within the Accountability section of this report.
C 2.5	If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the Trust or individual directors.	Within the Remuneration Report.

C 2.8	The annual report should describe the process followed by the Council of Governors to appoint the Chair and Non-Executive Directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.	Within the Remuneration Report.
C 4.2	The Board of Directors should include in the annual report a description of each Director's skills, expertise and experience.	Within the Directors' report. For each vacancy, the Remuneration and Appointments Committee reviewed the structure, size and composition of the Board during the year to ensure that there is a broad mix of skills, knowledge, experience and diversity.
C 4.7	All Trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well Led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the Trust or individual directors.	Well Led Review completed in 2023/24 and one commissioned for delivery in 2026/27.
C 4.13	The annual report should describe the work of the nominations committee(s).	Within the Remuneration Report.
C 5.15	Foundation Trust Governors should canvass the opinion of the Trust's members and the public, and for Appointed Governors the body they represent, on the NHS Foundation Trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the Board of Directors.	Within the Council of Governors section.
D 2.4	The annual report should include: • The significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed. • An explanation of how the audit committee (and/or auditor panel for an NHS Trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • An explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	Within the Accountability section of this report and the auditor's report.

D 2.6	The Directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the Trust's performance, business model and strategy.	Within Statement of CEO responsibilities as Accounting Officer.
D 2.7	The Board of Directors should carry out a robust assessment of the Trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	Within Annual Governance Statement.
D 2.8	The Board of Directors should monitor the Trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The Board should report on internal control through the annual governance statement in the annual report.	Within Annual Governance Statement.
D 2.9	In the annual accounts, the Board of Directors should state whether it considered it appropriate to adopt the going-concern basis of accounting when preparing them and identify any material uncertainties regarding going concern.	See Going Concern Statement.
E 2.3	Where a Trust releases an executive director, e.g., to serve as a Non-Executive Director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	Not applicable in 2025/26.
Appendix B, para 2.3 (not in Schedule A)	The annual report should identify the members of the Council of Governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	Within the Council of Governors section.
Appendix B, para 2.14 (not in Schedule A)	The Board of Directors should ensure that the NHS Foundation Trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS Foundation Trust's website and in the annual report.	Within the Council of Governors section.
Appendix B, para 2.15 (not in Schedule A)	The Board of Directors should state in the annual report the steps it has taken to ensure that the members of the Board, and in particular the Non-Executive Directors, develop an understanding of the views of governors and members about the NHS Foundation Trust, e.g., through attendance at meetings of the Council of Governors, direct face to face contact, surveys of members' opinions and consultations.	Within the Council of Governors section.

Additional requirement of FT ARM resulting from legislation	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	Not applicable in 2025/26.

The Board of Directors confirms that in relation to those provisions within the Code of Governance for which the Trust is required to 'comply or explain,' the Trust was compliant throughout the year to 31 March 2026 in respect of those provisions of the code which had effect during that time, save exceptions and explanations outlined in the table above.

Derbyshire NHS team supporting Healthcare Support Workers shortlisted for national award for second year in a row

A workforce training team at the Trust were shortlisted for a national award, in recognition of its innovative approach to supporting the development of Healthcare Support Workers (HCSWs).

The iCARE Programme team at the Trust was selected as a finalist at the Nursing Times' Workforce Awards for its initiatives to support HCSW of all disciplines who work with individuals accessing mental health services in DHCFT. The team were shortlisted for the 'Workforce Team of the Year' category.

NHS Oversight Framework
The NHS Oversight Framework (NOF) is NHS England's (NHSE) framework for assessing health systems including providers. It promotes transparency, improvement, and helps identify potential support or intervention needs. The NOF was revised in 2025/26 as a transitional one-year framework aligned to national planning priorities, using a defined set of metrics covering operational delivery, quality of care, workforce, productivity and financial performance.

The framework will be reviewed in 2026/27 to incorporate work to implement the ICB operating model and to take account of the ambitions and priorities in the 10 Year Health Plan for England.

NHS organisations are allocated to one of five 'segments.'

Segmentation indicates performance and whether improvement is required, from high performing across all domains (Segment 1) to low performance across a range of domains (Segment 4). An organisation assessed as Segment 4 combined with a low capability to improve is allocated to Segment 5.

NHS England's oversight response to an organisation is based on:

a) Its segment derived from scored metrics under five performing domains (being access to services, effectiveness and experience of care, patient safety, people and workforce, and finance and productivity)

b) Considering financial override which may limit a segment to be no better than 3

c) Contextual metrics which are not scored (for example those under sixth domain of improving health and reducing inequality) and

d) Capability assessments which consider the organisation's leadership and governance.

Trust's segmentation
In 2025/26, NHSE delayed confirming provider segmentation positions to allow additional data testing. The Trust's back dated position for Quarter 1 was confirmed as Segment 4. Following the publication of Quarter 2 NOF data, the Trust was placed into Segment 3, acknowledging improvements in performance.
The Segment 3 descriptor is 'The organisation and/or wider system are off-track in a range of domains or are in financial deficit'.

The Trust is not in financial deficit; however, the focus of NOF meetings with NHSE and the ICB during 2025/26 has been on improving the following areas of operational performance:

- Waiting times to access our community services
- People's length of stay in our adult and older adult ward environments
- Access to services for children and young people
- Availability of our 24-hour, face to face crisis response.

During 2025/26, there has been significant progress in improving the quality of care, supported by the implementation of the Quality Assurance Framework and delivery of the Quality Delivery Plan, aligned to the Trust's Person focused Strategic Objective.

The Trust retains overall GOOD rating, in 2025/26 services inspected by CQC in comprehensive inspections included Wards for Older Adults, Rehab and Long Stay service, Crisis and Health Based Place of safety all improved and are rated Good across all domains. There has also been measurable improvement in operational performance, with further targeted plans in place to sustain progress and address remaining areas of variation.

Provider capability assessment
The Board submitted a provider capability self-assessment to NHSE in October 2025. NHSE agreed with the Trust's self-assessment and allocated an amber-green Provider Capability rating to the Trust. The outcomes of the has been considered by the Board and has directly informed Board development priorities and governance improvement actions.

This segmentation information is the Trust's position as at 31 March 2026. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website: https://www.england.nhs.uk/nhs-oversight-framework/segmentation-and-league-tables/. The Trust is included on the non-acute hospital trust dashboard.

New artwork created by local NHS perinatal mental health team and Derby & Burton Hospital's Charity Air Arts team, displayed at The Royal Derby Hospital

As part of the Derby & Burton Hospital's charity's Air Arts programme, the 'Belong' exhibition for 2025-2026 proudly features a heartfelt contribution from the Perinatal Mental Health (PMH) team at the Trust.

This year-long exhibition explored the theme of 'belonging' – a sense of identity, community and connection. The PMH display captures this.

Statement of Chief Executive's responsibilities as the Accounting Officer of DHCFT

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS England (NHSE).

NHSE has given Accounts Directions which require the Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- Confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy
- Prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Mark Powell
Chief Executive
18 June 2026

Annual Governance Statement
1 April 2025 – 31 March 2026

Scope of responsibility
As accounting officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of Trust policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS foundation trust accounting officer memorandum.

The purpose of the system of internal control
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Trust for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts.

Capacity to handle risk
Leadership of Risk Management Process

Management of risk underpins the achievement of the Trust's Strategy and related objectives. The Trust believes that effective risk management is imperative not only to provide a safe environment and improved quality of care for patients and staff, but it is also significant in the business planning process where public accountability in delivering health services is required. Risk management is the responsibility of all staff and managers.

Strong leadership is provided to the risk management process though the Trust Board which has overall responsibility for managing risk in the Trust and ensuring implementation of the Risk Management Strategy. The Board monitors strategic risks through regular review of the Board Assurance Framework report and receipt of reports from the Audit and Risk Committee which provides assurance to the Board regarding the continued effectiveness of the Trust's system of integrated governance, risk management and internal control. Compliance with the Risk Management Strategy is monitored through internal audit reviews, committee reporting and periodic thematic deep dive.

All Board committees have responsibilities to monitor and review risks relevant to their remit including the extent to which they are assured by the evidence presented with respect to the management of the risks. Each committee is responsible for escalating concerns regarding the management of significant risks to the Trust Board.

There are key roles on the Trust Board in relation to risk:

The Chief Executive Officer has overall responsibility for maintaining a sound system of internal control that supports the achievement of the Board's policies, aims and objectives, whilst safeguarding funds and assets

The Director of Corporate Affairs and Trust Secretary supports the Chief Executive Officer in their role as the Accounting Officer of the organisation and has responsibility for risk in relation to the corporate governance framework, compliance and assurance including the Board Assurance Framework. Day to day responsibility for risk management is discharged through the designated

accountability of other Executive Directors. Health and Safety risks also sit under their portfolio.

The Director of Nursing, Allied Health Professionals, Quality and Patient Experience and the Medical Director are the joint executive leads for quality and patient safety, responsible for patient involvement, safeguarding, infection control and professional standards for nursing and allied health professional staff. They have delegated responsibility for the risk management and assurance function.

The Medical Director is also responsible for the professional standards of medical staff within the Trust, serious incidents and data security and protection (including cyber security).

The Director of Finance has delegated responsibility for risks associated with the management, development and implementation of systems of financial risk management and the risks associated with the Trust's Estate.

The Chief Delivery Officer has delegated responsibility for risks associated with operational management including overall emergency planning and resilience and business continuity. They also have delegated responsibility for risks relating to local commissioning and partnership working, strategy and business development, and organisational transformation.

The Director of People, Organisational Development and Inclusion has delegated responsibility for risk associated with the delivery of an effective People Services function including workforce planning, staff welfare, recruitment and retention.

The Trust Chair and Non-Executive Directors exercise non-executive responsibility for the promotion of risk management through participation in the Trust Board and the Board committees. They are responsible for scrutinising systems of governance and have a role in this Trust as chairs of Board committees.

The Risk Management Strategy formalises risk management responsibilities for the Trust within a broad corporate framework and sets out how the public (and all stakeholders) may be assured that risks are identified and managed effectively. It guides staff in the application of that framework through the identification, evaluation and treatment of risk as part of a continuous process. The Risk Management Strategy also enables the development of a positive learning environment and risk aware culture.

<u>Risk Management Training</u>
Staff are trained to manage risks through an embedded tiered risk management training programme comprising of the following elements:

- Trust Board – Board Assurance Framework development – annual session
- How To Manage Safely (Health and Safety) risk training
- Datix training for teams (Datix is the Trust's incident/risk/complaints recording system)
- Datix – new risk handlers one-to-one training
- 'Bite size' sessions on how to report incidents are delivered through Micro Soft Teams to support staff.

Uptake is monitored and reported to the Health and Safety Committee and the Audit and Risk Committee and is monitored through operational lines.

In addition, many of the courses delivered by the Trust support effective risk management and

delivery of the Risk Management Strategy. Examples include:

- Safeguarding – children and adult
- Safety planning and suicide awareness
- Data security and protection
- Infection control and prevention
- Medicines management courses
- Fire – awareness and fire warden
- First aid at work
- Falls prevention
- Manual handling
- 'Positive and safe' and 'promoting safer therapeutic services'.

Trust-wide guidance is provided to staff to encourage learning from good practice. Examples include: a 'Blue Light' system of alert notifications to rapidly communicate information on significant risks that require immediate action to be taken; a monthly 'Policy Bulletin' informing staff of key themes within new or updated policies and procedures, a Safeguarding Information Sharing document, and a 'Practice Matters' publication which focuses on learning and sharing best practice.

The risk and control framework

Identification, Evaluation and Control of Risks

The Risk Management Strategy details the identification of risk to the Trust and its evaluation, control and transference and is supported by a range of policies and procedures. These include the Risk Assessment Policy and Procedures; Incident Policy and Procedure; Duty of Candour Policy and Procedures; Safety Needs Assessment and Management of Safety Needs Policy; Learning from Deaths Procedure; and Freedom to Speak Up Policy and Procedure. In addition, the Risk Management Strategy supports the implementation of the Corporate Governance Framework and Health and Safety at Work Policy. The Risk Management Strategy was formally reviewed and reissued at the end of 2025. The 2026-2029 strategy will run from January 2026 until March 2029. A progress update on achievements against the strategy's objectives is considered annually by the Audit and Risk Committee each October.

Risk identification is undertaken both proactively via risk assessments and reactively via incident reporting, complaints, claims analysis, internal and external inspection and audit reports. Risk evaluation is completed using a single risk matrix to determine impact and likelihood of risk realisation with grading of risk resulting from the overall matrix score. Risk control and treatment plans identify responsibility and authority for determining effectiveness of controls and development of risk treatment plans and actions.

All risks are detailed on a single electronic Trust-wide risk register (Datix). The exception is for risk assessments relating to individual patients which are recorded on patient record systems, and those relating to individual staff arising from workplace assessments which are retained alongside the staff record. The Datix risk register has inbuilt ward/team, service/care group, divisional and Trust-wide level risk registers reporting from this central hub and notification through automated escalation of risks (depending on the rating of the risk identified).

The risk appetite for the Trust is clearly articulated in the Risk Management Strategy in the form of a risk appetite statement. The risk appetite statement informs decision-making at Board and committee level, including the acceptance, mitigation or escalation of risks where residual exposure exceeds appetite. The risk tolerance levels linked to the risk appetite are shown as 'acceptable', 'tolerable in certain circumstances' and 'unacceptable', and the grading for each level is mapped against the Risk Assessment Matrix. The risk appetite for risks on the Board Assurance Framework report is articulated in the Risk Management Strategy. From 2026/27 a risk appetite rating will be presented against each principal risk within the Board Assurance

Framework report.

Incident reporting is openly encouraged and supported by an online incident reporting form, accessible to all staff, which includes a link to 'frequently asked questions'. 'Bite size' sessions on how to report incidents are delivered every two weeks by the Risk Management Team through Micro Soft Teams. Incident investigation involves robust systems for reporting and investigating incidents to identify areas for organisational learning and good practice.

All serious incidents are overseen by the Executive Director led Executive Incident Group or the Operational Incident Group, dependent on the level of investigation required. The Patient Safety Incident Response Framework (PSIRF) methodology is the adopted approach for the Trust. Summary reports are provided to the Quality and Safeguarding Committee including assurance of action plans being completed.

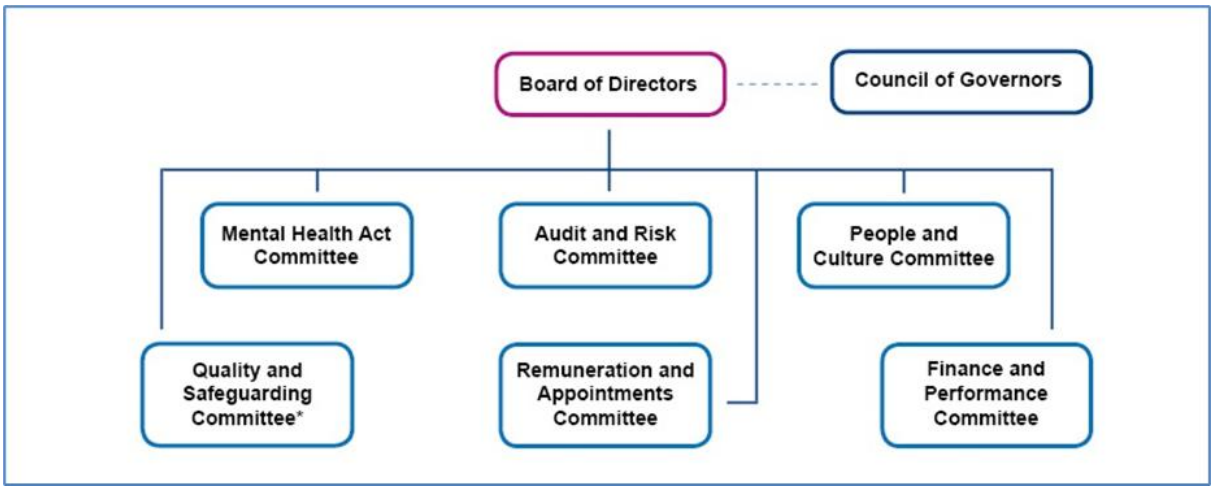
Quality governance arrangements

Overall responsibility for quality governance lies with the Trust Board, as part of its responsibility for the direction and operation of the Trust. The Board is supported in its role regarding quality governance by the Quality and Safeguarding Committee, which is constituted as a committee of the Board, led by a Non-Executive Chair and with both Executive and Non-Executive Director members.

Day to day oversight of quality governance is the responsibility of the Executive Leadership Team, with the leadership role in this area taken by the Director of Nursing, AHPs, Quality and Patient Experience. This is supported by the Medical Director, Deputy Medical Director, Clinical Directors, Deputy Director of Nursing and Patient Safety and the professional leads from within the nursing and patient experience teams. The Clinical and Quality Directorate supports quality governance in the Trust.

Trust governance structure

The Trust's governance structure is shown in the diagram below:



A summary of the key responsibilities of the Board committees in relation to risk management is detailed next:

The Audit and Risk Committee is responsible for providing assurance to the Board about the continued effectiveness of the Trust's system of integrated governance, risk management and internal control. In particular, the committee will review the adequacy of:

- All risks and control-related disclosure statements, e.g. Annual Governance Statement

- The Board Assurance Framework as a robust process for monitoring, assurance, and mitigation of significant risks to the attainment of the Trust's strategic objectives.

Overall, the Audit and Risk Committee provide assurances to the Board that the organisation has sufficient controls in place to manage the significant risks to achieving its strategic objectives and that these controls are operating effectively.

All Board committees, Finance and Performance Committee, Mental Health Act Committee, People and Culture Committee, Remuneration and Appointments Committee and Quality and Safeguarding Committee, have responsibilities to monitor and review risks relevant to their remit including the extent to which they are assured by the evidence presented with respect to the management of these risks. Each committee is responsible for escalating concerns regarding the management of significant risks to the Board and for determining areas and topics for organisational learning.

Assessment of quality performance information

Throughout 2025/26 the Board received the Integrated Performance Report (IPR) which incorporates quality indicators for specific service lines and quality metrics, as well as metrics around finance, workforce and performance.

The Quality and Safeguarding Committee and associated groups are active, and their outputs are clearly evidenced in the Trust's Annual Report. Elements of the Annual Report are subject to review by external auditors as well as extensive consultation and feedback internally and externally on its content.

The Trust has a Quality Assurance Framework in place used in all the services to review quality of care this includes Fundamental Standards of Care, audits, Board visits, and review of care against regulations, clinical evidence and best practice underpinned by the Trust Strategy and Quality Delivery Plan.

The Trust has continued to manage CQC action plans from previous inspections. The Quality and Safeguarding Committee receives assurance on the CQC actions and compliance to the standards of care, including those from the Mental Health Act visits.

During 2025/26, the Trust participated in NHS England's Provider Capability Assessment, which provides an external, evidence-based view of the Trust's capability across leadership, governance, performance oversight and improvement. The outcomes of this assessment have been considered by the Board and have directly informed Board development priorities and governance improvement actions. NHSE agreed with the Trust's self-assessment and allocated an amber-green Provider Capability rating to the Trust.

Data security risks

The Trust is committed to protecting personal information for our community, including our service receivers, our staff and all involved in support. We handle this as carefully as we would our own. The Trust is registered with the Information Commissioner's Office who oversee our compliance against the Data Protection Act 2018 and General Data Protection Regulation (GDPR) in the UK. Registration reference Z8416831.

The Board has put in place procedures to ensure that information is handled with appropriate regard to its sensitivity and confidentiality, which are available to all staff and which all staff are required to follow.

The Trust has in place the following arrangements to manage data security and protection risks:

- A Senior Information Risk Owner (SIRO) who is the Director of Corporate Affairs and Trust Secretary. The Medical Director has retained the role of Caldicott Guardian. Both these key roles have appointed deputies

- Annually completed Data Security and Protection Toolkit, with reported outcomes to the Audit and Risk Committee and Board
- Clear identification of information asset owners who have undergone training for their role and undertaken risk assessment for their respective assets
- Excellent compliance for mandatory Data Security and Protection training (97%-98%)
- Data security incidents reviewed by the Data Security and Protection Committee at each meeting
- Data security policy compliance reviewed by the Data Security and Protection Committee at each meeting, consistently 100% policies reviewed and in date
- Ongoing compliance with the implementation of the GDPR.

The last Data Security and Protection Toolkit review, completed in June 2025 by internal auditors 360 Assurance, resulted in a high level of confidence in the Trust's self-assessment. Two low level actions were recommended, which were completed on time.

Major risks

Major risks to the delivery of the Trust strategic priorities are identified in the Board Assurance Framework and reporting and review processes. At the start of 2025/26 these risks were as follows:

Ref	Risk	Risk Rating
Patient Focused – our services will deliver safe and high-quality care		
25/26 1A	There is a risk that the Trust will fail to provide standards for safety, and effectiveness as required by our patients, regulators, partners and our Board. There is also a risk of poor patient experience and outcomes	**HIGH**
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	**MODERATE**
25/26 1E	There is a risk that the Trust does not deliver key regulatory and strategic requirements related to dormitory eradication and that the Trust estate is not maintained sufficiently well to comply with regulatory and legislative requirements	**MODERATE**
People – Derbyshire Healthcare is a great place to work		
25/26 2A	There is a risk that we are unable to create the right culture with high levels of staff morale	**HIGH**
25/26 2B	There is a risk that we do not have an adequate supply of a diverse workforce with the right people with the right skills to support and deliver safe high-quality care	**HIGH**
Productive – our services will be productive, demonstrate best value for our population and be cost effective		
25/26 3A	There is a risk that the Trust fails to deliver its revenue and capital financial plans for 2025/26 caused by factors including non-delivery of Cost Improvement Programme (CIP) targets and increased cost pressures not mitigated resulting in a threat to our financial sustainability and delivery of our statutory financial duties	**MODERATE**
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	**MODERATE**

25/26 4B	There is a risk of reputational damage if the Trust is not viewed as a strong partner both within the Derby and Derbyshire Integrated Care System (ICS) and more broadly within the East Midlands Mental Health Provider Alliance	**MODERATE**
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	**MODERATE**

Progress during 2025/26 against the major risks and associated actions is summarised below.

Quarter 1
Patient focused: key gaps closed on all actions completed in 2024/25.

People: additional key gaps in control and actions identified relevant to 2025/26.

Productive: the current risk rating has improved, going from extreme to moderate, and action RAG ratings are improved to reflect the position at the start of the fiscal year and the updates provided against the 2025/26 measures.

Quarter 2
Patient Focused: the impact rating was reduced, reducing the risk rating from high to moderate. This was a result of the opening of new inpatient units and improved environments with clinical benefit being realised.

People: the People Plan was cross-referenced with the BAF People risks. to ensure that all content is reflected across both and as a means of closing any key gaps in control and monitoring progress to manage/mitigate the risks.

Quarter 3
Patient Focused: Risks 1B and 1D, both focused on delivery of key regulatory and strategic requirements relating to dormitory eradication had morphed over time and it was agreed to combine the remaining risk, root causes, controls and assurances currently cited across both risks and create a new risk (1E). 1B and 1D were then archived.

Quarter 4
Partnerships: the rating of risk 4C was altered from high to moderate as both the impact and likelihood scores were reduced. This was the result of key gaps in control having improved ratings as progress had been made against actions.

2026/27
An extensive review was undertaken on the Board Assurance Framework report in preparation for the first issue to ensure that the risks are relevant to the Trust's 2026/27 priorities and directly linked to the Trust Strategic Delivery Plan.

The rating of risk 1A was reduced from high to moderate as improvements had been made over the previous year, actions ad progressed and the CQC results map to the overall improved position across inpatient services.

The titles of risks 2A and 2B were updated.

Risk 1C was moved to the productivity section as the most relevant for the remaining risk.

The title of risk 3A was added to, to include the added risk of a Capital Departmental Expenditure Limits (CDEL) breach linked the MRFD dormitory eradication programme and associated capital commitments. The risk rating was increased from moderate to high.

Risk 4A was archived as working arrangements are business as usual and the major changes have been overcome.

Risk 4C was archived and the remaining gap in operating standards and clinical risks for Learning Disabilities and Autism services is now included in the key gaps in control under Risk 1A.

Following the above changes the references were refreshed and the status at the start of 2026/27 is shown below.

Ref	Risk	Risk Rating
Patient focused – our services will deliver safe and high-quality care		
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	**MODERATE**
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	**MODERATE**
People – Derbyshire Healthcare is a great place to work		
26/27 2A	There is a risk that we are unable to sustain a positive, inclusive and compassionate 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	**HIGH**
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	**HIGH**
Productive – our services will be productive, demonstrate best value for our population and be cost effective		
26/27 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 dormitory eradication programme and our associated capital commitments	**HIGH**
26/27 3B	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	**MODERATE**
Partnerships – our organisation will identify new ways of working, through new collaborative approaches		
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	**MODERATE**

The full details of these risks, including the controls and assurances in place and the actions identified and progress made in mitigating the risk, are shown in the Board Assurance Framework report, which is submitted to the Audit and Risk Committee and Board quarterly.

All operational risks on the Trust-wide risk register with a residual risk of 'high' or 'extreme' are cross-referenced to the associated strategic risk in the Board Assurance Framework report.

Assessment against NHS Improvement Well Led Framework

The last external assessment under the above framework was undertaken in 2023 by the Office of Modern Governance. The assessment of the Trust's governance arrangements as set out in the report was a positive one. During 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 improvement. These areas were reflected in the recommendations and were built into the action plan, monitored by the Audit and Risk Committee, with all actions now being completed. The Trust has commissioned its next external assessment against the revised Single Assessment Framework, with preliminary work starting in March 2026.

The Board continues to receive regular updates on the robustness of the Trust's corporate governance processes. The Board has continued to receive assurance through its committee structure. The committees have in turn received assurance on governance through a variety of internal and external sources, such as the Head of Internal Audit Opinion and the external audit of the Annual Governance Statement, overseen by the Audit and Risk Committee.

Embedding of risk management

Risk management systems and processes are embedded throughout a wide range of Trust activities, with significant risks reported through the risk register systems and processes. Risks reported include clinical risks, health and safety risks, business continuity risks, data security risks and commissioning risks.

The Trust is a learning organisation, where staff are encouraged to report incidents honestly and openly through an online incident reporting form, with incidents escalated and managed depending on their grade and subject category. Learning is evidenced at team, service and Trust-wide level through feedback on incident forms, serious incident investigation reports and 'Blue Lights' (staff communications for urgent risks).

The Trust uses an Equality Impact Assessment (EIA) tool as the evidence-based framework to proactively and consciously engage and consider the impact of 'due regard' (legal duty as set out in the Equality Act 2010) on all key decisions, proposals, policies, procedures, services and functions that are relevant to equality. The tool is used to identify relevance to equality and potential inequalities, barriers to access and outcomes arising out of our processes, decisions, services and employment. If there is an adverse effect on people with protected characteristics, the Trust seeks to mitigate or minimise those effects.

EIA is embedded in all Trust policies and through cover sheets for reports for Trust Board and committees which requires the authors of the papers to 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.

Public stakeholders' involvement in managing risks

The Trust seeks and welcomes feedback from and involvement of stakeholders in relation to the provision of services and the management of risk which may impact on them. Ways in which public stakeholders are involved include:

- A range of processes for receiving and learning from patients and carer feedback including ‘EQUAL Group’, a Trust patient and carers committee
- The Council of Governors and its governance structure
- The Trust’s engagement with Overview and Scrutiny Committees and Healthwatch
- Collaborative work with partners in the Derbyshire health and care system and with the Integrated Care System (ICS), and in the new Derbyshire, Nottinghamshire and Lincolnshire ICB cluster
- Trust membership and Annual Members Meeting.

Compliance with CQC Registration

The Trust’s last comprehensive inspection from the CQC took place during 2019/20 and resulted in an overall rating of ‘Good’.

During 2025/26, the CQC have continued to undertake targeted inspections and assessments across the Trust’s services in line with the Single Assessment Framework.

Inspections include: Wards for Older People with Mental Health Problems (April 2025), Forensic Inpatient or Secure Wards (August 2025), Long Stay or Rehabilitation Mental Health Wards for Working Age Adults (January 2026), and Mental Health Crisis Services and Health-Based Places of Safety (January 2026). All the inspected services have achieved ‘Good’ ratings. The Trust’s overall rating remains Good. In August 2025 the Trust had a section 120 review of the adult of working age pathway review under Mental Health Act (1983), this inspection does not result in a rating, however there were no breaches reported under Mental Health Act (1983) and Mental Health Act Code of Practice.

At the time of publication, the Trust is awaiting the outcome of the inspection of Community Mental Health Services for Adults of Working Age.

Reports for these inspections are available on the CQC website.

On the basis that the CQC has set out its ambition to have a Single Assessment Framework baseline of all provider Trusts by 2027 and our last Well Led report being issued in 2020, we are preparing for a well led inspection during 2026/27.

The foundation trust is fully compliant with the registration requirements of the CQC.

The foundation trust has published on its website an up to date register of interests, including gifts and hospitality, for decision making staff (as defined by the trust with reference to the guidance) within the past 12 months as required by the managing conflicts of interest in the NHS guidance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer’s contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Control measures are in place to ensure that all the organisation’s obligations under equality, diversity and human rights legislation are complied with.

The foundation trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a green plan following the guidance of the Greener NHS Programme. The Trust ensures that its obligations under the Climate Change Act and the adaptation reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

The Trust Board carries the final overall corporate accountability for its strategies, policies and actions as set out in the codes of conduct and accountability issued by the Secretary of State.

The Trust has a robust committee governance structure in place with committees reporting into the Board, as per page 81.

The Board has approved terms of reference for all committees. A review of effectiveness is undertaken and annual reports from the committees are received at Board during the year. Work is well underway on the annual reports from committees for 2025/26.

The Trust continues to review its operational efficiency metrics throughout the year via the Integrated Performance Report (IPR).

Improvements in triangulation of data continues to take place across the Board committees and are escalated as part of the committee reporting into Board. The Board relies upon the IPR as a primary source of triangulated assurance.

Internal audit services provide the Trust with an independent and objective opinion on the effectiveness of the systems in place for risk management, control and governance.

The Audit and Risk Committee approve the annual audit plan, which is set using a risk management approach. The Quality and Safeguarding Committee approves the annual clinical audit plan.

External audit services report on the accuracy and appropriateness of the Trust statutory reports (Annual Accounts and elements of the Annual Report).

The Trust has delivered a year end performance position which is on plan. This is alongside delivering a challenging Cost Improvement Programme in full. This is despite a challenging NHS national and local system position. This is described in more detail in the financial performance section of the annual report. Finance and Performance Committee scrutinise the financial performance and financial risks throughout the year.

During the year, the Trust moved into National Oversight Framework Segment 3 with continued improved performance around access and Inappropriate out of area placements.

Pressures and challenges remain with regards to the ability to invest in key areas to reduce waits where demand is increasing. Other key risks relate to managing increased acuity and out of area placements. In addition, further work is ongoing to manage financial sustainability and reduce the underlying operational deficit.

The Board receives assurance on economy, efficiency and effectiveness through committee scrutiny, internal audit work and monitoring of delivery against statutory financial duties.

Information governance

Between 1 April 2025 and 31 March 2026 three concerns were reported by third parties to the Information Commissioner's Office (ICO) by our Trust references:

IC-370838-Y8Q4: Staff subject access request: There was a delay in responding to questions raised as part of staff investigation process. Lessons were learned to ensure queries raised by staff in the investigation process are responded to and shared with relevant teams supporting the process.

IC-433722-Q7G1: Staff subject access request: The Trust needed to categorise this as complex and required an extension. There was a cross-over in communication with the ICO. Lessons were

learned to ensure timely communication with the requestor and coordination between the teams supporting the process.

IC-433974-N3F0: Freedom of Information request from a staff member: A complaint was raised regarding the Trust's delayed response and withholding certain information.

The ICO have not indicated that any further action should be taken for the above.

There have been two further incidents reported externally via the Data Security and Protection Toolkit:

Toolkit Reference 47202: Incident related to ethical hacking and potential vulnerability of a third-party supplier.

Toolkit Reference 42500: Incident related to a patient record that was part of a discontinued Trust service, and disclosure of a service user record to an incorrect recipient via email.

These incidents informed further strengthening of policies, staff guidance and assurance reporting to the Data Security and Protection Committee.

Data quality and governance

The Trust recognises that high quality data is a critical enabler of safe care, effective decision making and delivery of the Trust Digital Plan. As services become increasingly digitised, the accuracy, completeness and timeliness of data are essential to ensure confidence in clinical systems, reporting, and information sharing across partner organisations. Digital literacy and data quality principles are reinforced through refresher, mandatory and role specific training, system guidance, and ongoing support from Digital, Information Governance and reporting teams. This helps staff understand not only how to record information correctly, but why accuracy and completeness matter. Feedback mechanisms are in place to provide healthcare professionals with visibility of the data for which they are responsible.

The Trust is pleased to maintain data quality standards higher than the national average recognised via our mandatory Mental Health Services Data Set (MHSDS) and the Community Services Data Set (CSDS).

Overall accountability for data quality was reconfirmed during the year as part of the remit of the Audit and Risk Committee, with routine reporting included on the committee forward plan. Any issues identified are captured and addressed through updates to policies, systems and processes, providing assurance to the Board that it can rely on the information presented. Data quality is however an area of increased scrutiny, and the Board is committed to improving effectiveness and efficiency of data, management information and reporting.

Review of effectiveness

As accounting officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within DHCFT who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Risk Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The processes applied in maintaining and reviewing the effectiveness of the system of internal control are:

The Board of Directors:

- Is responsible for approving and monitoring the systems in place to ensure there are proper and independent assurances given on the soundness and effectiveness of internal control.

- The Board Assurance Framework report itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed

The Audit and Risk Committee:

- Is responsible for independently overseeing the effectiveness of the Trust's systems for internal control and for reviewing the structures and processes for identifying and managing key risks
- Is responsible for reviewing the establishment and maintenance of effective systems of internal control
- Is responsible for reviewing the adequacy of all risk and control-related statements prior to endorsement by the Board
- In discharging its responsibilities, it takes independent advice from the Trust's internal auditor 360 Assurance, and external auditor Forvis Mazars
- agrees the annual Internal Audit plan which is developed using a risk-based process aligned with the Trust's Board Assurance Framework and strategic objectives.

Internal Audit
The headline internal audit opinion provided by the Trusts internal auditors 360 Assurance is as follows:

Overall Opinion
I am providing an opinion of significant assurance that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and controls are generally being applied consistently.

The basis for forming this opinion is informed by the completion by the Trust's internal auditors of eight Trust audits undertaken in 2025/26; they were issued the following assurance ratings:

Significant Assurance	Business Continuity Board Assurance Framework Data Quality of a board level indicator Financial Management
Moderate Assurance	Medical Revalidation and Appraisal Care Planning
Limited Assurance	Learning from Patient Safety Incidents (PSIRF)
Other	DSPT (NHSE opinion level – the assurance level is low risk *)

Two high rated risks were identified in the PSIRF audit; there is an action plan in place to address the issues raised.

My review is also informed by:

- Registration with the CQC
- Regular CQC Mental Health Act visits and CQC engagement meetings
- NHS England's compliance return and governance statements
- Compliance with NHS England's National Oversight Framework
- Audit reports received during the year following on from the internal audit and external audit plans and fraud risk assessment agreed by the Trust's Audit and Risk Committee
- NHS England's Provider Capability Assessment – an overall rating of Amber-Green for 2025/26

Conclusion
No significant internal control issues were identified during 2025/26.

Signed: 

Date: 18 June 2026

Mark Powell
Chief Executive

Nursing recognition stories for Mental Health Nurses Day

A series of features celebrated Trust nurses who shared reflections on their long-term- commitment to mental health care.

These features spotlighted the extraordinary dedication of the Trust's nursing workforce, showcasing compassion, expertise and resilience. The stories provided insight into the mental health nursing. This recognition also supported ongoing efforts to strengthen retention and celebrate contributions to local healthcare.

Annual Accounts 2025/26

Derbyshire Healthcare NHS Foundation Trust

Annual Accounts for the year ending 31 March 2026

Foreword

Presented to Parliament pursuant to Schedule 1, prepared in accordance with paragraphs 24 & 25 of Schedule 7 of the National Health Service Act 2006 by Derbyshire Healthcare NHS Foundation Trust.

Independent auditor's report to the Council of Governors of Derbyshire Healthcare NHS Foundation Trust

Report on the audit of the financial statements

Opinion on the financial statements

We have audited the financial statements of Derbyshire Healthcare NHS Foundation Trust ('the Trust') for the year ended 31 March 2026 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, and notes to the financial statements, including material accounting policy information.

The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual 2025/26 as contained in the Department of Health and Social Care Group Accounting Manual 2025/26, and the Accounts Direction issued under the National Health Service Act 2006.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2026 and of the Trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2025/26; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the "Auditor's responsibilities for the audit of the financial statements" section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, and taking into account the requirements of the Department of Health and Social Care Group Accounting Manual, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the Annual Report and Accounts, other than the financial statements and our auditor's report thereon. The Directors are responsible for the other information. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or

apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in these regards.

Responsibilities of the Accounting Officer for the financial statements
As explained more fully in the Statement of Chief Executive's Responsibilities as the Accounting Officer, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

The Accounting Officer is required to comply with the Department of Health and Social Care Group Accounting Manual 2025/26 and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another public sector entity. The Accounting Officer is responsible for assessing each year whether or not it is appropriate for the Trust to prepare financial statements on the going concern basis and disclosing, as applicable, matters related to going concern.

Auditor's responsibilities for the audit of the financial statements
Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

Based on our understanding of the Trust, we considered that non-compliance with the following laws and regulations might have a material effect on the financial statements: employment regulation, data protection, anti-bribery and corruption.

To help us identify instances of non-compliance with these laws and regulations, and in identifying and assessing the risks of material misstatement in respect to non-compliance, our procedures included, but were not limited to:

- gaining an understanding of the legal and regulatory framework applicable to the Trust, the environment in which it operates, and the structure of the Trust, and considering the risk of acts by the Trust which were contrary to the applicable laws and regulations, including fraud;
- inquiring with management, Internal Audit and the Audit and Risk Committee, as to whether the Trust is in compliance with laws and regulations, and discussing their policies and procedures regarding compliance with laws and regulations;
- inspecting correspondence, if any, with relevant licensing or regulatory authorities;

reviewing minutes of relevant meetings in the year; communicating identified laws and regulations throughout our engagement team and remaining alert to any indications of non-compliance throughout our audit; and considering the risk of acts by the Trust which were contrary to applicable laws and regulations, including fraud.

We also considered those laws and regulations that have a direct effect on the preparation of the financial statements, such as the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012)

In addition, we evaluated management's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls) and determined that the principal risks were related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates, in particular in relation to revenue recognition (which we pinpointed to the overstatement of the revenue in pre-year end period and existence of receivables, and significant one-off or unusual transactions.

Our audit procedures in relation to fraud included, but were not limited to:

- making enquiries of management, Internal Audit and the Audit and Risk Committee on whether they had knowledge of any actual, suspected or alleged fraud;
- gaining an understanding of the internal controls established to mitigate risks related to fraud;
- discussing amongst the engagement team the risks of fraud;
- addressing the risks of fraud through management override of controls by performing journal entry testing;
- testing of revenue received in the pre-year end period; and
- testing of year-end receivables for existence.

There are inherent limitations in the audit procedures described above and the primary responsibility for the prevention and detection of irregularities including fraud rests with both management and the Audit and Risk Committee. As with any audit, there remained a risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal controls.

We are also required to conclude on whether the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom, (Revised 2024) and Supplementary Guidance Note 01, issued by the Comptroller and Auditor General in November 2024.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at **www.frc.org.uk/auditorsresponsibilities**. This description forms part of our auditor's report.

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2026.

We have nothing to report in this respect.

Responsibilities of the Accounting Officer

The Chief Executive as Accounting Officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the Trust's use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required under Schedule 10(1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in

its use of resources, and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our work in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in March 2026.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice
In our opinion:

- the parts of the Remuneration Report and Staff Report subject to audit have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2025/26; and
- the other information published together with the audited financial statements in the Annual Report and Accounts for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception under the Code of Audit Practice
We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the NHS Foundation Trust Annual Reporting Manual 2025/26; or
- we refer a matter to the regulator under Schedule 10(6) of the National Health Service Act 2006; or
- we issue a report in the public interest under Schedule 10(3) of the National Health Service Act 2006.

We have nothing to report in respect of these matters.

Use of the audit report
This report is made solely to the Council of Governors of Derbyshire Healthcare NHS Foundation Trust as a body in accordance with Schedule 10(4) of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust as a body for our audit work, for this report, or for the opinions we have formed.

Delay in certification of completion of the audit
We cannot formally conclude the audit and issue an audit certificate until we have received confirmation from the National Audit Office that the group audit of the Department of Health and Social Care has been completed and that no further work is required to be completed by us.

Mark Surridge, Key Audit Partner
For and on behalf of Forvis Mazars LLP (Local Auditor)

Three Chamberlain Square, Birmingham, B3 3AX

19 June 2026

STATEMENT OF COMPREHENSIVE INCOME FOR THE PERIOD ENDED 31 MARCH 2026

	NOTE	**2025-26 £000**	2024-25 £000
Operating income from continuing operations	4 & 5	**262,465**	251,410
Operating expenses of continuing operations	7	**(262,805)**	(270,009)
OPERATING SURPLUS/(DEFICIT)		**(340)**	(18,599)
FINANCE COSTS			
Finance income	11	**1,473**	1,901
Finance expense - financial liabilities	12	**(3,210)**	(3,605)
PDC Dividends payable		**(4,460)**	(4,977)
NET FINANCE COSTS		**(6,197)**	(6,681)
SURPLUS/(DEFICIT) FOR THE YEAR		**(6,537)**	(25,280)
Other Comprehensive Income/(Expenditure)*		**4,139**	(7,397)
TOTAL COMPREHENSIVE INCOME(EXPENSE) FOR THE YEAR		**(2,398)**	(32,677)

***** Other Comprehensive Income/(expenditure) relates to the revaluation of the Land and Buildings that has been adjusted through the revaluation reserve.

The notes on pages 177 to 221 form part of these accounts.

Breakeven Duty - The below does not form part of the Statement of Comprehensive Income

	2025-26 £000	2024-25 £000
Adjusted financial performance (control total basis):		
Surplus / (deficit) for the period	(6,537)	(25,280)
Add back all Impairments/(reversals)	5,510	23,998
Retain impacts of DEL I&E Impairments	(262)	(139)
Remove I&E impact of capital grants and donations	0	(1,063)
Remove I&E impact of IFRIC 12 schemes on an IFRS 16 basis	6,470	7,973
Add back I&E impact of IFRIC 12 schemes on former UK GAAP basis	(5,170)	(5,488)
Adjusted financial performance surplus / (deficit)	**11**	**1**

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2026

	NOTE	**31 March 2026**	31 March 2025
		£000	£000
Non-current assets:			
Intangible assets	14	**2,672**	2,070
Property, plant and equipment	13	**207,438**	198,574
Right of use assets	15	**7,099**	8,118
Trade and other receivables	19	**1,158**	1,396
Total non-current assets		**218,367**	210,158
Current assets:			
Inventories	18	**320**	188
Trade and other receivables	19	**4,317**	4,718
Cash and cash equivalents	24	**26,925**	19,071
Total current assets		**31,562**	23,977
Current liabilities			
Trade and other payables	24	**(28,044)**	(21,186)
Borrowings	26	**(3,077)**	(2,534)
Provisions	30	**(929)**	(781)
Other liabilities	25	**(6,734)**	(7,047)
Total current liabilities		**(38,784)**	(31,548)
Total assets less current liabilities		**211,145**	202,587
Non-current liabilities			
Borrowings	26	**(38,983)**	(40,705)
Provisions	30	**(1,719)**	(1,960)
Total non-current liabilities		**(40,702)**	(42,665)
Total Assets Employed:		**170,443**	159,922
FINANCED BY:			
TAXPAYERS' EQUITY			
Public Dividend Capital		**143,228**	130,309
Revaluation reserve		**56,652**	52,513
Other reserves		**8,680**	8,680
Income and expenditure reserve		**(38,117)**	(31,580)
Total Taxpayers' Equity:		**170,443**	159,922

The financial statements on pages 172 to 176 were approved by the Audit and Risk Committee on behalf of the Board on the 18 June 2026 and signed on its behalf by:

Mark Powell - Chief Executive

STATEMENT OF CHANGES IN TAXPAYERS EQUITY FOR THE PERIOD ENDED 31 MARCH 2026

	Public Dividend capital	Revaluation reserve	Other reserves	Income and Expenditure Reserve	Total reserves
	£000	£000	£000	£000	£000
Taxpayers Equity at 1 April 2025	**130,309**	**52,513**	**8,680**	**(31,580)**	**159,922**
Surplus/(deficit) for the year	**0**	**0**	**0**	**(6,537)**	**(6,537)**
Revaluations/Impairments	**0**	**4,139**	**0**	**0**	**4,139**
Public Dividend Capital Received	**12,919**	**0**	**0**	**0**	**12,919**
Taxpayers Equity at 31 March 2026	**143,228**	**56,652**	**8,680**	**(38,117)**	**170,443**

STATEMENT OF CHANGES IN TAXPAYERS EQUITY FOR THE PERIOD ENDED 31 MARCH 2025

	Public Dividend capital	Revaluation reserve	Other reserves	Income and Expenditure Reserve	Total reserves
	£000	£000	£000	£000	£000
Taxpayers Equity at 1 April 2024	123,159	59,910	8,680	(6,300)	185,449
Surplus/(deficit) for the year	0	0	0	(25,280)	(25,280)
Revaluations/Impairments	0	(7,397)	0	0	(7,397)
Public Dividend Capital Received	7,150	0	0	0	7,150
Taxpayers Equity at 1 April 2025	130,309	52,513	8,680	(31,580)	159,922

Information on reserves

Public dividend capital (PDC) - is a type of public sector equity finance which the Trust has received to fund capital projects.

Revaluation reserve - increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Other Reserves – this reserve was created when two Trusts merged and the accounts were consolidated. This will represent the merged I&E and Revaluation Reserves at the point of merger and will remain unchanged.

Income and expenditure reserve - the balance of this reserve is the accumulated surpluses or deficits of the Trust.

STATEMENT OF CASH FLOWS FOR THE PERIOD ENDED 31 MARCH 2026

	NOTE	**2025-26 £000**	2024-25 £000
Cash Flows from operating activities			
Operating Surplus/(Deficit) from continuing operations		**(340)**	(18,599)
Operating Surplus/(Deficit)		**(340)**	(18,599)
Non cash income and expenses			
Depreciation and Amortisation		**8,380**	9,396
Impairments		**5,510**	23,998
Income recognised in respect of capital donations		**0**	(1,063)
(Increase)/Decrease in Inventories		**(132)**	70
(Increase)/Decrease in Trade and Other Receivables		**535**	894
Increase/(Decrease) in Trade and Other Payables		**2,954**	(1,102)
(Increase)/Decrease in Other Current Liabilities		**(313)**	(1,370)
Increase/(Decrease) in Provisions		**(155)**	326
Net Cash Inflow/(Outflow) from Operating Activities		**16,439**	12,550
Cash flows from investing activities			
Interest Received		**1,473**	1,901
Purchase of intangible assets		**(1,121)**	0
Purchase of Property, Plant and Equipment		**(12,543)**	(26,595)
Net Cash Inflow/(Outflow) from Investing Activities		**(12,191)**	(24,694)
Cash flows from financing activities			
PDC Capital Received		**12,919**	7,150
Capital Element of Private Finance Lease Obligations		**(1,406)**	(1,371)
Interest Element of Private Finance Lease Obligations		**(1,850)**	(1,857)
Interest Element of Finance Lease Obligations		**(1,224)**	(1,606)
PDC Dividend paid		**(4,833)**	(4,739)
Net Cash Inflow/(Outflow) from Financing Activities		**3,606**	(2,423)
Net increase/(decrease) in cash and cash equivalents		**7,854**	(14,567)
Cash and Cash Equivalents at Beginning of the 1 April		**19,071**	33,638
Cash and Cash Equivalents at 31 March	22	**26,925**	19,071

NOTES TO THE ACCOUNTS

1. Accounting policies and other information

NHS England has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (DHSC GAM) which shall be agreed with the HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DHSC GAM 2025-26 issued by the Department of Health and Social Care. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DHSC Group Accounting Manual permits a choice of accounting policy, the accounting policy that is judged to be the most appropriate to the particular circumstances of the NHS Foundation Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with the terms considered material in relation to the accounts.

1.1 Going Concern

The annual report and accounts have been prepared on a going concern basis. An NHS foundation trust's assessment of whether the going concern basis is appropriate for its accounts is solely based on whether it is anticipated that the services it provides will continue to be provided with the same assets in the public sector. In addition, in making their going concern assessment each year, Trust management consider all available information about the future prospects of the Trust which enables them to consider and confirm the declaration regarding whether there is any material uncertainty to the trust continuing to be a going concern.

1.2 Accounting convention

These accounts have been prepared under the historical cost convention, modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

These accounts have been prepared using the going concern convention.

1.3 Consolidation

The Trust does not have any subsidiary, associate company or joint venture or joint operations arrangements.

Charitable funds are managed by Derbyshire Community Health Services NHS Foundation Trust on behalf of the Trust and do not have to be consolidated into the accounts.

1.4 Critical judgments in applying accounting policies

The following are the critical judgments, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Asset lives

The Trust has to make assumptions and judgments when determining the length of an asset's estimated useful life. This will take into account the view provided during the professional valuation and also the Trust's assessment of the period over which it will obtain service potential from the asset.

In determining the estimated useful lives of assets the Trust has taken into consideration any future lifecycle replacement that will enhance and prolong the life of the asset; specifically in relation to assets capitalised under PFI contract arrangements.

Intangible assets are amortised over their expected useful economic lives on a straight line basis in a manner consistent with the consumption of economic or service delivery benefits.

PFI

The PFI scheme has been reviewed under IFRIC 12 and it is deemed to meet the criteria to include the scheme on balance sheet.

1.5 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimating uncertainty at the end of the reporting period, which have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Property Valuation estimation

Assets relating to land and buildings were subject to a Desktop revaluation during the financial year ending 31 March 2026. This resulted in an increase in asset valuations of £4m, reflecting the trend in market prices. The valuation was based on prospective market values at 31 March 2026, which has been localised for the Trust's estate. Note 13.4 outlines the changes from this report. The Trust also commissions formal valuations for assets that have been classified as "available for sale" during the period, note 23, we do not have any assets held for sale in this accounting period.

1.6 Revenue

Where income is derived from contracts with customers, it is accounted for under IFRS 15.

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional, a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

The main source of income for the Trust is contracts with Commissioners for health care services. The Trust's income is largely received from commissioners via block contracts for the provision of services. These service requirements are agreed on an annual basis, with no carry-over to future years. Block contract income is received each month for the services that have been provided that month.

Education and Training income mainly relates to salary of trainees and placement tariff for undergraduates and is received on a quarterly basis, recognised on a monthly basis, to contribute to the salaries and other expenditure paid in that period. Income received in relation to future training provision is deferred as per the requirements of IFRS15.

Income from Pharmacy sales is accounted for in the period the items that have been sold in.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met and is measured as the sums due under the sale contract.

1.7 Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including non-consolidated performance pay earned but not yet paid. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

NHS Pensions

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

The Schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

NEST

The Trust offers a second NEST pensions scheme for employees who do not want to be in the NHS Pension Scheme but want to be auto enrolled in a pension.

This pension is free for employers to use and the employee pays a 1.8% contribution charge and a management charge of 0.3% a year. The scheme then invests the employee’s contribution to support the pension payments on their retirement.

1.8 Expenditure on other goods and services

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable for those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property plant and equipment.

1.9 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.10 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes
- It is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust
- It is expected to be used for more than one financial year
- The cost of the item can be measured reliably; and
- The item has an individual cost of at least £5,000 or collectively, a number of items have a cost of at least £5,000 and individually have cost more than £250, where the assets are functionally interdependent, they have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Land and buildings used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position at their re-valued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses.

Revaluations of property plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period, in years where a revaluation does not take place, an indexation factor is applied.

Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in

accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

Depreciation, amortisation and impairments

Freehold land, properties under construction, and assets held for sale are not depreciated. Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

In accordance with the *GAM*, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the

income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the "Statement of Comprehensive Income" as an item of "other comprehensive income".

De-recognition

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use.

This condition is regarded as met when the sale is highly probable the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to the income and expenditure reserve. Following reclassification, the assets are measured at the lower of their existing carrying amount and their "fair value less costs to sell". Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment that are due to be scrapped or demolished do not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.11 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when:

- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- where the cost of the asset can be measured reliably, and
- Where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at cost. Software that is integral to the operating of hardware, for example an operating system is capitalised as part of the

relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

Assets are capitalised in the month following the completion of the project, allowing time for final invoices to be received and accurate costs to be capitalised.

Measurement

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally generated intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition are initially met. Where no internally generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

From 1 April 2025, intangible assets are carried at cost. Where intangible assets have been carried historically under a revaluation approach following initial recognition, the carrying net amount as at 31 March 2025 will be considered to be the deemed historic cost. In accordance with the GAM this change in valuation basis is being applied prospectively.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.12 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration.

There are further expedients or election that have been employed by The Trust in applying IFRS 16. These include;

The measurement requirements under IFRS 16 are not applied to leases with a term of 12 months or less under paragraph 5 (a) of IFRS 16.

The measurement requirements under IFRS 16 are not applied to leases where the underlying asset is of a low value which are identified as those assets of a value of less than £5,000, excluding any irrecoverable VAT, under paragraph 5 (b) of IFRS 16.

The Trust will not apply IFRS 16 to any new leases of intangible assets applying the treatment described in section 1.14 instead.

HM Treasury have adapted the public sector approach to IFRS 16 which impacts on the identification and measurement of leasing arrangements that will be accounted for under IFRS 16.

The Trust is required to apply IFRS 16 to lease like arrangements entered into with other public sector entities that are in substance akin to an enforceable contract, that in their formal legal form may not be enforceable. Prior to accounting for such arrangements under IFRS 16 [the entity] has assessed that in all other respects these arrangements meet the definition of a lease under the Standard.

The Trust is required to apply IFRS 16 to lease like arrangements entered into in which consideration exchanged is nil or nominal, therefore significantly below market value. These arrangements are described as peppercorn leases. Such arrangements are again required to meet the definition of a lease in every other respect prior to inclusion in the scope of IFRS 16. The accounting for peppercorn arrangements aligns to that identified for donated assets. Peppercorn leases are different in substance to arrangements in which consideration is below market value but not significantly below market value.

The nature of the accounting policy change for the lessee is more significant than for the lessor under IFRS 16. IFRS 16 introduces a singular lessee approach to measurement and classification in which lessees recognise a right of use asset.

For the lessor leases remain classified as finance leases when substantially all the risks and rewards incidental to ownership of an underlying asset are transferred to the lessee. When this transfer does not occur, leases are classified as operating leases.

1.12.1 The Trust as lessee

At the commencement date for the leasing arrangement a lessee shall recognise a right of use asset and corresponding lease liability. The Trust employs a revaluation model for the subsequent measurement of its right of use assets unless cost is considered to be an appropriate proxy for current value in existing use or fair value in line with the accounting policy for owned assets. Where consideration exchanged is identified as below market value, cost is not considered to be an appropriate proxy to value the right of use asset.

Lease payments are apportioned between finance charges and repayment of the principal. Finance charges are recognised in the Statement of Comprehensive Income.

Irrecoverable VAT is expensed in the period to which it relates and therefore not included in the measurement of the lease liability and consequently the value of the right of use asset.

The incremental borrowing rate of 0.95% has been applied to the lease liabilities recognised at the date of initial application of IFRS 16 and new leases in 2026 5.32%, 2025 4.81%, 2024 4.72% and 2023 at 3.51%.

Where changes in future lease payments result from a change in an index or rate or rent review, the lease liabilities are remeasured using an unchanged discount rate.

Where there is a change in a lease term or an option to purchase the underlying asset The Trust applies a revised rate to the remaining lease liability.

Where existing leases are modified The Trust must determine whether the arrangement constitutes a separate lease and apply the Standard accordingly.

Lease payments are recognised as an expense on a straight-line or another systematic basis over the lease term, where the lease term is in substance 12 months or less, or is elected as a lease containing low value underlying asset by The Trust.

1.13 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as "on-Statement of Financial Position" by the Trust. The underlying assets are recognised as property, plant and equipment, together with

an equivalent PFI liability measured in alignment with the principles of IFRS 16 from 1 April 2023 as mandated by the FReM.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary

- Payment for the fair value of services received
- Repayment of the finance lease liability, including finance costs, and
- Payment for the replacement of components of the assets during the contract 'Lifecycle replacement'

Services received

The cost of services received in the year us recorded under the relevant expenditure headings with 'operating expenses'.

PFI assets, liabilities and finance costs

The PFI assets are initially measured using the principles of IFRS 16. Subsequently, the assets are measured at current value in existing use per the policies applied under IAS 16.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

Where there is a change in future lease payments resulting from a change in an index or a rate used to determine those payments, including for example a change to reflect changes in market rental rates following a market rent review. The entity remeasures the PFI liability to reflect those revised payments only when there is a change in the cash flows (i.e. when the adjustment to the payments takes effect). The entity shall determine the revised payments for the remainder of the PFI arrangement based on the revised contractual payments. As subsequent measurement of the PFI asset is per IAS 16 than IFRS 16, the opposite entry to adjustment of the PFI liability for such remeasurements is charged to Finance Costs. Given this represents a change in the measurement basis of the PFI liability for 1 April 2023, PFI liabilities have been remeasured to include all the index linked changes relating to the capital element of the contract which would have taken place since the arrangement commenced. The entity has remeasured this using a cumulative catch-up approach by which the cumulative effect of the change in measurement of the PFI liability is recognised as an adjustment to the opening balance of retained earnings (or other component of equity as appropriate). Comparative information has not been restated

Lifecycle replacement

Components of the asset replaced by the operator during the contract ("lifecycle replacement") are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at cost.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle

replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a “free” asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the Trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust’s Statement of Financial Position.

Other assets contributed by the Trust to the operator

Assets contributed (e.g. cash payments, surplus property) by the Trust to the operator before the asset is brought into use, which are intended to defray the operator’s capital costs, are recognised initially as prepayments during the construction phase of the contract. When the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.14 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust’s cash management. Cash and bank balances are recorded at current vales.

1.15 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury’s discount rates.

Early retirement provisions are discounted using HM Treasury’s pension discount rate of 2.95% (2024-25: 2.40%) in real terms.

1.16 Clinical negligence costs

NHS Resolution, formerly NHS Litigation Authority operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed in note 31 to the Trust accounts, however, is not recognised.

1.17 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any “excesses” payable in respect of particular claims are charged to operating expenses when the liability arises.

1.18 Contingencies

Contingent liabilities are not recognised, but are disclosed in note 31.1, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity’s control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the Trust’s control) are not recognised as assets but are disclosed in note 31.2 where an inflow of economic benefits is probable.
Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.19 Financial Assets

Financial assets are recognised when the Trust becomes party to the contractual provision of the financial instrument or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or when the asset has been transferred and the Trust has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

Financial assets are initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through profit or loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices, where possible, or by valuation techniques, see IFRS 9 B5.1.2A

Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

Financial assets at fair value through other comprehensive income

Financial assets measured at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

Financial assets at fair value through profit and loss

Financial assets at fair value through profit and loss are held for trading. A financial asset is classified in this category if it has been acquired principally for the purpose of selling in the

short-term. Derivatives are also categorised as held for trading unless they are designated as hedges.

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the Trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

Impairment

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the Trust recognises a loss allowance representing expected credit losses on the financial instrument.

The Trust adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2), and otherwise at an amount equal to 12-month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.20 Financial liabilities

Financial liabilities are recognised when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged – that is, the liability has been paid or has expired.

Financial liabilities at fair value through profit and loss

Derivatives that are liabilities are subsequently measured at fair value through profit or loss, Embedded derivatives that are not part of a hybrid contract containing a host that is an asset within the scope of IFRS 9 are separately accounted for as derivatives only if their economic characteristics and risks are not closely related to those of their host contracts, a separate instrument with the same terms would meet the definition of a derivative, and the hybrid contract is not itself measured at fair value through profit or loss.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability. In the case of DHSC loans that would be the nominal rate charged on the loan.

1.21 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the secretary of State can issue new PDC to, and require repayments of the PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities except for:

(i) donated assets (including lottery funded assets)
(ii) average daily cash balances held with the Government Banking Services and National Loan Fund (NLF) deposits, excluding cash balances held in GBS accounts that relates to short-term working capital facility
(iii) PDC dividend receivable or payable.

The average relevant net assets are calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre audit” version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occurs as a result of the audit of the annual accounts.

1.22 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Trust’s surplus/deficit in the period in which they arise. Foreign currency transactions are negligible.

1.23 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in note 37 to the accounts.

1.24 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures

compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However, the losses and special payments note 38 is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.25 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.26 Insurance Contracts

IFRS 17 Insurance Contracts has replaced IFRS 4 Insurance Contracts and is effective for periods beginning on or after 1 April 2025. An insurance contract is a contract under which the issuer accepts significant insurance risk from the policyholder by agreeing to compensate the policyholder if a specified uncertain future event adversely affects the policyholder. The Trust has adopted the Standard and reviewed all existing contracts and found not to have any insurance contracts, therefore the accounts in 2025-26 have not had to be restated.

1.27 Accounting Standards that have been issued and have not yet been adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2025-26. These Standards are still subject to HM Treasury FReM adoption, with

- IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK- endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future has not yet been assessed

- IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK- endorsed and not yet adopted by the FReM. Early adoption is not permitted. The Trust as no subsidiaries, so this is not expected to have an impact.

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

Changes to valuation of property, plant and equipment (PPE) assets – The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to

quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £179m as at 31 March 2026.

2. Operating segments

The Trust has only one operating segment; that is the provision of healthcare services.

The total amount of income from the provision of healthcare services during the accounting period is £248,312k, including £208,107k from Integrated Care Boards (ICB's).

	2025-26	2024-25
	£000	£000
Clinical Income	**248,312**	236,339
Non-Clinical Income	**14,153**	15,071
Pay	**(195,370)**	(180,618)
Non-Pay	**(67,435)**	(89,391)
Operating Surplus/(deficit)	**(340)**	(18,599)

The Trust generated over 10% of income from the following organisations:

	2025/26	2024-25
	£000	£000
NHS Derby and Derbyshire ICB	**202,486**	190,834

3. Income generation activities

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes.

The Trust undertakes some minor income generation activities with an aim of achieving profit, which is then used in patient care, although those activities do not provide material sources of income or have a full cost of over £1m.

4. Income

4.1 Income from patient care activities (by type)

	2025-26	2024-25
	£000	£000
NHS England*	**14,422**	19,225
Integrated Care Boards	**208,107**	192,532
Local Authorities	**20,049**	19,708
Foundation Trusts	**5,583**	4,585
NHS Other	**151**	289
	248,312	236,339

*Included in the figure with NHS England is £11,784k (2024-25 £11,052k) of notional income for the additional 9.4% Pensions Contribution.

4.2 Income from patient care activities (class)

	2025-26	2024-25
	£000	£000
Block Contract income	**198,419**	188,320
Community income	**27,464**	27,062
Services delivered as part of a mental health collaborative	**7,151**	6,229
Income for commissioning services from other providers as a mental health collaborative lead provider	**3,129**	3,022
Other clinical income	**12,149**	11,706
	248,312	236,339

During 2025-26 it remained that contract income for patient care services was all paid under Mental Health Income contract arrangements.

4.3 Overseas Visitors

The Trust has not invoiced or received any income from overseas visitors.

5. Other operating income

	2025-26	2024-25
	£000	£000
Research and Development	**573**	601
Education and Training	**9,882**	9,839
Staff Costs	**241**	275
Receipt of Peppercorn Leases	**0**	1,063
Other Revenue	**3,457**	3,293
	14,153	15,071
Other revenue includes:		
PFI Land contract	**60**	60
Catering and Patient Shop	**274**	256
Pharmacy Sales	**0**	2
Services to specialist schools	**26**	144
Services to other NHS Providers	**2,560**	2,022
Transport	**0**	0
Other income elements	**537**	809
	3,457	3,293

5.1 Additional information on revenue from contracts with customers recognised in the period

	2025-26	2024-25
	£000	£000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	**2,894**	3,928
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	0	0

6. Income

	2025-26	2024-25
	£000	£000
From rendering of services	**262,465**	251,410
From sale of goods	**0**	0

7. Operating Expenses

	2025-26	2024-25
	£000	£000
Services from NHS Bodies	**5,329**	5,087
Purchase of healthcare from non-NHS bodies	**16,061**	19,933
Mental Health collaborative – purchase of healthcare from NHS bodies*	**3,064**	2,956
Employee Expenses - Non-executive directors	**143**	130
Employee Expenses - Staff and Executive Directors	**194,092**	180,488
Redundancy Costs	**1,135**	0
Drug costs	**4,709**	4,060
Supplies and services - clinical (excluding drug costs)	**704**	349
Supplies and services - general	**1,435**	1,321
Establishment	**5,591**	5,868
Research and development	**107**	2
Transport	**2,731**	2,925
Premises - business rates payable to local authorities	**1,447**	1,035
Premises	**7,283**	7,582
Lease Expenditure	**799**	565
Increase / (decrease) Provision	**115**	206
Depreciation on property, plant and equipment	**7,582**	7,403
Amortisation of intangible assets	**798**	1,993
Impairments of property, plant and equipment	**5,510**	23,998
Audit services- statutory audit	**130**	101
Internal Audit	**85**	81
Clinical Negligence Costs	**860**	845
Legal fees	**478**	368
Training, courses and conferences	**1,131**	963
Car parking & Security	**31**	31
Hospitality	**33**	49
Insurance	**40**	12
Other services, e.g. external payroll	**453**	457
Losses, ex gratia & special payments	**18**	28
Other	**911**	1,174
	262,805	270,009

8. Employee costs and numbers

8.1 Employee Costs	**2025-26 Total £000**	2024-25 Total £000
Salaries and Wages	**143,474**	134,056
Social Security Costs	**17,914**	13,220
Apprenticeship Levy	**694**	657
Employer Contributions to NHS Pension Scheme	**18,086**	16,946
Pension Costs paid by NHS England	**11,784**	11,052
Temporary Staffing (Agency and Contract)	**2,537**	5,089
Termination benefits	**1,135**	0
Employee benefits expense	**195,624**	181,020
Of the total above:		
Charged to Capital	**397**	532
Employee benefits charged to revenue	**195,227**	180,488
	195,624	181,020

There have been 5 cases of early retirements due to ill health in year at a value of £771k (2024-25 – 4 cases at £171k).

9. PENSION COSTS

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”.

An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

10. The Late Payment of Commercial Debts (Interest) Act 1998

There were no payments that were made in respect of the Late Payment of Commercial Debt (Interest) Act 1998 (No cases for 2024-25).

11. Finance Income

Finance income was received in the form of bank interest receivables totalling £1,473k (2024-25 £1,901k).

12. Finance costs

	2025-26	2024-25
	£000	£000
Interest in right of use lease obligations	**77**	84
Interest on obligations under PFI contracts:		
- main finance cost	**1,849**	1,857
- Remeasurement of PFI	**1,222**	1,615
Unwinding of discount on provisions	**62**	49
Total interest expense	**3,210**	3,605

13. Property, plant and equipment

2025-26	Land	Buildings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	**Total**
	£000	£000	£000	£000	£000	£000	£000	**£000**
Cost or valuation:								
At 1 April 2025	**10,810**	**174,098**	**4,946**	**4,138**	**713**	**5,179**	**4,758**	**204,642**
Additions	0	977	13,919	226	258	488	777	**16,645**
Revaluations	0	4,064	0	0	0	0	0	**4,064**
Impairments (Note 17)	0	(85)	(5,383)	0	(12)	(6)	(24)	**(5,510)**
Reclassifications – Assets Under Construction	0	60	(234)	0	0	134	40	**0**
Reclassifications – Depreciation Roll Up	0	(4,135)	0	0	0	0	0	**(4,135)**
Disposals/Derecognition	0	(28)	0	(100)	(280)	(583)	(305)	**(1,296)**
At 31 March 2026	**10,810**	**174,951**	**13,248**	**4,264**	**679**	**5,212**	**5,246**	**214,410**
Depreciation								
At 1 April 2025	**0**	**1,224**	**0**	**594**	**398**	**2,438**	**1,414**	**6,068**
Provided During the Year	0	4,836	0	131	102	809	457	**6,335**
Reclassifications – Depreciation Roll Up	0	(4,135)	0	0	0	0	0	**(4,135)**
Disposals/Derecognition	0	(28)	0	(100)	(280)	(583)	(305)	**(1,296)**
At 31 March 2026	**0**	**1,897**	**0**	**625**	**220**	**2,664**	**1,566**	**6,972**
Net Book Value at 31 March 2026	10,810	173,054	13,248	3,639	459	2,548	3,680	**207,438**

Net book value	Land	Buildings	Assets under Construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	**Total**
	£000	£000	£000	£000	£000	£000	£000	**£000**
Owned	10,810	139,509	13,248	3,639	459	2,548	3,680	**173,893**
PFI	0	33,545	0	0	0	0	0	**33,545**
Total at 31 March 2026	10,810	173,054	13,248	3,639	459	2,548	3,680	**207,438**

13.1 Revaluation reserve balance for property, plant & equipment

	Land including Right of Use	Buildings	Total
	£000	£000	£000
At 1 April 2025	9,081	43,432	52,513
Movements	75	4,064	4,139
At 31 March 2026	9,156	47,496	56,652

13.2 Property, plant and equipment

2024-25	Land	Buildings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	**Total**
	£000	£000	£000	£000	£000	£000	£000	**£000**
Cost or valuation:								
At 1 April 2024	**14,635**	**81,744**	**125,658**	**2,281**	**635**	**5,014**	**3,915**	**233,882**
Additions	0	3,416	7,706	0	78	767	1,781	**13,748**
Revaluations	85	8,440	0	0	0	0	0	**8,525**
Impairments (Note 17)	(3,910)	(12,055)	(23,942)	0	0	(2)	(7)	**(39,916)**
Reclassifications – Assets Under Construction	0	102,025	(104,476)	2,060	0	391	0	**0**
Reclassifications – Depreciation Roll Up	0	(6,669)	0	0	0	0	0	**(6,669)**
Disposals/Derecognition	0	(2,803)	0	(203)	0	(991)	(931)	**(4,928)**
At 31 March 2025	**10,810**	**174,098**	**4,946**	**4,138**	**713**	**5,179**	**4,758**	**204,642**
Depreciation								
At 1 April 2024	**0**	**6,870**	**0**	**654**	**301**	**2,100**	**1,866**	**11,791**
Provided During the Year	0	3,826	0	143	97	1,329	479	**5,874**
Reclassifications – Depreciation Roll Up	0	(6,669)	0	0	0	0	0	**(6,669)**
Disposals/Derecognition	0	(2,803)	0	(203)	0	(991)	(931)	**(4,928)**
At 31 March 2025	**0**	**1,224**	**0**	**594**	**398**	**2,438**	**1,414**	**6,068**
Net Book Value at 31 March 2025	10,810	172,874	4,946	3,544	315	2,741	3,344	**198,574**

Net book value	Land	Buildings	Assets under Construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	**Total**
	£000	£000	£000	£000	£000	£000	£000	**£000**
Owned	10,810	139,681	4,946	3,544	315	2,741	3,344	**165,381**
PFI	0	33,193	0	0	0	0	0	**33,193**
Total at 31 March 2025	10,810	172,874	4,946	3,544	315	2,741	3,344	**198,574**

13.3 Revaluation reserve balance for property, plant & equipment

	Land	Buildings	Total
	£000	£000	£000
At 1 April 2024	12,906	47,004	59,910
Movements	(3,825)	(3,572)	(7,397)
At 31 March 2025	9,081	43,432	52,513

13.4 Valuation

In the year, a desktop valuation was undertaken by the trust's external valuer NEWMARK, this led to an increase in value of £4,064k on last year's value.

The last full review was undertaken in 2024-25 where the valuer visited every site and evaluated the condition of the buildings.

13.5 Economic life of property, plant and equipment

The following table shows the range of estimated useful lives for property, plant and equipment assets

	Max Life Years	Min Life Years
Buildings excluding dwellings	90	1
Plant & machinery	60	5
Transport equipment	15	5
Information technology	10	5
Furniture & fittings	15	5

14. Intangible Assets

2025-26	Software Licences (Purchased)	Information Technology (Internally Generated)	Assets under construction	Total
	£000	£000	£000	£000
Cost or valuation:				
At 1 April 2025	1,178	5,101	0	6,279
Additions	744	0	656	1,400
Disposals/Derecognition	(663)	(617)	0	(1,280)
At 31 March 2026	1,259	4,484	656	6,399
Amortisation				
At 1 April 2025	1,084	3,125	0	4,209
Provided During the Year	86	712	0	798
Disposals/Derecognition	(663)	(617)	0	(1,280)
At 31 March 2024	507	3,220	0	3,727
Net Book Value at 31 March 2026	752	1,264	656	2,672

All Intangible assets are classed as owned and are amortised between 5 and 10 years.

14.1 Intangible Assets

2024-25	Software Licences (Purchased)	Information Technology (Internally Generated)	Total
	£000	£000	£000
Cost or valuation:			
At 1 April 2024	1,778	5,497	7,275
Impairments	(4)	0	(4)
Disposals/Derecognition	(596)	(396)	(992)
At 31 March 2025	1,178	5,101	6,279
Amortisation			
At 1 April 2024	1,192	2,016	3,208
Provided During the Year	488	1,505	1,993
Disposals/Derecognition	(596)	(396)	(992)
At 31 March 2024	1,084	3,125	4,209
Net Book Value at 31 March 2025	94	1,976	2,070

All Intangible assets are classed as owned.

15. Right of Use Assets

	2025-26	**2025-26**	2024-25	2024-25
	Property (land and buildings) £000	**Of which: leased from DHSC group bodies £000**	Property (land and buildings) £000	Of which: leased from DHSC group bodies £000
Valuation at 1 April	**11,147**	**5,088**	10,397	4,876
Additions	162	0	1,063	1,063
Rent Remeasurement	139	139	717	179
Revaluations	75	75	0	0
Lease Termination/ Derecognition	(217)	(217)	(1,030)	(1,030)
Valuation/gross cost at 31 March	**11,306**	**5,085**	11,147	5,088
Valuation at 1 April	**3,029**	**1,117**	2,530	1,426
Provided during the year	1,247	405	1,529	721
Reclassifications	0	0	0	0
Lease Termination/ Derecognition	(69)	(69)	(1,030)	(1,030)
Accumulated depreciation at 31 March	**4,207**	**1,453**	3,029	1,117
Net book value at 31 March	**7,099**	**3,632**	8,118	3,971
Net book value of right of use assets leased from other NHS Providers		**1,138**		1,063
Net book value of right of use assets leased from other DHSC group bodies		**2,494**		2,908

16. Impairments

Impairments of £5,510k have arisen in year, £5,248k impairment for the Making Room for Dignity Programme which have been reviewed by the Valuer as part of the revaluation. £262k relating over specification of Works in Progress, or Obsolescence from normal operations.

	2025/26	2024/25
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Over specification of assets	262	139
Other	5,248	23,859
Total net impairments charged to operating surplus / deficit	**5,510**	23,998
Impairments charged to the revaluation reserve	0	15,922
Total net impairments	**5,510**	39,920

17. Commitments

17.1 Capital commitments

The Trust is committed to spend approximately £9m on the development and refurbishment of the Radbourne Unit, this is part of the Making Room for Dignity (MR4D) programme to eradicate dormitories style wards.

18. Inventories

18.1 Inventories

	2025-26	2024-25
	£000	£000
Finished goods	**320**	188
Total	**320**	188
Of which held at net realisable value:	**0**	0

18.2 Inventories recognised in expenses

	2025-26	2024-25
	£000	£000
Inventories recognised as an expense in the period	**3,089**	2,808
Total	**3,089**	2,808

19. Trade and other receivables

19.1 Trade and other receivables

	2025-26	2024-25
	£000	£000
Current		
Contract receivables	**2,919**	2,895
Allowance for impaired contract receivables/assets	**(181)**	(222)
Prepayments (non-PFI)	**758**	1,616
PDC dividend receivable	**373**	0
VAT receivable	**440**	425
Other receivables	**8**	4
Total current trade and other receivables	**4,317**	4,718

Non-current		
PFI lifecycle prepayments	**1,158**	1,395
Other	**0**	0
Total non-current trade and other receivables	**1,158**	1,395
Of which receivables from NHS and DHSC group bodies:		
Current	**2,508**	3,772
Non-current	**0**	0

19.2 Allowances for credit losses

	2025-26 Contract receivables and contract assets	2024-25 Contract receivables and contract assets
	£000	£000
Allowances brought forward	**222**	432
Changes in Year		
New allowances arising	**0**	0
Reversals of allowances	**(41)**	(210)
Allowances as at 31 March	**181**	222

20. Other financial assets

There are no other financial assets as at 31 March 2026.

21. Other current assets

There are no other current assets as at 31 March 2026.

22. Cash and cash equivalents

	31 March 2026	31 March 2025
	£000	£000
Balance at 31 March	**19,071**	33,638
Net change in period	**7,854**	(14,567)
Balance at period end	**26,925**	19,071
Made up of		
Cash with Government banking services	**26,871**	19,026
Cash in hand	**54**	45
Cash and cash equivalents as in statement of cash flows	**26,925**	19,071

23. Non-current assets held for sale

The Trust has no Assets Held for Sale as at 31 March 2026.

24. Trade and other payables

	Current	Current
	2025-26	2024-25
	£000	£000
NHS payables	**3,445**	597
Trade payables - capital	**4,918**	1,014
Trade payables - Non-NHS	**5,388**	6,409
Accruals – Non-NHS	**6,479**	6,730
Annual Leave Accrual	**324**	260
Taxes payables	**1,914**	1,637
Social Security costs	**2,080**	1,745
Other payables	**3,496**	2,794
Total	**28,044**	21,186

The Trust does not have any non-current liabilities.

Other Payables include:

£2,515k outstanding pensions contributions at 31 March 2026 (31 March 2025 £2,352k). These were paid in April 2026.

25. Other liabilities

	Current	Current
	2025-26	2024-25
	£000	£000
Deferred income	**6,734**	7,047
	6,734	7,047

The Trust has no other liabilities.

26. Borrowings

	Current	**Non-current**	Current	Non-current
	2025-26	**2025-26**	2024-25	2024-25
	£000	**£000**	£000	£000
Right of Use Leases*	**1,171**	**4,963**	1,161	5,967
PFI liabilities	**1,906**	**34,020**	1,373	34,738
Total	**3,077**	**38,983**	2,534	40,705

The Trust has a PFI contract with Arden Partnership to operate and service buildings to provide patient care and clinical support services. The contract is due to expire during 2039.

The increase in the PFI costs relate to a change in accounting policy in relation to IFRS 16.

27. Right of Use lease obligations

27.1 – Maturity of Right to use Leases

Details of the lease charges are below:

	2025-26	2024-25
	£000	£000
Not later than one year	**1,220**	1,240
Later than one year, not later than five years	**4,067**	4,312
Later than five years	**1,188**	1,815
Sub total	**6,475**	7,367
Less: interest element	**(341)**	(239)
Total	**6,134**	7,128

The Trust is committed to pay per the above table.

27.2 Finance lease receivables

The Trust does not have any finance lease arrangements as a lessor.

28. Private Finance Initiative contracts

28.1 PFI schemes on-Statement of Financial Position

The Trust has a PFI contract with Arden Partnership to operate and service buildings to provide patient care and clinical support services. The contract is due to expire in 2039.

Under IFRIC 12, the asset is treated as an asset of the Trust; that the substance of the contract is that the Trust has a finance lease and payments comprise two elements - imputed finance lease charges and service charges.

Details of the imputed finance lease charges are shown in the table below:

Total obligations for on-statement of financial position PFI contracts due also below:

	2025-26	2024-25
	£000	£000
Not later than one year	**3,663**	3,148
Later than one year, not later than five years	**14,382**	13,731
Later than five years	**31,457**	34,134
Sub total	**49,502**	51,013
Less: interest element	**(13,576)**	(14,902)
Total	**35,926**	36,111

28.2 Charges to expenditure

The total charged in the period to expenditure in respect of the service element of on-statement of financial position PFI contracts was £1,522k (prior year £1,464k). In year £1,075k was released from the Lifecycle prepayment to revenue (£1,102k in 2024-25).

At present value the Trust is committed to the following charges:

	2025-26	2024-25
	£000	£000
Not later than one year	**1,529**	1,471
Later than one year, not later than five years	**6,192**	5,958
Later than five years	**12,719**	13,807
Total	**20,440**	21,236

28.3 Future Unitary Payments

	2025-26	2024-25
	£000	£000
Total future payments committed in respect of the PFI service concession arrangements	**78,719**	**81,933**
Of which payments are due:		
- not later than one year;	6,016	5,818
- later than one year and not later than five years;	24,060	23,266
- later than five years.	48,643	52,849

28.4 Unitary Payment payable to service concession operator

	2025-26	2024-25
	£000	£000
Unitary payment payable	**6,017**	**5,819**
Consisting of:		
Interest charge	1,849	1,857
Repayment of balance sheet obligation	1,406	1,371
Service element and other charges to operating expenditure	1,522	1,464
Addition to lifecycle prepayment	1,240	1,127
Total amount paid	**6,017**	**5,819**

29. Reconciliation of Liabilities arising from financing activities

	Lease Liabilities	PFI and LIFT schemes	Total
	£000	£000	£000
Carrying value at 1 April 2025	**7,128**	**36,111**	**43,239**
Cash movements:			
Financing cash flows - payments of Principal	0	(1,406)	**(1,406)**
Financing cash flows - payments of interest	(1,224)	(1,850)	**(3,074)**
Non-cash movements:			
Additions	162	0	**162**
Lease liability remeasurements	139	0	**139**
Remeasurement of PFI	0	1,222	**1,222**
Application of effective interest rate	77	1,849	**1,926**
Early terminations	(148)	0	**(148)**
Carrying value at 31 March 2026	**6,134**	**35,926**	**42,060**

	Lease Liabilities	PFI and LIFT schemes	Total
	£000	£000	£000
Carrying value at 1 April 2024	**7,933**	**35,867**	**43,800**

Cash movements:			
Financing cash flows - payments of principal	0	(1,371)	**(1,371)**
Financing cash flows - payments of interest	(1,606)	(1,857)	**(3,463)**
Non-cash movements:			
Lease liability remeasurements	717	0	**717**
Remeasurement of PFI	0	1,615	**1,615**
Application of effective interest rate	84	1,857	**1,941**
Carrying value at 31 March 2025	**7,128**	**36,111**	**43,239**

29.1 Other financial liabilities

The Trust has no other financial liabilities.

30. Provisions

	Current	**Non-Current**	Current	Non-Current
	2025-26	**2025-26**	2024-25	2024-25
	£000	**£000**	£000	£000
Pensions relating to other staff	**180**	**1,629**	167	1,731
Legal claims	**285**	**0**	66	0
Redundancy	**369**	**0**	268	0
Other	**95**	**90**	280	229
Total	**929**	**1,719**	781	1,960

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2025	119	1,779	66	268	509	2,741
Arising during the period	22	152	262	369	48	853
Change in Discount Rate	(2)	(66)	0	0	(7)	(75)
Used during the period	(22)	(159)	0	0	(76)	(257)
Reversed unused	(9)	(61)	(43)	(268)	(295)	(676)
Unwinding of discount	3	53	0	0	6	62
At 31 March 2026	111	1,698	285	369	185	2,648
Expected timing of cash flows:						
Within one year	22	158	285	369	95	929
Between one and five years	76	568	0	0	15	659
After five years	13	972	0	0	75	1,060
	111	1,698	285	369	185	2,648

The Trust holds a provision for pensions and by its nature this includes a degree of uncertainty in respect of timings and amount, due to the uncertainty of life expectancy. Future liability is calculated using actuarial values.

Other provisions – This includes other general Trust provisions relating to employee claims and Clinicians Pension Reimbursement.

£5,491k is included in the provisions of the NHS Resolution at 31/3/2026 in respect of clinical negligence liabilities of the Trust (31/03/2025 £2,693k).

31. Contingencies

31.1 Contingent Liabilities

There are no contingent liabilities as at 31 March 2026.

31.2 Contingent Assets

The Trust has instructed a VAT consultancy firm to investigate the VAT on Medical Agency costs after the outcome of the Isle of Wight case against HMRC. If this is successful there could be upto £2m in VAT refunds.

32. Financial Instruments

32.1 Carrying Values of Financial Assets

	2025-26 Held at Amortised Cost £000	2024-25 Held at Amortised Cost £000
Trade Receivables	**2,745**	2,677
Cash at bank and in hand	**26,925**	19,071
Total at 31 March	**29,670**	21,748

Trade Receivables are net of the credit loss allowance

32.2 Carrying value of financial liabilities

	2025-26 Held at Amortised Cost £000	2024-25 Held at Amortised Cost £000
Trade Payables	**21,211**	15,192
PFI and finance lease obligations	**42,060**	43,239
Total at 31 March	**63,271**	58,431

IFRS 7 requires the Foundation Trust to disclose the fair value of financial liabilities. The PFI scheme is a non-current Financial Liability where the fair value is likely to differ from the carrying value. The Trust has reviewed the current interest rates available on the market and if these were used as the implicit interest rate for the scheme the fair value of the liability would range from £14,850k to £21,095k.

32.3 Maturity of Financial Liabilities

	2025-26	2024-25
	£000	£000
In one year or less	25,675	19,840
In more than one year but not more than five years	18,449	18,043
In more than five years	32,645	36,760
Total	**76,769**	74,643

32.4 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with clinical commissioning groups and the way those clinical commissioning groups are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

100% of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. Derbyshire Healthcare NHS FT is not, therefore, exposed to significant interest rate risk.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2025 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's cash flows are mainly stable and predictable. Operating costs are incurred under contracts with clinical commissioning groups, which are financed from resources voted annually by Parliament.

The Trust funds its business- as-usual capital expenditure from internally generated sources. The Trust is part of the national dormitory eradication programme and has been allocated national PDC funding for that purpose. The Full Business Case were approved part way through 2022-23 and funding has been received for the year 2024-25. Cashflow and liquidity are fully considered as part of the process. Given the Trust's current level of cash reserves, it is not exposed to significant liquidity risks at this stage of the process. Future building cost inflation and associated affordability as well as cashflow implications are a key part of the business case considerations, in order to manage any future potential liquidity risks.

33. Events after the reporting period

There are no events after the reporting period 31 March 2026.

34. Audit Fees

The analysis below shows the total fees paid or payable for the period in accordance with the
Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008 (SI 2008/489).

	2025-26	2024-25
	£000	£000
External audit fees		
Statutory audit services	**130**	101
Non audit services	**0**	0
Total	**130**	101
Other audit fees		
Internal audit services	**65**	67
Counter fraud	**21**	14
Total	**85**	81

The auditor's liability for external audit work carried out for the financial year 2025/26 is unlimited.

The External Audit Fees figure above includes VAT as under the NHS VAT regime it cannot be reclaimed.

35. Related party transactions

Derbyshire Healthcare NHS Foundation Trust is a public benefit corporation authorised by NHS England - the Independent Regulator for NHS Foundation Trusts. All NHS Foundation Trusts are independent bodies which are not controlled by the Secretary of State. The Trust has considered whether or not the working relationships it has with any NHS bodies and Government departments and agencies meet the definition of a related part under IAS 24.

The value of transactions with government bodies and other related parties with which the Trust has had material dealings and which therefore require disclosure are:

2025-26	**Income £000**	**Expenditure £000**	**Receivables £000**	**Payables £000**
Related Parties with other NHS Bodies	**229,911**	**13,150**	**2,135**	**6,103**
2024-25				
Related Parties with other NHS Bodies	218,398	13,384	2,349	3,961

No Board Members of Derbyshire Healthcare NHS Foundation Trust have had related party relationships with organisations where we have material transactions and could have a controlling interest.

The Department of Health is regarded as a related party, as they are the Parent Department for Foundation Trusts. During the period Derbyshire Healthcare NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

NHS Derby and Derbyshire Integrated Care Board
University Hospitals of Derby and Burton NHS Foundation Trust
Derbyshire Community Health Services NHS Foundation Trust
NHS England
Chesterfield Royal Hospital NHS Foundation Trust
Sheffield Health and Social Care NHS Foundation Trust
NHS Staffordshire and Stoke-on-Trent ICB
NHS Business Authority
NHS Shared Business Services
NHS Providers
University of Derby
University of Sheffield
National Mental Health Directors Forum
Arkwright Society

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies. Most of these transactions have been with Derby City Council and Derbyshire County Council.

The Trust has also received payments from a number of charitable funds. The members of the NHS Trust Board are also the Trustees for the Charitable Funds held in trust for Derbyshire Healthcare which is managed by Derbyshire Community Health Services NHS Foundation Trust. The audited accounts for the Funds Held on Trust are available from the Communications Department.

The Register of Interests is available from the Legal Department.

36. Third party assets

The Trust held £84k cash and cash equivalents as at 31 March 2026 (£74k 31 March 2025) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

The Trust deposit accounts on behalf of the patients have been transferred into the Trust GBS accounts as they were attracting monthly charges and were no-longer beneficial to be held in individual accounts. The balance remains at £28k (£28k 31 March 2025).

37. Losses and special payments

	2025-26 Total number of cases Number	**2025-26 Total value of cases £000**	2024-25 Total number of cases Number	2024-25 Total value of cases £000
Loss of Stock	**11**	**12**	10	18
Bad Debts	**3**	**4**	4	8
Special Payments				
- Loss of Personal effects	**13**	**3**	12	4
	27	**19**	26	30

There were no clinical negligence, fraud, personal injury, compensation under legal obligation or fruitless payment cases accounted for in 2025-26 period where the net payment exceeded £300,000.

The above have been reported on an accruals basis and exclude provisions for future losses.

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dhcft.communications@nhs.net

@derbyshcft DHCFT www.derbyshirehealthcareft.nhs.uk

WE MAKE A POSITIVE DIFFERENCE IN EVERYTHING WE DO

Derbyshire Healthcare NHS Foundation Trust HQ
Ashbourne Centre, Kingsway Hospital, Derby DE22 3LZ

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