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Public Board Meeting

Agenda

Date: Wednesday, 30 September 2026

Time: 9.30am

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

Item	Time	Topic	Lead
1	9.30	Chair's welcome, opening remarks, apologies and declarations of interest 1.1 Trust Vision and Values 1.2 Register of Interests 2026/27	Selina Ullah
2	9.35	Board Story – Peer Support in Inpatient services <i>During this session, the presenter will share their experience(s), the content of which some people may find upsetting. Anyone affected by the issues raised can find support via the Trust website</i>	Tumi Banda
3	10.00	Minutes of the Board of Directors meeting held on 21 July 2026	Selina Ullah
4		Action Matrix and Matters Arising	
5		Questions from members of the public	
6	10.05	Chair's update	Selina Ullah
7	10.15	Chief Executive's update	Mark Powell
OPERATIONAL PERFORMANCE			
8	10.25	Integrated Performance report, including Quality, Operations, People and Finance 8.1 Board Committee Assurance Summaries, Committee Chairs to give assurance alongside presentation of the performance sections, stand-alone update for Audit and Risk Committee	Tumi Banda/Vikki Ashton Taylor/Rebecca Oakley/James Sabin Committee Chairs
BREAK 11.05am			
9	11.15	Emergency Preparedness, Resilience and Response (EPRR) core standards	Vikki Ashton Taylor
STRATEGY DEEP DIVE			
10	11.30	Patient	Tumi Banda/ Dr Girish Kunigiri
QUALITY GOVERNANCE			
11	11.50	Winter Planning - 2026/27 11.1 Appendix A - Board Assurance Statement 11.2 Appendix B - Executive Assurance Summary	Vikki Ashton Taylor/ Dr Girish Kunigiri/ Tumi Banda

STRATEGIC PLANNING AND CORPORATE GOVERNANCE			
12	12.00	Board Assurance Framework update	Justine Fitzjohn
13	12.05	Provider Capability Self-Assessment	Justine Fitzjohn
14	12.20	Freedom to Speak Up Guardian report (six-monthly)	Tamera Howard
REPORTS FOR NOTING AND/OR APPROVAL FOLLOWING ASSURANCE AT BOARD COMMITTEES			
15	12.30	<u>People and Culture Committee</u>	Ralph Knibbs
		15.1 Guardian of Safe Working Hours annual report	
		15.2 Guardian of Safe Working Hours quarterly report	
		15.3 10 Point Plan to improve the lives of Resident Doctors	
		15.4 Flu Campaign – 2026/27	
		15.5 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports, following sign-off at People and Culture Committee (for approval)	
		<u>Quality and Safeguarding Committee</u>	Lynn Andrews
		15.6 Learning from Deaths annual report	
		15.7 Safeguarding Children and Adults at Risk – annual report	
		15.8 Safer Staffing annual review	
		15.9 Research and Development annual report	
POLICY REVIEW			
16	12.35	Standing Financial Instructions Policy and Procedures	James Sabin
CLOSING BUSINESS			
17	12.40	Consideration of any items affecting the Board Assurance Framework (BAF)	Selina Ullah
18		Meeting effectiveness	
FOR INFORMATION			
Chair and Chief Executive’s Emergency Powers: NHIS SLA and Partnership Agreement			
Forward Plan 2026/27			
Glossary of NHS Acronyms			

Next meeting:

Date: Tuesday, 24 November 2026	Time: 9.30am	Location: Conference Rooms A&B, Research and Development Centre, Kingsway, Derby, DE55 3LZ. Arrangements will be notified on the Trust website seven days in advance of the meeting.
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There are no planned fire drills on the meeting date. Therefore, should the fire alarm sound, attendees should follow the green signage located above doorways and in the corridors and calmly evacuate the building by the stairwell exit. The lift should not be used and instructions from staff or fire wardens should be followed.

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

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

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

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





derbyshirehealthcareft.nhs.uk/about-us/strategy

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



DECLARATION OF INTERESTS REGISTER 2026/27

NAME	INTEREST DISCLOSED	TYPE
Selina Ullah Trust Chair	- Non-Executive Director, General Pharmaceutical Council - Non-Executive Director, Locala Community Partnerships CIC - Director, Muslim Women's Council - Trustee – NHS Alliance	(e) (e) (e) (e)
Chioma Akpom Non-Executive Director	- Director, Narini Limited - Director, 4CCCC Limited <i>from 01-Jun-2026</i>	(a) (a)
Deborah Good Non-Executive Director	- Trustee of Artcore – Derby - Director of Craftcore Derby	(e) (e)
Jo Hanley Non-Executive Director	Remediation Unit Director, Post Office Limited	(e)
Andrew Harkness Non-Executive Director	Spouse, Nicola Harkness, works at Staffordshire and Stoke-on-Trent Integrated Care Board <i>until 31-Jul-2026</i>	(e)
Ralph Knibbs Senior Independent Director	Trustee of the charity called Star* Scheme	(d)
Mark Powell Chief Executive	Treasurer, Derby Athletic Club	(d)
Vikki Ashton Taylor Deputy Chief Executive and Chief Delivery Officer	Justice of the Peace, covering Derbyshire and Nottinghamshire Magistrates	(d)
Girish Kunigiri Medical Director	- Trustee for the Bridge, Homelessness to Hope, Leicester - Vice Chair, ECT and Related Treatments Committee, Royal College of Psychiatry	(d) (e)
James Sabin Director of Finance	Spouse works at Sheffield Health & Social Care NHS Foundation Trust as Head of Capital and Therapeutic Environment	(e)
All other members of the Board of Directors have submitted a nil return, meaning they have no interests to declare.		

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

v1.1 DRAFT MINUTES

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

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

Tuesday, 21 July 2026

MEETING HELD IN PUBLIC

Commenced: 9.30am

Closed: 12.44pm

PRESENT

Selina Ullah	Trust Chair
Lynn Andrews	Deputy Trust Chair
Chioma Akpom	Non-Executive Director
Deborah Good	Non-Executive Director
Jo Hanley	Non-Executive Director
Andrew Harkness	Non-Executive Director
Mark Powell	Chief Executive
Vikki Ashton Taylor	Deputy Chief Executive and Chief Delivery Officer
Tumi Banda	Director of Nursing, Allied Health Professions (AHPs), Quality and Patient Experience
Justine Fitzjohn	Director of Corporate Affairs and Trust Secretary
Dr Girish Kunigiri	Medical Director
Rebecca Oakley	Director of People, Organisational Development and Inclusion
James Sabin	Director of Finance

IN ATTENDANCE

Anna Shaw	Associate Director of Communications and Engagement
Jo Bradbury	Corporate Governance Officer
DHCFT2026/057 Emma	Guest for Board Story
DHCFT2026/057 Becki Priest	Deputy Director of Patient Experience

APOLOGIES

Ralph Knibbs	Senior Independent Director
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OBSERVERS

Dave Allen	Public Governor, Chesterfield
Christopher Williams	Public Governor, Erewash
Jo Foster	Senior Nurse, DHcFT
Pete Henson*	Head of Performance and Delivery, DHcFT
Sarah Hyland*	Principal Clinical Psychologist, DHcFT
Leanne Walker*	Project Support Officer, DHcFT
Lesley Cuthbert*	
Claire Fitzpatrick*	
Naomi Lawrence*	
Zandra Reid*	Capital and Fixed Asset Accountant, Lubrizol Limited

* denotes on-line attendance

DHCFT/ 2026/056	<u>CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS</u>
	Selina Ullah, Trust Chair, welcomed Governors, observers, Executive Directors and Non-Executive Directors to the meeting. Housekeeping information was provided.

	In her opening remarks, Selina reflected on the national context, noting the appointment of a new Prime Minister and Health Secretary, along with the expectation that the new Health Secretary will be asked to address the social health care conundrum. Referencing the Government's continued focus on neighbourhood working, health inequalities and greater system working, the Board noted additional funding is unlikely, particularly given competing demands on the Treasury, especially around defence. Selina advised that today's papers should be considered within this wider environment and context. The apology for absence was noted. The Register of Interests was presented for transparency and as part of the fit and proper persons procedures.
DHCFT/ 2026/057	<u>BOARD STORY – 'YOUNG PEOPLE TRANSITIONING TO ADULT CARE'</u> Becki Priest, Deputy Director of Patient Experience, provided an update on the previous Board Story, advising that work had taken place to establish a Staff Carers Forum, including arrangements for co-chairing. It was noted that the formal launch would take place in September. Following positive staff feedback, patient and carer stories would be incorporated into Divisional Board's meetings. The Board was introduced to Emma, who would share her daughter's experience of transitioning from Children's to Adult services. Describing the impact of Covid-19, autism, attention deficit hyperactivity disorder (ADHD), severe depression, anxiety and the challenges experienced across education and health services, Emma explained that her daughter has been in the system since the age of 15. Involvement with multiple Care Co-ordinators was noted, along with lengthy waits, rejected referrals and limited continuity of therapeutic support. Poorly managed transitions were highlighted, resulting from fragmented services and ineffective communication between Psychiatry, Psychology, Education and Child and Adolescent Mental Health services (CAMHS). The Board heard that recommendations of senior professionals had not always resulted in access to the identified therapy, with placement on several waiting lists, with no completed course of therapy. Recounting the effect this had on her daughter, Emma described worsening mental health, feelings of rejection and the need for her family to continue challenging and following up care arrangements. Emphasising that waiting lists alone are not the issue, Emma suggested that clear criteria for therapy suitability were required and that progress should be monitored in a way that focused on the individual rather than short-term process metrics. Thanking Emma for sharing the personal and harrowing experience, Selina observed how systems and processes could lose sight of the person. Tumi Banda. Director of Nursing, AHPs, Quality and Patient Experience, reflected on the impact of moving from one waiting list or service to another, the importance of patient experience and the need to invest time and effort in the recommendations. Dr Girish Kunigiri, Medical Director, acknowledged the emotional nature of the story and noted the importance of a multi-disciplinary team approach, including joint discussions involving the whole family. Regarding access to therapy and the role of the independent sector, Becki pointed out that the provision of cognitive behavioural therapy involves different providers and the fragmentation of Children's services remains a challenge, with a more cohesive approach required.

	The importance of transition planning and continuity, particularly where trust has been built with individuals, was emphasised by Emma. Selina queried whether it was the perception that the NHS doesn't work with the private sector and if the issue relates to policy, commissioning or wider System arrangements. ACTION: It was agreed that Vikki Ashton Taylor, Deputy Chief Executive and Chief Delivery Officer, Girish and Tumi would relay the issues raised in the story to the appropriate teams and ask them to investigate the issues about fragmentation of services and lack of multi-disciplinary team working within Children's services, including transition to Adult services and why the Trust's clinicians are unable to issue referral letters to private providers. Thanking Emma for attending and sharing her and her family's experience, Mark Powell, Chief Executive, stated it would help the Board to consider how services can be developed. He welcomed Emma's further involvement in that work. Selina expressed well wishes for Emma's daughter and recognised her resilience and ambition to become a Psychologist. She stated that the experience described was not acceptable and that action should be taken. RESOLVED: The Board of Directors noted the experience shared and the recommendations presented, agreeing that further work should be undertaken to understand fragmentation, multi-disciplinary working and transition arrangements within Children's services and their impact on patient-centred care.
DHCFT/ 2026/058	<u>MINUTES OF THE LAST BOARD OF DIRECTORS MEETING</u> The draft minutes of the last meeting held on 19 May 2026 were accepted as a correct record of the meeting. Deborah Good, Non-Executive Director, was thanked for stepping in to chair the May meeting at short notice.
DHCFT/ 2026/059	<u>ACTION MATRIX AND MATTERS ARISING</u> The Board reviewed the Action Matrix. DHCFT/2026/038: DHCFT/2026/041 and DHCFT/2026/043: it was agreed that these completed actions could now be closed. DHCFT/2026/047: Lynn Andrews, Deputy Chair, raised concern at the lack of response from the commissioners in relation to the Assertive Outreach service. Whilst Tumi advised that this would be raised again with the Mental Health Board during the month, Mark confirmed that a formal correspondence would be sent to Amanda Sullivan, Chief Executive of the ICB Cluster, should no response be received by 24 July. At an NHSE meeting the previous day, Girish advised that it had been reported that no funding is available for expansion, with the only prospect being that the new Mental Health Strategy may enable the allocation of some monies. Vikki reported that the matter had been discussed at the Mental Health Delivery Board on 22 July and was on the agenda of the Derbyshire, Lincolnshire and Nottinghamshire ICB Cluster.
DHCFT/ 2026/060	<u>QUESTIONS FROM MEMBERS OF THE PUBLIC</u> No questions had been received.
DHCFT/ 2026/061	<u>DEPUTY CHAIR'S UPDATE</u>

	Lynn presented her Deputy Chair's update, which provided an overview of the work undertaken during June and early July when she was covering the Chair's absence, including stakeholder engagement, service visits and, System leadership activity. The Board noted that the Trust had continued to focus on delivering safe, high-quality care while progressing its strategic objectives within a challenging operational and financial context. Lynn reflected on the opportunity to step into the Chair's role and noted that the Provider Collaborative Board had demonstrated the complexity of working within a cluster arrangement, particularly in the context of the change of Government, Integrated Care Board (ICB) developments and the evolving wider System position. She highlighted the importance of focusing on what Derbyshire needed to do within that complex environment. Selina observed that System discussions were often focused on priorities such as elective recovery, with mental health not always being the primary focus. However, she referred to the feedback from the independent Well-Led review, conducted by AQUA, which indicated that stakeholders view the Trust as a good partner that contributes effectively. RESOLVED: The Board of Directors noted the contents of this report.
DHCFT/ 2026/062	<u>CHIEF EXECUTIVE'S UPDATE</u> Drawing attention to the national direction of travel, Mark highlighted a shift towards trusts being expected to look after themselves and the potential for this to create a more inward-looking approach. He related this to the earlier Board Story and emphasised the importance of building relationships and collaboration where each trust may otherwise take its own approach. The Board discussed the developing national Mental Health Strategy, including the call for ideas and evidence, noting that further discussion would be required once the strategy is published. Mark suggested the anticipated component parts will include a prevalence study, supply-side considerations and modern service frameworks for serious mental illness. He noted the importance of understanding the future outlook for mental health, while also expressing concern regarding the apparent absence of Learning Disabilities and Autism within the discussion. He further observed that, given finite resources, mental health providers may need to focus on those with serious mental illness, while recognising that prevention remains important. A formal welcome was expressed to colleagues who had transferred from Older People's Mental Health and Neurodevelopmental services at Derbyshire Community Health Services NHS FT (DCHS). Some teething issues were acknowledged, however, feedback indicated that teams feel welcomed. Mark reflected positively on the recent Staff Conference, emphasising the need to build on the engagement generated through the Personal Accountability Charter, Leadership Cascade and the planned 'Questions for Mark' approach, which was intended to support openness and transparency. Lynn welcomed the engagement approaches and described the Question Time proposal as 'brave'. She recognised that the Staff Conferences tends to attract those keen to engage and challenged how the organisation encourages those who prefer not to participate. Deborah also reflected that the Staff Conference had been a stand-out event and queried how the Trust would know whether the Leadership Cascade is proving to be effective. Mark acknowledged that he did not yet know whether the cascade was reaching all staff and emphasised the need for ownership by leaders, particularly those in the more challenging 24/7 services. He advised that, during his visits, he would ask about how messages were being shared and noted that leaders needed to identify appropriate methods, while recognising that the process would not be perfect. Deborah advocated to include this line of questioning during Board visits. The value of night visits was discussed, noting the different perspective offered compared with daytime visits. Selina encouraged Non-Executive Directors to undertake out of hours visits.

	James Sabin, Director of Finance reported that these visits had highlighted a few differences, including the culture; tighter staffing; reliance on on-call doctors; referrals to A&E involving multiple people and reduced accuracy, as well as staff not always being updated through regular communications, team meeting messages and limited access to training. RESOLVED: The Board of Directors noted the content of the report and discussed the key issues raised.
DHCFT/ 2026/063	<u>INTEGRATED PERFORMANCE REPORT (IPR) AND BOARD COMMITTEE ASSURANCE SUMMARIES</u> The IPR provided a high-level view of performance against a number of Operational, Financial, People and Quality metrics, and assurance regarding actions being taken to improve performance up to the end of May 2026 for internal measures and to the end of March 2026 where the data source is NHS England. The Board Committee Assurance Summaries from recent meetings were considered alongside the IPR. Points to note were brought to the attention of the Board by Executive Directors and Committee Chairs during the IPR discussions. <u>Quality</u> Tumi highlighted continued scrutiny of acuity, restrictive practice, prone restraint, violence and aggression, Care Programme Approach (CPA) compliance and patients not seen for over 12 months. He advised that the new Mental Health Personalised Care Framework guidance has now been published and that the Trust is scoping the work required. He also confirmed that patients waiting over 12 months were subject to fortnightly oversight across all Care Groups, with dashboard work providing improved visibility of data quality. Lynn emphasised that similar issues had been considered at the Quality and Safeguarding Committee, particularly in relation to patient safety, underscoring the need for consistency and sustainability in quality improvement. Selina challenged whether the Board could be assured of quality and safe services when only four of the 13 key performance indicators were rated green. Tumi responded that the metrics need to be triangulated and considered alongside the scale of intervention being undertaken. By way of example, he noted that ligature incident numbers had previously been much higher and that current interventions provided confidence in the direction of travel. <u>Operations</u> Continued strong national performance in access to Perinatal services was highlighted, along with improvements with the Mental Health Helpline and the successful implementation of the text messaging service launched on 1 June. Vikki reported continuing challenges in relation to patient flow, out of area (OoA) placements and length of stay (LoS), noting excellent progress with inappropriate OoA placements, including zero Adult Acute and Older Adult Acute placements. However, she added that the Trust continues to struggle to support patients within its own bed base. It was noted that traction has not been seen over the previous couple of months and that work remains ongoing, including the Getting it Right First Time (GIRFT) review and a review group established by Girish, which is expected to support improved traction on patient flow and LoS. Jo Hanley, Chair, Finance and Performance Committee, supported the operational update, noting that the Finance and Performance Committee had undertaken a deep dive on inappropriate OoA placements, recognising both the patient and financial impacts and the need to be realistic about what is achievable and to adopt different practices. Vikki acknowledged that it was too early to confirm whether the 111 change and text service were having a positive impact. However, she expressed confidence that the changes would free up clinicians' time, with artificial intelligence supporting generic queries.

People

Rebecca Oakley, Director of People, Organisational Development and Inclusion, reported a small dip in appraisal compliance and identified sickness absence as the main workforce risk, with absence remaining at 6.3%, along with an increase in long-term absence. She advised that the People team is supporting substantial work with managers and that wellbeing developments include online GP access, fast-track physiotherapy for musculoskeletal challenges and Occupational Health support.

Increased demand for bank and agency staffing, national updates, the Lord Mann review and the Leadership Cascade were highlighted.

On behalf of Ralph Knibbs, Chair, People and Culture Committee, Deborah advised that sickness absence remains higher than the same period in the previous year, resulting in a key focus for the People and Culture Committee. She noted targeted interventions and new innovations as helpful developments.

Chioma Akpom, Non-Executive Director, queried whether monthly benchmarking against other trusts was being undertaken. In response, Rebecca advised that benchmarking of sickness absence during May was 6%, with one non-mental health trust reporting 4%. Stressing that the Trust has adopted every area of best practice, Rebecca highlighted the current areas of focus are the new policy, accountability, use of data and cultural shift in absence management.

In relation to flow and quality performance metrics, Lynn suggested these might be considered in a more rounded way, with the identification of a model ward or area to emulate in other services. Rebecca agreed to consider this further. **ACTION.**

Tumi advised that a ward accreditation system is in development, with learning being taken from Birmingham counterparts and that further intelligence would be gathered, including the impact of vacancies on teams.

Finance

James reported that the Trust is approximately £200-£300k behind plan, He highlighted the £14.8m efficiency requirement, citing the driving factors as OoA placements, clinically ready for discharge (CRfD), agency expenditure and bank overspend linked to acuity observations.

Jo emphasised that the Trust should not underestimate the financial challenge during the year and advised that the Finance and Performance Committee had considered what was within the organisation's control, what was achievable and the worst-case scenario if the Trust does not break even.

The Board discussed the interdependencies between quality, operational performance, workforce and finance. Selina noted that the reports demonstrated those interdependencies and challenged that, where limited assurance was recommended, the narrative should address what had been done to respond to weaknesses in controls.

Lynn asked about the impact of improvement plans and emphasised the need for the Board to remain strategic and not become too operational.

Mark advised that further work was required by Lead Executives and Non-Executive Directors to consider the levels of assurance agreed during Committee meetings and to clarify what is required to move from limited to significant assurance and from significant to full assurance. He proposed that this be considered at a Board Strategy and Development Session, alongside the Board Assurance Framework (BAF) review, risk appetite, confidence in recovery plans and the Trust Strategy priorities and timescales. He noted the need for clearer definitions, greater consistency and a more dynamic approach to assurance, including consideration of what full assurance would mean in areas such as absence.

	Andrew Harkness, Non-Executive Director, queried whether assurance ratings were being used consistently, with a clear rationale, and reflected on what should be reported to Board and what should be considered by Committees. He also questioned how the Board was assured that patient care is co-ordinated operationally and that reporting focuses on what matters. Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary, noted that previous conversations had covered risk appetite, assurance levels, the impact on money and quality and the BAF and that the full BAF now goes to Committees, reflecting an improvement. Selina highlighted that the discussion evidenced the maturity of the Board in challenging itself. She recognised that feeling uncomfortable was a positive part of that process. The Board agreed that the matters would be considered further through the Board Strategy and Development Session. ACTION: Lead Executives and Lead Non-Executive Directors to consider the assurance levels agreed through Committee meetings, including the clarity required to move from limited to significant assurance and from significant to full assurance, to be considered at a Board Strategy and Development Session alongside the Board Assurance Framework review, risk appetite and confidence in recovery plans. RESOLVED: The Board of Directors: 1. Accepted limited assurance on current performance across the areas presented 2. Agreed to consider clearer definitions, greater consistency and a more dynamic approach to assurance.
DHCFT/ 2026/064	<u>TRUST STRATEGY DEEP DIVE – PRODUCTIVE</u> James presented the Deep Dive on the Productive pillar, which provided the Board with an update on progress against the agreed strategic priorities and objectives, noting that this pillar supports delivery of safe and high-quality care through financial sustainability, productivity, commercial development and sustainability and that the Trust is three months into Year 2 of the 2026/27 plan. Advising that delivery against the 2026/27 objectives was the focus of the report, James highlighted that the financial position was off-plan, with recovery plans in place in relation to OoA placements, CRfD, wider flow, Inpatient overspends linked to acuity and additional observations and the efficiency programme. He also reported progress across system optimisation and automation, copilot, transformation portfolio work, GiRFT, preparation for the Mental Health Act implementation in September 2026, the commercial unit and the Estates and Sustainability programme. The Board noted the key risks across the Productive pillar, including delivery of the financial and efficiency plans, demand and capacity pressures affecting productivity and flow, the pace of commercial development, transformation capacity and the delivery pace of the Digital Plan. The assurances provided through established governance arrangements, Board oversight, RAG ratings and key performance indicators across the four themes was also noted. Advising that the Finance and Performance Committee had discussed the report and noted the significant breadth of activity within the Productive pillar, Jo challenged what was being asked of staff in-year, particularly across the Digital Plan, Transport Plan and Green Plan. She observed that reductions in LoS and bed days would also support sustainability. Whilst commending the ambition, Jo questioned whether all elements could be delivered within current resources, emphasising the need to focus on the areas with greatest impact. Rather than simply adding further priorities, Selina agreed that the Board needs to prioritise two or three areas. She emphasised the need for discipline, while recognising that local priorities also need to be taken into account. Mark advised that the Trust has received a significant number of national requests in recent weeks and acknowledged that staff were being asked to do a great deal. He noted that whilst some aspects can be delivered, they may need to be scheduled over a longer timeframe, provided there is clear rationale for this. James confirmed that, while the financial position is off-track, assurance is provided on the other areas presented.

	RESOLVED: The Board of Directors: 1. Received assurance that progress across financial sustainability, productivity, commercial development and sustainability supports delivery of the Trust Strategy. Whilst the Trust is only three months into the 2026/27 plan, things are progressing well other than being financially off-plan. Recovery and focus remains on financial improvement here, but good progress continues in the other aspects of the strategy and workstreams 2. Noted the current progress, associated risks where not progressing as desired and the recovery actions in place. A key focus remains on OoA, CRfD (and wider general flow) and Inpatient overspends linked to acuity and additional observations 3. Supported the continued focus on productivity, transformation delivery and financial grip, recognising the need to move into not just resolving 2026/27 but a bigger emphasis on the medium-term financial sustainability.
DHCFT/ 2026/065	<u>FUNDAMENTAL STANDARDS OF CARE REPORT (CARE QUALITY COMMISSION (CQC) DOMAINS) (SIX-MONTHLY)</u> Tumi provided an update on the Trust's current regulatory position, recent CQC activity, Mental Health Act visits, Fundamentals of Care reviews and key quality developments across the CQC domains, noting the positive regulatory position and the continued assurance provided through CQC engagement and internal quality assurance arrangements. The Community Mental Health inspection had now been confirmed as 'good', with all services rated 'good' or 'outstanding' and the Trust continuing to work with the CQC on all action plans. The Board noted preparations for the anticipated Well-Led inspection, the Snowdrop action plan in collaboration with DCHS, the medical devices recovery plan, completion of actions relating to the Prevention of Future Deaths notice and positive external accreditation outcomes including Baby Friendly, Royal College and Triangle of Care. Lynn confirmed that quarterly assurance is received at the Quality and Safeguarding Committee. Reflecting on the progress made over the previous 12 months. Mark pointed out that the CQC publication of the Community Mental Health outcome represents a significant step forward, with the external regulator confirming services as 'good'. Selina acknowledged what had been achieved during a period of change and noted that the assurance grid was good and green. To sustain the position beyond CQC ratings, the importance of staff engagement and the enthusiasm being demonstrated by staff was highlighted. RESOLVED: The Board of Directors: 1. Noted the positive regulatory position, the progress made in response to inspection and review findings and the areas requiring continued oversight through Care Group, Divisional and Quality and Safeguarding Committee governance 2. Received significant assurance regarding the Trust's ongoing compliance with CQC regulations and fundamental standards of care.
DHCFT/ 2026/066	<u>OUTCOME OF BOARD STORIES (ANNUAL)</u> The Board received an overview of the stories presented between March 2024 and November 2025. It was noted that the stories provide a direct line of sight between lived experience, organisational learning and delivery of the Trust Strategy, particularly in relation to quality, equity, workforce culture, service improvement and partnership working. It was acknowledged that feedback should be provided to those who had shared their stories and it was confirmed that each story had been followed up, with learning used within the 4Ps and linked to continuous improvement and the Trust's culture. The Board noted that learning has been taken back into services and that clinicians are making their own improvements as a result.

	Reflecting on the emotional content of some stories and the difficulty to anticipate the depth of issues when they are shared live with the Board., it was agreed that consideration be given to providing a cautionary alert, where upsetting issues may be included. Drawing attention to the range of stories shared by patients, colleagues and carers, including learning from the autism assessment team story, Selina suggested improved narrative to clearly reflect the impact that had been made and the improvements sought for other services. Lynn also challenged what differences can be seen as a result. It was agreed that future reporting should place greater emphasis on the impact on outcomes. RESOLVED: The Board of Directors: 1. Received full assurance that Board stories provide a direct line of sight between lived experience, organisational learning and delivery of the Trust Strategy, particularly in relation to quality, equity, workforce culture, service improvement and partnership working 2. Imposed a caveat to include greater emphasis on outcomes with future reporting.
DHCFT/ 2026/067	<u>WINTER PLAN</u> Vikki presented the Trust's Winter 'Plan on a Page' for 2026/27, which had been prepared in response to a request from the ICB cluster and provided the Board with an early assurance position ahead of onward System submission and further Board reporting. It was noted that the plan focuses on patient flow and effective capacity, including actions intended to reduce delays and avoid patients waiting for extended periods in Acute settings. Advising that the plan represents early preparation as part of the single Derby and Derbyshire winter plan, Vikki reported that, following a subsequent letter dated 17 July from the NHS Chief Executive, an enhanced winter plan and extensive self-assessment would be completed and brought back to the Board prior to submission. Whilst the plan is broadly similar to that of the previous year, Vikki advised that a System-wide learning event had been undertaken, with consideration given to workforce capacity, peak activity and Bank Holiday pinch points, including the need to ensure services are staffed up where necessary. Acknowledging the challenging flow and financial position, Lynn noted that other areas were also relevant. Vikki confirmed that these issues had been factored into the planning, with the intention of ensuring staffing does not drop to minimum levels while avoiding additional spend. The high levels of sickness absence and consultant industrial action were highlighted as factors requiring a realistic approach. Vikki explained that winter planning is often Acute-focused and that Mental Health peaks do not always align with national winter planning assumptions, with no national plan to address this. Jo observed that both best and worst case scenarios need to be understood, noting that bank staffing remains a challenge that will have a cost impact. Whilst not possible to know the position with certainty, Mark requested assurance that annual leave planning is in line with expectations and that there is firm understanding and visibility across every professional group to ensure patient care is prioritised over holiday periods. ACTION: Executive Directors to ensure that reminders are being sent out about effective annual leave planning across every professional group to ensure patient care is prioritised over holiday periods. RESOLVED: The Board of Directors: 1. Noted the Trust's Winter Plan on a Page 2026/27 and the assurance position set out in the cover sheet 2. Received significant assurance that winter planning controls are in place across flow, prevention, workforce planning, IPC, vaccination and escalation, noting identified limitations linked to System dependencies

	3. Supported continued monitoring of LoS, CRfD, workforce hotspots, PIP delivery and System discharge barriers through existing governance routes 4. Noted that delivery impact remains dependent on timely System response across discharge, placements, Local Authority support, Community capacity and Acute interfaces 5. Agreed any further actions required before onward System submission or Board reporting.
DHCFT/ 2026/068	<u>FIT AND PROPER PERSONS DECLARATION</u> Selina presented the annual declaration report, which informed the Board of compliance with the national Fit and Proper Persons (FPP) Test Framework and the Trust's FPP policy. It was noted that NHS England had developed the framework in response to recommendations made by Tom Kark KC in 2019 and that the requirements also reflect CQC expectations in relation to Board Directors being fit and proper for their roles. The Board was advised that the process is actively managed starting with pre-employment checks and then on-going checks, including an annual self-attestation. Advising that all Board members have Disclosure and Barring Service checks in place, Selina highlighted that due to patient contact within their respective posts, Girish and Tumi undertake an enhanced check. FPP compliance for new members of the Board are reported to the Remuneration and Appointments Committee for Executive Directors and to the Nominations and Remuneration Committee for Non-Executive Directors. The annual compliance declaration had been submitted to NHS England by the 30 June deadline. RESOLVED: The Board of Directors: 1. Received full assurance from the Chair's declaration that that all Board Directors meet the fitness test and do not meet any of the 'unfit' criteria and that the Board is fit and proper 2. Noted the compliance against the national FPPT Framework.
DHCFT/ 2026/069	<u>PATIENT AND CARERS RACE EQUALITY FRAMEWORK (PCREF) (SIX-MONTHLY)</u> Girish outlined progress, key developments and next steps in relation to the PCREF Steering Group. It was noted that the national framework, launched in October 2024, was intended to improve equity of access, experience and outcomes for racially diverse populations, including patients, carers and staff from different ethnic backgrounds. Girish advised that there had been delays due to the PCREF Lead vacancy. However, a lead has now been recruited and is going through pre-employment checks. In the interim, Girish continues to chair the monthly Steering Group, which has generally good attendance from Divisions. The Board noted that the programme remains at an early implementation stage, with a focus on governance, data quality, engagement and pilot delivery. It was highlighted that work is progressing on data quality and analysis, including ethnicity data completeness, race-based analysis of the Mental Health Act and restrictive practice data, along with further deep dives to understand what the data indicates. Girish explained that the numbers are small in comparison with the total number of patients seen, but that hotspots will be identified from the data. The Board was informed that three pilot sites have been identified to support implementation and learning, including Forensic services, Older Adult services and an Acute area. It was noted that alongside Girish, Deborah attends the Steering Group meetings and that PCREF is also considered by the Mental Health Act Committee. Deborah expressed frustration at the length of time taken to implement the framework, while recognising that the appointment of the PCREF Lead was encouraging.

	Welcoming the progress made, Chioma recommended that outcomes need to be clearer and that the Trust should define what it was seeking to achieve. Girish confirmed that outcomes will be informed by the data and that the deep dives across the three pilot areas will be used to set the expected outcomes. RESOLVED: The Board of Directors: 1. Noted the progress made in implementing the PCREF framework 2. Supported continued development of the PCREF pilot programme and action plan 3. Endorsed the focus on improving data quality, community engagement and partnership working 4. Recognised the risks relating to capacity (awaiting appointment of PCREF Lead and Business Information team capacity), data completeness and representation and support mitigating actions 5. Received limited assurance on progress made so far.
DHCFT/ 2026/070	<u>TRUST STRATEGIC PLAN (QUARTERLY UPDATE)</u> Vikki presented the quarterly update on delivery against the Trust Strategic Plan at the end of Quarter 1, 2026/27, covering the period April to June 2026. It was noted that the Strategic Plan 2025-2028 was originally approved by the Board on 4 March 2025, with refined 2026/27 deliverables approved on 19 May 2026 following a review at the close of the first year. The Board was advised that 12 of the 15 strategic priorities were on-plan, with the three off-plan areas supported by rationale. Vikki explained that significant mobilisation had taken place across all priorities and that areas off-plan relate to improving access and achieving target wait times, supporting and promoting staff wellbeing and achieving financial sustainability through improved clinical and operational productivity. These areas are aligned to the relevant BAF risks and are subject to enhanced oversight through established governance routes. Key areas of progress were noted to include learning from incidents arrangements, the Violence and Aggression Collaborative, clearance of the complaints backlog, the Community safer staffing review, service transfers from DCHS, workforce vacancy reduction, delivery of the STRIVE Leadership Programme, mobilisation of the Mental Health Urgent Assessment Centre, progress with the Neighbourhood Mental Health Model and 24/7 pilot, digital delivery plan programmes, Positive Health Difference mobilisation, Estates priorities, ICB governance arrangements, Adult Social Care Living Well contract hosting and the East Midlands Provider Collaborative plan. The good level of detail provided was welcomed and Vikki was thanked for the update. RESOLVED: The Board of Directors accepted significant assurance in delivery of Strategic Plan ambitions at Q1, 2026/27.
DHCFT/ 2026/071	<u>REPORTS FOR NOTING AND/OR APPROVAL ON ASSURANCE AT BOARD COMMITTEES</u> These reports were received for information and noting having previously provided assurance to the People and Culture Committee and the Quality and Safeguarding Committee: <u>People and Culture Committee</u> <u>Medical Job Planning (annual)</u> The Board noted that the Trust is compliant with the current NHS England target of 90% completion of Consultant and SAS job plans and that new national priorities included service-level job planning, an increase in completed job plan rates to 95% for 2026/27 and the ability to demonstrate 98% delivery of job-planned activity. Risks to compliance, including increased NHS England compliance rates and the potential delay to completion of job plans in Adult Community services following the Clinical Director vacancy, were also noted, with mitigations in place through the Trust's approach to the 2026/27 job planning round, including training.

	RESOLVED: The Board of Directors: 1. Noted significant assurance on compliance with the job planning for all Doctors in the Trust 2. Noted the potential delay in the completion of job plans in 2026/27 for Adult Community services due to Clinical Director vacancy which has been recruited since June 2026 3. Supported the progress on elements related to measuring productivity going forward. <u>Quality and Safeguarding Committee</u> <u>Learning From Deaths/Mortality annual report - 2025/26</u> The report covered the period 1 April 2025 to 31 March 2026 and was required under the National Guidance on Learning from Deaths. The Board noted that the Quality and Safeguarding Committee had accepted the report as assurance of the Trust's approach and had agreed that it be considered by the Board and published on the Trust's website in line with national guidance. Lynn highlighted the limited assurance position and challenged the development of learning lessons and how teams learn from deaths. In response, Girish advised that it would take approximately eight months to move to significant assurance. RESOLVED: The Board of Directors: 1. Accepted the report with limited assurance of the Trust's approach 2. Agreed for the report to be published on the Trust's website as per national guidance. <u>Quality Account</u> It was noted that the Quality Account had been approved by the Committee in May under delegated authority due to the requirement for publication by 30 June and the absence of a Board meeting in June. The purpose of the Quality Account as an annual public report describing the quality of services delivered over the previous financial year, providing transparency and accountability, and setting out priorities for improving the quality of care, was noted. The key quality risks and priorities for 2026/27 were acknowledged to include demand and acuity, workforce sustainability, access and flow, unwarranted variation, digital dependency, equality and inclusion and consistency of experience. The assurances set out in the report included embedded Patient Safety Incident Response Framework arrangements, suicide and self-harm prevention planning, patient flow work, sustained reductions in restrictive practice, safeguarding assurance, workforce assurance, digital delivery and the Quality Assurance Framework. RESOLVED: The Board of Directors noted the publication of the Trust Quality Account 2025/26.
DHCFT/ 2026/072	<u>CONSIDERATION OF ANY ITEMS AFFECTING THE BOARD ASSURANCE FRAMEWORK (BAF)</u> Sickness absence was highlighted as a strategic risk with potential implications for the BAF, along with the need to consider whether the Board is assured by the mitigations in place. Mark reflected on the financial position being off-plan in months 1 and 3, noting that consideration is required as to how and when this should affect the BAF. In addition, reference was made to the Board story and the need to understand how the fragmentation of Children's services affects the provision of care on a day-to-day basis. In agreement that these issues should not be considered in isolation, Lynn emphasised the importance of understanding how they come together collectively. It was noted that the BAF is

	structured in component parts and that the Board needs to consider how learning from a difficult Board Story can influence day-to-day services. ACTION: Executive Leads and Lead Committees to consider the whether the BAF wording on sickness absence and the off-plan financial position is specific enough during the next review.
DHCFT/ 2026/073	<u>MEETING EFFECTIVENESS</u> Dave Allen, Public Governor, Chesterfield, noted the emotional impact of Emma's story and reflected on how the service had let her down, highlighting CAMHS as an area of interest and concern. He also noted the impact of trusts working separately, observing that this was not necessarily positive. Describing the Financial Plan as troubling, Dave further reflected that there was more insight than had previously been available. Chris Williams, Public Governor, Erewash, advised that Healthwatch has been extended to March 2027. The challenge of reaching the public to inform the CQC rating was highlighted by Anna Shaw, Associate Director of Communications and Engagement. Jo Foster, Senior Nurse was encouraged by the pertinent matters discussed and she noted that acuity on wards was not aligning.
The next meeting to be held in public session will be held in person on Wednesday, 30 September 2026 at 9.30am in Conference Rooms A and B, Centre for Research and Development, Kingsway, Derby.	

ACTION MATRIX - BOARD OF DIRECTORS - SEPTEMBER 2026							
Date	Minute Ref	Item	Lead	Action	Completion Date	Current Position	
24-Mar-2026	DHCFT/2026/023	Integrated Performance Report (IPR)	Committee Chairs/ Executive Leads	Committee Chairs and Executive Leads to consider assurance levels being received and review the parameters for escalation to Board.	31/07/2026 30-Jul-2026	There have been several discussions about this and there are some development areas about assurance levels highlighted within the AQUA review. Recommending this action is closed as it has been superseded by DHCFT/2026/063 (below action).	Green
19-May-2026	DHCFT/2026/047	Assertive Outreach (AO) Treatment - Community Mental Health Action Plan update	Tumi Banda	Further articulation and re-escalation to the Integrated Care Board (ICB) around the requirement for a stand-alone AO service.	24-Jul-2026 30-Sep-2026	On 02-Sep-2026, Mark Powell, CEO, formally wrote to the CEO of the ICB Cluster to update on Derbyshire Healthcare NHS FT's position regarding the provision of an AO service offer, to request funding to mitigate risks identified by the Trust and to seek an update on the ICB's strategic intent for Commissioning AO services in the future. Awaiting a response.	Amber
21-Jul-2026	DHCFT/2026/057	Board Story	Vikki Ashton Taylor/Girish Kunigiri/Tumi Banda	To relay the issues raised in the story to the appropriate teams and ask them to investigate the issues about fragmentation of services and lack of multi-disciplinary team working within Children's services, including transition to Adult services and why the Trust's clinicians are unable to issue referral letters to private providers.	31-Jul-2026	Followed up directly with relevant clinical teams to review pathway including internal referrals. Broader system wide work underway, led by Mark Powell, to review lead provider arrangements for children's services to reduce fragmentation. Feedback regarding fragmentation will be incorporated as part of the clinical pathway's focus set out in the emerging Clinical Plan.	Green
21-Jul-2026	DHCFT/2026/063	IPR - People	Rebecca Oakley	To consider identifying high performing teams within the Trust and focus on duplicating the good practice in other teams.	30-Sep-2026	Triangulation of workforce and culture indicators is being strengthened through the People Dashboard and reported into the People and Culture Committee, alongside discussion through the Culture Collaborative Group. This will support the identification and recognition of high-performing teams, enable us to better understand the factors contributing to their performance, and ensure that good practice and learning are shared and replicated across other teams and services.	Green
21-Jul-2026	DHCFT/2026/063	IPR	Lead Executives and Lead Non-Executive Directors	To consider the levels of assurance agreed during Committee meetings - further clarity on what is needed to move from limited to significant and/or significant to full assurance. To be covered at a Board Strategy and Development Session, in conjunction with the review of the Board Assurance Framework review, risk appetite and confidence in recovery plans.	24-Nov-2026	Committees to provide additional challenge on levels of assurance at meetings and be more specific on what is needed to improve. These areas have been identified in the AQUA Well-Led report and will be progressed through the action plan.	Amber
21-Jul-26	DHCFT/2026/067	Winter Plan	Girish Kunigiri/Vikki Ashton Taylor/Tumi Banda	To ensure that reminders are being sent out to all staff to ensure effective annual leave planning so patient care is prioritised over holiday periods.	30-Jul-2026	Included in leadership cascade	Green
21-Jul-26	DHCFT/2026/072	Consideration of any items affecting the Board Assurance Framework	Executive Leads and Lead Committees	To consider whether the wording on the BAF on sickness absence (Rebecca Oakley and People and Culture Committee) and the off-plan financial position (James Sabin and Finance and Performance Committee) is specific enough during the next review.	30-Aug-2026	Completed as part of the BAF review.	Green

Key:	Action Overdue	RED		0	0%
	Action Ongoing/Update Required	AMBER		2	29%
	Resolved	GREEN		5	71%
	Agenda item for future meeting	YELLOW		0	0%
				7	100%

Trust Chair's update

Purpose of Report

This report is intended to provide the Board with the Trust Chair's reflections on activity with, and for, the Trust since the previous Board meeting on 21 July 2026. The structure of this report reflects the role that I have as Trust Chair.

Our Trust and Staff

1. I begin this report with some service visits which are always a highlight for me. I visited the following services:

- Tissington House – Older People's service
- Dove Ward and Robin Ward on Carsington Unit
- In Reach Home Treatment team (IRHTT), Older People's service with Justine Fitzjohn, Director Corporate services and Angie Clegg, Governor, Amber Valley
- Derwent Unit – all wards with James Sabin, Director of Finance
- Kedleston - Forensic Inpatient service.

At Tissington House, Jill Smith, Service Manager spoke to me about the service improvements the service had undertaken. I was particularly impressed with the way apprenticeships had been used to develop pathways into Occupational Therapy. I spoke to a newly qualified Occupational Therapist (OT) as well as an apprentice who were both very complimentary about the culture within the team and Tissington House. The service is fully staffed and individuals felt supported. Training is seen as not only an investment in individuals but part of a medium- to long-term strategy in sustainability of the service by 'growing our own'. Jill spoke of service stability and an openness to innovate and improve. I also spoke to the Specialist Registrar who spoke highly of the service and the Nursing leadership. He felt team working, sharing of information and good practice were strong which enabled him to be a good colleague and provide a good service to patients. I also visited Dove Ward and Robin Ward at the Carsington Unit. The staff were very open about some of the difficulties they had experienced and the support that they had received from their managers and the senior leadership team. I was impressed with the confidence of the staff in speaking up. I spoke to the team leader from the Positive Practice team who shared information on some of the patients that he was supporting on the ward. I was struck by the complex needs of the patients that were being cared for on the wards and the extreme risks which were being managed. The IRHTT was an example of good team working and communication. We spoke to a number of team members who were consistent in their sense of team working and belonging and the willingness of individuals to go the extra mile.

At the Derwent Unit, we heard about the extreme pressure the unit had experienced during August. It was apparent that this is a regular pattern and that mental health providers experience their service pressures in the summer rather than in winter. We spoke about the need to have a 'summer pressures' planning mindset. James Sabin, Director of Finance, and I, also had discussions about standardisation of operating procedures, policies and practice, between the north and south, the use of Oxehealth and some of the challenges.

I visited Kedleston, Forensic Inpatient Unit on 14 September. Staff were open about the challenges and the improvements they are making.

My thanks to all of the teams we visited for their openness and willingness to share their day-to-day experiences with me.

2. On 11 August I, met with Vikki Taylor, Deputy CEO and Chief Delivery Officer. She updated me on a number of issues and developments within the Trust and communications with various stakeholders notably regarding the announcement of new Mental Health Emergency Departments (MHED) and the inclusion of Derbyshire Healthcare in the announcement which was factually incorrect. The Trust is developing a Mental Health Urgent Assessment Centre at the Radbourne Unit which has a different remit and referral criteria to that of MHEDs. Both Vikki and Communications have been busy trying to rectify the mistake and provide reassurance to colleagues and wider stakeholders.
3. We were inundated with nominations for the Trust HEARTS awards. We received a total of 170 nominations exceeding the number we received last year. The judges had a very difficult job as the standard was extremely high. Well done to all the nominees and a big thank you to everyone who nominated individuals, teams and services for the awards. The awards will be held on 21 October at 1.00 pm.
4. On 27 August we bid farewell to Leida Roome, Executive PA, and wished her well on her second retirement. Leida has been an integral part of the Corporate Admin team and has a long service history with the Trust spanning over 27 years. One of her duties has been to support the Non-Executive Directors (NEDs). Leida's willingness to help, her can-do attitude and energy will be missed by us all.
5. I attended the Learning and Engagement Hour on 8 September, which provided an opportunity to hear from our colleagues. The session focused on the progress on our 'no excuse for abuse' work which includes a number of workstreams including physical violence and verbal abuse, sexual safety, anti-racism, and police safety. We also heard from Lucy Moorcroft, Head of Organisational Development, Leadership and Wellbeing, about the improvements that have been made in response to colleague feedback in last year's Staff Survey and preparation for the 2026 Staff Survey, which was launched earlier this month.

Council of Governors

6. As I have mentioned in previous updates, the future role of governors in Foundation Trusts will not be a statutory requirement. The Health Bill is currently making its way through various stages in parliament. The NHS Alliance has organised various engagements sessions for chairs, trust secretaries and governors to develop guidance and tools. I joined a webinar session for chairs on 11 August titled 'What follows governors? Lead Governor, Brian Edwards has also attended a session specifically for governors.
7. On 11 August, I also met with Angela Kerry, Public Governor, Amber Valley and Neil Baker, Public Governor, Bolsover and North East Derbyshire, to finalise the agenda for the Governance meeting held on 25 August. The Governance Committee discussed the future of governors and the timetable of the Health Bill as it progresses through parliament. We informed governors that we will not be holding elections for any positions that become vacant arising from any governor stepping down or as the natural term comes to an end.
8. On 7 September, I met with Brian Edwards and Hazel Parkyn, Deputy Lead Governor, to update them on a number of matters concerning the Trust. We also spoke about the work being undertaken to ensure the Trust continues to embed our engagement work with stakeholders and partners within our governance arrangements.
9. On 8 September, I held a virtual coffee session with governors. We had a mix of both staff and elected governors. These meetings are informal and a means for us to get to know each other and the Trust.
10. I would like to thank all of the governors for their support to the Trust, leadership and their counsel to me. It is very much appreciated. I look forward to continuing to work with the governors as we shape our arrangements as the Health Bill works its way through the final stages.

11. The next meeting of the Council of Governors will be on 24 November, following the Public Board meeting on that day. The next Governance Committee takes place on 20 October.

Board of Directors

12. I continue to meet with my NED colleagues on a quarterly basis to review their objectives, development needs and to discuss their perspectives on how the Board and Trust is delivering Trust priorities.
13. On 16 September, the Board held a Joint Board and Divisional leadership day. The focus of the day included the assessment of the Trust, led by AQUA, against the Well-Led domains and how we become a mature leadership team using data and insight to drive decisions and achieve outcomes consistently. Having the tier of leadership below the Board was key for collective ownership as we shared and developed ideas for improvement and actions to take us forward.

System Collaboration and Working

14. On 22 July, Mark Powell, CEO, and I attended the Derbyshire, Lincolnshire and Nottinghamshire (DLN) Winter Planning Assurance and 10-Year Planning event led by the DLN Integrated Care Board (ICB). The expectations to make the left shifts remain without specific investments to enable this to happen. Mark and I continue to advocate for the Trust and mental health.
15. The chairs of the Derbyshire provider trusts met on 27 July, where we discussed our current financial challenges and the need for a continued focus on strategic commissioning to enable the providers to plan, prioritise and deliver in line with our cost improvement programmes (CIPs). I shared our concerns regarding expectations to deliver new developments driven from the centre that are without revenue funding and hence, future sustainability remains a concern.
16. I took part in a tour of the acute and emergency pathway at the Royal Derby Hospital. It was sobering to see firsthand the challenges front line staff face and the sheer volume of attendees. My thanks to Dr James Woodard, Divisional Medical Director, and his staff for their time and for speaking to us.
17. My regular meeting with the Kathy McLean, Chair of the DLN ICB, took place on 15 September. We updated each other on our respective organisational priorities and plans.
18. Mark Powell and I had a four-way meeting with Julie Houlder, Chair and Jim Austin, CEO, of Derbyshire Community Health Services NHS Foundation Trust (DCHS). We discussed the recent transfer of their services to the Trust and how we continue to support joint working between our respective organisations.

Regulators, NHS Providers, NHS Confederation and others

19. I attended the NHS Alliance Board meeting on 23 July. The Alliance reported on the operational aspects of the new legal entity following the merger of NHS Providers and NHS Confederation. We also received a report on the membership position and the general reception of the various providers and commissioners to the NHS Alliance. Overall, it appears to have gone smoothly. Members are happier that they have one membership organisation and they perceive a stronger voice to influence government.
20. On 12 August, I met with Helen Henderson, CEO of Healthwatch. We spoke about engagement, representation and capturing the lived experience of stakeholders in our governance arrangement. It was a useful meeting and provided further food for thought for us to consider as we align and develop our engagement activity across the Trust.
21. As I appraised in my previous update, I am leading the review of the NHS Alliance in relation to race equality and inclusion with the aim to propose recommendations for the Alliance in its internal work in becoming an antiracist organisation and embedding this in its external work. I met with Sir Ciarán Devane, CEO of NHS Alliance, to agree his role in leading the work within NHS Alliance on 13 August.

This was followed by a meeting with some of the senior leaders from NHS Alliance on 25 August. I also met with Lord Victor Adebawale, Commissioner of the review, on 14 September, and I joined the all staff briefing about the review on 8 September.

22. I met the Habib Naqvi, CEO of the Race and Health Observatory, about the work that the NHS Alliance is doing and to seek his input on 7 September.

23. I was invited to 10 Downing Street to attend a roundtable meeting with Muslim representatives from across the health sector on 9 September. Florence Eshalomi MP, the Faith Minister and Baroness Merron, Parliamentary Under-Secretary of State for Women's Health and Maternity, also attended the meeting. The meeting provided an opportunity to discuss the experiences of Muslim staff and patients, faith and belief literacy within the health service, and other issues of concern that individuals wanted to raise.

24. I attended the monthly update call for chairs led by NHSE for the Midlands region. The imperative to achieve financial plans that were submitted by trusts was reiterated.

Strategic Considerations		BAF Risk	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X	1A, 1E	1.1–1.4
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X	2A, 2B	2.1–2.4
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X	3A	3.1, 3.2
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X	4B	4.1

Risks and Assurances

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

Consultation

This report has not been to other groups or committees.

Governance or Legal Issues

Covered as part of the individual items.

Net Zero Duty Implications

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

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

None.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

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

Demonstrating inclusive leadership at Board level

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

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

Recommendations

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

Report prepared and : Selina Ullah
presented by: Trust Chair

Chief Executive's update

Purpose of Report

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

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

National and regional context

New mental health facilities

On 6 August, the Prime Minister made an announcement about a range of new mental health facilities opening across the country.

Derbyshire Healthcare is currently developing a new Mental Health Urgent Assessment Centre (MHUAC) at the Radbourne Unit in Derby, adjacent to the Royal Derby Hospital. We secured capital funding for the development earlier this year.

The MHUAC will support patients already in attendance at the Emergency Department in the Royal Derby Hospital, whose mental health needs could be better supported in the MHUAC. Referrals will be made through the Trust's existing clinical teams, with care being provided in the new MHUAC setting. Initially, our service will only take referrals from the Royal Derby Hospital Liaison team. We remain in dialogue with commissioners about the need for further revenue funding to be able to extend this service offer.

At the time of writing this update, we were making final preparations ahead of the new service opening to patients on Monday, 28 September 2026.

The Integrated Care Board (ICB) cluster has recently confirmed that similar capital funding has been identified to develop a MHUAC in Chesterfield, working towards opening by 2029. A site has not yet been identified for the Chesterfield MHUAC, but we will continue to share updates as this progresses.

The above is part of the Government's redesign of mental health services with the national direction of travel reflecting increasing emphasis on providing earlier intervention, improving access to community-based support and reducing reliance on hospital attendance wherever possible. These ambitions align closely with the Trust's own work to strengthen urgent care pathways, expand community support and developing the MHUACs in Derbyshire. Further revenue funding is required to ensure that any capital developments can be matched with the requirement for more staff.

Winter planning

NHSE requires all providers to complete a Board Assurance Statement (BAS) to accompany its 2026/27 Winter Plan for submission by 30 September. The Trust's final Winter Plan and BAS are included in this meeting pack for approval, having been fully scrutinised at the Finance and Performance Committee. The BAS gives Significant Assurance with no material operational capability gap identified.

National Quality Strategy

In July, NHSE published its new Quality Strategy for NHS-funded care in England. The strategy establishes quality as the organising principle for NHS services over the coming decade and brings together existing commitments and evidence into a single national framework.

The strategy emphasises three core components of quality, including patient experience, with a focus on co-ordinated, compassionate and responsive care delivered by staff who are skilled, supported and able to do their jobs well. This aligns with the Trust's overarching Strategy and our core enabling plans, including the Quality Delivery Plan, the Clinical Plan and the People Plan.

NHSE is expected to introduce a new suite of national quality measures during 2026/27. Whilst measurement is important, the strategy also emphasises the need for organisations to use data intelligently to drive improvement.

Thirlwall Inquiry report and recommendations

On 21 September, NHSE wrote to all NHS Trusts and ICBs following publication of Lady Justice Thirlwall's final report. The Inquiry found devastating failures by individuals and the wider system to act quickly enough to safeguard babies, alongside cultural and governance weaknesses that prevented concerns from being heard and acted upon. NHSE has emphasised that the learning is relevant to every Trust and ICB, not only organisations providing Neonatal services, and requires urgent, curious and open leadership focused on patient safety, safeguarding and speaking up. NHSE has requested that all Boards review the report and consider its findings at the next available public Board meeting, seeking assurance that appropriate systems, controls and organisational culture are in place to safeguard babies and children in every care setting to prevent similar failings occurring.

The Government has committed to begin a programme of action while it considers the recommendations in full. This includes developing a national approach to baby monitoring in neonatal units, strengthening guidance on insulin safety and medical examiner reviews of neonatal deaths, reviewing national safeguarding guidance and training, progressing regulation of NHS managers through a barring scheme, and continuing the National Bereavement Care Pathway for families experiencing neonatal loss.

The Trust will review the recommendations through its governance framework, with relevant matters referred to the Quality and Safety Committee and the People and Culture Committee, as appropriate, to oversee consideration of the findings, monitor any actions arising and provide assurance to the Board. Any risks identified should be discussed urgently with the NHSE regional team.

Housing support programme

As a Trust we welcome NHSE's launch of a national mental health housing support programme aimed at reducing housing-related barriers to discharge and supporting local delivery of rehabilitation and community-based care. The programme reflects the growing recognition nationally of the relationship between housing, recovery and mental wellbeing.

Learning disability annual health checks

NHSE has published updated guidance to strengthen identification of people with a learning disability and improve access to annual health checks and health action plans. The national ambition is to reduce health inequalities, improve preventative care and support earlier intervention. The aim will be to increase the uptake of these annual health checks, to support improvements in equitable access to preventative healthcare.

Equality and Human Rights Commission Code of Practice

On 5 August 2026, the Equality and Human Rights Commission (EHRC) Code of Practice for Services, Public Functions and Associations came into force. The Code provides statutory guidance on the implementation of the Equality Act 2010 and has implications for NHS organisations both as service providers and employers.

The Trust will be reviewing local policies and guidance against the Code and ensure that all patients are cared for with dignity, privacy, safety and respect, in line with the law. The issues addressed by the Code are recognised as highly sensitive for many people. The NHS continues to emphasise the importance of maintaining its values and ensuring inclusive, compassionate and respectful care for all patients, staff and visitors.

Local context

CQC ratings

The Care Quality Commission (CQC) report of our Working-Age Adult Community Mental Health teams (CMHTs) was published in July. The teams received a good rating in each domain and a good overall rating.

This is an improvement on the overall rating received in 2020, when the services were rated 'requires improvement'. This is a really positive step forward and reflects very well on the services' efforts to be patient focused during a challenging period. It also means that all Derbyshire Healthcare services now have an overall rating of either 'good' or 'outstanding'.

This achievement was discussed in our Board meeting in July but was not included in the previous paper due to timing of the CQC report being published.

Advancing Quality Alliance (AQUA) Trust Board Well-Led Development Review

Earlier this year the Board commissioned AQUA to undertake an independent Well-Led Developmental Review against the Care Quality Commission's updated Well-Led framework.

The final report was received in August and concluded that the Trust has made substantial progress in strengthening its Well-Led foundations, identifying particular strengths in strategic direction, culture, leadership capability, governance and partnership working. The review also highlighted a number of areas for further development, including strengthening the measurement of impact, embedding consistent leadership behaviours and demonstrating the outcomes of improvement activity. A development plan has been established and is being progressed through the Trust's governance arrangements to ensure continued organisational improvement and inspection readiness.

CQC Well-Led inspection

Referring to Well-Led readiness, the Trust has received advanced notice from the CQC that a provider-level Well-Led inspection will take place between 3 and 5 November 2026, with NHSE colleagues participating in the assessment of financial and resource governance.

The inspection will focus on leadership, culture, governance, risk management, strategic delivery, staff engagement and the extent to which the organisation demonstrates the eight Well-Led quality statements within the CQC Single Assessment Framework.

A readiness and communications programme is now underway, building on significant preparation already completed.

While the inspection represents an important regulatory milestone, the Trust continues to position Well-Led readiness as part of its broader commitment to continuous improvement, strong governance, an open and inclusive culture and the delivery of high-quality care and services for the communities it serves. The inspection provides an opportunity to demonstrate the significant progress made since the previous Well-Led review in 2020 and the substantial organisational developments delivered during that period.

Baby Friendly benchmark

Congratulations to our 0-19 Children's services in Derby City who successfully passed the new Baby Friendly Initiative assessment, scoring above the expected benchmarks in both the mother and staff audits. This was the team's first attempt to pass the new standards and reflects a significant milestone and a rare achievement.

Crisis text messaging service update

As part of our crisis support offer for local people in Derbyshire, we have launched a text messaging service that is being operated by our Derbyshire Mental Health Helpline team.

The helpline team initially offered this text messaging service to working-age adults who are already open to our CMHTs. They are now also offering the service to working-age adults who have been seen by our Urgent Assessment teams, including our hospital Liaison teams. One of the aims of the service is to improve access to support for individuals who may face barriers to engaging through traditional telephone-based services.

New research shows the challenges in preventing solitary drug use in the UK

The Trust has been working in partnership with the University of Derby to undertake research to prevent solitary drug use in the UK. Drug-related deaths in the UK continue to rise, with many happening when people use drugs alone, because of the heightened risk of fatal overdose in the absence of someone who can call for help or administer naloxone – a medication used to reverse or reduce the effects of opioids like heroin.

The partnership's research has revealed the attitudes that lead drug users to make these dangerous decisions. Overall, the data reveals that people are often using alone not because they are unaware of the risks, but because of the environments they inhabit, marked by stigma, scarcity, fractured relationships and inconsistent service practices. In a predominantly rural area like Derbyshire, where the research was conducted, issues were found to be exacerbated due to limited public transport and social isolation.

Both drug users and health professionals participating in the research highlighted the need for wider circulation of naloxone hydrochloride or 'naloxone' for short, which is typically delivered by injection and blocks opioid receptors in the brain.

These responses show that people who use drugs are not resistant to safety planning; rather, they want interventions that respect them, recognise their circumstances, and offer realistic tools to stay alive. We hope this important research, developed through our strategic partnership with the University of Derby, will shape the conversation around the subject of solitary drug use and, ultimately, result in fewer fatal incidents that could have been prevented.

This work is an example of our continued investment in research partnerships, in line with the National planning guidance which emphasises the importance of embedding research within NHS services, including strengthening research governance, monitoring activity and ensuring patients have opportunities to participate in research.

No excuse for abuse

Many colleagues have taken time to attend collaborative sessions exploring how we can further tackle violence and abuse. A range of valuable feedback and insights has informed our approach to how we will work together to tackle incidents of violence and aggression. We now have comprehensive action plans for the four agreed pillars of focus: physical violence and verbal abuse, sexual safety, racism and police partnerships. Following feedback from the AQUA review, for this and other initiatives, we will include how success will be measured.

Another area of progress has been our co-produced 'No Excuse for Abuse' campaign. We are currently working on a set of patient-facing posters, featuring our colleagues which will be launched shortly.

Carers Staff Network

I am delighted to share that, following feedback from colleagues, a new Carers Staff Network launched in July. The network is co-chaired by Becki Priest, Chief AHP and Deputy Director of Patient Experience, and Jenny Shields, Nurse, Willow Ward, Derwent Unit). Jenny previously shared her experience as a carer at May's Board of Directors meeting. Tumi Banda, Director of Nursing, Allied Health Professionals, Quality and Patient Experience, is the Executive sponsor of the network.

New electric fleet

Our Estates and Facilities team has recently updated the fleet of vans to be fully electric, which will save money and be better for the environment. The nine vans have distinctive branding to show their eco-credentials, and EV charging points have been installed at Kingsway, the Radbourne Unit, London Road, Dale Bank View in Swadlincote and the Derwent Unit in Chesterfield. This is an important step in achieving our Green Plan targets and in helping the NHS become a 'net zero' institution.

Charity golf day

Kedleston Park Golf Club has chosen the Radbourne Unit as their nominated charity for this year. In August, I was invited to take part in a charity golf event to say thank you for their efforts. I was delighted to hear that several thousand pounds had been raised which will be awarded to the Trust later this year. With NHS finances being so constrained, support for our Trust's charitable fund and our League of Friends will become increasingly valuable and important. If you know someone who is looking to raise money for charity, please ask them to consider the Trust.

National suicide prevention event at House of Commons

Trust colleague, Jo Leitner, Business Development Manager, recently attended the House of Commons launch of a new publication '[A Whole Society Blueprint for Suicide Prevention](#) in recognition of his work on suicide prevention.

Jo, who was previously the Trust's Suicide Prevention Lead, was invited to attend by The Churchill Fellowship, a UK charity.

Jo has played a key role in developing the Trust's current [Suicide Prevention Strategy and is opening the Erewash CVS conference on 16 September with a talk on suicide being everyone's business.](#)

Recent achievements

Congratulations to...

- **Ezinne Ignatius**, Occupational Therapy Assistant, Ward 35, Radbourne Unit, who was July's DEED of the month.

Ezinne was nominated for enabling male patients on Ward 35 to engage in activities to help their recovery, including a range of physical exercise each day, and for leading on the development of an exercise passport, co-produced with patients to promote exercise.
- **Geraldine Stone**, Lead Nurse, Specialist Memory Assessment and Dementia Support service, Dovedale Day Hospital, was June's DEED winner. A patient and her husband expressed how wonderful their appointment was with Geraldine, saying, "Our time with Geraldine was a pleasure as we were both immediately put at ease. The discussions needed for assessment were made interesting and retained my wife's attention. Sharing our situation was also helpful to me."
- **Selina Ullah**, Trust Chair, who won the 'Woman of the Year' category at the British Asian Women's Awards. This is a fantastic and well-deserved recognition of Selina's leadership, her commitment to equality, diversity and inclusion, and the positive impact she continues to make across the NHS and wider communities.
- Colleagues in our **Clinical Research team** who have worked together with the University of East Anglia on the National Institute for Health and Care Research iACT4carers project. This trialled internet-delivered self-help acceptance and commitment therapy (ACT) for family carers of people with dementia who were experiencing anxiety symptoms. The clinical effectiveness paper from the trial has now been published in The Lancet and is available online – this confirms carers using the digital platform had lower levels of anxiety and depression after three and six months compared with those receiving usual care alone and the meaningful benefits it made to those involved.

- Our **Knowledge and Library services team** who successfully met all 16 essential indicators in a recent Quality and Improvement Outcomes Framework (QIOF) assessment by NHSE. The assessment identified a number of areas of good practice including the library's welcoming environment that supports study, collaboration and wellbeing. The development of tailored digital guides for different professional groups and increased access to evidence through digital tools such as LibKey Nomad was also recognised.
- Seven colleagues from Derbyshire Healthcare have been named as finalists in the 2026 Apprenticeship Awards. Their shortlisting recognises the achievements of apprentices who are training and working in health and care roles across Derbyshire, making a positive difference in their teams while gaining the skills and experience needed to build careers in the NHS. Congratulations to **Modupeola Falase, Nathaniel David, Phoebe Louise Fullerton, Ben Chapman, Kerry-Anne Doyle, Laura Bevington** and **Niamh Kerry**.

Staff engagement

In memory of our former colleagues

In July we received the sad news that **Deborah Rogers** from our Children's services team had very sadly passed away. Colleagues from across the Trust came together to pay tribute to Deborah in a virtual, one-minute silence. Arrangements to include a lasting tribute to Deborah in our memorial garden at Kingsway Hospital are being planned for the end of this month.

Staff awards

This year's HEARTS awards will take place on 21 October – thanks to our sponsors (Patchwork, LIO, Hill Dickinson, Thalamos, Browne Jacobson and Arden Partnership) this year the event will take place off-site, at Makeney Hall.

170 nominations were submitted by colleagues, service users, carers and partner agencies. At the time of writing this paper, I had received the pack of nominations for this year's awards, ahead of the judging panel meeting in September. It is clear that there are many high-quality entries this year and I have shared my congratulations with everyone nominated. I am looking forward to the awards taking place next month.

Team visits

I have continued to get out across our different sites and have visited:

- The Finance team and Catering teams on 3 September
- Mental Health Together on 8 September (service users, carers, lived experience)
- Derby Recovery Partnership and the teams at Ripley Town Hall on 10 September
- Cubley Court and the Kedleston Unit on 14 September.

I have also met with colleagues from the ICB and NHSE as part of my routine, external relationship building.

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

- Vikki Ashton Taylor, Deputy Chief Executive and Chief Delivery Officer, has visited the following locations:
 - 30 July - Induction for the Neurodevelopmental Inpatient and Positive and Safe team, Chesterfield
 - 14 August - Ward 35 and 36, Radbourne Unit, Derby
 - 20 August – Mental Health Act team, Kingsway
 - 9 September – Derwent Unit and Specialist Day service team, Ash Green Centre, Chesterfield
 - 15 September – Radbourne Unit, Derby
 - 24 September – Derwent Unit, Chesterfield

- Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary, visited the south In-Reach Home Treatment team (IRHTT), Older Adults, Albany House, Kingsway Hospital, on 11 August
- Rebecca Oakley, Director of People, Organisational Development and Inclusion, visited Bluebell Ward in Chesterfield on 14 August.
- James Sabin, Director of Finance, has visited the following locations:
 - 29 July – South Dementia Rapid Response team (DRRT), Older Adults, Kingsway House
 - 13 August – Scarsdale Hospital, Chesterfield
 - 18 August – St Oswald's Hospital, Ashbourne
 - 20 August – Long Eaton Health Centre
 - 25 August – Radbourne Unit, new Refurb Ward, Derby
 - 27 August – Killamarsh CMHT, Chesterfield
- Tumi Banda, Director of Nursing, Allied Health Professionals, Quality and Patient Experience, has visited the following locations:
 - 29 July – Adult Neurodevelopmental services, Ash Green, Derwent Therapy and Recovery team and Willow, Oak and Sycamore Wards, Chesterfield
 - 4 August – Wards 35 and 36, Radbourne Unit, Derby
 - 5 August – Shared Therapies team, Carsington Unit, Derby
- Girish Kunigiri, Executive Medical Director has visited the following locations:
 - 31 July – Dovedale Memory Clinic, Derby
 - 12 August – Estates and Domestic teams
 - 13 August – North Derbyshire Dales Living Well Team and Child and Adolescent Mental Health services County Amber Valley North
 - 9 September – Mental Health Liaison team and Perinatal Mental Health North team.

Feedback from Executive and Board visits continues to inform local improvement actions and provides an important route for understanding staff experience, patient care and organisational culture. Themes identified through visits are routinely shared through governance arrangements to support learning and improvement.

Raising awareness and community engagement

Thank you to our **League of Friends**, who raised £535 at the Summer Fayre, with all proceeds supporting our patient-facing services. The League of Friends is a group of volunteers who meet regularly throughout the year to plan events and activities to raise valuable funds for our new services. The charity is looking for new members for the coming year – please contact Carole Elter by emailing leagueoffriends94@gmail.com if you would like to be involved.

In August, we promoted breastfeeding awareness month. We also provided public information and support ahead of A' level and GCSE exam results being published this summer.

There were a number of important awareness raising events taking place in September, including World Suicide Prevention Day on 10 September. Information on recognising sepsis was also shared ahead of World Sepsis Day on 13 September.

Strategic Considerations		BAF Risk(s)	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X	1A, 1E	1.1–1.4
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X	2A, 2B	2.1–2.4
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X	3A	3.1, 3.2
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X	4B	4.1

Risks and Assurances

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

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

Consultation

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

Governance or Legal Issues

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

Net Zero Duty Implications

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

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

None.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

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

Recommendations

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

**Report presented and
prepared by:**

**Mark Powell
Chief Executive Officer**

Integrated Performance Report (IPR)

Purpose of Report

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

Executive Summary

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

Quality performance

This section summarises performance across key quality, safety, patient experience and flow measures for May to July 2026.

Overall performance was mixed. Assurance is provided by sustained improvement in absconding, reduction in patients not seen for over 12 months, improved discharge indicators and established governance controls. Continued Board oversight is required for complaints timeliness, restrictive practice, assaults on staff, medication incidents, Care Programme Approach (CPA) reviews and discharge flow.

Areas of assurance

- **Absconding improved**, with incidents reducing from 19 in May to 8 in both June and July, remaining below the improvement threshold
- **Clinically ready for discharge (CRfD) improved** from 9.3% in May and June to 8.4% in July, although it remains above the 3.5% threshold; multi-agency discharge meetings continue to address system barriers
- **Patients not seen for over 12 months reduced** from 400 in May to 354 in July, indicating a sustained improving trajectory
- **CPA annual reviews improved** month on month from 76.3% in May to 79.9% in July, while remaining below the 95% target
- **Number of Falls remained stable** at 47, 46 and 45 across May to July; the dashboard reports that most falls resulted in no or low harm and were concentrated in Older Adult Inpatient services
- **Ligature incidents remained within expected variation**, with fixed-point incidents remaining low at two, five and three and established oversight through the Ligature Risk Reduction Group
- **Incident follow-up improved**, with outstanding incident investigation actions reducing from 177 to 68 between May and July
- **Governance controls remain established** through specialist groups, divisional performance reviews, Care Group meetings, patient safety oversight and multi-agency escalation routes.

Areas of risk

- **Complaints timeliness remains below target.** In July 2026, 42% of complaints were responded to within 90 working days, consistent with the previous report and below the 100% target
- **Restrictive practice remains above ambition.** Physical restraint increased from 151 in May to 170 in June before reducing to 154 in July; seclusion remained high at 31, 34 and 35 episodes

- **Prone restraint remains above the zero target**, with 10 incidents in May; 16 in June and eight in July. Targeted quality improvement work is focused on female wards and the Psychiatric Intensive Care Unit (PICU)
- **Assaults on staff increased** from 45 in May to 57 in June and 69 in July, with incidents concentrated in Older People's Inpatient wards, PICU and Audrey House. Race-related abuse remains a staff safety and equality concern
- **Medication incidents remained above the improvement threshold** at 158 in May and 162 in both June and July, although incidents were predominantly low or no harm and medicines governance actions remain in place
- **Patient-to-patient violence remained variable**, increasing from 39 incidents in May to 35 in June before reducing to 23 in July, with concentration in a small number of Inpatient areas
- **CPA compliance remains below target** despite improvement to 79.9% in July against the 95% target, requiring continued Divisional oversight
- **Discharge flow remains constrained** by housing, funding and social care availability, with CRfD performance remaining above threshold.

Operational performance

The Trust is demonstrating areas of strong performance, particularly in perinatal mental health access, dementia diagnosis, early intervention in psychosis, 72-hour post-discharge follow-up, individual placement support, and maintaining low 14-day mental health readmission rates.

However, several material performance risks remain across urgent access, Inpatient flow, long community waits, paired outcome measure completion, and learning disability and autism Inpatient trajectories.

The most significant pressures relate to demand exceeding commissioned capacity, especially within the Mental Health Helpline, adult autistic spectrum disorder assessment, Community Paediatrics and Community waits for neurodevelopmental assessment. These pressures are contributing to long waits, risk to national oversight framework performance, and a continued need for System-level action alongside internal recovery plans.

Inpatient flow remains a key area of concern. Although inappropriate out of area (OoA) Adult Acute placements have reduced significantly, external bed use persists, particularly for female PICU. Adult Acute and Older Adult length of stay (LoS) remain impacted by delays to discharge when clinically ready, with improvement plans now focused on 72-hour reviews, discharge processes, leave arrangements, Getting it Right First time (GiRFT) review meetings, flow team development and stronger clinical oversight. There is also now a focus on Community teams and bed utilisation versus population served, particularly in Derby City and a focus on crisis and home treatment response

There are also important data quality and practice-change issues. Completion of paired outcome measures at discharge is very low for both adults and children and Children and Young People (CYP) mental health waits over 104 weeks are being affected by outcome measure completion requirements and a national reporting issue that includes some adults first referred as children. These areas require urgent operational grip, clear standard operating procedures, and electronic solutions to support compliance.

The immediate priorities are to sustain improvements in helpline performance, accelerate actions to reduce OoA placements and LoS, deliver backlog reduction plans for Community Paediatrics and Neurodevelopmental pathways, strengthen outcome measure completion, resolve national reporting anomalies with NHSE and maintain system partner engagement on capacity, commissioning, and pathway transformation.

People performance

People performance remains strong across compulsory training, turnover and supervision, with all three measures meeting or exceeding their respective targets. The principal workforce risks are sickness absence and appraisal compliance. Vacancy levels remain broadly stable and agency use continues at a low level, supported by strengthened oversight and vacancy-filling activity.

High performing areas

The Trust continues to demonstrate strong performance across several key workforce metrics. Compulsory training compliance remains robust at 95.5% and continues to perform above the 95% target.

Annual turnover remains healthy at 10.4%, in line with national and regional benchmarks and below the Trust's 12% upper tolerance, indicating a relatively stable workforce.

Clinical supervision compliance is 96.0% and management supervision compliance is 95%, both above the revised 95% target following alignment of the supervision system with the updated policy.

Challenging areas

Sickness absence remains a key concern. The July 2026 monthly rate was 6.8%, comprising 4.3% short-term and 2.5% long-term absence. Anxiety, stress or depression-related illness remains the leading cause, reinforcing the need for sustained focus on wellbeing, early intervention and management capability.

Annual appraisal compliance rose by one percentage point to 87% from the June 2026 figure and remains below the revised 95% target. Focus is required on understanding the decline and completing appraisals that are overdue or approaching renewal, the People and Inclusion team is supporting these actions. The June 2026 vacancy rate was 4.3% of funded posts, a marked improvement on the May 2026 figure of 7.9%. Agency usage remains low compared with the previous year, with fortnightly oversight focused on filling vacancies and ensuring appropriate approval of agency use.

Financial performance

At the end of July, there is a deficit of £1.1m, which has been adjusted for the IFRS16 PFI adjustment, bringing the adjusted financial position to a deficit of £1.0m which is behind plan by £0.1m. The adverse position is mainly driven by OoA expenditure, acuity on the Inpatient wards and a gap in delivery of the efficiency programme, which has been partly mitigated by other underspends.

High performing areas

The plan includes an efficiency requirement of £14.8m with the plan assuming 72% is delivered recurrently. At the end of July efficiencies have delivered £4.2m against a plan of £4.2m. The forecast assumes that the current unidentified gap will be closed and the full efficiency programme will be delivered.

Cash at the end of July was £33.2m (£30.7m last month) against a plan of £23.4m, £9.8m above the plan. There are no concerns in relation to debt recovery.

The Better Payment Practice Code (BPPC) sets a target for 95% of all invoices to be paid within 30 days. BPPC is measured across both invoice value and volume of invoices. At the end of July, the volume of invoices was slightly under the target at 94.63%, but the value of invoices exceeded the target at 98.15%.

Challenging areas

Agency expenditure at the end of July is slightly over plan at £0.2m but is forecast to be below plan by the end of the financial year. Bank expenditure is above plan at the end of July by £0.7m and is forecast to be over plan by £1.8m by the end of the financial year.

At the end of July, OoA expenditure is above plan by £1.3m. The current forecast is based on a reducing trajectory which brings the forecast overspend to £1.3m by the end of the financial year.

Capital is below plan at the end of July by £1.5m. The forecast assumes full spend against the plan of £7.6m including £0.5m of national funded schemes.

Strategic Considerations		Board Assurance Framework Risks	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X	25-26 1A	1.2-1.4
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X	25-26 2A	2.1–2.4
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X	25-26 3A	3.1–3.3
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X	25-26 4A-C	4.1

Risks and Assurances

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

Consultation

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

Governance or Legal Issues

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

Net Zero Duty Implications

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

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

No meaningful impact identified.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

Recommendations

The Board of Directors is requested to:

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

Report presented by:

Tumi Banda

Director of Nursing, AHPs, Quality and Patient Experience

Vikki Ashton-Taylor

Deputy Chief Executive and Chief Delivery Officer

Rebecca Oakley

Director of People, Organisational Development and Inclusion

James Sabin

Director of Finance

Report prepared by:

Peter Henson

Head of Performance and Delivery

Rachel Leyland

Deputy Director of Finance

Liam Carrier

Assistant Director of Workforce Transformation

Joseph Thompson

Associate Director of Physical Health and Quality

Integrated Performance Report

30 September 2026

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

Responsible Committee: **Quality and Safety Committee**

Executive Summary

This update focuses on performance during May to July 2026. Measures are reviewed against the 2026/27 improvement ambitions in the Quality 2026 scorecard and the supporting Quality Dashboard. The period shows a mixed position: absconding, patients not seen for over 12 months and clinically ready for discharge (CRfD) improved; falls remained stable; and ligature activity remained within expected variation. However, complaints timeliness, restrictive practice, assaults on staff, medication incidents, Care Programme Approach (CPA) reviews and discharge flow require continued targeted action and Board oversight. Governance and mitigation remain in place through Care Group and Divisional performance reviews, specialist safety groups, patient experience and patient safety processes, and multi-agency discharge arrangements.

Overview

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

- In July 2026, 42% of complaints were responded to within 90 working days, consistent with the previous report and below the 100% target. The complaints improvement plan remains in place, with oversight through the Patient Experience team, care group performance meetings and the quarterly Patient and Carer Experience report.

Seclusion episodes per month (Target: ≤18)

- Seclusion episodes were 31 in May, 34 in June and 35 in July, above the improvement ambition throughout. Activity remains concentrated in the Psychiatric Intensive Care Unit (PICU) and male Adult Acute wards and is associated with acuity, distress, violence and aggression. Oversight continues through the Reducing Restrictive Practice Group, seclusion reviews and the Safer Steps Programme focused on the highest use areas.

Physical restraint incidents per month (Target: ≤88)

- Physical restraint remained above the improvement ambition, increasing from 151 incidents in May to 170 in June before reducing to 154 in July. Activity was concentrated in a small number of inpatient areas. Positive and Safe training remains above 85%, supplementary training continues and compliance is monitored through the Training and Education Committee and Reducing Restrictive Practice Group.

Physical restraint by prone position (Target: 0)

- Prone restraint remained above the zero target, with 10 incidents in May; 16 in June and eight in July. Incidents were mainly associated with intramuscular medication administration and repeated interventions involving a small number of patients on female wards and PICU. A targeted quality improvement project commenced in August 2026, with individual episode review and ward support continuing through the Positive and Safe team.

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

- Incidents were 39 in May; 35 in June and 23 in July, above the improvement ambition throughout but reducing by July. The Quality Dashboard identifies concentration in PICU and a small number of Adult Acute and Older People's wards. Oversight continues through the Reducing Restrictive Practice Group.

Assaults on staff by patients (Target: ≤24)

- Assaults on staff increased from 45 in May to 57 in June and 69 in July, remaining above the improvement ambition and showing a deteriorating trajectory. Incidents were concentrated in Older People's Inpatient wards, PICU and Audrey House. Monitoring continues through the Reducing Restrictive Practice Group and the Trust's No Excuse for Abuse approach; race-related abuse remains a key staff safety and equality concern.

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

- Ligature incidents were 52 in May, 90 in June and 75 in July. May met the improvement ambition, while June and July were above it; the dashboard reports no sustained increase and continued expected variation. Fixed-point incidents were two; five and three respectively, meeting threshold in May and July. Oversight is maintained through the monthly Ligature Risk Reduction Group alongside ward-level risk management and environmental safety plans.

Medication incidents per month (Target: ≤122)

- Medication incidents remained above the improvement ambition at 158 in May and 162 in both June and July. Incidents were predominantly low or no harm. Recurring themes include storage and temperature monitoring, controlled drug discrepancies, administration errors and prescribing or documentation issues. Mitigations include targeted education, strengthened ePMA use, ward action plans, Pharmacy Datix reviews and escalation through medicines governance groups.

Falls on Inpatient wards (Target: ≤39)

- Falls were 47 in May, 46 in June and 45 in July, remaining above the improvement ambition but showing a stable, slightly reducing trajectory. The Quality Dashboard reports that most incidents resulted in no or low harm and were concentrated in Older Adult Inpatient wards. Oversight continues through the Falls Lead, clinical leadership, bi-weekly falls prevention meetings and monthly Care Group performance review.

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

- Incidents reduced from 19 in May to eight in both June and July, meeting the improvement ambition throughout the period. The dashboard reports common cause variation with no emerging pattern of harm; monitoring continues through inpatient governance routes.

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

- DoC incidents were four in May; three in June and one in July. The Quality Dashboard reports 80% compliance for Q1, with four of five applicable incidents completed within the required timeframe; one case was completed one working day late because contact had to be arranged through probation. Cases remain subject to review and data may change.

CPA annual reviews (Target: ≥95%)

- CPA annual review compliance remained below the 95% target but improved from 76.3% in May to 78.8% in June and 79.9% in July. Variation across Divisions and the effect of small denominators require targeted oversight through Divisional performance reviews, cross-check meetings and service action plans. In July 2026 NHSE published the [mental health personalised care framework: the modern care programme approach](#). The Trust will be transforming to the new framework. This will be through a transformative programme. CPA key performance indicators will remain in place until the change is complete.

Proportion of patients CRfD (Target: ≤3.5%)

- The proportion remained above the 3.5% threshold at 9.3% in May; 9.3% in June and 8.4% in July, showing improvement by the end of the period. The principal causes remain unavailable suitable housing, funding arrangements and social care placements. Twice-weekly multi-agency discharge event meetings continue to escalate and resolve barriers.

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

- The number reduced from 400 in May to 376 in June and 354 in July. This is a positive trajectory but remains materially above the zero target and continues to represent an access, safety and regulatory risk. Oversight is maintained through Divisional business meetings, Care Group operational meetings and service performance improvement plans.

NHS Oversight Framework (NOF) 2026/27: percentage of Inpatients referred to and seen by an in-house Tobacco Treatment service who make a supported attempt to stop smoking (Target: 50%)

- Awaiting publication of Q1 data by NHSE.

NOF 2026/27 healthcare worker flu vaccination rate (Target: 49%)

- The proposed Trust target for 2026/27 is a 49% target (a 5% increase from the 2025/26 target). This is an annual measure, and the Campaign starts in October 2026 with the Trust Flu vaccination plan submitted for Trust approval in August 2026 via the People and Culture Committee.

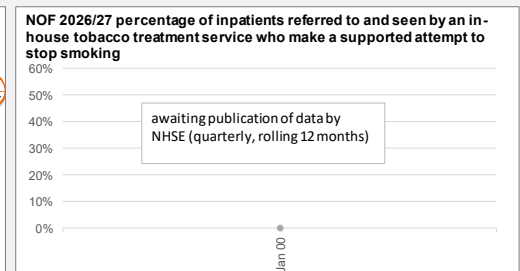
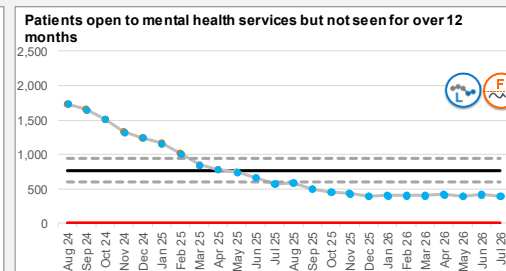
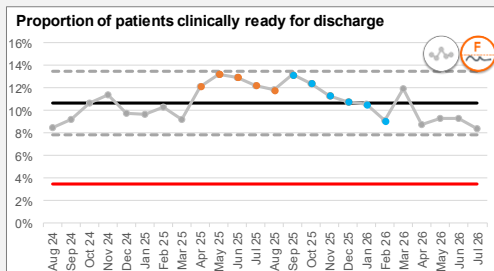
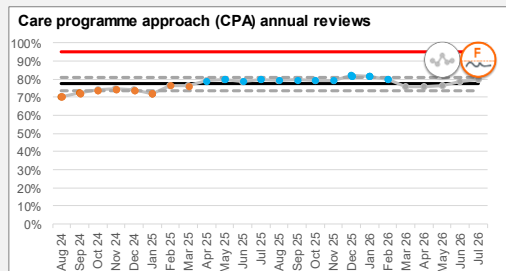
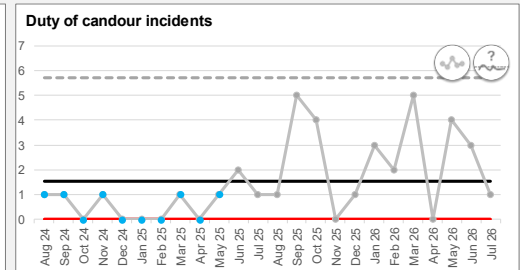
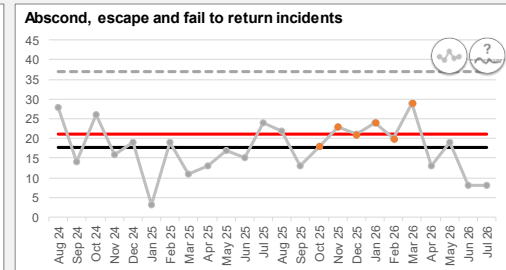
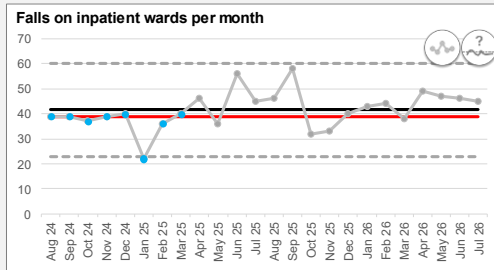
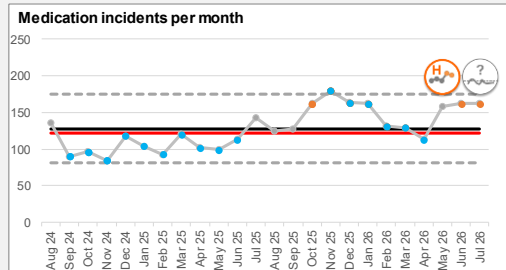
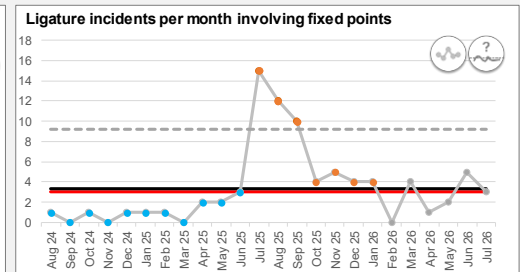
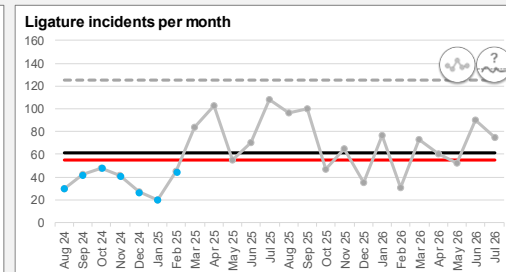
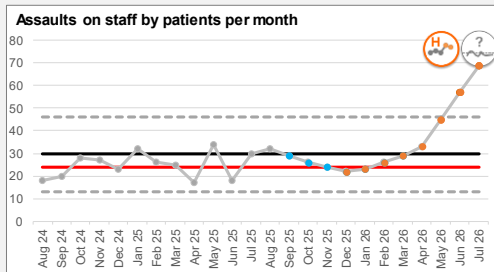
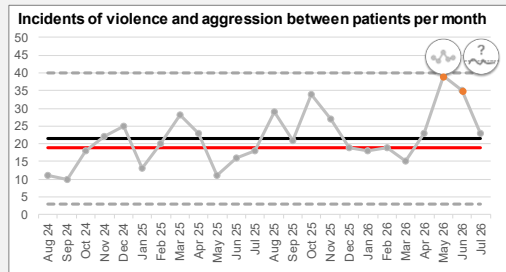
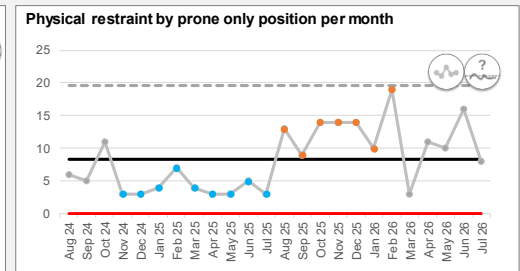
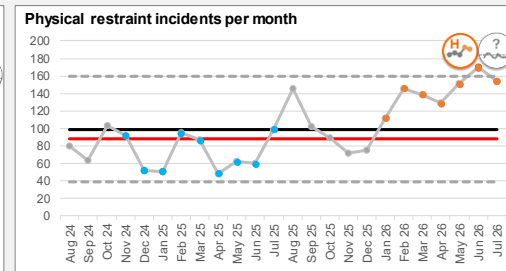
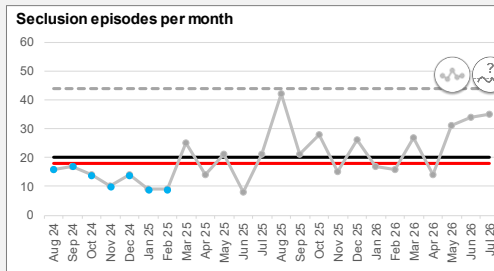
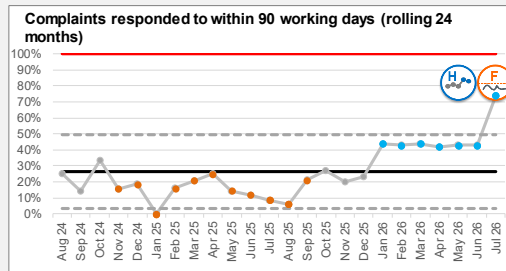
Measure	Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	
No. of complaints responded to within 90 working days (rolling 24 months)	100%	6%	21%	27%	20%	23%	44%	43%	44%	42%	43%	43%	74%	
Seclusion episodes per month	18	42	21	28	15	26	17	16	27	14	31	34	35	
Physical restraint incidents per month	88	145	102	89	72	75	112	146	139	129	151	170	154	
Prone restraint incidents per month	0	13	9	14	14	14	10	19	3	11	10	16	8	
Incidents of violence and aggression between patients per month	19	29	21	34	27	19	18	19	15	23	39	35	23	
Assaults on staff by patients per month	24	32	29	26	24	22	23	26	29	33	45	57	69	
Ligature incidents per month	55	96	100	47	65	35	77	31	73	60	52	90	75	
Ligature incidents per month involving fixed points	3	12	10	4	5	4	4	0	4	1	2	5	3	
Medication incidents per month	122	125	127	162	179	163	162	131	129	113	158	162	162	
Falls per month	39	46	58	32	33	40	43	44	38	49	47	46	45	
Abscond, escape and fail to return incidents	21	22	13	18	23	21	24	20	29	13	19	8	8	
Duty of candour incidents	0	1	5	4	0	1	3	2	5	0	4	3	1	
Care programme approach (CPA) annual reviews	95%	79%	80%	79%	79%	82%	82%	80%	76%	76%	76%	79%	80%	
Proportion of patients clinically ready for discharge	3.5%	12%	13%	12%	11%	11%	11%	9%	12%	9%	9%	9%	8%	
Patients open to mental health services but not seen for over 12 months	0	587	503	460	433	399	408	401	401	421	400	376	354	
NOF percentage of inpatients referred to and seen by an in-house tobacco treatment service who make a supported attempt to stop smoking ¹	50%											awaiting data		
NOF healthcare worker flu vaccination rate ¹	54%									44%	44%			

¹NHS England data

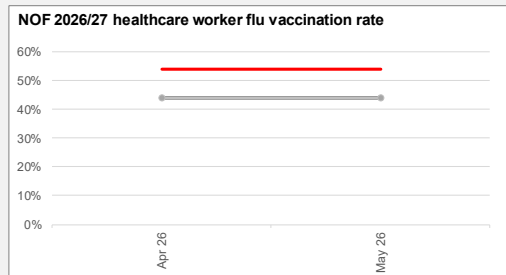
Target

Mean over the past 24 months

Quality Key Performance Indicators – Statistical Process Control Charts



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



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



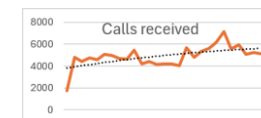
Deputy Chief Executive/ Chief Delivery Officer:
Vikki Ashton Taylor

Responsible Committee: **Finance and Performance Committee**

Executive Summary

Inflow

- Percentage of patients in crisis to receive face-to-face contact within 24 hours:** this is an NHS oversight framework (NOF) measure of the proportion of urgent referrals made to crisis teams and mental health single points of access who were seen face to face within 24 hours. In the latest published data, the service achieved 68% against the national average of 71% and placed in the worst performing quartile of providers. A full performance improvement plan (PIP) is in place, and weekly oversight meetings have been instigated to ensure recovery is swift. Some of the decline is due to a recent cleanse in data quality reporting and as a result we are expecting some recovery by next month owing to this. Sickness and Vacancies are a contributing factor in this metric and are outlined in the PIP. The position is expected to be recovered by the end of Q3.
- Mental Health Helpline:** From the latest official statistics in development published by NHSE (June 2026), the proportion of calls to the helpline which were abandoned (callers hung up) after interactive voice response call steering was second highest in the Midlands at 40%. In comparison, the national average for calls abandoned was 25%. The Trust's speed to answer calls was the third quickest in the Midlands, at 86 seconds. This was considerably quicker than the national average of 213 seconds. Demand for the service continues to remain high, with call volumes for the professional line being up to 200 per week and the helpline being up to 800 per week. The service remains focused on delivery of the performance improvement plan, with weekly performance cross-check meetings which have been reviewed by the new team leadership in place following operational phase 1b. The service continues to provide daily Mental Health Practitioner support to East Midlands Ambulance service (EMAS) colleagues in respect of the Mental Health Response Vehicle, and have also prioritised this as a service necessity, which in turn impacts on the wider pathway of Emergency Department avoidance and hospital admission. The team leadership also remain actively involved with the review of the Section 136 pathway and the development of the Mental Health Urgent Access Centre. Both the P3 team and the DHcFT team are currently under formal consultation regarding the move of premises and potential change in roles and responsibilities. Key updates since the previous report include:
 - The Mental Health text message service was successfully implemented on 1 July 2026 following completion of testing and staff training. The service is now operational and forms part of the wider offer to improve accessibility and choice for people seeking support. This has been a phased implementation plan, currently operational for known patients of working age adult services. There has been lower uptake than anticipated with only 22 text messages last month. As a result, we are expediting roll out, actively discussing with colleagues in CYP to next offer the service to their cohort, before going live to the whole of Derbyshire within the coming weeks
 - The transition away from the 0800 number was completed on 1 July 2026, streamlining access routes into the helpline and supporting improved data capture and reporting. We have seen continued improvement in the response times of both Health and P3 and continue to monitor this weekly. Health are currently answering 83% of the calls they receive, and P3 63% of the calls they receive. This shows continued improvement across the service and work continues to sustain and build on these figures
 - The professional line has successfully migrated to the Ignite platform, providing a single telephony infrastructure. Performance on the professional line has continued to improve, supported by strengthened roster management and reduced vacancy levels. As highlighted above
 - Engagement with the Integrated Care Board (ICB) regarding the future service specification continues. Discussions remain focused on ensuring that commissioning arrangements accurately reflect current service demand of all services provided by the helpline and support service activity and workforce requirements



- Recruitment remains challenging, although substantive vacancies have reduced. The service continues to explore alternative workforce models and skill mix opportunities, alongside ongoing recruitment activity and the use of bank staffing where appropriate
- Whilst improvements have been made, demand continues to exceed commissioned capacity. This remains a risk to performance and service delivery and continues to be highlighted through commissioning discussions and performance assurance processes.
- **Mental health 14 day readmission rate:** the rate of readmission to Adult Acute, Older Adult or PICU beds within 14 days of discharge remains fairly stable at 4% per month and below the national average of 6.7%.
- **Reduce A&E referrals to Liaison teams of patients known to Mental Health services:** this is one of three new mental health sector priority targets set this financial year. Currently there is no data however NHSE have advised that it should start to be published online from September onwards.

Outflow

- **Inappropriate out of area (OoA) Adult Acute placements:** placements have significantly reduced from a high of 28 back in January 2025. However, the Trust continues to require some externally commissioned beds (continuity of care placements) owing to acute bed demand exceeding bed capacity and there being no PICU provision for females in Derbyshire. At the time of writing there is one patient in an inappropriate OoA acute placement and eight female patients in inappropriate OoA PICU placements. In addition to the above, there are three females in continuity of care PICU placements and 12 patients in continuity of care acute placements. This financial year a mental health sector priority has been set to reduce adult acute inappropriate OoA placements by 50% from the March baseline. As there was only one patient out of area in March, this means that the Trust must effectively eliminate inappropriate acute placements by year end. As previously reported, to ensure improvement in the female OoA position are made there are two key actions in progress. Firstly, the appointment of a Clinical Bed Manager for six months to ensure case management and oversight of transition, step up and step down into the acute/enhanced care ward pathway. The role is expected to be in place by the end of September. Secondly there is an instruction to review the enhanced care ward facility (Audrey House). This will be carried out by the Clinical Bed Manager to review the female acute pathway, identifying areas of good practice and improvement areas to inform clinical, operational and commissioning next steps. This will be completed within four weeks of the appointment of the Clinical Bed Manager.
- **Average length of stay (LoS) for Adult Acute and PICU mental health beds (rolling three months):** the latest Mental Health services dataset data published by NHSE (May 2026) placed the Trust 15th highest of 48 NHS providers with an average LoS of 54 days. From internal data the July position reduced slightly to 53 days. Overall LoS has been inflated by discharges of PICU patients with unusually long LoS. Adult Acute LoS has reduced. There has been some impact seen of delays to discharge when clinically ready, which has inflated average LoS by three days. A revised performance improvement plan for adult LoS reduction and improved flow has been developed and is currently in the implementation phase. The key actions to improve the position include improving compliance of 72-hour review, improving the discharge process including compliance with the three-day leave guidelines and implementing the GiRFT review meetings. There is also work to refresh the system wide work on flow, completing phase 2 of the HACT (Housing Association Charitable Trust) project and completing the quality improvement project. Weekly reporting is in place regarding performance against a suite of Acute Inpatients fundamentals of care metrics. It is forecast to be back on trajectory in Q2 and to achieve the financial year end 10% reduction in LoS.
- **Average LoS for Older Adult mental health beds:** the latest Mental Health services dataset data published by NHSE (May 2026) placed the Trust 23rd lowest of 51 NHS providers with an average LoS of 89 days. From internal data, the July position has reduced significantly to 75 days. It is important to note that this reduction is a result of the transfer of Snowdrop Ward into the Trust's portfolio and the transfer date being used as the admission date for each patient who was on the ward at the time of transfer. The Older Adult LoS performance improvement plan has now been in place for eight months and June and July LoS data excluding Snowdrop Ward is showing 84.5 days against our planned trajectory of 82 for Q2. Delay to discharges when clinically ready has inflated average LoS by 10 days, which is significant, although the number of patients CRfD has reduced from 25 in September 2025 to eight in August 2026. With the bed days lost per month during the same period reducing from 600 to 130 days

- Further key actions to improve the position include implementing 72-hour reviews, implementing three-day leave process, increased clinical oversight of CRfD, developing and piloting a flow team, review of home of choice policy and earlier identification and escalation of complex discharges. Weekly reporting is now in place regarding performance against a suite of Older People Inpatients fundamentals of care metrics. We will be reporting 75 days for the NOF target in Q2 and forecast that we will maintain below the end of year target trajectory of 78.
- **Adult Acute and rehabilitation discharges followed up within 72 hours:** the national standard for follow-up after Inpatient discharge continues to be consistently exceeded, ensuring patients get support at the time they are most vulnerable and placing the Trust in the top 12 of providers nationally. This process is tightly monitored on a daily basis by the Trust's Performance Analyst to ensure the safety of patients.
- **Discharges from community mental health services with a paired outcome score:** a new NHS oversight framework (NOF) metric for this financial year is a measure of the proportion of people discharged from Community Mental Health services who had a paired outcome measure completed. This means completion of an outcome measure at the start of their episode of care, then repeating the same outcome measure at discharge in order to enable comparison of the scores at the start and end of treatment as a measure of effectiveness. For adults this is patient reported outcome measures, ie outcome measures completed by the patients themselves and for children, this can be patient or clinician reported. In the latest official data, the completion rate for adults was just 13% and for children was just 8%. This suggests that a significant change in practice is required. Action is being taken to revise the relevant standard operational procedures. Work across the adult and CYP teams has started with a review of the current outcomes being used, with a view of standardising the measures where possible and how we are reporting our data on the Mental Health services data set to capture episodic level care rather than each element of the care pathway. The performance improvement plans will be signed off by the respective Divisional Boards in September 2026.

Elective/access

- **Women accessing Specialist Perinatal Mental Health service:** the current access rate of 12.4% placed NHS Derby and Derbyshire ICB in the top eight performers nationally. The service continues to consistently provide support to large numbers of women during the periods before and after the birth of their children.
- **Adult autistic spectrum disorder assessment (ASD):** activity levels continue to exceed the commissioned target for assessments, with the full year target likely to be exceeded after just five months. Waiting times have reduced slightly but remain very high at around 50 weeks, with demand consistently far exceeding commissioned capacity.
- **Community waits over 52 weeks and waits under 18 weeks:** In the latest official data the Trust ranked sixth worst NHS provider in the country for waits over 52 weeks, at 54%. The national median was just 0.5%. From internal data the position has since improved to 48% in July 26. 35% of children have been waiting under 18 weeks to be seen. The majority of the long waits are for Community Paediatric ASD assessment and/or attention deficit hyperactive disorder (ADHD) assessment (665), with an additional 35 who have been waiting a long time for Physiotherapy. Demand for Community Paediatrics over the past six years has been as high as 450% above capacity and remains to date at 250% above. There has been limited System ownership to prevent flow into health services. There has been no increase in funding to match increased demand or population increase of 10% over the past 15 years. A performance improvement plan has been devised and implemented and further phased improvement through backlog reduction commenced in April 2026. Actions include:
 - Commitment to System ownership and prioritisation of early intervention strategy to reduce flow – internal development day planned for June 2026
 - Review of footprint wide early years programme following the success of the City Pilot to reduce the flow into secondary services for children aged 0-4
 - Paediatric Physiotherapy team have a planned recovery trajectory to reduce all Community waits to the 18 week target, despite a few individual cases where families have not engaged all waits are predicted to be below the 18 week referral to treatment by the end of August 2026
 - Community Paediatrician team – following a transfer of records splitting community waits by clinical priority age groups the 0-4 pathway is currently being targeted. There are a number of workforce issues including long term sickness and performance issues with the team which despite planning may mean that the target to reduce all waits under 52 weeks by November 2026 will still be challenging.

Productivity, skill mix and transformation are all in place to continue to review and consider system wide solutions in order to meet the target.

- **CYP mental health waits for help that are over 104 weeks:** this is a new NOF metric for 2026/27 and a medium-term plan target to eliminate 104 week waits by the end of the financial year. "Help" is defined by NHSE as completion of an outcome measure, plus completion of a clinical intervention. All but 14 of the children reported as still waiting for help have had clinical interventions but none of the total cohort have had a patient reported outcome measure completed. The 14 have not had a clinical intervention yet as they are currently on the waiting list for an ASD or ADHD assessment and so are yet to be seen. A PIP has been devised and is in implementation phase. Actions are also in progress across the wider trust which include firming up the various operational policies to make explicit the requirements for outcome measure completion and frequency, and to explore electronic solutions for dissemination of patients reported outcome measures to patients for completion in advance of appointments. A national reporting issue has also been identified where there are adults being included on this waiting list as they were first referred when aged under 18, the eldest being 41 years old and open to Neurodevelopmental Outpatients. Correspondence is ongoing with NHSE to resolve this. Full recovery remains on trajectory for March 2027.
- **Early intervention in Psychosis:** the Early Intervention services and At Risk Mental State (ARMS) services assess people who are suspected of experiencing a first episode of Psychosis. The national standard is to undertake an assessment and assign a Care Co-ordinator within two weeks of people being referred into the service (target 60%). For the last six months the target has been exceeded.
- **Individual work placement support:** over the last 12 months there has been a 16% increase in the number of people using Community Mental Health services in Derbyshire who have been supported to find work and stay in work by the *Work Your Way* Team.
- **Dementia diagnosis:** data is available at ICB-level only and NHSE is now publishing the data quarterly. In the latest quarter nationally 66.2% of patients had a recorded diagnosis. At 69.6%, NHS Derby & Derbyshire ICB placed 10th best in the country.
- **CYP mental health referrals receiving a full clock stop within four weeks:** this is one of three new mental health sector priorities for 2026/27. The target is to achieve 50% by financial year end, which is a significant increase from the current performance of 5%. This metric has historically applied to the Mental Health Support teams which are commissioned to achieve this target. In Derbyshire this contract is delivered by a private provider 'Compass'. Applying this metric to Tier 3 Child and Adolescent Mental Health services (CAMHS) is a challenge and we are currently reporting an average 20 week wait. Prior to the introduction of this metric the Trust was working to a three-year plan as agreed with the ICB to achieve the four week target. Work is currently underway to review the performance improvement plan to work towards this revised target.

Collaboratives

- **Transforming care programme:** for adults, the Trust and System have agreed a trajectory for 2026/27 to reduce from 32 Inpatients in Q1 down to 28 in Q4. As of July 2026, there were 19 adult Inpatients with autism, which is three above trajectory, and 17 adults with a learning disability and autism, which is one above trajectory, giving a total of 36 adults in total, four over the trajectory of 32. The agreed target threshold for CYP Inpatients is static at three per month. Currently there are four CYP Inpatients, which exceeds the target threshold by one. With ICB support, we continue to align the Learning Disability and Autism (LD&A) Patient Review team with the ICB Escalation team which will strengthen the transforming care pathway. Our aim is that the team will provide increased oversight and facilitating shared system ownership for the most complex cases across Derbyshire. The primary challenges with the LD&A patient is appropriate care and accommodation pre and post-admission alongside system tolerance of risk often leading to out of hours admissions. A performance improvement plan is now in place and shared with System partners to address these issues with the aim to achieve the target of LD&A admissions of 28 by March 2027.
- Living Well:** Living Well delivery remains broadly on track, with Adult Social Care funding now confirmed in principle and several practice and operational improvements underway. The main risks relate to workforce capacity, leadership resilience, ICB governance transition and sustainability beyond March 2027. Continued support is required to finalise contractual arrangements, maintain system oversight during ICB transition, and agree longer-term programme capacity and governance arrangements.

OPERATIONAL KEY PERFORMANCE INDICATORS

Measure	Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	
Long term plan metrics														
Inappropriate adult acute & PICU mental health out of area placements at month end [^]	5	11	10	4	7	4	7	3	6	6	11	7	9	
Women accessing specialist perinatal mental health services (rolling 12 months)* ^{^^}	1242	1395	1365	1360	1365	1360	1355	1385	1395	1365	1365			
Perinatal access rate (ICB)*	10%	12.6%	12.4%	12.3%	12.4%	12.3%	12.2%	12.5%	12.7%	12.5%	12.4%			
Individual work placement support access (rolling 12 months)*	690	760	755	780	810	805	845	845	860	885	910			
NHS oversight framework trust operational services scoring metrics for 2026/27														
Proportion of patients waiting over 52 weeks for community care	0%	65%	65%	66%	62%	66%	62%	63%	51%	52%	54%	55%	48%	
Proportion of patients waiting less than 18 weeks for community care	92%	14%	11%	16%	18%	20%	23%	20%	27%	25%	26%	27%	35%	
Children and young people's (CYP) mental health waits for help that are over 104 weeks*	5%			10%	10%	10%	11%	12%	13%	13%	12%			
Adults discharged from community mental health services with a paired outcome score*	60%									14%	13%			
CYP discharged from community mental health services with a paired outcome score*	60%									10%	8%			
Mean length of stay for adult acute mental health and PICU patients (latest 3 months)	46.5	52	52	52	55	56	57	56	52	51	54	54	53	
Mean length of stay for older adult acute mental health patients (latest 3 months)	78.1	86	92	107	101	86	87	93	96	95	89	79	75	
Adult acute and rehabilitation discharges followed up within 72 hours (latest 3 months)	80%	85%	89%	86%	91%	86%	91%	92%	89%	90%	88%	88%	91%	
Mental health 14-day readmission rate (latest 3 months)*	5%	5%	4%	5%	1%	2%	3%	5%	3%	4%	5%			
Percentage of patients in crisis to receive face-to-face contact within 24 hours*	71%	76%	75%	76%	75%	76%	78%	81%	71%	78%	68%			
Data quality maturity index	95%	99%	99%	99%	99%	99%	98%	97%	97%	98%	98%	98%	98%	
Key operational measures														
Children & young people eating disorder routine referrals seen within 4 weeks*	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			
Children & young people eating disorder urgent referrals seen within 1 week*	95%	#N/A	#N/A	#N/A	#N/A	#N/A	100%	#N/A	#N/A	#N/A	100%			
Dementia diagnosis rate - the data are now published quarterly only (ICB)*	68%	68.9%	68.8%	68.9%	68.8%	68.9%	68.7%	68.7%	69.8%			69.2%		
Early intervention in psychosis 2 week waits from referral to treatment - complete	60%	41%	52%	85%	56%	78%	41%	67%	73%	70%	88%	72%	63%	
Adult ASD assessment – number of people waiting at month end	219	1399	1379	1403	1445	1388	1375	1305	1284	1288	1293	1291	1180	
Adult ASD assessment – average wait (weeks)	18	53	55	55	54	56	53	50	50	49	49	48	50	
Adult ASD assessment – number of assessments completed per month	26	44	47	34	53	34	53	54	56	68	56	68	77	
Mental health sector priorities 2026/27														
Reduce adult acute out of area placements by 95% from March 26 baseline (1 patient)	0									0	2	1	1	
Reduce A&E referrals to Liaison teams of patients known to mental health services										Awaiting publication of data by NHSE				
Children & young people mental health referrals receiving a full clock stop within 4 weeks	50%									7%	5%			

Data not available yet - awaiting publication by NHS England

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

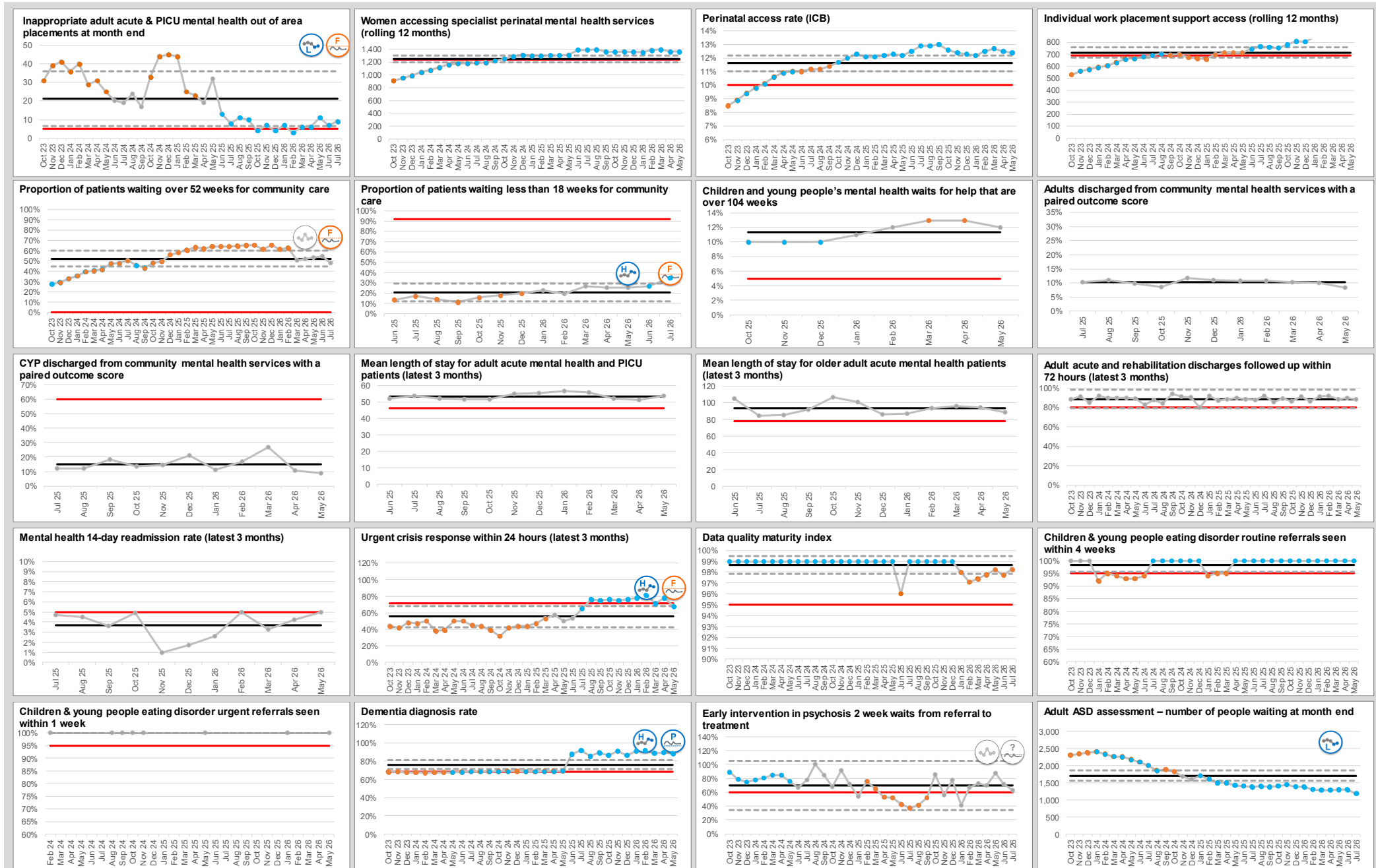
* Data source = NHS England

^{^^} Perinatal and maternal mental health services

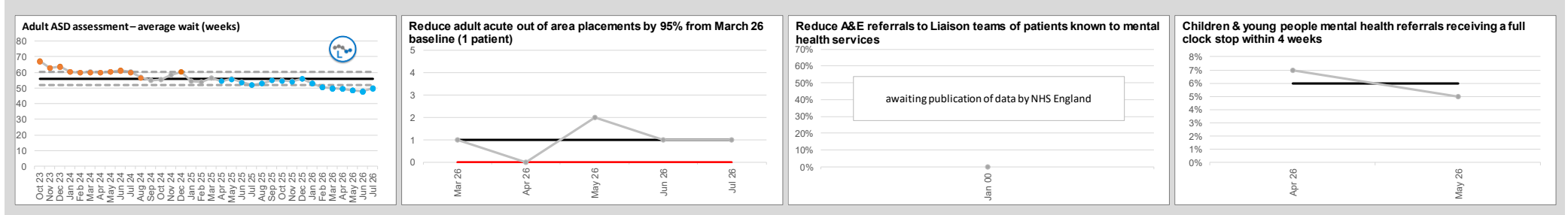
** Rolling 3 months, length of inpatient spell of patients discharged

For more information regarding the NOF 2026/27 see: <https://www.england.nhs.uk/nhs-oversight-framework/>

Operational Key Performance Indicators – Statistical Process Control Charts



Operational Key Performance Indicators – Statistical Process Control Charts





Director of People, Organisational Development and Inclusion:
Rebecca Oakley

Responsible Committee: **People and Culture Committee**

Executive Summary

People performance remains strong across compulsory training, turnover and supervision. Sickness absence and appraisal compliance remain the principal areas requiring focused action, while vacancy levels are broadly stable and agency use remains low.

Annual appraisal: compliance has fallen by one percentage point from the previous month to 87%. In April 2026 appraisal compliance was at 91%. This is below the revised 95% target. Actions will focus on understanding the decline and addressing appraisals that are overdue or approaching renewal. The People and Inclusion team is speaking with managers to ensure the hold appraisals in a timely manner and that systems are updated when the appraisal takes place.

Annual turnover: remains in line with national and regional comparators at 10.4% and has remained below the Trust's 12% upper tolerance for the last year.

Compulsory training: compliance remains high at 95.5% and continues to exceed the 95% target. Work continues to address training that is overdue or approaching renewal to sustain performance.

Sickness absence: the July 2026 monthly rate was 6.8%, an increase of 0.5% on the previous month and an increase of 1.3% compared to August 2025. Short-term absence accounted for 4.3% and long-term absence for 2.5%. Anxiety, stress or depression-related illness remains the leading cause. Work is underway to support our people to remain well at work. Our work to support long-term absence cases is starting to show improvement with a reduction in absence in May 2026 from 3.8% to the current rate. Short-term absence needs further dedicated focus.

Vacancy rate: the July 2026 rate was 4.3% which is a significant improvement on the May 2026 figure of 7.92% of funded posts. It is calculated from funded full-time equivalent posts less staff in post at month end.

Agency usage: has reduced significantly compared with the previous year and remains low. Agency staff continue to be used for medical roles, Registered Mental Health Nurses and some Healthcare Assistants. The Agency Reduction Panel meets fortnightly to oversee vacancy filling and ensure appropriate approval of agency use.

Supervision: compliance targets were reset to 95% to align with comparable mental health trusts and provide a sustainable benchmark. Following alignment of the supervision system with the revised policy, clinical supervision compliance is 96.0% and management supervision compliance is 95.2%, both above target.

NOF Staff Survey: the latest NHS Staff Survey measures included within the NOF provide an important assessment of staff experience, engagement and morale. The table below shows the Trust's reported performance against these measures and the national comparison, with the Trust reporting positive scores compared to the comparators in all areas other than advocacy. The results will continue to inform targeted action through the People and Culture governance arrangements.

NOF staff standards: performance against the NOF staff standards is set out in the table below. The measures provide assurance on the Trust's core workforce arrangements and highlight where further management action is required. The Trust is performing well against comparators.

PEOPLE KEY PERFORMANCE INDICATORS

Measure	Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	
People Performance														
Annual appraisals ⁴	95%	93%	93%	91%	91%	91%	91%	92%	92%	91%	88%	86%	87%	
Annual turnover (target 8-12%)	12%	10.1%	10.1%	10.4%	10.7%	10.8%	10.7%	10.8%	10.5%	10.5%	10.3%	10.4%	10.4%	
Compulsory training	90%	94.6%	94.6%	94.8%	94.5%	94.6%	94.5%	95.0%	94.8%	95.4%	95.5%	95.7%	95.5%	
Vacancy	5%	10.4%	9.1%	8.9%	8.5%	6.7%	6.4%	5.8%	5.6%	8.0%	7.9%	4.3%	4.3%	
Bank staff use	5%	4.5%	5.1%	4.5%	5.2%	4.7%	4.2%	4.7%	5.2%	5.7%	4.3%	5.4%	4.5%	
Agency staff use	1.9%	0.5%	0.4%	0.5%	0.4%	0.5%	0.4%	0.5%	0.7%	0.4%	0.4%	0.5%	0.3%	
Management supervision - staff compliant with supervision policy ³	95%	85%	87%	88%	86%	89%	88%	85%	94.8%	96%	95%	95%	95%	
Clinical supervision - staff compliant with supervision policy ³	95%	82%	83%	85%	86%	88%	88%	89%	96%	96%	96%	96%	96%	
NHS oversight framework														
NHS Oversight Framework (NOF) sickness absence rate	5%	5.5%	5.8%	6.6%	6.6%	6.3%	6.0%	6.2%	6.1%	6.3%	6.3%	6.3%	6.8%	
Long term sickness (28 days plus)	n/a	2.8%	3.5%	3.6%	3.9%	3.7%	3.2%	3.2%	3.5%	3.7%	3.8%	2.4%	2.5%	
Short term sickness (<28 days)	n/a	2.7%	2.3%	2.9%	2.6%	2.6%	2.8%	2.9%	2.6%	2.6%	2.5%	3.9%	4.3%	
NOF annual NHS staff survey - raising concerns sub-score ¹	6.64	6.76	6.76	6.76	6.76	6.76	6.76	6.76	6.64	6.64	6.64	6.64	6.64	
NOF annual NHS staff survey engagement theme score ¹	7.02	7.07	7.07	7.07	7.07	7.07	7.07	7.07	7.02	7.02	7.02	7.02	7.02	
NOF annual NHS staff survey advocacy rate ¹	6.87	6.02	6.02	6.02	6.02	6.02	6.02	6.02	6.02	6.02	6.02	6.02	6.02	
NOF annual NHS staff standards sub score ¹	7.77									7.82	7.82	7.82	7.82	
NOF national education and training survey overall satisfaction score ²	77.4%	78.9%	78.9%	78.9%	78.9%	78.9%	78.9%	78.9%	79.4%	79.4%	79.4%	79.4%	79.4%	

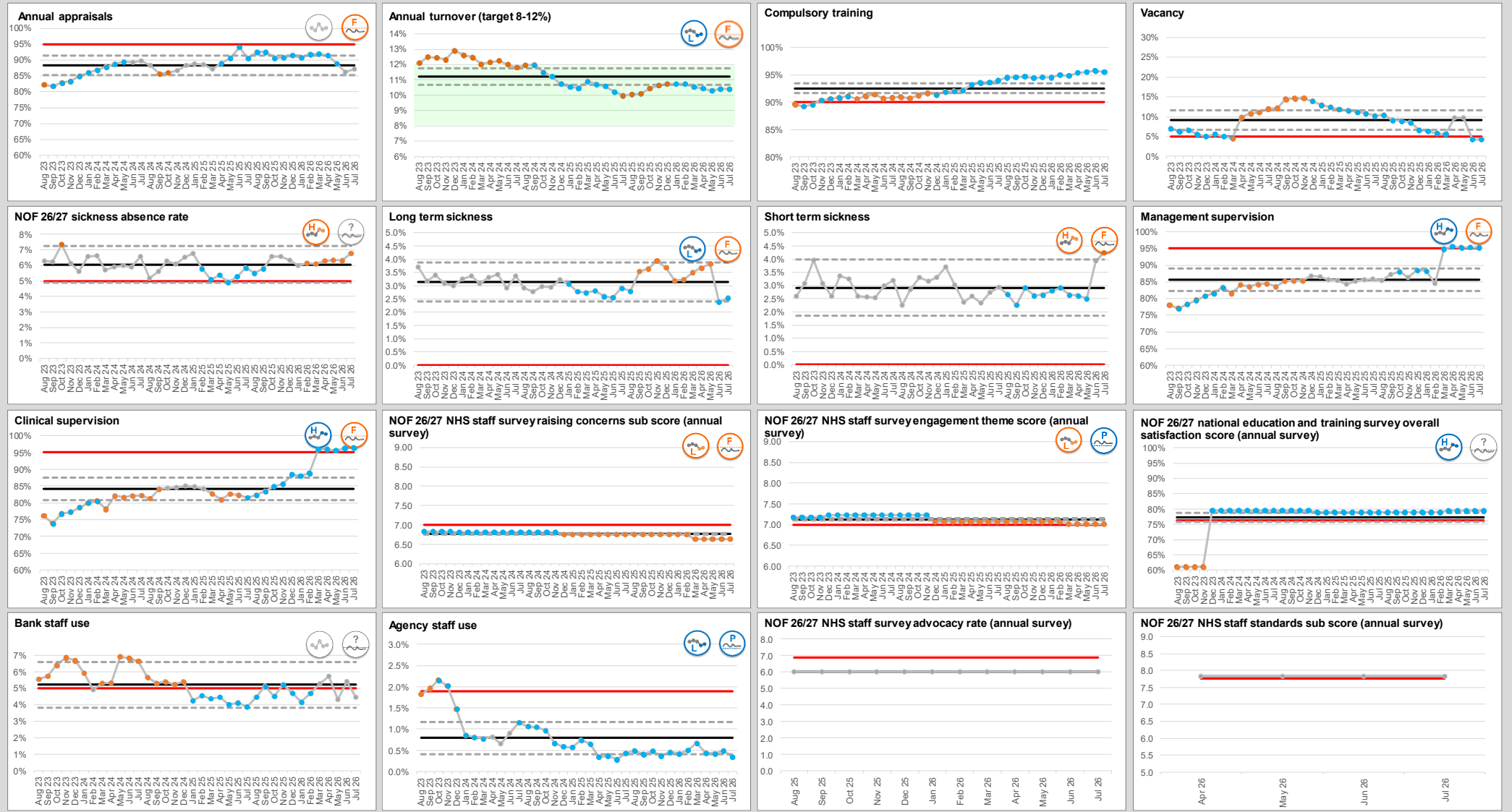
¹2025 survey results were published in March 2026. Target = national average (2024 raising concerns = 6.74, and 2024 engagement = 7.07).

²2025 survey results were published in March 2026. Target = national average.

³System changes implemented from March 2026

⁴Target increased from 90% in April 2026

People Key Performance Indicators – Statistical Process Control Charts





Director of Finance:
James Sabin

Responsible Committee: **Finance and Performance Committee**

Executive Summary

Overall

At the end of July, there is an overall deficit of £1.1m, which has been adjusted for the Private Finance Initiative (PFI) adjustment related to the International Financial Reporting Standards (IFRS) 16 accounting change, bringing the adjusted financial position to a deficit of £1.0m which is worse than plan by £0.1m.

The adverse position is mainly driven by OoA expenditure, acuity on the Inpatient wards and a gap in delivery of the efficiency programme, which has been partly mitigated by other underspends.

The forecast remains to achieve the breakeven plan. However, there are several risks that need to be managed throughout the financial year with regards to: the delivery of the efficiency programme in full, achieving the reducing trajectory in out of area expenditure and managing other costs pressures in year.

Efficiencies

The plan includes an efficiency requirement of £14.8m with the plan assuming 72% is delivered recurrently. At the end of July efficiencies have delivered £4.2m against the plan of £4.2m, 62% has been delivered recurrently against a plan of 61% YTD. The forecast assumes that the full efficiency programme will be delivered.

Temporary staffing

Agency expenditure at the end of July is slightly over plan at £0.2m but is forecast to be below plan by £0.2m at the end of the financial year. The two highest areas of agency usage continue to relate to Consultants and Nursing staff.

Bank expenditure is above plan at the end of July by £0.7m and is forecast to be over plan by £1.8m by the end of the financial year. The highest area of bank expenditure relates to Nurses, both qualified and unqualified.

Adult acute out of area placements

At the end of July, OoA expenditure is above plan by £1.3m. The current forecast is based on a reducing trajectory which brings the forecast overspend to £1.3m by the end of the financial year. However, if the current run rate continues spend could be as high as £6.7m which could lead to an overspend of £4.6m.

Capital expenditure

Capital is below plan at the end of July by £2.0m. The forecast assumes full spend against the plan of £7.6m which includes additional national funding of £0.3m which was not in the original plan.

Cash

Cash at the end of July was £33.2m (£30.7 last month) against a plan of £23.4m, £9.8m above the plan which is due to timing of cash receipts. There are no concerns in relation to debt recovery.

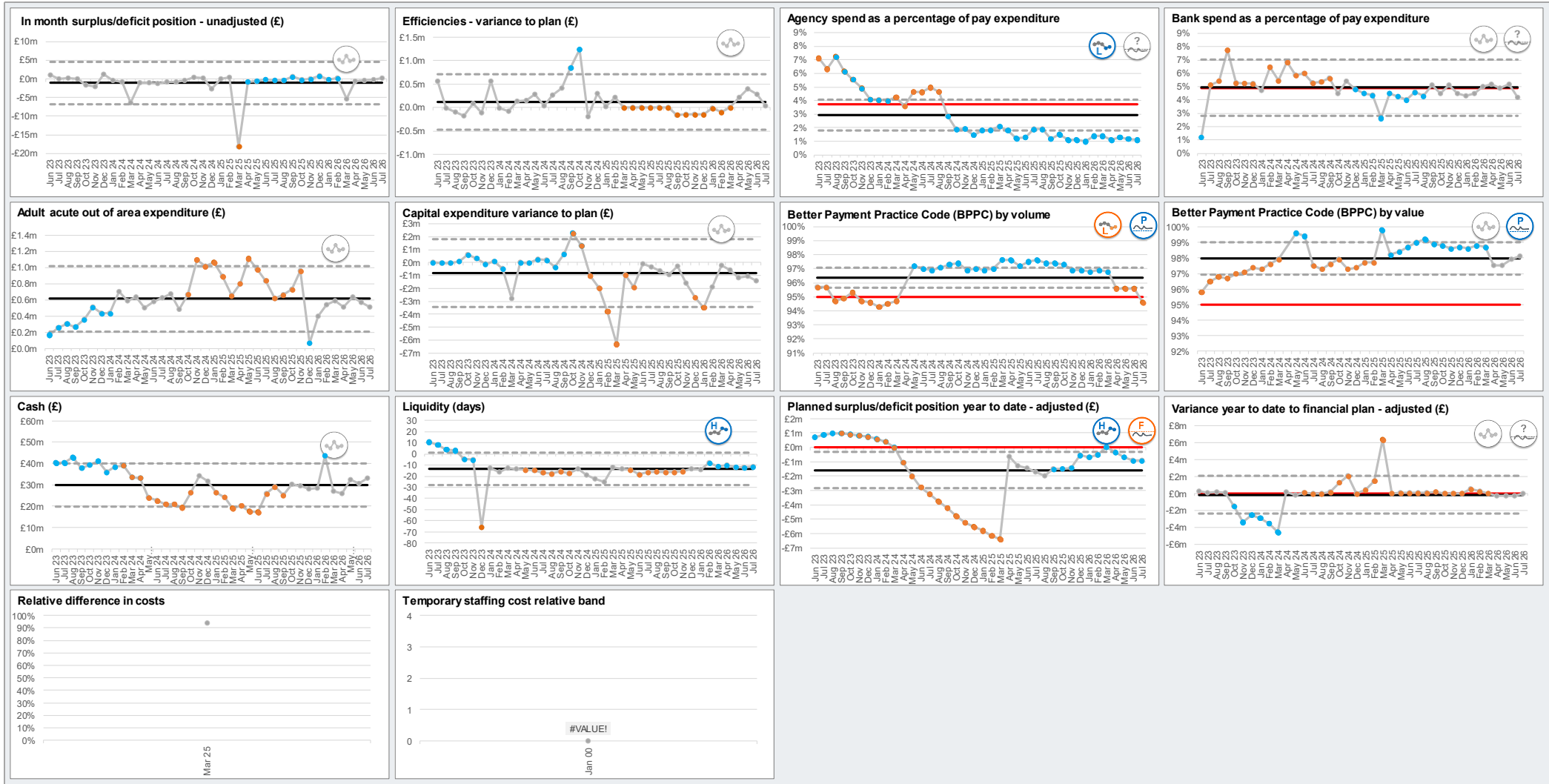
Better Payment Practice Code (BPPC)

The BPPC sets a target for 95% of all invoices to be paid within 30 days. BPPC is measured across both invoice value and volume of invoices. At the end of July, the volume of invoices was slightly under the target at 94.63%, but the value of invoices exceeded the target at 98.15%.

FINANCIAL KEY PERFORMANCE INDICATORS

Measure	Target	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	
Financial Performance														
In month surplus/deficit position - unadjusted (£)	-	£ 340,743	£ 546,298	£ 224,055	£ 16,211	£ 792,384	£ 181,752	£ 105,378	£ 5,302,531	£ 660,307	£ 341,136	£ 255,919	£ 187,903	
Efficiencies - variance to plan (£)	-	£ -	£ 153,000	£ 2,000	£ 1,000	£ 150,000	£ 17,000	£ 96,000	£ -	£ 213,000	£ 400,000	£ 281,000	£ 28,000	
Agency spend as a percentage of pay expenditure	3.7%	1.9%	1.2%	1.5%	1.0%	1.1%	1.0%	1.4%	1.4%	1.1%	1.3%	1.2%	1.1%	
Bank spend as a percentage of pay expenditure	4.9%	4.3%	5.1%	4.5%	4.9%	4.5%	4.3%	4.5%	5.0%	5.2%	4.9%	5.2%	4.2%	
Adult acute out of area expenditure (£000)	-	£ 618	£ 660	£ 727	£ 956	£ 60	£ 399	£ 543	£ 592	£ 513	£ 637	£ 564	£ 513	
Capital expenditure variance to plan (£)	-	£ 640,000	£ 917,000	£ 274,000	£ 1,606,000	£ 2,719,000	£ 3,479,000	£ 1,905,000	£ 244,000	£ 583,500	£ 1,167,000	£ 1,058,000	£ 1,432,000	
Better Payment Practice Code (BPPC) by volume	95%	97.4%	97.4%	97.3%	96.9%	96.9%	96.8%	96.9%	96.8%	95.6%	95.6%	95.6%	9460.0%	
Better Payment Practice Code (BPPC) by value	95%	99.2%	98.9%	98.8%	98.6%	98.7%	98.6%	98.8%	98.7%	97.5%	97.5%	97.9%	9810.0%	
Cash (£000)	-	£ 29,130	£ 25,167	£ 30,338	£ 29,717	£ 27,969	£ 28,403	£ 43,653	£ 26,925	£ 25,834	£ 32,492	£ 30,704	£ 33,241	
Liquidity (days)	-	-16	-16	-16	-16	-13	-14	-8	-11	-10	-12	-12	-12	
NHS oversight framework 2026/27														
Planned surplus/deficit year to date - adjusted (£)	£ -	£ 1,986,468	£ 1,521,049	£ 1,472,000	£ 1,421,000	£ 557,000	£ 669,000	£ 521,000	£ 11,000	£ 343,000	£ 678,000	£ 908,000	£ 912,000	
Variance year to date to financial plan - adjusted (£)	tbc	£ 65,060	£ 207,015	£ 5,116	£ 6,456	£ 33,609	£ 496,585	£ 240,026	£ 11,000	£ 296,000	£ 271,000	£ 275,000	£ 52,000	
Relative difference in costs	<100%													
Temporary staffing cost relative band										awaiting publication of data by NHSE				

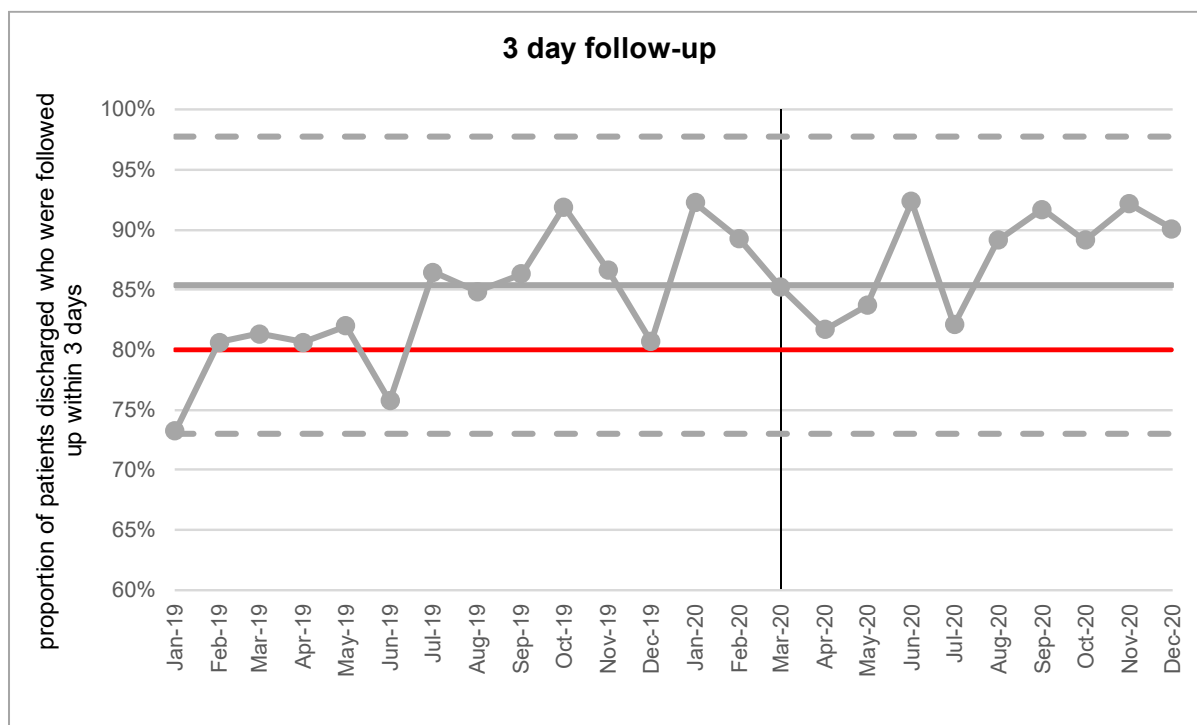
Financial Key Performance Indicators – Statistical Process Control Charts



Appendix 1

Statistical Process Control Chart (SPC) Guidance

Example SPC chart:



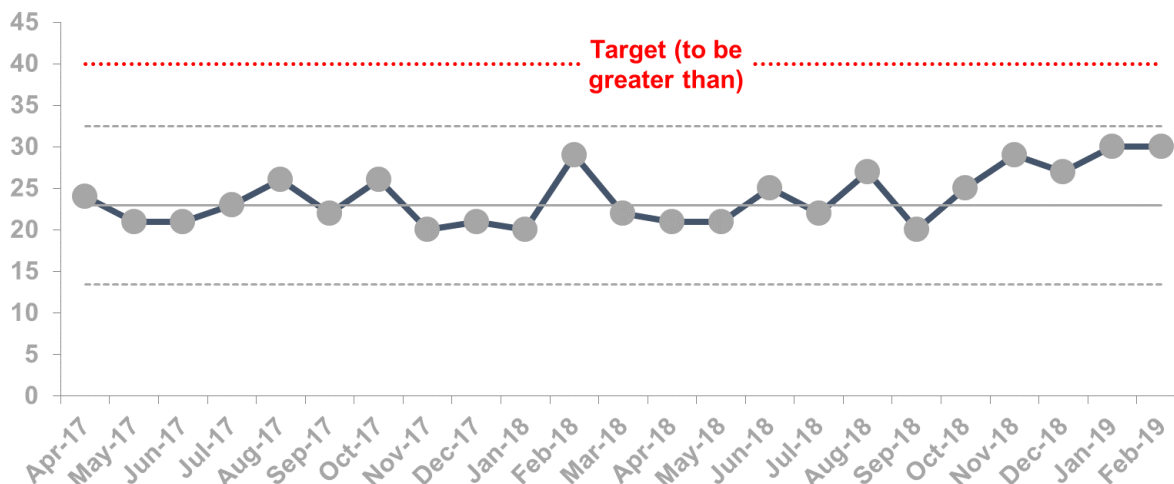
- The red line is the target
- The grey dots are the actual performance each month. They are coloured grey as performance each month is normal in this example
- The solid grey line is the average (mean) of all the grey dots
- The grey dotted lines are called process limits, or control limits.

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

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

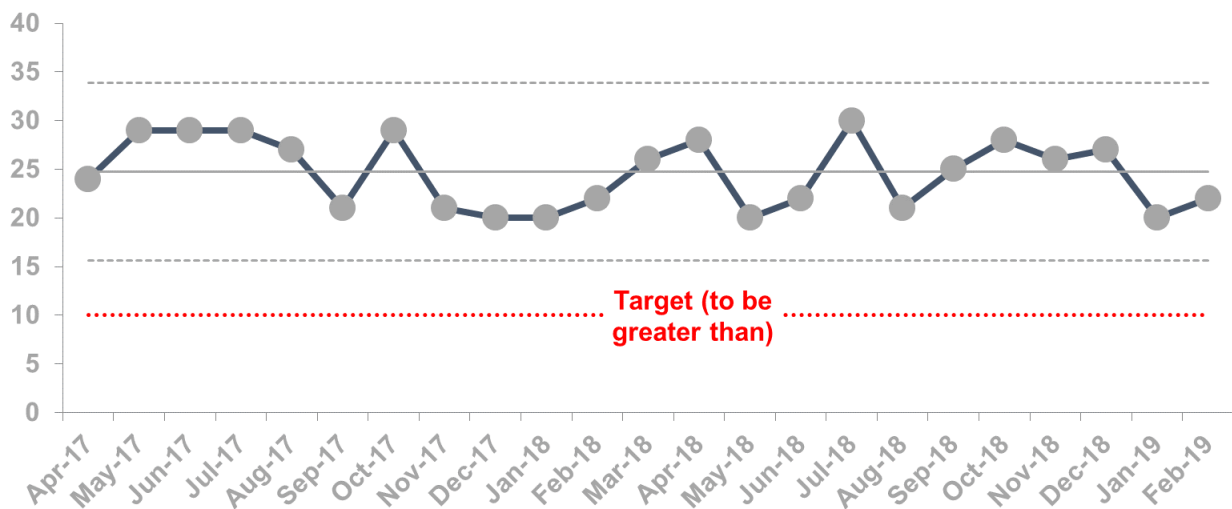
Things to look out for:

1. A process that is not working:



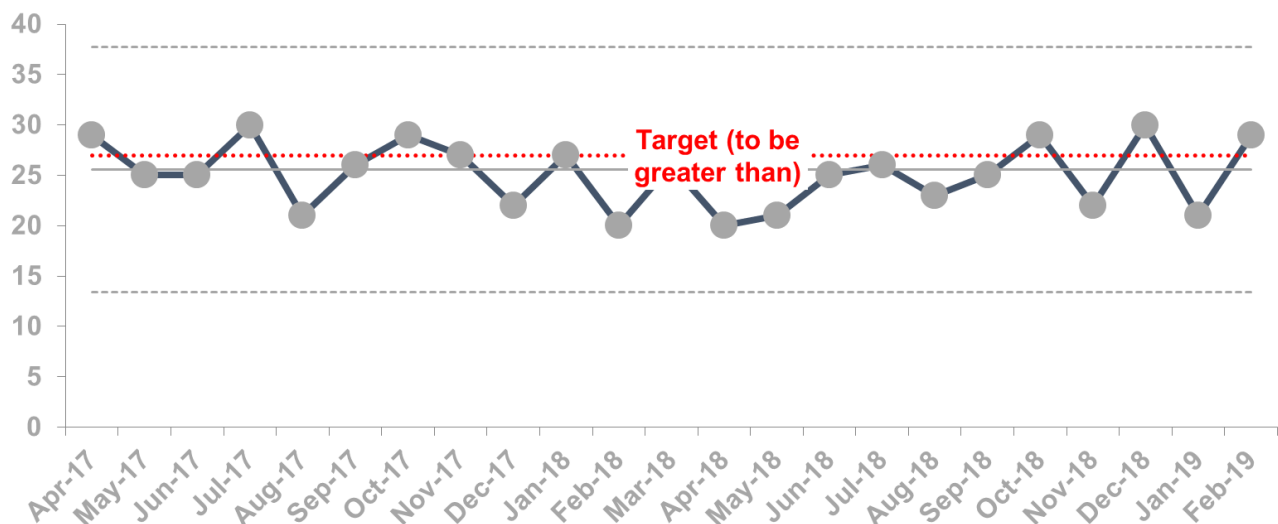
In this example the target is higher than the upper dotted grey line. This means that the target will never be achieved. To achieve the target, we need to change how we do things.

2. A capable process:



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

3. An unreliable system:

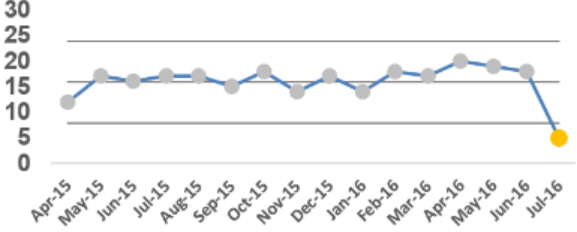
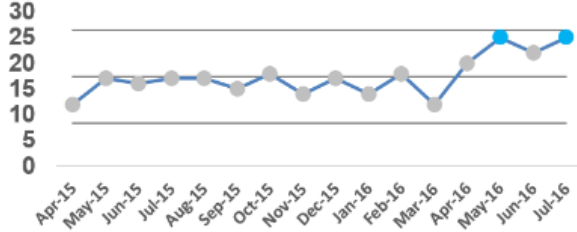
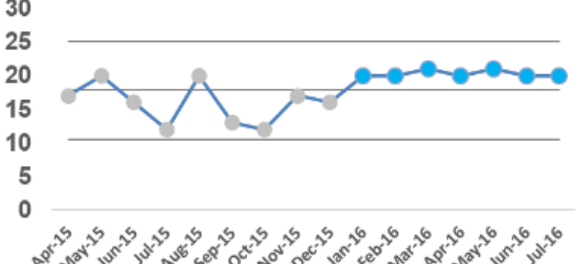
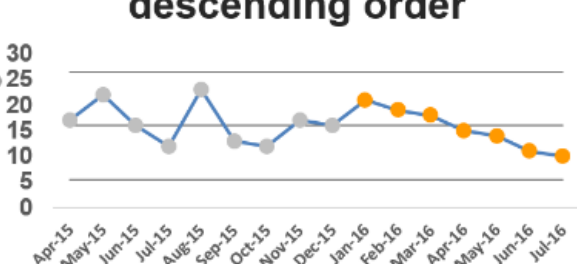


In this example, the target line sits between the two grey dotted lines. As it is normal for the grey dots to fall anywhere between the two dotted grey lines, this means that it is entirely random as to whether or not the target will be achieved. So, this system is unreliable and needs to be redesigned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

4. Unusual patterns in the data

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

There are four scenarios where this can happen:

A single data point outside the process limits  The chart shows a line of data points from April 2015 to July 2016. The y-axis ranges from 0 to 30. A central horizontal line is at 15, with two grey dotted lines at 10 and 20. Most points are grey and fluctuate around 15. The final point in July 2016 is orange and significantly lower, at approximately 5.	Two out of three points close to the process limits  The chart shows a line of data points from April 2015 to July 2016. The y-axis ranges from 0 to 30. A central horizontal line is at 15, with two grey dotted lines at 10 and 20. Most points are grey and fluctuate around 15. The points for May, June, and July 2016 are blue and are close to the upper limit of 20.
In this example the July 2016 performance is significantly lower than expected and falls beneath the lower grey dotted line.	Two out of three points close to one of the grey dotted lines is statistically significant, in this case they are blue, indicating better than expected performance.
Shift of points above / below mean line  The chart shows a line of data points from April 2015 to July 2016. The y-axis ranges from 0 to 30. A central horizontal line is at 15, with two grey dotted lines at 10 and 20. Points from April 2015 to December 2015 fluctuate around 15. Starting in January 2016, the points shift upwards and remain consistently above the 15 line, mostly between 18 and 22.	Run of points in consecutive ascending / descending order  The chart shows a line of data points from April 2015 to July 2016. The y-axis ranges from 0 to 30. A central horizontal line is at 15, with two grey dotted lines at 10 and 20. Points from April 2015 to December 2015 fluctuate around 15. From January 2016 to July 2016, the points show a clear consecutive descending trend, starting around 22 and ending around 10.
A run of seven points above or below the average line is significant. In this example it might indicate that an improvement was made to the process in Jan 2016 that has proven to be effective.	A run of seven points in consecutive ascending or descending order is significant. In this example things are getting worse over time.

Frequently seen in the NHS:

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

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

(Adapted from guidance kindly provided by Karen Hayllar, NHSE)

Appendix 2

Assurance Ratings

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



Board Committee Assurance Summary Reports to Trust Board – 30 September 2026

The following summaries cover key items discussed at the meetings that have been held since the last public Board meeting held on 21 July 2026 and are received for information.

- Audit and Risk Committee – 16 July 2026
- Finance and Performance Committee – 17 July 2026 and 11 September 2026 (verbal)
- Mental Health Act Committee – 3 September 2026
- Quality and Safeguarding Committee – 28 July 2026 and 8 September 2026
- People and Culture Committee – 10 September 2026

Key:

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

Audit and Risk Committee – key assurance levels for items – 16 July 2026

Review of Board Assurance Framework (BAF) Issue 2, version 2.2, 2026/27

The Committee noted the updates made following Executive Leadership Team review, including three linked operational risks requiring further consideration. Members welcomed the assurance provided through the existing process while recognising opportunities to strengthen the BAF's presentation, particularly in relation to trend information, clarity of key messages and the relationship between risk tolerance, current risk and target risk ratings.

Further development of the BAF as a more dynamic and insight-led document was supported, while retaining the elements that had worked well and had received positive audit feedback.

The Committee approved this issue of the BAF.

Operational Risk Management

The overall risk position was reported as stable, with risk review compliance at approximately 95%. However, members challenged the assurance provided in relation to long outstanding risk reviews and agreed that these should be escalated to the Board to provide visibility and support appropriate closure or acceptance of risks.

Significant assurance was accepted regarding the work undertaken to drive the risk management process and **limited assurance** around the escalation steps being taken to address non-compliance.

Data Quality update – Operational indicators data validation report (six-monthly)

Continued strong performance against national Data Quality Maturity Index measures was noted, along with the importance of high-quality data in supporting patient care, operational reporting, national submissions and future digital transformation.

The positive position achieved to date while challenging the scope of assurance was recognised, along with the need to consider data quality and data capture across wider Trust systems beyond the electronic patient record.

Work to support optimisation, standardisation, improved demographic data, workforce digital literacy and training was highlighted and it was agreed that further engagement with relevant colleagues would support a more rounded picture of data quality and capture.

	The Committee received significant assurance in relation to patient record and clinical systems.
	Data Security and Protection (DS&P) annual report The Committee recognised the work undertaken by the team, supported by Arden and Gem and 360 Assurance, alongside sustained high mandatory training compliance and strong performance in handling Subject Access Requests (SARs). Ongoing work to identify and respond to incident themes through Datix, with learning shared through feedback, newsletters and engagement with teams was acknowledged. The key areas of focus remain as cyber risk and inappropriate access to records, supported by audits, spot checks, induction messages and refresher training. Significant assurance was accepted.
	Conflicts of Interest and Declarations of Interest summary Significant assurance was received that declaration requirements are increasingly embedded within Trust processes. Members recognised the improvement trajectory while challenging the 2025/26 decision-maker return rate and seeking clarity on the expected threshold and escalation arrangements for 2026/27. The planned actions to improve compliance, including further reminders, clear deadlines, targeted follow-up and escalation where required were noted, with an ambition to achieve returns in the 90% range.
	Standing Financial Instructions (SFIs) waiver report (six-monthly) The Committee received significant assurance on the process followed to approve and record waivers and noted the transparency and financial discipline demonstrated through the report. It was noted that waiver expenditure for 2025/26 was broadly in line with the previous two financial years, with improved analysis of cumulative supplier spend included in response to 360 Assurance findings. No significant supplier or departmental concerns had been identified. Alignment of waiver documentation with the SFIs and planned updates to reflect the Procurement Act were mentioned.
	SFIs – review of changes The Committee approved revisions to the SFIs ahead of Trust Board for final ratification.
	Internal Audit progress report The Committee noted that the final 2025/26 report relating to Care Planning had identified two medium-risk findings with actions agreed for implementation by the end of September. Members acknowledged the positive outcome of the DS&P Toolkit review, including a low risk assurance rating and high confidence level, and received updates on planned reviews including the Fit and Proper Person Test, Seclusion as well as the usual Head of Internal Audit Opinion work.
	External Audit Key Performance Indicators It was confirmed that the key performance indicators had been met. The Committee welcomed the positive audit position, noting that the 2025/26 satisfaction survey remained outstanding, but that all other targets had been achieved and no significant issues had been reported
	Board Assurance Framework (BAF) – key risks identified: None.
	Items for discussion at Board or other Board committees: Concerns in relation to Operational Risks to be mentioned at Board. Items added to the Board Assurance Framework: None. Next scheduled meeting: 22 October 2026

Committee Chair: Chioma Akpom	Executive Lead: Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary
Finance and Performance Committee – key assurance levels for items – 17 July 2026	
	Productive Pillar update Progress continues across financial sustainability, productivity, commercial development and sustainability objectives. Digital solutions and estate rationalisation are progressing well; however, the Trust is £300k behind plan at Month 3, driven by out of area placement and Inpatient overspend pressures. The Committee supported continued focus on productivity and recognised the need to increase emphasis on medium-term financial sustainability. Significant assurance was accepted.
	Green Plan The report provided the Committee with significant assurance, with good progress on biodiversity, procurement and energy initiatives. Data quality and carbon measurement remain key risks.
	Radbourne Unit refurbishment update Significant assurance was received by the Committee. Ward 32 is on track for September completion. Cost increases are manageable. Four bed reduction creates operational pressure.
	Financial Governance and Performance – Month 2 Finance report The Trust reported a £1m deficit, £300k behind plan at Month 2 due to Cost Improvement Programme (CIP) delivery challenges, out of area placements and Inpatient overspends. Additional risks include potential Arden and GEM cost pressures and sustained workforce cost pressures. Despite a strong cash position and no significant debtor concerns, the Committee accepted limited assurance, recognising that achieving breakeven remains unlikely and that realistic deficit forecasting is required.
	Contracts update and progress report incorporating key risks Limited assurance was received due to continued significant contracting risks resulting from delayed and amended Integrated Care Board (ICB) contracts, Additional Roles Reimbursement Scheme funding changes affecting Primary Care networks and the need to renegotiate arrangements following changes to the IMPACT provider collaborative.
	Discussion paper on known service provision commissioning gaps and potential next steps The Committee reviewed a wider discussion regarding commissioned activity gaps, waiting list pressures and underfunded services. Limited assurance was accepted, with further strategic discussion with the Board requested.
	Discussion on Charitable Funds position - DEFERRED
	Improvement and Transformation – delivery of Trust Continuous Improvement Plan The Committee received significant assurance. Governance arrangements are in place, although some weaknesses remain that could impact delivery of specific objectives.
	Operational Performance Report Progress continues across operational performance, including reduction of inappropriate out of area placements and improvement in Community waiting times. However, continued pressures relating to discharges, Consultant sickness, clinical engagement and implementation of flow initiatives mean achievement of operational targets remains at risk. The Committee received limited assurance.

	Deep Dive into New Care Group Performance – DEFERRED
	Arden and Gem Commissioning Service Unit (AGCSU) update The Committee received significant assurance regarding the planned transition of IT and digital services from AGCSU to Nottingham Health Informatics Service. Appropriate controls and governance are in place, although some residual risks remain during implementation.
	System updates: ICB Finance Committee / System Directors of Finance System financial performance remains challenging. Most providers continue to report delivery against plan, although CIP delivery issues are being reported across the region. The East Midlands remains one of the most challenged systems nationally.
	Updates from Strategic and Partnership System meeting and forums The Trust has been invited to consider opportunities including the Working Well programme and Sheffield ADHD/autism waiting list support, subject to ensuring any expansion is financially sustainable.
	Emergency Preparedness, Resilience and Response (EPRR) report The Trust is forecast to achieve substantial compliance against EPRR core standards by August. Most domains are compliant, with remaining actions expected to be completed within planned timescales. Significant assurance was provided.
	Review and approval of Emergency Incident Response Plan and Procedures The Committee approved the Emergency Incident Response Plan and Procedures with full assurance that requirements of NHS England Core Standards had been met.
	Board Assurance Framework (BAF) 2026/27 risks overview The Committee reviewed risks allocated within the BAF. Financial sustainability remains the highest rated risk and requires further discussion at Board. Members also suggested a dedicated Board Strategy and Development Session to review risk appetite and strategic risks. Limited assurance was accepted.
	Key matters for Board attention - Financial performance is behind plan at Month 2, with continued pressures from out of area placements, inpatient overspends and CIP delivery - Financial sustainability remains a significant strategic risk and requires further Board discussion regarding recovery actions, medium-term planning and risk appetite - Commissioning and contracting risks continue, alongside known service provision gaps where activity exceeds commissioned funding - Radbourne Ward 32 remains on track for completion. However, the temporary reduction in bed capacity may create additional operational and financial pressures - Continued oversight is required regarding operational performance, particularly out of area placements, discharge pathways and Community waiting time trajectories. Overall assurance: Significant Assurance The Committee received a mixed assurance profile. Significant assurance was obtained across a number of strategic programmes including the Green Plan, Transformation Programme, Radbourne development, Arden and GEM transition and EPRR preparedness. However, limited assurance was received in relation to financial performance, operational performance and commissioning risks, reflecting ongoing pressures on delivery of the Trust's financial and operational objectives.
	Items for discussion at Board or other Board committees: - Financial sustainability risk and recovery planning to be discussed at Trust Board - Board consideration of organisational risk appetite and strategic risk management - Further Board Strategy and Development discussion requested regarding service commissioning gaps and underfunded activity.

	Items added to the Board Assurance Framework: Existing financial sustainability risks highlighted for continued Board oversight. Next scheduled meeting: 11 September 2026.
Committee Chair: Jo Hanley	Executive Lead: James Sabin, Director of Finance
Mental Health Act Committee – key assurance levels for items – 3 September 2026	
	Key Highlights and Summary of the last Mental Health Act Operational Group Minutes The Committee noted that, follow an audit into the Mental Capacity Act, a quality improvement project would be focusing on ensuring the clinical rationale for decisions was documented clearly in patient records. Areas requiring continued focus included Section 62 urgent consent to treatment and Second Opinion Appointed Doctor (SOAD) processes and Section 132 reading of rights compliance, Associate Hospital Manager activity and training compliance was noted. As the Group remains in development and transition, limited assurance was accepted and clearer outcome measures and trajectories to demonstrate effectiveness were requested.
	Mental Health Act Managers report The Committee noted a good standard of medical recommendations, with only 1% of recommendations failing scrutiny. The Committee also noted increased numbers of informal and detained patients, with formal admissions exceeding informal admissions. The improving trajectory in compliance with Section 132 and Section 132A reading of rights was welcomed but it was agreed that a specific risk on this should be added to the risk register. Improvements to the completion of holding-power forms and Section 62 documentation remain areas of focus, supported through ESR and face-to-face training. Significant assurance was agreed on the standard of medical recommendations and limited assurance on Section 132 and Section 132A reading of rights compliance, while noting the improving compliance trajectory.
	Training report Overall compliance was above the 90% target across the main Mental Capacity Act, Mental Health Act and Deprivation of Liberty Safeguards training areas. Assurance was qualified because ESR data for Section 12 and Approved Clinician requirements needed greater reliability. Future reports would reconcile role-based requirements and triangulate training with audit and practice outcomes. Significant assurance was received on overall training compliance and limited assurance in relation to Section 12 and Approved Clinician training.
	Use of Section 136 suites A sustained increase in Section 136 activity was noted, with most people discharged to the community following assessment. Work continues to strengthen earlier community intervention and crisis support. Assurance was provided that Nursing and physical healthcare checks continue during delays in medical assessment but the impact on patient safety of the delays will be escalated to the Director of Nursing. Revised Consultant on-call arrangements are due to commence and will be monitored, alongside continued work with commissioners on 24-hour Section 136 suite availability in Derby and Chesterfield. Management of increased activity, assessment demand and the timeliness of Mental Health Act assessments provided limited assurance.
	Patient and Carer Race Equality Framework (PCREF) The Committee received an update including progress in three pilots areas; forensic services, older adults and dementia, and acute inpatient services. The aim being to examine routinely collected data on access, experience and outcomes, identify disparities and target improvement activity. A roadmap

	is being prepared and the Committee asked for assurance on alignment with the Trust's strategic priorities, including community engagement work and the need for outcomes/measures of success.		
	Mental Capacity Act Quality Improvement Project The Committee supported the project to improve the quality of capacity documentation. SystemOne guidance, Directorate-led reflective learning and a re-audit at around six months were planned, with any approved AI-supported quality checks required to protect patient confidentiality.		
	Policy Review The Committee reviewed and ratified the following policies: • Mental Capacity Policy • Joint Policy for the Operation of Section 135 MHA 1983 • Deprivation of Liberty Policy and Procedure • The role of the Social Supervisor Policy and Procedure (Joint Policy). Further partner alignment was required for the Social Supervisor Policy, and the Right Care, Right Person National Agreement was to be progressed for virtual ratification before expiry at the end of September.		
	Items for discussion at Board or other Board committees: Section 136 patient-safety concerns arising from prolonged suite stays were to be discussed with the Executive Director of Nursing, Allied Health Professionals and Quality. Items added to the Board Assurance Framework: None. Next scheduled meeting: 3 December 2026.		
<table> <tr> <td>Committee Chair: Deborah Good</td><td>Executive Lead: Dr Girish Kunigiri, Medical Director</td></tr> </table>		Committee Chair: Deborah Good	Executive Lead: Dr Girish Kunigiri, Medical Director
Committee Chair: Deborah Good	Executive Lead: Dr Girish Kunigiri, Medical Director		
Quality and Safeguarding Committee – key assurance levels for items – 28 July 2026			
	Director of Nursing update Discussion included feedback from recent night visits, the arrangements in place to support communication, training and engagement for night staff and the governance routes through which actions and learning would be monitored. The Committee noted national publications, including the NHS Quality Strategy, the Mental Health Personalised Care Framework and Baroness Amos' independent investigation into Maternity and Neonatal services. The applicability of broader learning themes to the Trust was considered, including the need to review findings against existing plans and identify any further action required.		
	Medical Director update The Committee noted key developments across the Medical Directorate, including ongoing work to address bed flow, length of stay and out-of-area placements. Members noted that quality improvement activity, clinical engagement and governance arrangements are being progressed to support consistency of practice, timely decision-making and strengthened oversight. Updates relating to deprivation of liberty guidance, industrial action, recruitment, patient safety collaboration and developing academic partnerships were highlighted, including opportunities linked to medical leadership and research. Questions were raised regarding Patient Safety capacity, clinical engagement and strategic relationships with the University of Derby, with responses provided on current actions and planned next steps.		
	Assertive Outreach (AO) Community Mental Health Treatment- Deferred		

	This paper was deferred to September to enable further consideration of best practice benchmarking; the current resource position and learning from incidents. Interim assurance was provided that patient reviews, care plans and risk assessments have been completed across the teams, with relevant standards reviewed and external reporting undertaken.
	Medicines Optimisation Committee 3As report and valproate update Ongoing work to strengthen assurance in relation to valproate compliance; naloxone prescribing and medicines optimisation governance was noted. Discussion focused on the development and use of the SystmOne dashboard; the complexity of identifying all patients prescribed valproate where prescribing responsibilities sit across different service boundaries and the limited assurance position in relation to adherence to valproate guidance. Agreed mitigations included a planned snapshot audit; continued awareness raising and maintaining valproate as a standing agenda item.
	Reducing Restrictive Intervention The Committee noted progress in strengthening governance; training compliance and oversight arrangements. Members discussed continued areas of risk, including physical restraint; seclusion; observation compliance and prone restraint, alongside planned actions to strengthen incident learning; debriefing; safety huddles and targeted team support. The Committee challenged the evidence base for improvement actions; ethnicity data quality and the narrative relating to acuity, staffing and restrictive practice, noting the need for a more joined-up, data-led understanding of these factors. Limited assurance was received, recognising that agreed targets have not yet been achieved across all areas.
	Safer Staffing annual report The Committee noted the use of the Mental Health Optimal Staffing Tool (MHOST) as part of the evidence base for reviewing Inpatient staffing. Inpatient services were reported as safely staffed, with current funded establishments maintained at this stage, while recognising that staffing utilisation; observation demand; ward-level variation and the relationship between acuity; restrictive practice; safety; workforce and financial impact require further analysis. The need to triangulate MHOST outputs with wider quality; safety; workforce and financial indicators was discussed, noting that further assessments and clearer reporting would support future decision-making. An action was agreed for a comprehensive paper to be provided on the impact of increased acuity on finances and workforce, to support strategic planning across relevant committees. The report provided limited assurance.
	Clinical Research and Development (R&D) annual report – 2025/26, included annual review of R&D Operational Group Effectiveness and Terms of Reference (ToRs) Members noted sustained research activity; external funding; publication and presentation outputs; peer performance and positive assurance from the Library and Knowledge service self-assessment. Discussion focused on the contribution of research activity to Trust priorities; income generation; operational improvement and measurable organisational benefit, with actions agreed to further consider how research and evidence support could be better aligned to priority areas and efficiency plans. Significant assurance was received from the report and the Committee approved the annual review of the R&D Operational Group ToRs.
	Patient-Led Assessments of the Care Environment (PLACE) action plan from annual results It was reported that most actions are due for completion by the end of August, ahead of the next assessment. Members recognised that full assurance on delivery and impact would only be available once the plan has been implemented and tested through the next formal PLACE, with particular attention to food services and disability-related scores.

	The Committee received significant assurance .	
	Waiting Well – review of policy effectiveness Discussion focused on variable practice, the difficulty in retrieving and triangulating data, along with the need to better understand the impact of waiting lists on patient safety; experience; escalation; signposting and deterioration. Effectiveness and appropriateness of the policy was challenged, noting the need to review new NHSE guidance against the existing policy and identify any required updates and implementation actions. The Committee received limited assurance in relation to the Trust's compliance with the policy and the effectiveness of current governance arrangements.	
	Board Assurance Framework (BAF) – key risks identified: It was agreed that the risks relating to patients waiting well; the Suicide Prevention Lead position and the Personalised Care Framework should be reviewed and reflected appropriately within the BAF.	
	Items for discussion at Board or other Board committees: None. Items added to the Board Assurance Framework: None. Next scheduled meeting: 8 September 2026	
	Committee Chair: Lynn Andrews	Executive Lead: Tumi Banda, Director of Nursing, AHPs, Quality and Patient Experience
Quality and Safeguarding Committee – key assurance levels for items – 8 September 2026		
	Director of Nursing verbal update The Committee received an update on two serious incidents and the immediate actions taken to strengthen patient safety, governance and staff practice. Discussion covered transfer-of-care risks, observation standards and the timely progression of investigations. It was confirmed that reviews and learning are under way, with further investigation subject to ongoing police and coroner processes. The impact on patients, families and staff was acknowledged. The Committee also noted routine inspection activity involving the Care Quality Commission and Ofsted.	
	Medical Director update The update covered Inpatient workforce and skill-mix arrangements, clinical flow and the Getting it Right First Time programme. Current workforce arrangements on Wards 35 and 36 had operated without identified quality or safety concerns and would be retained, with a further review of patient safety, outcomes and professional support planned for early 2027. The Committee noted progress in strengthening oversight of care pathways and addressing length of stay and out-of-area pressures. Discussion highlighted the need for stronger senior clinical oversight of admissions, early and consistent community-team involvement in discharge planning, and action to address variation in community-service arrangements. The need for greater investment in Community services to support flow was acknowledged. It was advised that suicide-prevention functions would be retained following the end of dedicated funding and noted plans to revise the Consultant on-call rota. Further implementation plans and care models would be considered through the evolving Clinical Plan.	
	Fundamental Standards of Care The Committee was updated on regulatory activity, Mental Health Act monitoring, Fundamental Standards of Care oversight and targeted improvement work. The positive outcome of recent inspections was noted, with no regulatory breaches or outstanding actions.	

	The reported progress was welcomed. However, clearer evidence that regulatory and improvement activity is delivering measurable benefits for patient experience, safety, staff wellbeing and service effectiveness was requested. It was acknowledged that assurance remains largely standards-based, and work through the Clinical Plan will establish more consistent outcomes and measures. The importance of local ownership, effective training, reflective practice and routine multidisciplinary review of performance information was also emphasised. Significant assurance was accepted that effective governance arrangements are in place to oversee regulatory compliance, respond to learning from CQC activity and provide ongoing assurance regarding the quality and safety of services through the Quality Assurance Framework.
	Assertive Outreach (AO) Community Mental Health Treatment (six-monthly) The report updated on compliance with Fundamental Standards of Care for AO within Community Mental Health teams, the response to a recent incident and the revised Assertive and Intensive Support Policy. Reviews across all 11 Community teams found generally high compliance with care planning and risk assessment requirements, alongside areas for improvement. Strengthened governance arrangements were noted to include continuous quality monitoring, regular caseload review and greater scrutiny of the quality as well as completion of care plans and risk assessments. The Committee discussed the need to distinguish compliance issues from the wider gap in commissioned provision and noted that the funding shortfall has been formally escalated to the Integrated Care Board. The provision of clearer evidence of service gaps, the benefits that further investment could enable and the potential impact on patient outcomes was requested and it was agreed that the next quarterly report would include benchmarking against available national templates and comparable services. Embedment of the new, continuous quality monitoring process provided limited assurance.
	Patient Safety report – Quarter 1 (Q1), 2026/27 (quarterly) The paper indicated that incident rates have remained stable over the preceding five quarters, with no concerning upward trends. Progress included a reduction in self-harm incidents on Dove Ward and fewer outstanding learning responses and overdue recommendations. However, inconsistent completion of incident reviews within target timescales was noted, due to operational capacity pressures, reduced Patient Safety team resources and varying engagement across Care Groups. The Committee challenged whether learning arrangements are fully embedded and if anticipated improvements are achievable, emphasising to prioritise those actions most likely to improve patient outcomes where resources are constrained. Current capacity and capability within the Patient Safety team is being reviewed, alongside development of the Patient Safety Dashboard and strengthened operational support. Consideration was given to the context of recent incidents and increased reporting within Older Adult services, including work to align policy and practice while recognising differing service models and strengths. It was recommended to seek wider benchmarking with comparable organisations and exploration of digital tools to support analysis and reduce resource pressures. The Committee received limited assurance in relation to the application of the Patient Safety Incident Response Framework within the organisation.
	Inpatient Acuity Triangulation – the impacts of increased acuity on Finances and Workforce The Committee considered a triangulated review of Inpatient acuity, dependency and operational pressures. Increases in enhanced observations, restrictive interventions and supplementary staffing, alongside workforce vacancies and variation between wards were noted. The evidence indicated increased acuity over the preceding two years, although practice variation and changes to inpatient environments affected interpretation of the data.

	Assurance was sought that increased observations and restrictive interventions reflect clinical need and that the evidence provided a sufficiently robust basis for understanding patient safety, workforce and financial implications. Factors identified for further analysis included clinical complexity, comorbidity, demographic change, local management of more complex patients and the impact of service developments. The Committee concluded that the review demonstrated increased acuity but did not yet clearly explain the underlying causes or their implications. It was agreed that further evidence-based analysis would be provided, covering clinical and demographic factors, patient need, restrictive-practice trends, staffing and relevant quality indicators. Continued oversight would be maintained through existing reporting arrangements.
	Quality Dashboard Providing limited assurance the Dashboard for May to July 2026 reflected broadly stable performance, alongside continuing pressures relating to restrictive practice, medication incidents, falls, complaints timeliness, discharge flow, community waiting times and policy compliance. It was noted that improvement and oversight arrangements remain in place, with reductions reported in absconding and progress in addressing the complaints backlog. Particular concern was expressed about persistently high medication incidents, with further work under way to identify additional action, while longer-term resourcing requirements for the Patient Experience function is being considered. The Committee noted reduced Care Programme Approach compliance during transition to the national Personalised Care Framework. A transformation plan covering priorities, resources and safe implementation would be submitted to the Executive Leadership Team. The need to demonstrate a clearer link between dashboard measures, improvement activity and outcomes was emphasised.
	Safeguarding Children and Adults at risk annual report (prior to Board submission) The Committee was significantly assured that the Trust continues to meet its legal and statutory safeguarding obligations, supported by established governance, risk escalation, partnership working and external oversight. Effective multi-agency arrangements and the appointment of a Named Doctor for Safeguarding Children were noted, addressing a previously identified gap. It was noted that the Safeguarding team has maintained services during the vacancy, although some work had taken longer and capacity for development and succession planning has been limited.
	National Institute for Health and Care Excellence (NICE) guidance compliance (to include Clinical Audit update) The combined update on arrangements for implementing NICE and other national guidance, clinical effectiveness governance and the Clinical Audit-Based Quality Improvement Programme noted strengthened organisational oversight through the reconstituted Clinical Effectiveness Group, although the revised arrangements remained at an early stage of development. It was reported that 12 out of 22 registered audits were progressing to schedule, with 10 overdue. Two audits had been completed, with plans in place to address delays and strengthen monitoring. The Committee requested clarity that recommendations and overdue actions would be implemented, evidenced and formally closed. It was acknowledged that processes for demonstrating sustained improvement are not yet sufficiently mature. Prioritisation, continuity of audit delivery and closure of the learning loop would remain central as the arrangements developed. Limited assurance was accepted that the necessary processes and improvement activity are in place, while recognising that 45% of audits are significantly overdue and evidence of consistent implementation and measurable impact requires strengthening.
	Patient Experience report (Quarter 1. 2026/27) The report reflected improved complaint response performance, with established improvement and escalation arrangements. It was noted that delivery continues to be affected by sickness absence, overdue complaints and actions and delays between the Patient Experience team and operational managers.

	Recurring feedback themes included involvement in care planning, communication, access, timeliness and carer involvement. The Committee was advised that learning is being shared across services, while positive feedback continues to reflect compassionate, person-centred care. A clearer improvement trajectory was requested, with stronger links between complaint and positive-feedback learning and contextual reporting against the number of patients treated. The Committee accepted a limited but improving level of assurance.
	Quality Delivery Plan (Quarter 1, 2026/27) The update informed that improvement plans are in place and progress is being made, although longstanding risks remain across Community waiting times, patient experience, outcome measurement, physical health monitoring, restrictive practice, Inpatient flow, violence and aggression and digital and pathology developments. The increase in patient-to-staff assaults, including race-related abuse was discussed. The Committee requested clearer contextual analysis to support understanding of proportionality. Support arrangements for affected staff and liaison with relevant partners were noted. Limited assurance was received on progress against the Quality Delivery Plan.
	Learning from Deaths/Mortality report (Quarter 1, 2026/27) The Committee noted a reduction in reported deaths compared with the same period in the previous year, with stable mortality trends and no identified concerns relating to health inequalities. Most reviewed deaths required no further learning response, and no deaths occurring within the quarter met the Duty of Candour threshold. It was reported that overdue learning responses and recommendations have reduced substantially, supported by improved access to demographic information, although some delays remain. It was highlighted that national red-flag criteria are used to identify deaths requiring closer review and possible escalation. The Committee requested assurance that recurring learning on recognising and escalating physical-health deterioration is consistently embedded across services. Improvement measures included wider dissemination of reflective learning, relevant training, strengthened equipment and clinical support arrangements, enhanced review of incidents and physical-health data, and earlier learning through after-action reviews. The need for clear escalation where incidents recurred within the same service or involved the same staff was emphasised. Limited assurance was accepted.
	Quality and Equality Impact Assessment (QEIA) practice impacts of the process The update explained the process within the 2026/27 transformation programme, noting that projects are required to complete the relevant governance gateways before implementation and that most had received approval, with a small number requiring further work. Additional evidence of post-implementation impacts was requested, including whether intended benefits had been realised, unintended consequences had arisen and mitigations had been effective.
	Items for discussion at Board or other Board committees: It was agreed that The Committee's Assurance report to the Board should highlight progress in patient safety while recognising that further work remains. Items added to the Board Assurance Framework (BAF): The Committee agreed that the AO narrative would be reconsidered through the routine BAF review, noting that discussions had not identified a material change to the current position. Next scheduled meeting: Thursday, 8 October 2026.
Committee Chair: Lynn Andrews Executive Lead: Tumi Banda, Director of Nursing, AHPs, Quality and Patient Experience	
People and Culture Committee – key assurance levels for items – 10 September 2026	

	Director of People update It was reported noted that mapping against the six national staff standards is under way, with findings on gaps, compliance and impact to return within six weeks. Existing STRIVE and THRIVE programmes are considered to be aligned to the new Management and Leadership Framework and the first THRIVE programme is expected to commence in January. The Committee noted that the Trust remains on track as an early adopter of the People Portal (ESR2), supported by additional implementation funding and continues to engage with the Transforming People Services Programme. Although the national workforce plan has been further delayed, this was not expected to materially affect current work, as local activity had been aligned with anticipated requirements to avoid duplication.
	People and Inclusion Assurance Dashboard Workforce performance was reviewed, noting that mandatory training and staff turnover remain within target, while sickness absence at 6.8% continues to represent the principal workforce and strategic risk, remaining above the 5% target. Long- and short-term absence, rising Employee Relations case volumes and associated capacity pressures were highlighted. Strengthened case management and governance; Wellbeing summits, additional People team resource and planned work with Occupational Health were outlined, although improvement is not yet evident. It was agreed to conduct further analysis and triangulation of absence trends and their relationship with staff groups; length of service; turnover; vacancies; Employee Relations cases; temporary staffing; workplace injuries and patient acuity. The Committee requested that learning from Employee Relations and Freedom to Speak Up cases be brought together and shared through the new culture collaboration meeting. The Committee accepted significant assurance on mandatory training; staff turnover and clinical and managerial supervision, and limited assurance on vacancies and recruitment; attendance and absence; temporary staffing usage and annual appraisals.
	Organisational Learning from the culture of Care (CoC) Programme The CoC Programme had supported inpatient wards between March 2024 and March 2026 to develop autism-informed, trauma-informed and anti-racist cultures. It was noted that the Programme has delivered practical changes to ward environments and multi-disciplinary working; however, engagement, protected time and quantitative evaluation has been constrained by concurrent programmes; environmental and staffing changes; variable participation and data accessibility. Whilst several visible changes remain embedded, longer-term coaching has been more difficult to sustain. The Committee emphasised the importance of protected reflective time, coaching or mentoring to support application of learning, recognition of participating teams and clear alignment with related culture, Model of Care and organisational development work. Limited assurance was received, noting that further work was required to strengthen engagement and embed the strongest elements through the proposed Trust-wide approach.
	People Plan – 2025-2028 The Committee noted significant progress across leadership development; workforce planning; wellbeing services; the Personal Accountability Charter and wider culture work. Whilst most areas remain on track, talent and succession planning and flexible working have been delayed due to organisational change and competing priorities. Sickness absence was highlighted as an immediate risk with implications across quality, finance and wider objectives, with priorities already deferred where necessary. It was agreed that stronger impact and consistency measures will be developed during the next quarter, with programme evaluation and follow-up planned.

	The Committee received significant assurance on the overall delivery position across the four People Plan themes.
	Equality, Diversity and Inclusion (EDI) First-year progress against the EDI and Race Equality Delivery Plans was reviewed, noting strengthened governance, leadership visibility and collaboration, alongside progress in implementing the relevant Lord Mann Review recommendations. Demonstrating measurable impact was highlighted as the principal challenge. The discussion covered local teams understanding of their priorities and that speaking up activity, Recruitment Inclusion Guardian training and quality and equality impact assessments are delivering improvement rather than operating as compliance processes. It was confirmed that Divisional data and improved dashboards are to support local leadership and that closer collaboration between EDI, organisational development and Freedom to Speak Up will consolidate evidence. The Committee supported a more focused Year 2 approach, comprising clearly defined interventions, measurable outcomes, consistent implementation and scheduled review points.
	2025/26 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports (prior to sign-off at Board) Key highlights included improved Black and Minority Ethnic representation and disability declaration, positive Board representation and broadly equitable disability recruitment outcomes. It was noted that persistent inequalities remain. More detailed analysis was requested by role, Division, team and appointment stage to establish the drivers of disparities, effective practice and accountability. The Committee supported a smaller number of clearly defined, consistently delivered interventions with measurable impact, including a combined reframing of the WRES and WDES action plans focused on bullying and harassment, career progression, flexible working and reasonable adjustments, while retaining recruitment inclusion support. Subject to agreed updates, the reports and associated action plans were approved for Board submission, prior to publication on the Trust website.
	Staff Survey – 2026 It was noted that the survey will run from 14 September to 27 November 2026 and will include refreshed communications; targeted support for teams with low response rates; paper-based access where required and promotional activity linked to the flu vaccination campaign. Additional questions will provide a baseline for awareness and perceived impact of the Personal Accountability Charter (PAC), while identified survey measures will support evaluation of the Trust's Staff Standards. Discussions covered engagement with teams affected by organisational change and access to meaningful feedback where national confidentiality thresholds suppress results. It was confirmed that engagement remains difficult in some areas; with analysis by professional group and a locally governed feedback option for willing teams to be explored. The Committee emphasised local management ownership and tailored support for teams experiencing cultural or management barriers, supported by promotion through Divisional and Care Group boards, Board visits and practical myth-busting materials.
	Guardian of Safe Working Hours (GoSWH) annual report – 2025/26 and quarterly report The papers evidenced that exception reporting and the revised contractual arrangements are embedded, supported by training for Resident Doctors and Clinical Supervisors. An increase in reported exceptions was attributed to the new recording process rather than a confirmed deterioration in working conditions, although timely completion required further reinforcement. Particular pressure was identified on the southern on-call rota following increased Inpatient capacity and patient acuity, especially during the early evening. The Committee noted interim escalation

	thresholds; cross-unit support and co-ordinator assistance have been introduced, with evaluation planned by the end of the month to determine whether further support, including non-medical workforce capacity, was required.
	10 Point Plan to improve the working lives of Resident Doctors It was highlighted that the Trust is compliant with all eight elements within its direct control, with the remaining two managed by the regional deanery, and that governance arrangements have been embedded into business as usual. It was noted that Resident Doctor satisfaction is 79.4%, marginally below the 80% requirement, and an engagement plan is being developed in response to low survey participation. Established forums and supervisory arrangements continue to support concerns, including mitigations for the southern on-call issues. It was agreed that future reporting will demonstrate the Plan's impact on retention, wellbeing, career development and recruitment. The Committee accepted significant assurance.
	Workforce Plan – high-level The committee received the Trust three-year Workforce Plan which aligned workforce supply; skills, service transformation; financial requirements and national priorities. It was noted that the workforce position is broadly stable, with vacancies reduced to 2.49% and turnover remaining stable. However, occupational shortages, retirement-related turnover and an ageing workforce remained key risks. Delivery priorities include role and skill-mix redesign; advanced practice; digital tools; rostering; apprenticeships and new roles, together with further reductions in agency use and a bank target.
	Flu Campaign – 2026/27 The vaccination plan aims to increase frontline staff uptake from 43.6% to 49%, using a peer-vaccinator model, supported by relevant corporate and Divisional teams, with bookable; walk-in and roving clinics and reciprocal access through Derbyshire Community Health Services NHS Trust. It was advised that survey findings would inform targeted access, communications and myth-busting activity, including support for higher-risk and harder-to-reach staff groups and engagement through trusted network representatives where lower uptake had been identified. Operational risks relating to vaccinator capacity; vaccine storage; transport; supply and wastage; data quality; staff hesitancy and sickness absence are to be monitored through weekly reporting and the Flu Vaccination Steering Group. Significant assurance was received that a comprehensive delivery model is in place.
	Review of People and Culture Committee Board Assurance Framework (BAF) Risks The Committee agreed that the sickness absence entry should be revised to reflect inconsistent application and ownership of policy, together with any evidence-supported gaps in provision for stress and anxiety-related absence, rather than inadequate policies and processes. It was considered that the Making Room for Dignity risk relates more broadly to delivery of organisational development plans and culture learning, including THRIVE and Culture of Care and should be reframed or incorporated into the existing risk concerning the impact of organisational change on culture and morale.
	Items for discussion at Board or other Board committees: None. Items added to the Board Assurance Framework: None. Next scheduled meeting: Thursday, 5 November 2026.

Committee Chair: Ralph Knibbs	Executive Lead: Rebecca Oakley, Director of People, Organisational Development and Inclusion
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Emergency Preparedness, Resilience and Response (EPRR) annual report and core standards

Purpose of Report

To provide an overview of the works completed within the EPRR portfolio and substantial compliance for the August submission of the core standards.

Executive Summary

This annual report is set out within the 10 domains within the EPRR core standards. The Trust is expecting to submit a substantial compliance against the 2025/26 submission in August 2026.

This year has seen several incidents and events which has embedded EPRR into colleagues' daily business and developed further resilience and contingency. Projects have seen improved outcomes. Learning from previous events has been incorporated. There is always more to be done and opportunity to enhance the provision of the EPRR portfolio and we look forward to those next steps. The national NHS England core standards have been released, and it is anticipated that the Trust will be providing a substantial compliance again this year.

The below provides an update against the current compliance, this is subject to actions being completed and final ratification of documents.

As a Trust we are measured against the following domains:

- Governance [100% fully compliant]
- Duty to risk assess [100% fully compliant]
- Duty to maintain plans [81% fully compliant]
- Command and control [100% fully compliant]
- Training and Exercising [100% fully compliant]
- Response [100% fully compliant]
- Warning and Informing [100% fully compliant]
- Co-operation [75% fully compliant]
- Business Continuity [100% fully compliant]
- HazMat/Chemical, Biological, Radiological and Nuclear (CBRN) [90% fully compliant].

A substantial compliance was submitted at the end of August with four partials out of a total 58 standards. The report provides further narrative around each domain and works completed during 2025/26. It also references the four partials that remain.

Strategic Considerations		BAF Risk	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X		1.1 / 1.3
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.			
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X		3.3
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X		4.1 / 4.2

Risks and Assurances

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

Consultation

A version of this report has been received at Finance and Performance Committee and the Executive Leadership Team.

Governance or Legal Issues

- Civil Contingencies Act 2004
- NHS Emergency Preparedness, Resilience and Response Framework 2022
- NHS core standards.

Net Zero Duty Implications

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

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

Adaption is a key part of EPRR as we experience further extremes in weather. Consideration needs to be incorporated into local plans for excess heat/cold and flooding. EPRR is closely linked with the Green Plan and support projects where required.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

There are no equality related impacts within this report. Within local business continuity plans and other EPRR related plans, we ask colleagues to consider all equality, diversity and inclusion related matters for the services they provide and impact in the event of an incident.

Recommendations

The Board of Directors is requested to:

1. Receive the updated report
2. Be fully assured of ongoing work to maintain the Trust's level of compliance with the EPRR core standards.

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

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

Emergency Preparedness, Resilience and Response (EPRR)

Annual report and core standards update 2025/26

1. Introduction

This year has seen several incidents and events which has embedded EPRR into colleagues' daily business and developed further resilience and contingency. Projects have seen improved outcomes and learning from previous events has been incorporated. There is always more to be done and opportunity to enhance the provision of the EPRR portfolio and we look forward to those next steps.

The national NHS England (NHSE) core standards were released in July, and the Trust will be providing a substantial compliance again this year. The report is sectioned into the 10 domains within the core standards, it highlights successful completion of works and areas for ongoing improvement and progression. There is an action plan in development to confirm timescales for completion of relevant standards. There are a small number of partials remaining for the submission, this is due to changes in the workplan over 2025/26, the number of incidents/planned events the team have supported with and operational changes within the organisation.

Core standards

As part of the NHS EPRR Framework, providers must show that they can effectively response to all incidents whilst maintaining services to patients. This is done on an annual basis through the Core Standards. An overall assurance rating is assigned based on the individual standards ratings. Fifty-eight standards are applicable to us as a Mental Health Trust. The overall assurance ratings are:

Compliance Level	Definition
Fully	The organisation is 100% complaint with all standards it is expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the Core Standards it is expected to achieve. For each non-compliant Core Standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partially	The organisation is 77-88% compliant with the Core Standards it is expected to achieve. For each non-compliant Core Standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Not compliant	The organisation is compliant with 76% or less of the Core Standards the organisation is expected to achieve. For each non-compliant Core Standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

DHcFT is expecting a **substantial compliance**, this will be subject to the Integrated Care Board (ICB) Cluster and NHS EPRR regional team confirm and challenge session. The below table shows the 10 domains and the compliance at the point of submission in August 2026:

Please select type of organisation:
Click button to format the workbook

Mental Health Providers

Format Workbook

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	9	2	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	5	5	0	0
Warning and informing	4	4	0	0
Cooperation	4	3	1	0
Business Continuity	10	10	0	0
Hazmat/CBRN	10	9	1	0
CBRN Support to acute Trusts	0	0	0	0
Total	58	54	4	0

3. Governance

In line with the EPRR workplan, plans and documents have been undergone an annual review. The Chief Delivery Officer is the Accountable Emergency Officer (AEO). However, it has now been agreed that when covering the CEO role, this AEO function is provided by the Director of People, Organisational Development and Inclusion. The EPRR Strategic Leadership Group has been rebranded which has supported an increase in attendance.

Following events or incidents, actions and lessons identified are processed through debriefing reports and added to MS Planner which supports with completion and audit trails.

4. Duty to risk assess

The Trust-wide EPRR risk assessment has been developed using the local and national risk assessments. This is timetabled for an annual review within the EPRR Strategic Leadership Group meeting or following a change in the risk presentation/awareness. Where required, risks are escalated internally but also through the Health Emergency Planning Officers Group and Local Health Resilience Partnership.

5. Duty to maintain plans

To support with the review and development of Trust EPRR Plans, the consultation process is broad; it covers internal colleagues and EPRR Derbyshire Network, on occasion plans are consulted with other mental health trusts as appropriate. All plans are held on Focus, within the Emergency cupboard (Kingsway House) and held on Resilience Direct. The ICB and NHSE Regional colleagues provide extensive feedback for review and consideration during this period for each plan.

Incident response plan (IRP) was shared for consultation and has incorporated the comments as appropriate. This plan covers multiple aspects of the core standards. It has included changes to the organisational structure and naming conventions. It has incorporated lessons identified from incidents and exercises over the last year. The structure of the document is split into different sections to ensure that relevant aspects are referred to as required – for example the first section is the governance structure and accountability, the second section is incident response. This is the section that needs to be utilised in the event of an incident.

Adverse weather plan – we have seen an increase in weather extremes over the last year. They have posed different challenges to colleagues in ensuring continuity of services to patients and service users. The plan has undergone an annual review with minor changes due to no changes in national guidance.

Infectious disease – following a change in personnel infection prevention and control (IPC) is now supported by a new member of staff. They are in the process of reviewing plans and policies and bringing these documents up to the national standard. A new Highly Communicable Infectious Disease (HCID) is in the process of ratification currently which will support this standard. There is a potential that this will remain as a partial for this year's submission.

New and emerging infectious diseases (partial compliance) – this plan has not been reviewed within the last year. This standard will remain at partial for the August submission, it is on the workplan for completing in October/November.

Due to changes in organisational restructure and capacity, this document has not been updated for this year. The document is still relevant but the requirement is to review annually in order for the standard to be compliant.

Countermeasures – included within the EPRR IRP no changes have been made.

Mass casualty – an action card has been developed to support with expediting patients from acute trusts in the event of a mass casualty incident. Following the move of Talking Mental Health Derbyshire, we are reviewing the System-wide response to incidents. This is being supported by the Deputy Chief Psychologists and the ICB.

Evacuation and shelter plan – the generic plan has been reviewed and amendment to include the new buildings within our footprint. In addition to the main plan, individual site plans for been developed for each Inpatient setting. Several Community bases have also completed their site plans.

Lockdown – the Counter Terrorism and HazMat Plan is due for review in August, in line with its review schedule. The site plans have been developed for lockdown processes too.

Protected individuals – this has undergone its annual review with changes to reflect organisational change.

Excess fatalities – this is included within the Incident Response Plan there has been no changes to previous years.

Mass casualty planning (partial compliance) – the action card remains within the IRP. However, the Psycho-social Response plan has not been reviewed within the last year. There is an additional piece of work to complete to consider wider system response to psycho-social support. The capacity to facilitate the annual review for the plan has not been achievable, this is due to the number of incidents/exercises and events. Work is scheduled with a task and finish group to review the process within the cluster and update the document. Due to the nature of the cluster and new ways of working, it is expected that this document will be completed by February 2027. This is as a result of co-ordinating three NHS organisations responses and local authority/social care input.

6. Command and control

The Trust continues to maintain a response structure to an incident. This has been implemented on several occasions; a number of colleagues have been involved in Incident Management teams to ensure continuity of competencies.

Our on-call function has been reviewed with the outcome of one tactical on-call rota, (previously first north and south) and a Strategic on call rota (second on-call). We have also moved to a payment per shift method which supports in finding short notice cover. This has been developed within the cost envelope of on-call costs. In addition to this, we have reviewed the accountability and authority for agreeing actions and decision-making processes.

Further work is ongoing to develop the Trust bleep holders to support with appropriate escalation to on call. Thematic reviews are undertaken to consider patterns or frequent issues are presented to develop alternative options or change processes.

Within hours, our process remains the same with the AEO (or deputy) is the first point of contact for activation and the EPRR team is available to support.

7. Training and exercising

The Training Framework and training needs analysis have been updated; it is scheduled for the Training and Education Committee in July. Training compliance for on-call managers has improved but further work is required (66% 2024/25 up to 80% 2025/26). Bleep holder training is being developed to begin implementing in September. The training is being rolled out to wider members of the Information, Management, Technology and Records (IMT&R) team.

		Status							
		Meets Requirement		does not meet Requirement				Total n	
Competency		n	%	n	%				
Role specific		43	80%	11	20%			54	
383 LOCAL EPRR Incident Response and Management Training - 2 Years		43	80%	11	20%			54	

The training will be reviewed over August and incorporate any feedback from previous events. In addition, it will reflect any changes to EPRR plans and risk assessment.

To support with wider all staff engagement the EPRR team has participated in Business Continuity Awareness Week (May) and #30ways30days (September). This was to give opportunity to colleagues to consider their local plans and arrangements and their own personal resilience for incidents.

Every three years, the Trust must complete a live exercise. We are scheduling this within 2026/27, as it will require a multi-disciplinary team to develop and execute. The Trust has contributed and participated in several exercises during 2025/26. These are outlined below:

- Exercise Blue Cat – Trust tabletop exercise, call cascade and local business continuity management arrangements
- Out of hours Communications test – successful test
- Exercise Penelope – evacuation process, System-led exercise
- Exercise Frostguard – Winter Planning System exercise
- Exercise Pegasus – national government exercise to review pandemic planning over a period of three months
- Exercise Cortani – Derbyshire Resilience Partnership Exercise to look at flooding implications within the county
- Exercise Hermes and Toucan are external communication exercises – both tests had successful outcomes.

8. Response

The Incident Co-ordination Centre plan has undergone its annual review and supports a physical and virtual incident management response.

During the last 12 months we have responded to the following incidents and planned events:

- Work Experience presentation Joined Up Care Derbyshire – July 2025
- Protesting, Bayheath House – October 2025
- Storm Claudia – November 2025
- Resident Doctor industrial action (IA) – November 2025
- Vulcan Street, Derby evacuation – December 2025
- Resident Doctor IA – December 2025
- Alveston House explosion – December 2025
- Boyer Street House fire, Derby – December 2025
- Mental Health (MH) Helpline certificate error – December 2025

- Total power failure Kingsway – January 2026
- Storm Goretta – amber snow warning January 2026
- MH Helpline failure – January 2026
- London Road power outage – January 2026
- Yellow cold weather alert - February 2026
- Beeches air conditioning upgrade – February/March 2026
- Resident Doctor IA April 2026
- Telephony failure – April 2026
- Increase in counter terrorism level – May 2026
- Radbourne Unit electrical shut down – May 2026
- Ripley Town Hall planned power outage – May 2026
- Switchboard failure – May 2026
- Derbyshire Community Health Services NHS FT transfer IMT&R support – May/June 2026
- Resident Doctor IA – stood down – June 2026
- Amber warning for heat health alert – June 2026
- Derby City Primary School presentation – July 2026
- Commissioning Support Unit (CSU) transition Task and Finish – ongoing
- Community base planned moves – ongoing.

Following these types of events, the EPRR team considers if a full debrief is required or just locally within the team. We look for learning opportunities and themes emerging. As a result of this, we have developed a bleep holder training package, updated the Incident Management training package and amended three EPRR related plans/documents.

9. Warning and informing

The Communications and Engagement team is currently reviewing the EPRR Incident Communication Plan. The Trust continues to have an informal agreement for communications on call which has been agreed by the Executive Leadership Team. The team provides input into the EPRR Incident Response training and completes the communications during an incident module with colleagues. To support the team's development, they have undertaken EPRR training to highlight their role and requirements during an incident. The team has also contributed and attended System-wide exercises throughout the year.

10. Co-operation

The EPRR team actively participates in System and Derbyshire Resilience Partnership (DRP) planning meetings. In addition to this the AEO engages with relevant strategic meetings as required. The process to request and/or receive mutual aid arrangements has been detailed within the EPRR IRP.

One partial compliance remains within this section this is in relation to information sharing. Clarity is required to understand where work is required to finalise the information sharing agreements for EPRR purposes.

The partial compliance for this standard requires a multi-agency response, this is not just within the health system. This work has been delayed due to other prioritised work in the DRP. Work is ongoing within the DRP to update the previous sharing agreement. It is anticipated that this will be completed by December 2026. In addition to this, the Trust will also develop local documents to support with information sharing during incidents. This will be finalised by December 2026.

11. Business Continuity

Due to the organisational restructure, significant effort has been put in to align the business continuity arrangements to the new Care Group structure. Care Groups have seen the benefit of holding local exercises to test their processes and identify gaps. Corporate teams continue to maintain their business continuity document and were included in Exercise Blue Cat.

Following learning within the last year, several teams now have their own local plan within Care Groups. Whilst there is duplication in a few aspects of the plan, the physical locality is different. Therefore, different responses/considerations are required. The strategic business impact analysis will be produced once the remaining plans have been submitted to the EPRR team. The compliance against this is being monitored through the EPRR Strategic Leadership Group.

12. Chemical Biological Radiological Nuclear (CBRN) / hazardous material

The likelihood of this type of event remains low for the Trust. The plan is scheduled for its review in August as part of the EPRR workplan. A training session and exercise was conducted with the Care Group triumvirates. This covered evacuations, lockdown due to suspect package and management of a self-presenter. This session supported with the development of the individual site plans. Strategic training is being scheduled for Board development with the Counter Terrorism Security Advisors.

One partial compliance remains for personal protective equipment and FFP3 masks, training and testing. This is a piece of work which is being undertaken by the Physical Health team and Associate Director of Physical Health and Quality. The dates for training have been agreed and colleagues are booked on but this scheduled after the submission date.

13. Conclusion

There is no end destination for EPRR as every year we grow and develop better documents and learn from previous events. The number of incidents/events this year has been substantial. The core standards that are expected to remain partial for the August submission are different to last year. It is anticipated that the Trust will be submitting a substantial compliance for 2025/26.

The Trust Board can be assured of the following:

1. There is a workplan to continue progressing the EPRR portfolio
2. Compliance with business continuity has improved and embedded more than previous years
3. The profile of EPRR has risen within the organisation and colleagues are beginning to see the benefit of it
4. The Trust submitted a substantial assurance in August 2026.

Trust Strategy Deep Dive – Patient

Purpose of Report

This paper provides assurance that the Patient Focused strategic priority is being delivered through a coherent, system-wide approach to quality control, quality assurance and continuous improvement.

Executive Summary

The Board-approved Quality Delivery Plan, aligned to the Trust Strategy, the national 10-Year Health Plan and the Darzi domains of effectiveness, safety and experience, is supported by a co-produced Quality Assurance Framework; clear governance and regular reporting to the Quality and Safeguarding Committee; Strategic Portfolio Oversight Group (SPOG) and the Board. Delivery is embedded across services through Fundamentals of Care reviews; Care Group assurance meetings; Patient Safety Incident Review Framework (PSIRF); service accreditation; patient feedback, Board visits and improvement programmes. All planned 2025/26 priorities were delivered other than the transition from Care Programme Approach (CPA), which was appropriately deferred pending publication of national guidance.

The assurance position is substantiated by measurable evidence of delivery and impact. During 2025/26, 91 Fundamentals of Care visits and 152 Board visits strengthened scrutiny, organisational learning and leadership visibility. Fundamental Standards cross-checks are embedded across all Divisions; 98% of risk assessments are in date; no staffing category fell below the 80% fill-rate threshold; recent Care Quality Commission (CQC) inspections of Community, Crisis and Rehabilitation services were rated Good; and the Trust retained its overall “Good” rating. There are no inappropriate out-of-area placements, Family and Friends Test returns increased by 28% in June 2026 and lived experience has been strengthened through trained Experts by Experience and 15 Steps reviews. The 2025 Community Mental Health Survey also shows improvement in dignity, compassion, care planning, medication discussions and family and carer involvement.

Patient experience has been gathered in various ways, including 15 steps challenge; Bright Ideas; Friends and Family Test; Peer Support; EQUAL; Triangle of Care; complaints; compliments; concerns; Advocacy services; strengthening co-production and improved carer and patient representation and forums.

These arrangements demonstrate that quality is routinely monitored, triangulated and acted upon from team to Board level.

Therefore, significant assurance is provided on the strength of the strategic framework, governance, implementation and evidence of improvement. Sustained Executive and committee oversight remains necessary in relation to long waits; complaints timeliness and outstanding actions; outcome measurement; care-plan review compliance; violence and aggression; restrictive practice; length of stay; digital capacity and implementation of the Personalised Care Framework. These issues are identified, visible within established governance routes and subject to targeted improvement. Priorities for 2026/27 are agreed and in progress, while the developing Clinical Plan will provide the next stage of delivery by the end of 2026.

Strategic Considerations		BAF Risk	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X	1A	1.1-1.4
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.			
Productive: We will improve our productivity and design and deliver services that are financially sustainable.			
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.			

Risks and Assurances

The strategic priority is aligned to risks on the Board Assurance Framework (BAF).

Consultation

- ELT
- Quality and Safeguarding Committee.

Governance or Legal Issues

- Trust Strategy
- Quality and Safeguarding Committee
- CQC regulation and legislation.

Net Zero Duty Implications

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

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

None.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

No individuals or group have been disadvantaged in the delivery of the Patient Focused strategic priority.

Recommendations

The Board of Directors is requested to:

1. Receive significant assurance on the delivery of the Patient Focused strategic priority and not areas of improvement and focus
2. Note that the Clinical Plan as a key driver for the strategic priority is at an advanced stage of development and will be in place by end 2026.

**Report presented and
Prepared by:**

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

Deep Dive - Patient

The Trust Strategy has four pillars, with patient focused being one of four Trust-wide strategic priorities. The Patient focused strategic priority is being delivered through a coherent, System-wide approach to quality control, quality assurance and continuous improvement. The Quality Delivery Plan outlines our approach to achieving the quality ambitions outlined under this priority, through three pillars of quality care – effectiveness, safety and experience. This was co-produced by people that work in the services and those that use the services. The plan had input from all levels of the organisation acknowledging that we all contribute to the quality of the care that's delivered in the services. The plan was approved by Board in 2025/26 and runs until 2028.



In July 2025, the 10-Year Health Plan was published by NHSE with a focus on the three shifts: Hospital to Community; Analogue to Digital and Sickness to Prevention. In the plan it is outlined what makes up quality care.

The Quality Delivery Plan has been assessed against the 10-Year Health Plan.. Both plans have the same quality definition at outline by Lord Darzi. Quality care is delivered when all three components - effectiveness, safety and experience are present (Care Delivery Darzi, 2008). The Quality Delivery Plan is aimed at improving standards of care, compliance to regulation and standards, providing evidence-based care and having positive experience and outcome for carers, families and patients that use the services.

In December 2025 the Quality Assurance Framework was published in the Trust and outlined how quality is delivered, monitored and continuously improved on. This framework was set out to develop a quality culture in the organisation which sets out how we deliver quality care here.

Our Quality approach

The Quality Delivery Plan outlines our quality approach that focuses on Quality Control, Quality Improvement and Quality Assurance. The Quality Assurance framework has been co-produced and delivered to deliver our quality approach.

Quality Control	Quality Assurance	Continuous Quality Improvement
Team Audits	Patient Safety Incidents Response Framework (PSIRF)	Bright Ideas
Fundamentals of Care visits	Service Accreditation	Family First
15 Steps Challenge	Care Quality Commission (CQC) ratings	Patient experience plans
Infection, Prevention and Control (IPC) walkabouts	Mental Health Act (MHA) reviews	Zero out of area placements
Roster Check and Challenge	Quality and Safeguarding Committee assurance	Mental Health Optimal Staffing Tool (MHOST)
Focus on key performance indicators (KPIs)	CQC MHA Community	Culture of Care
Patient-Led Assessments of the Care Environment (PLACE) reviews	Patient feedback	Models of Care
Triangle of Care	NHS Oversight Framework (NOF) KPIs and ratings	Violence and Aggression Collaborative

Quality Assurance Framework

NHS
Derbyshire Healthcare
NHS Foundation Trust

Through our Quality Delivery Plan, we focus on how our work improves: **Safety • Effectiveness • Experience**

Our different quality visits



Fundamentals of Care (FoC)

Internal quality reviews aligned with recognised standards. Listening to patients and staff to check the basics are right.



15 Steps Challenge

A brief walkaround to understand first impressions experienced by patients, carers, and staff. Is the service welcoming? Does it feel safe and calm?



Board Visits

Senior leaders hearing what matters to you, meeting staff teams and patients to understand what is working well and find out where support is needed.



External Quality Visits

Independent partners providing oversight of service quality, safety, and patient experience. Feedback to teams, with actions agreed.

Visits to our services are:

Routine and part of planned assurance.

Risk-driven - triggered by concerns, feedback, incidents, or intelligence.

Focus on patient safety while maintaining dignity and respect.

Open and honest. We ask you to share strengths and challenges.

What happens next?

Immediate safety concerns are escalated
Learning is shared
Improvement actions are agreed
Progress is monitored

All visits are underpinned by our Quality Assurance Framework Policy.

Statutory visits to our services (e.g. CQC and SEND) are managed through a separate governance process.

Fundamentals of Care

This is a quality standard review framework that is in place for the Trust. It is aligned to evidence-based care and CQC single assessment framework. This framework is used to audit care in all care settings it is built to be flexible in line with each service and speciality. There are core standards that should be met, and there are specialist or specific standards for each service. In 2026, the framework included people with lived experience as part of the quality review process. This has strengthened the experience element of quality. Each service receives feedback and a report. The team produces an action plan for areas of improvement and the findings from each service are shared with the rest of the organisation sharing good practice and learning. The Quality and Safeguarding Committee receives assurance on whether the reviews are taking place, areas of concern and action being taken to address them.

In 2025/26, there were 91 Fundamentals of Care visits completed, with various areas of focus, such as learning from the Nottingham CQC reviews, risk assessment, care planning and medication safety. The Fundamental Care visit for Kingfisher Psychiatric Intensive Care Unit (PICU) was done collaboratively with Northamptonshire PICU to enhance the learning from an established PICU.

Experts by Experience

Training has been delivered to Experts by Experience to support their involvement in team visits. The training covers the role of Fundamentals of Care visits, the CQC regulatory framework and practical preparation for participating in reviews. This approach ensures lived experience is embedded within visits, providing a real-world perspective on the quality of care. Experts are trained to observe care, speak with staff and service users and highlight both strengths and areas for improvement. Feedback is shared on the day and contributes directly to action planning. This aligns internal inspection with CQC's Single Assessment Framework and the organisation's commitment to person-centred care.

The Quality Assurance Framework has delivered the 15 steps challenge in 2026. This is a toolkit that lets patients, carers and staff evaluate healthcare quality from a patient's perspective within the first 15 steps of entering a ward or clinic. The teams had feedback on quality from the perspective of those that use the services. This was run and overseen by EQUAL.

In 2025/26, there were 152 Board visits. These were visits by members of the Board and Governors visiting services and hearing how services are delivered. This allows the Board to triangulate their experience with reports, assurance reports and increase visibility of senior leadership in the services.

Patient experience

Patient experience has been gathered in various ways, including the 15 steps challenge; Bright Ideas; Friends and Family Test; Peer Support; EQUAL; Triangle of Care; complaints; compliments; concerns; Advocacy services; strengthening co-production and improved carer and patient representation and forums.

The 2025 Community Mental Health Survey indicates an improving overall experience of Community Mental Health services compared to the previous year, with stronger results for respect and dignity; compassion; family and carer involvement; participation in care planning; medication discussions and therapy privacy. Notable gains include family and carer involvement (+12.5%); support meeting people's needs (+11.4%); involvement in agreeing care plans (+11.0%); clarity about the purpose of medication (+9.5%) and therapy privacy (+8.5%).

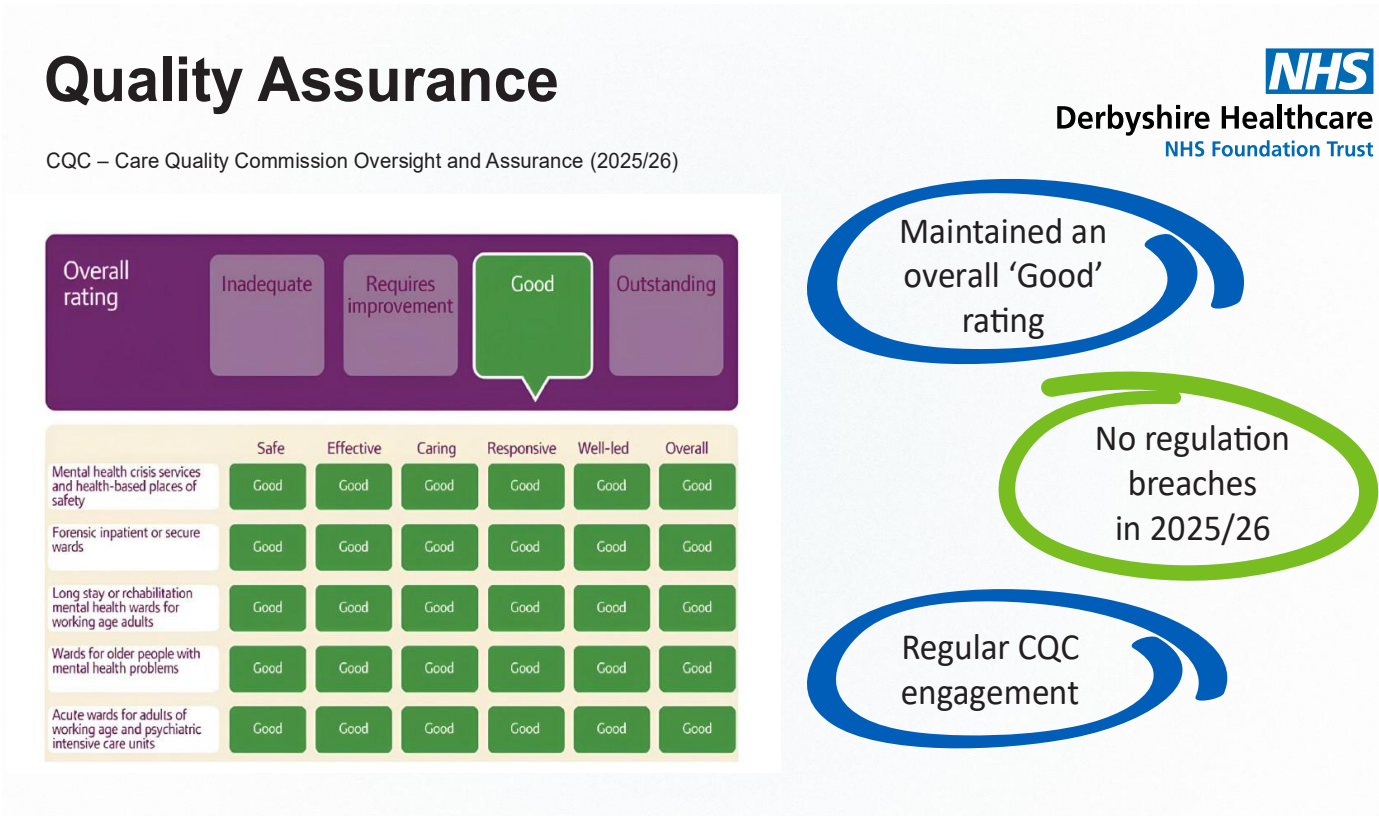
However, several material deteriorations require sustained management attention. These include care reviews completed within the previous year (–11.2%); support while waiting (–10.5%); proactive identification of access needs (–9.3%); physical health support (–8.0%) and employment support (–7.5%). Improvement plans have been developed and implemented to improve patient feedback and outcomes and these have been reflected a priority for 2026/27.

Fundamentals of Care assurance meetings

The Quality Delivery Plan has driven the focus on quality to be data driven. Each Care Group has Fundamentals of Care assurance meeting chaired by senior leaders to review, monitor and drive improvements in key performance indicators fortnightly, that links with the Directorate performance reviews. Since inception, the delivery plan had driven up compliance in risk assessments; care plans; supervision; training compliance; physical health; patient experience indicators and accountability.

Quality Assurance

The Patient Focused Strategic Objective delivery has seen various services improve in their ratings. Services that have been inspected since December 2024 show that there has been improvement in services and this aligns to the various initiatives that ensure quality control, assurance and continuous improvement. The illustration below shows the Trust retained its “Good” rating and various services improving in individual comprehensive services.



The Patient-focused strategic priority plans for 2025/26 were delivered, except for transition to the Personalised Care Framework, as the guidance had not been published.

The priorities for 2026/27 have been agreed by the Board and they are in progress. These are being measured against the Quality Delivery Plan and updates are given Quarterly to the Quality and Safeguarding Committee, Strategic Portfolio Oversight Group and The Board. Current performance indicates that:

Key areas of improvement:

- The July 2026 Safer Staffing Annual Review found no staffing category below the 80% fill-rate threshold and supported retention of current establishments pending repeat MHOST review
- Fundamental Standards of Care cross-checks are embedded across all Divisions
- Quality Assurance Framework is now in place
- Latest compliance shows 98% of risk assessments in date
- Recent Community, Crisis and Rehabilitation services inspected by the CQC have been rated Good
- PSIRF, Learning-the-Lessons groups, safeguarding audit and multi-agency arrangements are embedded
- There are no inappropriate out-of-area placements, supported by twice-weekly multi-agency discharge meetings
- Family and Friends Test returns increased by 28% in June 2026
- 15 Steps visits are embedded in Inpatient services
- Digital: four programmes and 16 projects active across the Trust
- Patient and carer pledges are being progressed and there is clear governance and structure to support meaning patient experience oversight.

Key areas requiring improvement:

- The average wait from referral to first contact was 121 days, with the longest waits in Neurodevelopmental and Children's Complex Health services
- Trust-wide outcome measurement, the clinical early-warning score project and automated physical-health reporting remain under development
- Care-plan review compliance for people on the Care Programme Approach (CPA) for over 12 months was 87%, requiring continued targeted improvement
- Only 42% of complaints were answered within 90 working days and outstanding complaint actions increased from 27 to 42
- Patient-to-staff assaults increased, with concentration in Older People's Inpatient wards, PICU and Audrey House
- Race-related abuse and aggression accounted for 82% of protected-characteristic incidents between May and July 2026
- Restrictive practice and Inpatient length of stay remain pressures, while Dialog Plus, Advance Choice Documents and lived-experience governance require further progress
- Northern pathology integration remains incomplete and digital programme-management capacity continues to require oversight
- The Personalised Care Framework was published in July 2026; a transition programme is required to move away from CPA.

Future developments

The Clinical Plan is under development to further delivery of the Patient Focused Strategic Priority, the plan is expected to be in place by the end of 2026. The Clinical Plan is the Trust's framework that sets out the clinical outcomes we want to achieve over the next three years, the populations we will prioritise, the model of care we will provide, the changes required in clinical practice and how we will measure whether those changes improve outcomes, safety, experience and equity.

Winter Planning - 2026/27: Effective Capacity, Performance and Operational Resilience

Purpose of Report

To provide the Board of Directors with assurance regarding the Trust's preparedness for Winter 2026/27 and to highlight the principal performance, capacity, workforce and system risks that may affect delivery during periods of sustained winter pressure. The paper also provides an update on the Trust's Winter Planning 2026/27 Board Assurance Statement (BAS) and its progression through the agreed governance route.

Executive Summary

NHS England (NHSE) requires all providers to complete a Winter Planning 2026/27 BAS, supported by an organisational Winter Plan, regional exercise testing and Board approval. A draft BAS has been completed and reviewed against the national requirements.

The assessment indicates that the Trust has established arrangements to support effective capacity, patient flow and operational performance through Winter 2026/27. Existing controls include discharge optimisation processes, flow governance, urgent mental health pathways, workforce resilience arrangements, Infection Prevention and Control (IPC) and operational escalation processes. These arrangements are designed to maintain service resilience and productivity during periods of increased demand.

The principal risks relate to sustained community demand, effective capacity constraints, delayed discharge, workforce availability and wider System dependencies. These risks are recognised within existing operational governance arrangements and are subject to routine monitoring through Divisional, Executive and Board oversight routes. Delivery of the Winter Plan is expected through existing business-as-usual arrangements and does not require additional investment outside approved operational processes.

The current BAS position supports a judgement of significant assurance. No material operational capability gap has been identified through the assessment. Remaining actions relate primarily to assurance validation, completion of the regional winter exercise, Quality and Equality Impact Assessment review, Board approval and final NHSE submission.

Strategic Considerations		BAF Risk(s)	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X	25-26 1A	Patient Focus
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X	25-26 2B	People
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X	25-26 3A	Productive
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X	25-26 4A	Partnerships

Risks and Assurances

The BAS assessment indicates that the Trust has established arrangements to support effective capacity, patient flow and operational performance throughout Winter 2026/27. Assurance is derived from existing business-as-usual controls, including discharge optimisation, flow governance, urgent mental health pathways, workforce resilience arrangements, IPC and operational escalation processes. These controls are intended to maintain service resilience and productivity during periods of increased demand.

The principal risks relate to sustained Community demand, constraints on effective capacity, delayed discharge, workforce availability and wider System dependencies. These factors may affect effective capacity, patient flow and operational productivity if pressures increase during the winter period. These risks are recognised within existing operational governance arrangements and will continue to be monitored through Divisional, Executive and Board oversight routes.

Current mitigation is focused on maintaining effective capacity through discharge optimisation, escalation arrangements, workforce planning and established urgent mental health pathways. Delivery of the Winter Plan is expected through existing operational arrangements and does not require additional investment outside approved business-as-usual processes.

The assessment has not identified any material operational capability gap that would prevent delivery of the Winter Plan. The remaining actions relate primarily to assurance validation, governance requirements and final approval processes rather than implementation of additional operational controls.

Consultation

- The Winter Plan and BAS have been developed using the NHSE framework and supporting evidence from operational, prevention, IPC and Emergency Preparedness, Resilience and Response leads. The position has been reviewed with the Director of Operations and relevant operational leads as part of the BAS assurance process
- Executive Leadership Team on 8 September 2026
- Finance and Performance Committee on 11 September 2026.

Governance or Legal Issues

Completion of the BAS forms part of the Trust's response to NHSE Winter Planning -2026/27 requirements. Submission must be supported by a Winter Plan, participation in a regional winter exercise and Board approval before submission to NHSE.

Net Zero Duty Implications

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

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

This paper is primarily an assurance and governance report. No significant additional net zero implications have been identified. Any operational or service changes arising through winter planning will continue to be considered through existing governance routes.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

The Winter Plan has been developed through existing operational, quality and governance arrangements. Completion of the QEIA review remains part of the final assurance and approval process prior to Board submission. No adverse equality implications have been identified through the current assessment.

Recommendations

The Board of Directors is requested to:

1. Receive significant assurance regarding the Trust's preparedness to maintain effective capacity, patient flow and operational performance throughout Winter 2026/27
2. Note that delivery of the Winter Plan is expected through existing business-as-usual arrangements and that no material operational capability gap has been identified
3. Note the principal risks to productivity, effective capacity and operational performance arising from sustained demand, discharge constraints, workforce pressures and System dependencies
4. Note that no additional financial investment has been identified as a requirement for delivery of the Winter Plan and that implementation will be managed through existing operational resources and governance arrangements
5. Support progression of the BAS following a governance route through the Finance and Performance Committee ahead of final NHSE submission.

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

Report prepared by: **Sifo Dlamini**
Business Manager

Lee Ryan-Doyle
Director of Operations

Appendix A – draft Winter Planning - 2026/27 Board Assurance Statement (BAS)

The draft Winter Planning - 2026/27 Board Assurance Statement (BAS) is provided as a separate Excel appendix. It contains the detailed self-assessment against the NHSE Winter Planning requirements, including the current assurance position, supporting narrative and outstanding actions prior to final Board approval and submission.

Appendix B – Executive Assurance Summary

The Executive Assurance Summary is provided as a separate Word appendix. It provides a concise overview of the Trust's current winter assurance position, principal risks to effective capacity and operational performance, remaining assurance actions and the planned route to Board approval and submission.

Winter Planning 26/27

Board Assurance Statement (BAS)



1. Purpose

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

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

Section A: Board Assurance Statement

Please include the Trust / Provider name at the top of the tab.
This section gives Trust the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 26/27 Winter Plan checklist

This section provides a checklist of what Boards should ensure is covered in their 2026/27 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2026**.



Winter Planning 26/27

Section A: Board Assurance Statement (BAS)

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.
Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Provider/Trust Name (drop down): OTHER - Please write below

If Other, write Provider/Trust Name: Derbyshire Healthcare NHS Foundation Trust

Contact details (email, phone number): Lee Ryan-Doyle. lee.ryan-doyle@nhs.net 07880460685

Date: 9/18/2026

Please complete these sections

Assurance statement			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Governan					
1	1.1	The Board has assured the Trust Winter Plan for 2026/27.	Yes	The Trust Winter Plan and BAS are progressing through the agreed governance route. The BAS has gone through TDG, ELT (8th Sept) and F&P (11th Sept) before Board consideration and final approval ahead of the 30 September 2026 submission deadline.	
	1.2	The Board is assured that a robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	Development of the Winter Plan is being informed through existing governance, quality and operational oversight arrangements. The final QEIA route and Board review position require confirmation as part of the approval process.	
	1.3	The Board is assured that the Trust's plan was developed with appropriate input from and engagement with all system partners, including primary care and social care.	Yes	The Trust plan is being developed through established system winter planning arrangements and engagement with Derby and Derbyshire partners, including system flow, vaccination, urgent care, community and social care interfaces where relevant.	
	1.4	The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	The Trust will participate in the NHS England regional winter exercise programme. The Director of Operations attended on the 10th September, and the BAS has been reviewed before final submission.	Await regional exercise date, outputs and lessons learnt.
	1.5	The Board has identified a named Executive Winter Sponsor with accountability for winter preparedness (including vaccinations), escalation and operational delivery.	Yes	Executive leadership arrangements are in place to oversee winter preparedness, escalation, operational delivery and vaccination planning. Lee Ryan-Doyle is identified through the working process as nominated lead, with the Trust Chief Pharmacist and Associate Director of Physical Health & Quality linked to winter sponsorship/vaccination planning.	Confirm final named Executive Winter Sponsor wording before final submission.
	1.6	The Board is assured that clear governance arrangements, escalation processes and operational leadership arrangements are in place throughout the winter period.	Yes	The Trust is using established governance, escalation and operational leadership arrangements are in place to oversee winter preparedness, maintain operational grip and support timely escalation of service pressures. This includes divisional governance, TDG, ELT, Board route, OPEL arrangements and operational escalation processes.	Collate final evidence links for OPEL, governance route and escalation arrangements.

Winter Planning 26/27
Section B: 26/27 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans.
Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

			Please complete these sections		
Section B: 26/27 Winter Plan checklist			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Prevention					
1	1.1	The Board is assured there are plans in place to deliver a frontline healthcare worker (FHCW) flu vaccination programme that achieves the trust level uptake ambitions and demonstrates: - the offer is accessible to all frontline staff between 1 October – 31 March with the majority of vaccinations completed by 30 November; - that both walk-in and bookable appointments are available; - that all FHCW vaccination activity will be recorded on Record a Vaccination Service (RAVS); and - the FHCW flag has been applied to the ESR records of all clinical and non-clinical staff who are in direct contact with patients to ensure accurate reporting on FDP.	Yes	The FHCW flag is not currently active, this has been discussed at the Trust Flu Planning Forum and will remain on the agenda for the next meeting following a conversation with ESR.	Validate flu programme evidence, RAVS recording, ESR FHCW flag and uptake trajectory.
	1.2	The Board is assured that frontline staff vaccination, respiratory virus prevention, and staff health measures are supported by targeted operational plans.	Yes	Respiratory virus prevention and staff health measures are being addressed through the winter vaccination and prevention planning process.	Peer vaccination plan has been agreed
	1.3	The Board is assured that plans are in place to offer vaccinations (flu and COVID-19) to long stay inpatients (21 days and above) and inpatients who are being discharged into a care home.	Yes	Ward staff will lead on the offer of patient vaccinations to those eligible. Record of vaccine uptake or refusal will be made via Pharmacy as part of discharge paperwork.	
	1.4	The Board is assured that population health intelligence and risk stratification information are used in partnership with system colleagues to identify and support vulnerable patients and high-risk cohorts ahead of and during periods of winter pressure.	Yes	The Trust recognises people with mental health needs as a vulnerable cohort within winter planning arrangements. Prevention, early intervention and wellbeing programmes support identification and management of higher-risk groups during periods of winter pressure.	
Occupancy					
2	2.1	The Board is assured that a review of discharges across each pathway required to manage bed demand and occupancy has taken place ahead of winter with system partners. These have been developed jointly with local authority, Community Health Service Providers and system partners, including holiday-period arrangements.	Yes	Existing discharge, CRFD/CFD and MADE arrangements support timely discharge, reduce avoidable length of stay and maintain patient flow during periods of increased demand. Performance is reviewed through established operational oversight arrangements.	
	2.2	The Board is assured that model discharge pathway requirements are in place to optimise discharge seven days a week across acute, community and social care services. This should include: - coordinated escalation, surge and extreme surge response arrangements, including bed escalation capacity, which have been tested and capable of safe activation to maintain patient flow, create additional capacity and support operational resilience during periods of increased demand. - executive-led governance arrangements to provide oversight of occupancy, the number of discharges required and delivered each day to support safe bed availability and flow, along with the number of patients who are NCTR by pathways 1 to 3 with monitoring of patients with long discharge delays. - targeted operational actions to reduce long discharge delays. - Discharge to Assess pathways that operate effectively with home first as the default and assessment taking place outside hospital wherever possible. These should be supported by integrated escalation arrangements with community and social care partners to maintain patient flow.	Yes	The Trust has established arrangements to support timely discharge throughout the week. Discharge optimisation is supported through CRFD/CFD oversight, MADE and established flow arrangements that support timely discharge and minimise avoidable delays. These arrangements operate throughout the week and form part of the Trust's winter response	
	2.3	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans will be implemented.	Yes	Winter planning includes continued focus on discharge optimisation, patient flow and effective use of inpatient capacity. Seasonal occupancy arrangements will continue to be refined through existing operational and governance processes ahead of final approval.	
	2.4	The Board is assured that Same Day Emergency Care (SDEC) and ambulatory emergency care pathways have been optimised to support admission avoidance.	Yes	DHCFT does not provide SDEC services. Equivalent admission avoidance is delivered through NHS 111 Press 2 Mental Health, Liaison Psychiatry, Crisis Services and the Mental Health Urgent Assessment Centre (MHUAC expected to open late Sept 26).	
	2.5	The Board is assured that frailty pathways have been reviewed and are operating effectively to support avoidance of unnecessary admission.	Yes	The Trust continues to support older adult and dementia pathways through established services and winter planning arrangements. These pathways contribute to admission avoidance, patient flow and effective use of inpatient capacity.	
Capacity					
3	3.1	The Board is assured that workforce resilience assumptions are evidenced and include safe staffing levels, appropriate skill mix, redeployment models and staff wellbeing support, with clear mitigations in place for sustained periods of increased demand.	Yes	Workforce resilience, urgent mental health capacity and operational arrangements are established. The assessment also recognises ongoing pressures relating to community demand, bed utilisation, crisis and home treatment services, and local system pressures within City and South Derbyshire. Further validation of winter staffing arrangements and service resilience over the Christmas and New Year period is being completed as part of the final assurance process.	
	3.2	The Board is assured that rotas have been reviewed to ensure consistent senior clinical decision-making capacity at times of peak pressure, including weekends, supported by clear escalation and supervision arrangements.	Yes	Senior clinical leadership and on-call arrangements are established across services to support operational decision-making and escalation throughout winter. These arrangements provide access to senior clinical advice during periods of pressure.	
	3.3	The Board is assured that elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	Elective and cancer delivery requirements are not applicable to DHCFT. The Board is assured that elective and cancer delivery requirements do not fall within the services provided by DHCFT and therefore do not present a winter planning risk for the organisation.	

	3.4	The Board has reviewed its 4-hour and 12-hour, and RTT trajectories, and is assured that the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off for 2026/27.	Yes	The Trust continues to monitor operational performance through existing governance arrangements. Escalation processes and service resilience plans support the management of winter pressures across relevant services.	
	3.5	The Board is assured that there are effective operational actions in place to ensure urgent community capacity is prioritised for the sickest patients.	Yes	Crisis, liaison, community and urgent mental health services provide alternatives to inpatient admission and support timely discharge where appropriate. These pathways form a key component of the Trust's approach to managing winter demand.	
Flow					
4	4.1	The Board is assured that emergency department crowding mitigations have been reviewed and implemented to actively eliminate corridor care as a patient safety priority. This should include implementation of relevant GIRFT recommendations, and with defined safety thresholds, clear escalation triggers, and routine Board level oversight of associated risks, including dignity, privacy and clinical harm.	Yes	DHCFT does not operate an Emergency Department. The Trust supports system flow through Liaison Psychiatry, crisis pathways, GIRFT reviews and established escalation arrangements linked to bed occupancy and operational pressures	
	4.2	The Board is assured that ambulance handover plans are deliverable and supported by appropriate operational arrangements and escalation processes.	Yes	Mental Health Liaison Teams, crisis pathways and established system interfaces support timely mental health assessment and provide alternatives to Emergency Department attendance where clinically appropriate. These arrangements support wider system flow during periods of increased demand	
	4.3	The Board is assured that escalation arrangements with system partners support timely transfer of care and patient flow.	Yes	Patient flow is supported through flow governance, CRFD/CFD oversight, MADE and established escalation arrangements. These mechanisms support early identification of pathway constraints and coordinated action with system partners.	
	4.4	The Board is assured that plans are in place to implement the Model ED and Model Discharge requirements ahead of winter.	Yes	Model ED requirements are not applicable to DHCFT. Relevant discharge principles are delivered through flow governance, discharge optimisation and established escalation arrangements	
Infection					
5	5.1	The Board is assured that plans, infrastructure, estates arrangements, IPC governance and operational capability are in place to enable the safe rapid reconfiguration of physical space, creation of additional clinical capacity and implementation of patient cohorting arrangements during periods of increased demand or infectious disease transmission, supported by appropriate environmental risk assessments and compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections.	Yes	Draft narrative pending IPC review: IPC, estates and operational arrangements are in place to support the management of infectious disease risks across Trust services. IPC governance arrangements support escalation, risk assessment and operational response during periods of increased demand.	Draft narrative pending IPC review: IPC validation of estates, cohorting and environmental risk assessment arrangements required.
	5.2	The Board is assured that IPC colleagues, including the Director of Infection Prevention and Control or nominated IPC Lead, have been engaged in the development of the winter plan, and are confident in the planned mitigations and actions.	Yes	Draft narrative pending IPC review: IPC governance and assurance arrangements are established in line with the Health and Social Care Act 2008 Code of Practice and support ongoing monitoring of infection prevention risks across Trust services.	Draft narrative pending IPC review: Awaiting DIPC confirmation.
	5.3	The Board is assured that fit testing arrangements are in place for relevant staff, are appropriately recorded and monitored, and can be rapidly expanded during periods of increased respiratory disease and gastrointestinal viral transmission. Appropriate PPE supply, stock management and escalation arrangements are in place to support periods of increased demand.	Yes	Selected staff will undertake fit-test training during August 2026, with rollout to frontline staff commencing from October 2026. Monitoring and recording arrangements will be maintained through ESR. HCID PPE stock will be available across five inpatient bases.	Confirm fit testing records, PPE stock management and escalation arrangements.
	5.4	The Board is assured, as encompassed by criterion 5 of the Health and Social Care Act 2008: code of practice on the prevention and control of infections, that a patient cohorting plan, including risk-based escalation, is in place that is understood by all staff and is ready to be activated by site management teams.	Yes	Draft narrative pending IPC review: Patient cohorting and escalation arrangements form part of the Trusts IPC response arrangements. Final confirmation of cohorting processes and staff activation arrangements is being sought through IPC governance processes.	Draft narrative pending IPC review: Confirm cohorting plan and evidence that staff understand activation process.
Leaders					
6	6.1	The Board is assured that on-call arrangements are in place and have been tested, and those on-call have access to medical and nursing leaders for urgent advice, and effective operational oversight to ensure urgent community capacity is prioritised for the sickest patients, where needed.	Yes	The Trust has a tactical and strategic on call function for operational oversight. Clinical support is provided via the On Call Consultant (1x North, 1x South) with 4 bleepholders covering the Trust inpatient units. There is one on site Resident Doctor in the North covering DU and Bluebell/Snowdrop and one in the South covering Kingsway Site and RU.	
	6.2	The Board is assured that plans are in place to monitor and report real-time pressures utilising the OPEL framework, with clear triggers for escalation and timely operational response.	Yes	OPEL arrangements are established and supported by action cards, ICB reporting and operational escalation processes linked to mental health bed pressures.	Attach OPEL framework and operational escalation evidence.
	6.3	The Board is assured that mutual aid arrangements have been reviewed and are capable of activation, if required.	Yes	There is specific guidance within the EPRR Incident Response Plan relating to mutual aid. It outlines the process to request and receive but also offer where required/capacity.	
	6.4	The Board is assured that business continuity plans have been reviewed and tested where appropriate.	Yes	Individual services hold local business continuity plans. A number of services have held their local business continuity exercise. Those outstanding will be captured within October.	

	6.5	The Board is assured that severe weather and infrastructure disruption contingencies have been reviewed.	Yes	The Trust has an Adverse Weather Plan which covers storms/gales/extreme cold etc. It includes learning from previous events and is based on national guidance. It is a well practiced plan and is utilised frequently.	
	6.6	The Board is assured that industrial action contingencies have been reviewed where relevant.	Yes	The Trust has responded to a significant number of industrial action events. A template response has been developed to support response and management for this type of event.	
	6.7	The Board is assured that plans are in place to support staff welfare through periods of high demand.	Yes	The Trust has provision for staff health and welfare, this is managed and supported by the People Services team.	
Specific					
7	7.1	The Board is assured that a plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via NHS 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	Yes	NHS111 Press 2 Mental Health, Mental Health Liaison Teams, Crisis and Home Treatment Teams, crisis alternatives and the forthcoming Mental Health Urgent Assessment Centre provide a comprehensive urgent mental health offer. Together these services support admission avoidance, system flow and timely access to care during periods of increased demand	
	7.2	The Board is assured that any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	Yes	Services utilise existing care planning, risk management and multidisciplinary review processes to support people at higher risk of crisis and those who frequently access urgent care services. These arrangements support proactive intervention and continuity of care throughout winter.	
	7.3	The Board is assured that liaison psychiatry pathways and Section 136 arrangements remain resilient during periods of peak demand.	Yes	Liaison Psychiatry and Section 136 services are supported by established pathways, dedicated staffing arrangements and operational oversight processes. Recent developments within Section 136 pathways further strengthen resilience during periods of peak demand	

Executive Approval

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

Trust / Provider Name: Derbyshire Healthcare NHS Foundtaion trust

Provider CEO name: Mark Powell

Date reviewed:

Provider Chair name: Selina Ullah

Date reviewed:

Please update following completion of the BAS template

Please provide name and contact details of designated Senior Responsible Officer (Executive Level)

Vikki Ashton Taylor - Chief Delivery Officer/Deputy Chief Executive vikki.ashtontaylor@nhs.net

Please provide confirmation that the SRO has reviewed and approved the responses within this document, confirming they are correct and complete.

Yes confirmed.

Please confirm date reviewed

9/18/2026

BAS Self-Assessment Dashboard

Trust

Overall Assessment Rating: 5 - Full assurance



Section B

Prevention
Flow, occupancy and discharge
Capacity and community
UEC Flow
Infection Prevention and Control (IPC)
Leadership and operational grip
Specific actions for Mental Health Trusts

Rating

5 - Full assurance
5 - Full assurance
5 - Full assurance
5 - Full assurance
5 - Full assurance
5 - Full assurance
5 - Full assurance

Appendix B – Winter Planning - 2026/27

Executive Assurance Summary and Decision Log

Executive Summary

The Trust has completed a Winter Planning - 2026/27 Board Assurance Statement (BAS) and assessed its current state of readiness against NHS England (NHSE) requirements. The assessment indicates that the key operational arrangements required to support winter delivery are established and operating, including urgent mental health pathways, patient flow arrangements, discharge optimisation, infection prevention controls (IPC), operational escalation processes and Executive oversight arrangements.

The principal risks relate to sustained community demand, effective capacity, workforce resilience and wider System dependencies. These risks are recognised within existing operational governance arrangements and continue to be monitored through Divisional, Executive and Board oversight processes.

No material operational capability gap has been identified through the assessment. The remaining actions primarily relate to governance, assurance validation and completion of the NHSE approval requirements, including the regional winter exercise, Quality and Equality Impact Assessment (QEIA) review and Board approval.

The current position supports a judgement of significant assurance, reflecting that the required controls are in place, known actions have been identified and management oversight arrangements are established.

Current Assurance Position

Area	Assurance	Rationale
Effective Capacity and Flow	Significant	Established flow, discharge and escalation arrangements support effective capacity and patient flow through winter.
Workforce Productivity and Resilience	Substantial	Core workforce resilience arrangements are in place with final Christmas and New Year assurance being completed.
Urgent Mental Health Access	Significant	NHS 111 Mental Health, Liaison Psychiatry, Crisis services, Section 136 and Mental Health Urgent Assessment Centre arrangements are established.
Prevention and IPC	Substantial	Prevention, vaccination and IPC controls are in place with final assurance activity underway.
Operational Escalation and System Flow	Substantial	Operational Pressures Escalation Levels Framework, on-call and operational escalation arrangements are established and in use.
Governance and Approval	Moderate	Regional exercise, QEIA review and Board approval remain outstanding.

Overall Assessment: The current assessment supports a position of Significant Assurance. The Trust has established arrangements across urgent mental health services, patient flow, discharge optimisation, workforce resilience, infection prevention and operational escalation. No material operational capability gap has been identified. Remaining actions relate primarily to assurance validation, governance requirements and final approval processes.

Sources of Assurance

Assurance is derived from existing operational controls rather than new arrangements. This includes flow and discharge oversight, urgent mental health pathways, workforce planning, IPC controls, OPEL escalation processes, business continuity arrangements and established operational governance. These controls are already in use and provide the basis for monitoring winter performance, resilience and escalation throughout the winter period.

Outstanding Actions and Milestones

Area	Action	Lead	Target
Prevention	Complete final flu vaccination, prevention and population health assurance evidence.	JT / Prevention Leads	Sep-2026
IPC	Complete IPC and DIPC validation of the winter position.	IPC Team	Sep-2026
Workforce Resilience	Confirm Christmas and New Year staffing, service resilience and occupancy arrangements.	SL / FB	Sep-2026
Governance	Complete QEIA review and confirm final governance route.	Governance Lead	Before Board
Assurance	Participate in the NHS England regional winter exercise and incorporate learning into the final BAS.	EPRR	Before Board
Approval and Submission	Obtain Board approval and submit the final BAS to NHSE.	Board / Trust	Sep-2026

Remaining actions relate primarily to assurance validation, governance requirements and final approval stages. No additional operational mitigations have been identified through the assessment. Existing delivery arrangements remain in place and will continue to be monitored through established governance routes

Executive Attention and Assurance Priorities

Area	Current Position	Assurance Required
Winter Readiness	The BAS identifies established arrangements across flow, urgent mental health pathways, workforce resilience, IPC and operational escalation. No material operational capability gap has been identified.	Note the current significant assurance position.
Performance and Capacity	Ongoing pressures relating to community demand, effective capacity, discharge and System flow remain recognised within the assessment.	Continue oversight through existing Divisional and Executive governance arrangements.
Workforce and Prevention	Final workforce, vaccination and IPC assurance activities remain in progress ahead of final submission.	Receive assurance that outstanding validation activities have been completed.
Governance and Submission	Regional exercise, QEIA review, Board approval and NHSE submission remain outstanding.	Support progression through the remaining governance route.

The remaining actions relate primarily to assurance validation and governance requirements rather than implementation of new operational controls. Existing arrangements are delivered through business-as-usual processes and will continue to be monitored through established performance, operational and governance routes

Review of Board Assurance Framework (BAF), issue 2, version 2.3, 2026/27

Purpose of Report

To meet the requirement for Boards to produce an Assurance Framework. This report details the current BAF risks, Issue 2, version 2.3 for 2026/27.

Executive Summary

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

Each Director has reviewed the risks, root causes, assurances and key gaps in control to ensure the report content is current and relevant and that risk ratings are appropriate.

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

Summary of updates

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

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

Actions around internal performance and measures to meet the NHS National Oversight Framework (NOF) have been added under this risk. They were previously captured in the partnership section but are better cited under Risk 1A as they link directly to the root causes.

Key gap in control: Review of Patient Carer Race and Equality Framework (PCREF) and develop implementation plan. This has been reviewed by the Medical Director (MD). The current position shows that we have met several measures identified to close the gap in control but work is still ongoing. The RAG rating remains amber with the MD stating:

Although we have momentum with our own actions, we are behind national target as it was expected that every organisation implemented the PCREF framework from 2024.

People - Derbyshire Healthcare is a great place to work

The Director of People, Organisational Development and Inclusion has thoroughly reviewed risks 2A and 2B and provided updates against the key gaps in control.

Key gap in control under Risk 2A: Inconsistent approach to flexible working impacting on staff morale. This has an improved RAG rating as work in progress to link the flexible working system to ESR which will focus all recording in one place.

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

Risk 3A: There is a risk that the Trust fails to deliver its revenue and capital financial plans for 2026/27. There is also the added risk of a Capital Departmental Expenditure Limits (CDEL) breach linked to following through on the Making Room for Dignity dormitory eradication programme

The title has been updated; the risk is now clearer and more succinct.

The Director of Finance has thoroughly reviewed Risk 3A and provided updates on actions to close key gaps in control and further measures to ensure they are relevant to the current position. Root causes have been added to and related actions have been recorded.

Risk 3B: There is a risk that the Trust's increasing dependence on digital technology for the delivery of care and operations increases the Trust's exposure to the impact of a major outage

The next review date for the actions linked to the gap in control regarding the plan to abolish Commissioning Support Units (CSU) has been set for the end of December as the transfer of services to a new provider isn't expected until Quarter 4, 2026/27. The next review will update on progress with that planned transfer.

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

Risk 4A: There is a risk of reputational damage if the Trust is not viewed as a strong partner both within the Derby and Derbyshire Integrated Care System (ICS) and more broadly within the East Midlands Mental Health Provider Alliance

The Chief Delivery Officer and the Director of Nursing, AHPs, Quality and Patient Experience agreed the removal of the first key gap in control. The outstanding gaps relating to the NOF are now included under Risk 1A as they directly link to the root causes of that risk.

Operational Risks

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

Removed – 23699: Governance - Trainee and Advanced Clinical Practitioners

Added in Quarter 2: No governance for trainee or Advanced Clinical Practitioners creates systemic risks that cut across quality, workforce, finance, compliance and reputation. This was linked to Risk 2B but has since been down-rated to moderate by the Director of Nursing. Further review has been requested of the People Development Lead.

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

There is potential for controls and ability to supplement data sets and as such the consequence rating is reduced, changing the current risk rating from high to moderate. The risk remains on the Datix risk register.

Removed – 23681: Nutritional Risks - No Clinical (Nutrition) Oversight Within the Catering Department

Updates were requested from a Clinical Lead and the Associate Director of Physical Health and Quality; the former has reviewed the risk and down-rated it to moderate. A wider review will be taken in conjunction with catering colleagues.

BAF Reporting Cycle/Format

All changes/updates to this issue of the BAF, compared with Issue 1, 2026/27, are shown in tracked changes. All text that has been stricken through will be removed from the next issue (Issue 3, 2026/27).

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

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

Risks and Assurances

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

Consultation

The BAF report is reviewed and updated by:

- Executive Directors
- Deputy Directors
- Managing Director
- Professional Leads
- Operational Risk Handlers.

The BAF was presented to the Executive Leadership Team (ELT) for full collective review and the Audit and Risk Committee (ARC) for approval:

ELT for full collective review: Version 2.1	8 July 2026
ARC for approval: Version 2.2	16 July 2026

Governance or Legal Issues

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

Net Zero Duty Implications

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

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

This report and the risk management system and processes do not use AI. There are significant climate and air pollution impacts from AI's energy consumption so by not contributing to that we are moving in line with the NHS move towards net zero.

Any other net zero implications are included in the detail of the BAF report.

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

Specific elements within each BAF risk and associated actions are addressed by the relevant lead Director if required.

Recommendations

The Board of Directors is requested to:

1. Review and Approve Issue 2 of the BAF for 2026/27 and the assurance the paper provides of the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic priorities
2. Continue to receive updates in line with the forward plan for the Trust Board.

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

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

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Trust Strategic Priorities	
Patient Focused - Our services will deliver safe and high-quality care	Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers
People - Derbyshire Healthcare is a great place to work	We will attract, involve and retain staff creating a positive culture and sense of belonging
Productive - Our services will be productive, demonstrate best value for our population and be cost effective	We will improve our productivity and design and deliver services that are financially sustainable
Partnerships - Our organisation will identify new ways of working, through new collaborative approaches	We will collaborate with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities

Risks to Trust Strategic Priorities 2026/27

Ref	Risk	Director Lead	Risk Rating	Responsible Committee
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	Director of Nursing, AHPs, Quality and Patient Experience (DON) / Medical Director (MD)	MODERATE	Quality and Safeguarding Committee
26/27 1B	There is a risk that the Trust does not deliver key regulatory and strategic requirements related to dormitory eradication and that the Trust estate is not maintained sufficiently well to comply with regulatory and legislative requirements	Director of Nursing, AHPs, Quality and Patient Experience (DON)	MODERATE	Quality and Safeguarding Committee
People - Derbyshire Healthcare is a great place to work				
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	Director of People, Organisational Development and Inclusion (DPOI)	HIGH	People and Culture Committee
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,	Director of People, Organisational Development and Inclusion (DPOI)	HIGH	People and Culture Committee

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	limiting the Trust's ability to deliver safe staffing, reduce reliance on temporary workforce solutions, and meet safety, quality and financial priorities			
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 Making Room for Dignity dormitory eradication programme and our associated capital commitments	Director of Finance (DOF)	HIGH	Finance and Performance Committee
26/27 3B	There is a risk that the Trusts increasing dependence on digital technology to deliver safe, timely and integrated care increases exposure to major system outages or cyber incidents, impacting patient safety, service continuity and strategic delivery	Chief Delivery Officer (CDO)	MODERATE	Finance and Performance Committee
Partnerships - Our organisation will identify new ways of working, through new collaborative approaches				
26/27 4A	There is a risk of reputational damage if the Trust is not viewed as a strong partner both within the Derby and Derbyshire Integrated Care System (ICS) and more broadly within the East Midlands Mental Health Provider Alliance	Chief Delivery Officer (CDO)	MODERATE	Trust Board

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

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

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

Root causes:

- a) Workforce supply and lack of capacity to deliver effective care across hotspot areas, increasing risks in the clinical and medical workforce
- b) Risk of substantial increase in clinical demand in some services, including high caseloads and wait lists in some community services
- c) Intermittent lack of compliance with Care Quality Commission (CQC) standards
- d) National Oversight Framework (NOF) Level 3 - Financial position and out of area placements and continued monitoring of quality standards across all Trust services
- e) Lack of embedded outcome measures at service level
- f) Lack of compliance with physical healthcare monitoring in primary and secondary care, not at the required level for reductions in mortality
- g) Restoration and recovery of access standards in autism and memory assessment services
- h) Lack of appropriate environment to support high quality care, i.e. single gender dormitories
- i) Local NHS Trusts will offer Recruitment and Retention Premium to Consultant Psychiatrists in specialist services and other clinical staff due to competitive practices that destabilises Trust clinical services and leads to a deterioration in waiting time and potentially in safety
- j) Data quality could be adversely affected due to the Electronic Patient Record (EPR) and its application
- k) Health inequalities across Derbyshire. Initial insights show gaps in access to service, case load and worsening patient outcomes for our patients
- l) Sustained pressure in the crisis and acute care pathway with bed occupancy over 85% and increased waiting time for patients to access bedded care from the community
- m) Gaps in Advocacy for Children who are under 18
- n) The community Intensive Support Team and Learning Disability models have non-standardised operating models and require more capacity
- o) Capacity to learn from other organisations in their ability to maintain adequate mortality, serious incidents and learning reviews to respond to improve practice and to also comply with the coroner's formal requirements
- p) Lack of systematic capture of patient experience and feedback in our services
- q) Lack of learning from patient or carer feedback from complaints and concerns due to delayed investigations and responses
- r) Safety and learning culture, learning from internal incidents, complaints and other sources of feedback is not developing and needs to be further embedded
- s) Inconsistent approach to working with families and carers, involving the care of family members
- t) Increased violence and aggression within the inpatient settings towards staff and other patients

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BAF Ref: 26/27 1A			Director Lead: Tumi Banda (DON) / Girish Kunigiri (MD)			Responsible Committee: Quality and Safeguarding Committee				
Key Controls										
Initial Risk Rating			Current Risk Rating			Target Risk Rating			Risk Tolerance	Risk Appetite
High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 4	Moderate	Likelihood 3	Impact 4	Not Accepted	Low
Preventative – Quality governance structures, teams and processes to identify quality related issues; mandatory training; Duty of Candour processes; clinical audits and research; health and safety audits; risk assessments; physical health care screening and monitoring; monitoring and effective responses to infection and control guidance, EQUAL unannounced visits to services and anonymised bright ideas service improvement ideas. Feedback intelligence from independent advocacy, Director visits in and out of hours and Board visits. Adherence to the Trust’s Quality Assurance Framework Detective – Quality dashboard reporting; Board visits virtual clinical service contact visits; incident, complaints and risk investigation; clinical audit; Fire Safety Regulations (FSR) compliance checks; mortality review process; physical health care monitoring clinics pilots; safety check log; Head of Nursing and Matron compliance visits, reviewed model of announced and unannounced visits to service throughout the 24-hour period; Fundamental Standards of Care visits; quality cross-checks: Inpatient and Community; 15 Steps challenge commencing in inpatient services; patient survey; friends and family test Directive – Trust Strategy; Quality Delivery Plan; Joint Child Adult and Family Safeguarding Strategy; Patient and Carer Experience pledges and associated workplans; Patient Safety Incident Response Plan (PSIRP); clinical strategies; policies and procedures available via Trust intranet; Central Alerting System (CAS) alerts; Risk Management Strategy; clinical sub committees of the Quality and Safeguarding Committee										
Assurances on controls – Internal						Assurances on controls – External				
Trust quality and performance dashboards Scrutiny of Quality Account by committees Programme of physical healthcare and other clinical audits and associated plans Infection Control Board Assurance Framework reported to NHS England Positive and Safe self-assessment Quality Assurance Framework Board visits and out of hours visits Fundamental Standards of Care visits Clinical audits Incident reporting and monitoring systems through Datix Quality and safeguarding workplan Patient, family and carer feedback Trust risk registers and scrutiny of the Risk Management Strategy by Board committees						National enquiry into suicide and homicide NHS Litigation Authority (NHSLA) scorecard demonstrating low levels of claims Safety Thermometer identifies positive position against national benchmark Trust fully compliant with National Quality Board Learning from Deaths guidance Engagement meetings with CQC taking place Patient Safety Incident Response Framework (PSIRF) implementation CQC comprehensive review 2020 Trust rated Good CQC inspections: Acute and PICU December 2024 rated Good; Wards for older people with mental health problems, July 2025 rated Good; Forensic inpatient or secure wards, September 2025 rated Good; Rehab and long stay unit, January 2026 rated Good, Crisis and Health Based Place of Safety, January 2026 Rated Good Quarterly CQC regulation oversight Regular NOF Level 3 meetings with NHS England (NHSE) and Integrated Care Board (ICB) ICB local review to ensure there are clear policies in place to meet the needs of people in Derbyshire with severe mental health illness Adult and Children Safeguarding Boards (Derby City and Derbyshire County) ICB Quality System Group for Integrated Care System (ICS) quality system monitoring				

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		Advisory support provided by the Trust to the system on bedded care standards for Learning Disability in-patient services			
Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Summary of progress	Action rating
Gap in operating standards and clinical risks for acute and community mental health services	Improvement of both inpatient and community care settings – Environments need to be improved <u>New internal performance improvement process and oversight in place</u> <u>Performance Improvement Plans for areas where Trust constitutional standards are not being met</u> [ACTIONS OWNER: DON] Set out improvement plans to achieve Royal College of Psychiatrists (RCP) accreditation across services [ACTION OWNERS: MD/DON/CDO] Implement Community Mental Health Framework (CMHF) Improve the out of area (OOA) placements and facilitate care closer to home Improve access to services [ACTIONS OWNERS: CDO/DON]	Improve working with carers and families Improving risk assessment and care planning for patients in community settings Deliver the assertive outreach pathway to support patients with complex care needs. Provision is part of the CMHT with a specialist service Improvement in operating standards compliance to be overseen by Quality and Safeguarding Committee Adherence to the Trust Assurance Framework across all the services to review and monitor quality of care Implemented Mental Health Community Framework (CMHF) to Quality and Safeguarding Committee Achieving waiting time access targets <u>Improvement in performance of constitutional standards and NHS National Oversight Framework (NOF) metrics</u>	(30.06.26) <u>(30.09.26)</u>	Increased performance management scrutiny and unannounced site visits undertaken with compliance checks Monitoring Fundamental Standards of Care and the quality measures through the Quality Dashboard Quality Assurance Framework in place to monitor quality and safety Triumvirate leadership in the place across divisions and care groups to take collective responsibility for quality and safety Governance structure to review, monitor, improve quality and give assurance to the Board is in place following implementation of the new operating model Implement and monitor the ten High Impact Actions including MADE events and working with system partners. Inappropriate OOA bed	AMBER

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		<u>Recovery action plans in place in all required areas</u>	use has significantly reduced Performance Improvement Plans in place and monitored Ongoing conversations with ICB cluster regarding appropriate funding to meet increased demand <u>CQC oversight engagement meeting changed to Quarterly</u> <u>ICB Clinical Quality Reference Group reviewed from monthly to quarterly</u> <u>Get it Right First Time (GIRFT) meetings established with the inpatient wards to review NOF metrics</u> <u>Group in place to review NOF metrics supported by executive team</u> <u>Recent update to NHSE for Assertive Outreach via Trust governance sign-off, ongoing working group to provide oversight and assurance. A financial gap (system) remains in terms of the ideal model</u> <u>CMHF: Current discussion with the ICB</u>	
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				<u>for the Trust to manage the contract and in turn the contract with both local authorities and the VCSE offer. The Trust is working with the ICB around outcome measures/benefits</u>	
Gap in operating standards and clinical risks for Learning Disabilities and Autism (LD&A) services	The community Intensive Support Team and Learning Disability models require improvement Improvements are required in rapidly returning patients who access Learning Disabilities and Autism (LD&A) services to local care to enable them to live in the least restrictive manner, as close to home as possible. Continue to work on developed delivery improvement plan, owned by system partners [ACTIONS OWNERS: CDO/DON/MD]	Review all models of support offered by the Intensive Support Team (IST) completed and improvement made Implement and embed delivery improvement plan to ensure focussed system action on existing inpatients who are placed inappropriately and out of area Enhancing and reviewing Listening and Engagement Active Partnerships (LEAP) procedures Improvement plans in admission avoidance, crisis alternatives to admission, including improvement in the use of Dynamic Support Registers as a means of admission avoidance Reduction in delayed discharges in units across the country resulting in NHSE escalations	(30.06.26) (30.09.26)	ICB have presented to both providers on how to ensure community offers are enhanced further through the review of pathway offers where resource is disproportionately allocated <u>TUPE for LD services completed 01 June 2026 Following agreement at each respective Trust Board: Plans in place to TUPE LD services from DCHS to the Trust during Quarter 1 2026/27</u> New Dynamic Support Pathway (DSP) launched following cross-agency redesign work The Trust with the ICB continues to meet with NHSE on a quarterly basis to monitor performance, focussing on those patients with a long length of stay and who are Clinically Ready for Discharge	AMBER

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Learning from independent and national forums on current issues affecting patient safety outcomes and experience	Participate in collaborative local and regional forums to gather learning Revisit all assurances and scrutinise practice, gathering intelligence and implement an improvement plan to enable all services to provide the highest standard of care which would be expected Monitor and implement the lessons from CQC Section 48 from other providers Patient safety incidents and patient experience and effectiveness to be triangulated in providing assurance on quality as set out in the Quality Delivery Plan [ACTIONS OWNERS: DON/MD]	Ensuring that staff are aware of how to raise concerns and speak up Implement the Accountability Framework Strengthen out of hours, weekends and night announced and unannounced visits. To promote access to multiple managers, relationships, so colleagues feel empowered to report any concerns Professional leads are in place and supported by Employee Relations to ensure that registered professional staff are aware of the requirements to practice in line with their professional codes Uphold safeguarding standards including PIPOT Timely investigation and response to concerns and complaints Patient safety team and patient safety lead working collaboratively to effectively evaluate risk and quality and identify learning and improvement Quarterly self-assessment of Assertive Outreach of quality and safety matrix as reported to Quality and Safeguarding Committee	(30.06.26) (30.09.26)	Options for staff to have conversations about care delivery and raise concerns available include Trust-wide and divisional engagements, Freedom to Speak Up, Schwartz Rounds Improvements in engagement of temporary staff identified Robust oversight of patient safety incidents, concerns, complaints, and compliments with scrutiny from independent partners, e.g. Healthwatch and experts by experience being core members of Patient and Carer Experience Committee External partnership working including Healthwatch and advocacy services within safeguarding and secure services. The Trust provides assurance and participates in external reviews alongside the ICB and Adult Safeguarding Board Trust-wide Learning, Culture and Safety Group established, providing oversight of teams/services with	AMBER
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				repeating patterns for improvements to be made Culture of Care Programme ended March 2026. The Trust will continue with Models of Care Action plan in place to improve responses to complaints and patient feedback Significant Level of assurance received in 2025 from ICB on the Safeguarding Accountability and Assurance Framework review and Section 11 compliance	
Clinical improvement in the current use and transformation of Care Programme Approach (CPA), to support safe community practice	Identify the Trust's preferred alternative model to replace CPA Establish transition plan which includes communications and training strategy and clear timeline for go live of the new system and detailing when use of CPA will cease Implement an improvement plan to enable all services to provide the highest standard of care [ACTIONS OWNERS: DON/MD]	Review of changes to national policy to replace CPA Safe and effective practice is in place Improve patient safety risk assessment, care planning and CPA review compliance in community services	(30.06.26) (30.09.26)	Ongoing oversight of CPA continues with focus on care planning and risk assessment CPA training continues at present until alternative identified – Not yet confirmed National consultation underway on a personalised care framework <u>Personalised Care Framework (PCF) - Modern CPA launched nationally in July 2026 - DON/MD reviewing with an implementation plan</u>	AMBER

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Review of the new Major Conditions Strategy and Suicide Prevention Strategy for England: To be considered as Trust Clinical Plan developed	Scrutinise new policy direction and develop new plans Routinely review incidents for learning in suicide prevention including cluster analysis and benchmarking [ACTIONS OWNERS: DON/MD]	Adjust strategy and policy to meet requirements Undertake a cluster analysis of in-patient and acute care pathway deaths	(30.06.26) (30.09.26)	Review of new strategy for Major Conditions and Suicide Prevention PSIRF priorities focusing on prevention and oversight Incorporated into the Trust's updated Suicide and Self Harm Prevention Strategy <u>Swicide Prevention Lead – Post ended in July 2026. The functions have been reviewed and devolved into existing operational structures</u> <u>Swicide Prevention Lead in post</u> New risk assessment, safety planning and suicide awareness training now in place, mandatory for all clinical staff Trust Suicide and Prevention Strategy published March 2026	GREEN
Review of Patient Carer Race and Equality Framework (PCREF) and develop implementation plan	Establish PCREF Steering Group Complete Self-assessment on PCREF Development of PCREF Champions – Scope to identify relevant service user and carer representative Improving data quality to ensure it reflects the community we serve Develop an annual report and project plan for the next three years [ACTIONS OWNER: MD]	Complete action plan on PCREF implementation Involvement of service users and carers in developments <u>Identify</u> PCREF Champions <u>in place</u> Validation of data quality Annual report production	(30.06.26) (30.12.26) 31.03.27	PCREF Steering Group established <u>February 2026</u>. Central oversight in place by Mental Health Act Committee <u>Trust PCREF self-assessment has been completed</u> <u>PCREF Lead is reviewing the action plan with service users to evolve it if necessary. Action plan implementation is ongoing</u>	AMBER

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		<u>Pilot sites to be implemented in line with national requirement</u>		<u>PCREF Lead recruitment process started/appointed. Ongoing work to identify Champions</u> <u>Submission for Trust Annual Report completed and now annual BAU</u> <u>Three pilot sites implemented in 2026; implementation of PCREF is behind the national target; work is ongoing</u>	
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Board Assurance Framework Report 2026/27 – Issue 2.3 Board September 2026

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

ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating
22790	Corporate Services – Pharmacy	Prescribing Valproate: Failure to comply with MHRA patient safety regulations	02.03.26: Awaiting go-live of questionnaire on SystmOne to allow consultants to record their valproate caseload. This is intended to give more transparent oversight of our level of assurance of adherence to safety guidance and will allow the level of risk to be reassessed 07.07.26: Questionnaire live on SystmOne. Audit of quality/accuracy of completion will be undertaken in the autumn by the Pharmacy team. The potential outcome from valproate affecting a pregnancy will remain a catastrophic outcome, so mitigation is about reducing the likelihood.	28.02.22	07.10.26	HIGH
23501	Corporate Services – Clinical Quality	Risk to Service Delivery - Patient Safety Team	There are currently several learning responses that require allocation with further investigations overdue. Coroners, staff, patients and families are waiting for the outcome of these learning responses. Risks include: • Distress to families/carers who are waiting for the outcome of learning responses - Risk of further harm • Reputation damage for the Trust • Possible increased distress for staff who are involved in the process Trust timeframes not being met, lack of training for new starters 11.02.26: Interim Patient Safety Lead in situ. Two investigators remain temporarily redeployed 01.06.26: Risk to remain open until backfill and substantive cover of Patient Safety Lead role is in place 08.07.26: Details of remaining overdue investigations, actions and incident reviews held in the Datix record. No current backfill for two investigators, which continues to impact the Patient Safety Team's capacity to reduce overdue learning responses and safety actions	08.05.25	08.10.26	HIGH

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

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

Impact:

Low quality care environment specifically related to dormitory wards at the Radbourne Unit

Crowded staff environment

Patient safety and dignity risks associated with dormitory in-patient bedded care at the Radbourne Unit

Non-compliance with statutory care environments at the Radbourne Unit

Non-compliance with statutory health and safety requirements at the Radbourne Unit

Final ward refurbishment cost unknown until we receive the final Guaranteed Maximum Price (GMP) in ~~late Quarter 4~~ Quarter 2 of 2026/27

Completion of the full Dormitory eradication programme has been delayed until ~~mid-late Quarter 3~~ 2027/28

Root causes:

- a. Long term under investment in NHS capital projects and estate
- b. Limited opportunity for Trust large scale capital investment
- c. Increasing expectations in care and working environments as national capital strategy and surrounding legislative and regulatory requirements evolve
- d. National capital funding restrictions for business-as-usual capital programme for Trusts and Integrated Care Systems
- e. Cost creep in the development has added pressure to the Making Room for Dignity programme and the ability to complete the Radbourne Unit refurbishments. Whilst funding is secured in relation to the first ward, issues with the foundations are driving up costs and delaying the completion of the programme
- f. CDEL restrictions limiting our ability to invest in capital even where we have the funds to proceed. Priority remains completion of the Making Room for Dignity and dormitory eradication programme thus less opportunity to invest in other areas in the short term

BAF Ref: 26/27 1B

Director Lead: Tumi Banda (DON)

Responsible Committee: Quality and Safeguarding Committee

Key Controls

Initial Risk Rating			Current Risk Rating			Target Risk Rating			Risk Tolerance	Risk Appetite
High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 3	Moderate	Likelihood 3	Impact 4	Tolerated	Moderate

Preventative – Routine environmental assessments for statutory health and safety requirements; environmental risk assessments reported through Datix; Infection, Prevention Control (IPC) risk assessments

Detective – Reporting progress against Premises Assurance Model (PAM) to the Executive Leadership Team (ELT); Dormitory Eradication Board reports into Trust Board; Quality dashboard reporting; Board visits virtual clinical service contact visits; incident, complaints, and risk investigation

Directive – Capital Action Team (CAT) role in scrutiny of capital projects; IPC policy and procedure; Continuous Improvement Plan; Estates Plan; Trust Strategy; Physical Health Care Strategy; Safeguarding Strategy; Suicide Reduction Strategy; clinical strategies; policies and procedures available via Trust intranet; Central Alerting System (CAS) alerts; Risk Management Strategy

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Assurances on controls – Internal			Assurances on controls – External		
IPC risk assessments Health and safety audits Premises Assurance Model System (PAMS) reporting Making Room for Dignity Programme Committee structure and working groups Trust quality and performance dashboards Bed Management processes Scrutiny of Quality Account by committees Programme of physical healthcare and other clinical audits Infection Control Board Assurance Framework reported to NHSE Positive and Safe self-assessment Quality Assurance Framework Cleaning and maintenance schedules Continuous Improvement Plan Estates and facilities management internal audit			Mental Health Capital funding secured External authorised reports for statutory health and safety requirements Regional reporting and NHSE oversight Gateway review process – Positive feedback from first stages Safety Thermometer identifies positive position against national benchmark Mental Health Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards CQC comprehensive review 2020 Trust rated Good CQC inspections: Acute and PICU December 2024 rated Good; Wards for older people with mental health problems, July 2025 rated Good; Forensic inpatient or secure wards, September 2025 rated Good; Rehab and long stay unit, January 2026 rated Good Patient Safety Incident Response Framework (PSIRF) implementation Monitoring of IPC standards compliance and reporting – ICS IPC Team		
Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Lack of adherence to national guidance and policy requiring the elimination of dormitory style inpatient facilities	Radbourne Unit dormitory eradication refurbishment to provide two 17-bed wards with single room en-suite, with additional staffing and new model of care, to complete dormitory eradication in Southern Derbyshire [ACTIONS OWNER: DON/CDO]	Delivery of approved business case Completion of the units at the Radbourne Unit CQC approval and sign off	30.06.28	FBC and revenue funding approved by ICS. National PDC capital funding approved by NHSE Making Room for Dignity Programme refurbishment of Radbourne Unit expected completion early 2027/28 Annual review of the delivery of same sex accommodation was completed and published by the Board in November 2025; The Trust is compliant with the guidance	AMBER

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

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People - Derbyshire Healthcare is a great place to work

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

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

Root causes:

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

BAF Ref: 26/27 2A

Director Lead: Rebecca Oakley (DPOI)

Responsible Committee: People and Culture Committee

Key Controls

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

Preventative – Freedom to Speak Up Guardian (FTSUG) self-assessment and six monthly reports; actions taken from staff survey results, people performance reviews and actions, training and education meeting, Equality, Diversity and Inclusion (EDI) working group, staff networks, health and wellbeing network, operating model structure

Detective – National staff survey, Quarterly Pulse Checks, FTSUG log and escalations; staff network engagement; WRES, WDES, wellbeing champion network, executive led engagement sessions; non-executive, executive and deputy visits to teams

Directive – National People Plan; strategic people priorities

Assurances on controls – Internal

National staff survey and reporting into board, ELT and divisions
Quarterly pulse check and action planning process
Exit interview analysis and reporting
People Plan

Assurances on controls – External

Benchmarking in mental health Trusts and at system level
Staff survey analysis and reporting

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Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Lack of planned leadership development growth, stretch programmes and opportunities including coaching and mentoring	Leadership section of the People Plan to align to organisational leadership needs Delivery of the People Plan priority: To be recognised for supporting and developing our people to work confidently in their roles Review and development of Trust leadership offer and impact [ACTIONS OWNER: DPOI]	Percentage of leaders with development plan as part of objectives Percentage of employees accessing leadership development programmes	(30.09.26)	STRIVE – Senior leadership programme currently being delivered in partnership with Kings Fund, Chartered Management Institute and Derby university Leadership development (delivered via a service level agreement with DCHS) notice served on contract, from July a new team and service will be situated within DHCFT. As part of the transition a full review of the current offer and any gaps taking place will be completed People Plan presented and signed off at People and Culture Committee (PCC) November 2025 – Includes clear direction on leadership development	AMBER
Lack of progress across EDI including staff networks and reporting (WRES/WDES/gender pay gap)	Staff networks have an embedded operating framework through which to maximise the impact of staff networks Clear measurable EDI plan that includes all national reporting and Trust level actions Support to bi-monthly network Chairs meetings through DPI, Head of EDI and EDI Manager Delivery of People Plan priority: To be recognised by our people for our values driven and inclusive culture	Clarify on role and function of staff network chairs and objectives for each network – Reviewed twice a year Annual updates by network Chairs of engagement undertaken to be included in annual reports Year on year change WRES/WDES, staff surveys and lived experience of staff through staff networks	(30.09.26)	Framework, including clear actions to progress and signed off at PCC Race equality plan developed in conjunction with BME network and supports key actions in WRES Staff network conference planned to taketook place in May 2026 EDI plan developed and presented at PCC in March	AMBER

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	[ACTIONS OWNER: DPOI]			2026 – Combines all WRES/WDES/gender pay gap actions EDI working group in place	
Lack of ownership and embedded models of care and cultures across MRfD workforce resulting in retention and turnover challenges and inconsistency of approach across MRfD programme	Review of all commissioned and in house owned programmes both clinical and non-clinical to be clear of the ‘ask’ and the ‘why’ Clear framework to ensure alignment across all programmes Comprehensive plan of delivery and outcome measures [ACTIONS OWNER: DPOI]	Delivery against plan including attendance on programmes Staff survey measures Bespoke MRfD surveys to measure awareness and impact of programmes	(30.09.26)	Revised programme board and workstreams to ensure alignment and learning from gateway review Wider organisational plan for acute wards in development, where appropriate cultural reviews are being commissioned All wards completed the programme, six month follow-up with each ward now planned<u>commenced</u> <u>Culture reviews completed on wards where triangulation of data has highlighted cultural risks</u>	RED
Not yet embedded the Trust personal accountability framework and inconsistent support for Employee Relations (ER) informal and formal cases	Fully embed Trust personal accountability framework across all teams and individuals to have ownership of their own behaviours Development and delivery of ER training for managers on cases and investigations Establish new ER services in Trust (currently in a shared service) [ACTIONS OWNER: DPOI]	Reduction in length of cases Reduction in formal cases Attendance at training by managers on cases and investigations Establishment of new ER in-house team	(30.09.26)	ER team transitioned out of DCHS Joint Venture into DHCFT June 2025 A kind life just culture training programme commenced, incorporating personal accountability framework – 150 colleagues have already attended Active Bystander training being rolled out <u>Reduction in formal cases across New Respect and Resolution policy</u>launched	RED

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Inconsistent approach to flexible working impacting on staff morale	Develop and embed a clear approach to flexible working that supports service delivery and staff Develop a clear and consistent way of recording and reviewing flexible working that supports both managers and staff [ACTIONS OWNER: DPOI]	Ability to record and track number of flexible working arrangements in place Staff engagement measures via staff survey and pulse check	(30.09.26)	Design of flexible working system linked to ESR to record requests for flexible working and approved requests in progress – <u>This will focus recording in one place</u> Flexible working group in place and currently designing training for the roll out of the system	RED MODERATE
Lack of robust absence management policy and processes that support both managers and staff	Review and relaunch a new absence management policy Review support provided to managers to review and move forward long term sickness absence cases Review Occupational Health access, support and usage to ensure maximising service and being used to Delivery of People Plan priority: To be recognised as a Trust that supports and promotes the wellbeing of our people [ACTIONS OWNER: DPOI]	Reduction in absence management across both long and short term absences Reduction in Occupational Health DNAs Staff survey and pulse check Improvements as part of NOF segment data	(30.09.26)	Absence plan developed and presented to PCC and ongoing scrutiny with further deep dive January 2026 Oversight working group established	RED
Lack of a stable positive culture due to high levels of organisational change impacting on morale	Review and develop organisational change policy to ensure clear and supportive approach for managers and staff Clear wellbeing processes for occupational health and other support mechanisms Effective, clear and open communication channels	Staff survey and pulse check engagement scores Financial balance	(30.09.26)	Fast track process for Occupational Health in organisational change Phase 1a operating model programme completed Phase 1b consultation concluded	RED

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

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People - Derbyshire Healthcare is a great place to work

There is a risk that we do not have an adequate supply of 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

Impact: May lead to reduced staffing levels and skill gaps which impact on safe staffing levels and addressing health inequalities in patient facing services and the ability of our supporting and corporate teams to support front line services

Root causes:

- There are occupational shortages nationally which mean that the supply of some professions creates long term vacancies and a lack of workforce planning in solutions to fill the gaps
- Pressures on workforce development and Continued Professional Development (CPD) funding may risk ability to develop skills and expertise
- Historical disproportionate growth in senior leadership posts in correlation with frontline clinical posts

BAF Ref: 26/27 2B

Director Lead: Rebecca Oakley (DPOI)

Responsible Committee: People and Culture Committee

Key Controls

Initial Risk Rating			Current Risk Rating			Target Risk Rating			Risk Tolerance	Risk Appetite
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 4	Not Accepted	Low

Preventative – Alliance, system and national Human Resources forums for sharing best practice and risk mitigation, website, workforce plan

Detective – People Performance Report in TLT, ELT and PCC; Bank and Agency Improvement Group; Combined Delivery Group with multi-disciplinary team (MDT) input; Medical Staffing Group, Sustainability Meeting; FTSU culture; exit interview process stay interview process

Directive –JUCD Careers Team; JUCD and People and Inclusion meeting; recruitment policy and procedure; TRAC recruitment system; safe staffing plans

Assurances on controls – Internal

People Performance Report at ELT and PCC
People Dashboard in PCC
PCC forward plan and deep dive plan
Workforce plan
People Plan

Assurances on controls – External

Healthcare Support Workers (HCSW) submissions
System operational planning process
Safe staffing report
Regular NOF Level 3 meetings with NHSE and ICB ~~(in relation to Making Room for Dignity (MRfD) recruitment)~~

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Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
An integrated workforce plan and planning process that feeds into pipeline plans and ensures we have the right people in the right place with the right skills	Develop a Trust Workforce Plan linking demand and capacity, workforce redesign to ensure a fully funded workforce Develop vacancy rate data and breakdown variances in vacancy data Delivery of all People Plan priorities: Attracting a high skilled and diverse range of applicants to our roles Retaining our diverse talent through growth and development Staff are delivering at the top of their professional standards Opportunities for professional and career development [ACTIONS OWNER: DPOI]	Reduced vacancy rates Time taken to fill vacant posts Transformational posts, e.g. apprenticeships all identified Reduction in agency costs Improved retention rates	(30.09.26)	Executive-led vacancy control meeting takes place every week for approval of all vacancies and workforce expenditure increases, i.e., job evaluation Divisional workforce planning session taking place in July 2026 Finance led workforce plans triangulated and signed off at regional level Revised agency control group in place	AMBER
We do not have an effective and embedded succession talent management processes	Develop a Talent Management Strategy Pilot career conversations for senior leaders and roll out career conversations for all colleagues Work as a system to develop system-wide approach to talent management and align where best for the Trusts Delivery of all People Plan priorities: Attracting a high skilled and diverse range of applicants to our roles Retaining our diverse talent through growth and development [ACTIONS OWNER: DPOI]	Career conversations taking place Internal appointments/promotions Reduction in turnover rate Key staff survey measures	(30.09.26)	Talent Strategy finalised Talent programme for senior executive leadership completed – To be run for senior leadership team following finalised operating model Talent and succession planning part of every Executive Director's objectives	RED

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Onboarding and retention process and planning needs to be embedded (this includes MRfD and challenges on retention of high numbers of newly qualified nurses)	Understand the key retention issues for posts/teams/professions with the highest turnover to deliver People Plan priorities to attract and retain newly qualified nurses Ensure 'stay conversations' form part of regular 1:1s Develop NHS retention framework for nursing [ACTIONS OWNER: DPOI]	Improvements to turnover Staff survey engagement scores	(30.09.26)	Additional posts added to the preceptorship team to support retention of high numbers of newly qualified staff Stay Surveys launched at months 3, 6 and 12 Revised induction commencing from May 2026	AMBER
Lack of inclusive recruitment practices and actions to consider the needs of people from different backgrounds, to support our commitment to embedding an inclusive culture	All chairs of recruitment panels have undergone inclusive chairs recruitment training Data driven recruitment practices Delivery of People Plan priority: To be recognised by our people for our values driven and inclusive culture [ACTIONS OWNER: DPOI]	WRES and WDES data shows year on year improvement, staff survey and lived experience of staff Increase the proportion of applications from ethnic minority groups, increase likelihood of shortlisting and reduce disparity in all areas	(30.09.26)	Job evaluation national assessment completed and work programme to improve efficiency of the process in place and presented to PCC National nursing profiles review – Working group in place with staffside representation Inclusive recruitment for chairs training: Ongoing roll out Cultural competence training commissioned rolled out, initially focusing on acute wards and now expanding wider. Board have also completed the training	RED
Effectiveness of recruitment policy, practice and processes	Review and develop existing recruitment Key Performance Indicators (KPIs) to ensure fit for purpose Where appropriate move away from TRAC to advertise jobs and use fast track processes, e.g. Indeed/MSforms Develop cohort recruitment for key posts	Time to recruit Number of applicants applying and successfully shortlisted Campaign impact and reach Financial savings through cohort recruitment	(30.09.26)	A range of recruitment methods are deployed to ensure we attract a diverse range of applicants Revised Service Level Agreement and KPIs in place for recruitment service	AMBER

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	Improve the multidisciplinary working (HR, communications and recruiting managers) to enable better planned and executed campaigns [ACTIONS OWNER: DPOI]				
Agency and bank usage control measures and reduction	Ensure bank and agency usage is controlled by clear processes and measures with accountability at team level on spend Agency off framework usage is managed with clear expectations Plan in place to reduce and align to agency price cap for all posts Bank staff are recognised and rewarded appropriately [ACTIONS OWNER: DPOI]	Agency and bank usage reduction Agency off framework nil return Agency price cap achieved Bank usage is appropriate and available to support where needed	(30.09.26)	Ongoing weekly agency approval in place for approval of all agency requests <u>Working group in place focusing on improvements in vacancy reduction across key posts, agency elimination and improvements in bank utilisation</u> <u>Assistant Director of Workforce is co-chair of national regional agency reduction group</u> <u>Consistent agency reduction demonstrated</u>	AMBER

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

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

There is a risk that the Trust fails to deliver its revenue and capital financial plans for 2026/27 ~~caused by factors including non-delivery of Cost Improvement Programme (CIP) targets and increased cost pressures not mitigated resulting in a threat to our financial sustainability and delivery of our statutory financial duties~~. There is also the added risk of a Capital Departmental Expenditure Limits (CDEL) breach linked to following through on the Making Room for Dignity dormitory eradication programme ~~and our associated capital commitments~~

Impact: The Trust becomes financially unsustainable. The Trust's National Oversight Framework rating has deteriorated and this could lead to a lack of organisational direct control in the longer term via increased regional and national intervention. Corrective action is needed and progress towards financial balance is required. In addition, we have an ambitious CIP requirement approaching 6% due to ongoing pressures. Further mitigations will be required if we don't control inpatient ward overspends and deliver on our out of area reduction programme

Root causes:

- a) Financial detriment (revenue, cash and/or capital) resulting from large capital development programme, in particular dormitory eradication and associated capital schemes
- b) Organisational financial detriment created by commissioning decisions or wider 'system-first' decisions including enactment of risk-sharing agreement in partnership arrangements or changes in NHS financial arrangements. System financial position resulting in required additional financial savings to support the System position from Mental Health funds
- a) Non-delivery of expected financial benefits from transformational activities
- b) Non-delivery of required levels of efficiency improvement
- c) Lack of sufficient cash and working capital
- d) Loss due to material fraud or criminal activity
- e) Unexpected income loss or non-receipt of expected transformation income (e.g. long-term plan (LTP) and Mental Health Investment Standard (MHIS) without removal of associated costs
- f) Costs to deliver services exceed programmes the Trust financial resources available
- g) Lack of cultural shift/behaviours to return to financial cost control regime. Areas of non-compliance with Standing Financial Instructions (SFIs) and financial duties. Ineffective grip and control measures to control inappropriate spending
- h) Inability to reduce temporary staffing expenditure and eradicate health care support worker agency spend
- i) Inability to reduce inappropriate out of area placements and effectively manage flow, impacted by Making Room for Dignity
- j) Inability to manage increasing demand and acuity in our inpatient settings
- k) Inability to provide safe care within funded staffing levels due to acuity and additional observation requirements
- l) Trust reluctance to remove costs in line with non-recurring income removal due to wider system impact (financial and Equality Impact Assessment concerns)
- m) Inability to timely respond due to the volume and bottlenecks associated with large levels of organisational change and transformation simultaneously ongoing. Delays caused by the level of organisational change and limited capacity
- n) Exit costs will impact on our financial sustainability. We do not necessarily have the financial flexibility to enact exits without putting at risk our financial obligation to breakeven

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- o) Level and pace of organisational change may result in extended timelines due to capacity across a range of services including People Services teams, staffside and wellbeing support
- p) Lack of progress in the digital and automation space. Lack of progress to modernise, utilise Robotic Process Automation (RPA) and AI reducing transactional resources
- q) Additional pressures, caused by the demise of Commissioning Support Units (CSU) and reprovision of some of our digital services
- r) Expectations around mental health, urgent care and community services are increasing costs but not being supported with revenue funding to date

BAF Ref: 26/27 3A

Director Lead: James Sabin (DOF)

Responsible Committee: Finance and Performance Committee

Key Controls

Initial Risk Rating			Current Risk Rating			Target Risk Rating			Risk Tolerance	Risk Appetite
Moderate	Likelihood 2	Impact 5	High	Likelihood 3	Impact 5	Moderate	Likelihood 2	Impact 5	Tolerated	Low

Preventative – Operating plan and financial plan agreed for 2026/27 in line with national requirement. Integrated Care Board (ICB) signed off and fully support the dormitory eradication programme and are supporting this through to completion as a pre-commitment. High quality business cases. Regular meetings with NHSE on programme progress. Meaningful stakeholder engagement (internal and external). Robust cash flow forecasting and delivery. Multi-disciplinary development of financial plans for new of work. System sign-off and appropriate governance arrangements for new programmes of work: Budget training, segregation of duties, management of commissioning risk through system engagement and leadership, mandatory counter fraud training and annual counter fraud work programme: Enhanced cash management and forecasting aligned to large capital and transformational programmes. Action plans in place and recovery plans for areas of focus. Deep dives commissioned via F&P Committee

Detective – Risk logs and programme-reporting (capital/transformation) informs ongoing financial risk assessment: Audits (internal, external and in-house); scrutiny of financial delivery, bank reconciliations; continuous improvement including cost improvement planning (CIP) and efficiency / QI delivery; contract performance, local counter fraud scrutiny

Directive – Business plans and templates set out clear financial plans and assumptions: Standing financial instructions; CIP Monitoring, Performance management reviews, Treasury management procedures, budget control, delegated limits, recruitment approval processes; business case approval process; invest to save/Quality Improvement methodology and protocol and Plan Do Study Act. Risk and gain share agreements; ~~strengthened governance processes around the Making Room for Dignity Capital Programme~~

Assurances on controls – Internal

Operational plan; financial planning including CIP planning, processes and delivery monitoring
CIP reporting to Trust Delivery Group, Executive Leadership Team and F&P Committee
 CIP programme group ~~established~~ under review to strengthen oversight.
 Further work and governance changes planned to drive the transformational plans and monitor progress
 Vacancy control process in place with Executive oversight

Assurances on controls – External

~~Monthly-Weekly~~ reporting into ~~ICB and~~ NHSE, in addition to routine monthly reporting into NHSE and across the system ~~Trust internal reporting~~
 All CIP plans and progress reporting into the EPMD for shared system oversight across the ICB
 NHSE feedback throughout progress of dormitory eradication Programme and business cases in programme
 Systems Finance Performance meetings
 System DOF meetings

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Performance management processes in place and being refreshed to add to assurance levels. Now also established and in place for corporate functions Appropriate monitoring and reporting of financial delivery – Trust overall and programme-specific Assurance levels gained at Finance and Performance Committee (F&P) Delivery of Counter fraud and audit work programme with completed and embedded actions for all recommendations Independent assurance via internal auditors including HFMA checklist, external auditors and counter fraud specialist that the figures reported are valid and systems and processes for financial governance are adequate <u>Governance process in place for the Making Room for Dignity programme</u> Strategic Portfolio Oversight Group		Internal Audits – Financial integrity and key financial systems audits External Audits – Strong record of high-quality statutory reporting with unqualified opinion National Fraud Initiative – No areas of concern Local counter fraud work – Referrals show good counter fraud awareness and reporting in Trust and no material losses have been incurred. Use of risk-based activity in new counter fraud standards Information Toolkit rating – Evidencing strong cyber risk management Regular NOF meetings with NHSE and ICB A clean year-end position and clean Value for Money (VFM) assessment as part of our year end audit			
Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Trust cash and capital risks related to national funded acute capital programme: Increased cost pressure now aligned to final refurbishment project	We will not have a Guaranteed Maximum Price (GMP) for Radbourne Until late Quarter <u>4-2 of 2026/27</u> [ACTION OWNER: DOF]	Cash and capital reporting as part of finance reporting into F&P and Board forecasting evidence of plan delivery and/or indicates areas of required management action	(30.06.26) <u>(30.09.26)</u>	Regular oversight of capital and cash position. Reporting to Trust Programme meetings and Committees on risks and mitigations Significant cost pressures on Radbourne Unit Refurb. The decision and affordability question of the second ward will be worked up in Quarter <u>4-2</u> aligned to receipt of the GMP	AMBER
Some partners moving away from business case assumptions and previous agreements Re-costing service provision, increasing Service Level Agreements (SLA) <u>Added pressure re SLA from Chesterfield Royal</u>	Close partnership working with ICB and system partners <u>Need to quantify impact and raise with commissioners</u> [ACTIONS OWNER: DOF]	Monitoring and reporting of income allocations and expenditure in year Transparent reporting of position shared with ICB to reduce challenge and ensure joint understanding and support	(30.06.26) <u>(30.09.26)</u>	MHLDA DB agreed to oversee revenue delivery contained within programme spend Still working through inter-Trust charges with Chesterfield Royal Hospital. Some concerns flagged to date as costs have risen well above baseline inflation	AMBER

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<u>Hospital and other costs such as rates</u>					
Insufficient substantive staffing into vacancies and temporary staffing costs for bank and agency staff do not reduce	Continued workforce strategies progressed to reduce agency and increase bank reducing risk Enhanced bank and agency costs reported as part of wider financial and workforce reporting Agency actions and controls are working and costs continue to reduce [ACTIONS OWNER: DPOI/DOF]	Continued reduced run rates evidence in spend Continued reduction in breaches in rates and framework providers	(30.06.26) (30.09.26)	Further work underway to comply with new mandate to ban use of band 2/3 <u>health care support worker</u> agency use	AMBER
Financial cost pressures created both internally and by system first decisions leading to the requirement for mitigations to close both the internal gap and the system financial gap	Additional 'stretch' management action required to reduce other cost and mitigate impact to achieve overall financial position <u>Additional CIP plans needed to close the CIP gap</u> <u>Close monitoring and oversight of Arden & Gem IT support transition to Nottinghamshire Health Informatics Service. Minimise cost pressure</u> Long list of unpalatable options drawn up and supported in principle by Board for further review. These are for consideration post planning nationally due to potential to impact patients and core Trust NHS offer. Need to develop these into costed and prioritised plans with clarity of patient and wider staff impact [ACTIONS OWNERS: DOF/MD/DON/CDO]	Alignment with our financial plan we are as an organisation Reduction of pay run rate in line with delivering on a planned headcount reduction <u>Reduction in CIP gap and non-delivery. Extent to which solutions are non-recurring</u> <u>Reduction in cost pressure linked to IT transition and CSU demise</u>	(30.06.26) (30.09.26)	Financial plan for 2026/27 is concluded but we need to continue to work on reducing the deficit as part of our longer term financial sustainability All new investments to follow governance processes with business cases via ELT, F&P and Board where appropriate and will require wider system support. All investments need a clear source of funding as increased CIPs beyond 6% is not credible Currently reviewing national toolkit and areas of further opportunities to strengthen grip and control <u>Weekly CIP returns monitoring progress</u>	AMBER

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

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Productive - Our services will be productive, demonstrate best value for our population and be cost effective										
There is a risk that the Trust’s increasing dependence on digital technology to deliver safe, timely and integrated care increases exposure to major system outages or cyber incidents, impacting patient safety, service continuity and strategic delivery. Impact: There is a risk that the Trust's digital infrastructure, systems, or data may be compromised due to an outage or failure to maintain adequate cybersecurity measures. This could lead to significant disruption to clinical services, compromise of sensitive patient or staff data, reputational damage, regulatory breaches, and potential harm to patients Root causes: a. Increasing reliance on a single electronic patient record b. Increasing use of video software for the direct provision of care and operational purposes c. Increasing electronic collaboration across health, social care and voluntary sector partnering organisations d. Increasing global instability and risk from state supported cyber attacks e. Increase in locally developed system solutions to support DHCFT and partner operations and performance										
BAF Ref: 26/27 3B		Director Lead: Vikki Ashton Taylor (CDO)					Responsible Committee: Finance and Performance Committee			
Key Controls										
Initial Risk Rating			Current Risk Rating			Target Risk Rating			Risk Tolerance	Risk Appetite
Moderate	Likelihood 3	Impact 4	Moderate	Likelihood 3	Impact 4	Moderate	Likelihood 2	Impact 4	Tolerated	Moderate
Preventative – Trust utilises NHS provided solutions as widely as possible, i.e., Office 365, NHS Mail to ensure compliance with mandated requirements. Use of the secure Health and Social Care Network (HSCN) specified by NHS Digital. Mandatory staff training on data security and protection at induction and annual refresher. Regular all staff communications regarding safe ways of working and phishing emails. Contract with NHS Arden and Greater East Midlands Commissioning Support Unit provides information governance and security services, includes review of risks and addressing of vulnerabilities. Subscription with NHS Digital Care Certification Programme highlights cyber vulnerabilities and monitors Trust’s compliance against them Detective – Cyber essentials framework: NHS Digital encourage all organisations to comply. Advanced Threat Protection (ATP) monitors every server and device to highlight threats and software vulnerabilities Directive – Compliance with NHS Digital requirements. Monthly rigor review meeting with NHS Arden and Greater East Midlands Commissioning Support Unit. Security and Protection Policies and Procedures. Business continuity policy and procedure; Digital Plan – In development										
Assurances on controls – Internal						Assurances on controls – External				
IM&T Strategy delivery update to F&P – Annual Embedded programme of software and hardware upgrades Live testing of business continuity plans Digital Plan – In development						Templar Cyber Organisational Readiness Report (CORS) Annual external cyber review and penetration test commissioned (vulnerability scan) Data Security and Protection (DSP) annual review by Internal Audit Compliance with DSP Toolkit: high levels of training compliance				

Board Assurance Framework Report 2026/27 – Issue 2.3 Board September 2026

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
NHS 10 year plan to abolish Commissioning Support Units (CSU). By Spring 2027 Arden GEM CSU is likely to be abolished will not exist beyond <u>31 March 2027</u> and DHCFT no longer and to benefit from respective cyber, network and technical services and support	<u>CSU transition project in place and joint initiative alongside DCHS, ICB, Arden GEM, North of England Care System Support and Nottingham Health Informatics Services.</u> Tracked by IMT+Records senior team <u>and CSU transfer task and finish group</u> National changes tracked via regional forum and Technical Design Authority <u>and task and finish group</u>. Alternative options — Plan in progress leading to options appraisal. Options may include: Some services provided in-house by DHCFT, contract with another supplier (NHS or private), wait for possible rebrand / merger of Arden Gem CSU and contract with new entity [ACTIONS OWNER: CDO]	Transfer of support services to a new entity	(30.06.26) <u>(31.12.26)</u>	Quarterly review leading to deadline in spring 2027 Due to significant links and sharing with DCHS across all levels of infrastructure, process, network, domain, DHCFT is looking to be in lockstep with DCHS in terms of joint approach to new ICT supplier Updated options appraisal and position statement provided for December ELT. DHCFT Internal CSU Transition task and finish group meeting every other week to ensure Trust requirements are met <u>New preferred supplier Service Level Agreement and partnership agreement under joint review alongside DCHS</u> <u>Dedicated finance subgroup commissioned to help with open book and transparent approach to transition costs</u> <u>Subject Matter Expert and technical workshops taken place to support secure transfer of services from Arden GEM to new supplier</u>	AMBER

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Unsupported IT devices are a potential security risk	Routine review and update of Trust assets. Ongoing cycle to refresh kit and update assets to comply with security updates <u>Routine rigour technical meeting with Arden GEM supplier to monitor and review compliance</u> <u>Routine asset management in place for all managers and staff to view and update staff owned assets such as laptop, mobile phone</u> <u>Routine ownership, membership prompts for staff and managers to confirm whether devices are still used and needed (otherwise disabled)</u> [ACTION] OWNER: CDO]	Compliance with monthly rigour and service reviews Removal of any unsupported devices/assets with each wave of security updates	(30.06.26) (30.09.26)	DHCFT the first Trust in the midlands to be fully compliant and phase out Windows 10 devices. Cycle will repeat with next wave of security updates Ongoing - Monthly rigour and service review meetings with IT service supplier <u>Testing in progress for new Microsoft Defender for Identity (MDI) and on track for completion ahead of government policy mandate to be in place before Autumn 2026</u>	AMBER
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Related operational high/extreme risks on the Corporate Risk Register:

ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating
21620	IT, IM and Patient Records	IT system collapse due to cyber attack	06.01.26: Cyber Security Operations Centre (CSOC) released high severity alert for need to update network switches nationally 27.04.26: Latest CSOC Cyber Security Operations Centre alert complete. Transition plan from Arden GEM CSU to NHIS will pose significant change and need to ensure DHCFT has correct levels of security in place. Capital plan to be used to support updates and replacement for network switches and Firewalls 03.08.26: This remains in the top three data security risks with additional concerns with Artificial Intelligence (either used maliciously, or where unexpected consequences of AI without controls). Ongoing challenges with keeping devices patched and up to date and with new suppliers and systems Improved controls detailed in Datix	08.02.19	03.11.26	HIGH

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Partnerships - Our organisation will identify new ways of working, through new collaborative approaches										
There is a risk of reputational damage if the Trust is not viewed as a strong partner both within the Derby and Derbyshire Integrated Care System (ICS) and more broadly within the East Midlands Mental Health Provider Alliance										
Impact: May have detrimental impact on patient experience and quality of care provided for people accessing services.										
Root causes: a) Silo working within the organisation b) Not actively engaging enough as part of a broader multi-agency partnership at Place and community level c) Increasing national expectations in provider collaboration and multi-disciplinary delivery model at Place level										
BAF Ref: 26/27 4A			Director Lead: Vikki Ashton Taylor (CDO)				Responsible Committee: Trust Board			
Key Controls										
Initial Risk Rating			Current Risk Rating			Target Risk Rating			Risk Tolerance	Risk Appetite
High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 3	Moderate	Likelihood 3	Impact 3	Tolerated	Moderate
Preventative – Active membership in each Local Place Alliance; Active participation in Integrated Place Executive; Meaningful stakeholder engagement (internal and external); Multi-disciplinary and cross organisational development and implementation of services										
Detective – Quality Improvement (QI) delivery; Contract performance; Continuing engagement in all Joined up Care Derbyshire governance from DHCFT representatives										
Directive – Integrated Care Strategy; Joint Forward Plan (JFP); Trust Strategy: <u>National Neighbourhood Health Framework</u>										
Assurances on controls – Internal						Assurances on controls – External				
Appointment to Managing Director roles Regular Trust Delivery Group (TDG) and ELT updates and discussions NED Board members on JUCD committees Developing collaborative plans with system partners to recognise and mitigate gaps within the system for ADHD and ASD diagnostics						Monthly Mental Health and Learning Disability assurance meetings with NHSE Monthly reporting by County and City Places to JUCD Place Executive Patient surveys conducted by Healthwatch CEO on ICB Board and Integrated Care Partnership (ICP) Regular NOF Level 3 meetings with NHSE and ICB				

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Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Some core constitutional targets not being met and risk to making progress, at pace and scale, for example, resulting in some patients being cared for outside of Derby and Derbyshire	New internal performance improvement process and oversight in place Performance Improvement Plans for areas where Trust constitutional standards are not being met Work with ICB cluster to agree commissioning intentions and future funding for specific services where demand outstrips capacity [ACTIONS OWNER: CDO]	Improvement in performance of constitutional standards and NHS Oversight Framework (NOF) metrics Recovery action plans in place in all required areas Agreed commissioning intentions and funding	(30.06.26)	Significant reduction in number of inappropriate Out of Area Placements, underpinned by a Performance Improvement Plan continues including a twice weekly Multi-Agency Discharge Event, roll out of home treatment service. New build facilities including a local PICU support improved patient flow and improved quality of care as the above will enable patients to be treated locally Performance Improvement Plans in place in relation to key access targets, measured in the NOF performance reviews for example, length of stay for acute and older adults, MH Helpline, crisis team responses (adult and children) and 104 week waits. NOF improvement in Quarter 2 to segment 3 from segment 4 Joint review underway for Mental Health Helpline. Awaiting confirmation of commissioning intentions for ADHD and ASD. Awaiting confirmation of recurrent funding for the social care element of the Living Well service	AMBER

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System partners report that DHCFT is inward looking and not easy to work with	To build stronger working relations and build stronger integrated ways of working and be more accessible, both from an organisational and service perspective To deliver integrated care and neighbourhood model of care [ACTIONS OWNER: CDO]	Increased delivery of integrated services Established mental health 24/7 neighbourhood hub Expand Living Well service offer to meet national requirements	(30.09.26)	Collaborative development of community mental health 24/7 pilot alongside general practice partner <u>organisations</u> Regular system partner meetings to increase collaborative working to improve access to services, for example, MADE events to reduce length of stay and Clinically Ready For Discharge numbers Active membership of all Neighbourhood (Place) Alliance Groups	GREEN
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Related operational high/extreme risks on the Corporate Risk Register: None

Board Assurance Framework Report 2026/27 – Issue 2.3 Board September 2026

Risk Rating

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

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

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

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

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

Action Owners

CEO Chief Executive Officer
 DOF Director of Finance
 MD Medical Director
 CDO Deputy Chief Executive / Chief Delivery Officer

DON Director of Nursing, AHPs, Quality and Patient Experience
 DPOI Director of People, Organisational Development and Inclusion
 DCA Director of Corporate Affairs and Trust Secretary

Definitions

Preventative A control that limits the possibility of an undesirable outcome
 Directive A control designed to cause or encourage a desirable event to occur
 Detective A control that identifies errors after the event

Provider Capability Self-Assessment - 2026

Purpose of Report

To present the 2026 Provider Capability Self-Assessment for Board approval, noting the requirement for Chair and CEO signatures and the submission deadline of 2 October 2026.

Executive Summary

Following the inaugural assessment in 2025, NHS England (NHSE) has launched the 2026 Provider Capability Assessment process. NHS trust boards are again required to assess their organisations against the six domains derived from The Insightful Provider Board:

1. strategy, leadership and planning;
2. quality of care;
3. people and culture;
4. access and delivery of services;
5. productivity and value for money; and
6. financial performance and oversight.

The guidance¹ states the self-assessment should not be a tick-box exercise; it is intended to test Board self-awareness, grip and delivery confidence, and to promote a “no surprises” relationship with oversight teams. The assessment is intended to consider the Board’s understanding of the issues facing the Trust, its grip and control, and its ability to deliver effective and sustainable action.

For 2026, the capability statements have been updated to give greater emphasis to:

- cybersecurity and digital maturity at Board level, including Board oversight of cyber risk and the role of digital technology in organisational improvement; and
- the Board’s oversight of staff experience, culture, capacity, development and wellbeing.

The Trust is required to give each domain a rating of Green, Amber-Green, Amber-Red or Red. In reaching its assessment, the Board must consider not only whether appropriate governance processes are in place, but whether those processes have been effective. The submission must identify the evidence underpinning the Board’s view, issues preventing a Green assessment, actions being taken and changes implemented since the 2025 submission.

Once submitted, NHSE regional teams will scrutinise the self-assessments and triangulate this with operational history and third-party intelligence to arrive at a capability view which, alongside segmentation, informs improvement support. The timetable is given in Appendix 1. The Trust’s current rating is **Amber-Green**. Explanation of ratings is given in Appendix 2.

¹ [NHS England » Assessing provider capability: guidance for NHS trust boards](#)

The self-assessment proposes the following ratings:

Domain	Proposed 2026 rating	Headline rationale
Strategy, leadership and planning	Green	A clear strategy, stable and appropriately skilled Board, strong governance and independent assurance are in place. Cyber risk is included in the Board Assurance Framework and the Digital Plan 2026 to 2028 has been ratified. Development remains focused on sharpening outcome measures, embedding risk appetite, strengthening digital maturity and demonstrating consistent System-wide impact.
Quality of care	Amber-Green	Established quality governance and positive external assurance are balanced by areas requiring further embedding, including quality improvement methodology, Patient Safety Incident Response Framework (PSIRF) implementation, organisational learning and consistent use of patient and carer feedback at service level.
People and culture	Amber-Green	The Board has a realistic view of staff experience and workforce risk, supported by the People Plan, staff survey, speaking-up intelligence and workforce reporting. The rating reflects variability in staff experience, sickness absence, change fatigue, leadership capacity and the need to improve feedback loops.
Access and delivery of services	Amber-Green	The Trust is demonstrating areas of strong performance,. Sustained improvement has been delivered with regards to better patient flow with a significant reduction in inappropriate out of area placements for adult acute and older adult patients. The average length of stay for both acute adults and older adults remains on track to achieve Q2 target. The Board has clear oversight and credible performance improvement plans where there is under performance against key national standards.
Productivity and value for money	Amber-Green	Governance and credible improvement plans are established, with evidence of gains in patient flow, out-of-area placements, agency control and corporate costs. Productivity measurement, comparative benchmarking and benefits realisation are not yet consistently mature.
Financial performance and oversight	Amber-Green	Financial governance and control remain strong, with delivery of the 2025/26 efficiency programme and financial balance. The Board recognises 2026/27 sustainability pressures, including out-of-area placement costs, inpatient acuity, temporary staffing expenditure and delivery of recurrent efficiencies and is driving performance improvement plans.

The proposed ratings recognise the strength of the Trust's core governance while being transparent about inconsistent outcomes or areas where arrangements are not yet fully embedded. In particular, the Amber-Green rating for access and delivery reflects continuing operational challenges despite evidence of Board grip, credible recovery planning and engagement with system partners.

In terms of evidence, NHSE have made it clear that they do not want to be sent additional items of evidence unless requested. A core piece of evidence that will be submitted with the self-assessment is the AQUA development review report and we will use existing assurance and compliance evidence to avoid duplication, for example the Annual Governance Statement, Board Assurance Framework (BAF)/Integrated Performance Report (IPR), internal audit reports, external reviews, evidence from recent Care Quality Commission reports, committee assurance summaries, Patient Safety Incident Review Framework (PSIRF) learning outputs, Model Health data.

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

Risks and Assurances

- Significant assurance is offered on the robust governance processes the Trust has in place when measured against the Insightful Board domains, which is evidenced in core documents such as the Annual Governance Statement which confirms strong internal and external controls
- Limited assurance is offered on the factors determining the Trust's current segmentation under the NHS Oversight Framework.

Consultation

The approach for completing the template has been shared with the Trust Chair. The Executive Leadership Team supported the initial draft and Executive Leads have liaised with their Committee Chairs during their review.

Governance or Legal Issues

This is a regulatory requirement from NHSE.

Net Zero Duty Implications

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

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

None.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

The paper cross reference equality-related matters within core evidence, for example, health inequalities, people plan, WRES/WDES.

Recommendations

The Board is requested to:

1. Confirm the proposed ratings, narrative, evidence, identified development areas and actions across all six domains and approve the 2026 Provider Capability Self-Assessment
2. Authorise the Chair and Chief Executive to sign it on behalf of the Board for submission to NHSE by 5.00pm on Friday 2 October 2026
3. Note the requirement that the Trust has to notify NHSE of any subsequent material in-year change affecting the Trust's capability assessment

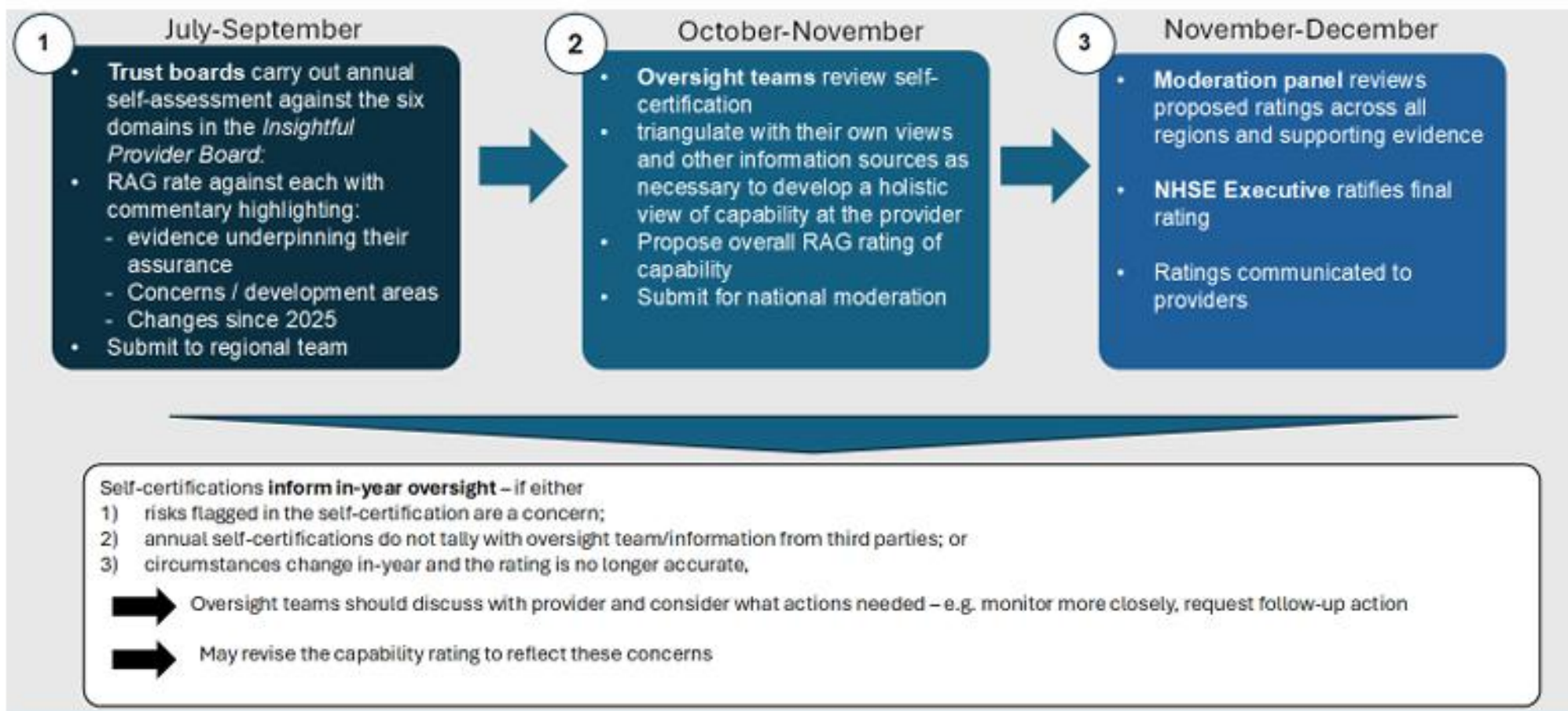
Report presented by:

**Selina Ullah
Trust Chair**

Report prepared by:

**Justine Fitzjohn
Director of Corporate Affairs and Trust Secretary, in
consultation with Executive Directors**

Summary of the capability assessment cycle 2026



Appendix 2

The provider capability ratings are:

Rating - in either a specific domain or overall	Indicative characteristics
Green High confidence in management	• Strong track-record across management team • No concerns with board's grip, • No reputational issues, system partner or other third-party concerns
Amber-green Some minor issues that should be addressed	• No material concerns, but some areas may require a watching brief and as yet are not affecting quality of care, delivery of core services, finance or the wider reputation of the NHS, or • Trust in 'probation' – no concerns but trust capability recovering from previous concerns before final assurance.
Amber-red Material issue needs addressing or failure to address major issues over time	• Serious governance/capability issues in at least one domain or capability statement and/or • Trust recovering from red-rating below, with serious issues still present but evidence of improvement and grip
Red Significant and persistent concerns	• Serious issues in multiple domains and/or • Serious ongoing issues in a single domain that management has been unable to address sufficiently over time • Trust in breach of governance licence condition or likely to be.

Provider capability self-assessment template 2026

Providers should use the form and the supporting annex to rate themselves across each domain and, following Chair and CEO sign-off, submit to their regional oversight lead at england.midlands.scot@nhs.net by **5pm Friday October 2**.

I. Strategy, leadership and planning	
Capability statements	Proposed domain rating
	Green
1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners 2. If in breach of licence: The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE	Board view The Board proposes a Green rating. The Trust has a clear strategy, supported by strong governance and aligned with national, regional and Integrated Care System priorities. It supports delivery of the Long Term Plan for mental health (MH) and maintains a strong focus on population health, prevention and service transformation. 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. 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. Our priorities are: Patient Focused, Productivity, People and Partnerships. Our strategic priorities are known as the 4 Ps. Our priorities align with system partners, and the importance to Trust of strong partnership working is reflected in our decision to have Partnerships as one of our four priorities. The Trust has entered a strategic partnership agreement with the University of Derby, to strengthen workforce development, research collaboration and student learning opportunities. In addition, we have developed a strong integrated community mental health service offer for the people of Derby and Derbyshire, alongside the VSCE (voluntary sector) and local authorities. This service not only delivers the Community Mental Health Framework requirements but also achieves eight of the ten principles set out in the national neighbourhood guidance. AQUA's independent assessment against the Well-Led framework recognised the clarity of the Trust Strategy and strong strategic maturity.

3. The board has the skills and expertise to deliver its strategy in the context of the 10-Year Health Plan. 4. The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served 5. The trust has an effective cyber security strategy and uses digital technology to support organisational improvement	Strategic oversight and delivery Strategic progress is monitored through the Strategic Delivery Plan, Integrated Performance Report (IPR), Board Assurance Framework (BAF) and committee assurance structure. In Q1 2026/27, the Board identified three priorities that were not progressing as planned: • operational performance • staff sickness • finance and efficiency plans The Board commissioned enhanced executive and committee oversight on these three areas, refreshed the relevant deliverables and strengthened performance monitoring. Strategic priorities, BAF risks and committee work programmes are now more closely aligned. Risk, cyber and digital assurance The Board maintains close oversight of risks relating to quality, workforce, finance, system partnerships, digital capability and cyber resilience. Cyber risk is explicitly included in the BAF. Assurance is provided through Finance and Performance Committee oversight, the Data Security and Protection Toolkit, external cyber readiness review, penetration testing and internal audit. The Digital Plan 2026-2028 is aligned with the Trust Strategy and a Cyber Plan has been drafted and will sit under the Digital Plan. Board capability and system leadership The Board is stable, with all roles substantively filled, and has the skills, capacity and experience required to deliver the strategy. Recent Non-Executive Director appointments were targeted to complement the existing skills base. All Board members are appraised under the NHS Board Member appraisal framework, including the Leadership Competency Framework, and Fit and Proper Person Test arrangements are in place and compliant. The Trust is an active and constructive system partner. Its five-year Strategy and annual delivery plans were developed with system partners and align with wider priorities. Evidence includes: • the successful transfer of services from Derbyshire Community Health Services enabling older adults inpatient mental health services to be provided by a single provider with mental health specialist knowledge, and the community neurodiverse service for the North of Derbyshire, enabling greater resilience and consistency of service offer with reduced fragmentation of services for service users • active involvement in new Integrated Care Board (ICB) governance arrangements including the Trust's CEO being the MH CEO ICB Cluster Board member, active participation in new ICB Cluster system governance including the MH Programme Board and working with the ICB Cluster to deliver a Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) waiting list previously held by another provider.
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- leadership within the East Midlands Provider Collaborative as Lead Provider for Perinatal MH resulting in increased focus on improving access to services for women from minority backgrounds who historically may not have sought help. In addition, the Trust has have taken on the responsibility for implementing and delivering an East Midlands wide Gambling Harms service to support people with gambling addictions.
- alignment of financial and digital plans with system plans

Independent assurance and governance effectiveness

AQUA found clear strategic maturity, credible and cohesive Board and Executive leadership, strong first-year delivery and robust governance. It also observed effective Board and committee structures, constructive challenge, good alignment with strategic priorities and improving triangulation. The Target Operating Model is strengthening accountability and operational grip.

The Annual Governance Statement confirms that there were no significant control issues. The Head of Internal Audit Opinion provided Significant Assurance, supporting confidence in the BAF and in the accountability and oversight provided through Board committees and operational management.

Development priorities and planned action

The Trust will address the development areas identified by AQUA. Priorities are to sharpen strategic priorities, strengthen outcome measures, improve alignment between the long-term financial and clinical strategies, demonstrate more consistent system-wide impact and embed risk appetite in decision-making.

Digital transformation is progressing but remains at an early stage of maturity.

Planned actions include:

- delivering the 2026/27 Strategic Delivery Plan
- implementing the Clinical Plan
- strengthening benefits realisation measures
- continuing Board development and succession planning

Developments since the 2025 submission

- The Target Operating Model has been introduced.
- The BAF has been realigned to 2026/27 priorities and now includes risk appetite.
- The Digital Plan 2026-2028 has been ratified.
- The Trust commissioned the independent AQUA Well-Led Developmental Review in July 2026.
- Leadership development has been extended to Clinical Directors and deputies through STRIVE.
- Following a review of Year 1 delivery, the Board approved refined 2026/27 deliverables in May 2026, with progress monitored through quarterly reporting.

	• Patient and Carer Race Equality Framework (PCREF) lead now in post, supporting the Executive Medical Director on progress, which is monitored at the Mental Health Act Committee. At Q1 2026/27, 12 of the Trust's 15 strategic priorities were delivering to plan, demonstrating strong mobilisation and delivery capability across most strategic objectives. The Clinical Plan 2026-2029 has been developed as the final one of the ten enabling plans supporting the Trust Strategy. A Cyber Security Plan has also been developed, and the Trust received Substantial Assurance against the 2025/26 Data Security and Protection Toolkit. Key evidence referenced • Trust Strategy, 2026/27 Strategic Delivery Plan and progress reports • the ten enabling plans and Financial Plan • Board Assurance Framework • Digital Plan 2026-2028 and cyber assurance reports • Board and committee terms of reference, papers and effectiveness reviews • Fit and Proper Person Test records, internal audit reports and succession plans • system and provider collaborative governance records • AQUA Well-Led Developmental Review report, August 2026 • Annual Governance Statement, including the Significant Assurance Head of Internal Audit Opinion for 2025/26 (Annual Report)

II. Quality of Care	
Capability statements	Proposed domain rating
	Amber-Green
6. The organisation has regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt). 7. The trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients	Board view The Board proposes an Amber-Green rating. The Trust has established quality governance, supported by the Quality Delivery Plan 2025-2028, Quality and Safeguarding Committee oversight, the Integrated Performance Report, Board Assurance Framework, clinical audit, patient safety and safeguarding systems, Board and quality visits, and patient and carer feedback. Recent Care Quality Commission (CQC) inspections provide positive external assurance with all recent inspections receiving a ‘Good’ rating. The rating reflects well-established arrangements alongside inconsistency in the use of quality improvement methods, patient and carer feedback at service level, PSIRF implementation and organisational learning. These areas are being addressed through agreed improvement plans. Quality oversight and triangulation The Board receives triangulated assurance from incidents, complaints, safeguarding, patient experience, clinical audit, mortality review, safer staffing, quality visits, Fundamental Standards assessments and external inspections. Quantitative and qualitative intelligence, including patient and staff stories, supports a rounded view of quality, safety and emerging risk. Board scrutiny has resulted in targeted action to improve complaint timeliness, strengthen patient safety investigation capacity and enhance organisational learning. Additional investigation capacity and focused improvement action eliminated the historic complaints backlog. Patient feedback reporting has also been strengthened through a Trust-wide patient and carer experience dashboard. Patient, carer and safeguarding assurance The Trust engages service users and carers through EQUAL (feedback network group) , co-production, peer support, expert patient arrangements and the Triangle of Care programme. In 2026, the Trust retained its two-star Triangle of Care accreditation, with external reviewers recognising progress in carer involvement across governance and frontline services. Safeguarding is overseen through the Quality and Safeguarding Committee, supported by established policies, procedures, training and partnership working with local safeguarding boards and statutory agencies.

8. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	Independent assurance and governance effectiveness AQUA observed strong alignment to quality risks, active challenge, clear escalation and evidence that decisions drive action. Board and quality visits combine observation, staff and patient feedback and performance information. Recent Good-rated CQC inspections continue to provide external assurance regarding service quality and governance. Development priorities and planned action Amber-Green reflects gaps in consistent effectiveness rather than an absence of governance. Priorities are to embed quality improvement methodology, strengthen Patient Safety Incident Response Framework (PSIRF) training, leadership capacity and learning responses, use patient and carer feedback more consistently at service level, and improve outcome and post-implementation reporting. Planned actions include: • delivering the PSIRF improvement plan and strengthening patient safety leadership • implementing an organisation-wide learning programme • developing the Quality Management System • strengthening complaints learning and outcome-focused reporting • embedding patient and carer feedback in service improvement Developments since the 2025 submission • The Trust has now completed a review of the 91 Fundamental Standards of Care. • A central patient and carer feedback dashboard was introduced. • The 15 Steps programme and Board and quality visits were expanded. • The historic complaints backlog was eliminated through a transformation programme. • PSIRF audit recommendations were incorporated into an improvement plan. • The Trust retained two-star Triangle of Care accreditation in 2026. Key evidence referenced • Quality Delivery Plan 2025-2028 and Quality Account • Integrated Performance Report, BAF and Quality and Safeguarding Committee papers • PSIRF internal audit and improvement plan • patient experience, complaints, clinical audit, safer staffing and mortality reports • Board and quality visit reports and Fundamental Standards assessments • CQC inspection reports and AQUA Well-Led Developmental Review, August 2026 • EQUAL, co-production, peer support, Triangle of Care, PCREF, WRES and WDES evidence
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III. People and culture	
Capability statements	Proposed domain rating
	Amber-Green
9. Staff feedback is used to both improve the quality of care provided by the trust and monitor and improve patient experience	Board view The Board proposes an Amber-Green rating. It promotes a strong, people-focused culture and has made workforce capacity, capability, experience and development a strategic priority through the Trust's People objective and People Plan 2025–28. The Board has established mechanisms to assure itself that the Trust has the workforce capacity and capability required to deliver its strategic, operational and quality priorities. Assurance is drawn from a combination of workforce performance data, quality and operational information, strategic workforce planning, professional and clinical leadership, staff feedback and committee scrutiny. This enables the Board to consider not simply workforce numbers, but whether the organisation has the right skills, leadership capacity, deployment, development and resilience in the areas required to deliver safe and effective services. The People and Culture Committee (PCC) provides detailed oversight on behalf of the Board, supported by the People Dashboard. This includes vacancy and recruitment, turnover and retention, sickness absence, temporary staffing and agency use, mandatory training, appraisal and supervision, employee relations, equality indicators, staff experience and Freedom to Speak Up intelligence. Areas of variation or concern can therefore be identified and explored at divisional and team level rather than relying solely on Trust-wide averages Workforce assurance is also considered alongside operational, quality and financial performance. This supports the Board in understanding where workforce capacity or capability may be contributing to service pressures and, conversely, where workforce interventions are having a positive impact on quality, productivity and delivery.

10. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels 11. Staff can express concerns in an open and constructive environment	The Board openly recognises where staff experience has deteriorated and where workforce risks could affect quality, productivity and financial delivery. Key workforce risks are reflected within BAF risks 2A and 2B, including workforce supply, sickness absence, leadership capacity, succession planning and organisational change fatigue. Mitigating actions and the effectiveness of controls are scrutinised through PCC and the Board. Staff voice, engagement and speaking up The Board engages directly with staff through forums, staff networks and Board visits. Feedback is used to shape improvement, supported by 'You said, we did' reporting. Staff networks provide inclusive spaces for colleagues to connect, share experiences and influence organisational change. The Board leads the speaking up culture and promotes an open environment in which staff can raise concerns without fear. The Freedom to Speak Up Guardian is highly visible and has direct access to the Chair, Chief Executive and lead Non-Executive Director. Themes and trends are reported to the Board and People and Culture Committee and triangulated with incident and workforce information to identify areas of concern. The Trust has high numbers of staff Speaking Up which the Board views as positive evidence that staff are willing to raise concerns. The Board has discussed bullying, harassment, discrimination, local resolution, communication of outcomes and leadership responsibility as recurring themes. The People and Culture Committee is the principal Board committee providing detailed assurance on delivery of the People Plan and workforce risks. It receives regular information on workforce performance, staff experience, equality, training, appraisal, supervision, wellbeing, employee relations, leadership and talent, and Freedom to Speak Up. Significant risks, areas of deteriorating performance and matters requiring greater Board oversight are escalated through the established governance arrangements. The Board and its committees increasingly seek evidence of impact rather than assurance based solely on activity. For example, recruitment initiatives are considered alongside vacancy and turnover trends; wellbeing and absence interventions alongside sickness performance; leadership development alongside staff experience and culture indicators; and equality actions alongside WRES, WDES and workforce representation data. The May 2026 Board People deep dive provided an opportunity for more detailed scrutiny of workforce capacity and capability. It recognised substantive progress, including strong appraisal, training and supervision compliance, turnover within tolerance and low agency usage, while also recognising that a number of cultural, leadership and workforce programmes remained at an early stage of embedding. Sickness absence remains an important workforce capacity risk. The Trust has strengthened its response through an Absence Oversight Group, revised policy and processes, hotspot analysis, targeted intervention and redesign of the wellbeing offer. The Board and PCC continue to monitor whether these interventions are producing sustained improvement and whether particular services require additional support.
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Leadership capacity and succession are similarly recognised as areas requiring continued attention. STRIVE and THRIVE, talent management and succession planning are intended to strengthen the leadership pipeline and reduce organisational vulnerability. The Board recognises that succession depth and leadership capability below Board level remain areas where further development and assurance are required.

AQUA observed effective committee oversight, targeted deep dives, increasing triangulation through the People Dashboard and heat map, and clear escalation. The Board is building on this by strengthening the connection between workforce, quality, operational and cultural intelligence so that it can more clearly assess whether workforce capacity and capability are sufficient to deliver Trust priorities.

Strategic workforce planning

Strategic workforce planning is increasingly integrated with the Trust's strategic, operational and financial planning processes to ensure that future workforce capacity and capability are aligned to service priorities. Workforce requirements are considered alongside activity, service transformation, productivity and financial plans, enabling the Trust to identify changes required in workforce numbers, skill mix, roles and capabilities.

The Board receives assurance through the People and Culture Committee, Finance and Performance Committee and wider Board reporting on the key workforce assumptions, risks and dependencies associated with delivery of Trust priorities. This includes consideration of establishment and affordability, vacancy and recruitment pressures, hard-to-recruit roles, workforce supply, retention, temporary staffing, productivity, new and developing roles, and areas where changes in service models require different workforce capabilities.

Workforce planning is supported by divisional and professional leadership, ensuring that Trust-level plans are informed by the requirements of individual services and professional groups. This enables emerging workforce gaps and future capability requirements to be identified and informs recruitment, retention, education and development, talent and succession planning.

The Board recognises the need to align workforce planning with quality, operational and financial plans, linking strategic priorities and service plans to workforce needs, interventions and measurable outcomes.

Development priorities and planned action

The Amber-Green rating reflects the strength of the governance and assurance arrangements alongside recognised variability in workforce experience and some areas where capacity and capability require further development. Priorities include:

- further developing the People Dashboard and team-level heat-map approach to identify workforce risks, variation and high-performing teams;

- strengthening triangulation between workforce, quality, operational, financial and staff experience information;
- using workforce planning more explicitly to demonstrate alignment between workforce capacity, skills and the Trust's future service priorities;
- strengthening leadership succession and talent pipelines, particularly in areas where succession depth is limited;
- continuing targeted action on sickness absence and workforce hotspots;
- embedding the Personal Accountability Charter and A Kind Life to strengthen behavioural and cultural expectations;
- demonstrating the impact, rather than simply the delivery, of leadership, wellbeing, Equality Diversity and Inclusion (EDI) and organisational development interventions; and
- identifying high-performing teams and systematically sharing and replicating the practices associated with strong staff experience, workforce performance and service outcomes.

Developments since 2025

- The People Plan 2025-2028 and EDI Plan 2026 have been implemented.
- The Target Operating Model has clarified roles and accountability.
- Leadership development has expanded to Clinical Directors and deputies, including STRIVE and THRIVE.
- The Freedom to Speak Up Policy was reviewed in April 2026 and a 2026-2029 plan was introduced.
- The wellbeing offer has been redesigned around six pillars.
- A staff carers forum was established in 2026.
- Derbyshire Healthcare was shortlisted eight times in the 2025 Asian Professionals' National Alliance (APNA) NHS Awards, providing national recognition of its leadership and commitment to equality, diversity and inclusion.
- Anti-racism, staff network and inclusive culture work has expanded
- The median gender pay gap improved

Key evidence referenced

- People Plan 2025-2028
- NHS Staff Survey 2025 and action plan
- People Dashboard and heat map
- People and Culture Committee papers
- Training and appraisal reports

	• Freedom to Speak Up reports, policy and plan • EDI Plan, WRES and WDES • staff network and engagement feedback • leadership development and succession plans
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IV. Access and delivery of services	
Capability statements	Proposed domain rating
	Amber-Green
12. Plans are in place to improve performance against the relevant access and waiting times standards 13. The trust can identify and address inequalities in access/waiting times to NHS services across its patients 14. Appropriate population health targets have been agreed with the ICB	Board view The Board proposes an Amber-Green rating. The Trust is demonstrating areas of strong performance, particularly in perinatal mental health access, dementia diagnosis, early intervention in psychosis, 72-hour post-discharge follow-up, individual placement support, and maintaining low 14-day mental health readmission rates. Sustained improvement has been delivered with regards to better patient flow, specifically a significant reduction in inappropriate out of area placements for adult acute and older adult patients. This improvement has been sustained all year. The average length of stay for both acute adults and older adults remains on track to achieve Q2 target. The Board has clear oversight and credible performance improvement plans where there is under performance against key national standards. The most significant pressures relate to demand exceeding commissioned capacity, especially within the mental health helpline, adult autistic spectrum disorder assessment, community paediatrics, and community waits for neurodevelopmental assessment. The Trust is in National Oversight Framework (NOF 3) and receives oversight of its plans to meet national standards, involving system partners where required. Access and delivery are reflected as a strategic risk in the Board Assurance Framework. The Board understands the underlying drivers, system dependencies and commissioning constraints, and has agreed recovery trajectories and improvement plans. 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.

Performance oversight and recovery

Performance is reviewed monthly through the Integrated Performance Report, Board Assurance Framework, Board committees and service-level information.

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 organisational restructuring was a direct result of the Board recognising that change was required to achieve our strategic priorities. In addition, the corporate directorates had been restructured to ensure better alignment, and improved capacity and capability to support the new divisions. This has included increased improvement, transformation and digital capability.

Recovery plans and trajectories are scrutinised where standards are not met, supported by Getting It Right First Time (GIRFT) reviews, system recovery programmes and external challenge.

Board scrutiny has led to external review through Mental Health Services Assessment Tool (MEN-SAT) and Housing Association Charitable Trust (HACT), which have resulted in more joined up working arrangements with the local authorities in relation to clinically ready for discharge patients, and stronger recovery planning and escalation of system dependencies. Recommendations are being implemented with system partners. Progress includes improved patient flow and a significant reduction in out-of-area placements. Clinically Ready for Discharge delays are materially affected by supported accommodation, housing and other system dependencies and the Trust is working closely with its system partners.

The Board also challenged the Assertive Outreach self-assessment, recognised that the service did not fully meet the national specification, required the issue to be reflected in corporate risk arrangements and escalated concerns through system governance routes. The Trust has raised commissioning capacity with the cluster ICB for a number of services.

There is evidence that targeted improvement plans are delivering recovery. Early Intervention in Psychosis performance recovered following implementation of an improvement plan and exceeded the two-week standard for the last six months. Memory Assessment performance also improved, with the proportion waiting over 18 weeks reducing from approximately 70% to 42%. We are placed 10th best in the Country for patients having had a recorded diagnosis. Individual work placement support: over the last 12 months there has been a 16% increase in the number of people using community mental health services in Derbyshire who have been supported to find work and stay in work by the Work Your Way Team.

Health inequalities and system working

The Trust uses population health and health inequalities information, supported by an agreed Health Inequalities Action Plan and dashboard embedded in the commissioner contract. Population health and health inequalities also form part of the Board's Strategy and Development programme. The key priorities include providing consistent services across the wide geographical and rural parts of Derbyshire, those living in deprived communities and focussing on those with multiple mental and physical health comorbidities and substance use. The priority population is those with serious mental illness, children and young people, learning disability and neurodevelopment disorder and older adults/frailty.

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.

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.

Health inequalities are a central part of the developing Clinical Plan, and progress is being made against Patient and Carer Race Equality Framework (PCREF). Joint working with ICB and local authority partners supports recovery where a collaborative approach is required. The Trust recognises that further work is needed to reduce unwarranted variation in access across geographies and population groups.

Trust reporting reinforces the importance of sustained focus on anti-racism, culturally responsive care, co-production and service redesign informed by community insight. Equality data capture is improving for example complaints data, learning from deaths reports, S136 reports and serious incident reporting which is then scrutinised for trends and improvement actions at various levels of governance including at the Mental Health Act Committee and the Quality and Safeguarding Committee.

To support Trust ambition in tackling health inequality and improving population health, Trust has identified the Executive Medical Director as the Executive Sponsor, appointed a PCREF Lead and is analysing the organisational data based on population health data which then forms part of service changes/improvement and delivery in a co-produced manner. The Trust is working closely with public health, local authorities and ICB in analysis of such data and works across partners in reviewing the care models/care pathway that bring better outcomes to patients and families and are clinically effective. Some of the examples include working with

communities in improving access and support for patients with serious mental illness and those specifically from ethnic background and those with deafness (Derby has high proportion of deaf people nationally).

The immediate focus for the Trust include building on some of the work which is already in place i.e. improving access and experience to mental health services from Black, Asian, and Minority Ethnic (BAME) communities and people with deafness. In addition, work is ongoing in meaningful analysis of data on racial disparities on statutory requirements such as detention under Mental health act, restrictive interventions, and enhancing patient voice from different communities in service improvement. There is also work ongoing in improving interpretation services. The next priority is to coproduce an action plan to strengthen PCREF implementation across the organisation.

There is strong governance and operational oversight of the work on health inequalities and population health. PCREF Steering Group is set up attended by all partner organisation s including ICB, public health/local authorities and voluntary sector. Progress on health inequality and population health is monitored via existing governance structure i.e. Quality and Safety Committee and the Board. All reports that are produced to various Committees and the Board are viewed through health inequality and population health angle too

Development priorities and planned action

Planned actions include:

- implementing MEN-SAT recommendations
- improving inpatient flow and reducing length of stay
- continuing structured recovery plans for national standards
- working with commissioners on community paediatrics and neurodevelopmental pathways
- developing the Clinical Plan to strengthen equitable access
- stratifying waiting lists by inequality
- strengthening population health measures and outcome reporting
- Delivery of the Community and Stakeholder Engagement Plan

Developments since 2025

- Out-of-area placements have reduced significantly since 2025.
- MEN-SAT recommendations are being implemented with partners.
- The Mental Health Urgent Assessment Centre (MHUAC) in Derby is due to open end September 2026 and capital funding awarded for a MHUAC in North of County (plan currently being worked up)
- Successful launch of MH helpline text service in Q2.
- Integrated service offer in partnership with Local Authorities and the Voluntary Sector to deliver the Community MH framework. This service offer delivers 8 out of 10 of the National neighbourhood MH standards.
- PCREF self-assessment published on web-site and PCREF action plan in place.

	• AQUA's review provided independent assurance and identified specific development actions relating to access, inequalities and partnership impact. • Agreement on the project working with Black communities in Derby City • The School Nursing digital population health programme received national recognition for improving the identification of need and targeting preventative interventions across Derbyshire communities. Key evidence referenced • Integrated Performance Report • Board Assurance Framework • operational performance improvement plans • MEN-SAT review and action plan • Health Inequalities Action Plan and dashboard • PCREF action plan and self-assessment • Community and Stakeholder Engagement Plan • ICB contract Schedule 6 • Clinical Plan development • Finance and Performance Committee and Quality and Safeguarding Committee papers
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V. Productivity and value for money	
Capability statements	Proposed domain rating
	Amber-Green
15. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	Board view The Board proposes an Amber-Green rating. The Trust has established governance for productivity and cost improvement, supported by the Productivity Steering Group, Finance and Performance Committee and integrated operational, workforce and financial reporting. National and local benchmarking includes Model Health System information, mental health productivity metrics and reference cost indices. The Board has good insight and credible improvement plans. Productivity gains have been demonstrated through improved patient flow, reduced out-of-area placements, agency controls, corporate cost reductions, service redesign and improvements in selected clinical pathways. Quality, equality, patient experience and staff wellbeing are considered alongside efficiency initiatives. The Amber-Green rating reflects that systematic productivity measurement, benchmarking and benefits realisation are still maturing, and efficiencies have not yet been fully extracted or consistently evidenced. Productivity oversight and delivery As part of planning for 2026/27, a new role was appointed into to lead on the productivity and efficiency agenda recognising this was an area increasing in importance. Now appointed and in place, this provides the resource to focus more on this area going forward. We are also now in receipt of MH benchmarking and metrics of value where previously the focus was very acute focused. We have procured a new system to help monitor productivity and improvement at a service line level and drive continuous improvement beyond our basic Electronic Patient Record (EPR) and finance and costing systems. The NOF metrics alongside our national cost collection returns show we benchmark well and we continue to focus on unwarranted variation. We also have a good NOF metric re data quality and continue to focus on strengthening this, where impacting productivity.

We are establishing a Productivity Steering Group, chaired by the new Productivity lead, under the portfolio of the Director of Finance. This reports to the Finance and Performance Committee. Productivity, cost improvement, workforce, activity and service performance are also reviewed through the Trust Delivery Group, Executive Leadership Team and Board.

Overall, the Trust is strengthening its productivity oversight through a single governance approach that combines peer benchmarking, Care Group deep dives, digital enablement and clear benefits realisation. NHS Model Hospital is a principal source for comparison with relevant peers, supported by local and national data. Material variation will be reviewed with clinical, operational, analytical, and finance leaders to determine whether it is warranted, data-driven or avoidable, and to agree with corrective action.

The Trust will use a Productivity Oversight Group to track the resulting programmes, including digital opportunities such as Heidi Health and Psymics, and will require clear baselines, owners, milestones and realised benefits.

Where a programme is expected to deliver a financial saving, the route from operational change to expenditure reduction will be clearly defined and validated. Historic planned and actual delivery figures will be included as evidence of the Trust's productivity track record.

Board scrutiny focuses on the sustainability of efficiency delivery, patient flow, agency utilisation, out-of-area placement expenditure, benefits realisation and operational ownership. Quality and Equality Impact Assessments are required for transformation and cost improvement schemes.

Assurance and effectiveness

AQUA found strong financial control, effective links between finance and operational impact, use of benchmarking and clear forward planning, including the cost improvement pipeline. The Trust has a sound record of financial control and has embedded efficiency, effectiveness and value for money within its operations and strategic planning.

The Trust participated in a national productivity pilot in 2024 and performed well on most indicators, while identifying further improvement opportunities. More recent national benchmarking also indicates areas for improvement. The Trust is continuing to assess its position as mental health productivity data becomes more established.

Development priorities and planned action

AQUA identified areas that the Trust was aware but it was helpful for them to confirm the increasing cost improvement delivery challenge, variable operational ownership, limited project management capacity, evolving national mental health benchmarks and a need for stronger benefits realisation and outcome measures.

Planned actions include:

- strengthening the Productivity Steering Group programme
- clarifying operational ownership and accountability
- expanding benchmarking and comparative analysis
- improving project management and analytical capacity
- strengthening benefits realisation and outcome reporting
- continuing to assess quality, equality, patient experience and staff wellbeing impacts

Developments since 2025

- The Productivity Steering Group has been established.
- Use of national mental health productivity benchmarking has increased.
- The Target Operating Model has clarified operational accountability.
- Corporate cost reductions and productivity improvements have been delivered in patient flow, out-of-area placements and selected clinical pathways.
- AQUA independently confirmed strong financial control and identified next steps for productivity ownership and benefits realisation.

Key evidence referenced

- Productivity Steering Group terms of reference and reports
- Finance and Performance Committee papers
- Integrated Performance Report
- cost improvement and corporate cost reduction reports
- Model Health System and mental health productivity benchmarking
- Quality and Equality Impact Assessments
- Trust Delivery Group reports

VI. Financial performance and oversight	
Capability statements	Proposed domain rating
	Amber-Green
16. The trust has a robust financial governance framework and appropriate contract management arrangements 17. Financial risk is managed effectively, and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes	Board view The Board proposes an Amber-Green rating. The Trust has strong and maturing financial governance, clear committee accountability, regular reporting and forecasting, and established contract and audit arrangements. The Board triangulates financial, workforce, productivity and operational information through the Integrated Performance Report, Finance and Performance Committee and Strategic Portfolio Oversight Group. During 2025/26, the Trust delivered its full £14.8 million efficiency programme and achieved financial balance. Financial plans are aligned with the system Joint Forward Plan. The Trust received positive external audit opinions on its accounts. Emerging 2026/27 pressures, including out-of-area placement expenditure, inpatient acuity, temporary staffing costs and efficiency delivery risks, are reflected in BAF Risk 3A and reviewed through Board and committee reporting and by NHS England. There is engagement with NHSE regional teams on financial recovery and sustainability, through NOF discussions, including when the Trust is forecasting off plan. The Board insists on Quality Equality Impact Assessments (QEIA) for all cost improvement schemes A number of our pressure points link directly to commissioning gaps. Examples being costs driven by Acuity and additional observation costs across inpatient areas not funded on a variable basis post covid, Place of safety being operated 24/7 and only commissioned for less than 12 hours a day across 2 of the 3 units. No discrete commissioned Assertive Outreach service and a lack of commissioned capacity to meet Autism and ADHD demand. These along with Out of areas and flow pressures, do mean financial balance and delivering of plan remains a risk despite being on plan at Q2. Long term financial sustainability remains a concern without material clinical transformation given our cost base is 80% pay, Financial oversight and control The Board actively scrutinises financial performance, forecasts, cost improvement delivery, workforce expenditure, productivity and financial risk supported by the role of the Finance and Performance Committee. It

18. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	challenges variances and mitigation plans, seeking assurance that actions are realistic, sustainable and aligned with quality objectives. Financial performance and risk are reviewed through the Finance and Performance Committee, Audit and Risk Committee, Executive Leadership Team, Trust Delivery Group and Board. Quality and Equality Impact Assessments provide clinical and equality safeguards for efficiency and transformation schemes. Independent and system assurance AQUA described financial governance as a notable strength and reported constructive challenge, clear planning, effective triangulation and strong system links. The finance team is well regarded, and the Trust is represented on the ICB Finance Committee and System Finance Sustainability Board. The Trust actively engages in system-wide financial planning. The Director of Finance is a member of the Derbyshire ICB Finance Committee and System Finance Sustainability Board, contributing to decisions on resource allocation across the system Independent assurance remains strong. The Head of Internal Audit Opinion for 2025/26 was Significant Assurance with no major weaknesses identified in financial systems or reporting, the 2025/26 Annual Governance Statement identified no significant internal control issues, external audit did not identify material governance weaknesses and implementation of agreed audit actions remains high. Development priorities and planned action AQUA confirmed increasing cost improvement pressure, variable ownership outside the finance function, reliance on some non-recurrent schemes, and the need to strengthen medium-term sustainability, alignment with the Clinical Plan and post-implementation assurance on savings. Planned actions include: • widening operational ownership of financial delivery • strengthening the medium-term financial plan and sensitivity analysis • improving recurrent cost improvement delivery • aligning financial and clinical strategies more closely • enhancing outcome reporting for Quality and Equality Impact Assessments Developments since 2025 • The Trust delivered its full £14.8 million efficiency programme and achieved financial balance in 2025/26. • The Target Operating Model has clarified accountability. • Financial sustainability has been strengthened within the Board Assurance Framework and committee deep dives.
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	• System financial leadership has continued through ICB governance arrangements. • AQUA's 2026 review provided independent assurance on controls and identified priorities for ownership, sustainability and impact assessment. Key evidence referenced • Annual Governance Statement 2025/26 • Head of Internal Audit Opinion 2025/26 and internal and external audit reports • Standing Financial Instructions • Board Assurance Framework • medium-term and annual financial plans • Integrated Performance Report and finance reports • cost improvement reports • Quality and Equality Impact Assessment policy and reports • ICB and system finance governance records
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Signed on behalf of the Board of Directors

Chair: Selina Ullah

Signature: _____ Date: 30 September 2026

Signed on behalf of the Board of Directors

Chief Executive: Mark Powell

Signature: _____ Date: 30 September 2026

Annex: Using a RAG-rating approach to derive the rating – guidance for providers

The table below sets out the approach providers should take to assess themselves across the six domains. Providers should set out, in their return template, a commentary covering the rationale behind each domain's rating, the evidence referenced in their return and improvements made since the last submission in 2025.

Note that regions will take their own views of capability across the board and will not have the level of detail that providers have – while the evidence here supports the rating it should not be considered automatic or algorithmic in every instance, rather it sets a general benchmark around different levels of capability taking account of the statements.

I. Leadership and strategy	
<i>Overarching expectation: the trust's board is working well as a unit to oversee the provider and has effective relationships with system partners and stakeholders. The board demonstrates the skills to oversee the delivery of safe, sustainable services, plans effectively and receives the right information to oversee performance and plan delivery as well as monitoring internal and external risk factors.</i>	
Capability statements	Indicative evidence
1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners 2. If in breach: The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE	<i>The following are indicative aspects of each level of capability but should not be seen as exhaustive</i> Green • Strategy is coherent, measurable, aligned with provider's objectives and system priorities. • If in breach: all undertakings being delivered; regulatory confidence restored and trust on track to compliance • Board has requisite range of skills; development plans active; succession plans in place; no vacancies > 3 months; no interims > 6 months. • Strong collaboration with local partners; joint planning; shared outcomes delivered. • Regular board reporting on cybersecurity matters, cyber built into Board Assurance Frameworks; digital strategy embedded.

3. The board has the skills and expertise to deliver its strategy in the context of the 10-Year Health Plan. 4. The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served 5. The trust has an effective cyber security strategy and uses digital technology to support improvement	Amber-Green • Strategy mostly aligned with the provider’s objectives but lacks depth or consistent delivery. • If in breach: On track to compliance with credible plans; minor slippage only. • Skills mostly adequate; some gaps recognised and being addressed. • Good relationships with system partners but inconsistent joint delivery. • Cybersecurity is mostly well-managed, but some areas lack maturity or consistency. • Concerns from independent board governance reviews or CQC well-led findings in past 6 months that are in hand Amber-Red • Strategy unclear, outdated, or inconsistently applied. • If in breach: Behind trajectory on return to compliance; repeated slippage; weak assurance. • Significant capability gaps at board level; weak development; over-reliance on individuals. • CQC well-led ‘requires improvement’ • Patchy collaboration; strained relationships; siloed behaviour. • Outdated systems; weak cyber assurance; limited digital use. Red • No credible strategy; board direction fragmented. • If in breach: persistent non-compliance; enforcement actions escalating; board grip absent. • Board lacks a number of core skills; no development; unsafe capability. • CQC well-led ‘Inadequate’ • Board isolated; system relationships dysfunctional. • No credible cyber strategy; repeated material incidents.
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II. Quality oversight

Overarching expectation: the trust’s board is set up for effective oversight of the quality of care it provides, monitoring safety, patient experience and using insights from third parties as appropriate. This is evidenced by robust information going to boards, a track record of high-quality care and an open, curious and enquiring approach on quality issues from executives and non-executives alike.

Capability statements	Indicative evidence
6. The organisation has regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt). 7. The trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients 8. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board #	<i>The following are indicative aspects of each level of capability but should not be seen as exhaustive</i> Green • Guidance is used effectively to drive improvements in quality of care. • Established quality governance arrangements in place; confidence in early warning systems; systems of triangulation identify issues before they become critical • Patient experience embedded in discussions around quality; concerns reach board quickly. Amber-Green • Mostly compliant with guidance and it is generally used to improve care; • Some gaps in the effectiveness of quality oversight e.g. escalation approaches or learning from close calls. Triangulation is used in places. • Systems in place to monitor patient experience but aren't always used consistently to escalate. Amber-Red • Guidance applied inconsistently • Board tends to be reactive to quality issues and actions to address issues are not consistently effective. • Limited insight into patient experience; slow escalation; weak or non-existent triangulation. Red • No regard for guidance; blind spots in safety and complaints. • Quality governance failing; evidence from third parties that serious risks are unmanaged. • No reliable patient experience monitoring.
III. People and culture	

Overarching expectation: the board has an accurate, evidence-based view of the trust's culture and improves the organisation as a place to work. This is evidenced by: staff input being collected, valued and used in board decisions; staff being able to speak up where they have concerns; and staff have access to training and other opportunities to carry out their roles as well as possible.

Capability statements	Indicative evidence
9. Staff feedback is used to both improve the quality of care provided by the trust and monitor and improve staff experience 10. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels 11. Staff can express concerns in an open and constructive environment	<i>The following are indicative aspects of each level of capability but should not be seen as exhaustive</i> Green: • Evidence that staff feedback drives improvement; strong culture indicated by high scores in staff survey, and Staff Standards measures. • Workforce plans credible; training embedded across the organisation; safe staffing levels in place and reviewed regularly. • Strong speaking-up culture. Amber-Green • Feedback collected but not consistently acted on. • Staff skills are mostly adequate but there may be gaps/insufficient depth in key areas. • Generally open culture; some pockets of concern in specific areas of the staff survey. Amber-Red • Feedback intermittently collected or when reported is out of date; limited impact on care or management actions. • Persistent gaps in skill levels in key areas; weak/ineffective training; • Evidence that staff groups indicate fear of speaking up; insufficient insights at board level. • Persistently lowest quartile in NHS staff survey Red • Persistent lowest 10% in NHS staff survey • Staff feedback ignored; culture deteriorating. • Unsafe staffing; no development in staff. • Evidence of a toxic culture; concerns suppressed.

IV. Access and delivery of services

Overarching expectation: the board understands the drivers of delivery of core national access standards and uses this to optimise the trust's performance. The Board has extracted the maximum reasonable performance from the resources, workforce and authority available to it, and does all it can to mitigate the impact of external factors.

Capability statements	Indicative evidence
12. Plans are in place to improve performance against the relevant access and waiting times standards 13. The trust can identify and address inequalities in access/waiting times to NHS services across its patients 14. Appropriate population health targets have been agreed with the ICB	<i>The following are indicative aspects of each level of capability but should not be seen as exhaustive</i> Green • Generally delivering on trajectory vs plans. • Clear knowledge/awareness of access and care levels across local geography and demographics in order to identify and address inequalities; can demonstrate measurable improvement. • Targets aligned with system partners; joint delivery plans in place where necessary (e.g. with provider collaborative partners). Amber-Green • Plans credible but inconsistent delivery. • Inequalities in access/care identified; actions underway but not yet fully addressing issues. • Targets aligned with system partners; joint delivery plans in place as necessary (e.g. provider collaborative) but not fully implemented or delivering desired outcomes.

	Amber-Red • Under-delivery or deterioration in performance but board cannot demonstrate a credible plan to address it; • Underperforming local peers with no evidence of mitigating factors • Known variation in the quality of and access to services but little or no evidence of addressing them. • Limited engagement across system partners to deliver access standards. Red • Behind trajectory on multiple access measures with no credible plan to address. • No insights into inequalities by demographic. • No engagement with rest of system
V. Productivity and value for money	
<i>Overarching expectation: the board understands how workforce, estate, asset utilisation, activity and provision of care interact at the trust to drive productivity. This is evidenced by a track record of improvements in productivity that are delivered within the wider context of quality of care and patient experience.</i>	
Capability statement	Indicative evidence
15. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	<i>The following are indicative aspects of each level of capability but should not be seen as exhaustive</i> Green • Board understands drivers of productivity and can use them to improve use of resources; provider in top 25% vs peers • Productivity improvements are discussed in the context of quality of care, patient experience and staff wellbeing

	Amber-green • Board has good insights and credible plans but has not fully extracted efficiencies • Performance vs peers flat/declining <12 months Amber-red • Board is aware of poor productivity and associated symptoms but has been unable to address them • Declining productivity vs peers >12 months Red • Board cannot explain the drivers behind poor productivity, quantify the upside or deliver improvement • Persistent bottom quartile in benchmarks vs peers
VI. Financial performance and oversight	
<i>Overarching expectation: the trust's board demonstrates a good financial understanding and literacy, leads the forecasting and risk management process and has a track record of overseeing the delivery of financial plans and efficiencies and offers strong challenge and insight. There is effective triangulation of workforce, activity and finance in both forward planning and in-year oversight.</i>	
Capability statements	Indicative evidence
16. The trust has a robust financial governance framework and appropriate contract management arrangements	<i>The following are indicative aspects of each level of capability but should not be seen as exhaustive:</i> Green • Track record of delivering financial plans 'without surprises'; cost improvement programmes are generally delivered

17. Financial risk is managed effectively, and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes 18. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	• Executives and Non-Executives understand the drivers of the trust's financial position and the board links finance discussions to quality of care, operational demand and workforce • Financial risks are reviewed regularly at board level; • Strong links between trust and system planning functions; supports system outturn. Impact of external factors outside the board's control are minimised Amber-Green • Occasionally off-plan, but generally returns to plan over time and by year-end • Cost improvement programs are delivered, but below forecast • Minimal reliance on one-off mitigations to hit plans Amber-Red • Understands headline numbers but struggles to explain or control how underlying drivers affect financial performance. • Unplanned reliance on agency/bank staff • Has recurring forecasting inaccuracies and missing planned performance – may rely on one-off mitigations to ameliorate under-performance • Shows weak linkage between workforce, activity levels, quality of care and financial performance. Red • Persistent plan under-delivery, with frequent unexpected in-year deterioration in performance vs plan, and little confidence in forecasts. Consistently misses savings targets. • Unplanned reliance on agency/bank staff • Board cannot clearly articulate factors behind the organisation's financial position; weak board-level financial governance, poor scrutiny of financial information and the factors behind performance • Track record of reliance on external support, regulatory intervention or year-end bailouts; little connection with system partners on financial planning and investment
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Freedom to Speak Up Guardian (FTSUG) report

Purpose of Report

This half-yearly report provides the Derbyshire Healthcare NHS Foundation Trust (DHcFT) Board with an overview of Freedom to Speak Up (FTSU) activity, an analysis of concerns and emerging themes, and priorities for strengthening speaking up culture.

Executive Summary

This report presents FTSU activity at Derbyshire Healthcare NHS Foundation Trust during January-June 2026, covering Quarter 4 (Q4), 2025/26 and Q1, 2026/27.

A total of 125 cases were recorded: 53 between January and March and 72 between April and June. This compares with 116 cases during the equivalent period in 2025, an increase of 7.8%.

The Trust continues to record a comparatively high volume of FTSU cases. Case volume can reflect staff awareness of and access to FTSU but may also indicate underlying workforce or cultural concerns. FTSU numbers are reported alongside staff-survey findings, reports of detriment, anonymous reporting, recurring themes, case outcomes and other workforce, quality and safety intelligence

Worker safety and wellbeing was the most frequently recorded theme, identified in 96 cases (76.8%). Other significant themes included inappropriate attitudes and behaviours (35 cases, 28.0%), bullying and harassment (24 cases, 19.2%) and patient safety and quality (20 cases, 16.0%).

Concerns were addressed through appropriate escalation; staff engagement; leadership and team-development work; signposting and referral to People services or Employee Relations processes where appropriate. FTSU intelligence is also being considered through the Culture Collaborative and Equality, Diversity and Inclusion (EDI) Working Group alongside workforce, quality, patient-safety, Organisational Development and Employee Relations information.

FTSU visibility continues to be supported through staff engagement, acute-unit drop-ins and the Speaking Up Champions network. Champions signposted 24% of cases to the FTSUG during the reporting period. The report provides assurance that accessible and independent speaking-up arrangements are in place across the Trust. Areas requiring continued focus include recurring workforce wellbeing concerns, reports of inappropriate behaviours, perceived detriment following speaking up, and the increase in anonymous reporting. Further work is underway to strengthen triangulation, measure the impact of actions and provide assurance that agreed improvements are resulting in better staff experience and safer care.

The Board is asked to note the themes and learning identified, support the continued independence and accessibility of FTSU, and seek assurance that actions are clearly owned, monitored and reviewed.

Strategic Considerations		BAF Risk	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X		
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X	2A / 2B	2.2, 2.3, 2.4
Productive: We will improve our productivity and design and deliver services that are financially sustainable.			
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.			

Risks and Assurances - Assurances: The Trust has established FTSU arrangements, including an independent Guardian, a Speaking Up Champions network, regular Board reporting and access to Executive and Non-Executive leadership. FTSU reporting is presented to the Trust Board and Audit and Risk Committee (ARC) every six months, providing assurance on activity, emerging themes and progress. The People and Culture Committee (PCC) also receives FTSU updates through the wider triangulated staff feedback dashboard. The ARC continues to oversee and monitor progress against the FTSU action plan - Risk: There is a risk that, where staff do not feel able to raise concerns safely, psychological safety may be undermined. This may affect patient safety, clinical effectiveness, staff wellbeing and experience, and could create reputational and regulatory risks for the Trust.

Consultation The report has been discussed with the Director of Corporate Affairs and Trust Secretary. The FTSUG meets regularly with the Chief Executive, the Non-Executive Director lead for FTSU and the Director of People, Organisational Development and Inclusion to discuss the themes within this report.
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Governance or Legal Issues Provider organisations are required under the NHS Standard Contract for 2026/27 to appoint and maintain at all times one or more FTSUGs.

Net Zero Duty Implications

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

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

Where appropriate, speaking up meetings are conducted virtually, reducing travel requirements and supporting the Trust's net zero commitments.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

- The FTSUG seeks assurance that concerns raised by staff with protected characteristics are appropriately supported through Employee Relations and EDI processes, and that wider themes or risks are considered by senior Trust leadership
- The report also identifies engagement by Black and Minority Ethnic (BME) colleagues in raising concerns through FTSU. This provides important intelligence about staff experience and supports continued assurance that concerns relating to race and other protected characteristics are appropriately addressed.

Recommendations

The Board of Directors is requested to:

1. Note the contents of the report, including the 125 FTSU cases recorded during January–June 2026, the themes identified, the associated learning and the actions underway
2. Support the continued development of the Trust's speaking-up culture through the mechanisms described in the report, including FTSU visibility and engagement, the Speaking Up Champions network, Culture Collaborative activity, staff-group engagement and triangulation with wider organisational intelligence
3. Agree the level of assurance that actions arising from FTSU concerns are appropriately owned, monitored and reviewed, with clear escalation where concerns remain unresolved or recurring
4. Support the continued independence, accessibility and confidentiality of the FTSU function, including appropriate Board oversight.

Report presented and prepared by:

**Tamera Howard
Freedom to Speak Up Guardian**

Freedom to Speak Up Guardian (FTSUG) – half-yearly report

1. Introduction

- 1.1 The FTSUG supports the Trust in developing an open and transparent culture where staff feel safe to raise concerns. Speaking up enables issues affecting patient safety, staff experience and organisational culture to be identified early and addressed appropriately. Freedom to Speak Up (FTSU) supports organisational learning and contributes to improvements in patient care and staff wellbeing. The Care Quality Commission (CQC) considers speaking up culture as part of its assessment of whether services are Well-Led. The current CQC Well-Led Quality Statement requires the Trust to confirm and evidence, *‘We foster a positive culture where people feel that they can speak up and that their voice will be heard.’*
- 1.2 This report covers the period January to June 2026 (Quarter 4 (Q4) of 2025/26 and Q1 of 2026/27). Reports are presented to the Board on a six-monthly basis.

2. Aim

- 2.1 This report provides the Board with:
- An overview of concerns raised through FTSU and the key themes identified during the reporting period
 - Learning and improvements arising from staff speaking up
 - Actions taken to strengthen the Trust’s speaking up culture and address barriers to raising concerns
 - Relevant national developments and updates from NHS England (NHSE) relating to FTSU
 - Key areas for Board assurance and consideration.

3. Summary of FTSU Concerns

- 3.1 Concerns raised through FTSU are recorded using categories established under previous National Guardian’s Office (NGO) guidance, alongside additional local themes. These include patient safety and quality; worker safety and wellbeing; bullying and harassment; attitudes and behaviours and leadership and management practices. The data also records whether concerns are raised anonymously, confidentially or openly; whether potential public interest disclosure issues are identified and whether individuals report experiencing detriment as a result of speaking up. This approach supports consistent reporting, analysis of trends and organisational learning.
- 3.2 Table 1 compares FTSU case numbers at DHcFT for January to June 2025 and January to June 2026. A total of 125 cases were recorded during the current reporting period, compared with 116 cases in the equivalent period in 2025, an increase of 7.8%. For historical context, the national average for mental health and learning disability trusts, including those providing Community services, was 40.3 cases per quarterly submission in 2024/25. DHcFT recorded an average of 62.5 cases per quarter during January–June 2026. These figures cover different reporting periods and provide contextual comparison.

Table 1: DHcFT FTSU case numbers, January–June 2025 and 2026

Reporting period	2025	2026	Average cases/quarter for MH, LD and Community trusts in 2024/25
January–March, Q4	76	53	-
April–June, Q1	40	72	-
Total	116	125	-
Average cases per quarter	58	62.5	40.3

Source: DHcFT September 2025 Board report, Table 2; NGO Summary of Speaking Up to FTSUGs: 2024/25

- 3.3 **Patient Safety and Quality:** During January–June 2026, patient safety and quality concerns were recorded in 20 cases (16.0%), compared with 16.4% between January and June 2025. These concerns are escalated to the Director of Nursing, AHPs, Quality and Patient Experience and the Executive Medical Director as appropriate. Nationally, patient safety and quality concerns represented 17.5% of cases in 2025/26. This provides context across all reporting organisations for the financial year April 2025–March 2026.

At the 2025/26 year-end, DHcFT's value on Model Health System's 12-month rolling FTSU measure was 263, compared with a peer median of 133, placing the Trust in the highest reporting quartile. This comparison is not adjusted for workforce size and does not, alone, indicate the quality of speaking-up culture.

Sources: National Guardian's Office, Freedom to Speak Up Case Data 2025/26: Reference Tables, page 6 and www.model.nhs.uk

A higher reporting rate may indicate awareness of and access to FTSU, but case volume alone is not a measure of organisational culture. It should be considered alongside staff survey findings; reports of perceived detriment; anonymous reporting; case outcomes and wider workforce, quality and safety intelligence.

Table 2: FTSU Data Q4, 2025/26 and Q1, 2026/27

Types of concerns and case characteristics	Q4 2025/26	Q1 2026/27
Patient Safety and Quality (NHSE / PIDA)	7	13
Bullying and Harassment (NHSE / PIDA)	10	14
Inappropriate Attitudes and Behaviours (NHSE)	11	24
Worker Safety and Wellbeing (NHSE)	38	58
Potential Fraud or Criminal Offence (PIDA)	0	1
Total Cases (individuals) reported to FTSU*	53	72
Public Interest Disclosure Act (PIDA) concerns	17	27
Reportable to NHSE: Bullying and Harassment / Patient Safety / Worker Safety / Inappropriate Attitudes and Behaviours*	41	66
Anonymous / Not known / Other	7	11
Person reports perceived detriment as a result of speaking up	1	4
Number of cases that have received feedback	46	61

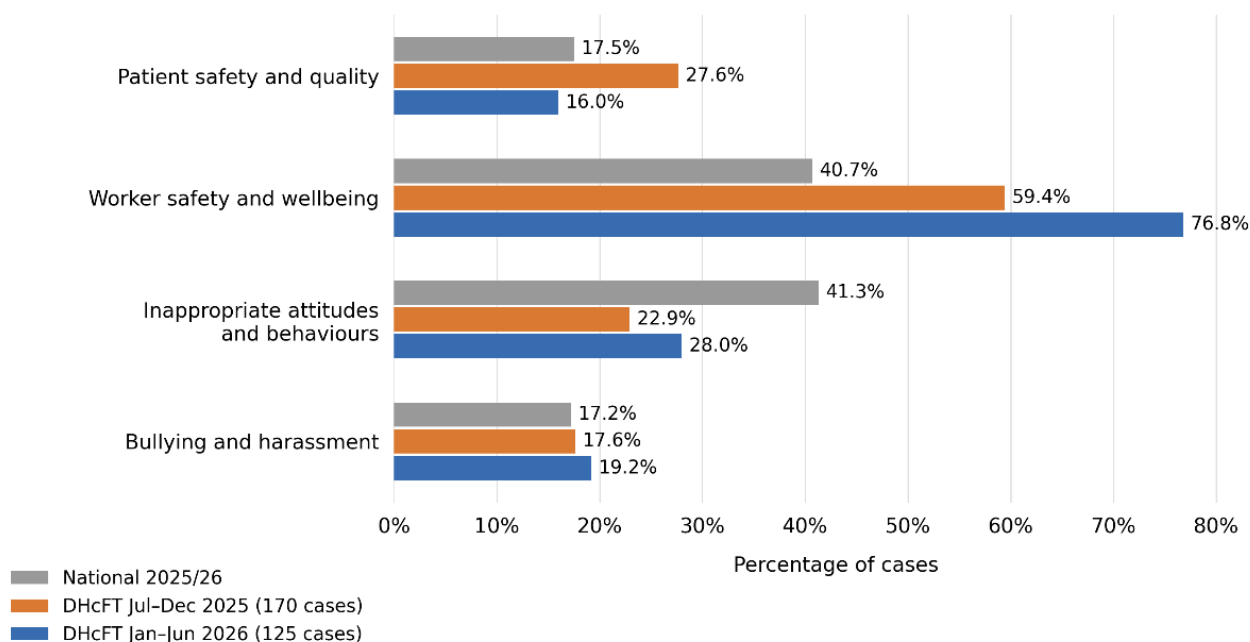
*Individual cases may include more than one concern theme. Therefore, theme totals are not additive.

- 3.4 **Bullying and Harassment concerns** were recorded in 24 cases (19.2%) raised to the FTSUG during January–June 2026, compared with 17.6% during July–December 2025, an increase of 1.6 percentage points. Nationally, bullying and harassment featured in 17.2% of cases during 2025/26. Staff are signposted to the Trust's Respectful Resolution policy; wellbeing support; staff-side/union support and Employee Relations where appropriate.
- 3.5 **Inappropriate Attitudes and Behaviours concerns** were recorded in 35 cases (28.0%) raised to the FTSUG during January–June 2026, compared with 22.9% during July–December 2025, an increase of 5.1 percentage points. Nationally, inappropriate attitudes and behaviours featured in 41.3% of cases during 2025/26.

Figure 1: Selected FTSU themes as a percentage of cases: DHcFT January–June 2026 compared with July–December 2025 and national figures for 2025/26.

FTSU themes: DHcFT and national comparison

Selected nationally reported themes



National data: April 2025–March 2026, all reporting organisations. Cases may include more than one theme.

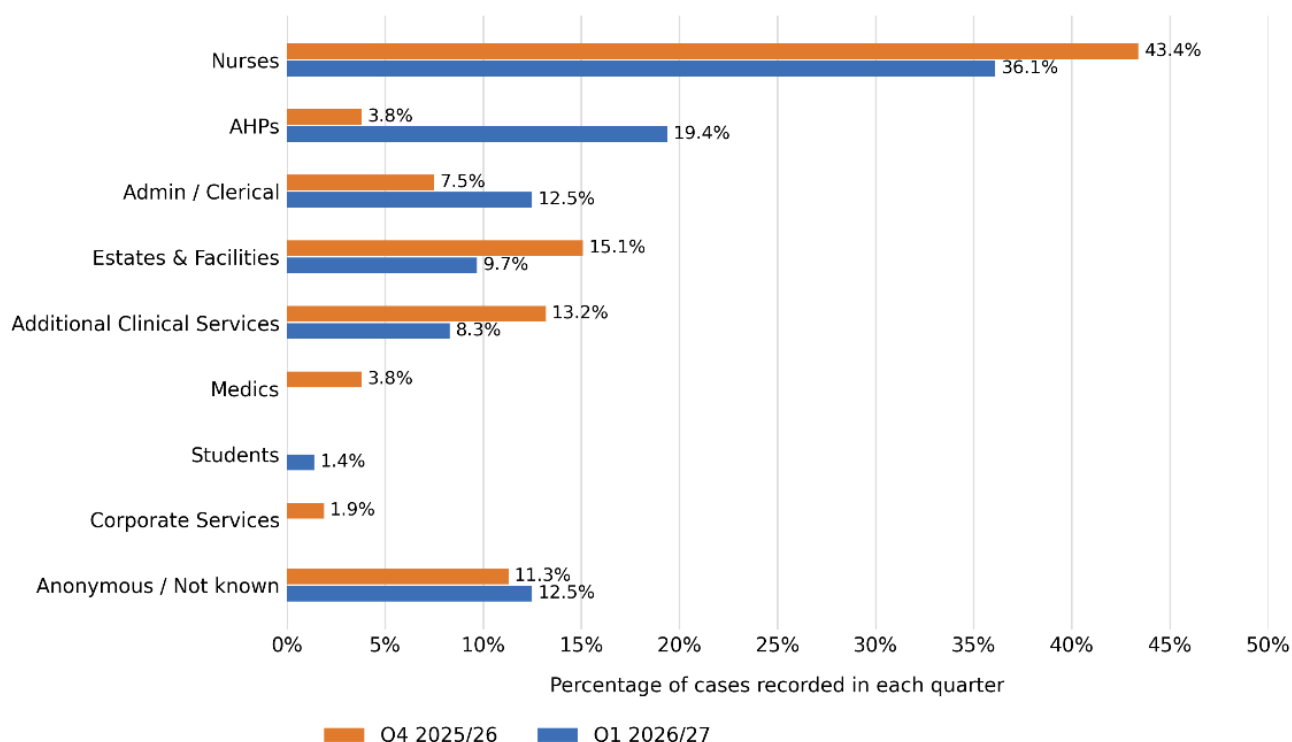
Sources: DHcFT reporting data; National Guardian's Office, Freedom to Speak Up Case Data 2025/26: Reference Tables.

- 3.6 Worker Safety and Wellbeing concerns** were 76.8% of cases during January–June 2026, compared with 59.4% during July–December 2025. Nationally, this theme featured in 40.7% of cases during 2025/26. Worker safety and wellbeing is a broad category that includes the reported impact of concerns on an individual's wellbeing and may overlap with other themes. The nature of these concerns and their reported impact on staff are explored in the thematic analysis later in this report.

Professional groups: During January–June 2026, Nurses accounted for 39.2% of all cases compared with 44.1% during July–December 2025. Nurses remained the largest professional group recorded among those speaking up. Nationally, registered Nurses and Midwives accounted for 27.7% of cases during 2025/26. Figure 2 shows professional groups of workers speaking up during Q4, 2025/26 and Q1, 2026/27, shown as a percentage of total cases recorded in each quarter.

- 3.7 Experiencing Detriment or Demeaning treatment:** During January–June 2026, five cases (4.0%) included a report of perceived detriment as a result of speaking up, compared with 2.9% during July–December 2025 and 1.7% during January–June 2025. Nationally, perceived detriment was reported in 2.9% of cases during 2025/26. The reported experience of detriment does not in itself establish wrongdoing. However, each report provides important intelligence regarding psychological safety, confidence to speak up and the effectiveness of organisational responses. Where appropriate, concerns are escalated to senior leaders and support is offered through People services, Wellbeing services, trade unions and other organisational processes.
- 3.8 Ethnicity of Workers:** During January–June 2026, 29.6% of all FTSU cases involved colleagues recorded as being from Black and Minority Ethnic (BME) backgrounds. This compares with 40.6% reported during July–December 2025. For workforce context, 24.9% of DHcFT staff were from BME backgrounds as of 31 December 2025, according to the ESR workforce snapshot published in the Trust's Public Sector Equality Duty Annual Report 2025/26. *Workforce source: [DHcFT Public Sector Equality Duty Annual Report 2025/26, Table 1, PDF pages 14–15](#).*

Figure 2 – Percentage of professional groups speaking up per quarter



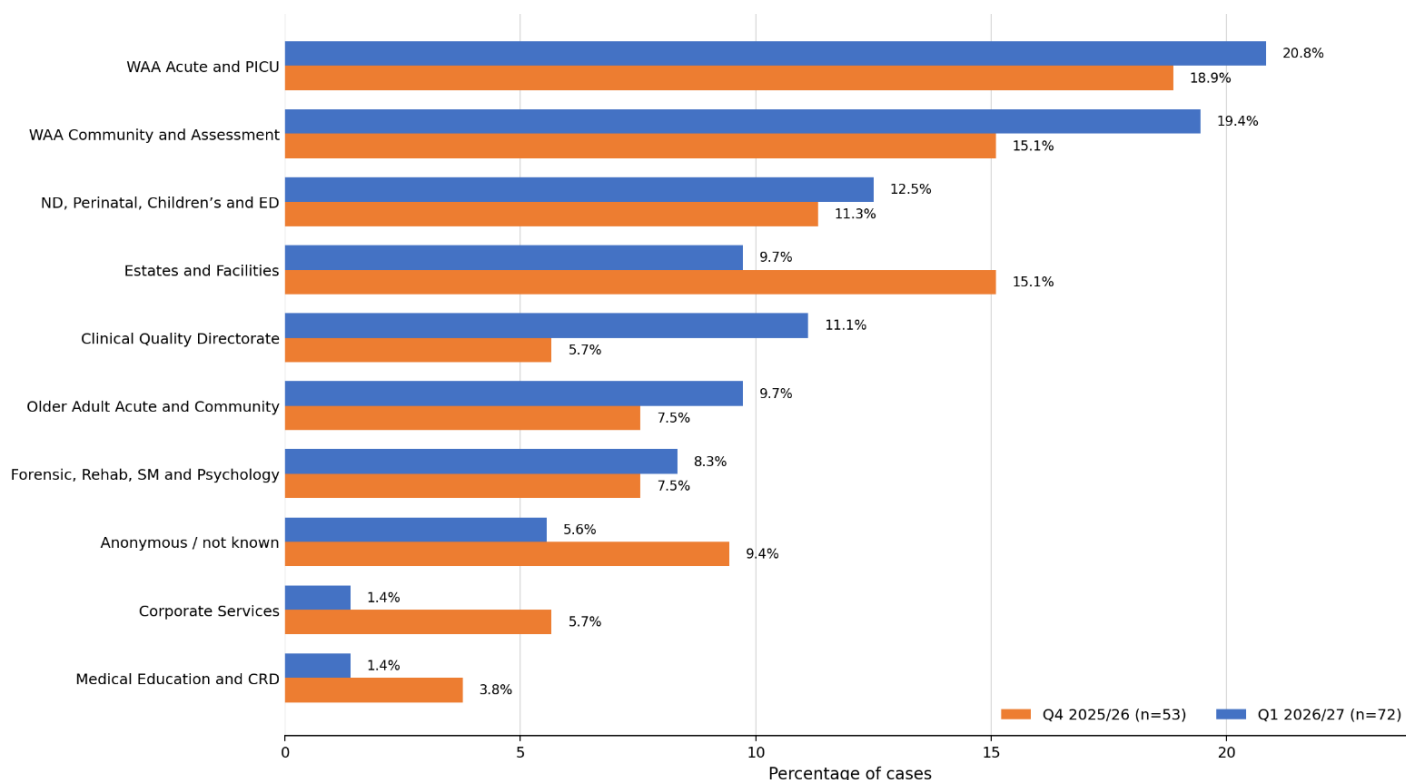
Source: FTSU Data January to June 2026. Percentages use all cases recorded in each quarter, including cases with no known professional group.

- 3.9 **Anonymous, Confidential or Open concerns:** During January–June 2026, 14.4% of cases were raised anonymously, 60% confidentially and 25.6% openly. Anonymous cases increased from 6.5% during July–December 2025 and 5.2% during January–June 2025. Nationally, anonymous cases represented 12.4% of cases during 2025/26.

The increase in anonymous reporting has been reviewed and initial themes do indicate concerns about confidentiality and other barriers to raising concerns openly, for example leadership behaviour and responsiveness, repercussions and confidence in follow up.

- 3.10 **Concerns raised by Care Group and Trust-wide service area:** Figure 3 shows the number of FTSU cases recorded against the Trust's Care Groups and Trust-wide service areas during January–June 2026. The themes arising within these areas are explored later in the report.

Figure 3: FTSU case numbers by Care Group and Trust-wide service



4. Emerging or ongoing themes, learning and action points

This section summarises themes arising from FTSU concerns during January–June 2026, alongside recorded responses and wider organisational improvement work. It includes subsequent progress updates from the Culture Collaborative available at the time of preparing this report. Themes may overlap, and actions include completed work and ongoing interventions.

- 4.1 **Workforce safety, workload and patient care:** Worker safety and wellbeing featured in 96 cases (76.8%), and patient safety and quality in 20 cases (16.0%). Concerns included staffing, workload, working arrangements, professional accountability and the impact of operational pressures on staff wellbeing and safe care.

Action and Improvement

- Concerns were escalated to Operational, Nursing, Medical and People leaders. Responses included review of working arrangements, clarification of decisions and access to senior support
- In a Community service, management confirmed enhanced clinical supervision and caseload oversight, alongside a requirement for a wider team improvement plan and fortnightly senior review. Subsequent staff feedback questioned whether the oversight was effective in practice, requiring continued follow-up
- Senior People leaders confirmed that planned reviews of changes to management roles would consider workload, responsibilities and wellbeing
- The Culture Collaborative records ongoing wellbeing visits and access to support in services experiencing cultural difficulties or organisational transition. Team development work has also identified recommendations concerning leadership visibility, support following incidents and incident-reporting arrangements.

Learning: operational changes need clear communication, staff involvement and review of their practical impact. Staff feedback remains important in assessing whether agreed measures are supporting wellbeing and safe care.

- 4.2 **Leadership, workplace culture and psychological safety:** Inappropriate attitudes and behaviours featured in 35 cases (28.0%), and bullying and harassment in 24 cases (19.2%). Staff described undermining or intimidating behaviour, inconsistent management responses, poor communication and limited confidence that concerns would lead to change.

Action and Improvement:

- Wider organisational development (OD) activity includes the ongoing *A Kind Life* programme and team away days across services in partnership with the University of Derby, supporting work on values, behaviours and team relationships
- Culture Collaborative updates record completed away-day and engagement programmes in services where concerns had been identified. Outputs include agreed action plans addressing communication, leadership visibility, role clarity and multi-disciplinary working, supported by ongoing leadership supervision
- One ward's 12-month improvement programme includes weekly wellbeing visits, monthly staff drop-ins and fortnightly action-plan reviews. Follow-up survey feedback indicates that staff feel more engaged, listened to and connected to the wider organisation. This is encouraging evidence of progress, with continued support in place and demonstrates impact of responding to FTSU concerns
- Within a Children's service, FTSU themes informed leadership discussions, staff listening sessions and opportunities for individual feedback. The team engaged positively, and work continues with service leaders and People colleagues
- Individual responses also included reflective supervision, clarification of probation processes, senior apologies and commitments to regular feedback.

Learning: targeted team development and consistent leadership support can help translate concerns into practical action. Follow-up listening provides an important indication of whether staff experience is improving.

- 4.3 **Equality, diversity and inclusion (EDI):** Concerns included racial discrimination and microaggressions; unequal treatment; disability-related disadvantage; reasonable adjustments and fairness in access to opportunities. Staff described the impact of inconsistent responses on wellbeing, trust and belonging.

Action and Improvement

- The FTSUG participates in the EDI Working Group, contributing themes from staff concerns to wider organisational discussions. An action agreed in April to bring together FTSU and EDI intelligence has progressed through the Culture Collaborative, linking OD, Employee Relations and workforce information to support earlier, co-ordinated intervention
- Joint OD and EDI listening and team-development work has informed targeted support around inclusion, working relationships, communication and rota fairness. Culture Collaborative updates record completed listening activity and recommendations shared with operational leaders, with further work underway where concerns persist
- The EDI conference took place on 13 May 2026, with feedback being collated. Racist-incident response process maps are available on Focus, with wider communication and distribution planned to help staff and managers understand the response expected
- Inclusive recruitment remains an area of focus, with actions to promote recruitment-chair training and review Recruitment Inclusion Guardian arrangements. People colleagues have also provided advice on reasonable adjustments and individual support needs
- A subsequent July update on an April FTSU concern identified a rostering-process issue affecting visibility of bank shifts for some staff groups. The response included measures to reinforce correct system use and consideration of wider fairness in allocation.

Learning: individual experiences can reveal wider barriers within workplace processes and culture. FTSU involvement in the EDI Working Group and Culture Collaborative supports co-ordinated action and follow-up on whether staff experience improves.

- 4.4 **Barriers to speaking up and perceived risk of detriment:** Five cases (4.0%) included reported perceived detriment. Wider concerns related to confidentiality, workplace relationships and fears among sponsored workers about possible consequences for employment or immigration status. These fears identify barriers to speaking up; they do not establish that sponsorship has been threatened or withdrawn. The Trust's expectation is that no worker should experience or fear disadvantage in relation to sponsorship or immigration status as a result of speaking up.

Action and Improvement

- The FTSUG provided confidential support, explained escalation options and supported access to People, wellbeing and trade union advice
- OD engagement has offered individual discussions, anonymous feedback and facilitated opportunities for staff to describe their experiences. In some team sessions, separate space was provided for staff to speak openly without managers present
- Following a senior leadership response, one worker chose to move from confidential reporting to direct, open discussion of their concerns
- Sponsorship-related fears have been captured as a cross-service theme within the Culture Collaborative, identifying the need for clearer reassurance and consistent management understanding of sponsored workers' circumstances.

Learning: accessible routes must be accompanied by a response staff can trust. Some workers choose not to escalate further, so this should not automatically be interpreted as satisfaction or resolution.

- 4.5 **Overall learning and priorities:** The themes demonstrate the close relationship between workforce pressures, leadership behaviours, inclusion and confidence to speak up. Recorded responses include management review, team development, agreed action plans and changes to processes. Follow-up staff feedback shows encouraging progress in some areas, while recurring concerns indicate where further work is needed.

The FTSUG's involvement in the EDI Working Group and Culture Collaborative provides established routes for bringing staff concerns together with OD, Employee Relations and workforce intelligence. This supports coordinated responses to individual concerns and wider organisational issues, including team culture, discrimination and fair access to opportunities.

The priority is to build on this work through clear ownership, timely feedback and review of whether agreed actions improve staff experience and patient care. Where concerns persist or progress is unclear, further assurance and escalation remain necessary.

5. Improving the speaking-up culture

This section summarises the actions undertaken during January–June 2026 to improve the visibility, accessibility and effectiveness of FTSU, together with the priorities for continued development. The focus is on engagement, access, support, triangulation and assurance. Staff survey findings are not repeated in this report, as they were presented to the Board previously.

- 5.1 **Visibility, accessibility and engagement:** The FTSUG promotes FTSU through Trust inductions; staff-group presentations; team meetings; listening events and regular face-to-face drop-in sessions. A bespoke video featuring Trust colleagues is available on Focus and is used in induction and training. The FTSUG undertakes drop-ins across the Trust's acute units, providing staff with an accessible opportunity to ask questions, discuss concerns informally and understand the routes available to raise issues confidentially.

The FTSUG also attends services and staff events where concerns or wider organisational intelligence indicate that additional engagement may be helpful. During the reporting period, engagement included presentations and discussions with Resident Doctors, students, trainees, preceptees and Healthcare Support Workers through the Trust's iCare programme.

These activities help ensure that staff understand the purpose of FTSU, the different routes available to raise concerns and the protections associated with speaking up.

- 5.2 **Supporting staff and communities who may face barriers to speaking up:** The FTSUG continues to provide an independent and confidential route for staff who may feel unable to raise concerns through local management arrangements. Particular attention is given to staff who describe concerns about confidentiality, perceived detriment, discrimination, workplace power imbalances or the potential impact of speaking up on their employment.

Engagement with Resident Doctors, internationally recruited staff, students, trainees, preceptees and Healthcare Support Workers provides opportunities to explain the FTSU process and to understand the circumstances that may affect confidence in raising concerns. Where appropriate, staff are signposted to additional support, including People; EDI; Occupational Health; staff-side and other organisational routes.

- 5.3 Triangulation and organisational learning:** FTSU is one of a range of routes through which the Trust listens to staff and assesses organisational culture. It complements, rather than replaces, local line management; People services; staff side; staff networks; incident reporting; patient safety processes and other routes through which staff can raise concerns or suggest improvements.

The FTSUG contributes anonymised themes to the Culture Collaborative, led by the Head of OD, Wellbeing and Leadership. This brings together intelligence from FTSU, OD, EDI, Employee Relations and workforce information to identify recurring concerns, coordinate targeted support and review progress. Themes are considered alongside relevant quality and patient-safety information, with appropriate regard to confidentiality and consent.

Where appropriate, FTSU themes are considered alongside NHS Staff Survey findings; quarterly Pulse Survey results; staff network feedback; Workforce Race Equality Standard and Workforce Disability Equality Standard information; Employee Relations themes; sickness absence; retention and turnover information; OD reviews and listening events; quality visits; patient safety and incident information and patient and carer feedback.

This triangulation supports earlier identification of emerging cultural, workforce and safety concerns. It also helps the Trust identify services or staff groups that may require further engagement or targeted support. Information is shared proportionately, with appropriate regard to confidentiality, consent and the risk of identifying individuals.

The FTSUG also participates in the EDI Working Group, ensuring that staff experiences inform discussions about discrimination, reasonable adjustments, inclusive recruitment and barriers to speaking up. These connections support a coordinated organisational response, linking concerns raised by individuals with wider team development and improvement work.

The People and Culture Committee receives wider staff feedback intelligence, while the Audit and Risk Committee monitors progress against the FTSU action and improvement plan. Further work is required to demonstrate consistently how triangulated intelligence results in action and whether staff experience and safe care improve as a result.

- 5.4 Speaking Up Champions network:** The FTSUG continues to support the Speaking Up Champions network through regular communication, meetings and opportunities to share good practice. Champions help increase awareness of FTSU within their services and provide an additional point of contact for staff who may be uncertain about how to raise a concern.

During January–June 2026, 24% of concerns were signposted to the FTSUG by FTSU Champions. This demonstrates the contribution of the network in improving access to the FTSU service and supporting staff to raise concerns through an independent route.

The network also provides feedback about barriers to speaking up and helps identify opportunities to improve the visibility and accessibility of FTSU across the Trust. Champion activity will continue to be developed in line with the needs of the new Care Group and wider organisational structures.

- 5.5 Connections between the FTSUG and Board members for support and assurance:** The FTSUG meets regularly with the Chief Executive, accountable officer for FTSU, the Non-Executive Director lead for FTSU and the Director of People, OD and Inclusion. These discussions provide direct access to Board leadership and enable consideration of emerging themes, identifying barriers to speaking up, reports of perceived detriment, organisational risks and areas requiring executive action or further assurance.

The Non-Executive Director for Speaking Up provides the FTSUG with support, constructive challenge and an additional route for assurance about the independence and effectiveness of the Trust's speaking-up arrangements.

The Board and Executives receive updates from the FTSUG on relevant national cases, inquiries and emerging learning. The FTSUG is also a member of the Trust Delivery Group, providing early awareness of significant organisational changes and their potential effect on colleagues and speaking-up culture.

The FTSUG will continue to report relevant themes through the established Board and committee arrangements, while maintaining appropriate confidentiality and ensuring that individual staff cannot be identified through routine reporting.

6. Learning, improvement and development in relation to speaking-up culture

This section summarises activity undertaken to evaluate and develop the FTSU service, share learning and support a consistent speaking-up culture across the Trust and the wider System.

- 6.1 **Evaluation feedback from staff who speak up:** An evaluation form is offered to staff following contact with the FTSUG. Feedback provides an opportunity to understand how staff experienced the process and whether they would feel able to speak up again. Between January and June 2026, 75.2% of respondents indicated that they would speak up again. This provides positive assurance regarding the support offered through the FTSU process. However, it also highlights that some individuals remain uncertain about raising concerns in the future. Feedback will continue to be reviewed to identify opportunities to improve the experience of staff who use the service and strengthen confidence in speaking up.
- 6.2 **Derbyshire Integrated Care System:** The FTSUG meets monthly with FTSU colleagues across the Derbyshire Integrated Care System. These meetings provide an opportunity to share learning, discuss common challenges, consider System-wide approaches to speaking up and promote consistency in practice.
- 6.3 **Regional and national FTSU networks:** The FTSUG regularly attends Midlands regional FTSU check-in meetings, quarterly Midlands FTSU network meetings and FTSU mentor and chair network sessions. The Trust recognises the challenging nature of the FTSUG role. The FTSUG receives wraparound health and wellbeing support, including clinical supervision from the Psychology team. Regional and national FTSU networks provide additional peer support, professional development and opportunities to share good practice.
- 6.4 **Speaking Up e-learning and manager/leadership development:** Speaking Up e-learning is available to Trust staff and forms part of the organisation's approach to ensuring that colleagues understand their responsibilities and the routes available when they have a concern. Compliance was reported at 96% in August 2026.

The Board has supported mandatory Speak Up training and has completed Follow Up training. The FTSUG supports consideration of additional development for managers, including Listen Up training or equivalent facilitated learning. This training helps managers strengthen their confidence and capability to respond constructively and compassionately when staff raise concerns.

The FTSUG will be liaising with the appropriate leads to assess how training completion translates into leadership behaviour and staff experience, using staff feedback, survey results, FTSU themes and evidence from local team interventions.

- 6.5 **FTSU strategy and policy development:** The FTSU Plan (Strategy) and the FTSU Policy have now been reviewed and refreshed and are available on the FTSU page on Focus (staff intranet). The review provided an opportunity to ensure that the Trust's arrangements remain clear, accessible and aligned with current NHSE expectations and good practice.

7. NHSE and national FTSU arrangements

- 7.1 **National arrangements:** The FTSUG role remains a requirement of the NHS Standard Contract for 2026/27. Following the closure of the National Guardian's Office on 30 June 2026, NHSE has taken on specified national functions, including quarterly data collection, guidance and specialist support for Guardians. Regional and national Guardian networks continue, with NHSE support during the transition.

- 7.2 **Implications for the Trust:** The revised arrangements place greater responsibility on organisations for maintaining effective speaking-up arrangements. This includes publishing accessible Guardian contact information, submitting quarterly FTSU data, supporting Guardian training and development, and providing access to independent, confidential psychological support. The Trust should maintain Board oversight of these arrangements and ensure that learning from concerns informs organisational improvement.

8. Conclusion

- 8.1 During January–June 2026, 125 FTSU cases were recorded, highlighting interconnected concerns about workforce wellbeing; patient safety; workplace behaviours; inclusion and confidence to speak up. Recorded responses and subsequent updates demonstrate management action, targeted team development and wider improvement work through the Culture Collaborative and EDI Working Group. There is encouraging evidence of progress in some services, alongside recurring concerns requiring continued attention and follow-through.
- 8.2 The report provides assurance that accessible FTSU arrangements are in place, themes are escalated and organisational responses are being coordinated. Further assurance is required on the consistency and timeliness of case outcomes, the effectiveness of actions in services with recurring concerns, the increase in anonymous reporting and the experience of staff reporting perceived detriment.
- 8.3 The Board is asked to note the findings and support the continued development, independence, accessibility and confidentiality of the FTSU function. The Board is also asked to seek assurance that actions arising from concerns have clear ownership, timescales, feedback and review arrangements, with further escalation where concerns remain unresolved or recurring.

Creating a safe speaking-up culture remains a shared organisational responsibility. Sustained improvement depends on leaders listening to staff, responding compassionately and consistently, and demonstrating that action improves staff experience and patient care.

Guardian of Safe Working Hours (GoSWH) annual report – 2025/26

Purpose of Report

This annual report from the DHcFT Guardian of Safe Working Hours (GoSWH) provides data about the number of Resident Doctors in training in the Trust, full transition to the 2016 Resident Doctor contract and any issues arising therefrom. The report details arrangements made to ensure safe working within the new contract and arrangements in place to identify, quantify and remedy any risks to the organisation.

Executive Summary

- Exception reports are usually raised by trainees when there are differences in total hours worked or there is inability to take contractual rest breaks. They can be also raised when education and training opportunities are missed or there is inadequate support during service commitments
- Total number of exceptions in the last year 78. Although, this is a higher number, the initial increase after introduction of reforms appears to continue at the same rate. Work schedule review, in particular, review of on call workloads might have played a major role
- There is a working group currently in place to investigate on call pressures, particularly in the south rota, led by the Deputy Director of Medical Education (DDME) south. More information and subsequent changes in rota will be examined in the next quarterly report
- Typical response from the relevant officers (Medical Education department, DDMEs, GoSWH) have been timely but completion of reports by trainees is still a concern as mentioned in my last quarterly report. There is plan in place to meet trainees in person and explain the process again to help mitigate this
- Good uptake of access and completion tests on the exception report platform denotes that the trainees have good understanding of the basics of raising a report
- Some of the columns (information about response times) do not have records from the whole year due to the difference in data collected in the old versus reformed exception report system. This would be easy to address in the next quarter as all data would be extracted from the new system.

Strategic Considerations		BAF Risk	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.			
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X	2A	2.1
Productive: We will improve our productivity and design and deliver services that are financially sustainable.			
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.			

Risks and Assurances

- There is a requirement for all NHS Trusts to adhere to 2016 Resident Doctor contract. Failure to do so will impact on the experience of the resident doctors and reputation of the Trust
- The Trust has a GoSWH Medical Lead who monitors the implementation of the contract
- The progress is reported regularly to the Joint Local Negotiating Committee (JLNC) and if any issues are managed effectively. Any concerns are effectively raised through existing channels of governance.

Consultation

- The GoSWH regularly shares the reports to the JLNC, the Trust Medical Training Committee (TMTTC), the Resident Doctor Forum (RDF), Medical Directorate Meeting and its constituent Resident Doctors
- People and Culture Committee, 10 September 2026.

Governance or Legal Issues

There is a requirement for all NHS Trusts to adhere to 2016 Resident Doctor contract and our rotas are compliant.

Net Zero Duty Implications

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

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

No impact.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

None.

Recommendations

The Board of Directors is requested to note the contents of the report.

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

Report prepared by: **Dr Praveena Peddireddi**
 Guardian of Safe Working Hours

1. Resident Doctor data

Extended information supplied from 1 April 2026-30 June 2026.

Numbers in post for resident doctors in training

Numbers of doctors in post WTE	North	South
FY1	3	5
FY2	3	5
GP ST	3.8 (head count 4)	5.6 (head count 7)
CT	9.8 (head count 11)	10.6(head count 11)
HSTs	7.4 (head count 8)	8.2 (head count 9)
Paediatrics ST	0	1.6 (head count 2)

Key

CT = Core training resident years 1-3

FY1/FY2 = Foundation year resident (years 1 and 2)

HST = Specialty training resident (ST) years 4-7

GP ST = General practice specialty registrar

Paediatrics ST = Paediatrics specialty training resident (year 4+)

2. Exception Reports

Aggregated data, covering the period 1 June 2025-21 June 2026

Grade	No of exceptions raised	No of exceptions closed	No of exceptions outstanding
CT1-3	31	27	4
ST4-7	24	23	1
GP	7	6	1
Foundation	16	16	0
Total	78	72	6

Action taken

Payment	30
Time off in lieu	35
Not agreed (pending review)	6
No action	5
Review of work schedule	2
Total	78

Response time (*this is an aggregate of new format only as data from old format not available*) from 1 January-21 June.

Grade	48 hours	14 Days	Longer than 14 days	Open
CT1-3	1		11	

Foundation			6	
ST4-7			10	
GP	1		6	

- Marked delay in closing exception reports is due to time taken by the trainees to respond
- Most exception reports had their typical response between two to three days from the relevant responders (Medical Education, Deputy Director of Medical Education, etc)
- It appears as if trainees need more information about responding to queries through email and closing exceptions as needed
- This is being mitigated by the GoSWH addressing trainees in person during induction instead of the usual online meeting after the regular induction takes place.

3. Work schedule reviews

Two reviews of work schedule were done with suitable agreement between trainee and Clinical Supervisor in both instances.

4. Fines

- Current balance: £3,383.84 through cost code G62762 available for Resident Doctors to spend
- Fines' money set aside for a Board-supported away day for Resident Doctors.

5. Locum/Bank shifts covered - 1 April 2026-30 June 2026)

	North	Cost	South	Cost
Locum/bank shifts covered	13	£22,080	71	£47,798
Agency locum shifts covered	0	0	0	0

6. Agency Locum - 1 April 2026-30 June 2026

Nil

7. Vacancies - 1 April 2026-30 June 2026

	North	South
CT1-CT3	0.4	0.2
ST4-7	3	0
GP registrars	0.4	0.6
Foundation	0	0

8. Qualitative information

Rota workloads

- DDME led action group met multiple times over the last year to understand and mitigate on call work pressure in the new built sites. Various options are still being explored without introducing a second night doctor in the first instance

Exception reporting reform

- Exception reporting reform became online from 4 February 2026
- Some initial glitches with trainees finishing test reports which look like they are sorted now

- On going issues with trainees not 'closing' their exception reports leading to increased response time depiction on the report. This needs to be addressed. GoSWH is arranging to meet trainees in person on the day of induction to address this. Historically, this was an online meeting which was scheduled for three weeks after the regular induction.

9. Compliance of rotas

Current work schedules are compliant with the 2016 Resident Doctor contract.

10. Other concerns raised with the GoSWH

None not already covered.

Guardian of Safe Working Hours (GoSWH) quarterly report - 1 June to 7 August 2026

Purpose of Report

This quarterly report from the DHcFT Guardian of Safe Working Hours (GoSWH) provides data about the number of Resident Doctors (RD) in training in the Trust, full transition to the 2016 RD contract and any issues arising therefrom. The report details arrangements made to ensure safe working within the new contract and arrangements in place to identify, quantify and remedy any risks to the organisation.

Executive Summary

The Board is requested to note:

1. Exception reports

- a. Exception reports are usually raised by trainees when there are differences in total hours worked or there is inability to take contractual rest breaks. They can be also raised when education and training opportunities are missed or there is inadequate support during service commitments
- b. In the new exception report reform, all trainees are required to finish an “access and completion” test. After implementation of the reforms, this is the first cohort where access and completion tests were completed on a timely basis. We had 39 completions in the first week. This is a direct reflection of work put in by the Medical staffing and Medical education in this aspect
- c. The current report will contain details of the exceptions raised from 1 June to 7 August. This is not a clear quarter period. Report has been done this way due to a discrepancy in the dates of earlier reports. The guardian would like to streamline the time periods and dates of submissions before the next report is due
- d. At the time of drafting total exception reports for the period are 25. The trend of increase in exceptions continues. As mentioned in my last report, this can be explained partly by increase in on-call workload after the new built wards on Kingsway became operational. Another reason might be the increase in uptake of reporting by trainees due to the additional anonymity provided by the new exception report reform. For rota workloads and possible mitigations, please refer to point 2
- e. Individual break-up of the exception reports and outcomes are discussed immediately after each table in the main report.

2. Rota workloads

- a. After scoping exercises and task and finish groups organised by Dr Machin, Trust South Deputy Director of Medical Education (DDME), some changes were put in place as of 17:00 hours on 20 July to address increased workload in the south
- b. E1 and E2 are two rotas for evening on call in the south
- c. During evening and long day shifts, the E1 RD will cover Radbourne Unit (to include calls from Derby Royal Hospital, eg A+E) as well as Dove Ward, Robin Ward and Wren Ward (Carsington Unit, Kingsway site). The E2 RD will cover the remaining clinical areas at Kingsway site. This represents an increase in the E1 workload and a reduction in the E2 workload hoping to make both rotas equitable
- d. An attempt is made to limit the number of admissions and hence waiting times for initial clerking during on call rotas. This is employed when there are five or more patients waiting to be clerked on a weekend long day, three or more during weekday evenings and two or more during night shifts.

- Bleep holders will be informed by the residents about the waiting times and the ultimate decision to hold further admissions will continue to lie with the bleep holder
- e. Feedback was sought from the leaving cohort on 4 August, and the changes will be formally reviewed on 17 of August.

3. Vacancies in trainee numbers

- a. There are three vacancies in higher trainee numbers in this rotation. All three are from the north.

Strategic Considerations		BAF Risk	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.			
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X	2A	2.1
Productive: We will improve our productivity and design and deliver services that are financially sustainable.			
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.			

Risks and Assurances

This report from the DHcFT GoSWH provides data about the number of RDs in training in the Trust, full transition to the 2016 RD contract and any issues arising therefrom. The report details arrangements made to ensure safe working within the new contract and arrangements in place to identify, quantify and remedy any risks to the organisation.

Consultation

- The GoSWH has shared the previous quarterly and annual reports to this
- with the Joint Local Negotiating Committee (JLNC), the Trust Medical Training Committee (TMTC), the Resident Doctor Forum (RDF) and its constituent RDs. Following presentation to this Committee, this report will be shared at the next RDF meeting, its constituent RD, the TMTC and the JLNC
- People and Culture Committee, 10 September 2026.

Governance or Legal Issues

None.

Net Zero Duty Implications

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

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

Not applicable.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

None.

Recommendations

The Board of Directors is requested to note the contents of the report and the mitigation planned or put in place to manage increase in exception reporting.

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

Report prepared by: **Dr Praveena Peddireddi**
 Guardian of Safe Working Hours

Guardian of Safe Working Hours (GoSWH) quarterly report

1. Resident Doctor (RD) data

For the period 1 June to 7 August

Numbers in post for RDs in training

Numbers of Doctors in post WTE	North	South
FY1	3	5
FY2	3	5
GP ST	3.8 (head count 4)	5.6 (head count 7)
CT	9.8 (head count 11)	10.6 (head count 11)
HSTs	7.4 (head count 8)	8.2 (head count 9)
Paediatrics ST	0	1.6 (head count 2)

Key

CT = Core training resident years 1-3

FY1/FY2 = Foundation year resident (years 1 and 2)

HST = Specialty training resident (ST) years 4-7

GP ST = General practice specialty registrar

Paediatrics ST = Paediatrics specialty training resident (year 4+)

2. Exception reports

Aggregated data, covering the period 1 June to 7 August

Location	No of exceptions raised	No of exceptions closed	No of exceptions outstanding
North	3	3	0
South	22	22	0
Total	25	25	0

- It is important to note that all three exception reports from the north were by the higher trainees who are on a non-resident on-call (NROC) rota
- Typically, most reports generated by higher trainees will be due to work generated from Mental health act assessments (MHAA)
- The Trust is working closely with the councils (both city and county) to address these and try to organise MHAAs during working hours
- There are several suggestions already under consultation in this direction
- Conclusions and action plans, if any, will be included in the next report.

Grade	No of exceptions raised	No of exceptions closed	No of exceptions outstanding
CT1-3	11	11	0
ST4-7	4	4	0
GP	5	5	0
Foundation	5	5	0
Total	25	25	0

Response time

Grade	48 hours	7 days	Longer than 7 days	Open
CT1-3	4	0	7	0
Foundation	0	0	5	0
ST4-7	0	0	4	0
GP	2	0	3	0

Action taken

Payment	15
Time off in lieu	3
Not agreed (pending review)	0
No Action	5
Withdrawn	1
Work schedule review	1
Total	25

- Marked delay in closing exception reports is due to time taken by the trainees to respond
- Most exception reports had their typical response between two to three days from the relevant responders (Medical staffing, DDME, etc)
- It appears as if trainees need more information about responding to queries through email and closing exceptions as needed
- This is unchanged since the last report. GoSWH organised face-to-face sessions with trainees as part of induction to address this and stressed the importance of closing reports in a timely manner
- Improvements, if any, will be seen in the next report.

3. Work schedule reviews

- One recommendation of work schedule review in this quarter
- Outcome of the review was not available at the time of drafting this report
- GoSWH will include this outcome in the next review.

4. Fines

- Current balance: The current total of fines available for the RDF to spend is £3,383.84 through cost code G62762.
- Fines' money set aside for a Board-supported away day for resident doctors.

5. Locum/Bank shifts covered (1 June to 7 August)

	North	Cost	South	Cost
Locum/bank shifts covered	18	11,240.00	39	24,363.60
Agency locum shifts covered	0	0	0	0

6. Agency Locum (1 June to 7 August)

Nil

7. Vacancies (1 June to 7 August)

	North	South
CT1-CT3	0.4	0.2
ST4-7	3	0
GP registrars	0.4	0.6
Foundation	0	0

8. Qualitative information

- Rota workloads

- Rota workloads continue to be heavy leading to increased stress in the RDs working on site, particularly in the south
- Urgent meetings were organised by the GoSWH with various resident representatives after expression of frustration by them about perceived slow progress of the task and finish group
- This led to escalation to the senior operational management, Medical staffing and the BMA with further discussions in the resident doctor forum chaired by the GoSWH
- RD on-call job profiles were adjusted to make the workload more equitable and manageable, particularly for the evening and weekend long day shifts (the E1 and E2 rotas)
- Feedback collected and the report generated were due on 17 August
- Further management and distribution of workload would depend on this report and will be made available for the Board in my next quarter report.

9. Compliance of rotas

Current work schedules are compliant with the 2016 resident doctor contract.

10. Other concerns raised with the GoSWH

None not already covered.

10 Point Plan to improve the working lives of Resident Doctors

Purpose of Report

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

Executive Summary

This report provides an update on the Trust's implementation of NHSE's *10 Point Plan for Improving the Working Lives of Resident Doctors*. The programme was introduced by NHS England in August 2025 to address key workforce challenges affecting Resident Doctors, namely 'getting the basics right for Resident Doctors'. The 10 points include wellbeing, rota management, annual leave, course reimbursement; car parking during on call shifts; training and workplace experience. In response, the Trust has made significant improvements on the 10 points, established governance arrangements through the People and Culture Committee, aligned reporting with the Guardian of Safe Working Hours (GoSWH) to support sustainable delivery and Board assurance on a quarterly basis.

The Trust's overall compliance score with the 10 Point Plan improved from 65% at baseline in September 2025 to 77% in December 2025, representing a 12% increase. Key achievements include the appointment of a Senior Lead for Resident Doctor Experience (SLRDE) and Resident Doctor Peer Lead (RDPL), implementation of annual leave guidance, improvements to study leave reimbursement processes, continued delivery of compliant rota arrangements, and the development of a comprehensive Board Assurance Framework. Resident Doctor feedback has also informed improvements to workplace wellbeing, including enhanced kitchen facilities, vending machines, library facilities, shared workspace and rest areas and initiatives to improve on-call parking arrangements. The details on the compliance is in the attached board assurance framework document and appendix attached. The Trust's detailed compliance with the 10 Point Plan can be found within the attached Board Assurance Framework report. Current compliance is positive, with 14 out of 17 in place and the remaining four items not applicable.

Whilst substantial progress has been made, several challenges remain. The Trust does not currently have a dedicated Rota Co-ordinator for Resident Doctors, with rota management continuing through joint working between Medical staffing and Medical Education impacting on compliance with rota and scheduling transparency in recent months due to staff sickness. The Executive Medical Director is working with Director of People, Organisational Development and Inclusion to review the Human Resource support to the Medical Education alongside Medical Directorate.

In addition, response rates to the 2024 and 2025 National Education and Training Survey (NETS) were limited, restricting the availability of benchmarking data. An action plan has been developed to improve engagement with future surveys, and the Trust awaits the 2026 survey results which is due to be circulated in early Autumn 2026 to provide further evidence of impact. A separate report relating to the on call rota in the south of Derbyshire will be presented to the Board.

Overall, the Trust is well placed to continue embedding the 10 Point Plan within business as usual arrangements. The next phase of work will focus on demonstrating measurable outcomes, strengthening links with quality and educational assurance processes, and maintaining Resident Doctor engagement to support continued improvement in workforce experience, wellbeing and retention. The Board is asked to receive significant assurance regarding progress to date and support the ongoing implementation of the programme.

Strategic Considerations		BAF Risk	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X Workforce wellbeing and training environment contribute to safe, effective patient care	1A	1.1 Improve safety and effectiveness in line with our quality ambitions
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X Workforce attraction, retention, wellbeing and engagement	2A	2.1 Be recognised for attracting and retaining the best people 2.4 Be recognised as a Trust that supports and promotes the wellbeing of our people
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X Improved rota management, annual leave processes and reimbursement arrangements improve workforce efficiency	3A	3.1 achieve financial sustainability through improved clinical and operational productivity
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X Collaborative working with NHSE, the East Midlands Deanery and regional trusts, Medical Education, Guardian of Safe Working Hours	4A	4.1 Build partnerships that deliver on the needs of our communities

Risks and Assurances

- Failure to implement the 10 point plan may jeopardise the Trust's standing as a postgraduate local education provider, and in turn impacting patient care.

This report provides significant assurance that:

- The Trust has established appropriate Executive leadership, governance and accountability arrangements to oversee delivery of the NHSE 10 Point Plan to improve the working lives of Resident Doctors
- Compliance with the national programme has improved from 65% to 77% from the baseline assessment in August 2025 to the 12 week follow up assessment in December 2025, showing a 12% improvement
- The programme has transitioned from a stand-alone initiative towards a sustainable business-as-usual model as per NHS England guidance through existing workforce governance structures and from October 2026 compliance will be reported through the Education Quality Framework and provider self-assessment report (PSAR)
- Compliance will therefore be reported through the Board Assurance Framework document as recommended by NHSE (appendix).

Consultation

- Consultation has taken place with Dr Girish Kunigiri, Senior Lead for the 10 Point Plan; Dr Rachel Gorny, Peer Lead for the 10 Point Plan; Medical staffing and Resident Doctor representatives. This is primarily through the Resident Doctor Forum and Trust Medical Training meetings
- People and Culture Committee, 10 September 2026.

Governance or Legal Issues

NHS England has set out clear expectations for all trusts to achieve within a limited time frame. This includes embedding the role of Resident Doctor Peer Lead (RDPL) and embedding the work as business as usual. From October, the 10 Point Plan will be in the Education quality framework and the PSAR.

Net Zero Duty Implications

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

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

Digital Transformation: Minor reduction in expected emissions through planned electronic rostering and streamlined workforce administration processes. No material impact on the Trust's Net Zero objectives has been identified.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

The initiatives described are intended to improve staff experience, wellbeing, engagement, access to support, and employment processes for all Resident Doctors and are therefore, anticipated to have an overall positive impact across the workforce. No adverse impacts have been identified at this stage.

Assessment of potential equality impacts has been informed through engagement with Resident Doctors via baseline and progress surveys, feedback gathered through the Resident Doctors Forum, consultation with Resident Doctor representatives and the Resident Doctor Peer Lead and ongoing discussions with the Directors of Medical Education and Senior Lead for Resident Doctor Experience. These mechanisms provide opportunities for engagement with Resident Doctors from all protected characteristic groups and foster engagement between Resident Doctors, educational leaders, and Trust management.

Improvements to rota management, annual leave processes, exception reporting, study leave arrangements, workplace wellbeing facilities, and rest areas may support staff with disabilities, those who are pregnant or returning to work following maternity leave, staff with caring responsibilities and those requiring greater flexibility in working arrangements. Improved communication and representation structures may also help ensure that concerns relating to race, religion or belief, sex, sexual orientation, gender reassignment, age, marriage and civil partnership are identified and addressed in a timely manner.

Recommendations

The Board of Directors is requested to:

1. Note the progress on NHSE 10 Point Plan for Improving the Working Lives of Resident Doctors in the Trust
2. Note significant compliance in regard to the Board Assurance Framework September 2026.

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

Report prepared by: **Dr Rachel Gorny**
 Resident Doctor Peer Lead (RDPL)

Resident Doctor Board Assurance Framework v1.0						
	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance Rating
1. Workplace wellbeing – Ensuring that audit has taken place and improvement plans developed to address any gaps, supported by Resident Doctor Peer Lead.						
Organisational or board systems and process should be in place to ensure that:						
1.1	Completed baseline audit	Completed August 2026				3. Compliant
1.2	Approved improvement plan in place	Board report December 2025			SI senior lead and Peer Lead in place, annual leave guidance implemented	3. Compliant
2. Rota transparency – Compliance with 8-week schedules, 6-week rotas with improvement plans in place where performance needs to improve.						
System and process are in place to ensure that:						
2.1	Compliant with 6- and 8-week rota standards	Rotas are managed between Medical Education and Medical staffing		Personalised rotas are distributed 8 weeks or more prior to start date, due to staff sickness and lack of dedicated Rota Co-ordinator some personliased rotas were not disributed within recommended rota standards		2. Partially compliant
2.2	Clear monitoring of compliance and reported at Board sub-committee level		The Trust has made significant improvements on the 10 points, established governance arrangements through the People and Culture			3. Compliant
3. Annual leave reform – Adoption of national best practice initiatives						
System and process are in place to ensure that:						
3.1	Adopted the local annual leave local rules and process questionnaire	New annual leave guidance has been embedded from spring 2026				3. Compliant
3.2	Completion of Rota Co-ordinator training	N/A	No current Rota Co-ordinator			0. Not applicable
4. Board-level leadership – Senior leads and peer representatives are in place						
System and process are in place to ensure that:						
4.1	Appointed Resident Doctor Senior Board Lead and a Non-Executive Director for Resident Doctors'	Dr Girish Kunigiri (MD)				3. Compliant
4.2	Appointed Resident Doctor Peer Lead and they are engaged in line with national guidance	Dr Rachel Gorny, HST				3. Compliant
4.3	Robust progress updates in place which involve Resident Doctor	Yes, Peer Lead is involved in all progress updates				3. Compliant
4.4	Clear support plan in place to assist the RDPL	Supported through RDF/DME/senior peer lead meetings, Resident Doctor Forum and Trust Medical Training Committee				3. Compliant
5. Payroll accuracy – Trusts have commenced payroll improvement activity and are monitoring						
System and process are in place to ensure that:						
5.1	Implementing payroll improvement methodology	ESR/Payroll input prioritised within responsible processing teams				3. Compliant
5.2	Reduction in payroll errors	Monthly monitoring in place to ensure improving / satisfactory position				3. Compliant
5.3	Monthly error reporting compliance undertaken	National reporting of under and over payments in place				3. Compliant
6. Mandatory Training – no unnecessary duplication and MLOGs in place and working with RDs						
System and process are in place to ensure that:						
6.1	Signed MoU and processes in place for monitoring that no unnecessary training is being repeated	Training is logged on ESR		Training logs are now portable through ESR and RDs can contact People services team if gaps occur		3. Compliant
6.2	Mandatory Training Local Oversight Group (MLOG) in place	TMTC		Monitored in TMTC		3. Compliant
6.3	The MLOG involves Resident Doctors in ensuring that local STATMAN requirements are necessarily and proportionate	TMTC		Monitored in TMTC		3. Compliant
7. Exception reporting – Adoption of new national framework						
System and process are in place to ensure that:						
7.1	Clearly communicated new approach and local processes to all Resident Doctors	Through Dr Peddireddi, GoSWH and communicated to Resident Doctors during induction and RDF meetings/TMTC				3. Compliant
7.2	Implemented local and national data reporting requirements	This is reported through GoSWH report	Due to being a smaller Trust, doctors may have roles as GoSWH/Medical Education as well as direct/Clinical Supervisor roles	An advice and consent document is being developed to allow RDs to choose an alternative CS or Consultant to raise concerns with	Timeline for target compliance is by December 2026	2. Partially compliant
8. Expense reimbursement – Adoption of fast-track course costs						
System and process are in place to ensure that:						
8.1	Adopted new reimbursement process	Yes re audit 2026				3. Compliant
8.2	Meeting target reimbursement time of 6 weeks.	Yes				3. Compliant
8.3	Doctor satisfaction meeting ≥80% target	Based on GMC NTS 2025 survey overall satisfaction of resident Doctors was 79.43 (national average 78.4) we are above the national average in overall satisfaction but under the target of 80%	We fall slightly below the national average scores for clinical supervision; educational supervision and governance and study leave were slightly below average. These have been addressed and we are awaiting the 2025 NETS survey results and the GMC 2026 NTS results			2. Partially compliant

Trust Flu Vaccination Plan - 2026/27

Purpose of Report

This report provides an overview of the Trust Flu Vaccination Plan - 2026/27 for frontline healthcare workers for the 2026/27 flu season against a set target of 48.6%.

Executive Summary

This report provides an overview of the Trust's 2026/27 flu vaccination plan for frontline healthcare workers. The plan builds on the 2025/26 campaign, where the Trust achieved 43.6% uptake, and proposes a 2026/27 ambition of 48.6%, rounded to 49%, representing a 5 percentage point year-on-year improvement. ESR occupation code flagging currently identifies 1,876 staff as frontline. Against this denominator, a 49% uptake ambition equates to approximately 919 staff vaccinations. With 1,200 doses ordered, the current supply is sufficient to cover the projected staff uptake and provide capacity for eligible patient vaccination within the programme.

Delivery will be through a peer vaccinator-led model supported by the Physical Health Hub, Pharmacy, Communications and Engagement, People services, Divisional leadership and the existing Derbyshire Community Health Services (DCHS) service level agreement (SLA). The model is designed to improve access for ward-based, Community, shift-working and Corporate staff through local vaccination sessions, walk-in and bookable clinics, roving support, DCHS site access and targeted communications.

However, there is a supply and wastage risk to manage. If uptake is significantly higher than anticipated, the ordered stock may not be sufficient to meet all staff and patient demand. Conversely, if uptake is lower than planned, unused vaccine stock may result in avoidable wastage. This wastage risk may be increased by the peer vaccinator model if vaccine stock is distributed across numerous Trust fridges and local storage points, making stock visibility, redistribution and timely use more complex. Pharmacy and the Flu Vaccination Steering Group will therefore monitor usage, uptake, remaining stock and storage locations throughout the campaign to inform redistribution, escalation or wastage mitigation actions.

Key risks relate to timely identification and release of peer vaccinators, cold chain capacity, vaccine storage and transport arrangements, data quality and reconciliation through the Record a Vaccine Service (RAVS), ESR and the Federated Data Platform (FDP), staff awareness or hesitancy, and the need to evidence vaccination offers for eligible long-stay Inpatients and patients discharged to care homes. Transport is a particular operational risk because the Trust does not have daily deliveries to all Trust sites, including northern and many southern locality areas. These risks are mitigated through divisional oversight, pharmacy governance, additional administrative support, targeted communications, weekly uptake monitoring during peak delivery, and escalation through the Flu Vaccination Steering Group and Trust Delivery Group (TDG).

Strategic Considerations		BAF Risk(s)	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X		
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X	2a and 2b	2.4
Productive: We will improve our productivity and design and deliver services that are financially sustainable.			
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.			

Risks and Assurances

Key risks

- Peer vaccinators may not be identified, trained or released consistently across all teams, creating a risk that the peer vaccinator-led model does not provide sufficient coverage across inpatient, community and corporate settings
- Cold chain capacity, storage arrangements and vaccine transport processes require confirmation before launch, particularly where delivery is planned across multiple localities. Transport is a potential risk because the Trust does not have daily deliveries to all Trust sites, including northern and many southern locality areas
- Vaccine supply may not match actual demand if uptake differs materially from the 49% planning assumption: higher than anticipated uptake could create a shortfall, while lower uptake could result in wastage of unused stock. The peer vaccinator model may also increase wastage risk if stock is held across numerous Trust fridges and local storage points
- There is a risk that uptake may not reach the proposed 49%, if staff fatigue, hesitancy, access barriers or limited local engagement reduce participation
- Data quality and reporting may be affected by ESR frontline healthcare worker flagging, RAVS upload timeliness, FDP reconciliation and external vaccination declarations
- There is a risk of over-reliance on limited administrative capacity to support RAVS uploads, data reconciliation, reporting and campaign monitoring
- Staff may remain unaware of access routes if communications are not repeated, locally targeted and clear about peer vaccinator sessions, central clinics and DCHS SLA arrangements
- Offers of vaccination to eligible long-stay inpatients and patients discharged to care homes may not be consistently evidenced unless ward-level recording and digital reporting processes are strengthened
- High sickness rate, there has been an increase in staff increase rate which stands at 6.79%. When staff are unwell due to certain illnesses may not be eligible for vaccination which may adversely impact vaccination uptake.

Key assurances

- A 2026/27 flu vaccination delivery plan is in place, with a proposed frontline healthcare worker uptake target of 48.6%, rounded to 49%, representing a five percentage point improvement on the 2025/26 uptake of 43.6%
- ESR occupation code flagging identifies 1,876 frontline staff.

A 49% uptake assumption equates to approximately 919 staff vaccinations; with 1,200 doses ordered, current supply is sufficient to cover the projected staff uptake and eligible patient vaccination requirements, subject to active stock monitoring

- The campaign will be delivered through a peer vaccinator-led model, supported by the Physical Health Hub, Pharmacy, Communications and Engagement, People Services and Divisional leadership
- The existing DCHS SLA will remain in place to provide additional access routes for staff, including access to DCHS vaccination sites where appropriate
- Governance oversight will be provided through the Flu Vaccination Steering Group, with reporting through the TDG and relevant People, Quality and Infection Prevention and Control (IPC) governance routes
- Weekly uptake monitoring during peak delivery will support early identification of low uptake areas and enable targeted Divisional action
- Recording and reporting arrangements will use RAVS, ESR frontline healthcare worker flagging, FDP reconciliation and local validation to strengthen data assurance
- The communications approach includes leadership cascade, targeted staff messaging, FAQs, frontline staff stories, peer vaccinator visibility and a planned staff survey to inform engagement and access planning
- Patient vaccination offer and recording for eligible long-stay inpatients and patients discharged to care homes will be strengthened through ward-level review, discharge documentation and digital reporting where feasible
- Staff wellbeing plans and support are in place to address increased staff sickness rates.

Consultation

- Pharmacy Department
- Deputy Director of Nursing and Quality
- Divisional Head of Clinical Practice
- Care Group Heads of Clinical Practice
- Physical Health Hub
- Clinical Matrons
- People and Culture Committee, 10 September 2026.

Governance or Legal Issues

- The Flu Vaccination programme will be delivered in line with national seasonal flu vaccination guidance, infection prevention and control requirements, medicines governance and Trust policy
- Governance oversight will be provided through the Flu Vaccination Steering Group, with reporting through the TDG and relevant People, Quality and IPC governance routes
- The Pharmacy team will provide medicines governance oversight, including vaccine supply, cold chain, storage, transport, Patient Group Direction (PGD) or written instruction arrangements, and escalation of any medicines safety incidents
- Peer vaccinators will be required to complete appropriate training and competency assurance before administering vaccinations, with clear arrangements for consent, contraindications, documentation, anaphylaxis response and incident escalation
- Vaccination records and uptake reporting will be managed through RAVS, ESR frontline healthcare worker flagging, FDP reporting and local reconciliation, with appropriate information governance controls in place
- The existing DCHS SLA will require clear clinical governance, data sharing, cold chain, incident reporting and escalation arrangements for any vaccinations administered to Trust staff through DCHS access routes.

Net Zero Duty Implications

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

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

N/A.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

No inherent adverse equality impact has been identified. However, unequal access or uptake could arise if the vaccination programme is not delivered consistently and equitably.

The delivery model is designed to reduce barriers through peer vaccinators, inpatient and community-based delivery, sessions around shift changes, DCHS vaccination sites, roving clinics and accessible communications.

Specific consideration will be given to staff who may face barriers linked to disability, pregnancy, working patterns, geographical location, religion or belief, language or communication needs or other protected characteristics.

Uptake will be monitored by division, staff group and geography, with demographic analysis undertaken where data quality and sample sizes allow. Any material variation will be reviewed to identify potential access, communication or equality-related barriers, with targeted action taken where needed.

Equality considerations will be overseen by the Flu Vaccination Steering Group throughout the campaign and reflected in the end-of-season evaluation.

Recommendations

The Board of Directors is requested to receive significant assurance that a comprehensive delivery model is in place to support achievement of the Trust's 2026/27 frontline healthcare worker flu vaccination ambition of 49% and that the plan recognises the operational challenges to delivery and through the flu steering group these will be actively managed.

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

Report prepared by: **Joseph Thompson**
 Associate Director of Physical Health and Quality

Purpose

The purpose of this plan is to set out the Trust's approach to improving flu vaccination uptake for frontline healthcare workers during the 2026/27 seasonal vaccination campaign. The plan supports winter preparedness, infection prevention and control (IPC), staff wellbeing, patient safety and service resilience.

The plan builds on the Trust's 2025/26 campaign, which was co-ordinated through the Health Protection Unit and Pharmacy service, with the Trust exceeding the national Federated Data Platform (FDP) target of 40.7% and achieving 43.34% in the IPC update report. The Trust's submitted Staff Flu Plan also records a 2025/26 flu uptake figure of 0.436 and identifies a presumed 5% improvement ambition.

Proposed 2026/27 target: achieve 48.6% uptake, rounded to 49%, for frontline healthcare workers, representing a five percentage point improvement on the 2025/26 uptake of 43.6%.

Strategic aims

The 2026/27 flu campaign will aim to:

- Increase frontline healthcare worker flu vaccination uptake from 43.6% to **48.6% (49%)**
- Provide a clear, accessible and equitable vaccination offer to all eligible staff
- Implement a peer vaccinator model across Inpatient, Community and Corporate settings
- Maintain access through the existing service level agreement (SLA) arrangement with Derbyshire Community Health Services (DCHS), including access to DCHS vaccination sites where appropriate
- Strengthen recording and reporting through the Record a Vaccine Service (RAVS), FDP and local data reconciliation
- Ensure eligible long-stay Inpatients and patients being discharged to care homes are offered vaccination and that this offer is evidenced
- Use targeted communications, trusted peer voices and frontline staff stories to improve engagement.

National and system context

The national 2026/27 flu programme confirms that all frontline healthcare workers, including clinical and non-clinical staff who have contact with patients, should be offered flu vaccination from 1 October as part of organisational policy to prevent the transmission of flu. NHS England's 2026/27 flu programme also identifies the need for trusts and Integrated Care Boards (ICBs) to reduce variation in uptake, with particular focus on frontline healthcare workers.

National 2025/26 data showed frontline healthcare worker uptake across NHS trusts in England was 45.0%, an increase of 7.5 percentage points from the previous season, but with significant variation between organisations. This reinforces the need for a practical, accessible and locally owned model for Derbyshire Healthcare NHS Foundation Trust.

Governance and leadership

The campaign will be overseen through a Flu Vaccination Steering Group, reporting through Trust Delivery Group and relevant People, Quality and IPC governance routes.

Area	Lead/route	Key responsibility
Executive leadership	Tumi Banda and Rebecca Oakley	Executive oversight for staff vaccination, winter preparedness and workforce engagement.
Operational delivery	Associate Director Physical Health and Quality and Physical Health Hub, supported by Pharmacy and People services	Delivery model, peer vaccinator training, clinic coordination, data capture and escalation.
Pharmacy governance	Chief Pharmacist/Pharmacy team	Vaccine supply, cold chain, storage, PGD/ written instruction governance and medicines safety.

Area	Lead/route	Key responsibility
Communications	Communications and Engagement team	Staff campaign, frontline stories, FAQs, intranet content, leadership cascade and myth-busting.
Divisional accountability	Divisional Boards/Care Group leadership	Release of peer vaccinators, local uptake oversight, targeted support for low uptake areas.
System partnership	DCHS/JUCD Seasonal Vaccination Sub Group	Mutual access arrangements, System learning, escalation of barriers and benchmarking.

Delivery model

The 2026/27 campaign will use a peer vaccinator-led model, supplemented by central clinics, DCHS SLA access and targeted Physical Health Hub support.

Peer vaccinator approach

The Trust's submitted plan states that delivery will be **peer vaccinator led with support from the Trust Physical Health Hub**. Staff members have come forward who will be trained and supported to deliver vaccinations within their own areas, shifting the model from a primarily clinic-based approach to vaccination closer to staff places of work.

Delivery assurance for 49% uptake ambition

Assurance is provided that plans are in place to deliver a frontline healthcare worker flu vaccination programme designed to achieve the 2026/27 uptake ambition of 48.6%, rounded to 49%. The vaccination offer will be available to all eligible frontline healthcare workers from 1 October 2026 to 31 March 2027, with delivery focused on completing the majority of vaccinations by 30 November 2026 to support winter preparedness and maximise protection ahead of peak seasonal pressure.

The offer will include both walk-in and bookable appointments, supported by peer vaccinators, local vaccination sessions, roving clinics, DCHS SLA access and targeted support for areas where access or uptake is lower. This blended delivery model is intended to improve convenience for ward-based, Community, shift-working and Corporate staff and reduce barriers to vaccination.

Frontline healthcare worker vaccination activity will be recorded on the RAVS system. A frontline healthcare worker flag will be applied to ESR records for all clinical and non-clinical staff who have direct contact with patients, enabling accurate reporting through FDP and supporting reconciliation of uptake data throughout the campaign.

Implementation approach

- Identify potential peer vaccinators through the existing Physical Health Champions network and clinical lead structures
- Confirm that peer vaccinators are registered staff where required for vaccine administration
- Use a Microsoft Form or equivalent to confirm willingness, role, base, division, clinical registration and training needs
- Map peer vaccinators by geography, service line, inpatient site, community base and corporate area
- Identify gaps and agree mitigations with operational managers
- Provide protected time for training and delivery
- Each peer vaccinator will be asked to offer a small number of planned vaccination sessions within their locality or team, with dates publicised locally.

Central and roving clinic offer

The peer vaccinator model will be supplemented by:

- Trust-wide bookable and walk-in clinics
- Physical Health Hub-led clinics at priority sites

- Pop-up clinics aligned to induction, training events, team meetings and staff engagement events
- Targeted roving support for low uptake services
- Out-of-hours access where possible, particularly for night staff and shift workers.

The planning discussion identified the value of offering sessions first thing in the morning and later in the day to capture night staff and staff finishing shifts.

DCHS SLA offer

The existing SLA with DCHS will remain a key route for access, particularly for staff based near DCHS vaccination sites.

The SLA should confirm:

- Which DCHS sites Derbyshire Healthcare staff can access
- Whether access is walk-in, bookable or both
- How DCHS-administered vaccinations will be reported back to Derbyshire Healthcare
- How data will be entered or reconciled into RAVS / FDP
- Cold chain, clinical governance and incident reporting arrangements
- Named operational contacts for both organisations
- Escalation process for access, supply or recording issues.

Training and competency

Peer vaccinators will complete the required theoretical and practical training before vaccinating staff.

Training will include:

- Vaccine administration
- Vaccine specific awareness
- Consent and contraindications
- Cold chain awareness
- Documentation and RAVS recording requirements.

Peer vaccinators will be required to confirm compliance with Trust mandated training for basic life support inclusive of anaphylaxis recognition and response and infection prevention and control.

The Physical Health Hub will provide practical support and competency sign-off where appropriate.

Peer vaccinators will be recognised through a visible identifier, such as a badge or lanyard, and through local recognition routes.

Vaccine supply, storage and cold chain

Vaccine supply, storage and handling will be managed by the Trust Pharmacy team. ESR occupation code flagging currently identifies 1,876 staff as frontline. Based on the 49% uptake ambition, this would require approximately 919 staff vaccine doses. The Trust has ordered 1,200 doses, which is sufficient to support the projected staff uptake and provide capacity for eligible patient vaccination, assuming uptake remains broadly in line with planning assumptions.

The key operational risk is variance from the planned uptake assumption. If staff uptake is significantly higher than 49%, available stock may not be sufficient to cover all staff and patient demand. If uptake is lower than anticipated, unused vaccine stock may result in wastage. There is also a potential increase in vaccine wastage risk associated with the peer vaccinator model, as vaccines may be stored across numerous Trust fridges and local storage points, increasing the need for robust stock visibility, temperature monitoring, redistribution and return of unused stock. Transport is an additional risk, as daily deliveries are not available to all Trust sites, including northern and many southern locality areas. This may affect the timely movement of vaccine stock, redistribution between sites and return of unused doses. Therefore, the Pharmacy team and Flu Vaccination Steering Group will monitor doses administered, remaining stock, storage locations, projected demand, transport routes and wastage risk throughout the campaign.

Operational requirements will include:

- Confirmation of vaccine delivery date and quantity
- Identification of approved vaccine storage points in the north and south of the county
- Pharmacy-approved cold chain process for peer vaccinator sessions
- Use of appropriate vaccine transport bags or cold boxes
- Confirmation of transport routes and contingency arrangements for sites without daily deliveries, particularly northern and southern locality areas
- Confirmation of medicine fridge capacity, particularly in northern localities
- Enhanced monitoring of stock held across multiple Trust fridges to reduce wastage risk linked to the peer vaccinator model
- Clear process for vaccine collection, transport, administration and return of unused stock
- Daily reconciliation of vaccine use, wastage and remaining stock
- Escalate through the Flu Vaccination Steering Group if uptake tracking indicates a likely shortfall in available stock or avoidable wastage.

Data, recording and reporting

Accurate recording and reporting will be central to delivery and assurance.

The Physical Health Hub will be responsible for recording and reporting alongside trained peer vaccinators. RAVS is the system used for recording vaccinations, with outputs feeding national reporting through FDP. All frontline healthcare workers, including clinical and non-clinical staff in direct contact with patients, will be flagged on ESR to ensure that the information extracted through to FDP is accurate.

Key actions

- Maintain RAVS access for vaccinating staff and administrative staff
- Add additional administrators to avoid single point of failure
- Establish daily upload processes during the first phase of the campaign
- Reconcile internal vaccination records with FDP data
- Capture staff who receive vaccination externally, for example via GP or Community pharmacy. How?
- Validate ESR frontline healthcare worker flagging for clinical and non-clinical staff in contact with patients
- Report uptake weekly via Flu vaccination group during peak campaign delivery, then fortnightly or monthly as uptake stabilises. Update on progress will be provided to Trust delivery group as they fall along with any escalations and paper to People and Culture Committee
- Use Divisional dashboards to identify low uptake services and target support.

There is a known reporting risk linked to ESR and external vaccination data. The Trust's Staff Flu Plan identifies a long-standing issue where variation between GP and ESR personal information can affect registration of vaccination status.

Communications and engagement

The campaign will use a phased communications approach, focusing on accessibility, trust and relevance to frontline staff.

The Trust plan identifies the Communications and Engagement Team as leading the communication and engagement plan. Previous lessons learned confirm that communications are core to delivery, that patient safety messaging is important, that personal testimonies from senior leaders and trusted colleagues are valuable, and that system-aligned communications materials will be beneficial. A vaccination web page will also be set up as a resource for both peer vaccinators and staff requiring information around vaccinations.

Communication principles

- Use frontline staff voices, not only executive messaging
- Keep messages short, practical and repeated through different channels
- Focus on protecting patients, colleagues, families and service resilience
- Avoid making vaccination feel like a Corporate target
- Make access routes clear and easy
- Address myths and concerns directly through FAQs

- Reinforce that the vaccine is free for eligible staff.

Microsoft Teams staff survey

A Microsoft Teams survey will be issued to all staff at the start of the campaign to ask whether they intend to have the flu vaccination and, where staff indicate that they do not intend to be vaccinated, to provide the main reason. The survey responses will be used to support operational planning, including the scheduling and location of vaccination clinics, identification of teams or staff groups requiring additional access, and targeted communications to address common concerns, dispel myths and support compliance with the Trust's winter resilience and infection prevention priorities.

Proposed communication phases

Phase	Timing	Focus
Preparation	August 2026	Brief operational managers, call-out for peer vaccinators, prepare FAQs, map champions and confirm training requirements.
Engagement	September 2026	Leadership cascade, Physical Health Champion webinar to explain the model and benefits. Trust-wide launch, intranet page, booking link, DCHS access routes
Launch	1 October 2026	Peer vaccinator map and Executive/frontline launch content.
Peak delivery	October to December 2026	Weekly uptake updates, local sessions, frontline staff stories, myth-busting, targeted reminders, Divisional escalation.
Mop-up	January to March 2027	Target low uptake teams, offer catch-up clinics, focus on new starters, external vaccination capture and data reconciliation.

Equity of access

The campaign will aim to ensure all eligible frontline staff have a clear and practical opportunity to receive vaccination.

Equity actions:

- Offer vaccination across Inpatient, Community and Corporate sites
- Provide sessions at shift change times and during team meetings
- Use peer vaccinators to reduce travel and improve convenience
- Maintain DCHS site access through SLA
- Provide information in accessible formats
- Monitor uptake by division, staff group and geography where data allows
- Review demographic patterns if available to identify variation in uptake.

Patient vaccination and discharge to care homes

The Trust will ensure that eligible long-stay inpatients and patients discharged to care homes are offered flu vaccination prior to discharge. This will be done in conjunction with the Trust Digital team via a questionnaire within SystmOne.

Actions:

- Confirm eligibility criteria in line with Green Book guidance
- Use ward-level weekly review to identify eligible patients
- Record vaccination offered, accepted, declined or contraindicated
- Include vaccination status or offer status in discharge documentation where appropriate
- Explore SystmOne reporting fields or tick-box functionality
- Report compliance through the Flu Vaccination Steering Group and IPC governance.

Improvement trajectory and milestones

The target for 2026/27 is **48.6% uptake among frontline healthcare workers, rounded to 49%**, representing a five percentage point improvement on the confirmed 2025/26 uptake of 43.6%.

Milestone	Proposed expectation
Campaign launch	1 October 2026
First clinic delivery wave	Week commencing 5 October 2026
Peer vaccinator coverage map complete	Before launch
Initial uptake review	End of October 2026
Mid-campaign checkpoint	End of November 2026
Peak delivery checkpoint	End of December 2026
Mop-up and targeted support	January to March 2027
Final evaluation	April 2027

Indicative uptake trajectory, with the majority of vaccinations expected to be completed by 30 November 2026:

Date	Proposed cumulative uptake ambition
End October 2026	20%
End November 2026	34%
End December 2026	42%
End January 2027	46%
End February 2027	48.6%
End March 2027	Maintain at or above 48.6% (49%)

Risks and mitigations

Risk	Mitigation
Peer vaccinators not identified in all teams	Use Physical Health Champion list, Divisional mapping and operational manager escalation. Physical Health Hub to cover gaps.
Staff not released for training or clinics	Executive and Divisional leadership message confirming protected time and operational expectations.
Cold chain constraints, particularly in northern localities	Confirm Pharmacy-approved storage points, transport process and cold chain equipment before launch.
Inaccurate uptake data due to ESR/GP data mismatches	ESR flag validation, RAVS admin support, external vaccination self-declaration and FDP reconciliation.
Low uptake due to fatigue or hesitancy	Use trusted peer voices, FAQs, team-based engagement and concise safety messaging, focused on choice, facts and patient protection.
Vaccine supply does not match actual uptake: higher than anticipated uptake may create a stock shortfall, while lower uptake may result in wastage. Wastage risk may be increased if vaccine stock is distributed across numerous Trust fridges as part of the peer vaccinator model.	Monitor uptake, doses administered, remaining stock and fridge locations weekly through Pharmacy and the Flu Vaccination Steering Group; escalate early if projected demand exceeds supply, if stock cannot be redistributed effectively, or if wastage risk increases.
Vaccine transport arrangements may not support timely delivery, redistribution or return of unused stock because daily deliveries are not available to all Derbyshire Healthcare NHS Foundation Trust sites, including northern and many southern locality areas.	Agree Pharmacy-approved transport routes, collection points, contingency arrangements and escalation triggers before launch; monitor transport issues through the Flu Vaccination Steering Group.
Staff report lack of awareness or access	Use leadership cascade, Focus, staff social media, team meetings, peer vaccinators and DCHS access routes.

Risk	Mitigation
Patient discharge offer not evidenced	Add local documentation process, weekly ward review and discharge summary recording where feasible.

Assurance measures

Measure	Reporting route
Frontline healthcare worker uptake against 48.6% target, rounded to 49%	Flu Vaccination Steering Group, TDG, People and Culture Committee
Number and distribution of peer vaccinators	Flu Vaccination Steering Group and divisional boards
Number of clinics delivered	Flu Vaccination Steering Group
DCHS SLA access utilisation	Flu Vaccination Steering Group
RAVS upload timeliness	Physical Health Hub
External vaccination declarations	Physical Health Hub/Workforce
Low uptake teams and targeted actions	Divisional governance
Eligible Inpatients/care home discharge offers	IPC/Quality governance
Lessons learned	End-of-season review

Summary

The Trust is asked to approve the proposed 2026/27 flu vaccination delivery model, noting that the campaign will be peer vaccinator led and supported by the existing SLA with DCHS. The proposed frontline healthcare worker uptake target for 2026/27 is **48.6% (rounded to 49%)**, representing a five percentage point improvement on the 2025/26 uptake of 43.6%. ESR occupation code flagging identifies 1,876 staff as frontline; a 49% uptake ambition equates to approximately 919 staff vaccinations. With 1,200 vaccine doses ordered, current supply is sufficient to cover projected staff uptake and eligible patient vaccination requirements, provided uptake remains broadly in line with the planning assumption.

- The Board is asked to note the stock risk: if uptake is significantly higher than anticipated there may not be sufficient vaccine to meet demand, while lower than anticipated uptake could result in wastage
- The Board is also asked to note the transport risk, as daily deliveries are not available to all Trust sites, including northern and many southern locality areas, which may affect timely stock movement, redistribution and return of unused doses
- Additional administrative resource will be required to support RAVS uploads, data reconciliation and campaign reporting
- Divisional leaders will be expected to support release of peer vaccinators and local uptake improvement
- Patient vaccination offer and recording for eligible long-stay inpatients and patients discharged to care homes will be strengthened through ward-level processes and digital reporting where feasible.

Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports (2025/26)

Purpose of Report

To present the Trust's 2025/26 WRES and WDES annual reports, provide assurance on the key findings and set out the priority actions for 2026/27.

Executive Summary

The 2025/26 WRES and WDES reports demonstrate continued progress in workforce representation and data quality, alongside areas where further improvement is required.

WRES data shows BME representation increased from 20.4% in 2025 to 25.5% in 2026 (894 colleagues), with BME Board representation at 42.9%. However, disparities remain in recruitment and progression. White applicants were 2.29 times more likely to be appointed following shortlisting, compared with 1.81 in 2025, and BME colleagues remain under-represented at senior levels. Reported discrimination amongst BME colleagues reduced from 14.8% to 13.9%, although a disparity with White colleagues remains.

WDES data shows disability declaration increased from 11.5% in 2025 to 12.7% in 2026 (445 colleagues), strengthening the quality of workforce data. Recruitment outcomes remain close to parity, moving from 0.90 to 0.94. The formal capability indicator reduced from 13.23 to 2.27. However, this is based on very small numbers and should be interpreted with caution. Reasonable adjustments remain a positive area, with 82.5% of colleagues with a long-term condition or illness reporting that appropriate adjustments had been made.

Overall, the data demonstrates positive progress in representation and workforce data quality, while highlighting continued disparities in recruitment, progression and staff experience. The 2026/27 WRES and WDES action plans have been developed in response to these findings and will provide the framework for targeted improvement and ongoing assurance.

Progress will be monitored through quarterly workforce reporting, Staff Survey findings, Employee Relations and Freedom to Speak Up intelligence and staff feedback, with oversight through established Trust governance arrangements.

Strategic Considerations		BAF Risk	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.			
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X	2A/B	2.1 to 2.4
Productive: We will improve our productivity and design and deliver services that are financially sustainable.			
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.			

Risks and Assurances

- Key risks are persistent inequalities in recruitment, progression and staff experience; under-representation in senior roles; bullying, harassment and discrimination; pressure experienced by Disabled staff to attend work when unwell; and gaps in workforce declaration/data quality
- Assurance is provided through the WRES and WDES 2026/27 action plans, quarterly workforce monitoring, Staff Survey and Employee Relations intelligence, staff network feedback, inclusive recruitment activity, reasonable adjustments work and reporting through the Trust's governance arrangements.

Consultation

The reports will be shared with relevant staff networks and the People and Inclusion team. WRES and WDES findings are also informed by workforce data, Staff Survey results, Freedom to Speak Up themes, Employee Relations data, recruitment information and staff feedback.
People and Culture Committee, 10 September 2026

Governance or Legal Issues

N/A.

Net Zero Duty Implications

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

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

N/A.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

The Equality, Diversity, and Inclusion (EDI) Plan aligns with the Trust's obligations under the Equality Act 2010, specifically the Public Sector Equality Duty (PSED). This duty requires public bodies to eliminate unlawful discrimination, advance equality of opportunity and promote good relations among individuals with protected characteristics. The plan also adheres to NHS frameworks like the WRES, WDES and gender pay gap reporting. By collecting data, implementing inclusive policies and ensuring regular reporting, the Trust aims to maintain transparency and accountability in upholding the rights and dignity of all staff and service users.

Recommendations

The Board of Directors is requested to:

1. Approve the WRES report
2. Approve the WDES report
3. Approve the WRES/WDES Action Plans
4. Agree for the reports to be published on the Trust website.

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

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

Workforce Race Equality Standard (WRES)

Annual Report 2025/26

July 2026

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Introduction

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

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

Five indicators of the WRES are populated with workforce data from our Electronic Staff Record (ESR) and show comparative data for BME and White staff. This includes the distribution of staff in each pay band, access to training, likelihood of being appointed following shortlisting, likelihood of entering a formal disciplinary process, and representation in very senior leadership. The remaining four indicators are populated with comparative data from the national Staff Survey and include experiences of bullying, harassment and abuse from colleagues and the public, discrimination and perceptions of fairness in career progression.

While the WRES provides an important measure of workforce race equality, the Trust recognises that quantitative data alone cannot fully explain colleagues' experiences. Throughout 2025/26, WRES findings have therefore been considered alongside Staff Survey results, Freedom to Speak Up themes, Employee Relations data, recruitment information, staff network feedback and targeted listening events to better understand the lived experiences of colleagues from ethnically diverse backgrounds.

During 2025/26 the Trust has continued to strengthen its commitment to race equality through implementation of the Race Equality Plan, delivery of targeted improvement programmes and strengthened governance arrangements. This report should therefore be read alongside the Trust's Equality, Diversity and Inclusion Plan, People Plan and wider organisational improvement programmes. Together these provide the framework for reducing inequalities, improving staff experience and creating an inclusive workplace where everyone feels valued, respected and able to thrive.

Context

As of 31 March 2026, the Trust employed **3,507 colleagues**, of whom **894 (25.5%)** identified as Black and Minority Ethnic (BME), compared with **2,562 (73.1%)** who identified as White and **51 (1.5%)** whose ethnicity was unknown. This represents continued growth in workforce diversity, with the proportion of BME colleagues increasing from **12.6% in 2018** to **25.5% in 2026**, more than doubling over an eight-year period. Whilst this demonstrates sustained progress in workforce representation, the data throughout this report shows that increased diversity has not yet translated into consistently equitable workforce outcomes across recruitment, career progression and staff experience.

	2018	2019	2020	2021	2022	2023	2024	2025	2026
Percentage of staff in the Trust who are BME, by headcount, as of 31 March	12.6	12.9	13.8	15.5	16.7	18.5	19.0	20.4	25.5

While representation continues to improve, the Trust recognises that workforce diversity alone does not guarantee equitable experiences or outcomes. During 2025/26 significant work has therefore focused on improving psychological safety, inclusive leadership, career progression and organisational culture. This has included targeted listening events, staff network engagement, Race Equality Working Group activity, reciprocal mentoring, anti-racism initiatives and strengthened leadership accountability.

What are the nine WRES Indicators?

Indicator No	Source	What it Measures
1	ESR	Representation of White and BME staff across pay bands and senior grades compared with their representation in the total workforce.
2	Trac	The likelihood of White applicants being appointed from shortlisting compared with BME applicants.
3	P&I	The likelihood of White staff entering a formal disciplinary investigation compared with BME staff (based on a two-year rolling average).
4	OLM	The likelihood of White staff accessing non-mandatory training and continuing professional development (CPD) compared with BME staff.
5	SS	Comparison of experiences of harassment, bullying or abuse from patients, relatives or the public between White and BME staff.
6	SS	Comparison of experiences of harassment, bullying or abuse from colleagues between White and BME staff.
7	SS	Comparison of perceptions of equal career progression and promotion opportunities between White and BME staff.
8	SS	Comparison of experiences of workplace discrimination from managers, team leaders or colleagues between White and BME staff.
9	ESR	Comparison between the ethnic composition of voting Board members and that of the overall workforce. Only voting Board members are included.

Indicator 1

The table below shows staff distribution across pay bands (Under Band 1 to Very Senior Manager (VSM)). Data are collected in three main occupational groups: non-clinical, clinical (non-medical), and clinical (medical and dental). The figures as of 31 March 2026 are shown in the following table. The headcount figure is the total headcount. The arrows show changes from last year.

Non Clinical	BME	White	Unknown
Under Band 1	0 tu	0 tu	0 tu
Band 1	0 tu	0 q 1	0 tu
Band 2	76 p 15	162 p 11	7 p 1
Band 3	31 p 2	166 q 11	1 tu
Band 4	20 p 3	150 tu	3 tu
Band 5	18 p 2	78 p 1	2 p 2
Band 6	7 q 1	53 p 4	1 tu
Band 7	4 tu	30 q 1	1 p 1
Band 8A	1 p 1	26 p 5	0 tu
Band 8B	2 p 2	13 q 3	0 tu
Band 8C	1 tu	5 q 5	0 tu
Band 8D	0 tu	6 p 2	0 tu
Band 9	0 tu	1 q 2	0 tu
VSM	2 tu	4 tu	0 tu
	162 p 24	694 tu	15 p 4

Clinical	BME	White	Unknown
Under Band 1	0 tu	0 tu	0 tu
Band 1	0 tu	0 tu	0 tu
Band 2	4 p 1	2 q 1	0 tu
Band 3	230 p 65	260 q 5	8 q 1
Band 4	18 tu	128 p 1	0 tu
Band 5	177 p 18	251 q 31	6 q 1
Band 6	123 p 1	711 p 14	11 p 1
Band 7	39 q 2	299 q 43	3 q 1
Band 8A	15 q 2	94 p 5	0 tu
Band 8B	1 q 3	42 q 10	0 tu
Band 8C	2 tu	15 q 3	0 tu
Band 8D	0 tu	12 p 6	0 tu
Band 9	1 tu	0 q 1	0 tu
VSM	0 tu	0 tu	0 tu
	610 p 78	1814 q 68	28 q 2

Medical	BME	White	Unknown
Consultant	49 p 2	31 q 1	1 q 2
(Of which, Senior Medical Managers)	11 tu	3 q 1	0 tu
Career grade	37 p 9	10 q 2	1 p 1
Trainee grade	36 p 6	13 p 3	6 p 2
	122 p 17	54 tu	8 p 1

Indicator 1: Overall assessment: Workforce representation is improving, but progression into senior roles remains unequal.

The Trust continues to become increasingly representative of the communities it serves, with the proportion of staff from Black and Minority Ethnic (BME) backgrounds increasing from 12.6% in 2018 to 25.5% in 2026. This represents significant progress in workforce diversity. However, increasing representation has not yet resulted in consistently equitable workforce experiences. As demonstrated throughout this report, disparities remain in recruitment outcomes, career progression, staff experience and workplace culture. Therefore, the Trust continues to focus on improving equality of opportunity as well as workforce representation.

Workforce diversity continues to improve across all staff groups, particularly within clinical services where representation broadly reflects the overall Trust workforce. However, BME colleagues remain underrepresented within senior clinical and non-clinical leadership roles, particularly at Band 8a and above. Although the number of BME staff in senior roles has increased over recent years, progression into leadership positions has not kept pace with the overall growth in workforce diversity.

During 2026/27, the Trust will continue to analyse progression data alongside recruitment, development opportunities and staff experience to better understand barriers to career progression and to target improvement activity where disparities are identified.

Non-Clinical Workforce

As of March 2026, the overall percentage of BME staff in non-clinical roles (18.9%) is lower than the figure across the whole Trust (25.5%). 89.5% of the total number of BME staff in non-clinical roles are concentrated in Bands 2 to 5, 80.1% of the total number of non-clinical white staff are concentrated in Bands 2 to 5.

In terms of the total number of non-clinical staff at bands 8a and above; 3.7% of the BME workforce are in these roles, compared to 8.0% of White staff working in non-clinical roles. There are a total of six BME staff in these roles (9.8%), and 55 are White Staff (90.2%). This represents a small increase in BME staff in these roles compared with last year.

15 staff of unknown ethnic group have not been included in the above narrative.

Clinical (non-medical)

The overall percentage of BME staff in clinical (non-medical) roles is almost identical (25.2%) to the Trust average (25.5%). Further analysis of groups of staff can bring some of the data into sharper focus. **For example, the majority of registered nurses (amongst others) are employed at Bands 5, 6 and 7 and, to an extent, the band increase represents career progression.**

For Bands 8a and above BME staff comprise 10% of the clinical workforce and White staff 90%. This is a slightly wider gap than last year. 3.1% of BME clinical staff are in bands 8a and above compared to 9.0% of white staff. During 2025/26, the Trust commenced a detailed review of career progression into senior roles. This includes analysis of recruitment outcomes by pay band, applicant diversity, recruitment panel diversity and progression into Band 8a and above posts. Findings will inform targeted actions through the Race Equality Plan, Inclusive Recruitment Programme and leadership development initiatives to improve equitable progression. 28 staff of unknown ethnic group have been excluded for this narrative paragraph.

Clinical (medical and dental)

In clinical (medical and dental) roles, disparities are not reflected through overall representation in the same way as for other staff groups. Other areas for consideration include clinical awards, academic posts and fitness to practise referrals.

Indicator 2

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

The table below shows the “disparity ratio” where complete parity, or equality, is represented by the number 1. A number of 2 would be that a shortlisted candidate is twice as likely to be appointed. In Indicator 2, a number above 1 shows the extent to which a White candidate is more likely to be appointed. A figure above 1:00 indicates that White candidates are more likely than BME candidates to be appointed from shortlisting. The table below shows the trend over time.

Indicator 2 table

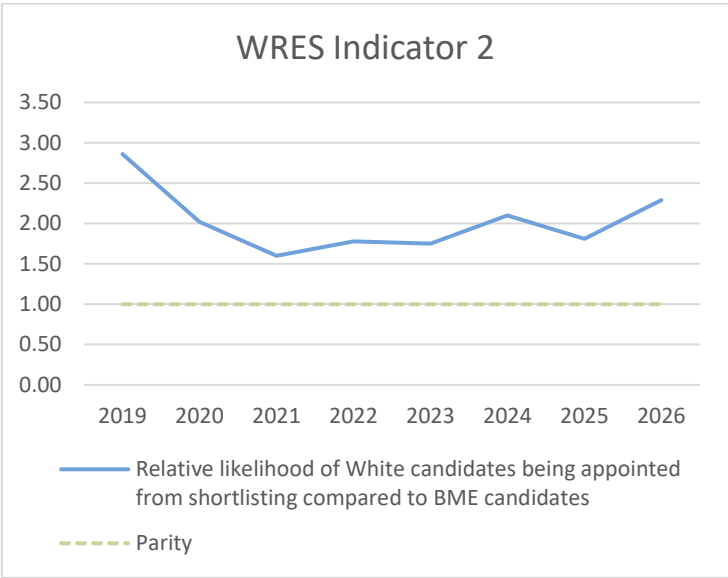
	2019	2020	2021	2022	2023	2024	2025	2026
Relative likelihood of White candidates being appointed from shortlisting compared to BME candidates	2.86	2.02	1.60	1.78	1.75	2.10	1.81	2.29

Recruitment continues to attract applicants from diverse backgrounds; however, disparities remain following shortlisting. During 2025/26 White applicants were 2.29 times more likely to be appointed following shortlisting than BME applicants. Whilst this represents an organisational indicator, further analysis demonstrates the importance of understanding outcomes by profession, pay band and service, rather than relying solely on Trust-wide data.

During the reporting year, the Trust strengthened its Inclusive Recruitment Programme through enhanced Inclusive Recruitment and Selection training, continued development of Recruitment Inclusion Guardians and improved recruitment governance.

Quarterly monitoring now includes applicant diversity, shortlisting outcomes, appointment rates, panel diversity and applicant withdrawal data to enable more targeted interventions where disproportionality exists.

Recruitment equity remains a priority within the Trust's Race Equality Plan and progress will continue to be monitored through regular reporting to the Equality Diversity and Inclusion Working Group and People and Culture Committee.



Further analysis is required to understand where local disparities exist and to target improvement activity effectively. This work is ongoing. As progression into higher bands occurs less frequently, trends need to be monitored over a longer period and considered alongside staff survey findings, training uptake, and exit interview data for BME staff.

Representation across the higher pay bands continues to be influenced by consultant-level roles. However, BME staff remain under-represented in senior clinical and non-clinical positions. While recruitment continues to attract a diverse range of applicants, disparities remain between application, shortlisting and appointment.

During 2025/26, the Trust strengthened its Inclusive Recruitment Programme through the continued delivery of Inclusive Recruitment and Selection training, a review of the Recruitment Inclusion Guardian role, and enhanced governance and oversight of recruitment practices.

Recruitment reporting has also been strengthened and now includes analysis of applicant diversity by pay band, shortlisting and appointment outcomes, candidate withdrawals, and recruitment panel diversity. Quarterly reporting is used to identify areas of disproportionality, monitor progress, and inform targeted actions to improve equity throughout the recruitment process.

Indicator 2: Overall assessment: Recruitment remains the highest organisational priority.

Indicator 3

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

Indicator 3

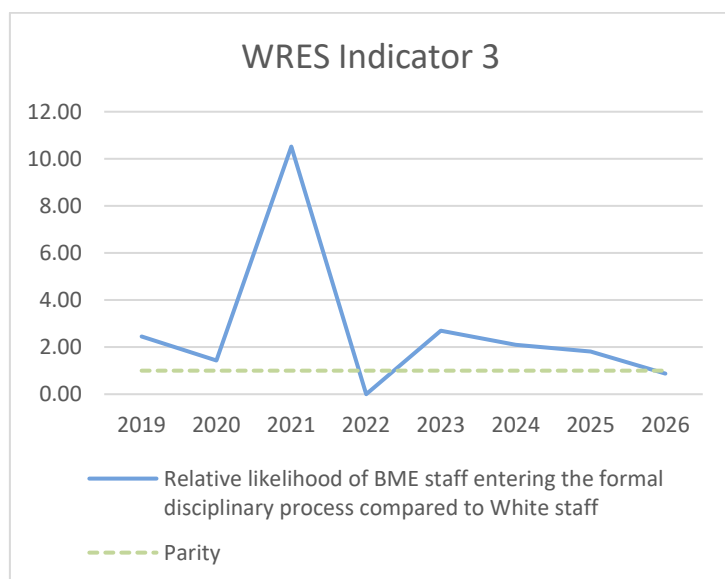
	2019	2020	2021	2022	2023	2024	2025	2026
Relative likelihood of BME staff entering the formal disciplinary process compared to White staff	2.45	1.43	10.52	0.00	2.70	2.10	1.81	0.88

Disciplinary data	White	BME	Unknown
Total staff in workforce	2,563	894	51
Number of staff entering formal disciplinary	21	8	-
Proportion of staff	0.82%	0.89%	
Relative Likelihood of BME staff entering the disciplinary process compared to White staff	1.09		

Although relatively small numbers can result in year-on-year variation, disproportionality within formal disciplinary processes continues to be monitored closely. Workforce data alone cannot explain why disparities occur and therefore quantitative information is considered alongside Employee Relations data, case reviews and wider organisational intelligence.

The Trust remains committed to ensuring disciplinary processes are fair, proportionate and consistently applied. During 2026/27 further analysis will continue to identify any emerging themes, including by profession, pay band and service, enabling targeted interventions where required.

The chart below shows the official WRES Indicator 3 trend submitted to NHS England. The disciplinary table that follows provides additional analysis using the Trust's local Employee Relations data to support organisational learning and improvement.



Whilst the relative likelihood has reduced over recent years and reached parity in 2026, the increase in formal disciplinary cases for both White and BME staff highlights the need for continued monitoring. Quantitative data alone does not explain the reasons behind formal disciplinary action and should be considered alongside employee relations case reviews, staff survey findings, Freedom to Speak Up themes and workforce feedback. During Q2, 2026, the Trust began developing a Cultural Collaboration approach, bringing together Employee Relations, Equality, Diversity and Inclusion (EDI), Organisational Development (OD) and Freedom to Speak Up (FTSU) to strengthen organisational learning, improve consistency in employee relations processes, and inform targeted WRES improvement actions.

Indicator 3: Overall assessment: Continue monitoring to ensure fair and equitable processes.

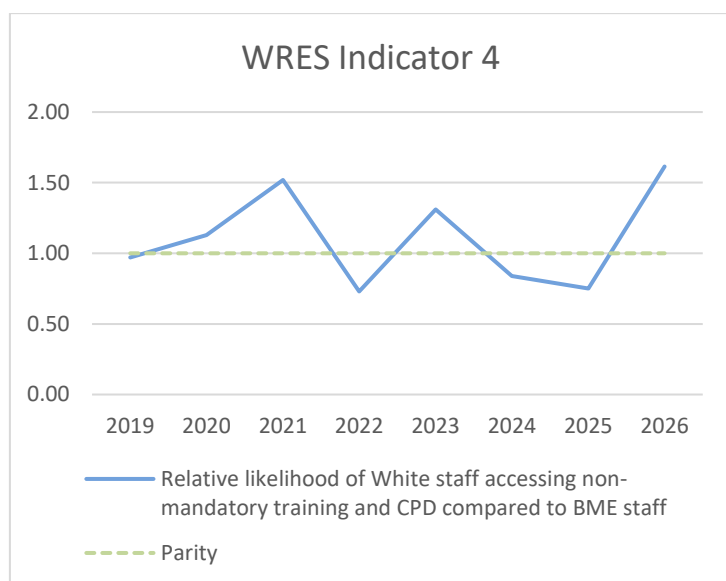
Indicator 4

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

Indicator 4

	2019	2020	2021	2022	2023	2024	2025	2026
Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff	0.97	1.13	1.52	0.73	1.31	0.84	0.75	1.61

The 2026 data shows an increase in the disparity between White and BME staff accessing non-mandatory training and continuing professional development (CPD), with White staff more likely to access these opportunities. As equitable access to learning and development is important for career progression, further analysis will be undertaken to understand the reasons for this disparity, including any differences across staff groups, services and pay bands. The findings will inform targeted actions to improve equitable access to development opportunities and support progression for all staff.



Access to learning and professional development plays a significant role in supporting career progression and reducing workforce inequalities. The 2026 data indicates a disparity in access to non-mandatory training and CPD between White and BME staff, highlighting the need for further investigation.

During 2026/27, the Trust will undertake more detailed analysis by profession, pay band and Division to understand potential barriers to accessing development opportunities. This work will inform future leadership development, reciprocal mentoring, career progression initiatives and wider workforce planning.

Indicator 4: Overall assessment: Further analysis required into access to development.

Indicators 5-8

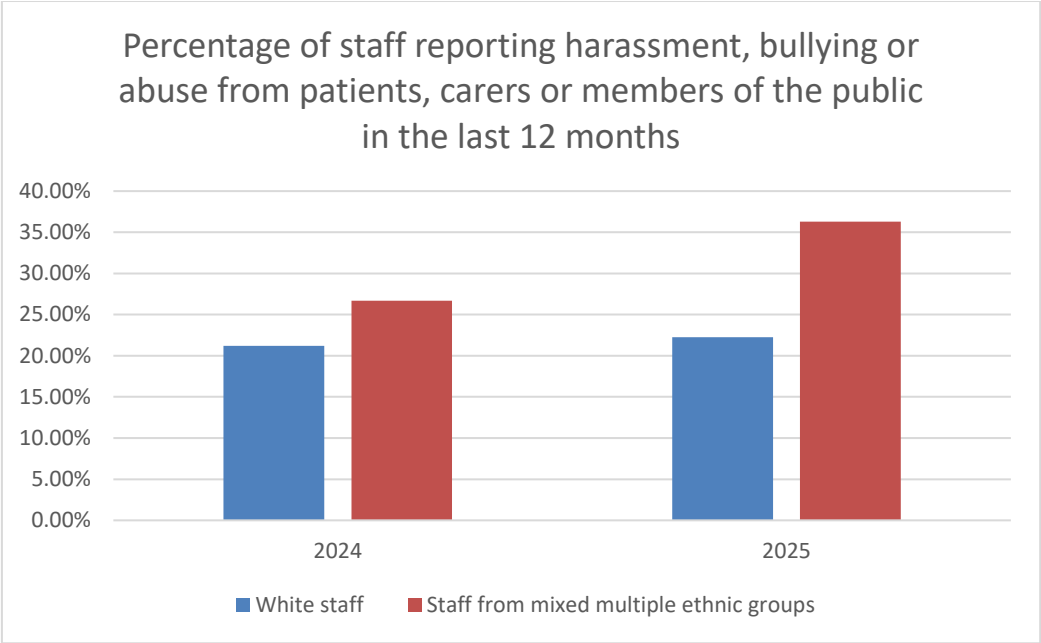
Data for the following Indicators are taken from the 2025 NHS staff survey and do not include figures for 2026 as those results will be published early 2027. The Trust is benchmarked against 50 Mental Health and Learning Disability trusts.

Staff Survey findings continue to demonstrate that colleagues from ethnically diverse backgrounds report poorer workplace experiences than their White colleagues across several indicators. Whilst individual measures fluctuate each year, the overall pattern remains consistent, with higher levels of bullying, harassment, discrimination and lower confidence in career progression reported by BME staff.

These findings align with wider organisational intelligence including Freedom to Speak Up themes, staff network feedback, Employee Relations data and targeted listening events. Together they provide a broader understanding of workforce experience and inform the Trust's ongoing Race Equality improvement programme.

Indicator 5

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



In 2025, the percentage for non-white staff* experiencing harassment, bullying or abuse from patients, relatives or members of the public has increased since 2024, and remains higher than for white staff.

This organisation is benchmarked against Mental Health and Learning Disability and Mental Health, Learning Disability and Community trusts (48 organisations).

Staff Survey 2025	2024	2025
DHcFT white staff	21.19%	22.26%
DHcFT All other ethnic groups*	26.69%	36.28%
Benchmarking data-white staff	21.29%	21.38%
Benchmarking data-all other ethnic groups*	31.64%	33.83%

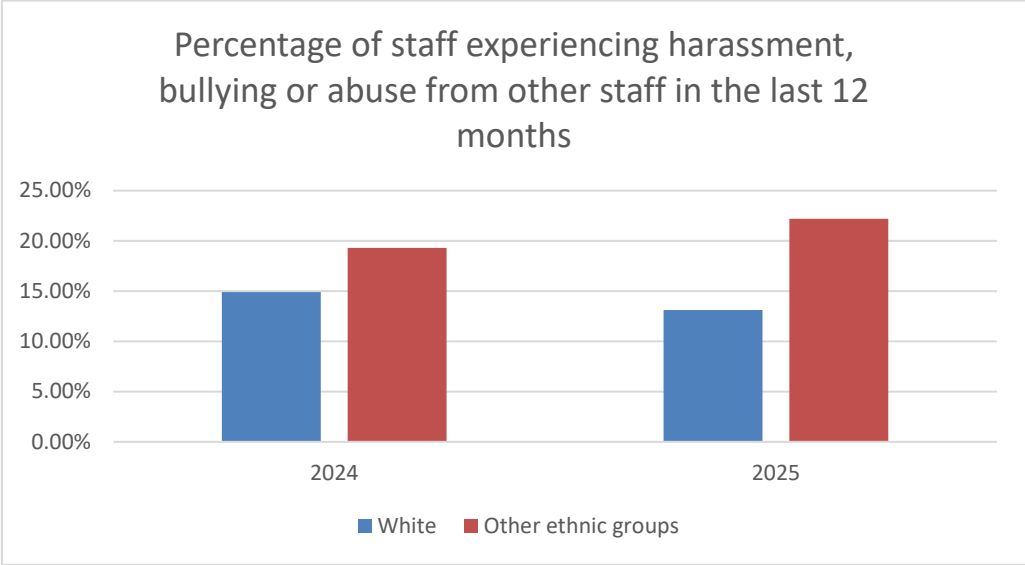
Comparison to the benchmarking data set shows that rates of harassment bullying and abuse are slightly higher than comparative NHS Trusts.

**Staff from all other ethnic groups combined*

During 2025/26, the Trust strengthened its response to racist abuse through the development of a dedicated reporting pathway, improved governance arrangements and the establishment of Race Equality as a key workstream within the No Excuse for Abuse programme. Learning from incidents, staff feedback and organisational data will continue to inform preventative action, improve staff support and strengthen organisational learning.

Indicator 6

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



In 2025, the percentage of non-White staff experiencing harassment, bullying or abuse from staff has increased since 2024, and remains higher than for white staff. A persistent disparity has remained where none-white staff are more likely to experience harassment from this group.

Staff Survey 2025	2024	2025
DHcFT white staff	14.92%	13.13%
DHcFT All other ethnic groups	19.31%	22.20%
Benchmarking data-white staff	16.48%	16.94%
Benchmarking data-all other ethnic groups	21.23%	20.22%

For non-white staff, the figure is higher than the benchmarking group, for White staff it is slightly lower.

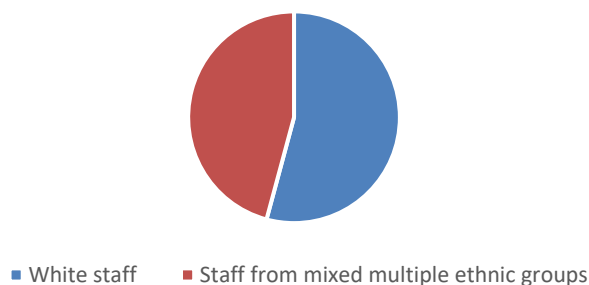
The Trust recognises that reducing bullying, harassment and abuse requires sustained cultural change rather than individual interventions alone. During 2025/26 work included targeted listening events, intercultural communication initiatives, Active Bystander training, strengthened staff network engagement and the introduction of a reporting pathway for racist incidents involving staff. Progress will continue to be monitored through Staff Survey results, Freedom to Speak Up themes and workforce equality data.

Indicator 7

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

Note: Due to changes in the question wording in 2025, previous years' results for WRES indicator 7 are not reported.

Percentage of staff believing that there are equal opportunities for career progression / promotion in 2025



In 2025, the percentage for non-white staff believing that the trust provides equal opportunities for career progression was 51.45% compared to 60.86% for White staff. This indicates a slight decrease in the confidence of non-white staff in equal opportunities for progression/promotion from last year. A wide and persistent disparity has been evident year on year.

Staff Survey 2025	2025
DHcFT white staff	60.86%
DHcFT All other ethnic groups	51.45%
Benchmarking data-white staff	58.40%
Benchmarking data-all other ethnic groups	51.61%

Confidence in equal opportunities for career progression remains a significant priority for the Trust. During 2026/27 recruitment outcomes, internal promotion, leadership development participation and progression into senior roles will continue to be monitored to identify any barriers affecting BME colleagues. Reciprocal Mentoring, Inclusive Recruitment and leadership development programmes will support this work.

Indicator 8

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

Percentage of staff reporting that they had experienced discrimination from their manager or other colleagues



In 2025, the percentage of non-white staff who have personally experienced discrimination at work from their manager/team leader or other colleagues was 13.9% (slightly lower than 14.8% last year) compared to 5.38% for White staff.

Reducing discrimination requires a sustained organisational focus on culture, leadership and accountability. Alongside strengthened reporting mechanisms, the Trust has continued to invest in staff networks, Freedom to Speak Up, Active Bystander training and targeted engagement with colleagues. Progress will continue to be monitored through WRES indicators, Staff Survey findings, Employee Relations data and wider organisational intelligence.

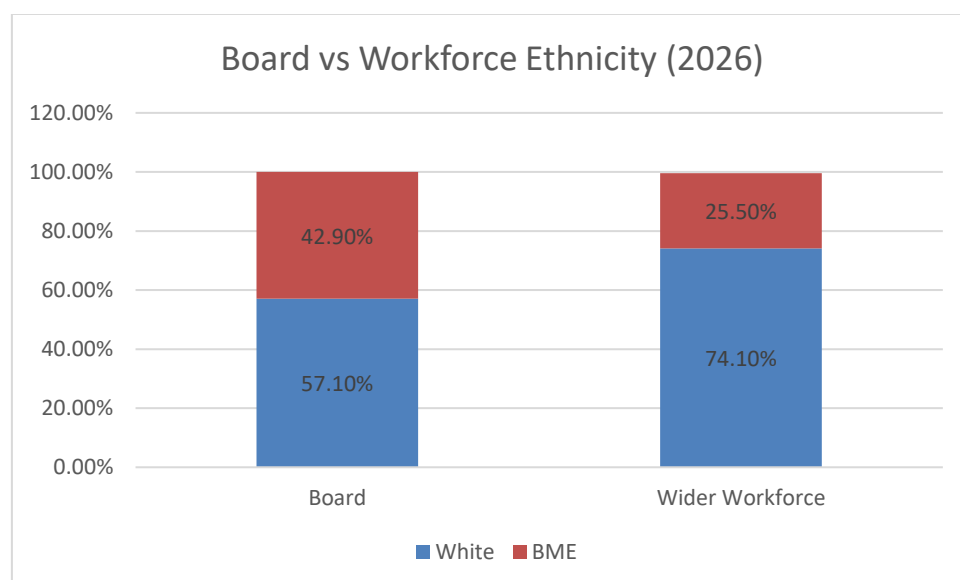
Staff Survey 2025	2024	2025
DHcFT white staff	5.09%	5.38%
DHcFT All other ethnic groups	14.81%	13.90%
Benchmarking data-white staff	6.08%	5.80%
Benchmarking data-all other ethnic groups	13.23%	12.69%

Indicators 5–8: Overall assessment: Staff experience remains poorer for BME colleagues and requires sustained cultural improvement.

Indicator 9

Board vs Workforce Ethnicity (2026)

The chart below shows the comparison between Board membership and overall workforce ethnicity. This demonstrates that BME representation at Board level (42.9%) is significantly higher than in the overall workforce (25.5%). Both these figures have increased since last year.



This table shows the representation of BME staff at Board level.

Board membership 2026	White	BME	Unknown
Total number of board members	8	6	0
of which are voting members	6	6	0
Non-voting members	2	0	0
Exec Board members	4	3	0
Non-exec Board members	4	3	0
% Board members by ethnicity	57.10%	42.90%	0

Whilst Board representation is more diverse than the overall workforce profile, the Trust recognises that representation alone does not demonstrate equality. Our continued focus is on ensuring that leadership, decision-making and organisational culture lead to equitable experiences, opportunities and outcomes for all colleagues.

Conclusions

The 2026 Workforce Race Equality Standard demonstrates that Derbyshire Healthcare continues to make sustained progress in workforce diversity, with BME representation increasing from **12.6% in 2018** to **25.5% in 2026**. Board diversity has also continued to improve, with **42.9% of Board members** identifying as BME compared with **25.5% of the overall workforce**. However, the report also demonstrates that improvements in representation have not yet translated into equitable workforce outcomes, with persistent disparities remaining across recruitment, career progression, staff experience and perceptions of discrimination.

Despite these positive developments, the data continues to highlight persistent inequalities in workforce experience and career progression. BME staff remain underrepresented in senior clinical and non-clinical roles (Band 8a and above), with disproportionate representation at lower pay bands. Recruitment data also indicates that White applicants continue to be more likely than BME applicants to be appointed from shortlisting, although further local analysis is required to understand where these disparities occur and the factors contributing to them.

Workforce experience indicators continue to show that BME staff are more likely than White colleagues to experience harassment, bullying or abuse from both patients and colleagues, report discrimination at work, and have lower confidence that the Trust provides equal opportunities for career progression. While some indicators show small year-on-year improvements, the overall pattern of disparity remains consistent and requires sustained attention.

The Trust has already implemented a range of initiatives to address these issues, including strengthened reporting pathways for racist incidents, the relaunch of the BME Staff Network, reciprocal mentoring, respectful communication training, executive support for staff networks, and enhanced equality, diversity and inclusion support. The impact of these interventions will continue to be monitored alongside more detailed analysis of recruitment, promotion, disciplinary processes, access to continuing professional development, staff survey findings and exit interview data to better understand the underlying causes of inequalities.

Overall, this year's WRES findings demonstrate encouraging progress in workforce representation but reinforce that representation alone does not equate to race equality. Achieving equitable outcomes in recruitment, career progression, staff experience and organisational culture remains a priority. The Trust is committed to using the evidence from this report to inform targeted action, strengthen accountability, and ensure that all staff, regardless of ethnicity, have equal opportunity to thrive, progress and feel valued within the organisation.

The actions below summarise progress made during the 2025/26 reporting period in response to the previous WRES Action Plan. Whilst progress has been made, the 2026 WRES findings demonstrate that further work is required to address the remaining inequalities. The findings from this report have informed the development of the 2026/27 WRES Action Plan, which builds on the work completed to date and sets out the Trust's priorities for the coming year.

Progress made against 2025/2026 WRES Action Plan:

Progress has been made against the 2025/26 WRES Action Plan, with activity increasingly aligned to the Trust's wider Race Equality Plan and workforce priorities.

Inclusive recruitment activity has been strengthened through the relaunch of Panel Chair training and the development of the Recruitment Inclusion Guardian approach.

Recruitment monitoring has also expanded to include applicant diversity, shortlisting, appointments, panel diversity and applicant withdrawals. Quarterly reporting arrangements are being established to provide greater oversight of where disparities occur within the recruitment pathway.

Analysis continues to identify under-representation of BME colleagues within senior roles, particularly at Band 8a and above. Career progression therefore remains a priority. Partners in Progress reciprocal mentoring will support this work during 2026/27, alongside further analysis of progression and access to leadership and development opportunities.

The Trust's Race Equality Plan has been implemented, with oversight through the Race Equality Working Group. Wider activity has included targeted staff listening and culture work, the relaunch of the BME Staff Network and alignment with the No Excuse for Abuse programme. These provide mechanisms for staff experience and workforce data to inform improvement activity.

A core group of staff have also completed Active Bystander Train-the-Trainer training. Wider rollout has progressed more slowly than anticipated due to trainer capacity and will be considered alongside the Trust's wider culture improvement and race equality work.

Work is continuing to strengthen understanding of retention and staff experience. Exit information is being considered alongside Employee Relations data, Freedom to Speak Up themes and Staff Survey findings, with further ethnicity analysis required to identify recurring themes and areas for targeted intervention.

During 2026/27, the emphasis will be on demonstrating impact from these interventions, strengthening divisional ownership and using recruitment, progression, Employee Relations and staff experience data to provide clearer assurance on whether racial inequalities are reducing.

WRES action plan 2026 to 2027

Priority	What the data tells us	Agreed actions	How we will measure success	Monitoring and assurance
1. Recruitment fairness	White applicants were 2.29 times more likely to be appointed following shortlisting. The greatest losses must be identified across the recruitment process.	Review application, shortlisting, interview and appointment data by band, role and Division where numbers allow. Target Panel Chair training, Inclusive Recruitment Guidance and Recruitment Inclusion Guardian support at areas with persistent disparities.	Reduce the overall appointment likelihood ratio from 2.29, with progress towards 2.10 or below. Identify where disparities occur and put targeted action in place where persistent gaps are identified.	Quarterly recruitment reporting through the EDI Working Group. Persistent disparities and progress against agreed actions will be escalated to the relevant Division.
2. Career progression and senior representation	BME representation increased from 20.4% to 25.5%, but BME colleagues remain under-represented at senior levels. Overall representation does not show whether access to progression is equitable.	Review progression by band, role and Division, including Bands 2 to 3, 5 to 6 and 7 to 8. Use the findings to target mentoring, development and talent opportunities.	Establish the baseline for BME representation and progression by band. Identify priority gaps and demonstrate improved access to development and progression opportunities.	Quarterly monitoring of representation, applications, appointments and progression by band. Review participation, experience and progression outcomes from targeted programmes.
3. Bullying, harassment, discrimination and formal processes	BME colleagues reporting discrimination reduced from 14.8% to 13.9%, but the gap with White colleagues remains. BME colleagues are also disproportionately represented in some formal processes.	Triangulate Staff Survey, Employee Relations, Freedom to Speak Up, formal case and racist incident information. Review learning from panel hearings and target Race Equality, management and culture support at identified hotspots.	Improved BME staff experience, a narrowing of inequalities with White colleagues and evidence that concerns are raised safely, responded to and acted upon.	Quarterly review of staff experience, formal processes, incidents and speaking-up themes through the EDI Working Group, with action escalated where disparities persist.

Governance and assurance: Progress will be reviewed quarterly through the EDI Working Group, triangulating WRES data with Staff Survey, recruitment, Employee Relations, Freedom to Speak Up, racist incident data and staff feedback. Divisions will be responsible for responding to identified inequalities and delivering agreed actions. Key themes, persistent disparities and Trust-wide actions will be escalated through the Trust Delivery Group and relevant People governance, with PCC/Board providing strategic oversight and assurance on progress and impact.



Workforce Disability Equality Standard (WDES)

Annual Report - 2025/26

July 2026

www.derbyshirehealthcareft.nhs.uk

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Introduction

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

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

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

Numerical data¹ from the WDES provides a degree of insight into disability equality at the Trust but is best used in conjunction with additional information (such as Freedom to Speak Up, employee relations and recruitment) and the qualitative data from the lived experiences of our colleagues themselves. The quality of disability declaration data recorded on ESR has continued to improve following targeted work to encourage staff to record their disability status. Whilst some staff have not declared a disability status, increasing declaration rates provide greater confidence in the analysis presented within this report. This is explored below in more detail.

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

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

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

This report provides assurance to the People and Culture Committee on the Trust's performance against the Workforce Disability Equality Standard (WDES), highlights areas of progress, identifies continuing inequalities experienced by Disabled staff, and outlines the actions being taken to improve workforce experience and outcomes.

Context

The Trust serves the population of Derby City and Derbyshire County, both of which have different profiles in terms of disability. In the 2021 census, data shows the percentage of people indicating that their day-to-day activities were limited by a long-lasting condition or illness. In Derbyshire the figure was 20.1%.

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

This definition is unlikely to cover various conditions which might be defined as a disability. Similarly, the NHS Staff Survey asks whether staff have a disability or long-term condition, and this is recorded differently on ESR as solely a disability. This makes direct comparison between the datasets more challenging, however, the WDES does indicate clear trends and disparities between disabled and non-disabled staff.

Figures from the Department for Work and Pensions in 2021/22 indicate that 24% of the total population have a disability². The Trust in 2024 had 10.25% who disclosed a disability which is below the Derbyshire county average.

The continued increase in disability declaration rates provides greater confidence in the quality of workforce data. Whilst declaration rates remain below the estimated prevalence of disability within the wider population, the improvement supports more meaningful analysis of workforce experience and outcomes for disabled colleagues.

At 31 March 2026, 12.7% of the Trust workforce had declared a disability- a continued increase year on year, but still below both local and national population averages.

A snapshot of data taken on 31 March 2026 shows the total number of staff employed by Derbyshire Healthcare NHS Foundation Trust was 3507. Of these:

- 445 identified as Disabled (12.7%)
- 2697 identified as non-Disabled (76.9%)
- 365 had no disability status recorded (10.4%).

(This unknown figure has decreased slightly from last year, indicating better declaration rates this year)

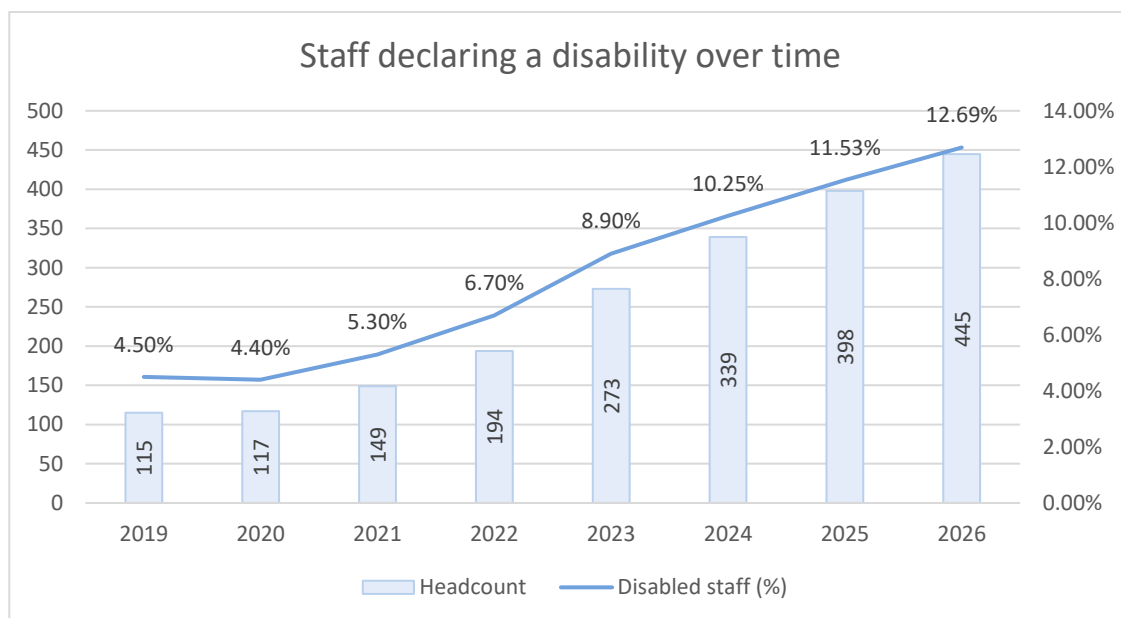
Recorded proportion of disabled staff employed within the Trust

	2018	2019	2020	2021	2022	2023	2024	2025	2026
% of staff in the trust who are disabled, by headcount, as at 31 March	-	4.5	4.4	5.3	6.7	8.9	10.3	11.5	12.7

Although disability declaration rates have continued to improve year on year, 10.4% of staff have not yet recorded their disability status on ESR. Increasing declaration rates remains a priority as this improves the quality of workforce data, enables better understanding of staff experience and ensures colleagues can access appropriate workplace support where required.

Year	Disabled staff (%)	Headcount	Notes
2018			No data recorded
2019	4.50%	115	First formal dataset
2020	4.40%	117	Relatively stable
2021	5.30%	149	Noticeable rise
2022	6.70%	194	Continued growth
2023	8.90%	273	Almost doubled since 2019
2024	10.25%	339	First time above 10%
2025	11.53%	398	Highest to date
2026	12.69%	445	Highest to date

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



What are the WDES Indicators?

Indicator No	Source	What it Measures
1	ESR	Disability Representation across all bandings = to that of the Trust overall workforce figure.
2	Trac	Relative likelihood of 1 signals that non-disabled candidates and disabled candidates are equally as likely to be appointed from shortlisting.
3	P&I	Relative likelihood of 1 signals that Disabled staff and non-disabled staff are equally as likely to enter in to the capability process.
4a, 4b	SS	Experience of Disabled staff and non-disabled staff being the same or a narrowing of the inequality gap between disabled and non-disabled staff.
5		
6		
7		
8		
9		
10	ESR	A board that is = to the staff Disability representation figure in its own representation.

Indicator 1

Indicator 1 measures the distribution of staff across pay bands (Bands <1 to Very Senior Manager). The clinical workforce shows that disabled colleagues are represented across all pay bands, with the largest numbers employed in Bands 5 and 6, reflecting the overall Trust workforce profile. Representation decreases at Band 7 and above, with relatively small numbers of disabled staff in senior clinical and leadership roles. Whilst this partly reflects the smaller number of posts available at higher bands, continued monitoring of recruitment, career progression and retention will help the Trust better understand any barriers to progression and inform targeted improvement actions.

Data is presented in three main occupational groups: non-clinical, clinical (non-medical), and clinical (medical and dental). Figures are shown for 2025 with arrows to indicate change. The percentage figure is the proportion of Disabled or non-Disabled staff within each pay band. Percentage figures are rounded to whole numbers.

Non-Clinical

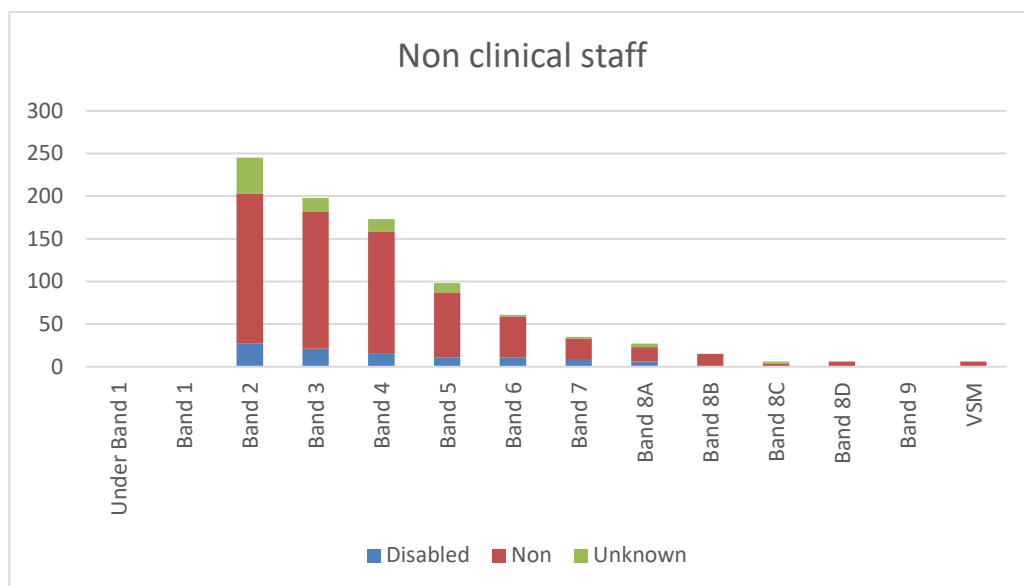
Non Clinical	Disabled	Non	Unknown
Under Band 1	0 tu	0 tu	0 tu
Band 1	0 tu	0 tu	0 tu
Band 2	27 p 6	176 p 24	42 p 42
Band 3	21 q 3	161 q 6	16 p 16
Band 4	15 p 5	143 q 2	15 p 15
Band 5	11 p 3	76 p 2	11 p 11
Band 6	11 p 3	48 tu	2 p 2
Band 7	8 p 3	25 q 1	2 p 2
Band 8a	6 tu	17 p 7	4 p 4
Band 8b	1 q 1	14 tu	0 tu
Band 8c	0 q 1	4 q 1	2 p 2
Band 8d	0 tu	6 p 2	0 tu
Band 9	0 tu	1 q 2	0 tu
VSM	0 tu	6 tu	0 tu
	100 p 15	677 p 23	94 q 10

Clinical

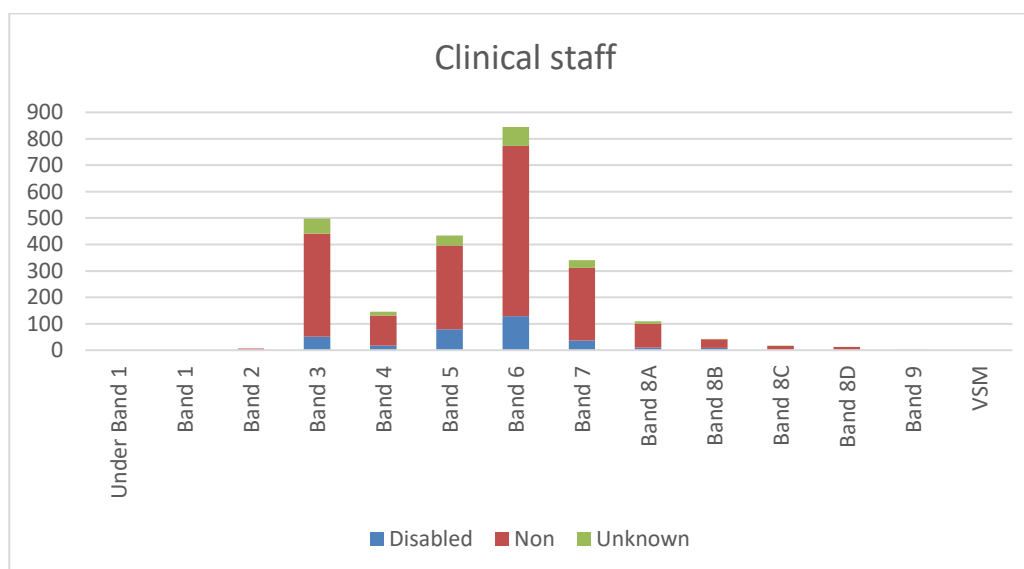
Clinical	Disabled	Non	Unknown
Under Band 1	0 tu	0 tu	0 tu
Band 1	0 tu	0 tu	0 tu
Band 2	1 tu	5 p 1	0 q 1
Band 3	51 p 12	390 p 60	57 q 13
Band 4	17 p 4	114 q 2	15 q 1
Band 5	79 tu	317 p 2	38 q 16
Band 6	129 p 11	644 p 14	72 q 9
Band 7	37 tu	274 q 31	30 q 15
Band 8a	10 p 1	90 p 2	9 tu
Band 8b	9 p 2	32 q 14	2 q 1
Band 8c	1 q 1	15 q 2	1 tu
Band 8d	2 p 2	10 p 4	0 tu
Band 9	0 q 1	1 tu	0 tu
VSM	0 tu	0 tu	0 tu
	336 p 30	1892 p 34	224 q 56

Medical and Dental

Medical	Disabled	Non	Unknown
Consultant	6 p 2	61 p 2	14 q 5
Career grade	1 p 1	32 p 2	15 p 5
Trainee grade	2 q 1	35 p 3	18 p 9
	9 p 2	128 p 7	47 p 9



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



Indicator 2

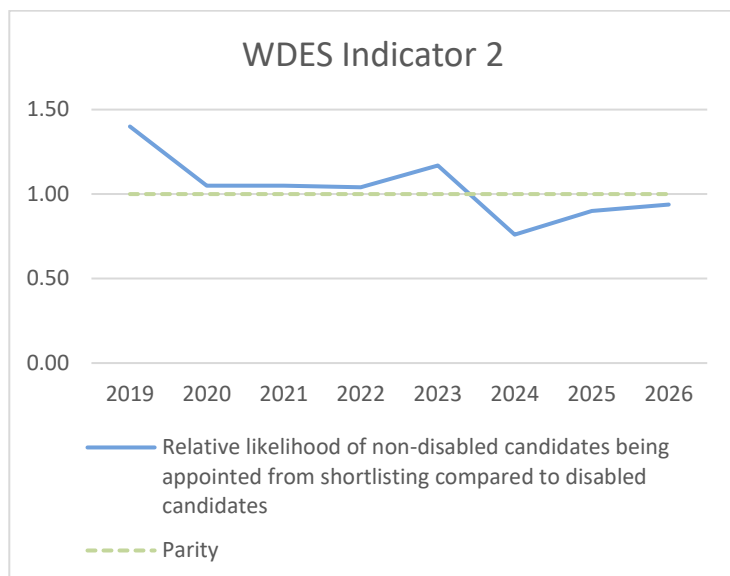
Relative likelihood of staff being appointed from shortlisting

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

Disabled applicants were slightly more likely to be appointed following shortlisting than non-disabled applicants (0.94). This continues the positive trend towards fairer recruitment. The Trust will continue to strengthen inclusive recruitment practices and ensure managers understand reasonable adjustments throughout the recruitment process.

Indicator 2

	2019	2020	2021	2022	2023	2024	2025	2026
Relative likelihood of non-disabled candidates being appointed from shortlisting compared to disabled candidates	1.40	1.05	1.05	1.04	1.17	0.76	0.90	0.94



In 2026, Disabled applicants were slightly more likely to be appointed than non-Disabled applicants, though the disparity was small (0.94). This compares to 0.90 in 2025, showing a further shift towards parity. Manager training and guidance are expected to strengthen this area further.

The continued improvement in this indicator suggests that the Trust's work to strengthen inclusive recruitment is having a positive impact. Inclusive Recruitment and Selection training and increased awareness of reasonable adjustments continue to support fair and inclusive recruitment practices.

Whilst the overall position has moved closer to parity, further analysis is required to understand whether disparities exist within particular staff groups, professions, pay bands or disability types. Improving disability declaration rates will continue to strengthen the quality of workforce data and support targeted action where inequalities are identified.

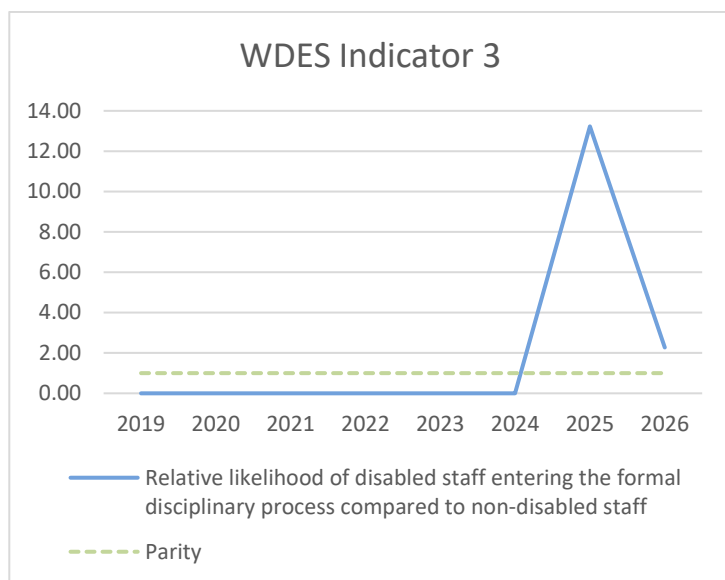
Indicator 3

Relative likelihood of staff entering the formal capability process

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

Indicator 3

	2019	2020	2021	2022	2023	2024	2025	2026
Relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff	0.00	0.00	0.00	0.00	0.00	0.00	13.23	2.27



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

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

Indicators 4a to 9

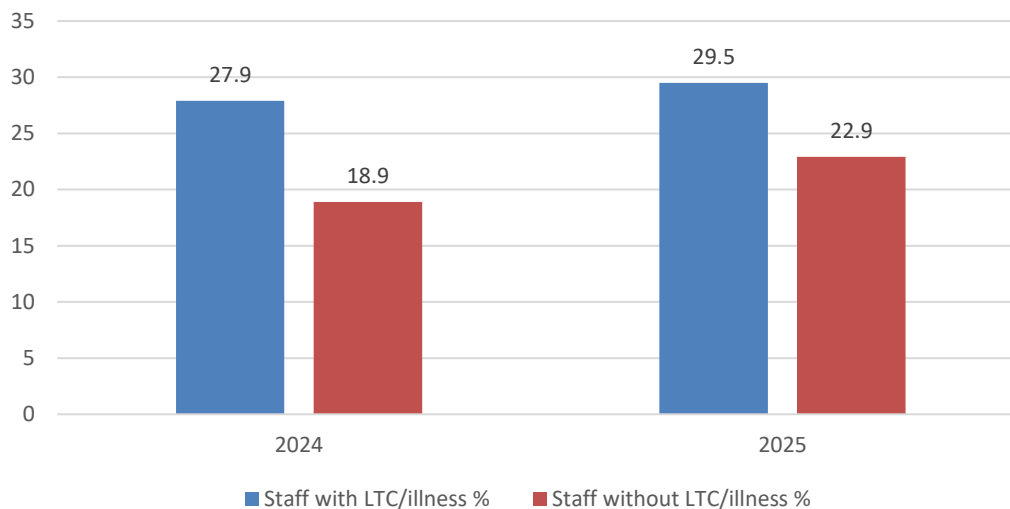
Data for the following Indicators are taken from the 2024 NHS staff survey³ that was published in March 2026. A benchmarking report compares Derbyshire Healthcare to other Mental Health and Learning Disability Trusts (50 organisations are in the benchmarking group) as well as comparing those with a disability to those that do not. This year, the Staff Survey has used “long term condition or illness” instead of “disability”.

Disabled staff continue to report higher levels of bullying, harassment and abuse than non-disabled staff. Although reporting has increased, suggesting greater confidence in speaking up, reducing these experiences remains a priority. The Trust will continue to support this through the No Excuse for Abuse campaign and wider inclusion work.

Indicator 4a

This indicator (4a (i)) shows the percentage of disabled staff experiencing harassment, bullying or abuse from patients, service users or members of the public in the last 12 months.

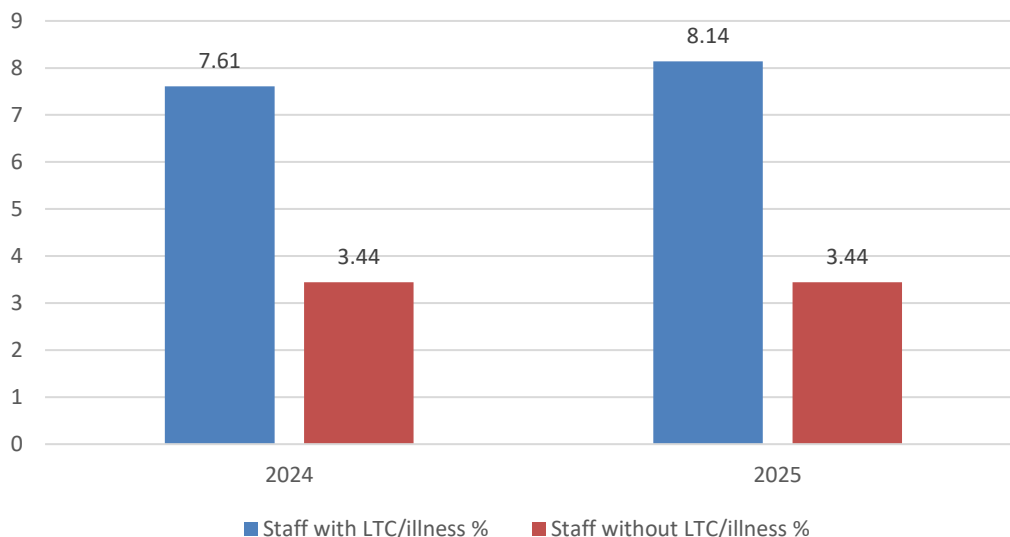
% of staff who experienced at least one incident of harassment, bullying or abuse from: Patients / service users, their relatives or other members of the public



In 2025, the percentage of staff with a long-lasting health condition that experienced harassment, bullying or abuse from patients, service users or members of the public was 29.5% compared to 27.9% last year. This is slightly higher than the benchmarking figure of 27.24% and remains higher for staff with long terms conditions compared to those who don't.

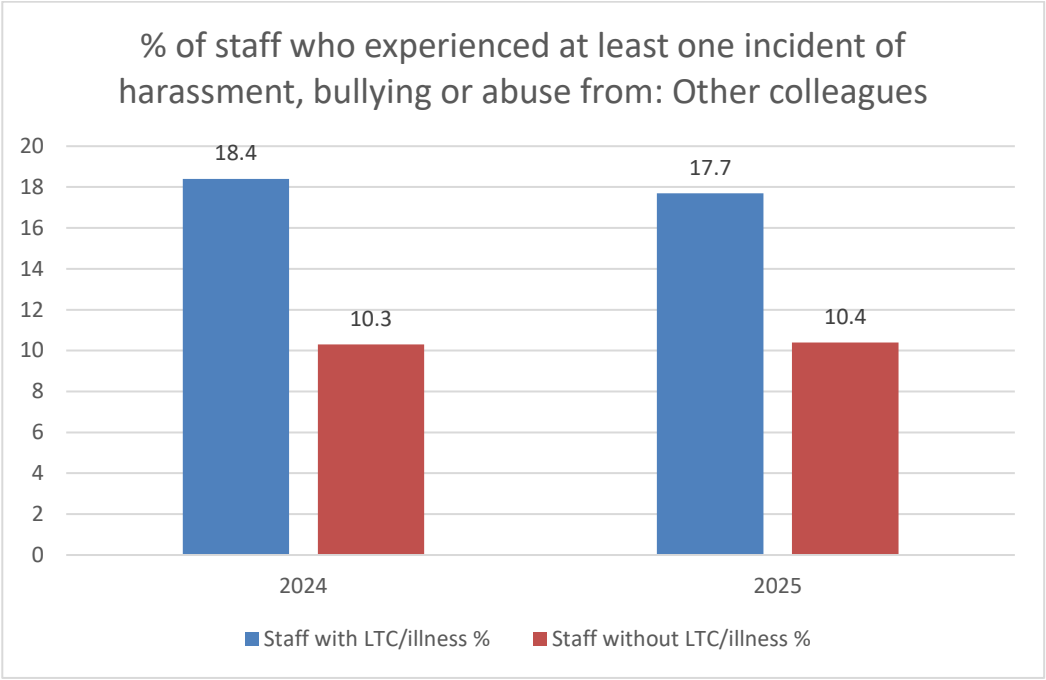
Indicator 4a (ii)

% of staff who experienced at least one incident of harassment, bullying or abuse from: Managers



In 2025, the percentage of staff with a long-lasting health condition that experienced at least one incident of harassment, bullying or abuse from managers was 8.1% compared to 7.6% last year. This is lower than the benchmarking figure of 11.55% but remains higher for staff with long terms conditions compared to those who do not have long-term health conditions.

Indicator 4a (iii)

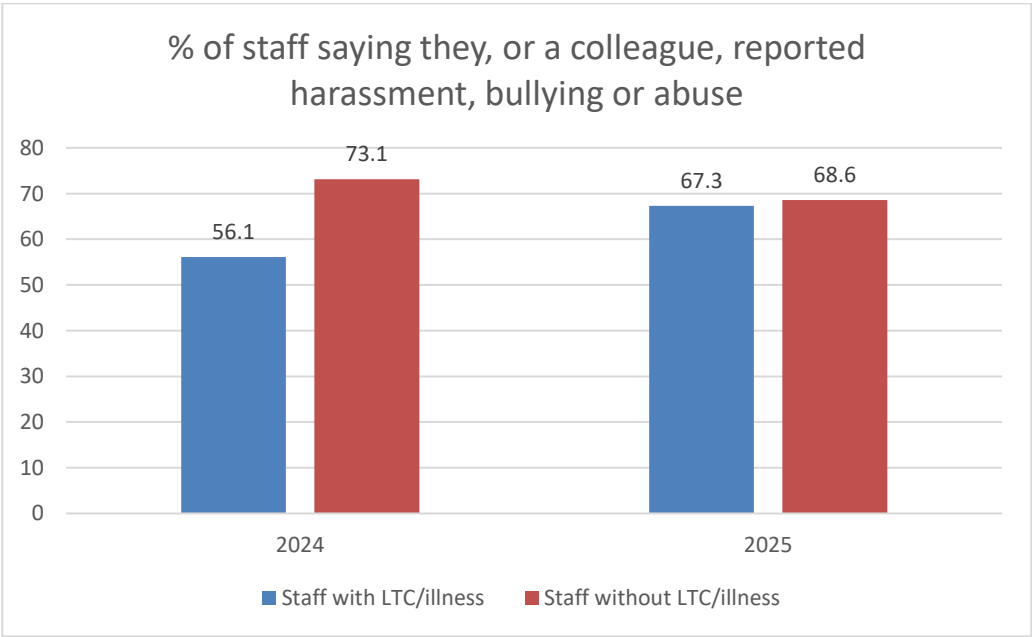


In 2025, the percentage of staff with a long-lasting health condition that experienced at least one incident of harassment, bullying or abuse from other colleagues was 17.7% compared to 18.4% last year. This is slightly lower than the benchmarking figure of 18.9% but remains higher for staff with long terms conditions compared to those who don't.

The Trust has recently launched a campaign “No Excuse for Abuse” aiming to tackle bullying, harassment and abuse to all staff. We need to consider how those with long-term conditions/disabilities can best be supported by this work.

Indicator 4b

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

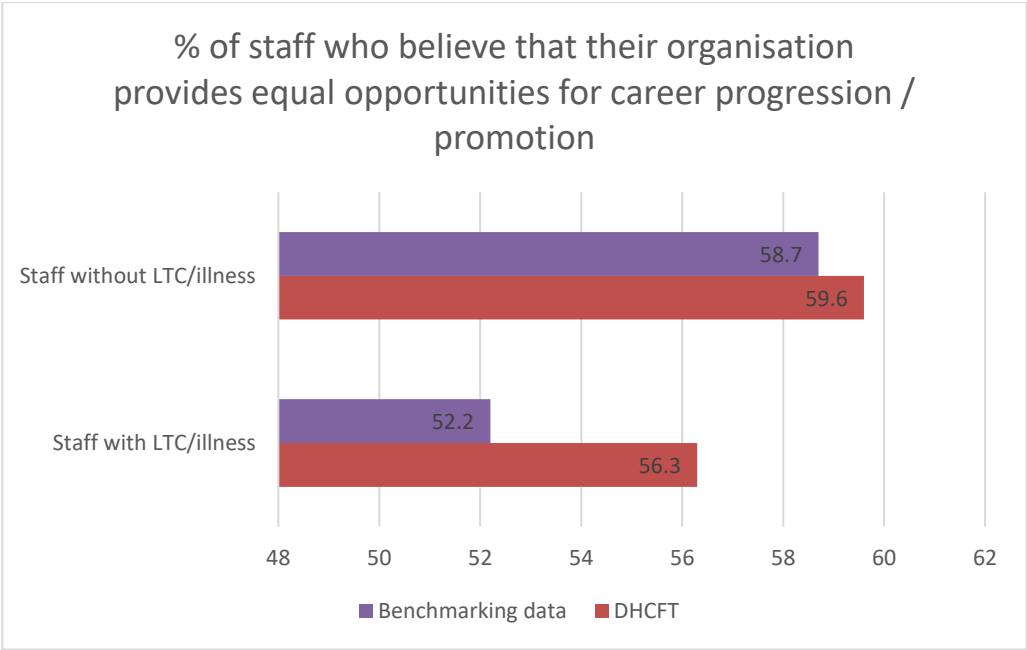


In 2025, 67.3% of staff with a long-term condition or illness said that they or a colleague had reported harassment, bullying or abuse, compared with 68.6% of staff without a long-term condition or illness. The figures have shown an increase in reporting for both groups from 2024 which is a positive change in reporting.

The Trust figures are similar but slightly higher than those in the benchmarking group (61.7% for those with LTC/illness; and 66.3% for those without).

Indicator 5

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



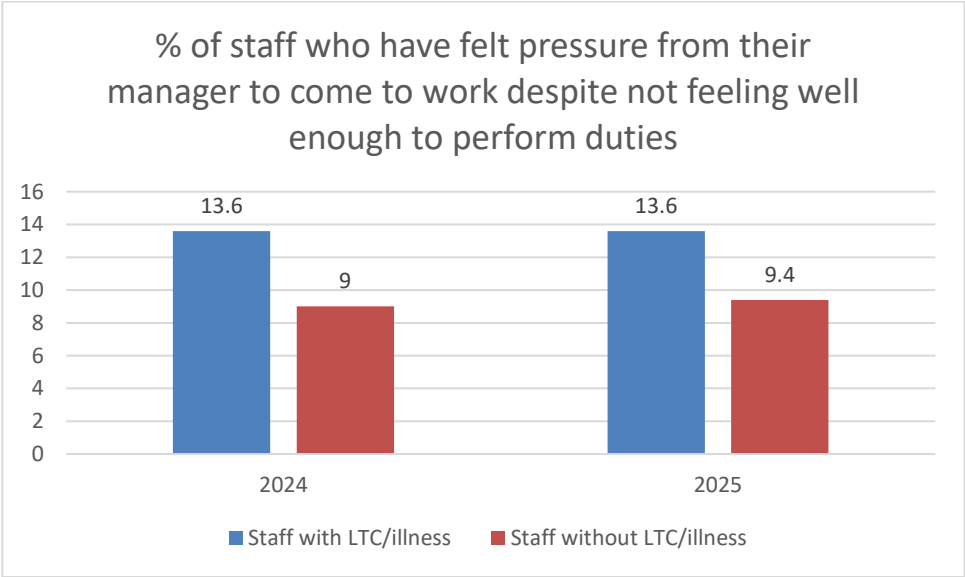
The percentage of staff with a long-term condition or illness who believed that the organisation provides equal opportunities was 56.3% compared to 59.6% of staff without an LTC/illness.

The Trust figures are higher than those in the benchmarking group, which is positive, however the data indicates that a large number of staff feel that there is not equal of opportunity for career progression. A deeper dive into the data is required to better understand the reasons for this finding.

[Note: Due to changes in the question wording in 2025, previous years' results for WDES metric 5 (Q15) are not reported.]

Indicator 6

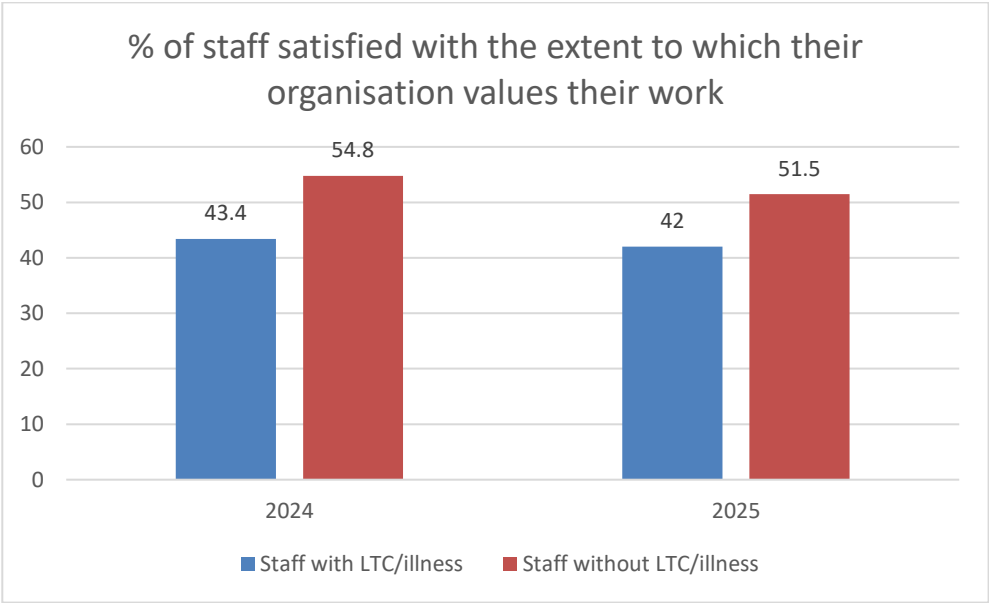
Percentage of staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.



In 2025, the percentage of staff with a disability that felt pressure to come to work despite not feeling well enough was 13.6% compared to 9.4% of staff without a disability. The figure for those with a disability has remained the same as last year and continues to show a significant difference between those with a disability and those without. The Trust’s sickness/absence policy has undergone an overhaul this year. Further investigation is needed to determine why staff are reporting that they have felt pressured to return to work.

Indicator 7

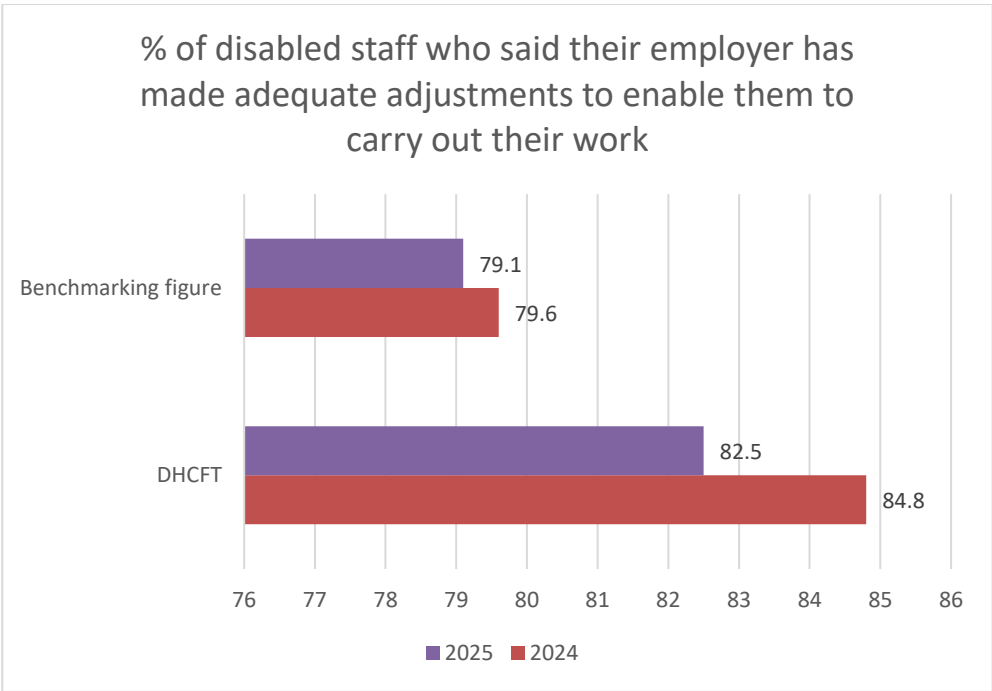
Percentage of staff saying they are satisfied with the extent to which the organisation values their work.



In 2025, 42% of disabled staff felt their organisation values their work which reduced slightly from 2024, and this figure remains significantly lower than staff without a disability (51.5%). The figures for DHcFT are similar to the benchmarking figures of 42.5% (staff with LTC/illness) and 52.8% (staff with no LTC/illness). It is important to continue to develop programmes to ensure that staff feel valued in their workplaces.

Indicator 8

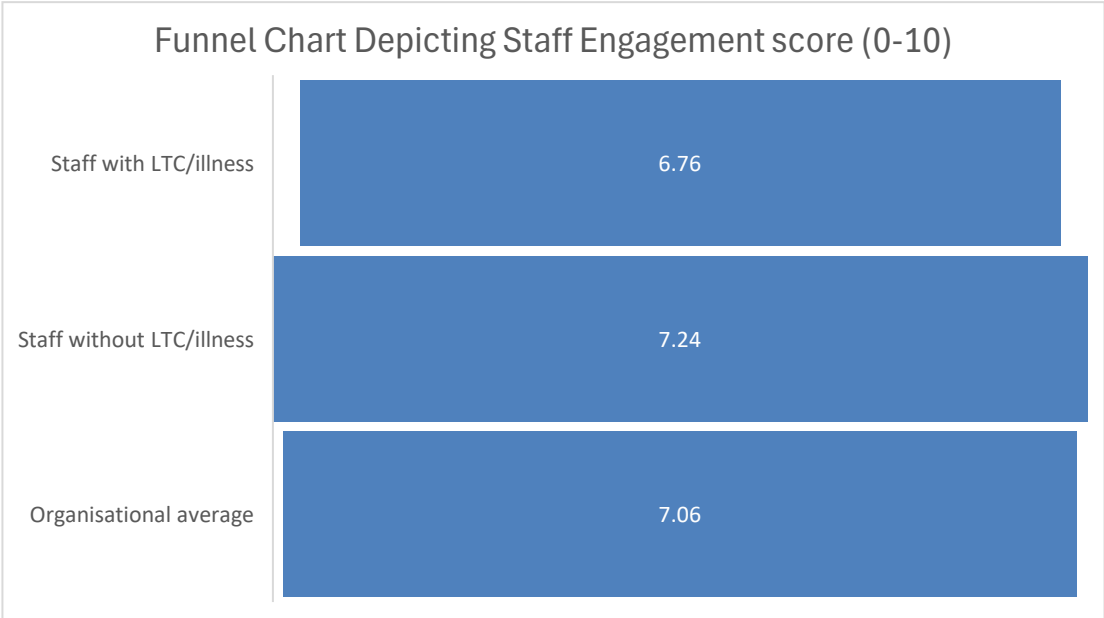
Percentage of staff with a long-lasting health condition or illness saying their employer has made reasonable adjustments to enable them to carry out their work.



Figures from the staff survey show that 82.5% of staff with a long-lasting condition or illness felt that reasonable adjustments had been made. This compared to a benchmarked figure of 79.1%. This has slightly reduced from 2024 but remains above the benchmark. At DHcFT our Disability and Wellness Staff network (DAWN) has been instrumental in obtaining a centralised budget for workplace adjustments, and qualitative feedback has indicated that this is working well in helping staff to access the adjustments they need.

Indicator 9

Staff engagement score for disabled staff, compared to non-disabled staff. The data shows a decrease in staff engagement in 2025 for all groups.



The figure above shows more work is needed to engage those with disabilities/long term health conditions with the Staff surveys to ensure all voices are heard.

A refresh of the DAWN Staff Network with increased membership and visibility is in progress. The network will consider disability awareness campaigns aligned to National Inclusion Week.

Indicator 10

At 31 March 2025, the Trust Board had 14 members. One1 member (7.1%) declared a disability, compared with 12.7% of the Trust workforce.

There are currently no Disabled Executive Directors.

Improving senior-level representation remains a strategic priority.

Conclusions

The 2025/26 WDES results demonstrate continued progress in several areas, while reinforcing the need for continued action to address persistent inequalities experienced by Disabled staff. The continued reduction in unknown disability status and increase in recorded disability declarations provide greater confidence in the quality of our workforce data. Recruitment indicators have continued to improve, with Disabled applicants marginally more likely to be appointed than non-Disabled applicants, reflecting the positive impact of ongoing work to strengthen inclusive recruitment practices.

There are also positive indications that staff continue to benefit from reasonable adjustments, with the Trust remaining above the national benchmark, supported by initiatives such as the central workplace adjustments budget developed in partnership with the DAWN Staff Network.

Reporting of bullying and harassment has increased across all staff groups, suggesting growing confidence in speaking up, and the Trust appears to be performing favourably against benchmarking in a number of staff experience measures.

Despite this progress, the findings highlight several areas requiring focus. Disabled staff continue to report poorer experiences than their non-Disabled colleagues in relation to bullying, harassment and abuse, feeling valued at work, perceptions of equal opportunities for career progression, and pressure to attend work when unwell. Representation of Disabled colleagues at the most senior levels of the organisation also remains below the proportion of Disabled staff within the wider workforce. While some indicators, such as formal capability processes, are based on very small numbers and should be interpreted with caution, they will continue to be monitored over time.

The Trust will continue to build on the progress made by improving disability declaration rates, strengthening manager capability around disability inclusion and reasonable adjustments, increasing engagement with the Staff Survey, refreshing and raising the profile of the DAWN Staff Network, and supporting initiatives such as the No Excuse for Abuse campaign to ensure the experiences of Disabled colleagues are considered as part of this. The Trust will continue to embed disability inclusion across the organisation and work towards creating a workplace where all colleagues feel valued, supported and able to thrive.

In June 2023, NHS England published its EDI Improvement Plan⁴ with six high impact actions, some of which are aligned to the WDES objectives below.

Progress against 2025/2026 WDES Action Plan

Progress has been made against the 2025/26 WDES Action Plan, with several actions completed or moving into business-as-usual arrangements.

Inclusive recruitment activity has continued, with five Panel Chair training sessions delivered during 2026 and the Recruitment Inclusion Guardian approach progressing. Recruitment outcomes will continue to be reviewed to identify and address any disparities affecting disabled applicants.

The revised Reasonable Adjustments process was launched in February 2026, supported by a central workplace adjustments budget. Three Trust-wide manager training sessions were delivered in partnership with Ward Hadaway. The focus for 2026/27 will be on monitoring the consistency and effectiveness of the process and understanding staff experience of accessing reasonable adjustments.

Work towards Disability Confident Leader status has commenced, supported by the DAWN Staff Network, EDI and Recruitment teams, and will continue during 2026/27.

A core group of staff have completed Active Bystander Train-the-Trainer training. Wider implementation has progressed more slowly than anticipated due to trainer capacity. The next phase will consider alignment with the Trust's No Excuse for Abuse programme and how impact on staff experience can be measured.

Further work is required in relation to career progression and retention. Analysis of exit information has commenced to better understand the experiences of disabled colleagues leaving the Trust. Divisional action will also be strengthened through the use of WDES, Staff Survey and wider workforce data.

During 2026/27, the emphasis will move from delivery of individual interventions towards demonstrating impact, strengthening divisional ownership and monitoring outcomes through existing Trust governance arrangements.

⁴ [NHS equality, diversity, and inclusion improvement plan \(england.nhs.uk\)](https://www.england.nhs.uk/equalitydiversityandinclusionimprovementplan/)

WDES action plan 2026 to 2027

Priority	What the data tells us	Agreed actions	How we will measure success	Monitoring and assurance
1. Bullying, harassment and staff experience	Disabled colleagues continue to report poorer experiences in bullying and harassment, feeling valued and pressure to attend work when unwell.	Use WDES, Staff Survey, Employee Relations, Freedom to Speak Up and staff feedback to identify hotspots. Target management and culture support and use feedback from Disabled colleagues and the DAWN Network to shape improvements.	Improved staff experience for Disabled colleagues, with a narrowing of the gap with non-disabled colleagues in bullying and harassment, feeling valued and pressure to attend work when unwell.	Quarterly review of staff experience data, targeted activity and feedback from Disabled colleagues and the DAWN Network through the EDI Working Group.
2. Career progression and senior representation	Further analysis is required to understand whether Disabled colleagues have equitable access to development, progression and senior roles.	Review progression by band, role and Division. Identify barriers to development, mentoring, talent programmes and promotion, and target support at the areas of greatest need.	Establish the baseline for Disabled staff representation and progression by band. Identify priority gaps and demonstrate improved access to development, mentoring and progression opportunities.	Quarterly monitoring of representation, development access and progression outcomes, supported by feedback from Disabled colleagues and the DAWN Network.
3. Reasonable adjustments and flexible working	82.5% of colleagues with a long-term condition or illness reported that appropriate adjustments had been made, above the latest national position of 75.1%.	Evaluate the central reasonable adjustments budget and MindView, including uptake, timeliness, staff benefit, manager awareness and value for money. Use staff feedback to improve guidance, flexible working and consistency.	Maintain the reasonable adjustments score at 82.5% or above and improve the timeliness and consistency of locally controlled adjustments. Evidence positive staff experience and benefit from the central budget and MindView.	Quarterly review of requests, completion times, central budget and MindView use, staff feedback and outcomes through the EDI Working Group.

Governance and assurance: Progress will be reviewed quarterly through the EDI Working Group, triangulating WDES data with Staff Survey, Employee Relations, Freedom to Speak Up, reasonable adjustments data and feedback from Disabled colleagues and the DAWN Network. Divisions will be responsible for responding to identified inequalities and delivering agreed actions. Key themes, persistent disparities and Trust-wide actions will be escalated through the Trust Delivery Group and relevant People governance, with PCC/Board providing strategic oversight and assurance on progress and impact.



Learning From Deaths report – Quarter 1 (Q1), 2026/27

Purpose of Report

The 'National Guidance on Learning from Deaths' requires each trust to collect and publish specified information on a quarterly and annual basis. This report covers the period Q1, 2026/27.

The Board of Directors is requested to accept this report as assurance of the Trust's approach and agree for the report to be published on the Trust's website as per national guidance.

Executive Summary

This report provides an overview of the Trust's Learning from Deaths activity for Quarter 1 (1 April to 30 June 2026). During the reporting period, the Trust received 484 notifications of death, representing a 9% reduction compared to Q1 2025/26, with six Learning Disability deaths reported. No Inpatient deaths occurred during the quarter. Overall, mortality trends have remained stable, and there is no evidence from the available data to suggest significant health inequalities contributing to mortality outcomes.

The Trust continues to strengthen its Learning from Deaths processes through regular audits of red flag deaths, enhanced Electronic Patient Record (EPR) identification processes and the development of an Incident Review Tool (IRT) audit programme. Progress has also been made in embedding the new Trust-wide Learning the Lessons Forum, which now provides organisational oversight of learning from mortality reviews, patient safety incidents, patient experience, clinical audit and research activities. Positive engagement has been reported, with actions being tracked through an organisational action matrix.

A total of 50 deaths met the Trust's red flag criteria and were reported through Datix, resulting in a range of learning responses, including case record reviews, multi-disciplinary reviews, after action reviews, assurance reviews and patient safety incident investigations. Completed reviews provided assurance that in approximately 74% of cases no further learning response was required, indicating that the care provided did not raise concerns warranting additional investigation.

Analysis of completed learning responses identified recurring themes relating to risk assessment and care planning, recognition and escalation of physical health deterioration, clinical documentation, physical health monitoring, care co-ordination and communication, management of disengagement, substance misuse, and family and carer involvement. These themes have been shared with service leaders and will be disseminated through Care Group Learning the Lessons forums to support quality improvement activity across the Trust.

There were no deaths occurring within the quarter that met the threshold for Duty of Candour, although one historic death from 2025/26 was determined during this reporting period to meet Duty of Candour criteria following completion of a case record review. Appropriate engagement, apology and communication with the family were undertaken in line with statutory requirements.

40 learning responses relating to deaths are currently active, with 22 of them being overdue. The collective average of days learning responses are overdue is 142. There has been a significant reduction (55%) of overdue learning recommendations.

Looking forward, key priorities include resolving delays in obtaining cause of death information from external organisations, improving demographic data quality through greater use of EPR-derived information, implementing the IRT audit programme, and continuing to strengthen mechanisms for organisational learning and assurance under the Patient Safety Incident Response Framework (PSIRF).

Conclusion and Assurance Statement

Considering the outstanding actions described above, this report provides limited assurance that the Trust has effective processes in place to ensure that learning from deaths is identified and widely disseminated to inform service improvements.

Further improvements to learning response completion time are required to provide greater assurance. Development of a Patient Safety Dashboard to support real-time monitoring and escalation is underway and proposals to backfill staffing resource in the Patient Safety team have been prepared for the Executive Leadership Team. It is anticipated that the benefits of these actions will be reflected as gradual improvements in the data evidenced in subsequent publications of this report, but it is anticipated that the benefits will not be fully realised until at least Q4, 2026/27.

Strategic Considerations		BAF Risk	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X	1A	1.1
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.			
Productive: We will improve our productivity and design and deliver services that are financially sustainable.			
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.			

Risks and Assurances

- This report provided limited assurance to the Quality and Safeguarding Committee that the Trust is following recommendations outlined in the National Guidance on Learning from Deaths, owing to delays in learning response completion and overdue learning recommendations. This presents a risk that opportunities for learning and improvement are not identified in a timely manner
- No concerns have been noted in relation to mortality data.

Consultation

- This report has been shared with the Medical Directorate for review. No further feedback was provided
- This report has been reviewed by the Executive Medical Director and areas of feedback have been addressed prior to submission
- Quality and Safeguarding Committee, 8 September 2026.

Governance or Legal Issues

- The report indicates limited adherence to the PSIRF and National Guidance on Learning From Deaths
- Outcome 4 (Regulation 9) Care and welfare of people who use services
- Outcome 14 (Regulation 23) Supporting staff
- Outcome 16 (Regulation 10) Assessing and monitoring the quality of service provision
- Duty of Candour (Regulation 20).

Net Zero Duty Implications

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

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

There are no expected implications in relation to net zero duty.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Data scrutinised through a health inequalities lens shows that the Trust's incident profile in respect to patient demographics is in keeping with that established in research and national data and there are no clear causes for concern identified in patient safety incident data.

Recommendations

The Board of Directors is requested to:

1. Accept this report with limited assurance of the Trust's approach
2. Agree for the report to be published on the Trust's website as per national guidance.

Report presented by: **Lynn Andrews**
 Chair, Quality and Safeguarding Committee

Report prepared by: **Tom Larder**
 Interim Patient Safety Lead

Learning From Deaths

Quarter 1, 2026

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1. Background

In line with the Care Quality Commission's (CQC) recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a framework for NHS Trusts - 'National Guidance on Learning from Deaths'. The purpose of the framework is to introduce a more standardised approach to the way NHS trusts report, investigate, and learn from patient deaths, which should lead to better quality investigations and improved embedded learning. To date, the Trust has met all the required guidelines.

In line with this national guidance, the trust is required to publish annual reports to public board meetings on to key performance statistics and figures.

This report presents the data for 1 April 2026 to 30 June 2026.

2. Current Position and Progress

This section of the report will provide an overview of DHcFT's current position and areas of progress in relation to its mortality review process and procedure.

- Cause of death information is currently being sought through the coroner offices in Chesterfield and Derby but only a very small number of cause of deaths have been made available.
- Medical examiner offices at Acute trusts provide independent scrutiny of non-coronial deaths, including those in the Community. They carry out a proportionate review of medical records and liaise with doctors completing the Medical Certificate of Cause of Death (MCCD). They give families and next of kin an opportunity to ask questions and raise concerns. There is an agreement in place for cause of death information to be released to the DHcFT Patient Safety team for patients open to our service in the six months prior to their death. This agreement is in place with University Hospitals of Derby and Burton (UHDB) and Chesterfield Royal Hospital (CRH) via working relationships between the corresponding Patient Safety teams.

This has been slow to come into force due to numerous technical issues for the varies EPR systems and a shortage of medical examiners. We have escalated the delay to the Integrated Care Board (ICB) Patient Safety Lead, and plans are in place to meet with the representatives from UHDB and CRH in September to seek a resolution. If this issue remains unresolved, the Patient Safety team will escalate this to the Director of Nursing to be raised on the ICB Risk Register.

- Regular audits continue to be undertaken to ensure compliance with policy and procedure for the reporting of Red Flag deaths. This includes auditing complaint data against names of deceased patients to ensure this meets the requirements specified in the National guidance. The last audit was completed 7 May 2026. Red flag deaths are clinical 'red flags' determined through the National Learning from Deaths guidance that indicate the need for care reviews or investigations to determine if the death was potentially avoidable.
- A process is now embedded within the Electronic Patient Record, which aids staff in identifying deaths which meet the threshold for Datix reporting. This process fulfils stage one of the Learning from Deaths procedure.
- In line with changes made to the assurance and oversight of learning post-incident, the Trust Mortality Committee was stood down and superseded by Trust-wide and Care group Learning the Lessons meetings, which aim to triangulate learning across a broader spectrum of sources, including mortality, Patient Safety Incidents, Patient Experience, clinical audit and clinical research. The Trust-wide Learning the Lessons forum holds oversight and governance for the dissemination and embedding of learning post-incident and feed key information and directives to the Care Group Learning the Lessons groups to inform and drive forward quality improvement programmes across the Trust.

The Trust-wide Learning the Lessons has now met twice. The next meeting is scheduled for 7 September 2026. The meeting has seen good engagement from Operational services and has received positive feedback from attendees. Meeting minutes have provided information to be disseminated to the Care Group Learning the Lesson meetings. An Action Matrix has been generated to track progress with actions discussed and agreed within the forum.

Given the meeting remains in relatively early stages, feedback and review will be continuously considered to further embed this into routine practice.

- DHcFT’s Patient Safety team has re-established the Regional Mortality Review Networking as of March 2026 and the first two meetings received great representation from other external partner agencies across the region. A further meeting is being arranged for September 2026 and will focus on shared learning and practice around integration of Learning from Deaths guidance and procedure with the Patient Safety Incident Response Framework (PSIRF).
- We are developing an Incident Review Tool (IRT) Audit Group to strengthen our approach to incident learning under the PSIRF. The purpose is to ensure that outcomes from incident reviews are being shared appropriately, learning is effectively disseminated across services and that there is alignment between the IRT process and the broader PSIRF requirements. It is anticipated that this will be up and running by the end of September 2026.

3. Data Summary of all Deaths

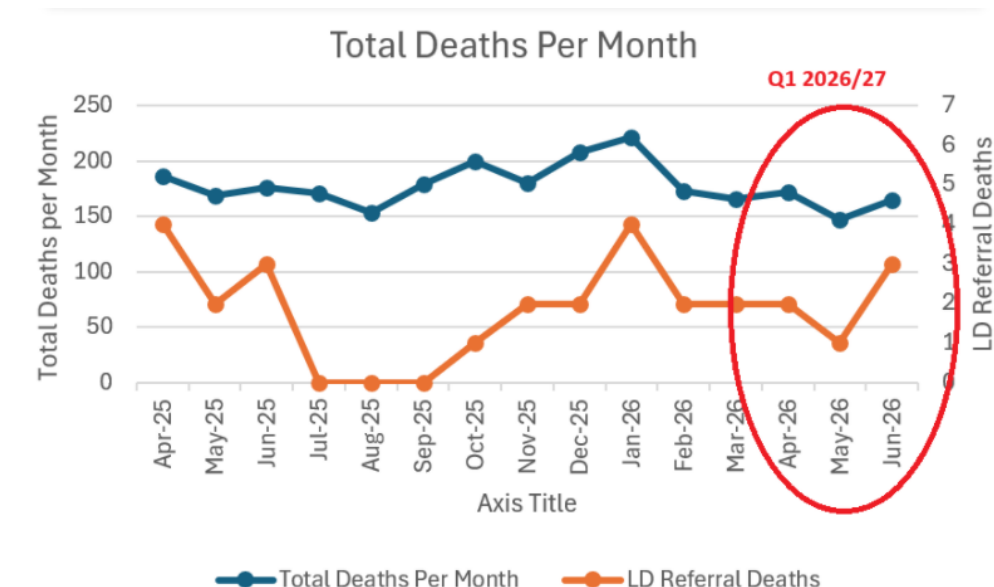
The following table outlines the number of notification of deaths received for the period:

	Apr	May	Jun
Total Deaths Per Month	172	147	165
LD Referral Deaths	2	1	3

*Correct as of 03 August 2026

**Please note that Inpatient and Learning Disability (LD) data is subject to additional scrutiny based upon whether a) the patient has an open Inpatient, and b) there is an open LD referral at time of death regardless of whether the Trust has seen the patient.*

Between 1 April 2026 to 30 June 2026, the Trust received 484 notifications of death of patients who had been in contact with our services or discharged within six months of the incident. Of these deaths, 250 patients were male; 234 female. 397 were white British and 50 Other Ethnic Groups. The youngest age was zero years (in Community Paediatrics), the oldest age recorded was 100. The Trust has reported six Learning Disability deaths in the reporting timeframe.



Overall, total deaths for Q1, 2026/27 are 9% lower than compared to Q1, 2025/26 and LD Referral deaths have been 33% lower than Q1, 2025/26. Total deaths reported across the past five quarters have maintained a stable rate.

4. Review of Deaths

Only deaths which meet the clinical 'Red Flags' (laid out in National Learning from Deaths Guidance) are reported through the Trust incident reporting system (Datix). These deaths are reviewed through processes outlined within the Trust's *Incident Reporting and Investigation Policy and Procedure*.

The table below lists the number of deaths reported through the Datix Incident Reporting System and those that met the criteria for reviewed by the organisation:

Total number of deaths between 1 April 2026 to 30 June 2026 reported on Datix.	42 "Unexpected deaths"
	Seven "Suspected Suicide deaths"
	One "Expected - end of life pathway" <i>NB some expected deaths do not meet the criteria for reporting and have therefore been rejected from the Datix Incident Reporting System. These rejected incidents are not included in the above figure</i>
Incidents assigned for a review.	41 incidents assigned to the Operational Incident Group
	Nine incidents assigned to the Executive Incident Group

The list below details the criteria for which notification of deaths should be recorded through the Trust's incident reporting system:

Any patient, open to services within the last six months, who has died and meets the following:

- Homicide – perpetrator or victim
- Domestic homicide - perpetrator or victim
- Suicide/self-inflicted death, or suspected suicide
- Death following overdose
- Death whilst an inpatient
- Death of an inpatient who died within 30 days of discharge from a DHcFT hospital
- Death following an inpatient transfer to Acute hospital
- Death of patient on a Section of the Mental Health Act or Deprivation of Liberty Safeguards (DoLS) authorisation
- Death of patient following absconson from an Inpatient unit
- Death following a physical restraint
- Death of a patient with a learning disability
- Death of a patient where there has been a complaint by family/carer the Ombudsman or where staff have raised a significant concern about the quality-of-care provision
- Death of a child (this will also be subject to scrutiny by the Child Death Overview Panel)
- Death of a patient open to safeguarding procedures at the time of death, which could be related to the death
- Death of a patient with historical safeguarding concerns, which could be related to the death
- Death where a previous Coroner's Regulation 28 has been issued
- Death of a staff member whilst on duty
- Death of a child under the age of 18 of a current or previous service user who has died in suspicious circumstances
- Where an external organisation has highlighted concerns following the death of a patient, whether they were open to the Trust at time of death or not
- Death of a patient with autism
- Death of a patient who had a diagnosis of psychosis within the last episode of care
- Death of a patient who had a diagnosis of an eating disorder within the last episode of care or within six months of discharge
- Death of a patient open to Crisis Home Resolution team or equivalent at the time of death.

5. Inpatient Deaths

No inpatient deaths were reported during the period of 1 April 2026 to 30 June 2026.

6. Learning Responses for 1 April 2026 to 30 June 2026

The table below outlines the number of deaths that have been recorded through the Trust incident reporting system Datix and the learning response that has been commissioned. All deaths reported through the Datix system meeting the Trust 'red flag' will have an Incident Review Tool completed. This is then reviewed and a decision made as to whether a further Learning Response is required.

Financial Year	Datix	Case Record Review	Patient Safety Incident Investigation	After Action Review	MDT Review	Assurance Review	Other Patient Safety
2023/24	119 deaths	39	16				
2024/25	141 deaths	23	3				
2025/26	255 deaths	28	7				
2026/27	50 deaths	6	1	2	2	1	1

Please note: 2 deaths are currently awaiting a decision.

This indicates that for 74% of the total deaths so far within the period of April to June 2026 the completed Incident Review Tools provided assurance that there were no concerns with care that warranted the commissioning of a learning response.

7. Duty of Candour (DoC) for 1 April 2026 to 30 June 2026

DoC refers to the Trust's obligation under Regulation 20 of the Health and Social Care Act 2008 to be open, honest and transparent with patients (or their families) when mistakes occur in care or treatment that result in significant harm.

Between 1 April 2026 to 30 June 2026, there were no deaths which met the criteria for DoC. It should be noted there are Learning Responses for this period which remain active. Therefore, DoC figures change.

Some catastrophic incidents can be subject to a patient safety learning response (ie Patient Safety Incident Investigation or Case Record Review). DoC for these incidents can be assessed at the date of the report being signed off by the Executive Incident Group. Therefore, the date of which DoC can be assessed for incidents subject to a patient safety learning response can sit outside of the reporting period for which the incident occurred.

One death has been identified during this financial year as DoC having occurred during 2025/26. The Trust continues to support the families involved in engagement with patient safety incident response. The table below provides an overview with narrative around the nature of the DoC and improvement work in place to address this.

No	Incident Date	Date DoC confirmed	Narrative
1	06-Feb-2025	16-Apr-2026	This catastrophic incident was assessed as meeting DoC threshold on 16 April 2026 because the Case Record Review highlighted that there were two periods of time where there is no documentation that the patient received any support from Derby Drug and Alcohol Complex needs team. These periods are approximately six weeks between the last appointment in late October 2024 and the patient's self-referral on 12 December 2024. Approximately seven weeks between self-referral and the patient's death on 4 February 2025. The CoD was: 1.(a) Left Ventricular Failure 1.(b) Ischaemic and hypertensive heart disease.

			Regulation 20 was met because an apology/explanation was given via 'phone to daughter on 23 April 2026. Report released adhering to daughter's preferences. DoC letter and report was 27 April 2026. Regulation 20 has been completed in line with the daughter's requests. Recommendations for improvement relate to the introduction of processes to: • Ensure follow-up of patients who have not received recent contact from the Trust • Inform Key Workers where duty contacts or self-referrals are received to promote continuity of care.
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8. Learning from Deaths Procedure

Following implementation within the Electronic Patient Record which aids staff in identifying deaths which meet the threshold for Datix reporting, the Patient Safety team continues weekly random audits for deaths against the red flags to provide assurance that the new process is working as intended. This process fulfils stage one of the Learning from Deaths in that all deaths are considered for red flags as identified under the national Learning from Deaths procedure.

The Patient Safety team has developed an Incident Review Tool (IRT) audit process which will be allocated to Medical and Nursing colleagues. All national mortality red flags sit within the Trust's overarching red flags for the reporting of deaths as an incident. The process will work to ensure that outcomes from incident reviews are being shared appropriately, learning is effectively disseminated across services and that there is alignment between the IRT process and the broader PSIRF requirements.

Engagement is planned with clinical colleagues to begin implementing the audit and we expect this to be up and running by the end of September 2026.

9. Analysis of Data

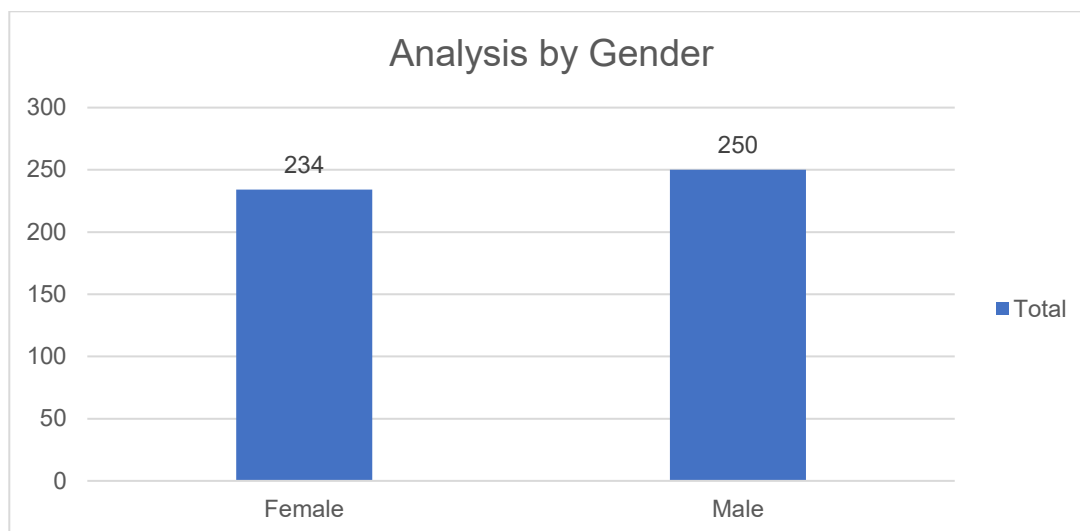
9.1. Analysis per notification system since 1 April 2026 to 30 June 2026

EPR System	Number of Deaths
SystmOne	484
Grand Total	484

The data above shows the total number of deaths reported by each notification system. All of the death notifications were pulled from SystmOne. This clinical record system is aligned to our largest population of patients and a population at greatest risk of death due to the proportion of older people in our care.

9.2. Analysis by gender

The data below shows the total number of deaths by gender 1 April 2026 to 30 June 2026. There is very little variation between male and female deaths; 234 female deaths were reported. compared to 250 males.

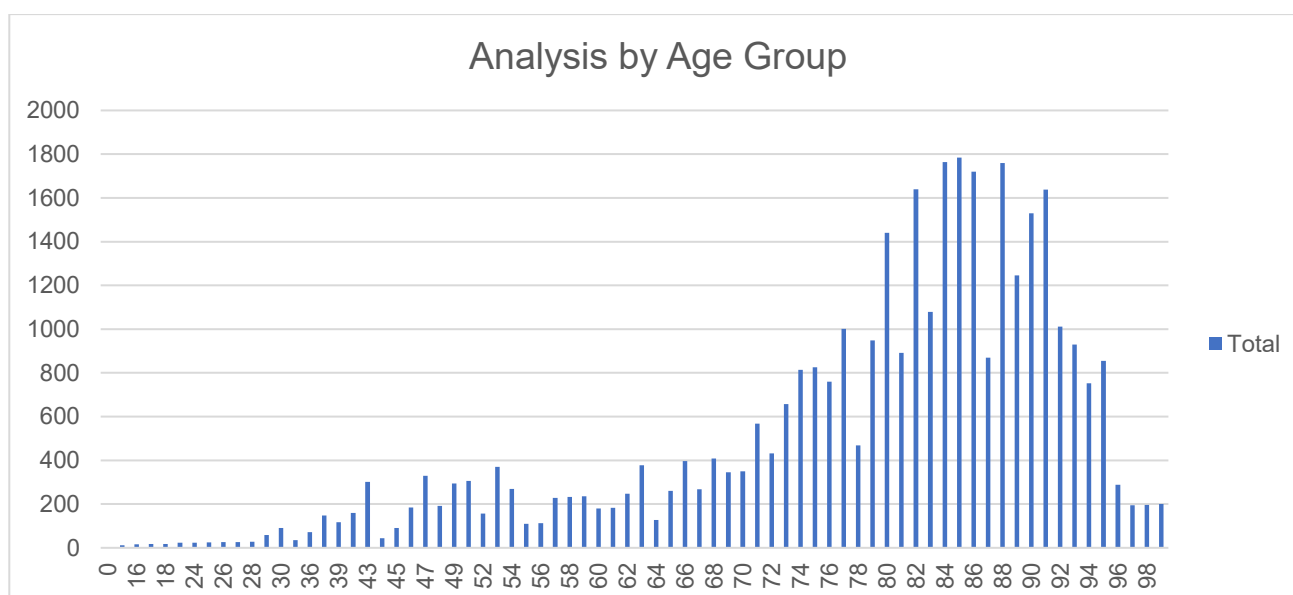


Gender	Number of Deaths	%	Open Referrals to DHcFT
Male	250	52%	52%
Female	234	48%	48%
Grand Total	484		

The data indicates that gender representation in death rates are proportionate to open referrals to DHcFT.

9.3. Analysis by age group

The youngest age was classed as zero (in community paediatrics), and the oldest age was 100 years. Most deaths occurred within the 79 to 89 age groups – this is largely consistent with our 2024/25 report.

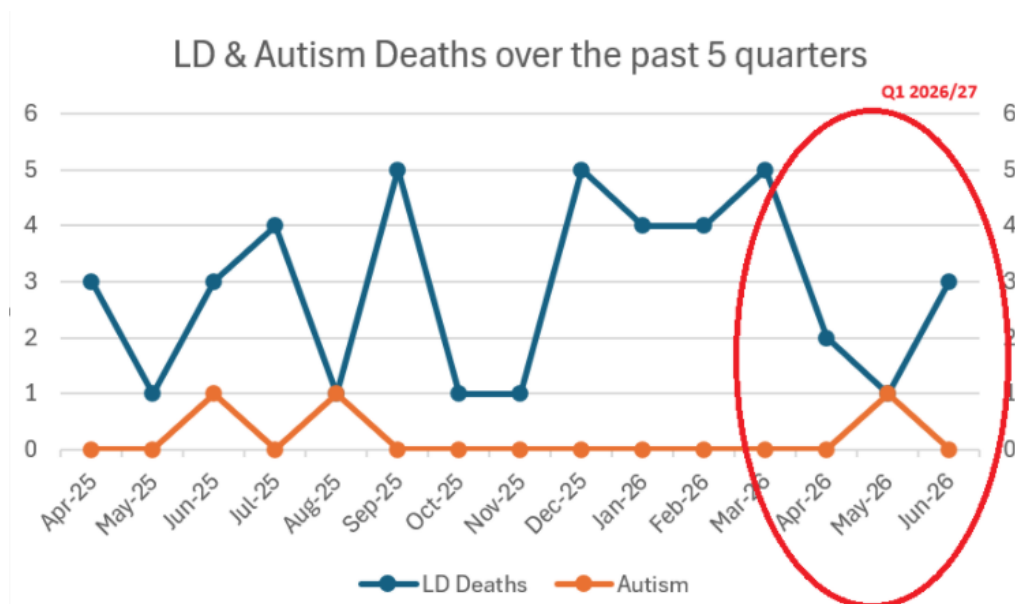


The data indicates that most reported deaths correlate with mortality rates related to natural aging.

9.4. Learning Disability (LD) deaths

The Trust reviews all deaths relating to patients diagnosed with a Learning Disability. The Trust also currently sends all LD deaths that have been reported through the Datix system to the LeDeR programme.

	Apr	May	Jun
LD Deaths	2	1	3
Autism	0	1	0



During, 1 April 2026 to 30 June 2026 the Trust has recorded six LD deaths. Of these six deaths, five were reported through the Trust's Datix system.

Data over the past five quarters shows variability in LD Death rates, whereas Autism rates remain consistently low. Within Q1, 2026/27, LD Deaths were lower than rates throughout Q2, Q3 and Q4 of 2025/26 but comparable to Q1, 2025/26.

9.5. Analysis by ethnicity

White British is the highest recorded ethnicity group with 397 recorded deaths; 50 deaths were from Other Ethnic Groups. The following chart outlines all ethnicity groups, representing the number of deaths, the percentage of total deaths and a comparison to the number of total open referrals to DHcFT:

Ethnicity	%	Open referrals to DHcFT
Asian or Asian British - Any other Asian background	0%	1%
Asian or Asian British - Bangladeshi	-	0%
Asian or Asian British - Indian	-	1%
Asian or Asian British - Pakistani	1%	1%
Black or Black British - African	-	1%
Black or Black British - Any other Black background	0%	0%
Black or Black British - Caribbean	-	0%
Mixed - Any other mixed background	-	1%
Mixed - White and Asian	-	0%
Mixed - White and Black African	0%	0%
Mixed - White and Black Caribbean	-	1%
Not Known	4%	4%
Not stated	2%	1%
Other Ethnic Groups - Any other ethnic group	10%	15%
Other Ethnic Groups - Chinese	-	0%
White - Any other White background	1%	2%
White - British	81%	71%
White - Irish	1%	0%

The data shows that deaths by ethnicity are largely proportionate with the demographic profile of all patients open to DHcFT, with the exception of White British groups who are slightly overrepresented mortality data.

9.6. Analysis by religion

Christianity is the highest recorded religion group with 253 recorded deaths, 93 deaths had no recorded religion assigned. The chart below outlines all religion groups compared to the religious profile of patients with an open referral to DHcFT:

Religion	Number of Deaths	%	Open referrals to DHcFT
Baha'i	-	-	0%
Buddhist	-	-	0%
Christian	253	42%	23%
Declines to Disclose	2	0%	1%
Hindu	-	-	0%
Jewish	-	-	0%
Muslim	7	1%	1%
None	208	34%	36%
Not Recorded	93	15%	29%
Other	2	0%	2%
Pagan	-	-	0%
Sikh	1	0%	0%
Unknown	43	7%	9%
Grand Total	484		

People within the 'Christian' religious group appear over-represented in mortality data. This aligns with research findings that attribute this to Christians largely being an older age population, and therefore, more represented in death rates (Sherwood, 2022). There is no overt indication of any health inequalities in mortality data relating to deaths.

9.7. Analysis by sexual orientation

Heterosexual or straight is the highest recorded sexual orientation group with 352 recorded deaths; 97 have no recorded information available. The chart below outlines deaths in all sexual orientation groups compared against open referrals to DHcFT:

Row Labels	%	Open referrals
Bi-sexual	0%	2%
Gay/Lesbian	1%	1%
Heterosexual	71%	46%
Not Recorded	21%	44%
Not Stated (PERSON asked but declined to provide a response)	7%	8%
PERSON asked and does not know or is not sure	0%	-
Grand Total		

Mortality data would indicate that Heterosexual groups are overrepresented compared to open referrals to the Trust. However, in open referral data, heterosexual groups are the most highly represented group and there are a significantly high number of patients whose sexual orientation is not recorded. Therefore, there is no clear indication of health inequalities in the data.

9.8. Analysis by disability

This section of the report usually focuses on analysis of data relating to the representation of disabilities in mortality data. Unfortunately, recent changes to data capture relating to disabilities within the SystmOne Electronic Patient Record mean that this data is not currently extractable for the Mortality Database, and regrettably we are unable to provide valid data in this report.

This has been escalated to our colleagues in the Information Management, Technology and Records (IMT&R) team. However, we have been advised that there is no fix for this solution. Moving forward, we will be able to collate information as to whether a disability is present or not and unfortunately will not be able to provide statistics relating to the nature of the disability.

Disability Present	%	Open Referrals to DHCFT
No	37%	62%
Yes	64%	38%

The data does not indicate any over representation of disabled persons within mortality data.

9.9. Data quality improvements

A 'demographic comparison report' has been developed by the IMT&R team which allows for the demographic data associated with NHS numbers of reported deaths to be compared to demographic data for all open referrals to DHCFT. Therefore, demographic data in compared and analysed in this report has been generated from the EPR, resulting in greater accuracy and validity.

NB. Please note that our Mortality Database is continuously updated as deaths are reported to us. Many deaths are reported retrospectively and as such the data is rarely static. Data presented in this report is accurate to the time it was generated but is likely to change over time as further deaths are retrospectively reported.

10. Closed Learning response outcomes for the period

11 Learning responses were completed within the last quarter. These consisted of:

- Two After Action Reviews
- One Assurance Review
- Two Multi-disciplinary Reviews
- Six Case Record Reviews
- One Patient Safety Incident Investigation
- One Other Patient Safety Learning Response

The following table details an executive summary of the key learning themes that have emerged from learning responses that were approved by the Executive Incident Review Group over this quarter.

Learning themes have been directly fed back to service leaders and involved staff. They will also be added to the agendas for the Care Group Learning the Lessons Forums for dissemination and to incorporate into quality improvement projects.

Learning Theme:	Detail:
1. Risk Assessment Quality, Dynamic Review and Documentation	The most recurrent theme is the need for more robust, formulation-led risk assessment and ongoing review of risk. Several reports identified that risk assessments were completed but did not always reflect changing presentation, cumulative risks, disengagement, substance misuse, physical deterioration, family concerns or relapse indicators. Care plans were often present but lacked sufficient depth, contingency planning, escalation thresholds or dynamic risk formulation. Learning: Risk assessments and care plans need to be living documents that are routinely updated when risks, engagement levels or clinical presentation change.
2. Escalation of Deterioration and Early Intervention	Several investigations highlighted missed opportunities to recognise and escalate deterioration, whether this related to mental state, increasing suicide risk, mobility decline, physical deterioration, infection, substance misuse or increasing vulnerability. Evidence suggested deterioration was often visible but not always fully reflected within escalation processes or care planning.

	Learning: Staff should place greater emphasis on cumulative risk factors and ensure clear escalation when deterioration, disengagement or increasing complexity becomes evident.
3. Documentation, Record Keeping and Clinical Rationale	Poor or inconsistent documentation was a frequent finding. Reviews identified gaps in risk assessments, post-incident monitoring, care planning, physical healthcare records, wound management documentation, neurological observations, and recording of clinical rationale for decisions. In several cases, care may have been appropriate, but inadequate documentation limited assurance. Learning: Clear documentation of assessment findings, clinical reasoning, escalation decisions and follow-up actions is essential for safe, coordinated care.
4. Physical Health Monitoring and Holistic Care	A number of reports highlighted the importance of maintaining focus on physical healthcare alongside mental health needs. Issues included delayed recognition of infection, inconsistent physical health monitoring, failure to respond to physical deterioration, and the interaction between physical and mental health conditions. Learning: Mental health services must continue to adopt a holistic approach, ensuring physical health concerns are actively monitored, escalated and reviewed alongside mental health care.
5. Care Coordination, Communication and Handover	Several reviews identified fragmented communication between teams, services or wards. Concerns related to ward transfers, information sharing, multidisciplinary oversight, communication with primary care and ensuring important information was handed over effectively. Learning: Stronger multidisciplinary communication, structured handovers and clearer ownership of actions are required to reduce the risk of information being lost across care pathways.
6. Engagement, Disengagement and Assertive Follow-Up	Many cases involved fluctuating engagement, missed contacts, non-attendance or difficulties maintaining involvement with services. Reviews identified ongoing efforts by staff to engage patients but also highlighted the need for clearer escalation pathways and contingency planning when patients disengage. Learning: Disengagement itself should be regarded as a significant clinical risk factor and reflected within care planning, relapse prevention and risk management.
7. Substance Misuse and Co-Occurring Mental Health Needs	Several incidents involved alcohol or substance misuse as a significant factor influencing risk, emotional dysregulation, impulsivity, engagement and vulnerability. Reviews emphasised the need for better joint working, care planning and management of co-occurring mental health and substance misuse issues. Learning: More integrated approaches are required when managing people experiencing both mental health difficulties and substance misuse.
8. Family, Advocacy and Carer Involvement	A recurring positive theme was the value of family involvement in identifying concerns and supporting patients. Conversely, some reports found missed opportunities to involve carers, advocates or important social contacts, particularly where capacity concerns existed or deterioration was reported by family members. Learning: Families, carers and advocates can provide valuable collateral information and should be involved wherever appropriate and lawful.

11.Prevention of Future Death Notices (PFDs)

The Trust did not receive any prevention of future death notices for this quarter.

12.Active Learning Responses & Recommendations

Moving forward, this report will incorporate the data on Learning Response Completion across each quarter (up to a maximum of five quarters) to demonstrate progress over time. Unfortunately, as this data was not captured in previous publications of this report it is not possible to refer to previous Quarter's data at this time.

Outstanding Learning Responses for reported Deaths:

	Q1, 2026/27
Investigation awaiting	14
Report to be finalised by PST	12
Amendments	7
Allocation	2
COD awaiting	2
Investigation received	3
Total	40

	No
No of Overdue Learning Responses	22
Longest Overdue	344 days
Collective Average Overdue	142 days
Collective Median Overdue	119 days
Collective Mode Overdue	196 days

Analysis:

- There are 22 overdue learning responses relating to deaths as of this reporting period. The primary challenge for completion is capacity of learning response leads who sit within Operational services and also delays in learning response allocation, review and approval as a result of the Trust's organisational restructure. The restructure process has now concluded, and there is much greater clarity in roles and responsibilities which is anticipated to aid in progression of incidents through the review process.
- The data indicates that while overall there has been a positive reduction in outstanding learning responses from previous quarters, there remains a significant challenge in progressing vastly overdue learning responses that have been allocated to learning response leads throughout the Operational services.
- The Patient Safety team has now launched 'After Action Reviews' as a formalised learning response methodology and a training video resource has been developed and is accessible to staff on Focus. After Action Reviews are promoted within the PSIRF and learning from peer providers within the Midlands region reflects that these have become their learning response of choice in responding to most incidents. They take the format of a multi-disciplinary discussion with staff involved in the incident, local leads and subject leads/experts where the incident is reviewed using a structured approach, informed by the Systems Engineering Initiative for Patient Safety (SEIPS) framework.

After Action Reviews have been stipulated within our Patient Safety Incident Response Plan since its implementation in March 2024, but prior to this quarter have not been formally introduced or utilised.

- The Patient Safety team has also launched 'Multi-agency/Multi-disciplinary Reviews' as another formalised learning response. Plans are in place to develop training resources which will be uploaded to Focus to support learning response leads in conducting these moving forwards.

Multi-agency/Multi-disciplinary Reviews are utilised to review learning and improvement themes from multiple patient safety incidents that all share similar the circumstances. They are underpinned by human factors theory and acknowledge that 'Work as done' often does not align with 'work as prescribed' by policy, procedure and guidance owing to sub optimal work systems. Rather than explore individual incidents in great depth, participants review several incidents to consider what 'work as done' looks like, and to understand this through a SEIPS lens.

- The introduction of After Action Reviews and Multi-agency/Multi-disciplinary Reviews as additional learning response methodology represents a significant step towards further embedding the PSIRF and will provide much more proportionate and timely learning response moving forward.

Recommendations post learning response:

**Please note, it is not possible to separate this data between death and non-death incidents. Therefore, data relating to outstanding learning recommendations also refers to those generated through review of major incidents that did not result in a death.*

Active		
Rating	Q4 2025/26	Q1 2026/27
High Priority – Cause of Incident	6	1
Medium Priority – Indirectly related to cause of incident	112	95
Low Priority – Not related to cause of incident	63	40
Total	181	136
Overdue		
Rating	Q4 2025/26	Q1 2026/27
High Priority – Cause of Incident	3	1
Medium Priority – Indirectly related to cause of incident	87	39
Low Priority – Not related to cause of incident	37	30
Total	127	70

The table below summarises the number of current overdue patient safety recommendations by year of which they were uploaded to the Datix system:

No of overdue recommendations by year as reported in each quarter:		
Year	Q4, 2025/26	Q1, 2026/27
2020/21	1	1
2021/22	2	1
2022/23	7	2
2023/24	5	0
2024/25	47	7
2025/26	65	37
2026/27	-	22

Analysis:

- The total number of overdue recommendations has reduced by 57 and the total number of active recommendations has reduced by 45 since the last quarter.
- Comparison of overdue recommendations by the year they were uploaded to the Datix system demonstrates progress in closing and completion of older incidents.

- Much of the positive reduction in patient safety recommendations has been achieved through:
 - Updating the records, evidence and audit trail of recommendations that had already been completed but not updated on the Datix system
 - Reviewing and updating recommendations that have been superseded by developments to practice and service delivery (these have been brought to the Executive Incident Review Group for oversight and approval of recommendation closure)
 - Linking and closing duplicate actions where the same recommendation already exists
 - Liaising with relevant leads within the new organisational structure to ensure action ownership is passed on to the correct lead.

References:

Sherwood, H. (2022). Why is the Christian Population of England and Wales declining? The Guardian. Available online: <https://www.theguardian.com/world/2022/nov/29/why-is-the-christian-population-of-england-and-wales-declining>



Safeguarding Children and Adults at Risk annual report - 2025/26

Purpose of Report

The Annual Report provides significant assurance to the Trust and to the Safeguarding Children Partnership and Adult Safeguarding Board that effective safeguarding governance, risk management and assurance arrangements are in place, enabling the Trust to discharge its statutory duties and continuously improve safeguarding practice through scrutiny, learning and partnership working.

Executive Summary

The Trust has continued to effectively discharge its statutory safeguarding responsibilities throughout 2025/26, providing significant assurance regarding safeguarding governance, compliance and practice. Independent scrutiny, including oversight against Care Quality Commission (CQC) requirements, has demonstrated robust systems and processes are in place.

This report outlines the key achievements, challenges and learning from safeguarding activity during the year, including the work of the Safeguarding Unit and Multi-Agency Safeguarding Hub (MASH). Analysis of safeguarding referrals, advice activity, audits and reviews has informed ongoing improvements to training, policy, procedures and clinical practice.

The report provides evidence of the quality, impact and breadth of safeguarding activity undertaken to protect children, young people, adults and families, supported by a strong programme of workforce development, governance, quality assurance and partnership working.

Overall, the report provides significant assurance that the Trust maintains effective safeguarding arrangements, a culture of continuous learning, and robust oversight mechanisms to support high standards of safeguarding practice.

Strategic Considerations		BAF Risk	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X	1A: 1B	1.1-1.3
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X	2A	2.2 & 2.4
Productive: We will improve our productivity and design and deliver services that are financially sustainable.			
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X	4A	4.1 & 4.2

Risks and Assurances

- The Safeguarding Unit maintains robust arrangements for the identification, management and escalation of safeguarding risks. Risks are routinely reviewed through the Safeguarding Children and Safeguarding Adults Operational Groups, with matters requiring strategic oversight escalated to the Quality and Safeguarding Committee, Safeguarding Children Partnership and Adult Safeguarding Board as appropriate
- The Trust can be assured that it continues to meet its statutory safeguarding responsibilities and its commitment to promoting the safety, welfare and wellbeing of children, young people and adults
- The Trust remains compliant with the expectations set out within the NHS Safeguarding Accountability and Assurance Framework (SAAF), which provides clarity regarding safeguarding leadership, governance, accountability and system-wide partnership working, while supporting effective professional practice at a local level
- Performance against the NHS Safeguarding Accountability and Assurance Framework and Section 11 safeguarding requirements provides assurance that the Trust is meeting its legal, statutory and regulatory safeguarding obligations.

Consultation

- The team has consulted internally and with partners throughout the year as appropriate to specific areas of activity, for example, policy development, public protection developments, refining processes within the MASH
- The report is written after consultation between the Assistant Directors for both Safeguarding Adults and Children and the wider team
- Quality and Safeguarding Committee, 8 September 2026.

Governance or Legal Issues

The Trust meets statutory obligations and legal duties with regard to: Mental Health Act [1983]; Mental Capacity Act [2005]; The Care Act [2014]; Children and Families Act [2014]; Human Rights Act [1998] Domestic Violence, Crime and Victims Act [2004] and our internal systems, structures and processes are joined up and effective.

Statutory guidance issued under Section 29 Of The Counter-Terrorism And Security Act 2015

Section 26 of the Counter -Terrorism and Security Act 2015 (the Act) places a duty on certain bodies ("specified authorities" listed in Schedule 6 to the Act), in the exercise of their functions, to have "due regard to the need to prevent people from being drawn into terrorism". This guidance is issued under Section 29 of the Act. The Act states that the authorities subject to the provisions must have regard to this guidance when carrying out the duty.

Health Specified Authorities

80 - The Health specified Authorities in Schedule 6 to the Act are as follows:

NHS Trusts

NHS Foundation Trusts.

- NHS England has incorporated 'Prevent' into its safeguarding arrangements, so that Prevent awareness and other relevant training is delivered to all staff who provide services to NHS patients. These arrangements have been effective and should continue
- The Chief Nursing Officer in NHS England has responsibility for all safeguarding and a Safeguarding Lead, working to the Director of Nursing, is responsible for the overview and management of embedding the Prevent programme into safeguarding procedures across the NHS. This is replicated in our Trust.

Section 325 to 327B of the Criminal Justice Act 2003 (CJA) established Multi-Agency Public Protection Arrangements (MAPPA) in each of the 42 criminal justice areas of England and Wales.

These arrangements are designed to protect the public, including victims of crime, from serious harm by sexual or violent and other dangerous offenders. MAPPA are the statutory arrangements for managing sexual and violent offenders. MAPPA is not a statutory body but is a mechanism through which agencies can better discharge their statutory responsibilities and protect the public in a co-ordinated manner.

The Trust meets the required standards for our regulators and our professional regulatory bodies Codes of Practice, ie, Safe, Caring, Effective, Responsive, Well Led and Safeguarding are the gold threads that runs throughout. We apply national guidelines and evidence based best practice, eg, NICE, DoH, National Statistics.

The Trust contributes as an equal partner in multi-Agency forums eg, MAPPA; MARAC; Channel; Child and Adult Safeguarding Boards and sub groups and takes part in peer assessment, benchmarking and self-assessment and assurance.

The Trust invests in staff across multiple agencies and services to ensure high levels of competence and confidence and achieve consistently good practice that is constantly updated and refreshed within a culture of learning from both successful and adverse situations.

Net Zero Duty Implications

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

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

Safeguarding activity is not directly impacted by the Trust's Net Zero Duty. However, there are relevant indirect considerations. The use of digital platforms to support safeguarding meetings (eg MARAC, MASH, multi-agency reviews and supervision) continues to reduce travel requirements and associated carbon emissions, supporting sustainable models of care.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

The field of safeguarding adults at risk of abuse is underpinned by the following six key principles:

- **Empowerment** – of the individual to make decisions
- **Protection** – support and representation for those in need
- **Prevention** – of abuse/neglect as well as helping the person to reduce the risks of harm and abuse that are unacceptable to them
- **Proportionality** - responses should be least restrictive to the person's rights
- **Partnerships** – working collaboratively to prevent, identify and respond to harm

- **Accountability** – and transparency in delivering safeguarding. Safeguarding is intended to support those most vulnerable to being at risk of abuse, many of whom have protected characteristics relating to age, gender, disability, religion and sexual orientation. The intention of safeguarding governance and due diligence is to recognise the vulnerability to abuse of people engaging with Trust services and apply the principles to all aspects of safeguarding practice.

The Trust cannot mitigate all the population health outcomes for children and adults in our community. However, it can influence the wider system and put in place preventative or detective measures to reduce preventable harms.

The Trust cannot stop abuse, but it can assess, engage, offer early detection and intervene to reduce the impact of abuse and monitor the harms associated with being at risk of harm.

Recommendations

The Board of Directors is requested to:

1. Receive and approve the Safeguarding Children and Adults annual report
2. Receive the report which is offered by the Executive Lead with significant assurance regarding the fulfilment of legal and statutory duties.

Report presented by: **Lynn Andrews**
 Chair, Quality and Safeguarding Committee

Report prepared by: **Safeguarding team**
 including MASH Health, Safeguarding Trainers and the
 Operational team members

Deborah Archer
Safeguarding Unit Co-ordinator

Safeguarding Children and Adults at Risk Annual Report 2025/26



Derbyshire Healthcare NHS Foundation Trust
Reporting Period: 1 April 2025–31 March 2026
Date of Submission: September 2026

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INTRODUCTION

This Annual Safeguarding Report 2025/26 provides assurance to the Trust Board on how Derbyshire Healthcare NHS Foundation Trust (DHcFT) has met its statutory responsibilities to safeguard children, young people, their families and adults at risk.

Safeguarding is central to delivering safe, effective and compassionate care. DHcFT recognises that harm can occur at any life stage and is committed to protecting individuals from abuse, neglect and exploitation, while promoting person-centred care, dignity and the best possible outcomes for those who use our services.

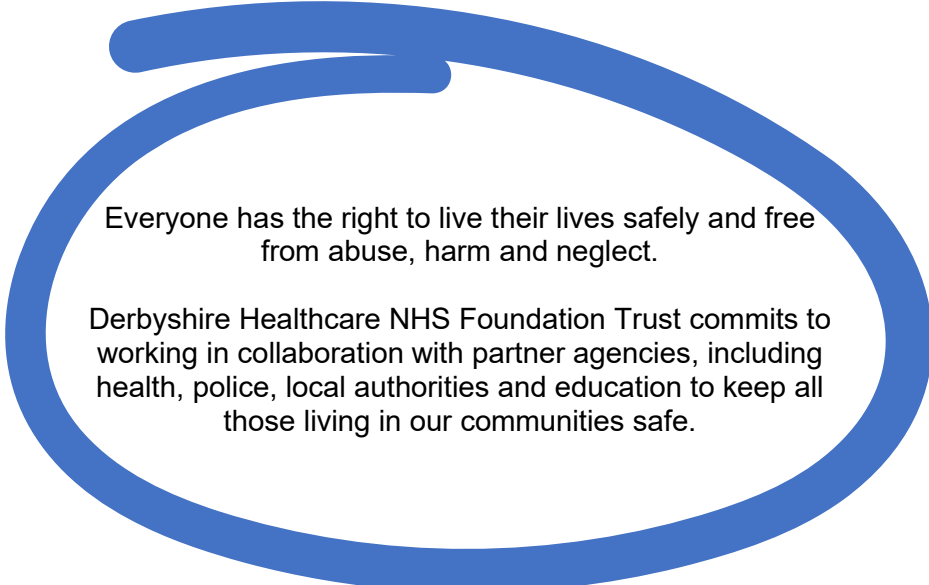
The purpose of this report is to provide a review and analysis of the year's safeguarding activity and our objectives for the coming year.

The Trust fulfils its safeguarding duties in line with the Children Act 1989 and 2004, the Care Act 2014, the Mental Capacity Act 2005, Working Together to Safeguard Children and relevant national NHS safeguarding guidance. Safeguarding is embedded as a priority responsibility for all staff, supported by clear leadership accountability, robust clinical governance arrangements and effective partnership working across local safeguarding systems.

This report describes the Trust's safeguarding governance framework and provides oversight of safeguarding activity across all services, demonstrating how safeguarding concerns are identified at the frontline and escalated through Operational, Divisional and Executive assurance routes to the Trust Board. It outlines how learning from safeguarding incidents, audits, Child Safeguarding Practice Reviews, Safeguarding Adult Reviews and multi-agency processes has informed service improvement and strengthened safeguarding practice.

The Trust Board retains ultimate accountability for safeguarding and receives assurance through the Quality and Safeguarding Committee, executive leadership oversight and established governance processes.

Our thank you continues to all the staff within the Trust for all their continued commitment and the hard work that goes towards safeguarding our staff, communities and people who use our services. As a Trust team, we will do our utmost to continue '*keeping up the great work*' so we can continue to move forward together and with our partners agencies.



Everyone has the right to live their lives safely and free from abuse, harm and neglect.

Derbyshire Healthcare NHS Foundation Trust commits to working in collaboration with partner agencies, including health, police, local authorities and education to keep all those living in our communities safe.

MAP OF TRUST LOCALITY



SAFEGUARDING UNIT REPORTING STRUCTURE

Derbyshire Healthcare NHS Foundation Trust (DHcFT) is committed to effective partnership working to discharge its statutory safeguarding responsibilities. The Trust works closely with Derby City and Derbyshire Safeguarding Children Partnership and Adult Safeguarding Boards, with representation and attendance at all relevant subgroups and multi-agency forums. Effective safeguarding is underpinned by strong partnership working, an open and transparent culture, consistency in practice, respectful challenge and collaborative co-operation.

Robust governance arrangements are in place to ensure clear oversight and accountability. Safeguarding Children and Adults Operational Groups report on a twice-yearly basis to the Quality and Safeguarding Committee, which in turn reports directly to the Trust Board. This provides assurance on safeguarding performance, governance, risks and learning across the organisation.

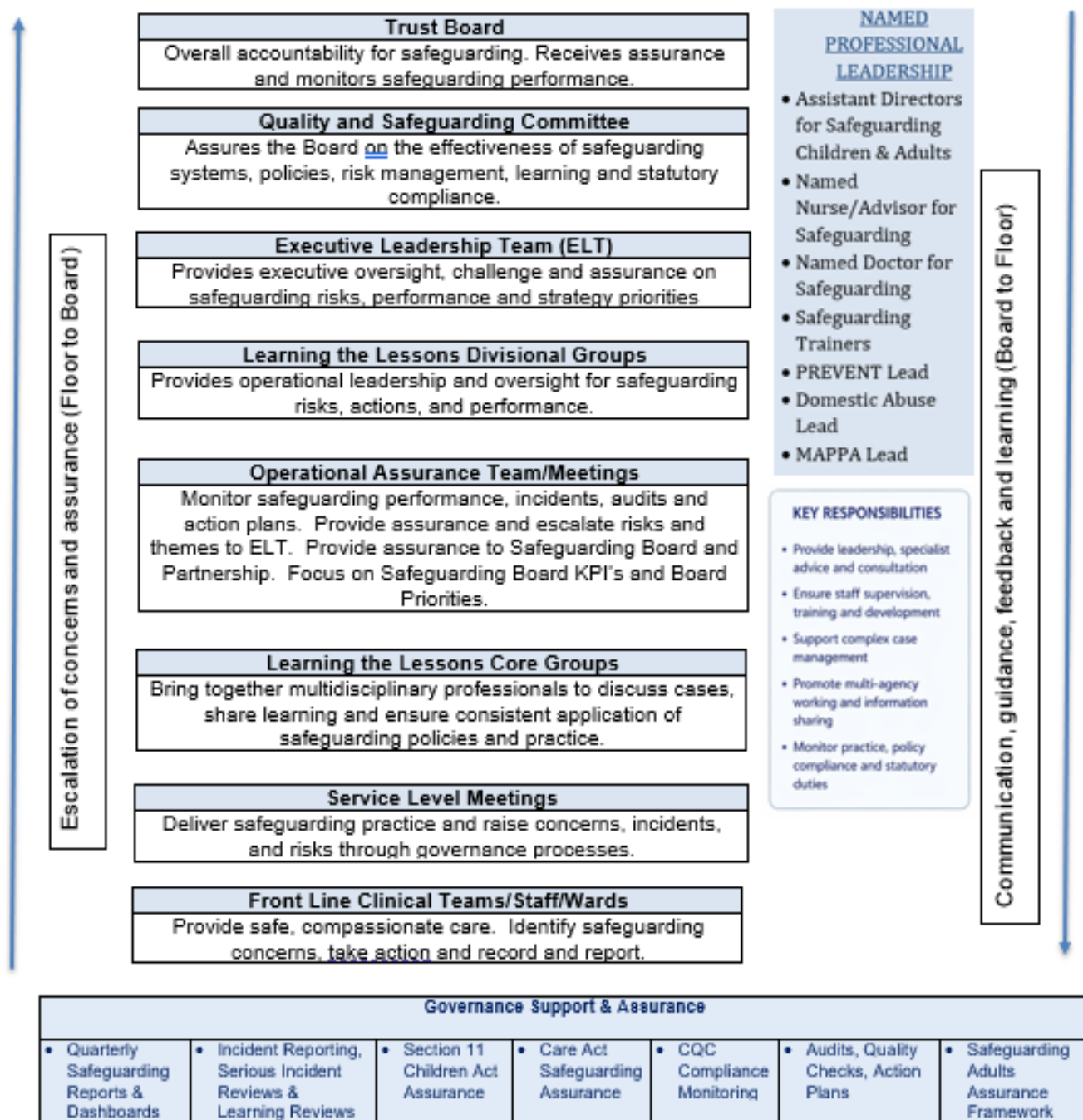
The Safeguarding Unit produces a bi-monthly Safeguarding Information report, which is disseminated across the Trust. This ensures that staff are kept informed of new guidance, legislation, policy updates, learning and other relevant safeguarding information to support safe and effective practice.

Both Safeguarding Operational Groups have established escalation routes to raise matters requiring Executive or Committee consideration, including inclusion on the Trust Risk Register where appropriate. In addition, these groups promote the sharing of good practice, innovation and lessons learned, enabling continuous organisational learning and improvement across the Trust.

GOVERNANCE AND ESCALATION

The Safeguarding Governance Structure follows a clear “floor-to-board assurance” model, ensuring concerns and assurance move both upward to the Board and downward to frontline teams.

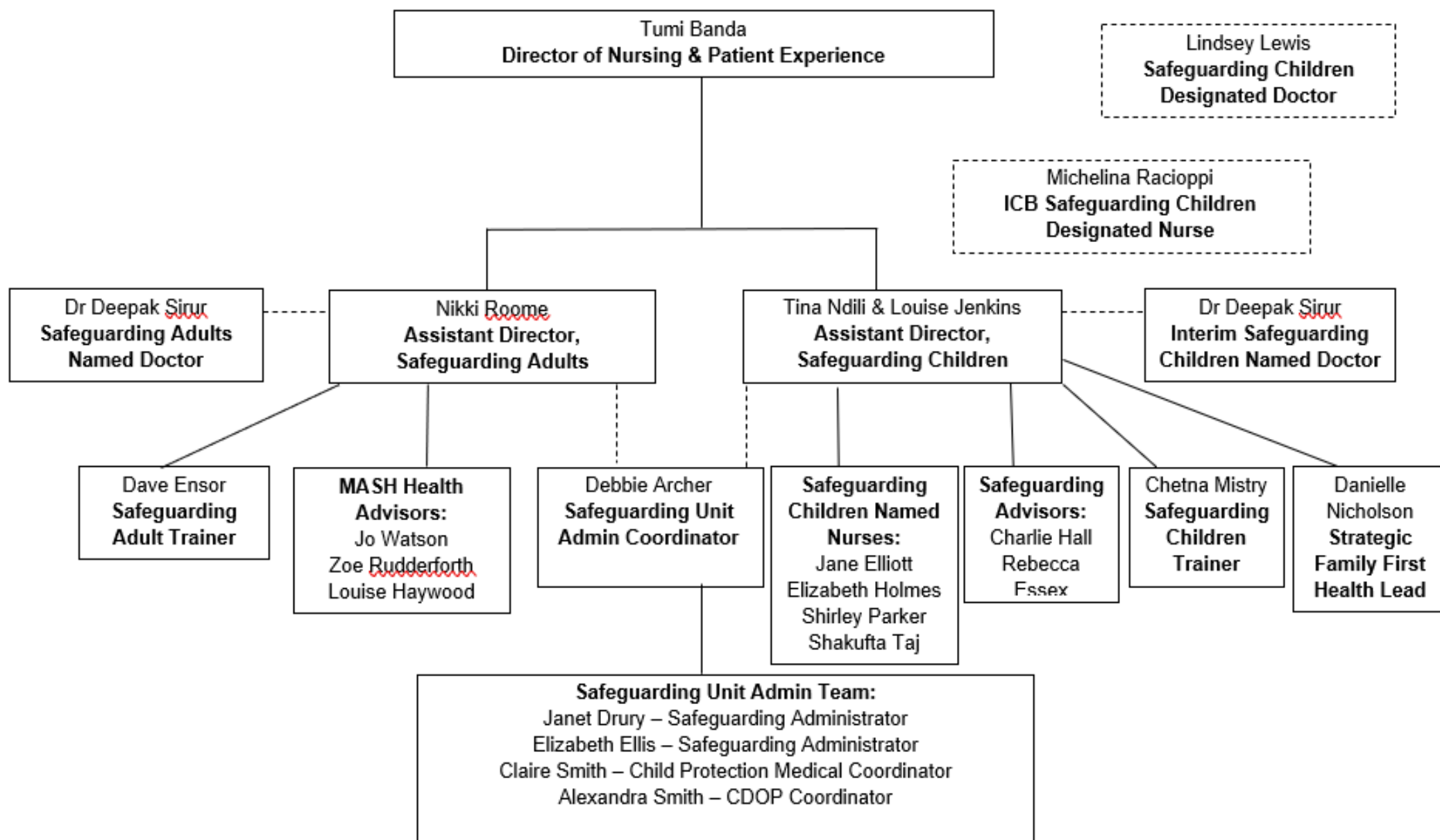
DHcFT Safeguarding Governance Structure:



This structure provides:

- clear oversight of safeguarding risks and quality issues
- escalation pathways for safeguarding concerns
- Executive accountability
- Board assurance and scrutiny
- communication from Board back to frontline services
- safeguarding reports
- safeguarding dashboards
- incident reviews
- serious incident/learning reviews
- Section 11 Children Act assurance/SAFF assurance
- Care Act safeguarding assurance
- CQC compliance monitoring
- audit programmes and action plans.

SAFEGUARDING UNIT STRUCTURE



SAFEGUARDING LEGISLATION

Safeguarding adults and children is enshrined within UK law and is key to ensuring that all NHS statutory safeguarding functions are fulfilled as per legislation, statutory guidance, and regulations.



DHcFT Safeguarding Policy and Procedures are located on the Trust Intranet for staff to refer to and are regularly reviewed and updated.

Links to Policies:

[Safeguarding Children Procedures](#)

[Safeguarding Adults Policy & Procedures](#)

SAFEGUARDING CHILDREN'S PERFORMANCE DASHBOARD – 2025/26



Item	Metric	2025/26			
		Quarter 1	Quarter 2	Quarter 3	Quarter 4
1	Number of advice calls received and reported	322	346	340	340
2	Number of supervision/group sessions	142	112	115	115
3	Number of Information Exchange Form Research completed / strategy discussions or meetings attended	86	74	69	50
4	Number of child Protection medicals – Suspected NAI & Neglect	20	47	34	15
5	Number of children discussed at CHANNEL	11	15	15	16
6	Number of MARAC cases with children discussed at MARAC	244	257	189	206
7	Number of referrals to CSC	3	14	11	7
8	CIC Caseload - Born In Lives In	211	211	218	213
	CIC Caseload - Born In Lives Out	346	332	335	322
	CIC Caseload - Born Out Lives In	3	1	2	0
	Total CIC Caseload	560	544	555	535
9	Number of Child Deaths	12	11	15	8
10	Number of children referred for risk of FGM	0	1	2	0
11	Number of children open to CIN Services within the quarter	224	215	196	159
12	Number of Early Help Assessments (EHA) completed	86	66	88	98
13	Number of STANDARD Domestic Violence Notifications received from the Police.	295	284	280	315
	Number of MEDIUM Domestic Violence Notifications received from the Police.	426	394	432	455
	Number of HIGH Domestic Violence Notifications received from the Police.	116	110	86	88
14	Number of children on a child protection plan	2977	2972	2976	2952

	Number of children on an Education Health Care Plan (EHCP)	2962	2855	2776	2699
15-17	Number of children on an EHCP who are on a Child Protection Plan	217	213	206	201
	Number of children on an EHCP who are on a Child In Need Plan	103	106	105	112
18	Number of children admitted to an adult inpatient bed	1	0	1	0
19	Number of young carers	41	40	38	37
20	How many babies on the Trust Mother & Baby Unit	14	9	12	4
	How many of these are on a Child Protection Plan	0	1	1	1
21	Number of LADO Referrals made that met threshold	0	0	0	0

Key for acronyms within Dashboard:

NAI	Non-Accidental Injury
MARAC	Multi Agency Risk Assessment Committee
CSC	Children's Social Care
CIC	Children in Care
FGM	Female Genital Mutilation
CIN	Children In Need
EHCP	Education Health Care Plan
LADO	Local Authority Designated Officer

Analysis of Safeguarding Children Performance Dashboard

The Safeguarding Children's Performance Dashboard for 2025/26 provides quarterly analysis of key child protection and welfare metrics, this continues to highlight demand alongside shifts in service delivery and System pressures.

Advice Calls and Supervision Sessions

The number of advice calls remained consistently high across all quarters, indicating sustained demand for safeguarding advice and support. Supervision and group session activity reduced in Q2 and stabilised thereafter. This pattern may reflect workforce and capacity pressures, with ongoing review of the supervision model to ensure it continues to meet staff needs and supports effective practice.

Child Protection and Case Metrics

Child Protection medicals were at its highest in Q2 before declining in subsequent quarters, while the number of children discussed at Channel shows a gradual increase across the year. MARAC activity remains high, with some fluctuation across quarters. The total Children in Care caseload remains stable, indicating continued statutory demand without significant escalation.

Domestic Abuse Notifications and Child Plans

Domestic violence notifications remain a significant highlight of safeguarding demand, with an increase in medium-risk notifications over the year and sustained high-risk cases. Early Help Assessments increased in the latter half of the year, alongside a reduction in Children in Need, suggesting a shift toward earlier intervention.

It is noted that data relating to Child Protection Plans and some safeguarding indicators are currently subject to data quality issues, with work underway through the SystemOne Safeguarding Working Group to strengthen accuracy and reporting assurance.

SAFEGUARDING ADULTS' PERFORMANCE DASHBOARD – 2025/26

			QUARTER			
	METRIC		1	2	3	4
1	Number of adult safeguarding referrals made where allegation is within their own service		100	141	140	131
2	Number of PiPoT referrals substantiated within Organisation.		N/A	1	1	0
3	Full attendance at MAPPA 3 meetings (monthly)		100%	100%	100%	100%
4	Number of MAPPA 3 cases within the Trust.		2	3	3	2
5	Number of adult cases discussed at CHANNEL.		12	13	15	11
6	MASH Health strategy discussions for children		141	111	104	88
7	MASH Health strategy discussions for adults		15	9	13	7
8	Number of domestic violence medium cases discussed at triage		370	329	312	371
9	Number of urgent DoLS authorised.		7	6	10	10
10	Number of Standard DoLS applied for to the LA.		0	0	1	10
11	Number of people with an authorised DoLS granted by Supervisory body.		0	0	0	1
12	Number of referrals to coroner for people who have passed away and have an authorised DoLS granted by Supervisory body		0	0	0	0
13	Sexual Safety in Trust Inpatient Service. Incidents of alleged inappropriate sexual behaviour, sexual assault and sexual abuse to a patient by another patient or other party	Other Party to Patient	5	6	2	4
		Patient to Other Party	0	0	3	1
		Patient to Patient	2	9	3	8
		Patient to Staff	1	6	0	4
		Staff to Patient	2	2	2	1
		Staff to Staff	0	0	0	0

Key for acronyms within Dashboard:

PiPoT	Person in a Position of Trust
MAPPA	Multi Agency Public Protection Arrangement
MASH	Muli Agency Safeguarding Hub
DoLS	Deprivation of Liberty Safeguards
LA	Local Authority

Analysis of Safeguarding Adult Performance Dashboard

The performance dashboard continues to provide data that offers a level of assurance to the Trust regarding safeguarding activity, trends, and areas of challenge.

Where we see themes emerging, we have endeavoured to provide more learning for staff. We identified themes around domestic violence which has focussed bespoke learning from Domestic Homicide Reviews for Inpatient staff. We have developed 'Guidance for identifying when domestic abuse may be a concern'.

The Adult Safeguarding Trainer remains in post and the safeguarding training compliance has improved and the evaluations continue to be positive. The improved compliance is felt to be in part to be due to the delivery of safeguarding training on MS Teams.

The Operational meeting provides a safe space to discuss complex cases and safeguarding themes that may need to be raised with the Safeguarding Adults Board or require further focus in our training. It is also used as a forum to feedback learning from Domestic Homicide Reviews and Safeguarding Adult Reviews. This meeting provides assurance to the Safeguarding Adults Board that performance is being monitored and managed effectively, and that progress is being made towards meeting the agreed key performance indicators (KPI) targets.

The Safeguarding team continues to ensure that the organisation understands the importance of the right referral at the right time to ensure the referrals submitted are appropriate and of good quality. Guidance has been developed to support this.

MASH Health Advisors continue to consistently meet the required KPIs as part of this Trust contracted activity.

The quality priority and improvement work around professional boundaries, and sexual safety is ongoing and visible throughout DHcFT. We have responded to all sexual safety incidents in a timely manner offering support and assurance to our service users, staff and our multi-agency partners. We have provided training to the i-care programme around sexual safety and boundaries which has had positive feedback. Sexual safety training has now commenced within other areas within the organisation.

The performance and evidence provided in this annual report demonstrates that we have continued to meet our statutory and Public Protection duties and also reflects the key strategic priorities of the Derby and Derbyshire Safeguarding Adult Boards, Prevention: Making Safeguarding Personal and Quality Assurance.

DHcFT SAFEGUARDING CHILDREN TRAINING POSITION



Introduction

This annual report provides an overview of Safeguarding Children Mandatory Training at DHcFT for the financial year 2025/26. It covers training delivery, capacity, challenges, and progress.

Mandatory training compliance and training delivery (See tables 1-3 below for data)

Safeguarding Children Level 1 continues to be delivered by e-learning. Safeguarding Children Level 2 is offered both by e-learning and face-to-face virtual training via Microsoft Teams. Safeguarding Children Level 3 is offered via face-to-face virtual training on Microsoft Teams. However, this competency can also be achieved through external training provided by the Derby and Derbyshire Safeguarding Children Partnership and by professional body training in specialist areas.

During the financial year 2025/26, Safeguarding Children Level 1, Level 2, and Level 3 (1-yearly) met and exceeded the Trust compliance target. Safeguarding Children Level 3 (3-yearly) was slightly below the Trust target at 84%.

Across the year, 1,900 training spaces for Level 2 and Level 3 were offered. Of these, 1,210 were booked, 925 people attended the training, and 206 did not attend.

In addition to mandatory training, additional Safeguarding Children analysis training was developed and delivered to the 0 to 19 service.

A narrative video about the Safeguarding Unit and the support offered was produced, along with a written piece explaining what intersectionality is and its significance to safeguarding and shared via the Safeguarding Unit information-sharing document.

Challenges

Key challenges continue to include non-attendance at training due to staff sickness, work commitments, personal reasons and unknown factors. Some classes had to be cancelled because the minimum number required for the training (eight) was not met, despite emails being sent out to inform staff that spaces were available. Some classes also had to be cancelled due to trainer absence. Some staff are not booking on due to difficulties booking via ESR and some believe they do not need to complete the training or that they have already achieved the competency through external training. These challenges are being addressed by contacting non-compliant staff, correcting training records and supporting them to book onto the training.

Progress

Safeguarding Children Level 2 and Level 3 training continues to align with the Core Skills Training Framework and the Intercollegiate Document for Safeguarding Children and is updated to reflect changes in legislation, guidance, and national, regional and local learning from Child Safeguarding Practice Reviews and other relevant case studies.

The Safeguarding Children resource pack, which includes national and local guidance and policy links, continues to be regularly updated and shared with participants to enhance learning.

Safer Internet Day was supported by the Trust's executive members and will continue as an annual event. Some of the session topics will also be available as continuous professional development short sessions moving forward.

Table 1

2025/2026 Training Compliance Data	Total (n)	Compliant	Not Compliant	Compliant (%)	Change from last year
Total	3,334	2,946	388	88%	-1%
Safeguarding Children - Level 1 - 3 Years	728	697	31	96%	3%
Safeguarding Children - Level 2 - 3 Years	696	622	74	89%	-1%
Safeguarding Children - Level 3 - 1 Years	332	298	34	90%	-4%
Safeguarding Children - Level 3 - 3 Years	1,578	1,329	249	84%	-3%

Table 2

2024/2025 Training Compliance Data	Total n	Compliant	Non-Compliant	Compliant (%)
Total	3,146	2,815	331	89%
Safeguarding Children Level 1 - 3 Yearly	670	620	50	93%
Safeguarding Children Level 2 -3 Yearly	571	516	55	90%
Safeguarding Children Level 3 - 1 Yearly	345	325	20	94%
Safeguarding Children Level 3 - 3 yearly	1,560	1,354	206	87%

Table 3

Spaces and Attendance 2025/2026	Capacity	Booked On	Attended	Did Not Attend
Total	1,900	1,210	925	206
Safeguarding Children Level 2	395	136	68	23
Safeguarding Children Level 3	1,505	1,074	857	183

DHcFT SAFEGUARDING ADULTS – TRAINING POSITION

This report provides an update to the 383 Safeguarding Adults Level 3 (including Levels 1 & 2, plus DoLS, MCA & Wrap/PREVENT) training in DHcFT covering dates 1 April 2025 to 31 March 2026.

Target audience for Safeguarding Adults (UKL Skills for Health – Core Skills Training Framework [v1.6.2]):

- **Level 1:** all staff working in health care settings
- **Level 2:** all practitioners who have regular contact with patients, their families or carers, or the public
- **Level 3:** registered health care staff who engage in assessing, planning, intervening and evaluating the needs of adults where there are safeguarding concerns (as appropriate to role).

1 April 2025

Training Name	Target Group	Compliant	Non-Compliant	Compliant %	Change from 2024
383 LOCAL C Safeguarding - Adults Level 1 (Non Clinical) (3-yearly)	764	689	75	90%	Up 7%
383 LOCAL C Safeguarding - Adults Level 1+2 (All Clinical) (3-yearly)	542	507	35	90%	Up 2%
383 LOCAL R Safeguarding - Adults Level 3 (3-yearly)	1,834	1,710	124	93%	Up 6%

1 April 2026

Training Name	Target Group	Compliant	Non-Compliant	Compliant %	Change from last year
NHS CSTF Safeguarding Adults - Level 1 - 3 Years	812	748	64	91%	Up 1%
NHS CSTF Safeguarding Adults (Version 2) - Level 2 - 3 Years	641	589	52	92%	Down 1%
NHS CSTF Safeguarding Adults (Version 2) - Level 3 - 3 Years	1,837	1,706	131	93%	No change

In the period 1 April 2025 to 31 March 2026, there have been 46 classes with an initial maximum enrollee number of 30. Class sizes were increased in expectation of higher demand due to new inpatient units and increased staffing. This has given a potential 1,380 attendees over the year. However, the increased demand has not happened. There have been 790 attendees, achieving compliance in this subject, which is a 57% attendance rate (a 3% increase on average last year). Most common reasons given by staff for withdrawing are staffing/work commitments/sickness. In total, six classes were rescheduled due to low numbers (less than nine staff involved).

All MCA, DoLS and PREVENT training at Level 3 has been included in a full day training package alongside the Safeguarding Adults level 3. All staff members attending the class will receive full compliance in Safeguarding Adults Level 3 (including Levels 1 & 2), MCA, DoLS, Prevent and WRAP. This has proved to be effective in Training Passport compliance.

Half day Level 2 classes are also offered, specifically for non-registered staff, delivered via MS Teams. 12 classes have been offered, maximum numbers being 35, with 420 spaces in total. There have been 175 attendees in total (including the rescheduled) giving 41% attendance (1% increase on last year). These are separate to e-Learning Levels 1 and 2 classes available. Numbers are expected to be higher in the forthcoming year. However, staff continue to cite work commitments/or alternatively use e-Learning option for convenience.

Actions taken to increase attendance for all levels

There are still a number of staff that book and do not attend. Reasons given are (in order of activity): work commitments/staff shortages; illness; lack of childcare; personal reasons; no reason given.

Requesting compliance reports from Systems Information team enables identification nearing or 'out of date' and then 'bcc' emailing all to advise of their status. Staff are advised to check ESR and book onto available classes. Personal liaison to offer last minute cancellations taking other blended approaches to encouraging staff participation. This is reported to be effective in reaching compliance.

ONLINE HARMS TRAINING

DHcFT's first Safer Internet Day 2026 continuous professional development awareness day was co-developed with the Derby and Derbyshire Safeguarding Children Partnership, Local Authority, Police and services across the organisation and delivered across the organisation. The event used the UK Safer Internet Centre campaign theme, "Smart tech, safe choices – Exploring the safe and responsible use of AI". The day consisted of guest speakers, shared multimedia, discussions on current online harm themes, hints and tips and learning from case studies. The recordings from the day, along with the associated resource pack, are available on Focus, the Trust intranet page.

LEVEL 4 SAFEGUARDING TRAINING

A Level 4 annual safeguarding training was commissioned and delivered to the Safeguarding team on 4 December 2025. This was designed and delivered by an independent Safeguarding and Leadership Consultant to meet the team's required competency. The days aims and objectives were:

Session one: Exploring the current context for safeguarding practice

- Settling into a development programme - Arriving, checking in with each other, slowing down and getting on the balcony
- Exploring the current context of safeguarding practice including:
 - Progress since our development workshop last year
 - Changes and developments in safeguarding work locally since last year
 - Current and likely future context for Safeguarding Practice locally and regionally
 - Organisational developments and other systemic changes.

Session two: Exploring the emerging policy context-themes and reports
Emerging themes from the National Safeguarding Panel

- Safeguarding children with mental health needs
- Safeguarding pre-school children with parents with mental health needs
- Extrafamilial harm
- Pre-birth assessment processes
- Race, racism and safeguarding children
- Rise in online harm
- IICSA creating a Child Protection Authority.

Session three: A focus on the Families First Partnership reforms, local implementation and implications for the Trust

- An overview of the reforms
- An exploration of local implementation
- An exploration of implications and issues for the Trust.

Session four: Creating an action and development plan for the next year

- Identifying and agreeing an initial action plan and developmental priorities for work over the next year.

The trainer presented an extremely informative, challenging session which was enjoyed by all and received excellent feedback and evaluation. The team was able to achieve their competence as required by both adults and children, 'Safeguarding: roles and competencies for health care staff'.

SAFEGUARDING CHILDREN ADVICE THEMES



Top five advice themes:

	2024/25	2025/26
1	Parenting Skills/Capacity/Basic Care	Parenting Skills/Capacity/Basic Care
2	Domestic Abuse	Neglect
3	Neglect	Domestic Abuse
4	Physical Injury/Abuse	Child Mental Health
5	Emotional Abuse	Emotional Abuse

We continue to analyse the calls for advice into the Safeguarding Unit:

- Domestic Abuse is again in the top five themes. Staff are more confident and competent in dealing with Domestic Abuse in their practice, are more familiar with procedures and the impact on families. Domestic abuse remains a Trust priority and is covered extensively in safeguarding training
- Neglect is still a significant issue/challenge within our organisation. Parenting skills/capacity, basic care and self-neglect features regularly
- Due to the nature of a large proportion of the Trust patient group, we have a large number of staff concerns around our patients'/clients' capacity to parent, where mental health, substance misuse and or learning disability features
- A new top five theme seen this year of concerns around child's mental health. Whilst it has always been high, it has not met the top five previously
- Drop in physical injury/abuse – 148 compared to last year's at 248.

SAFEGUARDING ADULT ADVICE THEMES

Top five advice themes:

	2024/25	2025/26
1	Mental Health	Mental Health
2	Domestic Abuse	Domestic Abuse
3	Physical Injury/Abuse	Historical Abuse
4	Historic Abuse	Sexual Abuse/Exploitation
5	Financial Abuse	Financial Abuse

Analysis – the top five advice themes demonstrate consistency across both years, with Mental Health and Domestic Abuse remaining the most frequent areas of advice. Historical Abuse has increased in prominence in 2025/26 and Sexual Abuse/Exploitation now appears within the top five, suggesting increased awareness and complexity in relation to trauma, exploitation and sexual harm. Financial Abuse remains a consistent theme, while Physical Injury/Abuse no longer appears in the top five. Overall, the data provides assurance that safeguarding advice continues to focus on key areas of adult safeguarding risk and complexity.

CHILDREN AUDITS

Continuous Quality Audits (CQA) have remained embedded across the Children's Division throughout the year, with a minimum of five clinical records audited per team. The programme continues to provide a structured approach to monitoring quality, strengthening clinical practice, and evidencing improvement.

This has been further strengthened through Fundamentals of Care (FoC) cross-check activity, providing triangulated assurance against frontline practice, patient experience, and documentation standards.

Key improvements across services

- Improved care plan content, including greater integration of physical health considerations, consistently reflected in both audits and FoC cross-checks
- Strengthened risk assessment narratives, improving clarity of clinical formulation and shared understanding of risk
- Improved goal setting, with clearer evidence of care progression
- Positive practice noted through FoC:
 - More consistent patient-centred documentation
 - Evidence of care being delivered in line with documented plans
- Ongoing work to embed consistency through template development.

Continued need to strengthen

- Clinical analysis and formulation within records
- Consistency in risk documentation
- Clear articulation of goals and outcomes.

FoC cross-checks also highlight

- Positive staff engagement and commitment to care quality
- The importance of evidencing "what difference care has made" within records.

ADULT AUDITS

Focussed audits are on our safeguarding audit plan for 2026.

Multi-agency audits are undertaken three-monthly by City and County Adult Safeguarding Boards. DHcFT contributes to these. The learning from the audits is reflected in Level 3 training and disseminated throughout the Trust via information sharing documents, by the learning on one page document (LOOP).

Themes for the last year have been:

- Domestic Abuse in Older Adults
- Adult Safeguarding Repeat Referrals
- Self-Neglect
- Cuckooing.

SECTION 11 AUDIT

NHS Derby and Derbyshire integrated Care Board (DDICB) and Derby and Derbyshire Safeguarding Children Partnership (DDSCP) wrote to the Trust on 6 June 2025 after receiving the Section 11 self-assessment and undertaking the virtual safeguarding children quality meeting on the 20 May 2025. The assurance was noted as below in Table 1.

Table 1

Section 11 compliance rating (2023/24)	
Standard 1	Full compliance except Section 1.3 rated amber/green
Standard 2	Full compliance
Standard 3	Full compliance
Standard 4	Full Compliance
Standard 5	Full compliance

The ICB wrote, “We would like to take this opportunity in thanking you and the Safeguarding team for your hard work and strong commitment to safeguarding children, young people and families in Derby and Derbyshire”.

Standard 1

Dr Deepak Sirur, took on a sessional one programmed activity (PA) commitment to act as interim Named Doctor for Children, Safeguarding, we thank him for his continued support to this priority role.

The Trust is looking at various options after there has been no success in the new permanent appointment of a Paediatrician into this position. We are now looking to partner with other trusts in the long term.

Due to this interim position, full compliance to this section could not be awarded.

SAFEGUARDING ADULTS’ ASSURANCE FRAMEWORK (SAAF)

The SAAF return was submitted in December 2024 and the SAAF interview was completed by the ICB in July 2025. The letter provided a ‘Good’ assurance rating with innovation, which was the highest level of assurance available. It concluded that DHcFT's safeguarding arrangements:

Fully met the requirements of the NHS Standard Contract SC32
 Demonstrated strong safeguarding leadership, expertise, and understanding
 Contained no significant omissions or areas of concern
 Showed safeguarding training compliance above 90%
 Evidenced service improvements and a commitment to continuous safeguarding development.

SEXUAL SAFETY

DHcFT is committed to a zero-tolerance approach to sexual misconduct, implementing the NHS Sexual Safety Charter through robust policies, training, reporting mechanisms, support services and ongoing organisational improvement to ensure staff and patients are safe. Key actions taken include:

- Establishment of a multi-professional Sexual Safety Working Group to oversee delivery of the Charter principles
- Development and review of policies, including alignment of the PiPoT (Person in a Position of Trust) process and reporting arrangements
- Delivery of sexual safety and boundaries training, awareness sessions and inclusion of sexual safety within staff I-CARE programme. Implementation of the Sexual Safety Charter continues, with training now being rolled out across clinical and non-clinical services to strengthen awareness, reporting and appropriate responses to sexual safety concerns
- Promotion of clear reporting routes through Datix, Freedom to Speak Up and management processes, with all allegations taken seriously and investigated appropriately
- Provision of support for those affected by sexual harm, alongside partnership working with police, Social Care and Human Resources where concerns arise.

The Trust continues to strengthen its approach through training, policy development, learning from incidents, staff engagement and implementation of NHS England guidance, providing ongoing assurance to the Quality and Safeguarding Committee that sexual safety remains a strategic priority.

PUBLIC PROTECTION



MARAC – Multi-Agency Risk Assessment Conference

The Multi-Agency Risk Assessment Conference (MARAC) provides a multi-agency approach to managing cases of domestic abuse where the victim has been identified as being at high risk of serious harm or homicide. MARAC meetings bring together representatives from both statutory and voluntary agencies with the aim of sharing information and developing a safety plan for victims and their families with a view to reducing the risks and the likelihood of repeat victimisation.

Victims do not attend the meetings but are represented by an Independent Domestic Violence Advisor (IDVA) who speaks on their behalf and ensures that the victim's voice and wishes are considered within safety planning discussions. MARAC meetings continue to be held weekly, alternating between the south and north of the county, enabling cases from both areas to be discussed on a fortnightly basis.

During the reporting period 01 April 2025 to 31 March 2026, there were 1,232 MARAC referrals for the South MARAC (Derby City, Erewash and South Derbyshire). This represents a relatively small increase of 69 referrals compared to the previous reporting year. The MARAC Repeat Referral process was implemented during the last reporting period with an aim to reduce the number of referrals and is now embedded within the Safeguarding Team and other partner agencies.

Since the previous annual report, there has still been ongoing concerns regarding the attendance of the North MARAC mental health representatives (not attended by DHcFT Safeguarding team) at this meeting. The issue was looked into again in November 2025 with named individuals provided to represent Mental Health teams in the North at meetings. Despite this, the Safeguarding team continued to receive reports of inconsistent attendance and limited representation from Mental Health Services within the North MARAC process. Given the importance of mental health involvement within multi-agency risk management and safety planning, these concerns have now been escalated at a senior level to support resolution and ensure partner agency responsibilities are consistently fulfilled.

The role of the MARAC mental health representative in Derby City has remained consistent since responsibility was transferred to them during the last reporting period. Mental health representation for Erewash and South Derbyshire was also transferred back from the Safeguarding Team to the respective Mental Health Teams. However, due to staffing pressures, service demands and structural changes within teams, maintaining consistent attendance has proved challenging at times. To improve continuity and provide a more sustainable arrangement, one identified representative has now been allocated to cover both Erewash and South Derbyshire. This transition process is currently ongoing and expected to be completed within the coming weeks.

Charlie Hall remains as the MARAC representative for children's health in Derby City. During the reporting period, the Safeguarding Team temporarily completed children's health research for MARAC over a three-month period due to staffing pressures within School Nursing. Responsibility for this work was subsequently handed back to them on 05/03/26 once staffing levels had stabilised and services were able to resume responsibility for this task.

DHcFT is represented at the quarterly MARAC Steering Group meeting by Elizabeth Holmes (Named Nurse Safeguarding Children). The MARAC Steering Group agenda covers routine review of data, referrals, attendance, victim engagement, information sharing, action planning, equality and diversity, administration, funding, governance, and key documents to support effective MARAC oversight.

Operation Encompass is a police and education early information safeguarding partnership enabling educational settings to offer immediate support to children experiencing domestic abuse. DHcFT is represented at the quarterly multi-agency Op Encompass Working Group by Elizabeth Holmes (Named Nurse Safeguarding Children).

MAPPA (Multi-agency Public Protection Arrangements)

The purpose of MAPPA is to *"Protect the public, including previous victims of crime, from serious harm by sexual and violent offenders"* (MAPPA Guidance (2012) Version 4.0, Section 1). These arrangements are statutory.

It does this by ensuring that all relevant agencies work together effectively to:

- Identify all MAPPA offenders
- Complete comprehensive multi-agency risk assessments
- Devise, implement and review robust multi-agency risk management plans
- Focus the available resources in a way which best protects the public from serious harm.

DHcFT continues to maintain 100% attendance at MAPPA 3 meetings and case reviews.

DHcFT attends out of area MAPPA 3 meetings where the offender is known to Derbyshire.

PREVENT:

The Prevent Strategy has three specific strategic objectives.

- Respond to the ideological challenge of terrorism and the threat we face from those who promote these views
- Prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support
- Work with sectors and institutions where there are risks of radicalisation that we need to address.

Channel is a part of the UK's Prevent strategy; it is a voluntary program requiring consent from the individual before any support is offered. This consent is crucial for participation in Channel. Support is tailored to the individual's needs after consent is given. DHcFT has a Prevent Policy which reflects our commitment to the strategy.

DHcFT is fully committed to attendance at the Channel meetings. The Assistant Director of both Safeguarding Adults and Children and the Named Safeguarding Doctor attend the Channel meetings. We continue to maintain attendance at these meetings within the targeted requirements. This despite increasing demands on the volume. initial monthly half day meetings have continued as whole day meetings covering potential interventions for adults and young people. Test and Learn meetings in the 'pre-channel' space have also been held to consider cases which were sub threshold but may need further consideration to manage risk and support needs of clients referred requiring additional attendance from a senior member safeguarding team. This is managed through considered cross cover for the meeting between the Named Doctor and the Children and Adults Assistant Directors through the day so that core business within the trusts safeguarding unit can continue to be supported.

Increased challenges are faced with respect to perceived involvement or not of mental health services for cases where risks are heightened but not necessarily in the context of treatable mental illness/disorder and the Trust's involvement at the meeting allows for discussion around such complexities with respect to thresholds but also to take back internally should further clarity be required on decisions made by teams. As to whether relevant cases meet the threshold for mental health team involvement or not. There is also appearing to be a rise in the number of cases where neurodiversity is potentially impacting on risk profile of individuals and challenges associated with relevant assessments, identification and management plans where services and provision are not directly commissioned to be provided by the trust or provision is not at a level to timely or urgently meet the volume of referrals.

Our Level 3 safeguarding adults training supports this process by focus on understanding the risk of radicalisation to ensure staff understand the risk and build the capabilities to deal with it, communicate and promote the importance of the duty and ensure staff implement the duty effectively. Training is updated on a regular basis to reflect national expectations and training concordance is monitored through the Trust's mandatory training assurance systems. This is further supported by advice and guidance from the Trust Safeguarding team who will provide clarity and or support where appropriate relevant escalation policies.

SOCEX:

The purpose of the SOCEX (Serious Organised Crime and Exploitation) meeting is to co-ordinate a multi-agency approach to identifying, preventing and disrupting serious organised crime and exploitation, safeguarding children, young people and vulnerable adults through shared intelligence, agreed actions and effective partnership working. The priorities are as follows:

- Pursue: Deliver an effective multi-agency collaboration to target, disrupt and prosecute exploiters
- Prevent: Prevent people from engaging in serious organised crime or becoming victims of exploitation
- Protect: Protect the community from the risk of serious organised crime and exploitation and increasing awareness and resilience against this threat
- Prepare: Working together to ensure an effective multi-agency structure and response to serious organised crime and exploitation.

Aims of a SOCEX meeting across the County of Derbyshire:

- To provide a coordinated multi-agency response to serious organised crime and exploitation affecting children, young people and vulnerable adults, ensuring risks are understood and addressed collectively
- To identify, assess and disrupt organised criminal activity, including child sexual exploitation, criminal exploitation, modern slavery and related harms, using shared intelligence and agreed tactical actions
- To safeguard and protect children, young people and vulnerable adults, prioritising prevention, early intervention and contextual safeguarding responses linked to people, places and peer groups
- To agree, monitor and progress operational actions, ensuring clear ownership, timescales and accountability across agencies through action logs and tasking arrangements
- To strengthen partnership working and information sharing, ensuring effective links with the Derby and Derbyshire Safeguarding Children Partnership and the Derbyshire Safeguarding Adults Board
- To support community safety and disruption activity, including targeting high-risk locations, organised crime groups, and repeat perpetrators, while promoting community engagement and awareness
- To provide assurance to strategic boards, escalating risks, themes and learning to SOCEX Strategic and Safer Communities governance structures as require.

This is underpinned by information and intelligence sharing and has 100% attendance now by the Safeguarding Team, mainly the Safeguarding Advisor on a six-monthly basis. This has also provided an interesting development opportunity.

MASH HEALTH ADVISORS 2025/26

The aim of this report is to reflect on the Health Advisors activity from 1 April 2025 to 31 March 2026.

MASH Adults

MASH Health received approximately 1466 referrals from Adult Social Care, this is a decrease in referrals from the previous year, which takes it back to subsequent data from previous years.

The reduction is aligned to the implementation of a triage system, which has provided a gateway for the referrals that do not meeting threshold. This has allowed for MASH Health to prioritise purposeful research and enhance the quality of exchange to the referrals received, thus workload has continued but in a more meaningful manner.

A total of 1,458 professionals were liaised with in relation to these referrals which is a 10.33% decrease from the previous year. This is more reflective of subsequent years, as the previous year had been up by 37%.

A total of 44 adult strategy discussions were attended which is a reduction of 39 from the previous year. This could be suggestive of the improved system of triaging referrals and the quality of exchange to mitigate the need for a further meeting to discuss.

The themes of abuse for adult safeguarding's remain largely consistent with previous years with – domestic abuse, financial and material, self-neglect, psychological, neglect and acts of omission, physical and sexual being the main categories of abuse for referrals. Referrals involving mental health and substance misuse remain stable in data. This review period has noted the need to introduce 'risk to others', 'homelessness' and 'hate crime' as themes within adult safeguarding.

MASH Children

MASH Health attended a total of 517 strategy meetings. which is an increase of 16.18% on the previous year, which had been down by 20%, evidencing that this reduction was not sustained.

There continues to be a high volume of both children and adults being considered as part of these strategy discussions. The number of people discussed monthly is consistent, ranging between 495 and 545 per quarter. On a monthly basis however, this can range from 13 to 105 people and evidences the peaks and flows around research duties.

Domestic Abuse Triage

A total of 1,382 medium risk domestic abuse cases were discussed at medium risk domestic abuse triage – an increase of 77 cases to last year, which had seen an increase of 16% on the previous year.

As of 13/04/26 meetings have increased to three a week and will include open referrals to Children's Social Care. This is likely to increase data further and will be reflected in next year's data. This is foreseen to increase workload with the team and will be monitored.

Protecting Children Online (PCOT)

There has been an increase of 14 PCOT cases being discussed within PCOT triage since the last year, which had already seen a 44% increase from the year before, evidencing sustained activity in this area of MASH duties. Terms of Reference and improved processes in relation to PCOT have now been agreed and introduced into duties. MASH Health included advice from Records Manager and Data Protection Officer in the Information Management, Technology and Records team at DHcFT in these agreements.

Advice Calls

MASH Health Advisors completed a total of 331 advice calls during this period, which is a 103% increase on the previous year's figures, which had also been up by 64% to the subsequent year. This data is collected from emails received from the Safeguarding Unit. However, many colleagues in the Trust now contact MASH Health direct and therefore, this figure is likely to be slightly higher. Advice calls are in relation to safeguarding adult concerns for the Trust. This data is evidencing the sustained and ongoing increase of activity for MASH Health in their advice duties. MASH Health now support advice calls for DHcFT Inpatient staff in Derby City, which has accounted for this sustained increase.

Delegated Inquiries

MASH Health continue to complete Section 42 delegated enquiries for incidents that take place on DHcFT Derby City Inpatient wards. These figures have increased in the review period going from 12 in the first quarter to 30 in the fourth quarter. The total number this year was 87 and is an increase of 27.94% from last year. Delegated enquires can sometimes entail multiple attempts to retrieve information and the need to liaise with multiple professionals, often generating a high volume of work that is incorporated into a working day.

Additional Information and Conclusion

MASH Health had staff changes in this review period due to maternity leave. This led to staff training duties, which was managed internally alongside other duties without any additional support.

Adults safeguarding duties in some areas have reduced. However, this has allowed for the improved quality in our responses and the ability to effectively respond to pressures across other duties. Overall, this has been another busy period for MASH Health that has been effectively managed by the team.

FAMILY FIRST PARTNERSHIP

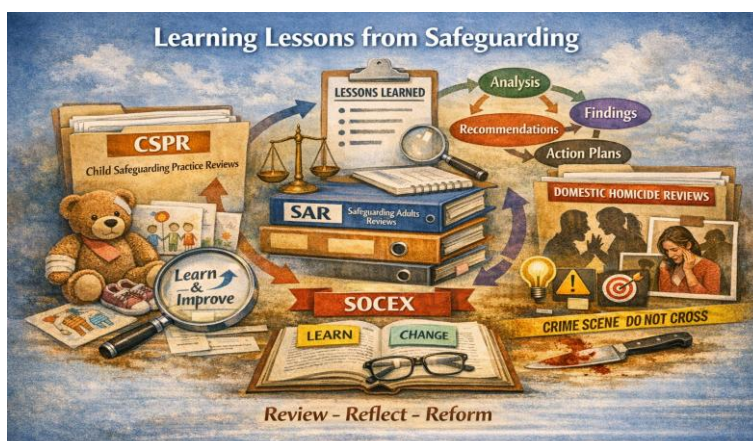
From January 2026, a dedicated health lead has been in post to drive Family First reforms within the health sector and there has been significant progress since. We've held briefings with the 0-19 service, Child and Adolescent Mental Health services, GP Practices, Primary Care and Midwifery teams to raise awareness and strengthen implementation. While these sessions have been very positive, it's clear that Midwifery teams need further support to fully embed the early help offer. We are prioritising this moving forward.

Our efforts are currently focused on two main strands: Family Help and Multi-Agency Child Protection teams (MACPT). Health has played a central role in piloting a new MACPT team within the City. We've secured funding for a full-time specialist Health Visitor who is now completing joint visits and acting as a key decision maker in section 17/47 progression for children at risk of harm. There is also funding for a full-time Mental Health Worker to support Social Workers where there is a possible mental health need within the family unit that is affecting their ability to effectively parent the children in the household. Additionally, we're in discussions to fund a MACPT health lead position to build on the pilot's progress and sustainability.

On the Family Help side, we're ensuring that preventative work happens at the earliest opportunities for children and families. We're starting pilots with GP Practices to facilitate community conversations involving Midwifery, Health Visitors and family hubs. These pilots focus on families in the antenatal period who are considered more vulnerable, so that an early package of care can be put in place to support them and prevent escalation.

Recognising the need for more support in Midwifery, we're developing a business case for an Early Support Worker to be placed within the University Hospitals of Derby and Burton, which will help Midwifery teams recognise and implement early help. Alongside this, a new model for Family Help is being developed to bring partner agencies together sooner. A mapping exercise is underway to ensure all professionals are aware of the available support for families.

LEARNING FROM REVIEWS



Child Safeguarding Practice Reviews (CSPR)

As a Trust we are fully engaged in Child Safeguarding Practice Reviews and associated meetings. This includes attendance with rapid review and learning meetings, completion of single-agency reflections, contribution to partnership discussions, and robust governance oversight to ensure learning is embedded and actions are delivered.

The Trust is notified by the Safeguarding Children Partnership when a Child Safeguarding Practice Review is initiated and when the organisation is identified as a relevant agency. The Safeguarding team co-ordinates the Trust's response, sharing agency information and supporting System-wide reflection on safeguarding practice, the Trust's involvement with the child and family, decision-making, professional judgement and risk assessment, strengths in practice and areas for development.

DHcFT has been involved in two Child Safeguarding Practice Reviews (CSPR) throughout the year with minimal involvement. However, has provided input. Some of the key themes from both reviews and lines of enquiry are substance use by mother and the presence of substances in and around the home. Safeguarding measures and escalation, including how written agreements were used in the Child Protection Plan. Tolerance to child neglect and processes surrounding elective home education not being sufficient in ensuring education status being known to the correct Local Authority and Health services.

The Trust's Quality and Safeguarding Committee is kept abreast of all CSPR via reports and in turn, updates the Trust Board. We continue to strengthen the response to learning from reviews on behalf of the Trust.

Learning Briefs and Best Practice Guidance are developed by the Partnership to disseminate the learning throughout the organisation.

Domestic Homicide Reviews (DHRs) and Safeguarding Adult Reviews [SARs]

DHcFT maintained full engagement in all Safeguarding Adult Reviews and Domestic Abuse Related Death Reviews throughout 2025/26, providing senior representation, agency reports and action plan oversight. Learning from reviews has been embedded through safeguarding training, supervision, policy development and practitioner forums, with assurance provided that recommendations are progressing within agreed timescales.

SAFEGUARDING CHILDREN PARTERSHIP AND SAFEGUARDING ADULT BOARDS PRIORITIES/ PARTNERSHIP WORKING

The DDSCP 2025/26 priorities build on *Working Together to Safeguard Children (2026 update)* and learning from Child Safeguarding Practice Reviews (CSPRs). The Partnership focus is on early identification, effective multi-agency working and embedding learning into practice.

1. Neglect and Early Help

- Strengthening understanding and identification of neglect across all agencies
- Consistent use of thresholds and early help pathways
- Improved professional curiosity and escalation where progress is not seen.

2. Children's Experiences of Domestic Abuse

- Improving recognition of children as victims in their own right
- Strengthening multi-agency responses to high-risk cases
- Alignment with MARAC and learning from Domestic Homicide Reviews (DHRs)

3. Online Harm and Exploitation

- Safeguarding children from online abuse, grooming, and exploitation
- Professional confidence in recognising digital risk indicators
- Alignment with Prevent and Channel duties of impact on frontline practice.

Derbyshire Safeguarding Adults Board (DSAB) Strategic Plan 2025–2028, the three strategic priorities are:

Prevention – supporting people to stay safe, reducing the risk of abuse and neglect, promoting early intervention, and strengthening community awareness.

Inclusion and Empowerment – ensuring people are at the centre of safeguarding, promoting Making Safeguarding Personal, valuing lived experience, and enabling adults to have choice, control and involvement in decisions affecting them.

Performance and Quality Assurance – improving the effectiveness of safeguarding arrangements through audits, reviews, learning, scrutiny, and holding agencies to account for safeguarding outcomes.

Our partnership logos include:



TRUST TRANSFORMATION (Learning Lessons)

The Learning the Lessons (LtL) meetings have been established across all care groups through a governance structure to triangulate learning, drive quality improvement, and provide assurance of embedded practice change. The agenda covers:

- Patient safety incidents and post learning and learning responses
- Complaints and compliments – patient and carer experience
- Safeguarding practice and learning – SARs, etc
- Clinical audits and QI
- Inquests/Prevention of Future Deaths
- Local and national learning
- Inspection CQC/SEND learning and practice.

A Trust-wide LTL meeting has now been established (first meeting May 2026), creating an overarching structure for oversight. This will support the triangulation of learning across the organisation, provide oversight to Board and quality committee and support the two-way flow of information. There is demonstrable progress in:

- Structured learning forums
- Consistent thematic review
- Strengthening of learning culture.

TEAM COMPLIANCE RATES

As at 23 April 2026:

	Supervision	Appraisal	Training
Safeguarding Children	100%	100%	100%
MASH	100%	100%	66%

KEY OBJECTIVES 2026/27



GLOSSARY OF ACRONYMS

Acronym	Full Form
CIC	Children In Care
CIN	Children In Need
CQC	Care Quality Commission
CPA	Care Programme Approach
CSE	Child Sexual Exploitation
CSC	Children's Social Care
CSPR	Child Safeguarding Practice Review
DCHS	Derbyshire Community Health Services
DDSCP	Derby and Derbyshire Safeguarding Children Partnership
DDICB	Derby and Derbyshire Integrated Care Board
DHCFT	Derbyshire Healthcare Foundation Trust
DHRS	Domestic Homicide Reviews
DV	Domestic Violence
DOLS	Deprivation Of Liberty Safeguards
EHCP	Education Health Care Plan
ESR	Electronic Staff Records
FGM	Female Genital Mutilation
IEF	Information Exchange Form
KPI	Key Performance Indicators
LA	Local Authority
LADO	Local Authority Designated Officer
MDMs	Multi-Disciplinary Meeting
MAPPA	Multi-Agency Public Protection Arrangement
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hub
MCA	Mental Capacity Act
MHA	Mental Health Act
MOGP	Markers Of Good Practice
MSP	Making Safeguarding Personal
MST	Microsoft Team
NAI	Non-Accidental Injury
PCOT	Protecting Children Online Team
PDL	Professional Development Lead
PiPoT	Person in a Position of Trust
POLIT	Police Online Investigation Team
RAG	Red Amber Green (rating)
SAAF	Safeguarding Accountability and Assurance Framework
SARS	Safeguarding Adults Reviews
SEND	Special Educational Needs and Disabilities
SOCEX	Serious Organised Crime Exchange
SUDI	Sudden Unexplained Death in Infancy
TOC	Triangle Of Care
TUPE	Transfer of Undertakings (Protection of Employment)
WRAP	Workshop to Raise Awareness of Prevent

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Safer Staffing annual report (six-month update)

Purpose of Report

To provide a six-month update on the Trust's safer staffing position across Inpatient services, including progress against the annual establishment review, Mental Health Optimal Staffing Tool (MHOST) findings, Care Hours Per Patient Day (CHPPD), fill rates, vacancy rates and use of temporary staffing. The report seeks to provide assurance that current funded establishments remain appropriate to support safe, effective and person-centred care, while highlighting areas of ongoing workforce risk and the actions being taken to maintain safe staffing, roster resilience and compliance with national guidance and regulatory requirements.

Executive Summary

This safer staffing annual report provides assurance that the Trust continues to maintain safe Inpatient staffing arrangements in line with National Quality Board guidance, Care Quality Commission (CQC) Regulation 18 and the principles of the NHS Long-Term Workforce Plan. The review has considered CHPPD, MHOST outputs, establishment reviews, fill rates, vacancy data and use of temporary staffing, alongside professional judgement and ward-level quality and safety intelligence.

Overall, the review did not identify a requirement for immediate establishment alterations. Although MHOST outputs indicated lower recommended staffing levels in several areas, professional judgement concluded that current establishments in the Acute Inpatient wards remain appropriate when triangulated with acuity, dependency, enhanced therapeutic observations, environmental factors, incident response requirements, ward configuration and minimum safe staffing expectations. Therefore, the wards will retain their current establishment pending repeat MHOST scoring and further review within six months. In the Psychiatric Intensive Care Unit and Enhanced Care Unit, staffing will be reviewed dynamically.

The workforce position is broadly stable for registered Nursing, with Band 6 and Band 5 vacancy rates below the national NHS Nursing vacancy benchmark. The main workforce risk remains within the Band 3 Healthcare Assistant (HCA) workforce, where vacancies are more significant and have the greatest potential impact on roster resilience, observation capacity and continuity of care. Targeted recruitment, retention and deployment of support workers remains a key priority.

Fill rate data provides assurance that staffing levels have remained within safe parameters, with no category falling below the 80% threshold. Periods where non-registered night staffing exceeded 130% were linked to enhanced therapeutic observations and care, reflecting patient acuity and risk rather than routine over-establishment. Agency use has reduced following the cessation of non-registered agency staffing in line with national guidance from February 2026. However, this should not be interpreted as reduced staffing demand.

Ongoing oversight through safer staffing governance, establishment reviews, roster check and challenge, and repeat MHOST scoring will continue to support safe, effective and sustainable staffing across inpatient services. A review of establishments will be repeated in November 2026 using the second round of MHOST scoring data.

Strategic Considerations		BAF Risk	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X	1A	1.1-1.4
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X	2A,2B	
Productive: We will improve our productivity and design and deliver services that are financially sustainable.			
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.			

Risks and Assurances

Risks

- **Band 3 HCA vacancies remain the principal workforce risk**, with a higher vacancy rate than registered nursing and approximately 33 full-time equivalent gaps across inpatient areas
- **MHOST outputs indicate lower recommended establishments in several wards**, but reductions are not currently supported due to acuity, dependency, observation requirements, ward configuration and professional judgement
- **Enhanced therapeutic observations continue to drive additional staffing demand**, particularly at night, with some non-registered night fill rates exceeding 130%
- **Reduced agency use following the cessation of non-registered agency staff may mask ongoing underlying staffing demand**, which is now being managed through bank, substantive staffing and internal redeployment
- **Some wards continue to experience localised workforce and operational pressures**, including vacancies, sickness, high acuity, seclusion, incident response requirements, flexible working arrangements and environmental constraints
- **Skill mix and establishment alignment issues remain in some areas**, including variation in Band 4/Nursing Associate posts, Support Worker vacancies and budget-to-post alignment.

Assurances

- **No staffing category fell below the 80% fill-rate threshold**, providing assurance that minimum safe staffing levels were maintained during the reporting period
- **Band 6 and Band 5 registered Nursing vacancy rates remain below the national NHS Nursing vacancy benchmark**, indicating a comparatively stable registered nursing position
- **No immediate Inpatient establishment reductions are recommended**, ensuring that professional judgement and patient safety considerations remain central to staffing decisions
- **MHOST has been used alongside professional judgement, quality intelligence and ward-level review**, rather than as a standalone determinant of establishments
- **Where fill rates exceeded 130%, this was linked to enhanced therapeutic observations and care**, reflecting active response to acuity and risk rather than routine over-establishment
- **Agency use has reduced following implementation of national guidance**, with non-registered agency staffing ceased from February 2026
- **Weekly roster check and challenge arrangements are in place**, led through the Clinical Quality Directorate, to support effective roster management and safe deployment
- **Repeat MHOST scoring and further establishment review within six months** will provide additional assurance and support ongoing triangulation with incidents, observation demand, vacancies and quality outcomes.

Consultation

- Head of Clinical Practice team
- Director of Nursing
- Lead Allied Health Professional
- Deputy Director of Nursing
- Managing Director Acute services
- Quality and Safeguarding Committee.

Governance or Legal Issues

- Outcome 4 (Regulation 9 Care and Welfare of People Who Use Services)
- Outcome 14 (Regulation 23 Supporting Staff)
- Outcome 16 (Regulation 10 Assessing and Monitoring the Quality-of-Service Provision)
- National Quality Board guidance on Safe Staffing (2016)
- Safe, sustainable, and productive staffing in Mental Health services
- Improvement resource to help standardise safe, sustainable, and productive staffing decisions in mental health services. Edition 1 (January 2018).

Net Zero Duty Implications

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

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

N/A.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

There are potential adverse effect(s) on people with protected characteristics (REGARDS). Details of potential variations /inequalities in access, experience and outcomes are outlined below, with the appropriate action to mitigate or minimise those risks.

Recommendations

The Board of Directors is requested to:

1. Receive and note the Safer Staffing annual review and the assurance provided in relation to compliance with National Quality Board guidance and CQC Regulation 18
2. Approve the recommendation to maintain current Inpatient funded establishments at this stage, with no immediate reductions, recognising that professional judgement, acuity, dependency, enhanced observation requirements, ward configuration, and quality and safety intelligence do not support reducing establishments despite some lower MHOST outputs
3. Receive limited assurance on the ongoing actions being taken to address the issues highlighted.

Report presented by: **Lynn Andrews**
 Chair, Quality and Safeguarding Committee

Report prepared by: **Joseph Thompson**
 Associate Director of Physical Health and Quality

Introduction

The Trust’s approach to safe staffing continues to focus on the organisation’s ability to provide person-centred, trauma-informed care, ensuring that patients receive care from staff with the right skills, in the right place, at the right time. This is in line with National Quality Board (NQB) guidance and the NHS Long-Term Workforce Plan, which was released in June 2023.

The strategic direction for the Long Term Workforce Plan falls into three clear priority areas:

- **Train:** significantly increasing education and training to record levels, as well as increasing apprenticeships and alternative routes into professional roles, to deliver more Doctors and Dentists, more Nurses and Midwives and more of other professional groups, including new roles designed to better meet the changing needs of patients and support the ongoing transformation of care
- **Retain:** ensuring that we keep more of the staff we have within the health service by better supporting people throughout their careers, boosting the flexibilities we offer our staff to work in ways that suit them and work for patients, and continuing to improve the culture and leadership across NHS organisations
- **Reform:** improving productivity by working and training in different ways, building broader teams with flexible skills, changing education and training to deliver more staff in roles and services where they are needed most, and ensuring staff have the right skills to take advantage of new technology that frees up clinicians’ time to care, increases flexibility in deployment and provides the care patients need more effectively and efficiently.

In line with these guiding documents, this report focuses on the Trust’s approach to staffing, including:

- Care Hours per Patient Day (CHPPD)
- A review of Inpatient establishments
- Fill rates and the use of temporary and agency staff.

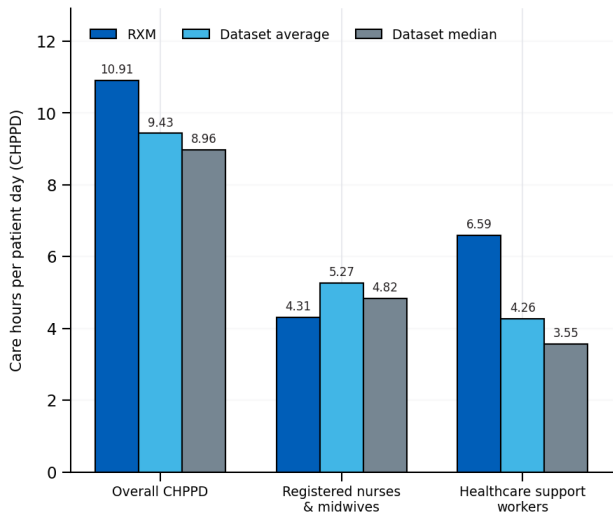
CHPPD

CHPPD includes total staff time spent on direct patient care but also on activities such as preparing medicines, updating patient records and sharing care information with other staff and departments. It covers both temporary and permanent care staff but excludes student Nurses and student Midwives and staff working across more than one ward. CHPPD relates only to hospital wards where patients stay overnight.

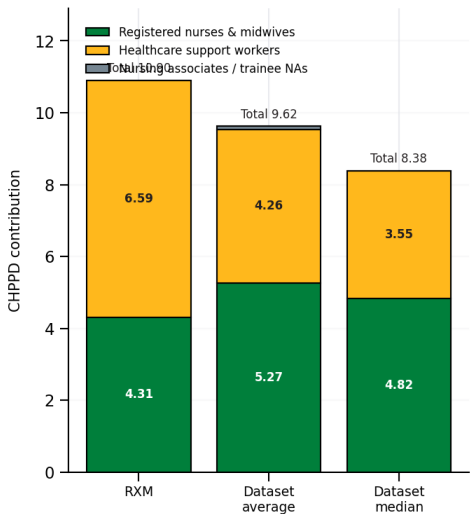
Derbyshire Healthcare NHS Foundation Trust (RXM): CHPPD benchmark, April 2026

Comparison against all organisations in the NHS England trust-level CHPPD dataset (n=190)

RXM compared with national dataset average and median



Skill-mix profile behind total nursing CHPPD



Source: NHS England Trust Level CHPPD April 2026 workbook provided by the user. Note: CHPPD = care hours per patient day. Dataset average/median calculated across 190 organisations in the attached workbook.

As shown in the graphs above, as of April 2026, DHcFT reports an overall CHPPD of 10.91, which is above the national dataset average and median. However, the profile of care delivery is weighted towards Healthcare Support Workers (HCSW), with HCSW CHPPD significantly above the dataset average, while Registered Nurse and Midwife CHPPD is below average.

Therefore, the Trust continues to use CHPPD alongside professional judgement, acuity and dependency data, quality outcomes and annual establishment reviews to assure itself that the staffing profile remains appropriate to patient need and clinical risk.

Establishment review: Inpatient services

The annual inpatient establishment review is a statutory responsibility for the Executive Director of Nursing, Allied Health Professionals (AHPs), Quality and Patient Experience, to complete on behalf of the Board.

Demonstrating sufficient staffing is one of the fundamental quality and safety standards required to comply with the Care Quality Commission (CQC) regulation. CQC Regulation 18; “To meet the regulation, providers must provide sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service at all times”.

The review has fully considered multi-professional contributions to inpatient care settings across all Care Groups.

Inpatient establishments were reviewed using the Mental Health Optimal Staffing Tool (MHOST). MHOST is a multi-disciplinary, evidence-based system that enables ward-based clinicians to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that ward establishments reflect patient needs in acuity and dependency terms. The attached MHOST implementation guidance confirms that the tool should be used to support, not replace, professional judgement, and should be triangulated with quality metrics, incident data, observation requirements, ward configuration, patient flow and clinical complexity. Therefore, the dependency descriptors provide a structured way to interpret acuity, with Level 1 reflecting low dependency and Level 5 reflecting highest dependency, usually requiring one-to-one care, constant supervision, seclusion, extra care or significant risk management depending on the clinical specialty.

Only staff that had been trained were tasked to collect the data. All wards had three to four staff trained. The collection of the data was supervised by the Ward Manager of each unit/ward. Wards were provided with the guidance and the data collection tool.

Data was collected between 1 and 31 October 2025. Following analysis, this was fed back to individual wards through a series of meetings in February 2026, including Operational Managers, Clinical Matrons, Finance representatives and e-roster representatives. Meetings were chaired by either the Associate Director of Physical Health and Quality or the Divisional Head of Clinical Practice. It should be noted that membership varied between meetings. During these meetings, factors that the tool cannot fully quantify, such as risk, observation levels, skill mix, clinical complexity, environmental and ward layouts and levels of admission, discharge and transfer, were considered as part of a structured clinical judgement discussion. An overview of each review is included below.

For the purposes of this review, the acuity graphs in each ward section have been interpreted against the relevant MHOST specialty descriptors. For Adult Acute wards, increasing dependency reflects movement from self-caring patients with lower risk and readiness for discharge, through to patients who are heavily reliant on the ward team, present with fluctuating or high risk, require frequent therapeutic engagement, or may require one-to-one support. For the Psychiatric Intensive Care Unit (PICU), higher dependency indicates patients who are fully dependent on the ward team for safety and care, may require frequent intervention, seclusion or extra care arrangements. For Perinatal and low secure services, the descriptors have been interpreted in the context of specialist mother and baby care, security requirements, relational risk, observation demand and the need for constant supervision where applicable. This approach supports a clearer narrative link between the graph profile, observed clinical demand and the decision to maintain current establishments pending repeat scoring.

Enhanced therapeutic observations: October to November 2025

The following table summarises the number of inpatient observations recorded by ward and observation level for the period October to November 2025 when the MHOST data was being collected. The figures combine both months and include Levels 1, 2, 3 and 4 where recorded:

Ward	Level 1	Level 2	Level 3	Level 4	Total
Audrey House ECW	0	1,388	28,604	982	30,974
Bluebell Ward	0	25	19,279	20,510	39,814
Cherry Tree Close	0	161	9,749	24,919	34,829
Cubley Female Kingsway	0	1,851	18,777	11,170	31,798
Cubley Male Kingsway	0	1,956	24,695	10,171	36,822
Dove Ward	0	237	45,782	13,732	59,751
Kedleston Unit – Curzon Ward	0	0	49	16,324	16,373
Kedleston Unit – Scarsdale Ward	0	0	0	24,153	24,153
Kingfisher House PICU	225	524	28,305	5,654	34,708
Oak Ward	0	242	10,563	28,677	39,482
Perinatal Inpatient	0	1,217	8,343	1,763	11,323
Robin Ward	0	584	49,064	11,127	60,775
Sycamore Ward	0	1,211	27,203	20,710	49,124
Tissington Kingsway	0	346	20,133	22,990	43,469
Ward 35 RU	0	211	35,089	22,765	58,065
Ward 36 RU	0	232	27,541	25,260	53,033
Willow Ward	0	645	8,939	30,266	39,850
Wren Ward	0	47	55,588	9,748	65,383
Grand Total	225	10,877	417,855	301,776	730,733

Key observation findings: October to November 2025

- **Level 1 observations:** These were recorded only on Kingfisher House PICU, with 225 observations across the two-month period
- **Level 2 observations:** Cubley Male recorded the highest volume, with 1,956 observations, followed closely by Cubley Female with 1,851 observations, Audrey House with 1,388 The perinatal inpatient unit with 1,217 observations, and Sycamore with 1,211
- **Level 3 observations:** Wren Ward recorded the highest volume, with 55,588 observations, followed by Robin Ward with 49,064 observations and Dove Ward with 45,782 observations.

This indicates the highest users of Level 1 and 2 observations were the PICU, Older People's Organic wards, Enhanced care Unit, Perinatal ward and Sycamore ward (which was a female ward at the time of data collection). This is reflected in the narrative for each ward below.

The highest users of Level 3 observations were Wren Robin and Dove wards which were all female wards.

Overview of inpatient establishment reviews conducted in April 2026

Snowdrop Ward (Snowdrop ward TUPE in May 2026 so was not part of the establishment review schedule and does not yet have staff trained in MHOST Scoring)

Snowdrop Ward transferred into the Trust through TUPE arrangements in May 2026; therefore, this summary represents an early post-transfer assessment of establishment, skill mix and operational staffing arrangements.

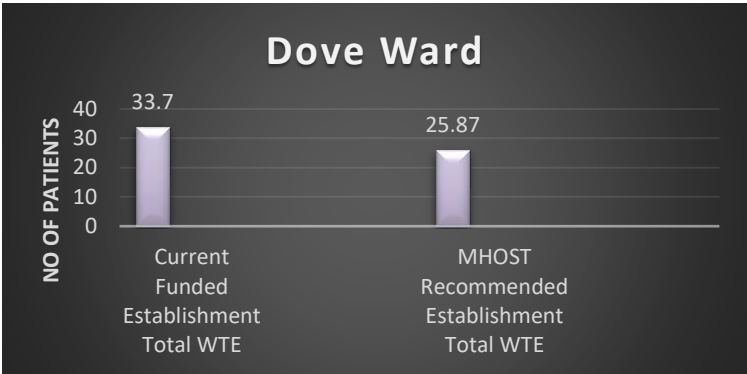
The ward has an identified leadership structure in place, including a Service Manager, Matron and Ward Manager, with substantive registered Nursing, Nursing Associate, Nursing Assistant, AHP and administrative provision. Current shift numbers are reported as 10, 10 and nine across the day, supported where required by bank staffing, with no agency usage reported since TUPE.

However, there are areas requiring further review as the ward continues to embed within DHcFT governance arrangements. The document identifies six nursing assistant vacancies, a need to formalise baseline staffing numbers and escalation arrangements for enhanced observations, and a number of staff working alternative patterns linked to Occupational Health recommendations.

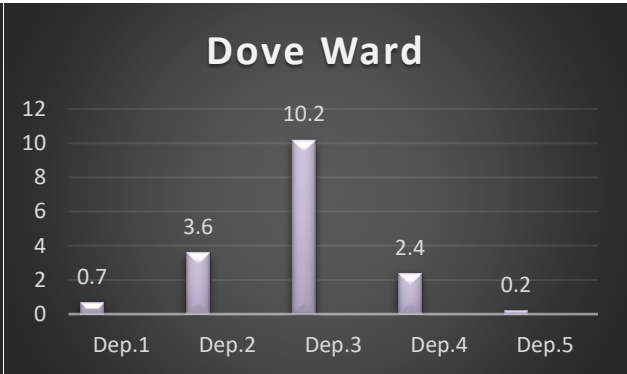
Further assurance is planned through review of Occupational Health advice, employee relations oversight of sickness, establishment review and use of the MHOST tool, with work expected to commence in September 2026.

Dove Ward

Funded establishment and MHOST recommended descriptors



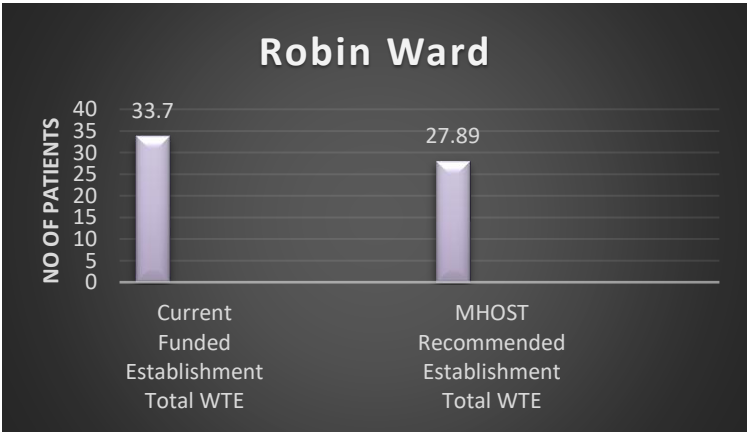
Acuity based on MHOST dependency



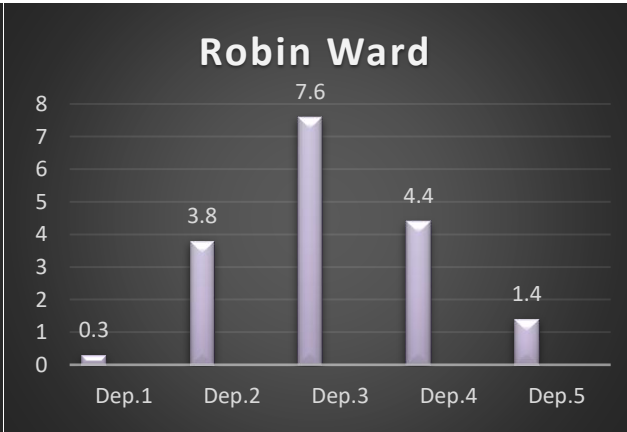
The Dove Ward review identified significant operational pressure linked to patient acuity, incident volume, enhanced observations, vacancies and reliance on temporary staffing. The MHOST dependency profile indicates a proportion of patients requiring medium-high to high dependency support, which, in Adult Acute ward descriptors, reflects patients who are heavily reliant on the ward team, present with fluctuating or high risk, have significant mental, social or physical health needs and require frequent therapeutic engagement. This is supported by the therapeutic observation data for October to November 2025, where Dove Ward recorded 45,782 Level 3 observations, the third highest volume across Inpatient wards. This indicates sustained higher-acuity observation demand. The ward was described as an outlier for incidents compared with other female Acute wards, with one patient contributing a high proportion of incidents during the review period. Bank and agency usage was noted to be high, with concerns about the impact on continuity, ward familiarity and therapeutic engagement. While there is no Band 6 vacancy, material gaps remain across Band 5 Nursing and Band 3 Healthcare Assistant (HCA) staffing, with both groups below funded establishment; these vacancies are being actively recruited to, and progress was reported as positive with an expectation for a full establishment by September 2026. The review did not recommend an immediate establishment change based on the first MHOST baseline but identified a need to review the practice of absorbing observation levels into base night staffing, particularly for female wards with high acuity. Additional monitoring of incidents, restrictive interventions, observation levels and temporary staffing usage will support the next review cycle.

Robin Ward

Funded establishment and MHOST recommended descriptors



Acuity based on MHOST dependency

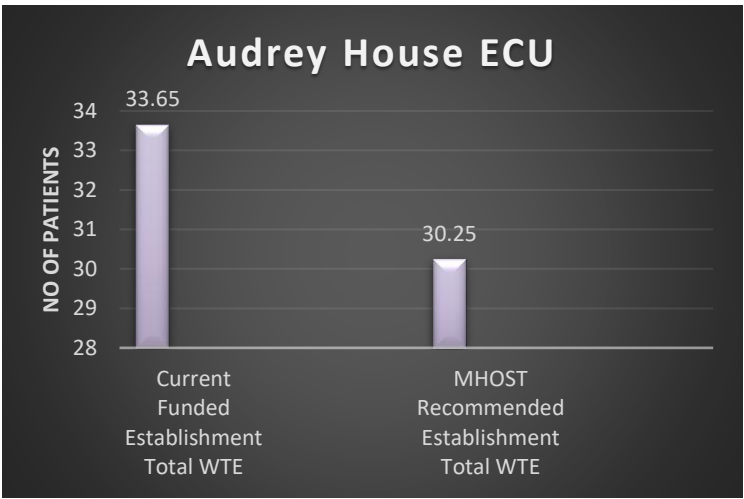


The Robin Ward discussion highlighted a broadly stable funded establishment but with complexity around vacancies, proposed Registered Nurse Associate post creation and alignment between budgets and actual posts.

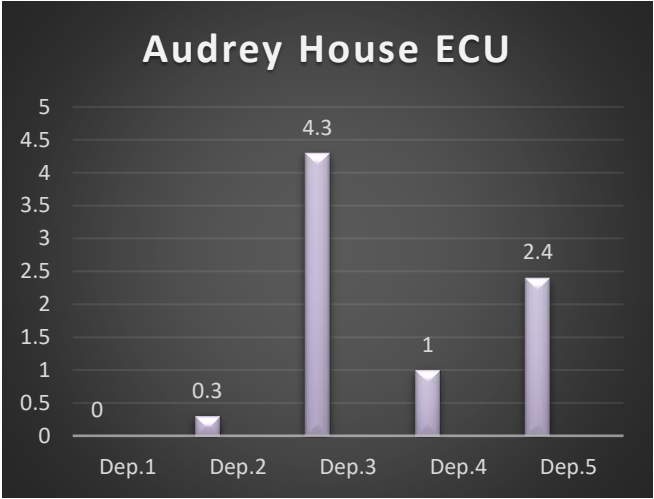
The MHOST acuity graph indicates a mixed dependency profile, with activity not confined to low dependency patients and evidence of patients requiring medium-high or high levels of ward support. In Adult Acute ward terms, this reflects people who may be more dependent on staff for mental, social or physical health needs, may have inconsistent engagement, fluctuating risk and barriers to safe discharge. The therapeutic observation data reinforces this position, with Robin Ward recording 49,064 Level 3 observations between October and November 2025, the second highest volume across Inpatient wards. This indicates significant higher-acuity observation demand and supports the ward’s approach of adding staffing where observation requirements exceed safe baseline capacity. There is no Band 6 vacancy, but vacancies remain across Band 5 Nursing and Band 3 HCA posts, indicating continued workforce pressure within the wider establishment. The ward reported periods of increased clinical activity, including prolonged enhanced observations and a complex patient presentation, although current activity was described as returning towards normal. A key safety concern related to the management of observation levels, particularly where high numbers of patients are prescribed Level 3 observations and staff capacity is stretched across multiple observation requirements. The ward does not routinely absorb observation levels at night and instead adds staffing to mitigate risk, reflecting concern that a reduced night staffing model would not safely support incident response, medication administration, co-ordination and therapeutic engagement. No immediate establishment change was agreed, but there was a strong recommendation to review observation policy and practice, including thresholds for additional staffing when observation demands are high.

Audrey House

Funded establishment and MHOST recommended descriptors



Acuity based on MHOST dependency



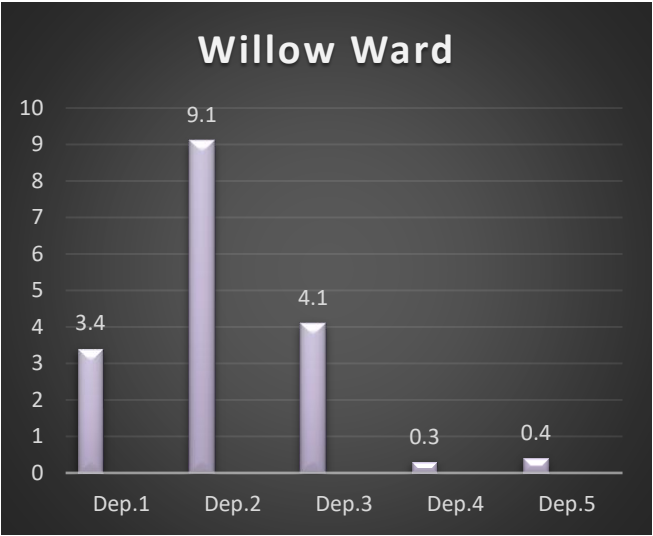
The Audrey House discussion identified the need for clearer alignment between funded establishments, actual posts and budgeted roles, particularly where Registered Nurse Associate posts are being created through residual vacancies. The MHOST dependency profile should be interpreted in the context of the unit’s enhanced care function, where patients may present with higher levels of risk, inconsistent engagement and increased reliance on staff for safety, therapeutic engagement and personal care. The presence of medium-high or high dependency patients within the acuity graph supports the view that staffing decisions should not be driven solely by the numerical MHOST output. The therapeutic observation data provides further evidence of this acuity, with Audrey House recording 1,388 Level 2 observations and 28,604 Level 3 observations between October and November 2025. This places Audrey House among the highest users of Level 2 observations and demonstrates sustained enhanced observation demand. Although there is no Band 6 vacancy, shortfalls remain in both Band 5 Nursing and Band 3 HCA staffing, with in-post levels below funded establishment. The review also highlighted variation in the allocation of AHP and support roles across wards, with a recommendation to consider more standardised expectations linked to ward population and clinical need. Patient safety considerations focused on the impact of high numbers of Level 3 observations, night staffing pressures and the need for clearer guidance on when additional staff should be deployed. No immediate establishment change was agreed, but the review identified actions to strengthen budget clarity, observation policy and preparation for the next MHOST review cycle in May.

Willow

Funded establishment and MHOST recommended descriptors



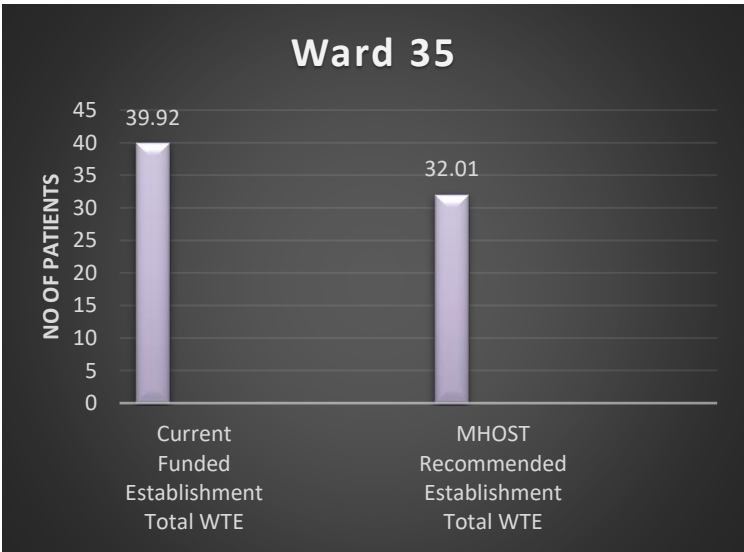
Acuity based on MHOST dependency



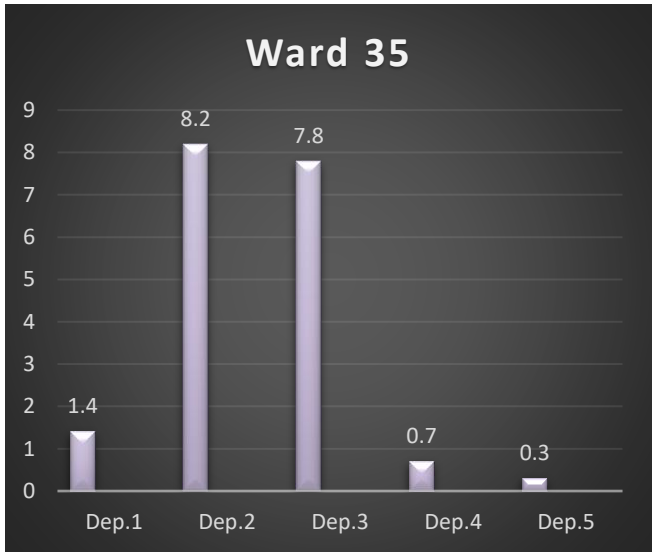
The Willow review identified that current staffing is above the level suggested by the initial MHOST output, but professional judgement did not support a reduction at this stage. The MHOST dependency graph indicates that the ward’s acuity is not limited to low dependency presentations, with patients requiring support consistent with medium and higher dependency descriptors. For an Adult Acute ward, this includes people who may be more reliant on the ward team, have barriers to discharge, require increased therapeutic engagement or present with fluctuating risk. The ward is close to funded Band 6 and Band 5 staffing levels and is over-established in Band 3 HCA posts, providing a comparatively stronger vacancy position than several other wards. Key considerations included the safety requirements of a female ward, night staffing resilience, the physical environment and operational pressures associated with supervised access to the Sky Garden. The review also identified budget and establishment clarity issues, particularly around Band 4 posts funded from the Band 5 budget and Band 3 over-establishment resulting from previous over-recruitment. The agreed position was to maintain the current funded establishment pending repeat MHOST scoring and to address budget clarity, over-establishment and environmental factors that affect staffing deployment.

Ward 35

Funded establishment and MHOST recommended Descriptors



Acuity based on MHOST dependency

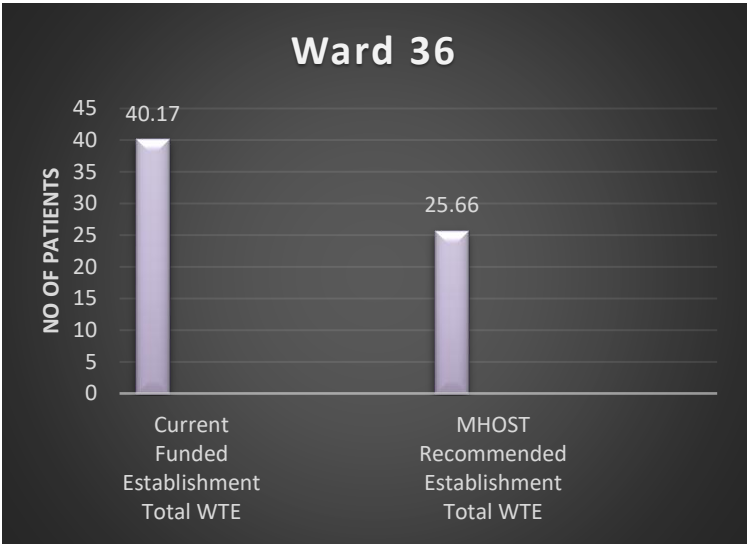


Ward 35 was reviewed alongside the wider Radbourne configuration. The MHOST acuity graph indicates a dependency profile that includes patients requiring more than low-level support, with Adult Acute descriptors suggesting reliance on the ward team, fluctuating risk, barriers to discharge and requirements for active therapeutic intervention.

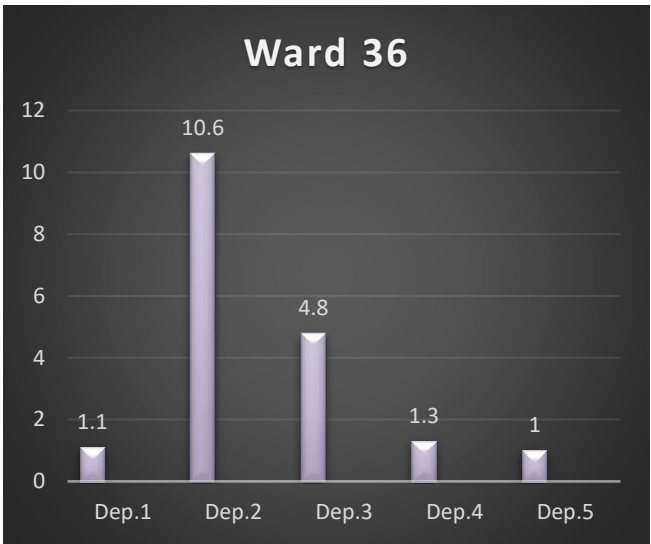
Although MHOST outputs suggested a lower staffing template than the current funded position, the meeting concluded that this does not fully reflect the standalone nature of the unit or the requirement for Ward 35 and Ward 36 to support each other during incidents. The review noted ongoing Band 3 and Nursing Associate vacancies, with no Band 6 vacancy and only a small Band 5 Nursing gap; the significant Band 3 HCA shortfall remains the main vacancy pressure for the ward. High bank usage and particularly high night-shift temporary staffing reliance present a continuity and assurance risk, and recruitment to Nursing Associate vacancies was therefore identified as a priority. No reduction to the establishment was recommended at this stage, with the current position to be reviewed again following repeat MHOST scoring and further consideration of bed numbers, unit configuration and incident response requirements.

Ward 36

Funded establishment and MHOST recommended descriptors



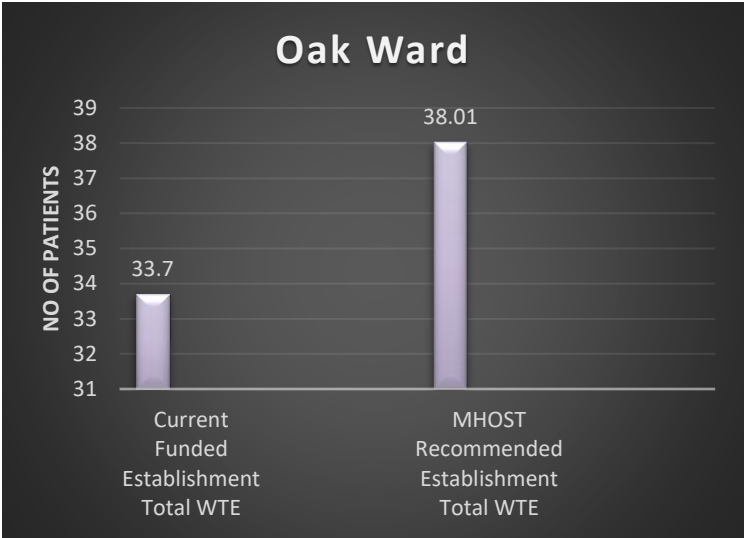
Acuity based on MHOST dependency



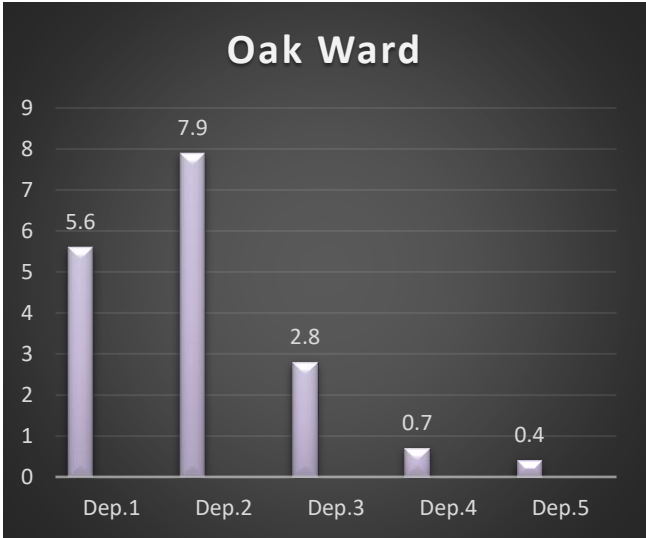
Ward 36 demonstrated a broadly balanced position, with actual staffing closely aligned to MHOST recommendations and the current funded establishment judged appropriate for the patient group. The MHOST dependency graph indicates a spread of acuity requiring more than routine low-dependency care. In Adult Acute descriptors, this includes patients who require staff support for mental, social or physical health needs, may have fluctuating risk and may require enhanced engagement to maintain safety and progress care. The ward has no Band 6 vacancy and a modest Band 5 Nursing gap, but a substantial Band 3 HCA shortfall presents the most significant workforce pressure and remains under active recruitment. The discussion highlighted that the ward frequently releases staff to support incident response elsewhere within the Radbourne configuration, a factor not fully captured within the MHOST calculation and a key reason not to reduce staffing at this stage. Flexible working arrangements were described as manageable within roster planning. Training assurance was positive, with staff in charge appropriately trained and preceptors supported. The agreed position was to maintain the current establishment, progress recruitment and repeat MHOST scoring in May, supported by communication and drop-in sessions for staff involved in the scoring process.

Oak Ward

Funded establishment and MHOST recommended descriptors



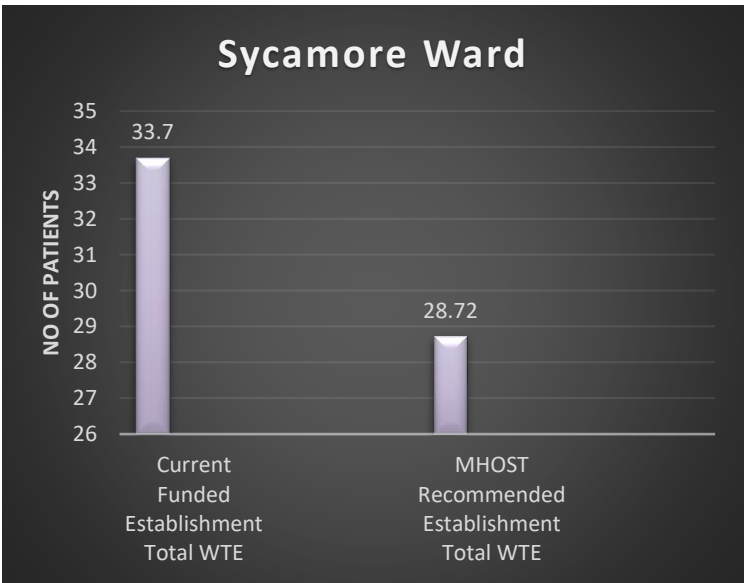
Acuity based on MHOST dependency



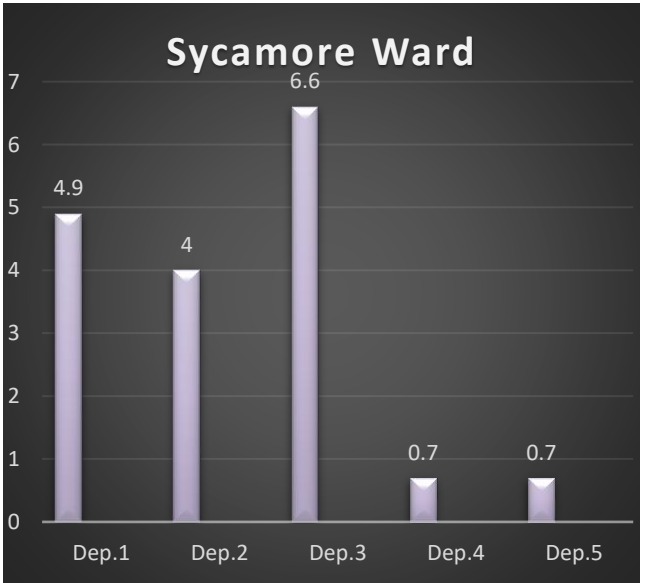
Oak Ward’s current establishment remains appropriate and should not be reduced at this stage, despite MHOST indicating that a slightly lower staffing level may be sufficient. The acuity graph indicates a clinically mixed dependency profile, including patients whose needs align with medium-high or high Adult Acute descriptors. This means patients may be heavily reliant on staff, present with fluctuating or high risk, require frequent engagement and need coordinated multi-disciplinary input. The review identified an overall adequate frontline staffing position, but with a clear skill mix imbalance: the ward has a small Band 6 shortfall, is over-established in Band 5 registered Nurses and has a notable Band 3 HCA vacancy. Ongoing risks include a relatively inexperienced registered Nursing workforce, one extended preceptorship and fixed or flexible working arrangements that may reduce roster resilience. Operational pressures such as chaperoning, external appointments, tribunals and multidisciplinary activity also reduce available ward staffing and are not fully captured by MHOST. Professional judgement concluded that a reduction would not be safe, particularly as night shifts require a minimum of four staff. Therefore, the recommendation is to maintain the current establishment, continue monitoring through safer staffing governance, and repeat the MHOST and establishment review in six months.

Sycamore Ward

Funded establishment and MHOST recommended descriptors



Acuity based on MHOST dependency

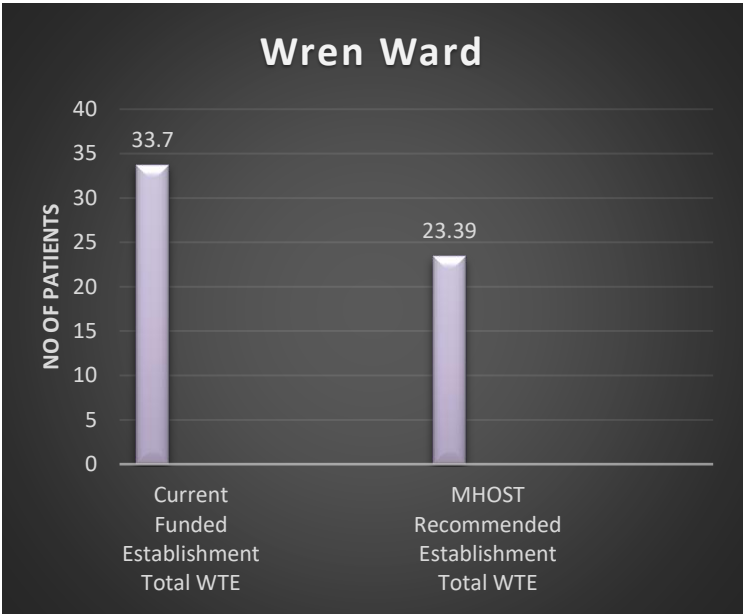


Sycamore Ward’s current establishment remains appropriate at this stage, with staffing broadly aligned to the funded position.

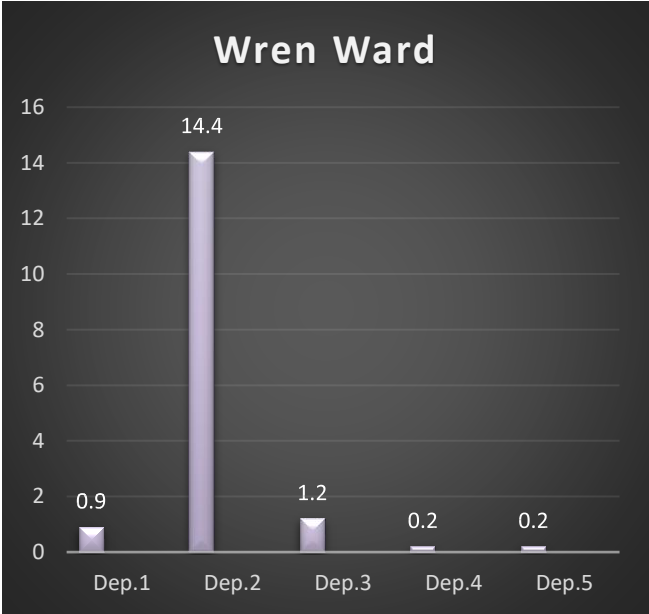
The MHOST acuity graph supports a picture of variable dependency, with some patients requiring support consistent with Adult Acute medium or higher dependency descriptors, including increased reliance on staff, fluctuating mental state or risk and greater need for therapeutic engagement. The therapeutic observation data also identifies Sycamore as one of the higher users of Level 2 observations, with 1,211 Level 2 observations and 27,203 Level 3 observations recorded between October and November 2025. This indicates a sustained level of enhanced observation demand, supporting the decision not to reduce staffing despite the lower MHOST night staffing model. The ward has a very small Band 6 shortfall, is over-established in Band 5 Nursing and has a Band 3 HCA vacancy, supporting continued monitoring of support worker pressures. The review identified workforce risks requiring ongoing oversight, including uncertainty around future Band 4 funding, maternity leave and sickness pressures within the Band 3 workforce, and repeated short-term absence among Band 6 staff. Although MHOST suggested a lower night staffing model, professional judgement concluded this would not be operationally safe due to the need for two registered nurses and two HCAs overnight. The ward benefits from a 31% headroom allowance and minimal bank use when substantive staffing is stable. No immediate establishment change is recommended, but continued monitoring of workforce pressures, Band 4 funding arrangements and repeat MHOST findings is required. Therefore, the recommendation is to maintain the current establishment, continue monitoring through safer staffing governance, and repeat the MHOST and establishment review in six months.

Wren Ward

Funded establishment and MHOST recommended descriptors



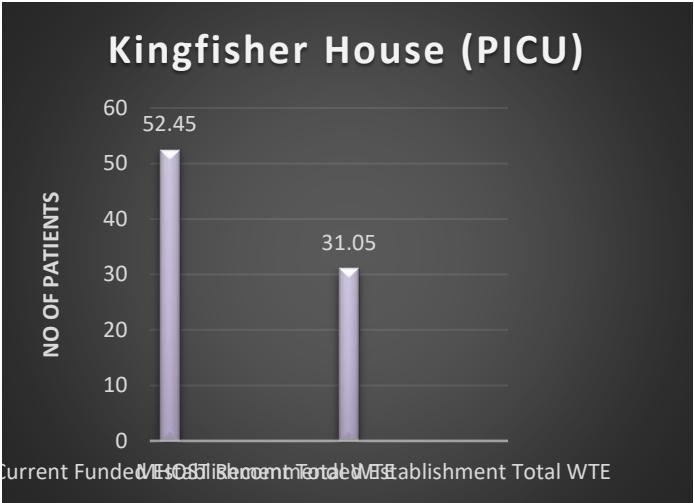
Acuity based on MHOST dependency



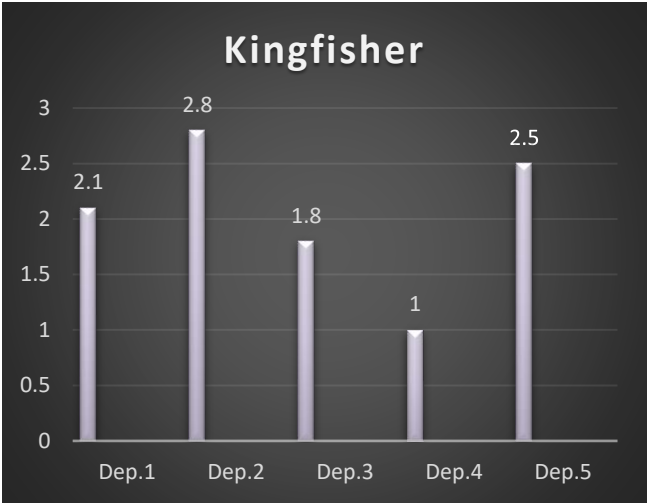
Wren Ward’s current establishment remains appropriate and no reduction is recommended, despite MHOST indicating a lower staffing requirement. The MHOST dependency graph suggests that ward acuity includes patients beyond low dependency, with Adult Acute descriptors indicating reliance on the ward team for care, engagement and risk management. This supports the professional judgement that minimum safe staffing, observation requirements and the need to respond to changing acuity should carry significant weight in establishment decisions. This is strongly supported by the therapeutic observation data, with Wren Ward recording 55,588 Level 3 observations between October and November 2025, the highest volume across inpatient wards. This indicates the greatest higher-acuity observation demand in the dataset and supports maintaining sufficient staffing capacity to respond to enhanced observation requirements. The review found the ward to be broadly well recruited, with no Band 6 vacancy and slight over-establishment in Band 5 Nursing. However, a Band 3 HCA shortfall remains and supports the need to clarify the Band 3 workforce position and whether the trainee nursing associate is included within the funded establishment. Workforce pressures include suspension or long-term sickness, owed hours from staff transfers, roster balance and the need to maintain safe cover across shifts. Five preceptorship Nurses are in place with appropriate support arrangements. Professional judgement concluded that the MHOST output does not fully reflect ward acuity, complexity or minimum safe staffing requirements, particularly the need for at least four staff overnight. Training compliance is broadly positive, agency use is low and sickness levels are generally low. The recommendation is to maintain the current establishment, clarify Band 3 and Band 4 workforce arrangements, repeat MHOST scoring in May, and complete a further establishment review w six months.

Kingfisher House (PICU)

Funded establishment and MHOST recommended descriptors



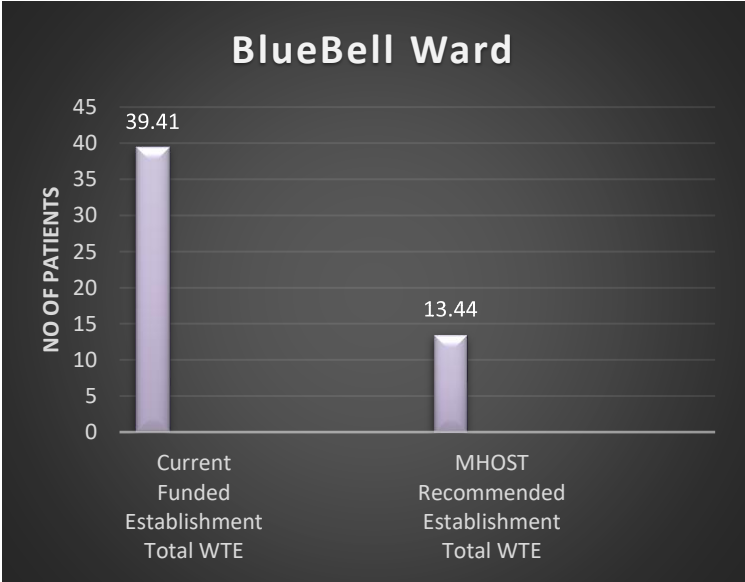
Acuity based on MHOST dependency



Kingfisher House’s current establishment did not require any increase as the MHOST indicated a significantly lower staffing requirement. However, the dependency profile must be interpreted against the PICU descriptors. Higher PICU dependency levels describe patients who are heavily or fully dependent on the ward team for safety and care, require frequent interventions, may require seclusion or extra care arrangements, and may present with risk of harm to self or others. Therapeutic observation data shows that Kingfisher House PICU was the only ward to record Level 1 observations during October to November 2025, with 225 observations, and also recorded 524 Level 2 observations and 28,305 Level 3 observations. This reinforces the need to interpret the MHOST output alongside observation demand, seclusion requirements and rapid acuity escalation within the PICU setting. The review found the ward generally manageable when patient numbers remain between eight and 10, but staffing resilience reduces when acuity rises, observations increase, seclusion is required or patient numbers approach 14. Vacancies remain across Band 6, Band 5, Band 4 Nursing Associate and Band 3 posts, with the largest gap in the Band 3 HCA workforce; staggered recruitment is in place to support safe induction and supervision. Training compliance provides positive assurance, with staff appropriately trained and no reported staffing-related red flags, complaints or concerns. Professional judgement concluded that the MHOST output does not fully reflect PICU acuity, observation levels, seclusion requirements or minimum safe staffing expectations. The recommendation is to maintain the current establishment, repeat MHOST scoring in May, complete a full establishment review within six months and benchmark against comparable PICUs.

Bluebell Ward

Funded establishment and MHOST recommended descriptors



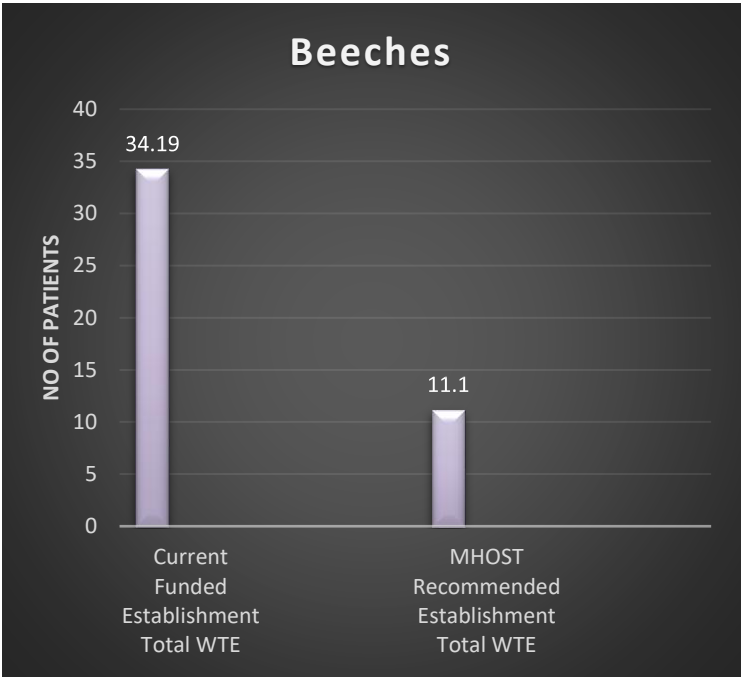
Acuity based on MHOST dependency



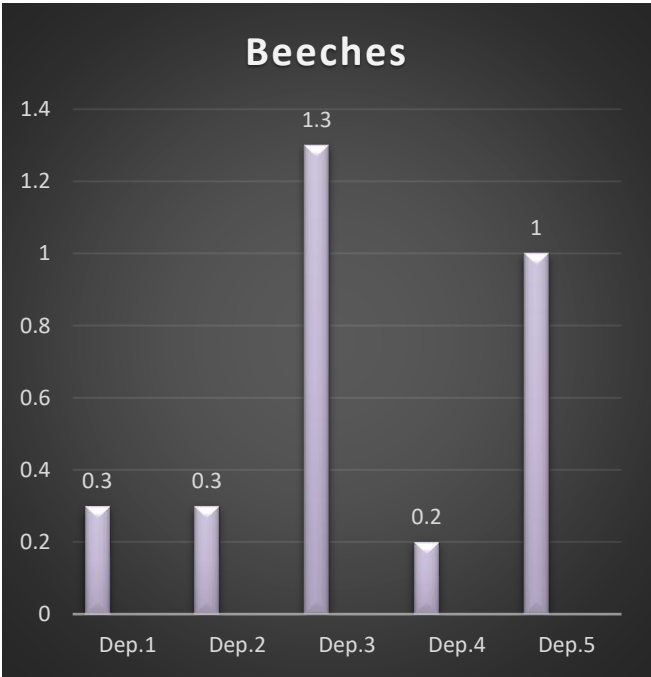
Bluebell Ward’s current establishment remains appropriate, with no change recommended at this stage. The MHOST acuity graph should be interpreted alongside the Adult Acute descriptors and the ward’s use of flexi beds, as higher dependency levels reflect patients who may be more reliant on the ward team, require active therapeutic engagement, present with fluctuating or high risk, or require enhanced observation to maintain safety. The review found that the staffing budget broadly aligns with the funded establishment, with no Band 6 or Band 5 Nursing vacancy and an over-establishment in Band 3 HCA posts, reflecting a positive vacancy position overall. The temporary Band 3 overage is expected to resolve through retirement and progression of a trainee Nursing Associate. The ward has a strong skill mix, supported preceptees and no recent safer staffing incidents or complaints. Flexible working arrangements are being managed without adversely affecting safe staffing. However, the ward is experiencing high acuity, regular use of flexi beds above its original 12-bed establishment, and pressures relating to bleep cover. MHOST outputs were considered inconsistent and did not reliably reflect actual staffing needs, so professional judgement was used. The recommendation is to maintain the current establishment, monitor flexi bed use, acuity, bleep cover and MHOST data accuracy, and repeat the MHOST and establishment review in six months.

Beeches (Perinatal Inpatient)

Funded establishment and MHOST recommended descriptors



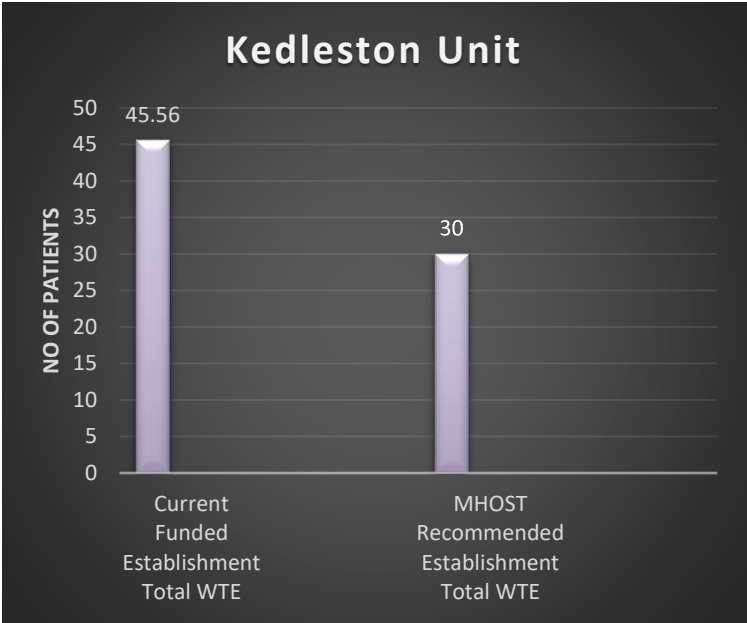
Acuity based on MHOST dependency



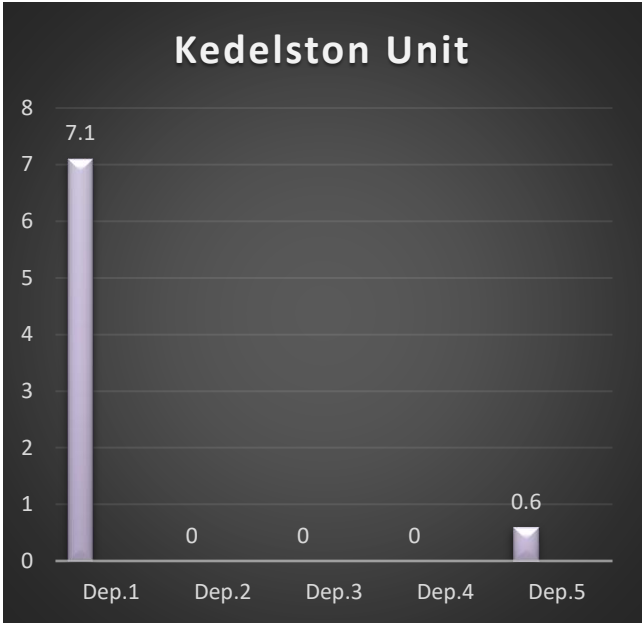
The Beeches’ current establishment remains appropriate and no reduction is recommended at this stage. The MHOST dependency graph has been considered against the perinatal Mother and Baby Unit descriptors, where higher dependency reflects increased risk, reduced ability of the mother to safely care for her baby without supervision, need for one-to-one observation or constant support, and situations where mental health significantly impairs parenting capacity. The therapeutic observation data identified the Perinatal Inpatient Unit as one of the higher users of Level 2 observations, with 1,217 Level 2 observations and 8,343 Level 3 observations recorded between October and November 2025. This supports the view that staffing decisions need to account for fluctuating acuity and enhanced observation requirements, particularly out of hours. The review confirmed that the six-bedded Mother and Baby Unit is currently achieving safe staffing within its funded establishment, with minimal bank use and no agency use for several years. Some workforce pressures remain, including a small Band 6 shortfall, a more significant Band 5 Nursing vacancy, recent Band 5 turnover, a small Band 3 HCA vacancy and the need to clarify the implications of NHS terms and conditions changes relating to Band 6 staffing expectations. Acuity can fluctuate rapidly, including enhanced observation requirements, and resilience is reduced overnight where one registered Nurse may have limited support to take breaks. MHOST indicates a lower staffing requirement, but professional judgement concluded that the tool does not fully reflect the specialist nature, acuity variation and out-of-hours support needs of the unit. The recommendation is to clarify Band 6 requirements, review night-shift break arrangements, benchmark against comparable Mother and Baby Units, repeat MHOST scoring in May and complete a further establishment review within six months.

Kedleston unit (Forensic low secure)

Funded establishment and MHOST recommended Descriptors



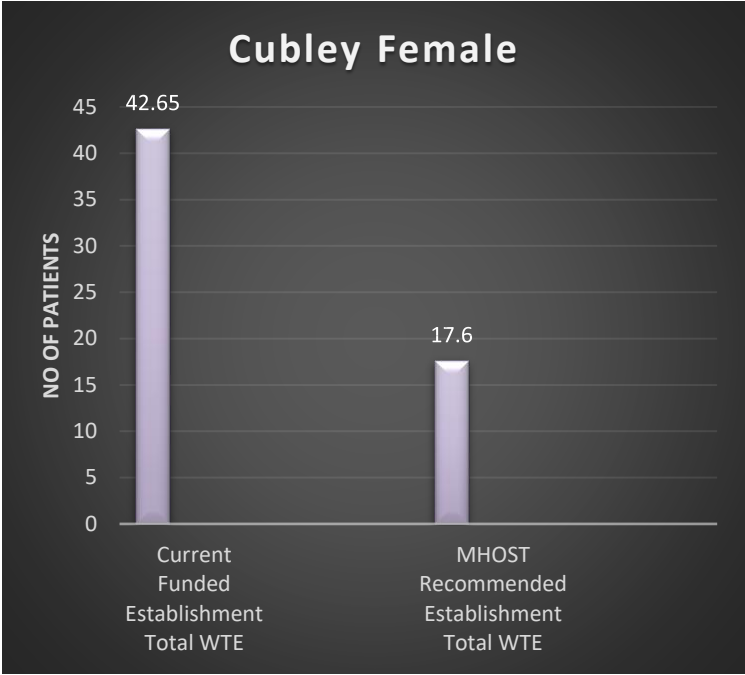
Acuity based on MHOST dependency



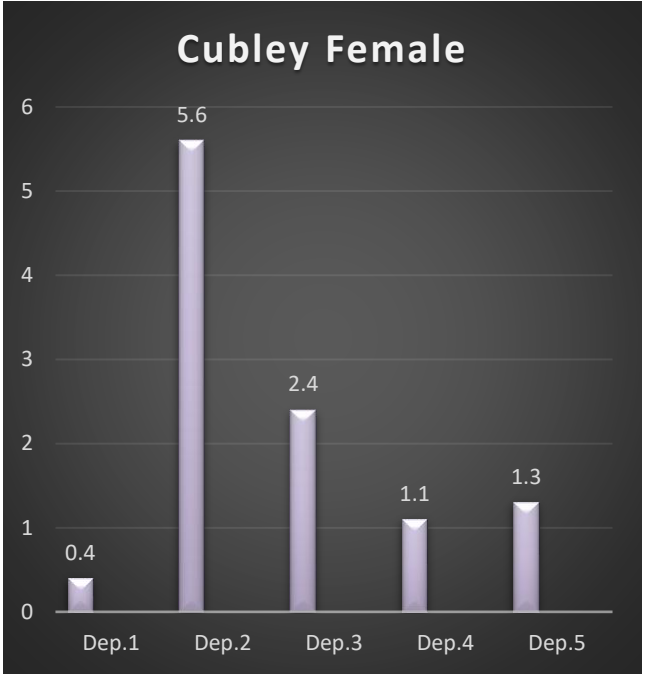
Kedleston’s current establishment remains appropriate and no reduction is recommended at this stage, despite MHOST indicating a lower staffing requirement. The acuity graph has been interpreted against the forensic low secure and rehabilitation descriptors, where increasing dependency reflects more predictable or serious risk behaviours, requirement for additional observations, potential harm to self or others, complex discharge needs, intermittent or constant one-to-one observation and security-related clinical activity. The review noted that Kedleston operates as one funded establishment across two ward areas, creating complexity in attributing staffing and costs. Vacancies are relatively limited, with no Band 6 vacancy and only small Band 5 and Band 3 HCA shortfalls; Band 7 and Band 6 leadership posts are substantively filled and recruitment is progressing for registered Nurse, Band 3 and Nursing Associate roles. Key risks relate to roster resilience, reasonable adjustments, restraint capability, safe gender mix, overnight cover, high-dependency patients requiring 2:1 support, medical cover challenges and incident risks within the low secure environment. Professional judgement concluded that MHOST does not fully reflect the complexity of the low secure model, two-ward configuration, acuity fluctuation, security requirements or minimum safe staffing expectations. The recommendation is to maintain the current establishment, seek NHS England clarification on MHOST scoring methodology, continue oversight of workforce and safety risks, repeat MHOST scoring in May and complete a further establishment review in six months.

Cubley Court

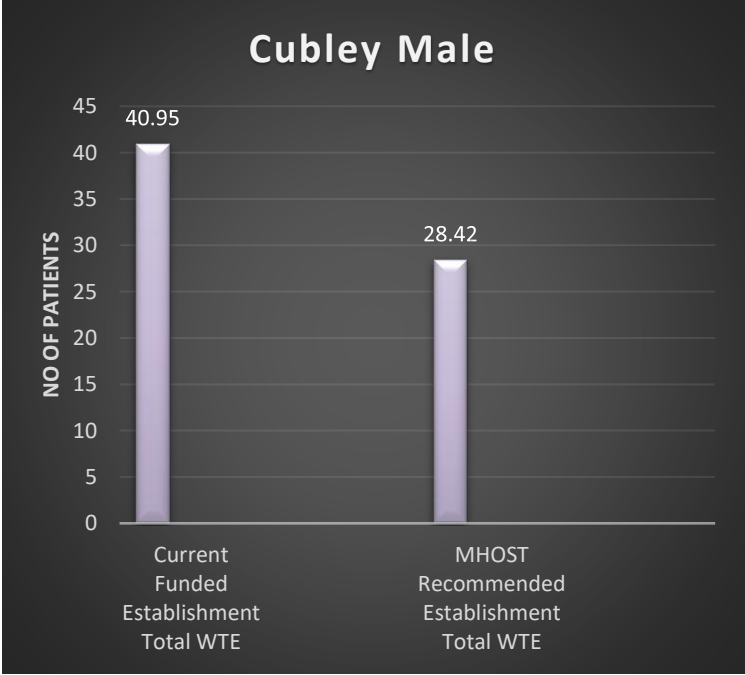
Funded establishment and MHOST recommended descriptors



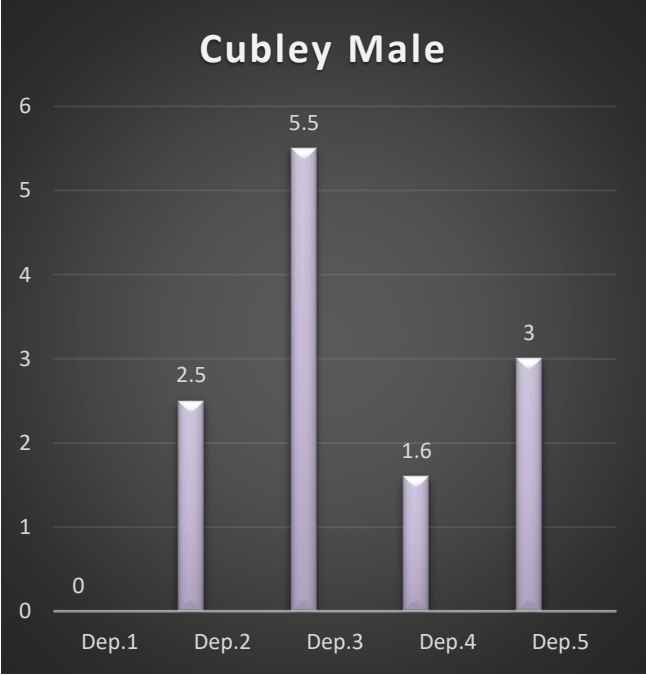
Acuity based on MHOST dependency



Funded establishment and MHOST recommended Descriptors



Acuity based on MHOST dependency



Cubley’s current establishment remains appropriate and no staffing change is recommended at this stage. The MHOST dependency graph was considered against the Older Adult descriptors, where increasing dependency reflects fluctuating mental and physical health needs, co-morbidities, increased supervision, support with daily living activities, risk management, complex medication requirements and, at the highest levels, one-to-one care or constant supervision. The therapeutic observation data shows that Cubley Male recorded the highest number of Level 2 observations, with 1,956 observations, while Cubley Female recorded the second highest number, with 1,851 observations, between October and November 2025. Cubley Male also recorded 24,695 Level 3 observations and Cubley Female recorded 18,777 Level 3 observations. This indicates sustained enhanced observation demand across both Older Adult wards and supports the decision to maintain sufficient staffing capacity to respond to acuity and supervision requirements. The review confirmed that staffing in post closely aligns with the funded establishment, with no Band 6 vacancy, Cubley Male fully established in Band 5 Nursing and Cubley Female slightly over-established in Band 5 Nursing; both Cubley areas, however, continue to show Band 3 HCA shortfalls.

The revised mixed-pod layout has supported more equitable staffing across the ward, improved team working and reduced staff stress, with no identified increase in risk or recent sexual safety incidents. Preceptorship, training compliance and flexible working arrangements provide positive assurance, and the ward is maintaining safe staffing without reliance on bank or agency staff. MHOST outputs were broadly aligned to the current staffing template, and the existing 8/8/6 model was judged appropriate. The recommendation is to maintain the current establishment, repeat MHOST scoring in May and complete a further establishment review w six months.

DHcFT Expected Staffing Levels

On Inpatient wards, there is an expectation that when enhanced therapeutic observation levels are required, the first one is absorbed within the expected staffing levels and any subsequent advanced levels observation would require enhanced staffing (by one member of unregistered staff). If a patient is placed in seclusion, then the staffing levels are expected to be increased by one member of unregistered staff to enable capacity for managing the seclusion process. If patients require an escort or overnight stay at an Acute hospital, staffing is also increased to accommodate this. Expected staffing levels for all inpatient services are demonstrated in table A below:

Table A

Inpatient service expected staffing levels									
	Morning Reg'd	Morning Unreg'd	Morning Total	Afternoon Reg'd	Afternoon Unreg'd	Afternoon Total	Night Reg'd	Night Unreg'd	Night Total
Kingfisher Ward	3	6	9	3	6	9	2	6	8
Audrey House	3	3	6	3	3	6	2	2	4
Cubley Court Male	3	5	8	3	5	8	2	4	6
Cubley Court Female	3	5	8	3	5	8	2	4	6
Tissing-ton Ward	3	3	6	3	3	6	2	2	4
Bluebell Ward	3	4	7	3	4	7	2	4	6
The Beeches	2	3	5	2	3	5	1	3	4
Cherry Tree Close	2	3	5	2	3	5	2	2	4
Kedleston Unit	4	4	8	4	4	8	2	4	6
Ward 33 (Robin)	3	3	6	3	3	6	2	2	4
Ward 34 (Ward 35)	3	3	6	3	3	6	2	3	5
Ward 35 (Dove)	3	3	6	3	3	6	2	2	4
Ward 36 (Ward 36)	3	3	6	3	3	6	2	3	5
Wren Ward	3	3	6	3	3	6	2	2	4
Sycamore Ward	3	3	6	3	3	6	2	2	4
Oak Ward	3	3	6	3	3	6	2	2	4
Willow Ward	3	3	6	3	3	6	2	2	4

Fill rates

Month	Average Fill % Registered DAY	Average Fill % Non Registered DAY	Average Fill % Registered NIGHT	Average Fill % Non Registered NIGHT
Nov-26	98	109	100	115
Dec-26	101	107	100	123
Jan-26	99	114	101	124
Feb-26	100	118	104	137
Mar-26	97	110	101	126
Apr-26	105	115	104	131
May-26	108	114	103	132

The fill rate data provides overall assurance that staffing levels have remained within safe parameters, with no staffing category falling below the 80% lower threshold during the reporting period. Registered Nurse fill rates were stable across both day and night shifts, indicating consistent coverage of registered staffing requirements. Non-registered day staffing also remained within the expected range, although it showed some planned or operational overfill. The main area requiring continued oversight is non-registered night staffing, which exceeded the 130% upper threshold in February, April and May 2026. Where staffing exceeded 130%, this was due to the requirement for enhanced therapeutic observations and care, reflecting additional patient acuity, risk and support needs rather than routine over-establishment. This suggests that safe staffing levels are being maintained, but that night-time staffing demand remains sensitive to observation requirements and will continue to be monitored through safer staffing governance.

Vacancy rate

Organisation	CC	Band 6 Nurse Funded	Band 6 Nurse in Post	Band 5 Nurse Funded	Band 5 Nurse in Post	Band 3 HCA Funded	Band 3 HCA in Post
Inpat Rehab CTC Kway	G61103	2.00	2.00	11.44	11.31	16.10	16.91
Robin Ward	G61107	3.00	3.00	14.60	12.76	16.10	14.56
Dove Ward	G61108	3.00	4.00	14.60	11.80	16.10	14.20
Ward 36 RU	G61109	3.00	3.00	14.60	13.56	22.57	16.72
Perinatal Inpatient RU	G61110	4.60	4.47	9.53	7.13	5.76	5.36
Ward 34 (interim Ward 35)	G61118	3.00	3.00	14.60	14.00	22.32	15.52
Tissington Ward	G61726	2.80	2.80	14.61	13.80	13.70	13.15
Cubley Male Kingsway	G61731	3.00	3.00	12.80	12.80	25.15	23.64
Cubley Female Kingsway	G61734	3.00	3.00	11.53	11.60	27.46	25.14
Bluebell Ward 'IP'	G64302	2.80	2.80	15.20	15.20	21.41	23.29
Kingfisher House 'IP'	G64305	6.00	4.00	13.10	12.00	33.35	26.04
Audrey House	G64306	3.00	3.00	14.60	12.40	16.05	14.56
Wren Ward	G64309	3.00	3.00	14.60	15.00	16.10	14.52
Sycamore Ward	G64312	3.00	2.91	14.60	15.80	16.10	14.80
Willow Ward	G64313	3.60	3.40	14.30	13.20	16.10	17.30
Oak Ward	G64314	3.00	2.60	14.60	15.60	16.10	13.40
Low Secure Kedleston	G61053	2.00	2.00	18.76	18.57	23.88	22.52
Total		53.80	51.98	238.07	226.53	324.35	291.63

Comparison with national NHS nursing vacancy rate (7.5%)

Staff Group	Local Rate	National NHS Nursing Rate	Position
Band 6 Nurse	1.4%	7.5%	6.1 percentage points better
Band 5 Nurse	6.3%	7.5%	1.2 percentage points better
Band 3 HCA	9.9%	No directly comparable national NHS HCA vacancy rate identified in the source	Higher than the nursing benchmark

When compared with the national NHS Nursing vacancy rate of 7.5%, Band 6 recruitment and retention are strong, with a vacancy rate of 1.4%, below the national nursing vacancy rate and Band 5 Nursing vacancy rates are 6.3%, remaining below the national nursing average.

Band 3 HCAs represent the most significant workforce challenge, with a vacancy rate of 9.9%, accounting for approximately 33 full-time equivalent (FTE) Inpatient vacancies.

Temporary staffing and agency use

As shown in the chart below, the use of agency staff is likely to be influenced by the decision to stop the use of non-registered agency staff in line with national guidance from February 2026. While this provides assurance that agency deployment has reduced and that national expectations are being implemented, it should not be interpreted as a reduction in underlying staffing demand. Temporary staffing pressures continue to be present and are increasingly being met through substantive staffing, internal redeployment and the use of bank staff. Continued oversight is in place through weekly check and challenge meetings in all inpatient areas, led by the clinical quality directorate, to ensure that rosters are being utilised efficiently and proportionately and that reduced agency use does not create unintended risk to safe staffing, continuity of care, observation capacity or quality of patient experience.

Temporary Staffing Workforce Report													
	2025								2026				
	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY
Total number of shift requests	3,444	3,021	3,639	4,478	3,693	4,386	4,244	4,206	4,182	4,367	5,146	4,126	4,263
Total number of shifts filled	3,122	2,661	3,227	3,729	3,070	3,817	3,481	3,378	3,530	3,551	4,156	3,495	3,543
Number of Shift filled by Bank	2,833	2,347	2,956	3,365	2,754	3,439	3,132	2,988	3,201	3,193	3,745	3,153	3,263
Number of shifts filled by Agency	289	314	271	364	316	378	349	390	329	358	411	342	280
Bank Fill rate	82%	78%	81%	75%	75%	78%	74%	71%	77%	73%	73%	76%	77%
Agency Fill rate	8%	10%	7%	8%	9%	9%	8%	9%	8%	8%	8%	8%	7%
Fill rate (%) (benchmark 80%)	90.7%	88.1%	88.7%	83.3%	83.1%	87.0%	82.0%	80.3%	84.4%	81.3%	80.8%	84.7%	83.1%
	■	■	■	■	■	■	■	■	■	■	■	■	■

Conclusion

The review provides assurance that current inpatient establishments remain appropriate at this stage, with no immediate staffing reductions recommended. This position is supported by triangulation of MHOST outputs, professional judgement, ward-level quality and safety intelligence, vacancy data, fill rates and the ongoing impact of enhanced therapeutic observations. The establishment review process will be repeated in November 2026 and will include updated MHOST scoring to ensure staffing recommendations remain aligned to patient acuity, dependency, clinical risk and service configuration. It should also be noted that Cubley Court and Tissington Ward are part of the MHOST Refresh Project, a national programme to update and revalidate the existing MHOST so that it better reflects modern mental health inpatient care, changes in patient acuity, new models of care and the evolving multidisciplinary workforce. The refresh was initiated in response to recommendations from the Healthcare Services Safety Investigations Body (HSSIB) and is being led by the Shelford Group in partnership with NHS organisations and subject matter experts.

Appendix 1

Working Age Adult Inpatient Acute ward current funded establishment and MHOST recommended establishments

Current funded establishment

Ward	Registered Nurse Funded (Band 6 + Band 5) Whole-Time Equivalent (WTE)	Band 3 HCA Funded WTE	Total Funded WTE
Wren Ward	17.60	16.10	33.70
Audrey House (ECU)	17.60	16.05	33.65
Dove	17.60	16.10	33.70
Oak Ward	17.60	16.10	33.70
Robin	17.60	16.10	33.70
Sycamore Ward	17.60	16.10	33.70
Ward 35	17.60	22.32	39.92
Ward 36	17.60	22.57	40.17
Willow Ward	17.90	16.10	34.00
Kingfisher House (PICU)	19.10	33.35	52.45
Total	291.16	325.01	616.17

MHOST recommended establishment

Ward	Registered Practitioner FTE	Support Worker FTE	Total FTE
Wren Ward	12.40	10.99	23.39
Audrey House	16.03	14.22	30.25
Dove Ward	13.71	12.16	25.87
Oak Ward	20.15	17.87	38.01
Robin Ward	14.78	13.11	27.89
Sycamore Ward	15.22	13.50	28.72
Ward 35	16.97	15.05	32.01
Ward 36	13.60	12.06	25.66
Willow Ward	9.53	9.16	18.70
Kingfisher House PICU	14.96	16.08	31.05
Total	202.91	181.61	384.54

Older Person's Inpatient wards

Current funded establishment

Ward	Registered Practitioner FTE	Support Worker FTE	Total FTE
Bluebell Ward	18.00	21.41	39.41
Cubley Male	15.80	25.15	40.95
Cubley Female	14.53	28.12	42.65
Tissington	16.90	13.70	30.60

MHOST recommended establishment

Ward	Registered Practitioner FTE	Support Worker FTE	Total FTE
Bluebell Ward	7.23	6.21	13.44
Cubley Male	13.02	15.41	28.42
Cubley Female	9.47	8.13	17.60
Tissington	8.92	7.66	16.58

Forensic, Rehabilitation and Perinatal services**Funded establishment**

Ward	Registered Practitioner FTE	Support Worker FTE	Total FTE
Kedleston	20.76	24.88	45.56
Cherry Tree	13.44	16.10	
Beeches	14.13	20.06	34.19

MHOST recommended establishment

Ward	Registered Practitioner FTE	Support Worker FTE	Total FTE
Kedleston	11.8	11.2	30
Cherry Tree	9.5	8.6	18.1
Beeches	5.7	5.5	11.1

Clinical Research and Development (R&D) annual report – 2025/26

Purpose of Report

The purpose of the report is to:

- Provide the R&D annual report – 2025/26
- Provide the annual review of R&D Operational Group Effectiveness and Terms of Reference
- Provide the first six-monthly research activity, performance and income report to Trust Board that has been recently introduced to support assurance against NHS Medium Term Planning Framework requirements.

Executive Summary

The 2025/26 R&D annual report demonstrates a strong year of delivery, influence and impact across the different functions - clinical research delivery, Library and Knowledge services, embedded service evaluations including self-harm and suicide prevention workstream, and clinical audit-based quality improvement. The team has taken on board feedback from the Quality and Safeguarding Committee on the 2024/25 annual report and paid attention to reporting more of the impact of our activities in 2025/26.

- **Clinical research delivery** has continued to strengthen the Trust's reputation as a research-active organisation, delivering National Institute for Health Research (NIHR) clinical research with positive participant experience. Of note are the developmental opportunities that have been provided to Trust colleagues, including piloting a Peer Research Delivery Lead role (page 4 of annual report). Page 25 highlights the valuable work of Trust colleagues who lead and support clinical research, expressing our appreciation for their contributions
- **Library and Knowledge service** achievements in 2025/26 demonstrate a mature, responsive and strategically aligned service that supports evidence-informed decision-making, improved patient care and the routine use of knowledge in practice. Completion of the Quality and Improvement Outcomes Framework (QIOF) self-assessment, with compliance against all 16 essential criteria, provides strong assurance that the service meets national expectations for quality, leadership, evidence access, workforce development and demonstrable impact on patient care (page 14)
- **Clinical service embedded evaluations and improvements** are delivered by a dedicated team working within clinical services. The team has demonstrated local impact through the effective use of routinely collected data, including evidence-based care pathways for frequent callers to the mental health helpline and evaluation of the Acute Alcohol Care team's effectiveness. This approach has improved service responsiveness, supported additional funding for service expansion and helped meet new service standards as just a few examples. The Derby Monitoring Study of Self-harm and the Multi-centre Study of Self-harm in England further demonstrate how systematic data collection informs national suicide prevention strategy (Page 15)
- **Clinical audit based quality improvement** is included in the annual report for completeness but has been reported to the Committee previously, in May 2026 (page 22).

Overall, the annual report provides strong assurance that R&D is making an important contribution to patient care, workforce development, partnerships and productivity. Good progress has been made in delivering our R&D strategic plan within the context of significant workforce pressures across all the R&D functions.

The key challenge for 2026/27 will be to sustain this progress whilst further developing the following four strategic goals:

- To achieve operational resilience, sustainability and quality in the delivery of R&D
- To attract income for growth in R&D capacity and capability

- To make better use of routinely captured data for better access, experience and outcomes
- To embed a culture that values R&D as a core function.

R&D Operational Group Effectiveness and Terms of Reference

The annual review provides positive assurance that the R&D Operational Group is operating effectively as the Trust's governance and oversight forum for research, clinical audit, and Library and Knowledge services. During 2025/26, five of six scheduled meetings proceeded as planned and were quorate, with one meeting cancelled due to non-quoracy and all outstanding business carried forward. Across the year, the Group maintained oversight of strategic delivery, policy development, clinical audit, research delivery, impact reporting, partnership development, health inequalities, use of routinely collected data, and operational capacity pressures. The review demonstrates that the Group is fulfilling its Terms of Reference, supporting escalation and assurance through the Quality and Safeguarding Committee and contributing to the Trust's wider strategic objectives and research ambitions. In 2026/27, the Group is focusing on expanding its membership.

Six-monthly Trust Board research activity, performance and income report covering 2025/26

This is the first six-monthly research activity, performance and income report to the Trust Board. It has been introduced to support assurance against NHS Medium-Term Planning Framework requirements, which recognise research as a core part of the NHS operating model and require providers to report to boards on a six-monthly basis their research activity, income and performance against the Government's 150-day clinical trial set-up targets.

The report provides assurance that the Trust sustained research delivery in 2025/26, with 450 participants consenting to take part in 40 NIHR studies, and that the reduction in recruitment numbers since 2025/26 reflects reclassification of a large observational study rather than reduced research ambition or delivery capability. The Trust also secured approximately £1.14m of external research funding and investment, supporting research activity in the Trust and wider Integrated Care System.

Key assurance is provided that non-commercial study set-up performance is strong and subject to ongoing monitoring; research income is governed through established R&D and Finance controls and used for its intended purpose; and commercial trial delivery issues are recognised, escalated and being actively managed.

The Trust met the 60-day local site set-up target for the ALTO-100 commercial clinical trial of an investigational medicinal product (CTIMP) ahead of target but did not meet the first participant recruitment target, meaning the overall benchmark was not achieved. A remedial plan is in place, with recruitment prioritised, escalation to the Research Delivery Network and further oversight through the R&D Operational Group. Two delivery risks requiring continued oversight is asked to be noted:

1. securing operational funding to deliver a service having secured the NIHR-funded Transcranial Magnetic Stimulation (TMS) equipment, and
2. protecting delivery of the Children HIV-Exposed Uninfected – Research to Inform Survival and Health (CHERISH) contract during planned Health Visiting service transfers.

Assurance Level: Significant Assurance is suggested - that there is a generally sound system of control designed to meet the system's objectives. However, some weakness in the design or inconsistent application of controls put the achievement of particular objectives at risk.

Strategic Considerations		BAF Risk	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X	1A	1.1
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X	2B	2.1/2.2
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X	3A	3.2
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X	4A	4.3

Risks and Assurances

- **Commercial trial delivery:** ALTO-100 achieved the 60-day local site set-up target. However, the first participant recruitment milestone was not met, resulting in loss of eligibility for the related performance recognition direct payment of approximately £2k. Recruitment is being prioritised, with progress monitored through the R&D Operational Group and escalation to the Research Delivery Network as required
- **Capital funding delivery:** The NIHR-funded TMS capital award, valued at approximately £100k, may be at risk of repayment if sustainable operational funding for the TMS service is not secured. Executive leadership oversight is in place to support resolution
- **Research contract delivery:** Planned Health Visiting service transfers may affect delivery of the CHERISH research contract if service engagement, capacity or pathway access is disrupted. The Trust is the lead as contracting organisation. Executive awareness and oversight are required to protect contractual delivery and manage any emerging risks.

Consultation

- 14 May 2026 R&D Operational Group - reviewed the Draft1 R&D annual report including annual review of R&D Operational Group Effectiveness and Terms of Reference
- 25 June 2026 Medical Directorate Meeting – reviewed proposed Board report on research activity, performance and income, including draft3 R&D annual report
- 28 July 2026 Quality and Safeguarding Committee.

Governance or Legal Issues

- The report provides assurance that research, clinical audit, Library and Knowledge services, and associated R&D activity are subject to established Trust governance arrangements, with oversight through the R&D Operational Group and escalation to the Quality and Safeguarding Committee as required.
- Research activity continues to be managed in line with applicable legal, regulatory and governance requirements, including Health Research Authority approvals, NIHR reporting expectations, sponsor and contractual obligations, information governance, data protection, confidentiality and research finance controls
- The key governance and legal issues requiring continued oversight relate to delivery of the NIHR-funded TMS capital award, the CHERISH research contract during planned Health Visiting service transfers, commercial CTIMP performance requirements, and ensuring research income is used for its intended purpose in accordance with relevant funding, contractual and financial governance requirements.

Net Zero Duty Implications

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

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

The report has limited direct net zero impact because it is primarily an assurance, governance and performance report. R&D activity may contribute positively through evidence-based service improvement, digital-enabled research processes, reduced duplication through partnership working, and better use of routinely collected data to support efficient models of care. Any future implementation decisions arising from the report, particularly in relation to capital equipment, procurement, estates use, travel associated with research delivery, and digital infrastructure, would continue to be assessed in line with the Trust's net zero duty.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

- The report identifies positive equality impacts through the Trust's continued focus on widening access to research, improving participation from underserved communities, and using routinely collected data to better understand variation in access, experience and outcomes. R&D activity supports the Public Sector Equality Duty by helping to advance equality of opportunity, reduce health inequalities and strengthen evidence-based service improvement for people across protected characteristics and inclusion health groups
- The main equality risk is that people from groups that are already underrepresented in research may continue to have less opportunity to take part in studies, benefit from innovation, or have their needs reflected in evidence used to shape services. This includes potential barriers linked to age, disability, ethnicity, language, digital exclusion, socioeconomic disadvantage, pregnancy and maternity, religion or belief, sex, sexual orientation and gender identity

- Mitigation is in place through the R&D strategic plan, Research Engagement Network activity, partnership working, inclusive recruitment approaches, monitoring of research activity and escalation through the R&D Operational Group and Quality and Safeguarding Committee.
Future reporting will continue to strengthen the use of equality, diversity and inclusion data to identify gaps in research access and demonstrate impact on equity of participation and outcomes.

Recommendations

The Board of Directors is requested to:

1. Receive the R&D annual report – 2025/26 and take significant assurance from the evidence of sustained delivery, impact, governance oversight and progress against the Trust's R&D strategic priorities. Significant assurance is suggested
2. Approve the annual review of the R&D Operational Group Terms of Reference, noting that the Group is operating effectively as the governance and assurance forum for research, clinical audit, and Library and Knowledge services. It is also expanding membership in 2026/27
3. Note the first six-monthly Trust Board research activity, performance and income report proposed, including the significant assurances provided, the identified delivery risks, issues and mitigations.

Report presented by: **Lynn Andrews**
 Chair, Quality and Safeguarding Committee

Report prepared by: **Rubina Reza**
 Head of Research and Development

Research and Development annual report – 2025/26



June 2026

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RESEARCH AND DEVELOPMENT

2025–26 HIGHLIGHTS

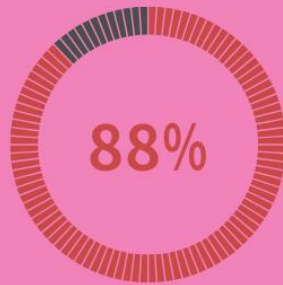
Over **400 service users, carers, and colleagues** provided informed consent to participate in more than **40 different research studies**.



We facilitated **12 interventional clinical trials**, (6 for older adults, 3 focusing on psychosis, 3 focusing on physical health).



88% of NIHR clinical research met the new **60 day set up timeframe**, exceeding the 75% requirement.



The **oldest research participant** aged **88 years old**, while the **youngest participant** was just **4 years old**.



Of the **71 participants** who provided feedback about their research experience, over **95%** said **they would consider participating in research again**.



48 Trust colleagues are enrolled on the University of Lincoln's online **Foundation Research Training** enhancing their research skills over March–July 2026.



47 Trust colleagues published articles in **37 journal articles** and **1 book**.



The Library and Knowledge Service delivered **26 induction and training** sessions to **354 participants**.



The Library and Knowledge Service delivered **76 evidence searches**, over **2,000 book loans**, and **490 journal articles**, with **600 Trust staff holding OpenAthens accounts** for resource access.



We participated in **90% (10 out of 11) national clinical audits** for which we were eligible. We also supported **19 local audits**.



R&D Strategic Plan Progress



What we achieved in 2025/26

The 2025/26 Research and Development Annual Report demonstrates a strong year of delivery and growing strategic maturity. We continued to strengthen our position as a research-active organisation and this year's activities reflect a team that is increasingly able to translate research opportunities into tangible benefits for patients, colleagues, and local communities. Numerous examples show how we are expanding access to opportunities and making a positive difference.

Core operational delivery was strong in 2025/26, exceeding non-commercial study set-up and first participant recruitment targets aligned to the government's 150-day metric. The team recruited 450 participants across 40 NIHR studies, and of 71 responses 95% were open to participating again. Clinical audit, embedded service evaluations and Library and Knowledge Services also demonstrated clear contributions to clinical service improvement, quality, productivity and patient outcomes.

Together, we have strengthened inclusive research, evidence informed practice and partnership working. This included first-time experience as Lead Contracting Organisation for the NIHR-funded CHERISH project, successful NIHR capital investment, and continued collaboration with Integrated Care System partners, universities, GP practices, VCSE organisations and community groups. These achievements position DHCFT as an active contributor locally, regionally and nationally, while directly supporting the Trust's strategic objectives around patient focus, people, productivity and partnership.

This progress has been delivered in the context of significant workforce pressures across Research and Development functions.

Priorities for 2026/27

- To achieve operational resilience, sustainability, and quality in the delivery of R&D
- To attract income for growth in R&D Capacity and Capability
- To make better use of routinely captured data for better access, experience and outcomes
- To embed a culture that values R&D as a core function.

National Institute of Health and Care Research (NIHR)

Local Clinical Research Delivery

During 2025/26, the Clinical Research Team supported over 40 National Institute for Health and Care Research (NIHR) studies, engaging more than 450 service users, carers and staff. Our R&D strategic goals continue to be on creating meaningful and accessible opportunities for research participation, strengthening collaboration with partners, communities, colleagues and the public, while directly supporting organisational priorities of being **patient-focused, productive, people-centred and partnership-driven**.



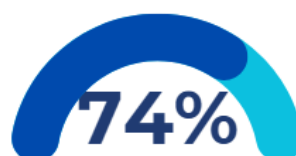
Supported over over
40 NIHR studies



Engaging more than
450 service users,
carers and staff

This year marks 20 years of the National Institute for Health and Care Research (NIHR), recognising two decades of sustained investment in research that improves health, care and outcomes for patients, communities and the NHS workforce. Our portfolio reflects this legacy, with Trust colleagues, patients and partners contributing to nationally significant studies that continue to shape policy, practice and service improvement.

Against this backdrop, this year's Clinical Research report focusses on the impact of our work. Latest figures indicate that 74% of NICE guidance utilises evidence from NIHR funded research, with the NIHR routinely commissioning studies to address key evidence gaps identified during guideline development. The Clinical Research Team ensure that the voice of our community is represented within that.



74% of NICE guidance utilises
evidence from NIHR funded research

[NIHR Evidence](#) – publishes selected NIHR-funded research studies that are most likely to be of interest to the public and professionals and inform changes to policy or practice through Alerts (single studies) and Collections (several studies).

As an example we participated in the ROSHNI-2 study several years ago, and the alert from the study shows, [Culturally-adapted therapy improved postnatal depression](#) in British South Asian women. We intend to use the learning from this study for a new NIHR research project which we are co-leading with University of Nottingham called **CHERISH**.

Additionally, this year we report on our performance in line with the UK governments commitment to reducing the time it takes to set up clinical trials in the UK. This commitment is a headline action of the [Life Sciences Sector Plan](#) and is reinforced in the [10 Year Health Plan for England](#). As part of this commitment to speed up the set-up of clinical trials, there is an accompanying expectation that all participating sites for a study must complete their set-up activities within 60 days followed by enrolling the first participant within 30 days.

Impact – the positive difference we make (*patient focussed, people, productive, partnerships*)

It has long since been known that research-active healthcare organisations consistently demonstrate better patient outcomes, including lower mortality rates, improved care processes, and higher patient satisfaction. There is an unavoidable time lag between the initiation of studies and the availability of longer-term outcomes. Research projects themselves often span many years, beginning with the identification of evidence gaps, followed by study design and the securing of funding to address these gaps.



Within this wider research lifecycle, the role of the Clinical Research Team at DHCFT sits at the critical delivery stage. Our focus is on delivering the funded research as one of multiple local research sites by supporting study set-up, identifying and recruiting eligible participants, and supporting them throughout their research journey. We act as the interface between research design and real-world delivery with those who represent our communities, ensuring studies are conducted safely, inclusively and ethically, in line with regulatory requirements. Participant involvement within research varies considerably, ranging from single-contact studies to long-term follow-up over several years, and the Clinical Research Team provides continuity and support throughout this process.

Whilst, the wider research process can take much longer, it is often clear to see that our research activity can deliver immediate, tangible benefit for our service users, our colleagues and our service as a whole.

Participating in a clinical research trial or project may enable earlier and broader access to novel interventions that may already have a growing evidence-base, but which are not always consistently available through routine pathways. There have been a number of examples of this this year:

A 12-month randomised, double-blind, controlled, international multicentre trial comparing changes in cigarette consumption after switching to high or low nicotine strength e-cigarettes in smokers with Schizophrenia spectrum disorders (GENESIS)



Last year we reported on the GENESIS study which was an international collaboration with the University of Catania and was underway at the time. GENESIS focuses on smoking reduction and harm reduction in people with schizophrenia spectrum disorders, a group historically underserved by smoking cessation services. While grounded in established harm-reduction evidence, the research responds to a clear evidence gap, as people with schizophrenia spectrum disorders are less likely to receive smoking cessation interventions and experience lower success rates when they do.

The full results from this project are not yet available and it will be a while before this work contributes to wider guidelines. However, participation in the study enabled individuals to access structured, person-centred harm-reduction support (including vaping as a safer nicotine delivery option), alongside repeated contact, monitoring and support that are not routinely available in standard care. The project engaged 15 service users from DHCFT. By the first follow-up, participants had reduced cigarette use by 50% from study entry, and four individuals had quit smoking altogether.

Multi-domain self-management in older people with osteoarthritis and multi-morbidities (TIPTOE) study



TIPTOE, a collaboration with the University of Cardiff, builds on the Bridges self-management approach, an established evidence-based model. The protocol explicitly recognises that routine care does not always meet the needs of older people with osteoarthritis and multiple long-term conditions.

Through research participation, individuals gain timely access to personalised, guided self-management support that might otherwise be inaccessible or delayed. We currently have 11 service users engaged with this project and in addition, three DHCFT colleagues have successfully completed specialist training in this approach, delivered by the Cardiff University team. This has strengthened organisational capability by expanding the skillset and expertise of our workforce, representing a tangible and sustainable benefit arising directly from involvement in the project.

"I am a newly qualified OT involved in the TIPTOE study which is looking at self-management for people living with joint pain. I am enjoying being involved in research so early in my career; I have been warmly welcomed and well supported. Being part of clinical research has meant embedding my learning about evidence-based practice on my course straight into my work and developing my understanding of what research looks like in practice. The skills I have learned delivering the TIPTOE intervention are also valuable and applicable to my clinical practice. I thought research involvement was limited to experienced practitioners, and that I may have missed my opportunity to be involved due to coming to my profession later in life. My positive experience with research now means I hope to engage further in research as my career develops."

Samantha Potter, newly qualified OT/TIPTOE Therapist/interventionist

Another example of impact on a local level is the Experience Based Co-design of Psychosis-Centred Integrated Care Services for Ethnically Diverse People with Multimorbidity (CoPICS) study. CoPICS explores how health and social care can better support ethnically diverse people living with psychosis and multimorbidity, addressing known inequalities in access, experience and outcomes. Using creative methods such as photovoice, artwork and reflective discussions, participants shared their experiences to help shape service improvements. This approach enabled people who may not typically engage in research to contribute their perspectives and demonstrates how co-production with people who have lived experience can help reduce inequalities and improve access to care and support on a local and national level.

Local findings were used to co-design practical resources, including a "Preparing for Your Outpatient Appointment" leaflet and a pilot initiative in Bolsover to increase awareness of third-sector support for people with mental health difficulties in a rural community. The impacts of these resources are currently being evaluated with results/outcomes coming soon.

In addition to individual portfolio studies, the Trust has contributed to major national programmes that have generated robust, longitudinal evidence to address workforce

inequalities across the NHS. One such programme is the UK-REACH study and its follow-on iCARE research, which have been collecting data over several years and together form one of the largest and most detailed national investigations into NHS workforce experience, particularly in relation to ethnicity, mental health, discrimination and retention.

Over the past six years, more than 250 colleagues were involved in UK-REACH and iCARE studies, demonstrating a strong commitment to research that supports and protects our workforce.



More than **250** colleagues
were involved in UK-REACH
and iCARE work packages

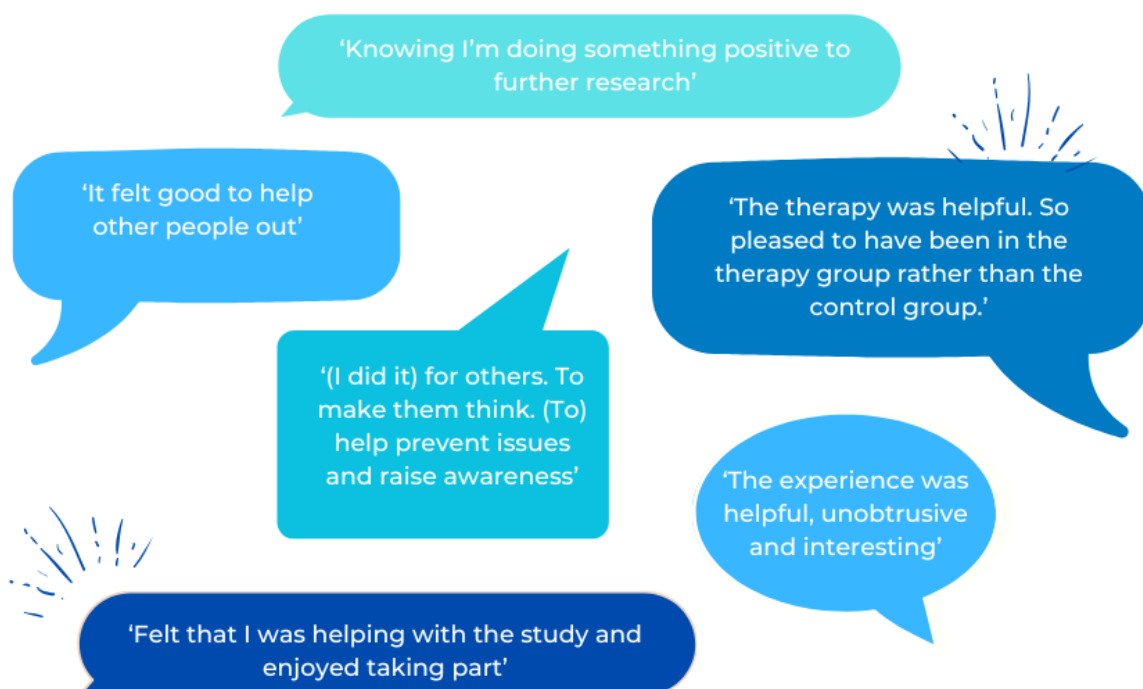
Together, these studies have generated high-quality evidence that is directly informing NHS policy, strengthening workforce protections, improving wellbeing, and supporting long-term retention through practical, evidence-based interventions. This work exemplifies the Trust's contribution to research that delivers meaningful impact not only for patients, but also for colleagues and the sustainability of the NHS workforce as a whole.

Participant Research Experience *(patient focussed)*

As well as acting as a bridge to new therapies not yet widely available or to shaping future care, participation in clinical research offers patients significant hope and social engagement, along with several other key benefits such as closer monitoring, personal empowerment and a sense of community for coming together with others. We routinely seek feedback through the annual Participant in Research Experience Survey to capture participants' experiences of engaging with our research and team. Since implementing this approach several years ago, feedback has been resoundingly positive. Below are some of the responses we gained this year.

Of the 71 participants who gave feedback about their research experience, over 95% said they would consider participating in research again.

What was positive about your research experience?



Research Delivery Performance *(productive)*

Timely study set-up is a key national priority for the NHS is a critical enabler of high-quality clinical research delivery and part of the success criteria in our R&D strategic plan. The 150-day set up target supports the NHS ambition to restore the UK's competitiveness in clinical research by accelerating trial initiation and reducing unnecessary bureaucracy. In line with this, the Clinical Research Team focuses on the stages of the pathway where the Trust has direct responsibility: the 60-day period from regulatory approval or site selection to study opening, followed by the 30-day target to achieve first participant, first visit. The section below outlines our performance against these two metrics during 2025/26. No Commercial projects were initiated during this period.

NHS Trust Level Metric	% Non-Commercial Studies	% Commercial Studies	Target
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Within 60 days of Health Research Authority approval or Site Selection, site is open	88%	N/A	75%
Within 30 days of opening, site achieves First Patient, First Visit (FPFV)	75%	N/A	70%

Partnerships

The Clinical Research Team continues to work collaboratively both internally, with Trust services and individual colleagues, and externally across the wider Joined Up Care Derbyshire network in line with our R&D strategic plan. Last year we reported on the breadth of services we supported, and this has continued during 2025/26, with further strengthening of our collaboration with the Parkinson's Disease service at University Hospitals Derby and Burton through the **CAN-PDP** and **COBALT** projects.

Research involving older people has been a significant area of activity this year, with studies including **Care Coach**, **ADAPT**, **TIPTOE**, **ANTLER 75+** and **FIND-ME**. This work has involved close collaboration with the Memory Assessment Service, 28 local GP practices, and a wide range of third-sector community organisations. We have also continued to strengthen partnerships with Early Intervention services through projects such as **El Mission**, **Feeling Safer** and **PPIp2**, alongside ongoing collaboration with inpatient services across studies including **PPIp2**, **VISIONQUEST**, **My Medicines Journey** and **Gambling Related Harm**.

Further details on the projects referenced above can be found in the Research Programme section of the appendix to this report.

Last year, we shared that we were awaiting the outcome of our second-stage NIHR Research for Patient Benefit grant application. We are pleased to report a successful outcome and start of the project ***CHERISH: The co-creation of a Health Visitor-led intervention, combining group exercise and behavioural activation approaches which can be adapted and tailored for mothers at risk of postnatal depression*** (NIHR209219). This achievement represents an important milestone for the team as we take on the role of Lead Contracting Organisation. The project formalises our partnership with the University of Nottingham as research sponsor for the study and the University of Derby as a collaborator, and marks a significant step forward in strengthening our local contribution to maternal mental health research

Investing in our people to build research capacity and capability

Last year we reported that we had been successful in securing some extra funding to allow us to work with three colleagues from our physiotherapy team, inpatient team and also Talking Mental Health Derbyshire for three months. You can read more about how this went here: [Strengthening the link: How 3 clinicians brought research into everyday care | NIHR RDN](#)

This year, with additional funding secured again, we built on this work through an extended embedded role with a colleague from one of our Working Age Recovery Teams, who shares reflections on his experiences below.— This initiative helped to increase the visibility of research within one of our more rural localities, where research activity had previously been less prevalent.



During my secondment as a Research Nurse in mental health, I have contributed to improving the visibility and accessibility of current research projects within community services. By actively promoting studies and engaging within my clinical team, I have helped increase awareness, which has directly supported the successful recruitment of participants into research. This role has also strengthened links between the Community Mental Health Team and the research team, fostering better collaboration and integration of research into care. From a professional development perspective, the secondment has enabled me to build skills required for working at a more senior level, particularly in relation to assessing capacity and obtaining informed consent. Overall, this experience has enhanced both service delivery and my own clinical and leadership capabilities.

Jake Cooper, Community Psychiatric Nurse and Research Link Role

We are also currently halfway through a 12-month role focused on introducing a Peer role within Clinical Research, and we look forward to reporting on progress from this work in the coming year. In the interim a brief update is provided.



PEER RESEARCH DELIVERY LEAD

“ Over the past 6 months, in my role as Peer Research Delivery Lead, I have learned much about the importance of research delivery in the trust - and the positive impact it has on care and service procedure.

It has been a lovely experience to work with a well informed and passionate team, who have been really supportive in assisting me and including me in their team. I've had opportunities to shadow a range of research projects and the different stages of research delivery, from recruitment to sample taking.

To witness the scope of research and how dedicated the trust is to facilitate research, is very inspiring. This has made me feel more passionate about my role and being able to share the privilege that is research delivery with Peers across the trust, aiming to bring more awareness and participation in research, with the goal of creating a better future for healthcare and treatment across the NHS.

I am grateful for the opportunity this has brought me and am thankful to be a part of such an incredible team.”

Michael Silvester

**TO FIND OUT MORE INFORMATION,
PLEASE CONTACT:**

Emilie Gotheridge
Lead Clinical Researcher
e.gotheridge@nhs.net



Background

- Peer Support Workers (PSW) are a growing workforce who play a vital role in health and social care using their own lived experience of mental health problems.
- Peer Researchers can use their insight and understanding of the populations being researched to contribute towards improving people's research experience and access to research for those who would not normally participate.
- Involving PSW in research also supports the development of a culture where all health and social care staff can contribute to research delivery as part of a Multi-Disciplinary Team.

About the role

- The post is a 12-month fixed-term pilot for a new role, Peer Research Delivery Lead, which commenced in December 2025.
- The first 6 months in role focused on a co-mentorship approach, with the peer researcher developing their own research knowledge alongside educating colleagues within the research department about PSW roles and sharing insights about research delivery from a lived experience perspective.
- Future focus for the role includes further developing the new Peer Research Network of research interested PSW to continue to promote clinical research awareness and involvement throughout DHCFT.



Beyond these dedicated research roles, we have seen wider interest from Trust colleagues in developing their research skills, **48 colleagues** chose to enhance their expertise by enrolling on the **University of Lincoln's online Foundation Research Training programme**.

The training offers a range of workshops, covering key topics such as ***Patient and Public Involvement and Engagement, Research Ethics and Governance, Critically Appraising a Research Article, Methodology, Applying for Funding, Disseminating, Sharing, and Publishing Findings, and Innovation.***

This programme, made available by all Integrated Care Boards in the East Midlands for their respective system partners, is not only strengthening individual capability but also enabling connections and opportunities to collaborate, network, and build partnerships across the region. This initiative is contributing to a more skilled and connected health and care research community, enabling our Trust colleagues to advance patient care.

Library and Knowledge Management

Strategy and Improvement Plan

The service is in the final year of its strategy, with progress measured with the annual plan. Improvement and Implementation Plan 2025–26:

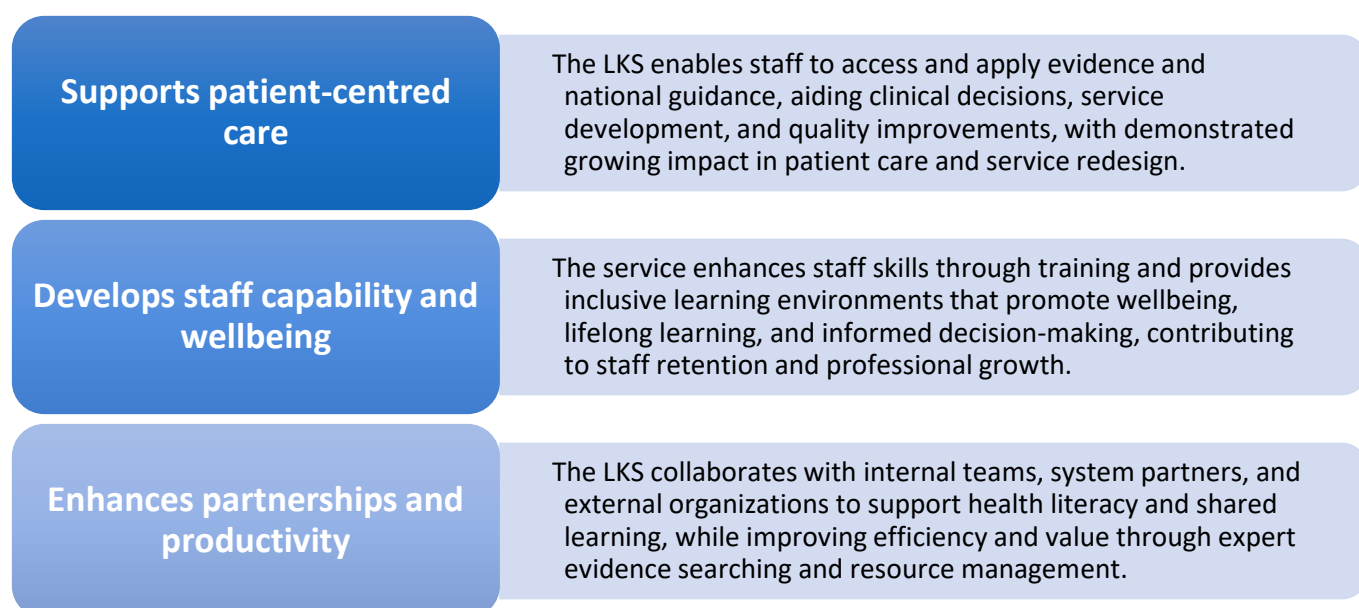
1. Increase impact on patient care – Substantially delivered, with sustained positive impact survey results, increased use of evidence summaries, embedded promotion activity, and reminiscence resources largely completed and ready for launch.
2. Mobilise evidence and knowledge – Largely complete, with all guides updated, digital presence refreshed, training delivery expanded, increased e-resource use, and outreach activity established.
3. Ensure efficiency and value for money – Fully achieved, through systematic analysis of usage data, informed subscription decisions, and consistent use of national and consortium procurement routes.
4. Provide quality assurance – Achieved, with QOIF submission completed and the annual report published, providing clear performance and assurance evidence.
5. Improve user experience – Strong progress embedded, evidenced by increased remote and e-resource use, maintained service standards, and positive usage and impact data.
6. Work in partnership – On track and embedded, with regular collaboration across Derbyshire NHS libraries, ICS networks, education, R&D and national programmes such as the Reading Agency.

7. Contribute to the Trust strategy – Achieved, with contribution monitored and evidenced through reporting and impact data.
8. Contribute to Knowledge for Healthcare programmes – Well underway, with health literacy training in place and an emerging knowledge mobilisation offer, including Board-level briefings.

The Quality and Improvement Outcomes Framework (QIOF) for NHS-funded knowledge and library services assesses six key areas including leadership support, access to evidence, workforce skills, service development, and impact on patient care. The service completed a self-assessment demonstrating compliance with all 16 essential criteria and is awaiting the final report .

Support for Trust Strategy

The Library and Knowledge Service (LKS) is integral to the Trust’s strategy by promoting evidence-based practice, learning, and collaboration to enhance care quality. It ensures timely access to high-quality evidence and supports clinical, managerial, and strategic activities for better outcomes.



Support for R&D Strategic Plan

The Library and Knowledge Service supports the R&D Strategic Plan by enabling access to evidence and helping staff apply it to practice, improvement and knowledge mobilisation as detailed in the annual improvement and implementation plan.

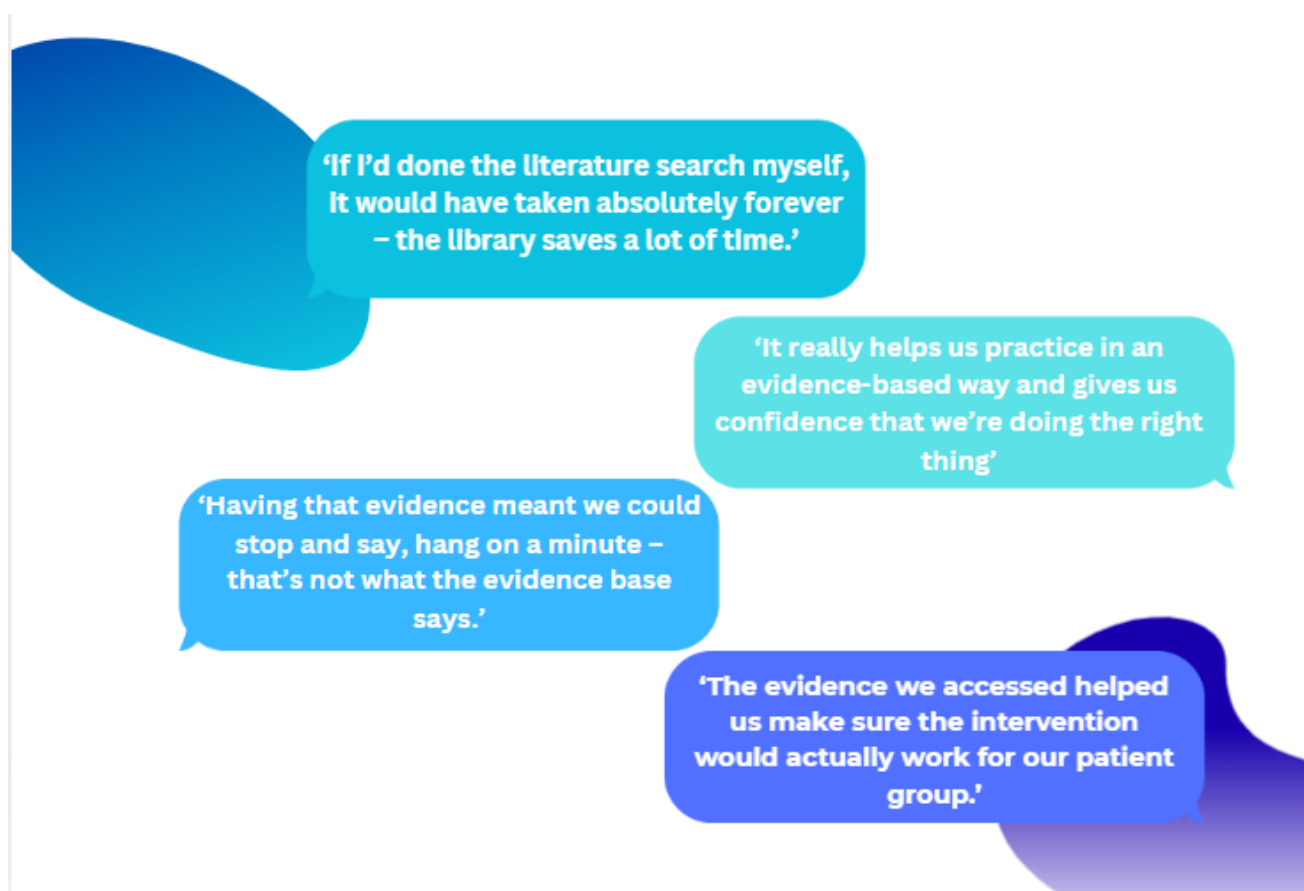
Kingsway Library Redesign

The library space was redesigned by removing half the shelving and adding two study pods and converting the quiet study room into a meeting room. This created a more open and

welcoming environment, resulting in a 43% increase in footfall. The pods are bookable and popular among users.

Impact Survey Results

The 2025 impact survey received 91 responses from diverse professional groups. The survey showed growing engagement and increased use of the library for literature searches, quality improvement, and patient care. Confidence, time saved, and informed decision-making measures improved significantly from 2023 to 2024 and remained high in 2025. Qualitative feedback reflects a shift toward viewing the library as integral to evidence-based practice and safe patient care. Follow up interviews were held with 10 people.



Access to Electronic Resources

Usage of electronic resources increased substantially, including over 5,000 e-book chapters read online and more than 5,200 journal article downloads (a 13% rise from the previous year). Over 600 Trust staff have OpenAthens accounts for resource access.

Evidence Searches

Evidence searching remains a core service with 76 searches completed during 2025/26, totalling 148 hours of work (average 2 hours per search). Most searches (64 hours) supported

patient care, with others aiding service development, professional development, and teaching. Summary writing was introduced for 76% of searches, providing detailed information on sources and key findings.

Print Resources

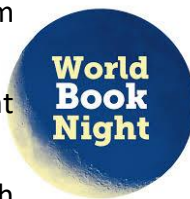
Print resources remain popular with over 2,000 book loans. Postal loans supplement e-books for staff not based near the main library. The collection was enhanced with 117 new print books, including new editions and special collections such as reminiscence resources and Reading Well for Families.

Training and Education

The service delivered 26 induction and training sessions to 354 participants, a 27% increase from the previous year. Training covered evidence-based practice, literature searching, and critical appraisal, delivered both in-person and via Microsoft Teams. The first outreach session was delivered to teams in Bakewell.

Other Highlights

- Development of memory boxes and reminiscence resources with contributions from a local knitting group, to be launched in May 2026.
- Participation in World Book Night with distribution of quick read books to inpatient wards and community teams.
- Ongoing staff book club hosted by the library, supporting wellbeing through discussions on books and reading.



Other Library Usage in 2025-2026

- 490 journal articles supplied by library staff, with 88% delivered same or next day.
- 965 registered users, including 295 new users during the year.

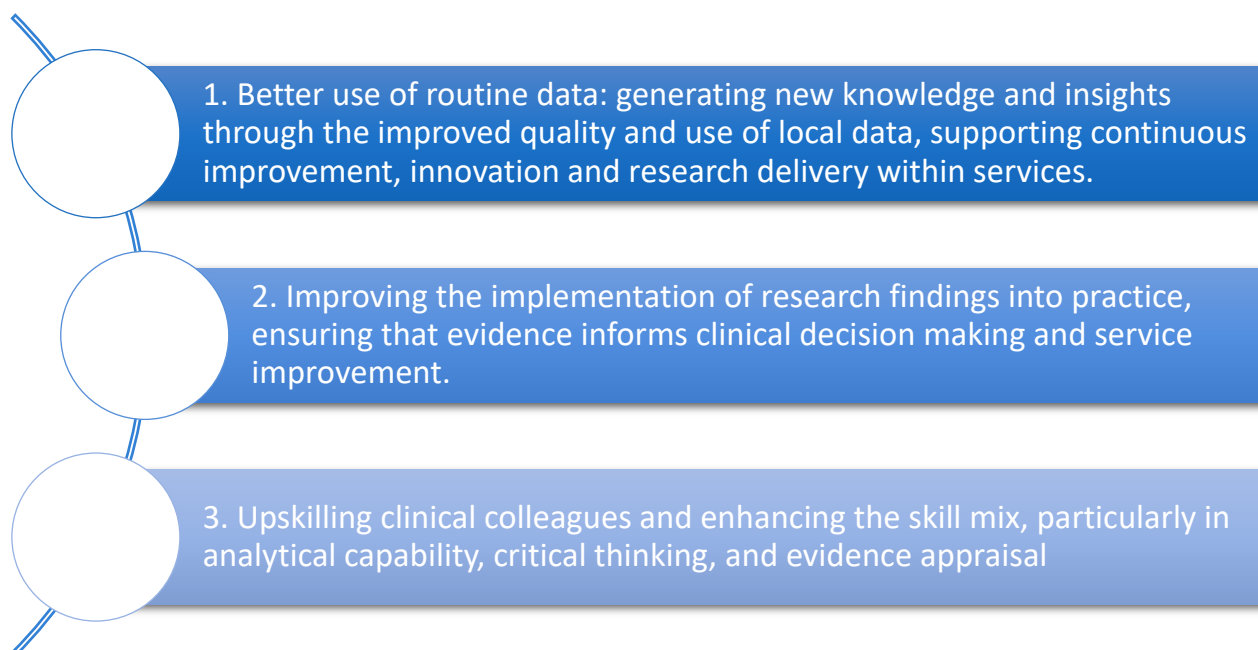
Clinical Service Embedded Evaluations and Improvements

The R&D department manages a number of embedded researcher posts, which are funded by the clinical services within which they are based.

The following services have an embedded researcher post: Mental Health Liaison/Alcohol Care Team, Criminal Justice Liaison and Diversion/RECONNECT/Mental Health Treatment

Requirement, Crisis Resolution and Home Treatment (Vacant), Mental Health Helpline, Adult Neuro-developmental (Vacant) and Perinatal.

The roles aim to increase:



In the current report, we share some examples of the work undertaken over the past year to support delivery of R&D and Trust strategy. For a fuller list of activity from the past year, please see our project tracker below.

In line with the R&D strategic plan we are undertaking a review in order to better operationalise and “report the local and wider impact of embedded researchers and reduce turnover for a sustainable core R&D workforce”.

Please note, the team had a very high absence rate (approximately 70% of team capacity) across the year, due to maternity leave, long term sickness, and pause of recruitment to two vacant posts (owing to internal review of embedded researcher operational model). Consequently, breadth and progress of workstreams have been significantly impacted. Staffing has now resumed to full quotient with the exception of two remaining vacancies (still subject to internal operational model review)

Project	What we did	What difference has this made	Expected long term impact	R&D Strategic Goal	Trust Strategic Priorities
Acute Alcohol Care Team Evaluation	Embedded routine evaluation approach from the point of service design - accurate capture and timely access and analysis of high quality service data Two-year post implementation evaluation in early 2025 enabling the demonstration of a 137.64% local return on investment - driven by reductions in readmissions and length of stay. National dissemination, incl: French K, Garton D. Dying for a Drink: An Alcohol Care Team Evaluation Two Years Post Implementation. BJPsych Open. 2025 Jun 20;11(Suppl 1):S186–7. doi: 10.1192/bjo.2025.10483. PMID: PMC12242521.)	This reliable, contemporaneous evidence was pivotal in preventing service decommissioning (which was imminently planned). The criticality of this work overtly apparent – acute alcohol services across England have been decommissioned over the past 24 months, due to limited evidence of impact. Stability achieved - recurrent funding now been secured with services' incorporation into the Royal Derby Hospitals block funding contract. Secured additional funding - Expansion of service provision to meet needs of most disadvantaged population - additional drug and alcohol homelessness workers; closer partnership working with Derby City Council.	Further reductions in length of stay – service stability has led to ongoing improvements in other areas of the country. Focus on innovation and development results from service stability – planned work includes investigating the effectiveness of using a non-invasive liver scanning as a motivational intervention to reduce alcohol consumption. National contribution and leadership – continued generation and sharing of robust service effectiveness data will inform national guidelines and service provision requirements – leading to increased presence and stability for acute alcohol services across the country.	Goal 3 Goal 4	Partnerships Patient Focused Productive
Real time self-harm data reporting - Derby Monitoring Study of Self-harm and Multicentre Study of Self-harm in England	Implemented real-time data reporting for self-harm presentations to the Emergency department. We have developed processes for increasing timely reportability of accurate, complete data of self-harm presentations, to increase utility and impact of the monitoring work on clinical care provision and development of the Mental Health Liaison Team. Self-harm attendance data has been captured through monitoring in Derby since 1989 - partner in the Multicentre	Identification and responsiveness to fall in assessment rate - exploring potential causes, national evidence bases and clinical practice guidelines. Subsequently resulting in a 20% increase self-harm assessments and other clinical discussion forums (drawing on the monitoring data) e.g. domestic violence prevalence, evidence base and clinical management. Informing national self-harm and suicide prevention policy. Our real time data is more accurate than hospital data on self-harm. We provide it to the Department of Health and Social	Ensure accurate understanding of current population need, service activity and effectiveness for the Mental Health Liaison Team. Increased clinician involvement and local impact - increase clinician engagement with the monitoring study and therefore increase the degree to which clinician experience and need informs the study, and study impact on service. Real time monitoring extended to CAMHS Liaison - who are also	Goal 2 Goal 3 Goal 4 Goal 5	Partnerships Patient Focused Productive People

	Study of Self-harm in England since early 00s. Extensive cleaning and other external factors meant reportable data was often several years behind.	Care (study funder) on a quarterly basis to inform national direction and priorities.	involved in data collection for the Derby/Multicentre Monitoring of Self-harm study		
Implementation of evidence-based care pathway for frequent users of the Mental Health helpline	Analysis of existing clinical activity data indicated small group of frequent callers – many of whom already open to mental health services. Improvement of routine data capture and reporting to accurately identify frequent callers, their current care offer and unmet needs. Review of existing evidence base to inform development of effective care pathway. Facilitation of cross-service and sector collaboration – develop individual care plans and capture accurate data	Proactive identification of patients with previously unmet needs and provision of consistent, joined up, trauma informed care -70% of callers have care plans -27 individuals identified as top callers Reduction in calls indicating people's needs are better met -27% of top 10 callers had 100% reduction in call volume after pathway implementation -69% of top ten frequent callers showed reduced call activity Increase in call handler's availability to answer other incoming calls Improved responsiveness to other callers -increase in professional line call answer rate from 57% to 72% (March 2026) Increased clinician confidence in how to support frequent callers - owing to clear process supported across teams and sectors. Further evaluation underway. Upskilling of clinicians in data capture, analysis and interpretation	Patients and the public: Improved experience when accessing the Helpline and shorter waiting times. Colleagues and staff: Fewer highly complex calls from high intensity users, supporting reduced burnout and improved wellbeing.	Goal 3 Goal 4	Partnerships Patient Focused Productive
				Goal 4	Patient Focused

Reduce average waiting time for Community Perinatal services – IN PROGRESS	Improve quality of, analyse and interpret referral data by sub team. Identified large variances in wait times across sub-teams e.g., outpatients, Psychology and community. Create a cross sub-team, targeted action plan, to reduce waiting time for referrals. E.g. increasing assessments where staff capacity allows e.g., bank shifts and MBU staff supporting PCMHT.	An overall reduction in the referral to assessment wait time. Observed reduction in average wait. Data will be published on Perinatal Microsite in line with the new Perinatal Quality Network standard. Better understanding of where blockages in patient flow are – which sub-team is experiencing highest demand/needs increased resources. Greater accountability for sub-teams in managing wait lists and wait times. Greater transparency and accuracy of average wait times for patients referred to the service. Meet new National Standard for publication of wait times for accessing the service.	Improvement in patient and colleague experience (e.g., wait and assessment/treatment delivered when required/relevant). Reduction in wait time between referral and treatment, leading to increase in effectiveness of care due to timely access at point of need. Reduction in people not receiving support – due to withdrawing from the waitlist or not accepting assessment appointments once offered.		Productive
Reconnect Service - Model Review	Improved and analysed routine data – to inform and lead on regional review of service model Identified Derbyshire RECONNECT had larger number of complex cases and lower staffing bands than other areas Evidence underpinned business case (NHS England East Midlands Commissioning Unit) for increase in number and banding of staffing.	Secured recurrent funding from NHS England for: Uplift in existing practitioner banding - 3 to 4 and 5 to 6. Increased capacity - additional Band 4 role Led on regional development of standardised key performance indicators	Inform update of national guidelines for RECONNECT services Focus on innovation and development - continue pioneering data led approach leading to further service evaluation and research delivery. For example: Enhanced Reconnect service pilot - bringing additional funding and focussed patient care.	Goal 4	Patient Focused Productive

Self-harm and Suicide Prevention

In 2026/25 we have strengthened the continuity and visibility of self-harm and suicide prevention - by deepening collaboration with local clinical and public-health partners. Key workstreams and outputs e.g. self-harm and domestic violence, have been shared with local services and incorporated into ongoing evaluation and improvement initiatives, supporting evidence-informed decision-making. Data capture expertise has been provided to clinical services e.g. CAMHS to increase robustness of routine data capture, which will be used to inform service provision and developments and enable further work in the area.

We have begun exploration of broadening out robust data capture and analysis of self-harm across other Trust services (initially those with an embedded researcher role) and have maintained active involvement in National and Regional suicide-prevention strategy groups, ensuring that emerging findings are translated into practice in a timely and meaningful way. Work is underway to apply insights into local training and service redesigns, positioning our programme as a sustained contributor to local prevention priorities.

Celebrating 50 years of Self-harm Monitoring

This year marks the 50th Anniversary of the Oxford Self-harm monitoring project. Set up and led by Emeritus Professor Keith Hawton OBE. Derby has been monitoring self-harm attendances to the Emergency Department for around 35 years and joined forces with monitoring study teams in Oxford and Manchester Universities in the early 00s, to create the Multicentre Study of Self-harm in England (funded by the Department of Health and Social Care).

The anniversary presents an opportunity for reflection on the significant impact the work has made on a national and international scale. For example:

- smaller pack sizes of common painkillers has saved lives (<https://buff.ly/3UYF4h4>)
- how self-harm is portrayed in the media (<https://buff.ly/bfcmRtl>)
- years of life lost to self-harm ([Premature death after self-harm: a multicentre cohort study - PubMed](#)),
- the protective effect of psychosocial assessments ([Does Clinical Management Improve Outcomes following Self-Harm? Results from the Multicentre Study of Self-Harm in England | PLOS One](#))
- inequalities (<https://buff.ly/WrviTVD>).

Key learning from the success includes making reliable, high quality data capture (and accessibility) part of routine clinical practice; making connections with experts in the field; learning from and sharing with others.

*“The event was a great opportunity to pause and reflect on all that has been achieved in the field of self-harm over the past 50 years. On how important **continuity, collaboration and generosity is for sustained progress**. We left the event feeling proud, inspired and privileged to be part of something that continues to drive significant advancements in the field of self-harm and suicide prevention.”*

Jenny Ness

Clinical Audit-Based Quality Improvement

During 2025/26, the Trust’s Clinical Audit Based Quality Improvement Programme played an important role in supporting delivery of the Trust Strategy by providing assurance, identifying unwarranted variation in practice and enabling continuous improvement across services. The programme comprised 29 clinical audit projects, spanning national and locally prioritised topics, with activity continuing across the year to ensure that audit findings translated into learning and improvement rather than one-off compliance.

Patient focused

Clinical audit directly supports the Trust’s ambition to deliver safe, high-quality, evidence-based care that is responsive to the needs and experiences of people who use our services. Audits undertaken during the year focused on key areas of care quality, including prescribing safety, physical health monitoring, seclusion reviews, care planning, discharge



29 clinical audit projects,
spanning **national** and
locally prioritised topics

processes and access to recommended psychological therapies.

Audit findings were used to identify variation in practice, highlight risks and confirm where care aligned well with national standards. In several cases, audit evidence supported meaningful improvements to care pathways, documentation and clinical decision-making, including the use of audit findings to strengthen a successful business case to improve access to evidence-based psychological therapies. This demonstrates how clinical audit helps ensure that care is both safer and more effective, and that improvement activity is grounded in real-world evidence.

People

The programme made a clear contribution to developing staff capability and embedding a culture of continuous improvement. Clinical audit provides colleagues with opportunities to build skills in data collection, analysis and improvement planning, supported by Quality Improvement (QI) methodologies.

During 2025/26, over two-thirds of our prioritised projects, priority 1 (national) and 2 (organisational) audits had a QI-trained project lead, with the majority of remaining projects supported by team members who had some QI training. This reflects a growing emphasis on equipping staff with the skills and confidence to lead clinical audit-based quality improvement in their own services, aligning with the Trust's People priority to support learning, professional development and engagement.



Over **two-thirds** of priority 1 and 2 audits had a **QI-trained project lead**

Partnerships

Clinical audit supports effective partnership working by enabling the Trust to benchmark performance against national standards, contribute to national audit programmes and share learning across teams, services and system partners. In 2025/26, the Trust participated in 90% of eligible national clinical audits, ensuring continued external assurance and contribution to wider NHS learning.



The Trust participated in **90%** of eligible **national clinical audits**

Learning from audit is shared through Trust committees, care group meetings, staff presentations and publication of reports on the Trust intranet, with some findings also contributing to peer-reviewed publications. This supports transparency, shared accountability and collaboration both within the Trust and across the wider system.

Productive

The updated RAG-rating approach introduced during the year supports the Trust's Productive priority by improving how progress and delivery are monitored. By moving away from fixed time-based rules to realistic, agreed completion dates, the programme now provides a more meaningful reflection of progress, particularly for system-level improvements that require sustained effort, digital change or governance approval.

Analysis of improvement actions shows that most changes continue to focus on education and training, with fewer system-focused interventions. This reflects the recognised complexity and resource implications of wider system change. In response, the programme has identified a clear focus for the coming year: supporting project teams to develop more sustainable, system-level improvements where feasible, alongside local training and guidance.

Overall contribution

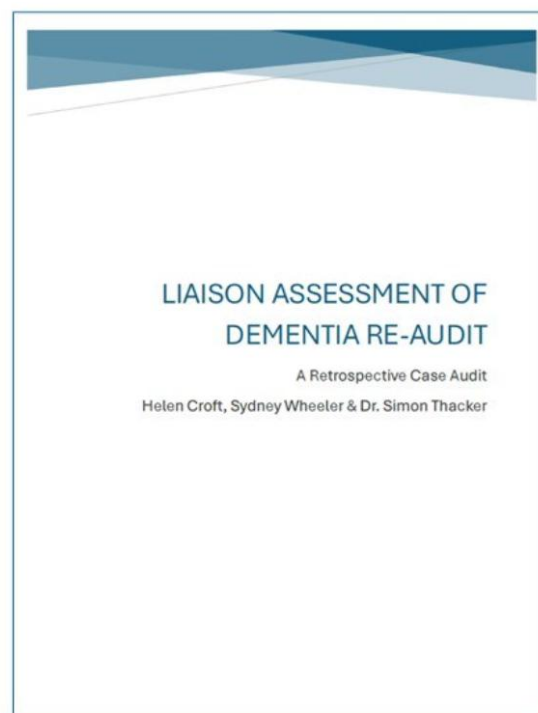
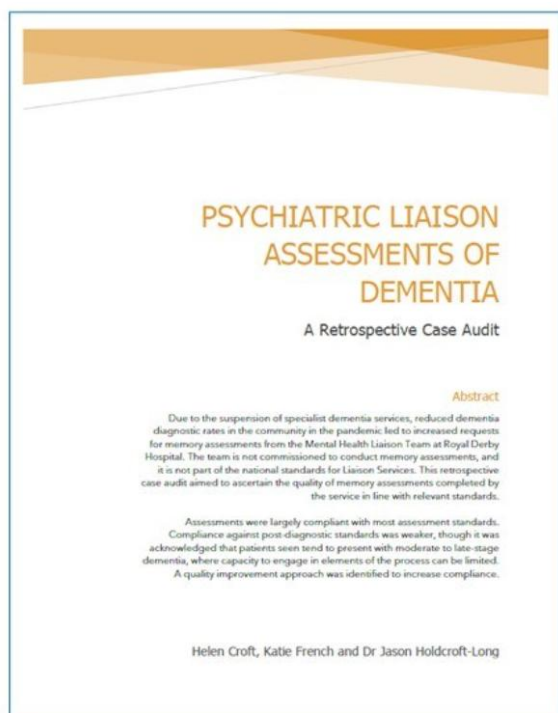
Overall, the 2025/26 clinical audit programme demonstrates how audit underpins the Trust Strategy by supporting safer, more effective services; developing staff capability; strengthening learning and partnership working; and promoting realistic, value-focused improvement. Clinical audit remains a key mechanism for assurance and continuous improvement, helping the Trust make a positive difference in everything it does. Here are some highlights:

The National Clinical Audit for Early Interventions in Psychosis has played a key role in bridging service gaps, driving significant improvements in CBTp provision for those who need it most.

The National Clinical Audit of Psychosis Early Intervention in Psychosis (NCAP EIP): phase 6 Trust priority clinical audit was completed. Whilst across the board the results were excellent, the national target for CBTp interventions in Early Intervention Teams showed the need for some improvement. Whilst this target was met by the North Derbyshire Early Intervention Service, it was not by the Derby City and South County Early Intervention Service as they did not have a fully trained CBTp therapist available. A business case was formulated to address this and the results of this audit were used to strengthen the case. We have subsequently recruited for the Band 7 post with the Band 8 post expected to be filled imminently.

Trust's dementia work set to be written into national policy

Elements of a Trust project on assessing dementia, developed by members of our Mental Health Liaison Team, are set to feature in a national policy statement as an example of good practice. The Liaison Team (South)'s Liaison Assessment of Dementia project has been picked up by the Academic Centre for Healthy Ageing (ACHA), who are writing a policy statement on acute diagnosis of dementia. The ACHA have interviewed Clinical Lead Helen Croft and intend to use and reference the Trust's project within the policy statement as a gold standard benchmark.



20 years of NIHR – Celebrating Colleague Contributions

In this landmark year celebrating 20 years of the NIHR, we proudly recognise the Principal Investigators, local collaborators and colleagues whose dedication and partnership with our Clinical Research Team make high-quality research possible.

Clinical leadership and collaborations have transformed health and care research delivery across the NHS. The NIHR anniversary message emphasises that, over two decades, research has moved from being “extra” to being part of routine clinical practice, with clinicians playing a vital role in leading, delivering and offering patients the choice to participate in research as part of every-day care. Depending on complexity, proportionate oversight of research can be specified by Research Sponsors through roles which can include:

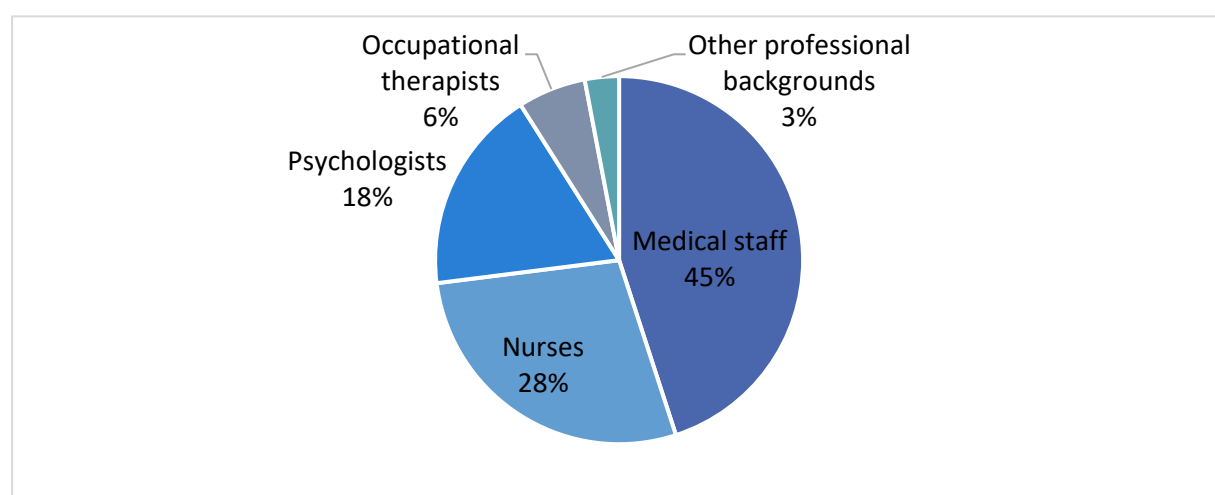


- **Principal Investigators** - a clinical leadership and oversight role taking responsibility for the conduct of clinical trials or other study designs at organisational sites. **Sub-investigators** - a supporting clinical role taking on responsibilities delegated by the Principal Investigator.

- **Local Collaborators** – a clinical or operational enabling role acting as a local point of contact to facilitate access to local services and resolve issues to help studies run smoothly.

No prior research experience is required; these are essentially clinical/operational roles. Study relevant training is provided including if required, Good Clinical Practice (GCP) in Research training. This is the internationally recognised ethical and scientific quality standards usually required for clinical trials. Our expert Clinical Research Team provides guidance and support to help colleagues develop research skills, with opportunities to take on the different roles.

During the 2025/26 period, research activity benefited from the leadership of Principal Investigators (PIs) or Local Collaborators from a wide range of professional disciplines. Representation across disciplines was as follows:



Sub-Investigator roles also included a significant proportion of resident doctors and other professionals.

We would like to extend our sincere thanks to all clinical colleagues who have contributed to our research projects this year and in previous years — whether as Principal Investigators, local collaborators, interventionists, sub-investigators, or simply introducing a project to a service user or colleague. Your expertise, time, and commitment are invaluable and play a vital role in advancing research and improving patient care.



Our Principal Investigators, sub-investigators and local collaborators – Thank You!

ADAPT - Madalina Cosmulescu, Consultant Psychiatrist, with Joby Joseph, Dementia Clinical Specialist

ALTO - Soma Datta with Sri Thiguti, Consultant Psychiatrists

ANTLER 75+ - Smita Saxena with Antony Prakash, Consultant Psychiatrists

CAN PDP - Nick Long, Consultant Psychiatrist with Dr Mohammed Saleem (CT3), Dr Holdcroft, Dr Roopa Rudrappa, Dr Promita Saha (SAS)

CareCoach - Kirsty Smith, Clinical Lead, with Suzannah Steeples, Lead Nurse

CECILIA - Vicky Evers, Advanced Occupational Therapist

CO-Pics - Kopal Tandon, Consultant Psychiatrist

COBALT - Kaanthan Jawahar, Consultant Psychiatrist, with Dr Rachel Gorny (Spec Reg), Dr Chinenye Omesili (ST4) and Simon Thacker, Consultant Psychiatrist

CONTACT GAD - Elinor Currey with Roseanne O Shea, Highly Specialist Clinical Psychologists

Crisis care pathways BPD - Liam Ennis with Alice Conlan, Principal Clinical Psychologists

EDGI - Joanna Miatt, Consultant Clinical Psychologist

El Mission - Jakob Wojcik, Lead Occupational Therapist with Graham Spencer, Lead Nurse

Feeling safer study - Donna Zawadski, Consultant Clinical Psychologist with Dr Hansen Ng, Dr Fergus Wade, Dr Memon Khalid, Consultant Psychiatrist

Gambling related harm - Mandizwidza Mpamhadz, Specialist Complex Needs Alcohol Nurse

GENES and HEALTH - Sabeeha Anisah, Lead Nurse

GENESIS - Leah McGowan, Advanced Nurse Practitioner, with Dr Smita Saxena, Dr Nachane (ST6)

GLAD - Richard Burton, Consultant Psychiatrist

ICONIC - Corinne Gale, Principal Clinical and Research Psychologist

My medicine journey - Lesley Fitzpatrick, Advanced Clinical Practitioner Lead

NCISH - Girish Kunigiri, Executive Medical Director

NCMH - Rahul Gandhi, Consultant Psychiatrist

PPiP2 - Soma Datta, Consultant Psychiatrist with Dr Ayesha Butt (ST5), Higher Psychiatry Trainee

PROSPER - Craig Burman, Specialist Clinical Psychologist

QUAD ADHD - Daniela Tomus, Consultant Psychiatrist

SAFE BED - Sue Walker, Clinical and Operational Developmental Lead for Children

SATURN - Aristos Markantonakis with Dr Daniela Tomus, Consultant Psychiatrists

Snacktivity - Joshua Ige, Divisional Lead Occupational Therapist

STORY - Stuart Laverack, Consultant Psychiatrist

TIPTOE - Mitra Raisi, Consultant Psychiatrist with Emma Frudd, Lead Nurse

UK REACH and KOLABO studies - Rubina Reza, Head of Research and Development

VISION QUEST - Graham Spencer, Lead Nurse



We have also included below additional quotes from colleagues who were involved in leading or supporting research projects. We hope others will be inspired to get involved or to explore the many [funded opportunities](#) available in the year.



My research has helped to identify the importance of accessible, consistent, person-centred crisis care for people with a diagnosis of borderline personality disorder. Participants have described how training, resources, and wider societal attitudes towards risk affect how crisis care is delivered. In the next phase, I will work with service users, caregivers and staff to work out how to overcome these challenges, and implement more consistent, accessible and person-centred care for people with BPD accessing crisis and acute services.

Liam Ennis, PI for the Crisis Care in BPD Study



“My involvement in the CAN-PDP (Cannabidiol for Parkinson’s Disease Psychosis) study at Derbyshire Healthcare NHS Foundation Trust has been an exceptionally valuable and enriching experience. This clinical trial, focusing on the use of cannabidiol in managing psychosis in Parkinson’s disease, provided me with hands-on exposure to high-quality research practice. I was actively involved in screening participants, confirming eligibility, obtaining informed consent, conducting study visits, reviewing prescriptions, and monitoring adverse events, which significantly enhanced my understanding of research governance, patient safety, and ethical conduct.

This experience has had a direct positive impact on my clinical practice, particularly in improving my confidence in assessing and managing patients with Parkinson’s disease psychosis, while maintaining a patient-centred and evidence-based approach.

Working closely within a multidisciplinary research team also allowed me to build strong professional networks and appreciate the importance of collaboration in delivering successful research outcomes. This has inspired my ambition to pursue a future role as a Principal Investigator.

I am sincerely grateful to Dr Nick Long, Caroline Cheetham, Rosemary Brodie, and Joely Morgan for their exceptional support and mentorship, which made this a highly rewarding and formative experience.

Dr Muhammad Afaq Saleem, CT3 Crisis team Chesterfield and Sub-Investigator for CAN PDP



“

I have found my experience of being part of the CONTACT GAD Study over the past 3 years a very enriching experience. I have developed a greater understanding, appreciation of and core skills in ACT as a therapeutic model in psychological therapy. I have gained a lot as a clinician and now feel I use this model as an integral part of the work I do as a psychologist in my OA CMHT. I feel this is due to the applicability of ACT to any psychological difficulty and the quality of the supervision offered by the study. The study has also allowed me to work with people who may not always get to secondary mental health service, also an enriching and rewarding opportunity. I also feel like I have contributed and been a part of something bigger- a research study for older people who are often neglected/ not considered in larger research trials so it has felt quite ground-breaking and the implications are exciting. Locally, the research team in the trust- particularly Joely Morgan has been a steady and knowledgeable person to go to with any queries around my role as a therapist and the finer aspects of the process for the trial. I would highly recommend the challenge and ultimate rewards of being a part of research as a clinician in the NHS; particularly when kind, knowledgeable and experienced support structures from the local and national research team are in place and work so well.

Dr Roseanne O'Shea, Clinical Psychologist and Sub Investigator for CONTACT-GAD

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Appendix 1: Research Programme

Selected studies referenced on page 8 to highlight Partnerships are included below for ease of reference. To view the complete 25/26 research programme, please use the following [link](#).

NIHR Studies open in 25/26 and now closed

Project Title	Project Scope	Progress
(IRAS 271052) CANnabidiol for Parkinson's Disease Psychosis, CAN-PDP PI Nick Long, Consultant Old age Psychiatrist	The purpose of this trial is to look at how safe and well CBD works in patients with Parkinson's disease psychosis, how well it is tolerated and whether CBD can reduce hallucinations and delusions associated with Parkinson's disease psychosis.	DHCFT have led the way with this project, being the Trust to involve the second highest number of service users. This project is providing important information with regards to patients who experience psychosis due to Parkinson's Disease. Follow up period has now ended but no results available yet.
(IRAS 338454) Testing the clinical and cost-effectiveness of CareCoach for family carers of people living with dementia (CareCoach) PI Kirsty Smith, Clinical Lead	CareCoach is a digital support programme for family members and friends who care for someone living with dementia. It offers easy-to-follow online learning, alongside regular support from a trained coach. The study looks at whether this programme helps carers feel more confident, improves their wellbeing and quality of life, and helps them manage the emotional and practical challenges of caring.	In Derbyshire Healthcare NHS Foundation Trust, we engaged 25 carers (receiving interest from over 70) by engaging with a wide variety of community groups to gain interest. This is now in the follow up phase.
(IRAS: 345161) Family Interventions in Dementia Mental health Environments (FIND ME) PI Bethany Myles Clinical Research Practitioner	This mixed methods study aims to provide detailed understandings of carers experiences and involvement when people living with dementia (PLWD) are detained within a Mental Health Ward (MHWs) for their own safety and the safety of others.	We engaged with the ward managers from the appropriate wards, they were happy to participate and engage in this study, completing the survey. We have 2 wards caring for this client group and both areas participated willingly. This is ongoing nationally and has moved on to the next work package which DHCFT is not participating in.

(IRAS 335673) Routine Screening for gambling disorder and gambling related harm within mental health and drug and alcohol services PI- Mandizwidza Mpamhadzi, Specialist Complex Needs Alcohol Nurse	This study aims to determine the appropriateness of mental health and drug and alcohol services in the UK for identifying and referring people experiencing gambling disorder and gambling-related harm. The study also aims to ascertain the feasibility of introducing gambling screening in mental health and drug and alcohol services and what the facilitators and barriers are in both screening and referral.	81 service users were offered the opportunity to talk about their experiences of gambling harm. We have supported individuals to access support from the East Midlands Gambling Harms service if they have been identified as having experienced gambling-related harm and feel they would benefit from support for this. This project is now in the analysis phase.
(IRAS 345079) Assessing the feasibility and implementation of the 'My Medicines Journey' intervention: a multi-methods evaluation (My Medicines Journey) PI Lesley Fitzpatrick, Advanced Clinical Practice Lead	My Medicines Journey aims to make medicines safer for older people when they leave hospital and return home. It focuses on helping people understand changes to their medicines, supporting them to manage their treatment confidently, and improving communication between hospital teams, community pharmacists, patients and carers. The study is currently testing how well this approach works in everyday NHS care across several sites.	Feedback from patients, carers and staff is being used to improve the toolkit and plan a larger study in the future. We engaged with Older Adult inpatient teams in the trust, particularly Tissington ward, met regularly with the clinical team and gave many older adults the opportunity to contribute to research (9 participated).
(IRAS 332680) VISION-QUEST Visual hallucinations: A questionnaire study PI Graham Spencer, Lead Nurse	VISION-QUEST asks individuals about their experiences of visual hallucinations in non-affective psychosis with the future goal of tailoring treatment options to these experiences.	14 people from a range of ethnicities from Derbyshire enrolled in this to give them a voice about their experience of living with visions. This project is now in the data analysis phase.

Studies currently open

Project Title	Project Scope	Progress
(IRAS 332672) Alzheimers and PTAU217 biomarker study in community memory services (ADAPT)	The ADAPT study is a large UK NHS clinical study testing whether a simple blood test can help doctors diagnose Alzheimer's disease earlier	16 service users so far have consented to take part in this important biomarker study that will help us to diagnose

PI- Madalina Cosmulescu, Consultant Psychiatrist	and more accurately in people who have memory problems.	Alzheimer's better in the future
(IRAS 1009793) Antidepressants to prevent relapse in depression in older people – a double blind randomised controlled trial to evaluate the effectiveness and cost-effectiveness of continuing antidepressants (Antler 75+) PI Dr Smita Saxena Consultant Psychiatrist	The ANTLER 75+ study is a UK-wide clinical research trial that looks at whether older adults aged 75 years and over should continue or stop long-term antidepressant medication once their depression has improved.	We have developed relationships with 28 GP practices to deliver this trial and have the highest number of participants than any other site nationally.
(IRAS 1004660) Combining memantine and cholinesterase inhibitors in Lewy body dementia Treatment trial (COBALT) PI – Dr K Jawahar Consultant Psychiatrist	The COBALT study is trying to find out whether adding a second memory drug (Memantine) helps people with Lewy body dementia or Parkinson's disease dementia feel and function better in everyday life.	Here at DHCFT we have successfully involved 5 service users and 5 carers in this valuable research study so far.
(IRAS 333754) Early Intervention in Psychosis Mental Health Mission Cohort (EI Mission) PI Jakub Wojcik, Occupational Therapist	The Early Intervention Mission (EIM) study is a large UK-wide mental health research programme focused on psychosis, particularly the early stages of illness. Its overarching goal is to improve early identification, monitoring, treatment, and prevention of psychosis by building a long-term, representative research cohort.	With clinical research so well embedded in our Early Intervention services, 30 service users have so far have taken part in this important study which is set to continue to collect data from those experiencing psychosis until 2028.
(IRAS 330744) Feeling Safer: A Cohort Study and a Randomised Controlled Trial of a Guided Online Programme for the Treatment of Persecutory Delusions (Feeling Safer). PI Donna Zawadski Consultant Clinical Psychologist	The Feeling Safer study looks at ways to help people who experience persecutory delusions – for example, feeling that others want to harm them or are against them – to feel safer in their daily lives. The study focuses on a guided online programme, which people can use with support.	Derbyshire Healthcare were the first site to enrol a participant to Oxford Universities virtual clinic, with us continuing to successfully offer this valuable study to services and service users across the county.
(IRAS 99740)	This project aims to understand if some cases of psychosis are caused	DHCFT has had 216 service users participate

Prevalence of Pathogenic antibodies in Psychosis 2 (PPiP2) PI Dr Soma Datta, Consultant Psychiatrist	by immune system problems, testing for antibodies which may suggest autoimmune concerns. This allows the opportunity to work with our inpatient acute wards, community teams, and specifically the Early Interventions in Psychosis services across our Trust to estimate the prevalence of these autoimmune diseases in people with first episode psychosis, or a relapse in their psychotic symptoms.	in this to date and has so far identified twelve people within our Trust who have such antibodies, offering them a further opportunity provided by the University of Oxford to trial a method to resolve their symptoms with immunotherapy.
(IRAS 324783) Multi-domain Self-management in Older People with osteoarthritis and multi-morbidities (TIPTOE) PI- Dr Mitra Raisi, Consultant Psychiatrist	The TIPTOE study approach focuses on self-management, helping people to develop skills, confidence, and routines that support their own health and wellbeing. Therapists here at DHCFT work with participants to deliver the TIPTOE intervention.	As the first mental health trust in the country to take part in this project we have now engaged 10 service users within the trust who are all taking part in the study intervention.



Research Activity, Performance, and Income

Six-monthly report to the Trust Board of Directors



September 2026

www.derbyshirehealthcareft.nhs.uk

 DHCFT  DERBYSHCFT  NHS_DERBYSHIREHEALTHCARE



Six-monthly Research Activity, Performance and Income report to the Trust Board of Directors scheduled for September 2026

The purpose of the report is to provide the Trust Board with assurance that Derbyshire Healthcare NHS Foundation Trust is meeting the new national requirement for six-monthly Board reporting of research activity, performance and income.

Executive summary

- The Trust is compliant with new six-monthly Board reporting expectations for research activity, performance and income
- Research activity was sustained in 2025/26, with 450 participants consenting to 40 National Institute of Health and Care Research (NIHR) studies; a reduction in activity from 2024/25 is due to the reclassification of the multi-centre monitoring study as non-research
- Non-commercial study set-up performance exceeded Research Delivery Network (RDN) targets; one commercial contract trial is underway and met the 60-day site set-up target but did not meet the 30 day first participant recruitment target
- The Trust secured circa £1.14m of external research funding and income, with governance arrangements in place through Research and Development (R&D) and Finance controls
- Delivery risks being managed are highlighted for the commercial contract clinical trial, the Transcranial Magnetic Stimulation (TMS) capital award service model and the CHERISH research contract during planned Health Visiting service transfers.

1. National reporting requirement

New reporting requirements arise from the [NHS Medium Term Planning Framework – delivering change together 2026/27 to 2028/29](#), which requires NHS providers to report research activity and income to boards on a six-monthly basis.

- all NHS providers must meet the site-specific timeframes of the government's 150-day clinical trial set-up target (for Delivery Organisations the relevant timeframe is the 90 days to first participant recruited to a trial)
- research activity and income should be reported to boards on a six-monthly basis to support embedding research as part of everyday care
- reports should include details of study set-up performance, how they are meeting the terms of research contracts outside the NHS HM Treasury allocations, commercial research income and how capacity building elements of commercial contract income are used, as set out in the research finance guidance.

To ensure compliance with these requirements, six-monthly research activity, performance and income reports have been scheduled for the Trust Board meetings in September 2026, as the annual report, and January 2027, as the mid-year update.

This report is presented to the Quality and Safeguarding Committee (QSC) in July 2026 prior to the September Board meeting so that there is opportunity to update the report as required following QSC review and recommendations.

2. 2025/26 annual research activity, performance and income

2.1 Research activity

This first report covers the 2025/26 period. It is intended that the 2025/26 annual report is presented to the Trust Board for the 2025/26 research activity. The annual report demonstrates sustained research activity across the Trust, with 450 participants consenting to take part in 40 NIHR studies. This compares to 1,735 participants across 31 studies in 2024/25.

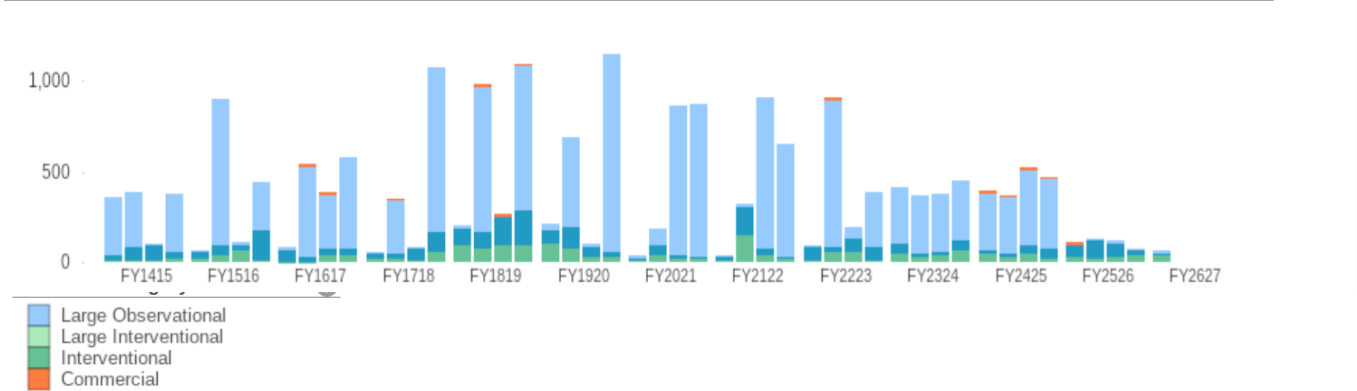
The research activity trend graph shows a reduction in large observational study participant numbers in 2025/26 compared with previous years. This reflects the reclassification of the multi-centre monitoring study as non-research, rather than a reduction in the Trust's research ambition or delivery capability.

Weighted recruitment reduced by only 4.85%, reflecting the complexity weighting applied to interventional study participants compared with large observational studies such as MCM. Further detail is provided in Appendix 1. The Board can be assured that the reduction in activity is recognised and is being addressed through the 2026/27 R&D strategic plan, which prioritises organisational support to scale research activity, strengthen recruitment pathways and increase patient access to research opportunities.

Research Activity Trends in My Trust

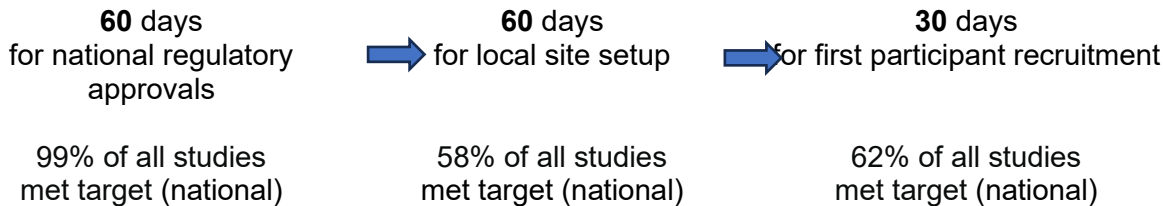
Explore changes in your local clinical research portfolio over time from 2014/15 to date

Number of recruited PARTICIPANTS by QUARTER year



2.2 Research performance: 150-day government clinical trial target

This target applies specifically to commercial contract Clinical Trials Involving Medicinal Products (CTIMP). It aims to boost investment in the life sciences sector. There are three separate milestones, each with defined start and end points. The combined total for these milestones must not exceed 150 days, as illustrated below, along with the national performance figures at the beginning of 2026/27.



Latest figures in [March 2026 - GOV.UK](#) showed the national target was met with the average set-up time for commercial clinical trials in the UK reduced to 122 days, down from 169 previously, 78% of studies recruiting first participant within 150 days, meaning faster access to new treatments on the NHS.

Delivery organisations like DHcFT contribute to the 90-day component of the overall 150-day target. DHcFT did not have any commercial contract clinical trials covering this national reporting period. For the single commercial trial that has since opened, the 60-day target was met, and the 30-day target was not met. This means that the overall 90-day target was not met (one out of one = 100% not met).

2.3 Trust performance on commercial contract clinical trials

The Trust successfully initiated a new commercial contract CTIMP and met the 60-day site set-up target. However, first participant recruitment was not achieved within the required 30-day window, meaning the overall 90-day benchmark was not met and the study will not attract performance recognition direct payment in 2027/28 of £2k (2025/26 figure) for this study.

Assurance is provided that the recruitment delay is recognised, escalated to the Research Delivery Network and is being actively managed. Recruitment is being prioritised and monitored through the R&D Operational Group, with 2026/27 actions focused on improving automated pre-screening and clinical pathway engagement to strengthen future commercial trial delivery.

Performance Overview: Commercial Contract Clinical Trial (ALTO-100)

IRAS No.	1012755	
Trial name (site name)	Randomized, placebo-controlled trial of ALTO-100 in bipolar disorder with depression (Derbyshire Healthcare NHS Foundation Trust)	
60-day	Met - 47 days	
30-day	Not met	90 days elapsed on 22 July 2026
90-day	Not met	137 days elapsed 22 July 2026

Benchmarking indicates that ALTO-100 recruitment delays are not unique to DHcFT, with only one of eight English sites having recruited a first participant and wider sites experiencing similar challenges. The Trust is actively seeking learning from other sites, the sponsor and the Research Delivery Network to identify common barriers. A key 2026/27 priority is to strengthen automated pre-screening and clinical trial readiness ahead of future commercial and non-commercial growth.

Reasons to date why eligible participants have declined a screening visit:

- Did not want to come off existing antidepressants
- Did not want to stop/cut down use of substances
- Did not want to take investigational medicinal product in case it made them better and then they would have to stop taking it after the study ended
- Did not want to take any additional medication.

Performance Overview: Benchmarking against all current trial sites

Delivery Organisation (Trial Site)	Ready to Start recruiting	First recruit date	60-day met	30-day met	90-day met
Organisation 1	15/01/2026	12/02/2026	75	28	103
Derbyshire Healthcare NHS FT	23/04/2026	22/07/2026	47	90	137
Organisation 2	13/02/2026	-	56	-	-
Organisation 3	01/04/2026	-	142	-	-
Organisation 4	-	-	43	-	-
Organisation 5	26/01/2026	-	92	-	-
Organisation 6	01/04/2026	-	158	-	-
Organisation 7	15/01/2026	10/06/2026	86	146	232

2.4 Trust performance on non-commercial clinical trials

The 90-day local site target was also used by the Research Delivery Network to assess non-commercial study performance in 2025/26. DHcFT performance was strong, comfortably achieving above the set target. Close monitoring of set-up timelines is in place to enable continuous improvement.

Performance Overview: Non-commercial study set up

2025/26 NHS Trust Site Level Metric	% Non-Commercial Studies	% Commercial Studies*	Target
60-day site set up	88%	0%	75%
30-day first patient recruitment	75%	0%	70%

*Note: due to the commercial contract clinical trial, ALTO-100 being confirmed on 30 March 2026, it was not included in the 2025/26 assessment due to an earlier data cut off period.

3. Research finance and funding/income: assurance summary

The Trust secured circa **£1.14m** of external research funding and investment in 2025/26. This supports research delivery infrastructure, participant recruitment, clinical equipment, inclusion of underserved communities, system research leadership, commercial trial delivery, and partnership-led grant activity aligned to local and national NHS and NIHR priorities.

Funding Overview: Confirmed Research Income and Strategic Assurance

Funding group	2025/26 value	Strategic purpose	Assurance
NIHR RDN delivery infrastructure, clinical supporting services and strategic funding	£434,631	Sustains core research delivery workforce, clinical support capacity, participant access and strategic inclusion activity.	Provides assurance that the Trust has funded infrastructure to deliver NIHR portfolio research and strengthen strategic priorities such as inclusion, public involvement and care home research.
System research leadership and Research Engagement Network funding	£111,045	Supports System research leadership, strategic coordination, communications and underserved community engagement across Joined Up Care Derbyshire.	Assures the Board that DHcFT is contributing to System research maturity, population health priorities and improved inclusion of under-represented communities in research.
Excess treatment costs	£11,590	Supports clinical research delivery where treatment costs exceed the cost of existing standard care.	Provides assurance that eligible treatment costs are identified and funded appropriately, reducing financial burden on provider services.
Commercial contract clinical trials income	£18,507	Supports industry-sponsored research to boost life sciences investment and access to new treatment development.	Provides assurance that commercial income is governed through R&D and Finance controls, supporting cost recovery, contractual delivery and reinvestment in capacity.
NIHR Research Capability Funding	£33,000	Maintains and builds capacity to deliver high-quality health research through recruitment-based income.	Supports delivery against recruitment and performance expectations and reinvestment in delivery capability.
NIHR capital investment	£118,560	Provides Transcranial Magnetic Stimulation equipment for shared clinical and research use.	Enables clinical service delivery of new service and future research capability in depression treatment, subject to the operational delivery model being secured.
Externally funded Research grant awards	£304,131	Supports funded programme in maternal mental health research	Demonstrates successful competitive grant capture, national research contribution and partnership working aligned to mental health research priorities.
Externally commissioned by Department of Health and Social Care	£112,200	Supports funded programme in suicide prevention/self-harm evidence and data surveillance system.	Demonstrates successful long-term collaboration for representative and reliable data on self-harm in England contributing to the National Suicide Prevention Strategy for England.
Total research funding/income	£1,143,664	External funding strengthens delivery capacity, innovation, inclusion and partnership-led research.	

Assurance is provided that research income is subject to established R&D and Finance governance, and as required research income is used for the purpose it is intended.

Commercial research income, including capacity-building elements, is used in line with national research finance guidance to recover costs, strengthen research delivery capability and support sustainable growth in patient access to high-quality research.

Key issues arising from 2025/26 activity, performance and income

- **Commercial Contract trial delivery:** ALTO-100 met the 60-day site set-up target but missed the first participant recruitment milestone, affecting eligibility for future performance recognition direct payments for this study
- **Capital funding contract delivery:** the TMS capital award requires a sustainable operational service delivery model to gain the intended clinical and research benefits
- **Research contract delivery:** planned Health Visiting service transfers may affect CHERISH delivery if service engagement, capacity or pathway access is disrupted.

4. Key delivery risks for noting

1. There is a strategic delivery risk that the Trust may be unable to meet the conditions of the NIHR capital award for TMS equipment if an operational funding model for service delivery is not secured. This would require repayment of funding to DHSC, with reputational risk and adverse impact on future funding applications. Mitigation is in place through executive leadership oversight, existence of an operational business case, and continued engagement with clinical, finance and research leads to confirm a way forward.
2. There is a strategic delivery risk that planned Health Visiting service transfers could affect the Trust's ability to deliver the NIHR RfPB (Research for Patient Benefit)-funded CHERISH research study. As the contracting organisation, failure to maintain delivery could result in contractual non-compliance, intended maternal health research benefits not achieved, and reputational risk with academic partners and the funding body. Mitigation will require early engagement with service leads, and partners to confirm delivery arrangements, maintain participant pathways and protect research contract obligations through the transfer period.

5. Recommendations

The Board is asked to note:

- that Research Activity, Performance and Income will be reported to the QSC on a six-monthly basis
- the progress made in embedding research as part of everyday care, the strengthened visibility of research activity, performance and income through six-monthly reporting, and the assurance provided that research funding is governed appropriately and aligned to delivery, new treatments, inclusion and patient access
- the identified delivery risks and the mitigations in place to protect contractual obligations, research capability and future funding opportunities
- that future reporting will be refined to meet the [Framework for NHS boards: monitoring research activity](#) published on 26 August 2026 by NHS England (NHSE).

Overall, the Board can be assured that the Trust is meeting the new reporting expectations, maintaining research delivery capability, strengthening oversight of research income and actively managing the specific risks that could affect commercial trial performance, contractual delivery and future research growth.

Appendix 1

2025/26 Research Activity based Funding Model - report prepared for R&D Operational Group 14 May 2026 by Gemma Harrison, Research Clinical Lead

Funding for NHS Trusts will be calculated using a single national formula comprising three components:

- **Historical allocation (50%):** Based on the previous year's allocation to provide baseline stability.
- **Activity-based funding (30%):** Based on recruitment activity weighted by study complexity (70%) and study count (30%) over the preceding three financial years. Complexity weights have been updated to reflect more accurately the service support requirements of different study types.
- **Performance-based element (20%):** Linked to delivery against key national metrics:
 - **Direct payments:** Around £2m will be distributed to NHS Trusts that are the first to set up or recruit to commercial and non-commercial studies in the UK, Europe, or globally. These payments are aligned to the UKCRD 150-day metric and are *not* subject to caps or collars.
 - **Performance improvement adjustments:** The remaining performance-based funding will be distributed according to site-level results on study set-up (60 days), first participant first visit (30 days), recruitment to time and target (for commercial studies), and growth in both the number of and recruitment to interventional commercial trials. Both absolute performance and year-on-year improvement will be recognised. These adjustments are subject to organisational caps and collars.

Performance based element

- is based on the UK government's commitment to reducing the time it takes to get a clinical trial set up from over 250 days, down to 150 days, by March 2026
- This commitment is a headline action of the recently published [Life Sciences Sector Plan](#) and is reinforced in the [10 Year Health Plan for England](#)
- to restore the UK's competitiveness in clinical research by accelerating trial initiation and reducing unnecessary bureaucracy.

As a trial location where clinical trials are delivered, the primary contribution of the Clinical Research Team falls within the latter stages of this timeline: the 60-day period from regulatory approval or site selection to being ready to open a project, followed by the subsequent 30 days to achieve first participant, first visit. Our performance against these metrics for 25/26 can be seen below.

NHS Trust Level Metric	% Non-Commercial Studies	% Commercial Studies	Target
Within 60 days of HRA approval or Site Selection, site is open	100%	N/A	75%
Within 30 days of opening, site achieves First Patient, First Visit (FPFV)	75%	N/A	70%

Governmental aim is to be 100% compliant in both metrics but the targets as above are the top level for funding increase (for this metric) year on year.

Activity based funding

- Measures participant recruitment numbers
- For DHcFT performance figures declined 2024/25 to 2025/26 by 75.6% due to the reclassification of the multi-centre monitoring study (MCM) as non-research. The second table below gives the same figures but with the MCM project numbers removed to give a more accurate representation (first table is the figures used to calculate our funding but the second table is useful when planning future workload/changes, etc)
- Positively, weighted recruitment only decreased by 4.85% because of the complexity weighting assigned to studies (interventional study recruit weighted at 175 versus one for a large observational study like MCM)

- A reduction in interventional study recruits also contributed to the overall decline (107 recruited in 2025/26 compared to 142 in 2024/25)
- Majority of our recruitment comes not from interventional projects but from observational research – but the decline in interventional projects from one year to the next does account for some of the reduction in figures.

	2024/25	2025/26	Difference	% Difference
Number of Participants	1,735 (*Int 142)	424 (Int 107)	-1,311	-75.6%
Number of Studies	31	31	0	0
Weighted Recruitment	45,211	43,020	-2191	-4.9%

*interventional study participants

The figures below provide a more accurate reflection of performance, with the MCM project for 2024/25 excluded.

	2024/25	2025/26	Difference	% Difference
Number of Participants	535 (Int 142)	424 (Int 107)	-111	-20.8%
Number of Studies	31	31	0	0
Weighted Recruitment	44,011	43,020	-991	-2.3%

[Policy Statement Action to enhance visibility of clinical research delivery](#)
[Guidance on detailed definitions and processes for site-level performance reporting – ukcrd.org](#)



Terms of Reference

Terms of Reference for the Research & Development Operational Group	
What	Main business covered by the Committee/Group The Research & Development Operational Group which covers Research, Clinical Audit and Library and Knowledge Management Services will: ▪ Maintain a strategic and operational oversight role taking account of effectiveness, quality impact including equity and resource allocations to provide assurance and make recommendations to the Quality and Safeguarding Committee. ▪ Support the implementation and delivery of the Trust's Research and Development Strategic Plan, ensuring that operational activities contribute to the achievement of its strategic objectives and priorities. ▪ Ensure that strategic plans, governance frameworks, policies and procedures are developed and implemented effectively across the Trust. ▪ Ensure clinical, intellectual and financial probity in managing services in accordance with governance frameworks and other policies and procedures. ▪ Ensure that service activity is subject to regular reports to the Trust Board of Directors and to outside bodies as required, via the DHCFT Governance Structure ▪ Promote the conduct and use of research and clinical audit to improve the current and future health and care of the population, maximising benefits of research from use of clinical data, adoption of proven digital / other innovations and advances. ▪ Support a range of activities to develop research and clinical audit skills and experiences and enable knowledge mobilisation and use and implementation of research evidence. ▪ Maintain key linkages with relevant external organisations and external sponsors and regulatory bodies as required to promote best practice and deliver statutory requirements in relation to services. ▪ Maintain key linkages internally ensuring Research and Development is Well Led and integrated within clinical and support services including Quality Improvement ▪ Work in partnership with patients, communities, and the public for meaningful contributions
Who	Membership and roles including identified Chair and Deputy Chair (where required)
Core	▪ Medical Director/Research & Development Exec Lead (Chair) ▪ Head of Research & Development (interim Deputy Chair) ▪ R&D Assistant (note taker) ▪ Chief Pharmacist ▪ Medical Senate Representative ▪ Divisional Lead ▪ Library & Knowledge Services Manager ▪ Research Clinical Lead ▪ Lead Health Services Researcher ▪ Recovery Lead (Social Care / Substance Misuse) ▪ Other service and professional leads for Clinical Psychology, Nursing, AHPs etc as needed.
Associates	▪ IM&T / Transformation / Clinical Digital practice leads ▪ Other Trust and Research, Clinical Audit and Library/Knowledge staff

Attending Members	Ranjit Badhan, Research & Clinical Audit Co-ordinator
Reporting Chairs	N/A
Quorum	Minimum numbers and attendance.
	Minimum to be quorate is either 3 core members, one of whom must be Chair or the delegated deputy; or 2 if both Chair and Deputy Chair present. If non-quorate, decisions to be ratified by the next quorate committee. If a decision is needed prior to the next meeting the Chair/Deputy can ratify the decision. Required frequency of attendance: 60% of meetings for core members. Non-attendees can submit comments by email. Email comments should count as quorate for decision making.
Delegation	Delegated decision-making responsibility
	- Agree the research, clinical audit and library services programme of activities - Receive and agree research, clinical audit and library services projects and reports according to procedures - Monitor progress of research, clinical audit and library services activity - Assess quality and impact of activities to ensure benefits are maximised - Escalate gaps in assurance and concerns identified as a result of poor compliance to governance arrangements or reported outcomes of service activities assessed as high risks
When	Frequency & timing
	Bi - Monthly (1.5 hour meetings)
Why	
	The Research & Development Operational Group exists to ensure that research, clinical audit, and knowledge management and mobilisation are strategically aligned, effectively governed, and demonstrably improving patient outcomes, experience, and equity of access, in line with CQC Well-led requirements and NIHR expectations for embedding research in routine care delivery.
How	
	The Research & Development Operational Group delivers its role through integrated oversight, assurance, and decision-making across research, clinical audit, and knowledge services to monitor performance, manage risk, optimise resources, and drive continuous improvement in quality, safety, and equity of care in line with CQC and NIHR expectations.
Reporting to	Next in-line Committee/Committee delegating responsibility

	Quality & Safeguarding Committee		
Responsible to			
	Quality & Safeguarding Committee		
Accountable to			
	Quality & Safeguarding Committee (QSC)		
Groups & Officers Reporting Schedule	Group/Officer R&D Operational Group QSC Audit & Risk Committee Trust Board via QSC QSC/Trust Board	Report on Research/Clinical Audit/Library Research/Clinical Audit/Library Clinical Audit Research/Clinical Audit/Library Quality Account contribution	Frequency 6 monthly/exceptions As per forward plan / escalations Annual As per reports / escalations Annual
Liaison/Key communications	Group/Officer QSC/Trust Board Audit & Risk Committee Key external organisations Integrated Care Board/System Research Delivery Networks Health Innovation Networks Applied Research Collaborations University of Derby Other academic institutions/ health organisations Non-statutory organisations POMH-UK/Royal Colleges/HQIP	Liaison by - person/means Exec Medical Director Exec Medical Director	Frequency As above As above
Review and Monitoring	Compliance against the Terms of Reference to be monitored by the group on an annual basis.		
Approved by	Committee and Date		
	To be Ratified by Quality & Safeguarding Committee28/07/2026 To be Reviewed and agreed at R&D Operational Group14/05/2026		

Annual Review of R&D Operational Group Meetings 2025-2026		
Meeting Date	Assurance	Meeting outcomes/outputs
8th April 2025 Attendees: Rubina Reza (Chair), Andreea Martinchi (notetaker), Antony Prakash, Martin Smith, Rais Ahmed, Katie French	There is assurance that the group was functioning effectively as a governance and oversight forum. The meeting was quorate, key policy development was reviewed, risks/issues were identified for follow-up, and partnership and health inequalities work was progressed in line with the group's Terms of Reference.	Occurred as planned. Quorate. The Clinical Audit Policy update was supported, with continued use of reaudit alongside QI approaches; a data-protection wording issue was identified for follow-up. Feedback from the Derbyshire Substance Use and Mental Health Inequalities Sandpit was positive, with agreement to request a post-event evaluation questionnaire. Progress toward a formal partnership with the University of Derby was noted, with potential future research opportunities highlighted.
10th June 2025 Attendees: A Chidambaram (Chair), R Reza, A Martinchi (note taker), M Smith, R Ahmed, Eleanor Fogwill, Laura Boulton, Gen Blakeley, Robin Pepper.	There is assurance that the group continued to deliver its strategic and operational oversight role. Discussion supported partnership development with the University of Derby, identified opportunities for collaborative research and data science, and maintained focus on funding opportunities and improved access to research for underserved communities.	Occurred as planned. Quorate. The group discussed the formal partnership with the University of Derby, including opportunities for collaborative research, data science input, and accelerated Knowledge Transfer Partnerships. Updates were shared on mental health research group funding opportunities and approaches to improving access to research for underserved communities.
13th August 2025	Limited assurance for this meeting, due to the meeting being cancelled for non-quoracy. All required decisions and outstanding items were carried forward to the next quorate meeting.	Cancelled due to apologies/non-quoracy.
8th October 2025 – Quorate Attendees: Rubina Reza (Chair), Andreea Martinchi (note taker), Rais Ahmed, Antony Prakash, Stephen Jones, Gemma Harrison, Ranjit Badhan.	There is assurance that the group was effective in monitoring progress, identifying operational pressures and agreeing actions. The meeting reviewed previous actions, considered the increasing R&D capacity demands, received updates across clinical audit, partnerships, strategy and grant activity, and agreed further actions on capacity, impact reporting and meeting planning.	Occurred as planned. Quorate The group reviewed progress against earlier actions and discussed increasing demand on R&D capacity, particularly from trainees and students. Updates were received on clinical audit processes, Quality & Safeguarding Committee feedback on the R&D strategic plan, commercial and MedTech partnerships, and a successful perinatal research grant in partnership with the University of Nottingham. Actions were agreed relating to capacity reporting, impact reporting, and meeting planning.
8th December 2025 – Quorate Attendees: Girish Kunigiri, Rubina Reza (Chair), Andreea Martinchi (note taker), Rais Ahmed, Stephen Jones, Jenny Ness, Marie Hickman,	There is assurance that the group maintained effective oversight of delivery, reporting and risk. The meeting reviewed outstanding actions, considered Trust Board reporting requirements including national trial set-up performance, received updates across Research, Library and Knowledge Services, and Clinical Audit, and agreed next steps on Board reporting, MedTech feasibility, strategy alignment and university collaboration.	Occurred as planned. Quorate. The group reviewed outstanding actions and discussed Trust Board reporting requirements for research, including performance against national trial set-up targets. Updates were received on Library and Knowledge Services activity, clinical research delivery, embedded researcher contributions, and clinical audit developments.

Annual Review of R&D Operational Group Meetings 2025-2026		
Meeting Date	Assurance	Meeting outcomes/outputs
Gemma Harrison, Ranjit Badhan.		The group agreed next steps for board reporting, MedTech feasibility processes, research strategy alignment, and university collaboration.
24 th February 2026 - Quorate Attendees: G Kunigiri (Chair), R Reza (Co-chair), A Martinchi (note taker), S Jones, A Prakash, Alex Rose, J Ness, M Hickman, G Harrison, R Badhan.	There is assurance that the group continued to provide active oversight of strategic delivery, data-enabled research, resource constraints and impact reporting. The meeting reviewed progress against the R&D forward plan, health inequalities dashboard and capacity reporting, considered IM&T and secure data environment requirements, and agreed actions on resource planning, assurance and impact reporting.	Occurred as planned. Quorate The group reviewed progress against actions including the R&D forward plan, health inequalities dashboard development, and R&D capacity reporting. Detailed discussions focused on improving access to routinely collected data for research, IM&T capacity constraints, secure data environments, and funding models. Updates were also received from Library and Knowledge Services, Clinical Research, and Clinical Audit, with actions agreed on resource planning, assurance, and impact reporting.

Standing Financial Instructions (SFIs) update – for approval

Purpose of Report

The Standing Financial Instructions (SFIs) have been reviewed and proposed changes are being presented to the Board of Directors for final ratification.

Executive Summary

SFIs are due for the annual review. The proposed updates have been agreed by the Audit and Risk Committee in July.

General updates have been made throughout the document, the more significant changes are as follows:

- Paragraph 3.2.5 has been added following a recommendation raised in a recent Internal Audit report
- The table in section 3.2.6 and 8.16 have been updated to reflect the new job titles in Operational Services along with clarification on limits
- The Procurement section (section 8) has been updated to reflect the change in the Procurement Act 2023
- Section 14.3.5 and 14.4.2 updated to include reference to nominated deputy
- Additional wording added to paragraphs 14.2.7, 17.1, 17.3 and 16.2.2
- New paragraphs added for 17.7, 17.8 and 21.5
- Updates for various job titles.

Strategic Considerations		BAF Risk(s)	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.			
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.			
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X	3A	3.1
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.			

Risks and Assurances

These SFIs identify the financial responsibilities which apply to everyone working for the Trust. They have been updated to clarify procedures that should be followed to ensure Trust's financial transactions are carried out in accordance with the law and with Government policy.

Consultation

Senior staff within the Finance Department have updated the SFIs with input from the Head of Procurement, Business Development Officer, Interim Information Management, Technology and Records Lead and Data Protection Officer, Deputy Director of People, Organisational Development and Inclusion and the Assistant Director of Legal, Governance and Mental Health Legislation.

These proposed changes have been presented to the Trust Delivery Group and have been agreed at the Audit and Risk Committee on 16 July 2026.

Governance or Legal Issues

These SFIs detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

Net Zero Duty Implications

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

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

The nature and remit of this document means that it has no impact on net zero duty.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

The nature and remit of this document means that it has no impact on equality, diversity or inclusion and therefore does not impact those with protected characteristics.

Recommendations

The Board of Directors is requested to ratify the Standing Financial Instructions.

Report presented by: James Sabin
Director of Finance

Report prepared by: Rachel Leyland
Deputy Director of Finance

Standing Financial Instructions Policy and Procedure

See also:	Located in the following policy folder on the Trust Intranet
Corporate Governance Framework	
Treasury Management Policy	Corporate and Risk
Counter Fraud and Bribery Policy and Procedures	Corporate and Risk
Disciplinary Policy and Procedure	People and Inclusion
Conflicts of Interest Policy	Corporate and Risk

Service area	Issue date	Issue no.	Review date	
Trust wide	October 2025	1	October 2026	
Ratified by	Ratification date	Committee/Group responsible for review:		
Trust Board	September 2026	Audit and Risk Committee		

Document published on the Trust Intranet under:



Did you print this document?

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

ACCESSIBLE INFORMATION STANDARD

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

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

Checklist for Standing Financial Instructions

Summary
These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust.

Name / Title of policy/procedure	Standing Financial Instructions	
Aim of Policy	These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust.	
Sponsor (Director lead)	Director of Finance	
Author(s)	Deputy Director of Finance Financial Controller	
Name of policy being replaced	Standing Financial Instructions	Version No of previous policy:

Reason for document production:	To provide a reference document and guidance detailing the financial responsibilities which apply to everyone working for the Trust.
Commissioning individual or group:	Director of Finance

Individuals or groups who have been consulted:	Date:	Response
Interim IMT & Records Lead - Data Protection Officer DPO	02-07-2026	Updates provided
Business Development Manager	03-07-2026	Updates provided
Head of Procurement	16-06-2026	Updates provided
Assistant Director of Corporate, Legal and Mental Health Legislation	02-07-2026	Updates provided

Name of policy document:	
Issue No:	

Trust Delivery Group	28-08-2026	Approved
Audit and Risk Committee	16-07-2026	Approved
Trust Board	30-09-2026	

Version control (for minor amendments)

Date	Author	Comment
	<i>Job title, not name</i>	

Name of policy document:	
Issue No:	

Standing Financial Instructions

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1. STANDING FINANCIAL INSTRUCTIONS

INTRODUCTION

1.1 Who Should Read These Standing Financial Procedures (SFIs)?

These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes.

You should read these SFIs and be aware of their relevance to you as you discharge your responsibilities if you are:

- A Director of the Trust
- A Service Manager
- A Senior Manager in a support function
- A budget holder
- Involved in placing orders for goods/services on behalf of the Trust
- Involved in negotiating contracts/other arrangements for the provision of goods/services
- Involved with the handling and safe custody of patients' monies and valuables
- Involved in the administration of Charitable Funds

ALL staff must be made aware of section 11 Standards of Business Conduct, within the Standing Orders of the Board of Directors and Standards of Business Conduct.

Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Director of Finance **MUST BE SOUGHT BEFORE YOU ACT**. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

Overriding Standing Financial Instructions

If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit and Risk Committee for referring action or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.

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1.2 TERMINOLOGY

1.2.1 Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions; and:

"Trust" means the Derbyshire Healthcare NHS Foundation Trust;

"Board" means the Board of Directors of the Trust;

"Budget" means a resource, expressed in financial terms and whole time equivalent (WTE) terms, proposed by the Trust for the purpose of carrying out, for a specific period, any or all the functions of the Trust;

"Chief Executive" means the Chief Officer of the Trust;

"Director of Finance" means the Chief Financial Officer of the Trust, who is also the Director of Finance;

"Budget Holder" means the Director or member of staff with delegated authority to manage finances (Income and Expenditure, Revenue and Capital) for a specific area of the Trust;

"Legal Advisor" means the Trust appointed person properly qualified to provide legal advice.

1.2.2 Wherever the title Chief Executive, Director of Finance, or other nominated officer is used in these instructions, it shall be deemed to include such other directors or staff who have been duly authorised to represent them.

1.2.3 Wherever the term "staff" is used it shall be deemed to include staff of third parties contracted to the Trust when acting on behalf of the Trust.

1.2.4 Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

1.3 RESPONSIBILITIES AND DELEGATION

1.3.1 The Board of Directors

The Board exercises financial supervision and control by:

- (a) formulating the financial strategy;
- (b) requiring the submission and approval of budgets within approved allocations/overall income;
- (c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);
- (d) defining specific responsibilities placed on members of the Board and staff as indicated in the Scheme of Delegation document.

They may delegate executive responsibility for the performance of operational functions to the Chief Executive in accordance with the Trust's approved Scheme of Delegation.

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1.3.2 The Chair

The Chair is responsible for leading the Trust Board and for ensuring that it successfully discharges its overall responsibility for the organisation as a whole.

1.3.3 The Chief Executive

Within these SFIs it is acknowledged that the Chief Executive is ultimately accountable to the Trust Board and it is the duty of the Chief Executive to:

- Implement the financial policies of the Trust Board in order to ensure that the Trust Board meets its obligations to perform its functions within the available resources.
- Ensure all staff are notified of the requirements of the Standing Financial Instructions.
- Delegate the management of resources to officers of the Trust in accordance with the Trust's approved Scheme of Delegation.
- Ensure that the Trust's financial obligations and targets are met.
- Take responsibility for the Trust's system of internal control.

In performing these duties the Chief Executive will take due consideration of the advice given by the Director of Finance.

It is a duty of the Chief Executive to ensure that members of the Trust Board and, staff and all new appointees are notified of, and put in a position to understand, their responsibilities within these Instructions.

1.3.4 The Director of Finance

The Director of Finance is responsible for:

- implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;
- maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;
- ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time.

The duties of the Director of Finance also include:

- the provision of financial advice to the Trust and its directors and staff;
- the design, implementation and supervision of systems of internal financial control; and
- the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

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1.3.5 All Board Members and Staff

All members of the Trust Board and staff of the Trust have a responsibility for:

- the security of the Trust's assets;
- avoiding loss;
- exercising economy and efficiency in the use of resources; and
- conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

For all members of the Board and any staff who carry out a financial function, the form in which financial records are kept and the manner in which members of the Trust Board and staff discharge their duties must be to the satisfaction of the Director of Finance.

1.3.6 Budget Holders

Have a responsibility to:

- Monitor activities to ensure resources are utilised in an effective and efficient manner;
- Ensure activities are conducted within the constraints of budgets;
- Provide all information and explanations required by the Director of Finance to ensure financial control, enacted through the business of the operational meetings, Trust Delivery Group, Finance and Performance Committee and the Trust Board;
- Ensure the security of Trust Assets including property, equipment and cash.

1.3.7 Contractors and their Staff

Any contractor or staff of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

2. AUDIT

2.1 THE AUDIT AND RISK COMMITTEE

2.1.1 In accordance with Standing Orders, the Trust Board shall formally establish an Audit and Risk Committee, with clearly defined terms of reference (which are contained in the Scheme of Delegation) and following guidance from the NHS Audit Committee Handbook, which will provide an independent and objective view of internal control including financial control.

2.1.2 Where the Audit and Risk Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wish to raise, the Chair should raise the matter at a full meeting of the Trust Board. Exceptionally, the matter may need to be referred to the Department of Health or NHS England.

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2.2 ROLE OF THE DIRECTOR OF FINANCE

2.2.1 The Director of Finance is responsible for:

- a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;
- b) ensuring an internal audit service exists to review, evaluate and report on the effectiveness of internal financial control to meet mandatory audit standards;
- c) ensuring that an annual audit report is prepared by Internal Audit and External Audit and as required by the Audit and Risk Committee and the Trust Board in accordance with current Department of Health and NHS England guidance.

2.2.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

- a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
- b) access at all reasonable times to any land, premises or staff of the Trust;
- c) the production of any cash, stores or other property of the Trust under a member of staff's control;
- d) explanations concerning any matter under investigation.

2.3 THE ROLE OF INTERNAL AUDIT

2.3.1 Internal Audit will review, appraise and report upon:

- a) Internal Audit shall independently verify the Annual Governance Statement and other declarations in accordance with guidance from the Department of Health.
- b) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;
- c) the adequacy and application of financial and other related management controls;
- d) the suitability of financial and other related management data;
- e) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:
 - (i) fraud and other offences,
 - (ii) waste, extravagance, inefficient administration,
 - (iii) poor value for money or other causes.

2.3.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be

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notified immediately, who shall in turn notify the Trust's Local Counter Fraud Specialist.

2.3.3 The Head of Internal Audit will normally attend Audit and Risk Committee meetings and has a right of access to all Audit and Risk Committee members, the Chair and Chief Executive of the Trust.

2.3.4 The Head of Internal Audit shall report to the Director of Finance who shall refer audit reports to the appropriate officers designated by the Chief Executive.

2.4 THE ROLE OF EXTERNAL AUDIT

2.4.1 The Trust's external auditor is appointed by the Council of Governors and is paid for by the Trust. The Auditor must comply with the principles set out in the Audit Code for NHS Foundation Trusts.

2.4.2 The Governors must ensure that a cost-effective external audit service is provided and periodically review arrangements in conjunction with the Audit and Risk Committee.

2.5 External Auditors for non-Audit Services

2.5.1 The independence and objectivity of the external auditors is an important element supporting good governance within the Trust. The auditor should be, and should be seen to be, impartial and independent. Accordingly, the auditor should not carry out any other work for an audited body if that work would impair their independence in carrying out any of their statutory duties or might reasonably be perceived as doing so.

2.5.2 Prohibited non-audit services

To ensure that the auditor's independence and objectivity is not impaired it is important the external auditors do not:

- Audit their own work
- Make management decisions on behalf of the Trust
- Undertake activities which (potentially) result in conflicts of interest
- Act as advocates for the Trust
- Creating any threat to their independence

Therefore, the Trust will apply the following prohibitions on non-audit work by the external auditor:

- Providing any services specifically prohibited by UK law or supporting guidance.
- Work related to the accounting records and financial statements that will ultimately be subject to external audit.
- Taxation assignments where there is no fixed fee or the fixed fee is greater than that allowed in this policy (see below).
- Internal audit services.
- Design/implementation of financial information technology systems.

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- Valuations services where the valuation has a potentially material impact upon the Trust's financial statements.
- Legal and litigation support or advice where the outcome could have a potentially material impact upon the Trust's financial statements.
- Provision of senior recruitment services.

2.5.3 Permitted non-audit services

Where the work is not disallowed under the previous paragraph the external auditors may be considered for individual assignments. In the majority of cases such assignments will be subject to formal tendering procedures held in accordance with the Trust's SFIs.

In certain circumstances the external auditors' detailed understanding of the Trust's business may result in a recommendation from the Director of Finance to the Audit and Risk Committee for the external auditors to be retained to undertake a permitted non-audit exercise, rather than undertake a formal tendering procedure. This may be, e.g., for reasons of efficiency, confidentiality or expert understanding of the Trust's position. These could include:

- Advice on the preparation of financial information and the application of GAAP or training support for accounting projects and in relation to accounting standards.
- Audit related services as defined in the APB Ethical Standard 5 (Revised).
- Assistance in tax compliance activities and advice on recent developments and/or complex or high-risk areas.

Secondments between the external auditors and the Trust will also be acceptable for lower (sub-Board) positions.

2.5.4 There is no financial limit in any one financial year relating to non-audit assignments secured by external audit through competitive tendering procedures. Nonetheless, the potential for the compromising of independence and objectivity must always be considered. Therefore, it will be the duty of the Director of Finance to draw the attention of the Audit and Risk Committee if the external auditor is awarded non-audit work to a value equal to or greater than the value of the external audit contract in any one financial year.

There will be a strict limit applied to any assignment awarded directly to the external auditor without a competitive tendering process. The value of any one assignment must not exceed £10,000 and there can be no more than two such assignments in any one financial year.

2.5.5 For awards made to the external auditor through a competitive tendering process – the approval will follow existing SFI requirements and will be reported by the Director of Finance to the next Audit and Risk Committee.

For awards made to the external auditor directly, without a competitive tendering process – a written request will be submitted to the Audit and Risk Committee. The

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Committee will give its consent either at a scheduled meeting or by written consent (as appropriate) based upon a submission which covers:-

- The service to be provided
- An explanation of the rationale for appointing the external auditor
- The safeguards in place to mitigate the threat to auditor independence (e.g., the application of 'Ethical Walls' by the audit firm)
- Estimate of fees and expenses
- An analysis of the expected total proportion of fees earned by the external auditors in the year which will be earned by non-audit work

The Audit and Risk Committee will need to provide approval on a formal, recorded, basis.

2.5.6 For the avoidance of doubt the phrase 'external auditor' in this policy covers not only the audit partner signing-off the Trust's accounts, nor the audit section or department undertaking the external audit but also the firm providing the audit.

2.5.7 Adherence to this policy will be monitored by the Audit and Risk Committee.

2.6 FRAUD and BRIBERY

In line with their responsibilities the Trust Chief Executive and Director of Finance shall ensure compliance with Secretary of State guidelines on fraud and bribery.

The Trust shall nominate an accredited individual to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by the NHS Counter Fraud Authority. The Trust has in place a Counter Fraud Champion who is currently the Director of Corporate Affairs and Trust Secretary.

The LCFS shall report to the Trust Director of Finance and work alongside NHS Counter Fraud Authority to ensure there is a zero-tolerance approach to Fraud and Bribery within the Trust.

The LCFS will provide a written report, at least annually, detailing the counter fraud work within the Trust which will be presented to the Audit and Risk Committee.

In accordance with the Trust Fraud and Bribery Policy, any suspicions involving financial crime must be reported to the Local Counter Fraud Specialist, and / or the Executive Director of Finance or via the NHS Fraud Reporting Line. All reported concerns will be treated in the strictest confidence and professionally investigated in accordance with the Fraud Act 2006 and Bribery Act 2010. Where evidence of Fraud and / or Bribery is identified all available sanctions will be pursued against offenders. This may include internal and professional body disciplinary sanctions, criminal prosecution and civil action to recover identified losses.

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2.6.1 Sanctions and Redress

The Trust is committed to pursuing and / or supporting NHS Counter Fraud Authority in pursuing the full range of available sanctions (criminal, civil and disciplinary) against those found to have committed fraud and / or bribery.

The Trust seeks to recover, and / or support NHS Counter Fraud Authority in seeking to recover NHS funds that have been lost or diverted through fraud and / or bribery.

The Trust publicises cases that have led to successful recovery of NHS funds.

2.7 SECURITY MANAGEMENT

In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

The Trust shall nominate a Non-Executive Director to ensure security has a high profile and is considered appropriately in the Trust's strategic direction. The Chief Executive has overall responsibility for security management. Key responsibilities are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

3. BUSINESS PLANNING, BUDGETARY CONTROL

3.1 PREPARATION & APPROVAL OF OPERATIONAL FINANCIAL PLANS AND BUDGETS

3.1.1 The Chief Executive will compile and submit to the Board an operational financial plan in accordance with current NHS England guidelines with due regard to the views of Council of Governors. The operational financial plan will include:

- In accordance with NHS England annual plan guidance, statements of the significant assumptions on which the plan is based;
- details of major changes in workforce, service delivery or resources to achieve the plan;
- any other relevant information as required by the regulator's guidance issued for the planning submission.

3.1.2 At the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit revenue and capital expenditure start budgets for approval by the Trust Board. Such budgets will:

- be in accordance with the aims and objectives set out in the operational plan;

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- accord with workload and workforce plans;
- be produced following discussion with appropriate budget holders;
- be prepared within the limits of available funds;
- demonstrate the achievement of key financial targets such as strategic financial objectives of the Trust and the regulatory financial regime as advised by NHS England;
- identify potential risks and mitigations.

3.1.3 The Director of Finance shall monitor financial performance against budget and plan and report financial performance to the Trust Board and subsequently to NHS England as required, in the appropriate templates issued by NHS England.

3.1.4 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled. This will be enacted through the business of appropriate meetings with managers and the Trust Board.

3.1.5 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

3.2 BUDGETARY DELEGATION

3.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing with a clear definition of:

- the amount of the budget and the purpose(s) of each budget heading;
- achievement of planned levels of service and individual or group responsibilities;
- the provision of regular reports and authority to exercise virement.

3.2.2 From time-to-time NHS England may issue guidance or instructions regarding additional approval processes for certain types of Trust expenditure. Where Foundation Trusts are required to comply, NHS England's approval process, as defined by their guidance, will override the authority to authorise as laid out in the Trust standing financial instruction, only for the specific type of expenditure concerned.

In cases where compliance with any additional approval regime by NHS England is *voluntary*, the Chief Executive will determine the appropriate course of action for the Trust and will notify budget holders accordingly, with the support of the Director of Finance.

3.2.3 In exceptional circumstances where large invoices are received which exceed the limits set out on 3.2.2i, then the Chief Executive and Director of Finance can jointly approve.

3.2.4 Authority for virements between budgets relating to a particular service or function shall be limited to:

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over £500,000	Countersigned by relevant Executive Director / Director of Finance
£100,000 to £500,000	Countersigned by Managing Directors /General Manager / Head of Service
Up to £100,000 *	Budget holder (* or total budget if less than £100,000)

3.2.5 The following finance officers have the authority to approve budget virement journals within the ledger:

- Finance Controller
- Finance Manager – Reporting Special Finance Analyst

3.2.6 With the exception of expenditure referred to in para 3.2.2 and 3.2.3 authority to authorise any one revenue order shall be limited to:

<i>£1,000,000 and above</i>	<i>Board of Directors</i>
<i>£500,000 to £999,999</i>	<i>Chief Executive and Director of Finance to jointly approve</i>
<i>£200,000 to £500,000</i>	<i>Chief Executive or Director of Finance</i>
<i>up to £200,000</i>	<i>Deputy Chief Executive, Executive Directors voting and non-voting but not Non-Executive Directors or Deputy Director of Finance</i>
<i>Up to £50,000</i>	<i>Director of Operations and Chief Psychologist</i>
<i>Up to £30,000</i>	<i>Financial Controller</i>
<i>Up to £25,000</i>	<i>Deputy Director of Operations</i>
<i>Up to £10,000</i>	<i>Care Group Operational Managers and Assistant/Associate Directors</i>
<i>Up to £1,000</i>	<i>Deputy Care Group Operational Managers and Heads of Service</i>
<i>Up to £100</i>	<i>Budget Holders</i>

3.2.7 With the exception of expenditure referred to in para 3.3.2 authority for planned expenditure of Capital Resources shall be limited to:

Expenditure on an individual project up to £100,000	Approved by the Capital Project group
Expenditure on an individual project between £100,000 and £1,000,000	Jointly approved by the Director of Finance and one other Executive Director
Proposed expenditure on a project in excess of £1,000,000	Board approval required (and process to be in accordance with NHS England guidance)

3.2.8 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI 13).

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3.2.9 The budgetary total or virement limits set by the Trust Board above must not be exceeded. Expenditure for which no provision has been made in an approved budget and which is not subject to funding under delegated powers of virement shall only be incurred after proper authorisation - i.e. by the Chief Executive or the Board of Directors as appropriate within delegated limits.

3.2.10 Unless approved by the Chief Executive, after taking the advice of the Director of Finance; budgets shall only be used for the purpose for which they were provided. Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.2.11 Non-recurring budgets shall not be used to finance recurring expenditure without the authority in writing of the Chief Executive.

3.3 BUDGETARY CONTROL AND REPORTING

3.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include monthly financial information presented to the Trust Board in a form approved by the Trust Board.

- a) Detailed financial information to Finance and Performance Committee covering but not limited to:
 - i) Income and expenditure position for year to date and forecast year end position
 - ii) Statement of Financial Position including any key exceptions
 - iii) Cash levels and key drivers
 - iv) Capital expenditure against plan.
 - v) Agency performance
 - vi) Key financial risks and mitigations
- b) the production of timely, accurate and comprehensive advice and financial reports to each budget holder, covering the areas for which they are responsible;
- c) investigation and reporting of variances;
- d) monitoring of management action to correct variances;
- e) arrangements for the authorisation of budget transfers;
- f) on-going training and support to budget holders to enable them to manage successfully.

3.3.2 The Director of Finance shall keep the Chief Executive and the Board of Directors informed of the financial consequences of changes in policy, pay awards, and other events and trends, whether national, local or internal, affecting budgets and shall advise on the financial and economic aspects of future plans and projects.

3.3.3 All Budget Holders are responsible for ensuring that:

- a) any likely overspending or reduction of income is not incurred without the prior consent of the Trust Board;
- b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and

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- c) no permanent staff are appointed without the approval of the Chief Executive as per 10.3.1.ii other than those provided for in the budgeted establishment as approved by the Trust Board.
- d) In the exceptional circumstance where a member of staff is engaged through terms deemed as 'off-payroll' by Her Majesty's Revenue and Customs (HMRC) and/ or NHS England, the relevant budget holder who is seeking to make these arrangements is responsible for ensuring compliance with HMRC rules and regulations and reporting, as informed by the Director of People, Organisational Development and Inclusion. All off-payroll engagements should be approved by a Director before commencement.
- e) Where costs may be committed by a third party there must be appropriately authorised by a specific governance process defined by a local operating procedure.
- f) Off-payroll arrangements will be reported to Trust Delivery Group and to Finance and Performance Committee on a regular basis in advance of the annual reporting requirements.

3.3.4 The Chief Executive or Director delegated by the Chief Executive is responsible for identifying and implementing cost improvements and value for money initiatives in accordance with the requirements of the Annual Plan and a balanced budget.

3.4 MONITORING RETURNS

The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted, accurately and on time and in the required format, to the requisite Organisation.

4. ANNUAL ACCOUNTS AND REPORTS

4.1 The Director of Finance, on behalf of the Trust, will:

- i. prepare and submit financial returns in such a form as directed by NHS England, with the approval of HM Treasury, specifically in accordance with International Financial Reporting Standards (as applied in the NHS England Annual Reporting Manual and the Department of Health Group Accounting Manual as well as HM Treasury's Financial Reporting Manual - FReM);
- ii. lay audited accounts before Parliament and send a copy to NHS England in accordance with the Annual Reporting Manual.

4.2 The Trust's Annual Accounts must be audited by an auditor appointed by the Council of Governors. The Audited Annual Accounts must be presented to the Annual Public Meeting of the Trust.

4.3 The Trust will compile and publish an Annual Report in accordance with NHS England's Annual Reporting Manual.

5. BANKING ARRANGEMENTS

5.1 GENERAL

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5.1.1 The Director of Finance shall monitor financial performance for working capital against budget and plan, periodically review them, and report to the Trust Board. All funds of the Trust shall be held in accounts in the name of the Trust. Only staff authorised by the Director of Finance may open a bank account in the name of the Trust.

5.1.2 The Board shall approve the banking arrangements and agree (or delegate agreement on their behalf of) the Treasury Management Policy prepared by the Director of Finance.

5.1.3 Bank and Government Banking Service (GBS) Accounts

The Director of Finance is responsible for:

- a) bank accounts and Government Banking Service accounts;
- b) establishing separate bank accounts for the Trust's non-exchequer funds where appropriate;
- c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;
- d) reporting to the Trust Board all arrangements made with the Trust's bankers for accounts to be overdrawn;
- e) reporting to Trust Board any proposals to draw down any or all of the Trust's working capital facility if such a facility is in place;
- f) ensuring the Trust does not exceed the limit of its approved working capital facility if such a facility is in place;
- g) monitoring compliance with DH guidance on the level of cleared funds.

5.1.4 ONLY authorised signatories within the Financial Control Team may make changes to Trust banking mandates including Direct Debits. No other persons within the Trust should activate, deactivate or make any changes whatsoever to any Trust direct debit arrangements. Staff wishing to do so should contact the Financial Controller.

5.2 BANKING PROCEDURES

5.2.1 The Director of Finance will prepare financial procedures on the operation of bank accounts for the approval of the Board of Directors.

5.2.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated in accordance with approved procedures.

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5.3 TENDERING AND REVIEW

- 5.3.1** Any commercial banking arrangements of the Trust should be reviewed at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business.
- 5.3.2** Competitive tenders should be sought at least every 3 years. The results of the tendering exercise should be approved by the Board. This review is not necessary for GBS accounts.

6. INCOME, FEES AND CHARGES

6.1 INCOME SYSTEMS

- 6.1.1** The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due. These systems shall include income due under contracts or extra-contractual arrangements for the provision of Trust services.
- 6.1.2** The Director of Finance is also responsible for the prompt banking of all monies received.

6.2 FEES AND CHARGES

- 6.2.1** The Trust shall refer to NHS England's Approved Costing Guidance in setting prices for contracts and services provided to other organisations, where applicable. However, pricing strategies will be determined by appropriate Trust Committees.
- 6.2.2** The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.
- 6.2.3** All staff must inform the Director of Finance promptly of money due arising from transactions which they initiate or deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions. The Director of Finance and the Chief Executive shall approve all contracts for income.

6.3 DEBT RECOVERY

- 6.3.1** The Director of Finance is responsible for the appropriate recovery action on all outstanding debts. Income not received should be dealt with in accordance with losses procedures. This includes the use of external debt recovery agents.
- 6.3.2** Should any staff detect that an overpayment has been made they should report immediately to the Director of Finance in order that recovery procedures can be initiated. The Trust will follow the overpayment policy in recovering debt owed as a result of employee benefit overpayment.

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7. SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

- 7.1** The Director of Finance and/or the Director responsible for the cashier's service shall prescribe and is responsible for systems and procedures for any staff handling cash, pre-signed cheques and negotiable securities on behalf of the Trust, including:
- i. approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable.
 - ii. the security and control of any such stationery.
 - iii. procedures for receiving and banking of cash, cheques and other forms of payment.
 - iv. circumstances in which unofficial funds may be deposited in safes.
 - v. prescribing systems and procedures for handling cash and negotiable instruments on behalf of the Trust. Where the Shared Services Organisation undertakes such issues as stated in 7.1, detailed requirements will be specified in a Service Level Agreement with the Shared Services Organisation.
 - vi. Issuing of High Street vouchers and the appropriate use of these vouchers.
- 7.2** Staff shall be informed in writing on appointment, of their responsibilities and duties for the collection, handling or distribution of cash, cheques, etc. Any staff whose duty it is to collect or hold cash shall be audited by the finance team to ensure the appropriate controls are in place for the safe keeping of the cash.
- 7.3** During the absence (e.g. on holiday) of the holder of a safe or cash-box key, the member of staff who acts in their place shall be subject to the same controls as the normal holder of the key. There shall be written discharge for the safe and/or cash-box contents on the transfer of responsibilities and the discharge document must be retained for inspection.
- 7.4** All cash, cheques and other forms of payment received by any other staff shall be passed immediately to the holder of a safe or cash-box key or to the cashier, from whom a signed receipt shall be obtained. No member of staff should keep Trust cash, cheques or other forms of payment, for whatever purpose, on Trust premises unless the Financial Controller is aware of the existence of such arrangements and can support and be assured on the systems and processes for the probity of such arrangements.
- 7.5** Official money may never be used for the encashment of private cheques.
- 7.6** The opening of coin operated machines (including telephones) and the counting and recording of the takings shall be undertaken by two members of staff together, unless authorised in writing by the Director of Finance. The coin-box keys shall be held only by a nominated member of staff.
- 7.7** Any loss or shortfall of cash, cheques or other cash equivalents, however occasioned, shall be reported immediately to the Financial Control Team in accordance with the agreed procedure for reporting losses (see also Section 16 Disposals, Losses and Special Payments).

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7.8 Petty Cash

7.8.1 All new floats or amendments to floats are authorised by the Director of Finance or Deputy Director of Finance, they will only be approved if they are essential to the service.

7.8.2 Petty Cash Limits floats are limited to £100 unless the amount reimbursed within a quarter is more and these will be considered on a case by case basis. The limits will be set as follows:

£50	Amount reimbursed in a month are less than £50
£100	Amounts reimbursed in a month are between £50 and £100
Above £100	Considered on a case by case basis dependent on spend within a month

7.8.3 All Petty Cash Floats must be held in a secure place and remain under the control of the designated Float Holder/Accounting Officer. The float holders who are going off duty and coming on duty will both check the petty cash together and a formal record of the check will be documented.

7.8.4 Petty Cash disbursements should be for the purpose agreed when the float was established. All disbursements must be supported by receipt(s). In circumstances where staff require an advance of cash to make a purchase, a record must be kept of the details and amount issued to ensure that all cash can effectively be accounted for until receipts and unspent cash are returned within 24 hours. Advances of cash need to be authorised by either the Director of Finance, Deputy Director of Finance or the Financial Controller prior to the advance being issued.

7.8.5 Reimbursements will not be made unless both signatories provided match the authorised signatories that is held on record for the float.

7.8.6 In exceptional circumstances Petty Cash above £50 may be issued with prior authorisation from the Director of Finance, Deputy Director of Finance or the Financial Controller.

7.9 Trust Credit Card

7.9.1 The Trust will hold credit cards in order to support the procurement process in allowing more flexibility to purchase goods but limited to exceptional circumstances. Standard procurement processes should be followed and suppliers set up through the usual procurement system to ensure good procurement governance. If the Trust credit card is used then the Trust's procurement processes will still need to be followed but the credit card will enable quicker payments to be made.

7.9.2 Access to the Trust credit card will be limited to Financial Control, Deputy Director of Finance and the Emergency Planning and Continuity Manager. The cards

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whilst not in use will be kept in a secure safe. Local procedures need to be in place to ensure the security of the credit card.

- 7.9.3** Fuel Purchasing Cards are held by the Estates Department, these should be kept in a secure place when not in use and documentation kept on usage.
- 7.9.4** Teams with Sum Up Purchasing cards must have local procedures in place to ensure they are being secured and used appropriately which can be audited by Financial Control.
- 7.9.5** Trust Purchasing Cards must follow trust procedures, be kept in a safe place and documentation available.
- 7.9.6** Pre-paid purchasing cards will be issued and audited by Financial Control who will put in place agreed limits and restrictions on the card as agreed with by the requester of the card.

7.10 Chip and Pin machines

- 7.10.1** The Trust holds chip and pin machines at various locations across the Trust.
- 7.10.2** The card holder is present when the card machine is in use and no payments are taken over the phone.
- 7.10.3** Local Procedures need to be in place to ensure the security of the machines.

8. TENDERING AND CONTRACTING PROCEDURE

8.1 Duty to comply with Standing Orders and Standing Financial Instructions

- 8.1.1** Every contract (other than for the delivery of Trust services delivered in accordance with the National Contract and commissioned by NHS or other Commissioners, (see 8.21) where made by the Trust, shall comply with these Standing Financial Instructions.
- 8.1.2** An exception from any of the following provisions of these Standing Financial Instructions may be made by the direction of the Trust or, in an emergency, by the Chair and Chief Executive, in accordance with SO 4.
- 8.1.3** Staff undertaking procurement activity should refer to the Trust Procurement Manual for further detailed information. The manual also includes reference to the 'No PO no pay' policy.

8.2 Bribery Act

All staff involved in tendering and contracting and other budget holder activities should be aware of the Bribery Act 2010 and should ensure that all dealings with other organisations and their staff do not bring them in breach of the Act. That could leave them open to criminal proceedings being commenced.

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8.3 Procurement Act 2023

The Procurement Act 2023 is UK legislation designed to modernise public procurement, making it simpler, more flexible, and more transparent. It aims to create a more competitive landscape for businesses, particularly small and medium-sized enterprises (SMEs) and social enterprises, while ensuring public funds are spent effectively. The Act came into force on February 24, 2025.

The Procurement Act 2023 represents a significant shift in how public procurement is conducted in the UK, promoting a more dynamic, inclusive, and accountable system.

8.4 Investment approach

Any potential major investment decision must be guided by relevant current Foundation Trust guidance, which sets out governance processes for all major investments undertaken by NHS foundation trusts.

8.5 Tendering

All tendering activity must be compliant with Procurement Regulations 2024 or any other such policy that may supersede it.

Formal Competitive Tendering

The standard method of procurement by the Trust shall be by way of competitive tender. The Trust shall ensure that such tenders are invited for the supply of goods, materials and manufactured articles and for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH); for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals.

8.5.1 Tender and Quotation Limits

The procurement of all goods and services should be preceded by a requisition and official order. By exception, urgent and/or emergency situations may be reasons why this is not possible and in these cases confirmation orders should be raised.

8.5.2 General Position on Quotations and Tendering

Below £10,000 (inc VAT) good purchasing practice is necessary i.e. seeking the best value for money.

8.5.3 The Trust's Procurement Department must be consulted prior to the commencement of any of the processes listed below

- For purchases up to £25,000(inc VAT) three written quotations are required.
- Supplies and service contracts above the current threshold require full

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compliance with the relevant Procurement Act 2023 procedure.

- In the event that purchases between £25,000 (inc VAT) and £50,000 (inc VAT) are procured through a compliant framework there is no requirement to obtain additional quotations. For purchases above £50,000 (inc VAT) procured through a compliant framework the Head of Procurement can recommend to Executives whether further competition is required. At all times value for money should be a prime consideration, even when procuring from a compliant framework.
- With regards to small works procurement (as defined by Procurement Act 2023) these rules shall override any other obligation contained in these Standing Financial Instructions relating to tender and quotation requirements.

8.6 Formal tendering procedures may be waived by officers to whom powers have been delegated by the Chief Executive without reference to the Chief Executive except in (c) to (f) below where:

- (a) The estimated expenditure or income does not, or is not reasonably expected to, exceed £50,000 (inc VAT) (in which case quotations process not tender process should be followed), or
- (b) Where the supply is proposed under special arrangements negotiated by the DH or Regulator in which event the said special arrangements must be complied with;
- (c) The timescale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for single tender;
- (d) Specialist expertise is required and is available from only one source;
- (e) The task is essential to complete the project, **and** arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate; this reason for waiver cannot be enacted if NHS England approval is required for management consultancy or other defined expenditure;
- (f) There is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering.

Requests for waiving formal tendering procedures should be in the form of a letter signed by the Chief Executive or their nominated deputy. These should then be entered in the waiver register and reviewed by the Audit and Risk Committee.

A waiver is not required for year two onwards of contracts that have already been through the procurement process that is outlined in these Standing Financial Instructions.

8.7 The limited application of the single tender rules should not be used to avoid competition or for administrative convenience or to award further work to a

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consultant originally appointed through a competitive procedure.

Where it is decided by the Chief Executive that competitive tendering is not applicable and should be waived by virtue of the above, the fact of the waiver and the reasons should be recorded in writing to the Chief Executive and documented in a register held by the Director of Corporate Affairs and Trust Secretary.

8.8 Tendering procedures are set out in Appendix 1.

8.9 Quotations - are required where formal tendering procedures do not apply where expenditure is expected to exceed £100,000 (inc VAT).

8.10 Where quotations are required they should be obtained from at least three firms/individuals.

8.11 All quotations should be treated as confidential and should be retained for inspection.

8.12 The Chief Executive or their nominated officer should evaluate the quotations and select the one which gives the best value for money. If this is not the lowest then this fact and the reasons why the lowest quotation was not chosen should be in a permanent record.

8.13 Non-competitive quotations in writing may be obtained for the following purposes:

- (a) the supply of goods/services of a special character for which it is not, in the opinion of the Chief Executive or their nominated officer, possible or desirable to obtain competitive quotations;
- (b) the goods/services are required urgently.

Instances of, and reasons for, non-competitive quotations are to be entered in the waiver register and reviewed by the Audit and Risk Committee.

8.14 Where tendering or competitive quotation is not required:-

The Trust shall procure goods and services in accordance with procurement procedures approved by the Trust as laid out in the Trust Procurement Manual.

8.15 Contracts - The Trust may only enter into contracts within its statutory powers and shall comply with:

- (a) its Establishment and Amendment Orders
- (b) The Trust's Standing Orders
- (c) The Trust's Standing Financial Instructions
- (d) Procurement Act 2023 and other statutory provisions

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- (e) any relevant directions from NHS England
- (f) such of the NHS Standard Contract Conditions as are applicable

Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

8.16 Save for deeds and contracts relating to the disposal, acquisition or leasing of land and buildings, the following shall apply:

Contract value range	Authorised to <u>approve</u> contract	Authorised to <u>sign</u> contract
Over £500k	Director of Operations or Executive Director	Executive Director (voting or non-voting) and Chief Executive
Over £200k	Director of Operations or Executive Director	One of the following; Director of Finance, Chief Executive or nominated officer (with appropriate approval limit).
Up to £200k	Director of Operations or Deputy Director of Operations	One of the following; Executive Director (voting or non-voting), nominated officer, Deputy Chief Executive or Deputy Director of Finance
Up to £50k	Care Group Operational Manager	v Director of Operations or Deputy Director of Operations
Up to £10k	Deputy Operational Manager	Care Group Operational Manager

All deeds and contracts relating to the disposal, acquisition or leasing of land or property, shall be executed under the Common Seal of the Trust and be signed by the Director of Corporate Affairs and **Trust Secretary** or a **Nominated Deputy** and an **Executive Director (voting or non-voting)** duly authorised by the Chief Executive and not from the originating department.

8.17 In all contracts made by the Trust, the Board shall endeavour to obtain best value for money. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

8.18 Personnel and Agency or Temporary Staff Contracts - The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment regarding staff, agency staff or temporary staff service contracts.

8.18.1 Where a member of staff is employed using such temporary arrangements the Director of People, Organisational Development and Inclusion will ensure that up-to-date guidance is available to managers and that compliance with such guidance is appropriately monitored and enforced to ensure that the Trust is able to comply with regulatory requirements including those of NHS England and Her Majesty's Revenue and Customs (HMRC).

8.19 Healthcare Services Agreements – service agreements with commissioners for the supply of healthcare services, are subject to the separate and specific

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provisions of the terms of authorisation of the Trust and must be in the form of legally binding contracts.

8.20 Cancellation of Contracts – Except where specific provision is made in model forms of contracts approved for use within the NHS and in accordance with SFIs 8.18 and 8.19, every contract shall include a written clause empowering the Trust to terminate the Contract and to recover from the Contractor the amount of any loss resulting from such cancellation if the Contractor or any person employed by the Contractor or acting on behalf of the Contractor has offered, paid or given, directly or indirectly, any gift in money or any other form to any employee or agent of the Trust as an inducement or reward in connection with their behaviour in relation to the Contract, or appears to have committed any offence under the Bribery Act 2010 or other appropriate legislation.

8.21.1 Determination of Contracts for Failure to Deliver Goods or Materials – There shall be inserted in every written contract for the supply of goods or materials a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the Trust may without prejudice determine the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good (a) such default, or (b) in the event of the contract being wholly determined the goods or materials remaining to be delivered. The clause shall further secure that the amount by which the cost of so purchasing other goods or materials exceeds the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.

8.22 The Chief Executive shall nominate officers with power to negotiate for the provision of healthcare services with purchasers of healthcare.

8.23 Contracts Involving Funds Held on Trust - shall do so individually to a specific named fund. Such contracts involving charitable funds shall comply with the requirements of the Charities Act.

9. NHS SERVICE AGREEMENTS AND CONTRACTS FOR THE PROVISION OF SERVICES

9.1 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable contracts with service commissioners for the provision of health services. In discharging this responsibility, the Chief Executive shall take into account:

- (a) The National Contract framework
- (b) Local health service planning priorities
- (c) The cost, price and volume of services to be provided and method of payment;
- (d) The standards and detailed specifications for service quality expected;

The Trust will work with any partner agencies involved in both the delivery and the commissioning of the service required. The contract will apportion

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responsibility for mitigating any contractual risks and the financial arrangements should reflect this.

The Chief Executive, as the Accounting Officer, will need to ensure that regular reports are provided to the Trust Board detailing actual and forecast income from contracts, this responsibility has been delegated to the Executive Director of Finance.

This will include information on any costing arrangements subject to local currency agreements, including any changes to payment systems e.g. National Tariff Payment System.

The decommissioning of any healthcare service will require approval by Trust Board.

10. EMPLOYMENT TERMS AND CONDITIONS

10.1 REMUNERATION

10.1.1 The Board should formally agree and record in the minutes of its meetings, the precise terms of reference of the Remuneration and Appointments Committee, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. The terms of reference of this committee are contained in the Scheme of Delegation.

10.1.2 Except where Agenda for Change rules apply, the Trust Board will approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those staff not covered by the Committee.

10.1.3 The remuneration of the Chair and Non-executive Directors will be determined by the Council of Governors in accordance with the Foundation Trust Constitution.

10.2 FUNDED ESTABLISHMENT

10.2.1 The workforce plans incorporated within the annual budgets will form the funded establishment.

10.3 STAFF APPOINTMENTS

10.3.1 No Director or staff may engage, re-engage employees, or re-grade job roles, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

- i) Unless within the approved budget and funded establishment limit and in accordance with appropriate guidance on such employment.
- ii) In certain circumstances, following the consideration of an 'Invest to Save' Business Case at ELT, the Chief Executive and the Director of Finance may approve appointments to unfunded posts. These posts must have a return on investment over an agreed period of time. Any agreements that are made will

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be reviewed and evaluated on a regular basis in order to assess the impact on delivering efficiencies laid out in the business case.

10.3.2 The Board will approve procedures presented by the Chief Executive for the determination of pay rates, conditions of service, etc., for staff.

10.3.3 When engaging staff or regrading roles the Trust's recruitment and job evaluation processes must be followed.

10.4 PROCESSING OF PAYROLL

10.4.1 The Director of People, Organisation Development and Inclusion is responsible for:

- i) specifying timetables for submission of properly authorised time records and other notifications;
- ii) making recommendations to the Director of Finance on the final determination of pay;
- iii) making payment on agreed dates;
- iv) agreeing methods of payment.
- v) maintaining and enforcing a Trust under and overpayment policy and seeking to recover any overpayments in line with that policy.

10.4.2 The Director of Finance and the Director of People, Organisational Development and Inclusion **will** as appropriate, issue instructions regarding:

- ii) verification and documentation of data;
- iii) the timetable for receipt and preparation of payroll data and the payment of staff;
- iv) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
- v) security and confidentiality of payroll information;
- vi) checks to be applied to completed payroll before and after payment;
- vii) authority to release payroll data under the provisions of the Data Protection Act;
- viii) methods of payment available to various categories of staff;
- ix) pay advances and their recovery;
- x) procedures for payment by cheque or bank credit;
- xi) procedures for the recall of cheques or bank credits;
- xii) maintenance of regular and independent reconciliation of pay control accounts;
- xiii) separation of duties of preparing records and handling cash; and
- xiv) a system to ensure the recovery from leavers of payments and property due to the Trust.
- xv) A system to record and report specific employee costs as required by guidance for example "high-cost off-payroll" employee costs.
- xvi) Maintenance of an up to date authorised signatory list for pay.

10.4.3 Nominated managers have delegated responsibility for:

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- i) Ensuring all members of staff with any secondary employment complete all required declarations in line with secondary employment policy or successor policy in place at the time.
- ii) Ensuring all staff absences are appropriately authorised. In the event of unauthorised absence the line manager is responsible for notifying payroll services to ensure payment for unauthorised absence is prevented or recovered.
- iii) Submitting time records, and other notifications in accordance with agreed timetables.
- iv) Completing time records and other notifications in accordance with the instructions of and in the form prescribed by the Director of People, Organisation Development and Inclusion or the Director of Finance.
- v) Submitting termination forms electronically immediately upon receiving confirmation of a member of staff's resignation, termination or retirement. Where a member of staff fails to report for duty in circumstances that suggest they have left without notice, the Director of People, Organisational Development and Inclusion must be informed at the earliest opportunity.
- vi) Submitting all employee-related updates promptly to avoid over or under payment and to ensure that staff records are accurate and up to date for their area of responsibility. These requirements include but are not limited to new starters, change forms and leavers.
- vii) An authoriser must ensure that timesheets, expense claims and other such notifications are appropriately checked and agreed as accurate before authorisation is given.
- viii) Ensuring that all Rostering systems for their area of responsibility are accurately maintained, in accordance with Trust policy, to ensure correct and timely payments are made to appropriate staff.

10.4.4 The Director of People, Organisational Development and Inclusion and the Director of Finance shall ensure that the chosen method for providing the payroll service is supported by appropriate contracted terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

10.4.5 In terminating a contract through the use of severance payments, the affordability of the payment should be assessed by the Director of Finance before proceeding. The Director of People, Organisational Development and Inclusion is responsible for ensuring all appropriate regulatory due process is followed for all types of termination payments. The proposed payment must be authorised by the Chief Executive via the use of the "Termination of Contract – Severance Payments Proforma". This document outlines the details and circumstances of the proposed severance payment. The Director of People, Organisational Development and Inclusion must ensure this guidance is maintained in line with current regulatory requirements.

All exit packages must be within the contractual limits or less. Where the Director of People, Organisational Development and Inclusion and the Remuneration and Appointments Committee proposes payment which exceeds contractual limits,

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appropriate approval must be sought from NHS England and the Treasury in line with regulatory policy.

In line with Freedom to Speak Up requirements the Chief Executive will personally review all settlement agreements that contain confidentiality clauses to ensure that such clauses are in the public interest.

Such settlement agreements will be made available for inspection by the CQC as part of their assessment to determine if the organisation is well-led
If the settlement requires Treasury approval the Trust will demonstrate that the confidentiality clause is in the public interest in that particular case.

10.5 CONTRACT OF EMPLOYMENT

10.5.1 The Trust Board shall delegate responsibility to the Director of People, Organisational Development and Inclusion for:

- ensuring that all staff are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and
- dealing with variations to contracts of employment; and
- dealing with termination of contracts of employment (except those cases subject to disciplinary rules and procedures) upon the advice of the Director of Finance on affordability.

11. NON-PAY EXPENDITURE

11.1 DELEGATION OF AUTHORITY

11.1.1 The Trust Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

Budget holders so delegated, and others who the Budget Holders shall formally nominate shall be authorised to approve requisitions, invoices and petty cash, subject to appropriate segregation of duties and subject to the scope and limit(s) of their budget(s).

11.1.2 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

11.2 CHOICE, REQUISITIONING, ORDERING, RECEIPT AND PAYMENT FOR GOODS AND SERVICES

11.2.1 Any member of staff authorised to requisition goods or services shall comply with procedures issued by the Director of Finance and, in choosing the item to be supplied or the service to be performed, shall always obtain the best value for money for the Trust. In so doing, the advice of the Procurement department shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance and the Chief Executive shall be consulted.

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11.2.2 The Director of Finance shall be responsible for the prompt payment of all properly authorised accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance. Payment for goods and services shall only be made once the goods and services are received (except for prepayments as below). Such requirements will be specified in a Service Level Agreement with the Shared Services Organisation as appropriate.

11.2.3 Official orders must state the Trust's terms and conditions of trade and be consecutively numbered. They must only be issued to, and used by, those duly authorised by the Chief Executive and be in a form approved by the Director of Finance.

11.2.4 All goods, services, or works shall be ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash. Verbal orders may only be issued very exceptionally - by a member of staff designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order". Goods may not be taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase.

11.2.5 The Director of Finance will:

- (a) advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed.
- (b) prepare procedural instructions where not already provided in the Scheme of Delegation or procedure notes for budget holders on the obtaining of goods, works and services incorporating the thresholds;
- (c) be responsible for the prompt payment of all properly authorised accounts and claims;
- (d) maintain a list of Directors/staff, authorised to certify invoices.
- (e) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:
 - i) Certification that:
 - goods have been duly received, examined and are in accordance with specification and the prices are correct;
 - work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
 - in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the

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rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
 - the account is arithmetically correct;
 - the account is in order for payment.
- ii) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.
- iii) Instructions to staff regarding the handling and payment of accounts within the Finance Department.
- iv) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as in SFI 11.2.6).

11.2.6 Prepayments are only permitted where exceptional circumstances apply. In such instances, where material (in excess of £10,000):

- a) the appropriate Executive Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;
- b) the Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed; and
- c) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and he must immediately inform the appropriate Executive Director or Chief Executive if problems are encountered, along with their Finance Manager who can ensure the correct accounting treatment is performed.

11.2.7 Managers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

- a) all contracts (other than for a simple purchase permitted within the Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance and the Director of Corporate Affairs and Trust Secretary in advance of any commitment being made;
- b) contracts above specified thresholds are advertised and awarded in accordance with Public Contract Regulation rules on public procurement;

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- c) where consultancy advice is being considered, the approval and procurement of such advice must be in accordance with current regulatory guidance for Foundation Trusts. When considering consultancy advice internal approval from the Director of Finance should be sought in line with delegated responsibility limits and always before any business case is sent for external approval from the Regulator. Wherever possible the preferred bidder should assist in the preparation of the required business case to the Regulator. The term consultancy advice is defined as the provision, to management, of objective advice and assistance relating to strategy, structure, management of operations of an organisation in pursuit of its purposes and objectives. Such assistance will be provided outside the “business as usual” (BAU) environment when in-house skills are not available and will be of no essential consequence and time limited. Services may include the identification of options with recommendations and/or assistance with (but not delivery of) the implementation of solutions. If in any doubt this is to be referred to the Director of Finance or Deputy for clarification.
- d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Directors or staff, other than:
 - i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;
 - ii) conventional hospitality, such as lunches in the course of working visits;
 - iii) the Conflicts of Interest Policy must be adhered to in all cases.
- e) no requisition/purchase order is to be placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;
- f) all goods, services, or works should be ordered on an official purchase order including wherever possible works and services executed in accordance with a contract but excluding purchases from petty cash;
- g) verbal orders must only be issued very exceptionally - by a member of staff designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";
- h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds or regulatory guidance;
- i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;
- j) changes to the list of Directors/staff authorised to certify invoices are notified to the Director of Finance;

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- k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance; and petty cash records are maintained in a form as determined by the Director of Finance;
- l) payments to local authorities and voluntary organisations made under the powers of the NHS Act shall comply with procedures laid down by the Director of Finance which shall be in accordance with these Acts.

12. EXTERNAL BORROWING AND INVESTMENTS

12.1 EXTERNAL BORROWING

- 12.1.1** The Director of Finance is responsible for ensuring that the sum of borrowing from all sources both short term and long term represents value for money, comply with any Regulatory limits and guidance and does not adversely impact on future cash flows.
- 12.1.2** Any application for a temporary loan or overdraft will only be made by the Director of Finance or by a member of staff so delegated by them and in any event a duly authorised signatory.
- 12.1.3** The Director of Finance must prepare detailed procedural instructions concerning applications for temporary loans and overdrafts.
- 12.1.4** All external borrowing must be consistent with the plans outlined in the current Business Plan and be recommended by Finance and Performance Committee to the Trust Board.
- 12.1.5** The Trust holds a separate Treasury Management Policy which covers both borrowings and investment in more detail.

12.2 INVESTMENTS

- 12.2.1** Foundation Trusts have discretion to invest surplus money for the purposes of, or in connection with, their functions. The Chief Executive, as accountable officer, is responsible for ensuring that surplus operating cash is invested in accordance with the Board of Directors' duty to safeguard and properly account for the use of public money.
- 12.2.2** The Director of Finance is responsible for advising the Trust Board on investment strategies for cash surpluses in accordance with best practice guidance and in line with NHS England's most current published guidance for Foundation Trusts.

13. CAPITAL EXPENDITURE AND PRIVATE FINANCE

13.1 CAPITAL INVESTMENT

- 13.1.1** All bids for Capital Investment should be approved by the Board of Directors (with due regard to the Trust's cash position and any associated investment strategies).

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13.1.2 The Trust will follow NHS England's Cash and Capital Regime and where applicable approval will be sought for any investment and property business cases in line with the requirements of the guidance. See NHS England: 'Capital guidance update 2023/24' and NHS England 'capital investment and property business case approval guidance for NHS trusts and foundation trusts'.

13.1.3 The Trust will follow NHS England capital regime in relation to system sign off and working within CDEL limits set by the Regulator.

13.1.4 The Chief Executive is responsible for ensuring that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans.

13.1.5 The Trust shall appoint the Capital Project Group or other appropriate meeting structure whose responsibilities shall be:

- a) the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost and meet their overall purpose; and
- b) ensuring that capital investment is not undertaken without commissioner(s)/ partner(s) written support, where required, and the availability of resources to finance all revenue consequences and capital charges; and
- c) to ensure that a robust financial appraisal is undertaken as appropriate for all business cases (which have been approved by the Trust's Finance and Performance committee as appropriate); and
- d) to ensure that appropriate project management and control arrangements are in place; and
- e) that the Director of Finance has certified professionally to the costs and revenue consequences detailed in business cases.

13.1.6 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of "Estatecode". The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

13.1.7 The approval of a capital programme shall not constitute approval for expenditure on any scheme. The Chief Executive shall issue to the manager responsible for any scheme (through the Capital Project Group):

- specific authority to commit expenditure;
- authority to proceed to tender or obtain quotations;
- approval to accept a successful tender or quotation and to place an order.

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The Chief Executive will issue a scheme of delegation for capital investment management in accordance with "Estatecode" guidance and the Trust's Standing Orders.

13.1.8 The Director of Finance shall issue the capital investment framework and procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

13.1.9 Delegated limits for the signing-off of expenditure on capital monies are covered in these SFIs.

13.2.1 The section below covers the approval process before orders are placed.

Expenditure on an individual project up to £100,000	Approved by the Capital Project Group
Expenditure on an individual project between £100,000 and £1,000,000	Jointly approved by the Director of Finance and one other Executive Director
Proposed expenditure on a project in excess of £1,000,000	Board approval required (and process to be in accordance with NHS England guidance)

13.2.2 The extent and progress of the manner in which Capital Investment monies are spent will be regularly reported to the Trust Delivery Group and Finance and Performance Committee. Any variation to the approved capital expenditure plan will require appropriate authorisation, in accordance with the above limits and be appropriately reported to regulators.

14. ASSET REGISTERS AND SECURITY OF ASSETS

14.1 ASSET REGISTERS

14.1.1 The Chief Executive is responsible for ensuring that a system exists for the maintenance of registers of assets, taking account of the advice of the Director of Finance on the form of any register and the means of updating and arranging for a periodic physical check of assets against the asset register to be conducted.

The Trust shall maintain an asset register recording fixed assets. The composition of information to be held within these registers shall be specified in the Trust's capital accounting policies.

14.1.2 Budget holders must confirm to the Director of Finance any fixed asset additions within their remit. Additions to the asset register will be validated by reference to:

- properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

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- stores, requisitions and wages records for own materials and labour with overheads; and
- lease agreements in respect of assets held under a finance lease and capitalised.

14.1.3 Budget holders must notify the Director of Finance where they propose that assets are to be sold, scrapped, or otherwise disposed of. Each disposal must be validated by reference to authorisation documents and invoices (where appropriate) and accounted for appropriately. (see disposals and condemnations section).

Budget holders must seek approval from the Trust Board to declare any land or buildings as surplus to NHS requirements and available for disposal and income.

The route to market for any sale of land and buildings will be determined by the Associate Director of Estates and Facilities and the Director of Finance but with final agreement by the Trust Board.

Budget holders and service managers must notify the Financial Controller if assets are being transferred between buildings or otherwise relocated, to allow for the asset register to be updated.

If any assets remain in empty buildings, it is the exiting service manager that is responsible for those assets until the building has been handed over to a new service or to Estates.

No assets that have been identified to hold Commissioner Requested Services in accordance with the NHS England Licence Agreement are allowed to be sold without prior consultation and agreement with NHS England in line with current guidance and approval from the Board. The trust asset register includes a list of all assets which have been identified as being locations of Commissioner Requested Services.

14.1.4 The value of owned buildings shall be indexed to current values and all assets shall be depreciated using methods and rates as specified by the appropriate accounting policies in use in the Trust. Periodically non-current assets will be subject to a formal revaluation exercise as described in the relevant Trust accounting policies. The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

14.1.5 The Director of Finance of the Trust shall calculate and pay capital charges as required.

14.2 SECURITY OF ASSETS

14.2.1 The overall control of assets is the responsibility of the Chief Executive.

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14.2.2 Asset control procedures (including fixed assets, cash, cheques, and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

- identification of additions and disposals;
- recording managerial responsibility for each asset;
- physical security of assets;
- periodic verification of the existence of, condition of, and title to, assets recorded;
- identification and reporting of all costs associated with the retention of an asset; and
- reporting, recording and safekeeping of cash, cheques and negotiable instruments.

14.2.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

14.2.4 Whilst each member of staff has a responsibility for the security of property of the Trust, it is the responsibility of Directors and senior staff in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board of Directors. Any breach of agreed security practices must be reported in accordance with instructions.

14.2.5 Any damage to Trust premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Directors and staff in accordance with both security policies and the losses procedure.

14.2.6 The organisation will take all necessary steps to recover financial losses due to fraud, theft of, or criminal damage to, its assets on a case-by-case basis in a timely manner.

The impact of the recovery of financial losses due to theft or criminal damage of its assets is regularly monitored and soundly evaluated by Trust Delivery Group and, where appropriate, improvements are made to the redress arrangements and the organisations approach to recovery.

14.2.7 IT assets and where practical Plant, Property and Equipment, should be marked as Trust property. IT assets shall be recorded, managed and secured in accordance with Trust asset management procedures, including inventory management, lifecycle management and secure disposal requirements.

14.2.8 Where appropriate the Trust's assets should be covered by the NHS arrangements for the pooling of insurance.

14.2.9 Each member of staff has a responsibility for the security of property of the Trust whilst working remotely or from home, see separate Home Working Policy.

14.3 PARTNERING ARRANGEMENTS, LEASE ACQUISITIONS AND LEASE ASSIGNMENTS

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- 14.3.1** Partnering arrangements involving the occupation of another party's property (NHS or non-NHS) or allowing another party to occupy part of the Trust's property, even if no financial consideration is involved, must be covered by formal agreement.
- 14.3.2** All arrangements where the Trust use or occupy a room, part or all of a building for any length of time must be covered by an appropriate written agreement.
- 14.3.3** Lease acquisition of properties must be covered by a formal lease arrangement.
- 14.3.4** The decision to sub-let a Trust property or to take on an assigned lease must be covered by a formal agreement or assignment.
- 14.3.5** The Director of Corporate Affairs and Trust Secretary (or nominated deputy) must be consulted on the legal position and will advise on the need for lease or license agreement and its content.
- 14.3.6** The Associate Director of Estates and Facilities is responsible for negotiating the heads of terms and will advise on matters of Health & Safety, rates, utilities, maintenance and insurance obligations.
- 14.3.7** The Director of Finance must be consulted to advise on the appropriate accounting treatment under IFRS 16. Following the change in accounting treatment and new leases to be funded from Business-as-Usual capital allocations, all new leases must go through the Capital Project Group for approval or recommendation depending on capital limits set out in 13.2.1.
- 14.3.8** The Director of Corporate Affairs and Trust Secretary is responsible for maintaining a full record of all agreements in a Trust-wide property database. This will include termination dates, break clause details, rent review dates, notice periods and financial commitments.

14.4 LEASE TERMINATIONS

- 14.4.1** The decision to vacate a Trust property must be covered by formal agreement.
- 14.4.2** The Director of Corporate Affairs and Trust Secretary (or nominated deputy) must be consulted on the legal position and will advise on the notice to the landlord.
- 14.4.3** The Associate Director of Estates and Facilities will facilitate the assessment of dilapidations and cancellation notifications e.g. rates, insurances, utilities.
- 14.4.4** The Director of Finance must be informed to ensure payments are cancelled in line with the agreement.
- 14.4.5** A full record of the agreement is to be maintained in the Trust wide property database.

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14.5 RENT REVIEWS

- 14.5.1** As part of the responsibility for record management there is a need to ensure that rent reviews are carried out in accordance with the lease agreement, and that agreement is either concluded within 2 months of the review date, or that the Finance department are advised of the liability that the budget holder may face. Rent Reviews shall be reported to the Capital Programme Group for consideration prior to being formally agreed.

15. STORES AND RECEIPT OF GOODS

- 15.1** Stores, i.e. controlled stores and departmental stores for immediate use should be:
- kept to a minimum;
 - subjected to annual stock take;
 - valued in accordance with Trust accounting policy.
- 15.2** Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to a member of staff by the Chief Executive. The day-to-day responsibility may be delegated by the Chief Executive to departmental staff and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer.
- 15.3** The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager or Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.
- 15.4** The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.
- 15.5** Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all material items in stock at least once a year.
- 15.6** Where a complete system of stock control is not justified, alternative arrangements shall require the approval of the Director of Finance.
- 15.7** The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also 16, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

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- 15.8** For goods supplied by NHS Supply Chain, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Director of Finance who shall satisfy himself that the goods have been received before accepting the recharge.
- 15.9** The Trust will follow any guidance issued by NHS England in relation to any centrally procured goods such as PPE.

16. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

16.1 DISPOSALS AND CONDEMNATIONS

- 16.1.1** The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to managers. Every effort should be made by managers to maintain assets of property plant and equipment in good order.
- 16.1.2** When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.
- 16.1.3** Surplus property, plant and equipment or any other Trust asset, which is in serviceable order, should not be disposed of. Due process must be followed whereby the surplus asset is reallocated within the Trust or temporarily stored appropriately. Requests to otherwise dispose of any serviceable asset must be approved by the head of department and notified to the Director of Finance.
- 16.1.4** All unserviceable articles shall be condemned or otherwise disposed of by a member of staff authorised for that purpose by the Director of Finance. The Condemning Officer shall record condemnation in a form approved by the Director of Finance, which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second member of staff authorised for the purpose by the Director of Finance.
- 16.1.5** The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

16.2 LOSSES AND SPECIAL PAYMENTS

- 16.2.1** The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

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- 16.2.2** Any member of staff discovering or suspecting a loss of any kind must immediately inform their head of department, who must inform the Chief Executive and the Director of Finance at the earliest opportunity. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved, but if the case involves suspicion of fraud, then the matter should be reported to the Local Counter Fraud Specialist for a criminal investigation. Consideration of police involvement will be discussed with the Local Counter Fraud Specialist. All security-related incidents must be reported to the Trust's Security Management Specialist. Actual or suspected information governance, confidentiality, cyber security or data protection incidents shall be reported and managed in accordance with Trust incident management procedures.
- 16.2.3** Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a financial nature, the Trust's Local Counter Fraud Specialist must also be notified at the earliest opportunity.
- 16.2.4** The Board of Directors shall approve the writing-off of losses. This approval is delegated to the Chief Executive (or Director of Finance / Deputy Director of Finance) in accordance with the Scheme of Delegation. Write-offs will only be reported to Audit and Risk Committee on an exceptional basis by value.
- 16.2.5** The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.
- 16.2.6** For any loss, the Director of Finance should, in consultation with the Director of Corporate Affairs and Trust Secretary, consider whether an insurance claim can be made.
- 16.2.7** The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.
- 16.2.8** No special payments exceeding delegated limits shall be made without the prior approval of the relevant body
- 16.2.9** Losses and special payments will only be reported to the Audit and Risk Committee on an exceptional basis by value or volume if there becomes any issue with a certain area.

17 INFORMATION MANAGEMENT AND TECHNOLOGY

- 17.1** The Director with responsibility for Information Management and Information Technology, who is responsible for the accuracy and security of the computerised (including financial) data and information of the Trust, shall be responsible for devising and maintaining appropriate Information Management and Technology procedures and policies for the Trust. The Trust shall ensure that all information systems, information assets and information processing activities comply with

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applicable Data Protection legislation, Information Governance requirements and NHS security standards.

- 17.2** The Director responsible for IM&T shall ensure that financial IM&T systems are developed and maintained in an appropriate manner, even in the event that the maintenance of such a system is outsourced.
- 17.3** The Director of Finance and the Director responsible for IM&T shall ensure that contracts for computer services for financial applications with another health organisation, any other agency or Shared Services Organisation shall clearly define the responsibility of all parties for the information governance, security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes. Contracts involving storage or processing of Trust information shall include appropriate provisions relating to data protection, security, records retention, business continuity, audit rights and incident reporting.
- 17.4** Where another health organisation, any other agency or Shared Service Organisation provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.
- 17.5** Where computer systems have an impact on corporate financial systems the Director of Finance shall satisfy themselves that:
- (a) systems acquisition, development and maintenance are in line with financial requirements;
 - (b) data produced by financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;
 - (c) Only appropriate persons shall have access to such data; and
 - (d) such computer audit reviews as are considered necessary are being carried out.
 - (e) Adequate business continuity/disaster recovery arrangements are in place.
- 17.6** The Director of Finance shall ensure that financial risks to the Trust arising from the use of IM&T are effectively identified and considered and appropriate action taken to mitigate or control risk.
- 17.7** Directors and senior managers responsible for information assets shall ensure appropriate governance, security, access controls and retention arrangements are maintained for systems and information under their control.
- 17.8** Appropriate cyber security controls, vulnerability management, incident response arrangements and cyber resilience measures shall be maintained in accordance with NHS requirements and Cyber Security policies

17.9 Freedom of Information

All Directors shall ensure that processes are in place and are subject to adequate control for the provision of information requests in line with The Freedom of Information (FOI) Act 2000.

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18. PATIENTS' PROPERTY

18.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in Trust property. Employees are required to follow the Trust Policy and Procedure for Service Users' Finance and Property.

18.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by;

- a) notices and information booklets,
- b) Trust admission documentation and property records,
- c) the verbal advice of administrative and/or nursing staff responsible for admissions.

The Trust will not accept responsibility or liability for patients' property brought into Trust premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

18.3 The Chief Operating Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

18.4 Where Department of Health instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Director of Finance.

18.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

18.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

18.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor in writing.

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19. CHARITABLE FUNDS

19.1 INTRODUCTION

- 19.1.1** Charitable funds are those gifts, donations and endowments held on trust for purposes relating to the Derbyshire Healthcare NHS Foundation Trust. They are administered on behalf of the Trust by the Directors of the Derbyshire Community Healthcare Services NHS Foundation Trust, acting as agents of the charitable fund.
- 19.1.2** The discharge of the DCHS's corporate trustee responsibilities is distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes. The Director of Finance shall ensure that each charitable fund is managed appropriately with regard to its purpose and to its requirements.
- 19.2** The Director of Finance shall periodically review the charitable funds in existence and shall make recommendations to the trustees regarding the potential for rationalisation of such charitable funds within statutory guidelines.

20. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT

- 20.1** The Director of Corporate Affairs and Trust Secretary shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. Staff should be aware of and comply with the Trust's 'Conflict of Interest Policy'.
- 20.2** Staff should make themselves aware of, and comply with, the Bribery Act 2010, Code of Conduct for NHS Managers 2002, and the Code of Practice for the Pharmaceutical Industry 2012 relating to hospitality / gifts from pharmaceutical / external industry.

21. RETENTION OF DOCUMENTS

- 21.1** The Chief Executive shall be responsible for maintaining a Policy and Procedure for the Retention, Preservation and Destruction of Records which all employees must follow.
- 21.2** Any documents held in archives shall be capable of retrieval by authorised persons.
- 21.3** Documents held under the requirements of current directions shall only be destroyed at the express instigation of the Chief Executive, and records shall be maintained of documents so destroyed in accordance with the Policy and Procedure for the Retention, Preservation and Destruction of Records.

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21.4 Associated policies which employees should be familiar with are: the Policy and Procedure for Offsite Records Storage, Policy and Procedure for Disposal of Confidential Information and the Information Lifecycle Management Policy and Procedure.

21.5 Information systems must support the retention, preservation, disposal and retrieval of records in accordance with the Trust's Records Management policies and the NHS Records Management Code of Practice.

22. RISK MANAGEMENT AND INSURANCE

22.1 The Chief Executive shall ensure that the Trust has a programme of risk management, which will be approved and monitored by the Board of Directors. Employees must comply with the Trust Risk Management policies and procedures.

22.2 The programme of financial risk management shall include:

- a) process for identifying and quantifying risks and potential liabilities.
- b) engendering among all levels of staff a positive attitude towards the control of risk.
- c) management processes to ensure all significant financial risks and potential liabilities are addressed, including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk.
- d) contingency plans to offset the impact of adverse events.
- e) audit arrangements including internal audit, clinical audit, health and safety review.
- f) arrangements to review the risk management programme.

The existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of internal control within the annual report and accounts.

The Director of Corporate Affairs and Trust Secretary shall ensure that insurance arrangements exist in accordance with the risk management programme.

Insurance arrangements with commercial insurers

22.3 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, three exceptions when the Trust may enter into insurance arrangements with commercial insurers. The exceptions are;

- a) Trusts may enter commercial arrangements for insuring motor vehicles owned or leased by the Trust including insuring third party liability arising from their use.

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- b) where the Trust is involved with a contractual arrangement to lease a building and the landlord or Private Finance Initiative consortium in respect of the PFI contract require that commercial insurance arrangements are entered into or the value of the building is in excess of the value covered by the NHS Resolution and further cover is required.
- c) Where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for NHS purpose the activity may be covered in a risk pool. Confirmation of coverage on the risk pool must be obtained from the NHS Litigation Authority. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements, the Director of Finance and Director of Corporate Affairs and Trust Secretary should consult the Department of Health.

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APPENDIX 1

Tendering Procedure

1. Invitation to tender

- (i) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.
- (ii) All invitations to tender shall state that no tender will be accepted unless:
 - (a) submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive or nominated Manager;
 - (b) that tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.
 - (c) It is submitted in accordance with the instructions issued via The Trust's electronic contract management system
- (iii) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.
- (iv) Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

2. Receipt and safe custody of tenders

The Director of Corporate Affairs and Trust Secretary or their nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening. In the case of tenders submitted by The Trust's electronic contract management, the tender maybe opened by the Head of Procurement.

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The date and time of receipt of each tender shall be endorsed on the tender envelope/package.

3. Opening tenders and Register of tenders

- (i) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two Directors which will include, if available the Director of Corporate Affairs and Trust Secretary or their nominated representative and a Director who is not from the originating department. In the case of tenders submitted by the Trust's electronic contract management, the tender may be opened by the Head of Procurement. These tenders are held in a secure environment compliant with ISO27001 infrastructure and available as a CESG accredited HMG Impact Level 3 service which allows handling of "restricted documents" classification. In this case sub sections (ii), (vi) and (vii) do not apply.
- (ii) A voting member of the Trust Board will be required to be one of the two approved persons present for the opening of tenders estimated above £400,000. The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the Trust's Scheme of Delegation.
- (iii) The 'originating' Department will be taken to mean the Department sponsoring or commissioning the tender.
- (iv) The involvement of Finance Directorate staff in the preparation of a tender proposal will not preclude the Director of Finance from serving as one of the directors to open tenders. The involvement of estates staff in the preparation of a tender proposal will not preclude the Director who has the portfolio responsibility for Estates from serving as one of the directors to open tenders.
- (v) All Executive Directors will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.
- (vi) Every tender received shall be marked with the date of opening and initialled by those present at the opening.
- (vii) A register shall be maintained by the Director of Corporate Affairs and Trust Secretary, or a person authorised by him, to show for each set of competitive tender invitations despatched, including those handled under the electronic contract management system (see 3 (i) above):
 - the name of all firms individuals invited;
 - the names of firms individuals from which tenders have been received;
 - the date the tenders were opened;

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- the persons present at the opening;
- the price shown on each tender;
- a note where price alterations have been made on the tender.

Each entry to this register shall be signed by those present.

A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

- (viii) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon their own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders.

4. Admissibility

- (i) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.
- (ii) Where only one tender is sought and/or received, the Chief Executive and Director of Finance shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

5. Late tenders

- (i) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or their nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.
- (ii) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or their nominated officer or if the process of evaluation and adjudication has not started.
- (iii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Director of Corporate Affairs and Trust Secretary or their nominated officer.

6. Acceptance of formal tenders

- (i) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of their tender before the award of a contract will not disqualify the tender.

Name of policy document:	
Issue No:	

- (ii) The most economically advantageous tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary; such good and sufficient reasons will be determined by those within the Trust with the requisite skill and experience in the matter being tendered for. Such reasons shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

- a) experience and qualifications of team members;
- b) understanding of client's needs;
- c) feasibility and credibility of proposed approach;
- d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

- (iii) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
- (iv) The use of these procedures must demonstrate that the award of the contract was:
- a) not in excess of the going market rate / price current at the time the contract was awarded;
 - b) that best value for money was achieved.
- (v) All tenders should be treated as confidential and should be retained for inspection.

7. Tender reports to the Trust Board

Reports to the Trust Board will be made on an exceptional circumstance basis only.

8. List of approved firms

a) Responsibility for maintaining list

A manager nominated by the Chief Executive shall on behalf of the Trust maintain lists of approved firms from whom tenders and quotations may be invited. These shall be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial

Name of policy document:	
Issue No:	

competence the Trust is satisfied. All suppliers must be made aware of the Trust's terms and conditions of contract.

b) Building and Engineering Construction Works

- (i) Invitations to tender shall be made only to firms included on the approved list of tenderers compiled in accordance with this Instruction or on the separate maintenance lists compiled in accordance with "Estmancode" guidance (Health Notice HN(78)147).
- (ii) Firms included on the approved list of tenderers shall ensure that when engaging, training, promoting or dismissing staff or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equal Pay Act 1970, the Sex Discrimination Act 1975, the Race Relations Act 1976, the Disabled Persons (Employment) Act 1944 and Equality Act 2010 and any amending and/or related legislation.
- (iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

c) Financial Standing and Technical Competence of Contractors

The Director of Finance may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

9. Exceptions to using approved contractors

If in the opinion of the Chief Executive and the Director of Finance or the Director with lead responsibility for clinical governance it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

Name of policy document:	
Issue No:	

EQUALITY IMPACT ASSESSMENT TEMPLATE: FRONT SHEET.

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

Please note 'policy' refers to strategy, project, commissioning, saving plan etc

Question	Response
Name of 'policy' being assessed	Standing Financial Instructions
Summary of aims and objectives of the 'policy'	The Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. The Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust.
Is this a new or existing 'policy'?	Existing
Please state which organisation is the EIA being completed for? - Derbyshire Healthcare NHS FT - Joint Derbyshire Healthcare NHS FT and Derbyshire Community Health Services - Other (please give details)	Derbyshire Healthcare NHS FT
Division/Team/Service	Trust wide
Date Stage 1 completed: Screening for Relevance:	10/07/2025
Is a Stage 2: EIA required to be completed after Stage 1? Please provide justification	No
Date Stage 2 EIA completed:	
Name/s, job title/s and contact/s details of person/s completing this assessment	Rachel Leyland, Deputy Director of Finance
Name, job title and contact details of responsible lead Director /Associate Director/Head of Service	James Sabin, Director of Finance
Has this EIA been logged in your Division/Service/Team EIA Tracker?	

Name of policy document:	
Issue No:	

EQUALITY IMPACT ASSESSMENT TEMPLATE: STAGE 1 SCREENING FOR RELEVANCE

(Please use plain English <http://www.plainenglish.co.uk/>, avoiding jargon and acronyms. EIA's are viewed by a wide range of people including decision-makers and the wider public)

Question	Response
1a: Summary of aims and objectives of the 'policy'	The Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. The Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust.
1b: Please state who this 'policy' will affect? • Patients or Service Users • Carers or families • Commissioned Services • Communities, in placed based settings • Staff - • Partners • Stakeholder organisations • Others (give details)	Staff
1c: Will the 'policy' impact equality and or inequalities? • Access to or participation in a service • Levels of representation in our workforce • Reducing quality of life (i.e., health, poverty education, standard of living)	No
1d: If there are 'no' impact on equality and or inequalities, please provide an explanation?	The nature and remit of this document means that it has no impact on equality, diversity or inclusion and therefore does not impact those with protected characteristics.
1e: If there are impacts on equality and or inequalities complete stage 2 EIA If you plan to complete the assessment at a later stage, please state the timescale for this.	

Name of policy document:	
Issue No:	

Emergency Powers of the Chair and Chief Executive

Purpose of Report

To inform the Board of the recent use of emergency powers by the Chair and Chief Executive.

Executive Summary

The Board has a mechanism for making timely decisions outside its scheduled meetings under its emergency powers, facilitating service continuity and mitigating potential, resulting risks due to delayed decision making.

The emergency powers have been used once recently as follows:

On 24 July 2026, the Chair and Chief Executive, having consulted with two Non-Executive Directors (Jo Hanley and Andrew Harkness), approved entry into the:

1. Nottinghamshire Health Informatics Service (NHIS) Service Level Agreement (SLA) recognising this presents the lower overall risk and that future service changes can be managed through formal contract variation mechanisms.
2. NHIS Partnership Agreement, noting the governance and legal considerations identified through the Trust legal advisor's review and the mitigating actions undertaken through legal negotiation and amendment.

Due to the requirement for agreements to be formally approved ahead of the NHIS Board meeting on 29 July 2026, approval was sought to use emergency powers as there was no scheduled Trust Board meeting within the required timescales. Delaying approval would risk impacting the agreed Arden and Gem Commissioning Support Unit (CSU) transition timetable, NHIS governance assurance and the organisation's ability to progress recruitment and service mobilisation activities.

Approval was subject to the assurances provided and any significant risks or issues identified in the final legal review being raised prior to the signed agreements/contract being shared with the provider.

Strategic Considerations		BAF Risk(s)	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X	3B	1.2
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X		
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X	3A	3.3
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X	3A/3B	

Risks and Assurances

Information on contractual, financial and service implications were provided in background reports.

Consultation

The arrangements for moving to the preferred provider for IT and digital services have previously been supported at Board, Finance and Performance Committee and the Executive Leadership Team.

Governance or Legal Issues

The powers which the Board has reserved to itself within its Standing Orders may in an emergency be exercised by the Chief Executive and the Chair, after having consulted at least two Non-Executive Directors (SO 6.2). The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board for noting.

Net Zero Duty Implications

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

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

The impact on net zero will be considered as part of the operational response.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

The impact on those with protected characteristics arising from the use of the emergency powers for the decision taken will be considered as part of the operational response.

Recommendations

The Board of Directors is requested to note the exercise of emergency powers by the Chair and Chief Executive as set out in the summary above.

**Report presented and
prepared by:**

**Justine Fitzjohn
Director of Corporate Affairs and Trust Secretary**

FORWARD PLAN - BOARD - 2026/27		19-May-2026	21-Jul-2026	30-Sep-2026	24-Nov-2026	26-Jan-2027	23-Mar-2027
Deadline for Approved Papers		07-May-2026	09-Jul-2026	19-Sep-2026	12-Nov-2026	14-Jan-2027	11-Mar-2027
DoCA/TS	Declarations of Interest	X	X	X	X	X	X
DoN	Patient/Board Story	X	X	X	X	X	X
CHAIR	Minutes/Matters Arising/Action Matrix	X	X	X	X	X	X
CHAIR	Board review of meeting effectiveness	X	X	X	X	X	X
CHAIR	Board Forward Plan (for information)	X	X	X	X	X	X
CHAIR	Emergency Powers of the Chair and the Chief Executive (for information, as required)			X			
CHAIR	Summary of Council of Governors meeting (for information)	X	X		X	X	
CHAIR	Chair's update	X	X	X	X	X	X
CEO	Chief Executive's update	X	X	X	X	X	X
PD, PC, JUCD	Joined Up Care Derbyshire Provider Collaborative	X			X		
OPERATIONAL PERFORMANCE							
DCEO/CDO/DoN/ DoF/DPODI	Integrated Performance report (Operations, Finance, People and Quality)	X	X	X	X	X	X
Committee Chairs	Board Committee Assurance Summaries	X	X	X	X	X	X
DCEO/CDO	Emergency Preparedness, Resilience and Response (EPRR) Core Standards			X			
DCEO/CDO	ICB Joint Forward Plan (ad hoc inclusion with CEO update)						
DoF	Medium-term Plan response (compliant with conditions; linked to activity and performance)	X					
Executive Lead	Strategy Deep Dive (4Ps - People, Productive, Patient, Partnerships)	People	Productive	Patient	Partnership		
DoF	Year-end Financial Position 2025/26	X					
Receipt of Reports (for noting following assurance at Quality and Safeguarding Committee (QSC)):							
DoN/MD	Safer Staffing annual review (QSC - Jul)			X			
QUALITY GOVERNANCE							
DoN	Assertive Outreach Treatment - Community Mental Health Action Plan update	X			X		
DoN	Fundamental Standards of Care report (CQC Domains) (six-monthly)		X			X	
MD	Medical Job Planning (annual) (PCC Jul/Jun)		X				
DoN	Outcome of Board stories (annual, Jun)		X				
DCEO/CDO	Transformation and Continuous Improvement (six-monthly)	X			X		
DCEO/CDO/MD/DoN	Winter Plan		X	X			
Receipt of Reports (for noting following assurance at People and Culture Committee (PCC)):							
MD	10 Point Plan to Improve the Lives of Resident Doctors (PCC - six-monthly Sep and Mar)				X		
MD	Guardian of Safe Working Hours report (PCC quarterly / annual report Jun Sep)	X	Deferred to Sep-2026	Deferred from Jul-2026	X	X	
MD	Medical Appraisal and Revalidation - annual report (PCC Apr)	X					
Receipt of Reports (for noting following assurance at Quality and Safeguarding Committee (QSC)):							
DoN	Delivery of Same Sex Accommodation (QSC Oct)				X		
DoN	Infection Prevention and Control annual report and IPC BAF (QSC Nov)				X		
MD	Learning from Deaths/Mortality report for approval (QSC quarterly / AR Jun)		AR		X	X	X
DoN	Looked After Children/Children in Care - annual report (QSC Sep)				X		
DoN	Quality Account (QSC sign-off Jun)		X				
MD	Research and Development (QSC six-monthly - Jul and Dec; AR Jul)			AR		X	
DoN	Safeguarding Children and Adults at Risk - annual report (QSC Sep)				X		
DoN	SEND - Special Educational Needs and Disabilities annual report (QSC May/Jun)	X					
STRATEGIC PLANNING AND CORPORATE GOVERNANCE							
DoF/DCEO/CDO/DPODI	2026/27 Plan (annual)	NHSE Feedback to Medium-Term Plan					
DoCA/TS	Annual Review of Register of Directors' Interests	X					
DoCA/TS	Board Assurance Framework update	X		X	X		X
DCEO/DCO	Clinical Digital Plan update (six-monthly)				X		
DoCA/TS	Continuation of Services Condition 7 - Provider Licence	X					
CHAIR	Fit and Proper Person Declaration		X				
FTSUG	Freedom to Speak Up Guardian report (six-monthly)			X			X
MD	Patient and Carers Race Equality Framework (six-monthly)		X			X	
DoCA/TS	Provider Capability Assessment			X			
DoCA/TS	Trust Sealings (six-monthly - for information)	X			X		
DCEO/CDO	Trust Strategic Plan (quarterly update, to include 4Ps Delivery Plans)	X	X		X	X	
Receipt of Reports (for noting following assurance at Audit and Risk Committee (ARC)):							
DoCA/TS	Year-end Governance reporting from Board Committees and approval of Terms of Reference (ToRs) (ARC Apr)	X					
Receipt of Reports (for noting following assurance at People and Culture Committee (PCC)):							
DPODI	2025/26 Flu Campaign annual report (PCC Jul-Sep)			X			
DPODI	Annual Approval of Modern Slavery Statement (PCC Apr/May, to be published on Trust website on approval)	X					
DPODI	Annual Gender Pay Gap report for approval (data for previous year reporting deadline Mar - PCC Jul)	X					
DPODI	Staff Survey results (PCC Mar)						X
DPODI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) request for Board delegated authority for People and Culture Committee meeting Sep to approve the October submissions						
DPODI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Strategic implications (retrospective sign-off on assurance at People and Culture Committee Sep)			X			
POLICY REVIEW							
DoF	Standing Financial Instructions Policy and Procedures (31-Oct-2026)			X			
CHAIR AND CHIEF EXECUTIVE EMERGENCY POWERS (for information)							
	Nottingham Health Informatics Service Level Agreement and Partnership Agreement - Sign-Off			X			

KEY**ARC****DCEO/CDO****DoCA/TS****DoF****DoN****DPODI****FTSUG****MD****PCC****PD, PC, JUCD****QSC**

Audit and Risk Committee

Deputy Chief Executive and Chief Delivery Officer

Director of Corporate Affairs and Trust Secretary

Director of Finance

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

Director of People, Organisational Development and Inclusion

Freedom to Speak Up Guardian

Medical Director

People and Culture Committee

Programme Director, Provider Collaborative, Joined Up Care Derbyshire

Quality and Safeguarding Committee

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Abbreviation	Term in Full
A	
A&E	Accident and Emergency
ABPI	Association of British Pharmaceutical Industry
ACCT	Assessment, Care in Custody & Teamwork
ACE	Adverse Childhood Experiences
AC/RC	Approved Clinician/Responsible Clinician
ADHD	Attention Deficit Hyperactivity Disorder
ADI-R	Autism Diagnostic Interview-Revised
ADOS	Autism Diagnostic Observation Schedule (assessment)
AED	Adult Eating Disorder
AED	Automated External Defibrillator
AEO	Accountable Emergency Officer
AfC	Agenda for Change
AFT	Advanced Foundation Trust
AHP	Allied Health Professional
AI	Artificial Intelligence
AIMS	Royal College of Psychiatrists Accreditation for Inpatient Mental Health Services programme
ALB	Arms-length body such as NHS Improvement (NHSI) and NHS England (NHSE)
AMaT	Audit Management and Tracking (audit/governance system (real-time reporting for clinicians, wards, audit departments and healthcare organisations))
AMM	Annual Members' Meeting
AMHP	Approved Mental Health Professional
ANP	Advanced Nurse Practitioner
ANPR	Automatic Number Plate Recognition
AO	Accountable Officer
AO	Assertive Outreach
AOVPN	AlwaysOn VPN (secure network access)
APC	Annual Physical Health
APNA NHS	Asican Professionals' National Alliance
APOM	Activity Participation Outcome Measure
ARAF	Annual risk Acknowledgement Form
ARMS	At Risk Mental State
ARRS	Additional Roles Reimbursement Scheme
ASC	Adult Social Care
ASD	Autism Spectrum Disorder
ASM	Area Service Manager
ATR	Alcohol Treatment Requirement
ATU	Acute Treatment Unit
B	
BAF	Board Assurance Framework
BAME	Black, Asian and Minority Ethnic
BCF	Better Care Fund
BCO	Building Control Officer
BCP	Business Continuity Plan
Be Seen (Psyomics)	A digital questionnaire system for service users. The tool aims to improve patient experience, help clinicians identify needs earlier, and support more efficient care pathways.
BI	Business Intelligence
BIA	Business Impact Analysis

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Abbreviation	Term in Full
BLS	Basic Life Support (ILS Immediate Life Support)
BMA	British Medical Association
BILD	British Institute of Learning Disabilities
BME	Black and Minority Ethnic group
BoD	Board of Directors
BPD	Borderline Personality Disorder
BPPC	Better Payment Practice Code
C	
CAARMS	Comprehensive Assessment of At-Risk Mental States
CAD	Community Action Derby
CANSAS	Camberwell Assessment of Need Short Appraisal Schedule
CAMHS	Child and Adolescent Mental Health Services
CASSH	Care and Support Specialised Housing
CBT	Cognitive Behavioural Therapy
CBRN	Chemical, Biological, Radiological and Nuclear
CCG	Clinical Commissioning Group (defunct from 1 July 2022)
CCCG	Collaborative Commissioning and Contracting Group (East Midlands Alliance)
CCQI	College Centre for Quality Improvement
CCT	Community Care Team
CDEL	Capital Departmental Expenditure Limit
CD-LIN	Controlled Drug Local Intelligence Network
C.DIFF	Clostridioides difficile
CDM	Construction Design and Management
CDMI	Clinical Digital Maturity Index
CE	Chief Executive
CEO	Chief Executive Officer
CER	Clinical Establishment Review
CERT	Community Enhanced Rehabilitation team
CESR	Certificate of Eligibility for Specialist Registration
CETR	Care, Education and Treatment Review
CFFSR	Counter Fraud Functional Standard Return
CGA	Comprehensive Geriatric Assessment
CGL	Change Grow Live
CHANNEL	Confidential, voluntary, multi-agency safeguarding programme that provides early intervention to protect vulnerable children and adults who might be susceptible to being radicalised
CHIME	Connectedness, Hope, Identity, Meaning, Empowerment recovery
CHPPD	Care Hours Per Patient Day
CIC	Children in Care
CIN	Children in Need
CIP	Cost Improvement Programme
CMDG	Contract Management Delivery Group
CMHF	Community Mental Health Framework
CMHT	Community Mental Health Team
CMO	Chief Medical Officer
CNST	Clinical Negligence Scheme for Trusts
COAT	Clinical Operational Assurance Team
COD	Cause of Death
COF	Commissioning Outcomes Framework
CoG	Council of Governors
COO	Chief Operating Officer
CP	Child Protection

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Abbreviation	Term in Full
CPA	Care Programme Approach
CPD	Continuing Professional Development
CPN	Community Psychiatric Nurse
CPR	Child Protection Register
CPRG	Clinical Professional Reference Group
CQC	Care Quality Commission
CQI	Clinical Quality Indicator
CQRG	Clinical Quality Review Group
CQUIN	Commissioning for Quality and Innovation
CRD	Clinically Ready for Discharge
CRG	Clinical Reference Group
CRH	Chesterfield Royal Hospital
CRHT	Crisis Resolution and Home Treatment
CROMS	Clinician Reported Outcome Measures
CRR	Case Record Reviews
CRS	(NHS) Care Records Service
CRS	Commissioner Requested Services
CSC	Commonwealth Scholarship Commission
CSDS	Community Services Data Set
CS	Clinical Supervisor
CSF	Commissioner Sustainability Fund
CSPR	Child Safeguarding Practice Review
CSTF	Core Skills Training Framework
CSU	Commissioning Support Unit
CT	Counter Terrorism
CTO	Community Treatment Order
CTR	Care and Treatment Review
CUF	Cost Uplift Factor
CYP	Children and Young People
D	
DAG	Divisional Assurance Group
DAR	Divisional Assurance Review
DARD	Drugs and Alcohol Related Deaths
DASP	Drug and Alcohol Strategic Partnership
DAT	Drug Action Team
Datix	Trust's electronic incident reporting system of an event that causes a loss, injury or a near miss to a patient, staff or others
DBS	Disclosure and Barring Service
DBT	Dialectical Behavioural Therapy
DDME	Deputy Director of Medical Education
DfE	Department for Education
DCHS	Derbyshire Community Health Services NHS Foundation Trust
DCO	Designated Clinical Officer
DDCCG	Derby and Derbyshire Clinical Commissioning Group
DDSAB	Derby and Derbyshire Safeguarding Adult Board
DDSC	Designated Doctor Safeguarding Children
DDSCB	Derby and Derbyshire Safeguarding Children Board
DDSCP	Derby and Derbyshire Safeguarding Children Partnership
DEED	Delivering Excellence Every Day
DHcFT	Derbyshire Healthcare NHS Foundation Trust
DHR	Domestic Homicide Review
DHSC	Department of Health and Social Care

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Abbreviation	Term in Full
DISCO	Diagnostic Interview for Social and Communication Disorders (assessment)
DIT	Dynamic Interpersonal Therapy
DLN Cluster	Derbyshire, Lincolnshire, Nottinghamshire Cluster
DME	Director of Medical Education
DNA	Did Not Attend
DoC	Duty of Candour
DoF	Director of Finance
DoH	Department of Health
DoL	Deprivation of Liberty
DoLS	Deprivation of Liberty Safeguards
DoN	Director of Nursing
DPA	Data Protection Act
DPI	Director of People and Inclusion
DPIA	Data Protection Impact Assessment
DPR	Divisional Performance Review
DPS	Data Protection and Security
DQMI	Data Quality Maturity Index
DRP	Derbyshire Resilience Partnership
DRR	Drug Rehabilitation Requirement
DRRT	Dementia Rapid Response Team
DSCRO	Data Services for Commissioners Regional Offices
DSFS	Derbyshire Support and Facilities Services
DS&P	Data Security and Protection
DSPT	Director of Strategy, Partnerships and Transformation
DTOC	Delayed Transfer of Care
DV	Domestic Violence
DVA	Derbyshire Voluntary Action (formerly North Derbyshire Voluntary Action)
DWP	Department for Work and Pensions
E	
EAP	Employee Assistance Programme
EbE	Expert by Experience
ECT	Enhanced Care Team
ECT	Electroconvulsive Therapy
ECW	Enhanced Care Ward
ED	Emergency Department
EDS2	Equality Delivery System 2
EHA	Early Help Assessment
EHCP	Education, Health and Care Plan
EHIC	European Health Insurance Card
EHR	Electronic Health Record
EI	Early Intervention
EIA	Equality Impact Assessment
EIP	Early Intervention In Psychosis
EIS	Early Intervention Service
e-LfH	e-Learning for Healthcare
ELT	Executive Leadership Team
EMDR	Eye Movement Desensitising and Reprocessing Therapy
EMPH	East Midlands Provider Collaborative
EMR	Electronic Medical Record
EPC	Energy Performance Certificate
EPMA	Electronic Prescribing and Medicine Administration
ePMO	Electronic Programme Management Office

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Abbreviation	Term in Full
EQIA	Equality Impact Assessment
EPR	Electronic Patient Record
EPRR	Emergency Preparedness, Resilience and Response
ERIC	Estates Return Information Collection
ESF	Estates Safety Fund
ESR	Electronic Staff Record
ETOC	Enhanced Therapeutic Observation and Care
ETP	Electronic Transfer of Prescriptions
EUPD	Emotionally Unstable Personality Disorder
EWTD	European Working Time Directive
F	
FBC	Full Business Case
FCMHT	Forensic Community Mental Health
FDP	Federated Data Platform
FFP3	Type of face mask for infection, prevention and control (IPC)
FFT	Friends and Family Test
FGM	Female Genital Mutilation
FIG	Feedback Intelligence Group
FOI	Freedom of Information
FOT	Forecast Out-Turn
F&P	Finance and Performance
FReM	Government Financial Reporting Manual
FSR	Full Service Record
FT	Foundation Trust
FT ARM	Foundation Trust Annual Reporting Manual
FTE	Full-time Equivalent
FTN	Foundation Trust Network
FTSU	Freedom to Speak Up
FTSUG	Freedom to Speak Up Guardian
FWS	Future NHS Workforce Solution
FYE	Full Year Effect or Financial Year End
5YFV	Five Year Forward View
G	
GAM	Group Accounting Manual
GBO	Goal Based Outcome
GDPR	General Data Protection Regulation
GGI	Good Governance Institute
GIRFT	Getting it Right First Time
GMC	General Medical Council
GMP	Guaranteed Maximum Price
GoSWH	Guardian of Safe Working Hours
GP	General Practitioner
GPFV	General Practice Forward View
H	
HACT	Housing Association Charitable Trust
HBPoS	Health Based Places of Safety
HCA	Healthcare Assistant
HCAI	Healthcare Associated Infection
HCHS	Hospital and Community Health Services (NHS)
HCID	Highly Communicable Infectious Disease
HCP	Healthy Child Programme

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Abbreviation	Term in Full
H1	First half of a fiscal year (April through September)
H2	Second half of a fiscal year (October through the following March)
HEE	Health Education England
Heidi Health	AI-powered documentation tool that listens to consultations and generates clinical notes, letters, and other records
HES	Hospital Episode Statistics
HFMA	Healthcare Financial Management Association
HIEM	Health Innovation East Midlands
HoNOS	Health of the Nation Outcome Scores
HoP	Head of Practice
HOPE(s)	The HOPE(s) model is an ambitious human rights-based approach to working with individuals in segregation, developed from research and clinical practice
HSCIC	Health and Social Care Information Centre
HSE	Health and Safety Executive
HSSC	Health and Safety Security Committee
HST	Higher Specialty Training
HV	Health Visitor
HWB	Health and Wellbeing Board
I	
I&E	Income and Expenditure
IAPT	Improving Access to Psychological Therapies
Icare	Increase Confidence, Attract, Retain, Educate
ICB	Integrated Care Board
iCIMS	Internet Collaborative Information Management System
ICM	Insertable Cardiac Monitor
ICO	Information Commissioner's Office
ICS	Integrated Care System
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IDVAs	Independent Domestic Violence Advisors
IFRS	International Financial Reporting Standards
IHR	Ill-Health Retirement
IIC	Inclusive Inter-cultural Communication
IG	Information Governance
ILS	Immediate Life Support (BLS – Basic Life Support)
IMHA	Independent Mental Health Advocacy
ImmForm	UKHSA ImmForm system – used to order medical products and collect vaccine uptake data
IMST	Information Management Systems and Technology
IMT	Incident Management Team
IMT&R	Information Management, Technology and Records
INQUEST	Official, public inquiry to discover the facts about a death. An inquest is conducted by a coroner to determine who the deceased was, and how, when, and where they died, especially in cases of sudden, violent, or unexplained deaths
IPC SAG	Infection Prevention and Control Strategic Action Group
IPP	Imprisonment for Public Protection
IPR	Integrated Performance Report
IPS	Individual Placement and Support
IPT	Interpersonal Psychotherapy
IQVIA	I (for IMS Health), Q (for Quintiles) and VIA (meaning 'by way of')
IRG	Incident Review Group
IRHTT	In-reach Home Treatment Team

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Abbreviation	Term in Full
IRT	Incident Review Tool
J	
JCVI	Joint Committee on Vaccination and Immunisation
JDF	Junior Doctor Forum
JLNC	Joint Local Negotiating Committee
JNCC	Joint Negotiating Consultative Committee
JTAI	Joint Targeted Area Inspections
JUCB	Joined Up Care Board
JUCD	Joined Up Care Derbyshire
K	
KLOE	Key Lines of Enquiry (CQC)
KPI	Key Performance Indicator
KSF	Knowledge and Skills Framework
L	
LA	Local Authority
LAC	Looked After Children
LCFS	Local Counter Fraud Specialist
LA – CYPD	Local Authority – Children and Young People Divisions
LADO	Local Authority Designated Officer
LCSPR	Local Child Safeguarding Practice Review
LD	Learning Disabilities
LD/A	Learning Disability and Autism
LeDeR	Learning Disabilities Mortality Review
LFPSE	Learning from Patient Safety Events
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender and Queer or Questioning, Intersex, Asexual
LHP	Local Health Plan
LHRP	Local Health Resilience Partnership
LHWB	Local Health and Wellbeing Board
LNC	Local Negotiating Committee
LOS	Length of Stay
LPS	Liberty Protection Safeguards
LSU	Long-Term Service Use
LTFT	Less Than Full-Time
LTP	Long Term Plan
LTS	Long Term Segregation
LTWP	Long Term Workforce Plan
LWSTO	Living Well Short-Term Offer
M	
M&E	Mechanical and Electrical
MADE	Multi-agency Discharge Event
MAPPA	Multi-agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference (meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors)
MARS	Mutually Agreed Resignation Scheme
MAS	Memory Assessment Service
MASH	Multi-Agency Safeguarding Hub
MaST	Management and Supervision Tool

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Abbreviation	Term in Full
MAU	Medical Assessment Unit
MBRACCE	Mothers and Babies: Reducing Risk through Audits and confidential Enquiries
MBU	Mother and Baby Unit
MCA	Mental Capacity Act
MCC	Medicine Clinical Committee
MCCD	Medical Certificate of Cause of Death
MD	Medical Director
MDA	Medical Device Alert
MDM	Multi-Disciplinary Meeting
MDR	Medical Device Regulation
MDSO	Medical Device Safety Officer
MDT	Multi-Disciplinary Team
Men-SAT	Mental Health Services Assessment Tool
MFA	Multi-Factor Authentication
MFF	Market Forces Factor
MHA	Mental Health Act
MHAC	Mental Health Act Committee
MHIN	Mental Health Intelligence Network
MHIS	Mental Health Investment Standard
MHLDA	Mental Health, Learning Disabilities and Autism
MHLT	Mental Health Liaison Team
MHOST	Mental Health Optimal Staffing Tool
MHPS	Maintaining High Professional Standards
MHRA	Medical and Healthcare products Regulatory Agency
MHRT	Mental Health Review Tribunal
MHRV	Mental Health Response Vehicle
MHSDS	Mental Health Services Data Set
MHUAC	Mental Health Urgent Assessment Centre
MiCAD	Reporting system for medical device service and repair
MIND	The leading mental health charity in England and Wales
MMaSP	Medicine Management Safety and Practice
MMC	Medicine Management Committee
MOC	Medicine Optimisation Committee
MoSCoW	Must have, Should have, Could have and Won't have (methodology)
MoU	Memorandum of Understanding
MPAC	Multi-Professional Approved Clinician
MRSA	Methicillin-resistant Staphylococcus aureus
MSC	Medical Staff Committee
MSK	Musculoskeletal (conditions)
MSP	Medicines Safety and Practice
MST	Multisystemic Therapy
MSU	Medium Secure Unit
MTFP	Medium-Term Financial Plan
N	
NAI	Non-Accidental Injury
NCISH	National Confidential Inquiry into Suicide and Safety
NCRS	National Cancer Registration Service
ND	Neuro-development
ND	Neurodiversity
NECS	North of England Care System Support
NED	Non-Executive Director
NETS	National Educational Training Survey

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Abbreviation	Term in Full
NEWS	National Early Warning Score (standard medical tool used across UK healthcare to track patient vital signs and spot signs of sudden worsening health)
NFI	National Fraud Initiative
NGO	National Guardian's Office
NHIS	Nottingham Health Informatics Service
NHS	National Health Service
NHSC	NHS Confederation
NHSCFA	NHS Counter Fraud Authority
NHSE	National Health Service England
NHSI	National Health Service Improvement
NHSEI	NHS England and NHS Improvement
NHSP	NHS Providers
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NIMS	National Immunisation Management System
NIMS	National Incident Management System
NIVS	National Immunisation and Vaccination System
NOF	NHS Oversight Framework
NPS	National Probation Service
NPSA	National Patient Safety Alert
NQB	National Quality Board
NR	Non-Recurrent
NRLS	National Reporting and Learning System
NROC	Non-Resident On-Call
O	
OBC	Outline Business Case
OBD	Occupied Bed Days
ODG	Operational Delivery Group
OoA	Outside of Area
OPMO	Older People's Mental Health Services
OP	Outpatient
OPEL	Operational Pressures Escalation Levels Framework
OSC	Overview and Scrutiny Committee
OSCE	Objective Structured Clinical Examination
OT	Occupational Therapy
P	
PAB	Programme Assurance Board
PAC	Personal Accountability Charter
PAG	Programme Advisory Group
PALS	Patient Advice and Liaison Service
PAM	Payment Activity Matrix
PARC	Psychosis and the reduction of cannabis (and other drugs)
PARIS	This is an electronic patient record system
PbR	Payment by Results
PCC	Police & Crime Commissioner
PCC	People and Culture Committee
PCF	Personalised Care Framework
PCLB	Provider Collaborative Leadership Board
PCN	Primary Care Networks
PCOG	Patient and Carer Operational Group
PCREF	Patient and Carers Race Equality Framework

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Abbreviation	Term in Full
PDC	Public Dividend Capital
PDF	Portable Document Format
PDSA	Plan, Do, Study, Act
PET	Psychiatric Emergency Team
PFI	Private Finance Initiative
PFF	Probation Feedback Form
PFR	Provider Finance Return
PGD	Patient Group Direction
PHC	Public Health Commissioners
PHCIC	Physical Healthcare and Infection Control Committee
PHE	Public Health England
PHE	Physical Health Equipment
PHSCC	Population Health and Strategic Commissioning Committee
PHSMI	Physical Health Serious Mental Illness
PHSO	Parliamentary and Health Service Ombudsman
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PIPoT	Persons in a Position of Trust
PJF	Professional Judgement Framework
PKB	Patients Know Best (a secure patient portal that allows people to access information about their care and communicate digitally with healthcare services)
PLACE	Patient-Led Assessments of the Care Environment
PLIC	Patient Level Information Costs
PMF	Performance Management Framework
PMH	Perinatal Mental Health
PMLD	Profound and Multiple Disability
PMO	Project Management Office
PNA	Professional Nurse Advocate
PODGG	Programme Oversight and Delivery Group
PPE	Personal Protection Equipment
PPI	Patient and Public Involvement
PPN	Public Protection Notice
PPT	Partnership and Pathway Team
PQN	Perinatal Quality Network
PREM	Patient Reported Experience Measure
PRN	Prescribed as necessary / Pro re nata
PROMS	Patient Reported Outcome Measures
PSED	Public Sector Equality Duty
PSF	Provider Sustainability Fund
PSII	Patient Safety Incident Investigations
PSIRF	Patient Safety Incident Response Framework
PSIRP	Patient Safety Incident Response Plan
PSQG	Patient Safety and Quality Group
PSR	Provider Selection Regime
PTU	Psychiatry Teaching Unit
PYE	Part Year Effect
Q	
QAG	Quality Assurance Group
QASI	Quality Assurance Serious Incidents
Q&SC	Quality and Safeguarding Committee
QEIA	Quality and Equality Impact Assessment
QIA	Quality Impact Assessment

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Abbreviation	Term in Full
QIPP	Quality, Innovation, Productivity Programme
QNCC	Quality Network for Community CAMHS
QOF	Quality and Outcomes Framework
QSIR	Quality, Service Improvement and Redesign
R	
RAID	Rapid Assessment, Interface and Discharge
RAP	Recovery Action Plan
RAVS	Record a Vaccination Service
RCGP	Royal College of General Practitioners
RCI	Reference Cost Index
RDF	Resident Doctor Forum
RDOG	Research and Development Operational Group
REGARDS	Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation
ReQoL	Recovering Quality of Life
RFI	Request for Information
ROAG	Responsible Officer Advisory Group
RoDP	Recognition of Deteriorating Patient
ROM	Reported Outcome Measure
RPOG	Restrictive Practice Oversight Group
RRN	Restraint Reduction Network
RRP	Recruitment Retention Proposal
RSD	Rejection Sensitive Dysphoria
RSV	Respiratory Syncytial Virus
RTS	Real Time Surveillance
RTT	Referral to Treatment
S	
s132	Section 132 of the Mental Health Act: As soon as a patient is detained under the Act the patient must be given their rights orally and in writing unless it is not practicable at that time. If this is the case, it must be documented in the patient's electronic care record
s136	Section 136 of the Mental Health Act: Police can use emergency powers if they think you have a mental disorder, you're in a public place and need immediate help. They can take you or keep you in a place of safety, where your mental health will be assessed.
SAAF	Safeguarding Adults Assurance Framework
SAB	Safeguarding Adults Board
SAF	Single Assessment Framework
SAM	Self-Administered Medication
SAR	Safeguarding Adult Review
SAS Doctor	Specialist, Associate Specialist and Specialty Doctor
SAT	Specialist Autism Team
SBARD	Situation, Background, Assessment, Recommendation and Decision (SBARD) tool
SBS	Shared Business Services
SCPHN	Specialist Community Public Health Nurse
SEIPS	Systems Engineering Initiative for Patient Safety
SEND	Special Educational Needs and Disabilities
SFI	Standing Financial Instructions
SI	Serious Incidents
SIG	Serious Incident Group
SID	Senior Independent Director
SIDS	Sudden Infant Death Syndrome

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Abbreviation	Term in Full
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement
SLaM	South London and Maudsley NHS Trust
SLR	Service Line Reporting
SLRDE	Senior Lead for Resident Doctor Experience
SMI	Severe Mental Illness
SNOMED CT	Systemised Nomenclature of Medicine – Clinical Terms
SOAD	Second Opinion Appointed Doctor
SoBS	Survivors of Bereaved by Suicide
SOC	Strategic Options Case
SOF	Single Operating Framework
SoCI	Statement of Comprehensive Income
SO	Standing Order
SOP	Standard Operating Procedure
SPBP	Strategic Business Partner
SPF	Social Partnership Forum
SPOA or SPA	Single Point of Access
SPOE	Single Point of Entry
SPOG	Strategic Portfolio Oversight Group
SPOR	Single Point of Referral
SSQD	Specialised Services Quality Dashboards
SSRB	Senior Salaries Review Board
STEIS	Strategic Executive Information System
STAH	St Andrew's House
StEIS	Strategic Executive Information System
STF	Sustainability and Transformation Fund
STOMP/STAMP	Stopping The Over-Medication of children and young People with a learning disability, autism or both / Supporting Treatment and Appropriate Medication in Paediatrics
STP	Sustainability and Transformation Partnership
SUI	Serious (Untoward) Incident
SW	Social Worker
SWARM	A swarm is a rapid learning response immediately following an adverse patient safety incident or "near miss", where a diverse team of medical professionals converges to handle a specific task simultaneously
SWW	Support While Waiting
SystemOne	Electronic patient record system
T	
10YHP	10-Year Health Plan
TAV	Team Around the Family
TARN	Trauma Audit and Research Network
TBT	Tobacco Dependence Team
TCP	Transforming Care Partnerships
TCS	Transforming Community Services
TDA	Trust Development Authority
TDG	Trust Delivery Group
TDT	Tobacco Dependence Team
Thalamos	Digital platform designed to streamline Mental Health Act processes by replacing paper-based workflows
TIC	Trauma Informed Care
TLT	Trust Leadership Team
TMAC	Trust Medical Advisory Committee (now Medical Senate)

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Abbreviation	Term in Full
TMT	Trust Management Team
TMTC	Trust Medical Training Committee
TOIL	Time Off In Lieu
TOOL	Trust Operational Oversight Leadership
ToRs	Terms of Reference
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
U	
UHDB	University Hospitals of Derby and Burton
UEC	Urgent and Emergency Care
V	
VARM	Vulnerable Adult Risk Management
VCOD	Vaccination as a Condition of Deployment
VCP	Vacancy Control Panel
VCSE	Voluntary, Community and Social Enterprise organisations
VdTMoCA	Vona du Toit Model of Creative Ability (<i>a practical guide for Acute Mental Health Occupational Therapy Practice</i>)
VfM	Value For Money
VO	Vertical Observatory
VTE	Venous Thromboembolism
VUCA	Volatility, Uncertainty, Complexity, Ambiguity
W	
WAP	Wireless Application Protocol
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent
Y	
YP	Young Person
YTD	Year to Date

22 September 2026