Derbyshire Healthcare NHS Foundation Trust

Public Trust Board Meeting

27 January 2026

Conference Rooms A and B

Research and Development Centre Kingsway Derby DE22 3LZ

Meeting Book - Public Trust Board Meeting - 2026-01-27

Contents and Page Numbers

Public Board Meeting

Agenda

Date: Tuesday, 27 January 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 2025/26	Selina Ullah
2	9.35	Board Story - Transforming Lives through CBT Psychotherapy in Secondary Care – Our Journey in Derbyshire - CBT Service Development	Tumi Banda
3	10.00	Minutes of the Board of Directors meeting held on 25 November 2025	Selina Ullah
4		Action Matrix and Matters Arising	
5		Questions from members of the public	
6	10.05	Chair's update - verbal	Selina Ullah
7	10.15	Chief Executive's update	Vikki Ashton Taylor
OPERATIONAL PERFORMANCE			
8	10.25	Integrated Performance report, including Operations, Finance, People and Quality *Note: Committee Chairs to contribute feedback as appropriate from the Board Assurance summaries*	Vikki Ashton Taylor/ James Sabin/Rebecca Oakley/Tumi Banda
BREAK 11.00am			
QUALITY GOVERNANCE			
9	11.10	Fundamental Standards of Care report (CQC Domains)	Tumi Banda
STRATEGIC PLANNING AND CORPORATE GOVERNANCE			
10	11.20	Patient and Carers Race Equality Framework (PCREF) (annual)	Girish Kunigiri
11	11.30	Trust Strategic Plan update (quarterly)	Vikki Ashton Taylor
12	11.40	Board Committee Assurance Summaries	Committee Chairs
REPORT FOR NOTING FOLLOWING ASSURANCE AT THE QUALITY AND SAFEGUARDING COMMITTEE			
13	12.05	Assertive Outreach Community Health Treatment – Action Plan update	Lynn Andrews
CLOSING BUSINESS			
14	12.15	Consideration of any items affecting the Board Assurance Framework (BAF)	Selina Ullah
15		Meeting effectiveness	

FOR INFORMATION
Forward Plans 2025/26 and 2026/27 Glossary of NHS Acronyms Summary of Council of Governors meeting held 25 November 2025

Next meeting:

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

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

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

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

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

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

Strategy on a page

Derbyshire Healthcare
NHS Foundation Trust

We make a positive difference in everything we do

Our vision

Our strategic priorities

Patient focus

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

Caring

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

Inclusive

We respect and include everyone in all we do.

Partnerships

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

Ambitious

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

WE MAKE A POSITIVE DIFFERENCE • IN EVERYTHING WE DO •

Belonging

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

People

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

Collaborative

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

Productive

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

Our values

Find out more

derbyshirehealthcareft.nhs.uk/about-us/strategy

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

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

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

Derbyshire Healthcare NHS Foundation Trust

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, 25 November 2025

MEETING HELD IN PUBLIC

Commenced: 9.30am Closed: 12.27pm

PRESENT	Lynn Andrews	Deputy Trust Chair (Chair)
	Ralph Knibbs	Senior Independent Director
	Deborah Good	Non-Executive Director
	Jo Hanley	Non-Executive Director
	Andrew Harkness	Non-Executive Director
	Geoff Lewins	Non-Executive Director
	Mark Powell	Chief Executive
	Vikki Ashton Taylor	Deputy Chief Executive and Chief Delivery Officer
	Tumi Banda	Director of Nursing, Allied Health Professions (AHP), Quality and Patient Experience
	Justine Fitzjohn	Director of Corporate Affairs and Trust Secretary
	Dr Girish Kunigiri	Medical Director
	Rebecca Oakley	Director of People, Organisational Development and Inclusion
	James Sabin	Director of Finance
IN ATTENDANCE	Chioma Akpom	Designate Non-Executive Director
	Jo Bradbury	Corporate Governance Officer
DHCFT/2025/093	Becki Priest	Chief AHP and Deputy Director of Patient Experience
DHCFT/2025/093	Rosie	Guest for Board Story
APOLOGIES	Selina Ullah	Trust Chair
OBSERVERS	Dave Allen	Public Governor, Chesterfield
	Greg Taylor	Clinical Lead, Older Adult Inpatient

DHCFT/ 2025/091	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** In the absence of Selina Ullah, Trust Chair, Lynn Andrews, Deputy Chair, welcomed Board colleagues and observers to the meeting. There were no declarations of interest raised with any of today's agenda items and the current Declarations of Interest Register was noted.
DHCFT/ 2025/092	**BOARD STORY** The Board welcomed Rosie, to share her experience of suicide prevention initiatives, linking into the new Suicide and Self-Harm Prevention Plan included on today's agenda. Rosie gave a powerful, lived experience story about the mental health difficulties she had experienced since her childhood, which escalated into adulthood when she experienced the loss of two people close to her and could no longer keep herself safe.

	At this point, Rosie had received support from one of the Trust's Acute Inpatient units, which she identified as a key turning point in her life, describing the unit as a place that could make a significant difference to herself and others in similar circumstances. Following her personal experience and individual recovery, Rosie has chosen to retrain as a Mental Health Nurse. She is now two years into her course and enjoying the new career path. The Board discussed the value of people with lived experience of Mental Health services in supporting others. Rosie shared a number of examples of how clinicians can help patients to open up. These included the importance of building rapport and preparation for ward rounds. It was noted that this approach would help to break down the traditional barriers between staff and patients. It was agreed that more immersive, scenario-based training for staff would be beneficial, especially around mental health and neurodiversity. Mark Powell, Chief Executive, advised that he and Tumi Banda, Director of Nursing, AHPs, Quality and Patient Experience, are involved in the development of the university programme and would promote the inclusion of work based, role play scenarios. Reflecting on the confidence with which Rosie had spoken, along with the manner in which she had responded to questions, Lynn stated her admiration and appreciation for today's attendance. **RESOLVED: The Board of Directors was greatly inspired by Rosie's presentation and noted her recommendations to improve patient experience.**
DHCFT/ 2025/093	**MINUTES OF THE LAST BOARD OF DIRECTORS MEETING** The draft minutes of the previous meeting held on 23 September 2025 were accepted as a correct record of the meeting.
DHCFT/ 2025/094	**MATTERS ARISING** There were no matters arising.
DHCFT/ 2025/095	**QUESTIONS FROM MEMBERS OF THE PUBLIC** No questions had been received.
DHCFT/ 2025/096	**CHAIR'S UPDATE** Presenting Selina's report, Lynn highlighted a range of different engagement events that had taken place over recent months, including meeting the Trust's Psychology team and the official openings of both the Derwent Unit, Carsington Unit, Audrey House and Kingfisher House. The Annual Members Meeting (AMM) and HEARTS awards had also taken place in October, with a high number of Trust staff receiving nominations for this year's APNA (Asian Professionals National Alliance) NHS awards. The Trust's anti-racism statement was referenced, following its finalisation at the Board Strategy and Development Session in October. It was noted that reported racism incidents are now measured within the Integrated Performance Report to underpin accountability. Lynn gave her own experiences of shadowing the Trust's Neurodivergence team undertaking a Fundamental Standards quality visit and a Board visit to the Patient Experience team. Dr Girish Kunigiri was welcomed to his first meeting of the Board of Directors, since commencing in post as the Trust's new Medical Director in October. The Board thanked Geoff Lewins, Non-Executive Director, who was stepping down from his role as Non-Executive Director, following eight years in post and welcomed Chioma Akpom, Designate Non-Executive Director, who would be joining the Board from 1 December in the substantive role. **RESOLVED: The Board of Directors noted the updates.**

DHCFT/ 2025/097	**CHIEF EXECUTIVE'S UPDATE** The report covered local issues and national developments. Mark Powell highlighted the new NHS medium-term planning framework. He explained the implications and the clear focus on financial plans, financial discipline, waiting times, access and quality of care with associated productivity requirements. The first submission is required by 18 December, with further submissions through January and February 2026. It was noted that Mark had represented mental health services at the recent first Board meeting of the new Derbyshire, Lincolnshire and Nottinghamshire Integrated Care Board (ICB) cluster. The Board congratulated the Kedleston Unit team for their recent 'good' rating from the Care Quality Commission (CQC) and those involved in a CQC monitoring visit under Section 120 of the Mental Health Act in October. Mark shared the Board's disappointment that the Trust had been unsuccessful in recent bids to continue provision of Substance Misuse services for adults, children and young people in Derby. The Trust has a long and positive history of providing local Substance Misuse services and the public health commissioners intend for the services to transfer to two charity sector organisations (Cranstoun and Change Grow Live services) from April 2026. Following a recent visit to the Substance Misuse team, Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary, had been accompanied by a Divisional People Lead, who had been able to offer one to one support to listen to colleagues' concerns around the forthcoming transfer. Lynn highlighted the importance for the Trust to ensure transfers such as this are managed well. Changes to the Trust's operating model came into effect this week, with the creation of two new Divisions, with five care groups. Mark explained that the model delivers a new triumvirate leadership and management approach to support the delivery of the priorities outlined in the new Trust Strategy. The report also highlighted a number of team and colleague successes since the last meeting, including Selina being named by the Health Service Journal (HSJ) as one of the 50 most influential Black, Asian and minority ethnic people in health. Consultant Psychiatrist, Dr Subodh Dave, was also named a Rising Star for his work with the Royal College of Psychiatrists and Doctors in Distress. Girish and Chioma were formally welcomed and Mark extended sincere gratitude to Geoff, noting that this would be his last Board meeting with the Trust. He stated that working with Geoff had been a pleasure, a privilege and great fun. **RESOLVED: The Board of Directors noted the update.**
DHCFT/ 2025/098	**INTEGRATED PERFORMANCE REPORT (IPR)** The report provided a high-level view of performance against a number of Operational, Financial, People and Quality metrics and provided assurance regarding actions being taken to improve performance. Operations Vikki Ashton Taylor, Deputy Chief Executive and Chief Delivery Officer, highlighted two areas of significant improvement which were; the waiting times to access Early Intervention in Psychosis services, with people receiving support in a timely manner and a significant increase in the percentage of people receiving crisis support within 24 hours of contacting the team. It was noted that the average length of stay remains slightly above average (over 60 days), with 25% of inpatients clinically ready for discharge and delays experienced due to housing and wider

social care needs. Vikki said the target is to improve to 52 days, for which a closely monitored recovery action plan is in place.

From an operational perspective, Vikki stated her confidence around some of the improving areas and was optimistic that the Trust would move to National Oversight Framework (NOF) Segment 3 in Q3, with the caveat this would depend on comparison to other organisations' improvements. James Sabin, Director of Finance, pointed out that any provider that is off-plan will automatically be placed in NOF 3 or 4 and that by default, another provider has to move up.

In reference to the Mental Health Helpline, Geoff enquired if there was an update on deactivation of the '0800' number in favour of the '111' press 2 option. It was noted that a timeline is being agreed with the ICB with consideration given to ensure there is no detrimental effect on the other areas of crisis support.

Due to staff sickness absence, the number of autism spectrum disorder (ASD) assessments had dropped, however, the total number remained above the level the Trust is commissioned to deliver. Reflecting on the current financial position, Jo Hanley, Non-Executive Director, cautioned this may not be sustainable moving forward.

Finance

James confirmed that as at month six (September) the Trust was slightly ahead of its cost improvement programme (CIP) and remains on plan to achieve this by the end of the financial year. Whilst no major risks were evident, James advised the challenges included expenditure on Adult Acute out of area placements and bank and agency usage.

James anticipated that a differential CIP would be imposed next year, particularly for those organisations furthest away from plan. Although there was no expectation at present, those providers that are achieving may be asked to contribute to those that aren't. Mark stressed that any such requests would require a Board discussion.

People

A recent increase in sickness absence reflected slightly higher levels than expected, with coughs, colds, flu, stress, anxiety and depression being the main reasons recorded by staff. Rebecca Oakley, Director of People, Organisational Development and Inclusion, advised that a review of the Sickness Absence Policy is underway. It was noted that a deep dive on Attendance and Absence was to be presented to the People and Culture Committee in January to indicate the level of control and the best way forward. Rebecca added that the national ambition is to set the target at 4.1%, noting that Trust compliance in October is c6%.

In response to a query from Deborah Good, Non-Executive Director, around support for managers to undertake difficult conversations, Rebecca confirmed engagement is taking place with the new triumvirate leadership to drive accountability. She added that the costs related to absence are also being shared to highlight the impact.

Referring to last year's attendance level (4.9%), Girish asked if the new operating model had impacted the recent upturn. However, Rebecca suspected the spike was due to increased cases of colds and flu and a further rise was not expected. It was confirmed that take up of the flu vaccination was c35%, which was comparative with other non-Acute trusts.

Some improvements had been made in the recording of annual appraisals and managerial/clinical supervision and more work is planned to focus on these areas. Although there were some positive aspects, such as agency/bank usage and appraisals, Geoff remained concerned that Supervision seemed inert. The lack of trajectory was attributed to incorrect data and Rebecca confirmed that work is underway to ensure the new structure is correctly mapped in ESR (electronic staff record).

Thanks were extended to those who had encouraged colleagues to complete the Staff Survey, noting the current response rate of 61.3%.

	Drawing attention to annual turnover (10%), Mark observed the limitations this presented in terms of workforce flexibility and cost reduction, due to the inability to redesign roles from staff leaving the Trust. Lynn emphasised the need to retain the large proportion of the workforce that is made up of Nursing and indicated that balance is required. <u>Quality</u> Tumi reported improvements in care planning and reduction in absconsions. However it was noted that challenges persist with restrictive practices, falls, incidents of moderate/catastrophic harm, medication incidents (including storage issues) and a rise in the number of complaints being received. Some fluctuations were expected following the opening of the new Acute units and the high volume of new staff, including recently qualified Nurses, for which the data is being monitored. A decrease in the use of bank and agency staff had been achieved, in line with national expectations. Due to the improved environment, James questioned the level of incidents and challenged whether the targets should be revisited. Tumi pointed out that a review is underway to reflect the sensory inputs within the Psychiatric Intensive Care Unit. However, the increase in falls was attributed to frailty and improved reporting, rather than the environment. The Board discussed the related factors affecting the indicators, including the changed Model of Care, staffing numbers, skills mix and the different set of services now being offered. The increased number of seclusion units and patients, along with the higher acuity had impacted the metrics. It was suggested that additional context was needed to reflect the situation and Girish agreed that further analysis around Patient Safety and incident reporting would be beneficial. Lynn pointed out that the purpose of the IPR is to draw the Board's attention to outliers and trends and it was agreed that the Quality and Safeguarding Committee should receive more detail around the context of the services being provided, in order to ascertain whether there are underlying issues. **Post-meeting note, deep dive to be presented to the Quality and Safeguarding Committee in February 2026**. **RESOLVED: The Board of Directors received limited assurance on current performance across the areas presented.**
DHCFT/ 2025/099	**<u>TRANSFORMATION AND CONTINUOUS IMPROVEMENT (BI-ANNUAL)</u>** The Board of Directors was presented with an update on development of the Transformation and Continuous Improvement (CI) Framework and associated Delivery Plan. Vikki reported that there are significant areas of pathway improvement which have been supported through work with system partners and the NHSE Mental Health Services Assessment Tool (Men-SAT) team. It was noted that a broader, System-wide action plan was in development. Feedback from the Digital Futures Day held the previous week had been very encouraging with positive engagement between those attending from external companies and Trust staff. The Board noted: • over 760 staff had received training in improvement methodology • the 78 active improvement projects, with a focus on patient flow, digital transformation and embedding a culture of CI • the case studies, which included reducing Paediatric Physiotherapy wait times and the rollout of Oxevision technology for safer Inpatient monitoring. Admiration was expressed by Girish that over 700 staff had received CI training. He asked if detail of the numerous projects is available Trust-wide. Vikki confirmed that staff can look up what programmes of change have been undertaken.

	It was noted that the Trust is currently mapping out the new leadership roles to address training gaps and a Development Programme, which includes CI, has been commissioned to support the new leaders. She committed to investigate further if there was any bespoke training for those with Lived Experience. The Board was advised that all projects link to strategic priorities. Vikki acknowledged compliments received about the embedment of CI and she stated that Maria Riley, Assistant Director of Transformation, should be credited for the work in this area. The focus on CI was applauded and it was recommended that more information around the outputs be included in future reporting. **RESOLVED: The Board of Directors noted the progress and next steps for implementation of the Transformation and Improvement Framework.**
DHCFT/ 2025/100	**TRUST STRATEGIC PLAN UPDATE** The Board of Directors received an update on progress in delivery of the Strategic Plan at the end of quarter 2 (Q2) 2025/26. Vikki confirmed that most deliverables are on track, however, access and waiting times for some services remain a concern. It was noted that recovery plans are in place and it is anticipated delivery will on course by Q4, with the exception of improved access. It was highlighted that focus is being placed on the following amber rated Strategic Plan deliverables: 1.2: Improve experience for, and empower, service users patients and carers 1.3: Develop effective quality governance systems and processes that facilitate shared learning and support a positive safety culture 1.4: Improve access to our services and achieve all target wait times 2.1-2.4: People deliverables It was clarified that the Trust has a Waiting Well Policy to support those waiting for appointments. Vikki gave the example of Talking Mental Health; the numbers had increased significantly and following escalation to the ICB, it had been agreed to close the waiting list and work with partners to address the issues. **RESOLVED: The Board of Directors noted the progress in delivery of the Strategic Plan at the end of Q2, 2025/26.**
DHCFT/ 2025/101	**BOARD ASSURANCE FRAMEWORK (BAF) UPDATE, ISSUE 3, VERSION 3.3, 2025/26** Justine presented the BAF update and explained that there have been improvements in risk status and the closure of some gaps in control. It was noted that key risks remain in patient safety, workforce, financial sustainability and partnership working. **RESOLVED: The Board of Directors:** **1. Reviewed and approve Issue 3 of the BAF for 2025/26 and the assurance the paper provides of the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives** **2. Agreed to continue to receive updates in line with the forward plan.**
DHCFT/ 2025/102	**TRUST SEALINGS (SIX-MONTHLY FOR INFORMATION)** This report provided the Trust Board with a six-month update of the authorised use of the Trust Seal since the last report to the Board on 3 June 2025.

	RESOLVED: The Board of Directors noted the information and received full assurance that use of the Trust Seal has been undertaken in accordance with the Standing Financial Instructions and Standing Orders of the Board of Directors.
DHCFT/ 2025/103	**DELIVERY OF SAME SEX ACCOMMODATION – DECLARATION OF COMPLIANCE** Tumi reported on compliance of the delivery of same sex accommodation guidance and the annual declaration. There had been two unavoidable breaches between April 2024 and March 2025. In terms of the new builds, where there is mixed accommodation the facilities are not shared. It was noted that when presented to the Quality and Safeguarding Committee had accepted significant assurance from the robust processes that are in place. **RESOLVED: The Board of Directors:** **1. Received significant assurance that the Trust has robust processes to prevent breaches, monitor and address breaches when they do occur** **2. Approved the Delivery of Same Sex Accommodation Compliance Declaration.**
DHCFT/ 2025/104	**SUICIDE AND SELF-HARM PREVENTION PLAN (FOR RATIFICATION)** Girish presented the Trust Suicide and Self-Harm Prevention Plan, which had been updated to reflect national guidance/best practice within mental health and incorporate local learning though patient safety workstreams. The Plan includes eight strategic priorities: • Improving data and evidence use and collection • Tailored, targeted support for priority groups • Addressing common risk factors • Promoting online safety and responsible media portrayals • Providing effective cross sector crisis support • Reducing access to the means and methods of suicide • Providing effective bereavement support • Making suicide prevention everyone's business. The document was welcomed by Mark. However, he highlighted the volume of content and lack of clarity around responsibility for actions in terms of time and resource. Girish confirmed that Jo Leitner, Suicide Prevention Lead, was developing an implementation plan to include priorities and timescales. He added that there had been a good deal of liaison with System partners. It was noted that progress is overseen by the Quality and Safeguarding Committee. **RESOLVED: The Board of Directors ratified the updated Plan.**
DHCFT/ 2025/105	**BOARD COMMITTEE ASSURANCE SUMMARIES** The assurance summaries from recent meetings of the Trust Board Committees were presented as a clear representation of the priorities that were discussed and will be taken forward in forthcoming meetings. The following points were brought to the attention of the Board by Committee Chairs: Audit and Risk Committee – 23 October 2025 Geoff Lewins, Committee Chair, confirmed that discussions had been fairly routine. However, he highlighted the operational risks associated with the new facilities, in particular, the increase in recorded ligature risks. He explained that he had expected the new units to have less of these risks by design, but understood why facilities, such as the outdoor gym, installed to support therapeutic recovery, would increase risks, however he was assured these new risks were being managed. Lynn advised the increased risks had also been discussed and were being monitored at the Quality and Safeguarding Committee. Finance and Performance Committee – 28 October 2025 (Extra-ordinary) and 4 November

	Jo Hanley, Committee Chair, reflected on the good assurances received at the two meetings. She highlighted the progress in improvement methodology training, along with the need for more evidence of outcomes and impact for the organisation and patients. It was noted that assurance on delivery of the Digital Plan had been delayed. By way of explanation, Mark made a commitment to ensure this is submitted to the next Committee, remarking that at this stage, it was only possible to give partial assurance. He added that the Plan is moving in the right direction. <u>People and Culture Committee – 6 November 2025</u> Reflecting on the People and Inclusion dashboard and those areas providing limited assurance, Ralph Knibbs, Committee Chair and Senior Independent Director, highlighted discussions around data accuracy, the structure recorded in ESR and the steps being taken to correct anomalies. It was noted that as the greater part of the Making Room for Dignity programme has moved through to business as usual, the Committee continues to monitor the ongoing impact of the Model of Care, Culture of Care and Organisational Development programmes, along with multi-disciplinary working, all of which present a longer-term transformation. The Committee had approved the final iteration of the three-year People Plan and was significantly assured that the priorities link to the Trust Strategy. In particular, Ralph stated the aspirational target for 100% leadership development amongst managers. It was clarified that every manager should have a development plan, which may include coaching and shadowing, along with a growth pathway. The clear governance structure in place for the 10 Point Plan to improve Resident Doctors' working lives was emphasised. <u>Quality and Safeguarding Committee – 8 October 2025 and 13 November 2025</u> Drawing attention to the Fundamental Standards of Care and the split assurances around this area, Lynn Andrews, Committee Chair, explained that the Committee is assured of the quality of care, however, implementation of the learning remains a work in progress. The Committee had been assured that actions are in place to reduce ligature risks, although due to the delayed rollout of ligature training limited assurance had been accepted. The Committee had raised concerns about triangulation of data from patient safety incidents, caused by capacity issues within the team. Lynn confirmed that this risk was to be included within the BAF. Mark stated the importance of robust data triangulation and he committed to address the team capacity concerns. It was noted that Committee Chairs are encouraged to escalate to the Board as and when resolutions are not dealt with effectively. **RESOLVED: The Board of Directors noted and accepted the Board Committee Assurance Summaries.**
DHCFT/ 2025/106	**<u>REPORTS FOR NOTING FOLLOWING ASSURANCE AT BOARD COMMITTEES</u>** The following reports were received for information and noting having previously provided assurance at Board Committees: **<u>People and Culture Committee</u>** <u>Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)</u>

Both reports provided narrative to the WRES and WDES data sets requiring submission to NHS England. The data and narrative are accompanied by action plans. Following Board delegated authority in September, the People and Culture Committee virtually approved the reports.

RESOLVED: The Board of Directors:
1. **Noted approval of the WRES and WDES reports by the People and Culture Committee prior to publication on the Trust's public-facing website**
2. **Agreed for the Trust Delivery Group to have quarterly oversight on progress towards action areas with progress updates to the People and Culture Committee.**

10 Point Plan to Improve Resident Doctors' Working Lives

This paper gave an update on progress following the NHE's introduction of a 10 Point Plan to improve Resident Doctors' working lives.

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

Quality and Safeguarding Committee

Children in Care Annual Report 2024/25

This report provided an overview of the progress, challenges, opportunities and future priorities to support and improve the health and wellbeing of children in care in Derby City. The assurance report provided the Board with scrutiny on how this service discharges its legal duties and clinical standard requirements.

RESOLVED: The Board of Directors:
1. **Received significant assurance of the work within the Trust around Children in Care and young people and the continued partnership working to ensure the best outcome is achieved for this vulnerable group of children and young people**
2. **Accepted the annual report and agreed on the key priorities set for 2024/25.**

Guardian of Safe Working (GoSWH) Report

This quarterly report from the Trust's GoSWH provided data about the number of Resident Doctors in training in the Trust, full transition to the 2016 Resident Doctor contract and any issues arising from that contract. The report detailed arrangements made to ensure safe working within the new contract and arrangements in place to identify, quantify and remedy any risks to the organisation.

The Board noted the reporting of exceptions, monitoring of rota compliance and the ongoing focus on wellbeing and safe staffing for Resident Doctors.

RESOLVED: The Board of Directors noted the contents of the report.

Infection Prevention and Control (IPC) Annual Report 2024/25 and IPC BAF

This report provided a comprehensive overview of IPC performance for 2025, including compliance against key standards, estates improvements, Patient-Led Assessments of the Care Environment outcomes, governance arrangements and cultural embedding.

The Board noted high compliance with standards, robust audit and outbreak management.

RESOLVED: The Board of Directors:
1. **Noted surveillance of healthcare associated infections, outbreaks and training compliance**
2. **Received assurance on cleanliness and governance**
3. **Noted the significant assurance received by the Quality and Safeguarding Committee.**

	Safeguarding Children and Adults Annual Report 2024/25 The annual report provided assurance that the Trust is meeting its legal and statutory performance and governance requirements to the Safeguarding Children Partnership and Adult Safeguarding Board, along with an ongoing focus on training, audit and learning from reviews. **RESOLVED: The Board of Directors:** **1. Received and approve the Safeguarding Children and Adults annual report** **2. Noted the significant assurance provided to the Quality and Safeguarding Committee regarding the fulfilment of legal and statutory duties.** Learning from Deaths/Mortality report – 1 April 2025 to 30 June 2025 and Learning from Deaths/Mortality report – 1 July 2025 to 30 September 2025 The Quality and Safeguarding Committee regularly receives and scrutinises the Mortality reports. These reports covered the period 1 April 2025 to 30 September 2025 and informed that reviewed themes include risk management, communication and care planning. **RESOLVED: The Board of Directors accepted these report with limited assurance of the Trust's approach and agreed for them to be published on the Trust's website as per national guidance.**
DHCFT/ 2025/107	**POLICY FOR ENGAGEMENT BETWEEN THE BOARD OF DIRECTORS AND THE COUNCIL OF GOVERNORS** Justine presented the policy which had been reviewed to ensure it reflects the current Code of Governance, the Trust's Constitution, Standing Orders and locally agreed protocols developed by the Council of Governors, for example the process for the appointment of the Lead and Deputy Lead Governor. **RESOLVED: The Board of Directors approved the revised policy document.**
DHCFT/ 2025/108	**CONSIDERATION OF ANY ITEMS AFFECTING THE BOARD ASSURANCE FRAMEWORK (BAF)** No items were considered to affect the BAF.
DHCFT/ 2025/109	**MEETING EFFECTIVENESS** The Board noted the constructive challenge and open discussion that had taken place, while emphasising the need to maintain a clear focus on patient care and the organisation's strategic direction. Drawing attention to the link between Rosie's story and the Suicide and Self-Harm Prevention Plan Dave Allen, Public Governor, Chesterfield, reiterated the need for early treatment to reduce the risk of minor self-harm leading to suicide. He expressed concern that the considerable financial efficiencies would likely impact negatively on services. Greg Taylor, Clinical Lead, Older Adult Inpatient, was interested in the Trust's benchmark with Lincolnshire and Nottinghamshire NHS trusts and was impressed by the broad issues covered within three hours.
The next meeting to be held in public session will be held in person on 27 January 2026 at 9.30am in Conference Rooms A and B, Centre for Research and Development, Kingsway, Derby.	

ACTION MATRIX - BOARD OF DIRECTORS - JANUARY 2026

Date	Minute Ref	Item	Lead	Action	Completion Date	Current Position	
25-Nov-2025	DHCFT/2025/099	Integrated Performance Report (IPR) - Quality	Tumi Banda	Quality and Safeguarding Committee (QSC) to receive context to explain the process of incident reporting.	10-Feb-2026	Item included on the QSC agenda for Feb-2026	Green

Key:	**Action Overdue**	RED		**0**	**0%**
	Action Ongoing/Update Required	AMBER		**0**	**0%**
	Resolved	GREEN		**1**	**100%**
	Agenda item for future meeting	YELLOW		**0**	**0%**
				1	**100%**

Chief Executive's Report

Purpose of Report

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

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

Executive Summary

This is our first Board meeting of 2026 and whilst we are now in late January the sentiment remains to wish all a Happy New Year and place on record our thanks as a Board to colleagues for their work over Christmas and New Year. I would also like to thank the League of Friends for supporting people in our services over the festive period.

As we convene for the first Board meeting of 2026, we recognise the ongoing challenges facing the NHS and reaffirm our commitment to supporting our staff and communities.

National and regional context

2026/27 Operational and financial planning

The Trust's final submission covering three years is due to be submitted on 12 February.

It will include the following:

- A plan that sets out delivery of quality and operational performance standards
- Revenue plans, including detailed efficiency plans
- A Workforce Plan in line with the Efficiency Plan
- A three-year Capital Plan, including the capital required to finish Dormitory eradication programme
- Sign-off Board Assurance statements.

The activity return has already been populated and signed-off for the three years.

To ensure scrutiny of final plans, ahead of the final submission on 12 February, an Extra-ordinary Finance and Performance Committee and an Extra-ordinary Board meeting have been scheduled for early February.

Strategic capital funding

In late 2025, NHS England (NHSE) announced £473m in capital funding over the next four years to support a left shift of care (ie the movement of healthcare services out of hospitals and into the community to be closer to patients' homes) across Mental Health, Learning Disability and Autism services.

The funding will help:

- Establish a neighbourhood mental health centre in every town or city in England
- Expand mental health emergency departments to be co-located with 50% of type one emergency departments

- Provide additional crisis accommodation for people with a learning disability and autistic people
- Invest in digital infrastructure
- Support additional priorities including a new neighbourhood mental health model and a 24/7 Mental Health Accident and Emergency (A&E) hub.

The Trust has submitted bids to secure capital funding to support delivery of points 1 and 2. Both bids have been successful with plans currently being developed for both. It is worth noting that neither of the priorities set out in points 1 and 2 come with access to extra revenue funding to help recruit a workforce to deliver the services. This presents a significant challenge that must be considered as part of these developments.

National Oversight Framework (NOF)

The Trust has moved into Segment 3 following the publication of Quarter 2 (Q2) NOF data released in December 2025. This is an improvement from last quarter where we were in Segment 4.

As a reminder, our ongoing areas where we are improving include:

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

The introduction of enhanced benchmarking tools, such as the NOF, provides valuable opportunities to gain experience from peers and share best practice.

We are currently waiting for confirmation of our Board Provider Capability rating from NHS England (NHSE), following the submission of our self-assessment in October.

Mental Health Act Reform

In December, the Mental Health Bill received Royal Assent, marking the most significant reform of mental health law in over forty years. Key reforms include statutory care and treatment plans, increased family involvement, an end to detention in police cells and a stronger emphasis on community alternatives. The Act addresses concerns around inappropriate detention of autistic people and those with learning disabilities, as well as racial disparities in detention rates. Implementation will be phased over the next decade, with preparations already underway in our Trust. Progress will be monitored through the Board's Mental Health Act Committee.

A concise overview of the Bill and its headline reforms can be read on this link The Mental Health Bill explained.

Adult Psychiatric Morbidity Survey

NHSE's survey, the first update since 2014, shows a mixed picture, with growing prevalence of common mental health conditions, while prevalence of serious mental illnesses have remained stable and socio-economic links persist, underlining the urgent need for prevention and early intervention. NHS Providers have highlighted that trusts are working to expand services and improve support with the staff and resources they have available, and the need for increased support for mental health and wider services. NHS Providers will also be actively engaged in the Independent review into mental health conditions, ADHD and autism: terms of reference - GOV.UK to ensure Trust leaders' views inform its recommendations.

Advanced Foundation Trusts

NHS England has published guidance for applicants for the Advanced Foundation Trust (AFT) Programme, introducing a renewed model that shifts power to the frontline based on the principle of earned autonomy.

The programme represents a significant evolution in how high performing NHS trusts will be recognised and empowered, directly supporting the three key shifts outlined in the NHS 10-Year Health Plan: sickness to prevention, hospital to community and analogue to digital. Those achieving AFT status will gain new freedoms to innovate and invest in prevention, community-based care and digital transformation. The consultation on this guide runs until 11 January 2026. In the meantime, NHSE has nominated eight of the highest-performing trusts to become the first to be assessed for AFT status as part of the "first wave". We will be planning some time in our 2026/27 Board Strategy and Development Programme to discuss our strategic approach on this matter.

Preventing Sexual Misconduct in the NHS

On 5 December 2025, NHS England wrote to all NHS trusts and Integrated Care Boards, building on the letter of August 2025 and detailing further actions to support the mitigation of sexual misconduct within the NHS. A Sexual Safety Charter and framework to support the reduction in sexual misconduct across the NHS was first published in 2023. The framework which is designed to support compliance and assure delivery of the principles set out within the charter was last updated in August 2025. The new actions are detailed below and will be built into our forward approach:

- All organisations are invited to put forward two people professionals to take part in national training on sexual misconduct investigations
- To ensure that investigators undertaking investigations related to sexual misconduct have received specialist training aligned to the national framework
- To ensure that responsible officers receive training on sexual safety misconduct cases.

The Board receives regular updates on sexual safety via the assurance reports from the Quality and Safeguarding Committee and triangulates this through other reporting, such as the Freedom to Speak Up Report.

Local context

Trust Board changes

Although attending in a designate capacity at the November Board, I would like to welcome Chioma Akpom, in her substantive role of Non-Executive Director and Chair of the Audit and Risk Committee.

Staff survey

We continue to receive a good level of participation in the NHS Staff Survey, with an overall response rate of 64%, which is the same number of staff who completed the survey last year. Whilst recognising this doesn't cover all colleagues, I am pleased that we continue to receive feedback that shows what we have been doing well and where we can continue to improve.

National analysis of the results is now underway, with publication expected in March. We have received some early, confidential data around our trends and are already starting work to inform our response and improvements.

Preparation for Trust Well Led Inspection

The Trust has not had a 'Board/Trust wide' Well-Led inspection since 2020 and in line with good governance practice, we are making good progress on our assessment and assurance against the Well-Led element of the CQC's Single Assessment Framework. An internal working group has been set up and regular updates are scheduled for the Board. We are testing compliance against the quality statements and arranging for mock interviews/focus groups with the Board and other senior leaders and our Council of Governors. An important element of Well-Led is the way the Board can demonstrate learning and reflection, and several development sessions have focused on this, including bringing in learning nationally.

This remains a key area of ongoing development for the Board and leaders across the Trust.

Raising awareness and community engagement

One of the Trust's strategic priorities is 'Partnerships', with a commitment to collaborate with our System partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.

Progress has been made in delivering the priorities of our Community and Stakeholder Engagement Plan, with the creation of a DHcFT Deaf Focus Group. Current actions include a review of Deaf service offers and Deaf accessibility on the Trust website. A piece of work has also begun which explores working with Communication Unlimited to increase workplace opportunities for the Deaf community.

New Trust operating model

We started the new year with the introduction of a new governance structure, developed in line with the new operating model that was introduced in November. This aims to reduce layers of decision-making and clarify roles and responsibilities, with consistent terms of reference, agendas, and action logs in place across the divisions. The new structure intends to promote collaborative working by emphasising multi-disciplinary and partnership working, with mechanisms for learning from incidents and sharing best practice. We will also embrace a digital focus to support transformation of service models.

Staff engagement on the second phase of our operating model started this month.

Recent achievements

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

- Ndey Jagne-Gagigo, Registered Nurse on Wren Ward at the Carsington Unit, was our DEED recognition scheme winner for October. She was nominated for her compassion, positivity and dedication, consistently uplifting patients and colleagues while exemplifying professionalism and teamwork
- In November, our DEED winners were the Learning Disability Community Support team. The team was nominated for their exceptional collaboration and commitment to improving services for people with learning disabilities
- Finally, in December, our DEED winner was Lea McGowan, Non-Medical Prescriber in the Derby City Adult Community Mental Health team. Lea was nominated by two related service users who set out the lifechanging impact on them delivered by Lea through her compassionate, innovative, partnership-based practice that aligns with our Trust values and priorities
- A Dalek named Dusty has been raising money for local NHS mental health services. Dusty is the creation of Samantha and Adrian Kennedy, from Oakwood, who travel to events up and down the country, entertaining people for free and raising money for the Trust's charitable fund
- The Trust's Communications and Engagement team was shortlisted for a national award for its efforts to raise awareness of the new East Midlands Gambling Harms service. The team was in the running for Best Communications Team at last year's Comms2Point0 UnAwards.

Staff engagement

Christmas decorations

In the run up to Christmas, teams took part in our annual Christmas decorations competition, making our services feel special for those who spending the festive period in our care. Congratulations to the Crisis team at the Hartington Unit in Chesterfield, who were our overall winners for 2025. Thank you to the League of Friends who supported the competition with prizes donated to the winning teams.

Team visits

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

- On 26 November I visited Cherry Tree Bungalows at Kingsway
- On 27 November, I visited the teams at The Ritz, Matlock, to talk to staff about any issues they wished to raise
- I visited the Dementia Rapid Response team and Perinatal team at Scarsdale Hospital in Chesterfield on 11 December, together with a visit to the Older Adults Community Mental Health team, Chesterfield Working Age Adults and Living Well teams at Bayheath House
- On 12 December, I joined Board colleagues to visit inpatient areas at the Carsington Unit, St Andrew's House and Kingfisher House to judge entries into the Trust's Christmas decorations competition
- On 16 December I visited Dovedale Day Hospital and London Road Resource Centre in Derby
- I visited the County Substance Misuse service at St Mary's Gate in Chesterfield on 22 January, followed by the 136 teams at the Derwent Unit, Chesterfield.

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

- Vikki Ashton Taylor, Deputy CEO and Chief Delivery Officer, visited Oak Ward, Derwent Unit, Ward 36, Radbourne Unit, Hartington Unit, Ilkeston Resource Centre, Audrey House
- Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary, visited the Derwent Unit in Chesterfield, Bluebell Ward at Walton Hospital, Chesterfield and tomorrow is scheduled to join a Board visit to Psychology services and various Child and Adolescent Mental Health services (CAMHS) at Ripley Resource Centre
- James Sabin, Director of Finance, has visited the Radbourne Unit, the Beeches Mother and Baby Unit and teams at Ripley Town Hall
- Tumi Banda, Director of Nursing, Allied Health Professionals, Quality and Patient Experience, joined Board visits to the Neurodevelopmental services teams at St Andrew's House in Derby and the Assessment Services Crisis team in Chesterfield. He also visited the Infant Feeding Managers Training team at St Paul's House and the Beeches Mother and Baby Unit
- Rebecca Oakley, Director of People, Organisational Development and Inclusion, has visited the High Peak Crisis Resolution and Home Treatment team, the High Peak Older Adults In-Reach and Home Treatment team and the Dementia Rapid Response team and In Reach Home Treatment Team.

Service user and carer feedback

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

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

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

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

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

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

Risks and Assurances

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

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

Consultation

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

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

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

Recommendations

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

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

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

Integrated Performance Report

Purpose of Report

The purpose of the report is to provide a high level view of performance against a number of Operational, Financial, People and Quality metrics, and to provide assurance regarding actions being taken to improve performance. The data period is up to the end of November 2025 for internal measures and to the end of September 2025 where the data source is NHS England.

Executive Summary

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

Quality

The current quality thresholds in the performance dashboard do not yet reflect recent expansions in Trust services, including new wards and specialist units. These thresholds are scheduled for an update in January 2026 to ensure they remain appropriate for the expanded service provision.

Areas of Performance

- **Complaints:** Both “Quick Resolution” and “Closer Look” complaints have decreased since September 2025, indicating improved service responsiveness and effective governance oversight
- **Duty of Candour:** Incidents requiring Duty of Candour remain low, reflecting a strong culture of transparency and risk management
- **Physical Restraint and Seclusion:** Physical restraint incidents have declined since August 2025 and new seclusion episodes are within Trust thresholds
- **Falls:** Inpatient ward falls have reduced since September 2025, supported by regular multi-disciplinary reviews for ongoing learning and prevention.

Areas of Challenge

- **Discharge Readiness:** The proportion of patients clinically ready for discharge remains well above the 4% target (averaging around 11%), highlighting persistent challenges in timely discharge processes
- **Medication Incidents:** There is an increase in medication incident reporting, attributed to both service expansion and improved reporting culture. While this reflects transparency, it also signals the need for continued focus on medication safety
- **Incidents of Harm:** Incidents resulting in moderate to catastrophic harm remain above 50, a threshold not adjusted for increased ward numbers, suggesting ongoing risks that require monitoring
- **Quality Targets:** Current quality targets do not yet reflect recent service expansions; an update is scheduled for January 2026 to ensure targets remain appropriate for the expanded provision.

Operational

Notable changes since the last report:

- **NHS oversight framework (NOF):** In quarter 2 (Q2) the Trust was placed in segment 3 overall, which was an improved position from segment 4 in the previous quarter. The Trust ranked 41st out of 61 providers, which was an improvement by five places since Q1.

Six of the scores have improved, and none have worsened:

NOF scores	Qtr1	Qtr2	Change
Overall	**Segment 4**	**Segment 3**	**Improved**
Access to services	**Segment 4**	**Segment 4**	**No change**
Percentage of patients waiting over 52 weeks for community services	3.98	3.97	Improved
Annual change in the number of children & young people accessing NHS finded mental health services	3.33	3.13	Improved
Effectiveness and experience of care	**Segment 4**	**Segment 4**	**No change**
CQC community mental health survey satisfaction rate score	2	2	No change
Percentage of inpatients with >60 day length of stay score	3.49	3.36	Improved
Patient safety	**Segment 3**	**Segment 3**	**No change**
NHS Staff Survey - raising concerns sub-score score	2.7	2.7	No change
Percentage of patients in mental health crisis to receive face-to-face contact within 24 hours score	2.93	2.96	Improved
People and workforce	**Segment 3**	**Segment 3**	**No change**
Sickness absence rate score	2.97	2.63	Improved
NHS staff survey engagement theme sub-score score	2.6	2.6	No change
Finance and productivity	**Segment 1**	**Segment 1**	**No change**
Combined finance score	1	1	No change
Relative difference in costs score	1.7	1.13	Improved

- **Inappropriate out of area (OoA) placements:** Following the significant reduction from a high of 28 back in January to the position of four back in September, in the last two months there was an increased requirement for OoA placements. A comprehensive performance improvement plan has been implemented, and the position has recovered in December to date, to **zero** Adult Acute and **zero** male Psychiatric Intensive Care Unit (PICU) placements, which will be reflected in the next report if sustained. The new male PICU for Derbyshire opened in July 2025 which has had a positive impact on the care of male patients. However, there is no PICU provision for females in Derbyshire and at the time of writing there are six OoA female PICU placements.
- **Early intervention in psychosis:** In November 2025, performance was just one person short of target for waiting time to completed treatment – the person was actually seen within two weeks but there was a slight delay in the allocation of a Care Co-ordinator post appointment. A performance improvement plan is in place, with anticipated recovery by December 2025. The positive impact of the plan can already be seen - two-week referral to treatment is now back on target for people currently waiting for treatment and performance in December to date is exceeding both targets.

Top three things to note from this report:

1. **NOF** challenges

   Performance improvement plans are in progress for all the challenging areas of the framework and are summarised in the main body of the report.

   Proportion of people waiting over 52 weeks for Community services: The Trust was ranked the second highest in quartile 4 at 68.15%. The national median was 0.33%. The threshold for attaining quartile 3 was 6.8%. The majority of these long waits are for Community Paediatric autistic spectrum disorder (ASD) assessment or attention deficit hyperactive disorder (ADHD) assessment. The planned transfer of these waits into the mental health services dataset in line with other providers, as advised by NHSE, will improve the position to around 16%. However, this would still place well within quartile 4. The transition of the records is planned to be progressed from January 2026 onwards, with further phased improvement through backlog reduction from April 2026.

   Crisis response: the requirement is for patients referred as “urgent” to be seen face to face within 24 hours. In the Q2 NOF ratings the Trust achieved 56.3%, against the provider median of 60.1%, placing in the second lowest quartile but not far off quartile 3 for which the threshold was 59.9%. A performance improvement plan has been implemented with completion scheduled for the end of December 2025. Year to date Q3 performance is 71.4%, which is a significant improvement and would have placed in the top end of quartile 3, the second highest quartile.

In the most recently published national Mental Health services dataset monthly data for October 2025, the Trust ranked 10th highest performing for crisis response when compared with the other providers.

Proportion of Acute inpatients discharged with a length of stay (LoS) of 60 plus days: In Q2, the Trust placed in the highest 25% of providers (quartile 4) at 28.6%. If people had been discharged when clinically ready for discharge (CRfD), the Trust would have placed in quartile 3. The threshold for attaining quartile 3 was 26.9%. Currently, nine patients are CRfD. Delayed discharges are inflating LoS by just under five days, and inflating LoS of 60 plus days by around 2.8%. Work is continuing with System partners to reduce CRfD delays and the Trust is actively engaged with the Midlands Learning and Improvement Network, which is supporting shared learning as an enabler to improve LoS. Performance improvement plan expected recovery date: December 2025.

Children and young people (CYP) accessing Mental Health services: In Q2, the Trust's position increased by 0.17% compared with the previous year, which placed in the second lowest 25% of providers (second worst quartile), which was an improvement since Q1 from the worst quartile. The provider median was an increase of 4.7%. This financial year in order to cut waiting times the Integrated care Board (ICB) has invested in Child and Adolescent Mental Health services (CAMHS). This is recurrent investment and is the first year of a three-year service improvement programme. Recruitment of more CYP Mental Health Practitioners is in progress, with the aim of reducing waiting times to four weeks over the course of the programme and will positively impact on the access metric. Performance improvement plan expected recovery date: April 2026

2. **High performing areas**

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

3. **Challenging areas**

   The other areas where standards are not currently being achieved remain the adult ASD assessment waiting list (although the Trust continues to significantly exceed commissioned activity levels) and the Mental Health Helpline performance against speed of answering calls and proportion of calls abandoned. Performance improvement plans have been formulated for the most challenging areas and are summarised in the main body of the report.

People

High performing areas: the areas where targets are consistently achieved include annual appraisals, completion of compulsory training, and the annual turnover rate.

Challenging areas: the areas where performance is most challenging include sickness absence, and completion of clinical and management supervision.

Financial

At the end of November, there is an overall deficit of £2.0m, 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 £1.4m, which is as per then plan.

The forecast outturn remains in line with the breakeven plan. However, there are several risks in delivering the financial plan:

- Delivery of efficiencies in full. Currently, efficiencies are ahead of plan at the end of month 8 by £0.2m, delivering savings of £8.7m and are forecasting full delivery of £14.8m by the end of the financial year.

There has been a change in the forecast between recurrent and non-recurrent schemes, which reflects the reduced savings from the operating model in year which is being mitigated by non-recurrent one-off benefits.

- Adult Acute OoA placements. Expenditure is currently above plan by £3.3m YTD and is forecast to be above plan by £4.5m. The forecast assumed current levels for December and then a reducing trajectory in line with the plan plus an additional five placements.
- Usage of bank and agency above planned levels. Currently, agency and bank are within planned levels and are forecast to remain below the plan at the end of the financial year.

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

Risks and Assurances

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

Consultation

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

Governance or Legal Issues

None.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

Recommendations

The Board of Directors is requested to:

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

Report presented by:

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
Assistant Director of Physical Health and Quality

Derbyshire Healthcare
NHS Foundation Trust

Integrated Performance Report

January 2026

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QUALITY PERFORMANCE

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

Responsible Committee: **Quality and Safety Committee**

Executive Summary

It is important to note that the Quality targets listed in the Performance dashboard do not account for the expansion and changes to Trust services since June 2025, including the addition of an Older People's functional ward, a male PICU, a female enhanced care unit (ECU), and an additional Acute inpatient ward. These targets will be updated in January 2026 to ensure accurate and proportionate oversight of Care Group quality performance.

Overview

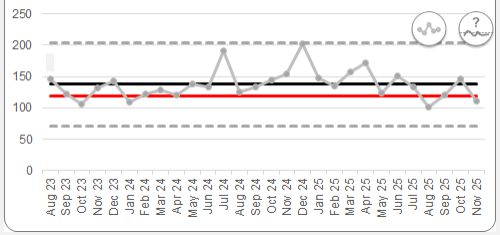
- **Quick Resolution (QR) Complaints and Closer Look (CL) (Formal Investigations):**
  The numbers of “closer look” and “quick resolution” complaints have been on a downward trajectory since September 2025. Themes are to be monitored and escalated through the Trust Learning the Lessons meeting as part of the new governance structure.
- **Duty of Candour:**
  The number of incidents requiring Duty of Candour remained low (four in both October and November), reflecting a culture of effective risk management and transparency.
- **Clinical Readiness for Discharge (CRfD):**
  The proportion of patients CRfD remained above the 4% threshold, at 11.4% in September, 10.8% in October, and 10.9% in November, suggesting ongoing challenges in timely discharge processes. However, this threshold does not reflect the additional inpatient wards and will be reviewed in January 2026.
- **Medication Incidents:**
  The data should be viewed with consideration that there are more inpatient wards now and Enhanced Community team support from Pharmacy, who are recognised as one of the top reporting groups. The increase in reports also reflects an overall culture of improved learning and reporting. Trends and themes such as storage of medicines, measuring of liquids and medicine doses missed have remained consistent and have been acknowledged at the monthly Medicine Safety and Practice meeting and are being addressed via an action plan overseen within the Medicine Management Committee and are included in the Medicines Safety Report to the Trust Quality and Safeguarding Committee for assurance.
- **Incidents of Harm:**
  Incidents of moderate to catastrophic harm have remained over 50 incidents, but the current threshold of 50 does not account for the increase in inpatient wards and the practice of recording racist incidents as major. The level of incidents of racism being reported by staff are being addressed via the Race Equality Working Group and a collaborative around reducing violence and aggression towards staff which is due to start in January 2026.
- **Physical and Prone Restraint:**
  Incidents involving physical restraint have been on a reducing trajectory since August 2025. The sustained number of prone restraint incidents is related to incidents of rapid tranquilisation and placing patients in seclusion safely. A deep dive into these incidents suggests that patients are moved out of this position as soon as is safe to do so, reflecting a culture of transparent reporting.
- **Seclusion Episodes:**
  The number of new episodes of patients held in seclusion has reduced overall between September and November 2025 and is currently in line with the Trust threshold of 12 incidents.
- **Falls on Inpatient Wards:**
  The number of falls has reduced since September 2025, and the threshold of 30 falls does not reflect the increase in inpatient wards. All patients who fall are discussed at a fortnightly falls meeting with input from the Trust Moving and Handling Lead and the patient ward multi-disciplinary team

Measure	Target	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	
Quality performance														
No. of compliments received	119	203	148	135	157	172	124	149	120	92	100	147	111	
No. of formal complaints received ("quick resolution")		19	8	18	10	3	8	13	21	17	19	14	13	
No. of formal complaints received ("closer look")		18	15	11	18	17	9	14	11	20	35	24	9	
Proportion of patients clinically ready for discharge	4%	10%	10%	10%	9%	11%	10%	11%	10%	11%	11%	11%	10%	
Proportion of patients on CPA >12 months who have had their care plan reviewed	95%	75%	73%	73%	76%	80%	81%	79%	80%	79%	78%	78%	78%	
Patients who have their employment status recorded as "in employment"		12%	12%	12%	12%	12%	12%	12%	12%	13%	13%	14%	14%	
Patients who have their accommodation status recorded as "settled"		49%	48%	47%	47%	48%	49%	49%	50%	51%	52%	53%	53%	
Number of medication incidents		71	62	55	92	69	63	71	95	98	98	110	115	
No. of incidents of moderate to catastrophic actual harm	48	57	59	63	51	66	56	76	91	62	111	53	72	
No. of incidents requiring Duty of Candour	1	0	0	0	1	0	1	1	1	2	4	4	3	
No. of incidents involving prone restraint	12	8	5	8	14	7	5	10	14	25	18	23	19	
No. of incidents involving physical restraint	46	52	67	114	103	65	73	81	114	144	100	88	72	
No. of new episodes of patients held in seclusion	14	14	9	9	25	14	20	8	18	39	23	28	14	
No. of falls on inpatient wards	30	40	22	36	40	45	37	58	38	46	57	33	32	
NHS oversight framework 2025/26														
Annual community mental health survey satisfaction rate (out of 10)*	6.7	6.50	6.50	6.50	6.50	6.50	6.50	6.50	6.50	6.50	6.50	6.50	6.50	
CQC safe inspection score (if awarded within the preceding 2 years)		not applicable - last rated in 2019												

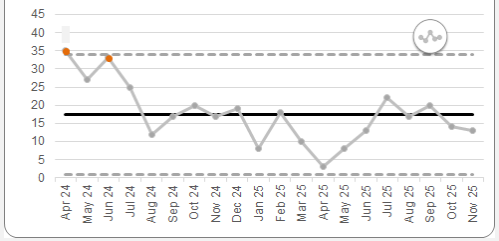
*the 2025 results are due to be published in Spring 2026

Quality Key Performance Indicators – Statistical Process Control Charts

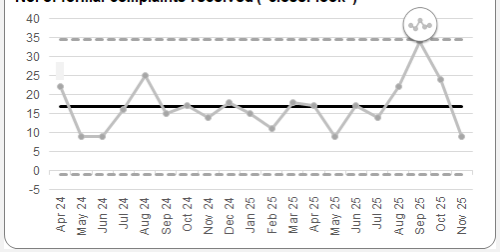
No. of compliments received



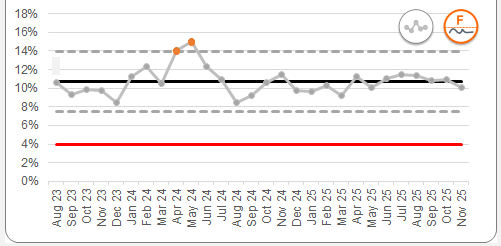
No. of formal complaints received ("quick resolution")



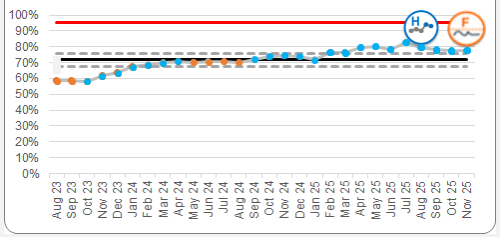
No. of formal complaints received ("closer look")



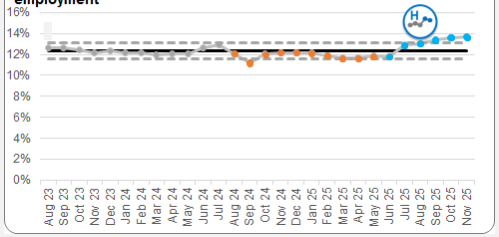
Proportion of patients clinically ready for discharge



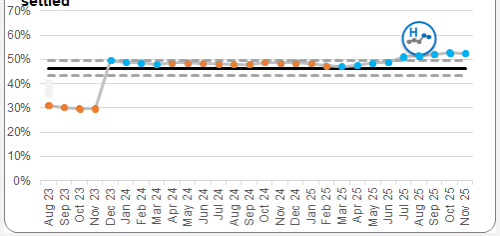
Proportion of CPA Review in last 12 Months



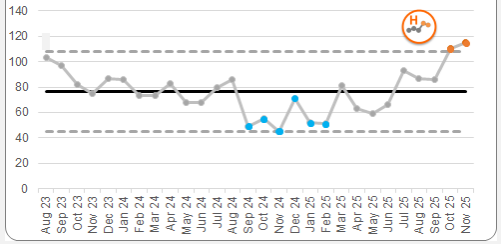
Patients who have their employment status recorded as "in employment"



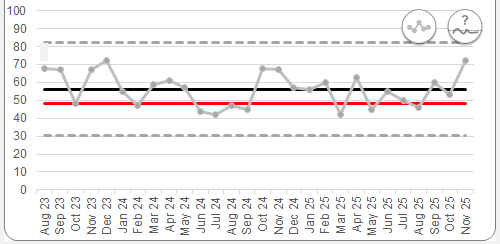
Patients who have their accommodation status recorded as "settled"



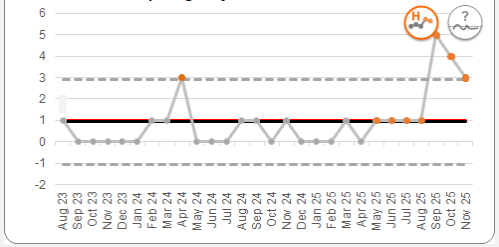
Number of medication incidents



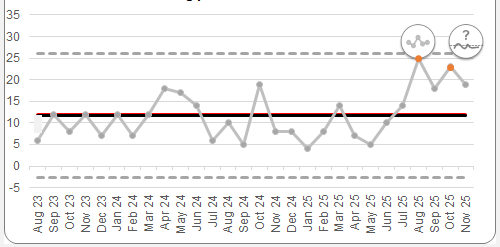
No. of incidents of moderate to catastrophic actual harm



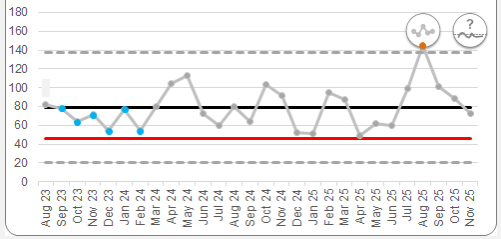
No. of incidents requiring Duty of Candour



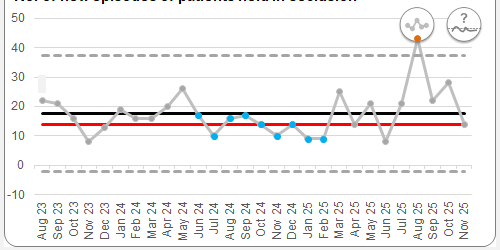
No. of incidents involving prone restraint



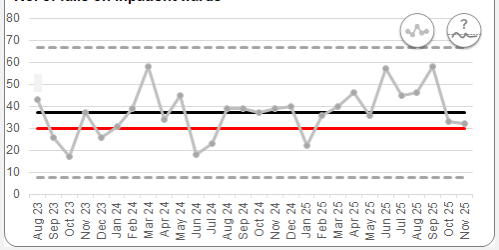
No. of incidents involving physical restraint



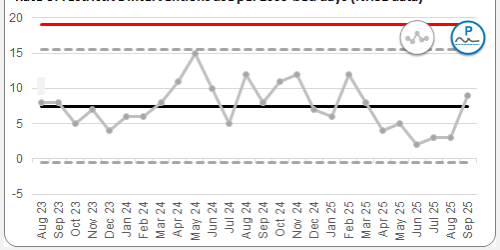
No. of new episodes of patients held in seclusion



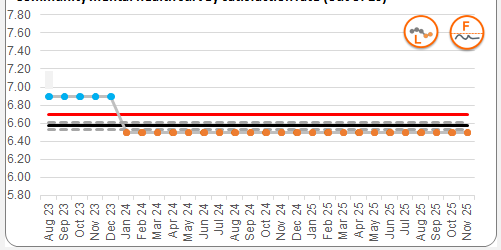
No. of falls on inpatient wards



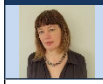
Rate of restrictive interventions use per 1000 bed days (NHSE data)



Community mental health survey satisfaction rate (out of 10)



OPERATIONAL PERFORMANCE



Deputy Chief Executive/ Chief Delivery Officer:
Vikki Ashton Taylor

Responsible Committee: **Finance and Performance Committee**

Executive Summary

Inflow

- **Percentage of patients in crisis to receive face-to-face contact within 24 hours:** NHS England have introduced this metric this financial year which is a measure of the proportion of urgent referrals made to crisis teams and mental health single points of access who were seen face to face within 24 hours. In the Q2 NOF ratings, the Trust achieved 56.3%, against the provider median of 60.1%, placing in the second lowest quartile but close to quartile 3 for which the threshold was 59.9%. A performance improvement plan has been implemented with completion scheduled for the end of December 2025. From internal data, year to date Q3 performance is 71.4%, which is a significant improvement and would have placed in the top end of quartile 3, the second highest quartile.
- **Mental Health Helpline:** From the latest official statistics in development that have been published by NHS England (October 2025), although the position has improved by 11% since last reported, the Trust's mental health helpline is again reported as performing less favourably when compared with other providers in the Midlands regarding the proportion of calls abandoned after interactive voice response call steering - 39%. In comparison, the national average for calls abandoned was 27%. Conversely, the Trust's speed to answer calls was the third quickest in the Midlands. Demand on the helpline has been increasing through various extensions of the service offer over the last three years, to include Street Triage, Mental Health Response Vehicle, shift to include mental health related activity from 111 (helpline now being the NHS 111 Mental Health Option 2) and Right Care Right Place (RCRP) as well as still providing the original service from when the line was established which includes urgent care and mental health wellbeing support. Despite the significant evolution of changes and demand on the helpline all of this has come without any additional funding. A performance improvement plan has been developed and is in progress.

Outflow

- **Inappropriate OoA Adult Acute placements:** following the significant reduction from a high of 28 back in January to the position of four back in September, in the last two months there was an increased requirement for OoA placements. A comprehensive inappropriate OoA placements performance improvement plan has been implemented, and the position has recovered in December to date, to **zero** adult acute placements, which will be reflected in the next report if sustained. The new male PICU for Derbyshire opened in July 2025 which has had a positive impact on the care of male patients. However, there is no PICU provision for females in Derbyshire and at the time of writing there are six OoA female PICU placements.
- **Proportion of Adult Acute inpatients aged 18-64 discharged with 60 days plus LoS:** In Q2, the Trust placed in the highest 25% of providers (quartile 4) at 28.6%. If people had been discharged when clinically ready, the Trust would have placed in quartile 3. The threshold for attaining quartile 3 was 26.9%. Currently, nine patients are CRfD. Delayed discharges are inflating LoS by just under five days, and inflating LoS of 60 plus days by around 2.8%. The Trust continues to work with System partners to reduce CRfD delays and is actively engaged with the Midlands Learning and Improvement Network which is supporting shared learning as an enabler to improving LoS. Performance improvement plan expected recovery date: December 2025.
- **Average LoS for Adult Acute, Older Adult and PICU mental health beds:** at 63 days, LoS continues to be inflated by delayed discharges - the average LoS to *discharge ready* for the three months to November 2025 was 55 days. In the latest national data the Trust ranked mid-table versus the other NHS mental health providers, with performance of 60 days against the provider average of 59.
- **Three-day follow-up:** the national standard for follow-up following inpatient discharge continues to be consistently exceeded, ensuring patients get support at the time they are most vulnerable.

Elective/access

- **Women accessing specialist Perinatal Mental Health service**: the service continues to support increasing numbers of women, and in the latest NHSE national data was ranked sixth highest performing service in the country against the national access standard.
- **Adult assessment - ASD:** activity levels continue to exceed the commissioned target for assessments, with the full year target exceeded after seven months. Waiting times remain high at around 54 weeks, with demand far exceeding capacity. The waiting list had been reducing but for the last two months has started to increase once more and now stands at 1,421 people waiting.
- **Community waits over 52 weeks:** in Q2, the Trust placed in quartile 4 and was ranked the second highest (worst performing) of all providers with 68.15% of CYP waiting over 52 weeks to be seen. The national median was just 0.33%. The threshold for attaining quartile 3 was just 6.8%. The majority of these long waits are for Community Paediatric ASD assessment or ADHD assessment. The planned transfer of these waits into the Mental Health services dataset in line with other providers, as advised by NHSE, will improve the position to around 16% presenting a more accurate picture. However, this would still place well within quartile 4. The transition of the records is planned to be progressed from January 2026 onwards, with further phased improvement through backlog reduction from April 2026.
- **Early intervention in psychosis:** the Early Intervention services assess people who are suspected of experiencing a first episode of psychosis. The national standard is to undertake an assessment within two weeks of people being referred into the service (target 60%). In November 2025, performance was just one person short of target for waiting time to completed treatment – the person was actually seen within two weeks but there was a slight delay in the allocation of a Care Co-ordinator post appointment. A performance improvement plan is in place, with anticipated recovery by December 2025. The positive impact of the plan can already be seen - two-week referral to treatment is now back on target for people currently waiting for treatment and performance in December to date is exceeding both targets.
- **CYP Mental Health access:** in Q2, the Trust's position increased by 0.1% compared with the previous year, which placed in the second lowest 25% of providers (second worst quartile), which was an improvement since Q1 from the worst quartile. The provider median was an increase of 4.7%. This financial year in order to cut waiting times the ICB has invested in CAMHS. This is recurrent investment and is the first year of a three-year service improvement programme. Recruitment of more CYP Mental Health Practitioners is in progress, with the aim of reducing waiting times to four weeks over the course of the programme and will positively impact on the access metric. Performance improvement plan expected recovery date: April 2026.

Collaboratives

- **Transforming care programme:** five of the eight targets for improving care for people with learning disabilities, autism or autistic spectrum conditions have been achieved. However, the numbers of inpatients have all increased above target levels:
  - Adults with a learning disability or autism in inpatient care: 25 (target 21)
  - Adults with autistic spectrum conditions in inpatient care: 16 (target 12)
  - CYP in specialised/secure inpatient care: seven (target three)

  Efforts to reduce adult neurodevelopmental inpatient numbers focus on standardising processes and improving oversight. A cluster-wide Standard Operating Procedure has been introduced to ensure consistent reporting and governance. Enhanced Case Management teams are being formed to streamline admission-to-discharge pathways and reduce delays, supported by compliance with 72-hour reviews to improve patient flow and shorten stays. Gatekeeping protocols and emergency admission reviews are under revision to prevent unnecessary admissions. CYP and Adult focus on the Dynamic Support Registers and dashboards are being implemented for real-time monitoring and early intervention. Additionally, the Performance Improvement Plans are being regularly reviewed through the Division.

Measure	Target	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	
Long term plan 2025/26														
Inappropriate adult acute & PICU mental health out of area placements at month end^	5	45	44	25	23	19	32	13	8	13	4	11	10	
Women accessing specialist perinatal mental health services (rolling 12 months)* ^^	1242	1340	1335	1340	1345	1340	1350	1390	1390	1395	1400			
Perinatal access rate (ICB)*	10%	12.4%	12.3%	12.4%	12.4%	12.3%	12.5%	12.8%	12.9%	12.9%	13.0%			
Individual work placement support access (rolling 12 months)*	690	665	660	700	715	715	715	745	765	760	755			
Average length of stay for adult acute, older adult & PICU mental health beds**	55	62	65	67	66	63	59	64	61	60	59	61	63	
NHS oversight framework 2025/26														
Proportion of people waiting over 52-weeks for community services*	0%	56%	58%	61%	63%	62%	64%	65%	64%	65%	68%	65%	65%	
Children and young people accessing NHS-funded MH services - annual change*	15.9%	0.3%	0.0%	0.0%	0.3%	-1.1%	-2.0%	0.6%	0.7%	1.8%	0.1%			
Proportion of acute inpatients aged 18-64 discharged with 60 days plus length of stay**	20.6%	25%	24%	27%	23%	21%	18%	31%	33%	27%	27%	33%	31%	
Percentage of patients in crisis to receive face-to-face contact within 24 hours*	65.4%	44%	44%	47%	53%	57%	50%	47%	52%	53%	65%			
Key operational measures														
Children & young people eating disorder routine referrals seen within 4 weeks*	95%	100%	94%	95%	95%	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	#N/A	#N/A	#N/A	
Inpatient discharges followed up within 72 hours	80%	80%	92%	87%	88%	90%	89%	90%	87%	88%	92%	85%	89%	
Dementia diagnosis rate (ICB)*	68%	68.9%	68.4%	68.5%	68.8%	69.0%	69.3%	69.2%	68.9%	68.6%	68.7%	68.9%		
Early intervention in psychosis 2 week waits from referral to treatment - complete	60%	71%	54%	76%	65%	56%	47%	43%	37%	39%	52%	85%	56%	
Early intervention in psychosis 2 week waits from referral to treatment - incomplete	60%	53%	81%	80%	56%	48%	46%	46%	50%	58%	75%	92%	88%	
Adult ASD assessment – number of people waiting at month end	219	1596	1709	1602	1495	1472	1399	1382	1356	1365	1332	1370	1421	
Adult ASD assessment – average wait (weeks)	18	60	54	54	57	55	56	54	56	53	56	55	54	
Adult ASD assessment – number of assessments completed per month	26	61	75	93	67	59	55	61	64	29	36	44	47	

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

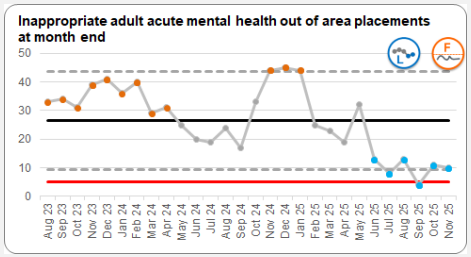
* Data source = NHS England

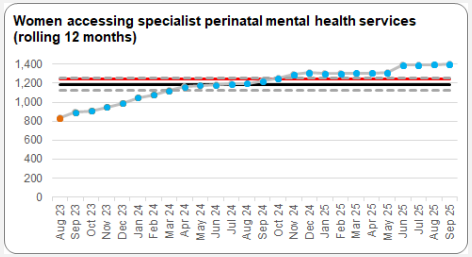
^^ Perinatal and maternal mental health services

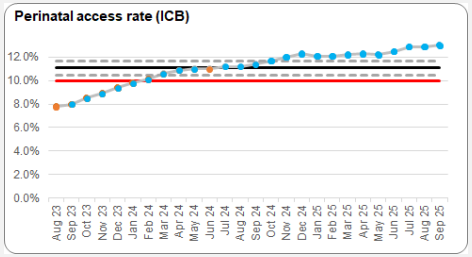
** Rolling 3 months, length of inpatient spell of patients discharged

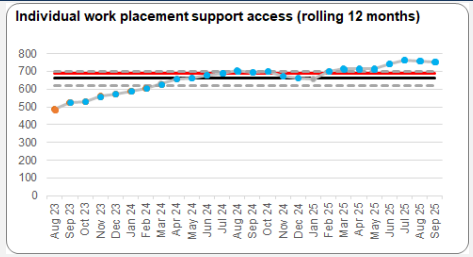
NHS oversight framework targets = minimum level required to have been placed in the top quartile in quarter 1

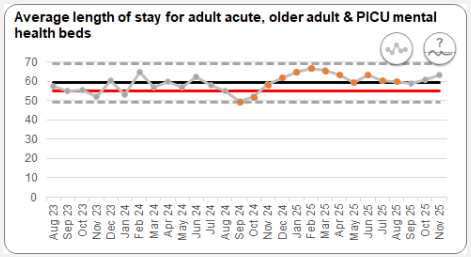
Operational Key Performance Indicators – Statistical Process Control Charts

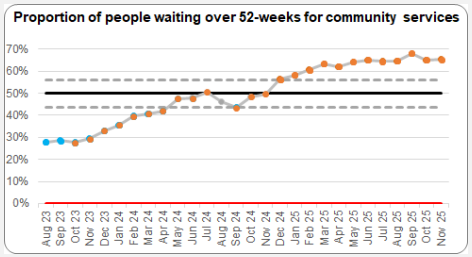


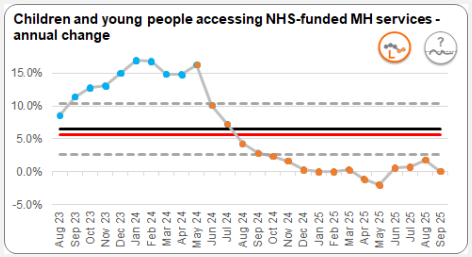


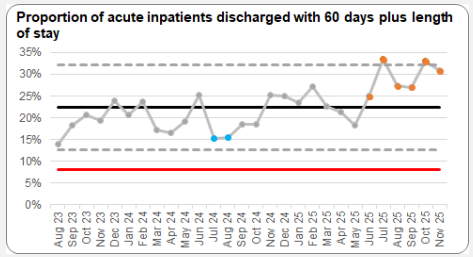


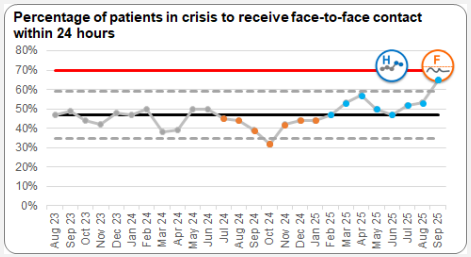


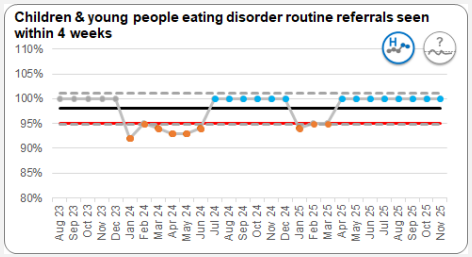


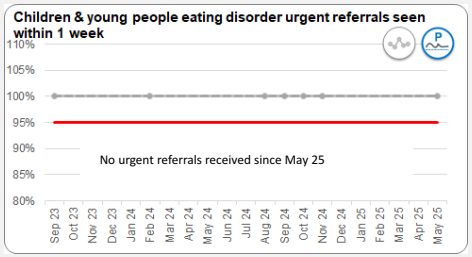


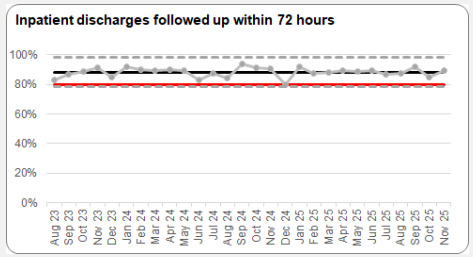


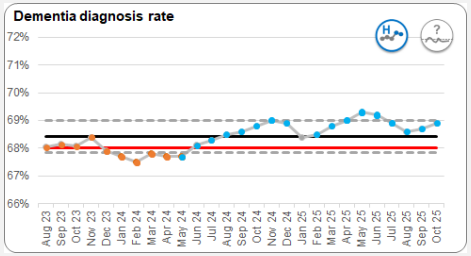


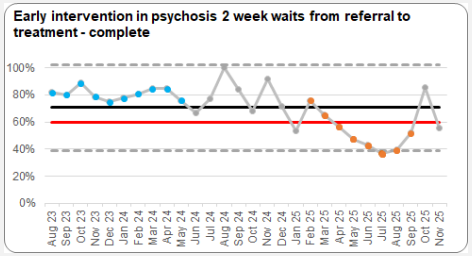


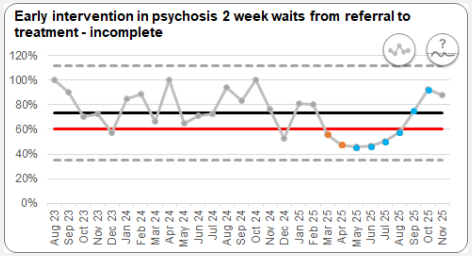


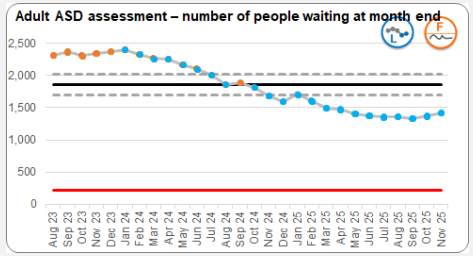


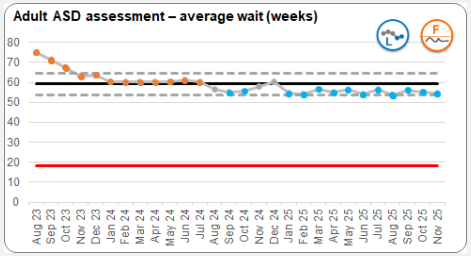


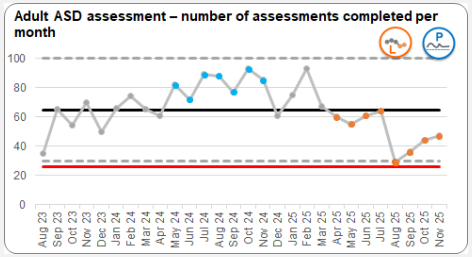


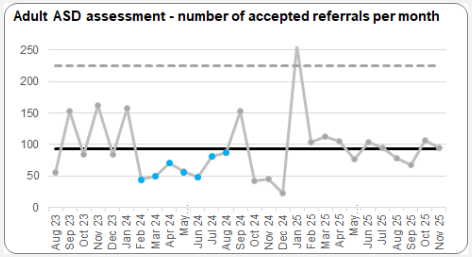












TRANSFORMATION AND IMPROVEMENT

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

FLOW PATHWAY

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

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

Interventions:

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

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

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

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

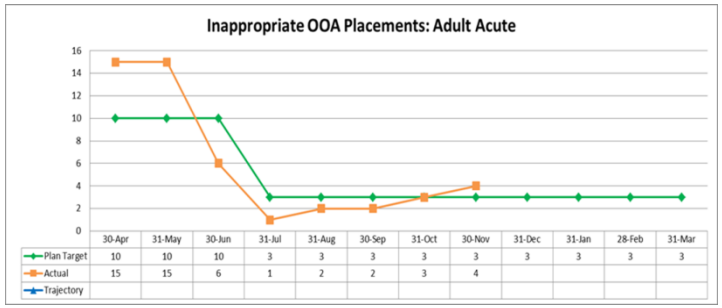
Action is currently focused on design of a strategic approach for integration and localisation of services in alignment with the 10-Year Health Plan ambition to transform Mental Health services into 24/7 neighbourhood care models; with a Board Strategy and Development Session hosted on 15 October to define strategic intent and next steps for action in delivery.

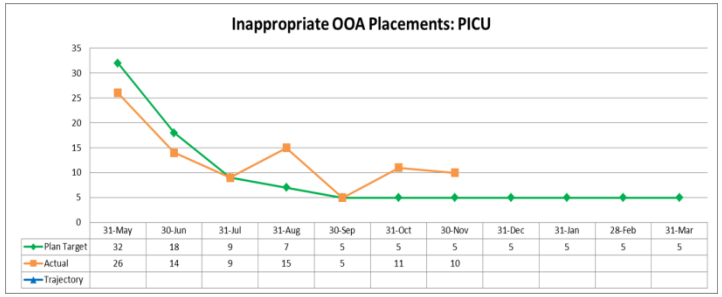
A workshop approach is being implemented with frontline teams, applying intelligence and insights in development of the model, pathway and strategic Inflow implementation plan for delivery from Q4 and into 2026/27. The first two workshops were hosted over Q3 with a further scheduled for January 2026.

Impact:

Delivery of the improvement trajectory over Q1 was impacted by delays against the anticipated opening dates of both acute units and associated transitional challenges requiring operation within a more limited bed base.

Accelerated focus through the rapid improvement plan has supported recovery, with the out of area placement position on 30 November slightly above the month end trajectory, but the position at 22 December being zero inappropriate OoA placements. Efforts are currently focused on sustaining this position over the critical festive period.





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

The Operational Plan ambition that follows achievement of reduced OoA placements is phased withdrawal from the privately commissioned beds. A revised trajectory has been agreed for this in Q4, reflecting delays against the anticipated opening dates across the new units.

TRANSFORMATION AND IMPROVEMENT

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

COMMUNITY AND CRISIS

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

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

Interventions:	**Impact:**
Metric: Access standards for Mental Health Helpline An improvement plan is in place comprising operational, improvement, and transformational solutions over 11 work streams that include: One access point though 111 mental health option and closure of the 0800 number; Addressing technical telephony system issues; Demand and capacity modelling; Developing the professional line; Enhanced data reporting through SystmOne; Resolution of NHSE data reporting; Resourcing of helpline and Mental health response vehicle; Triage process; High intensity users: and design of the strategic service model.	**Metric: Access standards for Mental Health Helpline** Phased recovery: Phase 1 – Operational and technical issues by 1 November 2025. Delivery of this has been challenged with a review and reset of the Q4 Performance Improvement Plan currently in progress. Phase 2 – Service model (to include demand and capacity modelling) and staffing by 1 April 2026.
Metric: People in mental health crisis seen face to face within 24 hours For Crisis services, an improvement plan is in place comprising operational, improvement and transformational solutions over eight work streams that include: Accurate triage and logging; Consistent overnight staffing; Review of triage functions; Modelling of demand and capacity; Streamlining administrative tasks; Weekly cross check meetings; Development of data reporting for emergency duty; Digital pilot for use of ambient voice technology. For Community services, a plan is in design to include revision of the standard operating procedure for response to urgent referrals; and development processes for review and correction of referral urgency level to drive accurate data capture.	**Metric: People in mental health crisis seen face to face within 24 hours** Recovery anticipated by November 2025. Latest internal reporting demonstrates delivery achieved aligned to agreed plan with this to be confirmed on publication of national datasets for Q3.
Metric: Early intervention in psychosis two-week referral to treatment An improvement plan is in place comprising operational, improvement and transformational solutions over eight work streams that include: Enhanced operational controls and breach analysis to inform learning and improvement action; Demand and capacity modelling; Workforce review; Pathway development in partnership with crisis service with potential prescribing before assessment and diagnoses; Review of assessment and allocation processes; and Review of flow along the pathways with the aim of ensuring effective deployment of all available capacity within the service.	**Metric: Early intervention in psychosis two-week referral to treatment** Recovery anticipated by December 2025 and currently on track for delivery.

TRANSFORMATION AND IMPROVEMENT

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

ELECTIVE ACCESS

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

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

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

TRANSFORMATION AND IMPROVEMENT

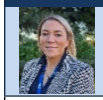
The Transformation and Improvement Portfolio is supporting achievement of improved performance across IPR measures through collaboration with key updates below.

JOINED UP PATHWAYS AND SERVICES: EAST MIDLANDS ALLIANCE

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

Interventions:	Impact:
East Midlands IMPACT Collaborative St Andrews has been issued with a Care Quality Commission (CQC) Notice of Proposal for civil enforcement action. All 'placing' commissioners have been notified in line with the request from NHSE. Financial stability for providers and reconfiguration of services to balance demand and capacity is an ongoing priority for 2025/26. Women's Enhanced Medium Secure service decommissioning is extended by six months until September 2025. Proposals with respect to male medium secure capacity remain under discussion by the Chief Executive Group.	**East Midlands IMPACT Collaborative** There is a reducing IMPACT inpatient population and despite increases in the general population of the region, fewer people per capita are being hosted in secure care now since the Provider Collaborative (PC) started in 2020. In 2024/25 there were 3,750 less occupied bed days than the prior year. A new male low secure 10-bedded ward opened on 1 June at St Andrews to support shift of activity from Part 1 providers to Part 2.
East Midlands CAMHS Collaborative The Patient Safety Incident Investigation following an unexpected patient death at St Andrews in October 2024 has been completed and improvement action planned. Safeguarding reviews are delayed whilst the incident is out with police. East Midlands Provider Collaborative (EMPC) escalated St Andrew's House to intensive quality assurance and improvement level of surveillance in August. Admissions into Inpatient services reduced in Q1 in comparison to Q4 and are below average for the year. There is an increasing trend of admissions of patients in the Transforming Care cohort over the last four quarters. The task and finish group completed development of the day service specification, and this has been presented to and agreed by the Provider Collaborative (PC) Programme Board.	**East Midlands CAMHS Collaborative** Business case for the expansion of the Family Ambassador Programme into the CAMHS Enhanced Community offer was approved by the Collaborative Commissioning and Contracting Group (CCCG) in May 2025. The CAMHS Provider Collaborative have been shortlisted for the HSJ Awards for Provider Collaborative of the Year.
East Midlands Adult Eating Disorder Collaborative Lincolnshire Partnership Trust has experienced difficulties associated with the unplanned absence of the Consultant Psychiatrist. The Lincolnshire System has recently reached out to Medical Directors and the Provider Collaborative for support. Following the increase in activity Q4, there has been a significant decrease in Q1, resulting in reduced OoA admissions and a slight decrease in activity on Welford Ward. Due to decreased activity in Q1, it is looking likely there will be sufficient surplus in 2025/26 to fund Waterlily in full into 2026/27 - see *Waterlily programme makes a big difference for adults with anorexia | Latest updates | Alliance*.	**East Midlands Adult Eating Disorder Collaborative** A contract has now been awarded for the new Adult Eating Disorder Unit, Nova Ward at Cygnet Elowen in Shipley, increasing inpatient capacity within the East Midlands by 12 beds, due to open to admissions on 25 August 2025. Welford Ward is trialling a new application (AIRMID) for sharing some clinical records with patients.
East Midlands Perinatal Provider Collaborative There are no performance or quality concerns for escalation. Interim mitigations remain in place with regards to high room temperatures at The Beeches whilst awaiting installation of air conditioning. Admissions and occupied bed days in Q1 have been consistent with Q4 although there has been a steady decrease in activity of patients originating from the East Midlands patients over the last 12 months.	**East Midlands Perinatal Provider Collaborative** Perinatal Learning Events are continuing, with good attendance from both Inpatient and Community teams at the event held on 2 July 2025. The learning at the event was based on recommendations from the MBRACCE report 2024.
East Midlands Gambling Harm Service In anticipation of additional funding associated with the gambling levy, the service is developing an expanded model of care to increase its reach across the East Midlands. The service has increased its annual referral target by 10% in response to higher demand with this on track to be achieved by year-end. There are no waiting lists, and access remains within agreed timeframe protocols. The service is adopting more suitable clinical measures to better track patient progress throughout treatment.	**East Midlands Gambling Harm Service** The service is enhancing understanding of how medications and health conditions influence gambling-related behaviours, using SystmOne insights to shape wider clinical practice. Patient feedback continues to demonstrate the positive and tangible difference the service makes in people's lives.

PEOPLE PERFORMANCE



Director of People, Organisational Development and Inclusion:
Rebecca Oakley

Responsible Committee: **People and Culture Committee**

Executive Summary

Update

Annual appraisals: continue to remain high at 91% and has surpassed the 90% Trust target for the last seven consecutive months. A slight decrease in compliance has occurred during the previous two months. However, efforts continue to address both appraisals that are out of date and those approaching renewal.

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

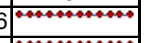
Compulsory training: compliance continues to remain high at 94% and has surpassed the 85% target for several years. A slight decrease in compliance has occurred over the previous month. However, efforts continue to address training that is out of date and training that is approaching renewal.

Sickness absence: for the month of November 2025 is running at 6.80%, an increase of 0.7% compared to the same period last year. The annual sickness absence rate is running at 5.77%, a reduction of 0.24% compared to the same period last year. Anxiety, stress or depression related illness remains the highest reason for sickness absence, followed by cough, cold, flu. Following formation of the Absence Oversight Group, the focus will be on development of its delivery plan. A high level overview has been produced which focuses on monitoring absence, policy compliance, hot spot areas, support for managers and support for our people. A Quality Improvement approach will continue to be taken to assist with reducing absence levels.

Filled posts: by contracted staff at the end of November continue to be 91% of funded posts. At the start of the financial year new investment is released which creates brand new vacancies, initially reducing the percentage of funded posts filled. This year continues to see a staged adjustment to vacancies throughout the year as service developments and cost improvement programmes are delivered.

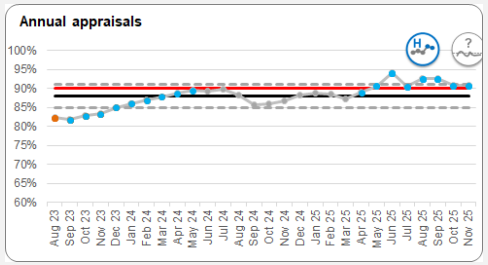
Agency usage: has reduced significantly compared to the previous year and continues to remain low. The authorisation panel to oversee agency requests across the Trust continues to remain in place.

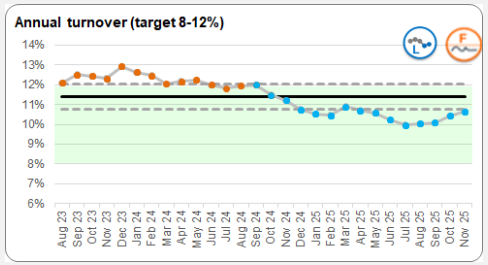
Supervision: compliance continues to remain a challenge in both clinical supervision at 86% and also management supervision at 86%. Whilst there has been sporadic incremental improvement in compliance over the year, efforts continue to work with teams with low compliance and rates are expected to increase further over the coming months.

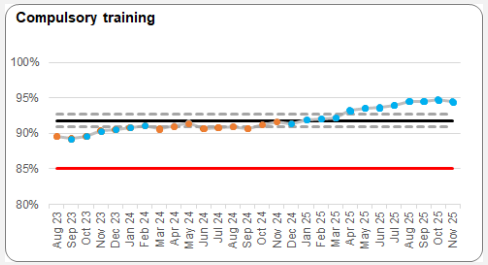
Measure	Target	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	
People Performance														
Annual appraisals	90%	88%	89%	89%	87%	89%	91%	94%	91%	93%	93%	91%	91%	
Annual turnover (target 8-12%)	12%	11%	11%	10%	11%	11%	11%	10%	10%	10%	10%	10%	11%	
Compulsory training	85%	91%	92%	92%	92%	93%	94%	94%	94%	95%	95%	95%	94%	
Filled posts	100%	86%	87%	88%	88%	88%	89%	89%	90%	90%	91%	91%	91%	
Bank staff use	5%	5.4%	4.3%	4.5%	4.4%	4.5%	4.0%	4.1%	3.9%	4.5%	5.1%	4.5%	5.2%	
Agency staff use	1.9%	0.6%	0.6%	0.7%	0.7%	0.3%	0.4%	0.3%	0.4%	0.5%	0.4%	0.5%	0.4%	
Management supervision	100%	87%	87%	86%	86%	84%	85%	86%	86%	85%	87%	88%	86%	
Clinical supervision	100%	85%	85%	84%	83%	81%	83%	82%	82%	82%	83%	85%	86%	
NHS oversight framework 2025/26														
Sickness absence rate	5%	6.5%	6.8%	5.8%	5.1%	5.4%	4.9%	5.3%	5.8%	5.5%	5.8%	6.8%	6.8%	
Annual NHS Staff Survey - raising concerns sub-score*	7.0	6.76	6.76	6.76	6.76	6.76	6.76	6.76	6.76	6.76	6.76	6.76	6.76	
Annual NHS staff survey engagement theme score*	7	7.07	7.07	7.07	7.07	7.07	7.07	7.07	7.07	7.07	7.07	7.07	7.07	
National Education and Training Survey overall satisfaction score (C.)**	76.2%	78.9%	78.9%	78.9%	78.9%	78.9%	78.9%	78.9%	78.9%	78.9%	78.9%	78.9%	78.9%	

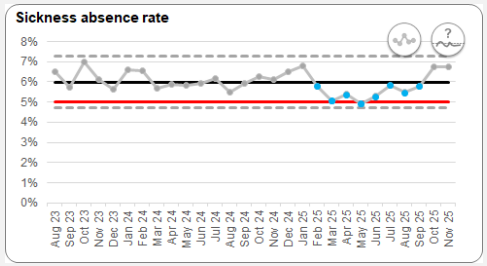
*2025 results are due to be published in March 2026
**2025 survey is currently in progress closing 2 December 2025, with the results to be published next year

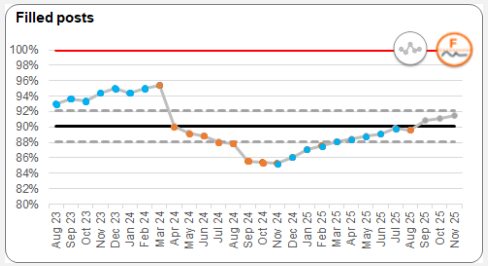
People Key Performance Indicators – Statistical Process Control Charts

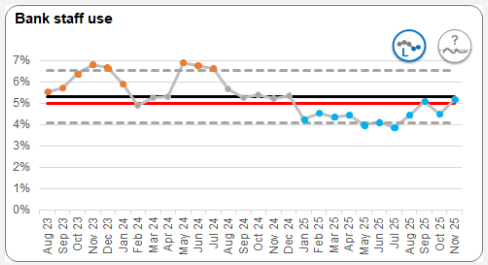


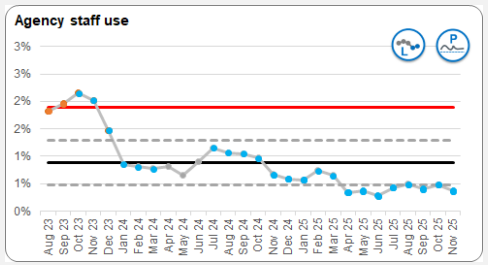


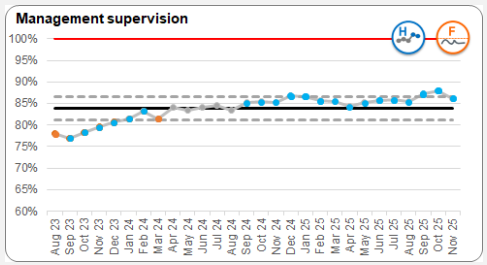


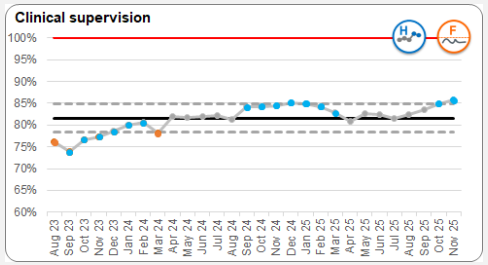


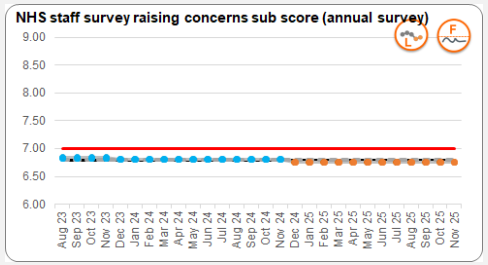


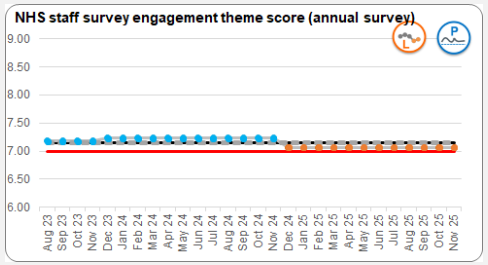


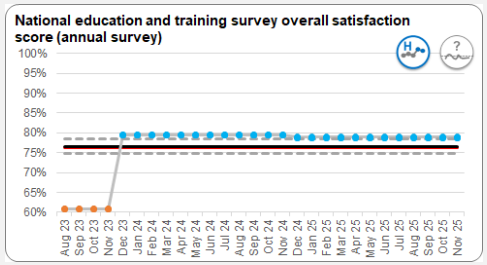












FINANCIAL PERFORMANCE

Director of Finance:
James Sabin

Responsible Committee: **Finance and Performance Committee**

Executive Summary

Overall

At the end of November there is an overall deficit of £2.0m, 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 £1.4m, which is as per the plan.

The forecast outturn remains in line with the breakeven plan. However, there are several risks in delivering the financial plan:

- Delivery of efficiencies in full
- Adult Acute out of area placements
- Usage of bank and agency above planned levels

Efficiencies

The plan includes an efficiency requirement of £14.8m with the plan assuming 82% is delivered recurrently. At the end of November, efficiencies delivered higher than plan by £0.2m, delivering savings of £8.7m. The forecast assumes the full efficiency plan is met in full. There has been a change in the forecast between recurrent and non-recurrent schemes, which reflects the reduced savings from the operating model in year being mitigated by non-recurrent one-off benefits.

Agency

Agency expenditure at the end of November is £1.8m, which equates to 1.0% of the total pay expenditure, and is below plan by £0.5m. Forecast agency expenditure is £2.5m which is below plan by £0.9m. The two highest areas of agency usage continue to relate to consultants and nursing staff.

Adult Acute OoA Placements

The biggest area of risk is in relation to Adult Acute OoA placements, with expenditure being above plan by £3.3m YTD and is forecast to be above plan by £4.5m. The forecast assumed current levels for December and then a reducing trajectory in line with the plan plus an additional five placements.

Capital Expenditure

Capital is below plan at the end of November by £1.9m. The plan included a 5% over planning assumption. It has been agreed for all organisations to remove the over-planning assumption from the forecast. As a System, there are several cost pressures that are emerging that need to be mitigated. Therefore, all organisations have been asked to consider contributing a further underspend on their capital plans to help mitigate the System capital position. We have paused expenditure by £200k and offered a further £850k by deferring expenditure on the self-funded Making Room for Dignity project, of which the £850k is expected to be returned in future years. There has also been new national funding agreed in relation to reducing OoA placements of £614k. Therefore, our capital expenditure is now forecast to be under plan by £393k.

Cash

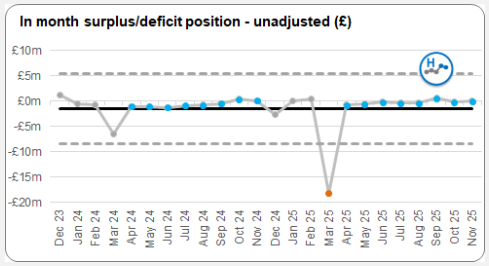
Cash at the end of November is at £29.7m which is higher than plan by £8.4m due to the timing of receipts. Cash levels at the end of March 2026 are forecast to be £23.9m, which is £1.5m below plan. Cash is forecast to be below plan due to some of the non-recurrent efficiencies being delivered through non-cash related benefits. There are no concerns in relation to debt recovery.

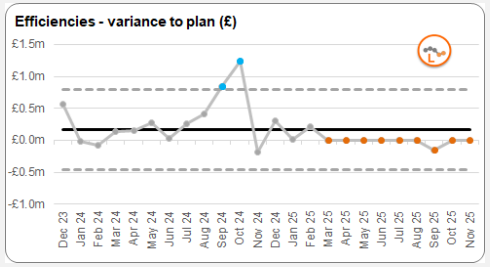
Better Payment Practice Code

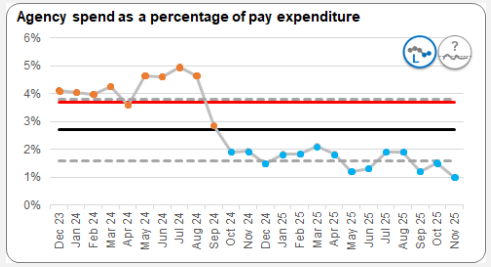
The Better Payment Practice Code (BPPC) sets a target for 95% of all invoices to be paid within 30 days. BPPC is measured across both invoice value and volume of invoices. At the end of November, both the value and volume of invoices exceeded the target at 99% and 97% respectively.

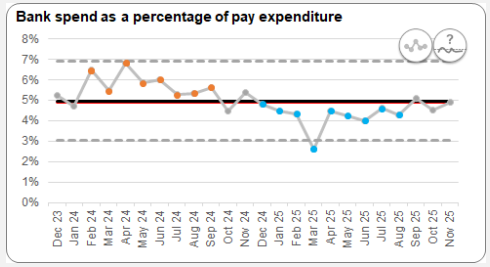
Measure	Target	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	
Financial Performance														
In month surplus/deficit position - unadjusted (£)	-	-£ 2,657,992	-£ 27,320	£ 505,698	-£ 18,160,011	-£ 759,497	-£ 618,647	-£ 181,431	-£ 356,503	-£ 340,743	£ 546,298	-£ 224,055	-£ 16,211	
Efficiencies - variance to plan (£)	-	£ 307,496	£ 11,618	£ 209,050	£ -	£ -	£ -	£ -	£ -	£ -	-£ 153,000	£ 2,000	£ 1,000	
Agency spend as a percentage of pay expenditure	3.7%	1.5%	1.8%	1.8%	2.1%	1.8%	1.2%	1.3%	1.9%	1.9%	1.2%	1.5%	1.0%	
Bank spend as a percentage of pay expenditure	4.9%	4.8%	4.5%	4.4%	2.6%	4.5%	4.3%	4.0%	4.6%	4.3%	5.1%	4.5%	4.9%	
Adult acute out of area expenditure (£000)	-	£ 1,012	£ 1,062	£ 889	£ 654	£ 799	£ 1,110	£ 977	£ 839	£ 618	£ 660	£ 727	£ 956	
Capital expenditure variance to plan (£)	-	-£ 1,047,000	-£ 1,969,000	-£ 3,798,000	-£ 6,307,000	-£ 953,000	-£ 1,907,000	-£ 107,000	-£ 333,000	-£ 640,000	-£ 917,000	-£ 274,000	-£ 1,606,000	
Better Payment Practice Code (BPPC) by volume	95%	97.0%	96.9%	97.0%	97.6%	97.6%	97.2%	97.5%	97.6%	97.4%	97.4%	97.3%	96.9%	
Better Payment Practice Code (BPPC) by value	95%	97.4%	97.7%	97.7%	99.8%	98.2%	98.4%	98.7%	99.0%	99.2%	98.9%	98.8%	98.6%	
Cash (£000)	-	£ 31,559	£ 26,415	£ 24,296	£ 19,071	£ 20,204	£ 17,589	£ 17,175	£ 25,805	£ 29,130	£ 25,167	£ 30,338	£ 29,717	
Liquidity (days)	-	-19	-23	-25	-12	-13	-14	-19	-16	-16	-16	-16	-16	
NHS oversight framework 2025/26														
Planned surplus/deficit year to date - adjusted (£)	£ -	-£ 5,540,510	-£ 5,813,263	-£ 6,154,302	-£ 6,383,704	-£ 643,118	-£ 1,289,243	-£ 1,442,742	-£ 1,714,677	-£ 1,986,468	-£ 1,521,049	-£ 1,472,000	-£ 1,421,000	
Variance year to date to financial plan - adjusted (£)	tbc	-£ 52,346	£ 420,664	£ 1,466,422	£ 6,384,643	£ 26,588	£ 43,183	£ 76,791	£ 63,671	£ 65,060	£ 207,015	£ 5,116	£ 6,456	
Relative difference in costs	<100%				93.76%									

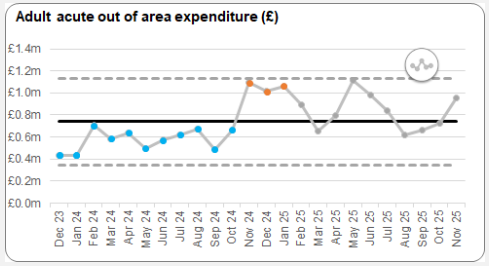
Financial Key Performance Indicators – Statistical Process Control Charts

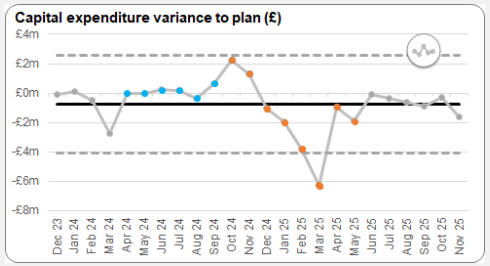


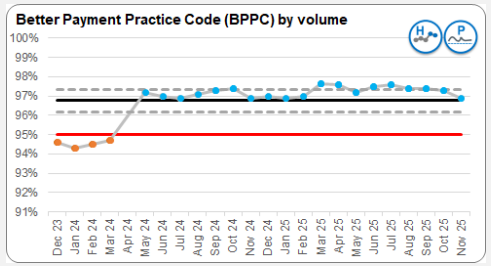


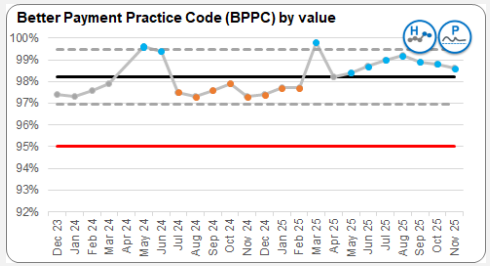


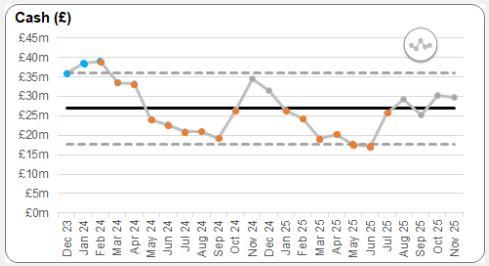


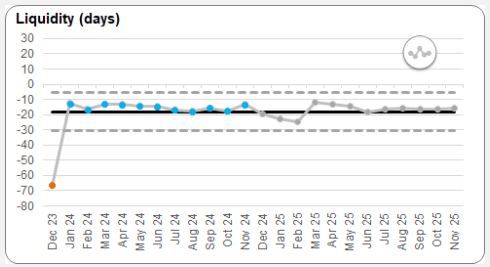


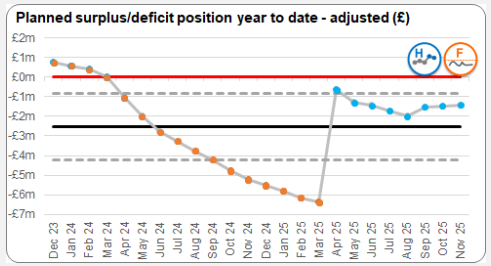


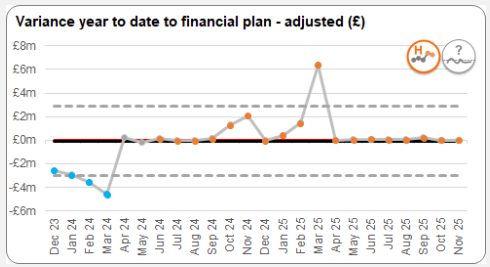


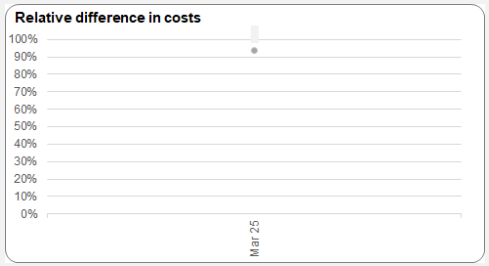








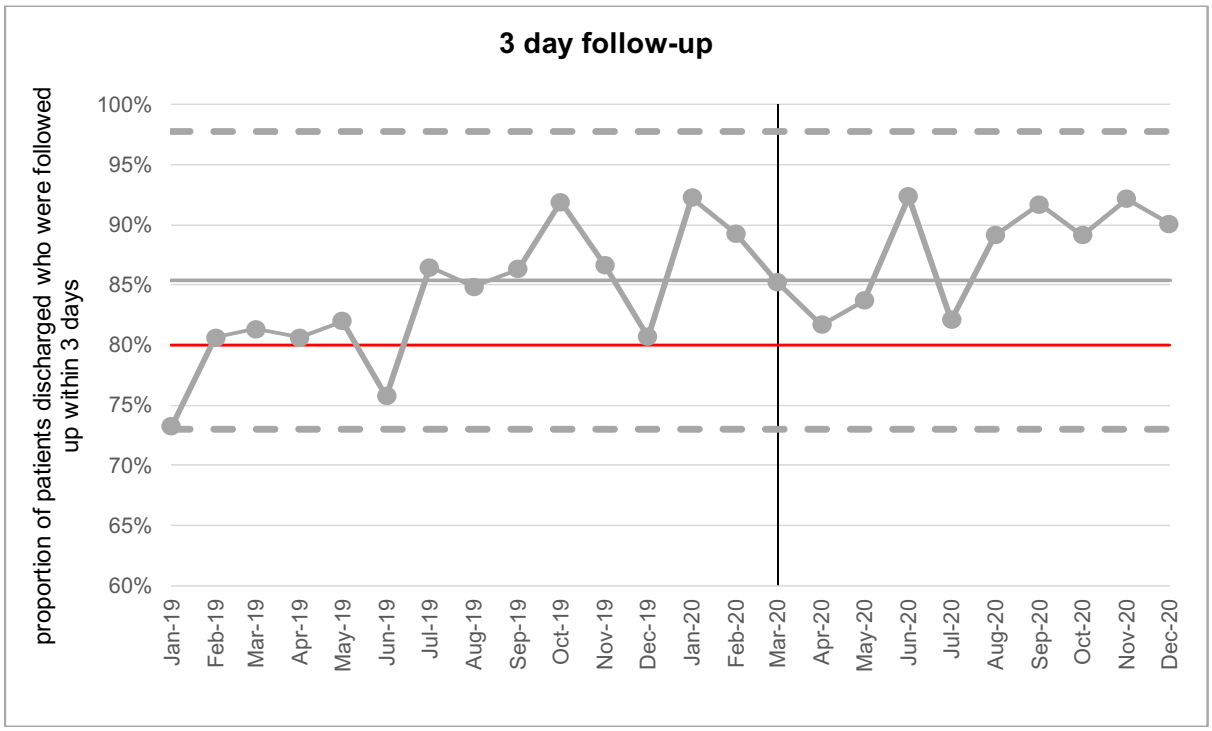




Appendix 1

Statistical Process Control Chart (SPC) Guidance

Example SPC chart:



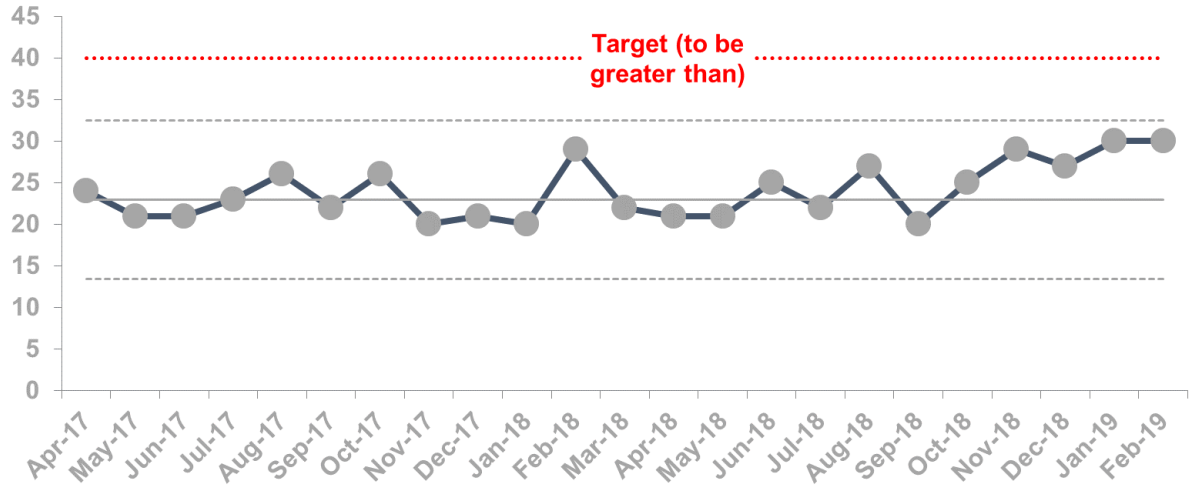
- The red line is the target
- The grey dots are the actual performance each month. They are coloured grey as performance each month is normal in this example
- The solid grey line is the average (mean) of all the grey dots
- The grey dotted lines are called process limits, or control limits.

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

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

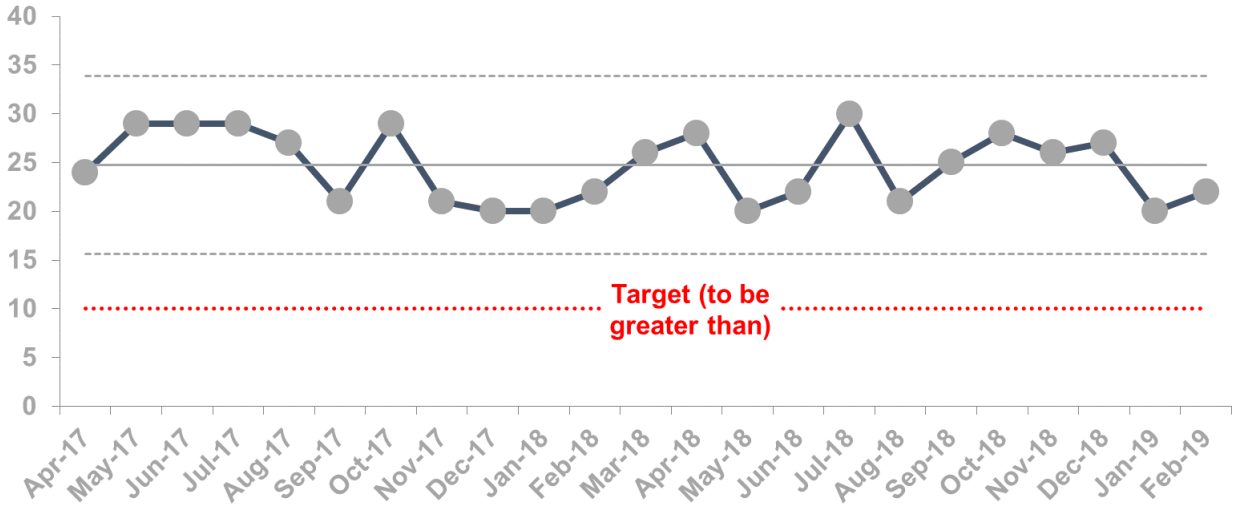
Things to look out for:

1. A process that is not working:



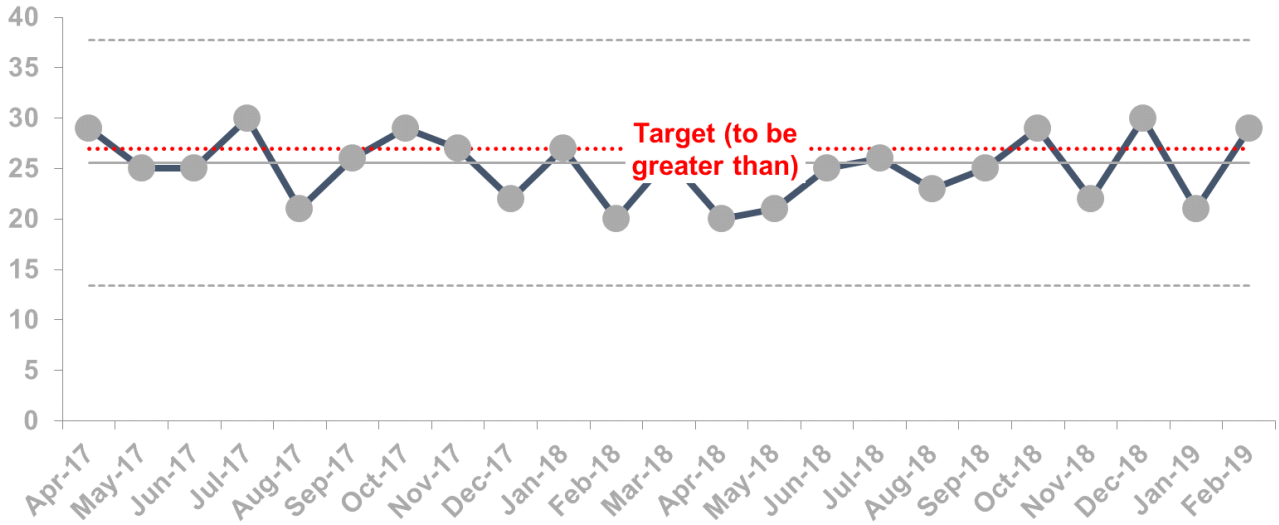
In this example the target is higher than the upper dotted grey line. This means that the target will never be achieved. To achieve the target, we need to change how we do things.

2. A capable process:



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

3. An unreliable system:

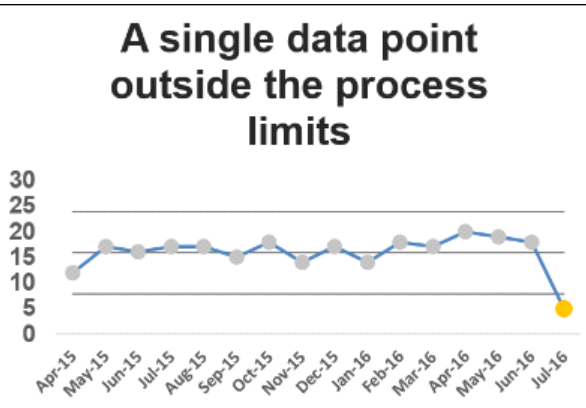
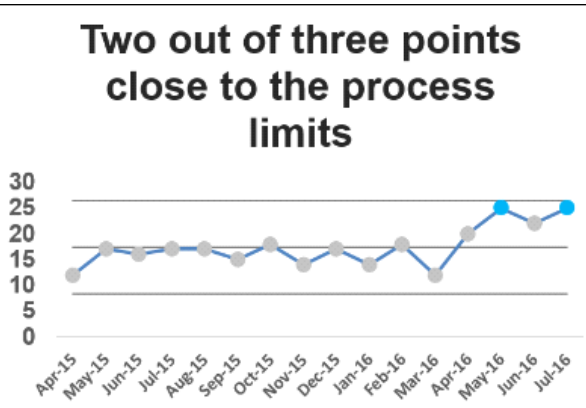
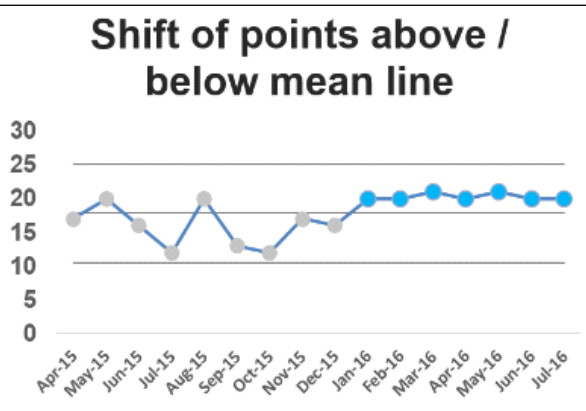
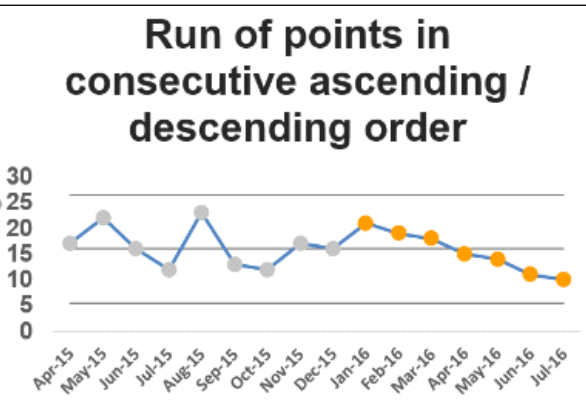


In this example, the target line sits between the two grey dotted lines. As it is normal for the grey dots to fall anywhere between the two dotted grey lines, this means that it is entirely random as to whether or not the target will be achieved. So, this system is unreliable and needs to be redesigned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

4. Unusual patterns in the data

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

There are four scenarios where this can happen:

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

Frequently seen in the NHS:

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

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

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

Appendix 2

Assurance Ratings

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 27 January 2026

Fundamental Standards of Care

Purpose of Report

To update the Board on the Fundamental Standards of Care and the performance against the standards as set out in the Care Quality Commission (CQC) key lines of enquiry.

Executive Summary

This report provides an update on the Trust's compliance with the Fundamental Standards of Care, including outcomes from Care Quality Commission (CQC) inspections, Mental Health Act visits, and ongoing quality improvement initiatives between July 2025 and January 2026.

The Kedleston Core Inspection in August 2025 rated the service as ‘good’ in all domains, highlighting effective leadership, safe care, and robust governance, while noting areas for improvement such as staffing-related leave cancellations and inconsistent advocacy attendance. Action plans have been implemented and monitored for these issues.

Adult Community Mental Health Programme: following a CQC initiative launched in 2025, the Trust has focused on Crisis and Community Mental Health services, conducting Fundamental Standards of Care visits with a focus on physical health monitoring and medicine optimisation. Compliance is overseen by governance teams and Divisional leadership.

Mental Health Act Monitoring visits: seven Mental Health Act visits occurred between July and December 2025, with reports noting improvements in ward environments and staff care, alongside areas needing enhancement such as section 17 planning and patient rights communication. A comprehensive Section 120 visit in October commended staff professionalism but identified System partner communication gaps and advocacy provision needs. No breaches were found.

Training and Supervision compliance: mandatory training compliance stood at 94.5% with role-specific training at 87.4%, while annual appraisals reached 90.8%. Managerial and clinical supervision rates were lower, with ongoing oversight to improve compliance and meet CQC staffing regulations.

Health Based Places of Safety (HBPOS): since April 2025, section 136 detentions increased by 56%, with police handovers mostly within one hour. Physical health assessments in 136 suites achieved 100% compliance in October 2025, supported by multi-lingual patient rights resources and a focused safety review with an action plan underway.

Ligature Risk Management: an increase in fixed-point ligature incidents was observed mid-2025, primarily involving door anchor points on specific wards. Door top alarms and a Ligature Risk Reduction Group have been implemented to monitor and address these incidents, with leadership sharing learning to enhance prevention.

The Trust eliminated out-of-area (OoA) placements for adult acute and male Psychiatric Intensive Care Unit (PICU) patients by December 2025, aided by the opening of a new male PICU. Female PICU placements remain OoA. Face-to-face crisis contacts within 24 hours improved from 56.3% in Q2 to 71.4% by Q3 2025, with performance plans in place. However, long waits over 52 weeks persist in Community Paediatric assessments, with planned data transitions and backlog reductions underway.

Patient Experience and Involvement: the 2024 Community Mental Health Survey had a 24.9% response rate, with plans for improvement underway. Experts by Experience have been trained to participate in care visits, embedding lived experience into quality assurance and action planning.

A new Operating Model was implemented in November 2025, restructuring the Trust into two Divisions to enhance multi-disciplinary collaboration and governance.

Fundamentals of Care (FoC) visits have been embedded into routine practice, with 85 visits conducted in 2025, including targeted reviews in Children's services and the PICU, Community services and Inpatient wards.

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

Risks and Assurances

The Fundamental Standards of Care have been developed in line with single assessment framework.

Significant assurance that the Trust responded to the Mental Health Act Visits and taken action to address areas of improvement.

Consultation

- CQC Operational Group
- CQC Oversight Group
- Quality and Safeguarding Committee.

Governance or Legal Issues

- CQC regulated activities and regulations
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Care Quality Commission (Registration) Regulations 2009
- Mental Health Act 1983.

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 review of Quality and Safety utilising Fundamental Standards of Care and CQC standards promotes equitable service delivery and no impact on the nine protected characteristics has been identified.

Recommendations

The Board of Directors is requested to:

1. Accept limited assurance on the Fundamental Standards of Care compliance; there is improved delivery of the standards in some areas whilst others require further improvement
2. Receive limited assurance on the CQC reviews core inspections and Mental Health Act visits, there have been no regulation breaches. However, areas of improvement have been highlighted in the reviews.

Report presented and prepared by:	**Tum Banda** **Director of Nursing, Allied Health Professionals (AHPs), Quality and Patient Experience**

The Board last received Fundamental Standards of Care updates in July 2025. This report covers the period from July 2025 to January 2026 and gives updates on the regulatory activity in the organisation and five Care Quality Commission (CQC) Domains.

CQC updates

Kedleston Core Inspection

The CQC carried out a full inspection across all five domains between 19 and 21 August, supported by a wide-ranging data request covering all domains. The service received a rating of ‘good’ in all domains and ‘good overall’. The Trust overall rating remains ‘good’.

CQC highlighted strong engagement, effective leadership, safe care and clear evidence of improvement. Governance systems were found to be robust, with compassionate, person-centred care, safe medicines management and a well-maintained environment.

The concerns raised were occasional leave cancellations due to staffing, inspectors noted this was always rescheduled at the earliest convenience but did cause frustration for some service user. It was noted that there was inconsistent advocacy attendance at multi-disciplinary meetings despite advocacy being proactively invited. Low compliance with supervision and appraisals was noted.

An action plan developed and implemented, the Trust is engaging with the Integrated Care Board (ICB) and advocacy service providers to improve the service delivery. There is a plan in place monitored by the ICB at through the Clinical Quality Review Group. Staff appraisals and supervisions are now compliant with Trust targets. The plan was completed and signed off by the Trust Delivery Group in December 2026.

Adult Community Mental Health Programme

In 2025, the CQC launched the Adult Community Mental Health Programme. This initiative followed a special review of services at Nottinghamshire Healthcare NHS Trust which was requested by the Secretary of State.

The CQC will assess all quality statements across all five Key Questions within two assessments service groups:

- Mental Health Crisis and health-based places of safety
- Community based mental health services for working age adults.

By November 2025, nine Trusts had been inspected, the initiative will review all providers that provide these services. All inspections will be unannounced.

There has been increased focus in the Crisis and Community teams to review and address areas that require improvement. The Community teams have weekly Fundamental Standards meeting supported by Human Resources and Clinical Quality teams. All the Community teams have had Fundamental Standards of Care visits and action plans are in place.

Fundamentals of Care (FoC) visits have been conducted in December 2025 across Adult Community Mental Health teams (CMHTs) with a specific focus on physical health monitoring for the severe mental illness cohort and medicines optimisation. These visits triangulated evidence from clinical records, practice observation and staff discussion. Oversight of this work is being coordinated jointly between the Physical Health Monitoring Clinic, CMHT Leadership, and Pharmacy, with additional input from the Head of Health and Safety. Compliance to the standards is being monitored by the Governance team and Senior Divisional Triumvirate.

Mental Health Act Monitoring Visits

There have been seven Mental Health Act visits between July and December 2025:

Bluebell Ward, 8 July 2025
Oak Ward, Derwent Unit, 27 August 2025
Sycamore Ward, Derwent Unit, 23 September 2025
Ward 36, Radbourne Unit 30, September 2025
Section 120 Mental Health Act Visit
Dove Ward, Carsington Unit, 3 December 202
Cubley Male, Cubley Court, 10 December 2025.

The reports have been received and actions and learning shared at the CQC Oversight Forum. There have been notable improvements in the environments in the new wards, staff have been described as caring, patients have reported good experience. The areas of improvement have been noted around section 17 planning and contingency plans, informing patients of their rights when there is a change in status or detention.

All the reports have been reviewed with the Senior Leadership team in the care groups and support is in place to support with the improvements. Actions for the reports up to September have been actioned and completed.

Section 120 Mental Health Act Monitoring visit, 7-10 October

The CQC carried out an announced monitoring visit under Section 120 of the Mental Health Act between 7 and 10 October 2025, covering all wards at the Radbourne Unit, Carsington Unit and Derwent Unit. The purpose was to review local assessment and admission processes, partnership working and compliance with the Mental Health Act and Code of Practice. The Trust co-ordinated preparations, facilitating engagement with staff, patients and key partner agencies, including the Local Authorities Approved Mental Health Professionals; police; East Midlands Ambulance service, advocacy providers and crisis alternatives. The CQC conducted interviews with 30 patients, six carers and a range of staff, including Responsible Clinicians; the Mental Health Act Office and senior managers, supported by a full review of records and documentation.

Inspectors commended the professionalism of staff, the quality of patient documentation (including Section 136 and admission records) and positive patient and carer feedback about care and responsiveness.

Areas for improvement were identified across System partners. These included ensuring nearest relatives are routinely identified and kept informed, improving the timeliness of Mental Health Act referrals between Responsible Clinicians and Approved Mental Health Professionals (AMHPs), and strengthening communication between local authorities and Crisis services. The CQC also noted the need to improve Independent Mental Health Advocacy (IMHA) provision, particularly for children and young people.

The findings indicate that while statutory Mental Health Act processes are in place, operational pressures and workforce challenges are impacting patient experience. No breaches of the Act were found during the inspection. A co-produced, System response and plan were submitted to the CQC and this being monitored through the CQC Oversight Group.

1. SAFETY

Training and Supervision

In January, Mandatory Training compliance was 94.5% and Role Specific Training compliance 87.4%; all within Trust targets. Annual Appraisals were 90.8%. Areas requiring improvements are Managerial Supervision which was 86.1% and Clinical Supervision was 84.8%. The People and Culture Committee now has oversight of the teams falling below 75% and seek assurance on improvements. 75% is deemed a breach of Staffing Regulation under CQC standards.

Health Based Places of Safety

Since April 2025, there has been an increase in section 136 detentions of 56% with an average of 35 detentions a month.

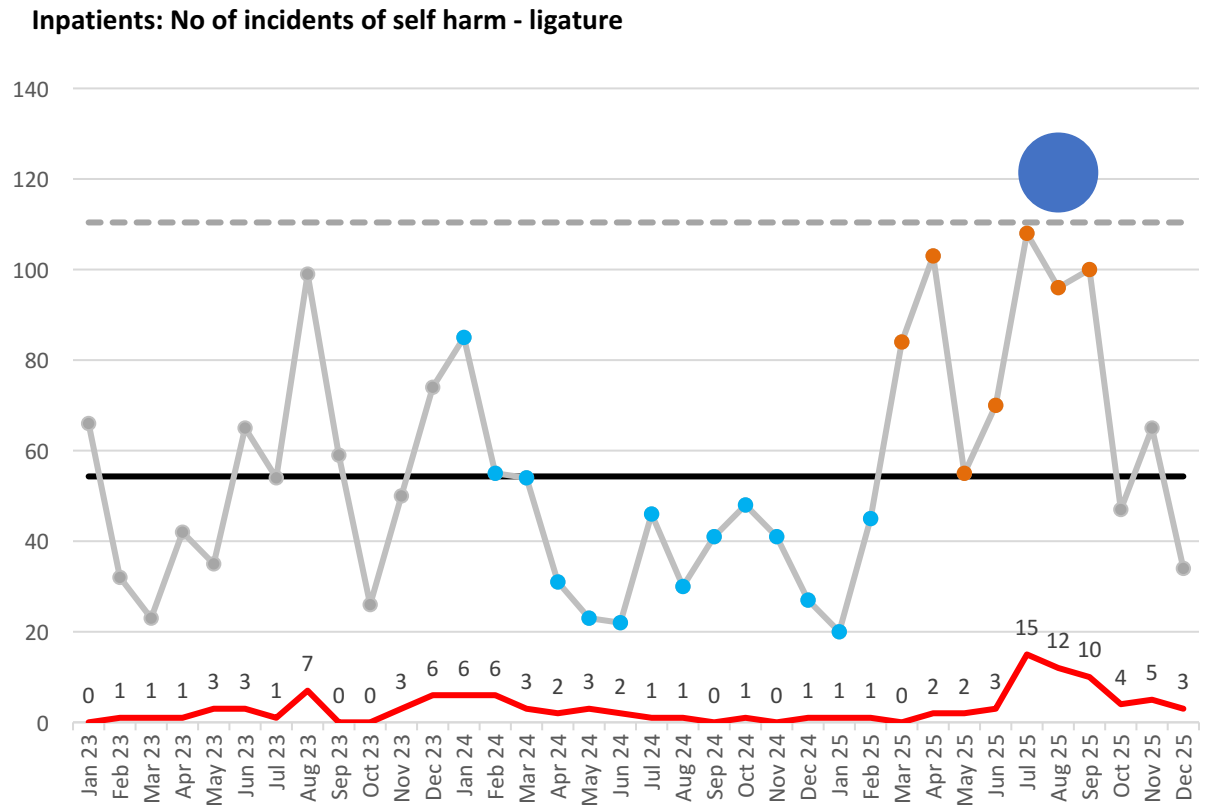
Police turnaround times from Derbyshire HBPOS, S136 Suites - 90% handover of patients from police to health are within one hour. Important to note – the police will still be required to stay if the assessment exceeds the risk threshold despite the one-hour standard.

There have been notable improvements in physical health assessments completed for patients detained in the 136 suites, last audit in October was 100% compliance. We now have a link to access 136 rights in multiple languages. The link has been shared with bleep holders and 136 staff to ensure that patients are informed of their rights.

A focused internal review was undertaken in October 2025 across all Health-Based Places of Safety (Radbourne, Carsington and Derwent Units). The review considered safety, environment, documentation, staff competence, and person-centred care, with reference to the CQC Single Assessment Framework.

The accompanying action plan identified 12 actions; eight have now been completed (including improvements to governance of incident learning) the remaining actions are on track and being followed in Fundamental Standards meetings in the Division.

Ligature Reduction



There has been an increase in fixed-point ligatures, 15 in July; 12 in August and 10 in September. The anchor point was the door. Those wards with a high number of fixed ligature points are Dove, Sycamore and Robin Wards. The door top alarms have been operational and alerted staff to the incidents and no harm was reported. The Ligature Risk Reduction Group is monitoring the incidents. The Matrons, Suicide Prevention Lead and Ward Managers have worked with the teams to share learning from the increase in incidents. Ligature Risk Reduction has now been launched for the inpatient settings.

2. EFFECTIVE

Digital Futures Day

On 18 November, we hosted our first ever Digital Futures Day, where we brought together over 100 colleagues to identify and explore opportunities for delivering safer, faster and more connected mental healthcare, by using existing and new digital technologies.

Plans are being followed up to support delivery of care with the latest technologies.

3. RESPONSIVE

Inappropriate out of area (OoA) placements:

A comprehensive performance improvement plan has been implemented, and the position has recovered to date, to zero Adult Acute and zero male Psychiatric Intensive Care Unit (PICU) placements, which will be reflected in the next report if sustained.

The new male PICU for Derbyshire opened in July 2025 which has had a positive impact on the care of male patients. There were zero OoA male PICU placements by end of December 2025. However, there is no PICU provision for females in Derbyshire, there are six OoA female PICU placements at the end of December 2025.

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

NHS England have introduced this metric this financial year which is a measure of the proportion of urgent referrals made to crisis teams and mental health single points of access who were seen face to face within 24 hours. In the quarter 2 (Q2) NHS Oversight Framework (NOF) ratings the Trust achieved 56.3%, against the provider median of 60.1%, placing in the second lowest quartile but close to quartile 3 for which the threshold was 59.9%. A performance improvement plan has been implemented with completion scheduled for the end of December 2025. From internal data, year to date Q3 performance is 71.4%, which is a significant improvement and would have placed in the top end of quartile 3, the second highest quartile.

Community waits over 52 weeks

In Q2, the Trust placed in quartile 4 and was ranked the second highest (worst performing) of all providers with 68.15% of children and young people waiting over 52 weeks to be seen. The national median was just 0.33%. The threshold for attaining quartile 3 was just 6.8%. The majority of these long waits are for Community Paediatric autism spectrum disorder assessment or attention deficit hyperactive disorder assessment. The planned transfer of these waits into the Mental Health services dataset in line with other providers, as advised by NHSE, will improve the position to around 16% presenting a more accurate picture. However, this would still place well within quartile 4. The transition of the records is planned to be progressed from January 2026 onwards, with further phased improvement through backlog reduction from April 2026.

4. CARING

The Community Mental Health Survey

The Community Mental Health Survey was undertaken by IQVIA for the Trust between August and November 2024. The final response rate for the Trust was 24.9% (302 responses from a usable sample of 1,212). For DHcFT, over 60% of respondents were over the age of 50 with 32% over the age of 66; this is a 10% difference when compared with the national picture. The care groups led by the Head of Clinical Practice are working on improvement plans.

The Trust has completed the patient survey for 2025 and the results have been shared with the organisation. However, they are embargoed still publication in March 2026.

Experts by Experience

Training has been delivered to Experts by Experience to support their involvement in team visits. The training covers the role of FoC 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.

Complaints

The rate of response for formal complaints is below the set Trust standard of 90 days. Whilst there have been improvements from 2024/25 the average response time was 187 days in 2025/26 to date the average is 145 days. The Patient Experience team is working with the Transformation team to improve the response rate. The plan of improvement will be sent to Quality and Safeguarding Committee in February 2026.

5. WELL-LED

Night Visit

The Director of Nursing, Allied Health Professionals (AHPs), Quality and Patient Experience (DoN), had a night visit starting when the night shifted commenced on 8 October 2025. The visit was facilitated by the bleep holders at Carsington, Kingsway and Radbourne and they were helpful in navigating the wards and the various stations that the teams have during the night. The DoN visited the Kingfisher PICU; Audrey House; wards on Carsington, Kedleston, Tissington, Cubley Court Male and Female, Cherry Tree Bungalows at Radbourne Wards 35 and 36; the Beeches and the 136 Units at Radbourne and Carsington.

The staff were welcoming, and they were happy to have a senior member of the team visit them. They spoke openly about what was going well and what their challenges were. Those recently inspected were proud of the outcome form their reports. The DoN spoke to a few patients; some had concerns about their care that the DoN handed over to the teams on duty and these have since been followed up on.

Areas of improvements identified are being followed up and monitored by Governance team.

New Operating Model

The new Operating Model in now in place from November 2025. There are now two Divisions: Community and Acute Mental Health services and the other division is the Older Adults MH services, Specialist and Children's services.

The new structure intends to promote collaborative working by emphasising multi-disciplinary and partnership working, with mechanisms for learning from incidents and sharing best practice.
The governance for the divisions and care groups has been updated. The new Care Group meetings are now in place with a new Divisional Delivery Board beginning in January.

Fundamental Standards of Care Visits

During the last 12 months, the FoC visiting process has been strengthened and embedded into business-as-usual practice. This has ensured that FoC visits are now undertaken routinely, with each team receiving a minimum of two visits per year. Experts by Experience are trained and embedded within the visiting teams, ensuring that lived experience is a core component of the assurance approach.

Between February and December 2025, a total of 85 FoC visits were carried out across the organisation, covering both inpatient wards and community services for all care groups. These visits have offered consistent insight into quality, safety and patient experience across all areas, helping to identify themes, drive improvements and provide ongoing assurance. All teams have received at least one visit with several care groups having received revisits. Targeted visits are undertaken where there are performance concerns or local intelligence.

Children's services

The Children's Services undertook unannounced FoC visits during August and early September. Visits were led by senior clinical leaders and included Experts by Experience. Staff valued the process and families reported feeling listened to and involved. The Division reported that the visits strengthened regulatory readiness, supported staff learning and ensured early identification of risks and improvements. The action plan is now complete.

Kingfisher, Psychiatric Intensive Care Unit (PICU)

A FoC visit was undertaken on 24 September 2025 to Kingfisher House PICU. The review panel included representation from Nursing, Clinical Quality, Training and lived experience partners, supported by a Specialist Matron with PICU experience from Northamptonshire Healthcare NHS Foundation Trust. The visit incorporated patient and staff engagement, environmental review and a sample audit of care plans, risk management documentation and incident processes. As a new service, the team has settled well and is working to improve on the delivery of the PICU Model.

Patient and Carer Race Equality Framework (PCREF)

Purpose of Report

To provide an overview on PCREF, process so far and the next steps in the implementation of PCREF in the Trust.

Executive Summary

PCREF[1] is a framework that was launched by NHS England in October 2023 with an aim for all mental health trusts in England to be anti-racist organisations.

The three key aspects of PCREF and their key components are:

1. Leadership and Governance
2. Organisational Standards
3. Patient and Carer feedback

Illustrated in the diagram in Appendix 1

Key milestones needed to achieve PCREF implementation:

1. Understanding the needs of the population based on ethnicity ie robust data collection on ethnicity.
2. Analysing inequality based on ethnicity in access, outcome and experience of service users including staff competency.
3. Having robust mechanism to incorporate the voices of service users, carers and communities.
4. Working in partnership to co-produce an improvement plan to tackle health inequality based on ethnicity.
5. Having a sample of services/teams implementing the PCREF.
6. Having adequate governance structure to capture health inequality based on ethnicity and to monitor the progress on implementation plan.

All Trusts were mandated to publish a self-assessment-checklist-.docx based on three key aspects of PCREF along with a co-produced improvement plan by the end of March 2025.

In addition, as a minimum each Trust needs to compile a series of measures (such as Mental Health Act (MHA) detentions, least restrictive practices based on ethnicity) shown as trends to demonstrate improvement over time. The Care Quality Commission (CQC) will be assessing how trusts implement PCREF during their inspections that will affect the overall trust rating.

Progress so far:

1. Executive Medical Director identified as an executive sponsor for PCREF.
2. Appointment of PCREF lead in Quarter 3 of 2025/26 (15 hours per month).
3. The sub-committees and the Board have been sighted of the requirement of PCREF with the last update to Quality and Safeguarding Committee in October 2025 (Appendix 2).
4. Agreement that MHA Committee will govern the implementation of the PCREF in the organisation.
5. Having a PCREF implementation plan that needs further work and is co-produced.
6. PCREF workshop organised on 23 January 2026 to all senior operational managers.

[1] NHS England » Patient and carer race equality framework

Challenges:

1. PCREF lead not having adequate capacity to oversee PCREF development and implementation across the Trust.
2. Lack of assurance on adequate progress with PCREF and is highlighted on the Board Assurance Framework (BAF).
3. Limited awareness on issues related to ethnicity data and ability to systematically analyse the population needs that will help with an implementation plan.

Moving forward:

1. Trust has agreed to have a dedicated PCREF lead until the end of March 2027 with a plan to fully embed this in the care groups business as usual. Recruitment is underway.
2. To complete the self-assessment checklist on PCREF and an improvement plan by the end of March 2026.
3. Setting up a PCREF Steering Group to oversee the development and implementation of PCREF Plan and will be chaired by Executive Medical Director or a deputy that will report to MHA Committee.
4. Quarterly update to MHA Committee and to the Board every 6 months. If any significant issues related to staff and/or to service users/carers the Executive Medical Director will report in his highlight report to the People and Culture Committee and to the Quality and Safeguarding Committee respectively.
5. Operational oversight will be via care group Operations meetings, Divisional Operations group meetings and Trust Delivery Group supported by the PCREF Lead.
6. Explore the possibility of being part of the national pilot sites to share and learn best practices.

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

Risks and Assurances

Non-compliance with PCREF may have an impact on tackling health inequality based on ethnicity and may affect Trust CQC rating.

Consultation

It has been consulted with Executive Leaders Team (6 January 2026) and tabled for discussion in Trust Delivery Group on 20 January 2026.

Governance or Legal Issues

PCREF is a mandatory requirement for all mental health trusts.

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:

Implementation of PCERF will have a positive impact on tackling health inequality and for the Trust moving towards become an anti-racist organisation.

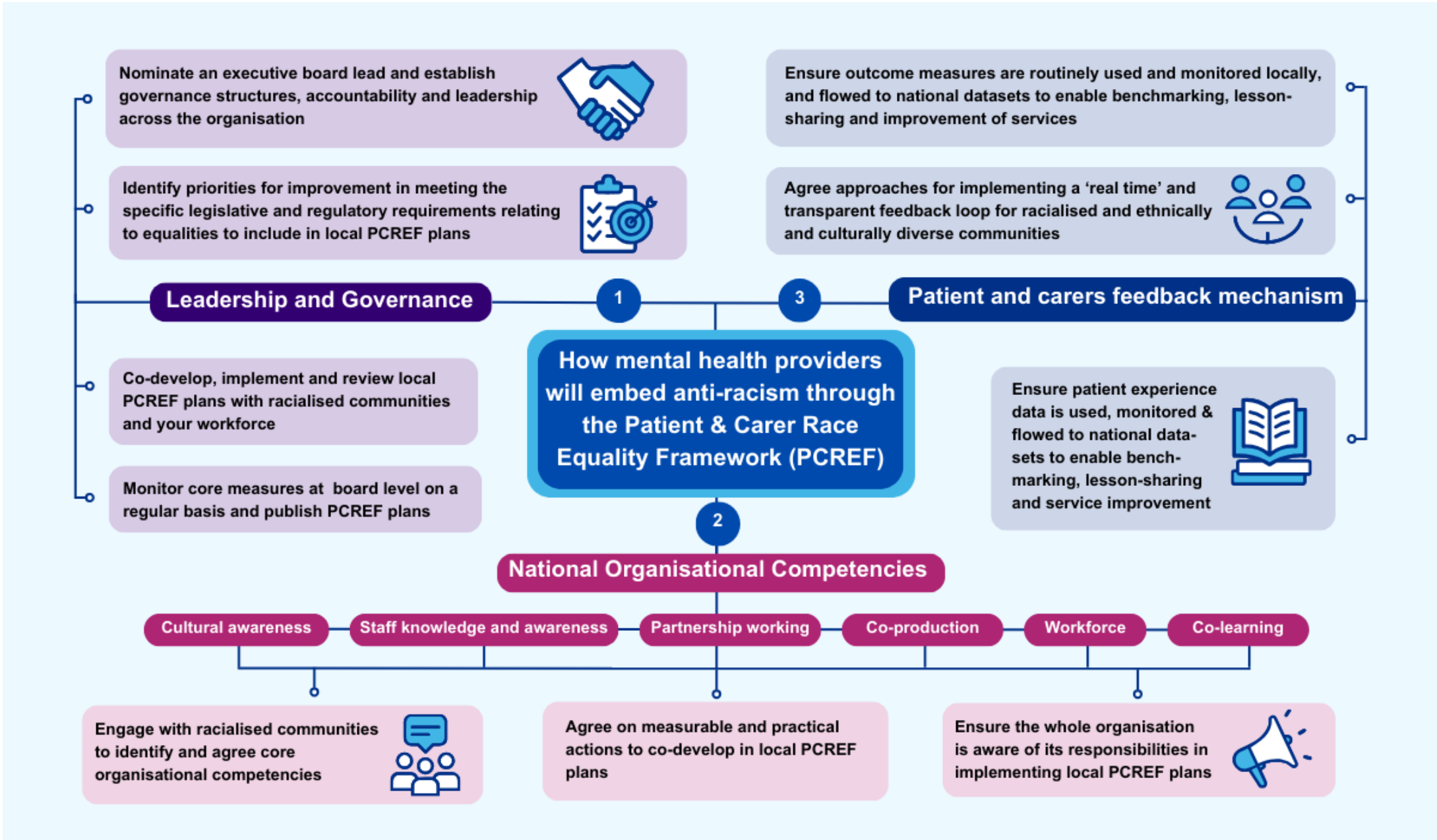
Recommendations

The Board of Directors is requested to:

1. Note the mandatory requirements of PCREF in the Trust and delay in its implementation.
2. Receive assurance that Trust is in the process of recruiting a full time PCREF lead and will complete the self-assessment checklist by the end of March 2026 with an intent to publish on Trust public website
3. MHA Committee will act on behalf of the Trust Board to oversee Trust compliance with PCREF. Operational oversight will be at the Trust Delivery Group.

Report presented and prepared by: **Dr Girish Kunigiri**
Medical Director

Appendix 1


How mental health providers will embed anti-racism through the Patient & Carer Race Equality Framework (PCREF)
1
Leadership and Governance
Nominate an executive board lead and establish governance structures, accountability and leadership across the organisation
Identify priorities for improvement in meeting the specific legislative and regulatory requirements relating to equalities to include in local PCREF plans
Co-develop, implement and review local PCREF plans with racialised communities and your workforce
Monitor core measures at board level on a regular basis and publish PCREF plans
2
National Organisational Competencies
Cultural awareness
Staff knowledge and awareness
Partnership working
Co-production
Workforce
Co-learning
Engage with racialised communities to identify and agree core organisational competencies
Agree on measurable and practical actions to co-develop in local PCREF plans
Ensure the whole organisation is aware of its responsibilities in implementing local PCREF plans
3
Patient and carers feedback mechanism
Ensure outcome measures are routinely used and monitored locally, and flowed to national datasets to enable benchmarking, lesson-sharing and improvement of services
Agree approaches for implementing a 'real time' and transparent feedback loop for racialised and ethnically and culturally diverse communities
Ensure patient experience data is used, monitored & flowed to national data-sets to enable bench-marking, lesson-sharing and service improvement

Derbyshire Healthcare
NHS Foundation Trust

Patient and Carer Race Equality Framework (PCREF) October update Quality and Safeguarding Committee

Overview

Derbyshire Healthcare
NHS Foundation Trust

- Change in Executive Leadership
- Only 15 hours a month allocated to advancing PCREF agenda
- Outline three main areas highlighting
  - Commitment statements
  - Objectives for each element
  - Key actions to be progressed
- Suggested format for EDI Community of Practice, PCREF Steering Group Terms of Reference under development

Leadership and Governance

Derbyshire Healthcare
NHS Foundation Trust

Commitments

- Allocate Executive Director/Sponsor for PCREF
- Ensure robust governance structure for improving racial equity in care
- Collect, monitor and use data relating to racial equity in care to inform decisions and improve patient outcomes
- Establish an independent mechanism for oversight on the implementation of PCREF, consisting of local community leaders, patients and carers, ICS related health inequalities collaborations and others as required

Leadership and Governance - Objectives

Derbyshire Healthcare
NHS Foundation Trust

- Six-monthly update report to Quality and Safeguarding Committee
- Understanding the population within Derby and Derbyshire in relation to race and diversity and comparison to Trust services
- Embed PCREF into service lines local governance processes, training and improvement programmes
- Establish and begin regularly meeting as PCREF Steering Group, feeding into established governance structures
- Roll out training/awareness campaign to improve data quality recording, including protected characteristics
- Work with services to systematically embed equity into their performance reporting
- Ensure significant service changes and new/reviewed policies are robustly assessed and considered through a racially informed lens.

Leadership and Governance – Key Actions

Derbyshire Healthcare
NHS Foundation Trust

- Undertake a governance structure review
  - Health Inequalities Steering Group – re-establish
  - PCREF Steering Group – develop Terms of Reference
  - EDI COP – Link with Head of EDI
- Need to recruit Lived Experience partners (service users and carers)
- Improve quality of data collection around protected characteristics
- KPIs to be introduced for Divisional/care performance reviews – Divisional compliance for data collection on protected characteristics
- Understand local population group data and proportionality of diversity within Derby and Derbyshire

Recording race
mation CWPT exar

Organisational Competencies

Derbyshire Healthcare
NHS Foundation Trust

Commitments

- Seek to embed racial equity within our Trust policies
- Identify and address implicit biases that may impact our work and ensure equitable treatment of racialised, ethnically and culturally diverse communities within our services
- Create an equitable environment for staff and meet the specific needs of staff from racialised, ethnically and culturally diverse backgrounds.
- Communicate transparently about our PCREF plans, progress and learning with our workforce

Organisational Competencies – Objectives

Derbyshire Healthcare
NHS Foundation Trust

- Start to understand the racialised patient journey through Trust services
- Review Inclusion Guardians for interview/recruitment panels and consider further developments
- Review mandatory training in relation to equality and diversity and consider racial lens on content
- Link with Health Inequalities Trust-wide work
- Internal Intranet page for PCREF
- Share learning and best practice throughout the organisation

Organisational Competencies – Key Actions

Derbyshire Healthcare
NHS Foundation Trust

- Review compliance for EDI training
- Consider any additional training requirements for EDI champions/Freedom to Speak up Guardians in relation to race/culture and diversity
- Development of a communications plan to promote, cascade and explore PCREF within the organisation
- Ensure collaboration with the BME network
- Develop training package for unconscious bias, cultural humility training – peer network support from other mental health trusts
- Consideration to re-establish reciprocal mentoring programme for leadership and management roles

Patient and Carer Feedback

Derbyshire Healthcare
NHS Foundation Trust

Commitment

- We will listen to patients, act on feedback and evidence where this has been implemented
- Established an infrastructure for co-production with racialised, ethnically and culturally diverse communities

Patient and Carers Feedback - Objectives

Derbyshire Healthcare
NHS Foundation Trust

- Establish an independent mechanism for oversight on the implementation of PCREF, consisting of local community leaders, patients and carers, ICS related health inequalities collaborations and others as required
- Establish community champions to inform service delivery/design and inclusion needs
- Develop simple guidelines for our workforce on how to effectively and sensitively engage communities in co-production activities such as service improvement.

Patient and Carer Feedback – Key Actions

Derbyshire Healthcare
NHS Foundation Trust

- Map current feedback mechanisms with service users and carers
- Develop process for ‘You said, we did’ with patient and carer feedback
- Further develop relationships with established groups within the Trust to support patient and carer involvement
- Consider research and development opportunities to better meet the needs of racialised communities within Derby and Derbyshire

What is a community of practice?

NHS
Derbyshire Healthcare
NHS Foundation Trust

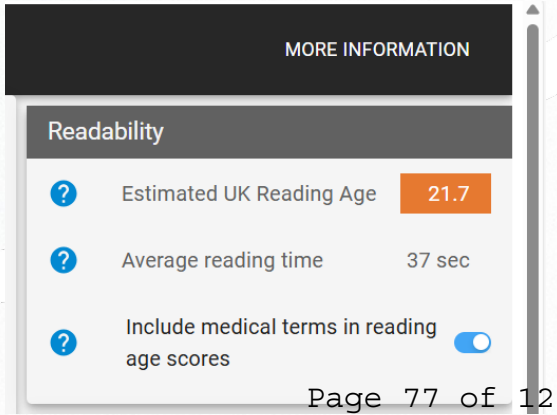
- Communities of Practice (CoPs) are self-organising and self-governing groups of people who share a passion for their field and strive, through collaboration, to become better practitioners

- Communities of Practice are not new in the NHS and have an established place in improvement work. The cross-professional and organisational boundary nature of CoPs gives them the potential for reducing fragmentation of practice in service into issues that really matter, such as Patient Safety; and that are typically complex and beyond the scope of any individual, profession or organisation

- In the NHS, “a CoP differs from a delivery network because membership is optional, and the ways of working are informal … it’s a conversational relationship of peers who want to share and learn from each other. They will also help… develop cross boundary relationships with leaders in other parts of the organisation or community.” (From the Improvement Leaders’ Guide, by the NHS Institute for Improvement and Innovation)

A doing and learning environment

Sharing knowledge, helping colleagues to share ideas, question and learn



Equality, Diversity and Inclusion (EDI) COP

Derbyshire Healthcare
NHS Foundation Trust

- Community – colleagues within the organisation who have a passion for EDI
- Practice – the community collaborates to learn and understand differences in EDI workstreams throughout the Trust
- Domain – Developing and embedding good practice and learning relating to EDI throughout the Trust

EDI COP – overview

Derbyshire Healthcare
NHS Foundation Trust

- **Aim**
  - To collaborate and identify EDI related projects/schemes/activities across the Trust.
- **Objectives**
  - To bring together people who are passionate about EDI and health inequalities
  - Sharing good practice and developments with staff, patients/service users and carers
  - Provide a point of reference for EDI related projects
  - Promote EDI as more than a ‘tick box’ exercise
  - Review national schemes and how the Trust links that into current practice (PCREF)
  - Avoid duplication of effort in EDI
  - Facilitate knowledge exchange and resource sharing

EDI COP – Outcomes and Expectations

Derbyshire Healthcare
NHS Foundation Trust

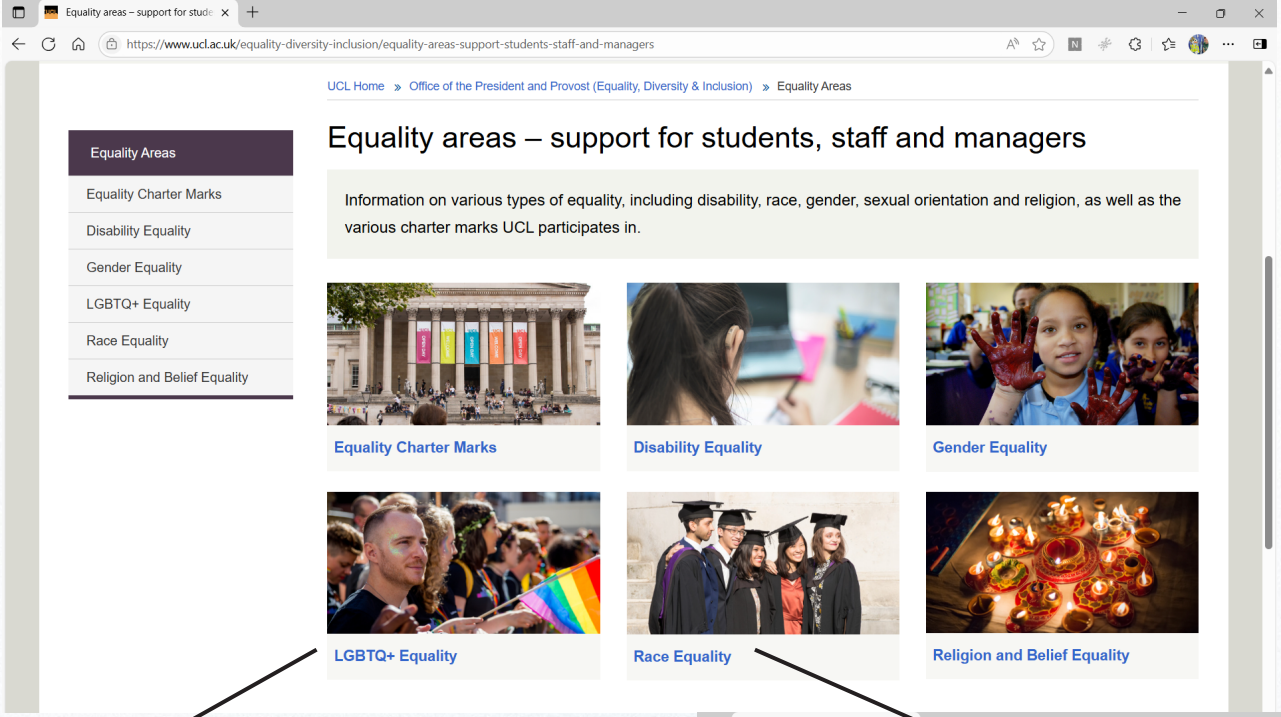
- Overview of EDI work within the Trust
- Consideration of an Equality, Diversity and Inclusion Committee
- Understanding data held
- Development of key performance indicators
    - Increase Division compliance with recording patient ethnicity data
- Development of EDI pages on focus to support staff
- Plan to support embedding EDI knowledge and awareness across the organisation

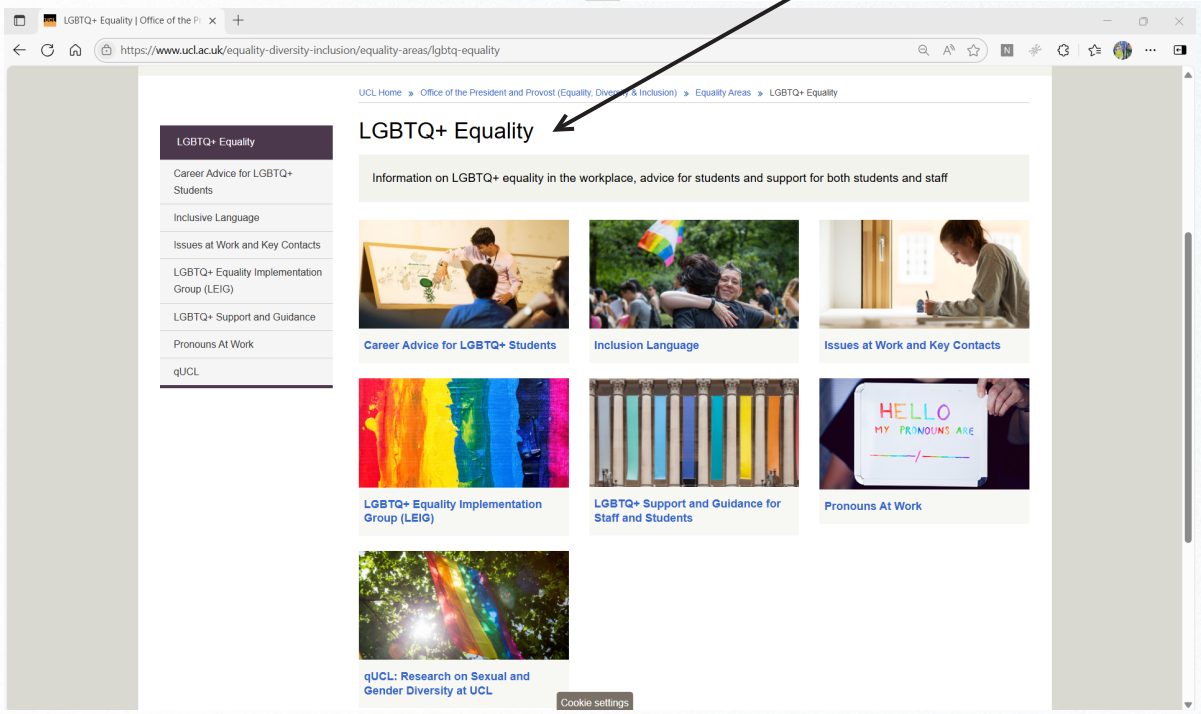
Example

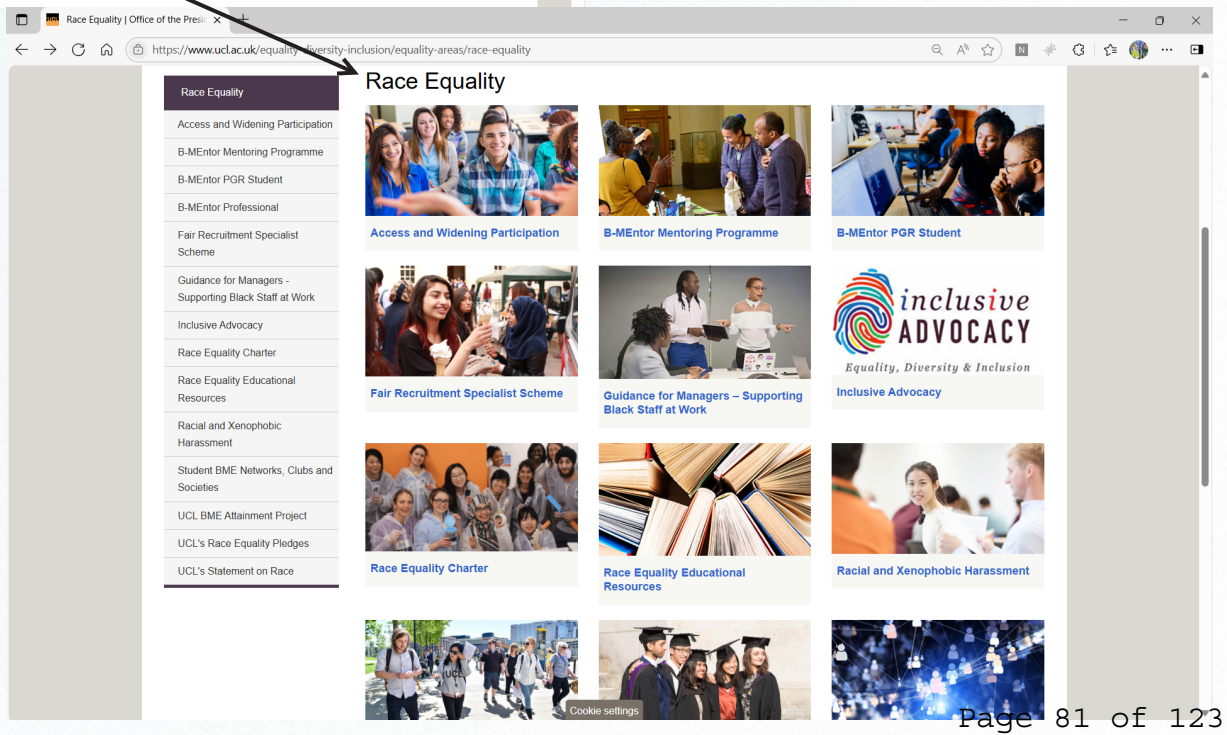
University College London

Equality pages

Derbyshire Healthcare NHS Foundation Trust







Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 27 January 2026

Trust Strategic Plan - 2025-28, Quarter 3 (Q3) progress update

Purpose of Report

To update the Board of Directors on progress in delivery of the Strategic Plan at the end of Q3 2025/26.

Executive Summary

The Strategic Plan 2025-28 was approved by the Board on 4 March 2025.

The enclosed report provides an update at the end of Q3 2025/26 on delivery of priorities and deliverables within the year one roadmap. The format is presented to reflect a status position at the current quarter end date and the expected position at the year end. The report also offers a view on completeness of intended assurances, which have been mapped to the papers received by the agreed oversight forum.

At the end of Q3, a number of concerns are identified and under active management via internal management forum, with escalation as appropriate through respective Board assurance committees. Focus is being placed on the following red and amber rated strategic plan deliverables:

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

Feedback monitoring maintained over Q3 with identified need to accelerate improvement in responsiveness to feedback and complaints. Action plan developed with progress and assurance being overseen by the Quality and Safeguarding Committee.

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

Action progressed but will be supported by enhanced arrangements within the new operating model which will be operationalised in quarter four.

Delay in publication of the new national Personalised Care Framework is impacting the expected timeline to design and deliver an aligned implementation plan.

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

The Clinical Services Delivery Plan remains in draft with progress to be made on agreed approach in development of this over the next quarter.

Access and waiting times are challenged across a number of services with recovery plans being overseen by the Trust Delivery Group and Finance and Performance Committee.

2.1 to 2.4: People deliverables

Progress across deliverables has been challenged by the requirement to invest significant leadership team capacity in the new operating model. Recovery of all deliverables is expected over Q4 with progress being overseen by People and Culture Committee.

3.2 Transform our clinical pathways and operating model

Design of the Corporate Transformation Programme is underway and to be accelerated in Q4 with a first draft to be received by the Executive Leadership Team in January.

3.3 Optimise our assets and enabling resources to improve services and care

Digital Delivery Plan delayed and to be finalised in quarter four applying insights and outputs from the Digital Futures Day hosted on 18 November 2025.

At this quarter end, two plan deliverables are deemed to be at risk in terms of annual roadmap delivery. Access recovery plans for some services will not deliver a compliant position by the 2025/26 year end. Full delivery of the Digital Delivery Plan ambitions are also at risk with focused action on accelerating progress over Q4.

All other deliverables are deemed to be on track for delivery by Q4 aligned to the annual roadmap however this position is dependent on timely receipt of a number of national outputs and publications that have been delayed beyond expected timelines, including the NHSE Personalised Care Framework and national cost collection outputs.

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

Risks and Assurances

- The Strategic Plan aligns with and seeks to enact the Trust's Strategy
- The source and forum for assurance is defined for each priority
- Risks to delivery will be managed via the Board Assurance Framework.

Consultation

The Strategic Plan was developed through engagement and consultation through two Board Strategy and Development Sessions, the Staff Conference and the Leadership Forum.

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

Recommendations

The Board of Directors is requested to note the progress in delivery of the Strategic Plan at the end of Q3 2025/26.

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

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

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NHS Foundation Trust

Strategic Plan 2025 - 2028

Progress Update: Q3 2025 – 2026

Patient focused

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

NHS Derbyshire Healthcare NHS Foundation Trust

Priorities for delivery of success	Roadmap to delivery of success 2025-26	Q3 Progress Update	Status Q3 Actual	Status Q4 Expected	Assurance mapped to Q3 papers
1.1 Improve safety and effectiveness in line with our quality ambitions	1.1.1 Develop and implement Quality Delivery Plan, agree improvement ambitions and measures, and establish associated governance 1.1.2 Monitor performance and implement action plans to address any identified improvement opportunities 1.1.3 Implement national initiatives including Culture of Care inpatient quality improvement programme and Patient Carer Race and Equality Framework	1.1.1 Quality Delivery Plan approved and published in Q2 including roadmap to delivery and measures of success. 1.1.2 Quality monitoring continuously developed over Q3 with mechanisms fully embedded, action plans delivered as appropriate to address identified areas of improvement and assurance overseen by QSC. Performance and improvement framework drafted and considered by QSC with broader consultation planned for Q4. Approach approved for safer staffing in community services with project to be launched in Q4. 1.1.3 Progress maintained in Culture of Care programme with coaching now underway for the five older adult wards and self assessment completed to inform plan for Q4. PCREF lead commenced in post with plan to further strengthen clinical support in Q4.	On track	Expected on plan at Q4	Agreed assurances considered by Quality and Safeguarding Committee (QSC)
1.2 Improve experience for, and empower, service users patients and carers	1.2.1 Define and agree experience measures across all services 1.2.2 Review and refine feedback mechanisms across all services 1.2.3 Monitor feedback and implement plan to address any identified improvement aligned to transformation and continuous improvement portfolio 1.2.4 Develop and agree framework for empowerment 1.2.5 Design and launch education programme 1.2.6 Develop and implement engagement through to co-production framework	1.2.1 Measures of experience defined through new Quality Delivery Plan with dashboard developed and operationalised in Q3 to track and assure delivery. 1.2.2 Feedback mechanisms further developed in Q3 with forward focus on standardisation and effective co-ordination and escalation across all services. Plan progressed to relaunch electronic patient survey in Q4. 1.2.3 Feedback monitoring maintained over Q3 with identified need to accelerate improvement in responsiveness to feedback and complaints. Action plan developed and progress to be overseen by QSC in Q4. 1.2.4 Approach defined within Quality Delivery Plan and action plans in delivery aligned to newly appointed remunerated lived experience roles across all services and renewed patient and carer experience meeting. 1.2.5 Education programme now focused on addressing identified need in physical health with CPD programme designed and funding secured for launch of delivery phase in partnership with DCHS over Q4. 1.2.6 Work plan for advancing coproduction and participation advanced with lived experience partners now part of fundamental care standard and quality visits. Further development of approach planned over Q4.	Accelerated recovery action required Q4 on timeliness of response to feedback and complaints	Risk to full recovery by Q4	Agreed assurances considered by QSC
1.3 Develop effective quality governance systems and processes that facilitate shared learning and support a positive safety culture	1.3.1 Review, refresh and embed quality governance systems aligned to new Quality Delivery Plan 1.3.2 Refine Learning Culture and Safety Group as a mechanism to develop and assure a positive safety culture 1.3.3. Agree preferred model and design plan for transition from Care Programme Approach to support safe care co-ordination	1.3.1 Plan for development of quality governance systems defined within the Quality Delivery Plan. Clinical governance arrangements drafted aligned to new operating model and to be ratified and operationalised in Q4. 1.3.2 Safety defined within new Quality Delivery Plan and associated development plan in delivery with a focus over Q3 on alignment and connection of approach and learning mechanisms under new operating model 1.3.3 Decision agreed to implement new NHSE Personalised Care Framework. Delayed final framework and guidance now expected to be published in Q4 with aligned implementation plan to be developed and agreed.	Delivery behind plan at Q3	Risk to delivery due to delay in NHSE Framework	Agreed assurances considered by QSC
1.4 Improve access to our services and achieve all target wait times	1.4.1 Launch and deliver year 1 Clinical Services Delivery Plan with a focus on improving access and on understanding and addressing health inequalities 1.4.2 Design framework for disproportionate allocation of resources based on needs of our population 1.4.3 Agree and monitor achievement of target waiting times across all services with a year 1 priority focus on eradication of inappropriate out of area (OOA) placements through 'end to end' pathway optimisation	1.4.1 Clinical Services Delivery plan remains in development with draft and forward approach to be considered by new Medical Director and via internal governance and assurance committees over Q4. 1.4.2 Framework for disproportionate allocation of resources in development aligned to 1.4.1 above. 1.4.3 Achievement of all target waiting times overseen in Q3 via internal performance framework and FPC. Focus on flow improvement action plan to reduce OOA placements, with Operational Plan trajectory achieved at end of Q3. Oversight and reporting developed for Q3 aligned to National Oversight Framework with continued focus on flow improvement alongside other challenged access targets.	Delivery plan delayed Access challenged across specific services	Risk to publication by Q4 Access recovery in specific services beyond 2025-26	Due once final draft plan agreed IPR considered by Finance and Performance Committee (FPC)

Delivery concerns at Q3 to be managed via management oversight forum and escalated to Quality and Safety Committee as required

1.2.3 Accelerated action required to improve responsiveness to feedback and complaints

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

People

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

NHS Derbyshire Healthcare NHS Foundation Trust

Priorities for delivery of success	Roadmap to delivery of success 2025-26	Q3 Progress Update	Status Q3 Actual	Status Q4 Expected	Assurance mapped to Q3 Papers
2.1 Be recognised for attracting and retaining the best people	2.1.1 Improve our recruitment and retention processes and systems to provide assurance on the experience of our people 2.1.2 Support managers to support our people to fulfil their potential and deliver new roles 2.1.3 Further mature and embed our workforce planning approach and develop multi-year Trust strategic workforce plan which reflects our role as system partner.	2.1.1 Stay Survey insights being applied to identify recurring themes, address retention risks and strengthen the new starter experience. Recruitment Services SLA performance is demonstrating improved oversight, with KPI trends actively tracked through the PCC dashboard and informing service-level challenge and improvement activity, offering enhanced assurance. 2.2.2 Inclusive intercultural communication training being delivered to managers in support of effective people management, particularly within diverse teams. Equality, Diversity and Inclusion training now embedded for all new managers. 2.2.3 Trust level workforce plan presented to PCC and advanced to Board in Q3. Care Group level plans for form next stage of development aligned to new operating model and to include EDI actions and targets. Strategic workforce planning being progressed aligned to national planning framework with first draft submission aligned to national timetable in December 2025.	Delivery behind plan at Q3	Expected on plan at Q4	Agreed assurances considered by People and Culture Committee (PCC)
2.2 Be recognised for supporting and developing our people to work confidently in their roles	2.2.1 Launch roadmap for leadership development and roll out year 1 plan including senior leadership programme 2.2.2 Embed talent management and succession planning framework 2.2.3 Develop standards and governance for advanced professional practice across roles 2.2.4 Develop learning culture for all staff including regular career conversations	2.2.1 STRIVE senior leadership development programme advanced in collaboration with The King's Fund and the Chartered Management Institute (CMI), with accreditation at Level 7 underway. First cohort scheduled to commence in January 2026. 2.2.2 Next phase of talent management and succession planning designed applying learning from pilot phase and agreed for commencement in February 2026 to flow from appointments to the new operating model. 2.2.3 Focus retained through Training and Education Steering Group on strengthening commissioning of professional programmes. Careers event hosted October 2025 to share what is available, with insight on gaps secured to inform approach. 2.2.4 Action progressed to embed learning culture aligned to accountability framework (see 2.3.1 below) with focus also on supporting managers to facilitate effective appraisal and career conversations as routine practice.	Delivery behind plan at Q3	Expected on plan at Q4	Agreed assurances considered by PCC
2.3 Be recognised by our people for our values driven and inclusive culture	2.3.1 Embed personal accountability charter within the people management and appraisal framework and develop competence of managers in restorative just culture 2.3.2 Deliver year 1 plan to develop EDI framework with a focus on diversity in recruitment and development offer, and equipping leaders with skills and data to improve 2.3.3 Refresh and deliver improvement plans for Workforce Race Equality and Disability Equality Standards	2.3.1 'A Kind Life' programme launched across the organisation, with the Personal Accountability Charter fully embedded within its design and delivery. This includes organisation-wide action masterclasses for all staff, active bystander training, and facilitated conversations training for leaders, supporting a restorative just culture and strengthening people management capability. Further activity is planned throughout 2026 to continue embedding and sustaining this approach. 2.3.2 and 2.3.3 Anti-Racism Strategy launched and in delivery, supported by established and active staff networks. Workforce Race Equality Standard and Workforce Disability Equality Standard improvement action plans embedded and being implemented, strengthening leadership capability, data-driven decision-making and accountability for improving equality, diversity and inclusion across the organisation.	Delivery behind plan at Q3	Expected on plan at Q4	Agreed assurances considered by PCC
2.4 Be recognised as a Trust that supports and promotes the wellbeing of our people	2.4.1 Embed a flexible working culture, supporting colleagues to balance home and work life and support delivery of services ,with clear action plans for delivery within one year 2.4.2 Continue to embed annual health and wellbeing assessment and deliver year 1 development plan 2.4.3 Develop psychology support and offer for staff 2.4.4 Review and refine attendance management policy and approaches to support colleagues and managers	2.4.1 Plan in delivery to embed flexible working, including new system and training in application of the policy. Progress to be accelerated flowing from appointments in to the new operating model and flexible working system to be finalised Q4. 2.4.2 Health and Wellbeing assessment SLA now in place to support regular monitoring and strengthen oversight of delivery and impact. Development of the Health and Wellbeing action plan for 2026 is underway. 2.4.3 Specialist psychological support pathway identified to provide staff with timely access to psychological support following traumatic incidents, supporting colleagues to remain well and safely at work. Pathway currently available via manager referral. 2.4.4 Targeted sub-groups established to address main causes of sickness absence, including stress, anxiety and depression, alongside a dedicated short-term absence working group. New internal sickness absence monitoring system launched, strengthening data visibility, consistency and manager support, and enabling more proactive and timely management.	Delivery behind plan at Q3	Expected on plan at Q4	Agreed assurances considered by PCC

Delivery concerns at Q3 to be managed via management oversight forum and escalated to People and Culture Committee as required

Cross cutting: National development of approach across people and leadership offers challenge in the timing and alignment of Trust action to ensure we harness opportunities but prevent delay. This remains under active consideration and management.

Productive

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

NHS
Derbyshire Healthcare
NHS Foundation Trust

Priorities for delivery of success	Roadmap to delivery of success 2025-26	Q3 Progress Update	Status Q3 Actual	Status Q4 Expected	Assurance mapped to Q3 papers
3.1 Achieve financial sustainability through improved clinical and operational productivity	3.1.1 Agree core priorities and deliverables for 25-26, to include reduction of OOA and premium spend 3.1.2 Deliver agreed financial plan on pathway towards financial balance and sustainability 3.1.3 Deliver year 1 plan for international medical recruitment on path to eradicate medical agency spend 3.1.4 Understand productivity and sustainability across all services and plan for optimisation or consider exit 3.1.5 Implement data flow for new national currency model 3.1.6 Develop literacy of our people in financial, capacity and activity planning	3.1.1 Financial plan agreed by ICB and NHSE with system deficit support of £45m enabling break even position across partners. Medium term financial planning progressed Q3 with first submission aligned to national timetable. 3.1.2 Financial plan remains on track at the end of Q3, including achievement of targets on agency and bank. 3.1.3 International medical recruitment plan progressed aligned to agreed plan and timeline over Q3. 3.1.4 Engagement maintained with NHSE pilot and recruitment underway for lead to develop productivity approach over Q4. Governance of productivity, efficiency and wider enablers reviewed and developed for launch in Q4. 3.1.5 National currency model currently on hold. National cost collection submission made in Q1 with outputs to be evaluated on publication. Publication was expected in Q3 but now delayed to Q4. 3.1.6 HFMA e-learning platform procured with access to 50 modules. Plan for launch and roll out aligned to second phase of operating model in Q4.	On track	Expected on plan at Q4	Agreed assurances considered by Finance and Performance Committee (FPC)
3.2 Transform our clinical pathways and operating model	3.2.1 Establish vision and ambitious transformation plan for integrated 'end to end' pathway and model of care across community and acute services and align to partnership development approach 3.2.2 Design and implement new operating model and accountability framework for delivery of services 3.2.3 Design and launch transformation plan for corporate services 3.2.4 Implement year 1 of agreed transformation programme 3.2.5 Implement transformation and improvement framework 3.2.6 Develop population health approach within the clinical transformation programme	3.2.1 NHSE Men-Sat recommendations applied to inform urgent care transformation plan. Community and crisis workshop series delivered over Q3 to support development of vision and plan. Board development session hosted and next steps defined to develop strategic intent for neighbourhood mental health model over Q4. 3.2.2 Phase one operating model successfully operationalised in Q3 through Triumvirate Leadership Transition sessions. Phase two in design and to be launched in Q4. 3.2.3 JUCD Provider Collaborative work programme and benefits realisation plan in delivery comprising five enabling corporate services with co-ordinated Trust plans in development and to be accelerated over Q4. 3.2.4 Assurance over design and delivery of transformation portfolio developed over Q3 overseen by the Strategic Portfolio Group and FPC. Deep dive process implemented with action agreed for areas of focus or concern. 3.2.5 Continued progress over Q3 in implementation of framework with key actions being enhancement of programme management and oversight arrangements and design of new approach for continuous improvement. 3.2.6 Population health intelligence being actively considered through development of the neighbourhood and urgent models of care to ensure these are aligned to local need. Approach to be further developed over Q4.	Corporate programme design to be accelerated Q4	Expected on plan at Q4	Agreed assurances considered by Finance and Performance Committee (FPC) and People and Culture Committee (PCC)
3.3 Optimise our assets and enabling resources to improve services and care	3.3.1 Deliver and track realisation of intended benefits from the Making Room for Dignity (MRfD) programme 3.3.2 Launch and deliver year 1 of agreed Estates Plan 3.3.3 Launch and deliver year 1 of agreed Digital Plan with a focus on consolidating gains from existing assets including EPR and design of 'end to end' digital workflow	3.3.1 MRfD programme fully operationalised with formal post project evaluation and benefits realisation reports completed aligned to agreed timeline for the two acute units in Q3, and PICU/ECU report due to be published Q4. 3.3.2 Estates Plan approved by FPC in Q2 and in delivery with plan on a page view being developed for publication. 3.3.3 Digital Futures Day hosted on 18 November to support further development of digital strategic intent aligned to 10 Year Health Plan. Digital Delivery Plan and roadmap in development aligned to outputs of the event alongside review and refresh of programme, work plan and arrangements to oversee and assure delivery.	On track Digital deliverables behind plan	Expected on plan at Q4 Risk to full delivery by Q4	Agreed assurances considered by FPC
3.4 Reduce emissions we control directly (the NHS Carbon Footprint)	3.4.1 Deliver year 1 of agreed Sustainability Plan and achieve a reduction on emissions in 2025-26 on course for 80% long term target	3.4.1 Sustainability Plan approved by FPC in Q2 and in delivery with plan on a page view being developed for publication. Progress made in delivery of key actions including EV chargers. Development of an associated Travel Plan a defined priority for Q4.	On track	Expected on plan at Q4	Agreed assurances considered by FPC

Delivery concerns at Q3 to be managed via management oversight forum and escalated to Finance and Performance Committee as required

3.1.4: Acceleration of productivity approach in Q4 dependant on recruitment of dedicated resource.	3.1.5 National currency model currently on hold and cost collection publication delayed to Q4.	3.2.3 Design of corporate transformation programme to be accelerated Q4

Partnerships

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

NHS Derbyshire Healthcare NHS Foundation Trust

Priorities for delivery of success	Roadmap to delivery of success 2025-26	Q3 Progress Update	Status Q3 Actual	Status Q4 Expected	Assurance mapped to Q3 papers
4.1 Build partnerships that deliver on the needs of our communities	4.1.1 Develop our partnership within the East Midlands Alliance, to enable the best mental health, learning disability and autism care and support for the people of the East Midlands and deliver year 1 plan across the priorities for: 1. Quality improvement and productivity 2. Enabling safe care 3. Developing our workforce 4. Improving population health 5.Reducing inequalities 4.1.2 Develop our role as Perinatal Lead Provider and in leading Gambling Harm services within the East Midlands. 4.1.3 Develop our strategic partnership with University of Derby and associated implementation plan 4.1.4 Develop partnerships within the JUCD Provider Collaborative with a year one focus on collaboration across services for Children and Young People 4.1.5 Deliver Community and Stakeholder Engagement Plan with year 1 priority focus on the deaf community, black communities and new migrant families 4.1.6 Proactively engage with regional and national learning collaboratives 4.1.7 Work in partnership to develop financial model and full business case for income generating business unit	4.1.1 East Midlands Alliance development plan for 2025-26 agreed and in delivery over the five agreed priorities with progress overseen through the Alliance Board and updates via Chief Executive Report to Board of Directors. Alliance event hosted in Q3 to share progress across the programme and collaboratives. Current focus on digital collaboration with bid for funding to digitise Mental Health Act assessments submitted to NHSE. 4.1.2 Action in developing East Midlands collaboratives reported to and overseen by Finance and Performance Committee. Highlights in Q3 include focus on continuous improvement and clinical learning into action for Perinatal, and continued progress made for Gambling Harm in increasing referrals and overall service activity. 4.1.3 Strategic partnership agreement signed with University of Derby with associated plan agreed and in delivery aligned to 4.3 below. 4.1.4 JUCD Provider Collaborative detailed work programme and benefits realisation plan in delivery comprising five enabling corporate services and four clinical pathways, including Children and Young People. Further workshop planned for Q4 to oversee progress to date and agree next steps for collaborative action. 4.1.5 Continued progress made in delivery of the Community and Stakeholder Engagement plan. Work continues to embed year 1 focus areas with a robust action plan for the Deaf community and a mapping exercise for our Black communities. Work with our Black communities will involve support from VCSE and PCREF colleagues. Dialogue is ongoing with our children's services to identify new migrant families and how to best reach them. Year 2 priorities are being developed with the relevant Board leads which include faith groups and local housing conversions. 4.1.6 Active engagement maintained in learning collaboratives with highlights in Q3 being progress on the Culture of Care programme supported by the National Collaborating Centre for Mental Health, along with collaboration through the new Midlands Learning and Improvement Network with a priority focus on improving length of stay. 4.1.7 Action delivered to further develop the model for an income generating business unit aligned to strategic intent defined via Q2 Board development session. Timeline and milestone plan to full business case being overseen via the Trust Delivery Group with plan for mobilisation in 2026-27 under development.	On track	Expected on plan at Q4	Agreed assurances considered by the Finance and Performance Committee and the Board of Directors
4.2 Excel in our role as an anchor organisation	4.2.1 Apply datasets alongside local demographics to establish baseline position and inform actions to develop our role across five domains: as an employer, a procurer, as a holder of property and assets, as a partner, and in sustainability	4.2.1 Action progressed over Q3 to secure learning and establish baseline to inform development of plan. Engagement in Q3 with system partners through JUCD Anchor Group to harness opportunities for action at scale with JUCD system plan in design and trust plan to be developed in full alignment to maximise potential opportunities and benefits for communities. Board Development session planned for Q4 to consider progress and next steps for action.	On track	Expected on plan at Q4	Assurance not yet due
4.3 Achieve University Hospital Trust status	4.3.1 Develop our strategic partnerships with academic institutions and deliver year 1 plan to develop research capability 4.3.2 Design and implement year 1 of action plan to be a centre for education across disciplines and achieve University Hospital Trust status	4.3.1 Strategic partnership agreement signed with University of Derby with associated plan agreed and in delivery to develop and strengthen research capability, and support ambition to achieve University Hospital status. Progress reported to and overseen by Board of Directors. 4.3.2 Action plan defined and to be launched in Q4.	On track	Expected on plan at Q4	Agreed assurances considered by the Board of Directors

Delivery concerns at Q3 to be managed via management oversight forum and escalated to Finance and Performance Committee as required

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

Board Committee Assurance Summary Reports to Trust Board – 27 January 2026

The following summaries cover the meetings that have been held since the last public Board meeting held on 25 November 2025 and are received for information.

- Quality and Safeguarding Committee 10 December
- Mental Health Act Committee 18 December
- Finance and Performance Committee 13 January
- People and Culture Committee 14 January
- Audit and Risk Committee 16 January

Key:

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

Quality and Safeguarding Committee – key assurance levels for items – 10 December 2025	
	Director of Nursing update The Committee discussed the draft Quality Assurance framework, noting it consolidates guidance from professional bodies, such as the National Institute for Health and Care Excellence, the Care Quality Commission (CQC) and the Royal College of Nursing, along with learning from incidents. The Committee emphasised the need for clarity on escalation routes, assurance processes and role responsibilities, suggesting the framework should explicitly map Operational and Assurance pathways and ensure consistency across the organisation. It was highlighted that the framework would provide thorough and accessible evidence of how the Trust evaluates quality.
	Fundamental Standards Report Feedback from recent CQC and Mental Health Act activity provided the Committee with **significant assurance**. A summary of the Section 120 visit indicated what had gone well, along with any identified concerns. It was noted that corrective actions are being implemented and monitored through to embeddedness. The Committee accepted **limited assurance** on the Fundamentals of Care programme due to some areas of non-compliance. It was noted that people with lived experience are now involved with the visits and are instrumental in successful outcomes.
	Medicines and Pharmacy update Attention was a drawn to two key areas of low compliance: • post-rapid tranquilisation monitoring and senior medical sign-off • regulatory requirements for valproate safety. It was noted that these issues are not unique to Derbyshire or the Trust and mitigations are being effected where possible. It is anticipated greater assurance will be reached by the start of February 2026.

	The Committee accepted **limited assurance** whilst recognising the improvements planned, which included Nursing taking a more active role in monitoring and supporting compliance.
	Risk Report The Committee noted the process of aligning all risks to the new builds and wards, reviewing and closing outdated risks and ensuring new risks are appropriate consider before adding to the register. It was agreed that the Paediatric waiting list risk should remain on the register.
	Safeguarding Children Assurance Report Following the Section 11 assessment in May 2025, it was noted that all standards had met requirements apart from the Trust safeguarding accountability structure, this was graded amber due to no permanent Consultant Paediatrician as the Named Doctor for Safeguarding Children. It was highlighted that the Safeguarding team is actively involved in child and adult safeguarding reviews, ensuring that learning is shared and integrated into practice. **Significant assurance** was received around safeguarding children activity, systems and controls within the Trust.
	Safeguarding Adults Assurance Report **Full assurance** was accepted around safeguarding adult activity and that statutory duties are being met. It was reported that all Domestic Homicide Reviews and Safeguarding Adult Reviews are on target and within timeframes. In addition, the Trust continues to participate and support working with multi-agency forums. Attention was drawn to the impact of domestic abuse on children and families; it was confirmed that Think Family is one of the priorities in the Quality Delivery Plan.
	Safer Staffing It was reported that fill rates had been consistently maintained within nationally recognised parameters (80–130%), and that no breaches had been reported in the last six months. There had been no incidents relating to compromised safety due to staffing issues. The impact of rising sickness rates on agency and bank usage, particularly due to flu, was discussed, with proactive roster planning and monitoring in place to mitigate risks. The Committee received **significant assurance** on the actions taken to address highlighted issues and from the progress made.
	Patient Experience Report Information in the report provided the Committee with **limited assurance** on the complaints process, noting improvements made and significant delays in many of the cases. It was emphasised that a credible improvement plan using the Trust Continuous Improvement methodology is being developed, which is to include defined performance targets for complaint handling and improved accountability.
	Care Planning/Person-Centred Care Improved compliance was highlighted, along with the robust systems that are in place to monitor performance through Divisional governance structures. It was noted that the required governance is now aligned with quality and safeguarding plans to ensure timely escalation of any deterioration in performance. The Committee discussed the forthcoming transition from the Care Programme Approach to the Personalised Care Framework, with plans to manage the change once the national guidance is published. The proposed level of **limited assurance** was accepted and a move to quarterly reporting was approved.

East Midlands Gambling Harms service (EMGHS) report

The Committee was presented with a year-to-date update, which highlighted increased referrals, improved access for women, patient satisfaction and future plans for data analysis and service expansion.

Significant assurance was received and six-monthly reporting was approved.

East Midlands Alliance Perinatal Mental Health Provider Collaborative

Significant assurance was provided by the report.

There were no patient safety or quality concerns to escalate in quarter 2.

It was reported that new air conditioning units will be installed in January/February 2026. As this requires an eight-week closure of the unit, the plan is to manage most patients in the community by moving staff out to provide wraparound support.

It was clarified that out of area placements do not incur additional cost due to block contract arrangements.

The Committee approved a move to six-monthly reporting.

Summary of Quality and Safeguarding Board Assurance Framework (BAF) Risks

The Patient Experience report was pointed out and the Committee recommended additional elements are needed to reflect the current situation and the associated risks, with a view to strengthening the measures that are to be included in the action plan.

The significant progress made around CQC ratings and other multiple successes was highlighted. However, it was noted that key challenges remain within the workforce and embedding improvement plans requires continued oversight.

It was suggested that further thought was needed around equality and diversity through the Gambling Harms service and the delivery of single sex accommodation.

In addition, the Committee was unsure if the absence of a national policy on transgender is captured sufficiently.

It was agreed this feedback would be considered.

Escalations to Board or other Committees: It was agreed that areas to raise for discussion at Board would be the position with Patient Experience and Patient Safety with regards to Learning the Lessons at the January Board meeting.

Items added to the Board Assurance Framework: As noted above.

Next scheduled meeting: 11 February 2026.

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

Mental Health Act Committee - key items discussed 18 December 2025

Mental Health Act (MHA) Operational Group Minutes and Action Matrix

The update provided the Committee with **limited assurance** due to areas of under-performance against targets.

It was noted that the alignment of data, specifically for Section 132 with the new Care Groups is in progress and the pathway for Duty of Candour will be mapped to ensure robustness.

Mental Health Act (MHA) Managers report

The Committee accepted **limited assurance** regarding the reading of rights, particularly on Inpatient wards (Section 132). Greater assurance was requested on the processes put in place to improve compliance.

It was agreed that the lack of access to Independent Mental Advocates for under 18s be included on the Risk Register.

Training report

The improved compliance was noted, along with additional actions undertaken to improve compliance further.

Limited assurance was accepted.

Use of Section 136 Suites/Section 135/136 report

An expected increase in use was noted, which was due to the opening of the new 136 suites. Physical healthcare checks for persons detained on a Section136 had also improved.

An e-Learning package for the Health Based Place of Safety has been revised.

The Committee agreed **significant assurance** on the processes for use of the 136 suites.

Mental Health Act Bill

The Committee was advised that Royal Assent has been given on the Mental Health Act Bill, which has now become law on 18 December 2025. A working group has been established to oversee the action plan for implementation.

Restrictive Practice Quality report

The report showed progress in key areas of training compliance; the effective risk management of patients who absconded and the management of restrictive practices.

A Quality Improvement project is ongoing to address the replacement of older, digital devices.

The Committee noted an increase in physical and prone restraint between July and August 2025, which correlated with a rise in seclusion episodes.

In relation to breakaway training, it was reported that all non-compliant staff will be trained by year-end.

Limited assurance was accepted based on areas of underperformance for recording and training.

Policy Review

The Committee supported and approved the following policies:

- Locking of doors on open wards, all units
- Reducing Restrictive Practice
- Mental Health Act 1983 Urgent Treatment
- Adult Inpatient Visiting Policy and Procedure
- Advance Decisions to Refuse Medical Treatment – Advance Statements and Lasting Power of Attorney
- Mental Health Act 1983 After Care for Detained Patients under Section 117 Policy and Procedures.

An update was provided on the Protocol and Policy for Conveyance of Service Receivers, subject to the Mental Health Act, which is linked to external providers.

Escalations to Board or other Committees: None.

Items added to the Board Assurance Framework: None.

Next scheduled meeting: 12 March 2026.

Committee Chair: Deborah Good	**Executive Lead: Girish Kunigiri, Medical Director (represented by Tumi Banda, Director of Nursing, AHPs, Quality and Patient Experience)**

Finance and Performance Committee – key assurance levels for items – 13 January 2026

Making Room for Dignity (MRfD) Programme update

The Committee received **significant assurance** from the update.

	Subject to also being supported by the People and Culture Committee and the Quality and Safeguarding Committee, the Post-Project Evaluations, Benefits Realisations returns were approved for onward submission to NHSE.
	Assurance on delivery of Digital Plan Preparation to develop the Plan provided the Committee with **significant assurance**. However, **limited assurance** was received on the Plan to date.
	Financial Governance and Performance – Month 8 Finance Report The Committee accepted **significant assurance** and noted the key points: • £1.4m deficit • On plan YTD • Breakeven forecast • Cost Improvement Plan performance strong and on plan • No concerns in relation to cash • Lots of capital commitment to conclude in Quarter 4 • Underlying deficit remains as per previous at c£4.5m.
	Review and approval of Treasury Management Policy and Procedures Following minor updates, the policy was ratified.
	Procurement update The improved capacity and achievement of full delivery of savings for 2025/26. The update highlighted a number of projects, including transport and IT, are due for completion in the remainder of 2025/56. It was noted that strengthened governance is leading to better contract planning and that wider partnership and collaboration work is progressing. **Significant assurance** was received on progress of the plan, recognising a low starting point.
	Operational Performance report Consideration was given to the overall good progress and pockets of under-performance. **Significant assurance** was taken from improved oversight, Out of area placement reductions, crisis performance; length of stay, waits and demand challenges and **limited assurance** for long waits.
	Collaborations and other alliances A brief update was shared, covering Cluster/Alliance projects, including temporary closure of the Mother and Baby Unit to facilitate works to install air conditioning. Planned expansion of the Gambling Harms service were noted.
	Arden & GEM – Commissioning Service Units (CSU) update **Limited assurance** was taken from the update. It was noted that any potential options must contribute to corporate efficiency and comply with the Procurement Act and national procurement rules.
	Operational and Financial Planning – 2026/27 An update on plans around the February final submission confirmed the focus remains on the progress of Cost Improvement Programmes and closure of the gaps, risk, capital constraints and overall System alignment.
	System updates: ICB Finance Committee/System Directors of Finance (DoFs) The verbal update highlighted System deficits/scrutiny across the wider cluster and that the Trust is on track to deliver for 2025/26. It was noted that due to the focus on planning for 2026/27 some System meetings have been stood down.

Emergency Preparedness, Resilience and Response (EPRR) report

The mid-year update reflected substantial compliance with audits positive and ongoing plan updates. The Committee accepted **significant assurance**, noting the work focused on addressing the finer details around site specific plans.

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

The requirement for continued focus on the Digital Plan development and Arden and Gem transition progress and monitoring was highlighted.

Escalations to Board or other Committees: Continued scrutiny on plans around Arden and Gem.

Items added to the Board Assurance Framework: None.

Next scheduled meeting: 10 March 2026.

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

People and Culture Committee – key assurance levels for items – 14 January 2026

People and Inclusion Assurance Dashboard

The Committee reviewed current performance. The main points were:

Mandatory Training: non-compliance in Level 3 ILL training was reported, with an action plan aiming for 76% compliance by end of January and 85% by end of February.

Turnover and Recruitment: increased turnover in clerical roles was highlighted, along with improvements in turnover for Healthcare Assistants (HCAs) and Registered Mental Health Nurses (RMNs).

Absence: the Committee noted a persistent high absence rate, with a slight reduction to 6.33% in December. Anxiety, stress, and depression remain the main reasons for absence, prompting the formation of a dedicated task and finish group under the Absence Oversight Group.

Supervision: ongoing efforts to improve clinical supervision compliance include a data cleanse, policy changes from hours to occurrences and system updates expected by end of March, with scrutiny at team level.

Temporary Staffing and agency usage: it was reported that a recent increase in agency usage for HCAs and RMNs was linked to recruitment delays and last-minute sickness. Initiatives to incentivise last-minute bank cover, as well as the need for improvements in the Temporary Staffing team's processes were discussed.

Significant assurance was accepted on progress shown for mandatory training, staff turnover, Temporary Staffing usage and Freedom to Speak Up and **limited assurance** on vacancies and recruitment, attendance and absence, clinical supervision and annual appraisals.

Making Room for Dignity (MRfD)

Transformational Improvement: the ongoing Organisational Development (OD) programme and six month follow-up for new wards were described, with additional cultural reviews triggered by data and concerns.

The Committee approved the next steps outlined in the report, the benefits monitoring and progression of the clinical models.

Post-Project Evaluation reports (Audrey House, Carsington Unit and Kingfisher House Psychiatric Intensive Care Unit (PICU): the Committee questioned the consistency of processes for project evaluations across all relevant committees and requested assurance of proper oversight and escalation of issues

The reports were considered and approved for submission to NHS England., subject to agreement by the Finance and Performance and Quality and Safeguarding Committees.

Benefits Realisation reports (Carsington and Derwent Unit): the challenge of isolating benefits from new builds within broader organisational metrics was discussed. It was proposed for regular reporting

	on operational support and OD interventions at the team level, with triangulation of people data, concerns, and quality measures to provide clearer assurance. The Committee approved the reports.
	Deep Dive – Attendance and Absence / Health and Wellbeing The formation of an Absence Oversight Group was outlined, along with a Delivery Plan divided into workstreams such as data, ER team roles, managerial ownership, health and well-being, training, governance and policy. New initiatives include a dedicated Teams channel for managers, bite-size training sessions and the use of AI tools for coaching conversations. The importance of enforcing policy triggers for absence management and ensuring operational managers are involved in oversight and policy development was discussed. The Committed advocated for a more proactive approach to keeping staff well at work, focusing training on high-absence areas and using data analysis to guide interventions. **Limited assurance** was accepted.
	Deep Dive – Recruitment Key Performance Indicators (KPIs) The Committee accepted **limited assurance** on work to date and recognised there is further work planned to provide further assurance. It was noted that Recruitment KPIs are above Midlands and national benchmarks, indicating slower processes, particularly for HCA and RMN roles. Delays in shortlisting, especially for high-volume roles, were identified and the piloting of application caps to make shortlisting more manageable was described, along with new processes to start candidates at Band 2 pending completion of required certification. It was highlighted that the creation of talent pools will enable quicker filling of vacancies without repeated advertising and shortlisting. The need for clear escalation processes when delays occur was emphasised, particularly around approval of references and start dates. It was agreed that a comprehensive action plan with timelines be brought back to the Committee, to clarity responsibilities between the Trust, the People team and the external Recruitment service provider.
	Equality, Diversity and Inclusion (EDI) Plan and Priorities update The Committee noted progress on the Delivery Plan and noted the key points: • Alignment and Integration of EDI Plans, under the overarching People Plan. A consolidated approach is being developed to clarify how different priorities fit together • Race Equality campaigns • Governance structure and assurance, including an EDI Working Group, Divisional Assurance Boards and Executive oversight • Staff-to-staff racism and action planning.
	NHS Staff Survey – 2025 – Fieldwork update The Committee received **significant assurance** that the Staff Survey fieldwork was delivered using a robust and comprehensive approach, underpinned by continuous improvement. A 64% response rate was reported (matching the previous year), with engagement initiatives such as Staff Survey Week, prize draws, Executive support and personalised emails contributing to the high participation. The process for analysing survey data was highlighted, with plans to release Divisional reports and action plans promptly. Efforts to improve engagement, including learning from this year's tactics and planning for further cultural work in low-engagement areas were discussed.
	Corporate Communications Plan and Community Stakeholder Engagement Plan – year one update

	The Committee was updated on progress in six key areas, including digital communications, sponsorship income and internal communications review. Work with the deaf community, black community and new migrant families was described, including the establishment of focus groups and collaboration with other organisations. It was noted that year two priorities include expanding engagement to faith groups and housing providers.
	Review of People and Culture Committee Board Assurance Framework (BAF) Risks It was agreed to strengthen the narrative around absence and recruitment.
	Items added to the Board Assurance Framework: None. **Next scheduled meeting:** 3 March 2026.

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

Audit and Risk Committee – key assurance levels for items – 16 January 2026	
	Board Assurance Framework (BAF) Proposed downgrades to risks 4B and 4C were presented and supported, the Committee sought clarification that the Executive Leadership Team had approved the proposed risk downgrades. The impact of governance structure changes on risk reporting was also mentioned. The Committee accepted **significant assurance** of the review process and approved Issue 4 (version 4.2) of the BAF for 2025/26.
	Operational Risk Management The report provided the Committee with **significant assurance** of the risk management process and that appropriate escalation steps are taken to address non-compliance. The high volume of risks due for review in January was described, along with the impact of operational model changes on workflow. The Committee was advised that plans to move ligature risk management out of Datix have been abandoned due to technical limitations. It was noted that responsibility for these risks remains with the Risk and Assurance Manager; Head of Health, Safety, Fire and Security services and the Divisional Head of Clinical Practice, with updated policies and internal governance oversight. Clarity on the new operational governance structure was requested.
	Annual Report Planning - Year End Timetable Planning The year-end timetable and key dates associated with the approval of the annual report and accounts provided **significant assurance** that year-end planning in relation to this element is under control.
	Data Security and Protection (DS&P) report The report covered the status of the DS&P toolkit, noting the different reporting cycle, ongoing clinical coding audits, high compliance with management training and strong performance in responding to subject access requests within legal deadlines.
	Data Quality update (six-monthly) The update covered the transition to Microsoft SharePoint and Teams for improved data management, regular reviews of access and distribution lists, the importance of version control and secure sharing practices. The Committee discussed the need for standardised data input processes to ensure accurate reporting, highlighting ongoing challenges with inconsistent use of electronic patient record systems and the impact on clinical and regulatory reporting.

	The establishment of a dedicated forum with clear terms of reference was recommended to address a gap in governance for data quality. The Committee also supported initiatives to empower staff and patients with self-service tools for data management.
	Accounting Standards/Policies for 2025/26 Annual Accounts The Committee agreed the Trust's accounting policies for the 2025/26 Annual Accounts and took **significant assurance** noting updates for desktop valuation, changes in valuation methodology, revised discount rates and the adoption of IFRS17.
	Debt Write-off report Potential debt cases were reported, detailing the status of enforcement actions and confirming that provisions exist to offset anticipated write-offs, in line with accounting policy.
	Standing Financial Instructions (SFIs) breaches The nature of compliance breaches, particularly in petty cash usage, was outlined. Ongoing efforts to reduce cash handling, increase use of purchasing cards and enhance training for staff responsible for floats were described. Consideration was given to the disparity between compliance by volume and value, with plans to improve analytics and consider enforcing a 'no purchase order, no pay' policy, subject to procurement capacity and further data analysis.
	SFI Waiver report (six-monthly) The Committee noted a low number of waivers and high compliance with procurement processes. **Significant assurance** was received on the process, with explanations provided for any high-value waivers.
	Commercial Insurance Options Appraisal **Significant assurance** was accepted that the Trust is actively monitoring and taking a commercially-informed decision regarding the risks it insures. The Committee agreed to move the insurance reporting schedule earlier in the year to accommodate broker requirements. The continued procurement of commercial property insurance for new builds due to the cap on NHS Resolution coverage was outlined. The Committee discussed the absence of national solutions for fleet and cyber insurance, the cost-benefit analysis of maintaining property insurance and the lack of known cases where trusts suffered unrecoverable losses due to underinsurance.
	Conflicts of Interest and Declarations of Interest Update A deep audit of procurement and decision-making staff against Companies House records had found no conflicts requiring action. The Committee noted improved declaration rates despite organisational restructuring. Challenges in managing gifts from service users was described, along with the growth of sponsorship for staff events and the need for ongoing communication and framework development to ensure compliance with policies. The Committee received **significant assurance** of the embedded processes.
	Internal Audit progress report It was reported that the internal audit plan is on track, with only two audits left to report and action tracking at 100%. The Committee noted that planning for the next financial year is underway.
	Counter Fraud, Bribery and Corruption progress report Updates to the Counter Fraud Policy training sessions held during International Fraud Awareness Week were highlighted, along with ongoing investigations, including salary repayment cases.

	External Audit progress report Following clearance from the National Audit Office, the Committee noted closure of the 2024/25 audit. The timetable for the 2025/26 audit, with planning and interim visits scheduled was outlined.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework:** None. **Next scheduled meeting:** 23 April 2026.
Committee Chair: Chioma Akpom	**Executive Lead: Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary (represented by James Sabin, Director of Finance)**

Assertive Outreach (AO) Community Mental Health (CMH) Treatment update from the Working Group on the actions from the Independent Mental Health Homicide Review into the tragedies in Nottingham

Purpose of Report

To provide an update on the work of the Assertive Outreach (AO) Working Group to date.

Executive Summary

Following the publication of the Independent Mental Health Homicide Review in Nottingham (5 February 2025), all Integrated Care Boards (ICBs) and Mental Health trusts have been required to develop action plans addressing the review's findings. This follows the tragic events in June 2023 and the investigation into the care and treatment of Valdo Calocane within Nottinghamshire Healthcare NHS Foundation Trust.

All Divisions have completed a self-assessment against the recommendations, outlining current practice and areas requiring improvement. Within this, the Adults of Working Age (AWA) Community Mental Health team (CMHT) has developed a dedicated Action Plan for AO and introduced additional, tailored, reflective and formulation supervisions for AO staff. Two summary tables in the main report provide detailed overviews of current status and proposed actions. AO practitioners are also now receiving reflective practice sessions and clinical formulation/case discussion sessions that are facilitated by Clinical Psychology colleagues.

The AO Working Group is linked to NHS England's Midlands regional team for Community Mental Health (CMH), ensuring that developments are aligned with regional and national learning and allowing for feedback and oversight. The Trust was requested to present at a Show and Tell event organised by NHS England's Midlands regional team on 22 October 2025, on using the Management and Supervision Tool (MaST) to enhance service delivery and patient care; as part of developing data visibility for caseload management and tracking people with serious mental illness across the organisation.

As of September 2025, AO is supporting **145** open cases across CMHTs, with projections indicating growth to approximately **100** service users, due to proactive case identification through MaST, which will give us a possible AO Caseload size of approximately **245** in total. Workforce capacity remains a central concern, with only 11.2 WTE Band 6 CPNs and 0.6 WTE Healthcare Assistants currently dedicated to AO. Fundamental Care Standards for AO cases are being closely monitored through dedicated, monthly supervision for AO workers. According to the AO Standard Operating Procedure, staff working a full-time equivalent of 1.0 should carry no more than 15 cases.

The Trust submitted the Intensive and Assertive CMH Treatment ICB Review Outcome Template on 3 September 2025 as part of its ongoing assurance process, in response to national expectations set out in Claire Murdoch's letter (February 2025). Action plans are subject to review and update at six and 12 months.

The work from the AO working group remains a critical area of focus for organisational assurance on the management of such cases, workforce planning and System collaboration to ensure safe, effective and high-quality care in line with national recommendations.

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

Risks and Assurances

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

Consultation

- The report has had limited time for consultation. However, a report was submitted to the Board of Directors on 3 June 2025
- Feedback from the AWA CMHT COAT meetings
- Quality and Safeguarding Committee, 8 October 2025.

Governance or Legal Issues

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Access to services and health inequalities consideration.

Recommendations

The Board of Directors is requested to:

1. Receive the paper to inform a future option to support AO cases in AWA CMHT
2. Accept limited assurance on current performance on the management of AO cases in AWA CMHT, noting scrutiny at the Quality and Safeguarding Committee.

Report presented by:	**Lynn Andrews** **Chair, Quality and Safeguarding Committee**
Report prepared by:	**Toby Marandure** **Head of Nursing, AWA CMHT and Substance Misuse**
	Dr Wendy Brown **Consultant Psychiatrist EI, Medical Appraisal Lead / Deputy Chair Serious Incidents Group (SIG)**
	Julie Pickford **Deputy Area Service Manager, AWA and Older Adults CMHTs**

Assertive Outreach (AO) Working Group update

Summary

The AO offer came under national scrutiny following the conviction of Valdo Calocane in January 2024 for the killing of three individuals. Community Mental Health (CMH reviews were commissioned and CQC published two reports, (i) Learning from the Nottinghamshire Healthcare Section 48 review Part 1, (ii) Learning from the Nottinghamshire Healthcare Section 48 review, Part 2.

The Trust completed the Integrated Care Board (ICB) Review Outcome Template and ICB Maturity Index Self-Assessment Tool review process, ensuring that recommended actions were integrated into senior governance structures, for both the Trust and the ICB. Both the ICB Review Outcome Template and ICB Maturity Index Self-Assessment Tool's main objective was to ensure appropriate intensive and assertive mental health care and treatment is available to meet the needs and to support the wellbeing of AO and Intensive Community Support for services users that require such support.

On 5 February 2025, all ICBs and Mental Health trusts received a letter from the National Director for Mental Health, Learning Disability and Autism and the Medical Director for Mental Health and Neurodiversity from NHS England. This letter stated that Mr Valdo Calocane, a patient experiencing serious mental illness, was failed by mental health services, which had devastating consequences.

Whilst acknowledging the work already undertaken by services, the letter set out the next steps. It asks services to review local actions plans with particular attention to:

1. Personalised assessment of risk across community and inpatient teams
2. Joint discharge planning arrangements between the person, their family, the inpatient and community team (alongside other involved agencies)
3. Multi-agency working and information sharing
4. Working closely with families
5. Eliminating Out of Area (OoA) placements in line with ICB three-year plans.

Purpose of working group

The Trust has set up a working group to focus on these actions. The group is multi-disciplinary, with representation from across all the Trust's Divisions. The group is chaired by a Consultant Psychiatrist and Head of Nursing.

The group is aware that a significant amount of work is already underway in the Trust, working closely with the System partners, which relates to the findings of the independent report. The group aims to work with the key leads of this work to avoid any unnecessary duplication and ensure collation of information. Therefore, the work of this group should be considered alongside work undertaken by the Trust as part of CQC action plans and prior work on the CMH Maturity Index Action Plan.

Please note that point 5 above (Eliminating OoA placements in line with ICB three-year plans) forms part the ongoing work of a separate group within the Trust and is not within the scope of this working group.

Timeline of AO work

Month/Year	Key Activities
Mar-2024	• NHSE issued Planning Guidance and CQC Section 48 reports (Part 1) issued • ICBs confirm that DNAs (Did Not Attend) are not used as a reason to discharge patients.
Jun-2024	• NHSE National Team provides guidance to ICBs and the Regional Team.
Jul-2024	• CQC Special Review (Part 2) issued • NHSE Midlands-wide Working Group established.
Aug-2024	• NHSE co-produced and developed CMH Maturity Index.
Sep-2024	• Local ICB Maturity Index system-wide workshops conducted • ICB template submissions: The Trust submitted the Review of Intensive and Assertive CMH returns due on **30 September**
Oct-2024	• ICBs return thematic analysis and review of template submissions on **9 October**.

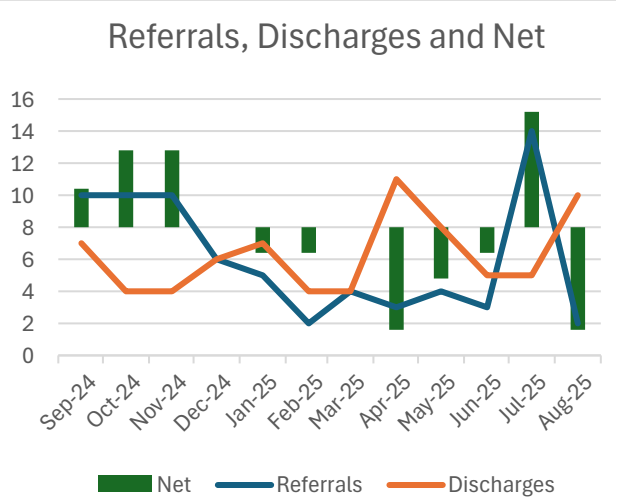
Nov-2024	• ICBs complete and share the Maturity Index • Update provided to the Regional Executive Team.
Dec-2024	• NHSDE Midlands Webinar held to share benchmarking data outcomes with ICBs • NHSE Regional Summary of ICB returns submitted to the national team • National Webinar to share thematic analysis of ICB returns.
Jan-2025	• Individual ICB Maturity Index Summary Reports produced and shared by NHSE • ICBs estimate resources required to address gaps identified in the reviews, informing national discussions.
Feb-2025	• Clinically led review of Action Plans to be initiated • Claire Murdoch's letter marking the publication of the Independent Mental Health Homicide Review, and as part of ongoing assurance, ICBs are required to review and update their action plans at both six and 12 months.
Mar-2025	• New guidance and standards for CMH services to be issued • NHSE will explore options for a Peer Review Programme in **2025/26** will begin • The Trust requested a working group to review Intensive and Assertive CMH Care. A review of the ICB's self-assessment scores on the CMH Self-Assessment Maturity Index Tool highlighted several key areas for improvement. The Nottingham Independent Review Actions Working Group was set up to implement and monitor the Trust's actions in response to the Independent Mental Health Homicide Review into the tragedies in Nottingham published in January 2025. This working group will be chaired by Dr Wendy Brown and co-chaired by Toby Marandure (HoN), with the support of Julie Pickford (Deputy ASM) and Rachel Williams • The Trust published a Practice Matters; the briefing focused on the learning identified through the Independent Investigation into the care and treatment of Mr Valdo Calocane. The external report highlights instances where Mr VC, a patient experiencing serious mental illness, was failed by mental health services, which had devastating consequences in June 2023 Nottingham when Barnaby Webber, Grace O'Malley Kumar and Ian Coates lost their lives.
Apr-2025	• The Trust Intensive and Assertive CMH Care Working Group to discuss the actions from the Independent review into the care and treatment of VC. All ICBs and Mental Health trusts have been asked by NHS England to review local action plans on key recommendations from the above Independent Review. NHSE requires these action plans to be presented at ICB and Trust Board no later than 30 June 2025. The group has been set up at the request of Tumi Banda, Director of Nursing, AHPs, Quality and Patient Experience. It will be chaired by Dr Wendy Brown, Consultant Psychiatrist, and Toby Marandure, Head of Nursing for Community and Substance Misuse, with support from Rachel Williams, Patient Safety Specialist.
Jun-2025	• The Trust presented a paper to Public Board • The Trust received feedback to the Trust by Midlands NHSE representatives on the Maturity Index.
Jul-2025	• The Trust published Practice Matters communication to all staff which focused on the focus on an update to the March 2025 Practice Matters which outlined the learning from the independent investigation into the care and treatment of VC • Practice Matters publication highlighted that Fundamental Care Standards visits will continue across all services to ensure sustained improvement and readiness for future CQC inspections, which includes management and support for AO cases. The Fundamentals of Care visits are scheduled to be repeated in three months' time to ensure continuous improvement and effective implementation of action plans. The publication also informed staff of the AO SOP and the use of MaST tool to identify AO cases.
Sep-2025	• The Trust submitted its Intensive and Assertive CMH Treatment ICB Review Outcome Template on 3 September 2025 as part of its ongoing assurance process, in response to national expectations set out in Claire Murdoch's letter (February 2025).

Performance data for AO in AWA CMHT

Referrals, Discharges to AO

The graph shows fluctuations in referrals, discharges, and the net difference between them over a 12-month period. Referrals generally decline from late 2024 into early 2025 before a sharp peak in July 2025, while discharges remain more stable with a gradual rise in spring and another increase towards August 2025.

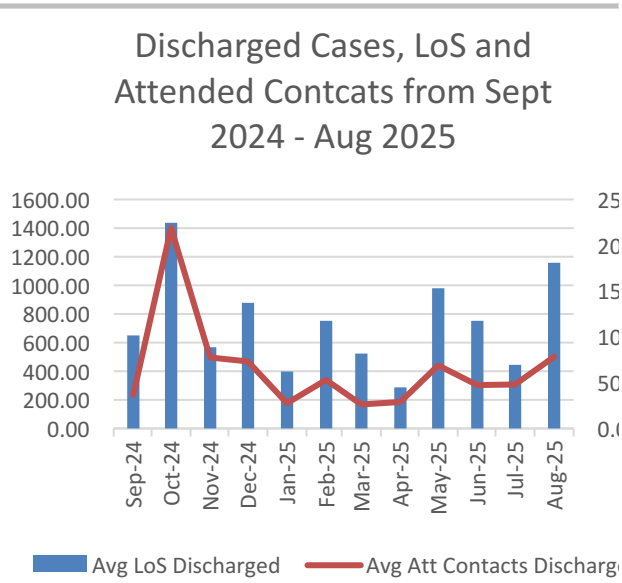
The net figure is positive in most months, particularly October, November, and July, indicating higher referrals than discharges, but dips into negative territory in April and August 2025, suggesting more discharges than new cases during those months. Overall, the trend highlights variable service demand with spikes in activity mid-year.



Discharges cases Length of Stay (LoS) and Attended Contacts

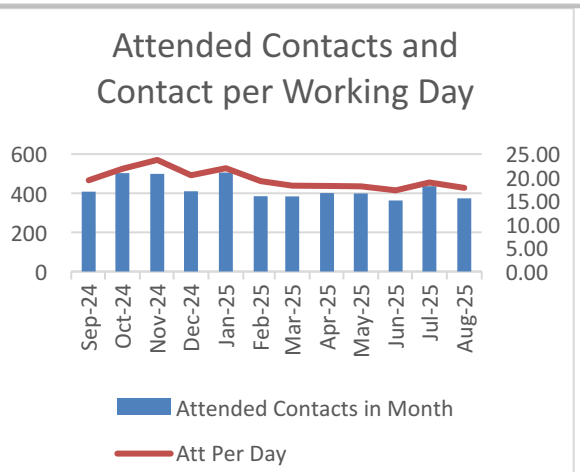
Length of stay with AO team shows significant variability, peaking sharply in one month before dropping to lower levels and then steadily rising again towards the end of the period. In contrast, attended contacts remain more consistent, generally fluctuating within a narrower range, suggesting a steadier pattern of service use despite changes in LoS.

NB: bar chart refers to left axis which measures the LoS and line graph refer to the right axis measures the contacts.



Attended Contacts and Contacts per working day

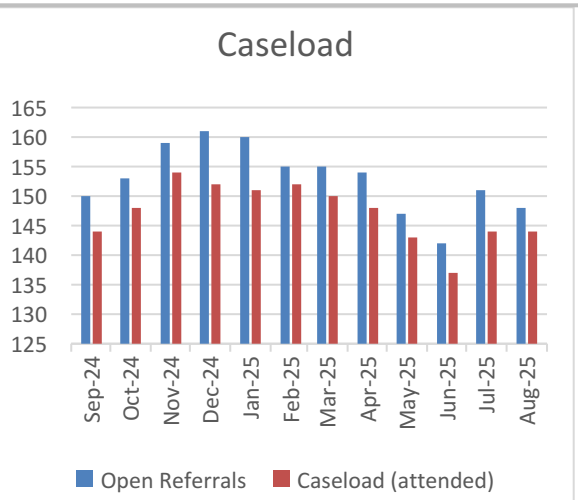
Monthly attended contacts fluctuate between around 370 and just over 500, with peaks in October, November and January, and lower levels from February through June. The daily attendance rate follows a similar trend, reaching its highest in November 2024 and maintaining relative stability after February 2025, generally between 17–20 contacts per day. Overall, the pattern suggests a consistently high workload, high demand for AO work with seasonal peaks in late autumn and early winter. With the projected increase of 100 cases, the demand on the service will increase hence the request for additional resources.



Caseload for AO between Sep-2024 and Aug-2025

The graph reveals a consistent disparity between Open Referrals and attended cases across the year, with referrals always exceeding attendance, suggesting potential service gaps or resource constraints. The highest referral numbers occur in December 2024, possibly due to when the AO SOP was implemented, while the lowest attendance is seen in June 2025, coinciding with a mid-year dip in both metrics.

This downward trend from December to June, followed by a modest recovery, may reflect operational challenges or fluctuating demand i.e correct identification of AO cases.



Inpatient Admissions for AO patients between Sep-2024 and Aug-2025

The graph illustrates monthly fluctuations in inpatient admissions, ranging from a low of two to a high of 10 cases. The inconsistency in monthly figures suggests that demand for inpatient services is not evenly distributed throughout the year. Monitoring these patterns will support the Trust to anticipate peak periods and allocate resources more effectively.

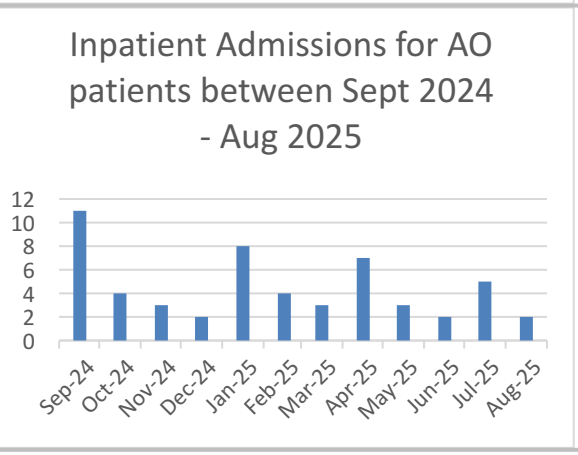
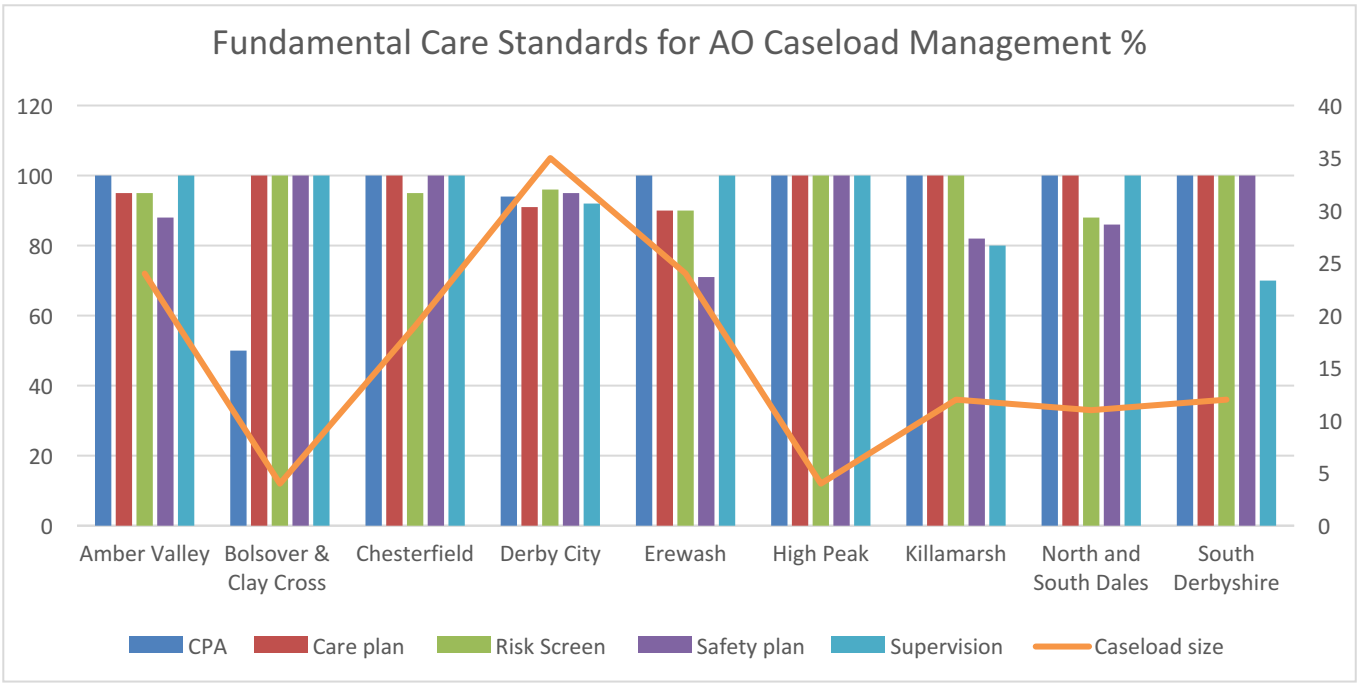


Table of Fundamental of Care Standards for AO caseload management



Fundamentals of Care standards for AO results highlights high performance with a few targeted areas needing attention, particularly CPA in Bolsover and Clay Cross and Safety Plan/Supervision in a few other teams:

- Most teams meet or exceed 90% in all standards, indicating strong overall performance
- Bolsover and Clay Cross has a notably lower CPA score (50%), which stands out as an area for improvement
- Erewash and Killamarsh have lower scores in Safety Plan (71% and 82%, respectively) and Supervision (Killamarsh: 80%, South Derbyshire: 70%), suggesting a need for improvement
- All other teams' standards are at or very close to 100%, reflecting robust adherence to care standards.

The two-weekly Fundamentals of Care Standard Cross-Check meeting started in April 2025 and dedicated monthly supervision sessions for AO staff have had a positive impact on compliance within the Division.

Ongoing work from AO/Nottingham Inquiry actions working group

The working group will continue to identify, and address identified gaps in each of the key areas of the action plan. The group will continue to meet monthly. Input from NHS England CMH Programme Managers is planned to provide support to the group. There will be updates provided from the regional/national teams every six months. Action plans will be monitored via Divisional governance structures.

The AO service continues to face some challenges in partnership working, clinical processes and patient engagement. Recent discussions with police partners highlighted the need for a formal process around information sharing, which has now been escalated as a formal workstream under the police Chief Superintendent.

Operational issues remain significant, including delays to MHA assessments caused by AMHPs requesting an available bed before assessments can be completed, especially when dealing with AO patients.

There are also other concerns around AO patient needs, with 31 individuals identified with alcohol misuse issues and 17 facing housing difficulties. Caseload pressures are evident across CMHTs, presenting a challenge for picking up new cases.

The absence of an AO dashboard limits oversight of performance in Fundamentals of Care Standards, such as physical health assessments, while difficulties persist in capturing outcome measures due to some AO patients declining to participate.

These gaps highlight the ongoing need for strengthened systems, improved engagement strategies and enhanced liaison across partners to ensure consistent delivery of care and risk management in AO services through the AO Working group. The gaps are being progressed in the working group and there are risk mitigation plans within the team in place.

FORWARD PLAN - BOARD - 2025/26		03-Jun-2025	22-Jul-2025	23-Sep-2025	25-Nov-2025	27-Jan-2026	24-Mar-2026
	Deadline for Approved Papers	20-May-2025	10-Jul-2025	11-Sep-2025	13-Nov-2025	15-Jan-2026	12-Mar-2026
DoCA/TS	Declarations of Interest	X	X	X	X	X	X
DoN	Patient/Board Story	X	X	X	X	X	X
CHAIR	Minutes/Matters Arising/Action Matrix	X	X	X	X	X	X
CHAIR	Board review of meeting effectiveness	X	X	X	X	X	X
CHAIR	Board Forward Plan (for information)	X	X	X	X	X	X
CHAIR	Summary of Council of Governors meeting (for information)	X	X		X	X	
CHAIR	Chair's update	X	X	X	X	X	X
CEO	Chief Executive's update	X	X	X	X	X	X
OPERATIONAL PERFORMANCE							
DCEO/CDO/DoN/ DoF/DPODI	Integrated Performance and Activity report (Operations, Finance, People and Quality)	X	X	X	X	X	X
DCEO/CDO	ICB Joint Forward Plan (ad hoc inclusion with CEO Update)						
DCEO/CDO	Emergency Preparedness, Resilience and Response (EPRR) Core Standards			X			
Prog Director	Making Room for Dignity progress - (Mar-2026 - formal approval of MRfD Post Project Evaluation and Benefits Realisation)	X					X
DCEO/CDO	Mental Health Services Assessment Tool (Men-SAT), including action plan (via Trust Delivery Group and Finance and Performance Committee)			X			
DoF	Year-end Position 2024/25	X					
Receipt of Reports (following assurance at Quality and Safeguarding Committee (QSC)):							
DoN/MD	Safer Staffing annual review (QSC - Jul)			X			
QUALITY GOVERNANCE							
DoN	Fundamental Standards of Care report (CQC Domains)		X			X	
MD	Medical Job Planning (quarterly)						X
DoN	Outcome of Board stories (annual Jun)						
DCEO/CDO	Transformation and Continuous Improvement (bi-annual)	X			X		
DCEO/CDO/MD/DoN	Winter Plan		X	X			
Receipt of Reports (following assurance at People and Culture Committee (PCC)):							
MD	10 Point Plan to Improve the Lives of Resident Doctors (PCC - Nov)				X		
MD	Medical Appraisal and Revalidation - annual report (PCC - May)	X					
Receipt of Reports (following assurance at Quality and Safeguarding Committee (QSC)):							
DoN/MD	Assertive Outreach Community Health Treatment - Action Plan update	X				X	
DoN	Children in Care/Looked After Children - annual report (QSC - Sep)				X		
DoN	Guardian of Safe Working Hours report (QSC - quarterly)		AR		X	X	
DoN	Delivery of Same Sex Accommodation (QSC - Oct)				X		
DoN	Infection Prevention and Control annual report and IPC BAF (QSC - Oct)				X		
DoN	Quality Account (QSC - May)						
DoN	Quality Delivery Plan (QSC - Jul)		X				
DoN	Safeguarding Children and Adults at Risk - annual report (QSC - Sep)				X		
DoN	SEND - Annual Special Educational Needs and Disabilities (QSC - May/Jun)	X					
MD	Learning from Deaths/Mortality report (QSC - quarterly)	AR			X		X
STRATEGIC PLANNING AND CORPORATE GOVERNANCE							
DoF/DCEO/CDO/ DPODI	2025/26 Plan	X					
DoCA/TS	Annual Review of Register of Interests	X					
DoCA/TS	Board Assurance Framework update	X		X	X		X
DoCA/TS	Continuation of Services Condition 7 - Provider Licence	X					
CHAIR	Fit and Proper Person Declaration		X				
FTSUG	Freedom to Speak Up Guardian report (six-monthly)			X			X
MD	Patient and Carers Race Equality Framework - annual					X	
MD	Suicide and Self-Harm Prevention Strategy				X		
DoCA/TS	Trust Sealings (six-monthly - for information)	X			X		
DCEO/CDO	Trust Strategic Plan (quarterly update)	X		X	X	X	X
DPODI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) *request for Board delegated authority for People and Culture Committee meeting Sep to approve the October submissions*			X			
DPODI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Strategic implications (retrospective sign-off on assurance at People and Culture Committee - Sep)				X		
Receipt of Reports (following assurance at Audit and Risk Committee (ARC)):							
DoCA/TS	Year-end Governance reporting from Board Committees and approval of Terms of Reference (ToRs) (ARC - Apr)	X					
Receipt of Reports (following assurance at People and Culture Committee (PCC)):							
DPODI	Annual Gender Pay Gap report for approval (PCC - May)	X					
DPODI	Annual Approval of Modern Slavery Statement (PCC - Mar, to be published on Trust website on approval)	X					
DPODI	Flu Campaign annual report (PCC - Jul)		X				
DPODI	Staff Survey results (PCC - Mar)						X
Committee Chairs	Board Committee Assurance Summaries	X	X	X	X	X	X
POLICY REVIEW							
DCEO/CDO	Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity (BC) Policy (30-Nov-2026)			X			
DoCA/TS	Fit and Proper Person Policy (31-Mar-2026)						X
DoCA/TS	Policy for Engagement between the Board of Directors and the Council of Governors (30-Nov-2025)				X		
DoF	Standing Financial Instructions Policy and Procedures (31-Oct-2025)			X			

KEY

ARC	Audit and Risk Committee
DCEO/CDO	Deputy Chief Executive and Chief Delivery Officr
DoCA/TS	Director of Corporate Affairs and Trust Secretary
DoF	Director of Finance
DoN	Director of Nursing, Allied Health Professionals, Quality and Patient Experience
DPODI	Director of People, Organisational Development and Inclusion
FTSUG	Freedom to Speak Up Guardian
MD	Medical Director
PCC	People and Culture Committee
QSC	Quality and Safeguarding Committee

FORWARD PLAN - BOARD - 2026/27		19-May-2026	21-Jul-2026	22-Sep-2026	24-Nov-2026	26-Jan-2027	23-Mar-2027
	Deadline for Approved Papers	**07-May-2026**	**09-Jul-2026**	**10-Sep-2026**	**12-Nov-2026**	**14-Jan-2027**	**11-Mar-2027**
DoCA/TS	Declarations of Interest	X	X	X	X	X	X
DoN	Patient/Board Story	X	X	X	X	X	X
CHAIR	Minutes/Matters Arising/Action Matrix	X	X	X	X	X	X
CHAIR	Board review of meeting effectiveness	X	X	X	X	X	X
CHAIR	Board Forward Plan (for information)	X	X	X	X	X	X
CHAIR	Summary of Council of Governors meeting (for information)	X	X		X	X	
CHAIR	Chair's update	X	X	X	X	X	X
CEO	Chief Executive's update	X	X	X	X	X	X
OPERATIONAL PERFORMANCE							
DCEO/CDO	Emergency Preparedness, Resilience and Response (EPRR) Core Standards			X			
DCEO/CDO/DoN/ DoF/DPODI	Integrated Performance report (Operations, Finance, People and Quality)	X	X	X	X	X	X
DCEO/CDO	ICB Joint Forward Plan (ad hoc inclusion with CEO update)						
DoF	Year-end Position 2025/26	X					
Receipt of Reports (for noting following assurance at Quality and Safeguarding Committee (QSC)):							
DoN/MD	Safer Staffing annual review (QSC Jul)			X			
QUALITY GOVERNANCE							
DoN	Fundamental Standards of Care report (CQC Domains) (6-monthly)		X			X	
MD	Medical Job Planning (annual) (PCC Apr/May)	X		X	X		X
DoN	Outcome of Board stories (annual, Jun)		X				
DCEO/CDO	Transformation and Continuous Improvement (bi-annual)	X			X		
DCEO/CDO/MD/DoN	Winter Plan		X	X			
Receipt of Reports (for noting following assurance at People and Culture Committee (PCC)):							
MD	10 Point Plan to Improve the Lives of Resident Doctors (PCC - Nov)				X		
MD	Medical Appraisal and Revalidation - annual report (PCC Apr)	X					
Receipt of Reports (for noting following assurance at Quality and Safeguarding Committee (QSC)):							
DoN/MD	Assertive Outreach Treatment - Community Mental Health Action Plan update	X			X		
DoN	Guardian of Safe Working Hours report (QSC quarterly / annual report Jun)	X	AR		X	X	
DoN	Infection Prevention and Control annual report and IPC BAF (QSC Oct)				X		
MD	Learning from Deaths/Mortality report (QSC quarterly)		AR		X	X	X
DoN	Looked After Children - annual report (QSC Sep)				X		
DoN	Delivery of Same Sex Accommodation (QSC Oct)				X		
DoN	Quality Account (QSC - May)		X				
DoN	Safeguarding Children and Adults at Risk - annual report (QSC AR Sep)				X		
DoN	SEND - Special Educational Needs and Disabilities annual report (QSC May/Jun)	X					
STRATEGIC PLANNING AND CORPORATE GOVERNANCE							
DoF/DCEO/CDO/DPODI	2025/26 Plan (annual)	X					
DoCA/TS	Annual Review of Register of Interests	X					
DoCA/TS	Board Assurance Framework update	X		X	X		X
Committee Chairs	Board Committee Assurance Summaries	X	X	X	X	X	X
DCEO/DCO	Clinical Digital Plan update (six-monthly)	X			X		
DoCA/TS	Continuation of Services Condition 7 - Provider Licence	X					
CHAIR	Fit and Proper Person Declaration		X				
FTSUG	Freedom to Speak Up Guardian report (six-monthly)			X			X
DoCA/TS	Trust Sealings (six-monthly - for information)	X			X		
DCEO/CDO	Trust Strategic Plan (quarterly update, to include 4 Ps Delivery Plans)	X		X	X		X
DPODI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) *request for Board delegated authority for People and Culture Committee meeting Sep to approve the October submissions*			X			
DPODI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Strategic implications (retrospective sign-off on assurance at People and Culture Committee Sep)			X			
MD	Patient and Carers Race Equality Framework - annual					X	
Receipt of Reports (for noting following assurance at Audit and Risk Committee (ARC)):							
DoCA/TS	Year-end Governance reporting from Board Committees and approval of Terms of Reference (ToRs) (ARC Apr)	X					
Receipt of Reports (for noting following assurance at People and Culture Committee (PCC)):							
DPODI	2025/26 Flu Campaign annual report (PCC Jul)			X			
DPODI	Annual Approval of Modern Slavery Statement (PCC Mar, to be published on Trust website on approval)	X					
DPODI	Annual Gender Pay Gap report for approval (data for previous year reporting deadline Mar - PCC Jul)			X			
DPODI	Staff Survey results (PCC Mar)						X
POLICY REVIEW							
DoF	Standing Financial Instructions Policy and Procedures (31-Oct-2026)			X			

KEY	
ARC	Audit and Risk Committee
DCEO/CDO	Deputy Chief Executive and Chief Delivery Officr
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DoF	Director of Finance
DoN	Director of Nursing, Allied Health Professionals, Quality and Patient Experience
DPODI	Director of People, Organisational Development and Inclusion
FTSUG	Freedom to Speak Up Guardian
MD	Medical Director
PCC	People and Culture Committee
QSC	Quality and Safeguarding Committee

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
A	
A&E	Accident and Emergency
ABPI	Association of British Pharmaceutical Industry
ACCT	Assessment, Care in Custody & Teamwork
ACE	Adverse Childhood Experiences
AC/RC	Approved Clinician/Responsible Clinician
ADHD	Attention Deficit Hyperactivity Disorder
ADI-R	Autism Diagnostic Interview-Revised
ADOS	Autism Diagnostic Observation Schedule (assessment)
AED	Adult Eating Disorder
AED	Automated External Defibrillator
AfC	Agenda for Change
AFT	Advanced Foundation Trust
AHP	Allied Health Professional
AI	Artificial Intelligence
AIMS	Royal College of Psychiatrists Accreditation for Inpatient Mental Health Services programme
ALB	Arms-length body such as NHS Improvement (NHSI) and NHS England (NHSE)
AMM	Annual Members' Meeting
AMHP	Approved Mental Health Professional
ANP	Advanced Nurse Practitioner
AO	Accountable Officer
AO	Assertive Outreach
AOVPN	AlwaysOn VPD (secure network access)
APC	Annual Physical Health
APNA NHS	Asican Professionals' National Alliance
APOM	Activity Participation Outcome Measure
ASD	Autism Spectrum Disorder
ASM	Area Service Manager
ATR	Alcohol Treatment Requirement
ATU	Acute Treatment Unit
B	
BAF	Board Assurance Framework
BCF	Better Care Fund
BCO	Building Control Officer
BCP	Business Continuity Plan
BI	Business Intelligence
BIA	Business Impact Analysis
BLS	Basic Life Support (ILS Immediate Life Support)
BMA	British Medical Association
BAME	Black, Asian and Minority Ethnic
BILD	British Institute of Learning Disabilities
BME	Black and Minority Ethnic group
BoD	Board of Directors
BPD	Borderline Personality Disorder
BPPC	Better Payment Practice Code
C	
CANSAS	Camberwell Assessment of Need Short Appraisal Schedule
CAMHS	Child and Adolescent Mental Health Services

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
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
CDM	Construction Design and Management
CDMI	Clinical Digital Maturity Index
CE	Chief Executive
CEO	Chief Executive Officer
CER	Clinical Establishment Review
CERT	Community Enhanced Rehabilitation team
CESR	Certificate of Eligibility for Specialist Registration
CGA	Comprehensive Geriatric Assessment
CHANNEL	Confidential, voluntary, multi-agency safeguarding programme that provides early intervention to protect vulnerable children and adults who might be susceptible to being radicalised
CHIME	Connectedness, Hope, Identity, Meaning, Empowerment recovery
CHPPD	Care Hours Per Patient Day
CIC	Children in Care
CIN	Children in Need
CIP	Cost Improvement Programme
CMDG	Contract Management Delivery Group
CMHF	Community Mental Health Framework
CMHT	Community Mental Health Team
CMO	Chief Medical Officer
CNST	Clinical Negligence Scheme for Trusts
COAT	Clinical Operational Assurance Team
COF	Commissioning Outcomes Framework
CoG	Council of Governors
COO	Chief Operating Officer
CP	Child Protection
CPA	Care Programme Approach
CPD	Continuing Professional Development
CPN	Community Psychiatric Nurse
CPR	Child Protection Register
CPRG	Clinical Professional Reference Group
CQC	Care Quality Commission
CQI	Clinical Quality Indicator
CQRG	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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
CSC	Commonwealth Scholarship Commission
CSDS	Community Services Data Set
CSF	Commissioner Sustainability Fund
CSPR	Child Safeguarding Practice Review
CSTF	Core Skills Training Framework
CSU	Commissioning Support Unit
CTO	Community Treatment Order
CTR	Care and Treatment Review
CUF	Cost Uplift Factor
CYP	Children and Young People
D	
DAG	Divisional Assurance Group
DAR	Divisional Assurance Review
DASP	Drug and Alcohol Strategic Partnership
DAT	Drug Action Team
Datix	Trust's electronic incident reporting system of an event that causes a loss, injury or a near miss to a patient, staff or others
DBS	Disclosure and Barring Service
DBT	Dialectical Behavioural Therapy
DDME	Deputy Director of Medical Education
DfE	Department for Education
DCHS	Derbyshire Community Health Services NHS Foundation Trust
DDCCG	Derby and Derbyshire Clinical Commissioning Group
DDSAB	Derby and Derbyshire Safeguarding Adult Board
DDSC	Designated Doctor Safeguarding Children
DDSCB	Derby and Derbyshire Safeguarding Children Board
DDSCP	Derby and Derbyshire Safeguarding Children Partnership
DEED	Delivering Excellence Every Day
DHcFT	Derbyshire Healthcare NHS Foundation Trust
DHR	Domestic Homicide Review
DHSC	Department of Health and Social Care
DISCO	Diagnostic Interview for Social and Communication Disorders (assessment)
DIT	Dynamic Interpersonal Therapy
DME	Director of Medical Education
DNA	Did Not Attend
DoC	Duty of Candour
DoF	Director of Finance
DoH	Department of Health
DoL	Deprivation of Liberty
DoLS	Deprivation of Liberty Safeguards
DoN	Director of Nursing
DPA	Data Protection Act
DPI	Director of People and Inclusion
DPR	Divisional Performance Review
DPS	Date Protection and Security
DQMI	Data Quality Maturity Index
DRR	Drug Rehabilitation Requirement
DRRT	Dementia Rapid Response Team
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
DTOC	Delayed Transfer of Care
DV	Domestic Violence
DVA	Derbyshire Voluntary Action (formerly North Derbyshire Voluntary Action)
DWP	Department for Work and Pensions
E	
EAP	Employee Assistance Programme
EbE	Expert by Experience
ECT	Enhanced Care Team
ECT	Electroconvulsive Therapy
ECW	Enhanced Care Ward
ED	Emergency Department
EDS2	Equality Delivery System 2
EHA	Early Help Assessment
EHCP	Education, Health and Care Plan
EHIC	European Health Insurance Card
EHR	Electronic Health Record
EI	Early Intervention
EIA	Equality Impact Assessment
EIP	Early Intervention In Psychosis
EIS	Early Intervention Service
e-LfH	e-Learning for Healthcare
ELT	Executive Leadership Team
EMDR	Eye Movement Desensitising and Reprocessing Therapy
EMPH	East Midlands Provider Collaborative
EMR	Electronic Medical Record
EPC	Energy Performance Certificate
EPMA	Electronic Prescribing and Medicine Administration
ePMO	Electronic Programme Management Office
EQIA	Equality Impact Assessment
EPR	Electronic Patient Record
EPRR	Emergency Preparedness, Resilience and Response
ERIC	Estates Return Information Collection
ESR	Electronic Staff Record
ETOC	Enhanced Therapeutic Observations and Care
EUPD	Emotionally Unstable Personality Disorder
EWTD	European Working Time Directive
F	
FBC	Full Business Case
FCMHT	Forensic Community Mental Health
FFT	Friends and Family Test
FGM	Female Genital Mutilation
FIG	Feedback Intelligence Group
FOI	Freedom of Information
FOT	Forecast Out-Turn
FSR	Full Service Record
FT	Foundation Trust
FT ARM	Foundation Trust Annual Reporting Manual
FTE	Full-time Equivalent
FTN	Foundation Trust Network
FTSU	Freedom to Speak Up
FTSUG	Freedom to Speak Up Guardian

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
F&P	Finance and Performance
FYE	Full Year Effect or Financial Year End
5YFV	Five Year Forward View
G	
GAM	Group Accounting Manual
GBO	Goal Based Outcome
GDPR	General Data Protection Regulation
GGI	Good Governance Institute
GIRFT	Getting it Right First Time
GMC	General Medical Council
GMP	Guaranteed Maximum Price
GoSWH	Guardian of Safe Working Hours
GP	General Practitioner
GPFV	General Practice Forward View
H	
HACT	Housing Association Charitable Trust
HBPOS	Health Based Places of Safety
HCA	Healthcare Assistant
HCAI	Healthcare Associated Infection
HCHS	Hospital and Community Health Services (NHS)
HCP	Healthy Child Programme
H1	First half of a fiscal year (April through September)
H2	Second half of a fiscal year (October through the following March)
HEE	Health Education England
HES	Hospital Episode Statistics
HFMA	Healthcare Financial Management Association
HoNOS	Health of the Nation Outcome Scores
HoP	Head of Practice
HOPE(s)	The HOPE(s) model is an ambitious human rights-based approach to working with individuals in segregation, developed from research and clinical practice
HSCIC	Health and Social Care Information Centre
HSE	Health and Safety Executive
HSSC	Health and Safety Security Committee
HST	Higher Specialty Training
HV	Health Visitor
HWB	Health and Wellbeing Board
I	
I&E	Income and Expenditure
IAPT	Improving Access to Psychological Therapies
Icare	Increase Confidence, Attract, Retain, Educate
ICB	Integrated Care Board
iCIMS	Internet Collaborative Information Management System
ICM	Insertable Cardiac Monitor
ICO	Information Commissioner's Office
ICS	Integrated Care System
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IDVAs	Independent Domestic Violence Advisors
IFRS	International Financial Reporting Standards
IIC	Inclusive Intercultural Communication
IG	Information Governance

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
ILS	Immediate Life Support (BLS – Basic Life Support)
IMHA	Independent Mental Health Advocacy
ImmForm	UKHSA ImmForm system – used to order medical products and collect vaccine uptake data
IMST	Information Management Systems and Technology
IMT	Incident Management Team
IMT&R	Information Management, Technology and Records
INQUEST	Official, public inquiry to discover the facts about a death. An inquest is conducted by a coroner to determine who the deceased was, and how, when, and where they died, especially in cases of sudden, violent, or unexplained deaths
IPC SAG	Infection Prevention and Control Strategic Action Group
IPP	Imprisonment for Public Protection
IPR	Integrated Performance Report
IPS	Individual Placement and Support
IPT	Interpersonal Psychotherapy
IQVIA	I (for IMS Health), Q (for Quintiles) and VIA (meaning 'by way of')
IRHTT	In-reach Home Treatment Team
IRT	Incident Review Tool
J	
JCVI	Joint Committee on Vaccination and Immunisation
JDF	Junior Doctor Forum
JLNC	Joint Local Negotiating Committee
JNCC	Joint Negotiating Consultative Committee
JTAI	Joint Targeted Area Inspections
JUCB	Joined Up Care Board
JUCD	Joined Up Care Derbyshire
K	
KLOE	Key Lines of Enquiry (CQC)
KPI	Key Performance Indicator
KSF	Knowledge and Skills Framework
L	
LA	Local Authority
LAC	Looked After Children
LCFS	Local Counter Fraud Specialist
LA – CYPD	Local Authority – Children and Young People Divisions
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
LTS	Long Term Segregation
LTWP	Long Term Workforce Plan
LWSTO	Living Well Short-Term Offer
M	
M&E	Mechanical and Electrical
MADE	Multi-agency Discharge Event
MAPPA	Multi-agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference (meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors
MARS	Mutually Agreed Resignation Scheme
MAS	Memory Assessment Service
MASH	Multi-Agency Safeguarding Hub
MaST	Management and Supervision Tool
MAU	Medical Assessment Unit
MBRACCE	Mothers and Babies: Reducing Risk through Audits and confidential Enquiries
MBU	Mother and Baby Unit
MCA	Mental Capacity Act
MCC	Medicine Clinical Committee
MD	Medical Director
MDA	Medical Device Alert
MDM	Multi-Disciplinary Meeting
MDR	Medical Device Regulation
MDSO	Medical Device Safety Officer
MDT	Multi-Disciplinary Team
Men-SAT	Mental Health Services Assessment Tool
MFA	Multi-Factor Authentication
MFF	Market Forces Factor
MHA	Mental Health Act
MHAC	Mental Health Act Committee
MHIN	Mental Health Intelligence Network
MHIS	Mental Health Investment Standard
MHLDA	Mental Health, Learning Disabilities and Autism
MHLT	Mental Health Liaison Team
MHOST	Mental Health Optimal Staffing Tool
MHPS	Maintaining High Professional Standards
MHRA	Medical and Healthcare products Regulatory Agency
MHRT	Mental Health Review Tribunal
MHRV	Mental Health Response Vehicle
MHSDS	Mental Health Services Data Set
MiCAD	Reporting system for medical device service and repair
MMaSP	Medicine Management Safety and Practice
MMC	Medicine Management Committee
MoU	Memorandum of Understanding
MPAC	Multi-Professional Approved Clinician
MSC	Medical Staff Committee
MSK	Musculoskeletal (conditions)
MSP	Medicines Safety and Practice
MST	Multisystemic Therapy
MSU	Medium Secure Unit

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
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
NGO	National Guardian's Office
NHIS	Nottingham Health Informatics Service
NHS	National Health Service
NHSC	NHS Confederation
NHSCFA	NHS Counter Fraud Authority
NHSE	National Health Service England
NHSI	National Health Service Improvement
NHSEI	NHS England and NHS Improvement
NHSP	NHS Providers
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NIMS	National Immunisation Management System
NIMS	National Incident Management System
NIVS	National Immunisation and Vaccination System
NOF	NHS Oversight Framework
NPS	National Probation Service
NPSA	National Patient Safety Alert
NQB	National Quality Board
NR	Non-Recurrent
NROC	Non-Resident On-Call
O	
OBC	Outline Business Case
ODG	Operational Delivery Group
OOA	Outside of Area
OPMO	Older People's Mental Health Services
OP	Outpatient
OSC	Overview and Scrutiny Committee
OSCE	Objective Structured Clinical Examination
OT	Occupational Therapy
P	
PAB	Programme Assurance Board
PAG	Programme Advisory Group
PALS	Patient Advice and Liaison Service
PAM	Payment Activity Matrix
PARC	Psychosis and the reduction of cannabis (and other drugs)
PARIS	This is an electronic patient record system
PbR	Payment by Results
PCC	Police & Crime Commissioner
PCC	People and Culture Committee
PCLB	Provider Collaborative Leadership Board
PCN	Primary Care Networks

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
PCOG	Patient and Carer Operational Group
PCREF	Patient and Carers Race Equality Framework
PDC	Public Dividend Capital
PDF	Portable Document Format
PDSA	Plan, Do, Study, Act
PET	Psychiatric Emergency Team
PFI	Private Finance Initiative
PFF	Probation Feedback Form
PFR	Provider Finance Return
PHC	Public Health Commissioners
PHCIC	Physical Healthcare and Infection Control Committee
PHE	Public Health England
PHE	Physical Health Equipment
PHSCC	Population Health and Strategic Commissioning Committee
PHSMI	Physical Health Serious Mental Illness
PHSO	Parliamentary and Health Service Ombudsman
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PiPoT	Persons in a Position of Trust
PJF	Professional Judgement Framework
PLACE	Patient-Led Assessments of the Care Environment
PLIC	Patient Level Information Costs
PMF	Performance Management Framework
PMH	Perinatal Mental Health
PMLD	Profound and Multiple Disability
PMO	Project Management Office
PODG	Programme Oversight and Delivery Group
PPE	Personal Protection Equipment
PPI	Patient and Public Involvement
PPN	Public Protection Notice
PPT	Partnership and Pathway Team
PQN	Perinatal Quality Network
PREM	Patient Reported Experience Measure
PROMS	Patient Reported Outcome Measures
PSF	Provider Sustainability Fund
PSII	Patient Safety Incident Investigations
PSIRF	Patient Safety Incident Review Framework
PSIRP	Patient Safety Incident Review Plan
PSQG	Patient Safety and Quality Group
PSR	Provider Selection Regime
PTU	Psychiatry Teaching Unit
PYE	Part Year Effect
Q	
QAG	Quality Assurance Group
QASI	Quality Assurance Serious Incidents
Q&SC	Quality and Safeguarding Committee
QEIA	Quality and Equality Impact Assessment
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity Programme
QOF	Quality and Outcomes Framework
QSIR	Quality, Service Improvement and Redesign

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
R	
RAID	Rapid Assessment, Interface and Discharge
RAP	Recovery Action Plan
RAVS	Record a Vaccination Service
RCGP	Royal College of General Practitioners
RCI	Reference Cost Index
RDOG	Research and Development Operational Group
REGARDS	Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation
ReQoL	Recovering Quality of Life
RFI	Request for Information
ROAG	Responsible Officer Advisory Group
RoDP	Recognition of Deteriorating Patient
ROM	Reported Outcome Measure
RPOG	Restrictive Practice Oversight Group
RRN	Restraint Reduction Network
RRP	Recruitment Retention Proposal
RTT	Referral to Treatment
S	
s132	Section 132 of the Mental Health Act: As soon as a patient is detained under the Act the patient must be given their rights orally and in writing unless it is not practicable at that time. If this is the case, it must be documented in the patient's electronic care record
s136	Section 136 of the Mental Health Act: Police can use emergency powers if they think you have a mental disorder, you're in a public place and need immediate help. They can take you or keep you in a place of safety, where your mental health will be assessed.
SAAF	Safeguarding Adults Assurance Framework
SAB	Safeguarding Adults Board
SAF	Single Assessment Framework
SAR	Safeguarding Adult Review
SAS Doctor	Specialist, Associate Specialist and Specialty Doctor
SAT	Specialist Autism Team
SBARD	Situation, Background, Assessment, Recommendation and Decision (SBARD) tool
SBS	Shared Business Services
SCPHN	Specialist Community Public Health Nurse
SEIPS	Systems Engineering Initiative for Patient Safety
SEND	Special Educational Needs and Disabilities
SFI	Standing Financial Instructions
SI	Serious Incidents
SIG	Serious Incident Group
SID	Senior Independent Director
SIDS	Sudden Infant Death Syndrome
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement
SLaM	South London and Maudsley NHS Trust
SLR	Service Line Reporting
SLRDE	Senior Lead for Resident Doctor Experience
SMI	Severe Mental Illness
SNOMED CT	Systemised Nomenclature of Medicine – Clinical Terms
SOAD	Second Opinion Appointed Doctor

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
SOC	Strategic Options Case
SOF	Single Operating Framework
SoCI	Statement of Comprehensive Income
SO	Standing Order
SOP	Standard Operating Procedure
SPOA or SPA	Single Point of Access
SPOE	Single Point of Entry
SPOG	Strategic Portfolio Oversight Group
SPOR	Single Point of Referral
SSQD	Specialised Services Quality Dashboards
SSRB	Senior Salaries Review Board
STEIS	Strategic Executive Information System
STAH	St Andrew's House
STF	Sustainability and Transformation Fund
STOMP/STAMP	Stopping The Over-Medication of children and young People with a learning disability, autism or both / Supporting Treatment and Appropriate Medication in Paediatrics
STP	Sustainability and Transformation Partnership
SUI	Serious (Untoward) Incident
SW	Social Worker
SystmOne	Electronic patient record system
T	
TAV	Team Around the Family
TARN	Trauma Audit and Research Network
TBT	Tobacco Dependence Team
TCP	Transforming Care Partnerships
TCS	Transforming Community Services
TDA	Trust Development Authority
TDG	Trust Delivery Group
TDT	Tobacco Dependence Team
TIC	Trauma Informed Care
TLT	Trust Leadership Team
TMAC	Trust Medical Advisory Committee (now Medical Senate)
TMT	Trust Management Team
TMTC	Trust Medical Training Committee
TOIL	Time Off In Lieu
TOOL	Trust Operational Oversight Leadership
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
U	
UHDB	University Hospitals of Derby and Burton
UEC	Urgent and Emergency Care
V	
VARM	Vulnerable Adult Risk Management
VCOD	Vaccination as a Condition of Deployment
VCP	Vacancy Control Panel
VCSE	Voluntary, Community and Social Enterprise organisations
VdTMoCA	Vona du Toit Model of Creative Ability *(a practical guide for Acute Mental Health Occupational Therapy Practice)*
VFM	Value For Money
VO	Vertical Observatory
VTE	Venous Thromboembolism

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
W	
WAP	Wireless Application Protocol
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent
Y	
YTD	Year to Date

16 January 2026

Report from the Council of Governors meeting

The Council of Governors has met once since the last report, on 25 November 2025. The meeting was conducted as a hybrid meeting.

Submitted Questions from Members of the Public

One question was submitted by a Trust member:

"Why don't Derbyshire Healthcare NHS Foundation Trust adhere to NHSE's Patient Safety Incident Response Framework guidelines?"

Assurance was given by the Deputy Chair that the Trust does adhere to the guidelines. The response was forwarded onto the member who raised the question.

Chief Executive's Update

The Chief Executive presented his update which focused on:

- NHS England's Medium-Term Planning Framework
- Confirmation that the new Integrated Care Board (ICB) for Derby and Derbyshire, Lincolnshire and Nottingham and Nottinghamshire (DLN) have appointed a new Executive team
- The official opening of the Trust's new mental health facilities (Derwent Unit in Chesterfield, Carsington Unit, Kingfisher House and Audrey House in Derby) have recently taken place
- After their recent inspection the Care Quality Commission (CQC) have rated the Kedleston Unit in Derby as 'good'
- Out of area placements have significantly decreased which is having a positive impact on service users and their families
- The Trust's financial plan
- The Trust's recent tender for Substance Misuse services for adults, children and young people in Derby was disappointingly unsuccessful.

Council of Governors Annual Effectiveness Survey

The Membership and Involvement Manger presented the results of the Annual Effectiveness Survey of the Council of Governors. Initially, the results were presented and discussed in full at the Governance Committee on 22 October 2025. The results overall were positive. Actions developed in response to the results were shared.

Non-Executive Directors Report

Lynn Andrews and Deborah Good, Non-Executive Directors presented an overview of their roles and activities at the Trust.

Verbal Summary of Integrated Performance Report (IPR)

Non-Executive Directors gave a verbal summary of the IPR focusing on key finance, performance, and workforce measures.

Escalation item to the Council of Governors from the Governance Committee

The Deputy Chair provided governors with assurance that the Trust has representatives at PLACE meetings.

Report from the Governance Committee

The Co-Chair of the Governance Committee presented a report of the meeting held on 22 October 2025.

Annual Members Meeting feedback

The Membership and Involvement Manager provided feedback on the Annual Members Meeting (AMM) which took place on 2 October 2025 online. It had been a very positive event which focused on the health and wellbeing of people in Derbyshire. A governor's task and finish group is being established to plan next year's AMM which is taking place on 30 September 2026.

Update on staff and governor public elections

The Membership and Involvement Manager gave an update on the elections which included:

- Confirmation of public governor and staff governor vacancies
- Timescale for the elections including nominations, voting and declaration of results
- Plans for promoting the elections.

Newly elected governors' terms of office will begin on 1 February 2026.

RECOMMENDATION

The Trust Board is asked to note the summary report from the Council of Governors meeting held on 25 November 2025.