Derbyshire Healthcare
NHS Foundation Trust

Public Trust Board Meeting

24 March 2026

Conference Rooms A and B, Research and Development Centre

Kingsway

Derby, DE22 3LZ

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Derbyshire Healthcare
NHS Foundation Trust

Public Board Meeting

Agenda

Date: Tuesday, 24 March 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	Patient Story – 'Grandad'	Tumi Banda
3	10.00	Minutes of the Board of Directors meeting held 27 January 2026	Selina Ullah
4		Action Matrix and Matters Arising	
5		Questions from members of the public	
6	10.05	Chair's update	Selina Ullah
7	10.15	Chief Executive's update	Mark Powell
OPERATIONAL PERFORMANCE			
8	10.25	Integrated Performance report, including Quality, Operations, People and Finance 8.1 Board Committee Assurance Summaries	Tumi Banda/Vikki Ashton Taylor/Rebecca Oakley/James Sabin Committee Chairs
BREAK 11.10am			
9	11.20	Making Room for Dignity (MRfD) – formal approval of Post-Project Evaluation and Benefits Evaluation reports	James Sabin
STRATEGIC PLANNING AND CORPORATE GOVERNANCE			
10	11.30	Board Assurance Framework update	Justine Fitzjohn
11	11.40	Freedom to Speak Up Guardian (FTSU) report	Tam Howard
12	11.50	Staff Survey	Rebecca Oakley
APPROVAL OF ENABLING PLANS TO TRUST STRATEGY			
13	12.00	Digital Delivery Plan – 2026-2028 *(reviewed at the Finance and Performance Committee on 20 March 2026)*	Girish Kunigiri
14	12.10	People Plan *(reviewed at the People and Culture Committee on 6 November 2025)*	Rebecca Oakley
REPORTS FOR NOTING FOLLOWING ASSURANCE AT BOARD COMMITTEES			
15	12.20	Quality and Safeguarding Committee 15.1 Guardian of Safe Working Hours (GoSWH) report 15.2 Learning from Deaths/Mortality report	Lynn Andrews

WE MAKE A POSITIVE DIFFERENCE IN EVERYTHING WE DO

REPORTS FOR NOTING FOLLOWING ASSURANCE AT BOARD COMMITTEES			
16	12.20	Quality and Safeguarding Committee 15.1 Guardian of Safe Working Hours (GoSWH) report 15.2 Learning from Deaths/Mortality report	Lynn Andrews
POLICY REVIEW			
17	12.25	Fit and Proper Person Policy	Justine Fitzjohn
CLOSING BUSINESS			
18	12.30	Consideration of any items affecting the Board Assurance Framework (BAF)	Selina Ullah
19		Meeting effectiveness	
FOR INFORMATION			
Forward Plan 2026/27 Glossary of NHS Acronyms			

Next meeting:

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

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

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

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

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

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

Strategy on a page

NHS
Derbyshire Healthcare
NHS Foundation Trust

Our strategic priorities

Our vision

We make a positive difference in everything we do

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.

WE MAKE A POSITIVE DIFFERENCE • IN EVERYTHING WE DO •

Ambitious

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

Belonging

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

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 • Director, Muslim Women's Council • Trustee – NHS Confederation • Vice Chair/Senior Independent Director – NHS Providers Board of Trustees	(e) (e) (e) (e) (e) (e)
Chioma Akpom *Designate from 06-Oct-2025 to 30--Nov-2025* Non-Executive Director *from 01-Dec-2025*	• Director, Narini Limited	(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).

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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, 27 January 2026

MEETING HELD IN PUBLIC

Commenced: 9.30am Closed: 12.33pm

PRESENT	Selina Ullah	Trust Chair
	Lynn Andrews	Non-Executive Director
	Ralph Knibbs	Senior Independent Director
	Chioma Akpom	Non-Executive Director
	Deborah Good	Non-Executive Director
	Andrew Harkness	Non-Executive Director
	Vikki Ashton Taylor	Deputy Chief Executive and Chief Delivery Officer
	Tumi Banda	Director of Nursing, Allied Health Professions (AHPs), Quality and Patient Experience
	Justine Fitzjohn	Director of Corporate Affairs and Trust Secretary
	Dr Girish Kunigiri	Medical Director
	Rebecca Oakley	Director of People, Organisational Development (OD) and Inclusion
	James Sabin	Director of Finance
IN ATTENDANCE	Anna Shaw	Associate Director of Communications and Engagement
	Jo Bradbury	Corporate Governance Officer
DHCFT2026/002	Becki Priest	Chief AHP and Deputy Director of Patient Experience
DHCFT2026/002	Ian Rigley	Lead CBT Psychotherapy Specialist/Consultant CBT Psychotherapist
APOLOGIES	Jo Hanley	Non-Executive Director
	Mark Powell	Chief Executive
OBSERVERS	Dave Allen	Public Governor, Chesterfield
	Christopher Williams	Public Governor, Erewash
	Pete Henson	Head of Performance and Delivery (online)
	Kristina Sadler-Brough	Operational Service Line Manager, Derbyshire Community Health Services (online)
	Jane Wall	Service Support Manager (online)

DHCFT/ 2026/001	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** Trust Chair, Selina Ullah, welcomed Board colleagues and observers to the meeting. The apologies for absence were noted. Selina advised that Vikki Ashton Taylor, Deputy Chief Executive and Chief Delivery Officer, would deputise for Mark Powell, Chief Executive. Attention was drawn to housekeeping information, the Trust Vision and Values and the Declaration of Interests Register. Selina highlighted a slight amendment, in that she is no longer associated with Accent Housing Group. There were no other changes.

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	No declarations of interest were raised with any of the agenda items.
DHCFT/ 2026/002	**BOARD STORY – TRANSFORMING LIVES THROUGH COGNITIVE BEHAVIOURAL THERAPY (CBT) PSYCHOTHERAPY IN SECONDARY CARE – OUR JOURNEY IN DERBYSHIRE – CBT SERVICE DEVELOPMENT** The Board welcomed Ian Rigley, Consultant Cognitive Behavioural Therapy (CBT) Psychotherapist, who was introduced by Becki Priest, Chief Allied Health Professional (AHP) and Deputy Director of Patient Experience. It was noted that Ian's story would review recent continuous service improvements/developments in the Adult and Child and Adolescent Mental Health service (CAMHS) CBT services, in the maintenance of recovery for individuals experiencing complex mental health clinical presentations. It was highlighted that CBT is a type of talking therapy, commonly used to treat a range of mental health problems; teaching therapy skills for dealing with different problems and focusing on how thoughts, beliefs and attitudes affect feelings and behaviours, whilst also helping patients live with past experiences to reduce the current impact. Ian outlined the team's previous long waiting lists, where people regularly dropped out prior to accessing services or were not ready to engage with services. The adult CBT service has introduced a therapy preparation group as a new mandatory step, which has provided the opportunity to engage with people while they were actively waiting for the CBT treatment, including signposting appropriately if psychotherapy is determined not suitable. This approach has led to positive results, with people being ready to engage in group work more readily, together with reduced anxiety and depression while waiting from treatment and patients "actively waiting". As a result, the waiting list has reduced, with adult patients starting treatment within a 19 week to 52-week time period from point of referral. Ian outlined the team's approach to finding clinical improvements/innovations, by solving problems, to help improve people's lives. The team's initiatives have provided solutions which are clinically effective and provide better outcomes for local people, being more cost effective and offering a positive patient experience – with the team receiving an increased number of compliments related to both adult services and CAMHS. Anecdotal observations were shared, referencing both individual and clusters of patients who have benefitted from these interventions. Selina suggested investigating the role of CBT in facilitating patients' return to work, especially in the context of post-Covid trauma, which aligns with government objectives for economic growth. Ian highlighted that by focusing help for people with their occupation performance/functioning is a central focus of CBT and emphasised the importance of close collaboration with the Individual Placement and Support (IPS) team, and other services, to help mobilise a person's recovery journey. An illustrative case was discussed, involving a patient who had suffered for three decades and following treatment, was now preparing for voluntary work. The transition of care to Primary Care services was mentioned, noting that these services include employment support. However, the persistent stigma surrounding psychosis, personality disorders and serious mental illnesses remain a barrier. The Board questioned why individuals with mental health issues should be excluded from such support. The transition of care to Primary services was mentioned, noting that these services include employment support. However, the persistent stigma surrounding psychosis and personality disorders remains a barrier. The Board questioned why individuals with mental health issues should be excluded from such support. Recognising the phenomenal achievements, Vikki highlighted how incredibly hard the team works and acknowledged Ian's strong, professional leadership style.

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	Pointing out that culture is a strategic responsibility of the Board, Lynn asked what had helped the positive shift in the team. In response, Ian cited the innovative and creative leadership style of Louise Braham, Business Development Lead and Chief Psychologist, which has fostered a united approach and joint aspirations across the system, within the services of the Divisional of Psychology and Psychotherapy, and how these services integrate with other Trust services. It was clarified that patients who are not ready for the preparation groups or CBT are supported to access preparatory services and approaches. In addition, Ian addressed the assumption that psychotherapy should be available immediately after crisis. He explained that CBT intervention can be destabilising, therefore, should be delivered at the right time to help promote the best possible recovery in the long-term. It was noted that improved communication between services would help to reduce misunderstandings and manage expectations. Selina expressed gratitude for the thought-provoking presentation and requested updates regarding ongoing innovations and outcomes. The meeting concluded with applause, reflecting the Board's appreciation and support for continued advancements in this important area. **RESOLVED: The Board of Directors was greatly inspired by the outstanding progress of the team.**
DHCFT/ 2026/003	**MINUTES OF THE LAST BOARD OF DIRECTORS MEETING** The draft minutes of the last meeting held on 25 November 2025 were accepted as a correct record of the meeting.
DHCFT/ 2026/004	**ACTION MATRIX AND MATTERS ARISING** There were no outstanding actions and no matters arising from the minutes.
DHCFT/ 2026/005	**QUESTIONS FROM MEMBERS OF THE PUBLIC** No questions had been received. It was noted that Trust Governors represent members of the public and are responsible for holding the Board to account, providing an additional route for questions.
DHCFT/ 2026/006	**CHAIR'S UPDATE - VERBAL** Selina provided the Board with her reflections on activity since the previous Board meeting on 25 November 20225 and drew attention to the below points: Pointing out the turbulence of the last year, with many changes being experienced at a local, system and national level, Selina emphasised that the Trust has worked hard to respond to changes and challenges, in order to continue delivering effective services, efficiencies and innovations. Colleagues were congratulated on the high number of successes achieved during this challenging time, including completion of the majority of the Making Room for Dignity programme. It was noted that the operational restructure continues to take place, with focus on maintaining service quality, patient safety and providing the best possible care. Selina shared an update of her visit to the Trust's School Nursing team, reflecting that demand and expectations of the service continue to increase. She explained the team has introduced the Lancaster model; a proactive approach designed to ensure that children and young people (between 5 and 16 years' old) and their families have their needs assessed at key stages. It was noted that as the team covers c150 schools within Derby and Derbyshire, certain schools are targeted, rather than assessment of all, to provide a clear picture of the bespoke health needs in the area. Thanks were expressed to three members of the Council of Governors, whose terms of office were coming to an end this month: Marie Hickman, Staff Governor for Admin and Allied Support; Sue Ryan, Lead Governor and Public Governor for Amber Valley and Christine Williamson, Public

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	Governor for Derby City west. Selina was appreciative of the outstanding support to the Board and wider organisation that has been provided. Selina updated the Board on the forthcoming merger of NHS Providers and the NHS Confederation, where a transition Board is now in place. It was noted that Sir Ciarán Devane, Executive Director of the Centre for Trust, Peace and Social Relations and former Chief Executive Officer (CEO) of the British Council, has been appointed as CEO of the new organisation, the naming of which awaits approval by the Secretary of State. Stressing the need to have a voice to represent membership and bridge communications with the public, Selina welcomed the merger. Her involvement with NHS Providers is logged in the Register of Interests. Christopher Williams, Public Governor, Erewash, highlighted the government's intention to close Healthwatch England with its responsibilities to be transferred to the Department of Health and Social Care. This significant restructuring reflects ongoing changes within the sector. Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary, remarked positively on the coming together of NHS Providers and the NHS Confederation, hoping to see a reduction in the combined subscription fees. Selina elaborated that financial pressures are driving the move towards a more proportionate subscription model, with further details regarding membership offers expected to be released in due course. **RESOLVED: The Board of Directors noted the content of the Chair's update.**
DHCFT/ 2026/007	**CHIEF EXECUTIVE'S UPDATE** On behalf of Mark, Vikki presented the report, which covered current local issues, national policy developments and also reflected a wider view of the Trust's operating environment. Vikki thanked all colleagues who had worked in the Trust's services during Christmas and the New Year period. She also reflected on the record number of entries received for the Christmas decorations competition. It was reported that a number of different Care Quality Commission (CQC) inspections were currently underway across Trust services, with initial verbal feedback being received this week and preparations underway ahead of a potential Trust-wide Well-Led inspection. The Board acknowledged that a team had arrived that day to carry out a Mental Health Act (MHA) assessment on Robin Ward. The Directors commended the ability for staff to highlight both positive aspects and ongoing challenges during these inspections. The importance of triangulating information from what was told, heard and seen during visits was emphasised to ensure a comprehensive understanding of service delivery and areas for improvement. It was noted that annual planning of funding allocations and delivery for 2026/27 is underway, in collaboration with NHSE and the ICB. The Trust's final operational and financial plan, covering the next three years, is due for submission in February. Vikki highlighted the submission of successful bids to secure capital funding to support the delivery of a neighbourhood mental health centre and to develop a mental health emergency department. She explained that plans are being developed for both schemes, noting that neither national initiative comes with revenue funding to recruit additional workforce to deliver these services. Mark's paper also mentioned a number of staff and team achievements from recent months. **RESOLVED: The Board of Directors noted the report.**
DHCFT/ 2026/008	**INTEGRATED PERFORMANCE REPORT (IPR)** The IPR report provided a high-level view of performance against a number of Quality, Operational, People and Financial measures up to the end of November 2025 for internal measures and to the end of September 2025 where the data source is NHS England.

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Quality

A reduction in 'Quick Resolution' and 'Closer Look' complaints received was highlighted. Addressing queries on the team's ability to deliver timely responses to complaints, Tumi Banda, Director of Nursing, AHPs, Quality and Patient Experience, stated that while there is no exact timeframe, a comprehensive plan would be presented to the Quality and Safeguarding Committee in February. Tumi also mentioned ongoing improvements, including a 10-step process prior to sign-off, involvement from the Transformation team and a more streamlined operational management model. The discussion included current performance metrics, the average response times to complaints, reference to last year's figures and a targeted improvement, with precise numbers to be provided.

It was noted that incidents requiring Duty of Candour remain low and physical restraint incidents have declined. However, the level of incidents of racism being reported by staff is 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.

Tumi described challenges around timely discharge processes, with mini multi-agency discharge events (MADEs) in place to try and remove the barriers.

The Board was advised that trends and themes identified from an increase in medication incident reporting are being addressed via an action plan, overseen by the Quality and Safeguarding Committee.

Tumi advised that a deep dive of prone restraint incidents suggests that patients are moved out of this position as soon as safely possible, reflecting a culture of transparent reporting.

Quality and Safeguarding Committee (10 December)

Lynn Andrews, Committee Chair and Non-Executive Director, highlighted the need for continued focus on patient safety, with Girish Kunigiri, Medical Director, reporting that updates would be provided to the Committee in February.

Selina raised concerns regarding the use of prone restraint, questioning whether there is an acceptable threshold. Tumi affirmed that the goal should be zero, particularly for planned interventions and those involving medication, while acknowledging that some cases are inherently challenging. Tumi stressed the importance of ensuring patient breathing is not compromised and noted that a strategy focusing on planned interventions would promote greater control and reduction in restraint usage. It was also observed that the Psychiatric Intensive Care Unit (PICU) generally reports higher numbers of incidents due to different patient demographics, with variation observed between individual wards.

Reflecting on strong performance and delivery, Lynn was delighted to share that the Committee had received significant and full assurance from the two safeguarding reports. However, in relation to Patient Experience, she acknowledged that whilst there is a good plan, the Committee does not receive assurance in a structured and triangulated way. It was noted that the Committee had wished to alert the Board of the situation, rather than request action.

Operations

Vikki reported that the Trust's performance has improved over quarter 3 (Q3), being placed in segment 3 of the National Oversight Framework (NOF), an improvement from being in segment 4 for Q2. This followed an improvement in performance across 50% of the metrics measured.

It was noted that a focus on increasing the number of face-to-face support contacts provided to people in crisis now places the Trust as one of the top 10 performing trusts nationally. Recognition of the team's commitment to improvement was highlighted.

In line with the planned trajectory following the opening of the Trust's new acute units, it was highlighted that the number of inappropriate out of area (OoA) placements for Acute and PICU

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services have reduced significantly. Vikki voiced her appreciation to those colleagues who have supported these achievements.

Reflecting on the NOF, Andrew Harkness, Non-Executive Director, pointed out that the measures are quite crude and a number of areas are not solely in the Trust's control, needing work with System partners.

It was clarified that the agreement for three commissioned beds for female PICU patients will continue. Vikki explained that work to review the access routes and pathway is underway, with Girish and Tumi's involvement. Girish asked for the Board's acknowledgement that those patients with high-intensive needs, especially those with multiple diagnoses and risk of self-harm, are likely to need a prolonged stay within a low-intensive environment. He added that due to a changed profile and growing acuity over recent years, increased observations and skill mix on wards are needed to align with patient needs.

Vikki clarified that operational improvements in relation to the Mental Health Helpline are on track, a review of the technological capability of the helpline is also underway. It was noted that the Trust is working with the Integrated Care Board (ICB) to review the service, which was originally commissioned as a Crisis service, however, now also provides an early intervention and signposting service.

<u>People</u>

A slight improvement around staff absence was reported, although anxiety, stress and depression continue to be the main reason colleagues are away from work and account for 32% of all absences. Rebecca Oakley, Director of People, Organisational Development and Inclusion, advised that a review of long-term absences is underway. The Board acknowledged the triangulation of data.

Rebecca highlighted positive improvements in turnover rates, particularly among Registered Nurses and Healthcare Assistants, with rates reducing as low as 6%. Although, a slight increase across Allied Health Professionals and administrative staff was noted, with a deep dive into these figures scheduled for the next People and Culture Committee meeting in March.

Significant attention was given to race equality work, with the establishment of a dedicated group and the development of a Race Equality Action Plan. It was noted that the Black and Minority Ethnic (BME) network is set to relaunch under the leadership of two co-chairs, and a new Incident Response process is scheduled for launch within the week. The Board also discussed the piloting of ward and service visits, aiming to foster a safe space that nurtures a positive culture among staff and patients alike.

A revised approach to clinical supervision was highlighted, which aims to confirm required compliance and address any teams where this is not being achieved.

Overall, the discussions reflected a proactive approach to workforce wellbeing, equality and operational improvement, with a clear commitment to benchmarking, collaborative working and continuous review of processes to address emerging challenges in the sector.

<u>People and Culture Committee (14 January)</u>:

Ralph Knibbs, Committee Chair and Senior Independent Director, highlighted the aim for a more preventative approach in relation to absence.

A deep dive of recruitment and time to hire benchmarking had drawn attention to delays to the shortlisting stage and approval of references. It was noted that specific measures are in place for each stage.

Ralph confirmed that the Committee continues to focus on organisational development and culture transformation. He reflected that the January meeting had included thorough discussion on clinical supervision and the requirements set out by the CQC, with an expectation of achieving at least 75% compliance, noting the distinction between compliance and expectation. Rebecca pointed out

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	that only a small number of teams were currently falling short. The rationale for underperformance was attributed to staff absences and data management issues, as well as a lack of clear ownership regarding responsibilities. Comparative analysis with the wider NHS context was discussed to better understand the scale and nature of the compliance ask. Performance reviews have identified data accuracy as a persistent challenge and a deadline extending to the end of March was set for colleagues to ensure their data is correct. Selina stressed the paramount importance of accurate record-keeping and Girish clarified the distinction between clinical supervision and management supervision, noting that professionals are bound by the regulations of their respective bodies and that there are various accepted methods for conducting supervision. Overall, a commitment to improving compliance rates, enhancing data accuracy, and ensuring that clinical and management supervision processes are robust and meet regulatory expectations was demonstrated. <u>Finance</u> James Sabin, Director of Finance, reported that the Trust's £1.4m deficit is in line with the financial plan for this year and work continues towards a break-even position at year-end. It was noted that the Trust remains ahead of its cost improvement programme, supported by a reduction in the number of inappropriate OoA placements and agency expenditure, which continues to fall below target. Discussion centred around the use of colour coding to represent various operational and cultural factors within the organisation. Emphasis was placed on how colour coding can be used to highlight patient experiences, with the 'red' category specifically indicating areas where patient explanations are essential and where staff are experiencing heightened pressure. There was consensus that the focus should not remain solely on financial concerns but should also encompass patient safety and complaints. The importance of triangulating information to provide a more holistic view was raised, with Chioma Akpom, Non-Executive Director, making a significant point regarding the value of triangulation in strengthening assurance. Ways to reflect this triangulation within the Integrated Performance Report (IPR) to give the Board greater assurance were considered. Selina tasked Vikki with exploring opportunities to strengthen triangulation within the IPR. The need for informed decision-making, based on comprehensive and detailed information, was also highlighted. **Action**. **RESOLVED: The Board of Directors received limited assurance on current performance across the areas presented.**
DHCFT/ 2026/009	**<u>FUNDAMENTAL STANDARDS OF CARE REPORT (CQC DOMAINS)</u>** Tumi provided an update on the Fundamental Standards of Care and the performance against the standards as set out in the CQC key lines of enquiry. The Board engaged in a detailed discussion regarding several key areas of organisational improvement. The lack of access to independent advocacy was highlighted as a significant concern, with escalation to the risk register noted. It was mentioned that advocacy services are currently managed by the ICB, with ongoing monitoring to ensure appropriate services are identified and provided. Further clarification was provided on the Kedleston Unit Core Inspection report, correcting the stated sign-off date from December 2026 to 2025. The importance of embedding lessons learned from recent inspections to promote sustainable working practices was emphasised. The aspiration for a live and accessible system that is available to all was discussed as part of a wider wish list for

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	improvement, with a focus on enhancing access and empowering teams through the provision of accurate data. Additionally, the Board expressed a desire to reduce siloed working, advocating for greater sharing of development and best practices across the entire organisation, rather than limiting improvements to individual services. Areas for improvement identified in recent reviews were also referenced, with an emphasis on following recommendations to drive positive change. **RESOLVED: The Board of Directors:** **1. Accepted limited assurance on the Fundamental Standards of Care compliance; noting improved delivery of the standards in some areas whilst others require further improvement** **2. Received limited assurance on the CQC reviews core inspections and Mental Health Act visits, noting there have been no regulation breaches. However, areas of improvement have been highlighted in the reviews.**
DHCFT/ 2026/010	**PATIENT AND CARERS RACE EQUALITY FRAMEWORK (PCREF) (ANNUAL)** Girish provided an overview on PCREF (introduced by NHS England, as a national anti-racism framework for mental health service providers, with the aim to reduce racial inequalities within services) process so far and the next steps for implementation in the Trust. The Board acknowledged that ethnically and culturally diverse groups continue to face barriers in accessing Mental Health services, and that their experiences tend to be worse than for the rest of the population. It was noted that within Trust services, men from a black background are more likely to be detained, restrained, experience seclusion and have a longer length of stay on wards. The need to understand why this is the case and how these health inequalities was highlighted. It was noted that all trusts were mandated to publish a self-assessment checklist based on three key aspects of PCREF along with a co-produced improvement plan. 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 CQC will assess how trusts implement PCREF during their inspections, which will affect the overall trust rating. Girish advised the intention to appoint a dedicated PCREF Lead and for that he will chair a PCREF Steering Group which will oversee delivery of a focused action plan and a Trust-wide self-assessment. The People and Culture Committee was noted for its role in oversight, while the Quality and Safeguarding Committee and the Mental Health Act Committee focus specifically on patient safety matters. Selina expressed disappointment at the lack of progress and pace. However, she welcomed a further update in six months' time. Girish highlighted the Trust's limited awareness on issues related to ethnicity data and the inability to systematically analyse the population needs that will help with an implementation plan. Andrew highlighted the necessity to reassess existing data, emphasising both the need for consistency and the importance of data cleansing to ensure reliability. The Board agreed on the need for freedom in approach and raised critical questions regarding the purpose of data collection and the optimal methods for combining various data sets to inform decisions at both Committee and Board levels. Selina expressed appreciation for the enthusiasm surrounding data improvement efforts and underlined that actions should align with established recommendations. Chioma shared that a six-monthly data quality report is presented at the Audit and Risk Committee, stating this is too infrequent, given the ongoing concerns around data quality and accessibility.

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	Selina suggested that existing groups are well-placed to advance these actions rather than establishing new forums. It was agreed that the Executive team would have further discussions regarding the next steps for PCREF and the frequency of reviews. **Action**. **RESOLVED: The Board of Directors:** **1. Noted the mandatory requirements of PCREF in the Trust and the delay in its implementation** **2. Received assurance that the 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 the Trust public website** **3. Noted that the MHA Committee will act on behalf of the Trust Board to oversee compliance with PCREF, noting that operational oversight will be at the Trust Delivery Group.**
DHCFT/ 2026/011	**TRUST STRATEGIC PLAN UPDATE (QUARTERLY)** The Board of Directors received a progress update on delivery of the Strategic Plan at the end of Q3, 2025/26. Vikki outlined that several initiatives remain off-track, notably, two specific actions are not expected to return to trajectory by Q4. The Board acknowledged that improved access to services is contingent upon greater collaboration from external partners. A delay in the delivery of the Digital Plan was reported, attributed to changes in medical leadership. However, the Board was encouraged by a recent, comprehensive plan presented by Girish and Maria Riley, Assistant Director of Transformation, at last week's Trust Delivery Group. It was noted that all other outstanding actions are anticipated to be back on track by Q2, subject to the 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. Justine commended the good progress and Selina recognised the efforts to achieve the current position. **RESOLVED: The Board of Directors noted progress in delivery of the Strategic Plan at the end of Q3, 2025/26.**
DHCFT/ 2026/12	**BOARD COMMITTEE ASSURANCE SUMMARIES** The Board Assurance summaries from recent meetings of the Trust Board Committees were accepted as a clear representation of the priorities that were discussed and will be taken forward in forthcoming meetings. Points to note were brought to the attention of the Board by Committee Chairs during the IPR discussions. **RESOLVED: The Board of Directors noted the Board Assurance Summaries during the IPR discussions.**
DHCFT/ 2026/013	**REPORT FOR NOTING FOLLOWING ASSURANCE AT THE QUALITY AND SAFEGUARDING COMMITTEE** This report was received for information and noting having previously provided assurance to the Quality and Safeguarding on 8 October 2025. Assertive Outreach Community Health Treatment – Action Plan update This paper provided an update on the work of the Assertive Outreach (AO) Working Group to date. Lynn discussed the allocation of resources across different localities, with Selina drawing attention to disparities noted in the Clay Cross/High Peak areas compared to Derby City, specifically querying whether the resources provided were equivalent to the caseloads managed by smaller teams.

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	Tumi provided clarity on the methods used to assign AO caseloads, explaining that several factors influence distribution, and that team members hold both specialist and generic caseloads. Other Board members emphasised the importance of regularly reviewing caseloads and key indicators to uphold patient safety standards. Girish acknowledged the considerable variation in patient numbers between teams, reinforcing the need for a consistent approach to caseload management. The discussion also addressed the Clinical Plan's objectives, particularly the establishment of a unified triage process and a single point of access to streamline patient management. Concerns were raised regarding the discharge process, with some consultants reportedly responsible for caseloads as high as 800 patients, which was deemed unsustainable and in need of urgent review to ensure manageable workloads and optimal patient care. **RESOLVED: The Board of Directors:** **1. Received the paper to inform a future option to support AO cases in Adults of Working Age (AWA) Community Mental Health team (CMHT)** **2. Accepted limited assurance on current performance on the management of AO cases in AWA CMHT, noting scrutiny at the Quality and Safeguarding Committee.**
DHCFT/ 2026/14	**CONSIDERATION OF ANY ITEMS AFFECTING THE BOARD ASSURANCE FRAMEWORK (BAF)** No issues were considered to affect the BAF. It was noted that this is the only scheduled Board meeting that does not include a full BAF report, as reporting was out of sync with the review schedules.
DHCFT/ 2026/15	**MEETING EFFECTIVENESS** The Board agreed that combining the IPR with the Board Committee Assurance Summaries allowed more meaningful discussion and triangulation between the committees. It was agreed that the agenda would be reviewed to accommodate the format at future meetings. **Action**. Reflecting on the Board Story, Ralph emphasised the importance of disseminating these experiences more widely across the organisation so that staff and carers can benefit from the insights gained by services. Dave Allen, Public Governor, Chesterfield, highlighted the significant benefits of attending the meeting in person, noting positive developments such as the reduction in OoA placements and a decrease in agency spending. However, he raised concern regarding the impact of budget cuts on patient services, underlining the need to keep patients at the centre of the strategic plan. There was also mention of issues relating to acute care, particularly the lack of information available for relatives and carers. The enduring value of the NHS was stressed, with comments on the pressures for change and the importance of safeguarding its future. Selina reassured the Board that the organisation remains on track, while Vikki reiterated that the primary objective in reducing OoA placements is to enhance the quality of the patient experience, ensuring that no patient is placed far from home unnecessarily, rather than solely focusing on financial savings or cost improvement programmes.
The next meeting to be held in public session will be held in person on 24 March 2026 at 9.30am in Conference Rooms A and B, Centre for Research and Development, Kingsway, Derby.	

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ACTION MATRIX - BOARD OF DIRECTORS - MARCH 2026							
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
27-Jan-2026	DHCFT/2026/008	Integrated Performance Report (IPR)	Vikki Ashton Taylor	Investigate the opportunities to incorporate greater triangulation into the IPR to strengthen assurance.	End of Quarter 1, 2026/27	Colleagues to meet and explore opportunities to incorporate further triangulation into the IPR.	Green
27-Jan-2026	DHCFT/2026/010	Patient and Carers Race Equality Framework (PCREF) (Annual)	Girish Kunigiri	Executive team to have further discussions regarding the next steps for PCREF and the frequency of reviews.	10-Feb-2026	An update on PCREF progress will be reported quarterly to the Mental Health Act Committee and Trust Delivery Group will be reported six-monthly to the Board.	Green
27-Jan-2026	DHCFT/2026/15	Meeting Effectiveness	Justine Fitzjohn/Jo Bradbury	Board agenda to be reviewed to combine the IPR and Board Committee Assurance summaries.	27-Feb-2026	Agenda reviewed.	Green

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 24 March 2026

Trust Chair's update

Purpose of Report

This report is intended to provide the Board with the Trust Chair's reflections on activity with, and for, the Trust since the previous Board meeting on 27 January 2026. The structure of this report reflects the role that I have as Trust Chair.

Executive Summary

Our Trust and Staff

1. On 28 January I had the opportunity to chair the recruitment panel for two Consultant appointments. Whilst we had applicants for the two roles we had advertised, we appointed to only one of the roles. I am pleased to say we have a very experienced senior Consultant joining us.
2. I attended the Chief Executive Officer (CEO) Engagement Hours on 11 February and 11 March, which provided an opportunity to hear from our colleagues. Deborah Good, Non-Executive Director (NED) also joined the call on 10 March. We received a presentation on the staff survey results and the trajectory of some of the indicators, which is indicative of the continuous organisational change that has been ongoing for the last three years, in response to the environmental and financial challenges facing the Trust and the wider NHS. Colleagues shared some of their frustrations and the pressures that they were facing daily, particularly in inpatient areas.
3. On 2 February I met with Anna Shaw, Associate Director of Communications and Engagement; Rebecca Oakley, Director of People, Organisational Development and Inclusion and Jayne Waterfall, Communications and Engagement Manager, to understand the approach being taken with the community engagement plan. This will strengthen the work that the Trust is already doing in relation to the delivery of our strategy.

Council of Governors

4. On 28 January, the Governance Committee was held. The business included the process for the annual appraisals for the NEDs and I. Ralph Knibbs, Senior Independent Director and NED, joined the meeting to receive the feedback from the Governors on me and my performance, at which point I excused myself from the meeting.
5. I would like to take the opportunity to welcome our new Governors and some of our Governors who have been re-elected. They are as follows:

   - Brian Edwards – Public Governor, High Peak and Derbyshire Dales (re-elected for second term of office)
   - Tom Bladen – Public Governor, Derby City West (re-elected for second term)
   - Lai Mei Li – Public Governor for Amber Valley
   - Jean Johnson – Public Governor for Bolsover and North East Derbyshire
   - Sarah Tupling – Public Governor for Derby City East
   - Stephen Handsley – Public Governor for Derby City West
   - Nicole Ellis – Staff Governor for Admin and Allied Support.

   Their terms of office began on 1 February. The Board and I look forward to working with the Governors, who bring a wealth of experience and knowledge to the Trust, and thank our retiring Governor, Susan Ryan, Public Governor for Amber Valley, for her contribution as Lead Governor.

On 10 February, I led the induction for the new Governors which was well attended and provided an opportunity to get to know each other.

There has been some changes in responsibilities amongst the Governors, notably Brian Edwards, Public Governor for Buxton, will be the interim Lead Governor and Angela Kerry, Public Governor for Amber Valley and Neil Baker, Public Governor for Bolsover and North East Derbyshire, will jointly chair the Governance Committee.

6. I would like to thank Jill Ryalls, Public Governor for Chesterfield, who was in her second term. Sadly, Jill has decided to step down. She was an active member of the Council of Governors and was recently one of the joint chairs of the Governance Committee.
7. On 9 March. I met with Brian Edwards in his capacity as Lead Governor, whom I briefed on some of the key issues and developments concerning the Trust.
8. I also facilitated a focus group of the Governors on 9 March to gather their feedback on the performance of our NEDs in preparation for their appraisals. I am grateful for their feedback on individuals which was insightful.
9. On 23 March, I met with the Staff Governors. These sessions provide useful feedback from colleagues and a sense check of how it feels in the organisation. This gives me and them the opportunity to pick up on any issues that may require attention, as well as hear from them as to how colleagues are feeling with new developments, any changes and the general sense of wellbeing and challenge within the organisation.
10. After today, the next meeting of the Council of Governors will be on 19 May, following the Public Board meeting that day. The next Governance Committee takes place on 21 April.

Board of Directors

11. On 3 and 6 February, Extraordinary Confidential Board meetings were held. The Board was appraised of a number of matters linked to the delivery of priorities and the submission of the Trust Financial Plan to NHS England.
12. I continue to meet with my NED colleagues on a quarterly basis to review their objectives, development needs and to discuss their perspectives on how the Board and Trust is delivering Trust priorities. This quarter I met with Ralph Knibbs and Jo Hanley.
13. The Board has begun the annual cycle of appraisals of the NEDs and the Executive Directors. The appraisals and objective setting of Ralph Knibbs, Lynn Andrews, Andrew Harkness and Deborah Good has concluded. I will be undertaking a light touch review with Jo Hanley and Chioma Akpom, both of whom joined the Trust as NEDs quite recently. The appraisal and objective setting for the CEO concluded on 18 March.
14. On 3 February, 25 February and 4 March the Board held its Strategy and Development sessions. These dedicated days allow us to reflect as a unitary Board on how we work together, the progress we are making in the delivery of the Trust strategy, to consider areas where more focus is required and whether the capacity and resources are available for achieving the outcomes we have stated. The Board concluded that it was time for a Strategy review and refresh, as the environment and policy drivers have changed considerably since the Strategy was developed.
15. Following the many Care Quality Commission (CQC) inspections of Trust services that have taken place, the Board is preparing for a future Well-Led inspection by the CQC. To assist with this, the Board has committed to carrying out a self-assessment as it is over three years since the last self-assessment was undertaken, and there has been considerable change within the Board since that assessment. All actions from the initial assessment have been concluded.
16. On 17 March, the Remuneration and Appointments Committee met and reviewed, as per the Terms of Reference of the Committee and NHSE guidance, the annual benchmarking of Executive Director pay.

System Collaboration and Working

17. The Provider Collaboration Board met on 11 February. We discussed the progress of a number of initiatives that the Board had commissioned and some of the future challenges and tensions of working as a collaborative, given some of the more recent national drivers and directives.
18. I have continued to meet regularly with the Chairs of the East Midlands trusts with the Regional Director and Executives, providing the Chairs with the performance of the region against national targets and guidance and communication from NHSE.
19. On 17 February, I had an introductory meeting with the new Chair of Nottinghamshire Healthcare NHS Foundation Trust, Tom Cahill. Tom comes with a wealth of experience in the NHS, mental health and learning disabilities and driving policy in NHSE.
20. On 5 March, I met with Kathy McLean, Chair of the new Derbyshire, Nottinghamshire and Lincolnshire Integrated Care System (ICS) Cluster. The Integrated Care Board (ICB) is undergoing a significant organisational restructure following the requirement to downsize the organisation by half and to change the focus to commissioning and performance management. I was informed that the restructure is almost complete and the ICB will, as commissioners, want to facilitate more conversations about risk sharing, aligning incentives and focusing on outcomes.
21. On 11 March, Mark Powell, CEO, and I held a four way meeting with Julie Houlder, Chair of Derbyshire Community Health Services NHS Foundation Trust (DCHS) and Jim Austin, CEO, DCHS.
22. On 17 March, the Provider Chairs met with Kathy McLean online. It was an opportunity for us as Chairs to update each other on some of the challenges we are facing and to hear from Kathy regarding priorities and the approach the ICB will be taking in driving the 10-year health plan and priorities.

Regulators, NHS Providers, NHS Confederation and others

23. On 10 March, I assisted NHSE as an assessor for its Aspirant Chairs Programme. It was a very positive experience and very reassuring to see the pool of talent that are aspiring to become the future chairs of NHS organisations.
24. I have attended regular briefings from NHSE for the Midlands region.
25. Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary and I attended a British Sign Language (BSL) training session organised by the Derby Deaf Club on 16 March.

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

Risks and Assurances

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

Consultation

This report has not been to other groups or committees.

Governance or Legal Issues

Covered as part of the individual items.

Net Zero Duty Implications

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

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

None.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

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

Demonstrating inclusive leadership at Board level

As a Board member, I have ensured that I am visible in my support and leadership on all matters relating to diversity and inclusion.

I attend meetings to join in the debates and conversation, to challenge where appropriate and also to learn more about the challenges of staff from groups who are likely to be, or seem to be, disadvantaged. I ensure that the NEDs are also engaged and involved in supporting inclusive leadership within the Trust.

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

Recommendations

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

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

Chief Executive's update

Purpose of Report

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

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

Executive Summary

National and regional context

NHSE National Priority Director appointment

Following Claire Murdoch stepping down from her national role, it has been announced that Dr Nick Broughton is the new National Priority Programme Director for Mental Health, Learning Disability and Neurodevelopmental Conditions.

Mental Health Act Reform

The first provisions of the Mental Health Act 2025 came into effect in February 2026, these relate to conditional discharge protocols for restricted patients and updated tribunal timelines. 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.

Provider Capability Rating / National Oversight Framework (NOF)

NHS England (NHSE) has allocated the Trust an overall capability rating of 'Amber-Green' for 2025/26, following the submission of our self-assessment in October. This was our expected capability rating based on our own assessment. NHSE will use this alongside their NOF segment to determine what actions and/or support may be needed. NHSE guidance defines an Amber-Green rating as 'some concerns or areas that need addressing'. These predominantly align to a small number of national targets which we regularly discuss with NHSE in our Provider Review Meeting.

Foundation Trust Annual Reporting Manual

NHSE has issued the Foundation Trust Annual Reporting Manual 2025/26, this guidance sets out the requirements we will follow as we pull together our Annual Reports and Accounts, the final version of which will be approved by the Audit and Risk Committee in June, under delegated authority of the Board.

NHS Confederation/NHS Providers merger

From April 2026, the above two organisations will come together to form The NHS Alliance. The merger brings together two influential national organisations in a significant step designed to strengthen collective leadership across the NHS. By uniting their expertise, The NHS Alliance aims to improve the support, insight and advocacy provided to NHS trusts, primary care services, integrated care boards, and voluntary, independent and community based providers. We are awaiting details of the membership offer.

East Midlands Alliance – Common Board Paper

Attached at Appendix 1 is the latest common board paper, which provides a summary of the work and plans of the East Midlands Alliance. This paper is shared with the six Boards of the providers that make up the East Midlands Alliance for mental health, learning disabilities and autism.

Local context

CQC activity in our Trust

On 20 January, the Care Quality Commission (CQC) began an inspection of several of our community-based mental health services. This included our Community-based Mental Health services for Adults of Working Age (our adult CMHTs, as they are often known) and our Mental Health Crisis services and health-based places of safety. At the time of writing, we are awaiting the inspection report, though the verbal feedback suggested that there were examples of good practice by the teams.

At the same time, on 20 January, CQC inspectors also visited our mental health rehabilitation inpatient service, Cherry Tree Close. This two-day inspection (20-21 January) resulted in the publication of a very positive inspection report, released on 23 February. The service was rated 'good' overall and also 'good' across all five of the CQC's key domains – Safe, Effective, Caring, Responsive and Well-led. This was an improvement on the previous inspection, when the service was rated 'requires improvement' for safety.

Cherry Tree Close operates across a number of bungalows on the Kingsway Hospital site in Derby. The staff help people to recover from the difficulties of longer-term mental health problems, supporting them to restore their confidence and live as independently as possible. The team of health professionals supporting the service users at Cherry Tree Close includes Nurses, Psychiatrists, Occupational Therapists, Physiotherapists, Dietitians, Psychologists and Social Workers.

In their report about Cherry Tree Close, the inspectors wrote: *"Care and treatment were delivered to a high standard. Staff demonstrated skill and innovation, delivering a wide range of interventions, including psychological therapies, vocational and educational support, and structured activity programmes. Patients had made consistent progress towards independence and personal goals. Patients told us they felt empowered, fully involved in decision-making, and supported to develop independence and control around their care."*

My thanks and congratulations to all colleagues who work in and support this service – the report reflects how hard the team are working to make a positive difference in everything they do.

As mentioned in my last report, we are continuing to assess our compliance as a Trust and a Board under the 'well led' element of the CQC's Single Assessment Framework.

Patient and Carer Race Equality Framework (PCREF)

In February, the Board of Directors received an update on the Trust's implementation of the Patient and Carer Race Equality Framework (PCREF). Introduced by NHS England, as a national anti-racism framework for mental health service providers, PCREF aims to reduce racial inequalities within services. We know that ethnically and culturally diverse groups continue to face barriers in accessing mental health services, and that their experiences tend to be worse than for the rest of the population. Within our services, men from a Black background are more likely to be detained, restrained, experience seclusion and have a longer length of stay on our wards. We want to understand why this is the case, and how we can address these health inequalities.

Dr Girish Kunigiri, Medical Director, has been appointed as the Trust's Executive Lead and he will lead a new PCREF steering group which will oversee delivery of a focused action plan and a Trust-wide self-assessment.

Service changes across Derby and Derbyshire

NHS trusts who provide services across Derby and Derbyshire had committed to open discussions about the services we provide, and to explore whether the way services are currently delivered offers the best way of delivering care to our local population.

These conversations are at an early stage, but there is one that is advancing: our Trust and Derbyshire Community Health Services NHS Foundation Trust are looking at a proposal for Older People's Mental Health (OPMH) services and Neurodevelopmental (ND) services, which are currently offered by both trusts, to transfer entirely to Derbyshire Healthcare. DCHS has highlighted the specialist clinical and governance expertise these services require, and both services are a natural fit with our established mental health portfolio. Detailed due diligence also continues, ahead of our Trust Board making a final decision about this service transfer.

New developments this year

The 10-Year Health Plan for England (launched in 2025) included a number of priorities for mental health services, in line with the three key shifts (to move from sickness to prevention, hospital to community, and analogue to digital).

The Trust has received confirmation from two bids that we secured capital funding to develop two national priorities: the development of a mental health urgent assessment centre and a 24/7 neighbourhood mental health hub. These will be exciting new developments for Derbyshire, transforming the way we provide community and crisis care. More detail on both these developments is outlined below. Whilst we will receive capital funding to support the development of these new facilities, we have not yet received confirmation of any additional staffing or wider infrastructure funding. This revenue funding to support both developments remains a live discussion with the Integrated Care Board (ICB).

Mental Health Urgent Assessment Centre:

A new Mental Health Urgent Assessment Centre will be developed at the Radbourne Unit in Derby, adjacent to the Royal Derby Hospital. The service aims to provide a more suitable environment for urgent mental health assessments for working age adults to reduce unnecessary attendances to the Emergency Department and, where appropriate, support patients into inpatient services. It will provide:

- A specialist environment for people in mental health crises, offering an alternative to acute emergency departments
- Integrated care services which will aim to provide a multi-disciplinary team to provide urgent assessment
- Access will initially be via referral through Urgent Assessment services
- The service will be implemented through a phased approach, and relevant news and updates around the offer will be shared as implementation progresses.

24/7 neighbourhood mental health hub:

Following careful analysis of local needs and health inequalities, we are looking to develop a new 24/7 neighbourhood mental health hub in Amber Valley, potentially during 2027. Our hope is that this will be the first neighbourhood hub and more will follow, in other Derbyshire neighbourhoods. Extending our existing Living Well services and learning from pilot sites from across the country, the hubs will:

- Provide round-the-clock, walk-in support for people with serious mental illnesses
- Bring together clinical teams with voluntary sector partners, housing support, employment advice and Peer Support Workers
- By offering walk-in access without needing a GP referral, the hubs aim to treat people earlier, reducing the need for emergency department visits.

As noted above, these developments are contingent on confirmation on additional staffing and wider infrastructure funding.

<u>Raising awareness and community engagement</u>

We continue to progress partnership work with our Deaf communities, as outlined in the Trust's Community and Stakeholder Engagement Plan.

This approach is extending to develop relationships with our Black communities, working with community partners to understand people's access and experience of our services.

Recent achievements

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

- In January I presented Angela Richardson, Mental Health Liaison team Nurse, with an award for 40 Years' Service. The *Derbyshire Times* and the *In Your Area* website ran stories about Angela, her award and her career
- The winner of our DEED staff recognition scheme (DEED stands for Delivering Excellence Every Day) for the month of January was Megan Moorhouse, Senior Occupational Therapist. Megan was chosen after being nominated by a service user for providing an extremely high level of therapeutic support and patient centred care at Kingfisher House, our Psychiatric Intensive Care Unit (PICU). The person nominating said: *"My recovery has really benefitted from the support and activities of this wonderful occupational therapist"*
- In February, I presented Lesley Newton-Griffiths, Health Protection Unit Nurse, with her 50 Years' Service Award, celebrating her longstanding contribution to patient care and her positive impact across the Trust
- The winner of our DEED scheme in February was a group of colleagues working in our Finance, Information Management and Technology, Reception and Kingsway Inpatient teams who have helped to develop a new Trust process for requesting taxis for service users. It was recognised that the Trust could save money and time by introducing an online taxi request form that goes through to a central booking team. The form asks colleagues to confirm that all other transport options have been explored and ensures that a manager or senior leader has approved the request, so there is clear accountability
- A local golf club, Kedleston Park Golf Club, has chosen to raise money this year for our Radbourne Unit Inpatient Mental Health Unit. This is being done through our charitable fund, and we will be promoting this charitable fund more often during the months ahead. We're very grateful to the captain and members of Kedleston Park Golf Club – their support for the Radbourne Unit reflects well on the unit's reputation for providing compassionate care for people with acute mental health needs.

Staff engagement

NHS Staff Survey results

The results of the 2025 NHS Staff Survey were published on Thursday 12 March. The response rate of Trust colleagues was the joint highest ever, at 64%, which is extremely positive as it means the feedback we receive is truly representative of the workforce.

In line with other NHS trusts, our results were slightly down on last year, which I recognise as a disappointing outcome, however, not unexpected given the level of change that the Trust has needed to deliver during 2025/26, which has impacted on some groups of staff. In response we have already started open and honest conversations with colleagues about how we can make improvements both Trust-wide and at team level.

Staff collaborative – tackling violence, abuse and aggression

On 30 January, a new staff collaborative met for the first time to shape how the Trust can prevent and respond to violence, abuse and aggression at work. This is a very important and concerning issue for the Trust and one that does not appear to be abating, despite our best efforts. The 30 January meeting was the first of four planned sessions for the collaborative, and the aim is to create a supportive space where colleagues could openly discuss the situations they have faced and work together to advise the Trust on next steps and the best way forward.

Team visits

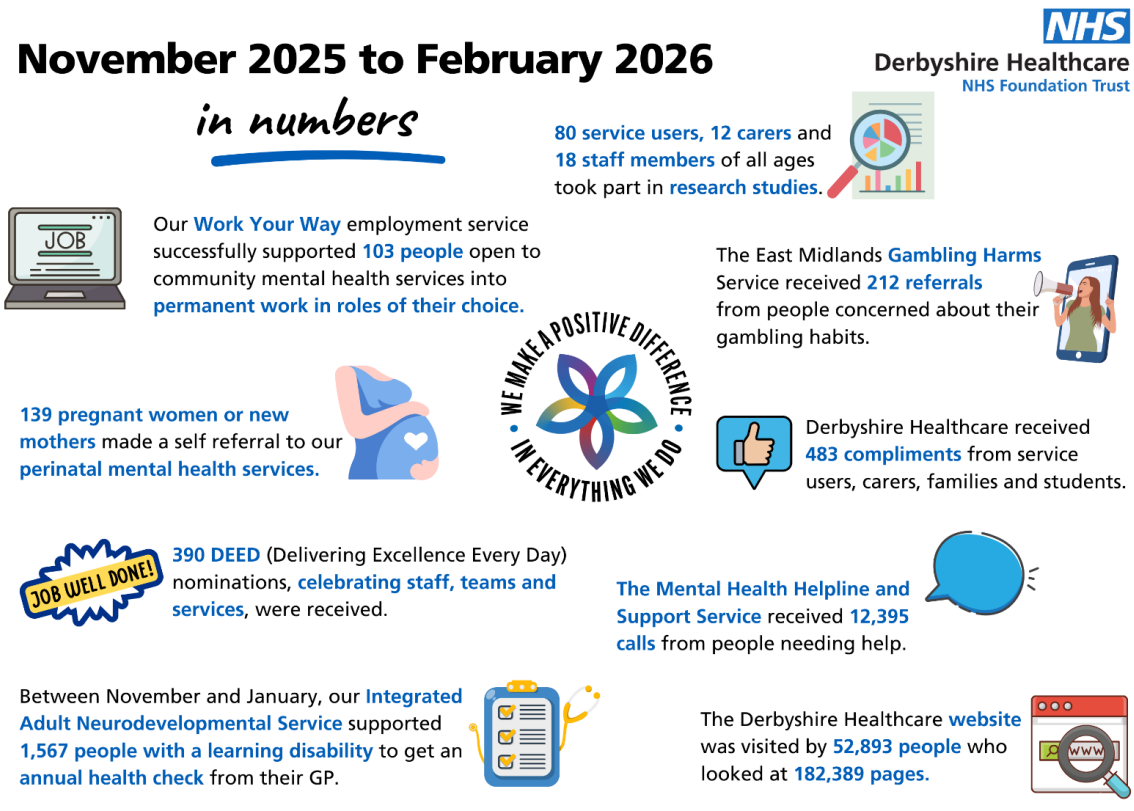
I have continued to get out and about to see our colleagues and service users at the following sites:

- I joined the Forensic Community Mental Health multi-disciplinary team meeting on 2 February
- On 4 February, I joined a Staff Network meeting with colleagues from our BME (Black and Minority Ethnic) network group

- On 5 February, I spent time with the various teams at St Andrew's House in Derby
- I joined a Board visit on 11 February to the North Early Intervention service team in Chesterfield and held an online all staff CEO Engagement Hour
- On 16 February, I held an online session for colleagues who joined the Trust in August last year, to hear from them about their first six months in post
- I held another all-staff CEO Engagement Hour on 10 March.

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

- On 30 January, Vikki Ashton Taylor, Deputy CEO and Chief Delivery Officer, attended Dove Ward, Wren Ward Carsington Unit and Kingfisher Ward, PICU. She visited the Adults of Working Age and Acute and Community Management team on 2 February. On 6 February, Vikki went to see staff and patients at the Carsington Unit, which she also visited on 5 March, along with Tissington House. On 9 March, Vikki saw staff at Kingfisher Ward and visited the MH Liaison Team on 19 March
- Tumi Banda, Director of Nursing, Quality, AHPs & Patient Experience, visited the South & Dales OA CMHT, South Derbyshire WAA CMHT and Living Well Team, CAMHS & LD Team on 29 January. He joined a Board visit to the ADHD and Paediatric Administration Team on 4 February and went to see staff in the IM&T team on 26 February. He also spent time with the Research & Development team on 10 March
- Girish Kunigiri, Executive Medical Director, spent the morning at the ECT Suite, Radbourne Unit, on 19 February. On the morning of 3 March, he spent time with the Paediatric consultant body and on 17 March, he went up to Chesterfield to meet with the CMHT teams based there. On 18 March, Girish also joined a Board visit to the Dietetics Department (Specialist Services)
- Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary, joined a Board visit on 28 January, to psychological services - CAMHS ID + CAMHS CBT & CAMHS Family Therapy teams, at Ripley Resource Centre. She also attended a Board visit to the Emotion Regulation Pathway Psychological Service at St Andrews House on 11 March
- James Sabin, Director of Finance, visited our eating disorders services in Belper on 10 February, and joined a Board visit to the Patient Safety Team at Kingsway on 18 February
- Rebecca Oakley, Director of People, Organisational Development & Inclusion, joined the Board visit to the eating disorders service on 29 January.



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

Risks and Assurances

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

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

Consultation

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

Governance or Legal Issues

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

Net Zero Duty Implications

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

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

None.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

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

Recommendations

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

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

Common Board paper

January 2026

1. Introduction

This paper provides a summary of the work and plans of the East Midlands Alliance including the discussions and agreements from the East Midlands Alliance Board meetings held in October and December 2025.

The same Board paper, agreed by the CEO group, is shared with the six Boards of the providers that make up the East Midlands Alliance for mental health, learning disabilities and autism.

2. The East Midlands Alliance

The East Midlands Alliance is made up of the six largest providers of mental health services in the East Midlands region:

- Derbyshire Healthcare
- Leicestershire Partnership
- Lincolnshire Partnership
- Northamptonshire Healthcare
- Nottinghamshire Healthcare
- St Andrew's Healthcare

The Alliance has agreed a **vision** for the Alliance:

Working together in partnership to enable the best mental health, learning disability and autism care and support for the people of the East Midlands.

The Alliance has also agreed a set of **values**:

- Working together
- Respectful
- Integrity
- Supportive

The Alliance agreed a set of **principles**:

- Patient first
- Care closer to home and maximising independence
- Subsidiarity – take decisions as locally as possible
- Collaboration by consent
- Not acting to the detriment of others
- Sharing and applying learning at pace

The Alliance agreed five **strategic objectives**:

1. Quality improvement and productivity
2. Enabling safe care
3. Developing our workforce
4. Improving population health
5. Reducing inequalities

This common Board paper includes summaries of the recent work under each of the strategic objectives.

3. Alliance Plan

The Alliance Board has received updates on the delivery of the annual plan for 2025/26. The March 2026 Alliance Board will receive a draft plan for 2026/27 developed by the professional groups and regional collaboratives. The Strategy Director forum will oversee the process.

4. Quality improvement and productivity

4.1 Mental Health Act best practice workshops

The Alliance has used funding from NHS England to commission Weightmans to run a series of best practice workshops between April 2025 and February 2026. The workshops are a mix of online and in-person sessions focusing on topics agreed by the Medical and Nurse Director forum.

The Mental Health Act best practice workshops have focused on:

- Adult eating disorders
- MHA reform
- Person-centred care and considerations
- MH detention and statutory forms
- Mental capacity and the Court of Protection
- Perinatal mental health

- CAMHS and detention
- CAMHS and eating disorders for under 18's
- Digital considerations: AI technology, risk and regulation
- Part III patients and the law
- First-Tier Tribunal – procedural matters
- Part IV of MHA – appropriate treatment and the role of professionals
- Perinatal mental health
- Complex presentations of veterans and related issues
- Adult safeguarding and the law
- First-Tier Tribunal masterclass – mock tribunal
- MHA reform

The slides and a recording of each workshop session have been posted on a closed part of the Weightmans website for the Alliance providers to access. The workshop slides are shared with the CEO group at their fortnightly meetings. Attendance at the sessions has continued to be good. The feedback from the sessions has been very positive.

Weightmans have also run sessions with each Alliance provider Board and presented at the annual learning event for the Alliance in October 2025.

4.2 Joint Medical Job Planning

The Alliance has secured funding from NHS England to establish a collective programme of work on medical job planning in mental health, to fund local activity and share learning.

The Medical Directors from Leicestershire Partnership NHS Trust and Lincolnshire Partnership NHS Foundation Trust are leading this work. Progress updates have been provided to the Alliance Medical and Nurse Director forum meetings.

4.3 Therapy Supervision

The Alliance Board in June agreed to distribute the remaining Therapy Supervision funds held by the Alliance to support local activity to increase the pool of therapy supervisors. Each provider was asked to submit a proposal to use the available funding in 2025/26.

The CEO group approved a set of funding proposals in July 2025. An update on the use of the funds and learning will be presented to the Alliance Board in March 2026.

4.4 Innovation and transformation

The Alliance Strategy Director forum worked with Health Innovation East Midlands (HIEM) to design an Innovation Exchange on productivity in healthcare. The Innovation Exchange focused on digital solutions to improve productivity in healthcare provision. Seventeen

outline proposals were invited to progress to full application in the East Midlands including four led by Alliance providers.

The Alliance also supported a HIEM Innovation Exchange looking at new technologies to support Adult ADHD services which took place in early December.

A further Innovation Exchange took place in early 2026 which showcased innovations that help people with learning disability who have behaviour that challenges to avoid harm from psychotropics.

4.5 Productivity and financial plans

The Alliance Board in March 2026 will include a focus on planning, productivity and efficiency. The CEOs will be joined by the Chief Finance Officers to share plans for 2026/27 and learning.

The CFO group will meet with the Heads of Procurement on 28 January to consider joint approaches to procurement that might deliver financial and efficiency benefits.

Also in January, the Heads of Legal Services from the Alliance providers will meet to consider joint approaches and sharing information to deliver financial benefits from the procurement of legal services, legal advice and legal training.

4.6 Open Dialogue pilot

Previous common Board papers have noted that Lincolnshire Partnership was prioritised by the Alliance CEOs to pilot an Open Dialogue model on behalf of the Alliance. Progress and learning from the pilot phase were shared with the Alliance learning event in October through a video feedback session from the Lincolnshire programme leads.

4.7 National Inpatient Quality Improvement programme

The Alliance has continued to work with the regional lead for the national Inpatient Quality Improvement programme through the Medical and Nurse Director forum. The focus in 2025/26 has been on Housing and Mental Health, and on the development of a system demand and capacity model for mental health. The February meeting of the Alliance Medical and Nurse Directors will consider priorities for 2026/27.

5. Enabling safe care

5.1 Patient Safety programme

The joint Alliance work on enabling safe care is largely delivered through the Alliance Patient Safety programme which is run with Health Innovation East Midlands. The national mental

health patient safety programme ended in 2022. The Alliance secured funding to continue the programme in the East Midlands for a further two years and recently agreed a further programme extension to cover 2025 to 2027.

The programme is sponsored by the Medical and Nurse Director forum and is chaired by the Medical Director from St Andrew's Healthcare.

The three Communities of Practice from the earlier phases of the programme have continued to meet, undertake work and share learning. The three Communities of Practice also met together to share approaches and consider opportunities to join up their work.

- Improving sexual safety
- Reducing suicide and self-harm
- Reducing restrictive practice

Two lived experience leads and a Health Innovation East Midlands lead presented learning from the reducing restrictive practice programme at the Alliance learning event in October 2025. The presentation focused on the Hear Us tool which has been developed and shared across the East Midlands. The tool is designed to enable more purposeful debriefs following an incident.

In November 2025, the leads from Leicestershire Partnership Trust and Health Innovation East Midlands presented a national webinar on their work as part of the Alliance Patient Safety programme focusing on self-harm. The project was led by a core team of three Nurses from LPT and supported by a multi-disciplinary team of experts in data analysis and improvement from Health Innovation East Midlands. In a short period of time, the ward saw over a 40% reduction in incidents without increasing restrictions.

The fourth workstream from the 2023 to 2025 programme focused on the use of mechanical restraint in High Secure settings in England and Scotland. This work has been completed, and a confidential report has been shared with the High Secure providers and NHS England. A shorter final briefing on the use of the Human Factors approach that was taken as part of this review, was shared with CEOs at the Alliance Board in December 2025.

The focus for the 2025 to 2027 Patient Safety programme is on three new priorities:

- The development of a common safety framework
- The development of tools to support the reduction of the risk of physical health deterioration in severe mental illness
- A review with recommendations on the effective use of Physician Associates in Mental Health providers in the East Midlands

Scoping, early review work and interviews have taken place under each of these programme headers. A fuller update and next steps will be shared with the Alliance Medical and Nurse Director forum in February 2026 and the Alliance Board in March 2026.

Linked to this programme, the Alliance and Health Innovation East Midlands will share early learning from the pilot sites for Martha's Rule in mental health at the medical and Nurse Director forum in February.

5.2 Digitising the Mental Health Act

The Alliance Board in December agreed to the development of a business case that sets out the potential benefits of working together to digitise the Mental Health Act. Derbyshire Healthcare have agreed to take a lead in producing a case and in highlighting the potential project to NHS England as part of the planning submissions. NHS England have created a dedicated capital budget for the digitisation of the Mental Health Act.

The Alliance Medical and Nurse Director forum meeting in October received a presentation from One London which led a collective approach to digitising the Mental Health Act process in London. The Board noted that in other regions, some providers have moved together in a first phase with others joining later. Five of nine Trusts in London are now using a single digital process to manage their application of the Mental Health Act.

The Alliance Board asked that the benefits to patients and staff are clearly articulated. The Board also noted that the learning from elsewhere in the country included the importance of working alongside local authority partners and the police in the design phase.

6. Developing our workforce

6.1 Retaining and developing Clinical Support Workers and their managers

The Alliance has run a successful programme to support the development, retention and career aspirations of Clinical Support Workers. Across the Alliance there have been issues with the recruitment and retention of Clinical Support Workers. The Alliance secured significant external funding to run a shared package of development programmes.

The core programme is called Developing Healthcare Talent. It is complemented by a programme that works with the line managers of Clinical Support Workers, known as the Developing Healthcare Leaders programme. Over 500 staff have been through the programmes to date. Both courses have high completion rates, and the feedback has been very positive. Case studies for both programmes have been developed and shared nationally.

The Alliance has run four of six cohorts of the core Clinical Support Worker development programme in 2025/26. Two further cohorts will run to March and April 2026 respectively.

The Alliance has run four of six cohorts of the Clinical Support Worker line manager development programme in 2025/26. The next cohort is fully subscribed and the subsequent cohort has good sign up and will start in March 2026.

The HR Director forum has also agreed to establish a Community of Practice for the Clinical Support Worker line managers that have completed the development programme to provide on-going support and learning. There are 65 graduates of the line manager programme signed up to the Community of Practice which will launch in February 2026.

The Alliance Board in June agreed to support a proposal from each Alliance provider to use some further local Clinical Support Worker funding in 2025/26. The Alliance Board asked the HR Directors to run a further sharing of learning session in April 2026 focused on the various local activities undertaken this year.

6.2 New Horizons programme

A case study has been developed summarising the two cohorts of support for internationally trained nurse recruits using the Clinical Support Worker personal development approach. The New Horizons pilot cohorts received very positive feedback. The Alliance does not hold any funding to commission additional cohorts, but providers could.

6.3 Recruitment and Retention Payments and Golden Hello audit

In September, the HR Director forum ran a further audit of additional recruitment and retention payments being made by the Alliance providers. The summary of the payments was shared with the CEOs at the Alliance Board in December. The CEOs welcomed the transparency and HR Director forum review.

6.4 Sharing learning on initiatives to tackle violence and aggression towards staff

The HR Director network had a focus on programmes and actions to address violence and aggression towards staff in September 2025. There was a particular focus on the work in Lincolnshire Partnership to broaden the responsibility and develop a wider programme of activity to support a reduction in violence and aggression towards staff.

6.5 Alliance workforce dashboard

The workforce dashboard for the Alliance has been reintroduced. The dashboard is now shared through an online system.

7. Improving population health

7.1 Collective service planning and piloting the CAMHS Day Care model

The Strategy Director forum has continued to lead work to consider opportunities for joint service planning across the East Midlands.

Each Alliance Board now includes a deep dive into one of the regional specialised collaboratives including their long-term plans to make a left shift, provide care closer to home and transform service models.

The October Alliance Board reconfirmed the prioritisation to pilot the CAMHS Day Care model in Leicestershire and Lincolnshire. The Board also agreed that the next system will be Derbyshire. The next steps are to establish the CAMHS Day Care pilots in Leicestershire and Lincolnshire.

7.2 Long term funding of Specialist service models to move care closer to home

The Alliance Board agreed at the October meeting to recurrently fund the CAMHS tier 3.5 services and the Waterlily programme in Adult Eating Disorders. Both of these developments support care closer to home and a move towards intensive day support rather than inpatient admission. The piloting of both approaches has demonstrated their effectiveness. Both have been developed with lived experience input and received very positive feedback from patients, families and carers during their pilot phases.

7.3 Regional Gambling Addictions service

The Alliance Board receives regular updates on the East Midlands Gambling Addictions service. The service has continued to see increases in referrals, has had a successful focus on increasing referrals from women and has introduced a new scale to measure progress.

The service has recently recruited additional resources to cover early evening slots and has progressed the initial thinking towards developing PROMS for the service.

In anticipation of the expected new investment into gambling harm support services linked to the gambling levy, the service is developing an expanded model of care to increase its reach across the East Midlands. The Gambling Harm service will work with NHS England and the two new East Midlands ICBs to agree on the medium-term use of that new funding.

7.4 Future Collaborative Hub provision

The Alliance CEOs have sponsored work to develop and implement a proposal for a single Collaborative Hub in the East Midlands and revised governance arrangements for the Collaborative and Alliance.

An NHS England commissioned independent review report into the Impact Forensic collaborative hub recommended that a single hub is developed for the East Midlands.

The Alliance Board meetings in October and December received updates on the plans to create a new East Midlands hub, bringing the two existing Collaborative hubs together.

The plans include each of the Alliance providers being represented in the recruitment process for a new lead role for the new hub. The CEOs asked to review the initial objectives for the new Hub Director role once they have been co-produced with Collaborative leads.

7.5 Revised governance arrangements

The January 2026 Strategy Director meeting will develop a revised governance proposal that brings the governance of the Alliance and the governance of the mental health Collaboratives closer together.

At the December Alliance Board, the CEOs agreed on a set of outline principles to inform this work. A more detailed proposal will be shared with the CEOs for comment ahead of formal presentation at the March Alliance Board meeting.

8. Reducing inequalities

8.1 Patient and Carer Race Equality Framework

The East Midlands Alliance has prioritised the sharing of learning and roll out of the Patient and Carer Race Equality Framework (PCREF). The Alliance CEOs and PCREF leads will meet with the national PCREF leads, Jacqui Dyer and Husnara Malik, on 6 February to hear about recent developments with the national PCREF programme, the role of the CQC in overseeing implementation of the PCREF and to share organisational updates.

8.2 Women's Secure pathway

The Impact Forensic collaborative is working with the East Midlands ICBs to address the health inequalities experienced by women from the East Midlands by transforming the women's secure pathway.

8.3 Rolling out the Waterlily Eating Disorder support programme

The October Alliance Board agreed to the roll out of the Adult Eating Disorder Collaborative Waterlily programme to all counties of the East Midlands following a review of the financial model and feedback on the pilot implementation.

9. Regional mental health collaboratives

9.1 Op COURAGE in the East Midlands

Op COURAGE is an NHS service developed with people who have served in the Armed Forces and experienced mental ill-health. In the Midlands (East and West), Op COURAGE is delivered in partnership by Lincolnshire Partnership NHS Foundation Trust, Birmingham and Solihull Mental Health NHS Foundation Trust, Coventry and Warwickshire Partnership NHS Trust, St Andrew's Healthcare, Walking with the Wounded, The Ripple Pond, Tom Harrison House, and Mental Health Matters.

The October Alliance Board meeting considered the actions being taken to reduce the scale of the waiting list for assessment and the December meeting heard that improvements had been made in terms of the size of the waiting list and the longest waits.

The service has begun the roll out of an assessment clinic model in the East Midlands to further improve waiting times. This model was trialled in the West Midlands and has proved successful. The planned assessment clinics commenced with the first taking place in Lincoln in October. This ran successfully with good outcomes for the veterans assessed on the day. The plan is to grow this model with regular clinics across the East Midlands.

9.2 Perinatal Collaborative

The specialist Perinatal collaborative for the East Midlands, led by Derbyshire Healthcare NHS Foundation Trust, is a partnership to deliver high-quality care for pregnant women and new mothers with serious mental illnesses who require admission to a Mother and Baby Unit, and to ensure seamless support between Mother and Baby Units and community perinatal mental health teams.

The December Board heard that both Mother and Baby Units (MBUs) remain on routine quality assurance and improvement level with no escalations in Quarter 2. A permanent air conditioning system will be installed at the Beeches in Derbyshire in early 2026.

9.3 Impact Forensic Collaborative

A deep dive into the Impact Forensic collaborative took place at the December Alliance Board. The meeting reviewed progress over the longer term in reducing the number of Out of Area Placements, reducing length of stay and improving occupancy.

The meeting also discussed the Impact Hub review undertaken by NHS England, the scale of combined deficit between the providers and commissioner, and the challenge of nationally negotiated bed day rates with the independent sector.

The December Board received a financial model for the next five years alongside a set of assumptions. The CEOs asked for some further work to be undertaken on the financial model and different scenarios run ahead of a further presentation to the CEO group in January. The model will be reviewed by the CFO group on 7 January and presented to the CEO group on the 9 January.

NHS England have asked Warwick University to review the financial sustainability of the Collaborative. However, the final scope of the review and the timescales are not yet agreed.

The CEOs are keen to develop a long-term strategy for the Collaborative in terms of transformation and financial stability.

9.4 CAMHS Collaborative

The October Alliance Board undertook a deep dive into the CAMHS Collaborative. The Board reviewed an update paper and a presentation on the future financial position, potential investment decisions and transformation for the CAMHS collaborative.

The Board received an update on the publication by NHS England of a developmental specification as part of the ongoing CAMHS Transformation work. Linked to this, the regional task and finish group have completed the development of the day service specification which has been presented to and agreed by the Provider Collaborative Programme Board.

The Board noted the investment in the Tier 3.5 model which has further reduced the demand for inpatient beds and supported patients closer to home. There is strong evidence of a successful left shift.

The Board discussed the use of a block payment model rather than one based on occupied bed days to support the CAMHS inpatient providers. It also reviewed the financial position of the CAMHS Inpatient providers and the CAMHS collaborative. The Alliance Board noted that St Andrew's Healthcare has given six months' notice on their CAMHS inpatient beds.

The Board also discussed the CAMHS Day service specification and the funding required to run the pilot sites in Leicestershire and Lincolnshire.

In December, the Alliance Board heard that the East Midlands CAMHS Collaborative had won provider collaborative of the year in the recent HSJ Awards. The Board acknowledged that achievement and recognition.

9.5 Adult Eating Disorders Collaborative

The October Alliance Board undertook a deep dive into the Adult Eating Disorders Collaborative. The Board heard that activity had decreased in Quarter 1 of 2025/26 and that there had also been a decrease in out of area admissions. With the decreased activity, the financial modelling that was presented demonstrated that the Collaborative can afford to fund the Waterlily project recurrently across the East Midlands. The Board had previously received feedback from the pilot areas and committed in principle to a wider roll out.

The AED Collaborative will take on the quality oversight of a new adult eating disorder unit, Nova Ward at Cygnet Elowen in Shipley, which will increase inpatient capacity within the East Midlands by 12 beds.

In December, the Alliance Board heard that the AED Collaborative had received recognition for the Waterlily programme which won an award for Community Initiative of the Year. The Board acknowledged that achievement and welcomed the external recognition of the progress that has been made.

10. Alliance communications and events

10.1 Alliance newsletter

A further quarterly newsletter was shared in October. The newsletter provides headline information on stories of interest and refers readers to the Alliance website for further detail. The website (www.eastmidlandsalliance.org.uk) provides a hub for information about the Alliance and the provider collaboratives.

The October Alliance newsletter included updates on the two new mental health units opening at Kingsway Hospital in Derbyshire and the new 12-bed specialised eating disorder ward has also opened in Shipley. It also focused on the success of the Waterlily programme, co-ordinated by the East Midlands Adult Eating Disorder Provider Collaborative, which recently won the Community Initiative Award at the HSJ Patient Safety Awards. Dr Girish Kunigiri, the then Chief Medical Officer at Lincolnshire NHS Foundation Trust took part in the 60 Second Showcase.

10.2 Alliance learning event

The Alliance held an annual learning event for Boards in October 2025. The session was opened by Gareth Harry, the national NHS England Director of Delivery for Mental Health, Learning Disabilities and Autism. There were also presentations from two lived experience leads on reducing restrictive practice and meaningful debriefs, the clinical and director lead for the CAMHS Collaborative for the East Midlands, and a legal overview from Weightmans. The session also included time for cross-organisational work and an opportunity to influence the priorities in the Alliance Plan for 2026/27.

The Communications team produced a short film of the day which has been shared with Alliance CEOs, national leads and uploaded to the Alliance YouTube channel.

11 Actions and recommendations

The Boards of the Alliance providers are asked to:

I. Note the updates in delivering the Alliance Plan for 2025/26;

II. Receive the updates from each regional mental health collaborative;

III. Note the progress on Alliance communications and the success of the Board learning event in October.

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 January 2026 for internal measures, and to the end of December 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

High performing areas:

- Duty of Candour: All qualifying incidents managed appropriately, demonstrating transparency and effective risk management
- Medication Safety: Sustained reduction in medication incidents since November 2025, supported by strong reporting culture and robust governance
- Falls: Majority of inpatient falls result in no harm, with consistent multi-disciplinary review and learning.

Challenging areas:

- Clinical Readiness for Discharge: Performance remains above threshold due to external system pressures (housing, funding, social care), limiting short term improvement
- Incidents of Harm: Reported levels remain above current thresholds, which no longer reflect service expansion or changes in reporting practice
- Restrictive Practices: Increased physical restraint linked to expanded inpatient provision; prone restraint remains a quality risk pending delivery of improvement plans
- Seclusion: Ongoing common cause variation with reliance on quality improvement activity to achieve sustained reduction.

Operational performance

Notable changes since the last report:

- **Inappropriate out of area (OoA) placements:** following the significant reduction to zero inappropriate OoA patients which occurred during December 2025, there has been an increasing demand for inpatient treatment which has resulted in three inappropriate OoA placements at the time of writing – two Acute and one female Psychiatric Intensive Care Unit (PICU)
- **Early intervention in psychosis:** the Early Intervention services and At Risk Mental State (ARMS) services assess people who are suspected of experiencing a first episode of psychosis. The national standard is to undertake an assessment and assign a Care Co-ordinator within two weeks of people being referred into the service. In January 2026 performance fell below target at just 41%. However, the position has been recovered in February 2026, with the services achieving 74% against the national 60% target
- **Transforming Care Programme:** Currently there are 20 learning disability and learning disability or autism patients in beds against a trajectory of 19 (+1) over trajectory, and 17 autistic spectrum disorder (ASD) patients in beds against a trajectory of 11 (+6) over trajectory; a total of 37.

Top three things to note from this report:

1. **NHS Oversight Framework (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 January position has improved slightly to 62% as the planned transition of records starts to have an impact. 14% of the remaining children and young people would have been waiting over 52 weeks. This is a significant reduction from 66%
   Crisis response: this is an NHS Oversight Framework (NOF) measure of the proportion of urgent referrals made to Crisis teams and mental health single points of access who were seen face to face within 24 hours. In the quarter 2 (Q2) NOF ratings, the Trust placed in the 2nd lowest (worst) quartile for performance against this metric. The Trust has ranked in the top 10 of all NHS providers through Q3, which indicates that the Trust is likely to place in the best quartile when the official Q3 NOF rankings are published
   Proportion of Acute inpatients discharged with a length of stay (LoS) of 60 plus days: Proportion of adult Acute inpatients aged 18-64 discharged with 60 days plus LoS: In the Q2 NOF rankings the Trust placed in the highest (worst) 25% of providers (quartile 4) at 28.6%. 48 of the current adult Acute inpatients have a length of inpatient episode of 60 days or more to date (31%)

   Children and young people accessing Mental Health services: 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 children and young people's 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.

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, children and young people 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 and waiting times (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 January, there is an overall deficit of £1.3m, 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 £0.7m, which is better than plan by £0.5m.

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 on plan at the end of month 10, delivering savings of £11.7m 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 £3.5m year to date (YTD) and is forecast to be above plan by £4.3m. The forecast assumes current levels for the remaining months of the financial year
- 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.

Triangulation

Early intervention: the service experienced a significant increase in demand at the same time as a significant level of staff turnover of 25%, vacancies peaking at 16% and periods of high levels of sickness absence which all inevitably impacted on waiting times.

Inpatients: recent work relating to an inpatient ward in relation to triangulation of staff and student feedback, ward key performance indicators and feedback from a CQC Mental Health Act visit, resulting in a cultural review being commissioned whilst further ongoing investigation is taking place.

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

Risks and Assurances

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

Consultation

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

Governance or Legal Issues

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

Net Zero Duty Implications

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

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

No meaningful impact identified.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

Recommendations

The Board of Directors is requested to:

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

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

Vikki Ashton-Taylor
Deputy Chief Executive and Chief Delivery Officer

Rebecca Oakley
Director of People, Organisational Development and Inclusion

James Sabin
Director of Finance

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

Rachel Leyland
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Liam Carrier
Assistant Director of Workforce Transformation

Joseph Thompson
Associate Director of Physical Health and Quality

Derbyshire Healthcare
NHS Foundation Trust

Integrated Performance Report

January 2026

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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 Psychiatric Intensive Care Unit (PICU), a female Enhanced Care Unit (ECU) and an additional Acute Inpatient Ward. The current metrics considered and current targets will be updated in April 2026 to align with the start of the new financial year to ensure accurate and proportionate oversight of Care Group quality performance.

Overview

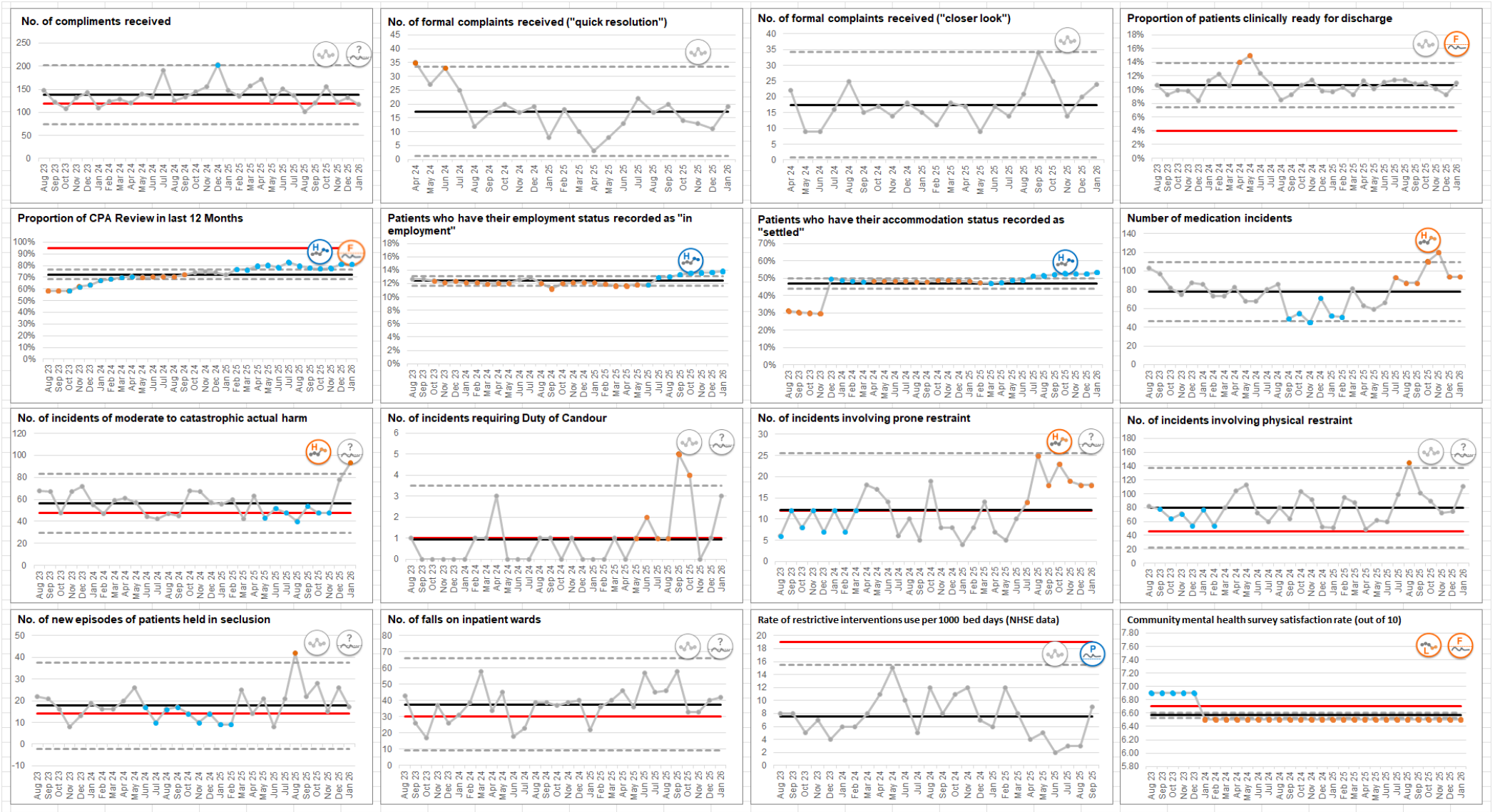
- **Quick Resolution (QR) Complaints and Closer Look (CL) (Formal Investigations):**
  The numbers of “closer look” and “quick resolution” complaints are following a pattern of common cause variation with the majority being raised in relation to the Working Age Adult Inpatient and Community Care Groups. Themes are monitored and escalated through the Trust Learning the Lessons meeting as part of the new governance structure and are monitored and explored through a monthly report from the Heads of Clinical Practice which is overseen at the Patient and Carer Experience Group every quarter. A plan is in place to ensure timely response to complaints
- **Duty of Candour (DoC):**
  Four incidents have met the threshold for DoC in the past three months and the duty was discharged appropriately in each case reflecting a culture of effective risk management and transparency
- **Clinical Readiness for Discharge (CRfD):**
  The proportion of patients CRfD has fluctuated between 9% and 11%, since February 2025. Discharging clinically ready patients is impacted by a lack of appropriate housing establishing funding and availability of social care placements. Twice weekly multi-agency meetings are held to discuss barriers, escalate concerns and support resolution but it is unlikely the 4% threshold will be reached over the next three months
- **Medication Incidents:**
  The number of medication incidents reported have been on a reducing trajectory since November 2025. The Increase between July and November 2025 should be viewed with consideration that there are more Inpatient Wards from this point and Enhanced Community team support from Pharmacy, who are recognised as one of the top reporting groups. 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 alongside violence and aggression towards staff through a collaborative around reducing violence and aggression towards staff which started in January 2026
- **Physical and Prone Restraint:**
  Incidents involving physical restraint are monitored via the Reducing Restrictive Practice Group every month and has increased in line with the increased number of Inpatient Wards since May 2025 including a PICU. The number of prone restraint incidents is related to incidents of rapid tranquilisation and placing patients in seclusion safely and This is being targeted by the Trust Positive and Safe team, teaching alternate ways of placing patients in seclusion and identifying alternate positions for intermuscular injection. A quality improvement plan started in March 2026 aims to eradicate prone only restraint by September 2026

- **Seclusion Episodes:**
  The number of new episodes of patients held in seclusion has continue to follow a pattern of common cause variation and is discussed monthly at the Reducing Restrictive Practice Group. A quality improvement group focusing on seclusion quality and reduction is ongoing on meets monthly. Benchmarking conversations with external organisations have also taken place to learn from others with a view to reduce use of seclusion within the organisation over the next six months
- **Falls on Inpatient Wards:**
  Between November 2025 and January 2026, 95% of falls reported caused no harm to patients 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 ward multi-disciplinary team

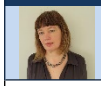
Measure	Target	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	
Quality performance														
No. of compliments received	119	135	157	172	124	151	137	101	121	155	122	132	117	
No. of formal complaints received ("quick resolution")		18	10	3	8	13	22	17	20	14	13	11	19	
No. of formal complaints received ("closer look")		11	18	17	9	17	14	21	34	25	14	20	24	
Proportion of patients clinically ready for discharge	4%	10%	9%	11%	10%	11%	11%	11%	11%	11%	10%	9%	11%	
Proportion of patients on CPA >12 months who have had their care plan reviewed	95%	77%	76%	80%	80%	78%	83%	80%	78%	78%	78%	81%	81%	
Patients who have their employment status recorded as "in employment"		12%	12%	12%	12%	12%	13%	13%	13%	14%	14%	14%	14%	
Patients who have their accommodation status recorded as "settled"		47%	47%	48%	49%	49%	51%	51%	52%	53%	53%	52%	53%	
Number of medication incidents		51	81	63	59	66	93	87	87	110	120	94	94	
No. of incidents of moderate to catastrophic actual harm	48	60	42	63	43	52	48	40	54	48	48	78	93	
No. of incidents requiring Duty of Candour	1	0	1	0	1	2	1	1	5	4	0	1	3	
No. of incidents involving prone restraint	12	8	14	7	5	10	14	25	18	23	19	18	18	
No. of incidents involving physical restraint	46	95	87	49	62	60	99	145	101	89	72	74	111	
No. of new episodes of patients held in seclusion	14	9	25	14	21	8	21	42	22	28	15	26	17	
No. of falls on inpatient wards	30	36	40	46	36	57	45	46	58	33	33	40	42	
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



OPERATIONAL PERFORMANCE



Deputy Chief Executive/ Chief Delivery Officer:
Vikki Ashton Taylor

Responsible Committee: **Finance and Performance Committee**

Executive Summary

Inflow

- **Percentage of patients in crisis to receive face-to-face contact within 24 hours:** this is an NHS Oversight Framework (NOF) measure of the proportion of urgent referrals made to Crisis teams and Mental Health single points of access who were seen face to face within 24 hours. In the quarter 2 (Q2) NOF ratings the Trust placed in the second lowest (worst) quartile for performance against this metric. A performance improvement plan was devised and implemented. The plan proved extremely effective and from the monthly mental health services dataset data published by NHS England the Trust has ranked in the top 10 of all NHS providers through Q3, which indicates that the Trust is likely to place in the best quartile when the official Q3 NOF rankings are published.
- **Mental Health Helpline:** From the latest official statistics in development published by NHS England (December 25), the proportion of calls to the helpline which were abandoned (callers hung up) after interactive voice response call steering remained high at 41%. In comparison, the national average for calls abandoned was 27%. Demand for the Trust's service is steadily increasing. In December 6.1k calls were received, which is the highest number on record and an increase of 9% since the previous month. This was well above the average of 4.8k calls received a month. Conversely, the Trust's speed to answer calls remained 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 out of area (OoA) Adult Acute placements:** there has been a significant reduction from a high of 28 back in January 2025. However, the Trust continues to require some external placements owing to demand exceeding bed capacity. The new male PICU for Derbyshire opened in July 2025 which continues to have a very positive impact on the care of male patients, with zero males placed OoA. However, there is no PICU provision for females in Derbyshire. Statistically, over the last three years seven to eight beds have been needed per day to meet the demand for female PICU care most of the time (85th percentile). At the time of writing, there are four females in PICU placements in total – three continuity of care and one inappropriate. There are also 21 adult Acute placements – 19 continuity of care and two inappropriate. So in total there are currently just three inappropriate OoA placements
- **Proportion of Adult Acute Inpatients aged 18-64 discharged with 60 days plus length of stay (LoS):** In the Q2 NOF rankings, the Trust placed in the highest (worst) 25% of providers (quartile 4) at 28.6%. The monthly Mental Health services dataset data published by NHS England indicates that this is likely to continue into Q3. If people had been discharged when clinically ready, the Trust would likely place in quartile 3. Currently, eight adult Acute patients are CRfD, delayed for a total of 308 days to date. Delayed discharges inflated average LoS by five days and inflated LoS of 60 plus days by 2.7% in Q3, and 5.4% in Q4 to date. 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 was implemented but did not have the intended impact. Therefore, a revised plan is in development. 48 of the current adult Acute inpatients have a LoS inpatient episode of 60 days or more to date (31%)
- **Average LoS for Adult Acute, Older Adult and PICU mental health beds:** the latest monthly Mental Health services dataset data published by NHS England (Q3) placed the Trust 15th highest of all NHS providers for average LoS, at 62 days.

However, if patients had been discharged when clinically ready to be discharged the Trust's Q3 average LoS would have been 54 days, which would place below the national average of 58 days. Currently, there are eight adults and nine older adults who are CRfD, who have been delayed for a total of 1,001 days to date. This creates a very poor patient experience and has a significant financial impact on the health system as it results in other patients having to be placed with private providers, at cost. Revised performance improvement plans for adult and older adult LoS reduction and improved flow are in development

- **Three-day follow-up:** the national standard for follow-up after inpatient discharge continues to be consistently exceeded, ensuring patients get support at the time they are most vulnerable. This process is tightly monitored by the Trust's Performance Analyst to ensure the safety of patients
- **Other triangulation work:** recent work relating to an inpatient ward in relation to triangulation of staff and student feedback, ward key performance indicators, and feedback from a Care Quality Commission Mental Health Act visit, resulting in a cultural review being commissioned whilst further ongoing investigation is taking place.

Elective/access

- **Women accessing specialist Perinatal Mental Health service**: the service continues to support increasing numbers of women before and after the birth of their children
- **Adult autistic spectrum disorder (ASD) assessment:** activity levels continue to exceed the commissioned target for assessments, with the full year target exceeded by 55% up to the end of January 2025. Waiting times remain very high at around 59 weeks, with demand far exceeding commissioned capacity. The waiting list has reduced over the last three months but over 1,200 people are currently waiting
- **Community waits over 52 weeks:** from the latest published data, the Trust is likely to be ranked fourth highest (worst) in the country for waits over 52 weeks, at 66%. The national median was just 0.3% (mean 8%). The January position has improved slightly to 62% as the planned transition of records starts to have an impact. Further phased improvement through backlog reduction is planned from April 2026. The majority of the long waits are for Community Paediatric ASD assessment or attention deficit hyperactive disorder assessment. The planned transfer of these waits into the Mental Health services dataset in line with other providers, as advised by NHSE, will improve the position to around 14% presenting a more accurate picture. However, this would still place well within quartile 4
- **Early intervention in psychosis:** the Early Intervention services and At Risk Mental State (ARMS) services assess people who are suspected of experiencing a first episode of psychosis. The national standard is to undertake an assessment and assign a Care Co-ordinator within two weeks of people being referred into the service (target 60%). In January 2026, performance fell below target at just 41%. Triangulation: the service has experienced a significant increase in demand at the same time as a significant level of staff turnover (25%), vacancies peaking at 16%, and periods of high levels of sickness absence which has all inevitably impacted on waiting times. The position has been recovered in February 2026, which will be reflected in the next report, with the services achieving 74% against the national 60% target. A revised performance improvement plan is in place which ensures continued progress. One of the key actions was to secure recruitment to improve the vacancy factor. As a result, two new starters are now in post. Another action includes ensuring there are stronger processes around allocation in order to break down the locality divide, ensuring timelier pick up (linking into the ongoing culture work). The performance improvement plan will be monitored via the Care Group Performance meeting and escalations to Divisional Board
- **Children and young people mental health access:** from the latest published data it is estimated that the Trust will rank in the second worst quartile of NHS providers once more when the official NOF Q3 data is published. The provider median was an increase of 5%. 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 children and young people's 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.

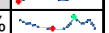
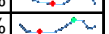
Collaboratives

- **Transforming care programme:** the Trust and System have reset a trajectory to have a total of no more than 32 patients in beds by the end of Q4, 2025/26. This trajectory, including the planning for 2026/27 and 2027/28 has been discussed and agreed with NHSE. Currently (data as of 16 February 2026), there are 20 learning disability and learning disability or autism patients in beds against a trajectory of 19 (+1) over trajectory, and 17 ASD patients in beds against a trajectory of 11 (+6) over trajectory; a total of 37. A performance improvement plan is in place with an emphasis on admission avoidance and an outflow plan in terms of supporting discharges. A deep dive group is being scheduled for week commencing 9 March 2026 to focus on secure Ministry of Justice patients; the group will include System partners across health and social care. There is also a separate opportunity to look at housing (accommodation) strategies. In terms of children and young people (CYP); there are three CYP against a trajectory of three (on target). The Trust/System will continue to meet with NHSE regional team monthly to monitor performance and progress.

Planning proposal 2026/27 - 2027/28

	Q1 26/27	Q2 26/27	Q3 26/27	Q4 26/27	Q1 27/28	Q2 27/28	Q3 27/28	Q4 27/28	Total
Adults Autism	17	16	14	12	12	11	10	9	
Adults LDA	15	15	16	16	16	15	15	15	
Adult Total	**32**	**31**	**30**	**28**	**28**	**26**	**25**	**24***	
CYP	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	

* 24 is rate per million ambition for Adults

Measure	Target	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	
Long term plan 2025/26														
Inappropriate adult acute & PICU mental health out of area placements at month end^	5	25	23	19	32	13	8	13	4	11	10	4	7	
Women accessing specialist perinatal mental health services (rolling 12 months)* ^^	1242	1340	1345	1340	1350	1390	1390	1395	1400	1395	1365	1360		
Perinatal access rate (ICB)*	10%	12.4%	12.4%	12.3%	12.5%	12.8%	12.9%	12.9%	13.0%	12.6%	12.4%	12.3%		
Individual work placement support access (rolling 12 months)*	690	700	715	715	715	745	765	760	755	780	810	805		
Average length of stay for adult acute, older adult & PICU mental health beds**	55	67	66	63	59	64	61	60	59	61	63	62	63	
NHS oversight framework 2025/26														
Proportion of people waiting over 52-weeks for community services*	0%	61%	63%	62%	64%	65%	64%	65%	68%	65%	65%	66%	62%	
Children and young people accessing NHS-funded MH services - annual change*	15.9%	0.0%	0.3%	-1.1%	-2.0%	0.6%	0.7%	1.8%	0.1%	0.4%	0.4%	1.0%		
Proportion of acute inpatients aged 18-64 discharged with 60 days plus length of stay**	20.6%	27%	23%	21%	18%	31%	33%	27%	27%	33%	31%	31%	31%	
Percentage of patients in crisis to receive face-to-face contact within 24 hours*	65.4%	47%	53%	57%	50%	47%	52%	53%	65%	76%	75%	76%		
Key operational measures														
Children & young people eating disorder routine referrals seen within 4 weeks*	95%	95%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Children & young people eating disorder urgent referrals seen within 1 week*	95%	#N/A	#N/A	#N/A	100%	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
Inpatient discharges followed up within 72 hours	80%	87%	88%	90%	89%	90%	87%	88%	92%	85%	89%	86%	91%	
Dementia diagnosis rate (ICB)*	68%	68.5%	68.8%	69.0%	69.3%	69.2%	68.9%	68.6%	68.7%	68.9%	68.8%	68.9%		
Early intervention in psychosis 2 week waits from referral to treatment - complete	60%	76%	65%	56%	47%	43%	37%	39%	52%	85%	56%	78%	41%	
Early intervention in psychosis 2 week waits from referral to treatment - incomplete	60%	80%	56%	48%	46%	46%	50%	58%	75%	92%	88%	63%	73%	
Adult ASD assessment – number of people waiting at month end	219	1617	1515	1491	1429	1400	1369	1385	1363	1386	1428	1365	1209	
Adult ASD assessment – average wait (weeks)	18	54	56	55	56	54	52	53	55	55	54	56	59	
Adult ASD assessment – number of assessments completed per month	26	93	67	59	55	61	64	29	36	44	47	34	53	

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

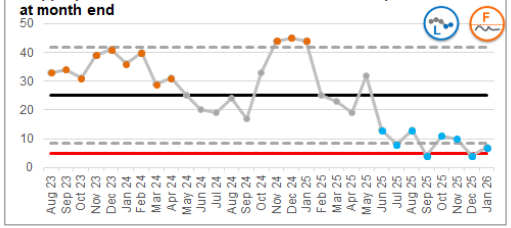
* Data source = NHS England

^^ Perinatal and maternal mental health services

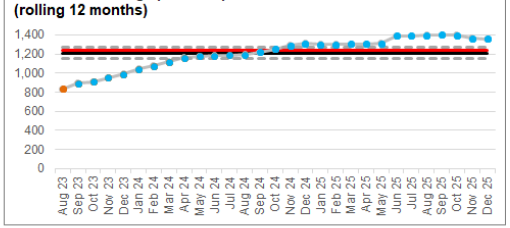
** Rolling 3 months, length of inpatient spell of patients discharged

Operational Key Performance Indicators – Statistical Process Control Charts

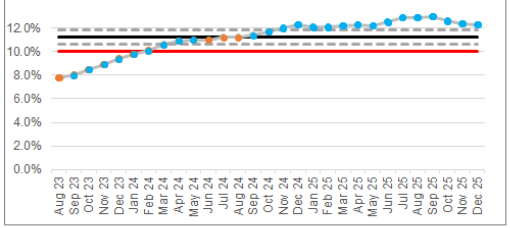
Inappropriate adult acute mental health out of area placements at month end



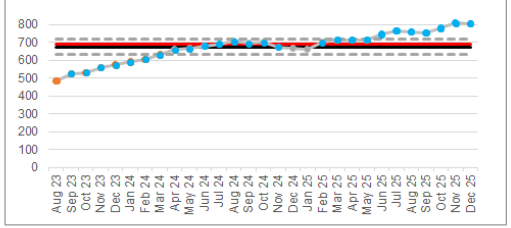
Women accessing specialist perinatal mental health services (rolling 12 months)



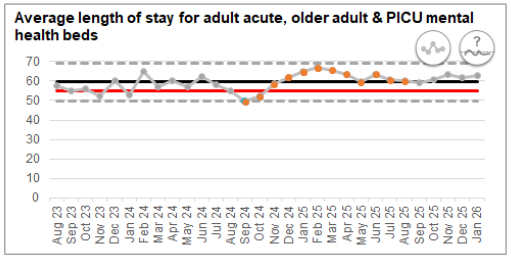
Perinatal access rate (ICB)



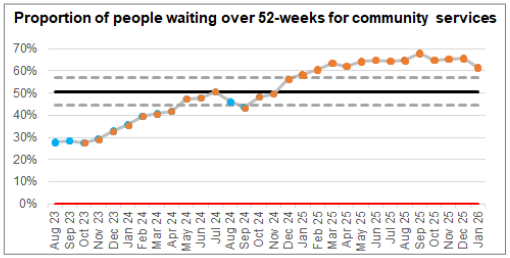
Individual work placement support access (rolling 12 months)



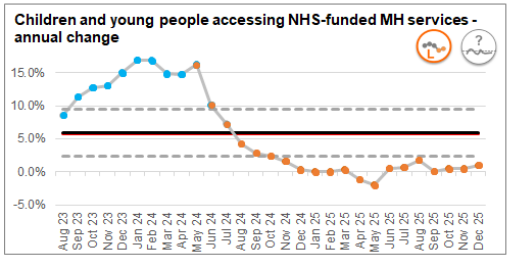
Average length of stay for adult acute, older adult & PICU mental health beds



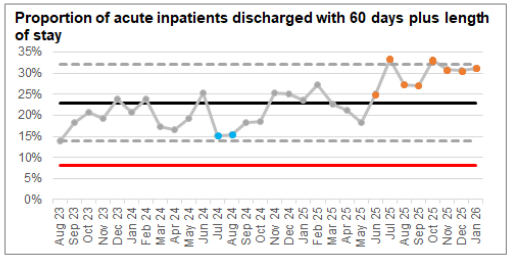
Proportion of people waiting over 52-weeks for community services



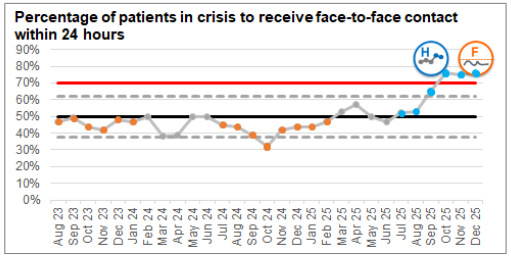
Children and young people accessing NHS-funded MH services - annual change



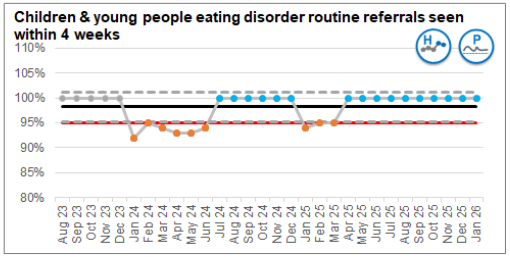
Proportion of acute inpatients discharged with 60 days plus length of stay



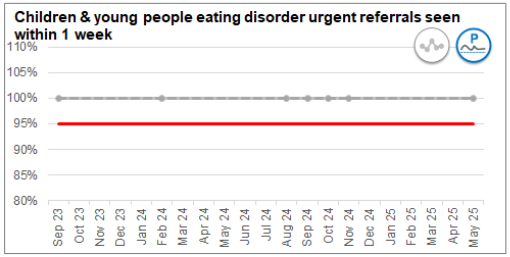
Percentage of patients in crisis to receive face-to-face contact within 24 hours



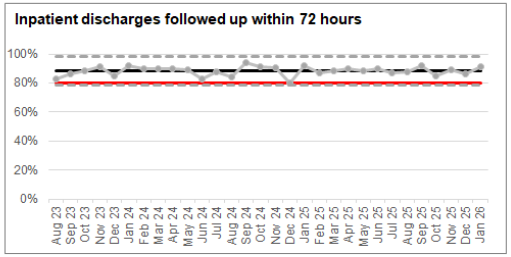
Children & young people eating disorder routine referrals seen within 4 weeks



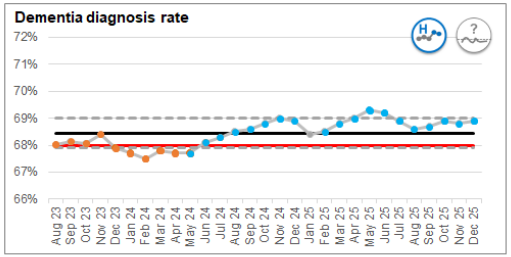
Children & young people eating disorder urgent referrals seen within 1 week



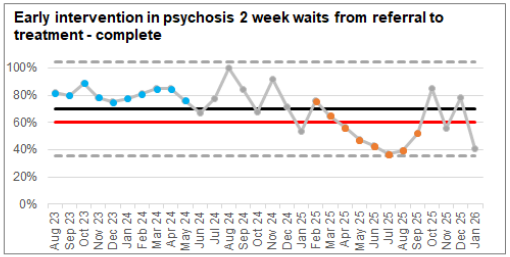
Inpatient discharges followed up within 72 hours



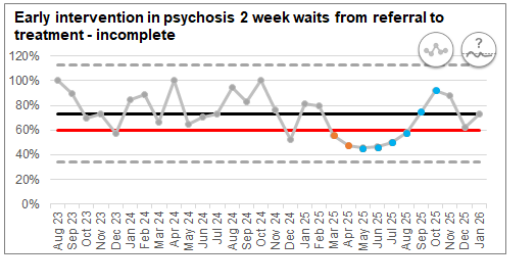
Dementia diagnosis rate



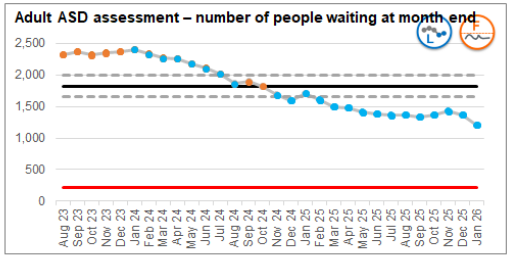
Early intervention in psychosis 2 week waits from referral to treatment - complete



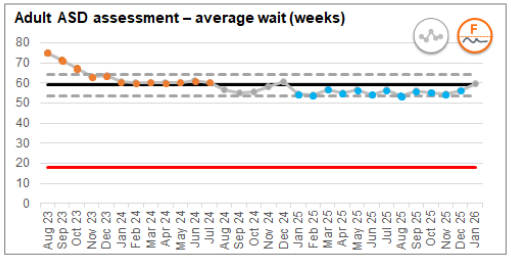
Early intervention in psychosis 2 week waits from referral to treatment - incomplete



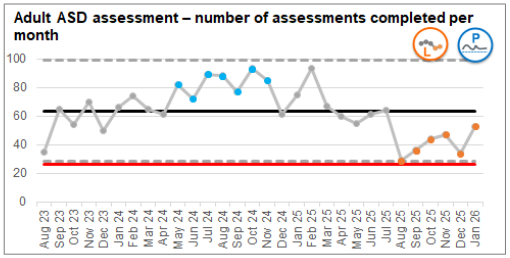
Adult ASD assessment – number of people waiting at month end



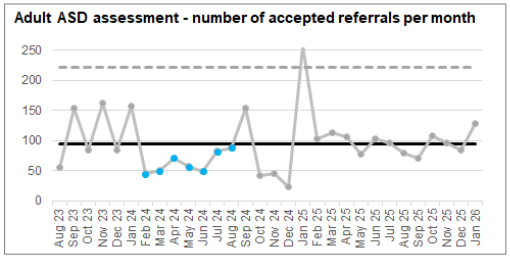
Adult ASD assessment – average wait (weeks)



Adult ASD assessment – number of assessments completed per month



Adult ASD assessment - number of accepted referrals per month



TRANSFORMATION AND IMPROVEMENT

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

FLOW PATHWAY

National Planning Priority 2025/25: Reduction of Adult Acute mental health inappropriate out of area placements

DHcFT Operational Planning Assumption 2025/26: Phased reduction of Adult Acute inappropriate OoA placements aligned to agreed trajectory for 2025/26

Interventions:

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

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

Opportunities identified through the JUCD Men-SAT review supported by the NHSE Mental Health Improvement Support Team have been incorporated to the action plan. We are also fully engaged with the 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.

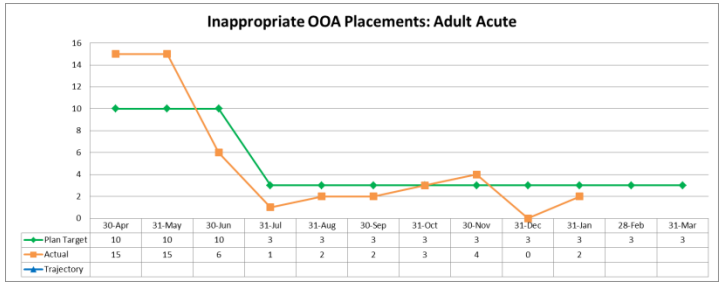
Action is currently focused on design of a strategic approach for integration and localisation of services in alignment with the 10-Year Health Plan ambition to transform mental health services into 24/7 neighbourhood care models; with a Board Strategy and Development session hosted in October to define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

A workshop approach has been implemented with frontline teams, applying intelligence and insights in development of the model, pathway and strategic Inflow implementation plan for delivery in 2026/27. The third workshop was hosted in January and outputs have been applied to inform a draft plan which is being consulted upon with the 120+ colleagues who have engaged with the process and is presented to TDG under separate cover.

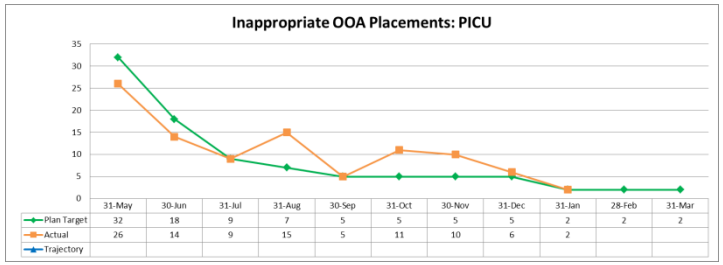
Impact:

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 31 January at 2, and remaining below the operational plan trajectory:



The planned trajectory for PICU OoA placements has been reset to reflect guidance from NHSE and the ICB to account for the three commissioned beds as appropriate and managed within continuity of care. At 31 January the position was two, aligned to the revised plan trajectory:



Focus for the next plan period is on further reducing long length inpatient stays 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: **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.	**Impact:** **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 delivered aligned to Performance Improvement Plan with action in delivery to sustain this over Q4.
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 of target delivered over initial Performance Improvement Plan. However, further challenges experienced with new PIP and recovery trajectory in development.

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: Children and young people 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 2024-24 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 Co-ordination or treatment by February 2027.
Metric: Adult ASD assessment service The service is commissioned to deliver 26 assessments per month but receives around 95 referrals with demand outstripping capacity. A new model has been implemented to increase productivity and volume of assessments that can be completed within commissioned resources, 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 autistic spectrum disorder assessment service** Trajectory is on track to achieve national standard for referral to assessment within three months (13 weeks) by June 2027.

TRANSFORMATION AND IMPROVEMENT

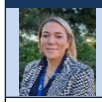
The Transformation and Improvement Portfolio is supporting achievement of improved performance across IPR measures through collaboration with key updates below.

JOINED UP PATHWAYS AND SERVICES: EAST MIDLANDS ALLIANCE

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

Interventions:	**Impact:**
East Midlands IMPACT Collaborative St Andrews (STAH) remains closed to admissions with continued support from the collaborative to the Intensive Oversight and Assurance Group and Recovery Support Programme steps. Occupancy rates have fallen slightly due to the opening of 12 additional Part 2 female beds following decommissioning of the national Women's Enhanced Medium Secure Service. The new ward (for IMPACT) is being mobilised at pace to increase occupancy. Financial stability for providers and reconfiguration of services to balance demand and capacity is an ongoing priority	**East Midlands IMPACT Collaborative** Transformation project underway between IMPACT and Nottinghamshire Healthcare to create a new "blended" service provision (medium to low patient journey) in one unit setting replicating the service in place at STAH. The model will support the collaborative in readiness for the anticipated new national specifications for Women's Secure Care that will make blended pathways that are all inclusive to all women a new standard.
East Midlands CAMHS Collaborative St Andrews remains on Intensive Quality Assurance and Improvement level in response to the systemic quality and safety concerns. Nottinghamshire Healthcare CAMHS Inpatients' Independent Closed Culture Review has been concluded with an action plan against the recommendations in development. There has been a significant decrease in occupied bed days in Q2. 34% of admissions were for patients within the Transforming Care cohort, an increasing trend since Q4. 88% of admissions that were due, non-compliant with pre-admission Care, Education, and Treatment Reviews or Local Area Emergency Protocol. Financial forecast of £8.7m carry forward for investment in 2026/27.	**East Midlands CAMHS Collaborative** The CAMHS Provider Collaborative has won provider collaborative of the year in the HSJ Awards. Leicestershire and Lincolnshire have been agreed as the day service pilot sites.
East Midlands Adult Eating Disorder Collaborative EMPC escalated Nova Ward to enhanced quality assurance and improvement level of oversight due to systemic quality concerns across Cygnet Elowen Hospital. The Provider is paused for new admission. A Quality Improvement Plan is in place with clear governance to oversee progress. Welford Case Manager oversight was increased for additional support and assurance on the progress of a local ward improvement plan. There has been a decrease in occupied bed days, mainly due to a marked decrease in out of area activity.	**East Midlands Adult Eating Disorder Collaborative** Waterlily won the 2025 Health Service Journal (HSJ) award for Community Care Initiative of the Year. Recurrent funding for the Waterlily project has now been agreed and the project can now be rolled out across all systems in the East Midlands.
East Midlands Perinatal Provider Collaborative Both Mother and Baby Units remain on routine quality assurance and improvement level with no escalations this quarter. Planned closure of The Beeches in February 2026 to allow installation of air conditioning and resolve ongoing issues over recent years with high room temperatures. Admissions in Q2 have been consistent with Q1 although there has been a significant increase in occupied bed days. Due to unavailability of beds, three patients were admitted to providers outside the East Midlands in Q2.	**East Midlands Perinatal Provider Collaborative** A focus on patient and carer experience, learning and improvement within the Q2 report demonstrates the positive breadth and depth of work across both units along with the strong focus on co-production with experts by experience.
East Midlands Gambling Harm service Significant additional funding allocation for 2026/27 is enabling service expansion planning with a focus on strengthening clinical capacity and exploring new partnerships for broader reach and recovery support. The service continues to improve, referral numbers with Q3 on track to achieve upper target. Service demand is driving challenges in resourcing late evening clinics with recruitment planned. Demand also driving need for resources to support awareness-raising, gambling harms training and input into strategic planning for service expansion.	**East Midlands Gambling Harm Service** Recent media coverage has helped raise awareness of the service, leading to a notable increase in referrals. The service has been nominated for the 'Comm2Point0 Unaward', recognising creative and effective work in communications. Patient feedback remains overwhelmingly positive, praising the professionalism of staff and the practical tools provided to manage gambling-related harms.

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 nine consecutive months. Efforts continue to address appraisals that are out of date and approaching renewal, to both maintain and increase compliance further.

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

Compulsory training: compliance continues to remain high at 95% and has surpassed the 85% target for several years. Efforts continue to address training that is out of date and approaching renewal, to both maintain and increase compliance further. In addition, a specific area of focus will now be on occurrences of 'Did Not Attend' (DNA) training to better understand reasons and potential barriers for non-attendance.

Sickness absence: for the month of January 2026 is running at 6%, a decrease of 0.78% compared to the same period last year. Short-term sickness absence represents 2.80% and long term absence represents 3.20%, a reduction of 0.74% compared to November 2025 when long-term sickness absence peaked at 3.94%. The annual sickness absence rate is running at 5.70%, a reduction of 0.42% compared to the same period last year. Anxiety, stress or depression related illness remains the highest reason for sickness absence, followed by cough, cold, flu. The Absence Oversight Group continues to focus on development of its delivery plan, covering absence monitoring, policy compliance, hot spot areas, support for managers and support for our people. A Quality Improvement approach will continue to be taken to assist with reducing absence levels.

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

Agency usage: has reduced significantly compared to the previous year and continues to remain low. The authorisation pane0l to oversee agency requests across the Trust continues to remain in place.

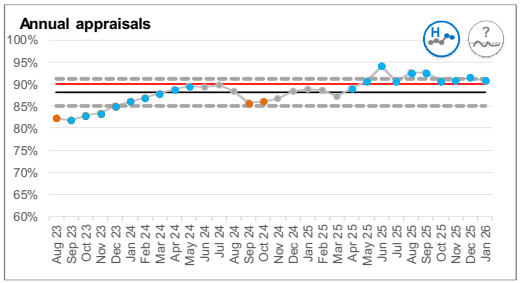
Supervision: Both clinical supervision and managerial supervision are at 88%. Whilst there has been incremental improvement in compliance over the year, efforts continue to work with teams with low compliance and rates are expected to increase further over the coming months. Several enhancements to the supervision recording system have now been implemented which fully align to the revised Trust Supervision Policy. The system enhancements will go live at the end of March 2026 and will be reflected in the next reporting period.

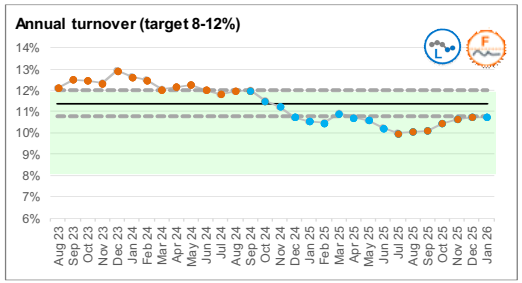
Measure	Target	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	
People Performance														
Annual appraisals	90%	89%	87%	89%	91%	94%	91%	93%	93%	91%	91%	91%	91%	
Annual turnover (target 8-12%)	12%	10%	11%	11%	11%	10%	10%	10%	10%	10%	11%	11%	11%	
Compulsory training	85%	92%	92%	93%	94%	94%	94%	95%	95%	95%	94%	95%	95%	
Vacancy	5%	12%	12%	12%	11%	11%	10%	10%	9%	9%	9%	7%	6%	
Bank staff use	5%	4.5%	4.4%	4.5%	4.0%	4.1%	3.9%	4.5%	5.1%	4.5%	5.2%	4.7%	4.2%	
Agency staff use	1.9%	0.7%	0.7%	0.3%	0.4%	0.3%	0.4%	0.5%	0.4%	0.5%	0.4%	0.5%	0.4%	
Management supervision	100%	86%	86%	84%	85%	86%	86%	85%	87%	88%	86%	89%	88%	
Clinical supervision	100%	84%	83%	81%	83%	82%	82%	82%	83%	85%	86%	88%	88%	
NHS oversight framework 2025/26														
Sickness absence rate	5%	5.8%	5.1%	5.4%	4.9%	5.3%	5.8%	5.5%	5.8%	6.6%	6.6%	6.3%	6.0%	
Long term sickness (28 days plus)	n/a	2.8%	2.7%	2.8%	2.6%	2.6%	2.9%	2.8%	3.5%	3.6%	3.9%	3.7%	3.2%	
Short term sickness (<28 days)	n/a	3.0%	2.4%	2.6%	2.3%	2.7%	2.9%	2.7%	2.3%	2.9%	2.6%	2.6%	2.8%	
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		
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		
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%	

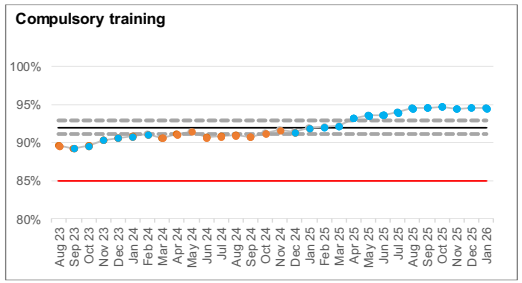
*2025 results are due to be published in March 2026

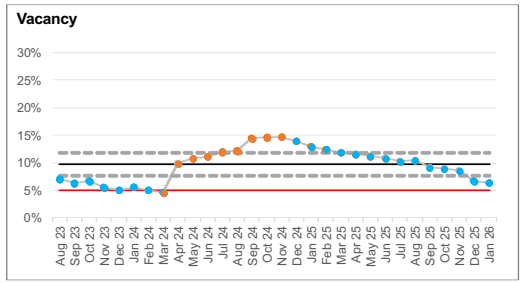
**2025 survey closed to responses on 2 December 2025, with the results to be published on 12 March 2026

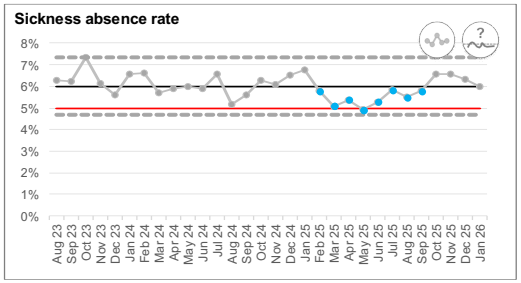
People Key Performance Indicators – Statistical Process Control Charts

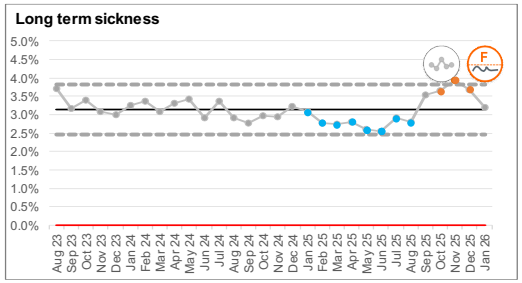


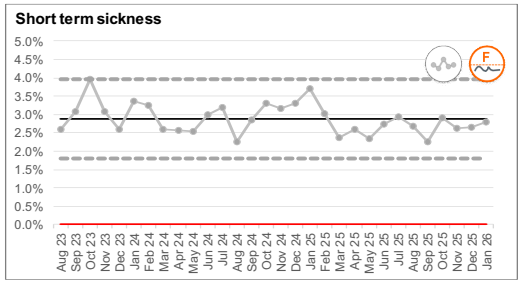


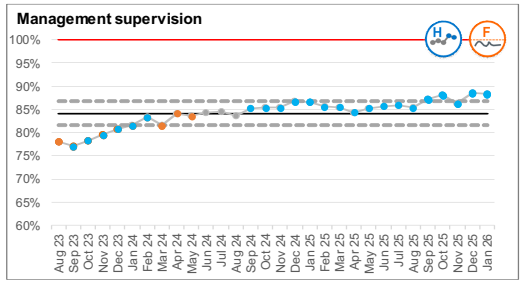


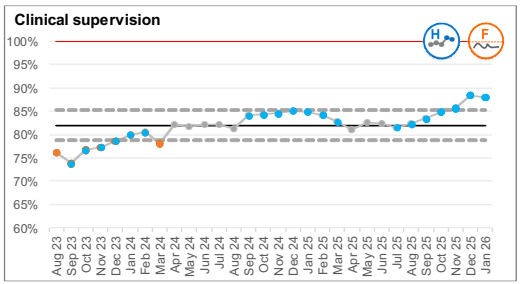


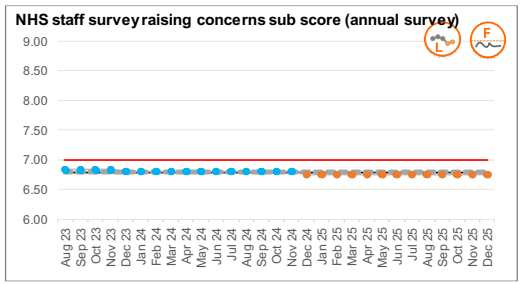


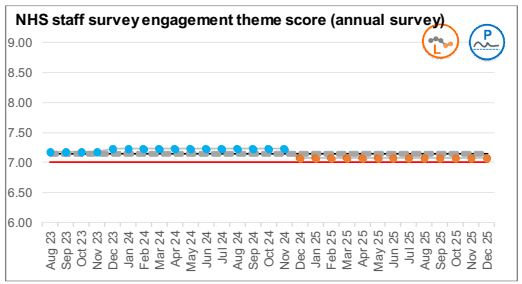


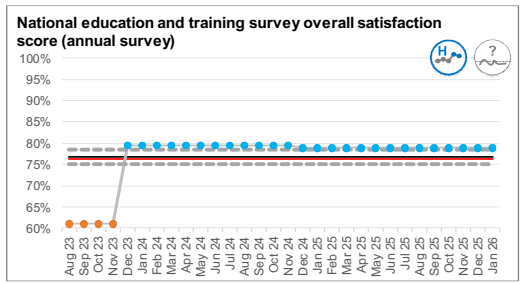


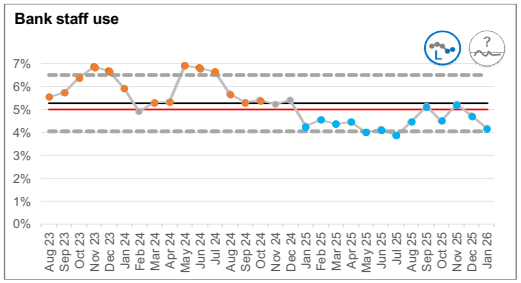


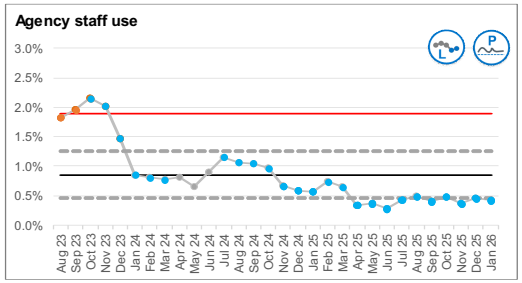












FINANCIAL PERFORMANCE



Director of Finance:
James Sabin

Responsible Committee: **Finance and Performance Committee**

Executive Summary

Overall

At the end of January, there is an overall deficit of £1.3m, 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 £0.7m, which is better than 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 January efficiencies were on plan, delivering savings of £11.7m. 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 January is £2.1m, which equates to 1.4% of the total pay expenditure and is below plan by £0.7m. 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 Out of Area (OoA) Placements

The biggest area of risk is in relation to Adult Acute OoA placements, with expenditure being above plan by £3.5m year to date and is forecast to be above plan by £4.3m. The forecast assumes current levels continue for the remainder of the financial year.

Capital Expenditure

Capital is below plan at the end of January by £3.5m. 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. 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 next financial year. 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 £0.5m.

Cash

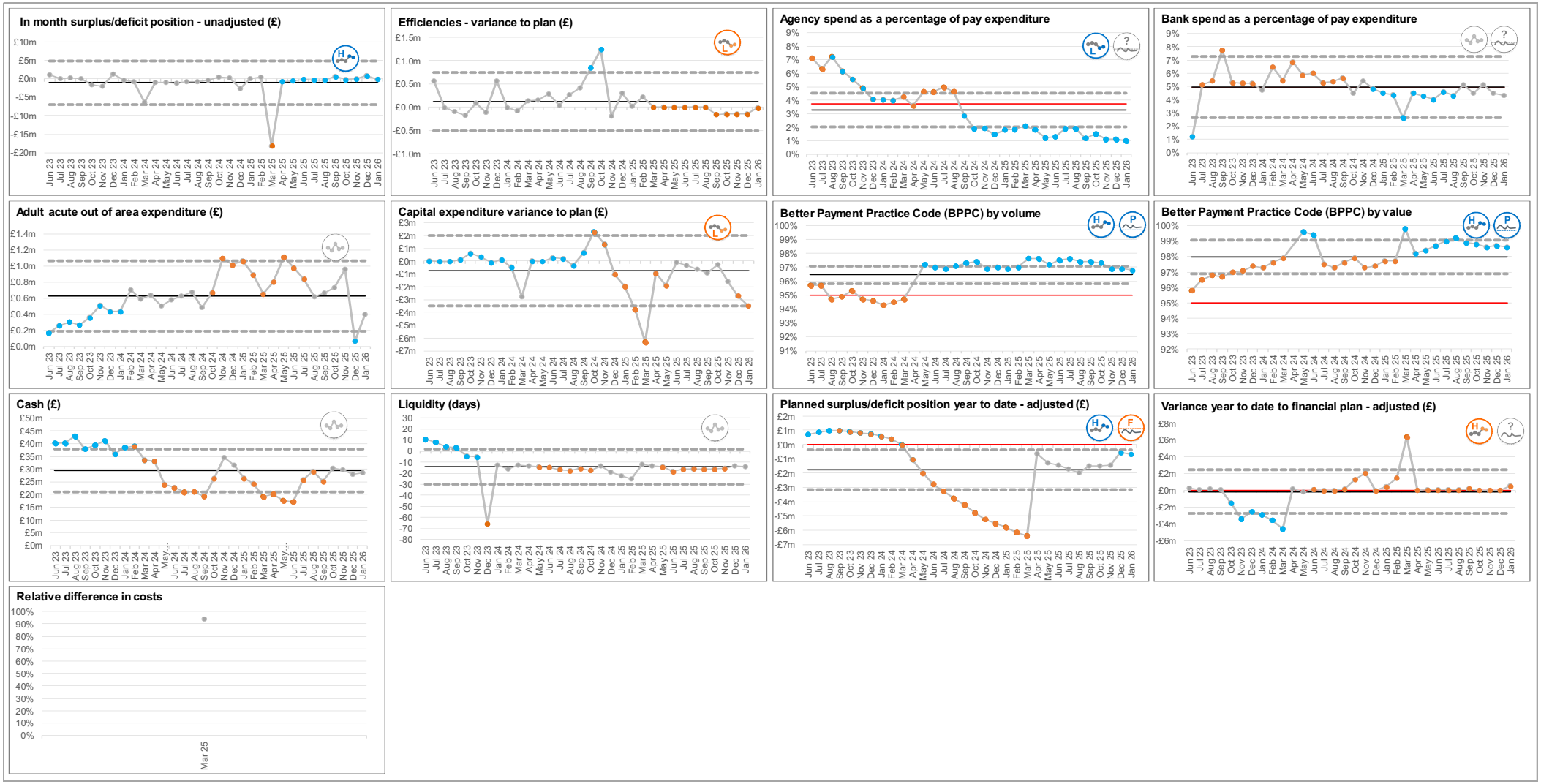
Cash at the end of January is at £28.4m which is higher than plan by £6.1m due to the timing of receipts. Cash levels at the end of March 2026 are forecast to be £23.9m, which is £1.5m below plan. Cash is forecast to be below plan due to some of the non-recurrent efficiencies being delivered through 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 January, both the value and volume of invoices exceeded the target at 99% and 97% respectively.

Measure	Target	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	
Financial Performance														
In month surplus/deficit position - unadjusted (£)	-	£ 505,698	-£ 18,160,011	-£ 759,497	-£ 618,647	-£ 181,431	-£ 356,503	-£ 340,743	£ 546,298	-£ 224,055	-£ 16,211	£ 792,384	-£ 181,752	
Efficiencies - variance to plan (£)	-	£ 209,050	£ -	£ -	£ -	£ -	£ 1	£ 1	-£ 154,000	-£ 152,000	-£ 151,000	-£ 150,000	-£ 17,000	
Agency spend as a percentage of pay expenditure	3.7%	1.8%	2.1%	1.8%	1.2%	1.3%	1.9%	1.9%	1.2%	1.5%	1.1%	1.1%	1.0%	
Bank spend as a percentage of pay expenditure	4.9%	4.4%	2.6%	4.5%	4.3%	4.0%	4.6%	4.3%	5.1%	4.5%	5.1%	4.5%	4.3%	
Adult acute out of area expenditure (£000)	-	£ 889	£ 654	£ 799	£ 1,110	£ 977	£ 839	£ 618	£ 660	£ 727	£ 956	£ 60	£ 399	
Capital expenditure variance to plan (£)	-	-£ 3,798,000	-£ 6,307,000	-£ 953,000	-£ 1,907,000	-£ 107,000	-£ 333,000	-£ 640,000	-£ 917,000	-£ 274,000	-£ 1,606,000	-£ 2,719,000	-£ 3,479,000	
Better Payment Practice Code (BPPC) by volume	95%	97.0%	97.6%	97.6%	97.2%	97.5%	97.6%	97.4%	97.4%	97.3%	96.9%	96.9%	96.8%	
Better Payment Practice Code (BPPC) by value	95%	97.7%	99.8%	98.2%	98.4%	98.7%	99.0%	99.2%	98.9%	98.8%	98.6%	98.7%	98.6%	
Cash (£000)	-	£ 24,296	£ 19,071	£ 20,204	£ 17,589	£ 17,175	£ 25,805	£ 29,130	£ 25,167	£ 30,338	£ 29,717	£ 27,969	£ 28,403	
Liquidity (days)	-	-25	-12	-13	-14	-19	-16	-16	-16	-16	-16	-13	-14	
NHS oversight framework 2025/26														
Planned surplus/deficit year to date - adjusted (£)	£ -	-£ 6,154,302	-£ 6,383,704	-£ 643,118	-£ 1,289,243	-£ 1,442,742	-£ 1,714,677	-£ 1,986,000	-£ 1,521,000	-£ 1,472,000	-£ 1,421,000	-£ 557,000	-£ 669,000	
Variance year to date to financial plan - adjusted (£)	tbc	£ 1,466,422	£ 6,384,643	£ 26,588	£ 43,183	£ 76,791	£ 63,671	£ 64,573	£ 207,403	£ 5,116	£ 6,456	£ 33,609	£ 496,585	
Relative difference in costs	<100%		93.76%											

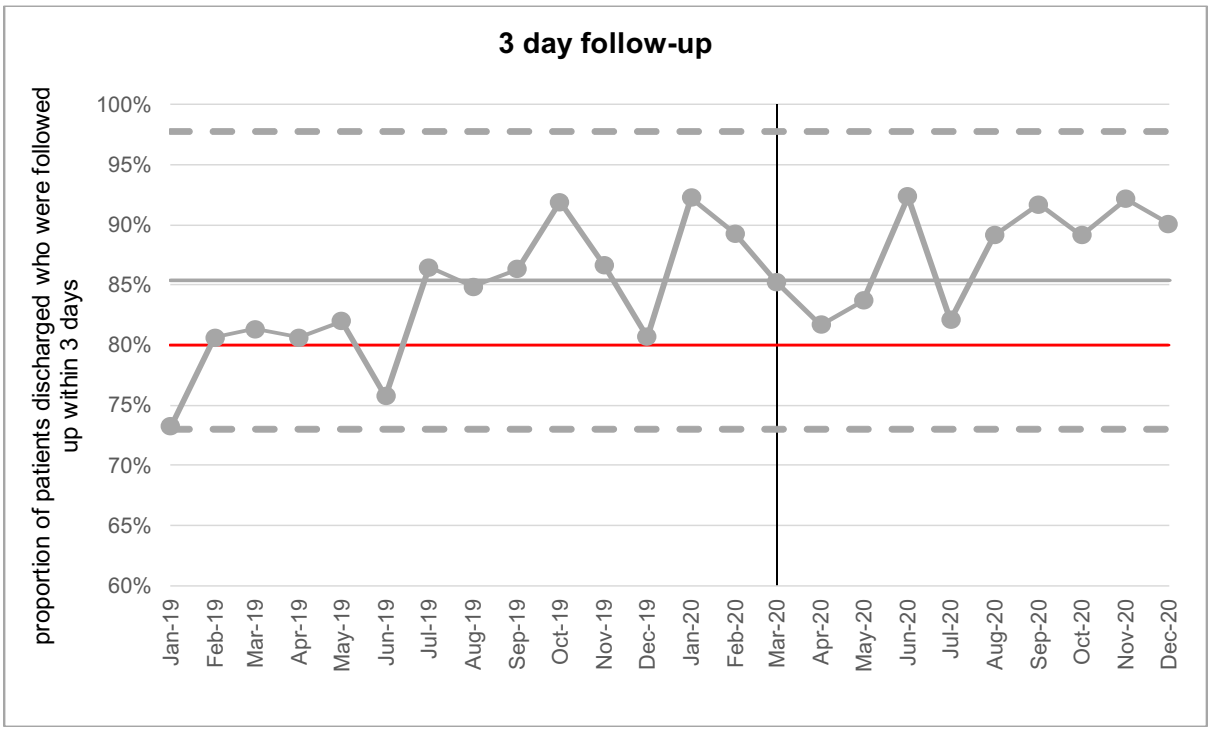
Financial Key Performance Indicators – Statistical Process Control Charts



Appendix 1

Statistical Process Control Chart (SPC) Guidance

Example SPC chart:



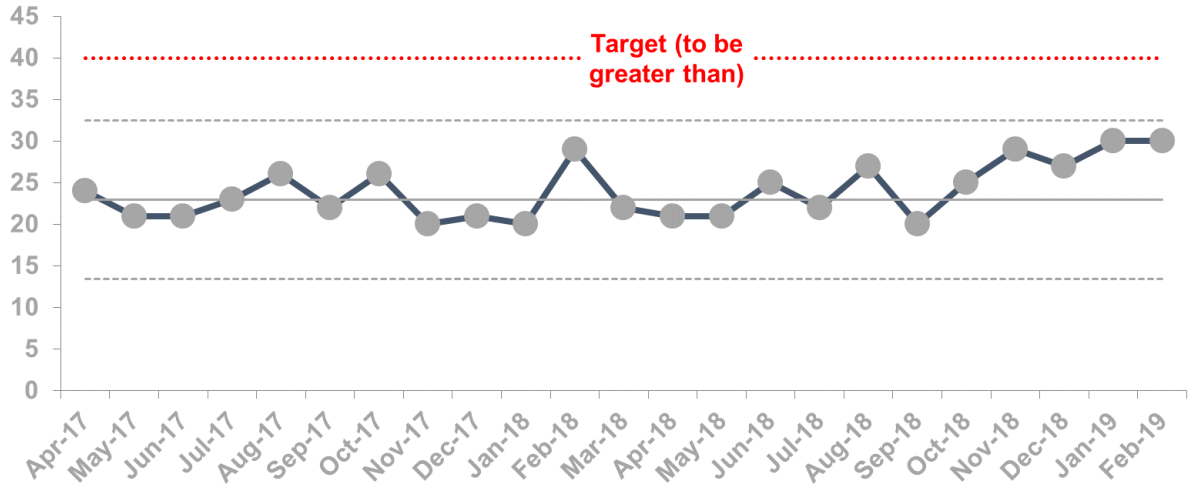
- The red line is the target
- The grey dots are the actual performance each month. They are coloured grey as performance each month is normal in this example
- The solid grey line is the average (mean) of all the grey dots
- The grey dotted lines are called process limits, or control limits.

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

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

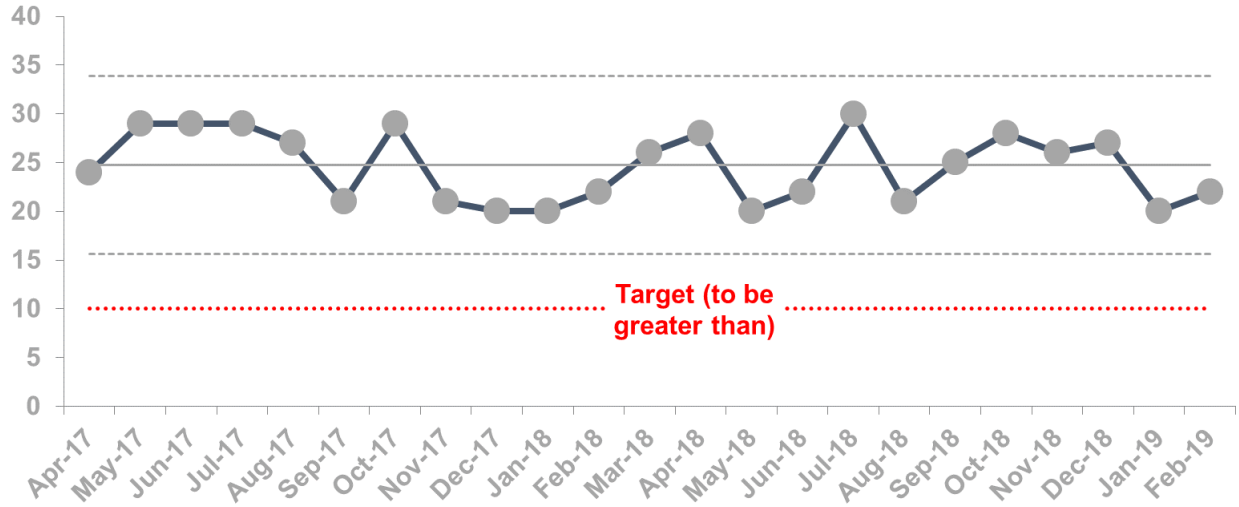
Things to look out for:

1. A process that is not working:



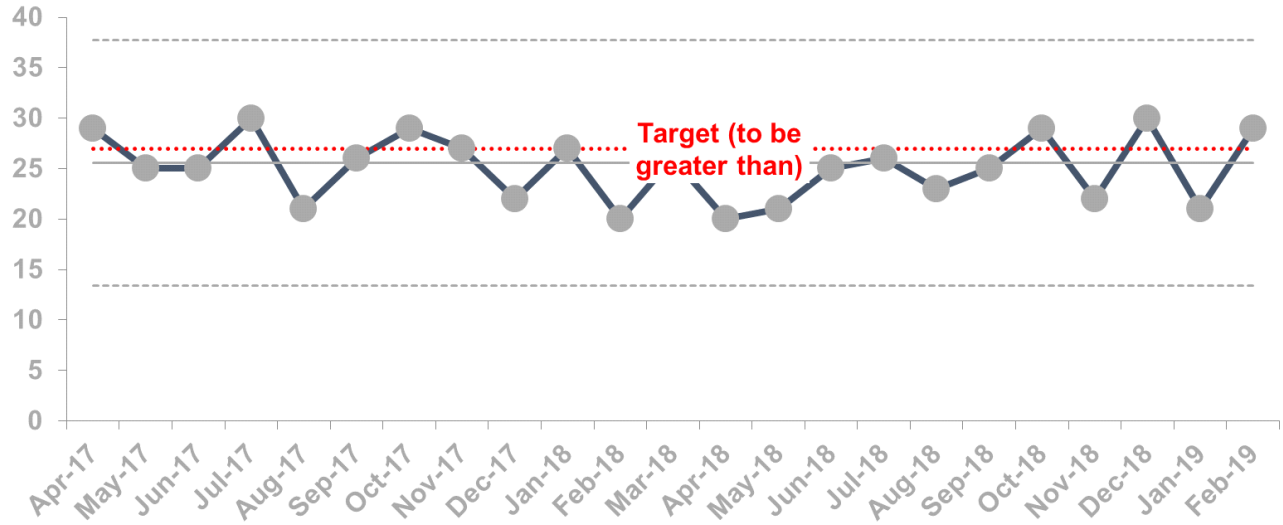
In this example the target is higher than the upper dotted grey line. This means that the target will never be achieved. To achieve the target, we need to change how we do things.

2. A capable process:



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

3. An unreliable system:

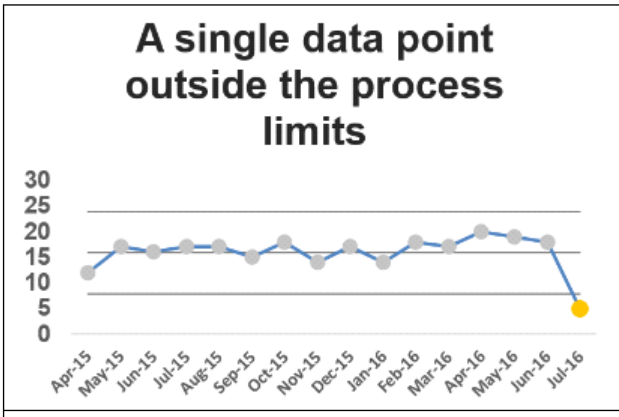
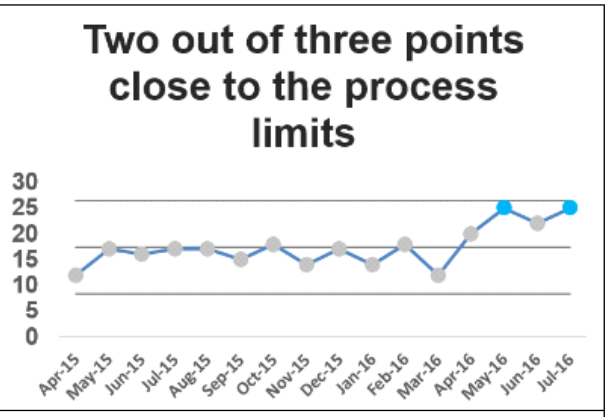
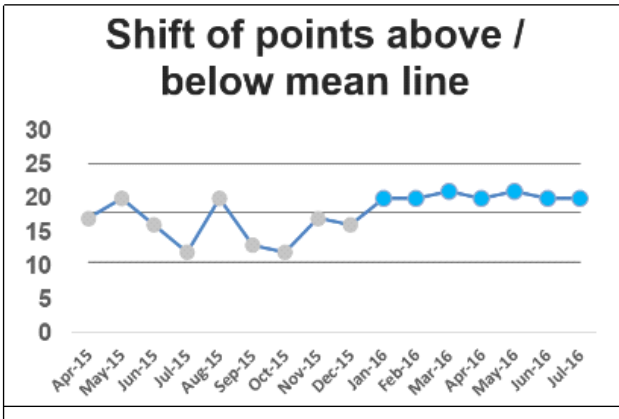
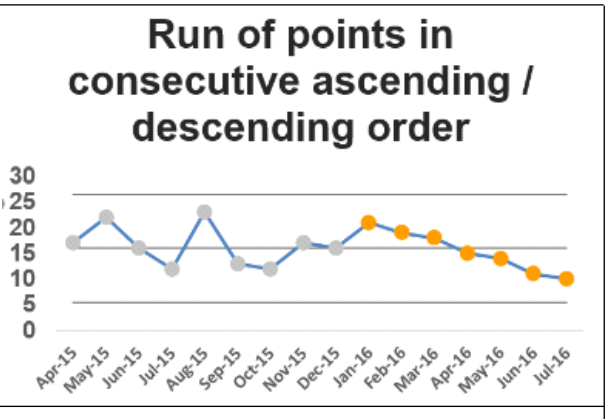


In this example, the target line sits between the two grey dotted lines. As it is normal for the grey dots to fall anywhere between the two dotted grey lines, this means that it is entirely random as to whether or not the target will be achieved. So, this system is unreliable and needs to be redesigned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

4. Unusual patterns in the data

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

There are four scenarios where this can happen:

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

Frequently seen in the NHS:

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

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

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

Appendix 2

Assurance Ratings

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

Board Committee Assurance Summary Reports to Trust Board – 24 March 2026

The following summaries cover key items discussed at the meetings that have been held since the last public Board meeting held on 27 January 2026 and are received for information.

- Quality and Safeguarding Committee – 11 February and 11 March
- People and Culture Committee – 3 March
- Finance and Performance Committee – 10 March (verbal update)
- Mental Health Act Committee – 12 March

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 – 11 February 2026
Director of Nursing update The update centred on the regulatory activity relating to the Care Quality Commission (CQC). This included the Mental Health Act (MHA) visit to the Dove Ward (December 2025) and the associated quality and safety issues; progress with the actions following the Special Education Needs and Disabilities (SEND) and the Cherry Tree Close Rehabilitation Unit inspection (January 2026). Special Educational Needs and Disabilities (SEND), compliance remains strong with the Integrated Care Board (ICB) commending high compliance across focus areas. Further improvements are planned for 2026 including Level 3 training roll out, strengthening the annual review process and better visibility of 'Support While Waiting'. The Cherry Tree Close CQC inspection indicated no breaches within the draft report showing 'Good' across all domains reflecting an improvement from 'requires improvement' rating for the 'effectiveness' domain. The Committee received **significant assurance** on the Cherry Tree Close position and progress with SEND. The Committee received **limited assurance** that the quality and safety concerns about Dove Ward from the CQC report have been followed noting that further triangulation for other metrics and concerns taking place had led to a lead in time to the Trust response.
Fundamental Standards of Care **Significant assurance** was accepted that fundamental standards of care process is delivered consistently, risks are identified and escalated promptly and learning is embedded in line with regulatory expectations, noting compliance and organisational response. It was noted that this supportive guidance is being favoured over an inspection approach, aiming to support improvements rather than merely identify shortcomings. A thematic review of fundamentals of care visits was presented, highlighting improvements in assurance frameworks, the embedding of Experts by Experience and ongoing challenges in documentation, care planning and physical health.

	Discussion focused on the importance of local manager engagement in quality visits, with plans to clarify the differences between Board and Fundamentals of Care visits and to encourage frontline staff participation. Consideration was given to the implementation and improvement of the quality assurance framework, highlighting the importance of clear communication and consistency in visit protocols. The challenge of maintaining engagement was noted, with 85 instances of clinical practice engagement in one year cited as a significant achievement.
	Assertive Outreach (AO) Community Mental Health Treatment (quarterly) While noting good progress has been made the paper provided **limited assurance** on current performance on the management of AO cases. Ongoing issues in accommodation for service users and the need for multi-disciplinary monitoring of patient contacts were highlighted. The discussion focused on data representation, family involvement in care planning, the discharge process and funding challenges. The importance of listening to families as part of the Care Plan was emphasised, particularly in the context of the discharge process. It was agreed seek clarification around the timescales with actions that required commissioner consideration with the existing recommendations, despite current limitations.
	Quality Dashboard The Committee received **limited assurance** on progress towards the achievement of some clinical performance targets. It was highlighted that efforts are underway to reduce prone restraint, with plans to improve data recording and differentiate between types and durations of restraint, aiming for eradication of prone-only restraint. A collaborative initiative has been launched to address high levels of violence and aggression towards staff, with new interventions and leadership oversight to drive improvements. Enhancements to ligature risk assessments and training, especially in high-risk environments, were emphasised. The reporting of racism within the organisation was discussed and the ongoing difficulty in involving external authorities, such as the police. The continuation of Divisional performance cross-checks and targets was supported.
	Ligature Risk Reduction (six-monthly report) It was agreed that any deviation from compliance must be formally recorded as a failure, particularly in the context of CQC benchmarking, which typically averages around 75%. This approach supports broader governance and scrutiny efforts. It was clarified that ligature risk assessments are based on the perception of the team, rather than dictated standards. This ensures mitigation strategies reflect the team's comfort and operational preferences, resulting in varied approaches across units. It was highlighted that female wards are at higher risk due to the population cared for, with increased instances of self-harm. Following due consideration for an alternative approach it was confirmed that Datix would remain the preferred platform for incident recording of ligature risk assessments. The report provided **limited assurance** on the progress made on the roll out of CQC Mental Health and Learning Disabilities ligature risk guidance and policy review/ratification, training reporting and training plan.
	Patient Safety report Accepting **limited assurance**, the Committee noted the impact on flow and efficiency due learning response delays and support the importance of Executive Incident group functionality. Improvement work has commenced to address key challenges. Investigation responses were discussed in relation to team stability, resource management and the effectiveness of operational

	structures. It was indicated that three months should be allowed to fully assess the impact and evidence the planned outcomes. The importance of conducting timely investigations and ensuring team accountability for learning, rather than relying solely on the Patient Safety team, was emphasised. The introduction of a team leader and a forthcoming Patient Safety Officer would support further progress, provided no additional issues arise in the next three months.
	Reducing Restrictive Intervention The Committee discussed the benchmark position regarding restrictive practices and observational compliance across different organisations in the East Midlands, including the fact that even minor physical contact, such as holding hands, was classified as restrictive in some settings. The overall positive direction of travel in reducing restrictive practices was recognised, however, concerns were raised around persistent challenges in observation compliance. The introduction of observation devices has revealed a combination of challenges related to both device functionality and clinical practice. It was emphasised that clinical practice should not be compromised by the procedural requirement to press buttons at specific times. Incremental improvements in compliance were reported with further progress indicated as consistent practice is embedded. However full compliance with the recording of observations will only be reached with software issues addressed. **Limited assurance** was received.
	Quality Delivery Plan The report identified areas of progress and where actions were not currently on track. The conversation focused on governance of the plan and the need for improved reporting and oversight. Confidence was expressed that the quality delivery objectives for 2025/26 would be achieved by the end of the year. Digital transformation emerged as a significant challenge, with caution against an overly iterative approach, advocating for a holistic review of digitisation across multiple systems. **Limited assurance** was accepted on progress towards quality delivery targets.
	Guardian of Safe Working Hours (GoSWH) Discussions centred on the impact of opening new wards and the resultant concerns regarding increased workload for doctors. It was clarified that, while the physical number of beds was similar, operational complexities had increased, including the need for doctors to travel between sites (for example, from Kingsway to Radbourne) at all hours, with a notable rise in the number of calls received, particularly at night. This escalation in workload was attributed not only to site logistics but also to system issues such as staffing shortages, which further compounded the challenge. It was confirmed that no specific patient concerns had been identified. The proposal to transfer assurance of this item to the People and Culture Committee was approved. Dr Praveena Peddireddi was welcomed as the new GoSWH.
	Learning from Deaths/Mortality report The Committee discussed the robustness of current processes for reporting patient deaths either open to the Trust or within six months of discharge. The need to revisit and strengthen the reporting procedures was highlighted, emphasising the importance of using the Incident Reporting Toolkit (PSII) to inform decisions on necessary investigations. The significance of involving patients' families in all investigations and ensuring adherence to Duty of Candour (DoC) where appropriate was also stressed. The Committee reflected on the progress made from 'Learning the Lessons', noting the necessity to embed these learnings and triangulate them with population health data and health inequalities. The report was accepted with **limited assurance** of the Trust's approach**.**
	Quality Assurance Framework

	The current iteration of the document has been developed in response to extensive feedback and suggestions, with the aim of enhancing understanding and consistency in quality standards across the organisation. One of the primary challenges discussed was the difficulty in articulating existing quality assurance measures, with the observation that, if asked, responses would have been inconsistent or fragmented. The Committee noted the importance of establishing a proactive and intentional strategy to achieve outstanding quality, rather than relying on happenstance or ad hoc efforts. The Committee ratified the Framework, noting the associated governance, equality and assurance arrangements. It was emphasised that the document should be viewed as a work in progress, with ongoing updates to reflect evolving best practices and feedback.
	Making Room for Dignity (MRfD) Programme formal approvals Post Project Evaluation reports (Audrey House, Carsington Unit and Kingfisher Unit) and Benefits Evaluation reports (Carsington and Derwent Units) The Committee reviewed the reports collectively, noting they were comprehensive and followed a consistent structure across different services. The Benefits Evaluation reports placed emphasis on the service model, particularly in areas such as Out of Area (OoA) and the Psychiatric Intensive Care Unit (PICU). It was emphasised that all evaluations are fundamentally linked to the underlying model of care. It was agreed to accept the reports which demonstrated the commitment to continuous improvement and safeguarding patient dignity within the MRfD Programme.
	Board Assurance Framework (BAF) – key risks identified: It was highlighted that the next iteration will incorporate progress from the Quality Delivery Plan, ensuring that any updates are closely aligned with the identified BAF risks.
	Items for discussion at Board or other Board Committees: There were no items for escalation of concern to the Board. The committee discussed the importance of effective communication between the Board Committees to minimise duplication as a number of the agenda items crossed over with other committees eg People and Culture Committee. It was acknowledged that several Committees share Non-Executive Directors, facilitating this approach and enhancing information flow. **Items added to the Board Assurance Framework:** None. **Next scheduled meeting:** 11 March 2026
Committee Chair: Lynn Andrews	**Executive Lead: Tumi Banda, Director of Nursing, AHPs, Quality and Patient Experience**
Quality and Safeguarding Committee – key assurance levels for items – 11 March 2026	
	Director of Nursing update The Committee noted the main points: • Funding of the NHS England Culture of Care programme will end on 31 March, with 10 workstreams focused on quality, safety and equality, transitioning into internal resources. There are plans for a final meeting with the Programme team to share resources and determine which learning is to be integrated into ongoing organisational models • Lessons learned from Mental Health Act inspections have been shared with the Medical Senate, highlighting issues with Section 58 (consent documentation); Section 132 (patient rights) and the importance of timely second opinions • Reference was made to learning from the North East London Foundation Trust, Alice Figueiredo case, with explanation of how outcomes are disseminated across services, including the Trust's

	Nursing Council and how job descriptions are being updated to reflect new accountability standards. The Committee accepted **limited assurance** as further work is required to improve incident reporting within the organisation.
	Fundamental Standards of Care The Committee received **significant assurance** that effective governance, oversight and regulatory compliance arrangements are in place in relation to Fundamentals of Care visits, noting improvements in Care Quality Commission (CQC) ratings and ongoing challenges, such as private visiting spaces and the ongoing dormitory eradication. Progress made against identified actions was noted, including outstanding Section 120B requirements and the related improvement plan. **Limited assurance** was accepted that effective governance, oversight and regulatory compliance arrangements are in place in relation to Mental Health Act monitoring.
	Medicines and Pharmacy update The update covered governance refinements in the Medicines department and the implementation of an electronic valproate risk assessment form, with Pharmacy monitoring compliance for at-risk groups. The Committee acknowledge the progress now being made. The Committee acknowledged the importance of quoracy and supporting action plans in relation to the Medicine Optimisation Committee and associated groups.
	Risk Report The alignment of risk registers with new governance structures was described, highlighting the closure and resolution of several risks, especially those identified during CQC visits. A risk identified by Working Age Adults (community) prompted a discussion about the 'waiting well' policy, which ensures regular touchpoints and wellness support for patients on waiting lists. **Limited assurance** was noted due to challenges in maintaining contact with all patients, especially those waiting over 50 weeks. The Committee insisted on assurance around policies/processes and importantly the application and effectiveness of these for identifying and acting before patient harm occurs. It was agreed to conduct a deep dive. The Committee accepted **significant assurance** regarding adherence to the Risk Management Strategy, reporting and monitoring schedules and routes of escalation regarding gaps in compliance.
	Sexual Safety report (six-monthly) The report highlighted the dual focus on patient and staff sexual safety, detailing training efforts, reporting mechanisms and collaboration with police. The importance of confidence to report incidents and the trauma-informed approach used in investigations was emphasised, noting that reporting rates have increased following training and awareness campaigns. **Significant assurance** was accepted that the Trust has met the requirements of the Charter and work continues to ensure full embedment.
	Patient Safety Incident Review Framework (PSIRF) – Learning from Patient Safety incidents – 360 Assurance Audit Findings from the recent internal audit were presented, identifying limited assurance and high-impact actions needed to meet national standards, with a Trust-wide learning group and process improvements underway. Completion of actions has commenced with an end date of August 2026. The Committee accepted **limited assurance** on the quality and consistency of PSIRF processes in place within the Trust.
	Clinical Governance for Quality and Safety A working document outlining the clinical governance architect following the move from seven Divisions to two. was presented for consideration.

	Acknowledging feedback that the governance diagrams did not make clear the process for assurance to Board committees, revisions will be considered to ensure that assurance flows are easily understood and include clear connections between committees, operational groups and Trust Board. It was agreed that the document will be re submitted in May, once amendments have been made.
	Getting it Right First Time (GiRFT) **Significant assurance** was accepted on progress in the development of the Community Enhanced Rehabilitation team (CERT), including System working, the housing project, the use of data and the implementation of goal-based outcomes. The Committee supported the reinvestment of monies saved by reduction in length of stay and the repurposing of Cherry Tree Close into CERT to expand the community rehabilitation offer further.
	National Institute for Health and Care Excellence (NICE) guidance compliance A report outlining the Trust's processes for identify, reviewing and implementing NICE guidance and national quality standards was presented. NICE guidance is considered as part of routine clinical practice and sits within the Trust Quality Plan. The Trust's compliance was summarised outlining the importance of ensuring implementation of the guidance to improve clinical practice and meet compliance. Ongoing efforts to support services seeking accreditation were described. **Limited assurance** around the Trust's integration of NICE and national quality standards into usual practice was accepted and the integration of the NICE Steering Group into a wider clinical effectiveness meeting acknowledged.
	Patient Experience report (quarterly The report described the slow progress being made to increase Friends and Family Test responses, the introduction of a new platform, 'Patients Knows Best' to receive patient feedback and themes arising from complaints which relate to waiting times, cancellations and lack of diagnosis. Good progress is being made to increase timely responses and reduced complaint backlog, and the Trust's strong compliance with Ombudsman standards were noted. Co-production initiatives, carer champions and the triangle of care standards were also discussed. The Committee received **limited assurance** from the report noting complaint performance measures are required to understand progress and impact of actions
	Board visits – Themes and Findings (quarterly) The structure and outcomes of Board visits were highlighted, noting positive feedback, identification of workforce and operational pressures themes and the use of feedback to aid immediate improvements. The Committee acknowledged the need to include more support services in future visits and detailed the escalation and follow-up process for issues raised during visits. The Board visit programme provided **significant assurance** of effective oversight of quality, workforce and culture themes, and that identified issues are being appropriately escalated and monitored through established governance arrangements, including alignment with BAF Risk 1A.
	Care Planning/Person-Centred Care The Committee discussed the improvements across services. A comprehensive update on care planning compliance, noting sustained high levels across teams and improvements in recording and review processes. Challenges around triage and assessment were discussed, along with the transition from the Care Programme Approach (CPA) to the Personalised Care Framework, as national. The Committee agreed to receive quarterly reports. **Limited assurance** was accepted on the basis that practice needs to be maintained in all areas.
	Quality review – Kingfisher House, Psychiatric Intensive Care Unit (PICU) The Committee noted a detailed and thorough review highlighting compliance with set standards, areas for improvement and plans to repeat the review after one year of reopening. Collaborative consultation and alignment across services was emphasised.

	The establishment of the unit has gone well since opening operating within a complex clinical environment. The Committee received **limited assurance** that Kingfisher House is consistently delivering safe care due to ongoing risks relating to workforce sustainability, reliance on temporary staffing, high levels of violence and restrictive practice and variable adherence to PICU standards which require continued close oversight.
	Community Mental Health Patient Experience Survey – 2025 results and improvement plan The Committee received the annual survey results noting the Trust's feedback and areas for improvement across core service areas, particularly around compassion and respect and dignity, family involvement, therapy privacy and care planning. Support while waiting, care reviews, physical health support and employment support identified as areas that had declined. Plans to split survey results by Care Group and anticipated improvements in patient satisfaction through increased co-production were discussed. The paper provided **limited assurance** that actions directly linked to the Community Mental Health Survey have been taken to improve patient experience.
	Review of Quality and Safeguarding Committee Board Assurance Framework (BAF) Risks The Committee noted unchanged main risks, improved quality assurance and the need to update controls for new ICB (Integrated Care Board) clusters. Discussion covered ongoing risks related to dormitory eradication and regulatory compliance.
	Items for discussion at Board or other Committees: None. **Items added to the Board Assurance Framework:** None. **Next scheduled meeting:** 14 April 2026

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

People and Culture Committee – key assurance levels for items – 3 March 2026

	People and Inclusion Assurance Dashboard The expanded dashboard was reviewed by the Committee. The main points were: Mandatory Training: ongoing improvements were highlighted, with the exception of Resuscitation Level 3 Immediate Life Support (ILS), with a small working group addressing areas of non-compliance. Vacancies and Turnover: trends were detailed, along with improved exit interview compliance and the use of stay surveys at three, six and nine months. Themes around career progression were identified for further action. The cultural reviews, the University of Derby partnership and the 'A Kind Life' programme were summarised, noting changes in commissioning and the need for Divisional ownership of outcomes. It was noted that the metrics are triangulated with business partners to inform targeted interventions. Absence: a gradual improvement was reported with a focus on long-term absence. Supervision: ongoing data cleansing for supervision records, including system improvements to address inaccuracies was described. Technical issues with recording for staff on maternity or long-term sick leave were noted. Appraisal: rates were reported as strong, with all Divisions above 85%. Freedom to Speak Up (FTSU): a notable drop in cases was discussed, with previous spikes attributed to specific group concerns. The need to monitor trends and reporting periods for accurate interpretation was noted. **Significant assurance** was accepted on the progress shown for mandatory training, staff turnover, temporary staffing usage, annual appraisals and FTSU and **limited assurance** was received for vacancies and recruitment, attendance and absence and clinical supervision.
	Making Room for Dignity (MRfD) – Organisational Development (OD) Programme

	The Committee received an update on the OD culture programme, including progress on ward sessions, follow-up plans and the need for ongoing triangulation and assurance. It was confirmed that all wards except Oak Ward had completed the initial OD culture sessions, with six-month follow-ups scheduled. However, it was noted that a single day of intervention is insufficient for full assurance of cultural change. The use of triangulation, combining data from key performance indicators, feedback and cultural reviews to identify areas needing further intervention was discussed. It was agreed that oversight of leadership and culture issues should remain with the People and Culture Committee, while patient safety concerns should be escalated to the Quality and Safeguarding Committee. The Committee accepted **significant assurance** that delivery of the culture programme has identified the next steps action plan. **Limited assurance** was accepted on progression of the action plan.
	Making Room for Dignity (MRfD) – formal approval of Benefits Evaluation reports (Audrey House and Kingfisher Unit) The positive people outcomes were summarised, including improved baseline staffing and retention. High agency usage in some areas was linked to clinical acuity. The reports were approved by the Committee.
	Assurance on contracted services The report provided **significant assurance** on the contracts held with University Hospitals of Derby and Burton for Payroll and Occupational Health services. The transition of several services from the Joint Venture (JV) to service level agreements (SLAs) was outlined, with the planned exit from certain contracts, **Significant assurance** was accepted that further work is being undertaken to assess the risks, mitigations and financial analysis of the services provided through the JV. **Limited assurance** was received for the arrangements managed through the JV and SLAs with DCHS.
	Committee year-end Effectiveness report and annual review of Terms of Reference (ToRs) Having reviewed the activity carried out during 2025/26 the Committee was satisfied it had performed effectively throughout the year. Meetings had been well chaired and performed under clear and structured agendas that were supported with well-informed reports. The minor revisions to the ToRs were agreed.
	Director of People update Key points noted included: • Participation in the national survey for the new appraisal framework and confirmed implementation of the pay award for Agenda for Change staff, including related measures for Nursing staff • The Trust has been selected as an early adopter of the NHS workforce solution, with associated investment and upcoming webinars, anticipated improvements in talent management and e-learning systems • The launch of a Violence and Aggression Action Group, the structure of sessions and the involvement of frontline staff.
	10 Point Plan to improve the working lives of Resident Doctors The substantial progress made by the Trust was highlighted and included compliance with eight of the 10 points, with the remaining two relating to deanery-controlled processes (rotation and single employer arrangements) It was noted that whilst the plan addresses basic support and consistency for Resident Doctors, it has not prevented industrial action, which is influenced by broader national factors. **Significant assurance** was accepted on actions the Trust is able to influence.
	Temporary Staffing Workforce (Bank focus)

It was reported that bank usage accounts for 73% of temporary staffing, with reductions in agency spend exceeding national targets and most usage concentrated in inpatient wards due to vacancies, enhanced care and sickness.

Ongoing efficiency initiatives were described and included the roster efficiency programme and the introduction of smart match AI to fill unassigned shifts, with early results being monitored for effectiveness.

It was agreed that future reporting will include data on staff experience and complaints, related to temporary staffing, triangulated with the staff survey and hotspot information.

Recommendations included the need to ensure accurate categorisation of temporary staffing reasons (eg vacancies v acuity) and to confirm that all roster options are exhausted before bank or agency shifts are booked.

Equality, Diversity and Inclusion (EDI) Delivery Plan

It was highlighted that the Plan consolidates the Workforce Race Equality Standard, Workforce Disability Equality Standard and gender pay gap actions, with the EDI Working Group providing oversight.

The need to define a concise set of metrics to track progress was discussed, with plans to develop a dashboard and ensure alignment with the personal accountability charter. It was agreed for increased socialising of the plan with the Board for broader input and accountability.

Due to its priority status, it was noted that the Race Equality Delivery Plan is to be separate.

The Committee supported the EDI Plan and accepted **significant assurance** that there is one clear plan for the delivery of EDI priorities for 2026. Due to the infancy of the plan, **limited assurance** was accepted on delivery.

Staff Survey – Trust-wide results 2025

The report showed that while most scores had declined compared to the previous year, the organisation remains above comparator averages in key domains, with particular strengths in compassionate leadership and line management. Areas for improvement were noted to be compassionate culture and raising concerns.

Delays in Divisional reports from the external provider were highlighted, however assurance that these will be distributed to Divisions and teams week commencing 16 March was received.

Review of People and Culture Committee Board Assurance Framework (BAF) Risks

Plans to review the people elements of the BAF, improve cross-checking and ensure Divisional leaders are aware of the strategic risks and objectives were emphasised.

The need to address succession planning and update MRfD risks were suggested.

Items for discussion at Board or other Board Committees: None.

Items added to the Board Assurance Framework: None.

Next scheduled meeting: 29 April 2026.

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

Mental Health Act (MHA) Committee - key items discussed 12 March 2026

Mental Health Act (MHA) Operational Group – key highlights and summary report

This was the first version of the new highlight report, replacing the full minutes and action matrix that was previously submitted to the Committee. The aim is to focus on assurance and escalations rather than the whole operational update.

Key points noted were:

	• Recruitment to increase the pool of Associate Hospital Managers (AHMs) would help improve their availability for panels. • Agreement to expand the training report to cover all relevant mental health legislation. • Recognition of a drop in MHA-related audits; work underway to identify priority audits aligned to future MHA reforms. • Rising use of Section 136 detentions and increased demand for Mental Health Act. • Proposed changes to the MHA Operational Group Terms of Refence were agreed.
	MHA Committee year-end Effectiveness report and Annual Review of Terms of Reference The Committee discussed the Mental Health Act year-end effectiveness report and concluded that overall, the Committee had worked to its Terms of Reference and been effective during 2025/2026. Several changes were proposed to the Terms of Reference.
	MHA Compliance report This replaces the MHA Managers report, the distinction being the focus on assurance and escalation rather operational detail. Discussion focused on the non-compliance with Section 132 rights (reading of rights) which continues to be a concern, noting the new Care Groups would be reviewing this issue and other concerns raised in relation to paperwork, lapses and risks. The Committee agreed the heat maps supported as a clearer way of targeting action. It was noted that admissions of under 18s had been to the 136 suites, not the wards and would be supported by the CAMHS staff. The Committee accepted **limited assurance** regarding the reading of rights, particularly on Inpatient wards. Further escalation to the Trust delivery Group was requested.
	Training report There had been improvement in Safeguarding training but there were areas of under-performance. Future reports would be refined to ensure full coverage of MH portfolios. **Limited assurance** was accepted.
	Mental Health Act 2025 Some limited sections were now in force. Most changes were linked to the draft Code of Practice which was expected late 2026/early 2027 and there would be a phased implementation from 2028 onwards. The workforce implications (including increased tribunal demand) were highlighted. There was agreement that current governance arrangements are sufficient until implementation pace increases. A working group has been established to oversee the action plan for implementation.
	Patient and Carer Race Equality Framework (PCREF) The Committee is responsible for overseeing PCREF and an update was given on process so far and the next steps in the implementation of PCREF in the Trust. The recruitment of a PCREF lead was underway, the Steering Group established and the self-assessment nearing completion (target end of March 2026). PCREF had been added as a standing quarterly agenda item for this Committee. **Limited assurance** agreed due to early stage of implementation.
	Restrictive Practice Quality report The report showed progress with sustained reductions in physical restraint, prone restraint and chemical restraint and stable seclusion levels consistent with expected variation. Compliance with Positive and Safe training remains high but observation recording performance remains below the Trust target in some areas, this would be targeted for improvement. There was an agreement to strengthen future reporting to include repeat restraint/seclusion for individual patients, ethnicity data and physical health monitoring following chemical restraint. **Limited assurance** was accepted based on areas of underperformance for recording.
	Policy Review The Committee supported and approved the following policy: • Section 117 Aftercare Policy

	Extensions were agreed on the following policies, subject to confirmation they remain fit for purpose: • Section 135 Joint Policy • Deprivation of Liberty Safeguards • Mental Capacity Act.
	Escalations to Board or other Committees: None. **Items added to the Board Assurance Framework:** None. **Next scheduled meeting:** 4 June 2026.
Committee Chair: Deborah Good	**Executive Lead: Dr Girish Kunigiri, Medical Director**

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 24 March 2026

Making Room for Dignity – Post Project Evaluation reports

Purpose of Report

The attached post-project evaluation (PPE) reports for Carsington Unit, Kingfisher House, Audrey House to go through the Trust governance route to be issued for consideration and approval prior to NHSE submission.

Executive Summary

NHS England requires submission of a post-project evaluation (PPE) for each Public Dividend Capital (PDC) funded capital project, around six months after completion of construction. This is part of the Full Business Case (FBC) approval conditions. The purpose of the PPE is to learn and evaluate the effectiveness of the project in realising the proposed benefits, and to:

- Identify particular aspects of the project which have affected benefits either positively or negatively
- Capture and document any lessons learned - what went well and what lessons the project team would like to share with others and recommendations for future projects
- Provide examples of how services have improved for patients, staff and stakeholders
- Understand if there are any outstanding risks and issues once the project is operational.

The Carsington Unit has transformed Adult Acute Mental Healthcare in Derbyshire by providing 54 modern, single ensuite bedrooms, replacing outdated dormitory accommodation. The new facility enhances privacy, dignity and therapeutic outcomes for patients, while also supporting staff wellbeing and multi-disciplinary teamwork. Patients now benefit from improved environments, better access to outdoor and activity spaces, and care closer to home.

Audrey House delivers a dedicated, female Enhanced Care Unit with single ensuite bedrooms, sensory rooms and therapeutic spaces. This project has enabled more women to receive high-quality care locally, improved privacy and dignity and fostered a positive, collaborative culture among staff. The unit’s design was shaped by input from service users and staff, ensuring a safe, supportive and recovery-focused environment.

Kingfisher House introduced Derbyshire’s first local Psychiatric Intensive Care Unit, offering 14 single ensuite bedrooms in a secure, therapeutic setting. The project has reduced the need for out-of-area placements, strengthened family involvement and created a safer, more comfortable space for both patients and staff. The facility’s modern design and strong teamwork have set a new standard for intensive mental health care in the region.

Strategic Considerations		BAF Risk (eg 1A)	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X	**25-26 1E** There is a risk that the Trust does not deliver key regulatory and strategic requirements related to dormitory eradication and that the Trust estate is not maintained sufficiently well to comply with regulatory and legislative requirements	**3.3** Optimise our assets and enable resources to improve services and care
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 risk and issue management process during construction and go-live is covered in section 6 of the reports.

Consultation

The reports have been considered and approved by the Programme Overview Steering Group; Programme Committee; Finance and Performance Committee, People and Culture Committee and Quality and Safeguarding Committee.

Governance or Legal Issues

The reports include an explanation of the governance process for the Programme.

Net Zero Duty Implications

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

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

The new facilities were specifically designed to operate as close to ‘net zero’ as is currently possible – this includes moving away from fossil fuel sources and inclusion of relevant green technology (air source heat pumps, solar and PV panels) and use of ‘modern methods of construction’ to reduce emissions during the construction phase. Additionally, a key aim of the programme was to provide care for our patients closer to home and their communities, thereby delivering an additional environmental benefit of reducing travel and transportation related emissions.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

- Involvement of service users and EDI representation has helped ensure the Programme Delivery team considers inclusion risks and consider how best to take action to mitigate them
- Each project within the Programme has a detailed EQIA completed which has been reviewed and accepted by the JUCD EQIA panel with ongoing regular reviews scheduled.

Recommendations

The Board of Directors is requested to:

1. Consider and discuss the post project evaluation reports for Carsington Unit, Kingfisher House and Audrey House
2. Approve the submission of the reports to NHS England.

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

Post Project Evaluation

Purpose

A post-project evaluation (PPE) should be completed around six months after completion of construction for all capital projects. This is now required as part of the FBC approval conditions and should be completed for all capital projects that have completed.

The purpose of the post-project evaluation (PPE) is to learn and evaluate the effectiveness of the project in realising the proposed benefits, and to:

- Identify particular aspects of the project which have affected benefits either positively or negatively.
- Capture and document any lessons learned- what went well and what lessons the project team would like to share with others and recommendations for future projects.
- Provide examples of how services have improved for patients, staff and stakeholders.
- Understand if there are any outstanding risks and issues once the project is operational.

Please contact capitaldeliverypmo@dhsc.gov.uk if your team would like to discuss the PPE, or request any further documentation relating to the project.

PPE-EXECUTIVE SUMMARY

Project Name & Trust:	South Derbyshire 10 Bed Enhanced Care Unit at Kingsway Hospital (Audrey House Enhanced Care Unit) Derbyshire Healthcare NHS Foundation Trust		
Date commenced construction:	July 2023	**Date of completion:**	*17 July 2025*
Project Manager:	Sifo Dlamini		
Project Sponsor/ SRO & email address:	Project Sponsor: James Sabin, Director of Finance (james.sabin@nhs.net)		
PPE Author:	Monique Chavda	**Email address of Author:**	monique.chavda@wsp.com

Benefits realisation

1. Project overview

This section should provide a brief background about the project.

Audrey House is an 8-bed Female Enhanced Care Unit located at Kingsway Hospital, Derby, delivered by Derbyshire Healthcare NHS Foundation Trust (DHcFT). The service is designed for women who require a higher level of support and security than is available on an Acute mental health ward, but do not meet the criteria for Psychiatric Intensive Care Unit (PICU) admission.

Audrey House, originally a rehabilitation unit and part of a PFI estate, has been refurbished to meet the requirements of the Enhanced Care Unit. The scheme is a core element of the Trust's wider Dormitory Eradication Programme and will support the elimination of inappropriate out-of-area placements (OAPs), ensuring that women in acute mental health crisis can be cared for locally in a safe, single-sex environment

The facility will provide single bedrooms with en-suite bathrooms, therapeutic and de-escalation spaces, sensory rooms, and outdoor access, improving privacy, dignity, safety, and patient outcomes. Its design has been co-produced with service users, carers, and staff to align with NHS England priorities, CQC recommendations, and best practice guidance.

By introducing this facility, DHcFT aim to repatriate patients currently placed out of county, reduce the need for restrictive practices, and provide a calm, therapeutic environment that supports recovery and continuity of care within Derbyshire.

2. Assessment of Deliverables

This section should provide detail on what was delivered. The extent to which projected deliverables, as outlined in the FBC were delivered.

Deliverables

FBC Planned Deliverables	Achievement
Accommodation and Bedrooms - 8 single ensuite bedrooms, including accessible (disabled/bariatric) and sensory rooms, all anti-ligature	Refurbished Audrey House at Kingsway Hospital into an 8-bed female-only incorporated ensuite single rooms, accessible (disabled/bariatric) and sensory rooms, with anti-ligature fixtures.
Therapeutic and Clinical Facilities – De-escalation suite, tribunal suite, therapy/activity spaces, family therapy suite, ADL kitchen, laundry, physiotherapy suite.	Designed and fitted dedicated de-escalation suite, tribunal suite, therapy/activity areas, family therapy suite, ADL kitchen, laundry and physiotherapy suite, aligned with national guidance and patient safety standards.
Patient and Visitor Spaces – Dedicated entrance and reception, multi-faith room, visitor areas (including child-friendly), lounges, dining spaces, and beverage points.	Created dedicated entrance/reception, multi-faith room, visitor and child-friendly spaces, plus day lounges, dining areas and beverage points to support dignity, privacy and inclusion.

FBC Planned Deliverables	Achievement
Outdoor and Recovery Spaces – Secure gardens, seclusion garden, and direct outdoor access for therapy and activity.	Integrated secure gardens, seclusion garden, and direct outdoor access to activity/therapy spaces, ensuring safe recovery environments.
Infrastructure and Sustainability – Energy efficient design, environmental controls, natural light/ventilation, and digital infrastructure upgrades.	Delivered energy-efficient systems (LED, efficient heating/cooling), environmental controls in rooms, maximised natural light/ventilation, and upgraded digital infrastructure.
Equipment and Handover – Costed clinical equipment schedule (Group 2 & 3), procurement, and completion-ready refurbished 8-bed unit for clinical use.	Developed a costed clinical equipment schedule (Groups 2 & 3), procured required items, and delivered a refurbished unit for service use.

Outcomes

The table below provides a high-level list of outcomes:

Outcomes	Achievement
Patient Care and Experience	Reduces the number of out-of-area placements for female patients who require an enhanced care facility and provides care closer to home and family; improves privacy, dignity and safety through single ensuite rooms; dedicated therapeutic and recovery spaces enhance patient experience.
Clinical Quality and Safety	Safer environment with anti-ligature fixtures; enhanced seclusion and de-escalation spaces; improved infection control; better staff visibility and monitoring.
System Impact and Service Pathways	Strengthens local acute care pathway by adding an enhanced care service between acute wards and PICU; reduces escalation to PICU; integrates with Kingsway's campus model alongside other services.
Financial and Resource Efficiency	Reduces spending on out-of-area placements and patient transport; improves value-for-money by repurposing existing estate; new unit funded from national capital and ICS-supported revenue.
Workforce and Organisational Development	Provides opportunities for new roles, specialist training and staff retention through improved environment; cultural and organisational change aligned with Trust's People & Inclusion priorities.
Estate and Sustainability	Replaces dormitory-style accommodation with modern, sustainable design; contributes to backlog reduction and aligns with NHS Net Zero goals.

Strategic Objectives (Project Investment Objectives)

Intended Strategic Objectives	Achievement
1) To repatriate and eliminate inappropriate female out of area placements: with development of a local Acute-Plus facility at Kingsway Hospital, with detailed design and business case development meeting target at April 2022 to enable construction to commence October 2022 refurbished by the PFI SPV contractors to the DHcFT-developed specification, and to achieve project completion through this investment by May 2023. (Whilst Acute-Plus service will not commence until November 2024, the building will be utilised as a decant facility in the interim to enable completion of the acute dormitory eradication programme.)	The Audrey House Enhanced Care Unit at Kingsway Hospital has been successfully refurbished and is now fully operational. Female patients who previously required out-of-area placements are now being cared for locally, closer to their families and support networks. The Trust worked with relevant teams to deliver the refurbishment to specification, creating a safe, modern, purpose-built environment.
2) To enhance privacy, dignity and safety for patients by: providing single sex ward (female only) with single bedroom and ensuite, based on similar scheme at Atherleigh Park MH Unit with detailed design and business case development meeting target at April 2022 to enable construction to commence July 2022 to achieve project completion through this investment by May 2023.	The Trust has delivered a female-only unit comprising 8 single ensuite bedrooms, each designed to modern safety standards and fully anti-ligature. Patients now benefit from improved privacy, dignity, and personal space, supported by therapeutic areas, de-escalation facilities, sensory rooms, and secure outdoor space. The new environment has transformed patient experience, creating a safe and dignified setting for recovery.

3. Financial management

Compare the planned costs with actuals, including identify any outstanding financial issues, such as excess funds, and how they will be handled.

The total capital approved for Audrey House Enhanced Care Unit at FBC stage in March 2023 was £3.99m. The refurbishment was completed and the unit opened in July 2025 at the capital level approved in March 2023.

	Planned	Actual	Variance
Budget	£3.99m	£3.99m	Nil
Schedule	November 2024	July 2025	8-months later than planned. Due to: ▪ National PDC approval 6-months later than planned ▪ 4-months delay due to additional works required by the nominated building control officer.
Scope	8 single ensuite bedrooms, including accessible and sensory rooms, all with anti-ligature fixtures. Therapeutic and Clinical Facilities – De-escalation suite, therapy/activity spaces, family therapy suite, ADL kitchen, laundry, therapy suite, lounges, dining spaces, and beverage points. Secure gardens, seclusion garden, and direct outdoor access for therapy and activity.	8 single ensuite bedrooms, including accessible and sensory rooms, all with anti-ligature fixtures. Therapeutic and Clinical Facilities – De-escalation suite, therapy/activity spaces, family therapy suite, ADL kitchen, laundry, therapy suite, lounges, dining spaces, and beverage points. Secure gardens, seclusion garden, and direct outdoor access for therapy and activity.	Not applicable

3a-Has the investment had an impact on backlog maintenance, and if so, how much by risk category has been eradicated as a result of this investment?
The refurbishment of Audrey House into the Enhanced Care Unit has had a positive impact on the Trust's overall backlog maintenance position. While backlog is not formally recorded against PFI estate (as lifecycle obligations ensure it is maintained to agreed standards), the investment effectively improved the condition of this building. Through the comprehensive refurbishment, any emerging risks within Audrey House have been addressed. The investment has therefore strengthened the Trust's overall estate condition profile, ensuring compliance with regulatory standards and reducing future maintenance liabilities

3b- Please outline the backlog issues faced and how they were impacting on safe, efficient and effective clinical care. How reducing the level of backlog has helped to deliver wider qualitative benefits?

Before refurbishment, Audrey House reflected the limitations of an older design, with layouts less suited to modern clinical practice and some facilities not optimised for patient privacy, observation or infection control. While these were managed under the PFI contract, they presented practical challenges for delivering care as efficiently and effectively as possible.

The refurbishment has addressed these issues by creating a modern, fit-for-purpose Enhanced Care Unit. The upgraded environment now supports:

- Safer care, through anti-ligature fittings and improved observation lines.
- Greater privacy and dignity, with single ensuite bedrooms.
- A more therapeutic and recovery-focused setting, with access to outdoor and activity spaces.
- More efficient working conditions for staff, reducing environmental barriers to care.

The investment has not only minimised potential backlog concerns but also delivered wider qualitative benefits that improve safety, patient experience, and service efficiency.

4. Assessment of Benefits as identified in the Full Business Cases
This section should set out whether the project achieved its planned objectives. Please provide evidence of:

- how the project preformed relative to the FBC (benefits realized, benefits not realized and any dis-benefits
- full detail of the benefits identified, quantified and realised to date (both cash and non-cash releasing). Please include as annexures: n up to date benefits register and the register of disbenefits
- Details of the Post Implementation Review
- How the benefits are embedded within common business process and operations, and whether the correct processes are in place to ensure benefits continue to be realised
- corrective action plans to address any benefits that have not been released on schedule
- forecast future benefits

How the project performed relative to the FBC (benefits realised, not realised, and any dis-benefits)

The initial post-implementation review of benefits realisation has shown the project has delivered on the investment objectives set out in the Full Business Case (FBC), with a record of benefits realisation across patient care, workforce, and financial efficiency. The full benefits realisation plan which includes information on cash and non-cash releasing benefits is to follow once complete

Benefits realised include:

- Accommodation and Bedrooms - 8 single ensuite bedrooms, including accessible (disabled/bariatric) and sensory rooms, with all anti-ligature fittings.
- Therapeutic and Clinical Facilities – De-escalation suite, tribunal suite, therapy/activity spaces, family therapy suite, ADL kitchen, laundry, and therapy suite aligned with national guidance and patient safety standards.
- Patient and Visitor Spaces – Dedicated entrance and reception, multi-faith room, visitor areas (including child-friendly), lounges, dining spaces, and beverage points.
- Outdoor and Recovery Spaces – Secure gardens, seclusion garden, and direct outdoor access for therapy and activity.
- Infrastructure and Sustainability – Energy efficient design, environmental controls in rooms, maximised natural light/ventilation, and upgraded digital infrastructure.

Dis-benefits:

- Significant difficulties were encountered with agreeing additional works required by the building control officer, this led to many months of delays with opening the unit, and the requirement to reschedule the opening date several times.

How the benefits are embedded within common business processes and operations

- Business-as-Usual Integration: Audrey House Enhanced Care Unit is now embedded in the Trust's operational framework, subject to standard assurance and performance monitoring.
- Workforce Development: Organisational development programmes support staff retention and culture.
- Performance Monitoring: Benefits are tracked through regular data collection, highlight reports, and operational dashboards.

Forecast future benefits

Looking forward, the Audrey House Unit aims to continue delivering value through:

- Sustained reductions in out of area placements with full elimination of inappropriate out of area placements planned by the end of the first operational year.
- Enhanced recruitment and retention driven by the high-quality environment and positive staff culture.

5. Change management

This section should provide detail on change management as set out in the FCB, including whether the change management and transition plan was successfully implemented.

The Full Business Case (FBC) set out a clear change management and transition approach, recognising that the move from dormitory-style accommodation to new, purpose-built facilities represented a significant cultural and operational transformation. The intention was to deliver change across several domains:

- Organisational and workforce transformation – ensuring sufficient staffing levels through recruitment pipelines, workforce redesign, and retention initiatives.
- Culture change – embedding trauma-informed and least restrictive models of care, with an emphasis on dignity, privacy, and sensory-sensitive environments.
- Training and development – equipping staff with the skills needed to work in new environments and within a revised model of care.
- Engagement and communication – involving patients, carers, and staff in shaping the design and transition, ensuring ownership and inclusivity.

These ambitions were reinforced in subsequent planning and funding documents, in particular the HEE funding request (2023), which provided additional investment to deliver the workforce transformation detailed in the FBC. The funding supported increased nurse apprenticeship places, practice facilitators, and administrative support for the delivery of training programmes, as well as embedding patient and carer voices at the centre of the programme through expert-by-experience roles and reference groups.

The majority of these ambitions were achieved, though not always in the form originally planned. The establishment of a Clinical Reference Group (CRG) ensured that principles of trauma-informed and sensory care informed all design decisions, from ward layouts to light fittings.

Workforce transformation proved more complex than anticipated. The FBC had assumed internal capacity for recruitment and training, but in practice, additional bids (such as the HEE request) were necessary to secure the resources needed. As described in the model of care training could not be fully delivered prior to opening, and staff in post were required to continue training new colleagues, resource pressures not foreseen in the FBC.

The table below highlights how change management was intended and delivered:

Theme	Intention (FBC)	Adjustment (HEE funding request, 2023)	Reality
Workforce transformation	Recruit and retain sufficient staff to safely operate the new specialist service.	Requested funding for additional nursing apprenticeships, practice facilitators, and admin support to sustain recruitment and training	Recruitment was more difficult than anticipated, however, the 54.96 wte new staff were fully recruited.
Culture change	Embed trauma-informed, least restrictive, sensory-	Emphasis on inclusivity and dignity, e.g., ensuite door dignity innovations,	Successfully achieved: CRG ensured all design decisions (lights,

	sensitive care across all new builds.	service-user led design features.	flooring, fittings) aligned with trauma-informed principles.
Training & development	Deliver model of care training; workforce for new environments.	HEE request sought funding to expand training capacity, apprenticeships, and practice facilitation to ensure readiness.	Training was fully completed before opening.
Transition & move	Smooth, well-planned repatriation of service users into new facilities.	Recruitment campaigns and staff engagement sessions planned to prepare the workforce.	Repatriation of service users from out of area placements was carefully planned and phased.

Construction and Build
The Full Business Case (FBC) placed considerable emphasis on ensuring that construction was managed through robust change control and governance arrangements. Audrey House is a PFI building and the Special Purpose Vehicle (SPV), Arden Partnership, has first option on carrying out the works and has opted to take up this option under a Variation Order.

The Trust supported a formal change control procedures to prevent unplanned cost escalation. Risks were identified in a joint risk allocation matrix, with construction risks primarily held by the contractor and transition risks shared with the Trust. These risks were reviewed regularly through programme governance structures, supported by external technical advisers and a dedicated Project Delivery Team to provide oversight, integration, and cost assurance.

In addition to cost and risk management, the FBC highlighted the importance of stakeholder engagement in construction decisions. Clinical Reference Groups and staff design workshops were built into the governance framework to ensure that ward layouts, ensuite designs, infection control, fire safety and sensory-sensitive features were clinically informed. The building was also required to align with the Trust's Green Plan, with a commitment to sustainability measures such as recycled materials, and reduced landfill.

Lessons learned included the importance of early use of design visualisation tools (e.g., 3D modelling or virtual walkthroughs) to help clinical teams to better understand the designs, and stronger integration between clinical and estates perspectives.

Overall
The change management and transition plan was successfully implemented, but the process was more adaptive and resource-intensive than envisaged in the FBC. The intentions (FBC), resource adjustments (HEE funding request), and practical realities together demonstrate that while the programme achieved its key aims, improved environments, embedded culture change, and better patient experience — these outcomes required iterative delivery, some additional funding, and lessons learned in governance and workforce planning.

6. Risk & issue management

Identify any outstanding issues and any risks which will transfer to the operational area(s) and who has responsibility for monitoring them.

Construction
The Audrey House Unit opened with no build-related issues that transferred from the project team to the operational / business as usual team.

Construction-related matters are formally reported via Micad, the Trust's estates logging system. This provides a transparent and auditable record of all issues raised, in line with governance and assurance requirements. Each submission is formally assessed and allocated to the appropriate responsible party, either the Trust's Estates Team (for maintenance matters within the Trust's remit) or the PFI provider (for defect-related or build-quality concerns). This allocation process establishes clear accountability and ensures that all matters are managed within defined lines of responsibility. Risks and issues are managed as per the agreed PFI contract agreements.

This governance framework ensures that both operational and construction-related issues are addressed in a structured, transparent, and accountable manner. It supports assurance from the Trust Board and relevant committees that the transition to the new facility is being managed effectively, risks are being mitigated, and patient care and safety remain safeguarded throughout the operational phase.

Operational
Audrey House opened with no operational issues. Inevitably, there is likely to be operational issues as the building moves further into business as usual. Operational issues arising within the building during its live phase are systematically reviewed and addressed in collaboration with clinical teams through the established post-move meeting process. These meetings provide a structured mechanism for capturing feedback, monitoring the impact of the transition to new facilities, and ensuring that any risks to service delivery, patient safety, or staff wellbeing are identified, prioritised, and mitigated in a timely manner. The area service manager is responsible for managing any clinical risks that occur in "business as usual" phase.

7. How has the project transitioned from being a project to a business-as-usual function, or if it is not an ongoing service, how the project has been closed down.

The project has now successfully transitioned from project handover go-live/business as usual. This transition was managed through a structured handover process, ensuring that all operational responsibilities, risks, and controls are embedded within the Trust's existing governance arrangements. Ownership has formally transferred to the relevant service and operational leads, who are accountable for ongoing delivery and performance.

Key elements of the transition have included:

Operational Handover: Core processes, workflows, and reporting arrangements have been integrated into the Unit and ward's standard operating procedures. Clinical teams are now leading

service delivery, supported by the Estates and Facilities Team and corporate functions as appropriate.

Issue and Risk Management: All residual risks and outstanding actions identified during the project have been captured, logged and mitigated. Construction-related defects and technical issues are managed via Mica and reviewed regularly with contractors and Estates, while operational issues are addressed through directorate governance structures.

Training and Capacity Building: Staff have received training on revised processes, systems, and escalation pathways. Induction materials have been updated to ensure new staff are supported, embedding resilience into long-term operations.

Sustainability and Continuous Improvement: A framework for continuous review has been established, ensuring that feedback from service users and staff informs ongoing refinements. Lessons learned from the project have been documented and shared to strengthen future capital and service transformation initiatives.

Governance: The MRfD programme governance has transitioned from the programme governance structure to BAU. With the Project workstream meetings moving to Post Occupancy management meeting to track and monitor defects, issues.

The service is now considered part of routine operational delivery, fully embedded within the Trust's business-as-usual structures, and subject to the same assurance and performance frameworks as other core services.

8. Has the investment added any additional capacity? If so, please give specific details & numbers.
The build has provided 8 female enhanced care beds which were previously not available to the Trust. This has been strengthened the service offering through the establishment of Audrey House Unit as a dedicated specialist environment, ensuring this patient group receives care that is local, more appropriate, safe and tailored to their needs.

9.Lessons Learnt review

The following outlines the key lessons learnt for the Audrey House project:

Design

Early involvement of clinical teams in the design phase ensures that environments are safe, functional, and patient-centred. Future projects can benefit from continuous feedback loops between design, estates, and clinical staff to refine layouts and address potential operational challenges before opening.

Construction

Close collaboration between estates and clinical teams during the build phase leads to swift issue resolution and ensures the facility is ready for occupation. Establishing clear communication channels and testing systems (like doors, alarms, and IT) well in advance of opening supports a smoother handover.

Clinical Environment

A well-integrated multidisciplinary team contributes significantly to creating a positive and therapeutic environment. Ongoing reflection, shared learning, and inclusion of diverse professional roles such as psychology and speech and language therapy help tailor the service model to patient needs.

Operational Readiness
Thorough preparation and early engagement across all departments are key to ensuring readiness. Future projects should plan structured briefings, simulations, and clear communication to improve staff confidence and minimise last-minute pressures. Flexibility and teamwork were major strengths that ensured a successful launch despite challenges.

Finance and Contracting
Transparent communication around financial drivers and contract arrangements helps teams understand project priorities and timelines. Embedding learning from procurement and equipment supply challenges.

Workforce
Staff commitment, adaptability, and collaboration were instrumental in delivering safe patient care under pressure. Investing in team-building activities, clear role definitions, and timely communication from senior leaders will further strengthen morale and cohesion during future service developments.

b) Provide examples of how services have improved for patients, staff and stakeholders

For Patients:

- The safe and timely admission of patients to Audrey House helped reduce out-of-area placements, enabling individuals to receive care closer to home and within familiar clinical teams.
- The introduction of a multidisciplinary approach, including psychology, occupational therapy, dietetics, and speech and language therapy, has enhanced the quality and range of therapeutic input available.
- The development of a clearer, evolving clinical model ensures that patient care is increasingly tailored to individual needs, supporting better recovery outcomes.

For Staff:

- Staff collaboration across different wards during and after the move has strengthened teamwork, communication, and understanding of shared roles.
- The unified team now works more cohesively, with improved referral management and reflective practice sessions helping to embed learning and professional growth.
- The flexibility and adaptability demonstrated during the opening have fostered resilience and confidence, supporting staff development and a stronger sense of purpose.

For Stakeholders:

- The project has demonstrated organisational agility and the ability to respond swiftly to service pressures while maintaining patient safety and quality.
- Close cooperation between estates, IT, and clinical services has improved problem-solving processes and responsiveness to operational challenges.

- Lessons learned from Audrey House are informing future planning, improving communication pathways, and strengthening governance for upcoming service developments.

10. Did this project set any net zero targets? If so, where the targets met and has any reduction been recorded.

The refurbishment of the Audrey House constitutes low level refurbishment and only minor reconfiguration or adaption to building fabric and therefore BREEAM is not applicable.

11. Provide any key recommendations to ensure that project lessons are learned, shared and implemented to benefit future project delivery.

Ensure Guaranteed Maximum Price is contractually secured rather than rely on inflationary protection clauses in the contract. Ensure full and ongoing engagement of clinical teams within the design process utilising design visualisation tools (e.g. 3D modelling or virtual walkthroughs) to ensure understanding of exactly what is being constructed, with visits enabled through the construction period to maintain morale and engagement. Necessity for late changes in design creates significant delay and additional costs. Robust pre-handover testing of all systems, doors, alarms and fittings is vital to avoid disruption once the building is occupied. Comprehensive aftercare agreements with sub-contractors need to be secured to minimise operational disruption. Detailed relocation plans on the day move ensuring each member of staff is clear on their individual role pre, during and post move.

12. Top 5 lessons learned

1. **Early and Consistent Communication is Essential**

Clear, direct, and timely communication between senior leaders, project teams, and frontline staff builds confidence, reduces uncertainty, and ensures everyone is informed and engaged throughout all stages of delivery.

2. **Collaborative Teamworking Drives Success**

The flexibility and commitment shown by staff across disciplines were key strengths. Future projects should continue to empower teams to work collaboratively and share ownership of outcomes.

3. **Thorough Operational Readiness Planning is Critical**

Early testing of systems, equipment, and logistics—combined with realistic timelines—prevents last-minute pressures and ensures safe, well-coordinated openings.

4. Strong Clinical Involvement Enhances Service Design

Involving clinical staff from the outset helps shape environments and models of care that are patient-centred, practical, and sustainable, improving the overall quality of service delivery.

5. Continuous Learning Strengthens Future Projects

Embedding reflective practice, capturing lessons as they occur, and sharing them across the organisation ensures continuous improvement and supports smoother delivery in future developments.

13. List of any annexures provided

Annex	Description
Not applicable	

Please contact capitaldeliverypmo@dhsc.gov.uk if your team would like to discuss the PPE, or request any further documentation relating to the project.

Post Project Evaluation

Purpose

A post-project evaluation (PPE) should be completed around six months after completion of construction for all capital projects. This is now required as part of the FBC approval conditions and should be completed for all capital projects that have completed.

The purpose of the post-project evaluation (PPE) is to learn and evaluate the effectiveness of the project in realising the proposed benefits, and to:

- Identify particular aspects of the project which have affected benefits either positively or negatively.
- Capture and document any lessons learned- what went well and what lessons the project team would like to share with others and recommendations for future projects.
- Provide examples of how services have improved for patients, staff and stakeholders.
- Understand if there are any outstanding risks and issues once the project is operational.

Please contact capitaldeliverypmo@dhsc.gov.uk if your team would like to discuss the PPE or request any further documentation relating to the project.

PPE-EXECUTIVE SUMMARY

Project Name & Trust:	South Derbyshire 54 Bed Adult Acute Mental Health Facility at Kingsway Hospital (Carsington Unit) Derbyshire Healthcare NHS Foundation Trust		
Date commenced construction:	November 2022	**Date of completion:**	*28/05/2025*
Project Manager:	Sifo Dlamini and Nicole Ellis		
Project Sponsor/ SRO & email address:	Project Sponsor: James Sabin, Director of Finance (james.sabin@nhs.net)		
PPE Author:	Monique Chavda	**Email address of Author:**	Monique.chavda@wsp.com

Benefits realisation

1. Project overview

This section should provide a brief background about the project.

The Carsington Unit is a newly constructed 54-bed adult acute mental health facility located on the Kingsway Hospital site in Derby. It forms a central part of Derbyshire Healthcare NHS Foundation Trust's "Making Room for Dignity" (MRfD) programme, which aims to eliminate dormitory-style accommodation and modernise inpatient mental health services across the county.

The Carsington Unit comprises three wards, Dove, Robin, and Wren, each offering 18 single, en-suite bedrooms for adults of working age. The facility is purpose-built to enhance privacy, dignity, and therapeutic outcomes, aligning with national NHS England and Care Quality Commission (CQC) standards for inpatient mental health care.

The MRfD programme was initiated in response to national directives to eradicate shared dormitory accommodation in mental health settings. Derbyshire had one of the highest proportions of dormitory-style wards in the country, with 118 out of 154 service users sharing four- or five-bed dormitories. The Carsington Unit replaces outdated facilities at the Radbourne Unit, providing a modern, safe, and therapeutic environment.

The Carsington Unit is integrated into the Trust's wider acute care pathway, supporting the relocation of male patients from the Radbourne Unit. It complements other MRfD developments, including the Derwent Unit in Chesterfield, Kingfisher House PICU on the Kingsway site and the refurbishment of Audrey House Enhanced Care Unit.

2. Assessment of Deliverables

This section should provide detail on what was delivered. The extent to which projected deliverables, as outlined in the FBC were delivered.

Deliverables

FBC Planned Deliverables	Achievement
54-bed Adult Acute Mental Health Facility at Kingsway	New-build development funded via NHS Dormitory Eradication Programme and Trust capital. Designed and delivered under the Procure22 framework with IHP as Principal Supply Chain Partner.
Three single-sex wards (18 single ensuite bedrooms each)	The recommended size for an acute ward is 15 beds; however, HBN technical guidance states where needed ward areas can be up to 18 beds, which has been utilised to calculate safe staffing levels. The ratio that is recommended is a 1:8 or preferably a 1:6 ratio of registrants for mental health staffing, therefore the Trust profiled three registrants for 18 beds in line with safer staffing guidelines.
Section 136 Suite, Shared Therapy Suite, Tribunal Suite, Reception/Admin areas	Incorporated into the building design brief and schedule of accommodation; included as essential spaces in the design feasibility and business case.

FBC Planned Deliverables	Achievement
Eradication of 54 dormitory beds from Radbourne Unit	54 single ensuite rooms provided in Carsington Unit at Kingsway. Separate scheme to refurbish remaining 2-wards (17-bed each) ongoing at Radbourne Unit.
Dormitory Eradication Programme requirements. Improved privacy and dignity (1:1 ensuite ratio)	Provided single ensuite bedrooms for patients instead of dormitory-style accommodation
Safer ward layouts and improved observation	The new facilities are CQC compliant with improved observations due to the building design anti-ligature measures.
Therapeutic and social spaces, including outdoor access.	Designed into the unit through therapy suites, social areas, and outdoor access from each ward, aligned to patient recovery needs.
Reduction in average length of stay	By providing fit-for-purpose facilities, better care pathways, and improved therapeutic environments that support faster recovery. Trend data on length of stay is still emerging and currently variable in the first 3-months post-opening.
Elimination of inappropriate out-of-area placements	Local capacity through the new unit, together with extensive work to improve care pathways and the model of care, will reduce the need for out-of-area placements, improving patient experience and supporting care closer to home. The trend for out of area placements has been consistently reducing in the first 3-months post opening.
BREEAM Excellent accreditation	Delivered through sustainable building design, energy efficiency measures, and meeting NHS sustainability/green plan requirements. The building is currently assessed as BREEAM 'very good' during construction and on track for BREEAM 'excellent' rating on final feedback due November 2025.
NHS Net Zero Carbon compliance	Adoption of energy-efficient systems, low/zero carbon technologies, and modern construction methods.
Modern Methods of Construction (MMC)	Integrated into the build to improve quality, reduce time and cost, and support sustainability targets.

Outcomes

This table provides a high-level outcome, for a detailed review of outcomes see the benefits section

Intended Outcomes	Achievement
All dormitory-style accommodation eliminated for 54 patients	Replacement of outdated shared dormitories with 54 single ensuite rooms at the Carsington Unit, Kingsway Hospital.
Every inpatient has privacy, dignity, and personal space	1:1 ensuite ratio and modern ward design ensures no patient shares bathroom facilities.
Improved therapeutic experience	Purpose-built therapy spaces, social areas, and outdoor access give patients greater choice and control in their recovery.
Reduced average length of stay to national benchmark	Better environments and clinical pathways enable quicker recovery and discharge. Trend data on length of stay is still emerging and currently variable in the first 3-months post-opening.
Reduce out-of-area placements	Local capacity through the new unit, ensures Derbyshire residents can be cared for within local services. Following the opening of the unit and extensive work to improve care pathways and the model of care, the trend for out of area placements has been consistently reducing in the first 3-months post opening.
Better patient outcomes and wellbeing.	Integrated care pathways and improved therapeutic environments support faster, more sustainable recovery.
Improved CQC compliance and regulatory assurance	Facility meets privacy, dignity, safety, and infection control standards. The new facilities are CQC compliant.
Staff retention and morale improved	Safer, modern, purpose-built environment reduces workplace stress and improves job satisfaction.
Local health system strengthened	Reduction in costly OOA placements, improved bed flow, and alignment with Joined Up Care Derbyshire strategy.
Contribution to environmental sustainability	The building is currently assessed as BREEAM ‘very good’ during construction and on track for BREEAM ‘excellent’ rating on final feedback due November 2025, reducing long-term environmental impact.
Confidence in future service model	Establishment of a sustainable two-site inpatient model in Southern Derbyshire.

Strategic Objectives (Project Investment Objectives)

Intended Strategic Objectives	Achievement
Investment Objective 1 - To eradicate 54 of the 63 dormitory beds currently at the Radbourne Unit: (Eradication of remaining dormitory beds and their bed re-modelling at Radbourne Unit is via a refurbishment programme outside the scope of this FBC and currently on hold pending funding availability) to provide all single ensuite bedrooms in the proposed new build in Derby, with design and business case development meeting the target of April 2022 to enable construction to commence September 2022 based on similar scheme at Farnham Road Hospital Redevelopment in Surrey, and PSCP confidence in the construction programme to achieve project completion through this investment by March 2024.	The Carsington Unit has delivered 54 single ensuite bedrooms in three 18-bed wards. The business case and design milestones were achieved in line with the programme, approval of the FBC was later than planned and construction commenced 3-months late in November 2022. The unit opened May 2025, 13-months later than planned in the FBC due to 3-months: ▪ National FBC approval later than planned ▪ 3-month value engineering delay to redesign foundations ▪ 2-months lost to bad weather in 2023 ▪ 3-months delay for additional CQC and S136 redesign in 2024 ▪ 2-month delay due to rectification of defect with ensuite shower floors.
Investment Objective 2 - To enhance privacy, dignity, safety and experience for patients by: increasing the current ratio of bedroom to shared bath/shower from 4:1 to 1:1 and the current ratio of bedroom to WCs from 4:2 to 1:1, with design and business case development meeting the target of April 2022 to enable construction to commence September 2022 based on similar scheme at Farnham Road Hospital Redevelopment in Surrey, and PSCP confidence in the construction programme to achieve project completion through this investment by March 2024.	Privacy and dignity were enhanced through provision of all single ensuite bedrooms, eliminating shared bath/shower and toilet facilities. Ratios were achieved at 1:1 for both bathrooms and WCs. The facility design and build programme was delivered successfully, with overall completion achieved in May 2025 due to a number of delays outlined above.
Investment Objective 3 - To improve the acute service delivery pathway and patient outcomes by: targeting DCHFT average length of stay (LOS) to national average LOS and elimination of inappropriate 'out of area' (OOA) placements for adult acute service users, with achievement of the average LOS in line with NHS Long Term Plan, and elimination of inappropriate OOA placements, by the end of the first operational year, 31st March 2025.	The new facilities and reconfigured care pathways are in place to support reductions in length of the national average, with improved discharge planning and therapeutic environment. Extensive work to improve care pathways and the model of care, will reduce the need for out-of-area placements, improving patient experience and supporting care closer to home, with full elimination of inappropriate

Intended Strategic Objectives	Achievement
	out of area placements planned by the end of the first operational year (May 2026).

3. Financial management

Compare the planned costs with actuals, including identify any outstanding financial issues, such as excess funds, and how they will be handled.

The total capital approved at FBC stage was £48.6m, this included an expected zero-rated VAT claim (value £7.1m) which was successfully achieved in 2024. An additional £0.55m was approved from Trust capital / CDEL in April 2024 to account for X1 clause inflationary pressures and weather delays, and a final £1.7m in March 2025 from Trust capital / CDEL to fund the remaining inflationary pressures (total X1 costs for Carsington Unit and Kingfisher House £2.76m) and additional works relating to CQC recommendations and S136 suite redesign. The total outturn cost of the Carsington unit was £50.8m.

	Planned	Actual	Variance
Budget	£48.6m	£50.8m	£2.2m
Schedule	April 2024	May 2025	13 – months later than planned. Due to: ▪ 3-months: National FBC approval later than planned ▪ 3-month value engineering delay to redesign foundations ▪ 2-months lost to bad weather in 2023 ▪ 3-months delay for additional CQC and S136 redesign in 2024 ▪ 2-month delay due to rectification of defect with ensuite shower floors.
Scope	54-bed new build, 3-wards, all single ensuite bedrooms. Access to outdoor space. S136 suite + therapy rooms. Piled foundation.	54-bed new build, 3-wards, all single ensuite bedrooms. Access to outdoor space. S136 suite + therapy rooms. Slab foundation.	Change of foundation to achieve £1m value engineering saving. Incorporation of additional CQC requirements following visit to existing units. S136 redesign.

3a-Has the investment had an impact on backlog maintenance, and if so, how much by risk category has been eradicated as a result of this investment?
The investment in the Carsington Unit has had an impact on backlog maintenance by enabling the relocation of patients from Wards 33 and 35 at the Radbourne Unit. This transition has reduced the demand on older facilities which has backlog maintenance. The vacated wards remain part of the Trust's property portfolio and, following a decision on their future use, a programme of refurbishment will be undertaken to ensure they continue to add value and an objective to reduce backlog maintenance.

3b- Please outline the backlog issues faced and how they were impacting on safe, efficient and effective clinical care. How reducing the level of backlog has helped to deliver wider qualitative benefits?
The development of the Carsington Unit has provided modern, fit-for-purpose facilities designed to support the highest standards of safe, efficient and effective clinical care. The relocation of services into this new environment has allowed clinical teams to work within spaces that are easier to maintain and more adaptable to patient needs.

- Reducing reliance on areas previously subject to backlog has supported wider qualitative benefits, including:
- Purpose-built facilities that enhance patient safety and wellbeing.
- Improved efficiency through modern layouts that support clinical delivery.
- A therapeutic environment that promotes dignity and recovery.
- Increased staff satisfaction and retention through access to high-quality working environments.

This investment demonstrates the Trust's commitment to providing high-quality care in modern, sustainable facilities while ensuring long-term value from its estate.

4. Assessment of Benefits as identified in the Full Business Cases
This section should set out whether the project achieved its planned objectives. Please provide evidence of:

- how the project preformed relative to the FBC (benefits realized, benefits not realized and any dis-benefits
- full detail of the benefits identified, quantified and realised to date (both cash and non-cash releasing). Please include as annexures: n up to date benefits register and the register of disbenefits
- Details of the Post Implementation Review
- How the benefits are embedded within common business process and operations, and whether the correct processes are in place to ensure benefits continue to be realised
- corrective action plans to address any benefits that have not been released on schedule
- forecast future benefits

How the project performed relative to the FBC (benefits realised, not realised, and any dis-benefits)

Whilst the finalisation of the full benefits realisation report for the Carsington Unit is ongoing the initial post-implementation review of benefits realisation has shown the project has delivered on the investment objectives set out in the Full Business Case (FBC), with a record of benefits realisation across patient care, workforce, and operational efficiency. The full benefits realisation plan which includes information on cash and non-cash releasing benefits is currently being finalised.

Benefits realised include:

- Transition from three dormitory-style wards to three 54-bed wards, all with single en-suite rooms, has improved privacy, dignity, and patient experience. The 'fit for purpose' design and build has been achieved. The design was co-produced with the service user and carer forum and incorporated significant feedback on existing building environments. The design is autism-informed, and the Clinical Reference Group ensured that principles of trauma-informed and sensory care informed all design decisions. Specifically designed low stimulation / de-escalation areas as well as sensory rooms have enabled maintenance of the Trust's low need for seclusion and physical restraint. Access to outside space has been welcomed for patient wellbeing, connection to nature and ability to self sooth and reduce distress. Access to therapeutic environments and sporting facilities alongside immediacy of access to physical exercise by provision of equipment on wards assists with physical health care, provide positive distraction as well as reduce aggression and therefore reduce use of restrictive practices.
- Following a pre-opening CQC visit to the Derwent Unit, which has the same design, the Carsington Unit is registered with the CQC as compliant. The eradication of dormitories ensures resolution of CQC formal regulatory action – to eradicate dormitory accommodation and provision of single gender wards also addresses the CQC Sexual Safety recommendations.
- The model of care, developed by clinicians, with the full support of the entire clinical team, has been implemented as planned (see change management section).
- Anti-ligature design reduces risk of self-harm for service users.
- Average length of stay data is still emerging following opening of the unit and is variable but with a slight downward trend.
- Following the opening of the unit together with extensive work to improve care pathways and the model of care, the trend for out of area placements has been consistently reducing.
- Environmental upgrades have supported sustainability goals and improved recruitment and retention.

Dis-benefits:

- A cost pressure of £2.2m above the original capital value was incurred, requiring funding through Trust capital / CDEL, due to contractual inflationary pressures, weather delays, and additional works relating to CQC recommendations and S136 suite redesign.

How the benefits are embedded within common business processes and operations

- Business-as-Usual Integration: The Carsington Unit is now embedded in the Trust's operational framework, subject to standard assurance and performance monitoring.

- Workforce Development: Organisational development programmes support staff retention and culture.
- Performance Monitoring: Benefits are tracked through regular data collection, highlight reports, and operational dashboards.

Forecast future benefits

Looking forward, the Derwent Unit aims to continue delivering value through:

- Sustained reductions in agency and bank staffing costs.
- Improved Clinical Outcomes as the model of care matures and data collection stabilises.
- Sustained reductions in average length of stay to the national average.
- Sustained reductions in out of area placements with full elimination of inappropriate out of area placements planned by the end of the first operational year.
- Enhanced recruitment and retention driven by the high-quality environment and positive staff culture.
- Environmental gains through ongoing energy efficiency improvements.

5. Change management

This section should provide details on change management as set out in the FCB, including whether the change management and transition plan was successfully implemented.

Clinical and Operational Changes

The Full Business Case (FBC) set out a clear change management and transition approach, recognising that the move from dormitory-style accommodation to new, purpose-built facilities represented a significant cultural and operational transformation. The intention was to deliver change across several domains:

- **Organisational and workforce transformation** – ensuring sufficient staffing levels through recruitment pipelines, workforce redesign, and retention initiatives.
- **Culture change** – embedding trauma-informed and least restrictive models of care, with an emphasis on dignity, privacy, and sensory-sensitive environments.
- **Training and development** – equipping staff with the skills needed to work in new environments and within a revised model of care.
- **Engagement and communication** – involving patients, carers, and staff in shaping the design and transition, ensuring ownership and inclusivity.

These ambitions were reinforced in subsequent planning and funding documents, in particular the HEE funding request (2023), which sought additional investment to deliver the workforce transformation envisaged in the FBC. This included expanded nursing apprenticeship places, practice facilitators, and administrative support to sustain training programmes, as well as embedding patient and carer voices at the centre of the programme through expert-by-experience roles and reference groups.

The majority of these ambitions were achieved, though not always in the form originally planned. The establishment of a Clinical Reference Group (CRG) ensured that principles of trauma-informed and sensory care informed all design decisions, from ward layouts to light fittings. The design

changes represented a marked culture change compared to the design constraints of the Radbourne unit.

Workforce transformation proved more complex than anticipated. The FBC had assumed internal capacity for recruitment and training, but in practice, additional bids (such as the HEE request) were necessary to secure the resources needed. As described in the model of care training could not be fully delivered prior to opening, and staff in post were required to continue training new colleagues, resource pressures not foreseen in the FBC.

The transition to single en-suite rooms and separation of older adults from younger adults aligned with the FBC's vision and has been widely welcomed, improving safety, privacy, and dignity. However, some unintended operational consequences emerged, for example, staff needing to proactively manage the risk of patient isolation in single rooms.

While governance was intended to be streamlined, reality revealed gaps in cost awareness and oversight. Clinical teams requested design changes with the best intentions (e.g. relocating windows and changes to the Section 136 suite), but without visibility of costs, decisions led to significant unplanned expenditure. Lessons learned included the importance of transparent governance, early use of design visualisation tools (e.g. 3D modelling or virtual walkthroughs), and stronger integration between clinical and estates perspectives.

The table below highlights how change management was intended and delivered:

Theme	Intention (FBC)	Adjustment (HEE funding request, 2023)	Reality
Workforce transformation	Recruit and retain sufficient staff; redesign the workforce to meet new model of care.	Requested funding for additional nursing apprenticeships, practice facilitators, and admin support to sustain recruitment and training	Recruitment was more difficult than anticipated; staff shortages meant training had to continue after opening, with clinical staff backfilling training roles. However, the 80 wte additional staff were fully recruited.
Culture change	Embed trauma-informed, least restrictive, sensory-sensitive care across all new builds.	Emphasis on inclusivity and dignity, e.g. ensuite door dignity innovations, service-user led design features.	Successfully achieved: CRG ensured all design decisions (lights, flooring, fittings) aligned to trauma-informed principles. Staff and patients welcomed the change.
Training & development	Deliver model of care training before transition; workforce for new environments.	HEE request sought funding to expand training capacity, apprenticeships, and practice facilitation to ensure readiness.	Training could not be fully completed before opening. Staff in post continued delivering training alongside clinical duties.

Engagement & communication	Extensive staff, patient, and carer involvement in shaping services to foster ownership.	Established service user/carer groups, expert-by-experience posts, design surveys, art therapy collaborations	Engagement was varied during the development of the project due to access and visibility of progress. Staff/patient involvement shaped positive outcomes but distance to sites reduced engagement.
Environment & estates	Replace dormitories with single en-suite rooms; separate adult and older adult services; design to improve dignity, safety, and wellbeing.	Additional designs included non-binary flexible ward spaces, improved therapy facilities, and inclusive-driven innovations.	Outcomes achieved: privacy and dignity improved; patients were safer and more comfortable. Some challenges (risk of isolation in single rooms, staff adjustment to new layouts). Splitting males and females across two sites was seen as overwhelmingly positive.
Governance & delivery	Anticipated structured oversight of design and transition; efficient change management.	HEE document emphasised inclusive governance and multi-disciplinary leadership.	In practice, late-stage design changes relating to incorporation of additional CQC recommendations following a visit to existing units, and redesign of S136 suite, created significant additional costs.
Transition & move	Smooth, well-planned moves into new facilities.	Recruitment campaigns and staff engagement sessions planned to prepare workforce.	Moves executed well, but morale was impacted by 8-week delay caused by shower defects. Despite challenges, transitions were successful overall.

Construction and Build

The Full Business Case (FBC) placed considerable emphasis on ensuring that construction was managed through robust change control and governance arrangements. The intention was that all building activity would be delivered under the standard ProCure 22 NEC3 Target Cost contract with a Guaranteed Maximum Price, supported by formal change control procedures to prevent unplanned cost escalation. Risks were to be identified in a joint risk allocation matrix, with construction risks primarily held by the contractor and transition risks shared with the Trust. These risks were to be reviewed regularly through programme governance structures, supported by external technical advisers and a dedicated Project Delivery Team to provide oversight, integration, and cost assurance.

In addition to cost and risk management, the FBC highlighted the importance of stakeholder engagement in construction decisions. Clinical Reference Groups and staff design workshops were built into the governance framework to ensure that ward layouts, ensuite designs, infection control, fire safety and sensory-sensitive features were clinically informed. The buildings were also

required to align with the Trust's Green Plan, with a commitment to sustainability measures such as recycled materials, reduced landfill, and achieving BREEAM Excellent accreditation.

Lessons learned included the importance of early use of design visualisation tools (e.g. 3D modelling or virtual walkthroughs) to help clinical teams to better understand the designs, and stronger integration between clinical and estates perspectives. Late changes to signed-off designs relating to CQC requirements following a visit to an existing unit, together with changes to the S136 suite, led to significant unplanned expenditure.

Overall
The change management and transition plan were successfully implemented, but the process was more adaptive and resource-intensive than envisaged in the FBC. The intentions (FBC), resource adjustments (HEE funding request), and practical realities together demonstrate that while the programme achieved its key aims, improved environments, embedded culture change, and better patient experience — these outcomes required iterative delivery, sustained external additional funding, and lessons learned in governance and workforce planning.

6. Risk & issue management
Identify any outstanding issues and any risks which will transfer to the operational area(s) and who has responsibility for monitoring them.

The Carsington Unit opened with a variety of small number of building-related issues and risks to be resolved which were managed or mitigated with staff and patient safety at the forefront of decision-making. Key unsatisfactory. These issues included: door alarm issues, temperature controls and signage.

Construction-related matters are formally reported via Micad, the Trust's estates logging system. This provides a transparent and auditable record of all issues raised, in line with governance and assurance requirements. Each submission is formally assessed and allocated to the appropriate responsible party, either the Trust's Estates Team (for maintenance matters within the Trust's remit) or the contractor (for defect-related or build-quality concerns). This allocation process establishes clear accountability and ensures that all matters are managed within defined lines of responsibility.

Where responsibility lies with the contractor, issues are tracked through weekly joint review meetings between the Trust and the contractor's project team. These meetings serve as a formal assurance forum, where progress against agreed action plans and timescales are scrutinised, unresolved issues are escalated, and remedial measures are agreed. Progress is monitored until closure is confirmed, and assurance is provided back through the governance structure to demonstrate that risks are being effectively controlled and that compliance with contractual obligations is being maintained.

This governance framework ensures that both operational and construction-related issues are addressed in a structured, transparent, and accountable manner. It supports assurance from the Trust Board and relevant committees that the transition to the new facility is being managed effectively, risks are being mitigated, and patient care and safety remain safeguarded throughout the operational phase.

Operational
The Carsington Unit opened with a variety of operational issues and risks. These were managed or mitigated in line with staff and patient safety measures. Key issues included:

Issue	Resolution / Mitigation
The building opened without a seclusion suite due to it being located in the Kingfisher House unit which was due to open 2-months later.	Assessed patients need for a seclusion and relocated them accordingly. Utilised local seclusion as required

Operational issues arising within the building during its live phase are systematically reviewed and addressed in collaboration with clinical teams through the established post-move meeting process. These meetings provide a structured mechanism for capturing feedback, monitoring the impact of the transition to new facilities, and ensuring that any risks to service delivery, patient safety, or staff wellbeing are identified, prioritised, and mitigated in a timely manner. The area service manager is responsible for managing any clinical risks that occur during the business-as-usual period.

7. How has the project transitioned from being a project to a business-as-usual function, or if it is not an ongoing service, how the project has been closed down.

The project has now successfully transitioned from project handover go-live/business as usual. This transition was managed through a structured handover process, ensuring that all operational responsibilities, risks, and controls are embedded within the Trust's existing governance arrangements. Ownership has formally transferred to the relevant service and operational leads, who are accountable for ongoing delivery and performance.

Key elements of the transition have included:

Operational Handover: Core processes, workflows, and reporting arrangements have been integrated into the Trust's standard operating framework. Clinical teams are now leading service delivery, supported by the Estates and Facilities Team and corporate functions as appropriate.

Issue and Risk Management: All residual risks and outstanding actions identified during the project have been captured, logged, and assigned for monitoring through business-as-usual governance forums. Construction-related defects and technical issues are managed via Mica and reviewed regularly with contractors and Estates, while operational issues are addressed through directorate governance structures.

Training and Capacity Building: Staff have received training on revised processes, systems, and escalation pathways. Induction materials have been updated to ensure new staff are supported, embedding resilience into long-term operations.

Sustainability and Continuous Improvement: A framework for continuous review has been established, ensuring that feedback from service users and staff informs ongoing refinements. Lessons learned from the project have been documented and shared to strengthen future capital and service transformation initiatives.

Governance: The MRfD programme governance has transitioned from the programme governance structure to business as usual. With the Project workstream meetings moving to Post Occupancy management meeting to track, monitor and resolve issues.

The service is now considered part of routine operational delivery, fully embedded within the Trust's business-as-usual structures, and subject to the same assurance and performance frameworks as other core services. The investment has delivered a maintenance of prior bed capacity, but with a significant enhancement in the environment.

8. Has the investment added any additional capacity? If so, please give specific details & numbers.

The investment has delivered a maintenance of prior bed capacity but with a significant enhancement in the physical environment.

The Radbourne Unit previously comprised four adult acute wards of 20 beds and one enhanced care ward of 10 beds, giving a total of 90 beds. Following reconfiguration, capacity is now distributed across Carsington Unit and Radbourne Unit. This includes three 18-bed adult wards at Carsington (54 beds), and two 17-bed adult wards at Radbourne (34 beds), with 2-beds transferring to Northern Derbyshire at the Derwent Unit. Specialist local capacity has been developed through other capital schemes within the Making Room for Dignity Programme, which are the subject of separate FBCs and PPEs.

9.Lessons Learnt review

a) In implementing the project what went well and what lessons would you like to share for others.

Design
Early attention to design is essential to ensure the building meets operational and clinical needs. Initial co-production of design proved beneficial. The importance of early use of design visualisation tools (e.g. 3D modelling or virtual walkthroughs) to help clinical teams to better understand the designs and gain a strong integration between clinical and estates perspectives. Necessity for late changes in design for S136 suites created significant delay and additional costs. Greater use of outdoor areas should balance therapeutic access with appropriate privacy.

Construction
Snagging is an inevitable part of any new build, so responsive estates and contractor support must be planned in from the outset. Robust pre-handover testing of all systems, doors, alarms and fittings is vital to avoid disruption once the building is occupied. Comprehensive aftercare agreements with sub-contractors should be secured to minimise downtime of facilities once in operation. Late identification of a serious defect in the ensuite showers led to an 8-week delay in opening the unit whilst the floor levels were rectified.

Clinical Environment
Modern ward design has a direct positive impact on patient wellbeing. Individual bedrooms with en-suite facilities, natural light, use of colour, and access to outside space all contribute to improved privacy, dignity, sleep and overall experience. Involving patients and carers early in the planning process helps to ensure the environment feels welcoming and meets their needs.

Ward Mobilisation
Mobilisation was supported by strong multidisciplinary teamwork and commitment from staff, which greatly contributed to the success of the move. Advance planning such as 'flight' plans, admissions preparation, and mobilisation meetings were helpful in creating structure and confidence. On the day, clear communication with patients and families, as well as strong support from transport and estates teams, ensures confidence and reduces anxiety. It is also valuable to consider the impact on teams that remain in older facilities, so their contributions and morale are not overlooked during the transition.

Operational Readiness
Access to the building ahead of opening is invaluable, allowing staff to familiarise themselves with systems and processes. All IT, telephony, keys, alarms and clinical equipment should be tested thoroughly prior to occupation. Running mock shifts and rehearsals can identify gaps and build staff confidence. Coordination of deliveries and stock management should be streamlined with clear roles and responsibilities.

Finance and Contracting
Strong procurement and contract management arrangements are critical, securing appropriate expertise to oversee complex supply chains avoids costly delays or gaps in provision. Consistent governance, decision-making structures and contractor aftercare support should be agreed from the outset, ensuring continuity and clarity across the life of the project.

Workforce
The workforce showed significant resilience, teamwork, and dedication in preparing for and managing the move. Their commitment was central to the positive outcomes achieved. For future projects, it would be helpful to ensure that recruitment processes are aligned with project timelines and that rostering systems are responsive to changing needs. Clearer communication and consultation with staff can further support morale during times of change. Finally, maintaining clarity of roles and responsibilities between ward-level teams and Trust-level functions will help to reduce pressure and support effective working relationships.

b) Provide examples of how services have improved for patients, staff and stakeholders
For patients:

For patients

- Patients moving into Carsington consistently described the new environment as a "lovely building" and were "wowed" on arrival.
- Having their own ensuite bedrooms provided greater privacy, dignity, and a calmer atmosphere compared to dormitory accommodation at Radbourne.
- Patients felt well supported on the move day, with secure transport and staff available for reassurance and conversations if they felt distressed.
- The therapeutic and activity areas were recognised as improvements, giving more appropriate spaces for recovery.

For staff:

- Staff now work in a modern, purpose-built environment that supports safer and more effective care delivery.

- The move into Carsington strengthened multidisciplinary team working, with strong collaboration across clinical, estates, and support services.
- The structured 'flight' plan and mobilisation meetings gave staff confidence in the process and clarity of roles.
- Post-move, estates and support teams provided swift responses to snagging, which reassured staff and enabled them to focus on patient care.

For stakeholders:

- The successful delivery of Carsington Unit demonstrated the Trust's ability to provide high-quality, modernised facilities that directly improve patient experience.
- The move reinforced effective partnership working across estates, procurement, contractors, and clinical teams.
- Feedback from patients about improved dignity, privacy, and atmosphere in Carsington reflects positively on the organisation's commitment to enhancing care environments.
- The lessons identified at Carsington contribute to a growing evidence base that will support better planning and efficiency in future service moves, reducing costs and disruption for patients and staff alike.

c) Are there any lessons to share from a commercial or procurement perspective?

The necessity to use the X1 clause in the P22 contract for inflationary protection during the (then) period of construction hyperinflation enabled the construction to proceed but added considerable unplanned cost to the overall outturn.

Ensuring appropriate PSCP sub-contractor response times for post opening defect resolution is vital to ensure unnecessary operational disruption.

10. Did this project set any net zero targets? If so, where the targets met and has any reduction been recorded.

The project aimed for a BREEAM 'excellent' certification to ensure sustainability targets are met. The build has achieved BREEAM 'very good' during construction and is expected to be certified as BREEAM 'excellent' on final submission feedback due in November 2025.

11. Provide any key recommendations to ensure that project lessons are learned, shared and implemented to benefit future project delivery.

Ensure Guaranteed Maximum Price is contractually gained rather than rely on inflationary protection clauses in the contract. Ensure full and ongoing engagement of clinical teams within the design process utilising design visualisation tools (e.g. 3D modelling or virtual walkthroughs) to ensure understanding of exactly what is being constructed, with visits enabled through the construction period to maintain morale and engagement. Necessity for late changes in design creates significant delay and additional costs.

Robust pre-handover testing of all systems, doors, alarms and fittings is vital to avoid disruption once the building is occupied. Late identification of poor workmanship on the ensuite shower floors led to an 8-week delay in opening.

Comprehensive aftercare agreements with sub-contractors need to be secured to minimise operational disruption.

Detailed relocation plans on the day move ensuring each member of staff is clear on their individual role pre, during and post move.

12. Top 5 lessons learned

1. **Ensure Defects that will impact on operational use are rectified prior to Building Handover.**

   Early testing and inspections of all areas to rectify the building defects the issues identified with the en-suite shower floor levels, led to an 8-week delay to opening whilst the contractor rectified the issues, with consequential impact on staff, patients and increased costs incurred by the Trust.

2. **Commercial contract provisions**

   The necessity to use the X1 clause in the P22 contract for inflationary protection during the (then) period of construction hyperinflation enabled the construction to proceed but added considerable unplanned cost to the overall outturn.

3. **Design Engagement and Understanding**

   The importance of early use of design visualisation tools (e.g. 3D modelling or virtual walkthroughs) to help clinical teams to better understand the designs and gain a strong integration between clinical and estates perspectives. Necessity for late changes in S136 design created significant delay and additional costs.

4. **Plan for Post-Move Support**

   Snagging was expected, and estates support was strong, but sub-contractor timescales to rectify identified defects post-opening impacted on operational provision**.**

5. **Recruitment Support for Significant Workforce Increases**

   There was an assumption that by phasing recruitment across the year prior to units opening there would be adequate internal capacity for recruitment and training, but in practice, additional resource was necessary to secure the overall significant increase in workforce across the programme and deliver the required training.

13. List of any annexures provided

Annex	Description
Not applicable	

Please contact capitaldeliverypmo@dhsc.gov.uk if your team would like to discuss the PPE or request any further documentation relating to the project.

Post Project Evaluation

Purpose

A post-project evaluation (PPE) should be completed around six months after completion of construction for all capital projects. This is now required as part of the FBC approval conditions and should be completed for all capital projects that have completed.

The purpose of the post-project evaluation (PPE) is to learn and evaluate the effectiveness of the project in realising the proposed benefits, and to:

- Identify particular aspects of the project which have affected benefits either positively or negatively.
- Capture and document any lessons learned- what went well and what lessons the project team would like to share with others and recommendations for future projects.
- Provide examples of how services have improved for patients, staff and stakeholders.
- Understand if there are any outstanding risks and issues once the project is operational.

Please contact capitaldeliverypmo@dhsc.gov.uk if your team would like to discuss the PPE or request any further documentation relating to the project.

PPE-EXECUTIVE SUMMARY

Project Name & Trust:	(South Derbyshire) 14 Bed Psychiatric Intensive Care Unit (PICU) for adults at Kingsway Hospital (Kingfisher House Unit) Derbyshire Healthcare NHS Foundation Trust		
Date commenced construction:	November 2022	**Date of completion:**	*22 July 2025*
Project Manager:	Sifo Dlamini and Nicole Ellis		
Project Sponsor/ SRO & email address:	Project Sponsor: James Sabin, Director of Finance (james.sabin@nhs.net)		
PPE Author:	Monique Chavda	**Email address of Author:**	Monique.chavda@wsp.com

Benefits realisation

1. Project overview

This section should provide a brief background about the project.

Kingfisher House is a purpose-built, two-storey Psychiatric Intensive Care Unit (PICU) designed to deliver high-acuity mental health care in a secure, therapeutic environment. The facility comprises 14 single-occupancy, en-suite bedrooms equipped with anti-ligature fittings to ensure patient safety. It includes two seclusion suites with direct access to secure garden spaces, supporting de-escalation and recovery in a calming setting. The unit also features dedicated therapy rooms, a sensory room, and activity spaces to promote holistic care. Staff areas are fully integrated, with clinical support rooms, medication storage, and observation points designed to maximise visibility and responsiveness.

The building is fitted with advanced security and access control systems, including swipe access, CCTV, and airlock entry points to manage movement between zones. A secure corridor links Kingfisher House to the adjacent Carsington Unit, enabling flexible patient transitions and shared operational support. The facility also includes a secure reception area, staff welfare zones, and clinical offices, all designed to meet the specific demands of intensive psychiatric care.

The project was initiated in response to national NHS policy requiring the elimination of inappropriate out-of-area placements for patients needing intensive psychiatric care. Prior to Kingfisher House, Derbyshire had no local PICU provision, resulting in an average of 14 male patients being placed in facilities outside the county. This not only disrupted continuity of care but also placed emotional and logistical strain on patients and their families.

Kingfisher House was designed to address this gap by providing single-room, ensuite accommodation for male patients requiring intensive support. The unit is physically connected to the newly built Carsington Unit, enabling smoother transitions for patients as their condition stabilises and they move to less intensive care settings.

The facility was constructed under the MRfD programme, which aims to eradicate dormitory-style accommodation and modernise mental health infrastructure across Derbyshire. The project was delivered in line with NHS capital investment guidance, with a Post Project Evaluation (PPE) conducted to assess benefits realisation, service improvements, and lessons learned.

Kingfisher House reached practical completion in June 2025, with commissioning activities including infection control assessments, IT infrastructure commissioning, clinical risk reviews, and artwork coordination completed shortly thereafter. The unit officially opened in July 2025, marking a significant milestone in the Trust's commitment to improving local mental health service.

2. Assessment of Deliverables

This section should provide detail on what was delivered. The extent to which projected deliverables, as outlined in the FBC were delivered.

Deliverables

FBC Planned Deliverables	Achievement
New purpose-built PICU with entrance/reception, emergency access, essential facilities, seclusion/de-escalation suite, therapy/activity suite with garden, day spaces, and 14 single ensuite bedrooms	The Trust delivered a new-build 14-bed male-only PICU at Kingsway Hospital. The facility included all required accommodation, designed and signed off with clinical input, and constructed by the PSCP through the Procure22 framework.
Care closer to home – improved patient, family and carer experience	Patients are cared for within Derbyshire at Kingsway Hospital, enabling easier access for families and carers and improving integration with local acute, rehab and community services.
Enhance privacy, dignity, and safety	The PICU was delivered as a single-sex ward with all single ensuite bedrooms, complemented by a seclusion suite and anti-ligature environment, enhancing privacy, dignity and safety.
Improved continuity of care and patient flow	Embedding the PICU within the local acute pathway improves continuity of care, reduced discharge delays and ensured patients remained within local services.
'Fit for purpose' HBN-compliant facility	The new PICU is compliant with HBN/HTM standards, NAPICU and QNPICU guidance, and successfully passed independent design reviews and DQIfH2 assessment.
Sustainable and healing environment	The unit delivers therapeutic indoor and outdoor spaces with natural light, access to gardens, and a comfortable environment designed to promote recovery.
BREEAM "Excellent" rating and NHS Net Zero Carbon alignment	The building is currently assessed as BREEAM 'very good' during construction and on track for BREEAM 'excellent' rating on final feedback due November 2025, incorporating sustainable design and modern construction methods, and aligned with Net Zero Carbon commitments.
Minimise ligature risk, maximise safety	The new environment incorporated anti-ligature fixtures and fittings, dedicated seclusion and de-escalation spaces, and met all relevant CQC and safety standards.
Aligned with Trust, ICS and national mental health policy	The PICU was delivered as part of the JUCD ICS Estates Strategy and aligned fully with NHS Long Term Plan commitments, securing approval from ICS and NHSE.
Modern, safe, and attractive working environment supporting recruitment and retention	The new PICU provides a modern and safe environment designed around safe staffing standards, supporting recruitment, retention and the Trust's People & Inclusion Strategy.

Outcomes

This table provides a high-level outcome, for a detailed review of outcomes see the benefits section

Intended Outcomes	Achievement
Locally accessible PICU services provided within Derbyshire	The Trust successfully opened the new 14-bed male-only PICU at Kingsway Hospital, ensuring local provision of psychiatric intensive care.
Elimination of inappropriate out-of-area placements	All Derbyshire patients requiring PICU care have been repatriated locally, eliminating inappropriate out-of-area placements
Improved patient, family and carer experience	Patients remain close to home, with improved access for families and carers, reducing disruption to relationships and care planning.
Enhanced privacy, dignity, and safety	Patients benefit from single bedrooms with ensuite facilities in a single-sex ward environment, with modern seclusion and de-escalation spaces.
Improved continuity of care	Patients receive treatment within an integrated local pathway, with seamless transition between PICU, acute wards, and community services.
"Fit for purpose" estate solution	The PICU has been delivered to HBN/HTM compliance, meeting national PICU guidance.
Aligned with Trust, ICS and national mental health policy	The scheme directly addresses priorities in the NHS Long Term Plan, the Trust's estates strategy, and JUCD ICS strategic vision, securing national approval.
Strengthened workforce environment	The new unit provides a modern, safe and attractive workplace, supporting staff recruitment, retention, and professional development.

Strategic Objectives (Project Investment Objectives)

Intended Strategic Objectives	Achievement
To repatriate and eliminate inappropriate 'out of area' placements: With the development of a local male PICU facility at Kingsway Hospital, with design and business case development meeting targets in April 2022 to enable construction start in September 2022, based on similar scheme at Farnham Road Hospital Redevelopment in Surrey, and to achieve project completion through this investment by 31 December 2023.	This objective has been achieved through the development and opening of the new male PICU facility at Kingsway Hospital. The investment has created high-quality local provision, enabling patients to be treated closer to home and eliminating the need for inappropriate out of area placements where possible. This not only improves continuity of care but also strengthens family and carer involvement in the recovery process. Although the programme was completed in July 2025 rather than December 2023 due to delays in accessing funding, with later construction commencement and subsequent construction-related delays, the final outcome is a facility that meets the intended service model, reduces pressure on external placements, and delivers significant benefits to patients, carers, and the Trust.

Intended Strategic Objectives	Achievement
To enhance privacy, dignity and safety for patients by: Providing single sex ward (male only) with single bedroom and ensuite accommodation, based on similar scheme at Farnham Road Hospital Redevelopment in Surrey, with design and business case development meeting targets in April 2022 to enable construction start in September 2022, to achieve project completion through this investment by 31 December 2023.	The new PICU provides a male-only ward with single bedrooms and ensuite facilities, ensuring a modern environment designed around privacy, dignity, and safety. The result is a therapeutic setting that promotes recovery, safeguards individual wellbeing, and enhances patient experience. Despite a later completion date, the facility now provides a sustainable, high-quality environment that delivers on all aspects of this investment objective.

3. Financial management

Compare the planned costs with actuals, including identify any outstanding financial issues, such as excess funds, and how they will be handled.

The total capital approved at FBC stage was £14.6m, which was confirmed in late December 2022, 6-months later than envisaged in the FBC. An additional £0.29m was approved from Trust capital / CDEL in April 2024 to fund initial X1 clause inflationary pressures and weather delays, and a final £0.5m PDC was approved in December 2024 to fund the remaining inflationary pressures (total X1 costs for Carsington Unit and Kingfisher House £2.76m).

	Planned	Actual	Variance
Budget	£14.6m	£15.4m	£0.8m
Schedule	December 2023 (based on July 2022 funding approval)	July 2025	19-months later than envisaged in FBC. Due to: ▪ 6-months delay in approval of PDC ▪ 6-month delay due to need to reschedule whole build programme as originally planned to build concurrent with Carsington Unit ▪ 2-months lost to bad weather in 2023 ▪ 3-month delay in build programme in 2024 ▪ 2-month delay due to rectification of defect with ensuite shower floors.
Scope	Purpose-built PICU with entrance / reception, emergency access, essential facilities, seclusion/de-escalation suites, therapy/activity suite with garden, day spaces, and 14 single ensuite bedrooms	Purpose-built PICU with entrance / reception, emergency access, essential facilities, seclusion/de-escalation suites, therapy/activity suite with garden, day spaces, and 14 single ensuite bedrooms	Not applicable

3a-Has the investment had an impact on backlog maintenance, and if so, how much by risk category has been eradicated as a result of this investment?

As Kingfisher House is a new build, there has been no inherited backlog maintenance. This means that from the outset, the service is operating in a modern, purpose-built environment, free from the risks typically associated with older estates infrastructure. The investment has therefore completely eradicated the potential for backlog maintenance at the point of opening, ensuring there is no legacy of risk across any category.

3b- Please outline the backlog issues faced and how they were impacting on safe, efficient and effective clinical care. How reducing the level of backlog has helped to deliver wider qualitative benefits?

Kingfisher House as a new build, and new local service, has no backlog maintenance. The facility has been designed to meet modern healthcare standards, providing a safe and compliant environment from day one.

This investment ensures that staff can focus fully on clinical care rather than being distracted by estate-related issues, and patients benefit from a high-quality, safe, and therapeutic setting. Reducing the risk of backlog by building new has also delivered wider qualitative benefits, such as:

- Improved safety through up-to-date compliance with building and healthcare regulations.
- Efficiency gains from modern layouts, equipment, and infrastructure that support smooth patient pathways and reduce delays.
- Enhanced patient experience through a purpose-built environment designed for comfort, dignity, and therapeutic benefit.
- Staff wellbeing and retention by providing a high-quality workplace designed with functionality and staff needs in mind.

In summary, the investment in Kingfisher House has delivered long-term resilience, sustainability, and quality improvements to clinical care.

4. Assessment of Benefits as identified in the Full Business Cases

This section should set out whether the project achieved its planned objectives. Please provide evidence of:

- how the project preformed relative to the FBC (benefits realized, benefits not realized and any dis-benefits
- full detail of the benefits identified, quantified and realised to date (both cash and non-cash releasing). Please include as annexures: an up to date benefits register and the register of disbenefits
- Details of the Post Implementation Review
- How the benefits are embedded within common business process and operations, and whether the correct processes are in place to ensure benefits continue to be realised
- corrective action plans to address any benefits that have not been released on schedule
- forecast future benefits

How the project preformed relative to the FBC (benefits realized, benefits not realized and any dis-benefits.

Benefits realised include:

- The Trust successfully opened the new 14-bed male-only PICU at Kingsway Hospital, ensuring local provision of psychiatric intensive care.
- All Derbyshire patients requiring PICU care have been repatriated locally, eliminating inappropriate out-of-area placements
- Patients remain close to home, with improved access for families and carers, reducing disruption to relationships and care planning.
- Patients benefit from single bedrooms with ensuite facilities in a single-sex ward environment, with modern seclusion and de-escalation spaces, providing privacy, dignity, and safety.
- Patients receive treatment within an integrated local pathway, with seamless transition between PICU, acute wards, and community services providing improved continuity of care.
- The PICU has been delivered to HBN/HTM compliance, meeting national PICU guidance and providing a "fit for purpose" estate solution .
- The scheme is aligned with national mental health policy in the NHS Long Term Plan, the Trust's estates strategy, and JUCD ICS strategic vision, securing national approval.
- The new unit provides a modern, safe and attractive workplace, supporting staff recruitment, retention, and professional development.

How the benefits are embedded within common business process and operations, and whether the correct processes are in place to ensure benefits continue to be realised
schedule

- Business-as-Usual Integration: Kingfisher House is now embedded in the Trust's operational framework, subject to standard assurance and performance monitoring.
- Workforce Development: Organisational development programmes support staff retention and culture.
- Performance Monitoring: Benefits are tracked through regular data collection, highlight reports, and operational dashboards.

Forecast future benefits

- Improved Clinical Outcomes as the model of care matures and data collection stabilises.
- Sustained reductions in out of area placements with full elimination of inappropriate out of area placements planned by the end of the first operational year.
- Enhanced recruitment and retention driven by the high-quality environment and positive staff culture.

5. Change management

This section should provide details on change management as set out in the FCB, including whether the change management and transition plan was successfully implemented.

Clinical and Operational Changes

The Full Business Case (FBC) sets out a clear change in management and transition approach, recognising that the PICU is the introduction of a new service offering to the Trust in a new, purpose-built facility represented a significant cultural and operational transformation. The intention was to deliver change across several domains:

- **Organisational and workforce transformation** – ensuring sufficient staffing levels through recruitment pipelines, workforce redesign, and retention initiatives.
- **Culture change** – embedding trauma-informed and least restrictive models of care, with an emphasis on dignity, privacy, and sensory-sensitive environments.
- **Training and development** – equipping staff with the skills needed to work in new environments and within a revised model of care.
- **Engagement and communication** – involving patients, carers, and staff in shaping the design and transition, ensuring ownership and inclusivity.

These ambitions were reinforced in subsequent planning and funding documents, in particular the HEE funding request (2023), which sought additional investment to deliver the workforce transformation envisaged in the FBC. This included expanded nursing apprenticeship places, practice facilitators, and administrative support to sustain training programmes, as well as embedding patient and carer voices at the centre of the programme through expert-by-experience roles and reference groups.

The majority of these ambitions were achieved, though not always in the form originally planned.

As part of the Making Room for Dignity programme, the Trust established a Clinical Reference Group (CRG). This group is responsible for ensuring that all clinically related issues are managed effectively and that patient care is delivered appropriately. The CRG also oversees that the new facilities are fit for purpose and designed to meet clinical standards.

In addition, the Trust created a Clinical Reference Group specifically for the Psychiatric Intensive Care Unit (PICU). As the PICU represents a new service within the Trust, the establishment of a dedicated, specialised group was considered essential to manage its implementation. This group provides a focused approach to the development of the service, supporting additional training, engagement, and communication activities necessary for a successful launch.

Furthermore, the Trust has developed a collaborative relationship with Leicestershire Partnership NHS Trust (LPT), which already operates a PICU within its service provision. Through this partnership, both Trusts are working together to share expertise, exchange knowledge, and support the development and operational growth of the new PICU. This collaboration is being facilitated through a buddy system with Leicestershire Partnership NHS Trust.

The establishment of a Clinical Reference Group (CRG) ensured that principles of trauma-informed and sensory care informed all design decisions, from ward layouts to light fittings. This represented a marked culture change compared to the constraints of current facilities.

The table below highlights how change management was intended and delivered:

Theme	Intention (FBC)	Adjustment (HEE funding request, 2023)	Reality
Workforce transformation	Recruit and retain sufficient staff to safely operate the new specialist service.	Requested funding for additional nursing apprenticeships, practice facilitators, and admin	Recruitment was more difficult than anticipated, however, the 70.88 wte new

		support to sustain recruitment and training	staff were fully recruited.
Culture change	Embed trauma-informed, least restrictive, sensory-sensitive care across all new builds.	Emphasis on inclusivity and dignity, e.g. ensuite door dignity innovations, service-user led design features.	Successfully achieved: CRG ensured all design decisions (lights, flooring, fittings) aligned with trauma-informed principles.
Training & development	Deliver model of care training; workforce for new environments.	HEE request sought funding to expand training capacity, apprenticeships, and practice facilitation to ensure readiness.	Training was fully completed before opening.
Transition & move	Smooth, well-planned repatriation of service users into new facilities.	Recruitment campaigns and staff engagement sessions planned to prepare the workforce.	Repatriation of service users from out of area PICU placements was carefully planned and phased.

Construction and Build

The Full Business Case (FBC) placed considerable emphasis on ensuring that construction was managed through robust change control and governance arrangements. The intention was that all building activity would be delivered under the standard ProCure 22 NEC 3 Target Cost contract with a Guaranteed Maximum Price, supported by formal change control procedures to prevent unplanned cost escalation. Risks were identified in a joint risk allocation matrix, with construction risks primarily held by the contractor and transition risks shared with the Trust. These risks were to be reviewed regularly through programme governance structures, supported by external technical advisers and a dedicated Project Delivery Team to provide oversight, integration, and cost assurance.

In addition to cost and risk management, the FBC highlighted the importance of stakeholder engagement in construction decisions. Clinical Reference Groups and staff design workshops were built into the governance framework to ensure that ward layouts, ensuite designs, infection control, fire safety and sensory-sensitive features were clinically informed. The building was also required to align with the Trust's Green Plan, with a commitment to sustainability measures such as recycled materials, reduced landfill, and on track for BREEAM Excellent accreditation.

Lessons learned included the importance of early use of design visualisation tools (e.g. 3D modelling or virtual walkthroughs) to help clinical teams to better understand the designs, and stronger integration between clinical and estates perspectives.

Overall

The change management and transition plan were successfully implemented, but the process was more adaptive and resource-intensive than envisaged in the FBC. The intentions (FBC), resource adjustments (HEE funding request), and practical realities together demonstrate that while the programme achieved its key aims, improved environments, embedded culture change, and better patient experience these outcomes required iterative delivery, and some additional funding.

6. Risk & issue management

Identify any outstanding issues and any risks which will transfer to the operational area(s) and who has responsibility for monitoring them.

Construction

Kingfisher House opened with a small number of build-related issues which were managed or mitigated with staff and patient safety at the forefront of decision-making. These issues included: door alarms, temperature control and access to the family visit garden, with one bedroom out of use and other minor issues.

Construction-related matters are formally reported via Micad, the Trust's estates logging system. This provides a transparent and auditable record of all issues raised, in line with governance and assurance requirements. Each submission is formally assessed and allocated to the appropriate responsible party, either the Trust's Estates Team (for maintenance matters within the Trust's remit) or the contractor (for defect-related or build-quality concerns). This allocation process establishes clear accountability and ensures that all matters are managed within defined lines of responsibility.

Where responsibility lies with the contractor, issues are tracked through weekly joint review meetings between the Trust and the contractor's project team. These meetings serve as a formal assurance forum, where progress against agreed action plans and timescales are scrutinised, unresolved issues are escalated, and remedial measures are agreed. Progress is monitored until closure is confirmed, and assurance is provided back through the governance structure to demonstrate that risks are being effectively controlled and that compliance with contractual obligations is being maintained.

This governance framework ensures that both operational and construction-related issues are addressed in a structured, transparent, and accountable manner. It supports assurance from the Trust Board and relevant committees that the transition to the new facility is being managed effectively, risks are being mitigated, and patient care and safety remain safeguarded throughout the operational phase.

Operational

Operational issues arising within the building during its live phase are systematically reviewed and addressed in collaboration with clinical teams through the established post-move meeting process. These meetings provide a structured mechanism for capturing feedback, monitoring the impact of the transition to new facilities, and ensuring that any risks to service delivery, patient safety, or staff wellbeing are identified, prioritised, and mitigated in a timely manner. The area service manager is responsible for managing any clinical risks that occur in "business as usual" mode.

7. How has the project transitioned from being a project to a business-as-usual function, or if it is not an ongoing service, how the project has been closed down.

The project has now successfully transitioned from project handover go-live/business as usual. This transition was managed through a structured handover process, ensuring that all operational

responsibilities, risks, and controls are embedded within the Trust's existing governance arrangements. Ownership has formally transferred to the relevant service and operational leads, who are accountable for ongoing delivery and performance.

Key elements of the transition have included:

Operational Handover: Core processes, workflows, and reporting arrangements have been integrated into the Unit and ward's standard operating procedures. Clinical teams are now leading service delivery, supported by the Estates and Facilities Team and corporate functions as appropriate.

Issue and Risk Management: All residual risks and outstanding actions identified during the project have been captured, logged, and assigned for monitoring through business-as-usual governance forums. Construction-related defects and technical issues are managed via Micad and reviewed regularly with contractors and Estates, while operational issues are addressed through directorate governance structures.

Training and Capacity Building: Staff have received training on processes, systems, and escalation pathways. Induction materials have been updated to ensure new staff are supported, embedding resilience into long-term operations.

Sustainability and Continuous Improvement: A framework for continuous review has been established, ensuring that feedback from service users and staff informs ongoing refinements. Lessons learned from the project have been documented and shared to strengthen future capital and service transformation initiatives.

Governance: The MRfD programme governance has transitioned from the programme governance structure to BAU. With the Project workstream meetings moving to Post Occupancy management meeting to track and monitor defects and issues.

The service is now considered part of routine operational delivery, fully embedded within the Trust's business-as-usual structures, and subject to the same assurance and performance frameworks as other core services.

8. Has the investment added any additional capacity? If so, please give specific details & numbers.
The investment has added additional capacity. Specifically, it has created 14 new specialist beds within a newly established Psychiatric Intensive Care Unit (PICU). This service is designed to provide a higher level of care and support for patients experiencing acute mental health crises who require intensive, short-term treatment in a safe and therapeutic environment.

The additional capacity will:

- Improve patient flow by reducing pressure on general adult acute wards.
- Enhance quality of care by ensuring individuals with the most complex needs have access to an appropriate level of intensive support locally.

- Reduce out-of-area placements, helping patients remain closer to home, family, and local services.
- Support staff and wider services by creating a dedicated environment for high-intensity care, allowing other wards to focus on recovery and rehabilitation.

In total, the 14 new PICU beds represent a significant expansion in specialist provision and strengthens the overall mental health service offering in the region.

9.Lessons Learnt review

a) In implementing the project what went well and what lessons would you like to share for others.

Design
Early collaboration between clinical, estates, and operational teams proved invaluable. Future projects should continue this integrated design approach to ensure spaces are functional, safe, and adaptable. Balancing safety features with operational flexibility will further enhance usability and reduce maintenance challenges.

Construction
Close coordination with contractors is essential to ensure craftsmanship quality and timely issue resolution. Building in more time for snagging and thorough pre-opening checks will help ensure a smooth transition. Maintaining open communication with construction teams fosters accountability and responsiveness.

Clinical Environment
Structured and phased admissions, along with well-planned staff familiarisation, contributed to a calmer clinical environment. Future openings should build on this by ensuring early staff engagement with the space and continuous feedback loops between clinical and estates teams to fine-tune the environment post-occupancy.

Operational Readiness
Comprehensive pre-opening training and cross-team collaboration were clear strengths. Embedding joint rehearsals and simulation exercises can further enhance readiness. Clear communication channels, especially around timelines and responsibilities, help maintain confidence and morale during fast-paced transitions.

Finance and Contracting
Collaborative problem-solving with contractors, such as the resolution of drainage issues, demonstrated the value of maintaining strong, ongoing relationships. Future contracts should include clear escalation pathways and shared accountability for post-handover fixes to streamline issue management and cost control.

Workforce
Team cohesion and proactive leadership were key to the successful opening. Early recruitment planning and ongoing workforce development—particularly in key support areas like domestic and catering—will strengthen resilience. Recognising the importance of staff wellbeing and team connection before and after opening supports sustained performance and morale.

b) Provide examples of how services have improved for patients, staff and stakeholders
For patients:

- The phased admission approach created a calmer, more structured experience for patients moving into the new ward, helping them settle in gradually and reducing stress during transition.
- Improved safety features, such as enhanced alarm systems and better environmental design, increased overall patient safety and confidence in the new setting.
- The cleaner, brighter, and more functional ward environment, following post-move improvements (e.g. drainage works, cleanliness upgrades), has enhanced comfort and wellbeing.
- Planned collection of patient voice and feedback demonstrates a commitment to ongoing service improvement and to involving patients in shaping their care environment.

For staff:

- Cross-team collaboration between clinical, operational, and estates teams fostered a stronger sense of unity and problem-solving culture, improving teamwork and morale.
- Pre-opening training and familiarisation sessions helped staff feel more prepared, confident, and connected before service launch.
- Clearer communication processes and shared learning from previous openings led to smoother operations and better coordination across roles.
- Violence checklist monitoring and plans for EFM staff to receive breakaway training improved safety awareness and staff confidence in managing complex clinical situations.
- Staff now benefit from a more structured operational approach, including consistent handover systems and clearer lines of accountability.

For stakeholders:

- The Kingfisher project demonstrated effective partnership working between estates, IM&T, operations, and clinical leadership, showcasing a model for future collaborative service openings.
- Stakeholders benefited from greater transparency and open communication, ensuring issues were identified and addressed promptly.

- The project strengthened relationships with contractors and partner organisations, leading to more efficient problem resolution and shared accountability (e.g. IHP's proactive resolution of drainage issues).
- Engagement with the Manchester team provided valuable benchmarking and shared learning, reinforcing the Trust's reputation for reflective and adaptive service delivery.

c) Are there any lessons to share from a commercial or procurement perspective?

The necessity to use the X1 clause in the P22 contract for inflationary protection during the (then) period of construction hyperinflation enabled the construction to proceed but added considerable unplanned cost to the overall outturn.

Ensuring appropriate PSCP sub-contractor response times for post opening defect resolution is vital to ensure unnecessary operational disruption.

10. Did this project set any net zero targets? If so, where the targets met and has any reduction been recorded.

The project aimed for a BREEAM 'excellent' certification to ensure sustainability targets are met. The build has achieved BREEAM 'very good' during construction and is expected to be certified as BREEAM 'excellent' on final submission feedback due in November 2025.

11. Provide any key recommendations to ensure that project lessons are learned, shared and implemented to benefit future project delivery.

Ensure Guaranteed Maximum Price is contractually gained rather than rely on inflationary protection clauses in the contract.

Ensure full and ongoing engagement of clinical teams within the design process utilising design visualisation tools (e.g. 3D modelling or virtual walkthroughs) to ensure understanding of exactly what is being constructed, with visits enabled through the construction period to maintain morale and engagement. Necessity for late changes in design creates significant delay and additional costs.

Robust pre-handover testing of all systems, doors, alarms and fittings is vital to avoid disruption once the building is occupied. Late identification of poor workmanship on the ensuite shower floors led to an 8-week delay in opening.

Comprehensive aftercare agreements with sub-contractors need to be secured to minimise operational disruption.

12. Top 5 lessons learned

1. **Early and Ongoing Collaboration is Key**

Strong collaboration between clinical, operational, estates, and IM&T teams was central to the project's success. Regular joint meetings, open communication, and shared problem-solving ensured issues were identified early and addressed effectively.

2. **Thorough Pre-Opening Preparation Enhances Readiness**

Comprehensive staff training and familiarisation before opening helped build confidence and cohesion. Simulated exercises and early engagement should continue to be a standard feature for future openings.

3. **Balance Safety with Flexibility in Design**

While enhanced safety systems improved risk management, some features reduced flexibility and increased fragility. Future projects should find the right balance between robust safety measures and operational practicality.

4. **Ensure Defects that will impact on operational use are rectified prior to Building Handover.**

Early testing and inspections of all areas to rectify the building defects the issues identified with the en-suite shower floor levels, led to an 8-week delay to opening whilst the contractor rectified the issues, with consequential impact on staff, patients and increased costs incurred by the Trust.

5. Invest in Workforce Stability and Support

Recruitment challenges highlighted the importance of early workforce planning, especially for key support roles such as nursing assistants and domestic staff. Building resilient teams through training, wellbeing support, and consistent staffing improves both service quality and staff morale.

13. List of any annexures provided

Annex	Description
Not Applicable	

Please contact capitaldeliverypmo@dhsc.gov.uk if your team would like to discuss the PPE, or request any further documentation relating to the project.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 24 March 2026

Benefits Evaluation report – Carsington Unit and Derwent Unit

Purpose of Report

Submission for approval of the Benefits Evaluation report for the Carsington Unit (opened on 28 May 2025) and Derwent Unit (opened on 20 March 2025), as part of the Making Room for Dignity (MRfD) Programme.

Executive Summary

This is a report detailing the extent to which benefits of the Carsington Unit and Derwent Unit new builds have been achieved, relative to the aims identified in the original business case. It uses data obtained from the six months post-opening, up to the end of November 2025.

The report also includes feedback from patients, visitors, staff, System partners and Trust Board members, as well as reflections from a patient in the form of a patient story.

The report is largely positive showing improvement against most metrics, with further work to do to provide greater confidence and assurance in the long-term over a larger sample of data. It is intended to refresh and review the document at 12 months for this purpose.

Please note that the Kingfisher House Unit and Audrey House Unit Benefits Realisation documents will be presented at the March meeting.

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

None identified.

Consultation

With all parties involved in the building and operationalisation of the Carsington Unit and Derwent Unit as part of the MRfD Programme, the Finance and Performance Committee, the People and Culture Committee and the Quality and Safeguarding Committee.

Governance or Legal Issues

None currently.

Net Zero Duty Implications

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

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

The new facilities were specifically designed to operate as close to 'net zero' as is currently possible – this includes moving away from fossil fuel sources and inclusion of relevant green technology (air source heat pumps, solar and PV panels) and use of 'modern methods of construction' to reduce emissions during the construction phase. Additionally, a key aim of the programme was to provide care for our patients closer to home and their communities, thereby delivering an additional environmental benefit of reducing travel and transportation related emissions.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

No adverse impact.

Recommendations

The Board of Directors is requested to approve the reports.

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

Report prepared by: **Joe Wileman**
Head of Programme Delivery

Derbyshire Healthcare
NHS Foundation Trust

MRFD

Making Room For Dignity Benefits Evaluation

Carsington Unit Open 28 May 2025

Review at 6 Months December 2025

WE MAKE A POSITIVE DIFFERENCE IN EVERYTHING WE DO

Description

Derbyshire Healthcare
NHS Foundation Trust

A modern 54 bedroom mental health adult acute unit based on the Kingsway Hospital site in Derby.

The Carsington Unit has three wards called Dove Ward, Robin Ward and Wren Ward. Each ward has 18 single bedrooms for adults of working age.

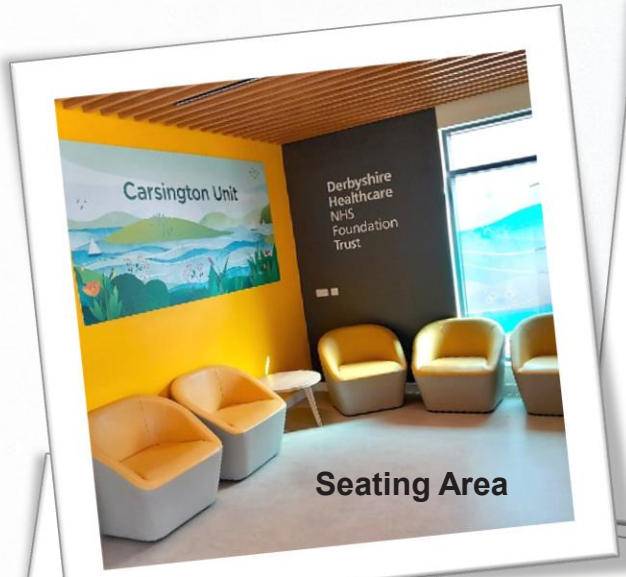
Project Costs – Carsington	
Original capital agreed at FBC – PDC funding	£39,865,000
Original capital agreed at FBC – Trust funding	£8,693,035
Total capital at FBC (October 2022)	**£48,558,035**
Additional Trust funding (April 2024)	£550,000
Additional Trust funding (March 2025)	£1,726,110
Total Outturn cost	**£50,834,145**





Carsington Unit in Pictures

Derbyshire Healthcare
NHS Foundation Trust



















Ward Staff

Jayne's Perspective…

Derbyshire Healthcare
NHS Foundation Trust

Jayne is a patient on the Dove Ward at Carsington in September 2025, and shares her thoughts on the new unit, and how it differs to the other older units she has experienced.

When I arrived at Dove Ward I was feeling a mix of emotions. Today I am telling about my experience to share with others.

Having my own bedroom has made a big difference. It has given me the quiet space to process my thoughts and reflect, which has helped me feel calmer. The ward itself feels spacious and open. I especially enjoy the lovely gardens which I can access directly from the ward. Being able to get fresh air and see the greenery makes the ward feel light and peaceful.

I really like the activities room. Taking part in the shared activities. Like artwork, is something I look forward to. I am proud to show some of the art pieces I have done.



I think my key reflections to share would be

…having my own bedroom helps me feel safe and calm,

…the gardens and open spaces make the ward feel welcoming,

…the creative activities give me a sense of pride and enjoyment.

What do our Patients and Visitors Say…

Derbyshire Healthcare
NHS Foundation Trust

- *"I really appreciate having my own space" (Robin Patient)*
- *"I like the open plan. It works but the dining room can get cramped" (Dove Patient)*
- *"I much prefer this to the Radbourne" (Wren Patient)*
- *"I like some of the new activities, especially the singing and the music therapy" (Dove Patient)*
- *"It feels a more relaxed atmosphere" (Robin Patient)*
- *"The staff always seem available for chats if I'm feeling distressed" (Robin Patient)*
- *"The move was well organised" (Dove Patient)*
- *"Always feel supported" (Robin Patient)*



What do our Staff and Partners Say…

Derbyshire Healthcare
NHS Foundation Trust

- *"It is a great environment for patients and staff with more space to move around"*
- *"The wards nice and colourful, and are friendly and inviting".*
- *There is good visibility which helps patients and staff to have conversations"*
- *"The outdoor spaces are great for doing group activities with patients and having some outdoor time"*
- *"The gym is excellent and patients will enjoy using it"*
- *"It is good to see patients having independence in their environments".*
- *"The new music therapy activity is a great addition and is showing positive results for patients.*
- *"These new units are a space built with lived experience at their core. These buildings are about creating environments where people feel safe, respected and empowered to heal." (EQUAL Forum Representative)*



What does our Trust Board Say…

Derbyshire Healthcare
NHS Foundation Trust

"The wards provide a wonderful, modern environment for adults accessing our services. The bespoke facilities promote privacy and dignity, with individuals having access to their own bedrooms alongside a range of therapeutic activities taking place within shared spaces. The benefits have been felt by our colleagues and visitors, as well as by people using our services."
Selina Ullah (Trust Chair)

"These facilities have been shaped by the voices of those who use our services or have loved ones who have needed mental health support from us. They set a new standard for therapeutic environments and are already making a difference to people's lives. The new units embody what modern mental health care should be – safe, respectful and recovery-focused."
Mark Powell (Chief Executive Officer)

"The wards are both modern and person centered. The signage is just one example of providing a better experience for people with sensory and visual needs. There is also a growing interest in our Trust from clinicians who want to come and work here."
Dr Girish Kunigiri (Medical Director)

"The new facilities bring care up to date. We can now provide inpatient care in facilities that promote recovery, safety, quality and better patient experience. Technology in the facility will ensure that patients can be empowered to participate in their care more than ever, reduce disturbance and improve patient safety along with our skilled staff."
Tumi Banda (Director of Nursing)

"The new environments are helping us move forward on our sustainability journey and working towards reducing carbon emissions. This might be small changes to lighting on refurbished wards like bluebell or more material changes to heating systems as the new builds come online. Better facilities are also positively helping staff recruitment and retention thus reducing the reliance on premium agency which helps our money stretch further for the benefit of patient care."
James Sabin (Finance Director)

"The opening of these new units in Derby make for another proud moment for Derbyshire. It's inspiring to see how far we've come – from plans on paper to a fully operational space that supports patients and staff with dignity and purpose. This unit is more than a building; it's a symbol of our commitment to respectful compassionate care."
Lynn Andrews (Deputy Trust Chair and Non-Executive Director)

The Model of Care

NHS
Derbyshire Healthcare
NHS Foundation Trust

Effective Implementation of the model of care and environmental changes will improve staff and patient experience as well as improve outcomes.

Patient focused

Patient and carer outcomes are captured utilising the 15 step patient challenge toolkits developed by NHSE.

People

An organisational development program has been developed separately to support us attracting and retaining staff as well as creating a positive culture.

Productive

Our MDTs deliver outcomes using metrics that demonstrate the productivity and quality of the work they are delivering.

Partnerships

The new buildings have afforded us the opportunity to forge new partnerships with external agencies for the benefit of patients.

Model of Care training was rated by 212 participants as 4.61 out of 5 for 'Relevant and engaging content' and 4.60 out of 5 for 'Ability to put training into practice'.



Patient Outcomes

Derbyshire Healthcare
NHS Foundation Trust

Quality benefits identified in the original business case

See table on slides 13-14 for more detail

Improved Privacy and dignity – **YES**
Appropriate use of space throughout the facility and Accessible outdoor spaces – **YES**
All patient bedrooms en-suite with access to natural daylight and views – **YES**
Co-location of functional and organic older adult services to improve support – **YES**
Welcoming building design – **YES**
Positive and improved Friends and Family feedback – More data required
Care plans in place within 72 hours – More data required
Care plans reviewed in 7 days – **IMPROVING** at 51% from previous avg of 39.8%
Improved completion rate of risk management plans – **IMPROVED** at 100% in Oct 25
Reduced restrictive interventions – **IMPROVING** at 23% reduction to Oct 25
Risk screens completed – **IMPROVED** at 100% in Oct 25
All Physical health checks completed – **IMPROVING** at 66% from previous avg of 61%
SMI Physical health checks completed – **IMPROVING** at 74% from previous avg of 67%

The Carsington UNIT environment is much better suited to the needs of the client group and offers single bedroom accommodation to support a therapeutic approach that aids recovery.

Patient Outcomes

People Outcomes

Derbyshire Healthcare
NHS Foundation Trust

Business case benefits considered staff attrition, vacancies and use of temporary staffing
See table on slides 13-14 for more detail

Staff Attrition Rate – NO SIGNIFICANT CHANGE
Previously 8.01% on Radbourne and currently 8.30% on Carsington to October.
The turnover of staff is within common cause variation.

Use of Bank Staff - IMPROVED
Previously 39.34% on Radbourne, reduced to 18.36% on Carsington in October.

Use of Agency Staff - IMPROVED
Showing downward trajectory to 0.31% in Sep and 0% in Oct against 0.84% and 0.26% respectively year on year.

Vacancies - IMPROVED
Previously 19.85% on Radbourne and 10.9% on Carsington in October.

The Carsington Unit is a great place to work, conducive to better patient outcomes and experiences, evidenced by improved measures for vacancies and use of bank and agency staff.

People Outcomes



Productivity Outcomes

Derbyshire Healthcare
NHS Foundation Trust

Business case benefits considered use of bank and agency staff, average length of stay, bed utilisation and loss of patient property
See table on slides 13-14 for more detail

Out of Area Placements – IMPROVED
Previously £875k per month (24-25) and currently £835k per month on average equating to £480k per year reduction. Further work underway is forecasting £3.23m reduction per year.

Use of Bank and Agency Staff – IMPROVED
Previously £219k per month (Radbourne 24-25+May) and currently £154k per month (Radbourne + Carsington May to Nov). A reduction of 65k per month on average.

Reduced Average Length of Stay – SLIGHT IMPROVEMENT
Previously 56 days (24-25) and currently 51 days (Apr-Sep). Continued programme of work and ongoing evaluation.

Bed Utilisation – NO SIGNIFICANT CHANGE
Previously 97% and currently 102% (Oct 25) from a low of 99% (Aug 25).

Avoidance of cost relating to loss of patient property – SUSTAINED IMPROVEMENT
Currently £0 for 6 months to Nov.



Partnership Outcomes

Derbyshire Healthcare
NHS Foundation Trust

Benefits to our partners, stakeholders and wider community…
See table on slides 13-14 for more detail

"These facilities and services are a testament to Derbyshire's commitment to placing dignity, privacy and recovery at the heart of mental health care. The design and therapeutic features reflect the compassion and dedication of all involved. Today is a celebration of progress and purpose."
– His Majesty's Lord Lieutenant of Derbyshire, Mrs Elizabeth Fothergill CBE



Benefiting our partners, stakeholders and wider community.

Partnerships

Benefit Measurement & Evaluation Data

Derbyshire Healthcare
NHS Foundation Trust

STRATEGIC PRIORITY	BENEFIT	CURRENCY	EVALUATION METHOD	Predicted Benefit	Carsington Baseline	Carsington 6 Mth Jun - Nov 25
PRODUCTIVITY	CRB1 The reduction (in cost) of current out of area placements, currently funded by the Trust at Mill Lodge	£	Data	*3/8ths of current acute mental health out of area beds funded by DHCFT, FY value £737K*	2024-25 £875k per mth avg	2025-26 £83k per mth avg
	CRB4 Saving from reduction in use of bank and agency staff	£	Data	Reduced expenditure	RU Yr Apr24 to May 25, £219k/mth	CU May to Nov £154k/mth
	CRB5 Avoiding loss of patient property that occasionally occurs in dormitory-style wards	£	Data	90% reduced loss patient property	0	0
	NCRB1 Reduction in average length of stay, to the national average.	LOS	Data	Reduce to 32 days	56 days avg Jun 24 - Jun 25	51 days avg Jun 25 to Aug 25
	NCRB3 Improved bed utilisation	Bed Occupancy %	Data	85% occupancy	97% avg year Apr 24 - Apr 25	Jun 101%, Jul 100%, Aug 99%, Sep 103%, Oct 102%
	NCRB5 Reduced admission rate	Number or readmits	Data		5.7% target 10% avg Jun 24 - Jun 25	Jun 40%, Jul 10%, Aug 12%, Sep 14%, Oct 13%
PEOPLE	NCRB2 Lower staff attrition rate	Staff turnover %	Data		Apr24/25, 8.01%	Jun to Oct 25, 8.3%
	New Benefit Added - Temporary Staffing (bank)	% of Establishment	Data	15% reduction in use of bank	Apr24/25, 39.34%	Jun to Oct 25, 18.36%
	New Benefit Added - Temporary Staffing (agency)	% of Establishment	Data	15% reduction in use of agency	Jul 0.65%, Aug 0.29%, Sep 0.84%, Oct 0.26%	Jul 0.04%, Aug 0.72%, Sep 0.31%, Oct 0%
	New Benefit Added - Vacancies	% of Establishment	Data		Apr24/25, 19.85%	Jun to Oct 25, 10.9%
P'SHIPS	SB1 The economic benefit of improving mental health wellbeing	£	Audit			Monitoring data
	SB2 Economic Impact of the construction on local trades, suppliers and businesses	£	Audit			Data required over a longer period of engagement

Benefit Measurement & Evaluation Data

Derbyshire Healthcare
NHS Foundation Trust

PATIENT	NCRB6 Improved privacy and dignity for service users and improved quality of service delivered	Number of Ind Rooms	Data	Improved Experience	dormatory provision	54 single bedrooms with ensuite
	Q&UM1 Eradication of dormitories and improved privacy and dignity for service users and improved quality	Number of Ind Rooms	Data	Improved Experience	dormatory provision	54 single bedrooms with ensuite
	Q&UM2 Maintaining and improving the Trust's low level of seclusion and restraint	Number of Sec&Res	Data	Improved Quality	RU year Apr24/25 , 594	Jun to Oct, 230
	Q&UM6 The approach and access for ambulances is appropriately provided	Confirmation of spec	Audit	Improved Quality	photographic evidence	photographic evidence
	Q&UM7 Outdoor spaces where access is required are accessible, well lit and accommodate users with limited mobility and wheelchair users	Confirmation of spec	Audit	Improved Experience	photographic evidence	photographic evidence
	Q&UM8 Appropriate use of space throughout the facility	Confirmation of spec	Audit	Improved Quality	photographic evidence	photographic evidence
	Q&UM9 All patient bedrooms ensuite with access to natural daylight and views of outdoor spaces	Confirmation of spec	Audit	Improved Experience	photographic evidence	photographic evidence
	Q&UM15 More frequent and better-quality contact between patients, families and friends	Survey	Audit	Improved Experience	photographic evidence	photographic evidence
	Q&UM16 Building designs have a human scale and feels welcoming	Survey	Audit	Improved Experience	photographic evidence	photographic evidence
	Q&UM18 Complaints - quick resolution	Number of QR complaints	Data	Improved Experience	year Apr24/25 , 16	Jun to Sep25, 3
	Q&UM19 Complaints - closer look	Number of CL complaints	Data	Improved Experience	year Apr24/25 , 17	Jun to Sep25, 5
	Q&UM20 Complaints - all	Number of complaints	Data	Improved Experience	year Apr24/25 , 33	Jun to Sep25, 8
	Q&UM21 Ratio of complaints to compliments	Ratio	Data	Improved Experience	year Apr24/25 , 33/63=0.5	Jun to Sep25, 8/7=1.1
	Q&UM22 Friends and family test % positive	F&F Analysis	Data	Improved Experience	av year 24-25, 66%	Jun to Aug 50% only 2 data points
	Q&UM24 Inpatient care plan reviewed in the last 7 days	Nnumber reviewed in 7 days	Data	Improved Quality	RU av year 24-25, 39.8%	Jun 55%, Jul 58%, Aug 49%, Sep 46%, Oct 51%
	Q&UM25 Risk management plans completed	Number of Risk plans completed	Data	Improved Quality	see Q&UM28	see Q&UM28
	Q&UM26 MHA.S.132 review of rights attempted - inpatients	Number attempted	Data	Improved Quality	No previous data available	Data requested
	Q&UM27 Restrictive interventions used	Number of interventions	Data	Improved Quality	RU all types, year to Apr24/25=1014	CU all types Jun to Oct 25, 327
	Q&UM28 Risk screens completed	Number of risk screens	Data	Improved Quality	no data in timeframe	Oct current patients 100%
	Q&UM29 Safety plans completed	Number of safety plans	Data	Improved Quality	no data in timeframe	Oct current patients 94.8%
	Q&UM30 Physical health check completed- all	Number of PHC completed (all)	Data	Improved Quality	May 61%	Jun 59%, Jul 70%, Aug 64%, Sep 67%, Oct 66%
	Q&UM31 Physical health check completed - SMI	Number of PHC completed (SMI)	Data	Improved Quality	May 67%	Jun 68%, Jul 78%, Aug 63%, Sep 80%, Oct 74%

Reflections and Learning

Derbyshire Healthcare
NHS Foundation Trust

Learnings from issues that have arisen, or successful design, construction, contracting and implementations approaches for sharing

The whole of the unit were engaged in the move process. Particularly useful was the pre-move preparation which brought about the use of posters, admission booklets and boards. There was a flight plan in place which was ordered, and schedule and transport was booked. Support services were stood up and down as required and everyone came together, multi-disciplinary teams working in partnership.

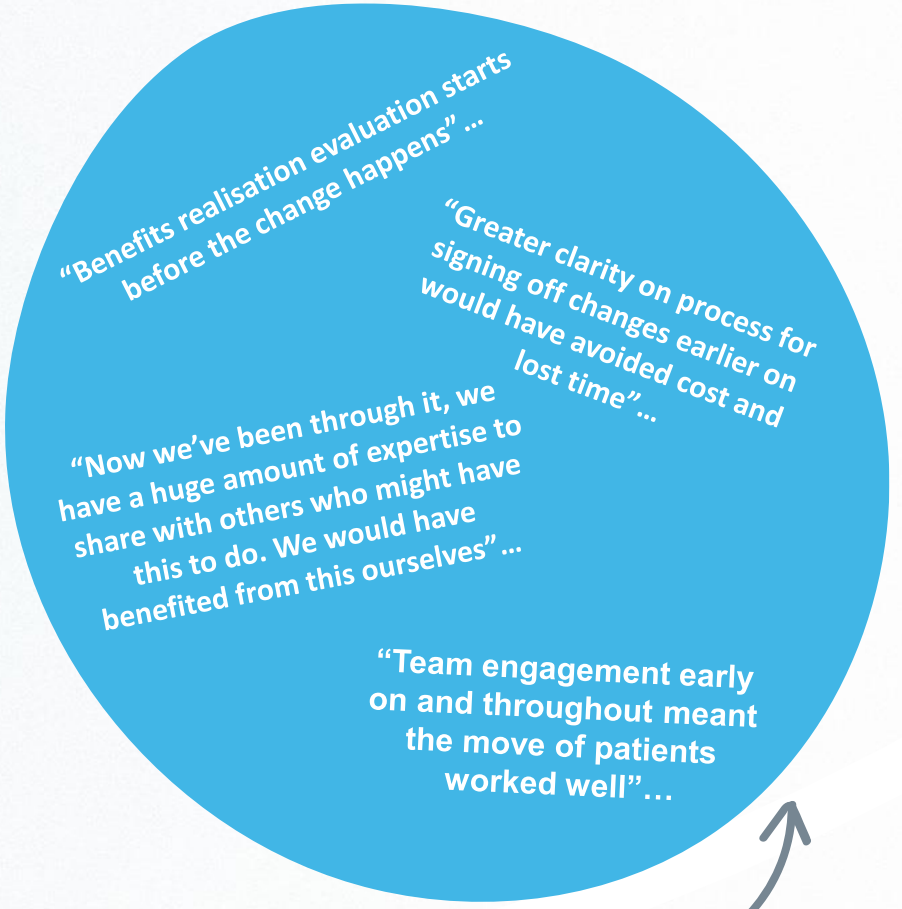
Competing demands added to pressure, and some areas were under-resourced to accommodate additional MRFD asks. In addition to staff delivering the project and moving services, also included support staff leading to particular delays in recruitment and procurement.

There were lots of snagging issues identified on the day of the move such as doors and shutters not working properly. Some staff did not have swipe access prepared, and some processes relating to alarm panels and door top had not been communicated fully or effectively.

Parking at Kingsway has become more challenging with increased demand and there needs to be a focus on parking practices and optimising capacity.

For evaluation purposes, it would have been beneficial to start collating baseline data earlier from the point when predicted benefits were identified rather than soon before go-live. Where patient groupings and configurations changed it made like for like data comparison difficult.

There is opportunity to learn from Derwent and Bluebell previously to improve on future moves. Continue to learn and share knowledge and experience.



Derbyshire Healthcare
NHS Foundation Trust

MRFD

Making Room For Dignity Benefits Evaluation

Derwent Unit – Opened 20 March 2025

Review at 6 months October 2025

Description

Derbyshire Healthcare
NHS Foundation Trust

The Derwent Unit is a modern 54 bedroom unit across three wards on two floors, relocated from the Hartington Unit. The wards are Oak Ward, Willow Ward and Sycamore Ward. It gives northern Derbyshire two additional beds for mental health inpatient services to serve more residents closer to home.

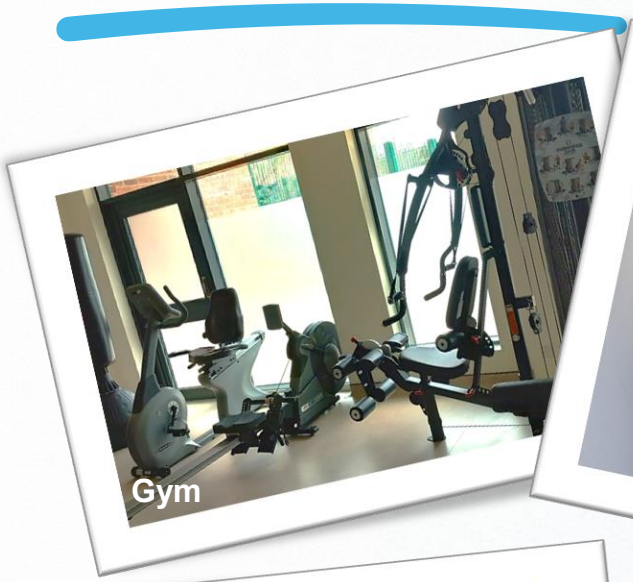


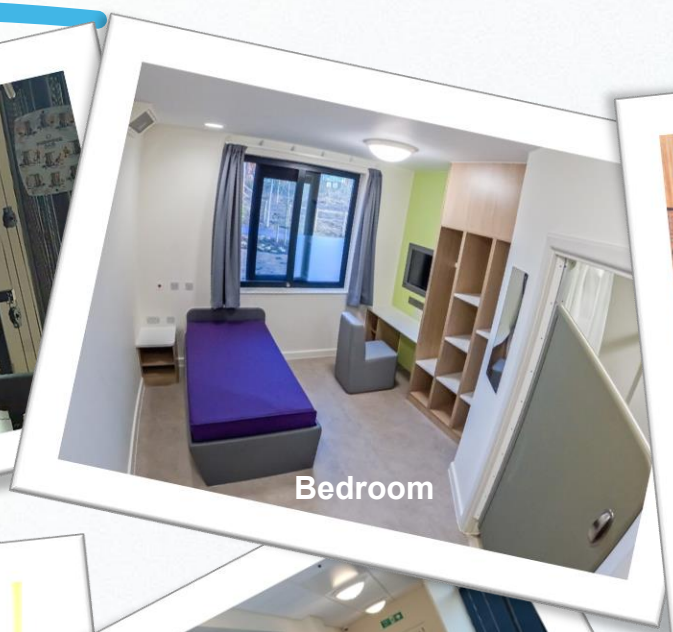
Project Costs	
Original capital agreed at FBC – PDC funding	£39,976,844
Original capital agreed at FBC – Trust funding	£9,938,763
Total capital at FBC (October 2022)	**£49,915,607**
Additional Trust funding (April 2024)	£1,261,393
Additional Trust funding (March 2025)	£1,850,226
Total Outturn cost	**£53,027,226**



Derwent Unit in Pictures

Derbyshire Healthcare
NHS Foundation Trust

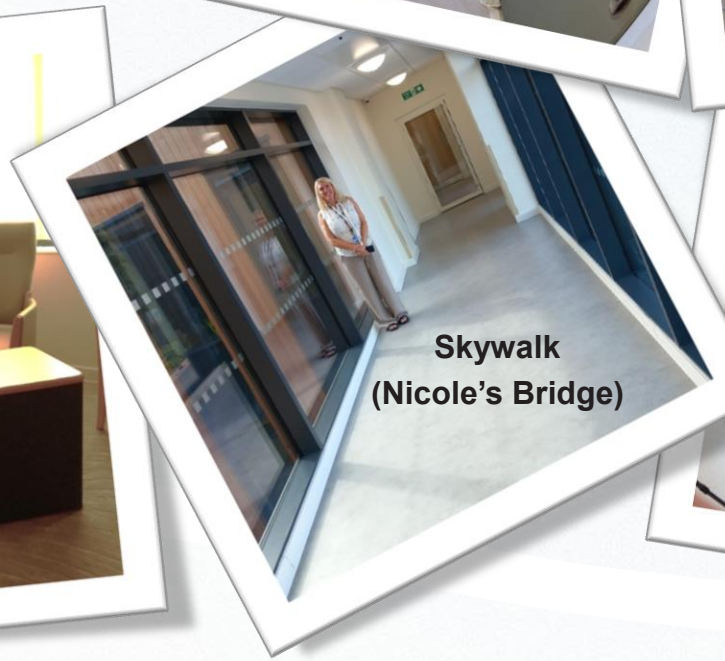

Gym


Bedroom

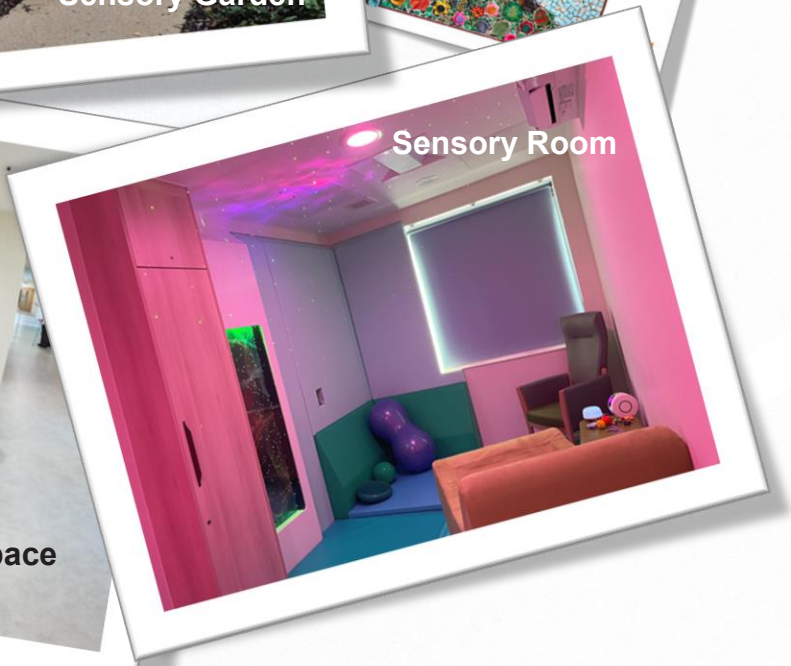

Sensory Garden


Patient Artwork


Multi-Faith Room


Skywalk
(Nicole's Bridge)


Communal Space


Sensory Room

A Patient's Perspective…

Derbyshire Healthcare
NHS Foundation Trust

Arizona and Katie are patients who transferred to the Derwent Unit. This is their experience in September 2025.

Arizona and Katie moved from the Hartington Unit and found the transition challenging due to increased patient activity and some adjustment difficulties moving from a female ward to a mixed unit. They feel that the new communal space, The Hive, is less social and welcoming than the old Hub at the Hartington, as it feels a bit more formal and structured rather than casual and relaxed, citing access to some activities, such as sessions with the hospital assistance dog, proving difficult. Generally though communal areas feel safe and friendly spaces. Arizona and Katie praised their open design, allowing easy interaction among patients and staff. They said they all call the triangular yellow seating 'The Cheese'. This refers to the open seating central to the ward space (see photo).

They feel the new unit's individual rooms with personal showers are a big improvement. They allow privacy and individual flexibility. Technology such as televisions and charging systems in rooms also provide them and the other patients with a better experience - although it is felt the charging compartments could be a little bigger to accommodate tablets. The underfloor heating is also something to look forward to although it has not been cold enough yet to experience it, even though there are occasional drafts from one or two windows making things feel a little cooler. In terms of getting outside into the fresh air though, access to gardens is very much valued.

There are still one or two issues such as some door access, and heavy doors being challenging for patients with mobility aids, and overall noise levels, especially alarms which can be distressing but it is expected these will be sorted soon.



"Having my own room and personal shower is a big improvement"

"I love being able to go out in the fresh air in the gardens"

"The open communal ward spaces feel safe and friendly"

What do our Patients and Visitors Say…

Derbyshire Healthcare
NHS Foundation Trust

- *"The ward is much brighter and good for mental health" (Sycamore Patient)*
- *"I have much better sleep here" (Oak Patient)*
- *"I like using my own TV and shower" (Willow Patient)*
- *"The splash of colours in nice on wards and bedrooms – makes it less clinical" (Sycamore Patient)*
- *"The outside areas are good" (Oak Patient)*
- *Sky garden is really good" (Willow Patient)*



What do our Staff and Partners Say…

Derbyshire Healthcare
NHS Foundation Trust

- *"Much better environment for patients and staff – calmer, brighter and more space to move around"*
- *The wards are very welcoming. What is great is that patients can see all our staff in the main office and have a conversation at any time"*
- *"The outdoor spaces are lovely to run group activities with patients and to enjoy some outdoor time"*
- *The gym is wonderful, great equipment, patients really enjoy this"*
- *"If it was me, or a member of my family coming into the unit, I'd feel so reassured"*



What does our Trust Board Say…

Derbyshire Healthcare
NHS Foundation Trust

"The wards provide a wonderful, modern environment for adults accessing our services. The bespoke facilities promote privacy and dignity, with individuals having access to their own bedrooms alongside a range of therapeutic activities taking place within shared spaces. The benefits have been felt by our colleagues and visitors, as well as by people using our services."

Selina Ullah (Trust Chair)

"The wards are both modern and person centered. The signage is just one example of providing a better experience for people with sensory and visual needs. There is also a growing interest in our Trust from clinicians who want to come and work here."

Dr Chidambaram (Medical Director)

"The new facilities bring care up to date. We can now provide inpatient care in facilities that promote recovery, safety, quality and better patient experience. Technology in the facility will ensure that patients can be empowered to participate in their care more than ever, reduce disturbance and improve patient safety along with our skilled staff."

Tumi Banda (Director of Nursing)

"The new environments are helping us move forward on our sustainability journey and working towards reducing carbon emissions. This might be small changes to lighting on refurbished wards like bluebell or more material changes to heating systems as the new builds come online. Better facilities are also positively helping staff recruitment and retention thus reducing the reliance on premium agency which helps our money stretch further for the benefit of patient care."

James Sabin (Finance Director)

The Model of Care

Derbyshire Healthcare
NHS Foundation Trust

Effective Implementation of the model of care and environmental changes will improve staff and patient experience as well as improve outcomes.

Patient focused

Patient and carer outcomes are captured utilising the 15 step patient challenge toolkits developed by NHSE.

People

An organisational development program has been developed separately to support us attracting and retaining staff as well as creating a positive culture.

Productive

Our MDTs deliver outcomes using metrics that demonstrate the productivity and quality of the work they are delivering.

Partnerships

The new buildings have afforded us the opportunity to forge new partnerships with external agencies for the benefit of patients.

Model of Care training was rated by 212 participants as 4.61 out of 5 for 'Relevant and engaging content' and 4.60 out of 5 for 'Ability to put training into practice'.



Patient Outcomes

Derbyshire Healthcare
NHS Foundation Trust

Quality benefits identified in the original business case

See table on slides 13-14 for more detail

Appropriate use of space throughout the facility and Accessible outdoor spaces – **YES**
All patient bedrooms en-suite with access to natural daylight and views – **YES**
Improved Privacy and dignity – **YES** with 36 individual rooms
Welcoming building design – **YES**
Appropriate access for ambulances and other vehicles coming to the unit – **YES**
Complaints – **IMPROVING** slightly* with 9 at 6 months from 20 all of last year

**Further thematic analysis underway to establish whether types of complaints have changed.*

Positive and improved Friends and Family feedback – **MORE DATA REQUIRED**

**There are fewer responses at the poor to very poor end of the scale with 9 versus 10 previously, but there are only 12 responses in the good to very good range compared to 59 previously. More time and data required.*

Care plans reviewed in 7 days – **IMPROVING** at 50% from 44% typical
Improved completion rate of risk management plans – **IMPROVING** at 100% Oct
Reduced restrictive interventions – **IMPROVING** at 26/mth avg from 49/mth avg
Risk screens completed – **IMPROVING** at 100% from 77.5%
All Physical health checks completed – **IMPROVING** at 74% from 38%
SMI Physical health checks completed – **IMPROVING** at 78% from 49%

The Derwent Unit environment is much better suited to the needs of the client group and offers single bedroom accommodation to support a therapeutic approach that aids recovery.

Patient Outcomes

People Outcomes

Derbyshire Healthcare
NHS Foundation Trust

Business case benefits considered staff attrition, vacancies and use of temporary staffing

See table on slides 13-14 for more detail

Staff Attrition Rate - IMPROVED

Previously 13.99% on Hartington and reduced to 6.64% on Derwent in September. The lower turnover of staff is a maintained data shift that can be considered special cause variation due to the improved working environment, conducive to providing effective patient care and improved patient experience, and aligning to the team's sense of purpose.

Use of Bank Staff - IMPROVED

Previously 22.38% on Hartington, reduced (maintained data shift) to 12.54% on Derwent.

Use of Agency Staff - IMPROVED

Previously 7.24% on Hartington, reduced (maintained data shift) to 1.03% on Derwent.

Vacancies - IMPROVED

Previously 15.02% on Hartington and zero on Derwent.

The Derwent Unit is a great place to work, conducive to better patient outcomes and experiences, evidenced by improved measures for vacancies, turnover, and use of bank and agency.

People Outcomes



Productivity Outcomes

Derbyshire Healthcare
NHS Foundation Trust

Business case benefits considered use of bank and agency staff, average length of stay, bed utilisation and loss of patient property
See table on slides 13-14 for more detail

Use of Bank and Agency Staff
Previously £408k per month (24-25) and currently £106k per month, a reduction of 302k per month on average.

Out of Area Placements - (£737k per year predicted reduction in business case)
Previously £875k per month (24-25) and currently £833k per month on average equating to £511k per year reduction. Further work underway is forecasting £3.23m reduction per year.

Reduced Average Length of Stay – Continued monitoring over longer period
Previously 51 days (24-25) and currently 51 days (Apr-Sep).

Improved Bed Utilisation
Previously 98.5% and currently 98.33% (Sep 25) from a low of 95.94% (Aug 25).

Avoidance of cost relating to loss of patient property
Currently £0 for 6 months to Sep.



Partnership Outcomes

Derbyshire Healthcare
NHS Foundation Trust

Benefits to our partners, stakeholders and wider community…

See table on slides 13-14 for more detail

"This facility represents a remarkable achievement for Derbyshire that places dignity, privacy and recovery at the centre of mental health care. The thoughtful design and therapeutic spaces reflect the compassion and commitment of everyone involved. Today is a celebration of progress, partnership and the power of purpose."
– His Majesty's Lord Lieutenant of Derbyshire, Mrs Elizabeth Fothergill CBE



Maintaining and further **establishing links with Chesterfield Royal Hospital** and **Providing more services closer to home** for the people of north Derbyshire



Benefit Measurement & Evaluation Data

Derbyshire Healthcare
NHS Foundation Trust

STRATEGIC PRIORITY	BENEFIT	CURRENCY	EVALUATION METHOD	Predicted Benefit	Derwent Baseline (HU 2024-25)	Derwent Months Apr - Sep 2025 (inc)
PRODUCTIVITY	CRB1 The reduction (in cost) of current out of area placements	£	Data	3/8ths of current acute mental health out of area beds funded by DHCFT, FY value £737K	2024-25 £8.864k - £739k/mth avg	2025-26 M1 to M6 £3.607k - £601k/mth
	CRB3 The reduction in travel costs for patients associated with out of area placements	£	Data	3/8ths of current acute mental health out of area patient travel costs funded by DHCFT, FY value £56K	24/25 M1-M11 1,101,477	No data currently
	CRB4 Saving from reduction in use of bank and agency staff	£	Data	Reduced expenditure	24-25 £2,449,075 - £408k/mth avg	25-26 M1-M6 £638,449 - £106k/mth avg
	CRB5 Avoiding loss of patient property that occasionally occurs in dormitory-style wards	£	Data	Reduction in claims for loss of patient		£0
	NCRB1 Reduction in average length of stay, to the national average.	LOS (avg)	Data	2 days . FY value £354K	51 days av/ year from June 2024	av 51 days from Apr - Sep25
	NCRB3 Improved bed utilisation	Bed Occupancy %	Data	2 extra beds , £530/day @ 85% occupancy, FY value £329K	98.5% av/year from Apr2024	Apr 100.43%, May 99.52%, Jun 96.05%, Jul 99.16%, Aug 95.94%, Sep 98.33%
	NCRB5 Reduced admission rate	Number or readmits	Data		5.55% target 10% av/year from June2024	Apr 0%, May 9.52%, Jun 5.71%, Jul 13.04%, Aug 21.43%, Sep 3.13%
PEOPLE	NCRB2 Lower staff attrition rate	Staff Turnover %	Data		24/25 M1 - 25/26M2 13.99%	Apr 12.11%, May 6.5%, Jun 2.07%, Jul 2.86%, Aug 4.51%, Sep 6.64%
	New Benefit Added - Temporary Staffing (bank)	% of Establishment	Data	15% reduction of current Hartington Unit bank and agency costs, FY value £54K	24/25 22.38%	Apr 17.47%, May 18.90%, Jun 17.51%, Jul 15.65%, Aug 17.06%, Sep 12.54%
	New Benefit Added - Temporary Staffing (agency)	% of Establishment	Data	15% reduction of current Hartington Unit bank and agency costs, FY value £54K	24/25 7.24%	Apr 2.41%, May 0.96%, Jun 0.49%, Jul 1.30%, Aug 1.21%, Sep 1.03%
	New Benefit Added - Vacancies	% of Establishment	Data		24/25 15.02%	Apr 10.31%, May 9.79%, Jun 9.79%, Jul -4.19%, Aug -3.44%. Sep -1.49%
P'SHIPS	SB1 The economic benefit of improving mental health wellbeing	£	Audit	value of relief from depression, 58 patients, FY value £129K		Monitoring data
	SB2 Economic Impact of the construction on local trades, suppliers and businesses	£	Audit	Imprvement to local economy		Data required over a longer period of engagement

Benefit Measurement & Evaluation Data

Derbyshire Healthcare
NHS Foundation Trust

STRATEGIC PRIORITY	BENEFIT	CURRENCY	EVALUATION METHOD	Predicted Benefit	Derwent Baseline (HU 2024-25)	Derwent Months Apr - Sep 2025 (inc)
PATIENT	NCRB6 Improved privacy and dignity for service users and improved quality of service delivered	Number of Ind Rooms	Data	Improved Experience		36
	Q&UM1 Eradication of dormitories and improved privacy and dignity for service users and improved quality of service delivered	Number of Ind Rooms	Data	Improved Experience	0	36
	Q&UM2 Maintaining and improving the Trust's low level of seclusion and restraint	Number of Sec&Res	Data	Improved Quality	24/25 526	150 Apr - Sep
	Q&UM6 The approach and access for ambulances is appropriately provided	Confirmation of spec	Audit	Improved Quality	Outdated Specification	photo evidence
	Q&UM7 Outdoor spaces where access is required are accessible, well lit and accommodate users with limited mobility and wheelchair users	Confirmation of spec	Audit	Improved Experience	Outdated Specification	photo evidence
	Q&UM8 Appropriate use of space throughout the facility	Confirmation of spec	Audit	Improved Quality	Outdated Specification	photo evidence, HIVE under review
	Q&UM9 All patient bedrooms ensuite with access to natural daylight and views of outdoor spaces	Confirmation of spec	Audit	Improved Experience	Outdated Specification	photo evidence
	Q&UM15 More frequent and better-quality contact between patients, families and friends	Survey	Audit	Improved Experience	Outdated Specification	photo evidence of space to add to survey
	Q&UM16 Building designs have a human scale and feels welcoming	Survey	Audit	Improved Experience	Outdated Specification	photo evidence of space to add to survey
	Q&UM18 Complaints - quick resolution	Number of QR complaints	Data	Improved Experience	6	3 Apr- Sep
	Q&UM19 Complaints - closer look	Number of CL complaints	Data	Improved Experience	15	7 Apr-Sep
	Q&UM20 Complaints - all	Number of complaints	Data	Improved Experience	21	10 Apr- Sep
	Q&UM21 Ratio of complaints to compliments	Ratio	Data	Improved Experience	21/25 0.84	10/31 0.32 Apr - Sep
	Q&UM22 Friends and family test % positive	F&F Analysis	Data	Improved Experience	87%	57% Apr - Sep
	Q&UM24 Inpatient care plan reviewed in the last 7 days	Nnumber reviewed in 7 days	Data	Improved Quality	current position only	Apr 48.9%, May 52.1%, Jun 39.3%, Jul 34%, Aug 44.1%, Sep 50%
	Q&UM25 Risk management plans completed	Number of Risk plans completed	Data	Improved Quality	70.40%	jun 90/108 83.9%, jul 79/10178.2%, aug 75/112 67.0%
	Q&UM26 MHA.S.132 review of rights attempted - inpatients	Number attempted	Data	Improved Quality	current position only	current position only, no access
	Q&UM27 Restrictive interventions used	Number of interventions	Data	Improved Quality	587 (avg 49/mth)	157 Apr - Sep (avg 26/mth)
	Q&UM28 Risk screens completed	Number of risk screens	Data	Improved Quality	av 24/25 77.5%%	Jun (mth 3) 89/108 82.4%, Current Oct 100%
	Q&UM29 Safety plans completed	Number of safety plans	Data	Improved Quality	av 24/25 87.1%	jun 85/87 97.7%, jul 77/78 98.7%, aug 73/76 96.1% - OCT 100%
	Q&UM30 Physical health check completed- all	Number of PHC completed (all)	Data	Improved Quality	av 24/25 37.58%	Apr 63.96%, May 74.47%, Jun 73.63%, Jul 75.92%, Aug 73.66%, Sep 73.95%
	Q&UM31 Physical health check completed - SMI	Number of PHC completed (SMI)	Data	Improved Quality	av 24/25 49.24%	Apr 70.51%, May 74.53%, Jun 79.29%, Jul 81.56%, Aug 80.14%, Sep 79.72%

Reflections and Learning

Derbyshire Healthcare
NHS Foundation Trust

Learnings from issues that have arisen, or successful design, construction, contracting and implementations approaches for sharing

The whole of the Hartington Unit were engaged in the move process, and access to the building a week ahead enabled effective planning and coordination. This meant that in most cases things were in place at the other end as they were needed. All wards and additional areas owned their own local space and preparations.

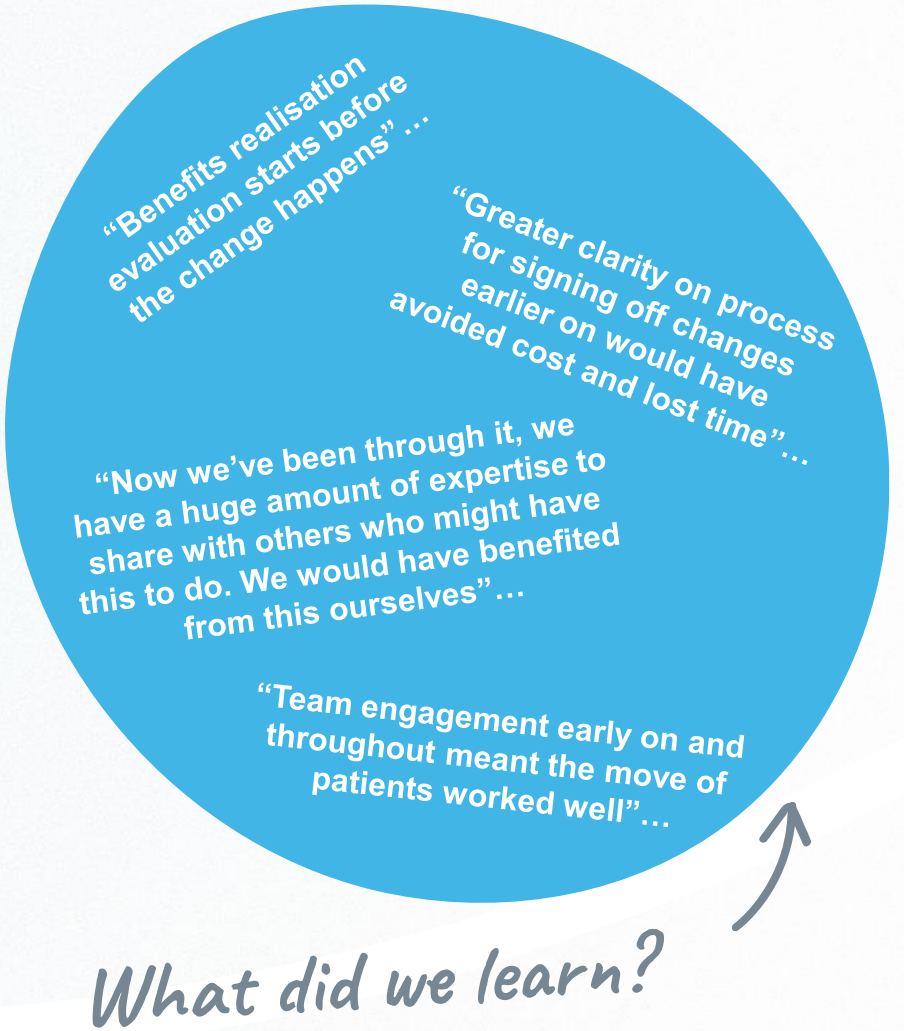
Departures and arrivals methodology for the move worked well and we were in ahead of scheduled on the day.

Some things could have been checked before the move day and rectified e.g. keys for cabinets and notice boards, shutters on kitchen hatches, testing phone numbers and extensions. It is acknowledged that snagging is a factor and there were issues every day in the first two weeks.

Some elements of the move were missed and needed addressing on the day such as pagers not working properly and keys not being ready, catering numbers, beds/linen, receptions staff arrangements, notice boards not up… Things we would be more aware of next time and captured in the learning lessons report.

For evaluation purposes, it would have been beneficial to start collating baseline data earlier from the point when predicted benefits were identified rather than soon before go-live. Where patient groupings and configurations changed it made like for like data comparison difficult.

There is opportunity to learn from Derwent and Bluebell previously to improve on future moves. Continue to learn and share knowledge and experience.



Benefits Evaluation reports – Audrey House and Kingfisher Unit

Purpose of Report

Submission of Benefits Evaluation reports for Audrey House, opened 15 July 2025 and Kingfisher Psychiatric Intensive Care Unit (PICU), opened 22 July 2025 as part of the Making Room for Dignity (MRfD) Programme for approval.

Executive Summary

This is a report detailing the extent to which benefits of Audrey House and Kingfisher Unit have been achieved relative to the aims identified in the original business case. It uses data obtained from the five months post-opening, up to the end of December 2025.

The report also includes feedback from patients, visitors, staff, System partners and Trust Board members, as well as more detailed reflections from patients in the form of a patient perspectives and stories.

The reports are largely positive showing improvement against most metrics, with further work to do to provide greater confidence and assurance in the long-term over a larger sample of data. It is intended to refresh and review the document at 12 months for this purpose.

Strategic Considerations		BAF Risk (eg 1A)	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X	**25-26 1E** There is a risk that the Trust does not deliver key regulatory and strategic requirements related to dormitory eradication and that the Trust estate is not maintained sufficiently well to comply with regulatory and legislative requirements	**3.3** Optimise our assets and enable resources to improve services and care
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

None identified.

Consultation

With all parties involved in the building and operationalisation of the Carsington Unit as part of the MRfD Programme, the Finance and Performance Committee, the People and Culture Committee and the Quality and Safeguarding Committee.

Governance or Legal Issues

None currently.

Net Zero Duty Implications

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

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

The new facilities were specifically designed to operate as close to 'net zero' as is currently possible – this includes moving away from fossil fuel sources and inclusion of relevant green technology (air source heat pumps, solar and PV panels) and use of 'modern methods of construction' to reduce emissions during the construction phase. Additionally, a key aim of the programme was to provide care for our patients closer to home and their communities, thereby delivering an additional environmental benefit of reducing travel and transportation related emissions.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

No adverse impact.

Recommendations

The Board of Directors is requested to approve the reports.

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

Report prepared by: **Joe Wileman**
Head of Programme Delivery

Derbyshire Healthcare
NHS Foundation Trust

MRfD

Making Room for Dignity Benefits Evaluation

Audrey House Open 15 July 2025
Review at five months January 2026

WE MAKE A POSITIVE DIFFERENCE IN EVERYTHING WE DO

Description

Derbyshire Healthcare
NHS Foundation Trust

A modern eight-bedroom female enhanced care unit on the Kingsway site in Derby. This service sits between Adult Acute Inpatient services and the Psychiatric Intensive Care Unit (PICU). It is an enhanced care facility providing an increased level of support for women locally.



Project Costs – Audrey	
Original capital agreed at FBC – PDC funding	£3,890,000
Original capital agreed at FBC – Trust funding	£104,051
Total capital at FBC (March 2023)	**£3,994,051**



Audrey House in Pictures

NHS
Derbyshire Healthcare
NHS Foundation Trust

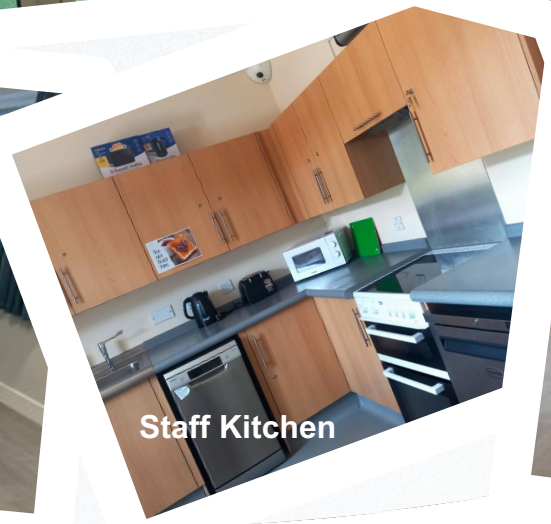














Patients' Perspectives…

Derbyshire Healthcare
NHS Foundation Trust

A group of patients on the ward were asked about their experience of Audrey House since its opening.

They said they liked the open design and that it was spacious and calming.

They all said, they liked the single bedroom spaces as it gave them privacy and their own space to do their own thing when they wanted to.

They said the sensory rooms were very good and that they found them beneficial.

They said, having no big office or room where staff are separated from patients means staff are always visible, present and accessible.

The layout means they can see the staff, and it is nice to welcome them each day.



What do our Patients and Visitors Say…

Derbyshire Healthcare
NHS Foundation Trust

- *"It has a nice, relaxed atmosphere"*
- *"You always see the staff about and you can easily find them and speak to them"*
- *"I feel supported"*
- *"it is a nice environment, bright, spacious and calming"*
- *"It is good to have a range of activities to do with different members of staff"*
- *The team work cohesively, with better processes around referrals and admissions"*
- *"It is a welcoming building for visitors, and the staff are nice".*



What do our Staff and Partners Say…

Derbyshire Healthcare
NHS Foundation Trust

- *"We worked collaboratively and flexibly during the opening with individuals taking on tasks outside of their normal roles to support the process"*
- *"Patient planning was challenging but ultimately successful, resulting in patients being safely admitted to the unit and reducing out of area use"*
- *"IT infrastructure was prepared well in advance"*
- *"Staff have come together as a unified team with improved collaboration and understanding of roles"*
- *The inclusion of new professional roles such as psychology, has positively contributed to the team's effectiveness"*
- *The team is more organised and cohesive in reviewing referrals"*
- *"There is continued progress in understanding roles and working styles, with shared vision focused on patient care and quality service".*



What does our Trust Board Say…

Derbyshire Healthcare
NHS Foundation Trust

"The unit provides a wonderful, modern environment for adults accessing our services. The bespoke facilities promote privacy and dignity, with individuals having access to their own bedrooms alongside a range of therapeutic activities taking place within shared spaces. The benefits have been felt by our colleagues and visitors, as well as by people using our services."
Selina Ullah (Trust Chair)

"These facilities have been shaped by the voices of those who use our services or have loved ones who have needed mental health support from us. They set a new standard for therapeutic environments and are already making a difference to people's lives. The new units embody what modern mental health care should be – safe, respectful and recovery-focused."
Mark Powell (Chief Executive Officer)

"The unit is both modern and person-centered. The signage is just one example of providing a better experience for people with sensory and visual needs. There is also a growing interest in our Trust from clinicians who want to come and work here."
Dr Girish Kunigiri (Medical Director)

"The new facilities bring care up to date. We can now provide inpatient care in facilities that promote recovery, safety, quality and better patient experience. Technology in the facility will ensure that patients can be empowered to participate in their care more than ever, reduce disturbance and improve patient safety along with our skilled staff."
Tumi Banda (Director of Nursing)

"The new environments are helping us move forward on our sustainability journey and working towards reducing carbon emissions. This might be small changes to lighting on refurbished wards like bluebell or more material changes to heating systems as the new builds come online. Better facilities are also positively helping staff recruitment and retention thus reducing the reliance on premium agency which helps our money stretch further for the benefit of patient care."
James Sabin (Finance Director)

"The opening of these new units in Derby makes for another proud moment for Derbyshire. It's inspiring to see how far we've come – from plans on paper to a fully operational space that supports patients and staff with dignity and purpose. This unit is more than a building; it's a symbol of our commitment to respectful compassionate care."
Lynn Andrews (Deputy Trust Chair and Non-Executive Director)

The Model of Care

NHS
Derbyshire Healthcare
NHS Foundation Trust

Effective Implementation of the model of care and environmental changes will improve staff and patient experience as well as improve outcomes.

Patient focused

Patient and carer outcomes are captured utilising the 15 step patient challenge toolkits developed by NHSE.

People

An organisational development program has been developed separately to support us attracting and retaining staff as well as creating a positive culture.

Productive

Our multi-disciplinary teams (MDTs) deliver outcomes using metrics that demonstrate the productivity and quality of the work they are delivering.

Partnerships

The new buildings have afforded us the opportunity to forge new partnerships with external agencies for the benefit of patients.

Model of Care training was rated by 212 participants as 4.61 out of 5 for 'Relevant and engaging content' and 4.60 out of 5 for 'Ability to put training into practice'.



Patient Outcomes

Derbyshire Healthcare
NHS Foundation Trust

Quality benefits identified in the original business case
See table on slides 13-14 for more detail

Improved Privacy and dignity – **YES**
Appropriate use of space throughout the facility and Accessible outdoor spaces – **YES**
All patient bedrooms en-suite with access to natural daylight and views – **YES**
Welcoming building design – **YES**
Positive and improved Friends and Family feedback – More data required
Care plans in place within 72 hours – More data required
Care plans reviewed in 7 days – **IMPROVING**
Improved completion rate of risk management plans – **IMPROVED** at 100%
Reduced restrictive interventions – **IMPROVING**
Risk screens completed – **IMPROVED** at 100%
All Physical health checks completed – **IMPROVED** at 100%
SMI Physical health checks completed – **IMPROVED** at 100%

The Audrey House environment is now much better suited to the needs of the client group, offering single bedroom accommodation and supporting a therapeutic approach that aids recovery.

Patient Outcomes

People Outcomes

Derbyshire Healthcare
NHS Foundation Trust

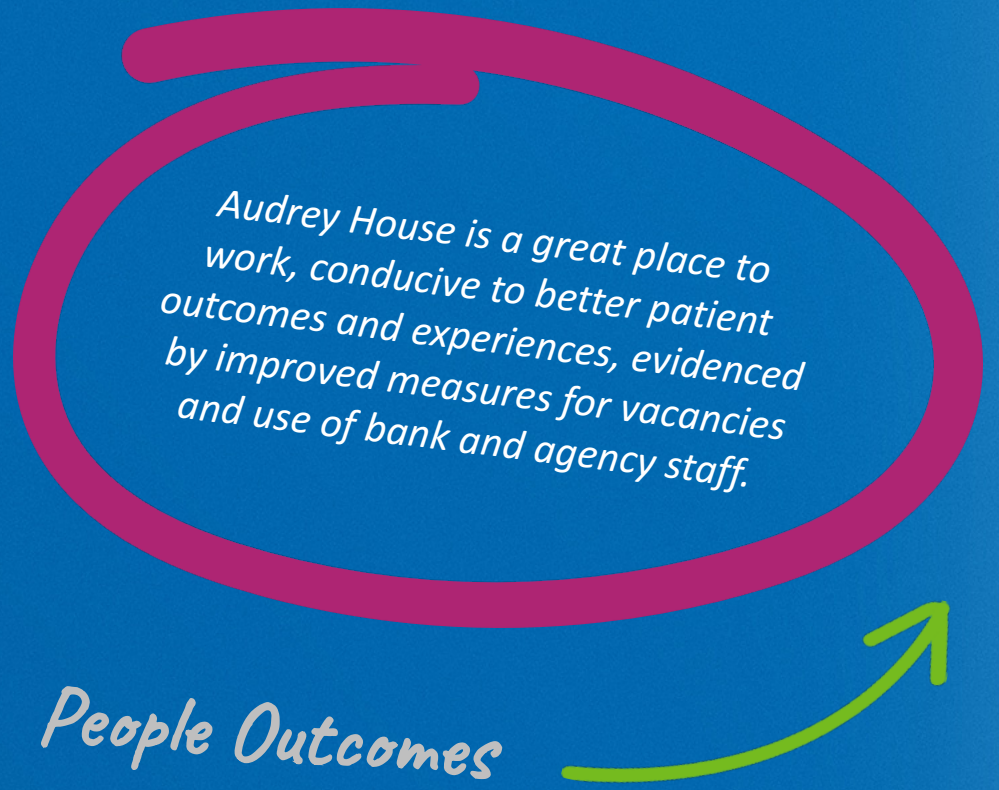
Business case benefits considered staff attrition, vacancies and use of temporary staffing
See table on slides 13-14 for more detail

Staff Attrition Rate - IMPROVED
No direct comparison but typically around 15% for cohort on Radbourne and now at 7.5% on Audrey House. Lower turnover of staff due to improved working environment, conducive to providing effective patient care and improved patient experience, aligning to the team's sense of purpose.

Use of Bank Staff – NO SIGNIFICANT CHANGE
Similar rates of bank staff use between 20-30%. Wider programme looking to address bank staff use.

Use of Agency Staff - IMPROVED
Reduced from similar cohort comparison and at 0% in November 2025.

Vacancies - IMPROVED
Reduced from similar cohort comparison and at 10.81% in November 2025.



Productivity Outcomes

Derbyshire Healthcare
NHS Foundation Trust

Business case benefits considered use of bank and agency staff, average length of stay, bed utilisation and loss of patient property
See table on slides 13-14 for more detail

Out of Area Placements – IMPROVED
Previously £875k per month (24-25) and contributing to a current £835k per month on average equating to £480k per year reduction. Further work underway is forecasting £3.23m reduction per year.

Use of Bank and Agency Staff – IMPROVED
Previously £219k per month (Radbourne 24-25) and contributing to a current £154k per month.
A reduction of 65k per month on average.

Reduced Average Length of Stay – IMPROVED
Previously 56 days for cohort on Radbourne (24-25) and currently 30 days on Audrey House (Jul-Dec).
Continued programme of work and ongoing evaluation.

Bed Utilisation – IMPROVED
Previously 108% and currently 92% (Dec 2025).

Avoidance of cost relating to loss of patient property – SUSTAINED IMPROVEMENT
Currently £0.



Partnership Outcomes

Derbyshire Healthcare
NHS Foundation Trust

Benefits to our partners, stakeholders and wider community…
See table on slides 13-14 for more detail

"These facilities and services are a testament to Derbyshire's commitment to placing dignity, privacy and recovery at the heart of mental health care. The design and therapeutic features reflect the compassion and dedication of all involved. Today is a celebration of progress and purpose."
– His Majesty's Lord Lieutenant of Derbyshire, Mrs Elizabeth Fothergill CBE





Benefit Measurement and Evaluation Data

Derbyshire Healthcare
NHS Foundation Trust

STRATEGIC PRIORITY	BENEFIT	CURRENCY	EVALUATION METHOD	Predicted Benefit	RU Baseline	Audrey House 6 Mth July- Dec 25
PRODUCTIVITY	CRB1 The reduction (in cost) of current out of area placements, currently funded by the Trust at Mill Lodge	£	Data	3/8ths of current acute mental health out of area beds funded by DHCFT, FYE £737K	2024-25 £875k per mth avg	2025-26 £835k per mth avg
	CRB4 Saving from reduction in use of bank and agency staff	£	Data	Reduced expenditure	RU Yr Apr24 to May 25, £219k/mth	*CU May to Nov £154k/mth*
	CRB5 Avoiding loss of patient property that occasionally occurs in dormitory-style wards	£	Data	90% reduced loss patient property	0	0
	NCRB1 Reduction in average length of stay, to the national average.	LOS	Data	Reduce to 32 days	62 av days LOS over 273 females on wards 33,34,35 apr 24 to May 25	30 days av July to Dec 25
	NCRB3 Improved bed utilisation	Bed Occupancy %	Data	85% occupancy	108% YTD Apr 24 - Mar 25 RU wards 33,34,35	Jul 37%, Aug 84%, Sep 88%, Oct 92%, Nov 102%, Dec 92%, YTD 82%
	NCRB5 Reduced admission rate	Number or readmits	Data		10%,target 10% 19 readmissions / out of 185 RU 33,34,35 YTD from Apr 25	Jul 50%, Aug 0%, Sep 0%, Oct 50% , Nov, Dec no data, total 33% 2 readmissions / out of 6 in cohort
PEOPLE	NCRB2 Lower staff attrition rate	Staff turnover %	Data		Apr 14.35% May 14.51% Jun 14.60% Jul 14.72% Aug 15.05% Sep 20.34% Oct 18.22% Nov 18.46% RU wards 34, 36	Apr 0.00% May 11.33% Jun 8.03% Jul 6.98% Aug 5.58% Sep 4.78% Oct 8.36% Nov 7.5%
	New Benefit Added - Temporary Staffing (bank)	% of Establishment	Data	15% reduction in use of bank	Apr 8.87% May 8.74% Jun 5.98% Jul 16.78% Aug 15.96% Sep 27.21% Oct 28.32% Nov 32.17% RU wards 34, 36	Apr - May - Jun 0.13% Jul 0.00% Aug 6.53% Sep 25.62% Oct 27.91% Nov 31.32%
	New Benefit Added - Temporary Staffing (agency)	% of Establishment	Data	15% reduction in use of agency	Apr - May - Jun - Jul - Aug 0.47% Sep 0.32% Oct 0.27% Nov 0.46%RU wards 34, 36	Apr - May - Jun - Jul - Aug 0.47% Sep 0.19% Oct 0.93% Nov 0.00%
	New Benefit Added - Vacancies	% of Establishment	Data		Apr 20.30% May 29.12% Jun 24.80% Jul 30.34% Aug 33.71% Sep 35.89%Oct 32.11% Nov 28.78% RU wards 34, 36	69.25% May 44.66% Jun 36.04% Jul 20.55% Aug 18.22% Sep 18.00 Oct 12.76% Nov 10.81%
P'SHIPS	SB1 The economic benefit of improving mental health wellbeing	£	Audit			*Monitoring data*
	SB2 Economic Impact of the construction on local trades, suppliers and businesses	£	Audit			*Data required over a longer period of engagement*

Benefit Measurement & Evaluation Data

Derbyshire Healthcare
NHS Foundation Trust

PATIENT	NCRB6 Improved privacy and dignity for service users and improved quality of service delivered	Number of Ind Rooms	Data	Improved Experience	OOA provision	8 single bedrooms with ensuite
	Q&UM1 Eradication of dormitories and improved privacy and dignity for service users and improved quality of service delivered	Number of Ind Rooms	Data	Improved Experience	OOA provision	8 single bedrooms with ensuite
	Q&UM2 Maintaining and improving the Trust's low level of seclusion and restraint	Number of Sec&Res	Data	Improved Quality	RU year Apr24/25 , 594	Jul 25 to Dec 25, 44
	Q&UM6 The approach and access for ambulances is appropriately provided	Confirmation of spec	Audit	Improved Quality	photographic evidence	photographic evidence
	Q&UM7 Outdoor spaces where access is required are accessible, well lit and accommodate users with limited mobility and wheelchair users	Confirmation of spec	Audit	Improved Experience	photographic evidence	photographic evidence
	Q&UM8 Appropriate use of space throughout the facility	Confirmation of spec	Audit	Improved Quality	photographic evidence	photographic evidence
	Q&UM9 All patient bedrooms ensuite with access to natural daylight and views of outdoor spaces	Confirmation of spec	Audit	Improved Experience	photographic evidence	photographic evidence
	Q&UM15 More frequent and better-quality contact between patients, families and friends	Survey	Audit	Improved Experience	photographic evidence	photographic evidence
	Q&UM16 Building designs have a human scale and feels welcoming	Survey	Audit	Improved Experience	photographic evidence	photographic evidence
	Q&UM18 Complaints - quick resolution	Number of QR complaints	Data	Improved Experience	RU Apr24 to Mar25, 16	Jul - Dec 25, 0
	Q&UM19 Complaints - closer look	Number of CL complaints	Data	Improved Experience	RU Apr24 to Mar25, 12	Jul - Dec 25, 0
	Q&UM20 Complaints - all	Number of complaints	Data	Improved Experience	RU Apr24 to Mar25, 28	Jul - Dec 25, 0
	Q&UM21 Ratio of complaints to compliments	Ratio	Data	Improved Experience	RU (28/61), 0.46	(0/1), 0
	Q&UM22 Friends and family test % positive	F&F Analysis	Data	Improved Experience	RU Apr24 to Mar25, 22	no reports for AH yet
	Q&UM24 Inpatient care plan reviewed in the last 7 days	Nnumber reviewed in 7 days	Data	Improved Quality	RU Apr24 to Mar25, 39.9%	No data available for AH
	Q&UM25 Risk management plans completed	Number of Risk plans completed	Data	Improved Quality	RU w35 & w36 100% 19/19 current data	100% 8/8 current data
	Q&UM26 MHA.S.132 review of rights attempted - inpatients	Number attempted	Data	Improved Quality	no report found	no report found
	Q&UM27 Restrictive interventions used	Number of interventions	Data	Improved Quality	RU w33,34,35,female, all int Apr24 -Mar25, 786	All int, Jul-Dec25, 51
	Q&UM28 Risk screens completed	Number of risk screens	Data	Improved Quality	RU w35 & w36 100% 19/19 current data	100% 8/8 current data
	Q&UM29 Safety plans completed	Number of safety plans	Data	Improved Quality	RU w35 & w36 94.7% 18/19 current data	100% 8/8 current data
	Q&UM30 Physical health check completed- all	Number of PHC completed (all)	Data	Improved Quality	RU w33, 34,35, female 451/1076, 41.91%	Jul 9/9, 100%,Aug 6/7, 85.71%,Sep &Oct 7/8,87.5%, Nov 9/9, Dec 10/10 100%
	Q&UM31 Physical health check completed - SMI	Number of PHC completed (SMI)	Data	Improved Quality	RU w33, 34,35, female 378/757, 49.93%	Jul 6/6,100%,Aug6/7, 85.71%,Sep7/8,87.5%,Oct,Nov Dev, 7/7,8/8,9/9, 100%

Reflections and Learning

Derbyshire Healthcare
NHS Foundation Trust

Learnings from issues that have arisen, or successful design, construction, contracting and implementations approaches for sharing

Clear, direct, and timely communication between senior leaders, project teams, and frontline staff builds confidence, reduces uncertainty, and ensures everyone is informed and engaged throughout all stages of delivery.

The flexibility and commitment shown by staff across disciplines were key strengths. Future projects should continue to empower teams to work collaboratively and share ownership of outcomes.

Early testing of systems, equipment, and logistics—combined with realistic timelines—prevents last-minute pressures and ensures safe, well-co-ordinated openings.

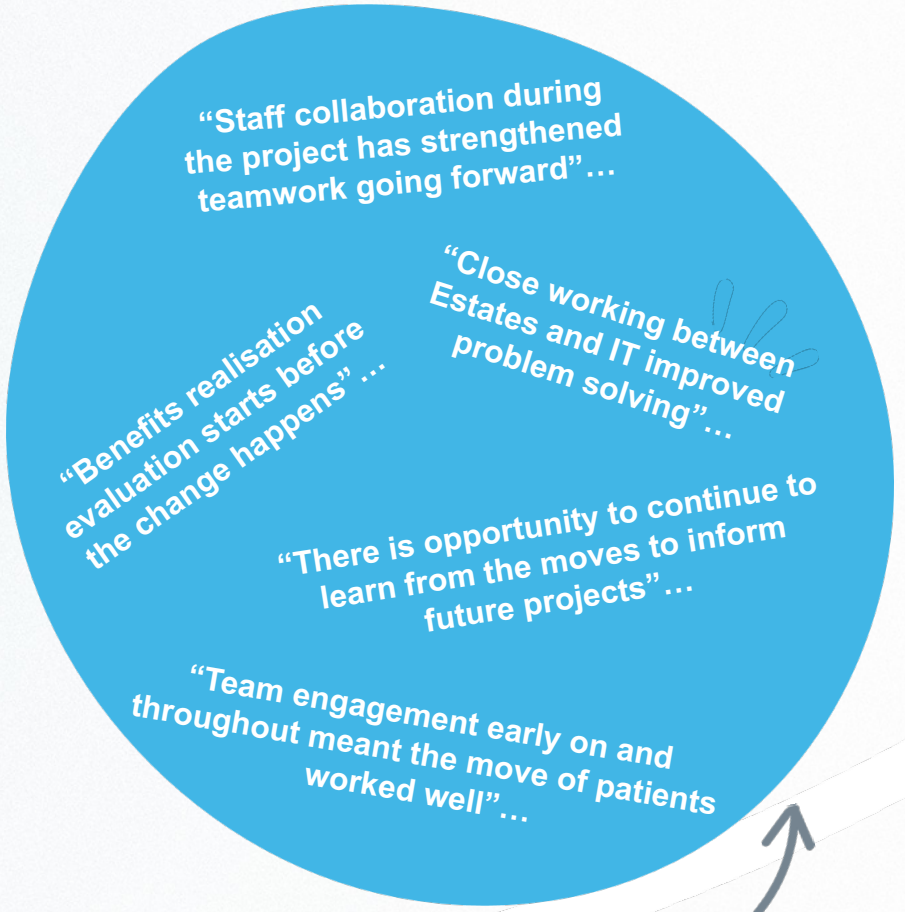
Involving clinical staff from the outset helps shape environments and models of care that are patient-centred, practical, and sustainable, improving the overall quality of service delivery.

Embedding reflective practice, capturing lessons as they occur, and sharing them across the organisation ensures continuous improvement and supports smoother delivery in future developments.

Competing demands added to pressure, and some areas were under-resourced to accommodate additional MRFD asks. In addition to staff delivering the project and moving services, also included support staff leading to particular delays in recruitment and procurement.

Parking at Kingsway has become more challenging with increased demand and there needs to be a focus on parking practices and optimising capacity.

For evaluation purposes, it would have been beneficial to start collating baseline data earlier from the point when predicted benefits were identified rather than soon before go-live. Where patient groupings and configurations changed it made like for like data comparison difficult.



What did we learn?

Derbyshire Healthcare
NHS Foundation Trust

MRfD

Making Room for Dignity Benefits Evaluation

Kingfisher Unit Open 22 July 2025
Review at five months January 2026

WE MAKE A POSITIVE DIFFERENCE IN EVERYTHING WE DO

Description

Derbyshire Healthcare
NHS Foundation Trust



A modern 14-bedroom male Psychiatric Intensive Care Unit (PICU) at Kingsway Hospital in Derby, providing easy access to a wide range of other specialist mental health facilities including a low secure unit and rehabilitation services.

Project Costs – Kingfisher	
Original capital agreed at FBC – PDC funding	£9,500,000
Original capital agreed at FBC – Trust funding	£5,120,000
Total capital at FBC (December 2022)	**£14,620,000**
Additional PDC funding (December 2024)	£507,000
Additional Trust funding (April 2024)	£286,877
Total Outturn cost	**£15,413,877**

Kingfisher

Kingfisher PICU in Pictures

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NHS Foundation Trust













Shakil's Perspective…

Derbyshire Healthcare
NHS Foundation Trust



Shakil has recently been discharged from Kingfisher and shares his experience of his time there.

My impression of the hospital is that it's amazing, it's the most modern hospital I've been in. The single bedroom with ensuite made a massive difference to me, it meant I could be on my own and rest well – even down to the ear plugs, it was like being in a hotel.

The activities with the Occupational Therapists was great, and I also really enjoyed playing on the pool table with others. It was a good space to mix with the other patients and get to know them. The staff were good too.

If I was ever feeling overwhelmed, my personal wrist band gave me access to my room whenever I wanted and gave me the privacy and quiet I needed when I needed it.

The outdoor spaces felt like going to the park, they were really good. I liked everything about Kingfisher, it was a modern and cosy space, even the laundry was good. It was a really good experience for me.

What do our Patients and Visitors Say…

Derbyshire Healthcare
NHS Foundation Trust

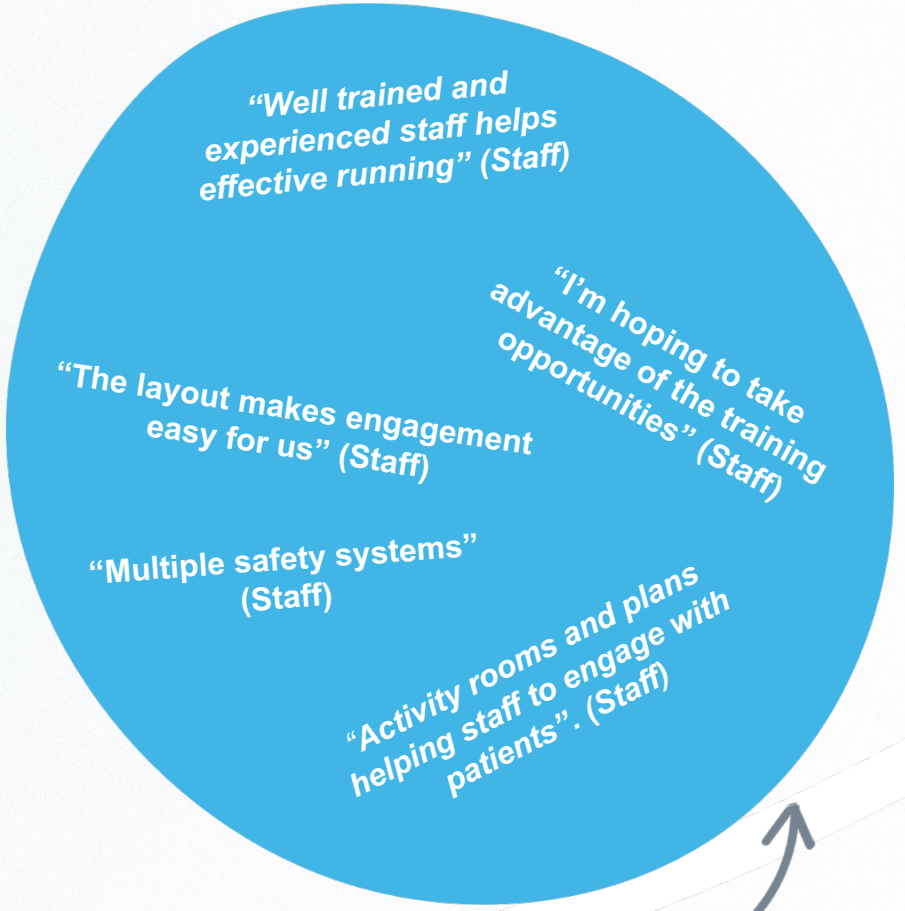
- *"It's great there is now a PICU. People who need this level of support needed to travel outside of the county for a bed and now they don't"*
- *The facilities are excellent, it's really modern"*
- *"I love the outdoor spaces; they really make a difference"*
- *"I like the activities and the staff who run them, there are good things to do"*
- *"A calming environment, even though it's not always calm".*



What do our Staff and Partners Say…

Derbyshire Healthcare
NHS Foundation Trust

- *"Fabulous environment, conducive to good patient outcomes"*
- *"Lessons learned from previous openings has improved the process"*
- *"Collaborative working across clinical, operational and estates contributed to the success"*
- *Conducting team training prior to opening was highly beneficial, allowing team members to connect and prepare effectively"*
- *"Linking with the Manchester team provided valuable insights into helping guide the opening"*
- *"Phased admission of patients to the new ward worked well"*
- *"Breakaway training for EFM staff will improve safety".*



They say...

What does our Trust Board Say…

Derbyshire Healthcare
NHS Foundation Trust

"The unit provides a wonderful, modern environment for adults accessing our services. The bespoke facilities promote privacy and dignity, with individuals having access to their own bedrooms alongside a range of therapeutic activities taking place within shared spaces. The benefits have been felt by our colleagues and visitors, as well as by people using our services."
Selina Ullah (Trust Chair)

"These facilities have been shaped by the voices of those who use our services or have loved ones who have needed mental health support from us. They set a new standard for therapeutic environments and are already making a difference to people's lives. The new units embody what modern mental health care should be – safe, respectful and recovery-focused."
Mark Powell (Chief Executive Officer)

"The unit is both modern and person centered. The signage is just one example of providing a better experience for people with sensory and visual needs. There is also a growing interest in our Trust from clinicians who want to come and work here."
Dr Girish Kunigiri (Medical Director)

"The new facilities bring care up to date. We can now provide inpatient care in facilities that promote recovery, safety, quality and better patient experience. Technology in the facility will ensure that patients can be empowered to participate in their care more than ever, reduce disturbance and improve patient safety along with our skilled staff."
Tumi Banda (Director of Nursing)

"The new environments are helping us move forward on our sustainability journey and working towards reducing carbon emissions. This might be small changes to lighting on refurbished wards like bluebell or more material changes to heating systems as the new builds come online. Better facilities are also positively helping staff recruitment and retention thus reducing the reliance on premium agency which helps our money stretch further for the benefit of patient care."
James Sabin (Finance Director)

"The opening of these new units in Derby make for another proud moment for Derbyshire. It's inspiring to see how far we've come – from plans on paper to a fully operational space that supports patients and staff with dignity and purpose. This unit is more than a building; it's a symbol of our commitment to respectful compassionate care."
Lynn Andrews (Deputy Trust Chair and Non-Executive Director)

The Model of Care

NHS
Derbyshire Healthcare
NHS Foundation Trust

Effective Implementation of the model of care and environmental changes will improve staff and patient experience as well as improve outcomes.

Patient focused

Patient and carer outcomes are captured utilising the 15 step patient challenge toolkits developed by NHSE.

People

An organisational development program has been developed separately to support us attracting and retaining staff as well as creating a positive culture.

Productive

Our multi-disciplinary teams (MDTs) deliver outcomes using metrics that demonstrate the productivity and quality of the work they are delivering.

Partnerships

The new buildings have afforded us the opportunity to forge new partnerships with external agencies for the benefit of patients.

Model of Care training was rated by 212 participants as 4.61 out of 5 for 'Relevant and engaging content' and 4.60 out of 5 for 'Ability to put training into practice'.



Patient Outcomes

Derbyshire Healthcare
NHS Foundation Trust

Quality benefits identified in the original business case

See table on slides 13-14 for more detail

Improved Privacy and dignity – **YES**
Appropriate use of space throughout the facility and Accessible outdoor spaces – **YES**
All patient bedrooms en-suite with access to natural daylight and views – **YE**
Welcoming building design – **YES**
Positive and improved Friends and Family feedback – More data required
Care plans in place within 72 hours – More data required
Care plans reviewed in 7 days – **IMPROVING** from 49% to 80% in December
Improved completion rate of risk management plans – **IMPROVED** at 100%
Reduced restrictive interventions – **IMPROVING**
Risk screens completed – **IMPROVED** at 100%
All Physical health checks completed – **IMPROVING** from 50% to 90% in December
SMI Physical health checks completed – **IMPROVING** from 47% to 88% in December

The Kingfisher environment is suited to the needs of the client group closer to home; offering single bedroom accommodation and supporting a therapeutic approach that aids recovery.

Patient Outcomes

People Outcomes

Derbyshire Healthcare
NHS Foundation Trust

Business case benefits considered staff attrition, vacancies and use of temporary staffing
See table on slides 13-14 for more detail

Staff Attrition Rate - IMPROVING
No direct comparison but lower than typical 15% rate at Radbourne with 3.45% for Kingfisher to November. Low turnover of staff aided by good working environment, conducive to providing effective patient care and improved patient experience, aligning to the team's sense of purpose.

Use of Bank Staff – NO SIGNIFICANT CHANGE
No previous local comparison. Tracking at 10.91% to September but increasing trajectory to December. Wider programme looking to address bank staff use.

Use of Agency Staff - IMPROVED
No previous local comparison. In line with wider inpatient areas at 0.9% in November 2025.

Vacancies - IMPROVING
Consistently reducing month on month and at 30.63% in December.

Kingfisher is a great place to work, conducive to better patient outcomes and experiences, evidenced by improved measures for vacancies and use of bank and agency staff.

People Outcomes



Productivity Outcomes

Derbyshire Healthcare
NHS Foundation Trust

Business case benefits considered use of bank and agency staff, average length of stay, bed utilisation and loss of patient property
See table on slides 13-14 for more detail

Out of Area Placements – IMPROVED
Male PICU contract with Elysium Healthcare ended 31 September saving £406k per month. Excluding known female occupancy from spot purchasing data, average spend dropped from £665k/month to £259k/month from October. Note this is a small data sample post end of contract and should be evaluated over a longer period for greater confidence.

Use of Bank and Agency Staff – IMPROVED
Previously £219k per month (Radbourne 24-25) and contributing to a current £154k per month. A reduction of 65k per month on average.

Reduced Average Length of Stay – IMPROVING
No previous local comparison. Typically, 56 days on Radbourne (24-25) and currently 48 days on Kingfisher (Jul-Dec). Continued programme of work and ongoing evaluation.

Bed Utilisation – IMPROVING
At 71% in December and within common cause variation on small data sample monitoring.

Avoidance of cost relating to loss of patient property – SUSTAINED IMPROVEMENT
Currently £0.



Partnership Outcomes

Derbyshire Healthcare
NHS Foundation Trust

Benefits to our partners, stakeholders and wider community…

See table on slides 13-14 for more detail

"These facilities and services are a testament to Derbyshire's commitment to placing dignity, privacy and recovery at the heart of mental health care. The design and therapeutic features reflect the compassion and dedication of all involved. Today is a celebration of progress and purpose."
– His Majesty's Lord Lieutenant of Derbyshire, Mrs Elizabeth Fothergill CBE





Benefit Measurement and Evaluation Data

Derbyshire Healthcare
NHS Foundation Trust

STRATEGIC PRIORITY	BENEFIT	CURRENCY	EVALUATION METHOD	Predicted Benefit	RU Baseline	Kingfisher House 6 Mth July- Dec 25
PRODUCTIVITY	CRB1 The reduction (in cost) of current out of area placements, currently funded by the Trust at Mill Lodge	£	Data	3/8ths of current acute mental health out of	*2024-25 £875k per mth avg*	*2025-26 £835k per mth avg*
	CRB4 Saving from reduction in use of bank and agency staff	£	Data	Reduced expenditure	RU Yr Apr24 to May 25, £219k/mth	*CU May to Nov £154k/mth*
	CRB5 Avoiding loss of patient property that occasionally occurs in dormitory-style wards	£	Data	90% reduced loss patient property	0	0
	NCRB1 Reduction in average length of stay, to the national average.	LOS	Data	Reduce to 32 days	50 av days LOS over 334 male on wards 33,34,36 apr 24 to May 25	48 days July to Dec 25
	NCRB3 Improved bed utilisation	Bed Occupancy %	Data	85% occupancy	104% YTD Apr 24 - Mar 25 RU wards 33,34,36	Jul 34%, Aug 67%, Sep 73%, Oct 60%, Nov 74%, Dec 71% YTD 67%
	NCRB5 Reduced admission rate	Number or readmits	Data		8%,target 10% 17 readmissions / out of 211 RU 33,34,36 YTD from Apr 25	Jul no data , Aug 33%, Sep 0%, Oct 0%, Nov 0%, Dec 0%, total 5.6% 1 readmission / out of cohort 18
PEOPLE	NCRB2 Lower staff attrition rate	Staff turnover %	Data		Apr 14.35% May 14.51% Jun 14.60% Jul 14.72% Aug 15.05% Sep 20.34% Oct 18.22% Nov	Apr - Oct 0.00% Nov 3.45%
	New Benefit Added - Temporary Staffing (bank)	% of Establishment	Data	15% reduction in use of bank	Apr 8.87% May 8.74% Jun 5.98% Jul 16.78% Aug 15.96% Sep 27.21% Oct 28.32% Nov	Apr - May - Jun - Jul - Aug 10.91% Sep 25.06% Oct 30.97% Nov 39.57%
	New Benefit Added - Temporary Staffing (agency)	% of Establishment	Data	15% reduction in use of agency	Apr - May - Jun - Jul - Aug 0.47% Sep 0.32% Oct 0.27% Nov 0.46%RU wards 34, 36	Apr - May - Jun - Jul - Aug 0.30% Sep 1.45% Oct 4.71% Nov 0.90%
	New Benefit Added - Vacancies	% of Establishment	Data		Apr 20.30% May 29.12% Jun 24.80% Jul 30.34% Aug 33.71% Sep 35.89%Oct 32.11% Nov 28.78%	Apr 71.06% May 70.72% Jun 58.80% Jul 52.78% Aug 45.77% Sep 37.67 Oct 37.07% Nov 30.63% 30.63% in
P'SHIPS	SB1 The economic benefit of improving mental health wellbeing	£	Audit			*Monitoring data*
	SB2 Economic Impact of the construction on local trades, suppliers and businesses	£	Audit			*Data required over a longer period of engagement*

Benefit Measurement and Evaluation Data

NHS
Derbyshire Healthcare
NHS Foundation Trust

PATIENT	NCRB6 Improved privacy and dignity for service users and improved quality of service delivered	Number of Ind Rooms	Data	Improved Experience	OOA provision	14 single bedrooms with ensuite
	Q&UM1 Eradication of dormitories and improved privacy and dignity for service users and improved quality of service delivered	Number of Ind Rooms	Data	Improved Experience	OOA provision	14 single bedrooms with ensuite
	Q&UM2 Maintaining and improving the Trust's low level of seclusion and restraint	Number of Sec&Res	Data	Improved Quality	RU year Apr24/25 , 594	Jul 25 to Dec 25, 106
	Q&UM6 The approach and access for ambulances is appropriately provided	Confirmation of spec	Audit	Improved Quality	photographic evidence	photographic evidence
	Q&UM7 Outdoor spaces where access is required are accessible, well lit and accommodate users with limited mobility and wheelchair users	Confirmation of spec	Audit	Improved Experience	photographic evidence	photographic evidence
	Q&UM8 Appropriate use of space throughout the facility	Confirmation of spec	Audit	Improved Quality	photographic evidence	photographic evidence
	Q&UM9 All patient bedrooms ensuite with access to natural daylight and views of outdoor spaces	Confirmation of spec	Audit	Improved Experience	photographic evidence	photographic evidence
	Q&UM15 More frequent and better-quality contact between patients, families and friends	Survey	Audit	Improved Experience	photographic evidence	photographic evidence
	Q&UM16 Building designs have a human scale and feels welcoming	Survey	Audit	Improved Experience	photographic evidence	photographic evidence
	Q&UM18 Complaints - quick resolution	Number of QR complaints	Data	Improved Experience	RU Apr24 to Mar25, 16	Jul - Dec 25, 3
	Q&UM19 Complaints - closer look	Number of CL complaints	Data	Improved Experience	RU Apr24 to Mar25, 12	Jul - Dec, 1
	Q&UM20 Complaints - all	Number of complaints	Data	Improved Experience	RU Apr24 to Mar25, 28	Jul - Dec 25, 4
	Q&UM21 Ratio of complaints to compliments	Ratio	Data	Improved Experience	RU (28/61), 0.46	(4/8), 0.5
	Q&UM22 Friends and family test % positive	F&F Analysis	Data	Improved Experience	RU Apr24 to Mar25, 22	no reports for KF yet
	Q&UM24 Inpatient care plan reviewed in the last 7 days	Nnumber reviewed in 7 days	Data	Improved Quality	RU Apr24 to Mar25, 39.9%	Jul,87.5% ,Aug,53.3%,Sep,46.2%,Oct,70.0%,Nov,81.8%,Dec,80.0%,
	Q&UM25 Risk management plans completed	Number of Risk plans	Data	Improved Quality	RU w35 & w36 100% 19/19 current data	100% 9/9 current data
	Q&UM26 MHA.S.132 review of rights attempted - inpatients	Number attempted	Data	Improved Quality	no report found	no report found
	Q&UM27 Restrictive interventions used	Number of interventions	Data	Improved Quality	RU w33,34,36,male,all int Apr24-Mar25,	All int, Jul-Dec25, 122
	Q&UM28 Risk screens completed	Number of risk screens	Data	Improved Quality	RU w35 & w36 100% 19/19 current data	100% 9/9 current data
	Q&UM29 Safety plans completed	Number of safety plans	Data	Improved Quality	RU w35 & w36 94.7% 18/19 current data	100% 9/9 current data
	Q&UM30 Physical health check completed- all	Number of PHC completed (all)	Data	Improved Quality	RU w33,34,36, male 451/1132, 49.93%	Jul 3/8,37.5%,Aug 11/16,68.75%, Sep 11/13,84.62%,Oct 8/10,80%,Nov 9/11,81.82%,Dec 9/10,90%
	Q&UM31 Physical health check completed - SMI	Number of PHC completed (SMI)	Data	Improved Quality	RU w33,34,36, male 381/808, 47.15%	Jul3/6,50%,Aug9/12,75%,Sep8/10,80%,Oct7/8,87.5%,Nov6/8,75%,Dec7/8,87.5%

Reflections and Learning

Derbyshire Healthcare
NHS Foundation Trust

Learnings from issues that have arisen, or successful design, construction, contracting and implementations approaches for sharing

The phased admission approach created a calmer, more structured experience for patients moving into the new ward, helping them to settle in gradually and reducing stress during transition.

Strong collaboration between clinical, operational, estates, and IM&T teams was central to the project's success. Regular joint meetings, open communication, and shared problem-solving ensured issues were identified early and addressed effectively.

Comprehensive staff training and familiarisation before opening helped build confidence and cohesion. Simulated exercises and early engagement should continue to be a standard feature for future openings.

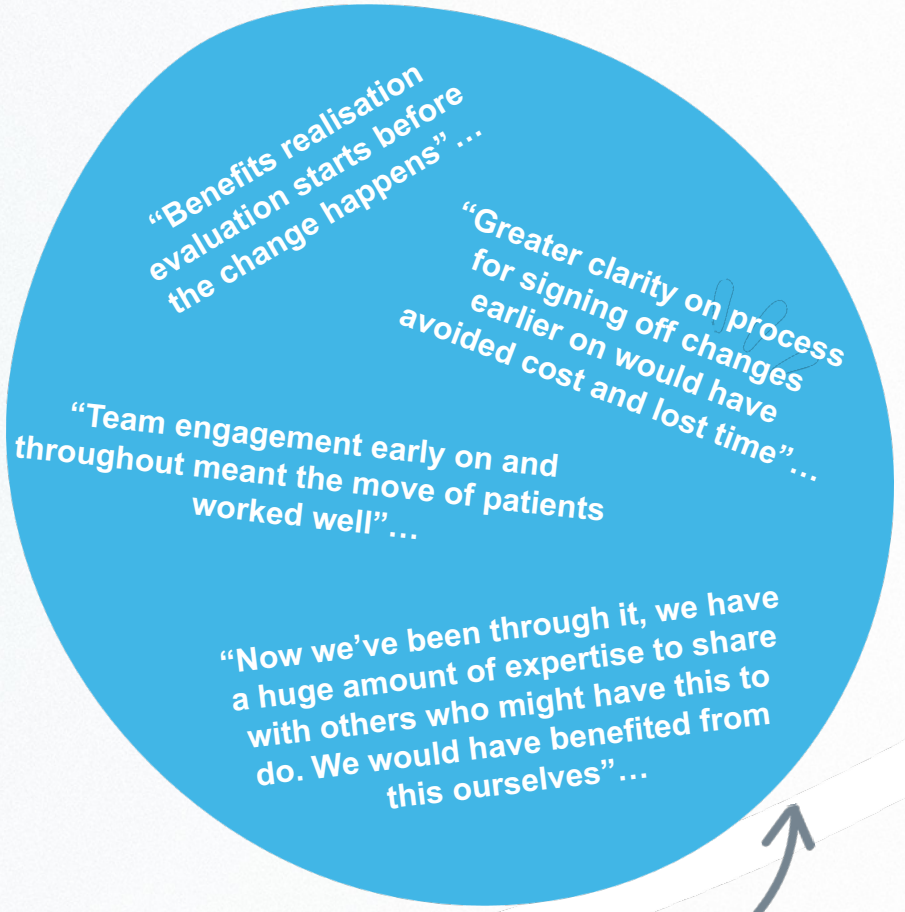
While enhanced safety systems improved risk management, some features reduced flexibility and increased fragility. Future projects should find the right balance between robust safety measures and operational practicality.

Recruitment challenges highlighted the importance of early workforce planning, especially for key support roles such as nursing assistants and domestic staff. Building resilient teams through training, wellbeing support, and consistent staffing improves both service quality and staff morale.

Competing demands added to pressure, and some areas were under-resourced to accommodate additional MRFD asks. In addition to staff delivering the project and moving services, also included support staff leading to particular delays in recruitment and procurement.

Parking at Kingsway has become more challenging with increased demand and there needs to be a focus on parking practices and optimising capacity.

For evaluation purposes, it would have been beneficial to start collating baseline data earlier from the point when predicted benefits were identified rather than soon before go-live. Where patient groupings and configurations changed it made like for like data comparison difficult.



What did we learn?

Board Assurance Framework (BAF) Issue 4, version 4.3, 2025/26 (for discussion)

Purpose of Report

To meet the requirement for Boards to produce an Assurance Framework. This report details the current BAF risks, Issue 4, version 4.3 for 2025/26.

Executive Summary

Director Leads, Deputy Directors, Directors of Operations, Operational Leads and Trust Senior Managers have reviewed the risks to the Trust's strategic objectives for 2025/26 and provided comprehensive updates for this issue of the BAF report.

Progress against risks has been updated to ensure it reflects the current status; any updates relating to prior versions are held on the archived BAF reports.

Every key gap in control and linked actions has been reviewed, the next quarterly review being due by 31 March 2026 unless a specific target date is identified. The next reviews will inform the first issue of the BAF report for 2026/27.

Summary of Updates

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

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

A further action has been identified to improve learning from incidents and patient safety outcomes:

> *Patient safety incidents and patient experience and effectiveness to be triangulated in providing assurance on quality as set out in the Quality Delivery Plan*

This will be measured by the effectiveness of the Patient Safety team and Patient Safety Lead working collaboratively. There is also a linked operational risk.

Risk 1C: There is a risk that the Trust's increasing dependence on digital technology for the delivery of care and operations increases the Trust's exposure to the impact of a major outage

The actions and progress have been updated to reflect the opening of the Psychiatric Intensive Care Unit (PICU) and Enhanced Care Unit (ECU).

People - Derbyshire Healthcare is a great place to work

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

The People and Culture Committee also received the BAF report in Quarters 3 and 4; there were no further updates to make.

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

The Director of Finance has thoroughly reviewed Risk 3A and provided updates on action to close key gaps in control including the steps being taken to reduce agency use for staffing.

The internal and external assurances have also been updated to ensure they are current.

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

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

The Chief Delivery Officer (CDO) has reduced the RAG rating against the action that some core constitutional targets are not being met risking progress at pace and scale.

Risk 4C: There is a risk to safe, effective clinical care across Derbyshire impacting upon patients, due to not achieving national standards and variation of clinical practice and service commissioning in the Learning Disability (LD) Transforming Care Partnership

The overall risk rating has been reduced by the CDO, likelihood and impact scores each being reduced from 4 to 3, which reduced the overall rating from high to moderate as both key gaps in control now have action ratings of amber due to progress made against the actions.

Operational Risks

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

NEW - Risk 23681: Nutritional Risks - No Clinical (Nutrition) Oversight Within the Catering Department – Newly logged, allocated to the Medical Director and linked to Risk 1A, this details multiple catering-related nutritional risks and cites non-compliance with national legislation and regulatory requirements as a root cause.

NEW - Risk 23650: Lack of Resources to Support Trust Projects – This has been added under Risk 1C and is now rated high. It details risk in meeting requirements in projects linked to transformation projects, the substance misuse contract and off-boarding, Derbyshire Community Health Services NHS FT (DCHS) service transfers to DHcFT and the new private health services provided by DHcFT.

REMOVED - Risk 23465: Clinical Risks to Children Due To Lack of Wheelchair Services – This has been removed from the BAF report as it has been re-categorised to divisional rather than Trust-wide. The risk remains rated high and is under review.

BAF Reporting Cycle/Format

All changes/updates to this issue of the BAF, compared with Issue 3 2025/26, are in tracked changes. All text that has been stricken through will be removed from the next issue (Issue 1 2026/27).

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

Following the Board BAF Development session in February the format of the report has been updated:

Risk tolerance scores have been updated in-line with the key at the end of the report and the title has been corrected in each risk header.

A new risk appetite section will be added to each risk in the first issue of 2026/27 and the key for rating will be added in the report to align with the Risk Management Strategy.

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

Risks and Assurances

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

Consultation

The BAF report is reviewed and updated by:

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

The BAF is presented quarterly to the Executive Leadership Team for review, the Audit and Risk Committee for approval and Board for review and approval.

Governance or Legal Issues

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

Net Zero Duty Implications

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

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

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Specific elements within each BAF risk and associated actions are addressed by the relevant lead director in taking forward.

Recommendations

The Board of Directors is requested to:

1. Review and Approve Issue 4 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. Continue to receive updates in line with the forward plan for the Trust Board.

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

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

Board Assurance Framework 2025/26 – Issue 4.3 Board March 2026

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

Risks to Trust Strategic Priorities 2025/26

Ref	Risk	Director Lead	Risk Rating	Responsible Committee
Patient Focused - Our services will deliver safe and high-quality care				
25-26 1A	There is a risk that the Trust will fail to provide standards for safety, and effectiveness as required by our patients, regulators, partners and our Board, There is also a risk of poor patient experience and outcomes	Director of Nursing, AHPs, Quality and Patient Experience (DON) / Medical Director (MD)	**HIGH**	Quality and Safeguarding Committee
25-26 1C	There is a risk that the Trusts increasing dependence on digital technology for the delivery of care and operations increases the Trusts exposure to the impact of a major outage	Medical Director (MD)	**MODERATE**	Finance and Performance Committee
25-26 1E	There is a risk that the Trust does not deliver key regulatory and strategic requirements related to dormitory eradication and that the Trust estate is not maintained sufficiently well to comply with regulatory and legislative requirements	Director of Nursing, AHPs, Quality and Patient Experience (DON)	**MODERATE**	Quality and Safeguarding Committee
People - Derbyshire Healthcare is a great place to work				
25-26 2A	There is a risk that we are unable to create the right culture with high levels of staff morale	Director of People, Organisational Development and Inclusion (DPOI)	**HIGH**	People and Culture Committee
25-26 2B	There is a risk that we do not have an adequate supply of a diverse workforce with the right people with the right skills to support and deliver safe high-quality care	Director of People, Organisational Development and Inclusion (DPOI)	**HIGH**	People and Culture Committee

Board Assurance Framework 2025/26 – Issue 4.3 Board March 2026

Productive - Our services will be productive, demonstrate best value for our population and be cost effective				
25-26 3A	There is a risk that the Trust fails to deliver its revenue and capital financial plans for 2025/26 caused by factors including non-delivery of Cost Improvement Programme (CIP) targets and increased cost pressures not mitigated resulting in a threat to our financial sustainability and delivery of our statutory financial duties	Director of Finance (DOF)	**MODERATE**	Finance and Performance Committee
Partnerships - Our organisation will identify new ways of working, through new collaborative approaches				
25-26 4A	There is a risk that the effects of both nationally and locally driven changes to roles and responsibilities across the Integrated Care Boards (ICB), and with its partners may impact negatively on the cohesiveness of the Derbyshire health and care system in our organisation	Chief Delivery Officer (CDO)	**MODERATE**	Trust Board
25-26 4B	There is a risk of reputational damage if the Trust is not viewed as a strong partner both within the Derby and Derbyshire Integrated Care System (ICS) and more broadly within the East Midlands Mental Health Provider Alliance	Chief Delivery Officer (CDO)	**MODERATE**	Trust Board
25-26 4C	There is a risk to safe, effective clinical care across Derbyshire impacting upon patients, due to not achieving national standards and variation of clinical practice and service commissioning in the Learning Disability (LD) Transforming Care Partnership	Chief Delivery Officer (CDO)	~~**HIGH**~~ **MODERATE**	Trust Board

Board Assurance Framework 2025/26 – Issue 4.3 Board March 2026

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

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

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

Root causes:

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

BAF Ref: 25-26 1A	**Director Lead**: Tumi Banda (DON) / Girish Kunigiri (MD)	**Responsible Committee**: Quality and Safeguarding Committee

Key Controls

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

Preventative – Quality governance structures, teams and processes to identify quality related issues; mandatory training; Duty of Candour processes; clinical audits and research; health and safety audits; risk assessments; physical health care screening and monitoring; monitoring and effective responses to infection and control guidance, EQUAL unannounced visits to services and anonymised bright ideas service improvement ideas. Feedback intelligence from independent advocacy, Director visits in and out of hours and Board visits
Detective – Quality dashboard reporting; Board visits virtual clinical service contact visits; incident, complaints and risk investigation; clinical audit; Fire Safety Regulations (FSR) compliance checks; mortality review process; physical health care monitoring clinics pilots; safety check log; Head of Nursing and Matron compliance visits, reviewed model of announced and unannounced visits to service throughout the 24-hour period; Fundamental Standards of Care visits; quality cross-checks: Inpatient and Community; 15 Steps challenge commencing in inpatient services; patient survey; friends and family test
Directive – Trust Strategy; Quality Delivery Plan; Joint Child Adult and Family Safeguarding Strategy; Patient and Carer Experience pledges and associated workplans; Patient Safety Incident Response Plan (PSIRP); clinical strategies; policies and procedures available via Trust intranet; Central Alerting System (CAS) alerts; Risk Management Strategy; clinical sub committees of the Quality and Safeguarding Committee

Assurances on controls – Internal	Assurances on controls – External
Trust quality and performance dashboards Scrutiny of Quality Account by committees Programme of physical healthcare and other clinical audits and associated plans Infection Control Board Assurance Framework reported to NHS England Positive and Safe self-assessment Head of Nursing and Matron compliance visits Board visits and out of hours visits Fundamental Standards of Care visits Clinical audits Incident reporting and monitoring systems through Datix Quality and safeguarding workplan Patient, family and carer feedback Trust risk registers and scrutiny of the Risk Management Strategy by Board committees	National enquiry into suicide and homicide NHS Litigation Authority (NHSLA) scorecard demonstrating low levels of claims Safety Thermometer identifies positive position against national benchmark CQC comprehensive review 2020 Trust is rated Good Trust fully compliant with National Quality Board Learning from Deaths guidance Engagement meetings with CQC taking place Patient Safety Incident Response Framework (PSIRF) implementation CQC inspection for acute and PICU December 2024 rated Good; Wards for older people with mental health problems, July 2025 rated Good; Forensic inpatient or secure wards, September 2025 rated Good Regular NOF Level 3 meetings with NHS England (NHSE) and Integrated Care Board (ICB) ICB local review to ensure there are clear policies in place to meet the needs of people in Derbyshire with severe mental health illness Adult and Children Safeguarding Boards (Derby City and Derbyshire County) ICB Quality System Group for Integrated Care System (ICS) quality system monitoring

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Summary of progress	Action rating
Gap in operating standards and clinical risks for acute and community mental health services	Improve the assessment interventions and risk management of patients requiring enhanced input or assertive outreach services	Improve working with carers and families	~~(31.12.25)~~ (31.03.26)	Increased performance management scrutiny and unannounced site visits undertaken with compliance checks	AMBER

	Compile outcome measures for acute and community services and create relevant dashboards for the services to inform areas for improvement Improvement of both inpatient and community care settings – Environments need to be improved [ACTIONS OWNER: DON] Set out improvement plans to achieve Royal College of Psychiatrists (RCP) accreditation across services [ACTION OWNERS: MD/DON/CDO] Implement Community Mental Health Framework (CMHF) Improve the out of area (OOA) placements and facilitate care closer to home [ACTIONS OWNER: CDO/DON]	Improving risk assessment and care planning for patients in community settings Deliver the assertive outreach pathway to support patients with complex care needs Improvement in operating standards compliance to be overseen by Quality and Safeguarding Committee Implemented Acute Inpatient Mental Health Service Accreditation (RCP Standards) reported in Divisional Performance Reviews and Quality Account Implemented Mental Health Community Framework to Quality and Safeguarding Committee Aim for no inappropriate out of area placements		Monitoring Fundamental Standards of Care and the quality measures through the Quality Dashboard Internal Trust programme Board in place to strengthen contribution and involvement in system-wide programme and delivery Living Well transformation mobilisation completed March 2025 Viability of the model may be at risk due to possibility of the social worker component not being funded by the ICB The funding has now been agreed for 2025/26 for social care and the voluntary sector to support the CMHF. The programme team supporting the delivery has been reduced and is committed for a further two years to support transformation Dashboard has been generated for inpatient acute services. DON leads a fortnightly forum around achieving compliance	

				CQC have reinspected acute inpatients areas and adjusted the rating of older adults and forensic inpatient services to good Implement and monitor the ten High Impact Actions including MADE events and working with system partners. Inappropriate OOA bed use has significantly reduced	
Learning from independent and national forums on current issues affecting patient safety outcomes and experience	Participate in collaborative local and regional forums to gather learning Revisit all assurances and scrutinise practice, gathering intelligence and implement an improvement plan to enable all services to provide the highest standard of care which would be expected Monitor and implement the lessons from CQC Section 48 from other providers Patient safety incidents and patient experience and effectiveness to be triangulated in providing assurance on quality as set out in the Quality Delivery Plan [ACTIONS OWNERS: DON/MD]	Ensuring that staff are aware of how to raise concerns and speak up Implement the Accountability Framework Strengthen out of hours, weekends and night announced and unannounced visits. To promote access to multiple managers, relationships, so colleagues feel empowered to report any concerns Professional leads are in place and supported by Employee Relations to ensure that registered professional staff are aware of the requirements to practice in line with their professional codes Uphold safeguarding standards including PIPOT	~~(31.12.25)~~ (31.03.26)	Options for staff to have conversations about care delivery and raise concerns available include Trust-wide and divisional engagements, Freedom to Speak Up, Schwartz Rounds Improvements in engagement of temporary staff identified Increased visibility of senior staff through Board visits and out of hours visits – New programme/dates launched September 2025 Robust oversight of patient safety incidents, concerns, complaints, and compliments with scrutiny from independent partners, e.g. Healthwatch and experts by	AMBER

		Timely investigation and response to concerns and complaints Patient safety team and patient safety lead working collaboratively to effectively evaluate risk and quality and identify learning and improvement		experience being core members of Patient and Carer Experience Committee 15 Steps is being launched through Patient Experience, ~~planned for~~underway from October 2025, led by experts by lived experience External partnership working including Healthwatch and advocacy services within safeguarding and secure services. The Trust provides assurance and participates in external reviews alongside the ICB and Adult Safeguarding Board Trust-wide Learning, Culture and Safety Group established, providing oversight of teams/services with repeating patterns for improvements to be made ~~Four~~ All older adult wards are currently actively participating in Culture of Care quality collaborative from September 2025 Review underway to improve response times to closer look complaints	

				Working Group for Independent Mental Health Homicide Review in place Significant Level of assurance received in 2025 from ICB on the Safeguarding Accountability and Assurance Framework review and Section 11 compliance	
Clinical improvement in the current use and transformation of Care Programme Approach (CPA), to support safe community practice	Identify the Trust's preferred alternative model to replace CPA Establish transition plan which includes communications and training strategy and clear timeline for go live of the new system and detailing when use of CPA will cease Implement an improvement plan to enable all services to provide the highest standard of care [ACTIONS OWNERS: DON/MD]	Review of changes to national policy to replace CPA Safe and effective practice is in place Improve patient safety risk assessment, care planning and CPA review compliance in community services	~~(31.12.25)~~ (31.03.26)	Ongoing oversight of CPA continues with focus on care planning and risk assessment CPA training continues at present until alternative identified – Not yet confirmed National consultation underway on a personalised care framework, latest draft was published in September 2025	AMBER
Review of the new Major Conditions Strategy and Suicide Prevention Strategy for England: To be considered as Trust Clinical Plan developed	Scrutinise new policy direction and develop new plans Routinely review incidents for learning in suicide prevention including cluster analysis and benchmarking [ACTIONS OWNERS: DON/MD]	Adjust strategy and policy to meet requirements Undertake a cluster analysis of in-patient and acute care pathway deaths	~~(31.12.25)~~ (31.03.26)	Review of new strategy for Major Conditions and Suicide Prevention PSIRF priorities focusing on prevention and oversight, linked to new strategies Suicide Prevention Lead recruited	AMBER

				Risk assessment, safety planning and suicide awareness training now rolled out with plan to extend to module 2 in October 2025 Trust Suicide Plan was ratified at Board in November 2025	
Review of Patient Carer Race and Equality Framework (PCREF) and develop implementation plan	Revisit new policy direction and develop new plans [ACTION OWNER: MD]	Review framework and develop implementation plan	~~(31.12.25)~~ (31.03.26)	New Patient and Carer Strategy has gone through QSG and will be launched in line with the wider Trust Strategy EDI lead is in position for PCREF Central oversight and resource to be identified	AMBER

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

ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating
22790	Corporate Services – Pharmacy	Prescribing Valproate: Failure to comply with MHRA patient safety regulations	24.05.23: ePMA now deployed to all services in the Trust which will help with our understanding of valproate use and can be incorporated into planning. Reporting will need to be constructed as part of the optimisation of ePMA 02.03.26: Awaiting go-live of questionnaire on Systm1 to allow consultants to record their valproate caseload. This is intended to give more transparent oversight of our level of assurance of adherence to safety guidance and will allow the level of risk to be reassessed	28.02.22	02.06.26	HIGH
23501	Corporate Services – Clinical Quality	Risk to Service Delivery - Patient Safety Team	There are currently learning responses and investigations overdue. Coroners, staff, patients and families are waiting for the outcome of these learning responses. Risks include: • Distress to families/carers who are waiting for the outcome of learning responses - Risk of further harm • Reputation damage for the Trust • Possible increased distress for staff who are involved in the process 11.02.26: Interim Patient Safety Lead now in situ to support the activity of the Patient Safety Team and with line management to Operational Patient Safety Manager (OPSM). Bank colleagues have been supporting with completion of assurance reviews to manage backlog of learning responses. Improvement Plan to be implemented following 360 Assurance review (deadline for August 2026). Delivery of these actions will likely have a beneficial impact on risk rating	08.05.25	11.05.26	HIGH

23681	Corporate Services – Clinical Quality	Nutritional Risks - No Clinical (Nutrition) Oversight Within the Catering Department	Multiple catering related nutritional risks having the potential to result in patient harm from choke, malnutrition, allergic reaction, delays in discharge, regulatory non-compliance, reputational impact, poor patient experience. DHCFT is non-compliant with the following national legislation and recommendations: • CQC regulation 14 'Meeting Nutritional and Hydration Needs' • NHS England National Standards for Healthcare Food and Drink (standards 1-4 out of 8 standards) • Report of the Independent Review of NHS Hospital Food recommendation 2b 'Ensure there is a named food service dietitian in every Trust responsible for overseeing patient, staff and visitor catering, with appropriate funding to support this role outside of clinical responsibilities' • PLACE (patient led assessment of care environment) - Food questionnaire • BDA (British Dietetic Association) Nutrition & Hydration Digest (legal compliment to NHS England National Standards for Healthcare Food)	18.02.26	18.05.26	HIGH

Board Assurance Framework 2025/26 – Issue 4.3 Board March 2026

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

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

Impact:
There is a risk that the Trust's digital infrastructure, systems, or data may be compromised due to an outage or failure to maintain adequate cybersecurity measures. This could lead to significant disruption to clinical services, compromise of sensitive patient or staff data, reputational damage, regulatory breaches, and potential harm to patients

Root causes:

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

BAF Ref: 25-26 1C	**Director Lead**: Girish Kunigiri (MD)	**Responsible Committee**: Finance and Performance Committee

Key Controls

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

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

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

Board Assurance Framework 2025/26 – Issue 4.3 Board March 2026

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
NHS 10 year plan to abolish Commissioning Support Units (CSU). By Spring 2027 Arden GEM CSU is likely to be abolished and DHCFT no longer and to benefit from respective cyber, network and technical services and support	Added to Trust risk register and tracked by IMT&R senior team. National changes tracked via regional forum and Technical Design Authority. Alternative options – Plan in progress leading to options appraisal. Options may include: Some services provided in-house by DHCFT, contract with another supplier (NHS or private), wait for possible rebrand / merger of Arden Gem CSU and contract with new entity [ACTION OWNER: MD]		~~(31.12.25)~~ (31.03.26)	Initial fact finding and options document prepared for F&P Quarterly review leading to deadline in spring 2027	AMBER
Unsupported IT devices are a potential security risk	Routine review and update of Trust assets. Ongoing cycle to refresh kit and update assets to comply with security updates [ACTION OWNER: MD]	Compliance with monthly rigour and service reviews Removal of any unsupported devices/assets with each wave of security updates	~~(31.12.25)~~ (31.03.26)	DHCFT the first Trust in the midlands to be fully compliant and phase out Windows 10 devices. Cycle will repeat with next wave of security updates Ongoing - Monthly rigour and service review meetings with IT service supplier	AMBER

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

ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating
23563	IT, IM and Patient Records	Risk to Service Provision by ArdenGem to the Trust	The government have announced that all CSUs will cease to exist by Spring 2027. All the technology used within the Trust is supported by AGEM who are one of the CSUs targeted. The skills provided by AGEM do not exist in the Trust 01.12.25: Arden GEM planning support to highlight risks and assurance with TUPE. Voluntary redundancy process scheduled for Feb- March 2026. Senior managers and subject matter experts possible flight risk (may lose local knowledge and experience) DHCFT is looking to be in lockstep with DCHS in terms of joint approach to new ICT supplier 14.01.26: Actions from F+P Committee: Risk updated in relation to consideration around current contract provision and degradation of service and Arden GEM serving notice (six month timeframe expected). Advice from legal services over contract sought	08.07.25	14.04.26	HIGH
21620	IT, IM and Patient Records	IT system collapse due to cyber attack	06.01.26: Cyber Security Operations Centre (CSOC) released high severity alert for need to update network switches nationally. Nationally organisations are unable to comply within 14 days due to scale of task. DHCFT has plan in place with Arden GEM and near completion for security updates 21.01.26: Risk updated to include reference to artificial intelligence (AI). This has been added in relation to inappropriate use or malicious use of AI as part of threat and risk of cyber attack	08.02.19	21.04.26	HIGH
23650	IT, IM and Patient Records	Lack of Resources to Support Trust Projects	Increased demand on IMT&R to support projects during end of financial year 2025 and start of 2026: • ND transformation project - Support for community paediactric services and alignment with mental health services for child cohort 5-16 • DCHS service realignment and transfer of services to DHCFT	17.12.25	14.04.26	HIGH

			• Derby city - Substance misuse contract end and offboarding • Arden GEM CSU transition planning • Patient Engagement Portal (PEP) project support • Support for new private health service No dedicated project team within IMT&R and no additional resources provided currently to support the above projects.			

Board Assurance Framework 2025/26 – Issue 4.3 Board March 2026

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

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

Impact:
Low quality care environment specifically related to dormitory wards
Crowded staff environment
Patient safety and dignity risks associated with dormitory in-patient bedded care
Non-compliance with statutory care environments
Non-compliance with statutory health and safety requirements
Final ward refurbishment cost unknown until we receive the final Guaranteed Maximum Price (GMP) in late Quarter 3
Completion of the full Dormitory eradication programme has been delayed until early 2027/28

Root causes:

g. Long term under investment in NHS capital projects and estate
h. Limited opportunity for Trust large scale capital investment
i. Increasing expectations in care and working environments as national capital strategy and surrounding legislative and regulatory requirements evolve
j. National capital funding restrictions for business-as-usual capital programme for Trusts and Integrated Care Systems
k. Cost creep in the development has added pressure to the Making Room for Dignity programme and the ability to complete the Radbourne Unit refurbishments. Whilst funding is secured in relation to the first ward, issues with the foundations are driving up costs and delaying the completion of the programme

BAF Ref: 25-26 1E	**Director Lead**: Tumi Banda (DON)	**Responsible Committee**: Quality and Safeguarding Committee

Key Controls

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

Preventative – Routine environmental assessments for statutory health and safety requirements; environmental risk assessments reported through Datix; Infection, Prevention Control (IPC) risk assessments
Detective – Reporting progress against Premises Assurance Model (PAM) to the Executive Leadership Team (ELT); Dormitory Eradication Board reports into Trust Board; Quality dashboard reporting; Board visits virtual clinical service contact visits; incident, complaints, and risk investigation
Directive – Capital Action Team (CAT) role in scrutiny of capital projects; IPC policy and procedure; Continuous Improvement Plan – Launch date to be confirmed; Estates Plan – In final stages with early draft having been through governance; Trust Strategy; Physical Health Care Strategy; Safeguarding Strategy; Suicide Reduction Strategy; clinical strategies; policies and procedures available via Trust intranet; Central Alerting System (CAS) alerts; Risk Management Strategy

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Assurances on controls – Internal	Assurances on controls – External
IPC risk assessments Health and safety audits Premises Assurance Model System (PAMS) reporting Making Room for Dignity Programme Committee structure and working groups Trust quality and performance dashboards Bed Management processes Scrutiny of Quality Account by committees Programme of physical healthcare and other clinical audits Infection Control Board Assurance Framework reported to NHSE Positive and Safe self-assessment Head of Nursing/Matron compliance visits Cleaning and maintenance schedules Continuous Improvement Plan – Launch date to be confirmed Estates and facilities management internal audit	Mental Health Capital funding secured External authorised reports for statutory health and safety requirements Regional reporting and NHSE oversight Gateway review process – Positive feedback from first stages Safety Thermometer identifies positive position against national benchmark Mental Health Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards CQC inspection adult acute December 2024 – Rated good CQC inspection older adults, April/May 2025 – Rated good Patient Safety Incident Response Framework (PSIRF) implementation Monitoring of IPC standards compliance and reporting – ICS IPC Team

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Lack of adherence to emerging national guidance and policy requiring the elimination of mixed sex wards and dormitory style inpatient facilities	~~Opening of ECU, PICU and new acute units with single rooms and en-suite facilities~~ Radbourne Unit dormitory eradication refurbishment to provide two 17-bed wards with single room en-suite, with additional staffing and new model of care, to complete dormitory eradication in Southern Derbyshire [ACTIONS OWNER: DON/CDO] National PDC capital funding approval [ACTION OWNER: DOF]	Delivery of approved business case Completion of the units CQC approval and sign off Successful transition and opening of the units	30.06.28	FBC and revenue funding approved by ICS. National PDC capital funding approved by NHSE Carsington Unit and Derwent Unit are now open ~~Bed management processes updated in line with the new available estate~~ ~~All Adult Acute inpatient facilities are currently single sex. The original design for one ward (Sycamore) also enables the ability to flex between being single sex and mixed sex as~~	AMBER

				~~appropriate. The PICU and Enhanced Care Unit are also single sex~~ Refurbishment of the Radbourne Unit can recommence. Expected completion early 2027/28 Radbourne Unit will progress with one ward due for completion early 2026/27 and one in 2027/28 – Expected completion date updated Annual review of the delivery of same sex accommodation was completed and published by the Board in November 2025; The Trust is compliant to the guidance	

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

Board Assurance Framework 2025/26 – Issue 4.3 Board March 2026

People - Derbyshire Healthcare is a great place to work

There is a risk that we are unable to create the right culture with high levels of staff morale

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

Root causes:

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

BAF Ref: 25-26 2A	**Director Lead**: Rebecca Oakley (DPOI)	**Responsible Committee**: People and Culture Committee

Key Controls

Initial Risk Rating			Current Risk Rating			Target Risk Rating			Risk ~~appetite~~Tolerance		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 3	Accepted	Tolerated	Not Accepted

Preventative – Freedom to Speak Up Guardian (FTSUG) self-assessment and six monthly reports; actions taken from staff survey results, people performance reviews and actions, training and education meeting, Equality, Diversion and Inclusion (EDI) steering group, staff networks, health and wellbeing network
Detective – National staff survey, Quarterly Pulse Checks, FTSUG log and escalations; staff network engagement; WRES, WDES, wellbeing champion network, executive led engagement sessions; non-executive, executive and deputy visits to teams
Directive – Joined Up Care Derbyshire (JUCD) People Strategy, National People Plan; strategic people priorities

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

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion	Progress against action	Action rating

			or (review)		
Lack of planned leadership development growth, stretch programmes and opportunities including coaching and mentoring	Leadership section of the People Plan to align to organisational leadership needs Delivery of the People Plan priority: To be recognised for supporting and developing our people to work confidently in their roles Review and development of Trust leadership offer and impact [ACTIONS OWNER: DPOI]	Percentage of leaders with development plan as part of objectives Percentage of employees accessing leadership development programmes	~~(31.12.25)~~ (31.03.26)	People Plan presented and signed off at People and Culture Committee (PCC) ~~for initial comments, final sign due~~ November 2025 – Includes clear direction on leadership development Leadership Service Level Agreement developed with joint venture delivery team	AMBER
Lack of progress across EDI including staff networks and reporting (WRES/WDES/gender pay gap)	Staff networks have an embedded operating framework through which to maximise the impact of staff networks Clear measurable EDI plan that includes all national reporting and Trust level actions Support to bi-monthly network Chairs meetings through DPI, Head of EDI and EDI Manager Delivery of People Plan priority: To be recognised by our people for our values driven and inclusive culture [ACTIONS OWNER: DPOI]	Clarify on role and function of staff network chairs and objectives for each network – Reviewed twice a year Annual updates by network Chairs of engagement undertaken to be included in annual reports Year on year change WRES/WDES, staff surveys and lived experience of staff through staff networks	~~(31.12.25)~~ (31.03.26)	Framework, including clear actions to progress and signed off at PCC Race equality plan developed in conjunction with BME network and supports key actions in WRES	AMBER
Lack of ownership and embedded models of care and cultures across MRfD workforce resulting in retention and turnover challenges and inconsistency of approach across MRfD programme	Review of all commissioned and in house owned programmes both clinical and non-clinical to be clear of the 'ask' and the 'why' Clear framework to ensure alignment across all programmes Comprehensive plan of delivery and outcome measures [ACTIONS OWNER: DPOI]	Delivery against plan including attendance on programmes Staff survey measures Bespoke MRfD surveys to measure awareness and impact of programmes	~~(31.12.25)~~ (31.03.26)	Revised programme board and workstreams to ensure alignment and learning from gateway review Bluebell ward and Sycamore ward organisational development culture programme completed	RED

				Remaining wards planned for November and December 2025	
Not yet embedded the Trust personal accountability framework and inconsistent support for Employee Relations (ER) informal and formal cases	Fully embed Trust personal accountability framework across all teams and individuals to have ownership of their own behaviours Development and delivery of ER training for managers on cases and investigations Establish new ER services in Trust (currently in a shared service) [ACTIONS OWNER: DPOI]	Reduction in length of cases Reduction in formal cases Attendance at training by managers on cases and investigations Establishment of new ER in-house team	~~(31.12.25)~~ (31.03.26)	ER team transitioned out of DCHS Joint Venture into DHCFT June 2025 ~~Pool of eight bank investigators recruited, trained and commenced on key investigations~~ A kind life just culture training programme ~~commissioned, will~~ commenced, incorporat~~ing~~e personal accountability framework – 150 colleagues have already attended~~.~~ Active Bystander training being rolled out New Respect and Resolution policy launched	RED
Inconsistent approach to flexible working impacting on staff morale	Develop and embed a clear approach to flexible working that supports service delivery and staff Develop a clear and consistent way of recording and reviewing flexible working that supports both managers and staff [ACTIONS OWNER: DPOI]	Ability to record and track number of flexible working arrangements in place Staff engagement measures via staff survey and pulse check	~~(31.12.25)~~ (31.03.26)	Design of flexible working system linked to ESR to record requests for flexible working and approved requests in progress	RED
Lack of robust absence management policy and processes that support both managers and staff	Review and relaunch a new absence management policy Review support provided to managers to review and move forward long term sickness absence cases Review Occupational Health access, support and usage to ensure maximising service and being used to	Reduction in absence management across both long and short term absences Reduction in Occupational Health DNAs Staff survey and pulse check Improvements as part of NOF segment data	~~(31.12.25)~~ (31.03.26)	Absence plan developed and presented to PCC and ongoing scrutiny with further deep dive planned for January 2026 Oversight working group established ~~Notice given to Goodshape (external absence management system) to enable in-house absence management to be developed~~	RED

	Delivery of People Plan priority: To be recognised as a Trust that supports and promotes the wellbeing of our people [ACTIONS OWNER: DPOI]				
Lack of a stable positive culture due to high levels of organisational change impacting on morale	Review and develop organisational change policy to ensure clear and supportive approach for managers and staff Clear wellbeing processes for occupational health and other support mechanisms Effective, clear and open communication channels	Staff survey and pulse check engagement scores Financial balance	~~(31.12.25)~~ (31.03.26)	Fast track process for Occupational Health in organisational change Phase 1a operating model programme completed Phase 1b planned to commence January 2026	RED

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

Board Assurance Framework 2025/26 – Issue 4.3 Board March 2026

People - Derbyshire Healthcare is a great place to work

There is a risk that we do not have an adequate supply of a diverse workforce with the right of people with the right skills to support and deliver safe high-quality care

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

Root causes:

a. There are occupational shortages nationally which mean that the supply of some professions creates long term vacancies and a lack of workforce planning in solutions to fill the gaps
b. Pressures on workforce development and Continued Professional Development (CPD) funding may risk ability to develop skills and expertise
c. Disproportionate growth in senior leadership posts in correlation with frontline clinical posts
d. Lack of triangulation of workforce and finance data
National and regional Recruitment Retention Premium (RRP) applications to hard to recruit posts impacting on Trust recruitment and retention

BAF Ref: 25-26 2B	**Director Lead**: Rebecca Oakley (DPOI)	**Responsible Committee**: People and Culture Committee

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk ~~appetite~~Tolerance**		
High	Likelihood 4	Impact 4	High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 4	Accepted	Tolerated	Not Accepted

Preventative – Alliance, system and national Human Resources forums for sharing best practice and risk mitigation, website, workforce plan
Detective – People Performance Report in TLT, ELT and PCC; Bank Improvement Group; Combined Delivery Group with multi-disciplinary team (MDT) input; Medical Staffing Group, Sustainability Meeting; FTSU culture; exit interview process stay interview process
Directive –JUCD Careers Team; JUCD and People and Inclusion meeting; recruitment policy and procedure; TRAC recruitment system; safe staffing plans

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

Board Assurance Framework 2025/26 – Issue 4.3 Board March 2026

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
An integrated workforce plan and planning process that feeds into pipeline plans and ensures we have the right people in the right place with the right skills	Develop a Trust Workforce Plan linking demand and capacity, workforce redesign to ensure a fully funded workforce Develop vacancy rate data and breakdown variances in vacancy data Delivery of all People Plan priorities: Attracting a high skilled and diverse range of applicants to our roles Retaining our diverse talent through growth and development Staff are delivering at the top of their professional standards Opportunities for professional and career development [ACTIONS OWNER: DPOI]	Reduced vacancy rates Time taken to fill vacant posts Transformational posts, e.g. apprenticeships all identified Reduction in agency costs Improved retention rates	~~(31.12.25)~~ (31.03.26)	Executive-led vacancy control meeting takes place every week for approval of all vacancies and workforce expenditure increases, i.e., job evaluation	AMBER
We do not have an effective and embedded succession talent management processes	Develop a Talent Management Strategy Pilot career conversations for senior leaders and roll out career conversations for all colleagues Work as a system to develop system-wide approach to talent management and align where best for the Trusts Delivery of all People Plan priorities: Attracting a high skilled and diverse range of applicants to our roles Retaining our diverse talent through growth and development [ACTIONS OWNER: DPOI]	Career conversations taking place Internal appointments/promotions Reduction in turnover rate Key staff survey measures	~~(31.12.25)~~ (31.03.26)	Talent Strategy finalised Talent programme for senior executive leadership completed – to be run for senior leadership team following finalised operating model Talent and succession planning part of every Executive Director's objectives	RED

Onboarding and retention process and planning needs to be embedded (this includes MRfD and challenges on retention of high numbers of newly qualified nurses)	Understand the key retention issues for posts/teams/professions with the highest turnover to deliver People Plan priorities to attract and retain newly qualified nurses Ensure 'stay conversations' form part of regular 1:1s Develop NHS retention framework for nursing [ACTIONS OWNER: DPOI]	Improvements to turnover Staff survey engagement scores	~~(31.12.25)~~ (31.03.26)	Additional posts added to the preceptorship team to support retention of high numbers of newly qualified staff Stay Surveys launched at months 3, 6 and 12	AMBER
Lack of inclusive recruitment practices and actions to consider the needs of people from different backgrounds, to support our commitment to embedding an inclusive culture	All chairs of recruitment panels have undergone inclusive chairs recruitment training Data driven recruitment practices Delivery of People Plan priority: To be recognised by our people for our values driven and inclusive culture [ACTIONS OWNER: DPOI]	WRES and WDES data shows year on year improvement, staff survey and lived experience of staff Increase the proportion of applications from ethnic minority groups, increase likelihood of shortlisting and reduce disparity in all areas	~~(31.12.25)~~ (31.03.26)	Job evaluation national assessment completed and work programme to improve efficiency of the process in place and presented to PCC National nursing profiles review – Working group in place with staffside representation Inclusive recruitment for chairs training: Ongoing roll out Cultural competence training commissioned rolled out, initially focusing on acute wards and now expanding wider. Board have also completed the training	RED
Effectiveness of recruitment policy, practice and processes	Review and develop existing recruitment Key Performance Indicators (KPIs) to ensure fit for purpose Where appropriate move away from TRAC to advertise jobs and use fast track processes, e.g. Indeed/MSforms Develop cohort recruitment for key posts	Time to recruit Number of applicants applying and successfully shortlisted Campaign impact and reach Financial savings through cohort recruitment	~~(31.12.25)~~ (31.03.26)	A range of recruitment methods are deployed to ensure we attract a diverse range of applicants Revised Service Level Agreement and KPIs in place for recruitment service	AMBER

	Improve the multidisciplinary working (HR, communications and recruiting managers) to enable better planned and executed campaigns [ACTIONS OWNER: DPOI]				
Agency and bank usage control measures and reduction	Ensure bank and agency usage is controlled by clear processes and measures with accountability at team level on spend Agency off framework usage is managed with clear expectations Plan in place to reduce and align to agency price cap for all posts Bank staff are recognised and rewarded appropriately [ACTIONS OWNER: DPOI]	Agency and bank usage reduction Agency off framework nil return Agency price cap achieved Bank usage is appropriate and available to support where needed	~~(31.12.25)~~ (31.03.26)	Ongoing weekly agency approval in place for approval of all agency requests Assistant Director of Workforce is co-chair of national regional agency reduction group Consistent agency reduction demonstrated	AMBER

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

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

There is a risk that the Trust fails to deliver its revenue and capital financial plans for 2025/26 caused by factors including non-delivery of Cost Improvement Programme (CIP) targets and increased cost pressures not mitigated resulting in a threat to our financial sustainability and delivery of our statutory financial duties

Impact: The Trust becomes financially unsustainable. The Trust's National Oversight Framework rating has deteriorated and this could lead to a lack of organisational direct control in the longer term via increased regional and national intervention. Corrective action is needed and progress towards financial balance is required. In addition, we have an ambitious CIP requirement approaching 6% due to cost pressures

Root causes:

a) Financial detriment (revenue, cash and/or capital) resulting from large capital development programme, in particular dormitory eradication and associated capital schemes
b) Organisational financial detriment created by commissioning decisions or wider 'system-first' decisions including enactment of risk-sharing agreement in partnership arrangements or changes in NHS financial arrangements. System financial position resulting in required additional financial savings to support the System position from Mental Health funds
b) Non-delivery of expected financial benefits from transformational activities
c) Non-delivery of required levels of efficiency improvement
d) Lack of sufficient cash and working capital
e) Loss due to material fraud or criminal activity
f) Unexpected income loss or non-receipt of expected transformation income (e.g. long-term plan (LTP) and Mental Health Investment Standard (MHIS) without removal of associated costs
g) Costs to deliver services exceed programmes the Trust financial resources available
h) Lack of cultural shift/behaviours to return to financial cost control regime. Areas of non-compliance with Standing Financial Instructions (SFIs) and financial duties. Ineffective grip and control measures to control inappropriate spending
i) Inability to reduce temporary staffing expenditure
j) Inability to reduce inappropriate out of area placements and effectively manage flow
k) Inability to manage increasing demand and acuity in our inpatient settings
l) Trust reluctance to remove costs in line with non-recurring income removal due to wider system impact (financial and Equality Impact Assessment concerns)
m) Inability to timely respond due to the volume and bottlenecks associated with large levels of organisational change and transformation simultaneously ongoing
n) Level and pace of organisational change may result in extended timelines due to capacity across a range of services including People teams, staffside and wellbeing support
o) Exit costs will impact on our financial sustainability

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BAF Ref: 25-26 3A	**Director Lead**: James Sabin (DOF)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk ~~Appetite~~Tolerance**		
Moderate	Likelihood 2	Impact 5	Moderate	Likelihood 2	Impact 5	Moderate	Likelihood 2	Impact 5	Accepted	Tolerated	~~Not Accepted~~

Preventative – Operating plan and financial plan agreed for 2025/26 in line with ICB requirement. Integrated Care Board (ICB) signed off and fully support the dormitory eradication programme and are supporting this through to completion as a pre-commitment. Devoted and adequate team for Programme delivery. High quality business cases. Regular meetings with NHSE on programme progress. Meaningful stakeholder engagement (internal and external). Robust cash flow forecasting and delivery. Multi-disciplinary development of financial plans for new of work. System sign-off and appropriate governance arrangements for new programmes of work: Budget training, segregation of duties, management of commissioning risk through system engagement and leadership, mandatory counter fraud training and annual counter fraud work programme: Enhanced cash management and forecasting aligned to large capital and transformational programmes

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

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

Assurances on controls – Internal	**Assurances on controls – External**
Operational plan; financial planning including CIP planning, processes and delivery monitoring CIP programme group established to strengthen oversight. Further work and governance changes planned to drive the transformational plans and monitor progress Vacancy control process in place with Executive oversight Performance management processes in place and being refreshed to add to assurance levels. Now also established and in place for 2025/26 for corporate functions Dormitory eradication and PICU programme monitoring and reporting Appropriate monitoring and reporting of financial delivery – Trust overall and programme-specific Assurance levels gained at Finance and Performance Committee (F&P) Delivery of Counter fraud and audit work programme with completed and embedded actions for all recommendations	Monthly reporting into ICB and NHSE, in addition to Trust internal reporting All CIP plans and progress reporting into the EPMO for shared system oversight across the ICB NHSE feedback throughout progress of dormitory eradication Programme and business cases in programme Systems Finance and Estates Committee/System Project Management Office/system DOF meetings Internal Audits – Financial integrity and key financial systems audits External Audits – Strong record of high-quality statutory reporting with unqualified opinion National Fraud Initiative – No areas of concern Local counter fraud work – Referrals show good counter fraud awareness and reporting in Trust and no material losses have been incurred. Use of risk-based activity in new counter fraud standards Information Toolkit rating – Evidencing strong cyber risk management

Independent assurance via internal auditors including HFMA checklist, external auditors and counter fraud specialist that the figures reported are valid and systems and processes for financial governance are adequate ~~New~~ Governance process in place for the Making Room for Dignity programme ~~and action plan in place in relation to the gateway review findings~~ Strategic Portfolio Oversight Group	~~Programme Director, Senior Responsible Officer completed NHS Better Business Case Training~~ Regular NOF meetings with NHSE and ICB A clean year-end position and clean Value for Money (VFM) assessment as part of our year end audit

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Trust cash and capital risks related to national funded acute capital programme: Increased cost pressure now aligned to final refurbishment project	We will not have a Guaranteed Maximum Price (GMP) for Radbourne Until late Quarter 4 Progressing another VAT claim to part fund final stage [ACTIONS OWNER: DOF]	Cash and capital reporting as part of finance reporting into F&P and Board forecasting evidence of plan delivery and/or indicates areas of required management action	~~(31.12.25)~~ (31.03.26)	Regular oversight of capital and cash position. Reporting to Trust Programme meetings and Committees on risks and mitigations Significant cost pressures on Radbourne Unit Refurb. The decision and affordability question of the second ward will be worked up in quarter 4 aligned to receipt of the GMP	AMBER
Additional revenue related to new builds, refurbishments and PICU not fully funded by system Some partners moving away from business case assumptions and previous agreements Re-costing service provision, increasing Service Level Agreements	Close partnership working with ICB and system partners. [ACTIONOWNER: DOF]	Monitoring and reporting of income allocations and expenditure in year Transparent reporting of position shared with ICB to reduce challenge and ensure joint understanding and support	~~(31.12.25)~~ (31.03.26)	MHLDA DB agreed to oversee revenue delivery contained within programme spend Still working through inter-Trust charges with Chesterfield Royal Hospital. No major concerns flagged to date	AMBER
Insufficient substantive staffing into vacancies and temporary staffing costs for bank and agency staff do not reduce	Additional management action and oversight	Enhanced bank and agency costs reported as part of wider financial and workforce reporting	~~(31.12.25)~~ (31.03.26)	Reports to ELT and F&P outlining current areas of pressure and required actions to be taken in year in order to remain on plan	AMBER

	Agency progress monitored and strengthened links to CIP oversight group Direct engagement solution takenbeing implemented re medics Agency actions and controls are working and costs continue to reduce [ACTIONS OWNER: DPOI/DOF]	Continued workforce strategies progressed to reduce agency and increase bank reducing risk Continued reduced run rates evidence in spend Continued reduction in breaches in rates and framework providers		Medical actions taken leading to reduced locum agency expenditure Further work underway to comply with new mandate to ban use of band 2/3 agency use	
Financial cost pressures created both internally and by system first decisions leading to the requirement for mitigations to close both the internal gap and the system financial gap	Additional 'stretch' management action required to reduce other cost and mitigate impact to achieve overall financial position Long list of unpalatable options drawn up and supported in principle by Board for further review. These are for consideration post planning nationally due to potential to impact patients and core Trust NHS offer. Need to develop these into costed and prioritised plans with clarity of patient and wider staff impact [ACTIONS OWNER: DOF/MD/DON/CDO]		(31.12.25) (31.03.26)	Financial plan for 2025/26 is concluded but we need to continue to work on reducing the deficit as part of our longer term financial sustainability All new investments to follow governance processes with business cases via ELT, F&P and Board where appropriate and will require wider system support Further system grip and control and investigation and intervention processes maybe addedCurrently reviewing national toolkit and areas of further opportunities to strengthen grip and control.	AMBER

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

Board Assurance Framework 2025/26 – Issue 4.3 Board March 2026

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

Principal risk: There is a risk that the effects of both nationally and locally driven changes to roles and responsibilities across the Integrated Care Boards (ICB), and with its partners may impact negatively on the cohesiveness of the Derbyshire health and care system in our organisation

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

Root causes:

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

BAF Ref: 25-26 4A	**Director Lead**: Vikki Ashton Taylor (CDO)	**Responsible Committee**: Trust Board

Key Controls

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

Preventative – Governance structures in place at a system and Delivery Board level. Ongoing close communication with NHSE, mental health and learning disability teams at a regional and national level
Detective – Continuing engagement in all Joined up Care Derbyshire governance from DHCFT representatives. Due diligence processes undertaken prior to accepting any lead provider responsibilities
Directive – Mental Health, Learning Disability and Autism System Delivery Board to engage widely across membership on the development of any provider collaborative with agreed plans and processes. Gateway process run by NHSE prior to agreement to establish the Trust as lead-provider in any regional collaborative

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

Board agreement required prior to undertaking of lead-provider responsibilities	

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Changes to governance at ICB and system level may create delays to decision making and cause increased governance burden	Keep Trust structures under continuous review against the wider governance landscape, including the provider collaboratives and alliance arrangements – This in turn may lead to a formal change of DHCFT governance arrangements Continue to influence within the system to ensure Lean and safe decision making and governance arrangements [ACTIONS OWNERS: CEO/DCA]	Board level assurance that the Trust's corporate governance systems are compatible with the new ways of working that would allow both Trust and system objectives to be achieved Board level assurance that the Trust's risks have been fully articulated and understood within the wider integrated care system	~~(31.12.25)~~ (31.03.26)	We have implemented a new divisional performance review process, underpinned by balanced scorecards. To ensure operational performance delivery of MHLDA constitutional standards that DHCFT is a lead or main provider Derbyshire Provider Collaborative Leadership Board have an agreed work programme as approved by ICB The Trust is an active member of and provides regular assurance to system-wide governance groups, e.g. their quality and safety group Memorandums of understanding and alliance agreements are in place where appropriate, i.e. LD Alliance Trust's risks reported to the ICB monthly for cross-reference with other providers for the ICB BAF	AMBER

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

Board Assurance Framework 2025/26 – Issue 4.3 Board March 2026

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

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

Impact:
May have detrimental impact on patient experience and quality of care provided for people accessing services.

Root causes:

a) Silo working within the organisation
b) Not actively engaging enough as part of a broader multi-agency partnership at Place and community level
c) Increasing national expectations in provider collaboration and multi-disciplinary delivery model at Place level

BAF Ref: 25-26 4B	**Director Lead**: Vikki Ashton Taylor (DSPT)	**Responsible Committee**: Trust Board

Key Controls

Initial Risk Rating			Current Risk Rating			Target Risk Rating			Risk ~~appetite~~Tolerance		
High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 3	Moderate	Likelihood 3	Impact 3	Accepted	Tolerated	Not Accepted

Preventative – Active membership in each Local Place Alliance; Active participation in Integrated Place Executive; Meaningful stakeholder engagement (internal and external); Multi-disciplinary and cross organisational development and implementation of services
Detective – Quality Improvement (QI) delivery; Contract performance; Continuing engagement in all Joined up Care Derbyshire governance from DHCFT representatives
Directive – Integrated Care Strategy; Joint Forward Plan (JFP); Trust Strategy

Assurances on controls – Internal	Assurances on controls – External
Appointment to Managing Director roles Regular TLT and ELT updates and discussions NED Board members on JUCD committees Developing collaborative plans with system partners to recognise and mitigate gaps within the system for ADHD and ASD diagnostics	Monthly Mental Health and Learning Disability assurance meetings with NHSE Monthly reporting by County and City Places to JUCD Place Executive Patient surveys conducted by Healthwatch CEO on ICB Board and Integrated Care Partnership (ICP) Regular NOF Level 3 meetings with NHSE and ICB

Board Assurance Framework 2025/26 – Issue 4.3 Board March 2026

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Some core constitutional targets not being met and risk to making progress, at pace and scale, for example, resulting in some patients being cared for outside of Derby and Derbyshire	New internal performance improvement ~~group~~process and oversight in place Recovery action plans for areas where Trust constitutional standards are not being met Improvement plan for joint autism service (with system partners) [ACTIONS OWNERS: CDO]	Improvement in performance of constitutional standards and NHS Oversight Framework (NOF) metrics Recovery action plans in place in all required areas	~~(31.12.25)~~ (31.03.26)	In-year progress delivering recovery action plans: Performance improvement in dementia diagnosis and perinatal access has resulted in DHCFT now delivering the core constitutional targets in this area and others Significant reduction in number of inappropriate Out of Area Placements, underpinned by a Recovery Action Plan continues including a twice weekly Multi-Agency Discharge Event, roll out of home treatment service~~, and piloting weekend working for community mental health teams.~~ . New build facilities including a local PICU~~, will~~ support improved patient flow and improved quality of care as the above will enable patients to be treated locally Flow improvement plan is impacting and out of area bed numbers and acute length of stay are reducing Recovery Action Plans in place in relation to key access targets, measured in the NOF p~~P~~erformance reviews ~~are in place for all divisions to monitor~~	~~RED~~ AMBER

				~~performance~~, for example crisis 24 hour face to face appointments	
System partners report that DHCFT is inward looking and not easy to work with	To build stronger working relations and build stronger integrated ways of working and be more accessible, both from an organisational and service perspective To deliver more integrated care [ACTIONS OWNER: CDO]	Increased delivery of integrated services	~~(31.12.25)~~ (31.03.26)	Collaborative development of community mental health 24/7 pilot alongside general practice partners Twice weekly mini MADE and weekly MADE events taking place. This is helping to develop our working relationship with social care and ICB colleagues whilst focusing on reducing length of stay and Clinically Ready For Discharge numbers Active membership of all Neighbourhood (Place) Alliance Groups Engagement with partners continues	GREEN
Police partners report they do not always feel supported by mental health services and are under pressure to respond to mental health crisis	To reduce inpatient absent and missing cases To support Police with education and training where appropriate To streamline process and timeline for 136 suite admissions and handover [ACTIONS OWNER: CDO]	Reduction in inpatient absent and missing cases Training sessions offered to Police partners: • Police mental health awareness training sessions • Suicide prevention work • Joint working with Trust safeguarding teams • Collaborative response to Right care Right Person (RCRP)	~~(31.12.25)~~ (31.03.26)	Police are a formal member of the MHLDA DB Mental Health Response Vehicle (MHRV) to be implemented during 2024/25, to jointly provide a Trust and Police response to mental ill health calls Crisis cafés have opened in Buxton, Ripley and Swadlincote – This reduces demand on Police call-outs Trust is a~~A~~n active member alongside the Police as a member of the RCRP	AMBER

		Increased handovers completed within one hour		implementation executive group covering the Derbyshire system With the opening of the Carsington we now have a third Section 136 Suite. The three units are supported with additional resources enabling a more responsive 136 provision within Derbyshire, harnessing effective working relationships with Police which has resulted in a reduction in time that Police are required to stay at the 136 suite	
Patient and carers groups report that they would like to see more progress in service user and carer involvement and moving from engagement to decision making	Peer support strategy and objectives for EQUAL and the Mental Health Engagement Group [ACTION OWNERS: DON/MD]	Peer support element will be included in the Quality Plan, to be launched in July 2025 Co-production in Patient and Carer Race Equality Framework (PCREF) requirements	~~(31.12.25)~~ (31.03.26)	EQUAL group established to support service user and carer engagement and informs future service improvements across the East Midlands Perinatal Mental Health Provider Collaborative DON has worked with the Patient and Carers Committee, EQUAL and the Carers Engagement Group to review their terms of reference and linkages to strengthen the cross-working of the groups	AMBER

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

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

There is a risk to safe, effective clinical care across Derbyshire impacting upon patients, due to not achieving national standards and variation of clinical practice and service commissioning in the Learning Disability (LD) Transforming Care Partnership

Impact: Poor partnership and system working could impact on the experience and quality of care provided for people with a ND disorder in Derbyshire

Root causes:

a) The community Intensive Support Team and Learning Disability models have non-standardised operating models and require more capacity
b) Currently the delivery and commissioning partnership in Derbyshire have not met national standards or local ambitions for more robust community-based offers, working across the geography and in an integrated way with partners including social care and the voluntary sector
c) The collective vision for Learning Disability services across Derbyshire and the formal outcome to achieve repatriation to Derbyshire has not been effective with some people remaining in outsourced areas of England for extended and significant periods of time
d) Health inequalities across our Derbyshire footprint – Initial insights continue to show gaps in access to service, case load and worsening patient outcomes. Mitigations need to be built alongside DCHS and the ICB

BAF Ref: 25-26 4C	**Director Lead**: Vikki Ashton Taylor (CDO)	**Responsible Committee**: Quality and Safeguarding Committee – DHCFT Quality and Performance Committee – Derbyshire ICS Mental Health, LD and Autism Board in terms of system operational delivery

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk ~~Appetite~~Tolerance**		
High	Likelihood 4	Impact 4	~~High~~Moderate	Likelihood 43	Impact 43	Moderate	Likelihood 3	Impact 3	Accepted	Tolerated	~~Not Accepted~~

Preventative – Health and safety audits; risk assessments; investment in estates development; workforce plan covering recruitment and retention. Mental Health Act Code of Practice
Detective – CQC inspection reports; Board visits virtual clinical service contact visits; incident, complaints and risk investigations; safety check log; Head of Nursing and Matron compliance visits
Directive – Trust Strategy; Physical Health Care Strategy; Safeguarding Strategy; Trust Policy Dashboard

Assurances on controls – Internal	**Assurances on controls – External**
Regional and national escalation process – Internal preparation	Advisory support provided by DHCFT to the system on bedded care standards for Learning Disability in-patient services Involvement of Local Government Association to deliver a peer review Involvement of external consultants

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Summary of progress on action	Action rating
The community Intensive Support Team and Learning Disability models require improvement	Review all models of support offered by the Intensive Support Team (IST) [ACTION OWNERS: CDO/DON/MD]	Outcome of review – Improved models of support	~~(31.12.25)~~ (31.03.26)	ICB have presented to both providers on how to ensure community offers are enhanced further through the review of pathway offers where resource is disproportionately allocated Ongoing discussions to commit more resources to community pathways The Trust is working alongside DCHS and has established an integrated service provision for neurodevelopmental services across both organisations The integrated model continues with a governance structure aligned	AMBER
Improvements are required in rapidly returning patients who access Learning Disabilities and Autism (LD&A) services to local care to enable them to live in the least restrictive manner, as close to home as possible	Continue to work on developed delivery improvement plan, owned by system partners. This includes new cohort stratification– Key action to implement embed approach to ensure focussed system action on existing inpatients who are placed inappropriately and out of area [ACTION OWNER: CDO]	Improvement plans developed and implemented resulting in a stabilised service and positive outcomes for patients Enhancing and reviewing Listening and Engagement Active Partnerships (LEAP) procedures Improvement plans in admission avoidance, crisis alternatives to admission, including	~~(31.12.25)~~ (31.03.26)	Derbyshire is no-longer in national escalation regarding performance with inpatient services after demonstrating improvement against plans. There has been a recent Standard operating Procedure (SOP) realignment request from NHSE which has resulted in a small number of	AMBER

		improvement in the use of Dynamic Support Registers as a means of admission avoidance Reduction in delayed discharges in units across the country resulting in NHSE escalations		additional patients being added New Dynamic Support Pathway (DSP) launched following cross-agency redesign work Cross-system delivery plan continues to be monitored through Neurodevelopmental Delivery group Board – Includes action plan in response to inflow, flow and outflow as discussed with NHSE and ICB leaders The Trust with the ICB continues to meet with NHSE on a quarterly basis to monitor performance and transformation, focussing on those patients with a long length of stay and who are Clinically Ready for Discharge	

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

ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating
23314	Corporate Services – IM&T	Interpretation of data submitted within NHSE datasets risks erroneous views on the Trust	30.10.24: NHSE interpret and analyse data submitted within mandated NHSE submissions. This analysis is not fed back to the Trust to allow them to validate and comment on before being published to the wider NHSE community, ICBs and others. This may also include historical analysis where the Trust has no way of rectifying any issues that might be raised. With this there is a risk that external organisations to the Trust are forming views on the Trust based on erroneous information Risk still resides and will remain so until NHSE, regional sections of NHSE and ICB's communicate and coordinate methodologies prior to publishing analysis – Situation unchanged since October 2025	30.10.24	11.05.26	HIGH

Board Assurance Framework 2025/26 – Issue 4.3 Board March 2026

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

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

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

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

Action Owners

CEO	Chief Executive Officer
DOF	Director of Finance
MD	Medical Director
CDO	Deputy Chief Executive / Chief Delivery Officer
DON	Director of Nursing, AHPs, Quality and Patient Experience
DPOI	Director of People, Organisational Development and Inclusion
DCA	Director of Corporate Affairs and Trust Secretary

Definitions

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

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 24 September 2026

Freedom to Speak Up Guardian (FTSUG) report

Purpose of Report

This paper is a half-yearly report to ensure Derbyshire Healthcare Foundation Trust (DHcFT) Board is aware of Freedom to Speak Up (FTSU) cases within the Trust; an analysis of trends within the organisation and actions being taken to improve speaking up culture.

Executive Summary

This report provides the Board with an overview of FTSU activity at DHcFT between July and December 2025 (Q2–Q3 2025/26), including the number of cases raised, key themes identified, and actions taken to strengthen speaking up culture across the Trust.

A total of 170 cases were raised during this period, representing a 46.5% increase compared with the 116 cases reported between January and June 2025. This increase reflects both ongoing workforce pressures and continued efforts to improve the visibility and accessibility of the FTSU service.

The most frequently raised themes during the reporting period were worker safety and wellbeing, patient safety and quality and inappropriate workplace behaviours. In particular, concerns relating to night shift break arrangements highlighted staff concerns regarding disproportionate break duration and lack of appropriate break facilities. The Trust has listened to staff concerns and agreed with staff side an alternative, which will continue to be monitored against feedback from colleagues in relation to their safety, wellbeing and patient care.

Concerns relating to bullying, harassment and inappropriate workplace behaviours also remained significant, with around 40% of concerns recorded as including elements of these issues. The Trust is responding through cultural improvement initiatives, including the 'A Kind Life' programme, targeted leadership support and strengthened monitoring of speaking up themes to enable earlier intervention.

The report also outlines actions taken to strengthen speaking up culture, including increased visibility of the FTSU Guardian, engagement with staff groups and continued development of the Speaking Up Champions network. The Board is asked to note the themes identified and support the continued development of the Trust's FTSU culture.

Key Messages for the Board

- Speaking Up cases increased by 46.5%, reflecting improved visibility of the FTSU service
- Workforce safety, workplace behaviours and discrimination remain the key themes
- Actions are underway to strengthen culture, leadership behaviours and staff wellbeing.

Strategic Considerations		BAF Risk (eg 1A)	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X		
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X	2A / 2B	2.2, 2.3, 2.4

Productive: We will improve our productivity and design and deliver services that are financially sustainable.			
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.			

Risks and Assurances

Assurances: FTSU reporting is presented to the Trust Board and the Audit and Risk Committee (ARC) on a six-monthly basis, providing assurance on activity, emerging themes and progress. The People and Culture Committee (PCC) also receives FTSU updates as part of the wider staff feedback dashboard.

- The Audit and Risk Committee continues to oversee and monitor progress against the FTSU action plan.

Risks:

- There is a risk to the organisation where staff do not feel able to raise concerns safely. A lack of psychological safety may impact patient safety, clinical effectiveness, staff wellbeing and experience and may also create reputational and regulatory risks for the Trust.

Consultation

Members of the Executive Leadership Team, specifically the Chief Executive, Director of Corporate Affairs/Trust Secretary and Director of People, Organisational Development and Inclusion. The FTSUG also meets with the nominated Non-Executive Director for FTSU.

Governance or Legal Issues

Trusts are required to have a FTSUG as part of the NHS standard contract terms and conditions.

Net Zero Duty Implications

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

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

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

- The FTSUG seeks assurance that concerns raised by staff with protected characteristics are appropriately supported through Employee Relations and Equality, Diversity and Inclusion (EDI) processes, and that any wider themes or risks are considered by senior Trust leadership
- The report highlights areas of positive practice, including the presence of FTSU Champions from a diverse range of backgrounds and evidence of engagement from Black and Minority Ethnic (BME) colleagues in raising concerns through Freedom to Speak Up.

Recommendations

The Board of Directors is requested to:

1. Note the contents of the report and the themes arising from FTSU activity during the reporting period
2. Support the ongoing mechanisms and activities in place to promote the FTSU agenda across the Trust
3. Provide assurance that the actions and proposals outlined by the FTSUG continue to support an open and transparent culture where staff feel safe to raise concerns.

Report presented and prepared by:	**Tamera Howard** **Freedom to Speak Up Guardian (FTSUG)**

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

1. Introduction

1.1 The FTSUG supports the Trust in fostering an open and transparent culture where staff feel safe to raise concerns. Speaking up enables issues affecting patient safety, staff experience and organisational culture to be identified early and addressed appropriately. Freedom to Speak Up (FTSU) is a key element of a learning organisation and contributes to improving patient safety, staff wellbeing and organisational improvement. The Care Quality Commission (CQC) considers speaking up culture as part of the Well-Led domain within its inspection framework.

1.2 This report covers the period July to December 2025 (Quarters (Q) 2 and 3 of 2025/26). Reports are presented to the Board on a six-monthly basis.

2. Aim

2.1 This report provides the Board with:

- An overview of concerns raised through FTSU and the key themes identified during the reporting period
- Learning and improvements arising from staff speaking up
- Actions taken to strengthen the Trust's speaking up culture and address barriers to raising concerns
- Relevant updates from the National Guardian's Office (NGO)
- Key areas for Board assurance and consideration.

3. Summary of FTSU Concerns

3.1 Concerns raised through FTSU are categorised in line with NGO guidance. These include themes relating to patient safety and quality, bullying and harassment, inappropriate attitudes and behaviours, worker safety and wellbeing, Public Interest Disclosure Act (PIDA) concerns, anonymous concerns and cases where individuals experience detriment as a result of speaking up. Reporting against these categories supports organisational learning and national benchmarking.

3.2 **Table 1** show the FTSU case numbers per quarter for DHcFT in 2024 and 2025 in comparison to the FTSU case number quarterly average for Mental Health trusts in 2024/25. This shows a 22.1% increase in number of FTSU cases per quarter from 2024 to 2025.

Table 1

DHcFT FTSU Cases per quarter 2024	DHcFT FTSU Cases per quarter 2025	Average cases logged per quarter for MH Trusts in 2024/25*
56.5	69	40.8

*Summary of Speaking Up to FTSUGs: 2024/25

3.3 **Patient Safety and Quality:** During Q2 and Q3 2025/26, patient safety and quality concerns represented 27.6% of cases, compared with 16.4% between January and June 2025. The increase was largely linked to 63 staff raising concerns about staff break arrangements and the potential impact on patient safety and quality of care. These concerns are escalated to the Director of Nursing, Allied Health Professionals (AHPs), Quality and Patient Experience and the Executive Medical Director as appropriate. Nationally, patient safety concerns represented 17.8% of cases in 2024/25 (Summary of Speaking Up to FTSUGs: 2024/25). Summary of Speaking Up to FTSUGs: 2024/25.

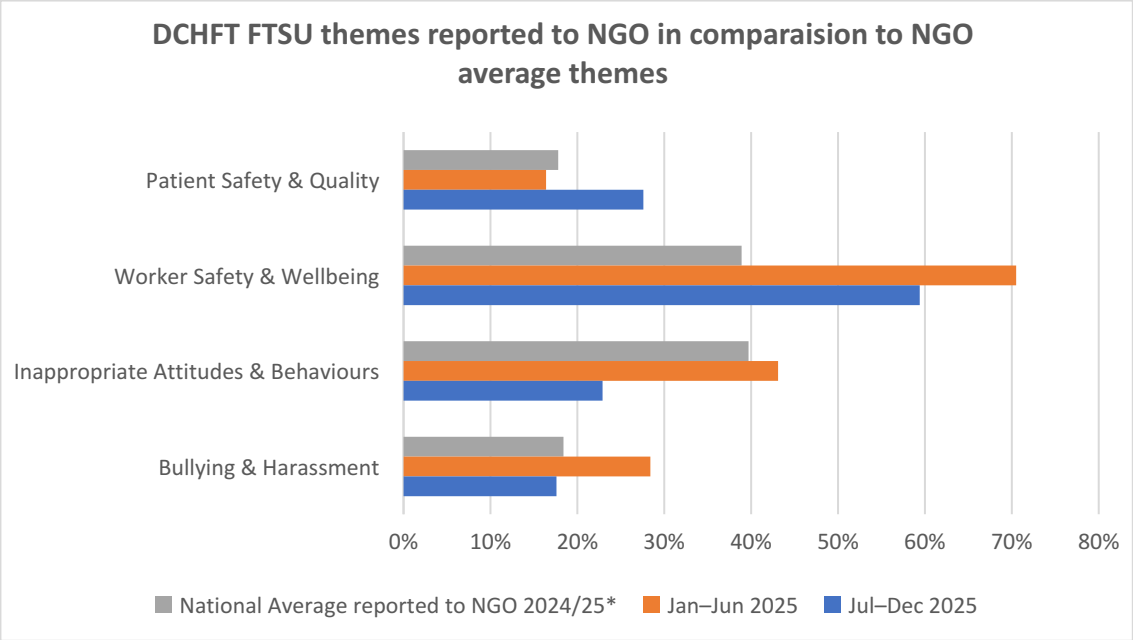
Table 2 shows that the FTSUG logged 61 cases in Q2 and 109 cases in Q3 2025/26. In Q4 2025/26, 44 cases have been logged (12 March 2026).

Table 2: FTSU Data Q2 and Q3 2025/26

Types of Concerns (Themes)	Q2 2025/26	Q3 2025/26
Patient Safety & Quality (NGO/PIDA)	14	33
Bullying & Harassment (NGO/PIDA)	18	12
Inappropriate Attitudes and Behaviours (NGO)	23	16
Worker Safety and Wellbeing (NGO)	37	64
Potential Fraud or Criminal Offence (PIDA)	2	0
Total Cases (individuals) reported to FTSUG*	**61**	**109**
Public Interest Disclosure Act (PIDA) concerns	34	45
Reportable to NGO: Bullying and Harassment / Patient Safety / Worker Safety / Inappropriate Attitudes and Behaviours*	92	125
Anonymous / Not known / Other	6	5
Person indicates suffering detriment as result of speaking up	2	3
Number of cases that have received feedback	**55**	**104**

*Individuals (cases) approaching FTSUG may log more than one concern theme.

Figure 1: Most frequently raised speaking up themes in comparison with the previous reporting period and national figures reported to the NGO



*Summary of Speaking Up to FTSUGs: 2024/25

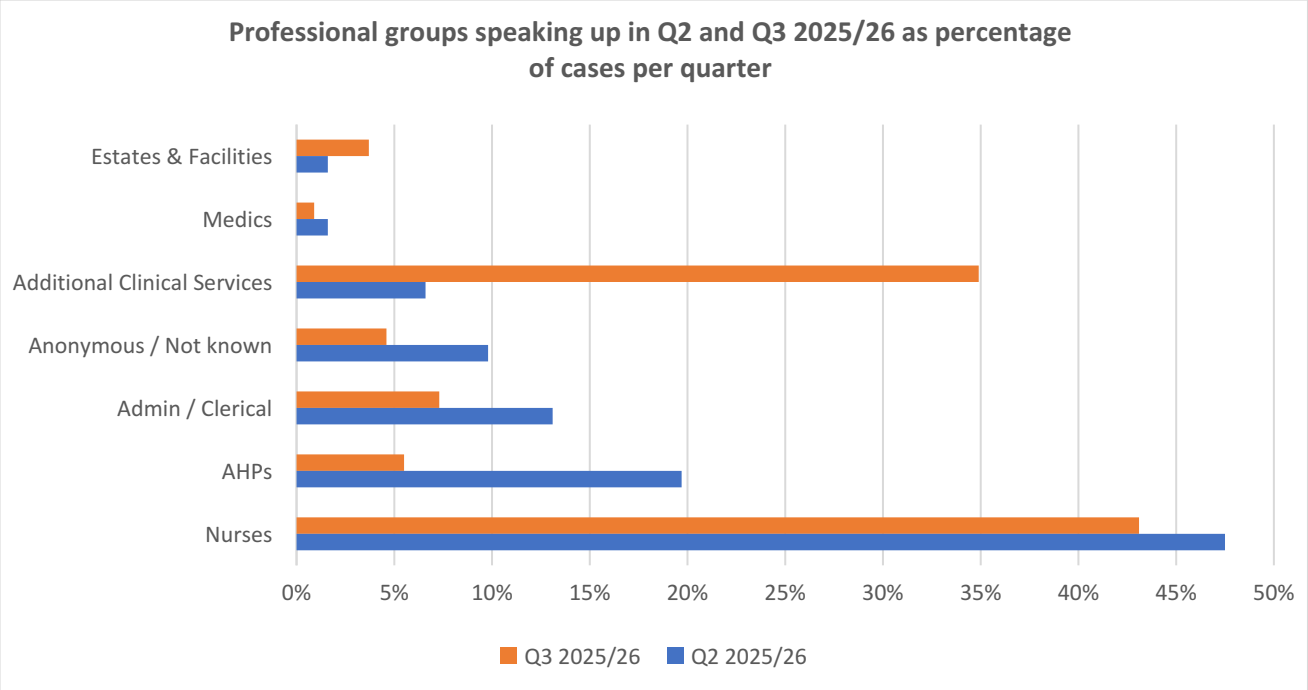
3.4 **Bullying and Harassment concerns** represented 17.6% of cases raised to the FTSUG from July to December 2025. This is a decrease on the 28.4% of cases raised from January to June 2025. Staff are signposted to the Trust's Respectful Resolution policy, wellbeing support, staff-side/union support and Employee Relations where appropriate.

3.5 **Inappropriate Attitudes and Behaviours concerns** represented 22.9% cases raised to the FTSUG from July to December 2025. This is a decrease on the 43.1% of cases raised from January to June 2025.

3.6 **Worker Safety and Wellbeing concerns:** 59.4% of cases involved an element of worker safety and wellbeing from July to December 2025. This is a decrease on the 70.5% of cases seen in January to June 2025. The FTSUG believes this increase is due to higher numbers of staff reporting the impact of the speaking up issues on their wellbeing.

3.7 **Professional groups:** From July to December 2025, 44.1% of staff approaching the FTSUG were Nurses. This is the same as Nurses approaching in January to June 2025 also at 44% of staff. It is also higher than the national average reported by the NGO at 28.3%. (Summary of Speaking Up to FTSUGs: 2024/25).

Figure 2: Professional groups speaking up in Q2 and Q3 2025/26 as percentage of total cases per quarter:



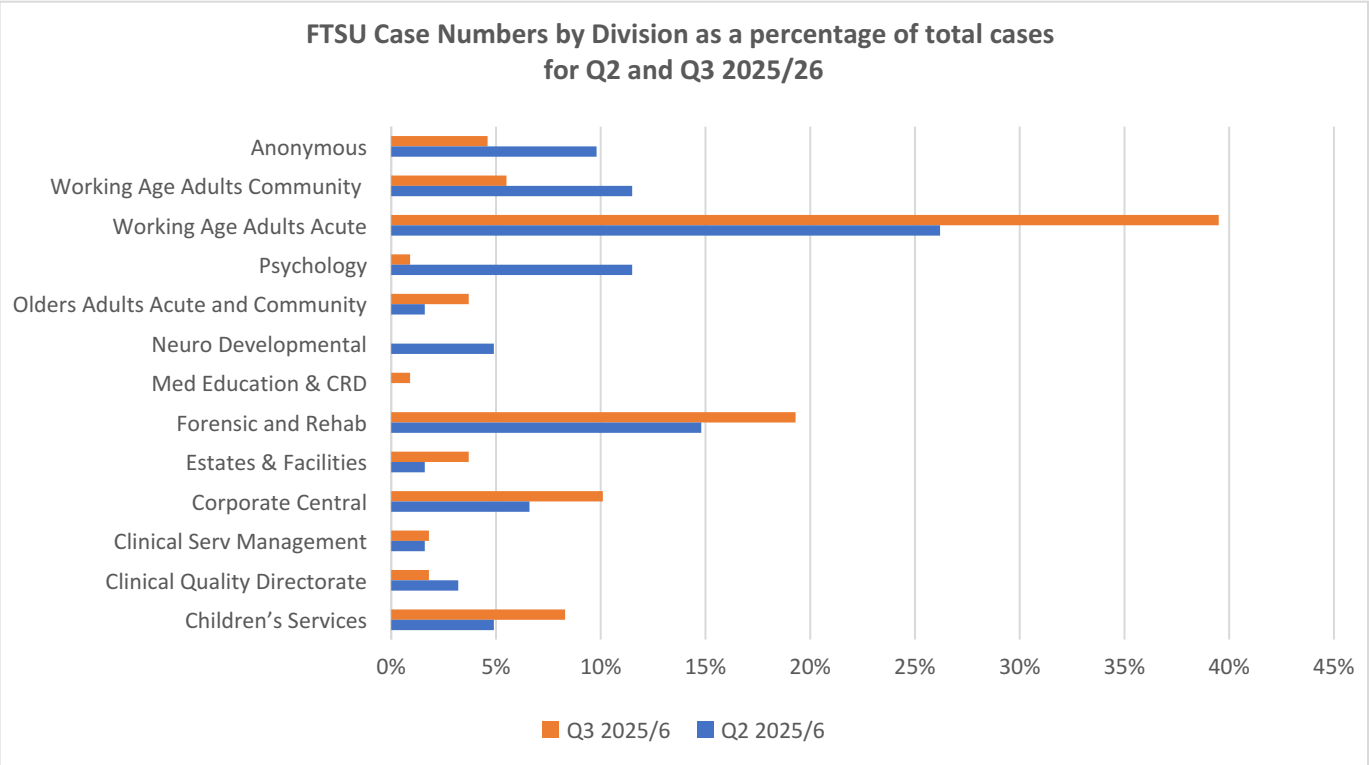
3.8 **Experiencing Detriment or Demeaning treatment:** From July to December 2025, 2.9% of workers reported that they had experienced a detriment or demeaning treatment as a result of speaking up. In January to June 2025 this was 1.7%. NGO average for detriment in 2023/24 was 2.9% (Summary of Speaking Up to FTSUGs: 2024/25).

3.9 **Ethnicity of Workers:** From July to December, 40.6% of colleagues speaking up identified as Black and Minority Ethnic (BME). This is an increase from January to June 2025, where 34.5% of staff speaking up identified as BME. 24.9% of DHcFT staff are from BME communities (Workforce Data Snapshot (ESR) Dec 2025).

3.10 **Anonymous, Confidential or Open concerns:** Anonymous concerns represented 6.5% of concerns. From January to June 2025, anonymous concerns represented 5.2% of cases. This is lower than anonymous concerns reported nationally in 2023/24, which were 11.6% (Summary of Speaking Up to FTSUGs: 2024/25).

3.11 **Concerns raised by Division:** Figure 3 shows the number of cases from Divisions across the Trust. There are high numbers of concerns from Working Age Adults Acute and Forensic and Rehabilitation as 63 staff spoke up about break patterns came predominantly from these Divisions. Future reporting will be aligned to the two new Divisions and Care Groups.

Figure 3: FTSU Case Numbers by Division as a percentage of total cases for Q2 and Q3 2025/26:



4. Emerging or ongoing themes with learning/action points Q2 and Q3 2025/26

During this reporting period, three high-impact themes dominated the concerns raised through FTSU. The following section summarises the issues and the actions and improvements underway.

4.1 Workforce Safety, Wellbeing and Break Arrangements

Concerns relating to workforce safety and wellbeing were raised by staff across inpatient areas, particularly in relation to proposed night shift break arrangements Staff highlighted concerns regarding disproportionate break duration and lack of appropriate break facilities as well as concerns about the consultation process, staffing levels and lone working.

Action and Improvement

- The Trust has listened to staff concerns and agreed with staff side an alternative, which will continue to be monitored against feedback from colleagues in relation to their safety, wellbeing and patient care
- A joint review with staff side continues to ensure we have a safe and sustainable break model
- A Trust-wide review of staff rest facilities has commenced
- The safer staffing workstream has been strengthened, with particular focus on night staffing, lone working and skill mix.

4.2 Bullying, Harassment & Inappropriate Workplace Behaviours

Bullying, harassment and inappropriate workplace behaviours remained a significant theme during the reporting period, with around 40% of concerns including elements of these issues. Staff described experiences of undermining or intimidating behaviour, defensive responses when concerns were escalated and a lack of psychological safety within some teams. These issues can affect staff morale, retention, team functioning and ultimately patient care. The concerns highlight the importance of consistent leadership behaviours and supportive team cultures where staff feel able to raise concerns without fear.

Action and Improvement

- The Trust is introducing the 'A Kind Life' programme to support cultural improvement and reinforce Trust values and behaviours
- Employee Relations' processes have been initiated or escalated where appropriate
- Targeted leadership support, coaching and mediation have been provided within identified teams
- FTSU monitoring and leadership visibility have been strengthened to support earlier identification and intervention where concerns arise.

4.3 Discrimination & Inclusion Concerns

During this reporting period, 16.4% of concerns raised included elements of discrimination, including racial discrimination, unequal treatment and disability-related disadvantage. Staff reported experiences of racial abuse from patients, inconsistent responses to racist behaviours and instances of discriminatory comments or micro-aggressions within teams. These issues have had a significant emotional impact on affected staff, particularly colleagues from Black and Minority Ethnic backgrounds, and highlight the importance of consistent organisational responses to discrimination.

Action and Improvement

- The Trust has approved and communicated a Trust-wide Anti-Racism Position Statement
- Racism-related Datix reports are now classified as Major Incidents, ensuring senior oversight and appropriate escalation
- A Race Equality Working Group has been established to oversee delivery of the Trust's Race Equality Strategy and monitor progress
- Collaboration between Equality, Diversity and Inclusion and FTSU has been strengthened to support staff and identify learning from reported concerns.

5. Improving Speaking Up Culture

5.1 Improving visibility and networking: The FTSUG presents at monthly Trust inductions, attends team meetings on request and holds regular face-to-face drop-in sessions in acute settings. The FTSUG participates in listening events across specific areas of the Trust where concerns have been raised.

5.2 Supporting communities who face barriers to speaking up: The FTSUG delivers presentations on FTSU to a range of staff groups, including the north and south Resident Doctors groups, preceptees, students and trainees and Healthcare Support Workers through the Trust's iCare programme.

5.3 Triangulation of data: The FTSUG meets regularly with senior leaders, including the Chief Executive and the Director and Deputy Director of People, Organisational Development and Inclusion, to review themes and triangulate data from speaking up. The FTSUG also produces a report for the People and Culture Committee to support the triangulation of workforce data relating to Freedom to Speak Up.

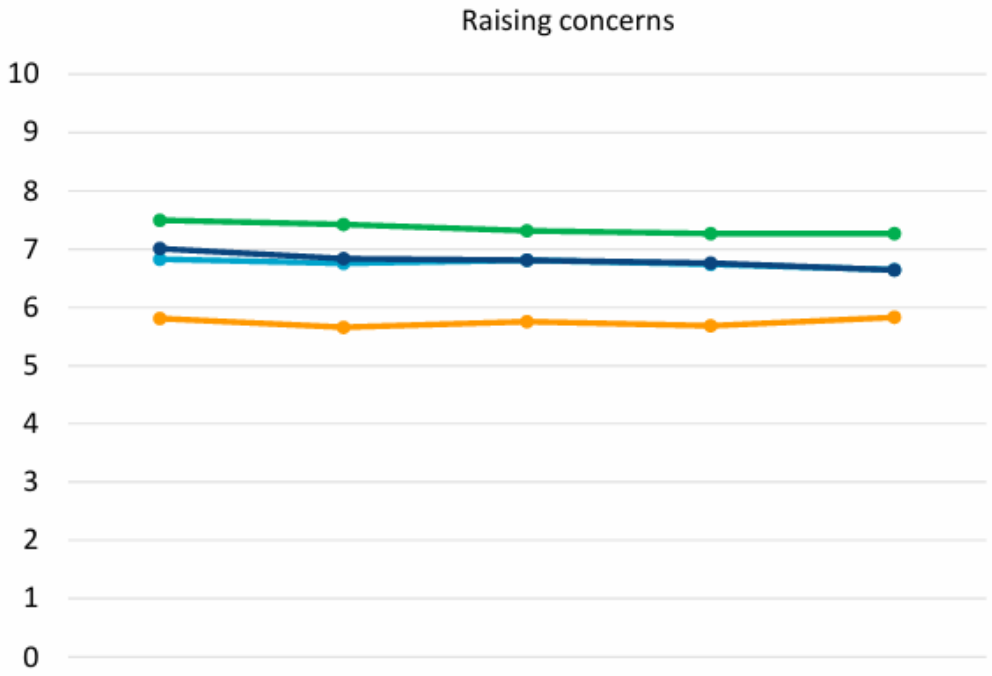
5.4 Network of FTSU Champions: The FTSUG holds monthly meetings with Speaking Up Champions to share good practice, provide support with speaking up matters and share updates from the NGO. Champions were involved in referring 21% of concerns raised between July and December 2025. DHcFT currently has 42 FTSU Champions representing a range of Divisions across the Trust. The recently updated FTSU Champions poster is available on Focus (staff intranet).

5.5 Non-Executive Director (NED) support: The FTSUG is supported by Lynn Andrews, NED lead for FTSU. The FTSUG meets with the NED on a monthly basis to discuss FTSU practice and areas for support and development.

5.6 Raising Concerns Staff Survey Results 2025: The 2025 score for *Raising Concerns* is 6.64, continuing a gradual decline from 7.01 in 2021 and now aligning with the sector average (6.64). While the score remains within the sector range, it sits below the best-performing organisations (7.26), indicating scope to strengthen staff confidence in speaking up. The increased number of responses in 2025 (2,149) provides greater confidence in the reliability of this result.

Suggested actions:

- Reinforce awareness and visibility of all speaking-up routes, including FTSU channels and local escalation processes
- Work with managers and staff networks to promote a positive speaking-up culture and ensure staff feel safe to raise concerns without fear of negative consequences.



	2021	2022	2023	2024	2025
Your org	7.01	6.84	6.81	6.76	6.64
Best result	7.49	7.42	7.31	7.26	7.26
Average result	6.83	6.76	6.81	6.74	6.64
Worst result	5.81	5.66	5.75	5.68	5.83
Responses	1689	1400	1890	2068	2149

6. Learning, Improvement and Development in relation to Speaking Up Culture within the Trust

6.1 **Evaluation feedback on Speaking Up:** An evaluation form is sent to individuals who have spoken up following their contact with the FTSUG via an online link. Between July and December 2025, 76.7% of respondents indicated that they would speak up again.

6.2 Derbyshire Integrated Care System (ICS): The FTSUG meets monthly with FTSUGs across the Derbyshire Integrated Care System to share learning and discuss system-wide approaches to FTSU.

6.3 FTSU Networks: The FTSUG regularly attends fortnightly Midlands Regional FTSUG Check-In meetings, quarterly Midlands Network FTSUG meetings, and FTSUG Mentor and Chair network sessions to support collaboration, development and learning.

6.4 Speak Up e-learning training: Speak Up e-learning training was launched for all staff on 1 April 2024. Compliance across the organisation currently stands at 93% (February 2026). The FTSUG would welcome the introduction of Listen Up training for managers as part of the mandatory e-learning programme, or the provision of equivalent face-to-face training.

6.5 FTSU Strategy and FTSU Policy Development: The revision of the FTSU Strategy Plan and FTSU Policy is currently underway as part of continued development and strengthening of the service.

7 National Guardian's Office and related National Changes

7.1 NHS England (NHSE) and the Department of Health and Social Care (DHSC) have confirmed that the FTSUG role will remain part of the NHS Standard Contract for 2026/27. The National Guardian's Office will close in June 2026, with arrangements in place to ensure continuity of support for Guardians nationally, through NHSE/DHSE.

8. Conclusion

8.1 Creating a culture where staff feel safe to speak up and experience psychological safety is a key element of organisational culture across the NHS. While the FTSUG plays an important role in supporting this agenda, responsibility for maintaining an open and supportive culture sits across the whole organisation. It is important that the Trust continues to listen to concerns raised by staff and uses this feedback as an opportunity to strengthen services, improve staff experience and enhance patient safety

8.2 The Board has a key role in reinforcing and sustaining a positive speaking up culture. By supporting the recommendations within this report and ensuring that learning from concerns is acted upon, the Trust can continue to promote openness, transparency and meaningful responses to the issues raised by staff.

NHS Staff Survey 2025 Benchmarking Results and Workforce Insights

Purpose of Report

To present the 2025 NHS Staff Survey benchmarking results for Derbyshire Healthcare NHS Foundation Trust and provide an overview of how the Trust performs in comparison with the national benchmarking group of Mental Health and Learning Disability trusts.

The report highlights key trends across the NHS People Promise elements, staff engagement and morale indicators, and identifies priority areas for improvement and organisational focus.

Executive Summary

The NHS Staff Survey 2025 received 2,167 responses from Derbyshire Healthcare staff, representing a **64%** response rate, which is significantly above the national median response rate of **52%** within the benchmarking group.

Overall results show that the Trust continues to perform around or above the benchmarking group average in several People Promise elements, including team working and compassionate leadership.

Key strengths include:

- Strong scores relating to team working and line management
- Continued positive results for compassionate leadership
- Staff reporting high levels of motivation and involvement

However, the benchmarking analysis also identifies several areas requiring continued organisational focus, including:

- **Burnout and health and safety climate**
- **Speaking up and confidence that concerns will be addressed**
- **Friends and Family questions**

Overall staff engagement remains broadly in line with benchmarking averages, though there has been a slight downward trend in engagement and morale indicators, reflecting wider workforce pressures.

The benchmarking data provides valuable insight to inform the Trust's People Plan priorities, culture improvement programmes and team development work, ensuring targeted interventions are focused on the areas that will most improve staff experience.

Strategic Considerations		**BAF Risk (eg 1A)**	**Strategic Delivery Plan Reference**
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.			
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X	2A / 2B	2.1/ 2.2 2.3 / 2.4
Productive: We will improve our productivity and design and deliver services that are financially sustainable.			
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.			

Risks and Assurances

There is a risk that declining scores in areas such as workload, burnout and morale may impact staff wellbeing, retention and organisational performance.

The Trust mitigates these risks through:

- targeted People Plan actions
- culture and leadership development programmes
- staff wellbeing initiatives and improvements
- ongoing staff engagement and listening approaches.

The benchmarking results provide assurance that the Trust continues to perform broadly in line with national peers while identifying areas requiring improvement.

Consultation

- People and Inclusion and Organisational Development colleagues
- Executive Leadership Team
- Findings will also be shared with operational leaders to support local action planning.

Governance or Legal Issues

The NHS Staff Survey forms part of the national workforce monitoring framework and supports compliance with NHS People Plan requirements.

Net Zero Duty Implications

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

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

N/A.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

- The NHS Staff Survey includes measures relating to equality, diversity and inclusion. Benchmarking data highlights staff experiences relating to discrimination, inclusion and fairness in career progression
- Findings will inform ongoing work to strengthen equality, diversity and inclusion across the Trust and ensure that workforce initiatives support equitable staff experiences across protected characteristics.

Recommendations

The Board of Directors is requested to:

1. Note the NHS Staff Survey 2025 benchmarking results
2. Consider the key themes identified within the benchmarking analysis
3. Support the continued development of targeted workforce improvement actions aligned to the Trust's People Plan priorities.

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

NHS
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NHS National Staff Survey Results 2025

WE MAKE A POSITIVE DIFFERENCE IN EVERYTHING WE DO

Organisation details

Derbyshire Healthcare NHS Foundation Trust

2025 NHS Staff Survey

Organisation details

Completed questionnaires	2,167
2025 response rate	64%

Survey details

Survey mode	Mixed

This organisation is benchmarked against:

Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts

2025 benchmarking group details

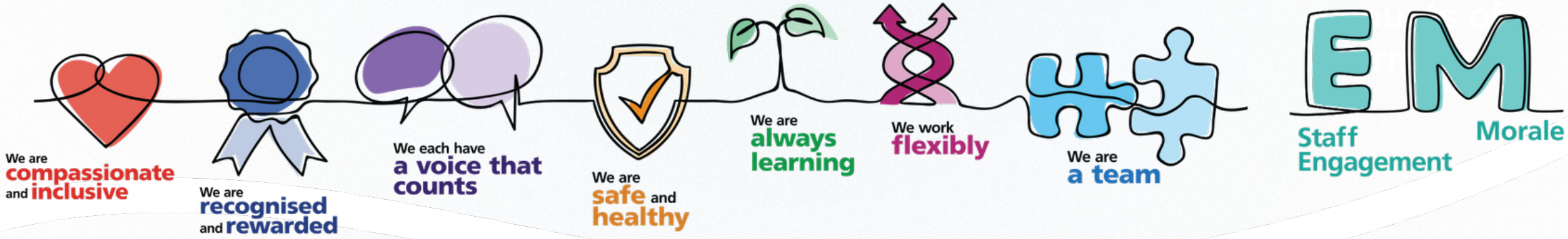
Organisations in group: 48

Median response rate: 52%

No of completed questionnaires: 145,759

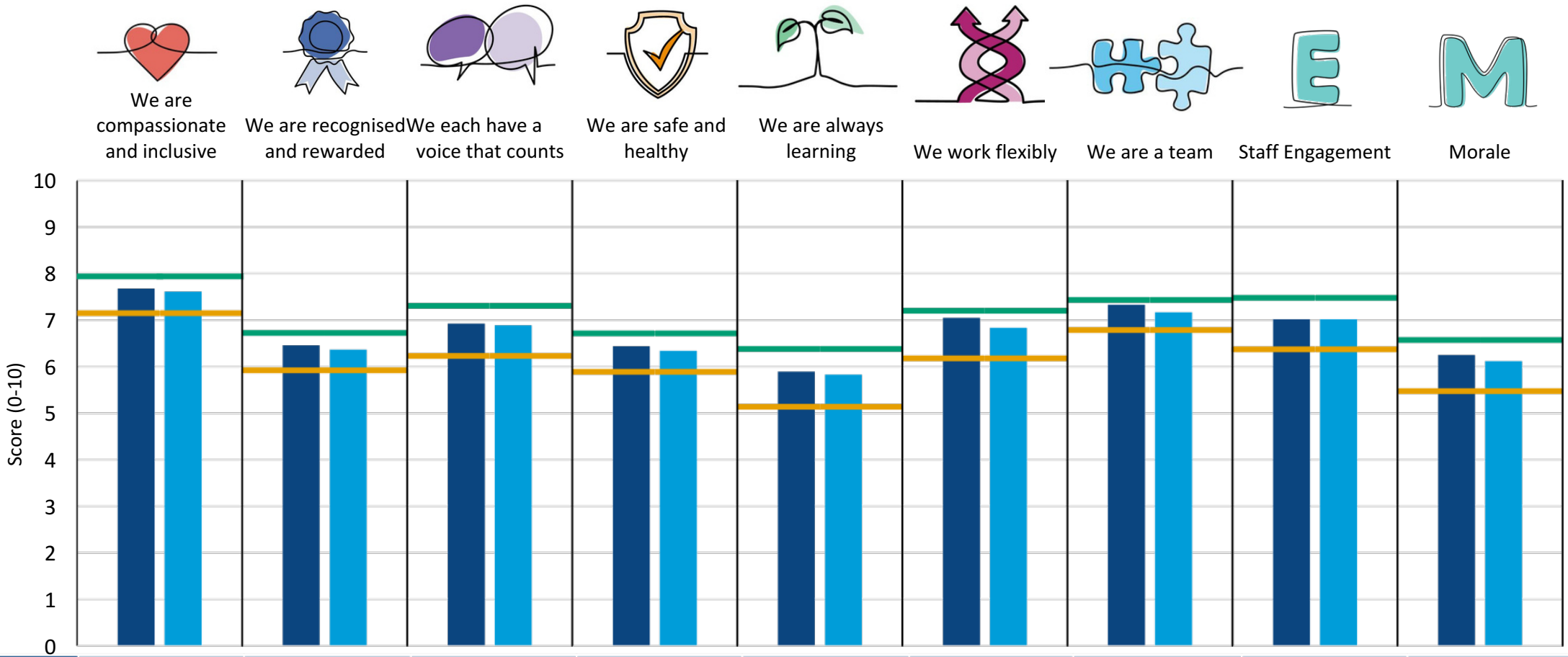
Derbyshire Healthcare
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People Plan Results



People Promise elements and themes: Overview

PeoplePromiseelements,themesandsub-scoresarescoredona0-10scale,**whereahigherscoreismorepositivethan a lower score**.

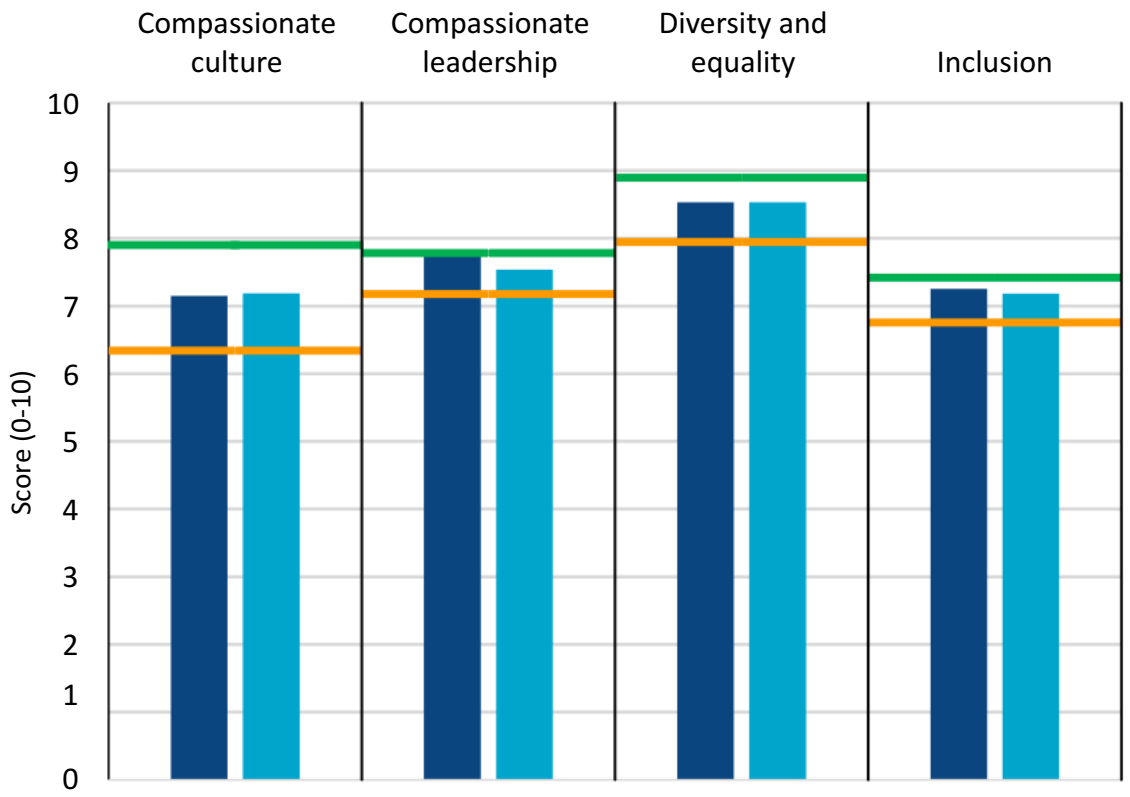


	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.68	6.46	6.93	6.44	5.90	7.05	7.33	7.02	6.25
Best result	7.94	6.72	7.31	6.72	6.38	7.20	7.43	7.48	6.57
Average result	7.61	6.37	6.89	6.34	5.83	6.84	7.17	7.02	6.12
Worst result	7.15	5.92	6.23	5.89	5.14	6.18	6.79	6.37	5.48
Responses	2158	2154	2140	2140	2072	2141	2153	2157	2157

People Promise elements, themes and sub-scores: Sub-score overview

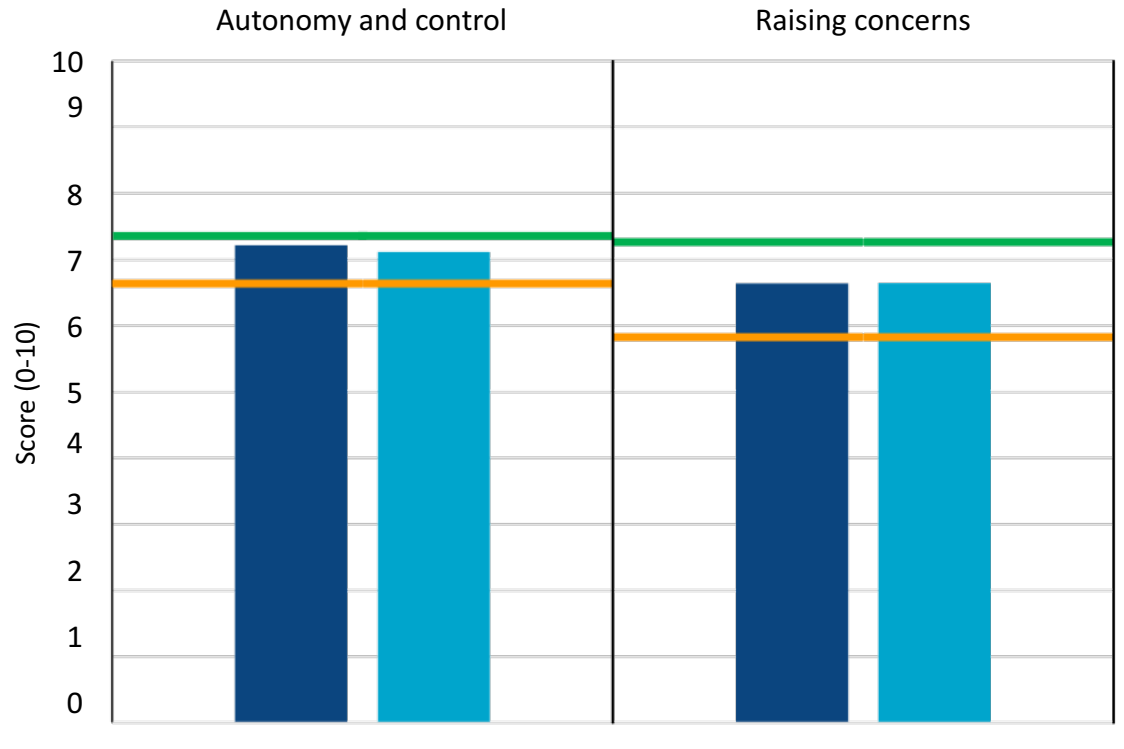
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 1: We are compassionate and inclusive



	Compassionate culture	Compassionate leadership	Diversity and equality	Inclusion
Your org	7.15	7.78	8.53	7.26
Best result	7.90	7.78	8.90	7.42
Average result	7.19	7.54	8.53	7.18
Worst result	6.34	7.18	7.95	6.76
Responses	2157	2155	2157	2151

Promise element 3: We each have a voice that counts



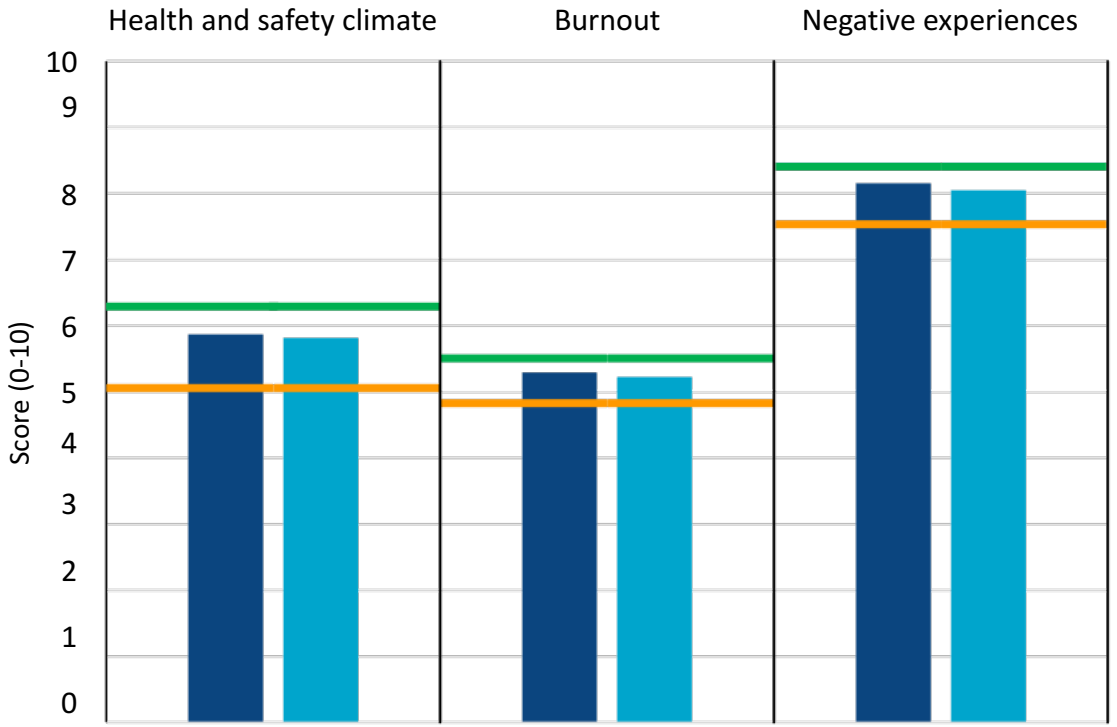
	Autonomy and control	Raising concerns
Your org Best	7.22	6.64
result Average	7.36	7.26
result Worst	7.11	6.64
result	6.64	5.83
Responses	2155	2149

Note: People Promise element 2 'We are recognised and rewarded' does not have any sub-scores. Overall trend score data for this element is reported on slide 21.

People Promise elements, themes and sub-scores: Sub-score overview

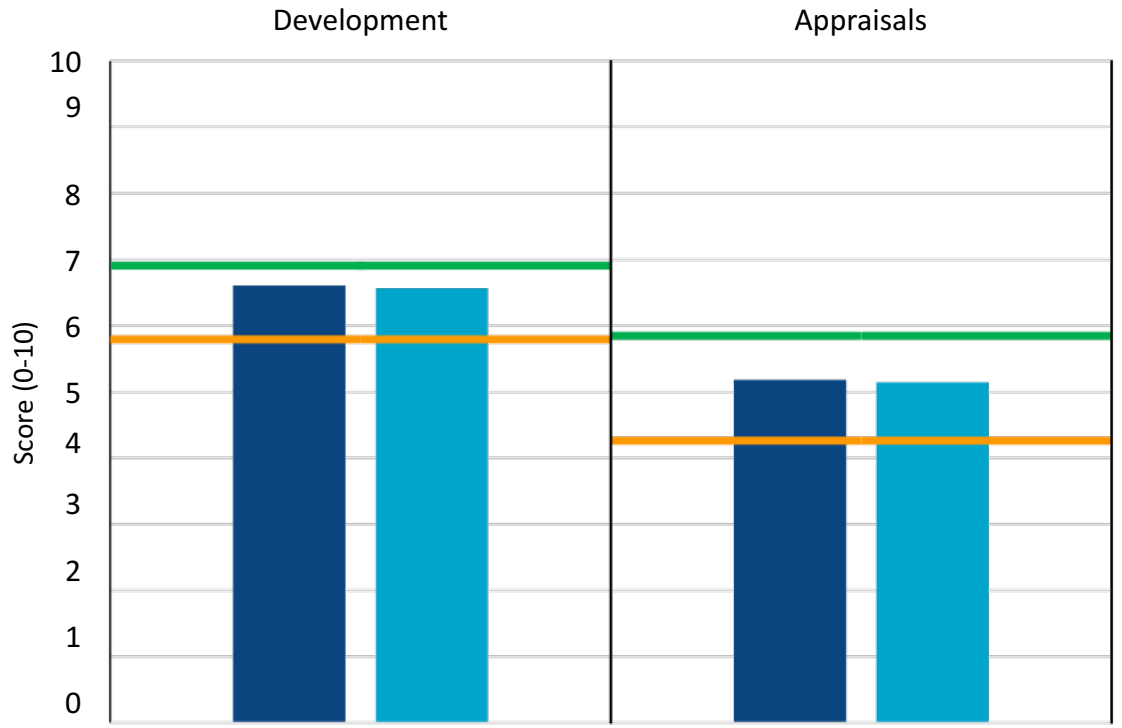
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 4: We are safe and healthy



	Health and safety climate	Burnout	Negative experiences
Your org Best	5.87	5.29	8.16
result Average	6.29	5.51	8.40
result Worst	5.82	5.23	8.05
result	5.06	4.83	7.53
Responses	2156	2160	2149

Promise element 5: We are always learning

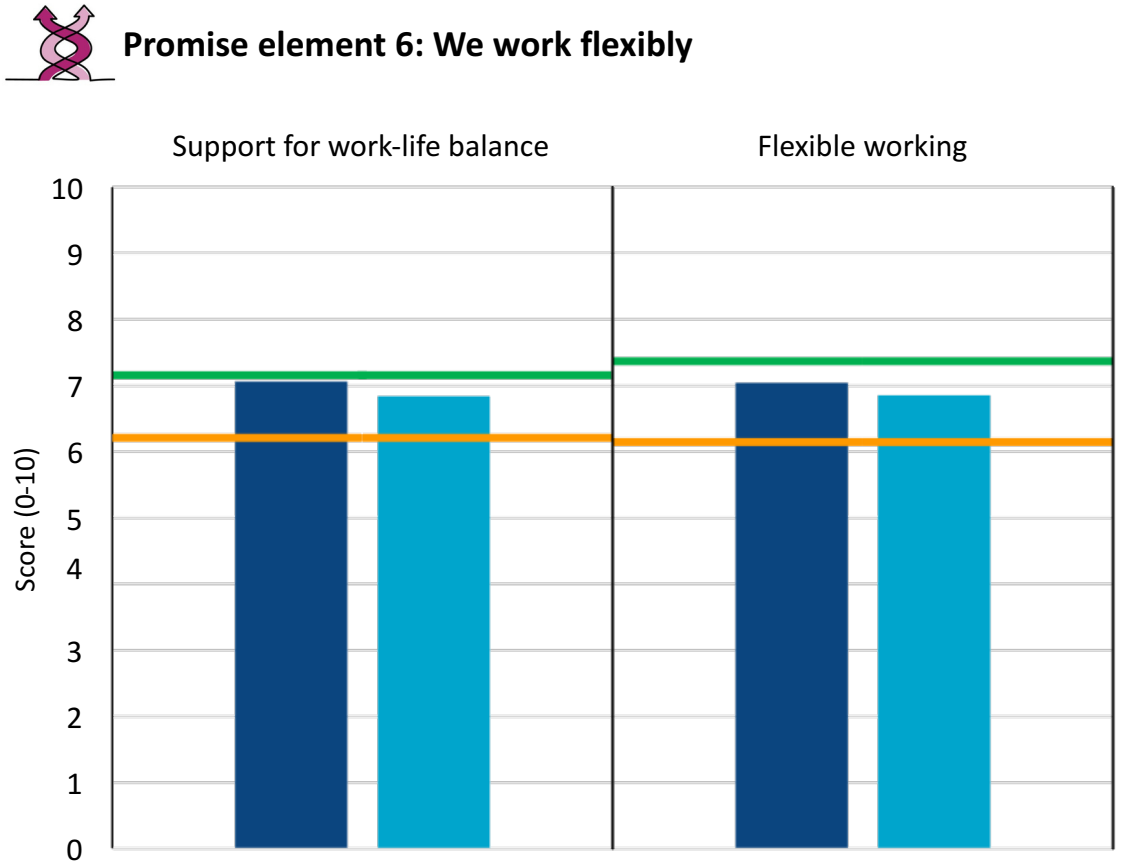


	Development	Appraisals
Your org Best	6.61	5.18
result Average	6.91	5.85
result Worst	6.57	5.14
result	5.79	4.26
Responses	2157	2075

People Promise elements, themes and sub-scores: Sub-score overview

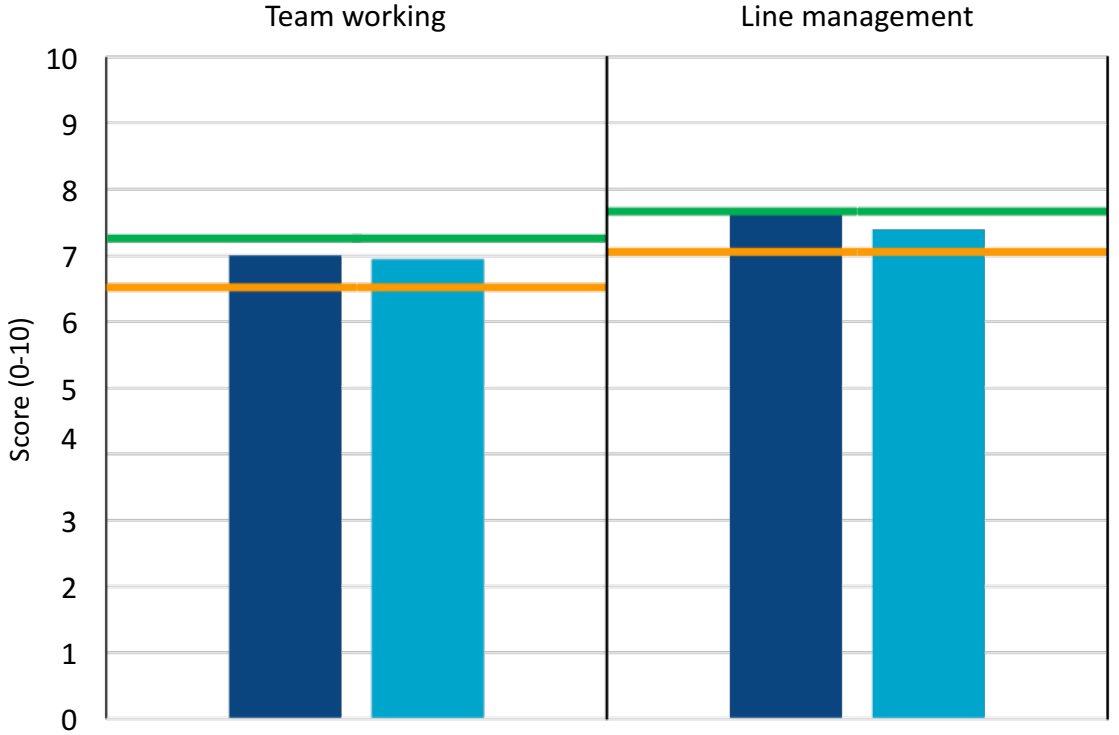
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Promise element 6: We work flexibly



	Support for work-life balance	Flexible working
Your org Best	7.06	7.04
result Average	7.15	7.37
result Worst	6.84	6.85
result	6.21	6.15
Responses	2155	2143

Promise element 7: We are a team

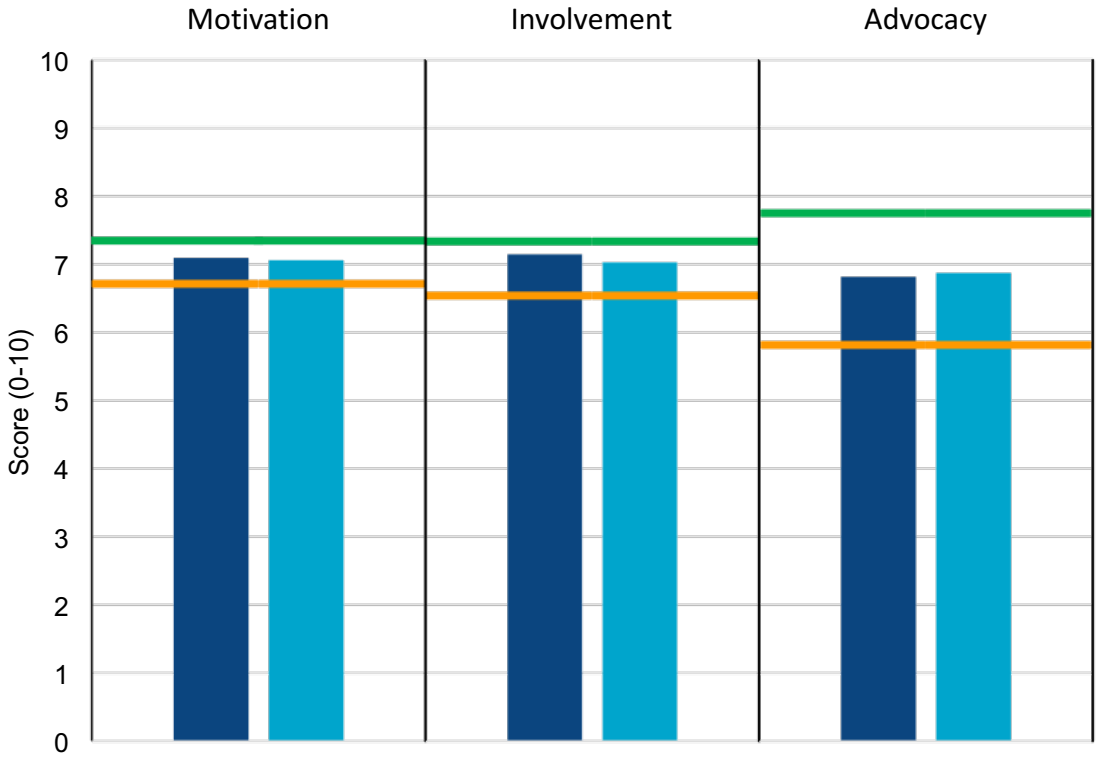


	Team working	Line management
Your org Best	7.00	7.66
result Average	7.26	7.66
result Worst	6.94	7.40
result	6.52	7.05
Responses	2155	2156

People Promise elements, themes and sub-scores: Sub-score overview

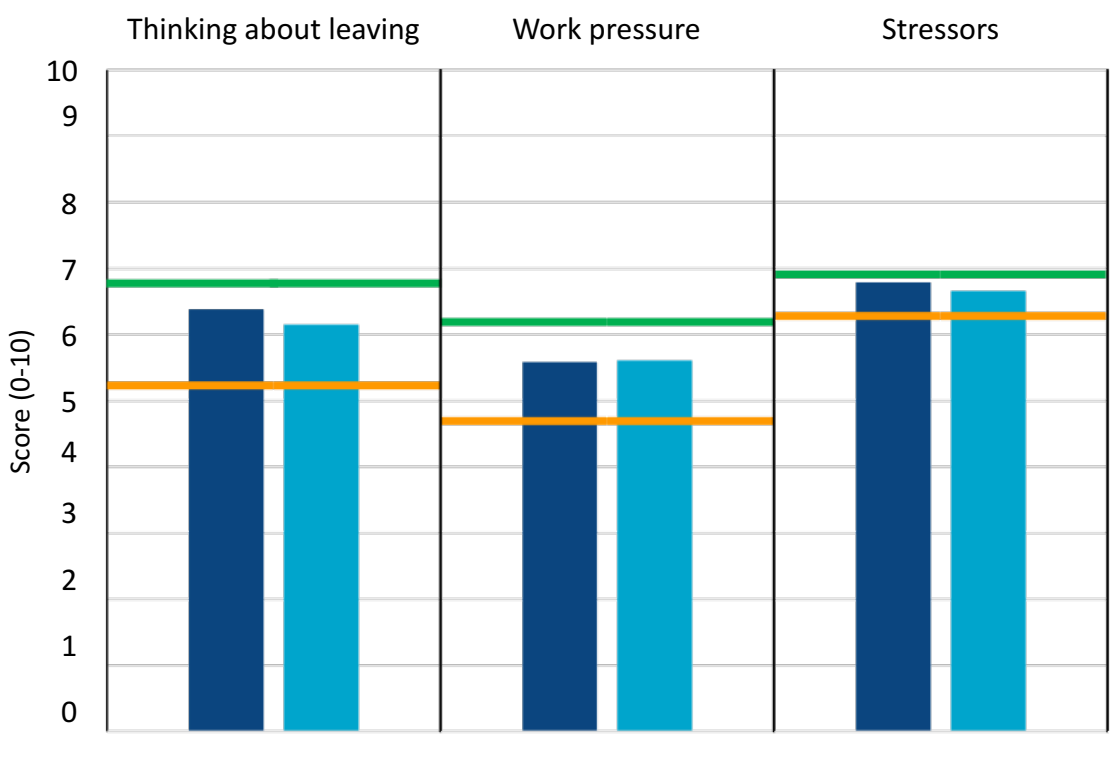
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

Theme: Staff engagement



	Motivation	Involvement	Advocacy
Your org Best result	7.09	7.15	6.82
Average result	7.35	7.33	7.75
Worst result	7.06	7.03	6.87
Your org result	6.71	6.54	5.82
Responses	2123	2154	2156

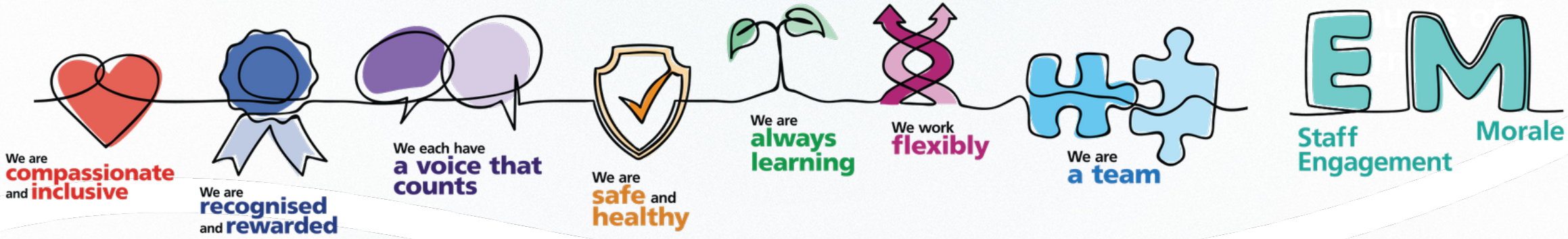
Theme: Morale



	Thinking about leaving	Work pressure	Stressors
Your org	6.39	5.59	6.79
Best result	6.77	6.19	6.91
Average result	6.15	5.61	6.66
Worst result	5.23	4.69	6.28
Responses	2150	2156	2149

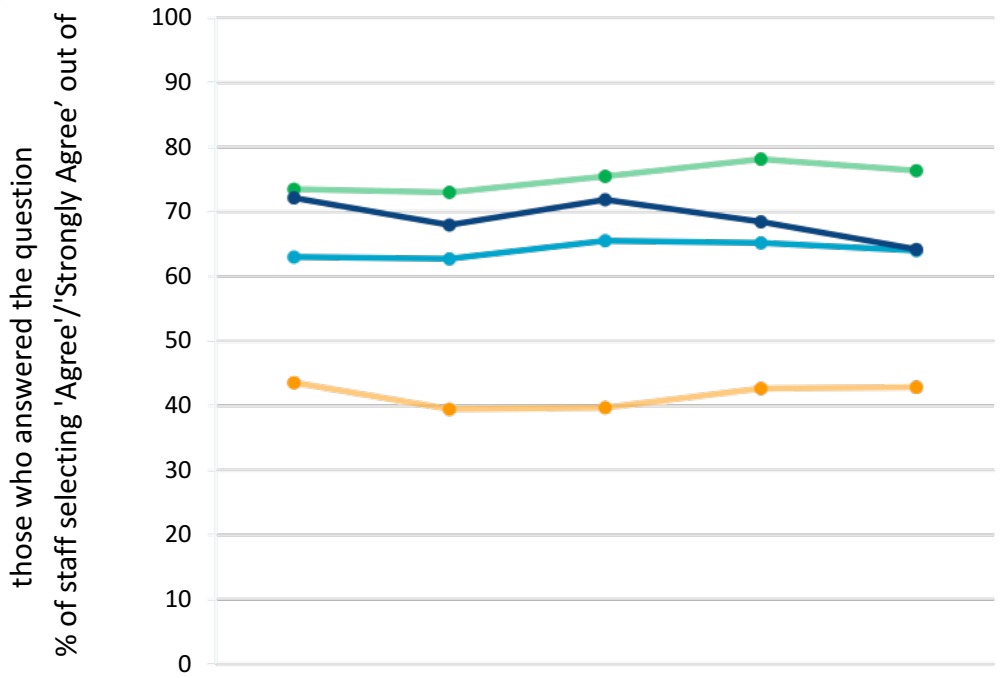
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People Plan Elements, Themes and Sub scores - Trends



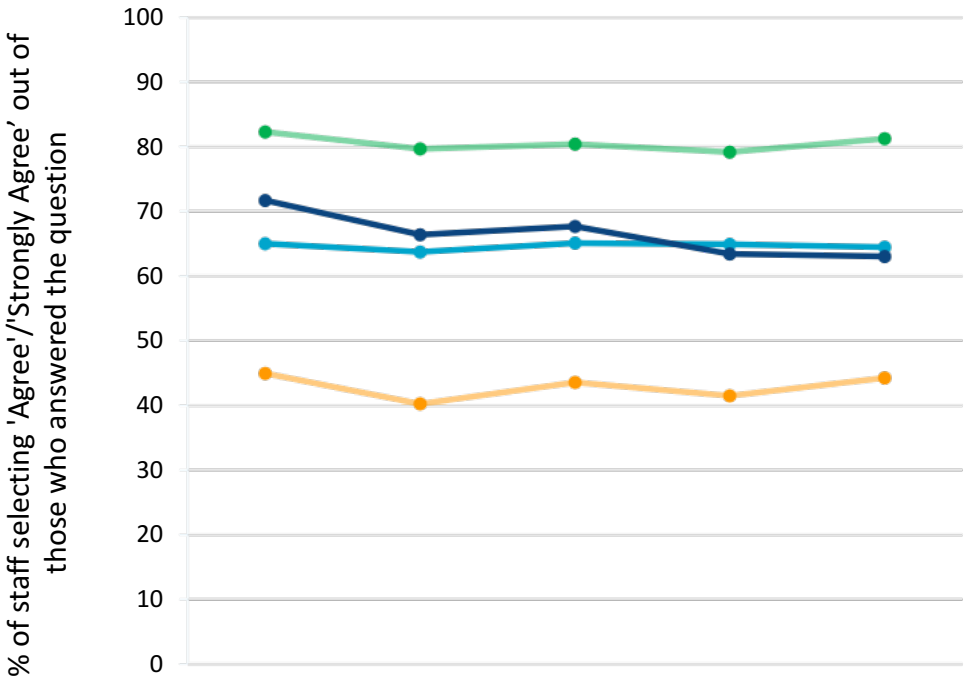
People Promise elements and theme results – We are compassionate and inclusive: Compassionate culture

Q25c I would recommend my organisation as a place to work.



	2021	2022	2023	2024	2025
Your org	72.17%	67.98%	71.89%	68.49%	64.23%
Best result	73.53%	73.02%	75.50%	78.17%	76.39%
Average result	63.05%	62.75%	65.53%	65.22%	64.00%
Worst result	43.58%	39.48%	39.70%	42.69%	42.89%
Responses	1699	1399	1896	2072	2154

Q25d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.



	2021	2022	2023	2024	2025
Your org Best	71.71%	66.40%	67.66%	63.42%	63.04%
result Average	82.30%	79.65%	80.41%	79.17%	81.28%
result Worst	64.99%	63.74%	65.09%	64.91%	64.45%
result	44.96%	40.24%	43.56%	41.49%	44.25%
Responses	1697	1404	1894	2067	2146

Top 5 improved scores

Derbyshire Healthcare
NHS Foundation Trust

Data Type	Metric		Sector	Organisation 2024	Organisation 2025	Difference
Question score	Q23a	In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review (Yes).	**88.0%**	**86.1%**	**89.6%**	**3.5%**
Question score	Q14d	The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it (Yes).	**64.5%**	**65.4%**	**68.0%**	**2.5%**
Question score	Q13d	The last time you experienced physical violence at work, did you or a colleague report it (Yes).	**89.6%**	**89.5%**	**91.7%**	**2.3%**
Question score	Q24f	I am able to access clinical supervision opportunities when I need to (Agree/Strongly agree).	**78.3%**	**81.7%**	**83.8%**	**2.0%**
Question score	Q12c	How often, if at all, does your work frustrate you (Never/Rarely).	**24.0%**	**23.7%**	**24.8%**	**1.1%**

Top 5 reduced scores

Derbyshire Healthcare
NHS Foundation Trust

Data Type	Metric		Sector	Organisation 2024	Organisation 2025	Difference
Question score	Q11b	In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities (No).	**65.8%**	**81.9%**	**69.4%**	**-12.5%**
Question score	Q21	I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc) (Agree/Strongly agree).	**72.9%**	**77.8%**	**72.9%**	**-4.9%**
Question score	Q15	Does your organisation act fairly with regard to career progression / promotion, regardless of e.g. age, disability, ethnic background, gender reassignment, religion, sex or sexual orientation (Yes).	**56.7%**	**63.5%**	**58.6%**	**-4.9%**
Question score	Q25e	I feel safe to speak up about anything that concerns me in this organisation (Agree/Strongly agree).	**64.8%**	**70.9%**	**66.2%**	**-4.7%**
Question score	Q25c	I would recommend my organisation as a place to work (Agree/Strongly agree).	**62.4%**	**68.3%**	**63.6%**	**-4.6%**

Appendix B: Significance testing – 2024 vs 2025

Survey Coordination Centre NHS

Statisticalsignificance helpsquantifywhetheraresultislikelydueto chance or tosome factor of interest. The table below presents the results of significance testing conducted on the theme scores calculated in both 2024 and 2025*. For more details, please see the Technical Guide.

People Promise elements	2024 score	2024 respondents	2025 score	2025 respondents	Statistically significant change?
We are compassionate and inclusive	7.75	2077	7.68	2158	Not significant
We are recognised and rewarded	6.52	2076	6.46	2154	Not significant
We each have a voice that counts	6.99	2063	6.93	2140	Not significant
We are safe and healthy	6.52	2063	6.44	2140	Not significant
We are always learning	5.93	1939	5.90	2072	Not significant
We work flexibly	7.10	2066	7.05	2141	Not significant
We are a team	7.32	2072	7.33	2153	Not significant
Themes					
Staff Engagement	7.07	2076	7.02	2157	Not significant
Morale	6.33	2077	6.25	2157	Not significant

*Statisticalsignificanceistested using a two-tailed t-test with a 95% level of confidence.

Staff Survey 2025

Focus Areas

Derbyshire Healthcare
NHS Foundation Trust

Recommending Derbyshire Healthcare as a great place to work

We will take further action to improve staff experience, wellbeing and engagement, so colleagues feel proud to recommend Derbyshire Healthcare as a place to work.

Recommending Derbyshire Healthcare as a place to receive care

We will take further action so staff feel confident that Derbyshire Healthcare provides high-quality, compassionate care and would recommend it as a place to receive care

Next Steps

Derbyshire Healthcare
NHS Foundation Trust

- Divisional reports shared with leaders
- Team level reports shared – over the next few weeks
- Team visits to discuss results and create co-produced action plans
- Trust-wide, Divisional and team level action plans due – April 2026
- Further engagement and triangulation across other data with low response rate areas.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 24 March 2026

Digital Delivery Plan - 2026-28

Purpose of Report

To present the Digital Delivery Plan 2026-28 for approval by the Board of Directors.

Executive Summary

A first draft Digital Delivery Plan was shared with the Executive Leadership Team (ELT) on 4 February 2026 with agreement to issue that version for consultation and feedback.

A plan consultation phase was launched via the CEO Engagement Hour on 10 February 2026. The draft plan has subsequently been shared with colleagues across multiple forums, including:

- Trust Delivery Group
- Divisional and Care Group governance
- Medical Senate
- Professional Groups, such as the Allied Health Professionals (AHP) Forum
- Patient and Carer Groups
- Joined Up Care Derbyshire partners.

The draft plan was issued with a digital form to capture feedback, alongside the opportunity to discuss and offer feedback through direct conversation and email. The insights secured, key themes and proposed action have been summarised and were considered by ELT on 10 March 2026.

The consultation feedback shows strong enthusiasm for the plan ambition; but clear concerns about deliverability, inclusion and governance. Actions have been defined that will further support the operational credibility and clarity that the Digital Delivery Plan needs to secure organisation-wide backing and deliver meaningful, sustained transformation. However, confidence in a new and enhanced approach to adoption will only be fully secured through this being put into practice and evidenced in action. An ongoing organisational dialogue on the detailed plans that underpin the Digital Delivery Plan and the progress being made in realising the deliverables and expected benefits will be a critical enabler in addressing the concerns and lack of delivery confidence raised through consultation feedback.

The revised draft Digital Delivery Plan version presented to Board has been developed to incorporate insights and feedback over the consultation phase. This version was supported by ELT on 10 March 2026, and is scheduled for further presentation to the Finance and Performance Committee on 20 March 2026. That meeting will take place prior to the distribution of Board papers and a verbal update on considerations and conclusion on support will therefore be verbally offered to the Board on 24 March 2026.

The leadership structure at page 13 of the Digital Delivery Plan is being finalised following agreement of a change in Executive portfolios effective 1 April 2026, with the Digital and Information Management, Technology and Records (IMT&R) functions transferring from the Executive Medical Director to the Deputy CEO and Chief Delivery Officer.

Strategic Considerations		BAF Risk (eg 1A)	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X	25-26 1C	
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		3.3
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X		

Risks and Assurances

- The delay in publication of the Digital Delivery Plan has been highlighted to the Board of Directors via the quarterly report on delivery of the Strategic Plan
- Risks to delivery of the plan and transformation portfolio will be managed via the new Digital Delivery Group with escalation to Trust Delivery Group (operational) and Strategic Portfolio Oversight Group (transformational) as appropriate.

Consultation

The Digital Delivery Plan has been developed through extensive consultation that has included the Digital Futures Day, discussions via the CEO engagement hour and the consultation phase set out within the enclosed report.

Governance or Legal Issues

The draft Digital Delivery Plan includes content that describes the governance and leadership that will oversee successful delivery of the plan, with a review and reset of existing arrangements underway.

Net Zero Duty Implications

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

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

The Digital Delivery Plan directly supports statutory commitments to achieve net zero by reducing carbon output associated with care delivery, estates, travel, supply chains, and operational processes.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Content of the Digital Delivery Plan and associated change programme is expected to have a neutral impact on those with protected characteristics. Further consideration will be given to impact via Quality and Equality Impact Assessments at individual project level.

Recommendations

The Board of Directors is requested to approve the Digital Delivery Plan 2026-28.

Report presented by: **Girish Kunigiri**
Medical Director

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

Derbyshire Healthcare
NHS Foundation Trust

DRAFT Post Consultation

Digital Delivery Plan

2026 - 2028



1. Introduction

At Derbyshire Healthcare NHS Foundation Trust, we recognise that modern, intuitive digital technologies, tools and services are critical enablers of our strategic priorities and our vision for 2028.

This Digital Delivery Plan sets out how we will accelerate our transformation through a digital-first approach, building on the significant progress and investment made so far. We will prioritise delivering value from our core systems, strengthening interoperability, and improving staff and patient experience by simplifying, standardising, and optimising how we work.

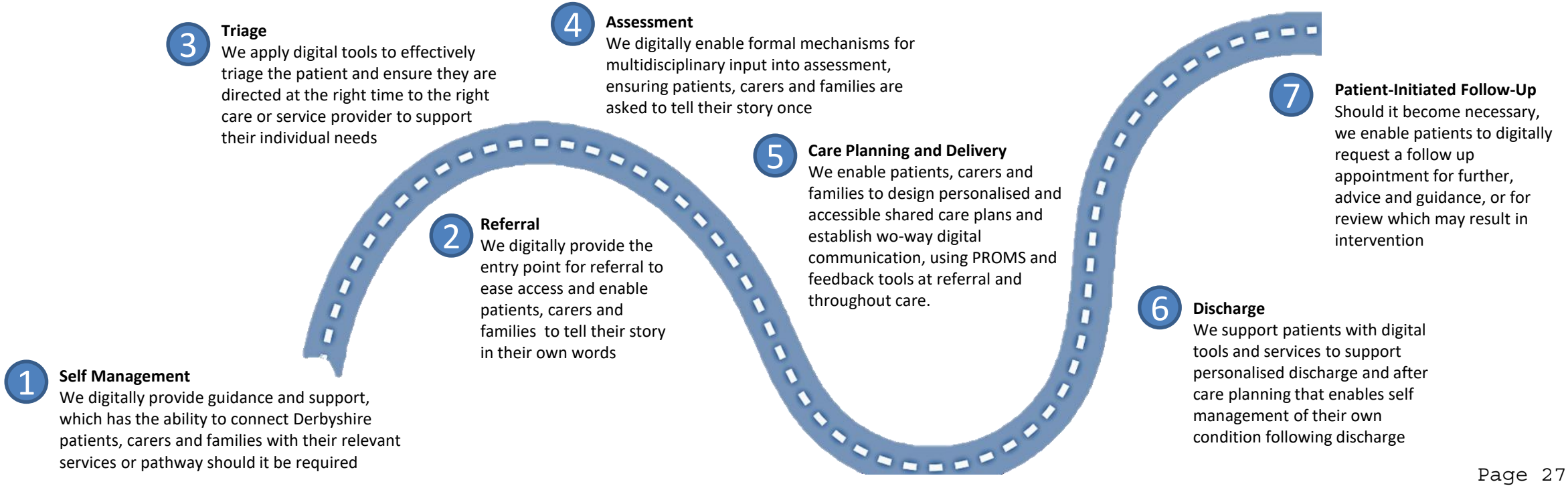
Delivery of this plan will improve patient care by ensuring records are accessible, accurate and up to date, and by enabling clinicians to use modern tools and data to support safe, effective decision-making. It will enhance our ability to personalise care, support prevention, and give patients clearer access to information and services. For colleagues, digital services will be more intuitive and streamlined, reducing administrative burden and freeing time to care. A stronger digital foundation will also support more efficient use of resources and enable seamless working with partners across Derbyshire through better-connected systems and shared data.

The next two years provide a pivotal opportunity to build on our momentum and accelerate the transformation of our services. By focusing as much on adoption as on technology, and by prioritising inclusion, we will maximise the impact of our investment and deliver meaningful positive improvements for our communities, our patients, our people and our partners.

2. Our vision

Derbyshire Healthcare NHS Foundation Trust

Aligned to our Clinical Delivery Plan our digital vision is to keep our communities well through self management strategies; to apply digital tools that support effective triage where patients need further support; for patients and their families to be fully involved in assessment, intervention, discharge and after care planning with full access to real time records; and for digital tools and services across the pathway to support clinical effectiveness and improved outcomes. In delivering this our people will implement a digital-first attitude for problem solving in clinical and non clinical settings, both within the Trust and through partnership working with broader services across the system.



1. **Self Management**
We digitally provide guidance and support, which has the ability to connect Derbyshire patients, carers and families with their relevant services or pathway should it be required

2. **Referral**
We digitally provide the entry point for referral to ease access and enable patients, carers and families to tell their story in their own words

3. **Triage**
We apply digital tools to effectively triage the patient and ensure they are directed at the right time to the right care or service provider to support their individual needs

4. **Assessment**
We digitally enable formal mechanisms for multidisciplinary input into assessment, ensuring patients, carers and families are asked to tell their story once

5. **Care Planning and Delivery**
We enable patients, carers and families to design personalised and accessible shared care plans and establish wo-way digital communication, using PROMS and feedback tools at referral and throughout care.

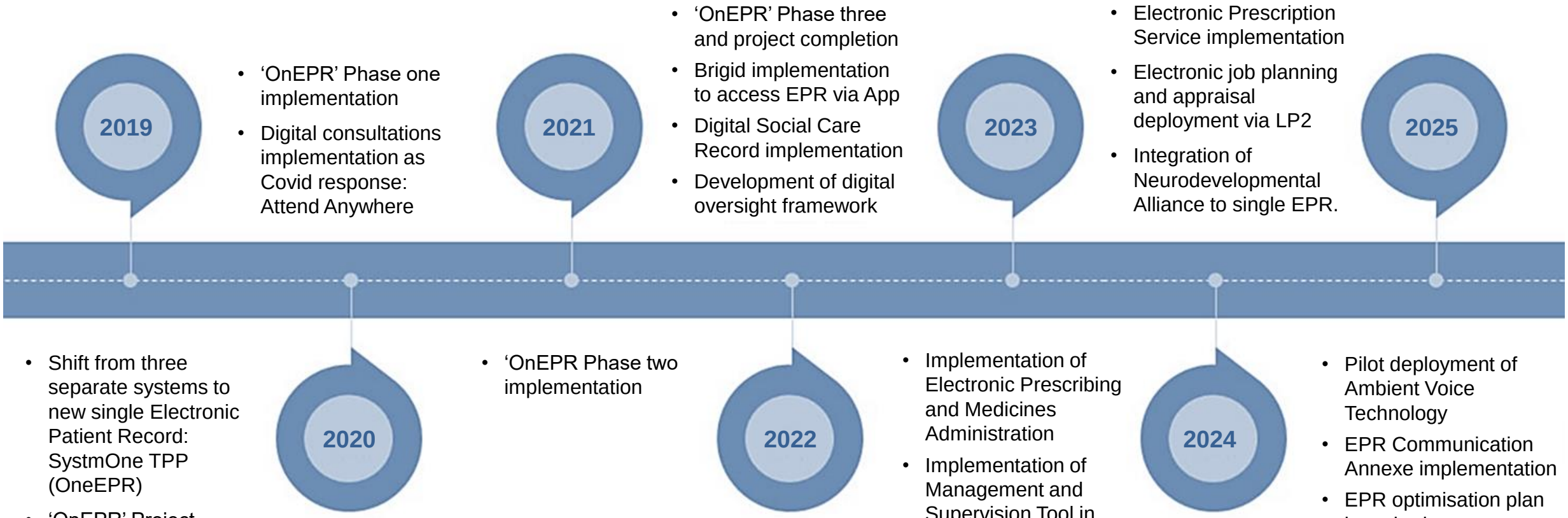
6. **Discharge**
We support patients with digital tools and services to support personalised discharge and after care planning that enables self management of their own condition following discharge

7. **Patient-Initiated Follow-Up**
Should it become necessary, we enable patients to digitally request a follow up appointment for further, advice and guidance, or for review which may result in intervention

3. Our digital journey so far

Derbyshire Healthcare NHS Foundation Trust

To support the development of our Digital Delivery Plan we have documented and reflected upon our journey so far. In doing so we have identified learning that has been applied to shape our forward plan.



4. Current baseline

In developing the Digital Delivery Plan we have sought to understand our digital baseline position and developed a Digital Catalogue for the current architecture.

A key priority that underpins our forward plan is the leverage of opportunities to optimise, connect and realise the full benefits of our current digital ecosystem. This will include standardising workflows and application of technologies in use where there is current identified variation and related opportunity.



5. Drivers of our plan

Derbyshire Healthcare NHS Foundation Trust

Our Digital Delivery Plan is shaped by a clear set of strategic drivers which collectively ensure that the deliverables defined within this plan are strategically aligned with local and national priorities; people-centred towards the needs of our patients and people; and future-ready, enabling innovation and sustainability.

10 Year Health Plan	Trust Strategy	Derbyshire Partners	What Good Looks Like Framework	Needs of Patients, Carers, Families and Communities	Needs of our People
The national digital vision for health and care sets out priorities for: • Integrated care systems: Seamless sharing of information across providers. • Personalised care: Digital tools that give patients more control over their health. • Data-driven decision-making: Advanced analytics to improve population health and resource allocation. Our Digital Delivery Plan aligns with these ambitions, ensuring achievement of national outcomes while meeting local needs.	Our Trust strategy is built around our Four P's: • Patient Focused • People • Productive • Partnerships The transformation that our Digital Delivery Plan seeks to deliver underpins and acts as an enabler to delivery of each of these priorities and the underlying delivery plans. Further detail on how this is translated into ambition and deliverable action is set out over the following sections.	Joined Up Care Derbyshire digital strategy is committed to: • Shared care records – Enabling clinicians to access accurate, real-time information. • Digital inclusion – Ensuring equitable access to digital services for all communities. • System-wide interoperability – Connecting health and social care for holistic support. Our Digital Delivery Plan aligns to and supports delivery of system priorities, enabling partners across health and social care to operate digitally and through automation where possible	The What Good Looks Like Framework has offered guidance for the safe and secure digitisation of health and care services in support of national ambitions The framework provides success measures in seven areas, supported by tools setting out criteria in each of area, against which we can assess our digital maturity to ensure all care systems have a core level of infrastructure, digitisation and skills. Our Digital Delivery Plan has been developed in alignment with the latest assessment of our digital maturity, and our target ambitions for development by 2028.	Our Quality Delivery Plan sets out how digital will support achievement of ambitions through three pillars of quality care – effectiveness, safety and experience. Our patients, their carers and families require us to better enable them to take an active role in managing their health and wellbeing, they require the ability to interact with us digitally, to access and contribute to their health and care records.. Our Digital Delivery Plan has been developed to deliver on the identified needs of our population and to underpin our Quality Delivery Plan.	In developing this plan we hosted our first Digital Futures Day. This brought together colleagues across all disciplines to identify and explore opportunities for delivering safer, faster and more connected mental healthcare by using existing and new digital technologies and tools. We have applied the insights of colleagues from that day and further tested these with our broader teams to define the priorities and the enablers to success that underpin this Digital Delivery Plan.

6. Digital ambitions

Derbyshire Healthcare NHS Foundation Trust

We have defined ambition statements for our Digital Delivery Plan that fully align with the Trust's strategic priorities and provide the basis for determining our delivery plans, and for appraising digital investments.

These ambitions were developed by applying the insights of colleagues shared at our Digital Futures Day in November 2025, and have since been triangulated with broader drivers set out within the prior pages of this plan, and through engagement with staff and stakeholders.

Digitally empower patients through access, integration, and personalisation



Build a connected digital ecosystem with shared systems and trust

Digitally equip and support staff with tools, training, and streamlined systems

Streamline processes and leverage digital technology to free time for care

7.1 Ambition into action

Derbyshire Healthcare NHS Foundation Trust

Insights from the Digital Futures Day have been applied to define how our digital ambitions can be realised. The table below defines the priorities for action against each digital ambition.

	1. Digitally empower patients through access, integration, and personalisation	2. Digitally equip and support staff with tools, training, and streamlined systems	3. Build a connected digital ecosystem with shared systems and trust	4. Streamline processes and leverage digital technology to free time for care
Focus for each ambition	1.1 Patient ownership and access 1.2 Joined-up care records 1.3 Personalisation and inclusion 1.4 Communication and feedback	2.1 System optimisation 2.2 Training and digital literacy 2.3 Automation and AI 2.4 Culture and engagement	3.1 Shared health systems and records 3.2 Interoperability and data sharing 3.3 Collaboration and co-production 3.4 Integration beyond health	4.1 Reduce admin burden 4.2 Data quality and access 4.3 Integration and interoperability 4.4 AI and innovation
How we will unlock each of our ambitions	1.1 Offer apps and portals for prevention and self management; Enable patient-held records and care plans; 1.2 Integrate systems to avoid duplication and “tell once”; Seamless transitions across services. 1.3 Accessible formats and tools; Address digital poverty and health inequalities for patients and communities 1.4 Two-way digital communication; Use PROMs and feedback tools at referral and throughout care.	2.1 Optimise SystmOne EPR functionality; Reduce clicks, simplify workflows. 2.2 Upskill staff with practical training and champion; Address fears and build confidence. 2.3 AI-assisted scribing and summarisation; Automate routine tasks (forms, outcome measures). 2.4 Involve staff in design and pilots; Clear communication on benefits and roadmap.	3.1 Optimised share care record across health, social care, and VCSE; Shared care plans and safety plans. 3.2 Robust agreements aligned with IG principles; Real-time, secure data exchange. 3.3 Engage partners and service users from the start; Define common goals and roadmap visibility. 3.4 Link with schools, police, voluntary sector; Reduce silo working and harmonise processes.	4.1 Automate documentation and reporting; Rationalise systems and eliminate duplication. 4.2 Accurate, real-time data dashboards; Predictive analytics for planning and triage. 4.3 Systems that “talk” to each other; Shared records across pathways. 4.4 AI for letters, summaries, and decision support; Digital tools for symptom monitoring and triage.

Our priorities for action have been further developed to cross cutting programmes and deliverables, along with a roadmap for delivery over the following section 7.2 and 7.3.

7.2 Digital programme and deliverables

Derbyshire Healthcare NHS Foundation Trust

	1. Digitally empower patients through access, integration, and personalisation	2. Digitally equip and support staff with tools, training, and streamlined systems	3. Build a connected digital ecosystem with shared systems and trust	4. Streamline processes and leverage digital technology to free time for care

Digital Programme	Digital Plan Deliverables
Digitise	Deploy Psyomics digital triage into community mental health services creating a connected, data-driven journey from first contact to follow up
	Deploy eMHA by Thalamos to fully digitise the Mental Health Act assessment process
	Evaluate the current pilot for Ambient Voice Technology and apply insight to design and develop plan for full leverage of potential benefits
	Explore opportunities and design plan to digitise, streamline and automate flow and bed management processes as a priority corporate programme
	Map paper and analogue information across clinical and corporate services and deliver prioritised phased plan to achieve paperless status by 2028
Optimise	Design and deliver plan to fully optimise and leverage benefits from SystmOne EPR
	Evaluate the current pilot for Microsoft Copilot applying insight to design and develop plan for full leverage of potential benefits
	Formally evaluate existing clinical and corporate digital infrastructure and deliver plan to fully leverage or exit
	Map manual processes and workflows across clinical and corporate services and deliver prioritised phased plan to streamline and automate by 2028
Connect	Deploy Patient Knows Best patient engagement portal as a platform for integration of our EPR with the NHS App as the digital front door
	Collaborate with partners to further leverage benefits of the Derbyshire Shared Care Record
	Understand and leverage opportunities for advancing digital collaboration across the existing architecture and through new deployments (e.g. eMHA)
	Design and deliver plan to leverage benefits of the Federated Data Platform in connecting data to improve care and streamline services
Enable	Complete baseline needs assessment and design and deliver plan to digitally engage and empower patients and carers
	Complete baseline needs assessment and design and deliver plan to develop the digital skills and confidence of our people
	Develop and maintain the infrastructure and resources required to underpin successful delivery the digital plan and enabling change programme

7.3.1 Digital delivery roadmap (1/2)

Derbyshire Healthcare NHS Foundation Trust

Programme	Deliverables	2026-27				2027-28			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Digitise	Deploy 'BeSeen' digital triage support tool into community, ND and CYP services creating a connected, data-driven journey from first contact to follow up	Plan and launch deployment	Phased deployment		Evaluate and plan to optimise	Optimisation			Evaluate for full benefits realisation
	Deploy an eMHA platform to fully digitise the Mental Health Act assessment process and pathway	Secure funding	Procure and plan	Phased deployment		Evaluate and plan to optimise	Optimisation		Evaluate for full benefits realisation
	Evaluate the current pilot for Ambient Voice Technology and apply insight to design and develop plan for full leverage of potential benefits	Deliver next phase pilot deployment	Evaluate pilot	Develop case and secure funding	Procure and plan	Phased deployment		Optimisation	Evaluate for full benefits realisation
	Explore opportunities and design plan to digitise, streamline and automate flow and bed management processes as a priority corporate programme	Explore opportunities (to include FDP)		Develop case and secure funding	Procure and plan	Phased deployment		Optimisation	Evaluate progress on ambition
	Map paper and analogue information across clinical and corporate services and deliver prioritised phased plan to achieve paperless status by 2028	Design phased plan for clinical services	Deploy phased plan: clinical services			Design phased plan for corporate services	Deploy phased plan: corporate services		Evaluate progress on paperless ambition
Optimise	Design and deliver plan to fully optimise and leverage benefits from SystmOne EPR, including through standardisation of use	Design prioritised phased plan	Deploy phase 1 plan: 'Quick wins' Measure progress throughout lifecycle		Deploy phase 2 plan: Medium tem actions Measure progress throughout lifecycle		Deploy phase 3 plan: Long tem actions Measure progress throughout lifecycle		Evaluate progress on optimisation
	Evaluate the current pilot for Microsoft Copilot applying insight to design and develop plan for full leverage of potential benefits and standardise use	Evaluate pilot and standardisation	Plan next phase deployment	Phased deployment		Evaluate and design year 2 plan	Optimisation		Evaluate for full benefits realisation
	Formally evaluate existing clinical and corporate digital infrastructure and deliver plan standardise use and to fully leverage or exit	Design and test framework	Design prioritised plan	Deploy phased plan		Evaluate and design year 2 plan	Deploy phased plan		Evaluate progress on ambition
	Map manual processes and workflows across clinical and corporate services and deliver prioritised phased plan to streamline and automate by 2028	Design phased plan for priority clinical workflows	Deploy phased plan: clinical services			Design phased plan for corporate workflows	Deploy phased plan: corporate workflows		Evaluate progress on paperless ambition
Connect	Deploy 'Patient Knows Best' patient engagement portal as a platform for integration of our EPR with the NHS App as the digital front door	Phased deployment			Evaluate and plan to optimise	Optimisation and development of full functionality			Evaluate for full benefits realisation
	Collaborate with partners to further leverage benefits of the Derbyshire Shared Care Record	Establish baseline and opportunities	Collaborate to deliver plan in partnership			Evaluate and design year 2 plan	Collaborate to deliver plan in partnership		Evaluate progress on ambition
	Understand and leverage opportunities for advancing digital collaboration across the existing architecture and through new deployments (e.g. eMHA)	Design and test framework	Design prioritised plan	Deploy phased plan		Evaluate and design year 2 plan	Deploy phased plan		Evaluate progress on ambition
	Design and deliver plan to leverage benefits of the Federated Data Platform in connecting data to improve care and streamline services	Establish baseline and opportunities	Design prioritised plan	Deploy phased plan		Evaluate and design year 2 plan	Deploy phased plan		Evaluate progress on ambition

7.3.2 Digital delivery roadmap (2/2)

Derbyshire Healthcare NHS Foundation Trust

Programme	Deliverables	2026-27				2027-28			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Enable	Complete baseline needs assessment and design and deliver plan to digitally engage and empower patients and carers	Establish baseline and opportunities	Design prioritised plan (to include Digital Inclusion Plan)	Deploy phased plan		Evaluate and design year 2 plan	Deploy phased plan		Evaluate progress on ambition
	Complete baseline needs assessment and design and deliver plan to develop the digital skills and confidence of our people	Establish baseline and opportunities	Design prioritised plan (to include Digital Inclusion Plan)	Deploy phased plan		Evaluate and design year 2 plan	Deploy phased plan		Evaluate progress on ambition
	Develop and maintain the infrastructure and resources required to underpin successful delivery the digital plan and enabling change programme	Complete baseline assessment	Design prioritised plan	Deploy phased plan		Evaluate and design year 2 plan	Deploy phased plan		Evaluate progress on ambition

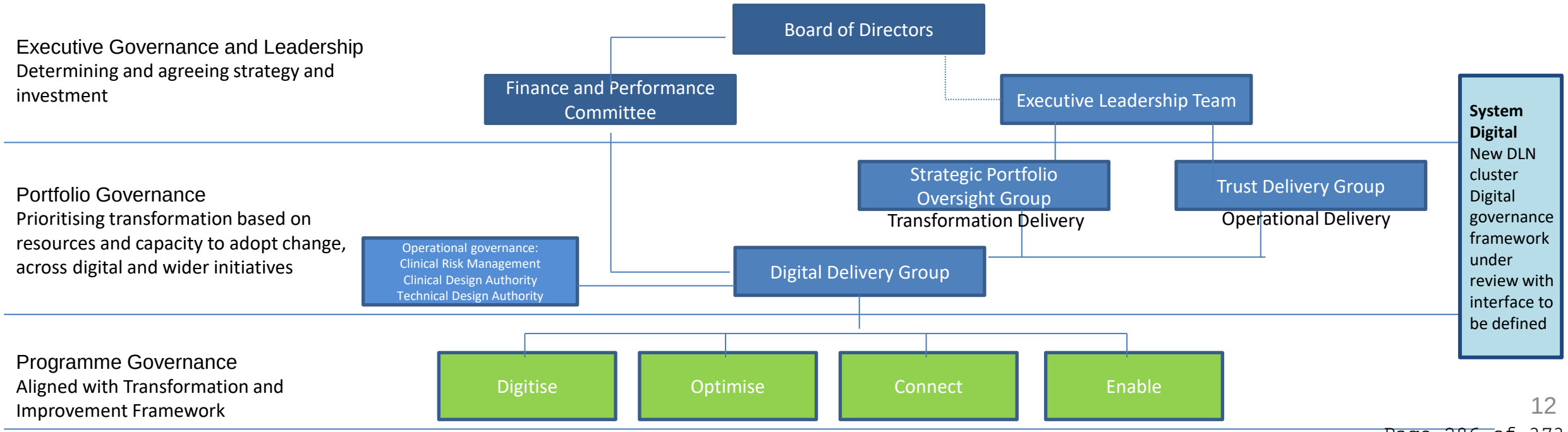
Deliverables that comprise the digital portfolio will be managed through a robust programme management approach in alignment with the agreed Transformation and Continuous Improvement Framework. The high level roadmap set out within the Digital Delivery plan will be underpinned by detailed programme and project documentation.

A robust benefits realisation and evaluation framework will be implemented with benefits and outcomes defined at the outset of each digital programme, to include those supporting better care and outcomes through enablement of the Clinical and Quality Delivery Plans. Evaluation will be robust and holistic, with learning identified and implemented to support our forward digital ambitions.

8.1 Delivery of success: Governance

Digitally-enabled transformation will be managed as a portfolio of work, by the Digital Delivery Group on behalf of the Trust Executive Leadership Team and Board of Directors.

The Digital Delivery Group will be reset in quarter 1 of 2026-27 with refreshed terms of reference and membership. The Group will oversee achievement of intended outcomes whilst managing priorities and constraints across the portfolio. Delivery will be led by programme and operational teams and aligned with the robust programme management processes defined within the Transformation and Continuous Improvement Framework.

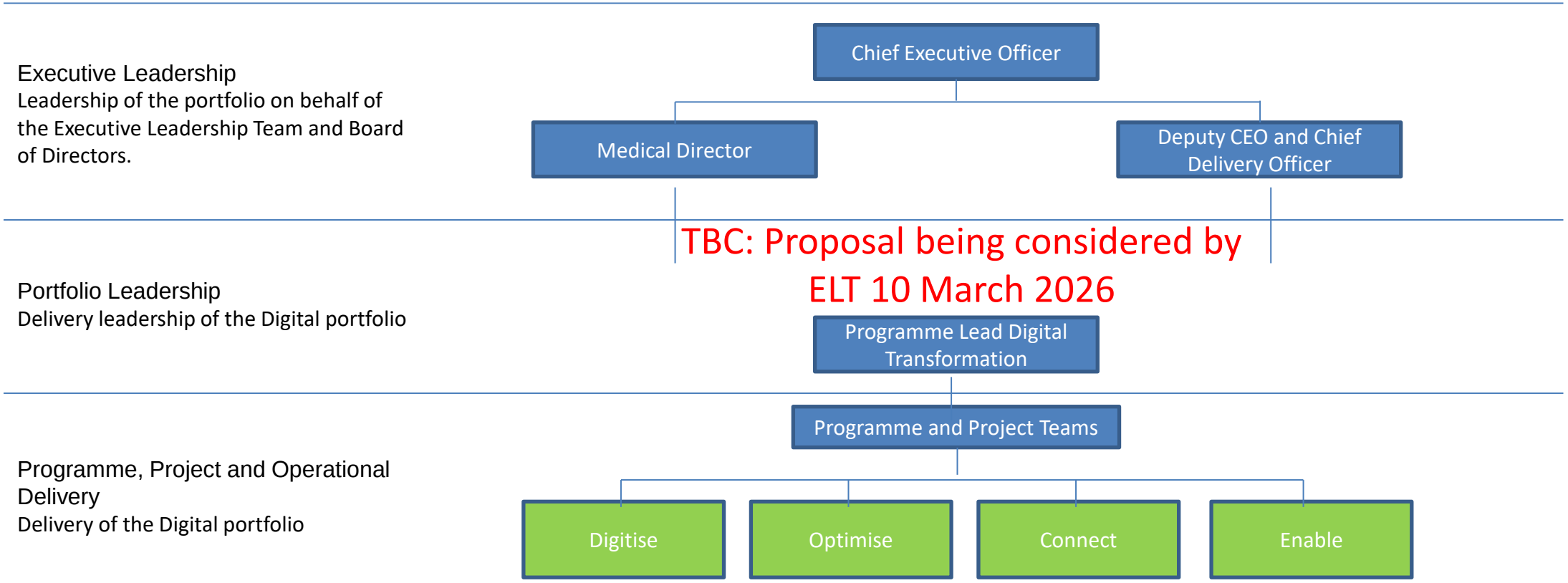


8.2 Delivery of success: Leadership

Derbyshire Healthcare NHS Foundation Trust

Responsibility for the operational leadership and delivery of the breadth of the Digital Delivery Plan is distributed across portfolios of the Executive Leadership Team aligned with the existing operational activity not detailed within this plan, such as the ongoing management of corporate services.

A triumvirate approach will be applied to the leadership of each project and programme comprising the portfolio in alignment with the Transformation and Continuous Improvement Framework.



9. Measuring success

Intended benefits and measures of success will be defined for each project and programme comprising the digital portfolio, with a robust governance and oversight framework for monitoring and evaluating realisation in alignment with the Transformation and Continuous Improvement Framework.

We will further measure overall success of the Digital Delivery Plan through progress against our baseline position in the 2025 the national What Good Looks Like (WGLL) Framework and Digital Maturity Assessment.

The Digital Delivery Plan programmes have been mapped to drive delivery in the seven pillars that comprise the WGLL framework for digital maturity improvement.



WGLL Pillar	Digital Programme	2026–2028 Focus
Ensure Smart Foundations	Digitise	Core infrastructure and interoperability
Safe Practice	Digitise and Optimise	Digital safety and reducing risks in clinical pathways
Improve Care	Optimise	Clinical pathway redesign and workflow optimisation
Healthy Populations	Connect	Data sharing and integration for proactive care
Empower People	Digitise, Connect and Enable	Access, NHS App integration and digital inclusion
Support Workforce	Enable	Capability building and digital skills development
Well Led	Enable	Governance and benefits management

10. Expected impact on patients, people and partners

We expect the delivery of our Digital Delivery Plan to have a significant positive impact on our patients, staff and partners, and how each interact with the Trust by 2028.

We have defined below how the experience of patients, staff and partners is expected to be different.

What will our patients say?

"My care providers can access all the relevant information they need in relation to my care, without the need for me to repeat myself many times.

I am able to access my records, know what has been written about my care and can interact digitally with the Trust and my care providers.

I can access and exchange information that will help me make decisions; influence and plan my care.

Other organisations supporting me can see relevant information, with my consent, that help them to deliver informed care.

I can make use of devices and technology to help me manage and monitor my care at home whilst knowing that health professionals can support if there are any concerns."

What will our people say?

"I' am able to access comprehensive information about my patients, at the point I need to and with ease.

The systems I use to access clinical information are fit for purpose and support me to work effectively.

I am able to develop the necessary digital skills to be able to use our digital tools and services, and know where to turn for help when I need it.

It is straightforward for me to digitally collaborate with others, whether in relation to patient care or another matter.

I have access to decision making tools that help me provide the best care I can.

It is not necessary for me to use manual administrative processes, and I interact digitally with the Trust."

What will our partners say?

"We have access to the right patient data and information to help us support patient pathways across organisations and deliver optimum care to our patients as a health and social care system.

We understand the health needs of our population and can shape services from the shared data we have."

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 24 March 2026

People Plan 2025-2028

Purpose of Report

The purpose of this report is to present the Derbyshire Healthcare People Plan 2025-2028. The Plan sets out how we will support, develop and value our people over the next three years, aligning with the national NHS Long Term Plan, our Trust Strategy and the People element of the Four Ps: Patient, People, Productive and Partnerships. It provides a framework for attracting and retaining the best colleagues, supporting professional development and leadership, embedding an inclusive and values-driven culture and promoting staff wellbeing.

Following presentation of the draft format to the Committee in September, the plan has been socialised through with key stakeholders and revised following comments received.

The Committee is now presented with the final version (subject to some further design).

Executive Summary

The Derbyshire Healthcare People Plan 2025-2028 describes how we will create a positive culture and sense of belonging, ensuring our colleagues feel supported, valued and able to deliver outstanding care. The Plan has been shaped by staff feedback from surveys, engagement events and networks, ensuring it reflects the voices and priorities of our people.

The Plan is structured around four high-level themes:

- **Attract and Retain the Best People** – to make Derbyshire Healthcare a great place to work by attracting a skilled, diverse workforce and creating the conditions for colleagues to stay, grow and thrive within the Trust
- **Support and Develop Our People** – to provide continuous opportunities for professional and personal growth, building strong leadership at every level and enabling all colleagues to reach their full potential
- **Inclusive and Values-Driven Culture** – to embed a culture shaped by our values – Caring, Inclusive, Ambitious, Belonging and Collaborative – where equality, diversity and inclusion are at the heart of everything we do, and where everyone feels they belong
- **Wellbeing and Support for Our People** – to prioritise health, wellbeing and flexible working, ensuring colleagues are supported to balance their personal and professional lives, and feel safe, valued and cared for at work.

Governance and oversight of the People Plan will sit with the People and Culture Committee, with regular reporting to the Trust Board to ensure accountability, progress and alignment with strategic priorities. It is proposed for the Committee to receive quarterly update on progress against the People Plan. Success will be measured through workforce indicators, staff feedback and lived experience, ensuring colleagues can see and feel the difference the Plan makes.

Strategic Considerations		BAF Risk (eg 1A)	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.			
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X	2A and 2B	2.1, 2.2, 2.3, 2.4
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

- Assurance that the draft demonstrates clear linkage with the NHS 10-year Plan and national People Promise priorities
- Delivering the People Plan is ambitious and will be challenging, requiring sustained support and commitment across the Trust
- Clear governance with Executive leads accountable for each theme will be needed
- Progress monitored through KPIs, staff survey feedback and workforce data dashboards
- Assurance that staff voice has been embedded in delivery, ensuring changes are visible and meaningful.

Consultation

- The People Plan has been shaped through engagement with colleagues across Derbyshire Healthcare. Feedback from the NHS Staff Survey, quarterly Pulse surveys, staff networks and strategy development sessions has informed the priorities and actions within the Plan
- NHS 10-year health plan
- People and Culture Committee.

Governance or Legal Issues

- Oversight through the People and Culture Committee, with regular reporting to Trust Board/Executive Leadership Team
- Alignment with the NHS 10-Year Plan and NHS People Plan requirements
- Compliance with statutory duties on equality, diversity, inclusion, health and safety and employment law.

Net Zero Duty Implications

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

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

The people plan aims to maximise digital opportunities to drive efficiencies through people processes and systems.

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:

- Directly addresses Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and LGBTQ+ Equality Standards
- Commits to a fully inclusive and values-driven culture, embedding the Personal Accountability Charter and anti-racism strategy
- Promotes equity in recruitment, development, wellbeing and progression across all staff groups
- Expected to have a positive impact on inclusion, belonging and staff experience.

Recommendations

The Board of Directors is requested to:

1. Receive the final People Plan, noting the scrutiny undertaken by the People and Culture Committee
2. Approve the Plan and the proposed quarterly updates to the People and Culture Committee on progress against the plan.

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

Report prepared by: **Lucy Moorcroft**
Organisational Development Lead

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People Plan 2025-28

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

Foreword

I am proud to introduce the Derbyshire Healthcare People Plan 2025–28. This plan sets out how we will work together to achieve our vision: "We make a positive difference in everything we do."

Our People Plan is more than a set of commitments; it reflects who we are as a Trust and who we aspire to be. It has been shaped by the voices of our colleagues across Derbyshire Healthcare, ensuring that it speaks to your experiences, your hopes, and your ambitions. At its heart, the plan is about people, how we support you, how we value you, and how we work together to deliver the very best care for our communities.

The challenges facing the NHS are well known. Demand is rising, resources are stretched, and the world around us continues to change. Yet within these challenges lie opportunities; to think differently, to embrace innovation, and to build an organisation that is strong, resilient and future-focused. The foundation of all of this is our people. It is your compassion, your skills, and your commitment that make the difference every single day. Our responsibility as a leadership team is to create the conditions for you to thrive, so that you can feel supported, proud, and able to deliver the very best for those we serve.

Our new values: Caring, Inclusive, Ambitious, Belonging and Collaborative, will guide us as we deliver this plan. They represent the culture we want to live and breathe every day; they describe how we work with one another, how we treat our patients and service users, and how we face challenges as one team. If we hold to these values, we will create a Trust where colleagues feel safe, respected and able to flourish, and where patients and communities experience care that is both outstanding and compassionate.



The People Plan is structured around four key priorities that will shape how we support and develop our people over the coming years. These priorities include how we attract and retain talented colleagues, how we nurture development and leadership, how we embed a truly inclusive and values-driven culture, and how we promote and protect the wellbeing of our people. Each of these areas is vital on its own, but it is their combination that will make the biggest difference. Together, they will help us create a workplace where people want to join, choose to stay, and are able to achieve their full potential.

I know that delivering this plan will not always be easy. It will require us to continue listening to one another, learn from experience, and adapt as circumstances change. But I also know that we are more than capable of doing this together. Across Derbyshire Healthcare I see daily examples of colleagues supporting one another, stepping up to challenges, and making a genuine difference to the lives of those we serve. It is this dedication, that gives me confidence in what we can achieve.

I want to thank you for your hard work, your compassion, and your commitment to Derbyshire Healthcare and the communities we serve. I am proud to work alongside you, and I look forward to the journey ahead as we bring this People Plan to life together. It is only by working as one team, living our values, and focusing on our people that we can achieve our shared vision of making a positive difference in everything we do.

Mark Powell

Chief Executive

Introduction

Our Derbyshire Healthcare People Plan 2025–28 underpins our wider Trust Strategy and is directly aligned with our strategic priorities – the Four Ps: Patient focused, People, Productive and Partnerships. The People Plan sits beneath the People priority, which commits us to attracting, involving and retaining staff while creating a positive culture and a true sense of belonging.

This Plan has been shaped through our Trust Strategy development sessions and informed by the voices of colleagues across Derbyshire Healthcare. Feedback gathered through the NHS Staff Survey, our quarterly pulse surveys, and ongoing engagement has been invaluable in helping us understand what matters most to our people.

Our People Plan is also aligned with the 10 Year Health Plan, which makes clear that our people are central to meeting the challenges of the next decade. Many of its national priorities are reflected here; a focus on growing and retaining our people; investing in leadership, learning and new roles, strengthening diversity, equality and inclusion, embedding health and wellbeing support and harnessing digital innovation to modernise the way we work.

By connecting national ambition with local priorities, this Plan provides us with a clear framework for the next three years. It sets out how we will attract and retain the best people, support and develop colleagues to reach their potential, foster an inclusive and values-driven culture, and promote the health and wellbeing of all our staff.



Most importantly, this is a People Plan shaped by our people. It reflects our shared vision, our new values of Caring, Inclusive, Ambitious, Belonging and Collaborative, and our commitment to making Derbyshire Healthcare a great place to work, where colleagues feel valued, supported and able to make a positive difference every day.

Rebecca Oakley

Director of People, Organisational Development and Inclusion

Caring Inclusive Ambitious Belonging Collaborative

Where everyone belongs

Our staff support networks are central to creating an inclusive culture at Derbyshire Healthcare. They reflect our focus on equality, diversity and inclusion and ensure that every colleague has access to support, guidance and opportunities to grow.

These networks provide safe and supportive spaces where colleagues can connect, share experiences and influence positive change across the Trust. They also play a vital role in developing understanding, building allyship, and shaping our culture so that everyone feels they belong.

Each network is led by colleagues who give their time to champion change and represent the voices of under-represented groups. Executive sponsors provide support and ensure the work of each network is recognised at Board level.

We currently have seven specialist staff networks:
LGBT+ Staff Network – providing support for LGBT+ colleagues, students and allies, promoting a safe and inclusive environment.

Disability and Wellness Network (DAWN) – supporting colleagues with disabilities or long-term conditions, promoting inclusion and wellness.

Black, Asian and Minority Ethnic (BME) Network – offering a safe space to discuss experiences, raise concerns and champion equality of opportunity.

Armed Forces Network – supporting veterans and reservists in the workplace and in accessing Trust services.

Women's Network – providing space for women to share experiences, raise concerns and drive positive change for our female colleagues.

Multi-Faith Forum – fostering understanding across faiths and non-faith, supporting identity and promoting compassion and diversity.

Christian Network – providing space for those with a Christian faith, with regular meetings, events and cross-system connections.

Our staff networks play a vital role in providing safe, supportive spaces for our colleagues, helping us to live our values and build a culture where everyone feels they belong.



People Plan on a page

NHS
Derbyshire Healthcare
NHS Foundation Trust

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

What we aim to do



1. To make Derbyshire Healthcare a great place to work by attracting a skilled, diverse workforce and creating the conditions for colleagues to stay, grow and thrive.

2. To provide continuous opportunities for professional and personal growth, building strong leadership at every level, and enabling all colleagues to reach their full potential.

3. To embed a culture shaped by our values, where equality, diversity and inclusion are at the heart of everything we do, and where everyone feels they belong.

4. To prioritise health, wellbeing and flexible working, ensuring colleagues are supported to balance their personal and professional lives, and feel safe, valued and cared for at work.

In the plan we will…

- Strengthen recruitment, leadership capability, and workforce development.
- Embed EDI, accountability, and a positive, psychologically safe culture.
- Enhance digital transformation, staff voice, and inclusive career opportunities.
- Improve wellbeing, flexible working, and support systems for managers and teams.

PATIENT-FOCUSED · PARTNERSHIPS · PEOPLE · PRODUCTIVE
4Ps STRATEGIC PRIORITIES

Our **People** strategic priority (one of the Trust's 4Ps) is: **We will attract, involve and retain staff creating a positive culture and sense of belonging.**

Personal Accountability Charter

NHS
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The People Plan sets out our commitment to creating a positive, inclusive and supportive working environment where colleagues feel valued, listened to and able to do their best work, delivering this plan relies not only on the actions we take as an organisation, but on how we each behave, lead and work together every day.

A strong culture of personal accountability underpins the successful delivery of the People Plan. This means taking ownership of our actions, demonstrating behaviours aligned to our values, and recognising the role we all play in shaping culture, staff experience and the quality of care we provide. The Personal accountability Charter supports consistency, fairness and trust across the organisation, helping to turn the ambitions of the People Plan into meaningful and sustained change.



Caring We provide safe care and support people to achieve their goals	**Caring behaviours** • We are kind • We are person-centred • We keep people safe	**How I can show caring behaviours** • I show kindness to others and think about their needs • I don't walk by if something is wrong or needs to be done • I meet professional standards
Inclusive We respect everyone in all we do	**Inclusive behaviours** • We are fair • We embrace and celebrate difference • We are professional	**How I can show inclusive behaviours** • I think about the impact of my actions on other people • I respect people and my surroundings and speak up when things don't feel right • I actively challenge discrimination
Ambitious We offer high quality services, and we commit to ongoing improvement	**Ambitious behaviours** • We learn • We are high performing • We are innovative	**How I can show ambitious behaviours** • I get the basics right, to underpin improvements • I listen, learn and improve • I deliver continuous improvements
Belonging We come together to create a culture that is welcoming, open and trusting	**Belonging behaviours** • We are honest • We are accountable • We communicate	**How I can show belonging behaviours** • I look after my own health and wellbeing • I recognise the value and contributions of all colleagues • I take responsibility for what I do
Collaborative We work together to achieve the best outcomes for our people and communities.	**Collaborative behaviours** • We work well with others • We engage • We are good partners.	**How I can show collaborative behaviours** • I work with others to achieve shared outcomes • I break down barriers to achieving the best outcomes • I empower people to be partners in their care.

Theme 1: Attract and retain the best people

Aim: To make Derbyshire Healthcare a great place to work by attracting a skilled, diverse workforce and creating the conditions for colleagues to stay, grow and thrive.

Sub-theme	Actions
Strengthen our recruitment and retention processes and strategic plan as a system partner	• We will strengthen our recruitment pathways to attract a skilled and diverse range of applicants. • We will ensure our recruitment practices are inclusive, accessible, and representative of the communities we serve. • We will embed Stay Surveys at 3, 6 and 18 months for new starters to strengthen retention. • We will develop robust data informed decision making through recruitment Service level agreements and Key Performance Indicators aligned with the PCC dashboard, to provide assurance and transparency. • We will strengthen our recruitment and onboarding processes to ensure every new colleague experiences a timely, welcoming, and supportive start, feeling valued and prepared from day one. • We will strengthen and embed rigorous job design and job evaluation processes and principles. • We will strengthen our redeployment process to improve efficiency, communication, and fairness, reducing delays and ensuring a positive experience for staff and managers • We will strengthen our medical recruitment strategy to attract and retain high-quality clinicians across all specialties, ensuring sustainable medical cover and continuity of patient care. • We will work with regional medical schools and system partners to create robust pipelines for medical trainees and newly qualified doctors.
Empower managers to support our people	• We will develop resources, training, and tools to help managers better support their teams. • We will create networks and forums for managers to share best practice and strengthen leadership across the Trust. • We will embed a culture of compassionate and inclusive leadership at every level. • We will deliver cultural training for managers, with a focus on supporting inpatient teams, international recruits and colleagues for whom English is not a first language.
Embed our workforce plan and build confidence	• We will implement a multi-year workforce plan that supports service delivery, staff wellbeing, and future growth. • We will monitor workforce trends and data to ensure proactive workforce planning and succession planning. • We will embed our workforce plan as part of the wider system workforce strategy, working collaboratively with partners to address shared challenges. • We will align our workforce planning with the 10 Year Health Plan and system workforce priorities. • We will align our medical workforce planning with national and regional frameworks, ensuring resilience across rotas and services.

Drive digital transformation	• We will develop and adopt digital solutions that improve staff experience, streamline recruitment, support workforce planning and increase efficiency. • We will use digital platforms to improve communication, learning, collaboration and staff benefits to aid retention.
Utilise staff voice to inform all that we do	• We will actively listen and act on staff feedback through the NHS Staff Survey, pulse surveys, stay surveys and engagement events. • We will ensure staff voice is at the centre of decision making and improvement plans. • We will provide transparent feedback loops so colleagues can see how their input has shaped actions. • We will work in close collaboration with our Trade Union and Staff Side colleagues to meaningfully engage with staff, strengthen staff voice, and jointly shape improvements that enhance the working lives and experiences of our workforce.
Offer a supportive benefits package	• We will enhance and promote our employee benefits package to ensure colleagues feel valued and supported. • We will benchmark our offer against peers to remain competitive and attractive as an employer. • We will regularly review benefits to ensure they meet the changing needs of our people.

We will know we have achieved this when:
• Retention improves, with reduced turnover and positive results in stay/exit surveys. • Onboarding is consistently strong, with new starters reporting they feel welcomed and prepared. • Our people better reflects the diversity of the communities we serve. • Managers feel confident and supported, with staff reporting increased trust in leadership. • Workforce plans are embedded and proactively shaping service delivery and succession planning. • Digital solutions are improving staff experience and streamlining recruitment and workforce processes. • Colleagues can clearly see opportunities for personal development and progression and have access to learning. • Colleagues feel their voice is heard, with clear evidence of changes made as a result of staff feedback. • Our employee benefits package is well used, well regarded, and benchmarked as competitive. • Recruitment and retention KPIs show improved time-to-hire, reduced vacancies, and greater stability.

Theme 2: Support and develop our people

Aim: To provide continuous opportunities for professional and personal growth, building strong leadership at every level, and enabling all colleagues to reach their full potential.

Sub-theme	Actions
Deliver a roadmap for leadership development to enable success	• We will design and implement a leadership development roadmap that supports colleagues at every stage of their career. • We will provide accessible training, mentoring and coaching opportunities to build strong and compassionate leaders. • We will embed inclusive leadership behaviours into all leadership programmes to ensure our values are lived in practice. • We will align our leadership roadmap with the national competency framework to ensure consistency and quality. • We will expand the leadership programme to include senior leadership pathways, building on the success of mid-level programmes.
Implement effective talent management and succession planning	• We will establish a clear and transparent talent management process to identify and nurture future leaders. • We will implement succession planning across all key roles to ensure resilience and continuity. • We will create career pathways and support frameworks so colleagues can see and plan their future with Derbyshire Healthcare. • We will build on learning from the pilot phase of our framework, refining and rolling it out Trust-wide.
Foster a learning culture for career and personal development for all	• We will promote a culture where continuous professional development is encouraged, supported and celebrated. • We will provide personal and professional development opportunities for all staff, regardless of role or level. • We will develop accessible learning resources to support continuous improvement and career growth. • We will embed an accountability framework for career conversations, ensuring appraisals and supervision routinely support staff growth. • We will provide training and support for managers to hold effective and meaningful career conversations.
Advance Organisational Development (OD) initiatives	• We will embed OD and change management skills across teams to support transformation and continuous improvement. • We will provide team development programmes and culture diagnostics to help services understand their strengths and challenges • We will provide OD consultancy support to leaders, managers and teams. • We will strengthen our OD data and insights to identify workforce challenges early and intervene proactively to support teams.

Promote career mobility and opportunities across the system	• We will develop career pathways across our system partnerships, enabling colleagues to gain new experiences and opportunities without leaving the NHS. • We will encourage secondment and development opportunities in partnership with NHS organisations, universities and other providers. • We will promote mobility as a way of retaining talent and broadening skills.

We will know we have achieved this when:

- Leadership development pathways are in place for all levels, with strong uptake and positive impact on staff confidence and leadership behaviours.
- Talent management and succession planning processes are embedded, with clear pipelines for future leaders and reduced gaps in key roles.
- Advanced professional practice standards are clearly defined, adopted and consistently applied across relevant roles.
- Staff report that career development opportunities are accessible, fair, and actively encouraged.
- A learning culture is evident through high engagement with training, increased internal progression, and recognition of learning achievements.
- Staff survey results show improvements in perceptions of development and support.
- A culture of continuous learning is evident through high engagement with training, strong appraisal completion, and recognition of learning.
- Career mobility across the system is established, with colleagues taking up secondments and system opportunities.
- Recognition and reward systems are in place and staff feel their contribution is valued.

Theme 3: Inclusive and values-driven culture

Aim: To embed a culture shaped by our values, where equality, diversity and inclusion are at the heart of everything we do, and where everyone feels they belong.

Sub-theme	Actions
Embed our Personal Accountability Charter	• We will embed the Charter within our appraisal and performance management frameworks, our suite of people policies and across all teams to set clear expectations of behaviour and professional standards. • We will support leaders and colleagues to role-model accountability in line with our Trust values and train leaders in restorative just culture to build confidence in fair and supportive approaches. • We will use the Charter as a foundation for building fairness, respect and trust in our culture.
Develop an Equality, Diversity and Inclusion (EDI) framework for inclusive recruitment and development	• We will design and implement an EDI framework that ensures recruitment, progression and development opportunities are fair and accessible. • We will review recruitment practices to reduce bias and promote diversity. • We will build inclusive career development pathways to support under-represented groups. • We will equip leaders with the data, insights and skills to act on inequalities and drive meaningful improvements. • We will ensure fairness, equity and transparency in all medical recruitment, appraisal and promotion processes.
Deliver WRES and WDES improvement plans	• We will deliver on our Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) commitments. • We will monitor, report and act on outcomes to address disparities in recruitment, progression and workplace experience. • We will engage staff networks and system partners to strengthen delivery of these plans. • We will explicitly align our WRES and WDES delivery with our anti-racism strategy, ensuring joined-up action and accountability.
Uphold LGBTQ+ Equality Standards	• We will adopt LGBTQ+ Equality Standards alongside WRES and WDES to ensure equity for LGBTQ+ colleagues. • We will provide targeted training, resources, and safe spaces to support LGBTQ+ staff. • We will monitor progress against national benchmarks to demonstrate improvement.
Ensure EDI accountability at all levels	• We will make equality, diversity and inclusion a shared responsibility across the Trust. • We will build EDI objectives into leadership roles, appraisals and performance frameworks. • We will strengthen governance and reporting structures to hold ourselves accountable for progress.

Implement 'A Kind Life' culture change programme	• We will roll out "A Kind Life" across the Trust to embed kindness as a core part of our culture. • We will deliver training, masterclasses and resources to support kindness in leadership and teams. • We will use kindness-based approaches to strengthen wellbeing, engagement and conflict resolution. • We will embed "A Kind Life" principles within medical teams to support compassionate leadership, reduce burnout, and strengthen team cohesion.
Launch and embed an anti-racism strategy and actions	• We will implement a Trust-wide anti-racism strategy to ensure our organisation is a safe, fair and inclusive place to work. • We will provide training, resources and forums to support staff in recognising and challenging racism. • We will hold leaders accountable for tackling discrimination and driving meaningful change.
Strengthening governance arrangements for our Staff Networks	• We will embed staff networks into our governance structures so their voices shape decision-making and strategy. • We will provide resources and executive sponsorship to strengthen their influence and impact. • We will celebrate and promote the work of networks to build wider engagement.
Focus on embedding psychologically safe teams	• We will embed our restorative just culture principles to ensure our people are well supported • We will embed our personal accountability charter and provide leadership development to encourage and embed psychological safety

We will know we have achieved this when:
• The Personal Accountability Charter is consistently embedded in everyday practice, with behaviours aligned to Trust values. • Our EDI framework drives measurable improvements in recruitment, development and representation. • WRES and WDES data shows year-on-year progress, with reduced disparities across staff experience and outcomes. • LGBTQ+ standards show yearly progress, with reduced disparities in outcomes and experiences. • Staff networks are embedded in governance structures and can demonstrate real influence on decision making. • Staff survey results show improved cultural competency and staff confidence in fairness and inclusion. • Equality, diversity and inclusion is demonstrably owned at every level of leadership, with accountability built into governance and appraisals. • "A Kind Life" is visibly embedded across the Trust, with kindness -based approaches supporting engagement, wellbeing and conflict resolution. • The anti-racism strategy is implemented and evidenced by staff reporting safer, fairer, and more inclusive experiences at work. • Menopause policy and accreditation are in place, with staff reporting improved support and awareness.

Theme 4: Wellbeing and support for our people

Aim: To prioritise health, wellbeing and flexible working, ensuring colleagues are supported to balance their personal and professional lives, and feel safe, valued and cared for at work.

Sub-theme	Actions
Embed a flexible working culture	• We will embed a flexible working culture across the Trust, ensuring all colleagues can access flexible options where service needs allow. • We will promote flexible working as a way to support wellbeing, inclusion and retention. • We will monitor uptake and impact to ensure flexibility is accessible and equitable by implementing a system to record requests and decisions. • We will provide training for managers and staff on applying flexible working policy fairly and effectively. • We will embed the national flexible working policy to ensure our approach aligns with national principles.
Strengthen our health and wellbeing offer	• We will strengthen and expand our wellbeing offer to meet the diverse needs of our people. • We will ensure colleagues have access to resources, initiatives and activities that promote physical, mental and financial wellbeing. • We will co-design elements of the wellbeing offer with staff, using feedback to shape what is provided. • We will use data-driven insights to prioritise and deliver targeted wellbeing interventions for teams most in need.
Develop a psychological support offer	• We will design and implement a psychologically informed support service for colleagues. • We will ensure staff have timely access to psychological support during periods of stress, trauma or significant pressure. • We will embed psychological support into our wider wellbeing framework. • We will establish a targeted psychology support offer, ensuring access to high-level, specialist advice for teams facing specific wellbeing or interpersonal issues.
Refine attendance management policies and processes	• We will refine our attendance management policy to balance compassionate support with accountability. • We will provide managers with tools and guidance to support colleagues effectively. • We will review processes regularly to ensure they remain fair, consistent and supportive.
Support leaders during formal processes	• We will provide targeted support, training and guidance for leaders managing during formal processes. • We will ensure leaders feel confident, well-equipped and supported to manage sensitive issues fairly, compassionately and in line with a restorative approach. • We will create peer support opportunities for leaders managing complex cases. • We will ensure medical leaders are trained and supported to manage complex formal processes with fairness, compassion and confidence.

Refresh our health and wellbeing assessment	• We will refresh our Trust-wide health and wellbeing assessment to better understand colleague needs. • We will use this insight to shape targeted interventions and monitor impact over time. • We will repeat assessments regularly to track progress and adjust our approach.
Ensure team-based Wellbeing	• We will strengthen our wellbeing approach with a focus on teams, not just individuals. • We will embed peer support, team check-ins and collective wellbeing practices to build resilience. • We will equip team leaders to promote wellbeing within their teams.
Deliver Sexual Safety and Violence Prevention Standards	• We will implement national Sexual Safety Charter and NHS Violence Prevention Standards. • We will provide training and resources to ensure staff feel safe from sexual harassment and violence at work. • We will embed governance and reporting to ensure accountability at Board level.
Introduce a Menopause Policy and accreditation	• We will implement a Menopause Policy to support colleagues experiencing the menopause. • We will pursue national accreditation to demonstrate our commitment as a menopause-friendly employer. • We will provide awareness training for leaders and resources for staff.

We will know we have achieved this when:
• Flexible working is embedded across the Trust, with transparent systems in place and equitable access for all staff. • Uptake of flexible working is monitored and shows positive impact on wellbeing, inclusion and retention. • Rostering practices are improved, with staff reporting fairer workloads and better work-life balance. • A comprehensive wellbeing offer is in place, co-designed with staff and well used across all staff groups. • Psychological support services are available and accessible, with positive staff feedback on impact. • Attendance management processes are fair, supportive and effective, with improved attendance outcomes. • Leaders feel well supported to manage sensitive and formal processes, with confidence demonstrated in feedback. • Regular wellbeing assessments inform ongoing improvements, with clear evidence of impact on staff experience and outcomes. • Sexual safety and violence prevention standards are fully embedded, with fewer incidents and improved staff confidence in safety.

Governance and progress monitoring

Delivering our People Plan requires strong governance, clear accountability and regular review. We are committed to ensuring that progress is transparent and that colleagues can see the impact of the actions we take.

Oversight of the People Plan will sit with the People and Culture Committee, with regular reporting to the Trust Board to ensure alignment with our strategic priorities and the 10 Year Health Plan. Executive leads will take responsibility for each theme, supported by the People, Organisational Development and Inclusion Team to drive delivery.

Progress will be monitored through:

- Quarterly updates to the People and Culture Committee, including progress against actions, risks and mitigations.
- Key performance indicators (KPIs) linked to recruitment, retention, development, wellbeing and inclusion.
- Staff feedback mechanisms, including the NHS Staff Survey, quarterly pulse surveys, focus groups and staff networks.
- Workforce data dashboards to monitor trends and outcomes.
- Regular reporting to Trust Board, setting out achievements, challenges and next steps.

Accountability for delivery will be shared across the organisation, with executive sponsors, divisional leaders and staff networks playing a key role in championing and embedding the Plan. Staff voice will remain central to the delivery of this plan, with regular feedback loops in place to show colleagues how their input has shaped decisions and actions.



Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 24 March 2026

Guardian of Safe Working Hours (GoSWH) report (quarterly) - December 2025

Purpose of Report

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

Executive Summary

The Board is requested to note:

1. Exception reports
    a. At the time of drafting, one exception report has taken longer than seven days to address. This is owing to a change in GoSWH and thus delays in addressing the exception report, coupled with the doctor submitting being on leave
    b. One exception report submitted for non-resident on call rest requirement breaches, incurring a fine and for payment to the doctor
    c. One exception report for an Higher Speciality Trainee (HST) doctor was submitted owing to a need to ‘act down’. They were given time off in lieu (TOIL), but ultimately this is dealt with through the stepping down procedure, which was followed
    d. One exception report for an HST doctor was submitted seeking clarification on their role during seclusion reviews. No actions were required, but this has been discussed further at the Resident Doctor Forum (RDF). Ultimately, there is a workload issue that is being looked in to separately with respect to Mental Health Act (MHA) assessments out of hours
    e. Several exception reports received from the same clinical area by two doctors that cross cover each other. They were both able to take back their time following discussion with the clinical supervisor. The GoSWH and Deputy Director of Medical Education (DDME) investigated further and highlighted wider multi-disciplinary team (MDT) staffing issues that led to these exception reports. However, the doctors report that the supervisor is supportive and TOIL has been realistic/taken.
2. Rota workloads
    a. A baselining hours monitoring exercise was completed for the Foundation Year 2 (FY2) to Core Trainee Year 3 (CT3) doctors participating in the out of hours rotas in the south and has since been repeated with new builds at Kingsway open and operational. Information from this has fed into a costed options appraisal, where one option is to have two doctors on site overnight. This is being led by Medical Education.
3. Exception reporting reform
    a. The exception reporting reform has come online from 4 February 2026
    b. The GoSWH and Medical Staffing met to consider a published implementation checklist from NHS Employers. Concerns were raised about the work required to go live in time, and that HR/Medical Staffing will need to lead on this. This has been live since then.
    c. A task and finish group with operational support throughout January was set up by the GoSWH to HR colleagues to oversee the above process.
4. GoSW role
    a. Dr Jawahar ended his role as the GoSWH on 30 November 2025. Dr Praveena Peddireddi was appointed as the GoSWH and commenced in role on 8 December 2025.

b. The Executive Medical Director has since the report was discussed in the Quality and Safeguarding Committee has liaised with the incoming GoSW to review the measures to mitigate exception reporting where possible.

Strategic Considerations		BAF Risk (eg 1A)	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X		
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X	2A	2.2
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 from the DHcFT GoSWH provides data about the number of resident doctors in training in the Trust, full transition to the 2016 Resident Doctor contract and any issues arising therefrom. The report details arrangements made to ensure safe working within the new contract and arrangements in place to identify, quantify and remedy any risks to the organisation.

Consultation

The GoSWH has shared the previous quarterly and annual reports with the Quality and Safeguarding Committee, the Joint Local Negotiating Committee (JLNC), the Trust Medical Training Committee (TMTC), the RDF and its constituent resident doctors. Following presentation to the Quality and Safeguarding Committee, this report will be shared at the next RDF meeting, its constituent resident doctors, the TMTC and the JLNC.

Governance or Legal Issues

None.

Net Zero Duty Implications

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

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

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:

None.

Recommendations

The Board of Directors is requested to:

1. Note the contents of the report
2. Welcome Dr Praveena Peddireddi as the new GoSWH.

Report presented by: **Lynn Andrews**
Chair, Quality and Safeguarding Committee

Report prepared by: **Dr Kaanthan Jawahar**
Local Negotiating Committee (LNC) Chair/former GoSWH

Guardian of Safe Working Hours report (quarterly) - December 2025

Background

Exception Reporting Framework for resident doctors was created in partnership with the Department of Health and Social Care (DHSC), NHS England, NHS Employers, the BMA and employer representatives, during a series of talks since the acceptance of the July 2024 pay deal. However the online tools to support the framework was not ready by providers (such as Allocate which DHCFT uses) until late 2025 with the deadline on its implementation on 4th February 2026 which DHCFT is compliant with. Exception reporting happens resident doctors day-to-day work varies significantly or regularly from your agreed work schedule.

1. Resident doctor data

Extended information supplied from 30 September to 10 December 2025.

Numbers in post for resident doctors in training

Number of doctors in post WTE	North	South
FY1	3	5
FY2	2.8	4.6
GP ST	6	6.4
CT	9.8	13.8
HSTs	4.6	6
Paediatrics ST	0	1.4

Key

CT = Core training resident years one to three
FY1/FY2 = Foundation year resident (years one and two)
HST = Specialty training resident (ST) years four to seven
GP ST = General practice specialty registrar
Paediatrics ST = Paediatrics specialty training resident (year four+)

2. Exception Reports

Aggregated data, covering the period 30 September to 10 December 2025:

Location	No of exceptions raised	No of exceptions closed	No of exceptions outstanding
North	14	14	0
South	4	4	0
Total	**18**	**18**	**0**

Grade	No of exceptions raised	No of exceptions closed	No of exceptions outstanding
CT1-3	6	6	0
ST4-7	3	3	0
GP	1	1	0
Foundation	8	8	0
Total	**18**	**18**	**0**

Action taken

Location	Payment	TOIL	Not agreed	No action required
North	0	13	0	0
South	1	3	0	1
Total	**1**	**16**	**0**	**1**

Response time

Grade	48 hours	Seven days	Longer than seven days	Open
CT1-3	0	5	1	0
Foundation	0	8	0	0
ST4-7	0	3	0	0
GP	0	1	0	0

At the time of drafting, one exception report has taken longer than seven days to address. This is owing to a change in GoSWH and thus, delays in addressing the exception report, coupled with the submitting doctor being on leave:

- One exception report submitted for non-resident on call rest requirement breaches, incurring a fine and for payment to the doctor
- One exception report for an HST doctor was submitted owing to a need to 'act down'. They were given time off in lieu (TOIL). However, ultimately this is dealt with through the stepping down procedure, which was followed
- One exception report for an HST doctor was submitted seeking clarification on their role during seclusion reviews. No actions were required, but this has been discussed further at the RDF. Ultimately, there is a workload issue that is being looked in to separately with respect to Mental Health Act assessments out of hours
- Several exception reports received from the same clinical area by two doctors that cross cover each other. They were both able to take back their time following discussion with the clinical supervisor. The GoSWH and Deputy Director of Medical Education (DDME) investigated further and highlighted wider multi-disciplinary team staffing issues that led to these exception reports. However, the doctors report that the supervisor is supportive and TOIL has been realistic/taken.

3. Work schedule reviews

No formal work schedule reviews undertaken.

4. Fines

Current balance: £1,926.89.

5. Locum/Bank Shifts covered (30 September to 10 December 2025)

	North	Cost	South	Cost
Locum/bank shifts covered	28	£16,705	38	£23,720
Agency locum shifts covered	0	0	0	0

6. Agency Locum (30 September to 10 December 2025)

Nil.

7. Vacancies (30 September to 10 December 2025)

	North	South
CT1-CT3	1.2	0.2
ST4-7	2.4	1
GP registrars	0.7	0.8
Foundation	0.2	0

8. Qualitative information

- Rota workloads
    - A baselining hours monitoring exercise was completed for the FY2 to CT3 doctors participating in the out of hours rotas in the south. This has since been repeated with new builds at Kingsway open and operational. Information from this has fed into a costed options appraisal, where one option is to have two doctors on site overnight. This is being led on by Medical Education
- Exception reporting reform
    - Exception reporting reform will come online from 4 February 2026
    - The GoSWH and Medical Staffing met to consider a published implementation checklist from NHS Employers. Concerns were raised about the work required to go live in time, and that HR/Medical Staffing will need to lead on this
    - A task and finish group with operational support throughout January has been suggested by the GoSWH to HR colleagues
- GoSWH role
    - Dr Jawahar ended his role as the GoSWH on 30 November 2025. Dr Praveena Peddireddi was appointed as the GoSWH and commenced in role on 8 December.
    - The Executive Medical Director has since the report was discussed in the Quality and Safeguarding Committee has liaised with the incoming GoSW to review the measures to mitigate exception reporting where possible.

9. Compliance of rotas

Current work schedules are compliant with the 2016 resident doctor contract.

10. Other concerns raised with the Guardian of Safe Working (GoSWH)

None not already covered.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 24 March 2026

Learning from Deaths/Mortality report

Purpose of Report

The 'National Guidance on Learning from Deaths' requires each trust to collect and publish specified information on a quarterly basis. This report covers the period 1 October 2025 to 31 December 2025. The Quality and Safeguarding Committee was requested to accept this Mortality Report as assurance of the Trust's approach and agree for the report to be considered by the Trust Board of Directors and published on the Trust's website as per national guidance.

Executive Summary

The Trust received 548 death notifications of patients who had been in contact with our services in Quarter 3 of 2025/26. There is very little variation between male and female deaths; 280 male deaths were reported, compared to 266 females.

There have been seven Learning Disability deaths in the reporting timeframe and no deaths of patients with a diagnosis of autism.

There have been two inpatient unexpected deaths due to physical health causes and one unexpected death during home leave.

The Trust commissioned 10 Learning Responses surrounding deaths through Case Record Review. In addition, there were one Patient Safety Incident Investigation commissioned, all of which are ongoing. Five learning responses were completed this period. Following is the learning emerging from Case Record Reviews and Patient Safety Incident Investigations (PSII):

Key themes for improvement:

- Risk Assessment and Management
- Documentation Quality
- Communication and Information Sharing
- Multi-disciplinary team (MDT) Working and Pathways
- Medication and Physical Health
- Observations and Falls Management
- Carer Involvement
- Crisis Response and Safety Planning
- System-Level Issues.

Strengths Identified:

- Effective community transitions
- Strong MDT working within Community Mental Health teams (CMHTs)
- Comprehensive assessments and proactive referrals
- Person-centred community safety planning
- Good safeguarding and confidentiality practice

These areas will be progressed through Care Group Learning the Lessons meetings and Divisional meetings which have commenced from January 2026. Where appropriate, improvement groups will be established to oversee implementation. The Divisional Learning the Lessons meeting and Executive Incident Review Group will hold oversight for actions resulting from Learning Responses, quality improvement plans.

The Trust Patient Safety team continues to meet with Medical Examiners to improve the flow of information in relation to cause of death.

Good practice identified through case note reviews is fed back to clinicians/wider team involved as part of our appreciative learning.

The mortality process to ensure compliance with policy and procedure on red flags (ie avoidable deaths) within the Electronic Patient Record (EPR) continues to have weekly audits, with the most recent being on 23 January 2026. The audit identified two deaths as having complaints, one had been Datix reported, the second did not meet the requirement as the complaint was not upheld.

The Trust Patient Safety Team had few challenges with capacity and dynamics within the team which is currently being resolved. An interim patient safety lead is in place. The Trust is actively reviewing the process of investigations under PSIRF, ensuring that there is robust system for tracking the progress in investigations, monitoring the action plan and learning. Since the report was submitted to the Quality and Safeguarding Committee in February 2026 a further discussion with the new operating model managers resulted in having a Learning the Lessons Group in each of the Care Groups (five) and one at the Trust level that will oversee the learning across the organisation and support with triangulation. There is also a plan to train 50 more managers/clinicians on PSIRF. In future the deaths on protectively characteristics will be reported based on population demographics/health inequalities once the data is available.

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

Risks and Assurances

This report provided limited assurance to the Quality and Safeguarding Committee that the Trust is following recommendations outlined in the National Guidance on Learning from Deaths.

Consultation

This report has been reviewed by the Executive Medical Director and Executive Incident Review Group membership.

Governance or Legal Issues

There are no legal issues arising from this report.

The Care Quality Commission Regulations - this report provides assurance as follows:

- Outcome 4 (Regulation 9) Care and welfare of people who use services
- Outcome 14 (Regulation 23) Supporting staff
- Outcome 16 (Regulation 10) Assessing and monitoring the quality of service provision
- Duty of Candour (Regulation 20).

Net Zero Duty Implications

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

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

None.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

- Between 1 October 2025 to 31 December 2025, there was very little variation between male and female deaths; 280 male deaths were reported, compared to 266 female deaths
- No unexpected trends were identified according to ethnic origin or religion.

Recommendations

The Board of Directors is requested to accept this report with limited assurance of the Trust's approach and agree for the report to be considered by the Trust Board of Directors and then published on the Trust's website as per national guidance.

Report presented by: **Lynn Andrews**
Chair, Quality and Safeguarding Committee

Report prepared by: **Louise Hamilton**
Safer Care Co-ordinator

Davinia Connelly
Operational Patient Safety Manager

Learning from Deaths/Mortality report (quarterly)

1. Background

In line with the Care Quality Commission's (CQC) recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a framework for NHS Trusts - 'National Guidance on Learning from Deaths'. The purpose of the framework is to introduce a more standardised approach to the way NHS trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and improved embedded learning. To date, the Trust has met all the required guidelines.

The report presents the data for 1 October 2025 to 31 December 2025.

2. Current Position and Progress

- The Patient Safety Team receives information on deaths from Datix filed by the teams and from other sources such as police, coroner office and medical examiner office.
- Only a very small number of cause of deaths (CoD) have been made available through the Coroner offices in Chesterfield and Derby
- Medical Examiner offices at Acute trusts provide independent scrutiny of non-coronial deaths including those in the community. They carry out a proportionate review of medical records and liaise with doctors completing the Medical Certificate of Cause of Death (MCCD). They give families and next of kin an opportunity to ask questions and raise concerns. There is an agreement in place for CoD information to be released to the DHcFT Patient Safety team for patients open to our service in the six months prior to their death. This agreement is in place with University Hospitals of Derby and Burton (UHDB) and Chesterfield Royal Hospital (CRH) via working relationships between the corresponding Patient Safety teams. This has been slow to come into force due to numerous technical issues for the various Electronic Patient Record (EPR) systems and a shortage of medical examiners. All medical examiners are now in place and electronic system issues are reportedly resolved. However, CoD information sharing remains slow. This will be actioned by Patient Safety now that the main areas have been resolved
- Regular audits continue to be undertaken to ensure compliance with policy and procedure for the reporting of Trust and National Learning from Deaths on red flag deaths (ie avoidable deaths). This includes auditing complaint data against names of deceased patients to ensure this meets the requirements specified in the National guidance. The last audit was completed on 23 January 2026 which identified two deaths as having complaints; one had been Datixed and the other was not required to be Datixed as the complaint was not upheld
- A process is now embedded within the Electronic Patient Record, which aids staff in identifying deaths which meet the threshold for Datix reporting. This process fulfils stage one of the Learning from Deaths procedure
- In line with changes being made to the assurance and oversight of learning post-incident, the Trust Mortality Committee was replaced with the Learning the Lessons Oversight Group which formed part of the Executive Incident Review Group. Given the structure and organisational changes an active decision was made to hold the Oversight Group. Operational services have now established Care Group meetings with a Division Learning the Lessons Oversight Group which will feed into the Trust Executive Incident Review Group. The Patient Safety team will continue to support Operational services to fully embed these meetings
- We are in the process of re-establishing the Regional Mortality Review Networking Group at DHcFT. The aim is to strengthen regional links, share learning from mortality reviews and support continuous improvement in patient safety. The next planned meeting is due to take place in March 2026
- We are developing an Incident Review Tool (IRT) audit process to strengthen our approach to incident learning under the Patient Safety Incident Response Framework (PSIRF). The purpose is to ensure that outcomes from incident reviews are being shared appropriately, learning is effectively disseminated across services and that there is alignment between the IRT process and broader PSIRF requirements.

3. Data Summary of all Deaths

Note that Inpatient and Learning Disability (LD) data is based upon whether the patient has an open Inpatient or LD referral at time of death. The following table outlines information from 1 October 2025 to 31 December 2025:

	Oct	Nov	Dec
Total Deaths Per Month	162	187	199
LD Referral Deaths	1	1	5

Correct as of 23 January 2026

Between 1 October 2025 to 31 December 2025, the Trust received 548 death notifications of patients who had been in contact with our services for patients opened or discharged within six months of their death. Of these deaths, 280 patients were male, 266 female and two unknown gender. The youngest age was zero years (as we provide services to children in Community Paediatrics), the oldest age recorded was 101. The Trust has reported seven LD deaths in the reporting timeframe and no deaths of a patients with a diagnosis of autism.

4. Review of Deaths

Of the 548 deaths there were 74 cases that met the criteria for Trust incident reporting system which is shown in the table below:

Total number of deaths between 1 October 2025 and 31 December 2025 reported on Datix.	60 “Unexpected deaths” Nine “Suspected Suicide deaths” Five “Expected - end of life pathway” NB some expected deaths have been rejected so these incidents are not included in the above figure.
Incidents assigned for a review.	74 incidents assigned to the Operational Incident Group.

Only deaths which meet the criteria below should be reported through the Trust incident reporting system (Datix) and these are also reviewed using the process of the *Incident Reporting and Investigation Policy and Procedure.*

Any patient, open to services within the last six months, who has died and meets the following:

- Homicide – perpetrator or victim. (This criterion only relates to patients open to services within the last six months)
- Domestic homicide - perpetrator or victim (This criterion relates to patients open to services within the last six months)
- Suicide/self-inflicted death, or suspected suicide
- Death following overdose
- Death whilst an inpatient
- Death of an inpatients who died within 30 days of discharge from a DHcFT hospital
- Death following an inpatient transfer to acute hospital
- Death of patient on a Section of the Mental Health Act or Deprivation of Liberty Safeguards (DoLs) authorisation
- Death of patient following absconsion from an inpatient unit
- Death following a physical restraint
- Death of a patient with a LD
- Death of a patient where there has been a complaint by family/ carer/ombudsman or staff have raised a significant concern about the quality of care provision
- Death of a child (and will likely be subject to scrutiny by the Child Death Overview Panel)
- Death of a patient open to safeguarding procedures at the time of death, which could be related to the death
- Death of a patient with historical safeguarding concerns, which could be related to the death
- Death where a previous Coroners - Regulation 28 has been issued
- Death of a staff member whilst on duty
- Death of a child under the age of 18 of a current or previous patient who has died in suspicious circumstances
- Where an external organisation has highlighted concerns following the death of a patient whether they were open to the Trust at time of death or not
- Diagnosis of psychosis within the last episode of care
- Autism

- Death of a patient who has an eating disorder within the last episode of care or death within six months of discharge
- Death of a patient under the care of the crisis and home treatment team (or equivalent) at the time of their death
- Death of a patient in Substance Misuse services – further guidance within the incident policy or how Substance Misuse deaths are managed.

5. Inpatient Deaths

During the review period there have been three inpatient deaths for the period which relates to two male patients who died due to physical health causes following transfer to the Acute hospital and one male patient who died during home leave due to morphine toxicity.

6. Learning Responses for 2023/24, 2024/25 and 2025/26

The table below outlines the number of deaths that have been recorded through the Trust incident reporting system Datix and the learning response that has been commissioned. All deaths reported through the Datix system meeting the Trust 'red flag' will have an Incident Review Tool completed. This is then reviewed, and a decision is made as to whether a further learning response is required.

Financial Year	Datix	Case Record Review	Patient Safety Incident Investigation
2023/24	119 deaths	39	16
2024/25	141 deaths	23	3
2025/26	116 deaths	20	5

Please note: 64 deaths are currently awaiting a decision.

7. Duty of Candour (DoC) for 1 October 2025 to 31 December 2025

The Trust achieved 100% compliance with Duty of Candour within this reporting period with four incidents meeting the threshold (where the date of the incident is within this reporting period). Where an incident is subject to learning response Duty of Candour is assessed at the date which the report is approved. Therefore, such incidents can sit outside of the specified reporting period. For transparency these incidents will be included within this report. There have been two incidents assessed as DoC which occurred outside of the reporting period. The Trust has a 50% compliance for these. DoC was not achieved due to the patient being deceased with no known family to engage. Learning identified for this period includes:

- Low staffing levels
- Professional boundaries
- Inappropriate medication safety in the community.

The Trust is active in promoting DoC and encourage all staff to be trained on DoC. 121 staff have been trained in DoC for this period. To date 304 staff have completed training this financial year with 1,007 staff compliant since the initiative began.

8. Learning from Deaths Procedure

The Trust has now completed a move in terms of its mortality process; a process has been implemented within the EPR which aids staff in identifying deaths which meet the threshold for Datix reporting. This process fulfils stage one of the Learning from Deaths in that all deaths are considered for red flags as identified under the national Learning from Deaths procedure. This will also allow for more joined up working with Corporate and Legal services, ensuring better sharing of information and identification of priorities for both services. Weekly random audits continue for deaths against the red flags to provide assurance that the new process is working as intended.

The Patient Safety team has been revising the function of its Mortality case record review process and developing an Incident Review Tool (IRT) audit process which will be allocated to Medical and Nursing colleagues.

This has been delayed due to capacity and service restructuring however forms part of an improvement plan under development for the Patient Safety team. All national mortality red flags sit within the Trust's overarching red flags for the reporting of deaths as an incident.

The process will work to ensure that outcomes from incident reviews are being shared appropriately, learning is effectively disseminated across services, and that there is alignment between the IRT process and the broader PSIRF requirements.

9. Analysis of Data

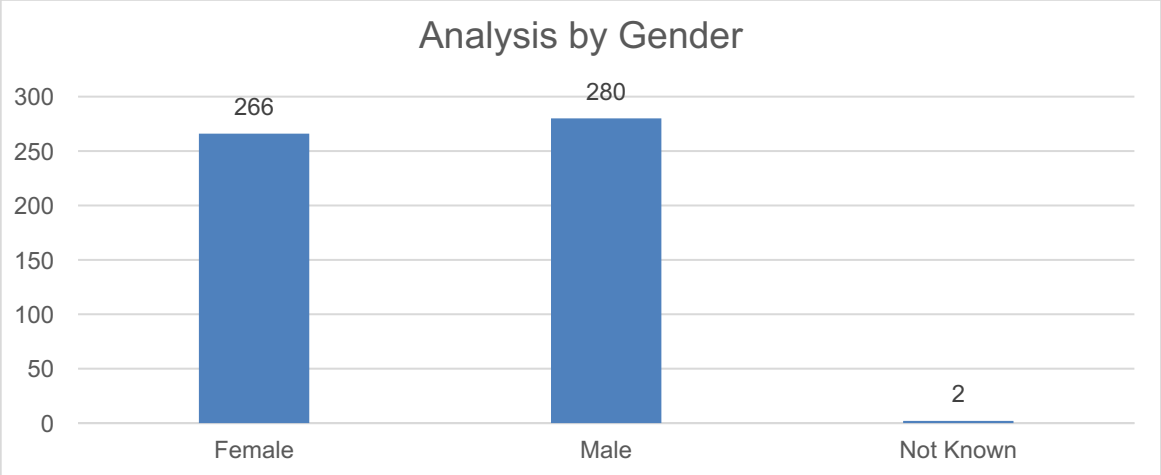
9.1. Analysis per notification system since 1 October 2025 to 31 December 2025

System	Number of Deaths
SystmOne (Trust EPR)	548
Grand Total	**548**

The data above shows the total number of deaths reported by each notification system. All of the death notifications were pulled from SystmOne (Trust EPR). This clinical record system is aligned to the population we serve.

9.2. Analysis by Gender

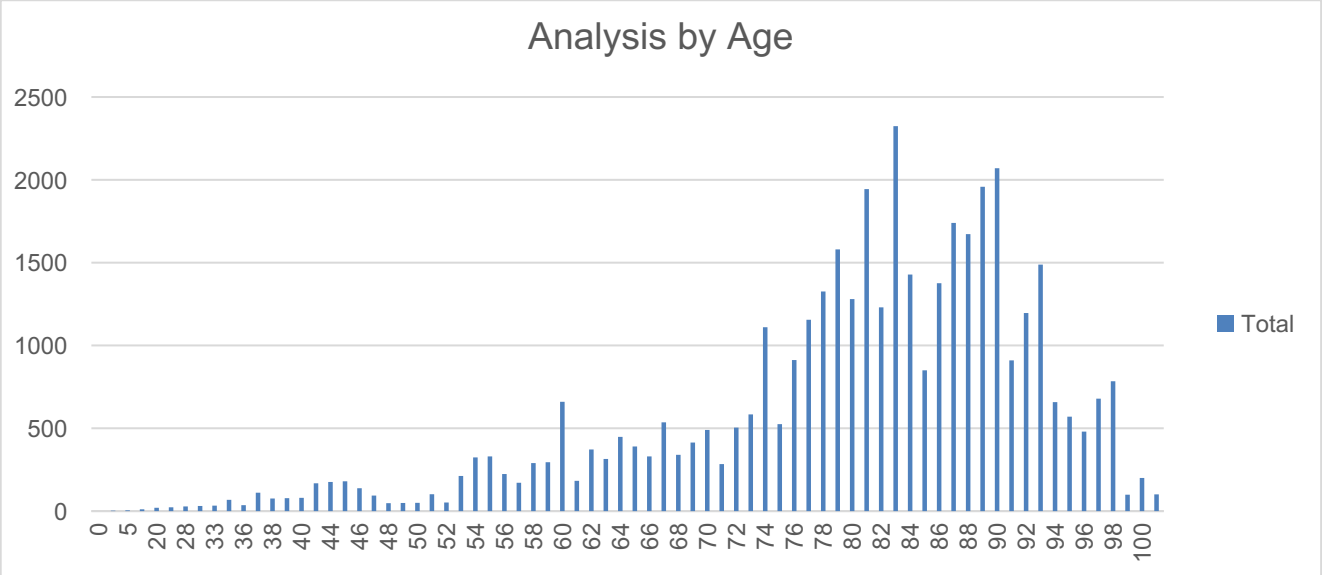
The data below shows the total number of deaths by gender during 1 October 2025 to 31 December 2025. There is very little variation between male and female deaths; 266 female deaths were reported. compared to 280 males.



Gender	Number of Deaths
Male	280
Female	266
Not Known	2
Grand Total	**548**

9.3. Analysis by Age Group

The youngest age was classed as zero (as we provide community paediatric services), and the oldest age was 101 years. Most deaths occurred within the 81 to 90 age groups:



9.4. Learning Disability Deaths (LD)

The Trust reviews all deaths relating to patients diagnosed with a Learning Disability. The Trust also currently sends all Learning Disability deaths that have been reported through the Datix system to the Learning Disabilities Mortality Review (LeDeR) programme that is led by the Integrated Care Board (ICB). Scoping is planned with operational services through their Learning the Lessons subgroups to consider the most appropriate management process for Learning Disability deaths moving forward.

	Oct	Nov	Dec
LD Deaths	1	1	5
Autism	0	0	0

Since 1 January 2022, the Trust has been required to report any death of a patient with autism. To date, 16 patients have been referred.

During 1 October 2025 to 31 December 2025, the Trust has recorded seven LD deaths. The Trust now receives a quarterly update from LeDeR (Learning from Deaths and Lives – people with learning disability and autistic people) which highlights national good practice and identified learning; this is shared in the monthly Mortality meeting. Benchmarking will take place in relation to the use of Datix to manage the reporting requirements around Learning Disability deaths.

9.5. Analysis by Ethnicity

White British is the highest recorded ethnicity group with 424 recorded deaths; 23 deaths had no recorded ethnicity assigned. The following chart outlines all ethnicity groups:

Ethnicity	Count of Ethnicity
Asian or Asian British - Bangladeshi	1
Mixed - Any other mixed background	2
Mixed - White and Black Caribbean	3
Black or Black British – Caribbean	3
Black or Black British - Any other Black background	4
Asian or Asian British – Pakistani	5
Asian or Asian British – Indian	5
White – Irish	5
Not stated	8
White - Any other White background	14
Not Known	23
Other Ethnic Groups - Any other ethnic group	51
White – British	424
Grand Total	**548**

9.6. Analysis by Religion

Christianity is the highest recorded religion group with 225 recorded deaths, 157 patient deaths were recorded as having no religious affiliation. The chart below outlines all religion groups:

Religion	Number of Deaths
Catholic: non Roman Catholic	1
Baptist	1
Protestant	1
Methodist	2
Roman Catholic	2
Jehovah's Witness	2
Catholic religion	3
Religion not given - patient refused	4
Religion NOS	4
Sikh	4
Muslim	5
Christian religion	9
Church of England, follower of	10
Church of England	13
Patient religion unknown	31
(blank)	74
Not religious	157
Christian	225
Grand Total	**548**

9.7. Analysis by Sexual Orientation

Heterosexual or straight is the highest recorded sexual orientation group with 396 recorded deaths, 121 have no recorded information available. The chart below outlines all sexual orientation groups:

Sexual Orientation	Number of Deaths
Not stated (person asked but declined to provide a response about their sexual orientation)	1
Person asked and does not know or is not sure (about their sexual orientation)	1
Homosexual	1
Female homosexual	1
Homosexuality NOS	3
Sexual orientation unknown	11
Sexual orientation not given - patient refused	13
(Blank)	121
Heterosexual	396
Grand Total	**548**

9.8. Analysis by Disability

The table below details the top 10 categories by disability. Memory impairment was the highest recorded disability group with 88 recorded deaths. 133 deaths had no disability recorded:

Disability	Number of Deaths
Hearing disability	15
Disability Questionnaire - Mobility and Gross Motor	16
Disability Questionnaire - Progressive Conditions and Physical Health	23
Disability status not given - patient refused	25
Disability Questionnaire - Personal, Self Care and Continence	27
No current problems or disability	29
Patient reports no current disability	40
Gross motor disability	76
Memory impairment	88
(blank)	133
Grand Total	**472**

There have been 220 deaths with a disability assigned and the remainder were blank or had no assigned disability.

7. Closed Learning response outcomes for the period

Closed learning responses within the PSIRF are designed to move away from blaming individuals towards a systems-based approach, aiming to identify underlying causes and implement meaningful improvements. During the review period five learning responses were completed. Key themes include:

- **Risk Assessment and Management.** Risk not updated after deterioration; high-risk indicators underestimated; escalation to Mental Health Act Assessment (MHA) missed; rationales for decisions not recorded
- **Documentation Quality.** Records inconsistent/outdated; risk assessments not reviewed; long-unused care plans; incomplete safety plans; discharge letters missing key clinical information
- **Communication and Information Sharing.** Critical risk information not shared across teams; inconsistent liaison with Substance Misuse services; low carer involvement; external agencies not fully informed
- **Multidisciplinary Team (MDT) Working and Pathways.** Weak crisis MDT processes; inconsistent nursing input; unclear pathways for substance misuse and out-of-hours escalation; late/incomplete discharge planning
- **Medication and Physical Health.** Poor escalation of missed depots; limited coordination with primary care; inadequate physical health monitoring after incidents
- **Observations and Falls Management.** Falls assessments inconsistent; neuro observations not aligned with policy; lack of standard falls-prevention equipment
- **Carer Involvement.** Requests not acted upon; carers excluded from key decisions like observations and discharge planning
- **Crisis Response and Safety Planning.** High-risk cases not escalated; nighttime monitoring lacked rationale; follow-up after crisis deferred; safety plans not tailored to known behaviours
- **System-Level Issues.** Need for standard inpatient operational policies; weak out-of-hours escalation structure; poor documentation of decision rationale; some cases triggered DoC.

Strengths Identified

- Effective community transitions
- Strong MDT working within Community Mental Health Teams (CMHT)
- Comprehensive assessments and proactive referrals
- Person-centred community safety planning
- Good safeguarding and confidentiality practice.

8. Moving Forward

The Trust Patient Safety Team had few challenges with capacity and dynamics within the team which is currently being resolved. An interim patient safety lead is in place.

There is an improvement plan in place for January-August 2026 which incorporates the following improvement actions:

- The Trust is actively reviewing the process of investigations under PSIRF, ensuring that there is robust system for tracking the progress in investigations, monitoring the action plan and learning
- Since the report was submitted to the Quality and Safeguarding Committee on 11 February 2026, a further discussion with the new operating model managers resulted in having a Learning the Lessons Group in each of the Care Groups (five) and one at Trust-level that will oversee the learning across the organisation and support with triangulation. These Learning the Lessons Groups aim to be fully embedded by August 2026, with clear evidence of the dissemination of learning from patient safety incidents throughout the organisation through meeting minutes and newsletters, and of assurance being provided to board around how learning themes are being addressed in practice
- There is also a plan to train 50 more managers/clinicians to complete Patient Safety Incident Investigations
- The Trust is working with an external consultant to develop a series of e-learning and teaching session plans based on the PSIRF and Human Factors. This will support employees within the organisation to develop a greater knowledge and understanding of the organisation’s incident review and learning processes at all levels
- In future reports, the deaths on protective characteristics will be reported based on population demographics/health inequalities once the data is available.

Derbyshire Healthcare NHS Foundation Trust
Report to the Board of Directors – 24 March 2026

Fit and Proper Person Policy

Purpose of Report

To present the refreshed Fit and Proper Person Policy and Procedure for approval.

Executive Summary

The policy has been updated to fully reflect and embed the NHS England Fit and Proper Person Test (FPPT) Framework for Board Members.

Areas updated include references to:

- Annual self-attestation for all relevant post-holders
- Defined three-yearly and annual re-checks (DBS, insolvency, professional registration)
- Explicit linkage to Board appraisal, 360-degree feedback, and the NHS Leadership Competency Framework
- Defined retention periods for FPPT documentation
- Restricted access to FPPT fields on ESR and reference to the national FPPT privacy notice.

The policy is a three-year renewal and refresh of an existing Trust policy with amendments embedding national guidance and regulatory requirements rather than changes to employment terms or practice.

Strategic Considerations		BAF Risk (eg 1A)	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.			
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X	2A and 2B	2.1, 2.2, 2.3
Productive: We will improve our productivity and design and deliver services that are financially sustainable.			
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.			

Risks and Assurances

Failure to comply with FPPT requirements could result in adverse findings through CQC Well-Led inspections or NHS England oversight. The Trust has been complying with the FPPT Framework from inception. An Internal Audit reviews of FPPT compliance will be undertaken in 2026/27.

Consultation

Earlier versions were reviewed through the Joint Consultative Committee and Executive Leadership Team. These amendments are in line with national guidance.

Governance or Legal Issues

- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Regulation 5
- CQC registration requirements
- NHS Provider Licence conditions
- Trust Constitution requirements for Directors.

Net Zero Duty Implications

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

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

No direct impacts.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

- All Board appointments follow national recruitment guidance, promotes equity in recruitment, development, wellbeing and progression
- The Board commits to a fully inclusive and values-driven culture, embedding the Personal Accountability Charter and anti-racism strategy.

Recommendations

The Board of Directors is requested to approve the revisions to the Policy.

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

Derbyshire Healthcare
NHS Foundation Trust

Fit and Proper Persons Policy and Procedure

See also:	Located in the following policy folder on the Trust Intranet
Disciplinary Procedure for Medical Staff Policy and Procedures	People and Inclusion
Disciplinary Policy and Procedures	People and Inclusion
Disclosure and Barring Service (DBS) Policy and Procedures	People and Inclusion
Recruitment and Selection Policy and Procedures	People and Inclusion
Freedom to Speak Up Policy and Procedure	Corporate and Risk

Service area	Issue date	Issue no.	Review date	
Trust wide	Marchy 202326	43	March 202629	
Ratified by	**Ratification date**	**Committee/Group responsible for review:**		
Board of Directors	March 202326	Director of Corporate Affairs and Trust Secretary		

Document published on the Trust Intranet under: Corporate and Risk Policies

Did you print this document?

Please be advised that the Trust discourages retention of hard copies of policies and can only guarantee that the Policy on the Trust Intranet site is the most up-to date version

ACCESSIBLE INFORMATION STANDARD

The Accessible Information Standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of service users.

Ensure you have considered an agreed process for: sending out correspondence in alternative formats and appointments for patients / service users with communication needs, where this is applicable.

Checklist for Fit and Proper Persons Policy

Summary (Plain English) Summarise the main points of the policy below in a style that is clear and easy to understand. Ensure the whole policy is written in plain English, using simple language where possible and avoiding convoluted sentences and obscure words. The resulting policy should be easy to read, understand and use,
The aim of this policy document is to ensure a clear process is in place to provide assurance that individuals within Board Director Positions at the Trust comply with the Fit and Proper Persons Test Regulations.

Name / Title of policy/procedure	Fit and Proper Persons Policy	
Aim of Policy	To ensure all Executive and Non-Executive Director posts (or anyone performing equivalent/similar functions) are filled by people that meet the requirements of the Fit and Proper Persons Regulations.	
Sponsor (Director lead)	Director of Corporate Affairs and Trust Secretary	
Author(s)	Director of Corporate Affairs and Trust Secretary ~~Director of Nursing & Patient Experience~~	
Name of policy being replaced	Fit and Proper Persons Policy and Procedure	**Version No of previous policy:** ~~2~~3

Reason for document production:	Renewal of required policy
Commissioning individual or group:	Trust Board

Individuals or groups who have been consulted:	**Date:**	**Response**
Executive Leadership Team	31/01/2023	Agreed ~~-~~ not required for 2026 refresh as all based on national guidance.

Version control (for minor amendments)

Date	Author	Comment
20.1.2023	Trust Secretary	Three yearly review, no significant updates. Old internet links removed, job titles revised.

Fit and Proper Persons Policy

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Fit and Proper Persons Policy

1. Introduction

1.1 Purpose

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 introduced a 'fit and proper persons test' for all NHS bodies. This policy outlines how the Trust will meet the requirements placed on the NHS which came into force on 1 October 2014 for all NHS bodies and for all providers on 1 April 2015.

Under the regulations, all provider organisations must ensure that Director level appointments meet the Fit and Proper Persons Test (FPPT) and the regulations place a duty on NHS providers not to appoint a person or allow a person to continue to be an Executive Director or equivalent or Non-Executive Director under given circumstances.

The regulations have been integrated into the Care Quality Commission's (CQC's) registration requirements and falls within the remit of their regulatory inspection approach. NHS England's FPPT framework for Board Members has been implemented and followed by the Trust since 30 September 2023 and should be read alongside this Policy.

Chairs of NHS Board of Directors are responsible for overall accountability for the implementation of FPPT arrangements in their organisations and its implementation will be monitored by NHSE (annual submission) and the CQC (Well-Led inspections).

1.2 Scope

This policy applies to all Board appointments, ie Executive and Non-Executive Directors and those senior managers which are formally recognised as part of the Trust's Executive Leadership Team (ELT). This includes permanent interim (over six weeks duration) and associate positions. It also includes those individuals who are acting up in Board level positions.

2. Requirements

The introduction of the Fit and Proper Persons Requirements (FPPR) requires the Trust Chair to:

- Confirm to the CQC that the fitness of all new Directors has been assessed in line with the regulations; and
- Declare to the CQC in writing that they are satisfied that they are fit and proper individuals for that role both on appointment and an ongoing basis and do not meet any of the 'unfit' criteria.

The Trust will make every reasonable effort to assure itself about existing post holders and new applicants and to make specified information about Board Directors available to the CQC on request.

Individuals who fall into the categories above must satisfy the Trust Chair they:

- Are of good character
- Hold the required qualifications and have the competence, skills and experience required for the relevant office for which they're employed
- Are able, by reason of their physical and mental health, after any required reasonable adjustments if required, capable of properly performing their work
- Can supply relevant information as required by Schedule 3 of the Regulations, ie documentation to support the FPPR
- Have not have been responsible for or privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on regulated activity (or providing a service elsewhere which if provided in England would be a regulated activity)
- Have no grounds of unfitness specified in Schedule 4 Part 1 of the Regulations apply to the individual.

In accordance with Schedule 4 Part 1 a person is deemed "unfit" if:

- The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged
- The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland
- The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986
- The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it
- The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland
- The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

2.1 Good character

In accordance with Schedule 4 Part 2, a person will fail the good character test if they:

- Have been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom would constitute an offence
- Have been erased, removed, struck off a register of professionals maintained by

a regulator of health care of social work professionals.

Whilst there is no statutory guidance on what constitutes 'good character', the CQC names the following features that are 'normally associated' with good character that trusts should consider when assessing an individual under FPPR, in addition to matters specified in Schedule 4 Part 2:

- Honesty
- Trustworthiness
- Integrity
- Openness
- Ability to comply with the law
- A person in whom the public can have confidence prior employment history, including reasons for leaving
- If the individual has been subject to any investigations or proceedings by a professional or regulatory body
- Any breaches of the Nolan principles of public life
- Any breaches of the duties imposed on directors under the Companies Act
- The extent to which the director has been open and honest with the trust
- Any other information which may be relevant, such as disciplinary action taken by an employer.

2.2 Serious mismanagement or misconduct

In consideration of any instances of misconduct or mismanagement, consideration will be given to relevant guidance issued by the CQC, as set out below. Providers will have to reach their own decision as to whether any facts that are alleged reach the threshold of being "serious misconduct or mismanagement".

- "Misconduct" means conduct that breaches a legal or contractual obligation imposed on the director. It could mean acting in breach of an employment contract, breaching relevant regulatory requirements (such as mandatory health and safety rules), breaching the criminal law or engaging in activities that are morally reprehensible or likely to undermine public trust and confidence

- "Mismanagement" means being involved in the management of an organisation or part of an organisation in such a way that the quality of decision making and actions of the managers falls below any reasonable standard of competent management. For example, failing to interpret data appropriately, failing to learn from incidents or complaints, and failing.

3. Trust Procedure

3.1 Pre-Employment

The CQC expects senior leaders to set a tone and culture of the organisation that leads to staff adopting a caring and compassionate attitude. Therefore, it is important that in

making appointments boards take into account the values of the organisation and the extent to which candidates provide good fit with those values. Values-based interviews, or values-based questions in other interviews, will be used.

All new appointments to the applicable posts will have the following recruitment checks in accordance with NHS Employment Check Standards issued by NHS employers, including:

- Proof of identity and right to work in the UK
- Proof of qualifications
- Professional registration and qualification check
- Full employment history and at least two detailed reference checks, one of which must be the most recent employer. Specifically, this includes validating a minimum of sixthree years continuous employment. The Board Member Reference template as provided in the FPPT Framework will be used for both starters and leavers
- Occupational health assessment
- Disclosure and Barring Scheme (DBS) check (aswhere appropriate to the role)
- Search of registers, eg disqualified directors, bankruptcy and insolvency, removed charitable trustees, employment tribunal decisions registry
- A web-search of the individual including Google, news and social media searches, this can be carried out by a specialist external agency.

The standards that the Trust will follow at the recruitment stage, the assurance process to follow and evidence required is outlined in Appendix 2. The Electronic Staff Records (ESR) FPPT data fields will be updated accordingly and data privacy notice issued. The privacy notice sets out the right to object if Directors have concerns regarding the proposed use of their data.

Information on a Board member`s file is expected to be held up to their 75th birthday or six years after leaving - whichever is later, after which such information should be securely and safely destroyed.

The FPPT ESR data fields should only be accessible only to the organisation's Chair, Chief Executive, Director of People, OD and Inclusion, Director of Corporate Affairs and Trust Secretary and Senior Independent Director.

Deputies who are appointed to act up into Board roles for a continuous period of six weeks or more are in scope for FPPT and will complete the required checks and self-attestation within 10 working days of appointment.

3.2 Declaration

Appointees will be asked to complete a self-attestation (Appendix 1)declaration to include:

- Confirmation of their reasonable health after reasonable adjustments are made of properly performing tasks related to their role (subject to the relevant

provisions of the Equality Act 2010)
- Any criminal and/or regulatory investigations
- Any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying out regulated activity
- Any undischarged bankruptcy, disqualification, debt relief orders, etc
- Any inclusion on the Children's or Adults barred lists
- Any prohibition from holding relevant position or office under any law.

3.3 External Recruitment Consultancy

Where the Trust engages recruitment consultants to asset with appointments, it may ask the consultants to carry out some or all the process, but the Trust will gain all necessary documentation to evidence that the checks have been carried out.

3.4 Ongoing Assurance

On an annual basis all relevant office holders will be asked to complete the fit and proper persons ~~declaration~~ self-attestation (See Appendix 1).

The Trust will review the checks carried out on appointment, every three years or annually as appropriate (See Appendix 3 which also includes the FPPT checklist).

With regard to the requirement for the Trust to be satisfied as to the post-holders, competence, skills and knowledge necessary for the post in which they are employed the following will be relied upon:

- Documented 360 Appraisals incorporating the NHS Leadership Competency Framework (LCF)
- Provision of adequate training opportunities to include both individual and collective development.

FTSU case summaries relevant to Board members (upheld/ongoing) will be considered annually by the Chair/SID as part of FPPT assurance.

3.5 Process to be followed on an issue or concern being raised

3.5.1 As set out above, some criteria are pass/fail, ie the Trust cannot appoint or have in place an individual in a relevant position if they do not satisfy the specific test. Other, particularly the tests of good character and any association with serious misconduct or responsibility for failure in a previous role, require the Trust to make a reasonable assessment as to fitness.

3.5.2 If, either at the time of appointment or later, it becomes apparent that circumstances exist or have arisen whereby a person may not be considered to meet all the requirements of a fit and proper person, the Director of Corporate Affairs and Trust Secretary shall inform the Chair (or if the person is the Chair, the Senior Independent Director (SID). The Trust must take appropriate action to investigation and rectify the matter.

3.5.3 The Chair (SID) shall, acting reasonably and having regard to guidance issued by the CQC or Monitor, determine whether the person meets the said requirements.

The Chair leads on addressing these concerns on a case-by-case basis and will need to consider whether an investigation is necessary or appropriate given the allegation. The Chair may choose to consult with the SID and the Director of People, OD and Inclusion to determine the appropriate process to follow and action to take.

~~The Chair will consider the guidance as issued by NHS Providers, Fit and Proper Persons Regulations in the NHS, namely the Fit and Proper Persons Investigation Ten Step Guide, which covers:~~

- ~~Step 1 Receiving concerns in relation to a director~~
- ~~Step 2 Deciding whether an investigation is necessary~~
- ~~Step 3 Choosing who should carry out the investigation~~
- ~~Step 4 Deciding the remit of the investigation~~
- ~~Step 5 Deciding who to engage in the investigation~~
- ~~Step 6 Agreeing any interim action~~
- ~~Step 7 Gathering evidence~~
- ~~Step 8 Managing competing factors in the investigation~~
- ~~Step 9 Making a final decision~~
- ~~Step 10 Managing the effects of the outcome~~

3.5.4 Should the Chair consider the individual to be suitable, despite existence of information relevant to issues identified in Schedule 4, Part 2, the Chair's reasons should be recorded for future reference and made available.

3.5.5 If the Chair (SID) determines that the person does not or no longer meets the said requirements, that person may not be appointed, or appropriate disciplinary action be followed in line their tenure of office shall be terminated and that person shall cease to act as a Director.

3.5.6 The Chair should keep the Council of Governors informed throughout any investigation into a Non-Executive Director. However, the tension between confidentiality and transparency may lead to the Chair involving only the Lead Governor.

3.5.7 If action is taken against an Executive Director as an outcome of the hearing because of the failure to comply with Fit and Proper Persons Policy then the right to appeal will apply in accordance with existing Trust Policy and Procedures. In relation to Non-Executive Directors any appeal will be overseen by the Council of Governors. The criteria for removing Non-Executive Directors/Chair are set out in the Trust's Constitution.

3.6 Implementation

It is the ultimate responsibility of the Trust Chair to discharge the requirement placed on the Trust, to ensure that all Directors meet the fitness test and do not meet any of the 'unfit criteria'. The Director of Corporate Affairs and Trust Secretary is responsible for ensuring consistent application of the policy during the appointment process and for ensuring that all appropriate documentation is complete, retained and available. The Director of Corporate Affairs and Trust Secretary will support the Trust Chair in preparing the annual declaration for the Trust Board, to evidence compliance, assessments against FPPT regulations will form part of Board member's annual appraisal.

The Director of Corporate Affairs and Trust Secretary may delegate responsibility for maintaining the records of completed Fit and Proper Persons declarations, initially to the PA to the Chief Executive.

In the annual submission to the NHS England Regional Director (deadline 30 June), the Chair will provide the overall summary of the FPPT outcome for the Board, with the SID signing off the Chair's FPPT. The NHSE submission reporting template will be used.

The Council of Governors' Nominations and Remuneration Committee will receive a report to confirm the outcome of the Fit and Proper Person Checks regarding new Non-Executive Director appointments. The Trust Board's Remuneration and Appointments Committee will receive a report to confirm the outcome of the Fit and Proper Person Checks regarding Executive Director/Board appointments.

4. Associated Documents and References

Care Quality Commission, (2018). Regulation 5: Fit and proper persons: directors, Guidance for providers and CQC inspectors.
Fit and proper persons: directors - Care Quality Commission (cqc.org.uk)

Care Quality Commission, Regulation 5: Fit and proper persons: directors.
Fit and proper persons: directors - Care Quality Commission (cqc.org.uk)

NHS Employment Standards.
https://www.nhsemployers.org/topics-0/employment-standards-and-regulation
NHS Improvement (2017), Guidance on senior appointments in NHS trusts.
Guidance-on-senior-appointments-in-NHS-trusts.pdf (england.nhs.uk)

NHS Providers (2018), Fit and Proper Persons Regulations in the NHS: What do providers need to know?
Fit and proper persons regulations in the NHS: What do providers need to know? (nhsproviders.org)

https://www.england.nhs.uk/publication/nhs-england-fit-and-proper-person-test-framework-for-board-members/

NHS England » NHS leadership competency framework for board members

5. Dissemination and Implementation

This policy will be made available on the intranet.

Awareness of this policy will be raised in the Statement of Main Terms and Conditions of Employment and local induction for relevant posts, and a summary will be published on the People Services section on the intranet.

6. Consultation and Approval

The Joint Consultative Committee (JCC) reviewed the first version of the policy and the Executive Leadership Team (ELT) agreed the policy, which was ratified by the Trust Board. The 2020 and 2023 renewal of the policy required very minor amendments and was therefore did not require further consultation. The 2026 refresh incorporates national guidance that the Trust is expected to comply with.

7. Equality and Diversity

The Trust is committed to ensuring that, as far as it is reasonably practicable, the way we treat staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

8. Monitoring Compliance with this Policy

Standard/ Process	**Monitoring and Audit**		
	By	**Committee**	**Frequency**
Instances of non-compliance with policy	The Director of Corporate Affairs and Trust Secretary	Remuneration and Appointments Committee and the Governors Nominations and Remuneration Committee	Annually
Pre-employment checks	The Director of Corporate Affairs and Trust Secretary (Non-Executive Director appointments) and Director of People and Inclusion (Executive Director Appointments)	Remuneration and Appointments Committee and the Governors Nominations and Remuneration Committee	Upon completion of process
Annual Review	The Director of Corporate Affairs and Trust Secretary	Trust Board	Annually

Appendix 1 – New starter/ Pre-employment and annual self-attestation declaration for Executive Directors, Non-Executive Directors and Director Equivalent Posts

Fit and Proper Persons Declaration

1 It is a condition of employment that those holding Director and Director equivalent posts provide confirmation in writing, on appointment and thereafter on demand, of their fitness to hold such posts. Your post has been designated as being such a post. Fitness to hold such a post is determined in a number of ways, including (but not exclusively) by the Trust's provider licence, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008 ("the Regulated Activities Regulations") and the Trust's Constitution.

2 By signing the declaration below, you are confirming that you do not fall within the definition of an "unfit person" or any other criteria set out below, and that you are not aware of any pending proceedings or matters which may call such a declaration into question.

Provider Licence

3 Condition of Derbyshire Health NHS Foundation Trust's Provider Licence ("The Licence") provides that the Licensee shall not appoint as a Director any person who is an unfit person, except with the approval in writing of NHS EnglandImprovement.

4 The Licence condition requires the Licensee to ensure that its contracts of service with its Directors contain a provision permitting summary termination in the event of a Director being or becoming an unfit person. The Licence also requires the Licensee to enforce that provision promptly upon discovering any Director to be an unfit person, except with the approval in writing of NHS EnglandImprovement.

5 An "unfit person" is defined within the Licence as:

(a) An individual:

(i) who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged; or

(ii) who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it; or

(iii) who within the preceding five years has been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of not

less than three months (without the option of a fine) was imposed on him; or

(iv) who is subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986; or

(b) a body corporate, or a body corporate with a parent body corporate:

(i) where one or more of the Directors of the body corporate or of its parent body corporate is an unfit person under the provisions of sub-paragraph (a) of this paragraph, or

(ii) in relation to which a voluntary arrangement is proposed under section 1 of the Insolvency Act 1986, or

(iii) which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act appointed for the whole or any material part of its assets or undertaking; or

(iv) which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act; or

(v) which passes any resolution for winding up; or

(vi) Which becomes subject to an order of a Court for winding up.

Regulated Activities Regulations

6 Regulation 5 of the Regulated Activities Regulations states that the Trust must not appoint or have in place an individual as a Director or performing the functions of or equivalent or similar to the functions of such a Director, if they do not satisfy all the requirements set out in paragraph 3 of that Regulation.

7 The requirements of paragraph 3 of Regulation 5 of the Regulated Activities Regulations are that:

(a) The individual is of good character.

(b) The individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed.

(c) The individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for

which they are employed.

(d) The individual has not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.

(e) That none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.

8 The grounds of unfitness specified in Paragraph 1 of Schedule 4 to the Registered Activities Regulations are:

(a) The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.

(b) The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.

(c) The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986.

(d) The person has made a composition or arrangement with or granted a Trust deed for creditors and not been discharged in respect of it.

(e) The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.

(f) The person is prohibited from holding the relevant office or position, or in the case of an individual carrying on the regulated activity, by or under any enactment.

Trust's Constitution

9 The Trust's constitution places a number of restrictions on an individual's ability to become or continue as a Director. A person may not become or continue as a Director of the Trust if:

(a) They have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged.

(b) They have made a composition or arrangement with or granted a Trust deed for their creditors and have not been discharged in respect of it.

(c) They have within the preceding five years been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on them.

(d) In the case of a Non-Executive Director, they no longer satisfy the relevant requirements for appointment

(e) They are a person whose tenure of office as a Chair or as a Member or Director of a Health Service body has been terminated on the grounds that his/her appointment is not in the interests of public service, for non-attendance at meetings, or for non-disclosure of a pecuniary/non-pecuniary interest.

(f) They have within the preceding two years been dismissed, otherwise than by reason of redundancy, by the coming to an end of fixed term contract or through ill health, from any paid employment with a health service body;

information revealed by a Criminal Records Bureau check is such that it would be inappropriate for him to become or continue as a Director on the grounds that this would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute;

(g) They have had their name removed, by a direction under section 46 of the 1977 Act from any list prepared under Part II of that Act and has not subsequently had their name included in such a list.

(h) They have been placed on the registers of Schedule 1 offenders pursuant to the Sexual Offences Act 2003 (as amended) and/or the Children and Young Person's Acts 1933 to 1969 (as amended) and his or her conviction is not spent under the Rehabilitation of Offenders Act 1974;

(i) They fail to abide by the Constitution.

(j) They are under 16 years of age.

I declare that I am a fit and proper person to carry out my role. I:

- am of good character
- have the qualifications, competence, skills and experience which are necessary for me to carry out my duties
- (where applicable) have not been erased, removed or struck-off a register of professionals maintained by a regulator of healthcare or social work professionals
- am capable by reason of health of properly performing tasks which are intrinsic to the position
- am not prohibited from holding office (eg directors disqualification order)
- have not been convicted of a criminal offence
- am not an un-discharged bankrupt nor have I been subject to bankruptcy restrictions, or have made arrangement/compositions with creditors that have not been discharged
- do not appear on any 'barred' list
- have not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity
- hold any registration with a relevant professional body necessary to carry out my role, I have the entitlement to use any professional titles associated with this registration. If I no longer meet the requirement to hold the registration, I will inform the regulator in question.

Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the chair.

~~I acknowledge the extracts from the provider licence, Regulated Activities Regulations and the Trust's constitution above. I confirm that I do not fit within the definition of an "unfit person" as listed above and that there are no other grounds under which I would be ineligible to continue in post. I undertake to notify the Trust immediately if I no longer satisfy the criteria to be a "fit and proper person" or other grounds which I would be ineligible to continue in post come to my attention.~~

Name and job title/role:	
Professional registrations held (ref no):	
Date of DBS check/re-check (ref no):	
Date of last appraisal, by whom:	
Signature of board member:	
Date of signature of board member:	
For chair to complete	
Signature of chair to confirm receipt:	
Date of signature of chair:	

Appendix 2 - Table of requirements for complying with the regulations at the recruitment stage

Below are standards that the Trust will follow at the recruitment stage, the assurance process to follow and evidence required.

	Standard	Assurance Process	Evidence
1.	The Trust should make every effort to ensure that all available information is sought to confirm that the individual is of good character as defined in Schedule 4, Part 2 of the regulations. The fit and proper persons 'test' must be applied before an individual is appointed to a position.	Recruitment checks in accordance with NHS Employment Check Standards issued by NHS Employers, including: • Proof of identity and right to work in the UK • Proof of qualifications • Professional registration and qualification check • Full employment history and at least two detailed reference checks, one of which must be the most recent employer. Specifically this includes validating a minimum of six ~~three~~ years continuous employment • Occupational health assessment • Disclosure and Barring Scheme (DBS) check (~~where~~ appropriate to the role) • Search of registers e.g. disqualified directors, bankruptcy and insolvency, charitable trustee and Employment Tribunals decisions registry • Google, news and social media searches	• References Using the FPPT Framework Board-Member-Reference-template • Outcome of other pre-employment checks • DBS check certificate ~~where appropriate~~ • Register and internet search results • List of referees and sources of assurance for Freedom of Information Act (FOIA) purposes
2.	Where the Trust deems the individual suitable despite not meeting the characteristics outlined in Schedule 4,	• Report and debate at the nominations committee(s)	• Record that due process was followed for FOIA purposes

	Part 2 of these regulations, the reasons should be recorded and information about the decision should be made available to those that need to be aware.	• Report and recommendation at the council of governors (for NEDs) or the board of directors (for executive directors) for foundation trusts, reports to the board for NHS trusts • Decisions and reasons for decisions recorded in minutes • External advice sought as necessary	
3.	Where specific qualifications are deemed by the Trust as necessary for a role, the Trust must make this clear and should only employ those individuals that meet the required specification, including any requirements to be registered with a professional regulator.	• Requirements included within the job description for all relevant posts • Proof of qualifications checked as part of the pre-employment checks	• Person specification • Recruitment policy and procedure
4.	The Trust should have appropriate processes for assessing and checking that the individual holds the required qualifications and has the competence, skills and experience required, to undertake the role; these should be followed in all cases and relevant records kept. NB While this provision most obviously applies to executive director appointments in terms of qualifications, skills and experience will be relevant to NED appointments.	• Recruitment checks including a candidate's qualifications and employment references • Recruitment processes including qualitative assessment, ~~and~~ values-based questions and questions to test against the Leadership Competency Framework • Decisions and reasons for decisions recorded in minutes	• Recruitment policy and procedure • Values-based questions and LCF questions • Minutes of council of governors • Minutes of board of directors

5.	In addition to 4. above, the Trust may consider that an individual can be appointed to a role based on their qualifications, skills and experience with the expectation that they will develop specific competence to undertake the role within a specified timeframe.	• Discussions and recommendations by the nominations committee(s) • Discussion and decision at board of directors or council of governors meeting • Reports, discussion and recommendations recorded in minutes of meetings • Follow-up as part of continuing review and appraisal	• Minutes of committee, board and or council meetings • NHSE Board member ~~NED~~ appraisal framework • Leadership ~~NED~~ Competency ~~competence~~ framework • Notes of Board Member ~~executive director~~ appraisals
6.	When appointing relevant individuals the Trust has processes for considering a person's physical and mental health in line with the requirements of the role, all subject to equalities and employment legislation and to due process.	• Self-declaration of past health issues subject to clearance by occupational health as part of the pre-employment process • Offer of appointment should be subject to this health screening • If a health issue is raised, should consider if it falls within definition of disability and if it does, consider whether reasonable adjustments in compliance with the Equality Act 2010 can be made.	• Occupational health clearance
7.	Wherever possible, reasonable adjustments are made in order that an individual can carry out the role.	• Self-declaration of adjustments required • Check steps taken are in line with requirements to make reasonable adjustments for employees under the Equality Act 2010 • NHS Employment Check Standards • Board/council of governors decision.	• Minutes of board meeting/council of governors meeting
8.			• NED Recruitment Information pack

	The Trust has processes in place to assure itself that the individual has not been at any time responsible for, privy to, contributed to, or facilitated, any serious misconduct or mismanagement in the carrying on of a regulated activity; this includes investigating any allegation of such potential behaviour and making independent enquiries. Where the individual is professionally qualified, it may include fitness to practise proceedings and professional disciplinary cases.	• Same checks set out in 1, ie. past employment history in accordance with NHS Employers pre-employment check standards including a self-declaration of fitness in which candidates provide an explanation of past conduct/character issues where appropriate • Clear consequences of false, inaccurate or incomplete information included in recruitment packs	• Reference request for executive directors and NEDs using the FPPT Framework Board-Member-Reference-template
9.	The Trust must not appoint any individual who has been responsible for, privy to, contributed to, or facilitated, any serious misconduct or mismanagement (whether lawful or not) in the carrying on of a regulated activity; this includes investigating any allegation of such potential behaviour. Where the individual is professionally qualified, it may include fitness to practise proceedings and professional disciplinary cases. N.B. CQC accepts that trusts will use reasonable endeavours in this instance. The existence of a compromise agreement does not indemnify the new employer and trusts will need to ensure	• Clear consequences of false, inaccurate or incomplete information included in recruitment packs • Core HR policies for appointments and remuneration • Checks set out in 1 above • Included in reference requests • Check publicly available information including serious case reviews	• Executive and non-executive Recruitment Information packs • Core HR policies • Reference request for executive directors and NEDs using the FPPT Framework Board-Member-Reference-template

	that their Core HR policies address their approach to compromise agreements.		
10.	A person who will be acting in a role that falls within the definition of a "regulated activity" as defined by the Safeguarding Vulnerable Groups Act 2006 must be subject to an enhanced DBS check. N.B. CQC recognises that it may not always be possible for trusts to access a DBS check as an individual may not be eligible.	• Where an executive director or NED meets the eligibility criteria, trusts should apply for an enhanced DBS check • If the director's role falls within the definition of a "regulated activity", the DBS check will establish whether the person is on the children's and/or adults' safeguarding barred list and whether they are prohibited from holding the office in question under other laws such as the Companies Act or Charities Act.	• DBS policy • Enhanced DBS checks for eligible post-holders
11.	As part of the recruitment/appointment process, trusts should establish whether the Individual is eligible for the relevant DBS check.	• Eligibility for DBS checks will be assessed for each vacancy arising • OR • All Board members will undergo DBS check on appointments and re-checks every three years. Enhanced DBS will apply for roles meeting the definition of regulated activity (eg Executive Medical and Nursing Directors) others will be a standard check.	• DBS policy

Appendix 3 – Complying with the regulations on an ongoing basis

Below are standards that the Trust will follow throughout the course of an individual's employment, the assurance process to be followed and the evidence to be produced.

	Standard	Assurance Process	Evidence
1.	The Trust should regularly review the fitness of directors to ensure that they remain fit for the role they are in; the trust should determine how often fitness should be reviewed based on the assessed risk to business delivery and/or the service users posed by the individual and/or role.	• Assessment of continued fitness to be undertaken each year as part of the appraisal process • Checks of insolvency and bankruptcy register and register of disqualified directors to be undertaken each year as part of the appraisal process • Board/Council of Governors to review, checks and agree the outcome • Regular DBS checks (three-yearly) • Regular checks of relevant professional regulator's register (annual) • Ensure there is an ongoing obligation in employment contracts to declare any criminal and/or regulatory investigations as soon as reasonably practicable	• Continued assessment as part of appraisal process • Register checks if necessary • Board/council minutes record that process has been followed
2.	If the Trust discovers information that suggests an individual is not of good character after they have been appointed to a role, the trust must take appropriate and timely action to investigate and rectify the matter.	• Core HR policies provide for such investigations • Revised contracts allow for termination in the event of non-compliance with regulations and other requirements	• Core HR polices • Contracts of employment (for executive directors and director-level equivalents) • Service agreements or equivalent (for NEDs)

	The Trust has arrangements in place to respond to concerns about a person's fitness in relation to Regulation 5(3) and (4) after they are appointed to a role whether identified by the trust itself or others – and these are adhered to.	• Contracts (for executive directors, and director-level equivalents) and agreements (for NEDs) incorporate maintenance of fitness as a contractual requirement	
3.	The Trust investigates, in a timely manner, any concerns about a person's fitness or ability to carry out their duties, and where concerns are substantiated, proportionate, timely action is taken; the trust must demonstrate due diligence in all actions.	• Core HR policies include the necessary provisions • Action taken and recorded as required	• Core HR policies
4.	Where a person's fitness to carry out their role is being investigated, appropriate interim measures may be required to minimise any risk to service users.	• Core HR policies	• Managerial action taken to backfill posts as necessary
5.	The Trust informs others as appropriate about concerns/findings relating to a person's fitness; for example, professional regulators, CQC and other relevant bodies, and supports any related enquiries/ investigations carried out by others.	• Core HR policies	• Referrals made to other agencies if necessary

Fit and Proper Person Checklist

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
First Name	□	□	□	x – unless change	□	□	Application and recruitment process.	Recruitment team to populate ESR. For NHS-to-NHS moves via ESR / InterAuthority Transfer/ NHS Jobs. For non-NHS – from application – whether recruited by NHS England, in-house or through a recruitment agency.
Second Name/Surname	□	□	□	x – unless change	□	□		
Organisation (ie current employer)	□	x	□	N/A	□	□		
Staff Group	□	x	□	x – unless change	□	□		
Job Title Current Job Description	□	□	□	x – unless change	□	□		
Occupation Code	□	x	□	x – unless change	□	□		
Position Title	□	x	□	x – unless change	□	□		

Employment History Including: • job titles • organisation/ departments • dates and role descriptions • gaps in employment	□	x	□	x	□	□	Application and recruitment process, CV, etc.	Any gaps that are because of any protected characteristics, as defined in the Equality Act 2010, do not need to be explained. The period for which information should be recorded is for local determination, taking into account relevance to the person and the role. It is suggested that a career history of no less than six years and covering at least two roles would be the minimum. Where there have been gaps in employment, this period should be extended accordingly.

Training and Development	□	□	□	□	□	*	Relevant training and development from the application and recruitment process; that is, evidence of training (and development) to meet the requirements of the role as set out in the person specification. Annually updated records of training and development completed/ongoing progress.	* NED recruitment often refers to a particular skillset/experience preferred, eg clinical, financial, etc, but a general appointment letter for NEDs may not then reference the skills/experience requested. Some NEDs may be retired and do not have a current professional registration. At recruitment, organisations should assure themselves that the information provided by the applicant is correct and reasonable for the requirements of the role. For all board members: the period for which qualifications and training should look back and be recorded is for local determination, taking into account relevance to the person and the role. It is suggested that key qualifications required for the role and noted in the person specification (eg professional qualifications) and dates are recorded however far back that may be. Otherwise, it is suggested that a history of no less than six years should be the minimum. Where there have been gaps in employment, this period should be extended accordingly.
References Available references from previous employers	□	□	□	x	□	□	Recruitment process	Including references where the individual resigned or retired from a previous role
Last Appraisal and Date	□	□	□	□	□	*	Recruitment process and annual update following appraisal	* For NEDs, information about appraisals is only required from their appointment date forward. No information about appraisals in previous roles is required.

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Disciplinary Findings That is, any upheld finding pursuant to any NHS organisation policies or procedures concerning employee behaviour, such as misconduct or mismanagement	□	□	□	□	□	□	Reference request (question on the new Board Member Reference). ESR record (high level)/ local case management system as appropriate.	The new BMR includes a request for information relating to investigations into disciplinary matters/ complaints/ grievances and speak-ups against the board member. This includes information in relation to open/ ongoing investigations, upheld findings and discontinued investigations that are relevant to FPPT. This question is applicable to board members recruited both from inside and outside the NHS.
Grievance against the board member	□	□	□	□	□	□		
Whistleblowing claim(s) against the board member	□	□	□	□	□	□		
Behaviour not in accordance with organisational values and behaviours or related local policies	□	□	□	□	□	□		

Type of DBS Disclosed							ESR and DBS response.	Frequency and level of DBS in accordance with local policy for board members. Check annually whether the DBS needs to be reapplied for. Maintain a confidential local file note on any matters applicable to FPPT where a finding from the DBS needed further discussion with the board member and the resulting conclusion and any actions taken/required.
Date DBS Received							ESR	
Date of Medical Clearance* (including confirmation of OHA)		x		x – unless change			Local arrangements	
Date of Professional Register Check (eg membership of professional bodies)		x				x	Eg NMC, GMC, accountancy bodies.	
Settlement Agreements							Board member reference at recruitment and any other information that comes to light on an ongoing basis.	Chair guidance describes this in more detail. It is acknowledged that details may not be known/disclosed where there are confidentiality clauses.

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Insolvency Check							Bankruptcy and Insolvency register	Keep a screenshot of check as local evidence of check completed.

Disqualified Directors Register Check	☐	☐	☐	☐	☐	☐	Companies House	
Disqualification from being a Charity Trustee Check	☐	☐	☐	☐	☐	☐	Charities Commission	
Employment Tribunal Judgement Check	☐	☐	☐	☐	☐	☐	Employment Tribunal Decisions	
Social Media Check	☐	☐	☐	☐	☐	☐	Various – Google, Facebook, Instagram, etc.	
Self-Attestation Form Signed	☐	☐	☐	☐	☐	☐	Template self-attestation form	Appendix 3 in Framework
Sign-off by Chair/CEO	☐	x	☐	☐	☐	☐	ESR	Includes free text to conclude in ESR fit and proper or not. Any mitigations should be evidence locally.
Other Templates to be Completed								
Board Member Reference	☐	☐	x	x	☐	☐	Template BMR	To be completed when any board member leaves for whatever reason and retained career-long or 75th birthday whichever latest. Appendix 2 in Framework.
Letter of Confirmation	x	☐	☐	☐	☐	☐	Template	For joint appointments only - Appendix 4 in Framework.

Annual Submission Form	x	□	□	□	□	□	Template	Annual summary to Regional Director - Appendix 5 in Framework.
FPPT Area	**Record in ESR**	**Local evidence folder**	**Recruitment Test**	**Annual Test**	**ED**	**NED**	**Source**	**Notes**
Privacy Notice	x	□	x	x	□	□	Template	Board members should be made aware of the proposed use of their data for FPPT – Example in Appendix 6.

EQUALITY IMPACT ASSESSMENT TEMPLATE: FRONT SHEET

Question	Response
1. Name of 'policy' being assessed	Fit and Proper Persons Policy and Procedure
2. Summary of aims and objectives of the 'policy'	The purpose of the Fit and Proper Persons Policy is to hold Trust Board members to account in relation to their conduct and performance and also to instill confidence in the public that the individuals leading the Trust are suitable to hold their position, in line with the requirements of the Fit and Proper Persons Regulations introduced in November 2014
3. Is this a new or existing 'policy'?	Existing
4. Please state which organisation is the EIA being completed for? 5. • Derbyshire Healthcare NHS FT • Joint Derbyshire Healthcare NHS FT and Derbyshire Community Health Services • Other (please give details)	Derbyshire Healthcare NHS FT
6. Division/Team/Service	Trust Secretariat
7. Date Stage 1 completed: Screening for Relevance:	11.01.2026~~20.01.2023~~
8. Is a Stage 2: EIA required to be completed after Stage 1? 9. Please provide justification	No
Date Stage 2 EIA completed:	
Name/s, job title/s and contact/s details of person/s completing this assessment	Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary
Name, job title and contact details of responsible lead Director /Associate Director/Head of Service	Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary
Has this EIA been logged in your Division/Service/Team EIA Tracker?	Yes

EQUALITY IMPACT ASSESSMENT TEMPLATE: STAGE 1 SCREENING FOR RELEVANCE

(Please use plain English http://www.plainenglish.co.uk/, avoiding jargon and acronyms. EIAs are viewed by a wide range of people including decision-makers and the wider public)

Question	Response

1a: Summary of aims and objectives of the 'policy'	The purpose of the Fit and Proper Persons Policy is to hold Trust Board members to account in relation to their conduct and performance and also to instill confidence in the public that the individuals leading the Trust are suitable to hold their position, in line with the requirements of the Fit and Proper Persons Regulations introduced in November 2014
1b: Please state who this 'policy' will affect? • Patients or Service Users • Carers or families • Commissioned Services • Communities, in placed based settings • Staff • Partners • Stakeholder organisations • Others (give details)	This policy applies to all Board appointments, ie Executive and Non-Executive Directors and those senior managers which are formally recognised as part of the Trust's Executive Leadership Team (ELT). This includes permanent, interim and associate positions. It also includes those individuals who are acting up in Board level positions.
1c: Will the 'policy' impact equality and or inequalities? • Access to or participation in a service • Levels of representation in our workforce • Reducing quality of life (ie health, poverty education, standard of living)	No
1d: If there are 'no' impact on equality and or inequalities, please provide an explanation?	All applicants and postholders will be covered by the Trust policies that cover EDI
1e: If there are impacts on equality and or inequalities complete stage 2 EIA If you plan to complete the assessment at a later stage, please state the timescale for this.	

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 reports)	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 (annual, from May-2026)						
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	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					
MD	Digital Delivery Plan (FPC - Mar)						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	
DPODI	People Plan (PCC - Nov)						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	
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 - Apr/May, 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
FPC	Finance and Performance Committee
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 Jul/Jan)		X				
DoN	Outcome of Board stories (annual, Jun)		X				
DCEO/CDO	Transformation and Continuous Improvement (bi-annual)	X			X		
DCEO/CDO/MD/DoN	Winter Plan		X	X			
Receipt of Reports (for noting following assurance at People and Culture Committee (PCC)):							
MD	10 Point Plan to Improve the Lives of Resident Doctors (PCC - Nov)				X		
MD	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				
MD	Research and Development (QSC Jun (AR) and Dec)		AR			X	
DoN	Safeguarding Children and Adults at Risk - annual report (QSC AR Sep)				X		
DoN	SEND - Special Educational Needs and Disabilities annual report (QSC May/Jun)	X					
STRATEGIC PLANNING AND CORPORATE GOVERNANCE							
DoF/DCEO/CDO/DPODI	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
MD	Patient and Carers Race Equality Framework (six-monthly)		X			X	
DoCA/TS	Trust Sealings (six-monthly - for information)	X			X		
DCEO/CDO	Trust Strategic Plan (quarterly update, to include 4 Ps Delivery Plans)	X	X	X		X	
Executive Lead	Trust Strategy 4Ps (People; Productive; Patient; Partnerships) - Deep Dives	People	Productive	Patient	Partnership		
DPODI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) *request for Board delegated authority for People and Culture Committee meeting Sep to approve the October submissions*			X			
DPODI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Strategic implications (retrospective sign-off on assurance at People and Culture Committee Sep)			X			
Receipt of Reports (for noting following assurance at Audit and Risk Committee (ARC)):							
DoCA/TS	Year-end Governance reporting from Board Committees and approval of Terms of Reference (ToRs) (ARC Apr)	X					
Receipt of Reports (for noting following assurance at People and Culture Committee (PCC)):							
DPODI	2025/26 Flu Campaign annual report (PCC Jul)			X			
DPODI	Annual Approval of Modern Slavery Statement (PCC Apr/May, to be published on Trust website on approval)	X					
DPODI	Annual Gender Pay Gap report for approval (data for previous year reporting deadline Mar - PCC Jul)			X			
DPODI	People Plan (PCC - Sep)				X		
DPODI	Staff Survey results (PCC Mar)						X
POLICY REVIEW							
DoF	Standing Financial Instructions Policy and Procedures (31-Oct-2026)			X			

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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
A	
A&E	Accident and Emergency
ABPI	Association of British Pharmaceutical Industry
ACCT	Assessment, Care in Custody & Teamwork
ACE	Adverse Childhood Experiences
AC/RC	Approved Clinician/Responsible Clinician
ADHD	Attention Deficit Hyperactivity Disorder
ADI-R	Autism Diagnostic Interview-Revised
ADOS	Autism Diagnostic Observation Schedule (assessment)
AED	Adult Eating Disorder
AED	Automated External Defibrillator
AfC	Agenda for Change
AFT	Advanced Foundation Trust
AHP	Allied Health Professional
AI	Artificial Intelligence
AIMS	Royal College of Psychiatrists Accreditation for Inpatient Mental Health Services programme
ALB	Arms-length body such as NHS Improvement (NHSI) and NHS England (NHSE)
AMM	Annual Members' Meeting
AMHP	Approved Mental Health Professional
ANP	Advanced Nurse Practitioner
AO	Accountable Officer
AO	Assertive Outreach
AOVPN	AlwaysOn VPD (secure network access)
APC	Annual Physical Health
APNA NHS	Asican Professionals' National Alliance
APOM	Activity Participation Outcome Measure
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
COD	Cause of Death
COF	Commissioning Outcomes Framework
CoG	Council of Governors
COO	Chief Operating Officer
CP	Child Protection
CPA	Care Programme Approach
CPD	Continuing Professional Development
CPN	Community Psychiatric Nurse
CPR	Child Protection Register
CPRG	Clinical Professional Reference Group
CQC	Care Quality Commission
CQI	Clinical Quality Indicator
CQRG	Clinical Quality Review Group
CQUIN	Commissioning for Quality and Innovation
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

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

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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
FTE	Full-time Equivalent
FTN	Foundation Trust Network
FTSU	Freedom to Speak Up
FTSUG	Freedom to Speak Up Guardian
F&P	Finance and Performance
FYE	Full Year Effect or Financial Year End
5YFV	Five Year Forward View
G	
GAM	Group Accounting Manual
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

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

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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
MPAC	Multi-Professional Approved Clinician
MSC	Medical Staff Committee
MSK	Musculoskeletal (conditions)
MSP	Medicines Safety and Practice
MST	Multisystemic Therapy
MSU	Medium Secure Unit
MTFP	Medium Term Financial Plan
N	
NAI	Non-Accidental Injury
NCISH	National Confidential Inquiry into Suicide and Safety
NCRS	National Cancer Registration Service
ND	Neuro-development
ND	Neurodiversity
NECS	North of England Care System Support
NED	Non-Executive Director
NETS	National Educational Training Survey
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)

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
PARIS	This is an electronic patient record system
PbR	Payment by Results
PCC	Police & Crime Commissioner
PCC	People and Culture Committee
PCLB	Provider Collaborative Leadership Board
PCN	Primary Care Networks
PCOG	Patient and Carer Operational Group
PCREF	Patient and Carers Race Equality Framework
PDC	Public Dividend Capital
PDF	Portable Document Format
PDSA	Plan, Do, Study, Act
PET	Psychiatric Emergency Team
PFI	Private Finance Initiative
PFF	Probation Feedback Form
PFR	Provider Finance Return
PHC	Public Health Commissioners
PHCIC	Physical Healthcare and Infection Control Committee
PHE	Public Health England
PHE	Physical Health Equipment
PHSCC	Population Health and Strategic Commissioning Committee
PHSMI	Physical Health Serious Mental Illness
PHSO	Parliamentary and Health Service Ombudsman
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PiPoT	Persons in a Position of Trust
PJF	Professional Judgement Framework
PLACE	Patient-Led Assessments of the Care Environment
PLIC	Patient Level Information Costs
PMF	Performance Management Framework
PMH	Perinatal Mental Health
PMLD	Profound and Multiple Disability
PMO	Project Management Office
PNA	Professional Nurse Advocate
PODG	Programme Oversight and Delivery Group
PPE	Personal Protection Equipment
PPI	Patient and Public Involvement
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
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
R	
RAID	Rapid Assessment, Interface and Discharge
RAP	Recovery Action Plan
RAVS	Record a Vaccination Service
RCGP	Royal College of General Practitioners
RCI	Reference Cost Index
RDF	Resident Doctor Forum
RDOG	Research and Development Operational Group
REGARDS	Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation
ReQoL	Recovering Quality of Life
RFI	Request for Information
ROAG	Responsible Officer Advisory Group
RoDP	Recognition of Deteriorating Patient
ROM	Reported Outcome Measure
RPOG	Restrictive Practice Oversight Group
RRN	Restraint Reduction Network
RRP	Recruitment Retention Proposal
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
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
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
ToRs	Terms of Reference
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
U	
UHDB	University Hospitals of Derby and Burton
UEC	Urgent and Emergency Care
V	
VARM	Vulnerable Adult Risk Management

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
VCOD	Vaccination as a Condition of Deployment
VCP	Vacancy Control Panel
VCSE	Voluntary, Community and Social Enterprise organisations
VdTMoCA	Vona du Toit Model of Creative Ability *(a practical guide for Acute Mental Health Occupational Therapy Practice)*
VFM	Value For Money
VO	Vertical Observatory
VTE	Venous Thromboembolism
VUCA	Volatility, Uncertainty, Complexity, Ambiguity
W	
WAP	Wireless Application Protocol
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent
Y	
YTD	Year to Date

16 March 2026