

Public Trust Board Meeting

21 July 2026

Conference Rooms A and B

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

Meeting Book - Public Trust Board Meeting - 21-Jul-2026

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Public Board Meeting

Agenda

Date: Tuesday, 21 July 2026

Time: 9.30am

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

Item	Time	Topic	Lead
1	9.30	Chair's welcome, opening remarks, apologies and declarations of interest 1.1 Trust Vision and Values 1.2 Register of Interests 2026/27	Selina Ullah
2	9.35	Board Story – 'Young People Transitioning to Adult Care'	Tumi Banda/Becki Priest
3	10.00	Minutes of the Board of Directors meeting held on 19 May 2026	Selina Ullah
4		Action Matrix and Matters Arising	
5		Questions from members of the public	
6	10.05	Deputy 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 11.05am			
STRATEGY DEEP DIVE			
9	11.15	Productive	James Sabin
QUALITY GOVERNANCE			
10	11.30	Fundamental Standards of Care report (CQC Domains) (six-monthly)	Tumi Banda
11	11.40	Outcome of Board stories (annual)	Tumi Banda
12	11.50	Winter Plan	Vikki Ashton Taylor/ Dr Girish Kunigiri/Tumi Banda
STRATEGIC PLANNING AND CORPORATE GOVERNANCE			
13	12.00	Fit and Proper Persons Declaration	Selina Ullah
14	12.05	Patient and Carers Race Equality Framework (PCREF) (six-monthly)	Dr Girish Kunigiri
15	12.15	Trust Strategic Plan (quarterly update)	Vikki Ashton Taylor

REPORTS FOR NOTING AND/OR APPROVAL FOLLOWING ASSURANCE AT BOARD COMMITTEES

16	12.25	<u>People and Culture Committee</u>	Deborah Good, on behalf of Ralph Knibbs
		16.1 Medical Job Planning (annual)	
		<u>Quality and Safeguarding Committee</u>	Lynn Andrews
		16.2 Learning from Deaths/Mortality annual report	
		16.3 Quality Account	

CLOSING BUSINESS

17	12.30	Consideration of any items affecting the Board Assurance Framework (BAF)	Selina Ullah
18		Meeting effectiveness	

FOR INFORMATION

Forward Plan 2026/27
Glossary of NHS Acronyms
Summary of Council of Governors meeting held 19 May 2026

Next meeting:

Date:	Time:	Location:
Tuesday, 22 September 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.



derbyshirehealthcareft.nhs.uk/about-us/strategy

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



DECLARATION OF INTERESTS REGISTER 2026/27

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

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

v1.1 DRAFT MINUTES

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS

Held in Conference Rooms A and B

Research and Development Centre, Kingsway, Derby DE22 3LZ

Tuesday, 19 May 2026

MEETING HELD IN PUBLIC

Commenced: 9.30am

Closed: 12.35pm

PRESENT

Ralph Knibbs	Senior Independent Director
Chioma Akpom	Non-Executive Director
Deborah Good	Non-Executive Director (chairing meeting)
Jo Hanley	Non-Executive Director
Andrew Harkness	Non-Executive Director
Mark Powell	Chief Executive
Tumi Banda	Director of Nursing, Allied Health Professions (AHP), Quality and Patient Experience
Justine Fitzjohn	Director of Corporate Affairs and Trust Secretary
Dr Girish Kunigiri	Medical Director
Rebecca Oakley	Director of People, Organisational Development and Inclusion
James Sabin	Director of Finance

IN ATTENDANCE

Anna Shaw	Associate Director of Communications and Engagement
Maria Riley	Assistant Director of Transformation
Jo Bradbury	Corporate Governance Officer
Jenny Shields	Registered Mental Health Nurse, DHcFT (Board story)
Tamsin Hooton	Programme Director, Provider Collaborative, Joined Up Care Derbyshire

DHCFT2026/036

DHCFT2026/042

APOLOGIES

Selina Ullah	Trust Chair
Lynn Andrews	Deputy Chair
Vikki Ashton Taylor	Deputy Chief Executive and Chief Delivery Officer

OBSERVERS

Karen Billyeald	Clinical Nurse Specialist Safeguarding Adults, DHcFT, Carer and Families Project Lead (Board Story)
Jo Foster	Senior Nurse, DHcFT and Staff Governor, Nursing (Board Story)
Stephen Handsley	Public Governor, Derby City West
Pete Henson	Head of Performance, DHcFT*
Cath Hill	Director, Advancing Quality Alliance (AQUA)
Jean Johnson	Public Governor, Bolsover and North East Derbyshire*
Angela Kerry	Public Governor, Amber Valley*
Nicola Spriggs	Performance Manager, DHcFT*
Gill Stevens	Deputy Director of People, OD and Inclusion, DHcFT
Christopher Williams	Public Governor, Erewash

* Denotes online attendance

DHCFT/ 2026/034	CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND <u>DECLARATION OF INTERESTS</u>
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	In the absence of Selina Ullah, Trust Chair, Deborah Good, Non-Executive Director, took the meeting as Chair and welcomed Board colleagues and observers to the meeting.
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	The apologies for absence were noted. Deborah communicated the housekeeping and fire safety information. Attention was drawn to the Trust Vision and Values and the Register of Directors' Interest for 2026/27, with no declarations of interest raised with any of today's agenda items.
DHCFT/ 2026/035	<u>REGISTER OF DIRECTORS' INTERESTS ANNUAL REPORT – 2025/26</u> The report set out the year-end Register of Directors' interests that will be published in the Annual Report for 2025/26. To ensure openness and transparency during Trust business, the Register is updated with each new interest declared/removed and the revised version is then reported to each Public Board meeting. Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary, reminded Board members to inform the Corporate Governance Officer of any new interests or changes to current interests as they arise.
DHCFT/ 2026/036	<u>BOARD STORY - HOW OUR PEOPLE AND THEIR VALUES SUPPORT EVERYTHING WE DO'</u> Deborah acknowledged the significant number of carers within the Trust's workforce and extended a welcome to Jenny Shields, Registered Mental Health Nurse, based on Willow Ward at the Derwent Unit in Chesterfield. Jenny shared a deeply personal narrative, recounting her brother's disappearance for three years, his homelessness and subsequent diagnosis of schizophrenia. Stressing the family's struggle for information and inclusion during his care, she highlighted key challenges, such as lack of support, consent issues, limited staff engagement and a sense of isolation stemming from the stigma around mental illness. It was noted that during one visit to see her brother at the Radbourne Unit, the Ward Manager had shown the family much appreciated kindness, understanding and compassion. Subsequently, the family had attended a monthly Carers Group, which had provided much needed support. The turning point came when the Group was cancelled due to lack of resources, prompting Jenny to retrain as a Mental Health Nurse (RMN). This calling was motivated by gaps in support and the positive impact of family involvement on patient outcomes, along with a desire to make a positive difference in the provision of support for families and carers. It was noted that Jenny qualified as an RMN in February 2025 and her dissertation was titled, <i>'the journey of family and carer involvement for adults with serious mental illness'</i>. Jenny advocated for the adoption of the six 'Triangle of Care' principles, emphasising early identification and involvement of carers, staff training, effective information sharing, designated carer leads, formal introductions and accessible support services. She went on to establish the Carers Group at the Derwent Unit in May 2025 and became Carers Champion for Willow Ward. Citing persistent barriers, including inconsistent staff engagement and poor communication regarding carer resources, Jenny's recommendations for improvement included appointing a full-time Family Liaison Nurse and embedding carer support structures, with better promotion of existing resources. In her capacity as Board Champion for Carers, Deborah described Jenny's account as heartfelt and difficult to hear, reaffirming her commitment to addressing these issues. Thanking Jenny for her openness, Jo Hanley, Non-Executive Director, queried whether staff disengagement stemmed from training gaps or cultural factors. Both influences were acknowledged by Jenny, noting that uncertainty and lack of information can heighten a family's defensiveness, which can lead to staff avoidance.

	Tumi Banda, Director of Nursing, AHPs, Quality and Patient Experience, commended Jenny's passion and expertise and asked to read her dissertation. He expressed disappointment that simple acts of kindness are not consistently observed. He stated that Becki Priest, Deputy Director of Patient Experience, is working on a structured carer support framework, in line with the Quality Plan. Drawing parallels with his own family experience in India, Dr Girish Kunigiri, Medical Director, underscored the universal nature of these challenges, advocating for collective responsibility, not just designated liaison roles. The need for clear, compassionate explanations of confidentiality was reiterated. The value of specific roles in Inpatient and Community settings and the importance of lived experience in driving change were also emphasised. Jenny graciously accepted the invitation to share her story at leadership events. Ralph Knibbs, Senior Independent Director, reflected on the power of personal stories to remind staff of their purpose. He supported the establishment of a Carers Network to amplify carer voices. Jenny emphasised her ongoing commitment to advocacy, noting that some professionals lack direct experience and thus understanding. Mark Powell, Chief Executive, expressed disappointment at the lapses in compassionate behaviour, reaffirming the Trust's commitment to kindness and support. He pledged his support with communications and future actions. RESOLVED: The Board of Directors committed to explore the issues raised, acknowledging the pockets of excellent care and the need for consistent, Trust-wide improvement.
DHCFT/2026/037	<u>MINUTES OF THE LAST BOARD OF DIRECTORS MEETING</u> The draft minutes of the last meeting held on 24 March 2026 were accepted as a correct record of the meeting
DHCFT/2026/038	<u>ACTION MATRIX AND MATTERS ARISING</u> Attention was drawn to the following: DHCFT/2026/017: Deborah reported ongoing engagement, with progress currently at the exploratory phase. The absence of a definitive timeline was pointed out by Mark and he asked that Becki address this. Action. DHCFT/2026/023: it was noted that there are ongoing discussions around escalations to Board, this would be actioned in conjunction with the well led review findings. The Board was in agreement that the completed actions can now be closed.
DHCFT/2026/039	<u>QUESTIONS FROM MEMBERS OF THE PUBLIC</u> No questions had been received.
DHCFT/2026/040	<u>CHAIR'S UPDATE</u> This report provided the Board with the Trust Chair's reflections on activity with, and for, the Trust since the previous Board meeting on 24 March 2026. On behalf of Selina, Deborah highlighted some key points from the report. Attention was drawn to the visit from Philip Ross, Chair and Charlotte Burrows, CEO, Design in Mental Health Network. Deborah noted that Philip had written about the exceptional new facilities, and the positive impact of the thoughtful design on patient, carers and staff colleagues alike on their experience, recovery and wellbeing.

	Selina's experience shadowing the Executive team was described as highly positive, offering valuable insight into the daily operations and responsibilities of Trust leadership. It was noted that <i>'a day in the life of an Executive Director'</i> had begun by shadowing James Sabin, Director of Finance, with visits to the Contracting team, Finance team and the Estates and Facilities service. As the Trust's Green Plan/Sustainability Lead, Deborah welcomed the electric vehicles and how the team was contributing to the sustainability agenda. Selina's recent appointment to the Board of the NHS Alliance was noted, recognising the opportunity this presents for influencing broader policy and practice. RESOLVED: The Board of Directors noted the content of this report.
DHCFT/ 2026/041	<u>CHIEF EXECUTIVE'S UPDATE</u> This report provided an update on current local issues and national policy developments and also reflected a wider view of the Trust's operating environment. Mark highlighted some key points, including the guidance and policy documents relating to the Neighbourhood Health framework, mentioning the ongoing activity in both physical and mental healthcare at local level. However, he acknowledged confusion regarding the framework's integration within existing structures. It was reported that through its Community and Living Well partnership, discussions are underway with the Integrated Care Board (ICB), looking to position the Trust as Lead Provider, with commissioning responsibilities. Mark reflected on the benefits of collaboration with local authorities and the voluntary sector, despite the challenges of co-ordinating multiple small, commissioned services. He confirmed that the aim remains to advance neighbourhood health, particularly the 24/7 urgent care model. Summarising the current position with the NHS Oversight Framework and the anticipated changes for 2026/27, Mark cautioned that Quarter 1 information, especially regarding Mental Health, would likely be delayed until August. He pointed out that at least eight new measures are expected, with some offering clear value and others remaining open to interpretation. Selina was commended for being a finalist at the British Muslim Awards, reflecting positively on the Trust. Additionally, congratulations were extended to Professor Subodh Dave, Foundation Training Programme Director, who has become President of the Royal College of Psychiatry. Girish was asked to invite Subodh to a future session with the Board. Action. The Board recognised concerns around staff morale, particularly linked to instances of abuse from patients/service users. Efforts are underway via the Violence and Aggression collaborative, with two sessions held and a third planned, aiming for tangible actions to mitigate these challenges. New staff engagement avenues to supplement existing channels were outlined. The Leadership Cascade initiative was highlighted as a means to disseminate key messages throughout teams. In addition, Mark highlighted plans to trial an unscripted live Q&A session, supported by the communications team, with the intention of fostering learning and sharing best practice. Central resources for the implementation of the new Mental Health Act (MHA) requirements were queried by Tumi. Girish explained the phased approach to the new legislation and the importance of the Code of Practice, which was not yet published. It was noted that wider discussions with the Treasury are ongoing, with final implications expected 2029/30. Mark added that while funding opportunities have not yet been discussed, the announcement of a new Mental Health Strategy is anticipated shortly, with further developments projected by year-end. Deborah commented on the anticipated benefits of digitising the MHA requirements, which would streamline operations.

	Justine referred to the Executive visits, which were of real benefit in understanding the breadth of services and learning from the staff about the services they work in. Deborah also highlighted the importance of today's Carer Story in promoting key messages. RESOLVED: The Board of Directors noted the report.
DHCFT/ 2026/042	<u>JOINED UP CARE DERBYSHIRE PROVIDER COLLABORATIVE ANNUAL REPORT 2025/26</u> The Board received the annual report and noted that the Provider Collaborative Board has agreed to strengthen the way that individual Provider Boards have oversight of its work, with formal reports presented bi-annually in future. This first annual report described the work of the collaborative over the past financial year and reflected on successes and challenges as well as pointing to the future direction of partnership working. Mark noted the considerable effort required to foster effective joint working amongst providers. Despite progress, Mark reflected that advancement has not been as swift as anticipated, highlighting the persistent challenge of aligning organisational objectives and strategies. He emphasised the need for providers to maintain connections with one another, especially in light of significant changes to the NHS operational model, warning against complacency and the temptation to operate in isolation. Tamsin Hooton, Programme Director, Provider Collaborative, Joined Up Care Derbyshire, expressed commitment to increasing the collaborative's visibility. She pointed out the value added in delivering best value, efficiency and improved clinical pathways for Derbyshire residents. It was acknowledged that proposals for improvement have sometimes been slow to materialise, however, tangible benefits are beginning to emerge. The past year was described as one of considerable change, noting the evolving relationship with the Integrated Care Boards (ICBs) and the greater alignment with neighbourhood structures. Looking ahead, Tamsin stressed the growing importance of collaborative working over the next 12 months, referencing the upcoming Provider Collaborative Workshop as a pivotal event. Drawing attention to the identification of Lead Provider organisations by some ICBs, Girish sought clarity on the rationale and timeframe for such developments. Tamsin responded that Lead Provider models are appropriate for certain services, citing the Trust's role as the sole mental health provider and noting the existence of adjacent services where this approach is being considered. Mark informed the Board that the ICB has recently agreed on its operational approach and expectations for providers. He committed to present the relevant slides, at the September Board meeting. He also discussed potential collaborative opportunities with Nottinghamshire and Lincolnshire, contingent upon the outcome of Nottinghamshire's ongoing enquiry. Recognising its complexity and also considerable benefits, Chioma voiced her interest in the digital workstream of the collaborative. It was suggested that Dawn Atkinson, Programme Manager, could provide additional expertise. Whilst acknowledging that AI and related technologies remain under-explored, the potential for scalable, streamlined collaboration was emphasised. Jo reflected that partnership efforts may vary depending on the project and that it is crucial to identify the right partner for each initiative. The decommissioning of Arden Gem was described as a key risk and priority for the collaborative. James explained that this transition will have significant implications, particularly regarding the move to Nottingham Health Informatics Service. RESOLVED: The Board of Directors: 1. Received the annual report 2. Noted the implications for the Trust.
DHCFT/ 2026/043	<u>INTEGRATED PERFORMANCE REPORT (IPR) AND BOARD COMMITTEE ASSURANCE SUMMARIES</u>

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

The Board Committee Assurance Summaries from recent meetings were considered alongside the IPR.

Points to note were brought to the attention of the Board by Executive Directors and Committee Chairs during the IPR discussions.

Quality

Tumi advised collaborative efforts to realign metrics with the Trust Strategy and Quality Plan. The allocation of complaints to Care Groups, with outcomes reported to the Quality and Safeguarding Committee was supported.

The importance of triangulating incident data with seclusion and restraint levels was discussed. Tumi reported that meetings of the Violence and Aggression Collaborative had been well-attended, fostering new ideas for improvement.

The introduction of a new metric relating to previous inspections was noted, particularly regarding practitioners' allocation and oversight.

Safer Staffing and Fundamental Standards of Care were highlighted by Andrew Harkness, Non-Executive Director, on behalf of Lynn Andrews, Chair, Quality and Safeguarding Committee, commending the efforts of Joe Thompson, Associate Director of Physical Health and Quality, Hannah Buckland, Compliance and Governance Manager and Rummy Jeleva, Governance and Compliance Co-ordinator, with 'good' Care Quality Commission (CQC) ratings for all domains. Limited assurance had been recognised in April, with actions underway to address gaps.

Suicide and self-harm prevention was another focal point, with training and education identified as crucial. Ligation risk reduction initiatives were reported to be nearing significant assurance. The improvements around Patient Safety concerns and learning the lessons were discussed in May.

Mark questioned the timescale for complaint resolutions. He also highlighted the significant assurance received by the Committee in relation to Assertive Outreach and was keen to revisit this later in the meeting.

It was clarified that complaints are to be prioritised this financial year to ensure they are resolved within 90 days, noting there is a backlog to work through.

Providing a triangulated perspective on the Patient Safety audit, Chioma Akpom, Chair, Audit and Risk Committee, reported limited assurance was accepted at the Audit and Risk Committee in April, with many actions already implemented or underway.

Justine commended the progress in ligation reduction. It was noted that once the learning is embedded following the intensive recruitment and training associated with the Making Room for Dignity (MRfD) programme, full assurance would be granted.

Operations

Maria Riley, Assistant Director of Transformation, covering for Vikki Ashton Taylor, reported positive improvements, particularly in reducing Length of Stay (LoS) (over 60 days) and Out of Area (OoA) placements, though some challenges persist and require partnership working.

The action plans in place for community waits were noted, with Maria praising the Memory Assessment Service for reducing waiting lists in the south.

As the Chair of the Finance and Performance Committee, Jo acknowledged positive steps in Early Intervention, Psychosis, OoA and the Psychiatric Intensive Care Unit (PICU), highlighting the absence of a female PICU and equality of access concerns.

The Mental Health Helpline and the demand versus commissioning for autism spectrum disorder assessments had been discussed, along with plans to reduce 52+ week waits. It was emphasised that LoS improvements depend partly on partner organisations, with some positive steps within the Trust's control.

Girish pointed out that challenges in LoS are exacerbated due to the occupation of beds by patients who are clinically ready for discharge.

Positive developments in the Living Well service were reported by James, with the withdrawal of council support offset by ICB funding.

Mark queried the visibility of high acuity inpatient data, prompting discussion on clinical risk and the need for more nuanced reporting; Tumi and Girish referred to the detailed indicators and skill-mix metrics, with Andrew requesting clearer definitions of acuity and advocating for System-wide risk sharing.

The Board noted the benefits resulting from the recent two phases of the operational model restructure, in particular, that all improvement plans have been led and sustained by the triumvirate leadership team.

People

Rebecca Oakley, Director of People, Organisational Development and Inclusion, reported stable People metrics, with appraisal compliance targets increased to 95% to drive further improvements. She highlighted a 5% uplift in mandatory training and that supervision systems are now aligned to policy, targeting 95% compliance.

It was noted that sickness absence remains a challenge, with marginal increases but clear progress in oversight and early intervention. Rebecca acknowledged that cultural change takes time and the focus must remain on accountability. She added that the People and Culture Committee is tracking progress to achieve a 5% absence rate.

Ralph summarised the reports received by the Committee, which included the Gender Pay Gap, Public Sector Equality Duty (PSED), Modern Slavery Statement and the Guardian of Safe Working Hours. A deep dive into the Wellbeing Offer had focused on leadership capability and support for staff. Recruitment metrics and sickness absence processes had been reviewed, with ongoing development and support for long-term sick staff.

In relation to those teams under 90% Training compliance, Rebecca described efforts to identify and address hotspots, balancing accountability and Divisional performance.

Ralph highlighted positive feedback from the staff survey, though the impact remains limited at this stage.

Finance

James presented a financial year end update, reporting that the Trust has achieved a modest surplus of £11k, marginally surpassing the breakeven plan and reflecting prudent financial management.

The Board noted that the required Cost Improvement Programme (CIP) efficiencies of £14.8m had also been delivered in full for 2025/26. James credited the Directorates for their ongoing commitment to delivering on CIPs, within the challenging environment.

An overspend in Adult Acute OoA placements was reported, totalling £8.3m, which is £4.4m above plan. This was identified as a key area for review.

	On a positive note, James highlighted that bank and agency expenditure remained below plan by £0.3m and £0.9m respectively. However, he flagged an increase in spend over the last three months, attributing this in part to staff absences. Emphasis was given to the importance of regaining control over these costs moving forward. It was noted that total capital expenditure concluded at £18.2m, slightly under the original allocation. Jo expressed appreciation for the Trust's achievement in meeting the breakeven target and commended the progress made, particularly in delivering efficiencies. However, she echoed the need for a more sustainable approach in future years RESOLVED: The Board of Directors: 1. Confirmed limited assurance was obtained on current performance across the areas presented, noting weaknesses in the design or inconsistent application of controls put the achievement of the system's objectives at risk in the areas reviewed 2. Requested further assurance around the impact for the Trust due to the higher level of patient acuity.
DHCFT/ 2026/044	<u>YEAR-END FINANCIAL POSITION - 2025/26</u> This paper provided a short update on the financial position for 2025/26, which was discussed in the IPR item. It was recognised that a more detailed report is provided and discussed at the Finance and Performance Committee on a monthly basis and at Audit and Risk Committee as part of the year end account review and sign-off process. The Board Assurance Framework (BAF) key risks relating to the delivery of the Financial Plan, currently graded as 'moderate' were noted. However, due to achievement in 2025/26, this has been refreshed as part of the BAF 2026/27 planning round. RESOLVED: The Board of Directors noted the financial position for 2025/26 and successful delivery of the required financial objectives of breakeven.
DHCFT/ 2026/045	<u>TRUST'S MEDIUM-TERM PLAN – NHSE FEEDBACK</u> James shared the NHSE feedback letter in relation to the Trust's Medium-Term Plan for 2026/27 to 2028/29 and five-year integrated delivery plan. A detailed analysis of the NHSE's response was provided, noting that while the Medium-Term Plan had been accepted, it was conditional upon the Trust meeting the specified target for LoS. James acknowledged that further improvement would be required by Year 3, characterising the targets as "very ambitious" and suggesting that a reassessment would be necessary at that stage. It was pointed out that the non-compliant part of the capital plan was not explicitly referenced in the NHSE feedback. James emphasised the need for a System-wide solution to be developed in the next quarter. Additional challenges noted included the significant CIP target and the current financial shortfall of £600k, which are being actively addressed. James outlined the requirement to submit medium- to long-term plans for 2027/28 by 31 August. The cruciality of an ongoing rolling programme of efficiency measures to drive down overheads, particularly across clusters, was stated. The Board was informed that much of this work is being channelled through the Finance and Performance Committee. The challenging nature of the year ahead was underscored. RESOLVED: The Board of Directors: 1. Noted the NHSE feedback and required conditions 2. Noted the non-compliance regarding Year 3 LoS submission, which was known and agreed as unrealistic at the time, due to progress already committed to regarding Years 1 and 2

	3. Noted the asks, including the continued development of CIPs through the full Quality and Equality Impact Assessment process by the end of May and plans for 2027/28 onwards to be developed by 31 August 2026.
DHCFT/ 2026/046	<u>STRATEGY DEEP DIVE – PEOPLE</u> Rebecca provided a deep dive across the strategic pillar of People, and specifically an overview of progress against delivery of the Trust's People Plan 2025–28. Feedback was welcomed on the format of this inaugural deep dive. The report included achievements to date across the four People Plan themes, key challenges and risks and the priorities and planned areas of focus for Years 2 and 3 of the programme. Achievement of the substantial organisational change was highlighted, attributing success to a values-led approach and recognition of the extensive effort invested by the team, particularly noting cross-team collaboration within the Joint Venture. Key achievements included progress on the Equality, Diversity and Inclusion (EDI) agenda, the introduction of the Personal Accountability Charter to drive cultural change and the effective, respectful resolution of Employee Relations cases. Support for major transformation programmes was also acknowledged. Rebecca candidly outlined several ongoing challenges, including adapting to a new leadership structure, addressing areas where staff survey results had declined and improving the use of organisational data. She noted the rapid pace of required digital transformation, early adoption of the new ESR system and AI policies, as well as persistent issues around sickness absence, reliance on temporary staffing and adapting to national directives such as the 10-Year Workforce Plan and NHS Staff Standards. The need to strengthen impact capability in the coming year was stressed, expressing both pride in progress and optimism for further improvements. Ralph commented on the People team's support of the Trust Strategy, particularly in leadership, Care Group restructuring, MRfD and day-to-day operational impact. He observed inconsistencies in implementation, highlighting the importance of understanding enablers and the rationale behind initiatives. He proposed observing team meetings to assess the impact of decisions. Welcoming the deep dive, Chioma sought clarity on the prevalence of red and amber RAG ratings. It was noted that ratings were based on this year's progress against the People Plan, with red indicating actions not yet started and amber representing those underway. Rebecca agreed to set realistic timelines for completion. It was confirmed that the deep dive was developed in line with BAF risks, noting the increasing detail required nationally due to the 10-Year Workforce Plan. Mark thanked Rebecca for leading the first of the Strategy Deep Dives. He emphasised the evolving process to assure progress and the importance of overlapping the deep dive detail with the BAF and Strategic Plan, ensuring appropriate mitigations are in place, building confidence in Executive and Committee oversight. The significant financial challenge posed by the 2026/27 CIP was stressed by James, along with the urgency of job planning and productivity improvements to reduce running costs, noting the need to improve the Trust's financial position. The pace of implementation was emphasised by Jo, who urged for immediate action on some priorities even if they are not at the top of the list. In agreement, Rebecca confirmed some actions, such as absence management, should be devolved to leaders to reduce reliance on temporary staff. The Board recognised that transformation may require more time, especially in relation to accountability. Andrew recommended a focus on setting clear trajectories for Year 1 and the identification of measurable outputs, both qualitative and quantitative. He also questioned the feasibility of completing all planned activities in Years 2 and 3, urging for clarification of priorities.

	RESOLVED: The Board of Directors: 1. Received assurance that the achievements and progress outlined in the paper support the delivery of the Trust Strategy and People Plan 2. Noted the challenges, risks and dependencies impacting delivery across some workstreams and the planned actions being taken to support delivery and maintain progress across the People agenda.
DHCFT/ 2026/047	<u>ASSERTIVE OUTREACH (AO) TREATMENT – COMMUNITY MENTAL HEALTH ACTION PLAN UPDATE</u> This paper informed and requested retrospective sign-off from the Board of Directors about the outcome of the Midlands Intensive and AO Self-Assessment Tool, which was submitted to Midlands Mental Health team, NHS England, on 6 May 2026. Tumi referenced the Self-Assessment Tool and the requirements outlined by CQC’s findings under Section 48 of the Health and Social Care Act, noting the need for improved outcomes. He identified gaps in patient monitoring, specifically through the Management and Supervision Tool (MaST), Care Programme Approach, Care Plans and risk assessments. Despite a pro-active approach to reach out to families for this cohort, the challenges associated with carer engagement was emphasised, some of whom are reluctant to participate. Difficulty with housing and social care partners was also pointed out, notably through 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) (MARAC). The limitations imposed by current resources were acknowledged, particularly the inability to support out-of-hours services for certain patients. Tumi highlighted recent escalations to the Director of Quality, ICB, with no clear resolution timeline. Referring to the assurance received at the Quality and Safety Committee, Mark expressed continued discomfort about the current service model. He noted that while care is provided to a defined group with complex needs, the AO service does not operate as a standalone outreach model, which he considered a significant risk due to lack of funding (estimated at around £2m). He stressed that although assurance was obtained for the existing pathway, it falls short of delivering a full AO service and warned that further escalations could necessitate changes to the self-assessment. The disparity between the service provided and the national benchmark for AO services, was highlighted by Jo, indicating a need for improvement to meet the standard. Pointing out the service statistics and the provision of care to 150 patients in an OA-like model, with over 100 additional patients managed by the Community Mental Health team, Girish confirmed that whilst these patients are not neglected, the full AO service requires additional funding. The need to re-escalate to the ICB was emphasised, with Chioma drawing attention to the predominantly ‘green’ scores recorded in the Self-Assessment. She recognised the significant gaps that would be reflected should the measure be assessed against a stand-alone service. Jo cited operational challenges due to insufficient funding and an imbalance between demand and ICB requirements. Deborah was concerned about inconsistent carer involvement and issues around information sharing, particularly when consent is not given. Tumi clarified that, while a standalone AO service is not in place, patients meeting AO criteria are cared for under the existing model. Whilst confidence in the quality of care for complex patients within available resources was reiterated, Mark pointed out that using resources in this way meant that it reduced the availability of resources to other patient groups. He asked for the limitations to be reflected in the BAF and

	called for further articulation and escalation to the ICB, emphasising shared risks and the need for a further self-assessment to determine whether a full AO model or simply good care is achievable. Action. RESOLVED: The Board of Directors: 1. Discussed the report, noting it had been received retrospectively 2. Agreed to retrospectively sign-off the Midlands Intensive and AO Self-Assessment Tool, which was submitted by 1 May 2026, recognising the rationale behind the process 3. Requested continued escalation and review through the Quality and Safeguarding Committee and ICB channels.
DHCFT/ 2026/048	<u>TRANSFORMATION AND CONTINUOUS IMPROVEMENT (BI-ANNUAL)</u> Maria provided a progress update on development of the Transformation and Continuous Improvement (CI) Framework and associated Delivery Plan. The MRfD programme was highlighted as an exemplary case of successful transformation, noting that the application of CI methodologies has enabled significant organisational change. Maria drew attention to Section 4 of the report, '<i>Continuous Improvement Approach update</i>' as evidence of ongoing work in this area, acknowledging the support provided by the Communication and Engagement team. The establishment of a new forum, dedicated to sharing improvement initiatives, was welcomed. Jo directed the Board's attention to the '<i>Programme Status</i>' outlined in the report, querying whether the indicated partial delivery aligns with expectations for the previous or current year's targets. Maria responded that the reported figures for OoA are for the previous year but not necessarily for LoS, for which all outcomes are not fully delivered. Contributing a reflective perspective, Jo cautioned that the breadth of the programme's ambitions may be overextending the organisation's capacity. RESOLVED: The Board of Directors accepted significant assurance in delivery of the agreed Transformation and Improvement Framework, noting 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.
DHCFT/ 2026/049	<u>BOARD ASSURANCE FRAMEWORK (BAF) ISSUE 1, VERSION 1.3, 2026/27 - UPDATE</u> Justine highlighted the cyclical nature of the BAF and confirmed that the framework has been subject to considerable scrutiny. She noted that recent efforts have resulted in the BAF being more closely cross-referenced to the Trust Strategy. A specific Partnership risk regarding uncertainty and instability associated with the ICBs was pointed out. Mark suggested that the relevant sections of the BAF be incorporated with the next deep dive It was noted that this version of the BAF had already been reviewed by the Audit and Risk Committee. RESOLVED: The Board of Directors: 1. Reviewed and approved Issue 1 of the BAF for 2026/27 and the assurance the paper provided of the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic objectives 2. Agreed to continue receiving updates in line with the forward plan for the Trust Board.
DHCFT/ 2026/050	<u>TRUST STRATEGIC PLAN (QUARTER 4 (Q4) UPDATE, TO INCLUDE 4 PS DELIVERY PLANS)</u> The Board was updated on progress in delivery of the Strategic Plan at the end of Q4, 2025/26.

	The three-year roadmap with progress against Year 1 deliverables was noted. Maria acknowledged the ambitious nature of the plan, noting that while the original target was 15 deliverables, 12 were actually delivered. Some elements had been deferred to 2026/27, including the Clinical Delivery Plan and the Digital Delivery Plan, signalling ongoing challenges in implementation. Deborah emphasised the importance of setting out achievements in a clear manner, maintaining transparency and ensuring that the Board was fully informed of both successes and areas requiring further attention. Andrew remarked upon the thorough challenges encountered during his attendance at the Strategic Portfolio Oversight Group. RESOLVED: The Board of Directors accepted significant assurance on the update and achievement at 2025/26 year end.
DHCFT/ 2026/051	<u>TRUST STRATEGIC DELIVERY PLAN – 2026/27</u> The proposed 2026/27 Strategic Plan deliverables were presented for approval. The significant developments that have occurred in Year 2 were highlighted, referencing the Board Strategy and Development Session as a pivotal event in shaping current priorities. The complex nature of the planning process was acknowledged, noting that the second phase now focuses on organisational capacity. Some formatting errors in the data were pointed out. The Board noted that ‘Must have, Should have, Could have and Won’t have’ (MoSCoW) methodology had contributed by framing the strategic choices, prompting consideration be given to what outputs are realistically achievable given present capacity constraints and reflection on the alignment between ambition, resources and the importance of prioritisation in the second phase of the plan. Deborah recognised the visible progress made so far and the greater clarity offered by the revised plan. Reflecting on organisational capacity, Chioma probed the underlying drivers of the plan, particularly regulatory requirements. Mark suggested the pragmatic way forward was to let the plan run and revisit the content in six months’ time. It was noted that the plan would be further scrutinised at committee level. The importance of concentrating efforts on key deliverables that would most effectively support the strategic objectives was stressed. RESOLVED: The Board of Directors approved the proposed 2026/27 Strategic Plan deliverables.
DHCFT/ 2026/052	<u>CORPORATE GOVERNANCE REPORT</u> The Board noted the assurance on Board Committee year-end reporting and was asked to approve the revised suite of Terms of Reference (ToRs) for Board Committees, to receive the Trust sealings report and to approve a regulatory self-declaration on continuity of services. RESOLVED: The Board of Directors: 1. Approved the suite of ToRs for Board Committees 2. Noted the assurance received by the Audit and Risk Committee that all Board Committees have effectively carried out their role and responsibilities as defined by their ToRs during 2025/26 and receive the year-end report of the Audit and Risk Committee 3. Noted the Trust seal report

	4. Approved the Continuation of Services Condition 7 self-declaration.
DHCFT/ 2026/053	<u>REPORTS FOR NOTING ON ASSURANCE</u> These reports were received for information and noting having previously provided assurance to the People and Culture Committee and the Quality and Safeguarding Committee. <u>People and Culture Committee</u> Annual Gender, Ethnicity and Disability Pay Gap report (March 2025) and PSED report - 2025/26 (for approval): The Board of Directors was provided with an overview, outlining how the Trust is meeting its obligations under the Equality Act 2010 and improving workforce equality outcomes. RESOLVED: The Board of Directors: 1. Accepted significant assurance in the progress that has been made in reducing the median gender pay gap and the key achievements across EDI as highlighted in the PSED report 2. Accepted limited assurance on the long term reduction across all pay gap measures due to the need for sustained and targeted action. <u>Guardian of Safe Working Hours (GoSWH):</u> This quarterly report from the Trust GoSWH provided data about the number of Resident Doctors in training in the Trust, full transition to the 2016 Resident Doctor contract and any issues arising therefrom. The report details arrangements made to ensure safe working within the new contract and arrangements in place to identify, quantify and remedy any risks to the organisation RESOLVED: The Board of Directors noted the contents of the report and the mitigation planned or put in place to manage increase in exception reporting. <u>Medical Appraisal and Revalidation – annual report:</u> This paper provided an update on medical appraisal and revalidation activity within the Trust during the 2025/26 medical appraisal cycle. RESOLVED: The Board of Directors noted the contents of this report, which offered assurance as there is a sound system; process, governance and assurance to meet the Trust objectives. However, inconsistent application arises in terms of the engagement of individual clinicians and is managed by the Deputy Medical Director via the Clinical Directors. <u>Modern Slavery Statement – annual review (for approval):</u> The Board was presented with the Trust's Annual Modern Slavery Statement. It was noted that the Statement had been considered and supported by the People and Culture Committee as evidence that the Trust has met the criteria for the preceding financial year. RESOLVED: The Board of Directors approved the revised Modern Slavery Statement for 2025/26 for publishing on the Trust's website, replacing the previous version. <u>Quality and Safeguarding Committee</u> <u>Special Educational Needs and Disabilities (SEND) annual report:</u> It was noted that the purpose of this report is to meet the quality requirement in schedule from Derbyshire ICB to provide an annual report of SEND. RESOLVED: The Board of Directors noted the limited assurance accepted by the Quality and Safeguarding Committee in some areas of the report due to the new nature of the requirements.
DHCFT/ 2026/054	<u>CONSIDERATION OF ANY ITEMS AFFECTING THE BOARD ASSURANCE FRAMEWORK (BAF)</u> The Board agreed to the inclusion of connectivity with the Strategy Deep Dives.

	It was also noted that the risks shared with the Trust and the ICB around with the AO service should be reflected more explicitly in the BAF.
DHCFT/ 2026/055	<u>MEETING EFFECTIVENESS</u> Jo remarked positively on the robust debate enabling Board members to challenge key areas effectively. She further recognised the quality of papers, which contributed to informed decision-making and constructive scrutiny. Mark expressed appreciation to Deborah, for Chairing the meeting at short notice, acknowledging that a few members were absent. He reflected on the evolving nature of the Board's deep dive approach.
The next meeting to be held in public session will be held in person on Tuesday, 21 July 2026 at 9.30am in Conference Rooms A and B, Centre for Research and Development, Kingsway, Derby.	

DRAFT

ACTION MATRIX - BOARD OF DIRECTORS - JULY 2026							
Date	Minute Ref	Item	Lead	Action	Completion Date	Current Position	
24-Mar-2026	DHCFT/2026/023	IPR	Committee Chairs/ Executive Leads	Committee Chairs and Executive Leads to consider assurance levels being received and review the parameters for escalation to Board.	31-Jul-2026 30-Sep-2026	Discussions held with the Deputy Chair and the Director of Corporate Affairs on assurance ratings and reporting as part of wider improvements. The Board will be discussing this in conjunction with the Well-Led review work.	Yellow
19-May-2026	DHCFT/2026/038	Action Matrix and Matters Arising	Becki Priest	Timeframe for establishment of a Carers Support Group.	14-Jul-2026	A Staff Carers forum has been established, with the first session planned to take place on 14-Jul.	Green
19-May-2026	DHCFT/2026/041	Chief Executive's update	Girish Kunigiri	Subodh Dave, Foundation Training Programme Director and President of the Royal College of Psychiatry to be invited to attend a Board Strategy and Development Session.	14-Jul-2026	Date confirmed for 01-Dec-2026.	Green
19-May-2026	DHCFT/2026/043	Integrated Performance Report (IPR) - Operations	James Sabin/Tumi Banda	Enhanced understanding of the impact for the Trust due to the higher level of patient acuity, to be explored further at Finance and Performance and Quality and Safeguarding Committees.	25-Jun-2026	Finance is working with the Rostering team, Operations and Human Resources to separately identify the volume and costs of rostered shifts supporting the difference variable aspects of Inpatient shift costs, such as escorting, observations and acuity. Initial reporting will commence from month 3 and be backward adjusted to 1 April and this will be built into the committee reports.	Green
19-May-2026	DHCFT/2026/047	Assertive Outreach Treatment - Community Mental Health Action Plan update	Tumi Banda	Further articulation and re-escalation to the Integrated Care Board (ICB) around the requirement for a stand-alone AO service.	TBC	Re-escalated to ICB and now referred to the MHLDA System Delivery Board – awaiting response to report back to the Board once received.	Amber

Key:	Action Overdue	RED		0	0%
	Action Ongoing/Update Required	AMBER		1	20%
	Resolved	GREEN		3	60%
	Agenda item for future meeting	YELLOW		1	20%
				5	100%

Trust Deputy Chair's update

Purpose of Report

During the reporting period, the Trust has continued to focus on delivering safe, high-quality care whilst progressing its strategic objectives against a challenging operational and financial backdrop.

This report provides an overview activities, together with key observations from stakeholder engagement, service visits and System leadership activities.

This report provides an update from Lynn Andrews, Deputy Chair, and the work she undertook whilst acting on my behalf during June/early July.

Executive Summary

From 6 June:

Council of Governors

A virtual coffee and catch up with Council of Governors on 8 June provided an informal opportunity to discuss key issues relating to their activities within the Trust and engagement with their wider constituencies. We discussed Trust communication channels, the role of governors moving forward and the transfer of Older People's Mental Health and Neurodevelopment services into the organisation on the 1 June 2026.

I thanked those members of the Council who met with AQUA, who are undertaking a review of the organisation using the Care Quality Commission (CQC) Well-Led standards, for their time, insight and contribution.

Our Trust and Staff

I attended the Joint Medical Senate and Trust Board session at the end of June chaired by Dr David Walker. It was a great opportunity to hear from clinicians and their teams about Doctors as Clinicians, Educators, Innovators and Improvers. The showcase of their work, skills and experience demonstrated how invaluable our staff are when considering opportunities for strategic development and transformation of clinical pathways of care.

Being a runner myself, I was keen to take part in the NHS Anniversary Park Run to celebrate 78 years since Aneurin Bevan, Minister for Health in 1948, spearheaded the creation of the health system. Vikki Ashton Taylor, Deputy Chief Executive and Chief Delivery Officer, thanked colleagues for their support and participation in the celebration, noting how events such as these support wider health and wellbeing.

As part of our workforce plan, I chaired two Consultant interview panels during this period which both had successful outcomes.

Board Strategy and Development

On 17 June, the Board received a session on cyber security. The session centred on how we understand, defend and respond to threats. While the Trust is compliant with the Data Security and Protection Toolkit to reduce the risks, there is a need to progress further with our cyber security as well as the technology to defend and respond to threats. It was a sobering reminder of how important it is to ensure we remain cyber alert and understand where our personal accountability lies to keep data safe. It is a timely opportunity to review whether the current Board Assurance Framework (BAF) risks remain the right ones, how they are framed and scored and how risk appetite is applied in practice.

I joined the Digital Futures session held online in June, where staff were updated on the progress with the Trust's Digital Delivery Plan. I was pleased to hear of the progress to date and how we are digitising services to support staff and patients improving their experience and care.

Remuneration and Appointments Committee

The Committee met on 9 June and received an overview of the Trust's Executive talent and succession arrangements and objectives for 2026/27. The Committee reviewed the identified organisational risks and mitigating actions relating to succession planning and supported the ongoing development of internal leadership talent and succession arrangements. The Committee approved the objectives of Chief Executive and Executives for 2026/27.

Audit and Risk Committee

I joined the Audit and Risk Committee on 18 June, where we reviewed the final Annual Report and Accounts with our external auditors and approved the document under delegated authority of the Board.

Board visits

Non-Executive Directors (NEDs) along with Executive and Governor colleagues have visited a range of services as part of Board visits across the Trust. These included:

- 3 June – Domestic and Hotel Services North Team – Deborah Good, NED; Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary and Sifo Dlamini, Business Manager
- 25 June – Mental Health Liaison team South (Assessment services) – Deborah Good, Justine Fitzjohn and Nicole Ellis, Business Manager.

We took the opportunity to thank staff working within these services for their professionalism, commitment, enthusiasm and personal contributions to improving the lives of the people we serve.

NHSE Aspiring Chairs programme

As part of the Trust and wider NHS succession planning programme, I was successful in accessing the NHSE Aspiring Chairs programme in May. I attended a development day in June exploring 'The Story of Now' which is a verbal self-portrait of who I am and how I have come to be the person I am today (in work). This also identified where my development needs are and opportunities to address these throughout the year-long programme.

I also met Russell Hardy, the recently appointed Chair of the NHS England Midlands team, a new role within the NHS with an evolving remit. Russell brings a wealth of experience to his role and is keen to work with and support the Midlands aspiring chairs.

System collaboration and working

Provider Collaborative Board

The Derbyshire Chairs and Chief Executive met on 1 July to discuss the Integrated Care Board clusters, (Derbyshire, Lincolnshire and Nottinghamshire (DLN)) new strategic commissioning model and governance framework. The meeting provided a valuable forum for strategic reflection at Chair and Chief Executive level and reinforced the importance of close partnership working, clear governance and collective leadership in taking forward System priorities. The open space also enabled reflection on the current challenges and alignment of organisational transformation priorities in support wider health system transformation.

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

Risks and Assurances

The Board can take assurance that the Trust level of engagement and influence is high in the health and social care economy

Feedback from staff and other stakeholders is being reported into the Board.

Consultation

None.

Governance or Legal Issues

As outlined on the Trust's governance framework – no legal issues of note.

Net Zero Duty Implications

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

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

The Trust continues to use virtual or hybrid meetings where appropriate.

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:

1. Note the contents of this report
2. Consider the observations provided
3. Highlight any areas for discussion or clarification.

Report presented by: **Selina Ullah**
Chair

Report prepared by: **Lynn Andrews**
Deputy Chair and Non-Executive Director

Chief Executive's update

Purpose of Report

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

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

National and regional context

New national Mental Health Strategy

The government recently launched a Call for Evidence to inform the development of a new Mental Health Strategy. The strategy will drive a shift to treat people earlier and faster, and support those with mental health conditions to stay active with education, work, family life and their communities. An opportunity to share views on the development of the new strategy closed on 10 July. The Department of Health and Social Care were also engaging with people with lived experience, to ensure their voices are heard.

Alongside the continued development of neighbourhood health, Mental Health Support teams, crisis alternatives and Community-based services, the new strategy will dovetail into the wider ambition of the 10 Year Health Plan and the three shifts towards prevention, digital innovation and care closer to home.

Lord Mann Review

Last month the government published its recommendations from the Mann Review, which aims to tackle antisemitism and other forms of racism across the NHS. The report outlines a number of recommendations for NHS bodies, highlighting our collective role in tackling racism and discrimination for patients and staff.

I am aware that some of the events we see at home and abroad can polarise opinions and harden division, going against the values that make the NHS what it is. Just like wider society, the NHS is not immune to the persistent and systemic challenges of all forms of racism (including antisemitism and Islamophobia).

I have been very clear with colleagues that any form of racism in the NHS is completely unacceptable and has no place in Derbyshire Healthcare. Racist behaviour towards our staff or patients will not be accepted. The Mann Review's recommendations will be integrated into our ongoing campaign to tackle violence, abuse and aggression campaign.

NHS Oversight Framework (NOF) 2026/27

In June NHS England published the refreshed [NHS Oversight Framework](#) (NOF). The framework aligns oversight arrangements with the NHS operating model and the 10 Year Health Plan, with performance linked to the degree of autonomy or intervention providers receive.

The revised NOF signals a continued shift towards a more rules-based and outcomes-focused approach to NHS performance management.

For our Trust, the framework reinforces the importance of maintaining strong governance and leadership, delivering transformation through community and neighbourhood models, and evidencing measurable improvements in patient outcomes and organisational performance. We are currently carrying out modelling against the new NOF metrics.

NHS Leadership and Management Framework – for all leaders and managers

In early July, the Department of Health and Social Care published the new [NHS staff standards](#). It also launched the new NHS [Leadership and Management Framework](#), which sets clear expectations for all NHS leaders and managers, including line managers and includes a code of practice.

Together these initiatives aim to strengthen leadership capability, talent management and professional development across the NHS, supporting delivery of the NHS 10 Year Health Plan. During 2026/27, NHS organisations are expected to embed the framework within appraisal, recruitment and development processes and support managers to undertake self-assessment and development planning by the end of Quarter 4. The Trust will review its existing leadership and management arrangements against the new national standards and engage with the development opportunities offered through the College as its programme is established.

Provider Boards already have their own leadership competency framework, and this will be updated from 2027/28 onwards, to ensure the two competency frameworks align.

Consultant Doctors – potential industrial action

Following the recent announcement from the British Medical Association that Consultant Doctors in England have voted in favour of a mandate to take strike action over the next 12 months, the Trust will be planning its response once further details are released, aiming to minimise the impact on services.

National Maternity and Neonatal investigation

Whilst not specific to the services we provide, the publication of the Amos Review of NHS Maternity and Neonatal services in England identifies learning for all NHS trusts. A key theme focuses on the importance of listening to patients and their families, with examples of women not being listened to, heard or believed by healthcare professionals working in Maternity and Neonatal services.

There is also learning about discrimination and racism embedded throughout the maternity system, together with stereotyping and discrimination against disabled, LGBT and minority ethnic families.

The Amos Review supports Martha's Rule, which gives patients, families and carers the legal right to request an urgent, independent medical review if a patient's condition is deteriorating and they feel their concerns are not being addressed.

The report and its recommendations will be received at the Trust's Delivery Group to ensure learning across our services, including proactively offering second clinical opinions when difficult circumstances arise.

Local context

New Integrated Care Board (ICB) Governance framework

The Derbyshire, Lincolnshire and Nottinghamshire (DLN) ICB cluster is developing a new strategic commissioning model and governance framework to support a more integrated, population-health focused approach to healthcare delivery across the three Systems. The emerging five-year commissioning strategy is centred on improving outcomes, reducing health inequalities, strengthening financial sustainability and accelerating the shift from hospital-based care to prevention, Community and Neighbourhood services.

A significant element of the programme is the establishment of Integrated Neighbourhood teams and neighbourhood mental health models, supported by new commissioning and governance arrangements designed to align planning, contracting, quality oversight and transformation activity across the cluster. The strategy includes ambitious plans to reduce avoidable hospital activity, expand Community-based alternatives, improve urgent care pathways and strengthen digital enablement through a single, co-ordinated commissioning approach.

For us, the proposals reinforce the strategic importance of Community Mental Health services, Neighbourhood working, prevention and Partnership delivery. The Trust will play a key role in delivering Neighbourhood 24/7 Mental Health Hubs, integrated Community services and wider population health initiatives as the new commissioning arrangements develop over the coming years.

Crisis text messaging service for adults open to Community Mental Health teams (CMHTs)

As part of our crisis support offer for local people in Derbyshire, the Trust has launched a new text messaging service. Initially, this service will be available to working-age adults who are already open to our CMHTs whilst we review the demand for the service.

I want to thank colleagues from the Mental Health Helpline and Support service for supporting this innovation, which complements our efforts to explore digital technology and increase the accessibility of our services.

Older People's Mental Health and Adult Neurodevelopmental service transfer

On 1 June 2026, our Trust took responsibility for a range of Older People's Mental Health (OPMH) services and Adult Neurodevelopmental (ND) services across North Derbyshire. The OPMH services include Snowdrop Ward at Walton Hospital in Chesterfield and Specialist Day Services which are based at Ash Green, also in Chesterfield. The Positive and Safe training team also transferred, to ensure continuity of training colleagues across our ward environments.

I am pleased to confirm that these changes mean we now provide specialist OPMH and ND services across the whole of Derbyshire, including Derby city. I am confident that bringing the teams together will allow us to provide the best possible care and outcomes for local people.

Helpline's contact number moves to 111 only

On 1 July 2026, our Derbyshire Mental Health Helpline and Support service switched off its 0800 number, meaning that the only way to contact the service is via NHS 111.

Using only NHS 111 is the approach recommended by NHS England. When people dial 111 and select 'mental health', they are put through to their local helpline team, who can tell them about local support services nearby. Having one number for the Derbyshire helpline also simplifies the call handling process and means the team can respond to calls more effectively. When people dial the old 0800 number, they are advised to call 111 instead.

Recent achievements

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

- Our **Adult Eating Disorders service** has recently been awarded the Royal College of Psychiatrists' (RC Psych) eating disorders accreditation. I know the team is delighted with this achievement and that it is very well earned. The accreditation process has been lengthy, with detailed collection of the evidence required which has involved the whole team. Congratulations to everyone who has supported this achievement
- Our **Mental Health Liaison team** at Royal Derby Hospital has recently received re-accreditation from RC Psych, through its Psychiatric Liaison Accreditation Network (PLAN). The team was praised for its innovative work and positive feedback from patients and carers. Well done to all the members of the team
- In May, we learned from the Carers Trust that, after submitting all our self-assessments, we have retained our two-star accreditation under their **Triangle of Care** scheme.

This rating reflects that all services including Crisis, Inpatient and Community care have been reviewed, and the Carers Trust's report notes that we have "continued to make steady progress in strengthening carer involvement across governance structures and frontline practice". The assessor from the Carers Trust also wrote to say that there are "some excellent examples of teams clearly articulating current practice, acknowledging challenges, and identifying meaningful areas for improvement". This continues to be a great achievement and testament to all those who are involved in this much valued area of our work.

Congratulations to:

- **Julie Tomlinson** – Community Psychiatric Nurse in our Forensic CMHT who was May's DEED winner. Julie demonstrated Trust values in action and did an amazing job of working collaboratively with team members and residential care. Her nomination said, *"there is little doubt that the timeliness and cohesive response prevented a serious incident from occurring"*
- Colleagues working at Bluebell Ward at Walton Hospital, who were the DEED of the month winners for April. Congratulations to **Emily Ulyatt, Charlotte Cooling, Natalie Nickson, Rebecca Redfern** and **Isabel Maseva** who received several nominations describing their professionalism, co-ordination and dedication to ensure positive outcomes for people in our care
- **Hayley Lawrence**, Senior Clinical Nurse Educator, who received the 'Rising Star' award at the British Forces in Business Awards recently. Hayley was recognised for her contributions to clinician education and leadership of the Armed Forces Staff Network, supporting veterans, service members and their loved ones
- **Joe Thompson**, Associate Director of Physical Health and Quality, who has been awarded the Culture of Care Leadership Recognition Award from the Royal College of Psychiatrists for his outstanding leadership and dedication driving the Culture of Care programme across the Trust
- **Madalaine Ellis**, Assistant Psychologist for the Specialist Autism team, who was shortlisted for the 'Best Newcomer' award in the National Learning Disabilities and Autism Awards. Madalaine was recognised for combining innovation, compassion and initiative to deliver meaningful change for autistic people so early on into her career.

Staff engagement

In memory of our former colleagues

In May we received the sad news that **Sally Morton** from our Child and Adolescent Mental Health services (CAMHS) Crisis and Home Treatment team in Derby had very sadly passed away, following a period of ill-health. Colleagues from across the Trust came together to pay tribute to Sally in a virtual one-minute silence. We will make arrangements to include a lasting tribute to Sally in our memorial garden at Kingsway Hospital later this year.

In July, we held a special event in our Memorial Garden in memory of **Emma Thomson**. A plant and plaque were placed in the garden in memory of Emma, creating a space for colleagues to visit and pay their respects.

Staff Conference

This year's Staff Conference took place on Thursday, 9 July at Pride Park, in Derby. The theme of the day was 'Small Changes, Big Impact: Together' and throughout the day we returned to the two central priorities from our Staff Survey; how we can work together to make the Trust a place that colleagues recommend as a great place to work and receive care. We welcomed local guest speaker Andy Cope on the day, who supported our conversations on these topics.

Virtual Digital Futures update

Last month, we held a virtual Digital Futures session, where we discussed progress on the Trust's Digital Delivery Plan, following the Digital Futures Day held late last year. The session highlighted our four key priorities: digitising services, improving existing systems, strengthening connections with partners and supporting both staff and patients to use digital tools confidently and safely.

I am pleased to see the progress that is being made in seeking to understand how technology can support clinicians in providing care in a number of our services.

Leadership Cascade

We have now held two of our new Leadership Cascades, where senior managers are provided with key information to share and discuss throughout their teams, creating a cascade across the Trust. Feedback suggests this has been well-received, although more focus is required to ensure all staff are receiving the cascade from their manager.

Questions for Mark?

In response to our updated approach to staff engagement, a new question and answer session with me will be trialled in July. This is an approach that seems to be valued in other trusts and an idea that has been well-received across our teams. I will be able to provide further details on this in my next report.

Team visits

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

- I met with our new teams at Ash Green and Walton Hospital in Chesterfield on 2 June, following the transfer of OPMH and ND services into the Trust
- On 3 June, I was up in the north of the county, seeing the North Derbyshire Dales Living Well team and the High Peak and Derbyshire Dales CMHT for Older Adults at the Ritz in Matlock. From there, I went to see the High Peak Adult and Older Adult team at Corbar View and then called in at Buxton Health Centre. To round off the day, I went over to the High Peak Crisis team in Chapel-en-le-Frith
- On 8 July, I visited CAMHS, the Learning Disabilities team and Physical Mental Health team (County Adults) at Dale Bank View.

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

- Vikki Ashton Taylor, Deputy Chief Executive and Chief Delivery Officer, has visited the following locations:
 - 30 April – 0-19 team at St Paul's House, Derby
 - 6 May – Memory Assessment Service (MAS) and Older Adult Day service at Dovedale Day Hospital in Derby
 - 3 June – Radbourne Unit
 - 5 June – Teams based at Snowdrop Ward, Walton Hospital
 - 8 June – North Perinatal team at Scarsdale Hospital
 - 16 June – Substance Misuse service at Bankgate, Swadlincote
 - 24 June – ND team at Ash Green, Chesterfield
 - 25 June – Board visit to the Mental Health Liaison team at Royal Derby Hospital
 - 2 July – Cherry Tree Close at Kingsway
 - 8 July – Specialist Day service team in Chesterfield
- Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary, visited the Domestic/Hotel services North team at the Derwent Unit in Chesterfield on 3 June
- Girish Kunigiri, Executive Medical Director, has been to the Wards at Carsington Unit at Kingsway on 22 May and the High Peak team in Bakewell on 3 June
- James Sabin, Director of Finance, spent time with the night shift on Dove Ward, Wren Ward and Robin Ward at the Carsington Unit in Derby on 17 June, along with Cubley Court male and female wards, Tissington House, Kingfisher House, Audrey House and then Willow Ward, Oak Ward, Sycamore Ward and the Section 136 team
- Tumi Banda, Director of Nursing, Allied Health Professionals, Quality and Patient Experience, has visited the following locations:
 - 20 May – St Paul's House, Derby
 - 27 May – Wards at the Derwent Unit in Chesterfield

- 3 June – Communications team, Kingsway
- 11 June – Snowdrop and Bluebell Wards at the Derwent Unit in Chesterfield
- 17 June - a series of Kingsway night visits with the Director of Finance to Tissington House, Audrey House, Robin Ward, Kingfisher Psychiatric Intensive Care Unit (PICU), Dove Ward, Wren Ward, Cubley Court Male and Female, Willow Ward, Sycamore Ward, Oak Ward and the Section 136 Suite
- 24 June – Board visit to the CMHT Bayheath House Chesterfield
- 25 June – Gambling Harms service at St Andrew's House
- 7 July – Adult ND services, Brooklands, Ilkeston
- Rebecca Oakley, Director of People, Organisational Development and Inclusion, joined a Board visit to the North Dales CMHT on 21 May.

Raising awareness and community engagement

Deaf and Black communities

We continue to engage with local Deaf and Black communities, in line with the priorities outlined in our Community and Stakeholder Engagement Plan. Last month we held our third Deaf Focus Group meeting with representatives from our local Deaf community. Actions included: how we capture data and book interpreters, how we can create workforce opportunities for Deaf people and cultural competency within the Trust. We have also started to work with Community Action Derby and local groups representing Black communities in Derby to explore how we can open local conversations relating to access, experience and outcomes of our services.

NHS birthday celebrations

The NHS turned 78 on Sunday 5 July. To celebrate, and as part of our wider focus on staff wellbeing, colleagues, partners and communities took part in a special parkrun at Markeaton Park in Derby at 9.00am on Saturday, 4 July. The League of Friends also held their annual Summer Fayre, raising valuable funds for Trust services. Thank you to everyone who supported these celebrations.

The Trust has recognised and celebrated many important awareness raising events over recent weeks including Carers Week, Learning Disability Week, PRIDE month, Volunteers Week and Dietitians week.

Service user and carer feedback

In our most recent Delivering Excellence Every Day (DEED) nominations, we received 23 entries from service users, carers and members of the EQUAL Forum. These ranged from nominations recognising a specific member of staff, to a team of people who had supported a service user on their recovery journey. Services nominated included:

- Dementia Rapid Response Team South
- Chesterfield Dementia Rapid Response Team, Scarsdale
- Child & Adolescent Mental Health Service Crisis & Home Treatment Team, Temple House
- Ward 36, Radbourne Unit
- Specialist Attention Deficit Hyperactivity Disorder (ADHD) Nursing Team, St Paul's House
- Erewash Community Mental Health Team
- Kedleston Unit, Kingsway
- Tissington House, Kingsway
- Willow & Sycamore Wards, Derwent Unit, Chesterfield
- Carsington Unit, Kingsway
- The Beeches Mother & Baby Unit, Derby
- Bluebell Ward, Walton Hospital
- Audrey House, Kingsway.

March to June *in numbers*



Derbyshire Healthcare
NHS Foundation Trust

120 service users, carers and staff members of all ages were involved in research studies



Our **Work Your Way** employment service successfully supported **111 people** open to community mental health services into **permanent work in roles of their choice**.

The East Midlands **Gambling Harms** Service received **235 self referrals** from people concerned about their gambling habits.



88 pregnant women or new mothers made a self referral to our **perinatal mental health services**.



Derbyshire Healthcare received **473 compliments** from service users, carers, families and students.



374 DEED (Delivering Excellence Every Day) nominations, **celebrating staff, teams and services**, were received.

The **Mental Health Helpline and Support Service** spoke to **12,007 people** who needed help.



From March to May, the Strategic Health Facilitation team in our **Integrated Adult Neurodevelopmental Service** supported **1115 people with a learning disability** to get an **annual health check** from their GP.



The Derbyshire Healthcare **website** was visited by **50,387 people** on **184,739 separate occasions**.



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

Risks and Assurances

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

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

Consultation

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

Governance or Legal Issues

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

Net Zero Duty Implications

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

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

None.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

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

Recommendations

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

**Report presented and
prepared by:**

**Mark Powell
Chief Executive Officer**

Integrated Performance report (IPR)

Purpose of Report

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

Executive Summary

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

Quality

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

Areas of assurance

- **Robust governance and oversight** is in place across key risks through established groups and divisional meetings
- **Ligature incidents improved**, with May achieving the reduction ambition and fixed-point incidents within threshold in April and May
- **Falls and ligature harm remains low**, with most incidents categorised as minor, insignificant, low or no harm
- **Duty of Candour compliance is strong**, with 100% compliance and no themes or patterns identified
- **Absconding improved**, with April and May achieving the reduction ambition
- **Medication safety, falls prevention and restrictive practice controls** are supported by targeted action plans, training and specialist governance
- **Older Adult long length of stay (LoS) improved** and remained within target throughout March–May
- **Flow and access risks are recognised**, with Multi-agency Discharge Event (MADE) meetings, Divisional oversight and improvement plans in place.

Areas of risk

- **Complaints timeliness remains below target**, at around 42% within 90 working days
- **Restrictive practice remains above ambition**, particularly physical restraint and prone restraint
- **Seclusion remains variable**, with March and May above the reduction ambition
- **Violence and aggression deteriorated**, including patient-on-patient incidents and assaults on staff. (*Racist abuse in patient-to-staff incidents remains a staff safety and equality concern*)
- **Medication incidents and falls remain inconsistent**, with performance above threshold in parts of the period
- **Care Programme Approach (CPA) annual review compliance remains below target**, at around 76%.
- **Clinically ready for discharge (CRfD) and Adult long LoS remain above target**, driven by system pressures

- **Patients not seen for over 12 months** remains a significant access, safety and regulatory risk.

Operational Performance

Notable changes since the last report:

- **Inappropriate out of area (OoA) placements:** the Trust continues to require some external placements owing to demand exceeding bed capacity, and no Psychiatric Intensive Care Unit (PICU) provision for females in Derbyshire. The Acute team continues to work on repatriation of female PICU patients once clinically appropriate to do so
- **Mental Health helpline:** the proportion of calls answered by the professional line has exceeded target for the last two months, and the proportion of calls answered by the helpline is improving towards target.

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. The quarter 4 (Q4) results have now been published by NHS England. The Trust's score has improved slightly every quarter and at financial year end was ranked 40th out of 61 NHS providers, remaining in segment 3.

- **Community waits over 52 weeks:** in the latest NHS oversight framework ratings (Q4) the Trust ranked sixth worst NHS provider in the country for waits over 52 weeks, at 51%. A performance improvement plan is in place which reflects interventions that are designed to increase clinic slot capacity through adjustment of the workforce and care delivery model, and improvement in did not attend rates. This relates specifically to the 0-4 pathway which is 100% provided by Community Paediatricians. The improved performance trajectory remains at November 2026. However, there are significant workforce risks that could derail from this target
- **Crisis response:** this is a NOF measure of the proportion of urgent referrals made to Crisis teams and mental health single points of access who were seen face-to-face within 24 hours. In the Q4 NOF ratings the Trust placed 14th best provider in the country for performance against this metric
- **Proportion of Acute Inpatients discharged with a LoS of 60 plus days:** at 29.8%, in the Q4 NOF rankings, the Trust placed 13th highest proportion of LoS over 60 days of all providers and in quartile 3. This was an improvement since the previous quarter. If people had been discharged when clinically ready, the Trust would have ranked 10 places better. A revised performance improvement plan is in progress, with all actions due to be completed by September 2026
- **Children and Young People (CYP) accessing Mental Health services:** with a 1.03% reduction in access, the Trust placed in the bottom 25% of NHS providers in Q4. Service improvement achieved an 8% increase in performance over the year. Improvements in expected clinical contacts across the service, which is reducing time from assessment to treatment, and in turn improving flow and productivity within the service.

2. High performing areas

- **Women accessing specialist Perinatal Mental Health service:** the service continues to consistently large numbers of women during the periods before and after the birth of their children. The current access rate of 12.7% placed NHS Derby and Derbyshire Integrated Care Board (ICB) in the top six performing ICBs nationally
- **Individual work placement support:** the Work Your Way team of employment specialists and job coaches has continued to help an increasing number of people using Community Mental Health services in Derbyshire to find work and stay in work

- **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, and placing the Trust in the top 12 of providers nationally. This process is tightly monitored by the Trust's Performance Analyst to ensure the safety of patients.

3. Challenging areas

- **Transforming care programme:** for adults, the Trust and System have agreed a trajectory for 2026/27 to reduce from 32 Inpatients in Q1 down to 28 in Q4. As of May 2026, there were 18 adult Inpatients with autism, which is two above trajectory, and 18 adults with a learning disability and autism, which is also two above trajectory, giving a total of 36 adults in total, four over the trajectory of 32. The agreed target threshold for CYP Inpatients is static at three per month. Currently there are four CYP Inpatients, which exceeds the target threshold by one
- **Average LoS for Adult Acute, Older Adult and PICU Mental Health beds:** the latest monthly mental health services dataset data published by NHS England (April 26) placed the Trust exactly mid-table of all NHS providers with an average LoS of 58 days. However, if patients had been discharged when CRfD the Trust's Q4 average LoS would have been 49 days, which would have placed 11th lowest. Revised performance improvement plans for Adult and Older Adult LoS reduction and improved flow have been developed and are currently in the implementation phase
- **CYP Mental Health waits over 104 weeks:** Child and Adolescent Mental Health services (CAMHS) are reporting 50 children waiting over 104 weeks against the planning target of 93. However, from April 2026, 2,500 neurodevelopmental waits were transferred from the Community Services Data Set (CSDS) (an NHSE-supported service transformation) which has changed the operational plan opening position as these are now counted within the Mental Health services data set, indicating we have 1,300 children waiting over 104 weeks. We await the final metric against this NOF target; an options appraisal paper is scheduled for Executive Leadership Team to inform options to address this.

People

High Performing Areas

The Trust continues to demonstrate strong performance across several key workforce metrics.

Compulsory training compliance remains robust at 95.5% and continues to perform above the newly increased target of 90%.

Annual turnover remains healthy at 10.3%, in line with national and regional benchmarks and below the Trust's 12% tolerance, indicating a relatively stable and non-static workforce.

Supervision compliance in both clinical and managerial remains above target. This followed successful implementation of aligning the supervision system to policy and a compliance target reset.

Challenging Areas

Sickness absence continues to remain a key area of concern, following an upward trend in annual sickness absence levels during the last three months. Annual sickness absence rates monitor performance against the same period in the previous year, when it is higher this increases the annual sickness absence rate. The annual sickness absence rate is running at 6.09% and the monthly at 6.34%. Long-term absence (3.8%) continues to be a significant contributor, with mental health-related conditions (anxiety, stress, depression) remaining the leading cause. This highlights the need for sustained focus on wellbeing, early intervention and management capability.

Annual appraisal compliance requires a renewed focus following a decrease in completion rates to 88% in May 2026. The target was also reviewed recently, following previous consistent high performance, and increased to 95%.

Financial

At the end of May, there is a deficit of £1.0m, which has been adjusted for the IFRS16 PFI adjustment, bringing the adjusted financial position to a deficit of £0.9m which is behind plan by £0.3m. The adverse position is mainly driven by OoA expenditure, acuity on the Inpatient wards and a gap in delivery of the efficiency programme, which has been partly mitigated by other underspends.

High Performing Areas

Cash at the end of May was £32.5m (£25.8 last month) against a plan of £23.8m, £8.7m above the plan. There are no concerns in relation to debt recovery.

The Better Payment Practice Code (BPPC) sets a target for 95% of all invoices to be paid within 30 days. BPPC is measured across both invoice value and volume of invoices. At the end of May, both the value and volume of invoices exceeded the target at 97.8% and 95.6% respectively.

Challenging Areas

The plan includes an efficiency requirement of £14.8m with the plan assuming 72% is delivered recurrently. At the end of May efficiencies have delivered £1.5m which is behind plan by £0.4m.

The forecast assumes that the current unidentified gap will be closed and the full efficiency programme will be delivered.

Agency expenditure at the end of May is slightly over plan at £0.1m but is forecast to be on plan by the end of the financial year. Bank expenditure is above plan at the end of May by £0.4m and is forecast to be over plan by £1.6m by the end of the financial year.

At the end of May, OoA expenditure is above plan by £0.6m. The current forecast is based on a reducing trajectory which brings the forecast overspend to £0.8m by the end of the financial year.

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

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

Risks and Assurances

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

Consultation

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

Governance or Legal Issues

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

Net Zero Duty Implications

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

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

No meaningful impact identified.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

Recommendations

The Board of Directors is requested to:

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

Report presented by:

Tumi Banda

Director of Nursing, AHPs, Quality and Patient Experience

Vikki Ashton-Taylor

Deputy Chief Executive and Chief Delivery Officer

Rebecca Oakley

Director of People, Organisational Development and Inclusion

James Sabin

Director of Finance

Report prepared by:

Peter Henson

Head of Performance and Delivery

Rachel Leyland

Deputy Director of Finance

Liam Carrier

Assistant Director of Workforce Transformation

Joseph Thompson

Associate Director of Physical Health and Quality

Integrated Performance Report

July 2026

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

Responsible Committee: **Quality and Safety Committee**

Executive Summary

This update focuses on performance during March 2026 to May 2026. The Quality metrics highlighted in green in the table below have been reviewed against the agreed improvement ambition to reduce the 24-month benchmark mean by 10% over 2026/27, where this ambition applies. These include medication incidents, falls on Inpatient wards, abscond, escape and failure to return incidents, seclusion episodes, physical restraint incidents, violence and aggression between patients, assaults on staff by patients and ligature incidents involving fixed points. Metrics with individual national or Trust targets are highlighted in blue. Overall, the period shows a mixed position: some indicators are either below or moving towards the 10% reduction ambition, while others remain above the agreed improvement threshold and require continued targeted action through the relevant governance and improvement groups. The updated measures remain aligned to the Trust Strategy, Quality Delivery Plan and the operational context created by increased inpatient activity and the Making Room for Dignity (MRfD) Programme and TUPE of Older People's Inpatient and Neurodevelopmental services from Derbyshire Community Health Services (DCHS).

Overview

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

- Performance remained below the 100% target during March to May 2026, with complaints responded to within 90 working days reported at 43.8% in March, 41.7% in April and 42.1% in May. Mitigation includes additional Bank Investigator capacity. The Patient Experience team has an improvement plan that is being supported by the Transformation team and assurance on progress is being monitored in Quality and Safeguarding Committee, Care Group performance meetings and the quarterly Patient and Carer Experience report with an improvement expected over the next six months.

Seclusion episodes per month (Target: ≤18)

- Seclusion episodes were 27 in March; 14 in April and 33 in May, against the 10% reduction ambition of ≤18.4 episodes per month. April achieved the ambition, but March and May were above threshold. Assurance is provided by targeted Positive and Safe team support to the PICU and Male wards at the Radbourne Unit via an individualised practice review, exploration of less restrictive alternatives and the introduction of seclusion reviews from May 2026. Oversight continues through the Reducing Restrictive Practice Group.

Physical restraint incidents per month (Target: ≤88)

- Physical restraint incidents remained above the 10% reduction ambition of ≤88.3 incidents per month throughout the period, with 139 incidents in March, 128 in April and 149 in May. This indicates deterioration against the improvement ambition and continued reliance on restraint interventions. The June dashboard provides mitigation that earlier peaks were driven by a small number of high-acuity patients and that restraint practice is being addressed through individualised care planning, targeted Positive and Safe support, supplementary training sessions and continued monitoring of compliance with Positive and Safe and breakaway training through the Training and Education Committee.

Physical restraint by prone position (Target: 0)

- Prone restraint remained above the Trust ambition of zero, with three incidents in March; 11 in April and 10 in May. Although March represented an improvement compared with February, the increase in April and May demonstrates that further targeted work is required to reduce prone restraint to zero by September 2026. Mitigation includes individual review of every prone restraint episode, ward-level support from the Positive and Safe team, continued use of alternative positions where safe, and a planned support programme with the Trust physical health team from June 2026 to improve staff confidence in administering intramuscular medication through alternative injection sites.

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

- Incidents of violence and aggression between patients were 15 in March; 23 in April and 38 in May against the 10% reduction ambition of ≤18.9 incidents per month. March achieved the ambition, but April and May were above threshold, with May showing a notable increase. The main areas of focus remain Organic Older Adult Inpatient services and the PICU, where increases are linked to multiple incidents involving a small number of individuals. Assurance is provided that incidents were reported as low or no harm, with continued monitoring and improvement work led through the Positive and Safe team and the monthly Reducing Restrictive Practice Group.

Assaults on staff by patients (Target: ≤24)

- Assaults on staff by patients were 29 in March; 33 in April and 43 in May against the 10% reduction ambition of ≤24.2 incidents per month. All three months were above threshold, with a deteriorating trajectory across the period. Mitigation includes ongoing oversight by the Reducing Restrictive Practice Group, direct engagement and support from the Positive and Safe team, and the staff collaborative on violence and aggression, which launched in January 2026, held a second session in April 2026 and has a dedicated workstream due to commence in June 2026. Equality-related assurance is also provided through the anti-racism workstream and PCREF governance, given the continued issue of racist abuse in patient-to-staff incidents.

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

- Ligature incidents were 73 in March, 60 in April and 53 in May against the overall reduction ambition of ≤55.0 incidents per month. This shows improvement across the period, with May achieving the ambition. Fixed-point ligature incidents were four in March, one in April and two in May against the 10% reduction ambition of ≤3.25, meaning April and May were within threshold but March remained above. Assurance is provided that over 90% of ligature incidents were categorised as minor or insignificant, fixed-point incidents represented a small proportion of the total, and continued monitoring takes place through the monthly Ligature Risk Reduction Group. A succession plan is also being progressed to maintain ligature training capacity following the planned departure of the suicide prevention lead.

Medication incidents per month (Target: ≤122)

- Medication incidents were 125 in March, 109 in April and 142 in May against the 10% reduction ambition of ≤121.6 incidents per month. April achieved the ambition, but March and May were above threshold, with May showing an increase. The main reported incident types continue to relate to storage and temperature monitoring. Mitigation includes targeted education and training, updates to medical induction and Trust-wide communications, strengthened ePMA use, ward-level action plans, routine pharmacy Datix reviews, escalation through medicines governance groups and storage issues being managed through the monthly Medicine Assurance Group.

Falls on Inpatient wards (Target: ≤39)

- Falls on Inpatient wards were 38 in March, 49 in April and 44 in May against the 10% reduction ambition of ≤38.9 falls per month. March achieved the ambition, while April and May were above threshold. Assurance is provided that 95% of falls recorded between February and May were categorised as minor or insignificant, all patients identified as high risk have falls prevention care plans in place, and high-risk patients are reviewed through individualised multi-disciplinary meetings and the bi-weekly falls prevention meeting. Further mitigation includes contactless patient monitoring in Cubley Court and Tissington and falls prevention training compliance at 91%, with learning reviewed through monthly Care Group performance meetings.

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

- Abscond, escape and failure to return incidents were 29 in March; 13 in April and 19 in May against the 10% reduction ambition of ≤21.0 incidents per month. April and May achieved the ambition, while March was above threshold. The March increase should be considered in the context of Inpatient acuity and did not indicate an associated increase in patient harm. Assurance is provided that incidents have been below the mean since April 2026 and continue to be monitored for patterns or themes through inpatient governance routes.

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

- DoC incidents remained above the zero target, with five incidents in March, one in April and one in May. Assurance is provided that DoC was discharged in 100% of applicable cases, incidents were reported across different teams with no identified themes or patterns and restorative actions were documented to prevent recurrence. Any DoC incident continues to be reviewed through the twice-weekly Trust Serious Incident Group.

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

- CPA annual review compliance remained below the 95% target, at 76.0% in March, 75.8% in April and 76.3% in May. Contributing factors include recording issues on the electronic patient record, staff sickness and acuity within Community services. Mitigation includes Divisional cross-check meetings, Care Group equivalent governance and bespoke action plans for any service below 85% compliance. The June dashboard also notes that compliance monitoring is embedded in Divisional performance arrangements, with small service numbers contributing to percentage variation.

Proportion of patients clinically ready for discharge (CRfD) (Target: ≤3.5%)

- The proportion of service users CRfD remained above the national 3.5% threshold, at 11.9% in March, 8.8% in April and 9.3% in May. Although this remains outside target, the position improved from March to April and remains below the Trust mean of 11% reported in the June dashboard. The main drivers continue to be lack of suitable housing, funding arrangements and availability of social care placements. Mitigation is through twice-weekly multi-agency discharge event (MADE) meetings with ICB, DHcFT Directors, Social Care, Continuing Healthcare and Housing colleagues to address barriers and support resolution.

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

- For adult discharges aged 18–64, the proportion with a LoS over 60 days was 30.0% in March, 29.5% in April and 29.7% in May, remaining above the 24.2% target. For discharges aged 65+, the proportion with a LoS over 90 days was 38.0% in March, 35.3% in April and 32.0% in May, which was within the 39.5% target throughout the period and showed sustained improvement. Key drivers for longer stays continue to include placement delays, care home leave requirements and housing barriers. Mitigation includes weekly clinical and operational review of patients with long LoS, escalation to MADE meetings, Divisional performance improvement plans, monthly Divisional board oversight and bi-weekly Older Adult Inpatient cross-check meetings.

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

- The number of patients open to Mental Health services but not seen for over 12 months was 401 in March, 421 in April and 400 in May, remaining above the zero target. This continues to represent an access, safety and regulatory risk and remains part of the Trust Strategy and improvement plan. Related assurance from the June dashboard is that access and waiting-time risks are recognised as a strategic concern, with performance improvement plans in place for the longest-waiting services and oversight through Divisional business meetings and monthly Care Group operational meetings. The Patients Open but Not Seen report is also being refined for inclusion in future Quality Dashboard reporting.

QUALITY KEY PERFORMANCE INDICATORS

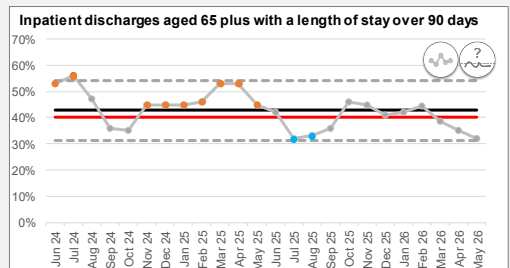
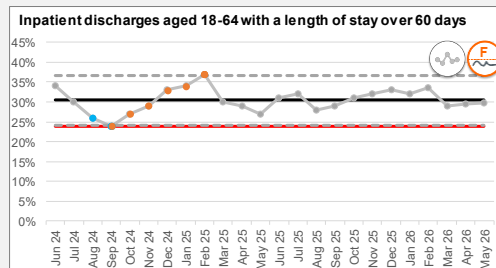
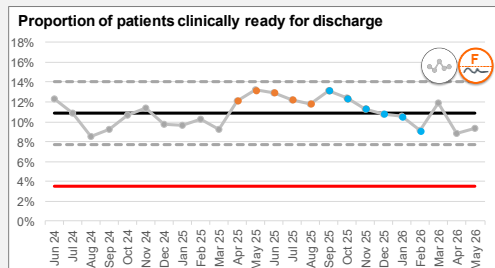
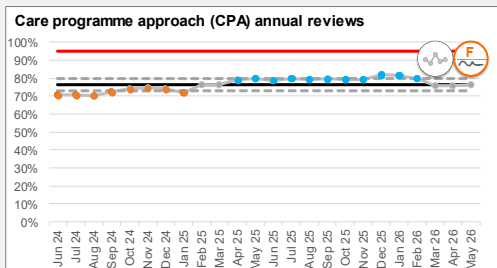
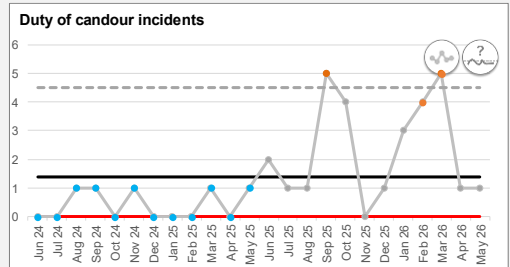
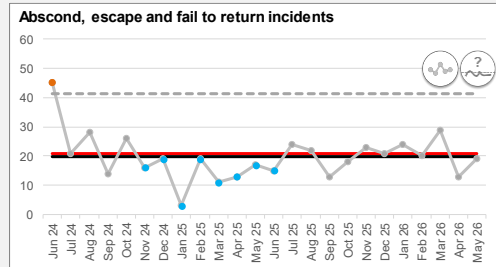
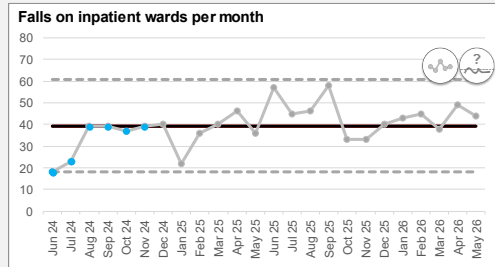
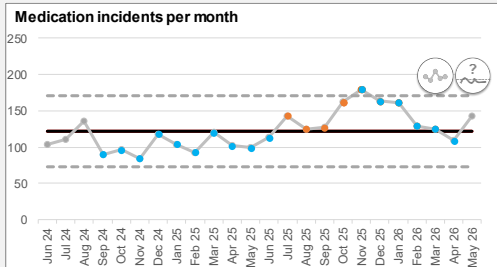
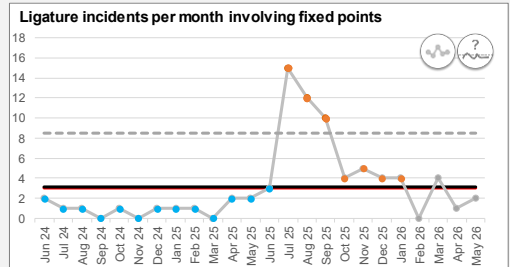
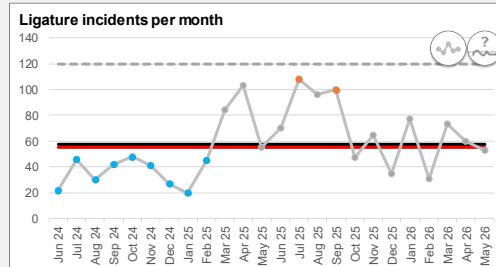
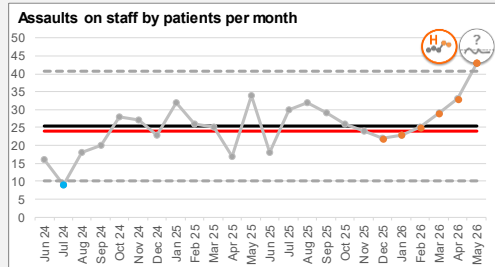
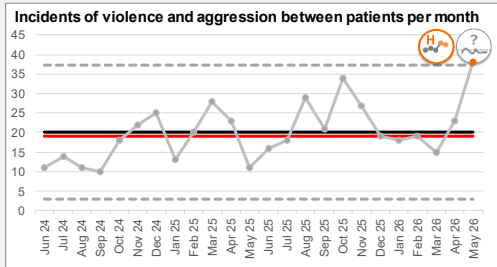
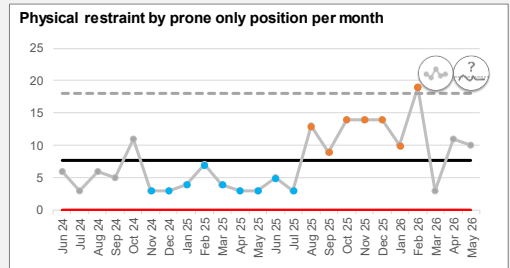
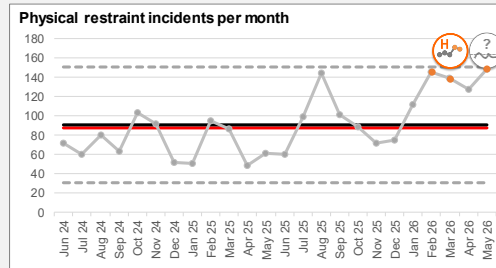
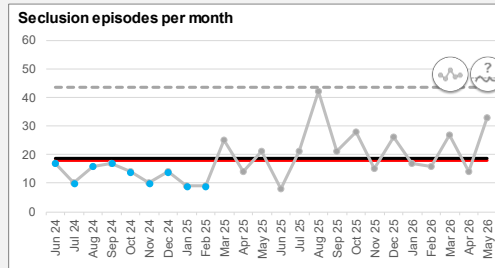
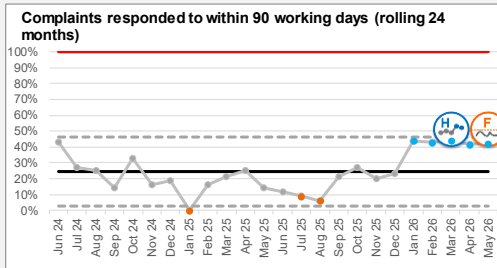
Measure	Target	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	
No. of complaints responded to within 90 working days (rolling 24 months)	100%	12%	9%	6%	21%	27%	20%	23%	44%	43%	44%	42%	42%	
Seclusion episodes per month	18	8	21	42	21	28	15	26	17	16	27	14	33	
Physical restraint incidents per month	88	60	99	145	102	89	72	75	112	146	139	128	149	
Prone restraint incidents per month	0	5	3	13	9	14	14	14	10	19	3	11	10	
Incidents of violence and aggression between patients per month	19	16	18	29	21	34	27	19	18	19	15	23	38	
Assaults on staff by patients per month	24	18	30	32	29	26	24	22	23	25	29	33	43	
Ligature incidents per month	55	70	108	96	100	47	65	35	77	31	73	60	53	
Ligature incidents per month involving fixed points	3	3	15	12	10	4	5	4	4	0	4	1	2	
Medication incidents per month	122	113	143	125	127	162	179	163	161	129	125	109	142	
Falls per month	39	57	45	46	58	33	33	40	43	45	38	49	44	
Abscond, escape and fail to return incidents	21	15	24	22	13	18	23	21	24	20	29	13	19	
Duty of candour incidents	0	2	1	1	5	4	0	1	3	4	5	1	1	
Care programme approach (CPA) annual reviews	95%	79%	80%	79%	80%	79%	79%	82%	82%	80%	76%	76%	76%	
Proportion of patients clinically ready for discharge	3.5%	13%	12%	12%	13%	12%	11%	11%	11%	9%	12%	9%	9%	
Inpatient discharges aged 18-64 with a length of stay over 60 days ¹	24%	31%	32%	28%	29%	31%	32%	33%	32%	35%	30%	30%	30%	
Inpatient discharges aged 65 plus with a length of stay over 90 days ¹	40%	42%	32%	33%	36%	46%	45%	41%	42%	44%	38%	35%	32%	
Patients open to mental health services but not seen for over 12 months	0	661	575	587	503	460	433	399	408	401	401	421	400	

¹NHS England data

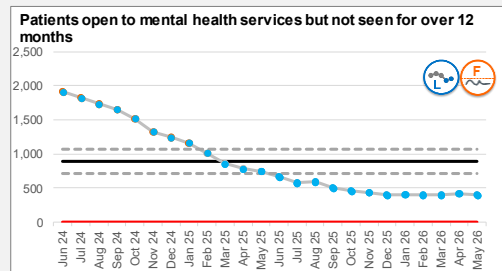
Target

Mean over the past 24 months

Quality Key Performance Indicators – Statistical Process Control Charts



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



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



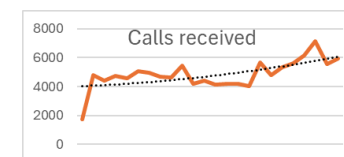
Deputy Chief Executive/ Chief Delivery Officer:
Vikki Ashton Taylor

Responsible Committee: **Finance and Performance Committee**

Executive Summary

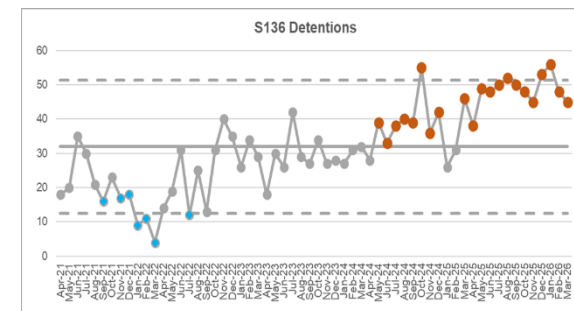
Inflow

- **Percentage of patients in crisis to receive face-to-face contact within 24 hours:** this is an NHS oversight framework (NOF) measure of the proportion of urgent referrals made to crisis teams and mental health single points of access who were seen face-to-face within 24 hours. In the Q4 NOF ratings the Trust placed 14th best provider in the country for performance against this metric.
- **Mental Health helpline:** From the latest official statistics in development published by NHS England (March 2026), the proportion of calls to the helpline which were abandoned (callers hung up) after interactive voice response call steering remained high at 49%. In comparison, the national average for calls abandoned was 27%. The Trust's speed to answer calls was the fourth quickest in the Midlands, at 80 seconds. This was considerably quicker than the national average of 239 seconds. Demand for the Trust's service continues to increase, averaging around 200 calls a day over the last six months. The performance improvement plan has been central to supporting the actions undertaken by the triumvirate. Weekly cross-check meetings review performance against the plan and there are fortnightly performance delivery and assurance meetings with the Divisional lead to ensure progression. Key actions and updates are as follows:
 - The Mental Health Text Message Service remains on track to be implemented from 1 July 2026. Training and testing of the new system is ongoing currently with weekly project implementation meetings in place
 - The 0800 number will cease on 1 July. This will ensure the route into the helpline is more streamlined and improve data
 - The professional line has moved over to the Ignite call management system, consolidating the technical infrastructure. Improvements to answering the professional line calls have continued to increase month on month (we have seen a 22% increase since Jan from 57% to 79% in May). This is largely due to improved roster management and reduction in vacancies
 - Continued work on securing a new service specification is being worked through with the ICB which is reflective of the service for 2026
 - Recruitment remains a challenge: 2.3 whole time equivalent vacancies remain. These are back out to advert but the service is also exploring at pace alternatives to Band 6
 - Work is ongoing with recruitment around opportunities for skill mix and recruitment drives. The team are also increasing bank opportunities to support the performance. Demand still outstrips capacity even with baseline recruitment filled and this continues to be a risk to performance and service delivery and has been highlighted as a gap in commissioning.



Outflow

- **Inappropriate OoA Adult Acute placements:** placements have significantly reduced from a high of 28 back in January 2025. However, the Trust continues to require some external placements owing to demand exceeding bed capacity and no Psychiatric Intensive Care Unit (PICU) provision for females in Derbyshire. High levels of acuity persist. For example, S136 detentions have significantly increased over the past two years and as 35% of S136 detentions have resulted in admission, this is having an impact on bed capacity. At the time of writing, there is one patient in an inappropriate OoA placement, and six female patients in inappropriate OoA PICU placements. In addition to the above, there are three females in continuity of care PICU placements, and 19 patients in continuity of care acute placements. Of the PICU patients, there is only one identified as CRfD. The male PICU for Derbyshire, which opened in July 2025, has enabled male patients to be cared for close to their family and local support networks. As a result there are zero male PICU patients OoA. To ensure improvements in the female OoA position are made, there are two key actions in progress, firstly the appointment of a Clinical Bed Manager for six months to ensure case management and oversight of transition, step up and step down into the acute/enhanced care ward pathway. The expressions of interest will shortly be put out to advert with the aim to recruit and have in place before the end of July. There is also an instruction to review our Enhanced Care Ward facility (Audrey House). This will be carried out by the Clinical Bed Manager to review the female acute pathway, identifying areas of good practice and improvement areas to inform clinical, operational and commissioning next steps. This will be completed within four weeks of the appointment of the Clinical Bed Manager.



- Proportion of Adult Acute Inpatients aged 18-64 discharged with 60 days plus LoS:** At 29.8%, in the Q4 NOF rankings, the Trust placed 13th highest proportion of LoS over 60 days of all providers and in quartile 3. This was an improvement since the previous quarter. If people had been discharged when clinically ready, the Trust would have ranked 10 places better. 9% of current adult inpatients are CRfD, totalling 713 delayed bed days to date. The most common reason for delay continues to be awaiting supported accommodation (60%). The Trust continues to work with System partners to reduce CRfD delays and is actively engaged with the Midlands Learning and Improvement Network which is supporting shared learning as an enabler to improving LoS. A revised performance improvement plan is in progress, with all actions due to be completed by September 2026. Whilst the actions will support improvement to compliance, there is a significant reliance on the System-wide work to place those CRfD into the right care and accommodation. Without the work across the System on housing care and accommodation there remains a risk to reaching this target.
- **Average LoS for Adult Acute, Older Adult and PICU Mental Health beds:** the latest monthly Mental Health services dataset data published by NHS England (April 2026) placed the Trust exactly mid-table of all NHS providers with an average LoS of 58 days. However, if patients had been discharged when CRfD the Trust's Q4 average LoS would have been 49 days, which would have placed 11th lowest. Revised performance improvement plans for Adult and Older Adult LoS reduction and improved flow have been developed and are currently in the implementation phase. The key actions to improve the position include improving compliance of 72-hour review, improving the discharge process including compliance with the three-day leave guidelines and implementing the Getting it Right First Time (GiRFT) review meetings. There is also work to refresh the System-wide work on flow, completing Phase 2 of the Housing Association Charitable Trust (HACT) project, completing the quality improvement project.
 - **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 and placing the Trust in the top 12 of providers nationally. This process is tightly monitored by the Trust's Performance Analyst to ensure the safety of patients.

Elective/access

- **Women accessing specialist Perinatal Mental Health service:** the service continues to consistently large numbers of women during the periods before and after the birth of their children. The current access rate of 12.7% placed NHS Derby and Derbyshire ICB in the top six nationally

- **Adult autistic spectrum disorder assessment (ASD):** activity levels continue to exceed the commissioned target for assessments, with the full year target exceeded by 81% last financial year and 2026/27 year to date target exceeded by 138%. Waiting times remain very high at around 52 weeks, with demand far exceeding commissioned capacity. The waiting list is slowly reducing over time. However, the number waiting is significant.
- **Community waits over 52 weeks:** In the latest NOF ratings (Q4) the Trust ranked sixth worst NHS provider in the country for waits over 52 weeks, at 51%. The national median was just 0.3%. From internal data the May position has deteriorated to 51%. The majority of the long waits are for Community Paediatric ASD assessment and/or attention deficit hyperactive disorder (ADHD) assessment. Demand over the past six years has been as high as 450% above capacity and remains to date at 250% above. There has been limited System ownership to prevent flow into health services. There has been no increase in funding to match increased demand or population increase of 10% over the past 15 years. A performance improvement plan has been devised and implemented and further phased improvement through backlog reduction commenced in April 2026. Actions include:
 - Commitment to System ownership and prioritisation of early intervention strategy to reduce flow – internal development day planned for June 2026
 - Review of footprint-wide early years programme following the success of the City Pilot to reduce the flow into secondary services for children aged 0-4
 - Paediatric Physiotherapy team has a planned recovery trajectory to reduce all Community waits to the 18 week target, despite a few individual cases where families have not engaged all waits are predicted to be below the 18 week referral to treatment by August 2026.
 - Community Paediatrician team – following a transfer of records splitting Community waits by clinical priority age groups, the 0-4 pathway is currently being targeted. There are a number of workforce issues including long-term sickness and performance issues with the team which despite planning may mean that the target to reduce all waits under 52 weeks by November will still be challenging. Productivity, skill mix and transformation are all in place to continue to review and consider system wide solutions in order to meet the target.
- **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%). Following successful implementation of the performance improvement plan, for the last four months the target has been exceeded.
- **Children and young people (CYP) Mental Health access:** with a 1.03% reduction in access, the Trust placed in the worst 25% of NHS providers in Q4. The provider median was an increase of 6.7%. Service improvement is ongoing, with staff in post. The CAMHS group programme is now running, alongside increases in allocations and expected clinical contacts across the service, which is reducing time from assessment to treatment, and in turn improving flow and productivity within the service. An additional 11 staff are in the process of being recruited which will increase the number of children seen by 400 per year. This will have a significant impact on the percentage recovery target by December 2026.
- **Individual work placement support:** the Work Your Way team of employment specialists and job coaches has continued to help an increasing number of people using Community Mental Health services in Derbyshire to find work and stay in work, with 79% reporting a positive experience.

Collaboratives

- **Transforming care programme:** for adults, the Trust and System have agreed a trajectory for 2026/27 to reduce from 32 inpatients in Q1 down to 28 in Q4. As of May 2026, there were 18 Adult Inpatients with autism, which is two above trajectory, and 18 adults with a learning disability and autism, which is also two above trajectory, giving a total of 36 adults in total, four over the trajectory of 32. There has been lack of progression on discharges from secure settings: 17 out of 38 Inpatients have a LoS of five years plus. The adult health commissioning pathway review of services is unpicking how services and job roles may require a change to support the System to perform effectively in discharging long stay patients. The agreed target threshold for CYP Inpatients is static at three per month. Currently there are four CYP Inpatients, which exceeds the threshold by one. With ICB support we have aligned the Learning Disability & Autism (LD&A) Patient Review team with the ICB Escalation team which will align the transforming care pathway with the ICB escalation pathway providing increased oversight and shared system ownership.

The primary challenges are with appropriate care and accommodation to support LD&A patients in the Community alongside System tolerance of risk often leading to out of hours admissions. A performance improvement plan is now in place and shared with System partners to address these issues with the aim to achieve the target of LD&A admissions of 28 by March 2027.

- **Living Well:** A weekly oversight group is in place to work through the current plans in relation to maintaining the Adult Social Care (ASC) offer within the Living Well Model. Further consideration needs to be given in relation to the contracting and commissioning arrangement around the ASC offer. The oversight group is monitoring data across and providing updates to both Divisional Assurance Board and TDG. The ICB Cluster is currently undertaking a review of the Living Well integrated Model of Care, with a view to making a commissioning decision in September 2026.

OPERATIONAL KEY PERFORMANCE INDICATORS

Measure	Target	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	
Long term plan 2025/26														
Inappropriate adult acute & PICU mental health out of area placements at month end [^]	5	13	4	11	10	4	7	4	7	3	6	6	11	
Women accessing specialist perinatal mental health services (rolling 12 months)* ^{^^}	1242	1395	1400	1395	1365	1360	1365	1360	1355	1385	1395			
Perinatal access rate (ICB)*	10%	12.9%	13.0%	12.6%	12.4%	12.3%	12.4%	12.3%	12.2%	12.5%	12.7%			
Individual work placement support access (rolling 12 months)*	690	760	755	780	810	805	810	805	845	845	860			
Average length of stay for adult acute, older adult & PICU mental health beds**	55	60	59	61	63	62	63	62	63	63	60	58	60	
NHS oversight framework 2025/26 trust metrics														
Proportion of people waiting over 52-weeks for community services*	0%	65%	68%	65%	65%	66%	62%	66%	62%	63%	51%	52%	54%	
Children and young people (CYP) accessing NHS-funded MH services - annual change*	15.9%	1.8%	0.1%	0.4%	0.4%	1.0%	0.4%	1.0%	1.7%	0.3%	-1.0%			
Proportion of acute inpatients aged 18-64 discharged with 60 days plus length of stay**	20.6%	27%	27%	33%	31%	31%	31%	31%	31%	34%	29%	29%	29%	
Percentage of patients in crisis to receive face-to-face contact within 24 hours*	65.4%	53%	65%	76%	75%	76%	75%	76%	78%	81%	71%			
Additional NHS oversight framework trust metrics for 2026/27														
Children and young people's mental health waits for help that are over 104 weeks*	5%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.3%	18%	22%			
Adults discharged from community mental health services with a paired outcome score*	12%	Awaiting publication of data												
CYP discharged from community mental health services with a paired outcome score*	28%		12.3%	12.3%	18.4%	13.8%	14.3%	21.4%	11.3%	16.8%	27.0%			
Mean length of stay for adult acute mental health and PICU patients (latest 3 months)	40	52	54	52	52	52	55	56	57	56	52	51	55	
Mean length of stay for older adult acute mental health patients (latest 3 months)	73	105	85	86	92	107	101	86	87	93	96	95	89	
Adult acute and rehabilitation discharges followed up within 72 hours (latest 3 months)	80%	88%	92%	85%	89%	86%	91%	86%	91%	92%	89%	90%	88%	
Mental health 14-day readmission rate (latest 3 months)*	5%		5%	5%	4%	5%	1%	2%	3%	5%	3%			
Proportion of patients waiting over 52 weeks for community care	0%	64%	64%	65%	65%	66%	62%	66%	62%	63%	51%	52%	54%	
Proportion of patients waiting less than 18 weeks for community care	92%	14%	17%	14%	11%	16%	18%	20%	23%	20%	27%	25%	26%	
Data quality maturity index	95%	96%	99%	99%	99%	99%	99%	99%	98%	97%	97%	98%	98%	
Key operational measures														
Children & young people eating disorder routine referrals seen within 4 weeks*	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Children & young people eating disorder urgent referrals seen within 1 week*	95%	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	100%	#N/A	#N/A	#N/A	100%	
Dementia diagnosis rate (ICB)*	68%	68.6%	68.7%	68.9%	68.8%	68.9%	68.8%	68.9%	68.7%	68.7%	69.8%			
Early intervention in psychosis 2 week waits from referral to treatment - complete	60%	39%	52%	85%	56%	78%	41%	78%	41%	67%	73%	70%	88%	
Adult ASD assessment – number of people waiting at month end	219	1403	1373	1391	1370	1394	1436	1379	1365	1295	1272	1274	1200	
Adult ASD assessment – average wait (weeks)	18	54	52	53	55	55	54	56	53	50	50	49	52	
Adult ASD assessment – number of assessments completed per month	26	29	36	44	47	34	53	34	53	54	56	68	56	

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

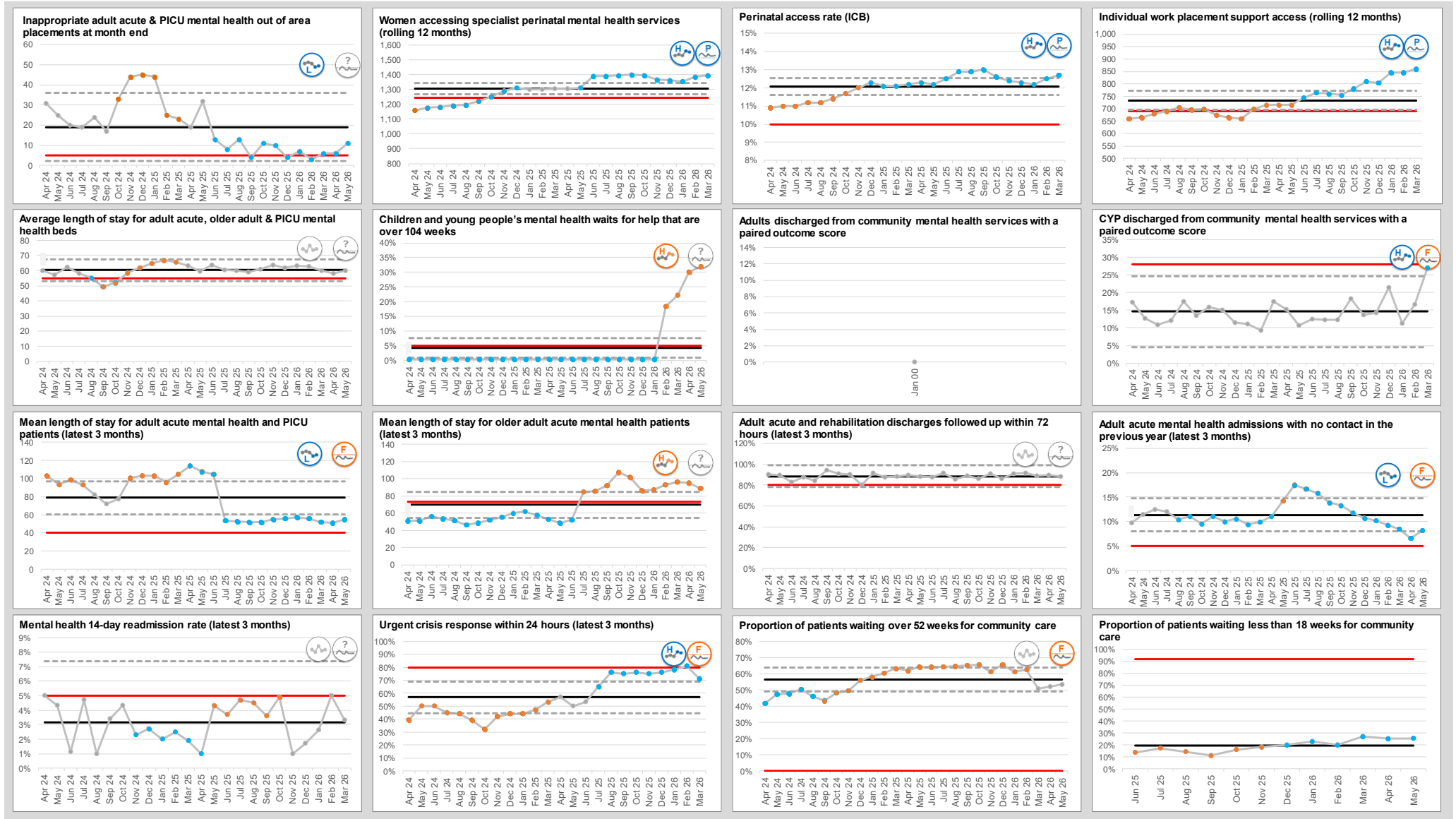
* Data source = NHS England

^{^^} Perinatal and maternal mental health services

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

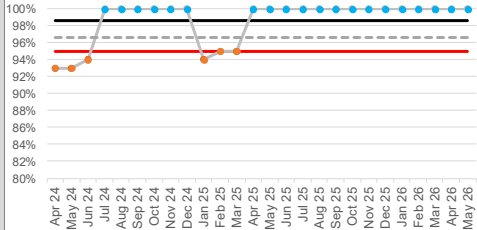
For more information regarding the NHS Oversight Framework 2026/27 see: [NHS England » NHS Oversight Framework](#)

Operational Key Performance Indicators – Statistical Process Control Charts

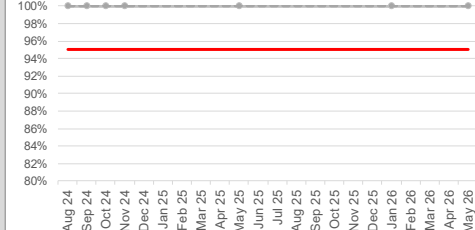


Operational Key Performance Indicators – Statistical Process Control Charts

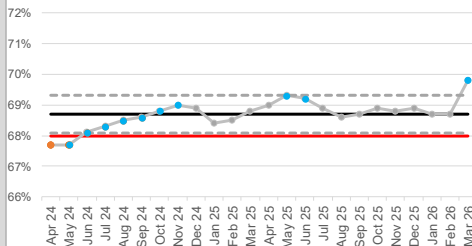
Children & young people eating disorder routine referrals seen within 4 weeks



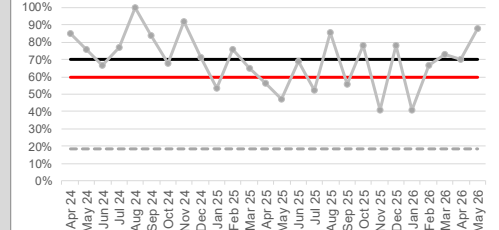
Children & young people eating disorder urgent referrals seen within 1 week



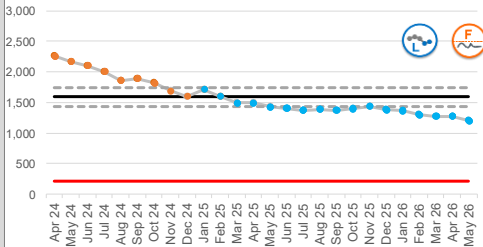
Dementia diagnosis rate



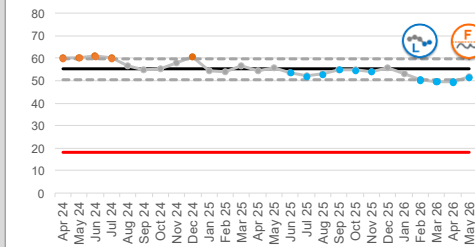
Early intervention in psychosis 2 week waits from referral to treatment



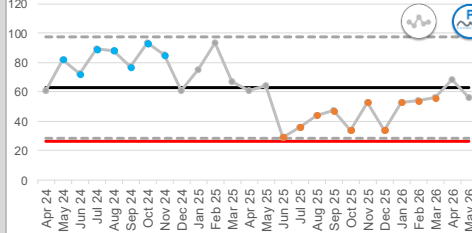
Adult ASD assessment – number of people waiting at month end



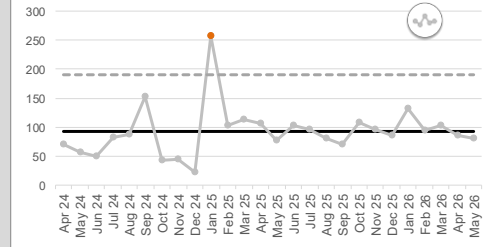
Adult ASD assessment – average wait (weeks)



Adult ASD assessment – number of assessments completed per month



Adult ASD assessment - number of accepted referrals per month



TRANSFORMATION AND IMPROVEMENT

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

FLOW PATHWAY

National Planning Priority 2025/26: Reduction of Adult Acute Mental Health inappropriate OoA placements

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

Interventions:

Analysis is currently underway to understand the rise in female OoA PICU placements which is driving the off-plan position for May 2026. This is including case review of patients placed to understand potential missed opportunities for PICU admission avoidance. An associated improvement plan will be designed and accelerated for delivery.

A comprehensive improvement and transformation plan remains in delivery for the Patient 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.

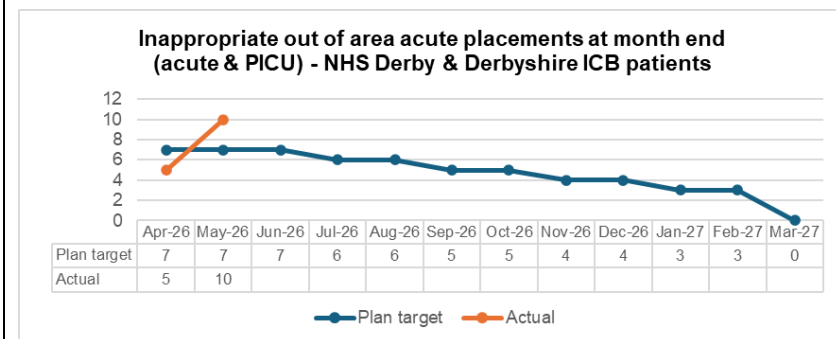
For Adult Acute our internal trajectory goes beyond the national ambition for eradication of area placements and further includes withdrawal from privately commissioned beds over 2026/27. This plan is aligned to and dependant on the reduction in LoS plans at the following page. However, at the current rate of admissions per annum to Trust Acute beds, to free up 16 beds of capacity would require an 11% reduction in LoS. The current trajectory for LoS is not only insufficient, but it will also not deliver aligned to the earlier delivery timescales for commissioned beds.

Additional interventions on admission avoidance are currently being scoped and considered to recover the trajectory on commissioned bed reduction. These include:

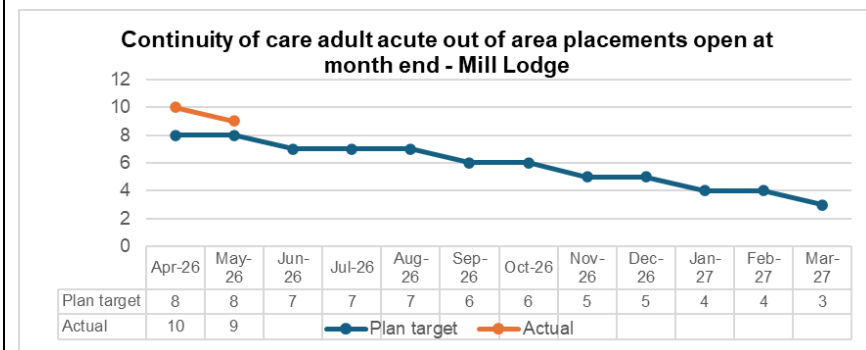
Pathway	Work stream
Inflow	1. Implementation of new Getting it Right First Time (GiRFT) operational and clinical standards across the 'end-to-end' pathway
	2. Mental Health Urgent Assessment Centre model
	3. Six-month secondment of a Clinical Bed Manager role to support gatekeeping and case management for OoA patients

Impact:

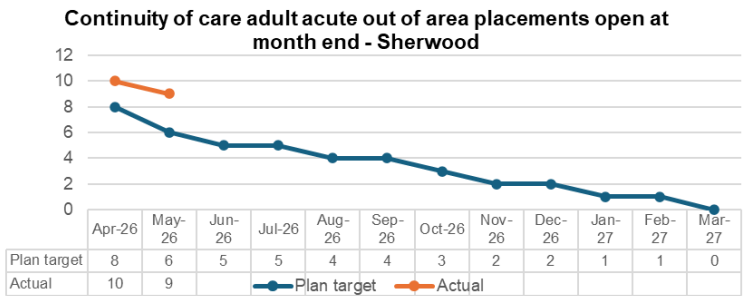
The inappropriate Adult Acute OoA placement position achieved at 31 May 2026 was 10 (two Acute and eight PICU), above the operational plan trajectory of seven.



The Adult Acute continuity of care OoA placement position achieved at 31 May 2026 was 16 (seven at Mill Lodge and nine at Sherwood), two above the operational plan trajectory of 14.



To support the ongoing design and development of opportunities and plans, a baseline assessment is underway of services and model of care across the 'end-to-end pathway' aligned to the newly-published GiRFT operational standards for urgent mental health care.



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

FLOW PATHWAY

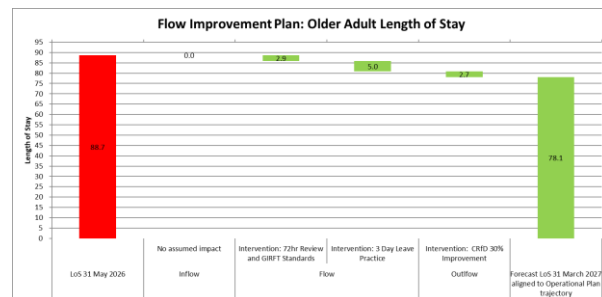
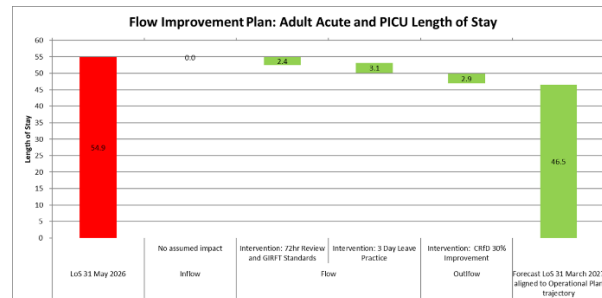
National Planning Priority 2026/27: Reduction of adult acute & PICU inpatient length of stay

Interventions:

A comprehensive improvement and transformation plan remains in delivery for the Patient 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
Flow	1. 72 hour review and GIRFT standards
	2. Inpatient leave protocol
Outflow	3. Clinically ready for discharge

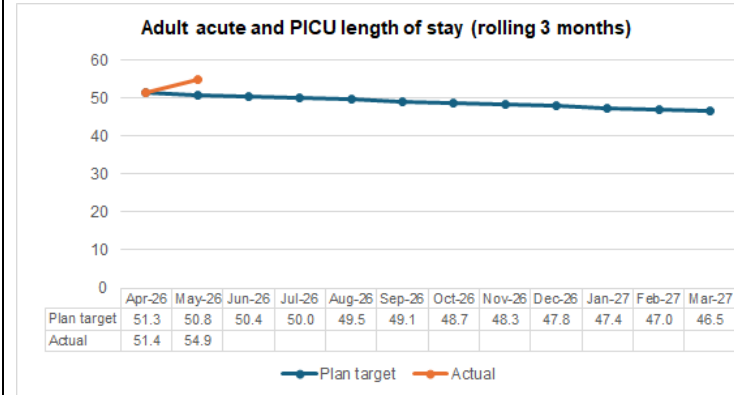
The 'bridges' below visualise the data driven improvement hypothesis that has been developed for length of stay with progress being tracked through enhanced oversight of ward level performance.



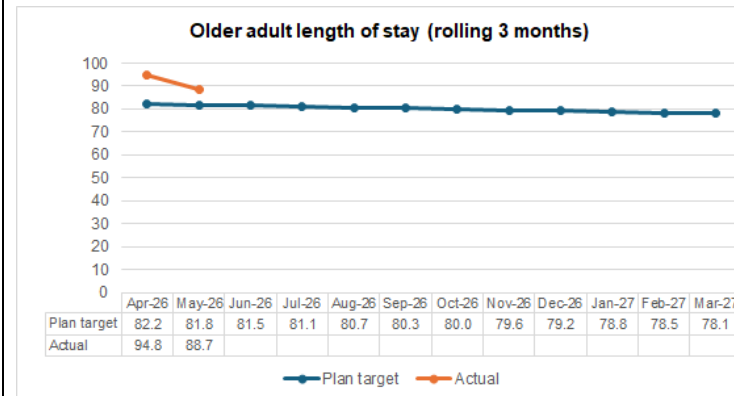
New GIRFT standards have been published for the clinical and operational pathway for urgent mental health care.

Impact:

Adult Acute and PICU LoS March to May 2026 was 54.9, above the operational plan trajectory of 50.8.



Adult acute & PICU length of stay March to May 2026 was 88.7, above the operational plan trajectory of 81.8.



A self-assessment against these is underway to understand further opportunities, alongside a quality improvement project across Adult Acute wards to support understanding and improvement of frontline practice, and a Quality Improvement project to identify earlier housing care and accommodation needs so intervention for onward referrals can be identified sooner and actioned in order to reduce discharge delays.	
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The Transformation and Improvement Portfolio is supporting achievement of improved performance across a number of measures across the IPR with key updates below.

FLOW PATHWAY

National Planning Priority 2026/27: Elimination of CYP Mental Health waits over 104 weeks

Interventions:

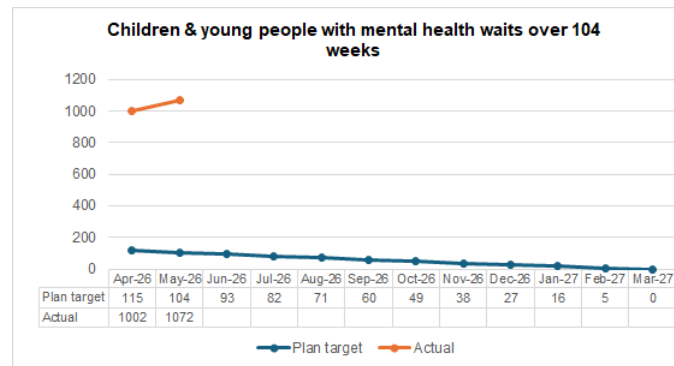
A Performance Improvement Plan is in place to eradicate Mental Health waits for CYP (excluding Neurodevelopmental (ND)) aligned to the Operational Plan trajectory by March 2027.

Transfer of ND waits from the CSDS has changed the Operational Plan opening position. Demand and capacity analysis is underway to explore hypothesis for reduction of the ND waiting list and a workshop has been established with the teams to further explore development of options and plans in June 2026.

Internal data for CYP Mental Health services indicate that there are now 50 children waiting over 104 weeks (excluding CYP ND Unit; Adult Mental Health and ND Units).

Impact:

At the end of May 2026, the number of CYP waiting over 104 weeks was 1,072, above the operational plan trajectory of 104. The trajectory is particularly challenging as it was set based on a baseline mandated by NHS England prior to the ASD and ADHD waits being transferred over from the CSDS.



National Planning Priority 2026/27: Elimination of Community waits over 52 weeks

Interventions:

Performance Improvement Plans are in place for CYP Physiotherapy and Community Paediatrics.

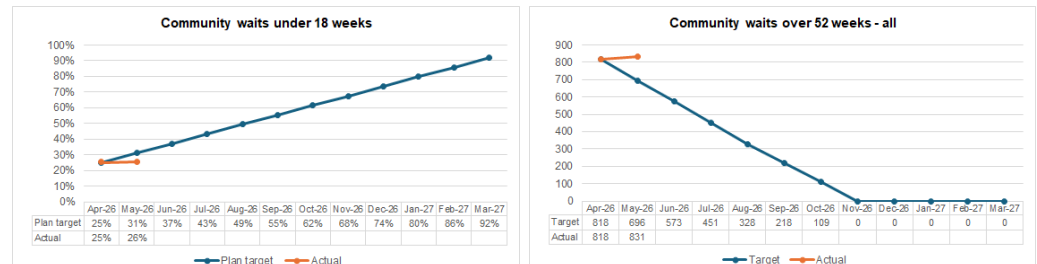
The improvement plans reflect interventions that are designed to increase clinic slot capacity through adjustment of the workforce and care delivery model and improvement in DNA rates.

Expected recovery trajectories:

- CYP Physio: end August 2026
- Community Paediatrics: end November 2026.

Impact:

At the end of May 2026, the number of children waiting over 52 weeks was 831, above the operational plan trajectory of 696. The waits consist of Community Paediatrics – 772, Community Physiotherapy – 58 and Nursing and Therapy support for long-term conditions (children's ND) – one.



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 2026/27: Various as set out below

DHcFT Operational Planning Assumption 2026/27: 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 10 work streams that include:

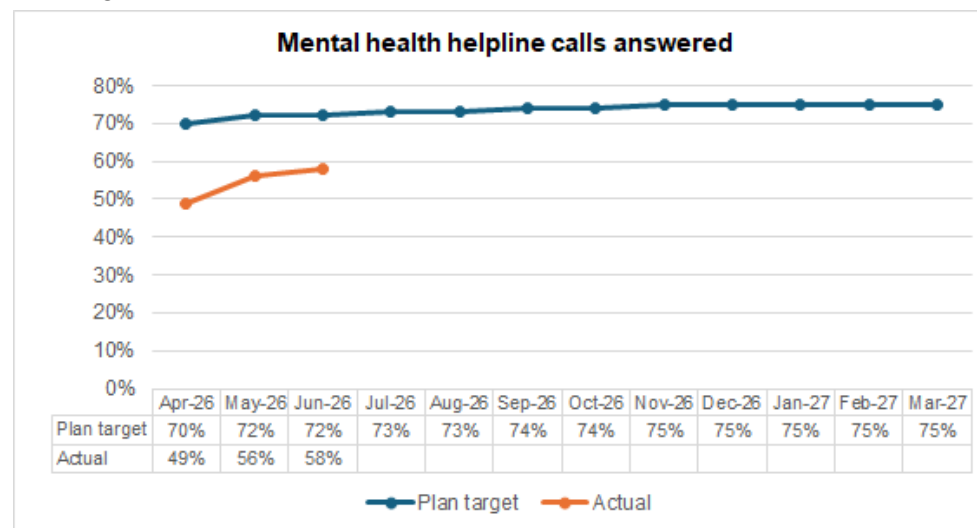
- one access point though 111 mental health option and closure of the 0800 number
- addressing technical telephony system issues by moving to one system
- demand and capacity modelling
- improving the professional line compliance
- enhanced data reporting through SystmOne
- resolution of NHSE data reporting
- resourcing of helpline and mental health response vehicle
- triage process
- high intensity users: and design of the strategic service model.

The plan has recently been reviewed for 2026-27 and presented to Trust Delivery Group.

Impact:

Metric: Access standards for Mental Health Helpline

A revised trajectory for 2026/27 has been designed, aligned to review and refresh of the performance improvement plan and conversation with the ICB regarding the service offer that can be delivered within funded resources given the significant imbalance in demand vs capacity demonstrated through modelling.



Professional line performance is exceeding target this financial year:

Professional Line	
Month	Calls answered
January	57%
February	67%
March	72%
April	76%
May	79%

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 (EMA)

National Planning Priority 2026/27: Various as set out below. Content reflects Q3 2025/26 reports as reported to the latest meeting of the EMA Board

Interventions:

East Midlands IMPACT Collaborative

St Andrews (STAH) beds remain closed with continued support from the collaborative to the Intensive Oversight and Assurance Group and Recovery Support Programme action plan. Detailed analysis has been completed of occupied bed days over the last five years with this demonstrating the success of interventions in maintaining a very slight upward trend.

Financial stability for providers and reconfiguration of services to balance demand and capacity is an ongoing priority with financial recovery plans presented for consideration by EMA Board.

East Midlands CAMHS Collaborative

STAH remains on Intensive Quality Assurance and Improvement level in response to the systemic quality and safety concerns. An action plan is in delivery for recommendations from the Nottinghamshire Healthcare CAMHS inpatients' Independent Closed Culture Review.

Concerns being addressed for the Chesterfield Enhanced Community service (tier 3.5) which has been significantly impacted by staff sickness and vacancies over Q3.

Recurrent funding has been supported following evaluation of the Enhanced Care Referral team. Financial forecast of £4m carry forward for investment in 2026/27.

East Midlands Adult Eating Disorder (AED) Collaborative

Nova Ward remains on enhanced quality assurance and improvement level of oversight due to systemic quality concerns across Cygnet Elowen Hospital. A Quality Improvement Plan is in place with clear governance to oversee progress.

Activity levels have increased following the significant reduction earlier in the year.

Due to ongoing funding pressures no additional transformational projects can be supported at this time with this position to be reviewed each quarter.

Impact:

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

Recruitment of the Co-production and Involvement Lead is progressing.

Family Ambassador Programme expansion into the CAMHS Enhanced Community services is progressing for the three pilot sites.

Leicestershire and Lincolnshire have been agreed as the day service pilot sites with an implementation plan in development.

East Midlands Adult Eating Disorder (AED) Collaborative

Projections now indicate a sufficient surplus to fully fund the Waterlily programme into 2026/27.

AED commissioning intentions have been agreed through the East Midlands Provider Collaborative governance, including the Strategic Partnership Board.

East Midlands Perinatal Provider Collaborative

Both Mother and Baby Units remain on routine quality assurance and improvement level with no escalations this quarter. Margaret Oates continues to have high room temperatures as an item on their risk register with mitigations in place.

Admissions increased in the quarter although average LoS for discharged patients has decreased. Due to acuity, two patients were initially admitted to beds outside of the East Midlands with repatriation as soon as beds available.

A drop in appraisal and clinical supervision rates has been addressed at The Beeches.

East Midlands Gambling Harms service

Significant additional funding allocation for 2026/27 is enabling service expansion planning with a focus on strengthening clinical capacity and exploring new partnerships for broader reach and recovery support. Service continues to improve referral numbers with quarter on track to exceed upper target. Service demand is driving challenges in wait times for late evening clinics with waiting well arrangements in place. Demand also driving need for resources to support awareness-raising, gambling harms training and input into strategic planning for service expansion.

East Midlands Perinatal Provider Collaborative

Air conditioning now installed at The Beeches with full resolution of ongoing issues over recent years with high room temperatures. Learning being reviewed from redeployment of teams to Community-based support over the period of closure for the unit.

A focus on patient and carer experience, learning and improvement within the quarterly report demonstrates the positive breadth and depth of work across both units along with the strong focus on co-production with Experts by Experience.

East Midlands Gambling Harms service

Lived experience partners have been engaged to support a project with Leicestershire County Council to develop messaging and raise awareness among local authority staff about gambling harm, available services, and support for affected others.

A funding bid has been submitted to NHSE to support data-led service improvement and reduce inequalities.



Director of People, Organisational Development and Inclusion:
Rebecca Oakley

Responsible Committee: **People and Culture Committee**

Executive Summary

Update

Annual appraisal: compliance has fallen by 3% compared to the previous month, now running at 88%. Compliance is below the revised 95% target and the previous target of 90%. Efforts will focus on reviewing reasons for the sudden lower compliance, alongside addressing appraisals that are out of date and approaching renewal.

Annual turnover: remains in line with national and regional comparators running at 10.3% and has remained below the Trust's 12% upper tolerance limit for the last year.

Compulsory training: compliance continues to remain high at 95.5% and continues to surpass the new target of 95%. Efforts continue to address training that is out of date and approaching renewal, to both maintain and increase compliance further.

Sickness absence: for the month of May 2026 is running at 6.3%, an increase of 1.41% compared to the same period last year. Short-term sickness absence represents 2.5% and long-term absence represents 3.8%. The annual sickness absence rate is running at 6.09%, an increase of 0.20% compared to the same period last year. Anxiety, stress or depression related illness remains the highest reason for sickness absence.

Vacancy rate: for the month of May 2026 is running at 7.92% of funded posts, a slight reduction of 0.04% compared to the previous month. The rate is derived from taking the number of funded full time equivalent (FTE) posts, less staff in post FTE at month end.

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

Supervision: compliance targets were reset to 95% to align with other Mental Health trusts, reflecting a more sustainable and realistic benchmark for ongoing compliance. The Trust's supervision system was successfully aligned to the revised Supervision policy for the end of March 2026 and compliance for clinical supervision continues to surpass the target at 96% and management supervision at 95.2%.

PEOPLE KEY PERFORMANCE INDICATORS

Measure	Target	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	
People Performance														
Annual appraisals ⁴	95%	94%	91%	93%	93%	91%	91%	91%	91%	92%	92%	91%	88%	
Annual turnover (target 8-12%)	12%	10.2%	10.0%	10.1%	10.1%	10.4%	10.7%	10.8%	10.7%	10.8%	10.5%	10.5%	10.3%	
Compulsory training	90%	93.7%	94.0%	94.6%	94.6%	94.8%	94.5%	94.6%	94.5%	95.0%	94.8%	95.4%	95.5%	
Vacancy	5%	10.9%	10.2%	10.4%	9.1%	8.9%	8.5%	6.7%	6.4%	5.8%	6%	8.0%	8%	
Bank staff use	5%	4.1%	3.9%	4.5%	5.1%	4.5%	5.2%	4.7%	4.2%	4.7%	5.2%	5.7%	4.3%	
Agency staff use	1.9%	0.3%	0.4%	0.5%	0.4%	0.5%	0.4%	0.5%	0.4%	0.5%	0.7%	0.4%	0.4%	
Management supervision - staff compliant with supervision policy ³	95%	86%	86%	85%	87%	88%	86%	89%	88%	85%	94.8%	96%	95.2%	
Clinical supervision - staff compliant with supervision policy ³	95%	82%	82%	82%	83%	85%	86%	88%	88%	89%	96%	96%	96%	
NHS oversight framework 2025/26														
Sickness absence rate	5%	5.3%	5.8%	5.5%	5.8%	6.6%	6.6%	6.3%	6.0%	6.2%	6.1%	6.3%	6.3%	
Long term sickness (28 days plus)	n/a	2.6%	2.9%	2.8%	3.5%	3.6%	3.9%	3.7%	3.2%	3.2%	3.5%	3.7%	3.8%	
Short term sickness (<28 days)	n/a	2.7%	2.9%	2.7%	2.3%	2.9%	2.6%	2.6%	2.8%	2.9%	2.6%	2.6%	2.5%	
Annual NHS staff survey - raising concerns sub-score ¹	6.64	6.76	6.76	6.76	6.76	6.76	6.76	6.76	6.76	6.76	6.64	6.64	6.64	
Annual NHS staff survey engagement theme score ¹	7.02	7.07	7.07	7.07	7.07	7.07	7.07	7.07	7.07	7.07	7.02	7.02	7.02	
National Education and Training Survey overall satisfaction score (C.)	77.4%	78.9%	78.9%	78.9%	78.9%	78.9%	78.9%	78.9%	78.9%	78.9%	79.4%	79.4%	79.4%	

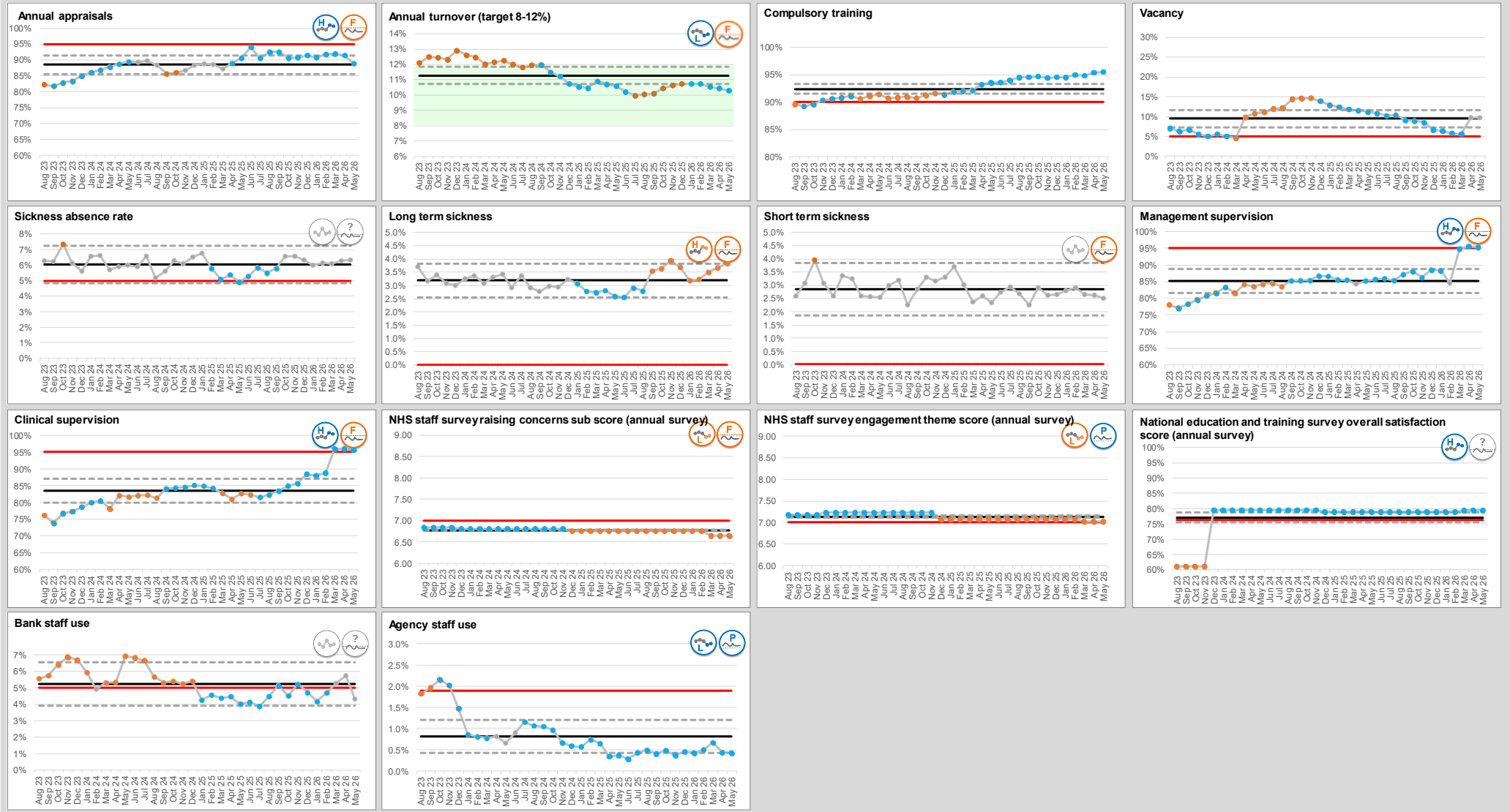
¹2025 survey results were published in March 2026. Target = national average (2024 raising concerns = 6.74, and 2024 engagement = 7.07).

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

³System changes implemented from March 2026

⁴Target increased from 90% in April 2026

People Key Performance Indicators – Statistical Process Control Charts





Director of Finance:
James Sabin

Responsible Committee: **Finance and Performance Committee**

Executive Summary

Overall

At the end of May, there is an overall deficit of £1.0m, which has been adjusted for the Private Finance Initiative (PFI) adjustment related to the International Financial Reporting Standards (IFRS) 16 accounting change, bringing the adjusted financial position to a deficit of £0.9m which is worse than plan by £0.3m.

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

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

Efficiencies

The plan includes an efficiency requirement of £14.8m with the plan assuming 72% is delivered recurrently. At the end of May efficiencies have delivered £1.5m which is behind plan by £0.4m, 58% has been delivered recurrently against a plan of 60% YTD. The forecast assumes that the current unidentified gap will be closed and the full efficiency programme will be delivered.

Temporary staffing

Agency expenditure at the end of May is slightly over plan at £0.1m but is forecast to be on plan by the end of the financial year. The two highest areas of agency usage continue to relate to Consultants and Nursing staff.

Bank expenditure is above plan at the end of May by £0.4m and is forecast to be over plan by £1.6m by the end of the financial year. The highest area of bank expenditure relates to Nurses, both qualified and unqualified.

Adult Acute OoA placements

At the end of May, OoA expenditure is above plan by £0.6m. The current forecast is based on a reducing trajectory which brings the forecast overspend to £0.8m by the end of the financial year.

Capital expenditure

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

Cash

Cash at the end of May was £32.5m (£25.8 last month) against a plan of £23.8m, £8.7m above the plan. There are no concerns in relation to debt recovery.

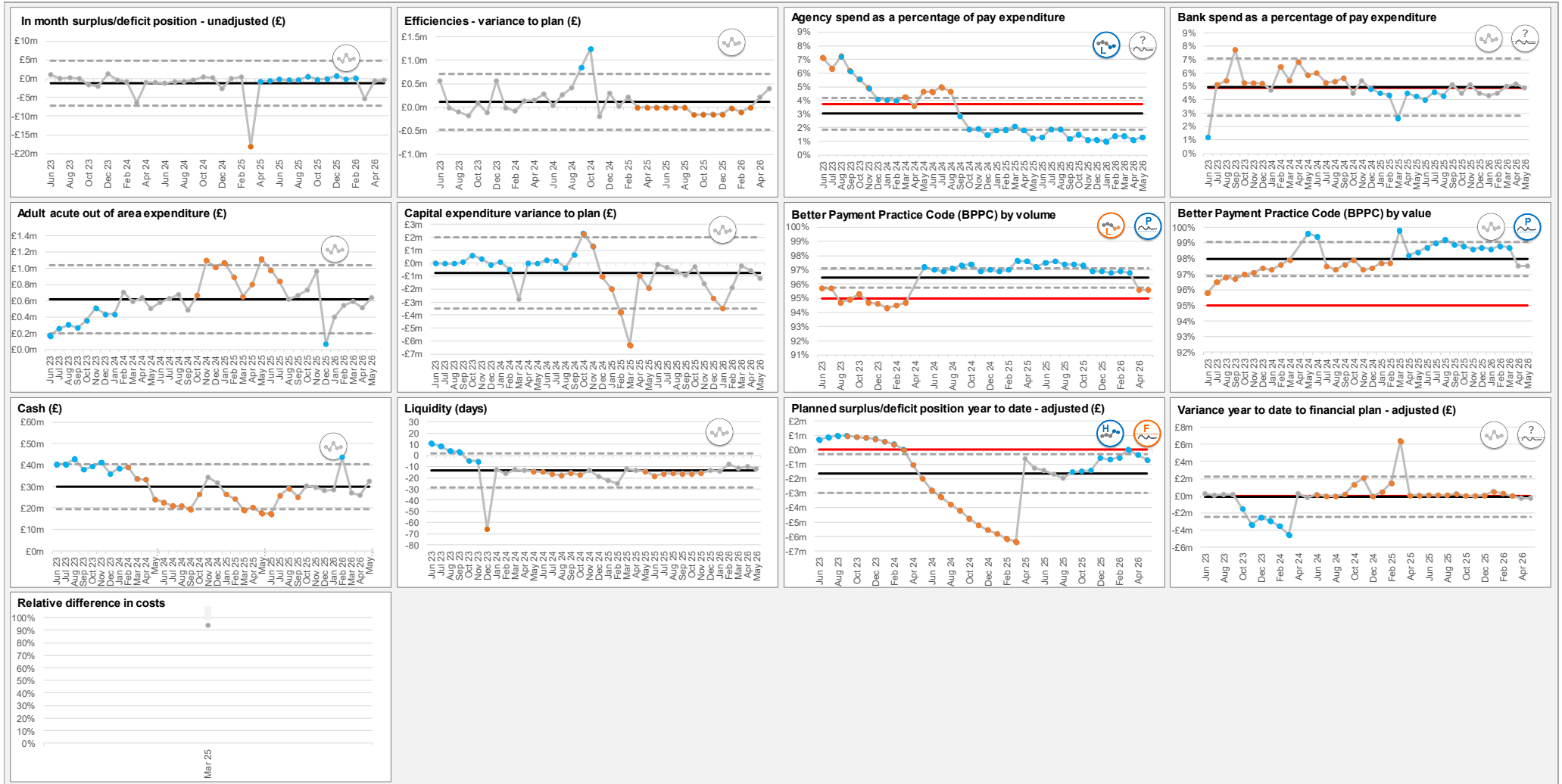
Better Payment Practice Code (BPPC)

The BPPC sets a target for 95% of all invoices to be paid within 30 days. BPPC is measured across both invoice value and volume of invoices. At the end of May, both the value and volume of invoices exceeded the target at 97.8% and 95.6% respectively.

FINANCIAL KEY PERFORMANCE INDICATORS

Measure	Target	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	
Financial Performance														
In month surplus/deficit position - unadjusted (£)	-	-£ 181,431	-£ 356,503	-£ 340,743	£ 546,298	-£ 224,055	-£ 16,211	£ 792,384	-£ 181,752	£ 105,378	-£ 5,302,531	-£ 660,307	-£ 341,136	
Efficiencies - variance to plan (£)	-	£ -	£ -	£ -	-£ 153,000	£ 2,000	£ 1,000	-£ 150,000	-£ 17,000	-£ 96,000	£ -	£ 213,000	£ 400,000	
Agency spend as a percentage of pay expenditure	3.7%	1.3%	1.9%	1.9%	1.2%	1.5%	1.0%	1.1%	1.0%	1.4%	1.4%	1.1%	1.3%	
Bank spend as a percentage of pay expenditure	4.9%	4.0%	4.6%	4.3%	5.1%	4.5%	4.9%	4.5%	4.3%	4.5%	5.0%	5.2%	4.9%	
Adult acute out of area expenditure (£000)	-	£ 977	£ 839	£ 618	£ 660	£ 727	£ 956	£ 60	£ 399	£ 543	£ 592	£ 513	£ 637	
Capital expenditure variance to plan (£)	-	-£ 107,000	-£ 333,000	-£ 640,000	-£ 917,000	-£ 274,000	-£ 1,606,000	-£ 2,719,000	-£ 3,479,000	-£ 1,905,000	-£ 244,000	-£ 583,500	-£ 1,167,000	
Better Payment Practice Code (BPPC) by volume	95%	97.5%	97.6%	97.4%	97.4%	97.3%	96.9%	96.9%	96.8%	96.9%	96.8%	95.6%	95.6%	
Better Payment Practice Code (BPPC) by value	95%	98.7%	99.0%	99.2%	98.9%	98.8%	98.6%	98.7%	98.6%	98.8%	98.7%	97.5%	97.5%	
Cash (£000)	-	£ 17,175	£ 25,805	£ 29,130	£ 25,167	£ 30,338	£ 29,717	£ 27,969	£ 28,403	£ 43,653	£ 26,925	£ 25,834	£ 32,492	
Liquidity (days)	-	-19	-16	-16	-16	-16	-16	-13	-14	-8	-11	-10	-12	
NHS oversight framework 2025/26														
Planned surplus/deficit year to date - adjusted (£)	£ -	-£ 1,442,742	-£ 1,714,677	-£ 1,986,468	-£ 1,521,049	-£ 1,472,000	-£ 1,421,000	-£ 557,000	-£ 669,000	-£ 521,000	£ 11,000	-£ 343,000	-£ 678,000	
Variance year to date to financial plan - adjusted (£)	tbc	£ 76,791	£ 63,671	£ 65,060	£ 207,015	£ 5,116	£ 6,456	£ 33,609	£ 496,585	£ 240,026	£ 11,000	-£ 296,000	-£ 271,000	
Relative difference in costs	<100%													

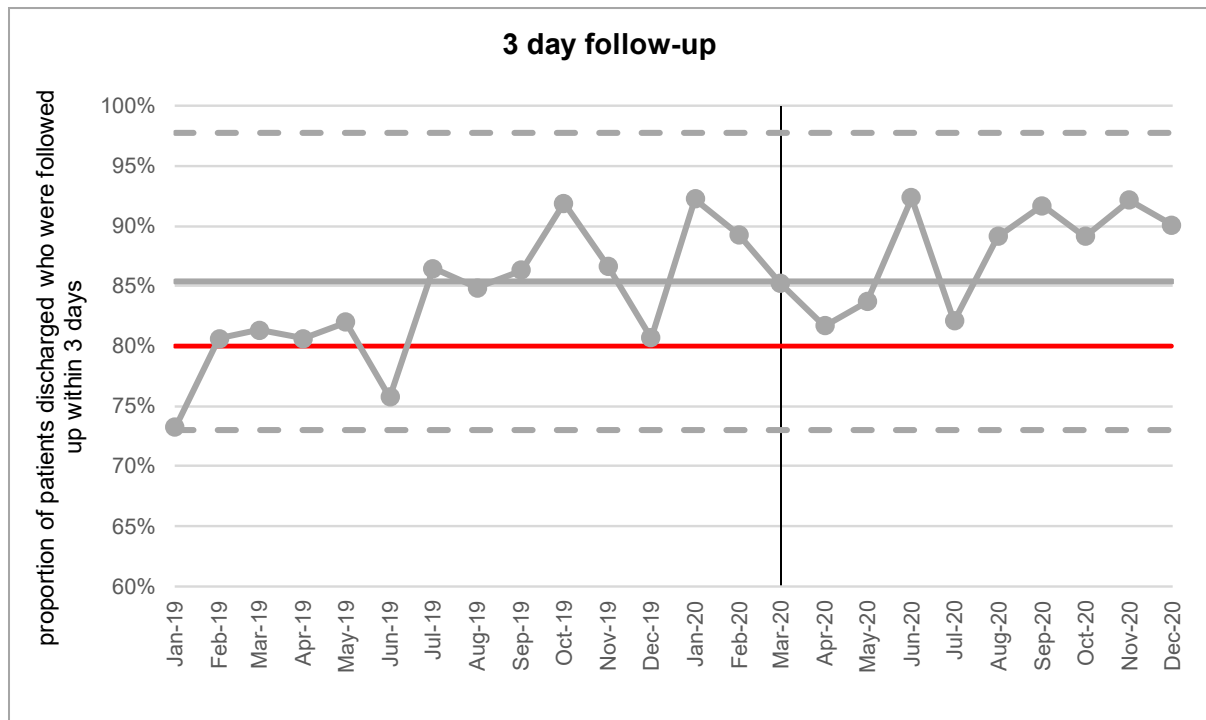
Financial Key Performance Indicators – Statistical Process Control Charts



Appendix 1

Statistical Process Control Chart (SPC) Guidance

Example SPC chart:



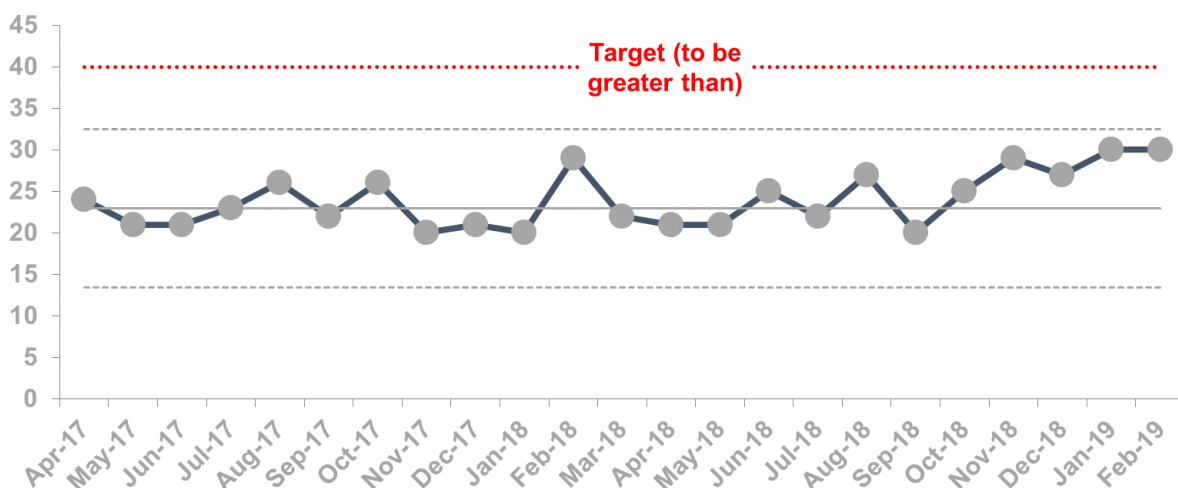
- The red line is the target
- The grey dots are the actual performance each month. They are coloured grey as performance each month is normal in this example
- The solid grey line is the average (mean) of all the grey dots
- The grey dotted lines are called process limits, or control limits.

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

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

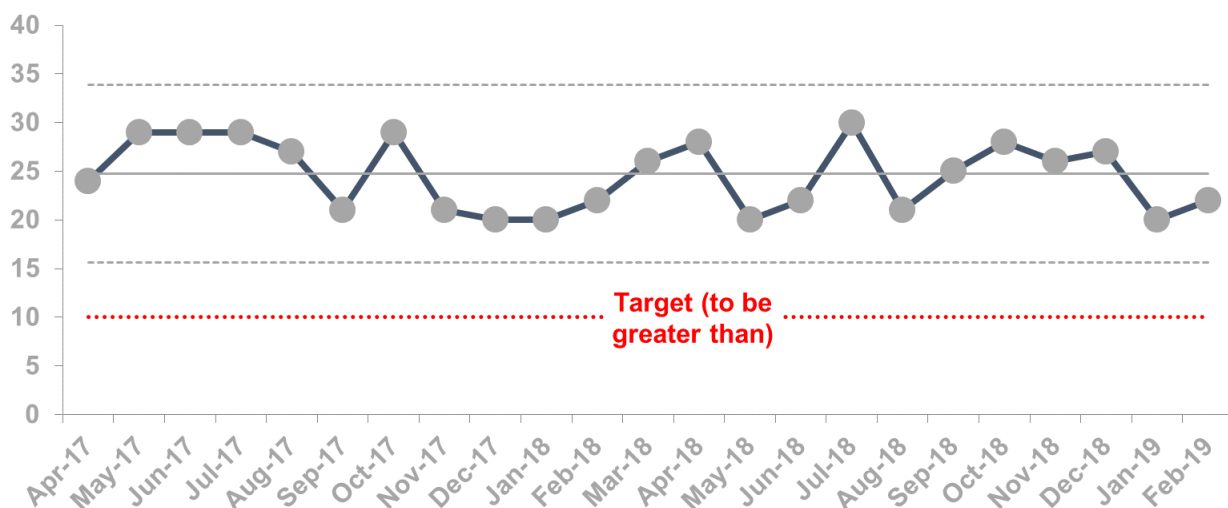
Things to look out for:

1. A process that is not working:



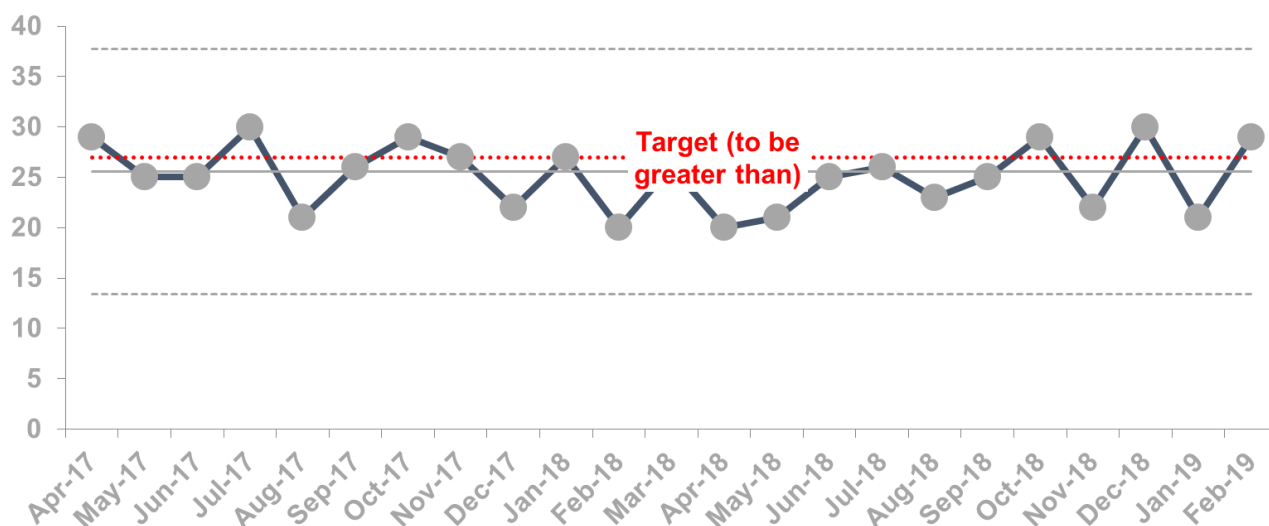
In this example the target is higher than the upper dotted grey line. This means that the target will never be achieved. To achieve the target, we need to change how we do things.

2. A capable process:



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

3. An unreliable system:

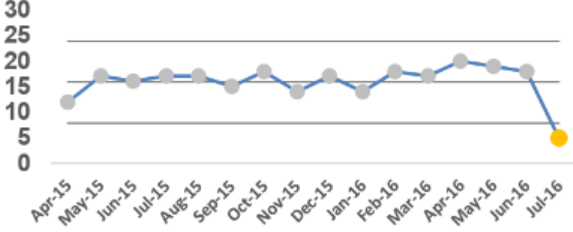
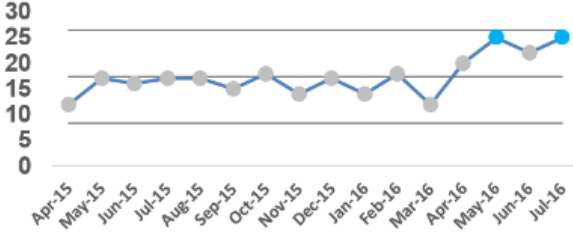
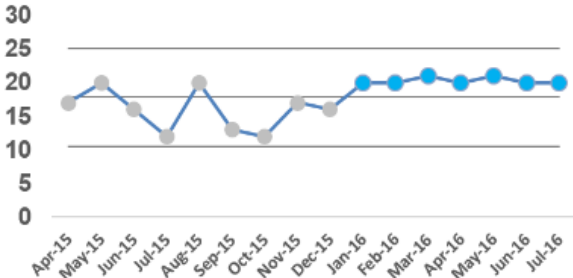
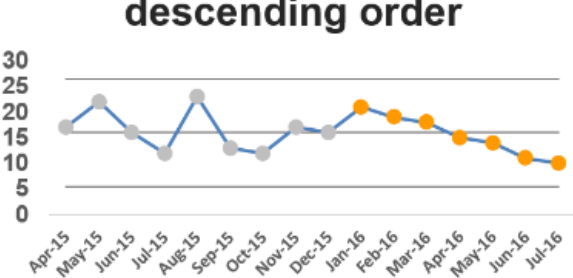


In this example, the target line sits between the two grey dotted lines. As it is normal for the grey dots to fall anywhere between the two dotted grey lines, this means that it is entirely random as to whether or not the target will be achieved. So, this system is unreliable and needs to be redesigned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

4. Unusual patterns in the data

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

There are four scenarios where this can happen:

A single data point outside the process limits  The chart shows a line of data points from April 2015 to July 2016. The y-axis ranges from 0 to 30. A horizontal line is drawn at approximately 18. Two grey dotted lines are drawn at approximately 15 and 21. Most points are grey, but the point for July 2016 is orange and significantly lower than the others, falling below the lower grey dotted line.	Two out of three points close to the process limits  The chart shows a line of data points from April 2015 to July 2016. The y-axis ranges from 0 to 30. A horizontal line is drawn at approximately 18. Two grey dotted lines are drawn at approximately 15 and 21. Most points are grey, but the points for May 2016 and June 2016 are blue and close to the upper grey dotted line, indicating better than expected performance.
In this example the July 2016 performance is significantly lower than expected and falls beneath the lower grey dotted line.	Two out of three points close to one of the grey dotted lines is statistically significant, in this case they are blue, indicating better than expected performance.
Shift of points above / below mean line  The chart shows a line of data points from April 2015 to July 2016. The y-axis ranges from 0 to 30. A horizontal line is drawn at approximately 18. Most points are grey, but from January 2016 onwards, the points are consistently above the mean line, indicating an improvement in the process.	Run of points in consecutive ascending / descending order  The chart shows a line of data points from April 2015 to July 2016. The y-axis ranges from 0 to 30. A horizontal line is drawn at approximately 18. Most points are grey, but from January 2016 onwards, the points are in a consecutive descending order, indicating that things are getting worse over time.
A run of seven points above or below the average line is significant. In this example it might indicate that an improvement was made to the process in Jan 2016 that has proven to be effective.	A run of seven points in consecutive ascending or descending order is significant. In this example things are getting worse over time.

Frequently seen in the NHS:

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

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

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

Appendix 2

Assurance Ratings

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



Board Committee Assurance Summary Reports to Trust Board – 21 July 2026

The following summaries cover key items discussed at the meetings that have been held since the last public Board meeting held on 19 May 2026 and are received for information.

- Finance and Performance Committee – 6 May 2026 and 8 July 2026 (verbal)
- Mental Health Act Committee – 4 June 2026
- Quality and Safeguarding Committee – 16 June 2026
- Audit and Risk Committee – 2 June 2026, 18 June and 16 July 2026 (verbal)
- People and Culture Committee – 2 July 2026

Key:

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

Finance and Performance Committee – key assurance levels for items – 6 May 2026	
	Financial Governance and Performance – Month 12 Finance report It was noted that the Trust achieved its financial objectives for 2025/26, delivering the full £14.8m efficiency programme and reporting a breakeven position following year-end adjustments. Financial risks for 2026/27 remain focused on workforce expenditure, out of area placements (OoA) and delivery of the Cost Improvement Programme (CIP), with regular monitoring arrangements in place. Significant assurance was received in relation to the Trust's year-end financial position and approved arrangements for the National Cost Collection submission.
	National Cost Collection Submission (pre-submission) The submission arrangements were approved. The areas of focused development were noted around granular/detailed job plans down to service level and up-to-date and robust floor area.
	Operational Performance report The Committee noted continued improvement in a number of key areas, including dementia waiting times, patient flow and length of stay. In recognition of ongoing challenges around discharge pathways, Neurodevelopmental services and System dependencies, limited assurance was received.
	Operational planning incorporating performance, finance and workforce Consideration was given to the 2026/27 progress against CIP development, capital planning and national planning requirements. Members were significantly assured that appropriate governance arrangements are in place to support delivery of the Trust's financial and operational plans, whilst recognising the continued need to strengthen CIP delivery and productivity improvements.
	System updates: Integrated Care Board (ICB) Finance Committee/System Directors of Finance Covered elsewhere in the agenda items.
	Updates from Strategic and Partnership System meeting and forums

	The East Midlands Alliance Provider Collaborative report provided the Committee with significant assurance . Members noted strong performance, along with ongoing management of financial risks associated with regional services.	
	Assurance of Health and Safety annual report The Committee received significant assurance from the report, noting improvements in training compliance and continued progress in medical device management, fire safety and health and safety arrangements.	
	Key matters for Board attention - Continued delivery of the 2026/27 CIP and expenditure control measures - Management of workforce, agency and OoA placement cost pressures - System-wide dependencies relating to discharge pathways and operational performance - Ongoing monitoring of financial sustainability, digital and cyber risks through the Board Assurance Framework. Overall assurance: The Committee received predominantly significant assurance across items considered, with limited assurance reported in relation to operational performance where external and System-wide challenges continue to impact delivery.	
	Board Assurance Framework – key risks identified/risks overview: The increased financial risk profile and inclusion of digital and cyber risks were noted.	
	Items for discussion at Board or other Board committees: None. Items added to the Board Assurance Framework: None. Next scheduled meeting: 17 July 2026.	
	Committee Chair: Jo Hanley	Executive Lead: James Sabin, Director of Finance
Mental Health Act Committee – key assurance levels for items – 4 June 2026		
	Key Highlights and Summary of the last Mental Health Act Operational Group Minutes The Committee welcomed the improved highlight-style reporting format. The need for clearer metrics, data quality challenges, trajectory improvement, and consideration of a multi-disciplinary approach were discussed. The Clinical Effectiveness Group is co-ordinating the Audit programme.	
	Mental Health Act Managers report Data trends over the financial year (up and including 13 May 2026) were presented to the Committee. Limited assurance was given on progress on compliance for Section 132 and Section 132A reading of rights and Community Treatment Order follow up. The Committee noted the deterioration in compliance and agreed that, should sufficient improvement not be demonstrated at the September meeting, further escalation to Trust Board would be considered. The Trust Delivery Group had requested action plans from each Care Group and these would be reported back to the September meeting.	
	Training report The overall compliance in the Training report in all areas is above 90%. Mental Health Act Training shows a minor decline but overall, this is still above target. Targeted training is planned for Band 5 and above Inpatient staff, along with improved tracking of Medics' compliance via the appraisal system. Compliance information for the Mental Health Act, Mental Capacity Act and the Deprivation of Liberty Act was also provided. The Committee accepted significant assurance .	
	Use of Section 136 suites	

	Following a recent visit by the Care Quality Commission, the service was rated as “Good” and only minor actions were identified. The Trust is only funded for two suites but operates three, the Committee discussed the impact of increasing demand, staffing pressures and occasional suite closures on the timeliness of assessments and noted plans to develop an operational paper for consideration by the Executive Leadership Team. Limited assurance was given due to managing some of the challenges associated with the increased number of assessments and the timeliness of assessment.
	Report on Complaints from Patients detained under the Mental Health Act The report spanned the period of Quarters 3 and 4, 10 October 2025 to 31 March 2026. The compliant levels are consistent with overall Trust trends. Limited Assurance was received due to the gaps in equality data collection but the Committee was assured all complaints are investigated on an individual level for learning and best practice.
	Patient and Carer Race Equality Framework (PCREF) The Committee received an update report on progress, key developments, and the next steps in relation to PCREF. Meetings took place in March and April 2026. Recruitment is underway for a lead. Progress is ongoing but has been delayed due to resource constraints. Limited assurance was received on the progress made so far.
	Care Quality Commission (CQC) Regulatory update – Mental Health Act (MHA) visits The Committee received an overview of the recent CQC MHA monitoring activity, with key themes such as patient involvement, advocacy access, documentation quality and governance with follow-through actions. The overall rating was “Good” across recent inspections.
	Restrictive Practice Quality report Gradual improvements on observation compliance were noted, along with a reduction in restrictive intervention trends. Key focus areas included reducing prone restraints with a target of full elimination, improving seclusion documentation, and ongoing targeted ward-level quality improvement and enhanced training oversight. Split assurance was given - Significant assurance was agreed on progress and grip but Limited assurance on the current data.
	Policy Review Deprivation of Liberty Policy: A recent Supreme Court judgment will have a significant implications. The Committee agreed an interim approach, to follow the internal briefing and to delay the full policy update, pending national guidance. It was noted the Mental Capacity Act Policy is also affected. The Committee confirmed its support for maintaining Human Rights considerations within relevant existing policies rather than developing a separate standalone Human Rights Policy. It was emphasised that fast track approval of external policies needs to happen, once ready.
	Board Assurance Framework (BAF) – key risks identified: None.
	Items for discussion at Board or other Board committees: None. Items added to the Board Assurance Framework: No additional issues were identified for immediate inclusion within the Board Assurance Framework, although the Committee agreed to continue monitoring progress relating to Section 132 compliance. Next scheduled meeting: 3 September 2026.

Committee Chair: Deborah Good	Executive Lead: Dr Girish Kunigiri, Medical Director
Quality and Safeguarding Committee – key assurance levels for items – 16 June 2026	
	Director of Nursing update The Committee noted the national award granted for the Culture of Care (CoC) Programme, with specific recognition of Joe Thompson, Associate Director of Physical Health and Quality. The transition of the CoC Programme to business as usual (BaU) was discussed, noting the cessation of national funding. Monitoring is to be incorporated into Fundamental Standards of Care, assuring that workstreams addressing racism, ward culture, violence and aggression continue, with King's Fund resources being utilised. Further to the Carer Board story, presented in May, the Committee welcomed the establishment of the first Carers Forum for staff (21 July).
	Medical Director update Two main points were raised: 1. The ICB's decision to withdraw funding for the Suicide Prevention Lead post, with the Trust working to sustain the essential functions. 2. The cancelled industrial action by Resident Doctors, noting that Consultants and other Doctors are now being balloted to negotiate terms further. Potential implications for other professional groups are being monitored.
	Fundamental Standards of Care Recent Care Quality Commission (CQC) Mental Health Act (MHA) visits were discussed. The Committee acknowledged the continued work on the 'Well-Led' framework, indicating efforts to strengthen leadership and governance within services. Attention was drawn to the successful attainment of the UNICEF 'Baby Friendly' accreditation and the Royal College of Psychiatry accreditation for the Adult Eating Disorders services. It was noted that the Executive team has visited staff transferring to the Trust from the Learning Disabilities service and Snowdrop Ward to support their integration. The Committee accepted significant assurance regarding the Trust's current regulatory position, governance oversight and progress against improvement activity relating to CQC inspections, MHA activity and wider quality assurance processes.
	Medicines and Pharmacy annual report – 2025/26 The Committee received the annual report which demonstrated strong Pharmacy support and good governance within the organisation. The conversation focused on enduring risks such as rapid tranquilisation, valproate compliance and medicines management standards, particularly on Adult Acute wards. Assurance around the use of medicines organisation-wide with the need for greater operational control was discussed, anticipating that the new management structure would support these aims. The arrangements in place to support medicines safety, medicines optimisation and the quality of Pharmacy services provided the Committee with significant assurance, whilst the areas of ongoing risk set out in the report, provided limited assurance.
	Physical Healthcare update (six-monthly) Changes in portfolio management around physical health were outlined, emphasising progress in embedding robust governance for infection prevention and control, health and safety and related areas. The Committee noted a shift in focus towards outcomes, with improvements in visibility across Inpatient, Community and Specialist services. The difficulty with integrating laboratory data into the Trust's electronic system was raised as a challenge. It was reported that compliance monitoring for blood pressure, cholesterol and glucose is

	hindered by reliance on manual data entry, which poses risks to patient care. The Committee acknowledged that suppliers are working actively to resolve these issues. Noting that the data for patients with serious mental illness is held by GPs and is not always accessible via Trust systems, the Committee recognised that compliance rates are likely underestimated, agreeing that further collaboration is needed to improve data flow and accuracy. Recent improvements in medical devices management were highlighted, noting that a new contract for servicing medical devices has been secured, with clear lines of accountability established and the prioritisation of high-risk equipment, such as ECG machines. Challenges in maintaining training standards, particularly in resuscitation, due to illness in the team were noted along with overall good compliance around tobacco eradication. Limited assurance was received.
	Quality Dashboard It was noted that the Positive and Safe team transitioned from DCHS on 1 June 2026, have been integrated into Clinical Quality, allowing the team to function as both a training unit and a proactive support resource, with the capacity to respond to incidents and deploy support as soon as concerns arise. An increase in seclusion, particularly among female patients at Audrey House, was attributed to specific complex cases. It was anticipated that continued focus and collaboration between the Positive and Safe team and the Physical Health team will support a reduction in prone restraint. It was noted that physical assaults on staff continue to be a concern, prompting the implementation of two engagement programmes aimed at reducing violence, abuse and aggression. Whilst a reduction in incidents of absconding from wards was reported, absconding during patient leave remains a theme, with feedback and close collaboration with Consultants to support patient engagement. The Committee noted the active work to reduce the backlog of complaints, with additional resources assigned to improve response rates. Compliance to respond within 90 days currently stands at 42%, with improvement plans in place. Service pressures has seen a recent increase in out of area placements which has necessitated further action to mitigate financial impact and improve quality of care. Limited assurance was received on progress towards clinical performance targets.
	Risk report It was reported that the new governance process is now complete, with risks being reviewed at Divisional and Care Group meetings. The Committee was assured that the 37 overdue risks are being actively followed up by the triumvirate, with heightened Board-level discussions to ensure risk ratings were appropriately agreed. It was pointed out that the risks are not all graded as high and the number can be reduced further. The need to transition from simply recording risks to actively managing and resolving them was underscored.
	Safeguarding Adults assurance report and Safeguarding Children assurance report The Committee noted that the Trust is meeting statutory training requirements for safeguarding, however, challenges persist in releasing staff for training due to service pressures. Efforts to improve compliance include enhanced rostering, e-learning and bespoke training using real organisational examples. Data accuracy issues were acknowledged, especially in children's safeguarding reports which rely on local authority data. The need to verify and reconcile this data to ensure consistency and reliability across reports was discussed. Confidence in keeping people safe within the parameters of the inaccuracies was stated.

	It was highlighted that the reduction in ICB involvement has increased the internal workload for Trust staff, who now undertake more reviews themselves. This raised some concern whilst the new governance structures are established. The ongoing challenge to appoint a named Safeguarding Children Doctor was highlighted, with interim support provided by the Safeguarding Adult Consultant. Significant assurance around safeguarding activity and regulatory compliance was accepted from both reports.
	Patient Safety annual report – 2025/26 The importance of embedding the Patient Safety Incident Response Framework (PSIRF) was emphasised, noting a consistent increase in both major and lower-level incidents, attributed to higher referral rates, increased acuity of patient presentations and the opening of Kingfisher House. The separation of profiles across all patient safety incidents to better understand health inequalities was discussed, noting that historically, the annual report has relied on Learning from Deaths data (now within a separate report). Positive progress in managing the volume of incidents was recognised. However, challenges remain around overdue learning responses, with some cases outstanding for 700 days, particularly in Learning Disability (LD) and Substance Misuse services. It was pointed out that current timescales are based on the old Serious Incident Framework, which historically has shorter timescales than PSIRF. Resource pressures on the Patient Safety team were acknowledged, though morale remains positive. The loss of the Suicide Prevention Lead was noted, acknowledging a review being undertaken to establish how actions from the Suicide Prevention Plan will be sustained. Live training modules will support staff in risk assessment, and formulation of plans. Limited assurance was received in relation to the application of PSIRF within the organisation and the overall management of patient safety, acknowledging that plans to improve upon this throughout the next year are in place.
	Learning from Deaths (included LeDeR) / Mortality annual report – 2025/26 A slight reduction in the number of deaths compared to the previous year offered assurance that overall mortality rates relating to patients who have been associated with the Trust are not increasing. The summary of deaths noted a total of seven inpatient deaths: two related to end-of-life care; three due to medical conditions or natural causes and two others subject to learning responses. Analysis of patient demographics was largely consistent with prior years. It was noted that the organisation continues to develop its learning portfolio with additional scrutiny, particularly regarding the thematic learning from deaths, which will be included in future reports. The Committee accepted limited assurance of the Trust's approach.
	Patient Experience report (quarterly) The Committee received a progress report on improvements being taken forward through the Patient Experience programme of work. Better responses to the Friends and Family Test were confirmed, along with the establishment of a patient survey. It was reported that the backlog of long-standing complaints has reduced from 25 to 3. In addition, the timeframe for complaints has shifted from 40 and 60 days to a 90-day window, based on complaint complexity. Limited assurance was accepted, noting that there is evidence of a positive trend and an improving picture within the scope of the report.
	Quality Delivery Plan (quarterly) Identified challenges included the Personalised Care Framework (delayed guidance), the transition to Dialog Plus and the engagement of individuals with lived experience. The lack of a suitable structure to support volunteers was noted, with this issue now being addressed.

	The Committee recognised IT and digital as significant barriers, especially in relation to data collection. It was confirmed that prioritisation of IT projects aligns with the Board's focus on the 4Ps, meaning some initiatives will be deprioritised and others will progress more slowly, reflecting Board direction. The Committee expressed satisfaction that the dashboard provides evidence for most items and acknowledged awareness of the current status. However, as that progress varies, limited assurance was received.
	Board visits – themes and findings (quarterly) It was confirmed that the process for collecting feedback and monitoring actions arising from these visits is now firmly embedded within the organisation. Feedback themes are routinely shared with Divisional boards and the CQC Oversight Group, reinforcing ongoing assurance and oversight. The Committee accepted significant assurance that the Board visit programme is effective in providing insight to 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 (including 360 Assurance audit report) Strong compliance was reported. However, a small number of specific teams continue to face challenges, primarily due to staff absences. The 360 Assurance review of care planning and risk assessments, aligned with CQC standards, provided moderate assurance. Actions are on track to meet the recommendations. In the absence of Personalised Care Framework guidance, the Trust is continuing with the Care Programme Approach. The report provided the Committee with limited assurance.
	Right Care Right Person (RCRP) progress report (bi-annual) Emphasising the alignment of the RCRP model with patient and partnership strategic priorities, real benefits arising from collaborative working were highlighted, particularly the reduction in absent and missing numbers over the past two to three years and the significant improvement in handover times in 136 Suites between police and service providers, increasing from 40% to 90% within an hour. The national attention and recognition received by the model was welcomed and it was noted that the Northern Ireland national team are to visit, seeking guidance for their own implementation. The service was described as being well embedded with governance processes to facilitate organisational learning and improvement. Significant assurance was accepted across the work through the RCRP Programme.
	East Midlands Perinatal Mental Health Provider Collaborative (six-monthly) It was explained that although occupancy figures can fluctuate significantly due to the small number of beds, regular monitoring is in place. The possibility of consolidating into a single unit had been explored, but current capacity and national requirements indicate the continued need for two separate units. It was reported that air conditioning has been installed at the Derbyshire Healthcare site, while the Margaret Oates unit, managed by Nottinghamshire Healthcare Trust, is prioritising heating issues through its own capital plans. The Committee received significant assurance on the quality and safety of services provided.
	East Midlands Gambling Harms service (six-monthly) The stretched target of 517 referrals was noted, referencing the increase in numbers seen and the associated costs and measures. The desire for more referrals to progress to treatment was discussed. The current attrition rate of 30-40% was acknowledged, noting the service has capacity to manage this, however, the importance of timely access was highlighted, along with the potential of increased pressure as numbers rise.

	The high turnover rate among Assistant Psychologists was pointed out, highlighting the need for early conversations to mitigate the impact on service continuity. Concerns were raised about SystemOne ability to provide adequate regional data, with challenges anticipated as numbers increase. Eagerness to collaborate with the Information Management, Technology and Records team to resolve issues was expressed. An action was recommended to increase the patient feedback response rate to validate the feedback and consider further improvements. Significant assurance was received.
	Joined Up Care Derbyshire All Age Carers Strategy The Committee noted the contents of the Strategy, considering opportunities for strengthening carer identification, involvement and support within services.
	Items for discussion at Board or other Board committees: None. Items added to the Board Assurance Framework: None. Next scheduled meeting: Tuesday, 28 July 2026.
Committee Chair: Lynn Andrews	Executive Lead: Tumi Banda, Director of Nursing, AHPs, Quality and Patient Experience
Audit and Risk Committee – key assurance levels for items – 2 June 2026	
	Annual Report and Accounts – progress update The Committee approved the latest version of the Annual Report and Accounts, which included the summary of changes since the first draft. It was noted that the Annual Governance Statement (AGS) was now embedded in the main document and the final version will be presented for sign-off on 18 June.
	Data Security and Protection (DS&P) report The Committee received an update on progress of the DS&P Toolkit v8, along with a summary of the latest DS&P group work, including compliance with the Data Protection Act, risk review, incident management and external reporting. It was reported that the toolkit audit is now 93% complete and that data security training compliance was approaching 99%. The exceptional performance in handling subject access requests (SARs) was noted, along with low levels of reportable incidents and no recent enforcement actions from the Information Commissioner's Office (ICO). The Committee was informed of a recently undertaken, successful penetration test, resulting in no concerns to escalate and a routine NHS England phishing exercise had shown improved staff awareness, with follow up training and communications planned. Significant Assurance was agreed on the update.
	Final Head of Internal Audit Opinion (HoIAO) and annual report 360 Assurance, Internal Audit, confirmed that the final HoIAO was significant assurance, with 95% of actions implemented during the year. It was noted that key performance indicators (KPIs) for timely sign-off of the Terms of Reference (ToRs) and management responses were below target and this will be closely monitored in 2026/27. The Committee discussed the value of linking audit findings to the Board Assurance Framework (BAF) for better strategic alignment.

	Counter Fraud, Bribery and Corruption annual report, including Counter Fraud Functional Standard Return (CFFSR)	
	It was reported that all 12 counter-fraud functional standards were rated green, with all required actions completed and ongoing actions tracked. 13 referrals had been received and assessed, with no outstanding cases at year-end. The paper included benchmarking data showing increased reporting due to higher staff awareness, with common issues including working while off sick and time sheet fraud. It was noted that seven investigations remain ongoing.	
	External Audit progress report – verbal update	
	Forvis Mazars, External Audit, confirmed that the audit of the financial statement is progressing well, with no significant issues or control weaknesses identified. The draft audit completion report was expected by the end of the week, with a closing meeting planned for a final review. It was noted that the relationship is productive and working well, with effective performance by the Trust's Finance team in this year's challenging circumstances.	
	Board Assurance Framework (BAF) – key risks identified: None.	
	Items for discussion at Board or other Board committees: The status of internal audit KPIs to be shared with the Executive Leadership Team. Items added to the Board Assurance Framework: None. Next scheduled meeting: 18 June 2026.	
	Committee Chair: Chioma Akpom	Executive Lead: Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary
Audit and Risk Committee – key assurance levels for items – 18 June 2026		
	Annual Report and Accounts 2025/26 –, including: • Management Letter of Representation • Statement of the Chief Executive's responsibilities • Trust Accounts consolidation (TAC) Schedules • Annual Report and Accounts. Minor presentation amendments and corrections to the accounts were highlighted, with no changes to the primary statements. It was confirmed that all adjustments were reflected in the final version. Some changes made in the Remuneration report and the wider annual report were referenced in the Table of Changes. No problems were anticipated with laying before Parliament, ahead of the summer recess.	
	External Audit Completion report – 2025/26 and External Audit annual report – 2025/26	
	Forvis Mazars, External Auditors, commended the Trust for its commitment to achieve an effective and efficient audit. The Audit Completion report 2025/26 confirmed that the financial statements give a true and fair view of the financial position of the Trust as at 31 March 2026 and of the Trust's income and expenditure for the year. An overview of the auditor's value for money commentary was provided, confirming a fundamentally clean bill of health for the organisation, while highlighting ongoing financial challenges facing the NHS sector and noting that these findings are consistent with other trusts.	
	Sign-off of Annual Report and Accounts (in accordance with delegated authority from the Trust Board)	
	The Committee verified its satisfaction with all documents and changes made, with unanimous approval of the Annual Report and Accounts. The Annual Report and Accounts for 2025/26 were accepted and approved.	

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

Items added to the Board Assurance Framework: None.

Next scheduled meeting: Thursday, 16 July 2026.

Committee Chair: Chioma Akpom

Executive Lead: Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary

People and Culture Committee – key assurance levels for items – 2 July 2026

Director of People update

The update covered the below areas:

Resident Doctors offer

The acceptance of the government's offer to Resident Doctors was noted, with the Trust awaiting detail on the actions required to support the offer, including the pay increase, creation of additional training posts and work relating to career progression.

It was further reported that SAS Doctors and Consultants are still out to ballot in relation to industrial action.

Lord Mann review

The review contains 36 recommendations, many of which are already reflected in work underway through the Trust's Equality, Diversity and Inclusion (EDI) plan, with further consideration needed in respect of specific actions, including adoption of relevant NHS principles and definitions relating to antisemitism and other forms of hostility and alignment with forthcoming NHS standards.

The need to ensure that measurables and implementation timescales are clearly reflected within the EDI plan was emphasised.

Band 5 Nursing review

It was advised that significant work has already been undertaken and that a comprehensive review had commenced through a working group involving staff side, People, Nursing and Operational colleagues.

Future Workforce Solutions

The Committee was informed that the Trust remains on track as an early adopter of the system, noting that the second stage would include release of identified funding and that discussions are taking place across the System for a collaborative implementation approach.

People and Inclusion Assurance Dashboard

The Committee reviewed current performance. The main points were:

Mandatory Training: it was highlighted that the positive compliance status has been maintained, noting that recent process changes appeared to be reducing episodes of non-attendance.

Vacancies and Recruitment: attention was drawn to the significant focus on Healthcare Assistant (HCA) and Registered Mental Health Nurse (RMN) recruitment, along with the aim is to reach full establishment by the end of July. The development of a flexible staffing resource was explained, to support reductions in agency and bank usage and to provide a first point of call for sickness cover and increased observations.

It was noted that the shortlisting target remains above the five-day ambition, currently at 6.8 days, and that the time to advertise continues to be affected by the Vacancy Control Panel process. The Committee recognised that further work is needed around the redeployment process and the high number of re-advertisements.

Attendance and Absence: the 6.34% sickness absence rate for May, above the Trust target of 5%, The Committee discussed the impact of the recent heatwave on short-notice absence. The pressure this had placed on operational colleagues was acknowledged. It was noted that other trusts in the region had experienced similar spikes.

Supervision and Appraisals: due to a reduction in appraisal performance, it was noted that a deep dive was being undertaken, including consideration of whether absences were a contributing factor.

Temporary Staffing usage: as a result of short-term absence notifications and cancellations, agency use had subsequently been required.

Freedom to Speak Up (FTSU): the Committee welcomed the introduction of RAG rating within the presented data.

The Committee was pleased to note that overall turnover sits at 4.45% and RMN turnover at 6.62%.

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

Medical Job Planning Performance and Assurance Plan (six-monthly)

It was reported that the Trust has a robust job planning process which has strengthened year on year, with increasing emphasis on compliance and productivity. The required compliance rate had moved from 90% to 95%, with a future expectation of 98%. The staged approach to service-level job planning, involving Doctors, other professionals and triumvirate colleagues in reviewing service demand was described, aligning medical job plans to service requirements and considering how resources are shared across teams.

The Committee was advised that mental health-specific job planning guidance for Doctors is due to be launched on 20 July and is expected to provide further clarity on direct and proxy productivity measures, for example ward rounds or daily meetings for Inpatient Consultants, and proxy measures such as contribution to reducing length of stay, recognising that outcomes are not solely attributable to individual Doctors, with a need to develop productivity measures service by service.

The expected timescale for completing Adult Community Division job plans is within three months.

The importance of ensuring that there is no mismatch between what is agreed in job plans, what is reflected in payroll and what is recorded in ESR was emphasised, noting that effective triangulation will support productivity and timely patient care.

The report provided the Committee with **significant assurance**.

Deep Dive – Leadership Development

It was noted that the transition of the Leadership Development, Wellbeing and Resolve services from the Joint Venture into the Trust is expected to take place in late July. The associated funding has transferred and had enabled the establishment of new posts, including the Head of Organisational Development, Leadership and Wellbeing role.

An outline of the current Leadership Development Offer identified the characteristics of the model in place up to the point of transition, along with usage data, levels of non-attendance and withdrawals from leadership development activity, highlighting areas where the offer could be strengthened.

The Committee reviewed the proposed direction of travel for the 2026 Leadership Development Offer, which was modelled around the NHS England Management and Leadership Development framework, focusing on three areas: personal impact, managing people and resources and delivering across health and care. It would be structured across five stages, from fundamentals through to Executive leaders and Board members.

The importance of aligning competencies with the required level of development and ensuring that managers had an ongoing base of support to embed and maintain learning following completion of development activity was emphasised.

The Committee discussed how potential future leaders and managers would be identified and whether access would be available for staff with leadership ambitions. Consideration was also given to the inclusion of generic business understanding, such as budgets, general management acumen, the NHS model and managers' responsibilities.

It was reported that accreditation with the Chartered Management Institute was being finalised, with the intention that programmes could be accredited at Levels 5 or 7 and that the Trust would become an approved accreditation centre.

	It was noted that forthcoming Workforce Race Equality and Workforce Disability Equality Standards data would inform future leadership programmes.
	Culture review: insights, assurance and improvement actions; including Making Room for Dignity (MRfD) Organisational Development (OD) Programme The Committee was updated on current culture review and early-intervention work taking place across the Trust, including progress with the MRfD OD Programme. A high level of demand from managers seeking support was reported, noting that the proposed model was intended to support triage, strengthen early intervention and prevent issues escalating to the point where urgent culture reviews were required. The Committee was advised that the proposed consultancy-style approach would support a more structured route for teams to access OD support, noting that previously, support had been accessed in a relatively ad hoc way and that the proposed approach would enable clearer referral, triage, diagnostic and discovery work, intervention design, delivery, follow-up and assurance. It was emphasised that Care Groups should have ownership of observation, governance and local action rather than OD or HR undertaking the work on their behalf. The success of the national Culture of Care programme was recognised in helping to shape aspects of ward development. It was suggested the learning should be used to inform the new OD programme.
	Rostering effectiveness and improvement programme It was reported that the roll-out of new units continues as business as usual, with 13 units recently progressed and that Community teams are invited to opt in. In relation to variation in rostering practice, these were noted to include inconsistencies in the management of breaks, long shift patterns and some elements of permanent night working, with the next phase moving into a fuller transformation programme focused on safer and fairer rostering, staff wellbeing and fatigue management, consistent rostering practice across the Trust and better use of workforce data. The Committee noted that the programme is expected to progress over the next 18 months and support improved roster optimisation, delivery of efficiency savings through the Cost Improvement Programme, improved management of annual leave and owed or net hours, reduced overtime and continued reduction in reliance on bank usage, while maintaining the Trust's planned no-agency usage approach.
	Absence Management (to include focus on Divisions) It was noted that absence management is a challenge across the whole NHS, but that the Trust is seeing rising absence levels. The report set out the main drivers of sickness absence, including stress, anxiety, depression, musculoskeletal issues and other common causes, emphasising that improvement requires a cultural shift and will take time. The Committee was advised that a number of supportive practices have developed over time, but that some long-term sickness cases have remained unresolved for too long, which has not always resulted in the right support or intervention for staff. In response, weekly meetings with Care Group managers are being held to review long-term sickness and high levels of short-term absence, scrutinise progress against process and ensure appropriate support and action plans are in place. It was emphasised that the focus is on understanding what individuals are able to do safely and consider whether alternative roles or environments would better support them. A range of targeted interventions was described, including Physiotherapy and Occupational Health input in areas with high levels of musculoskeletal issues, direct wellbeing support for staff, coaching for managers and Employee Relations colleagues and leadership training where managers lacked confidence in managing attendance. The Committee noted that the Microsoft Teams absence channel, which provides guidance, bite-sized training and support for managers in holding absence-related conversations, now has over 200 manager members. The next steps were noted to include an online GP support process for managers and employees, expected to launch in July, access to Physiotherapy appointments to support management of

	musculoskeletal issues, further promotion of the Health Assured offer and continued work with Occupational Health, where the current service is not yet meeting organisational needs. The approach was described as one of “radical kindness”. The need to be clear about the Trust’s ambitions, to identify which actions were making the greatest difference and to focus on the interventions likely to have the biggest impact, was emphasised. It was recognised that achieving the national target to reduce absence by 1% in-year was unlikely given the nature of NHS work, including pressurised, difficult and physically demanding environments and an ageing workforce. It was advised that assurance should focus on colleagues being supported to remain healthy at work, with the right interventions and processes in place, alongside wider consideration of engagement and how the Trust supports staff as an employer. The Committee accepted limited assurance on the current sickness absence position.
	Board Assurance Framework (BAF) – key risks identified: It was noted that existing references to ‘Absence’; should remain red and ‘Leadership’ should remain amber.
	Items for discussion at Board or other Board committees: None. Items added to the Board Assurance Framework: None. Next scheduled meeting: 10 September 2026.
Presented by Deborah Good, Non-Executive Director, on behalf of: Committee Chair: Ralph Knibbs	Executive Lead: Rebecca Oakley, Director of People, Organisational Development and Inclusion

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

Purpose of Report

To provide the Board of Directors with an update and review across the strategic Productive pillar, setting out progress against delivery of the agreed priorities and objectives.

Executive Summary

This report provides the first strategic deep dive into the Productive pillar, offering the Board visibility and assurance across delivery of financial performance, productivity, commercial development and sustainability priorities. It is recognised that last year's priorities were delivered in full and we are only three months into 2026/27 and Year 2 of the plan.

The Productive pillar is central to the Trust's ability to deliver safe and high-quality care sustainably, with a clear focus on:

- Achieving financial balance and delivering Cost Improvement Programme (CIP)
- Improving operational productivity
- Developing new commercial opportunities
- Embedding sustainability and delivering the Green Plan.

Over the past 12–18 months, the Trust has established a strong foundation across these areas, although Quarter 1 (Q1) reporting highlights that delivery against financial and efficiency plans is currently off-plan and requires recovery action.

Achievements we are proud of are:

1. Financial control and productivity foundations

- A clear financial sustainability programme has been embedded, including delivery expectations around:
 - “Deliver the Trust's agreed financial breakeven position”
 - “Achieve £14.5m in CIP with at least 66% recurrent savings by Q4”
- Strengthened governance through routine reporting to the Finance and Performance Committee and Executive oversight
- Establishment of mechanisms to track and assure efficiency delivery and cost improvement plans.

2. Embedding transformation and productivity infrastructure

- Delivery of a whole-Trust Transformation and Improvement Framework providing structured assurance across:
 - Productivity
 - Efficiency
 - Corporate services
- A portfolio of programmes covering:
 - Productivity
 - Efficiency plan
 - Corporate services
 - Estates and digital was established and is now governed through the Strategic Portfolio Oversight Group (SPOG) with increasing maturity in reporting

- Continuous improvement infrastructure strengthened through the LIVEQI platform, now hosting 96 improvement and transformation projects.

3. Digital and operational productivity gains

- Delivery of the Digital Plan and optimisation of core systems including SystmOne, with a focus on:
 - workflow automation
 - reducing manual processes
- Improving data-driven decision-making use of digital initiatives such as rota systems and operational platforms to improve workforce productivity and financial grip (linked to wider People Plan delivery).

4. Establishment of the commercial programme

- A Commercial Transformation Programme has been established within the portfolio, including:
 - development of new service lines
 - mobilisation of Positive Health Difference services
- “Commencement of trading and delivery of first treatments expected in Q3”
- Strategic intent includes:
 - development of an income-generating business unit
 - linking commercial activity to improved patient outcomes.

5. Estates and environmental sustainability progress

- Delivery of Year 2 Estates Plan priorities including:
 - Estate rationalisation
 - backlog maintenance reduction
 - improved utilisation of estate assets
- Clear sustainability ambition embedded:
 - “80% reduction on the emissions we control directly by 2028 to 2032”
- Integration of sustainability within:
 - estates strategy
 - procurement
 - service delivery aligned to the Trust’s Green Plan and statutory net zero duty.

Current Delivery Position

At Month 2 (May 2026), the Trust is reporting an adjusted deficit of £0.9m, which is £0.3m behind plan. The variance is principally driven by higher than planned Adult Acute out of area (OoA) placement expenditure, increased acuity and staffing pressures within inpatient services, and slippage against the planned delivery profile of the efficiency programme. Despite this early adverse position, the Trust remains committed to delivering its planned breakeven position for 2026/27, although a significant programme of recovery and financial grip will be required to achieve this.

The principal financial pressures currently being experienced include:

- Adult Acute OoA placements, which are currently overspent by £0.6m year to date and remain one of the most significant risks to plan delivery, although forecasts continue to assume achievement of the planned reducing trajectory through the remainder of the year
- Inpatient services where staffing pressures, enhanced observation requirements and patient acuity continue to generate additional expenditure, particularly across Adult Acute services. Temporary staffing expenditure, with agency costs slightly above plan and bank expenditure materially above plan. If current bank expenditure trends continue throughout the year, there is a potential full-year pressure of approximately £2.3m across inpatient areas

- While the financial position at Month 2 is behind plan, work is ongoing through the Trust's financial recovery, workforce and efficiency programmes to address these pressures and return performance to the planned trajectory.

Financial recovery and efficiency delivery

The Trust continues to operate within a challenging financial environment. At Month 2, the adjusted financial position is a deficit of £0.9m, which is £0.3m adverse to plan, reflecting pressures from OoA placements, Inpatient acuity and delayed delivery of some efficiency initiatives. Recovery actions have been mobilised and progress is being monitored through established governance arrangements, including the Executive Leadership Team, Trust Delivery Group and Finance and Performance Committee.

The efficiency programme remains a significant area of focus. There are currently 34 confirmed schemes supported by approved project documentation and a further five schemes under development. Submitted plans total £13.52m against a target of £14.55m, leaving a remaining gap of £1.02m which is expected to be addressed through schemes currently being developed and further opportunities identified across the organisation.

The overall quality of the programme remains strong, with 71% of planned savings identified as recurrent, increasing to approximately 80% once community transformation savings are fully transacted. Governance arrangements continue to mature, with 23 schemes having completed the Quality and Equality Impact Assessment process, whilst the remaining schemes continue through quality, equality and implementation gateways.

Although efficiency delivery is currently £0.4m behind plan at Month 2, largely due to implementation timing of a number of pay-related initiatives, the forecast remains that the programme will deliver in full over the course of the financial year. To date, £5.3m of savings have been transacted and further work is underway to accelerate implementation and strengthen delivery assurance.

Key risks and challenges across the Productive pillar include:

Financial sustainability

Whilst strong financial governance and reporting arrangements remain in place, delivery of the Trust's financial plan remains the most significant challenge within the Productive pillar.

At Month 2, the Trust is reporting a deficit of £0.9m, which is £0.3m adverse to plan. Key risks include:

- Delivery of the planned reduction in Adult Acute OoA placements
- Management of inpatient staffing costs associated with patient acuity and enhanced observation requirements
- Reducing bank and agency expenditure to planned levels
- Delivering the full recurrent efficiency requirement and mitigating the impact of any slippage within identified schemes
- Managing emerging in-year pressures relating to inflation, service transfers, risk-sharing arrangements and other external factors. The Trust has established detailed recovery arrangements and continues to monitor these risks closely through the Finance and Performance Committee, Executive Leadership Team and Trust Delivery Group governance structures.

The below includes further detail on the progress made across key developments, digital, commercial and sustainability.

Years 2 and 3 Priorities

The focus for Years 2 and 3 will be on accelerating delivery and strengthening impact aligned to the agreed productive strategy:

Financial and productivity

- Deliver financial plan trajectory to achieve sustainable balance
- Increase recurrent CIP delivery and reduce reliance on non-recurrent schemes
- Embed demand and capacity modelling across all services.

Commercial

- Fully establish the commercial unit and:
 - scale Positive Health Difference services
 - develop new income streams
- Deliver business case and operating model for income generation.

Digital and operational efficiency

- Continue system optimisation and automation
- Expand use of digital tools to:
 - reduce administrative burden
 - improve productivity.

Estates and sustainability

- Deliver full Estates Strategy and asset utilisation plan
- Continue carbon reduction trajectory and embed Green Plan
- Align estates transformation with service redesign and financial sustainability.

Strategic Considerations		BAF Risk (eg 1A)	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.			
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.			
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X	BAF Financial Sustainability Risk	3.1–3.4
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.			

Risks and Assurances

Risks: Key risks and challenges across the Productive pillar include:

Financial sustainability (More detail above)

- Delivery risk against financial and efficiency plans:
 - “anticipated to be an off-plan delivery position” at Q1
 - Gap between identified schemes and full CIP requirement in parts of the portfolio.

Productivity and demand pressures

- Capacity vs demand imbalance across key services impacting efficiency and flow
- Need to improve data quality and productivity insight to inform decision making (highlighted at SPOG).

Commercial development

- Risk to pace of commercial programme delivery due to:
 - clinical engagement requirements

Transformation capacity and delivery

- Scale of transformation portfolio and:
 - “challenges in resourcing such an extensive programme”

Digital and infrastructure delivery

- Risks impacting the delivery pace of the Digital Plan.

Assurances

- Delivery is monitored through established governance arrangements and Board oversight
- RAG ratings and key performance indicator measures are in place to provide oversight of progress, delivery and emerging risks across all four themes.

Consultation

Only where aspects of plan deliverables link to organisational change, eg CIP plans.

Governance or Legal Issues

Aligned to national policy and expectations. No adverse impact.

Net Zero Duty Implications

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

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

This aspect of our strategy is delivering on our environmental and net zero targets aligned to national policy. We are progressing at pace having made significant progress in the last two years and continue to report progress bi-annually via Finance and Performance Committee. Capital Departmental Expenditure Limit and capital limitations are the primary restriction in being able to do more or move faster.

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. Any CIPs linked to delivering efficiency goes via a full Equality Impact Assessment process.

Recommendations

The Board of Directors is requested to:

1. Take assurance that progress across financial sustainability, productivity, commercial development and sustainability supports delivery of the Trust Strategy. Whilst we are only three months into the 2026/27 plan, things are progressing well other than being off-plan financially. Recovery and focus remains on financial improvement here, but we continue to make good progress in the other aspects of the strategy and workstreams
2. Note the current progress, associated risks where not progressing as desired and the recovery actions in place. In particular, a key focus remains on OoA, CRfD (and wider general flow) and inpatient overspends linked to acuity and additional observations
3. Support the continued focus on productivity, transformation delivery and financial grip, recognising we need to move into not just resolving 2026/27 but a bigger emphasis on the medium-term financial sustainability.

Report presented and prepared by:

**James Sabin
Director of Finance**

Prepared with input from:

**Maria Riley
Assistance Director of Transformation**

**Louise Braham
Business Development Lead and Chief Psychologist**

**Andy Donoghue
Associate Director of Estates and Facilities**

Various updates in support of the Productive 2026/27 Strategic Plan

Financial Sustainability

The progress made during 2025/26 was positive and considered successful in that all our financial objectives were delivered. We achieved the required savings targets and had a successful year end process.

The plan for 2026/27 was agreed via routine governance routes and although challenging and with some Capital Departmental Expenditure Limit issues, this was supported and accepted.

At present the focus has been on progressing the Cost Improvement Programme (CIP) plan gaps and ensuring schemes are formally documented, risk assessed and progressed via a Quality and Equality Impact Assessment process. At the same time, pressures associated with out of area (OoA) and ward overspends, have meant our plans are off track at this early stage. Recover actions are being progressed but separate papers will cover this off in more detail. This update cover the other wider aspects of the productive component of our strategy.

Digital Delivery Plan contribution to the Strategic Priority: “Optimising our assets and enabling resources to improve services”

The Digital Delivery Plan 2026-2028 has been intentionally designed as a key enabler of the Trust's *Productive* strategic objective and particularly the priority of optimising our assets and enabling resources to improve services.

One of the four overarching digital ambitions is explicitly focused on productivity: "Streamline processes and leverage digital technology to free time for care." This ambition seeks to automate documentation and reporting, improve data quality and accessibility, strengthen interoperability and utilise AI-enabled tools to support clinicians and operational teams.

The accompanying delivery roadmap demonstrates that productivity benefits are embedded throughout the programme, with benefits realisation and evaluation built into each workstream. The plan commits to measuring outcomes rather than simply implementing technology, ensuring investments generate demonstrable improvements in efficiency, workforce productivity and service delivery.

Rather than focusing solely on the deployment of new technology, the plan prioritises optimisation, adoption and benefits realisation across the current digital estate. A core principle of the plan is to leverage opportunities to optimise, connect and fully realise the benefits of existing systems and technologies where variation and inefficiency currently exist. This approach supports improved productivity by ensuring that existing investments deliver greater value before further investment is considered.

Several of the plan's major programmes directly contribute to the strategic priority:

- SystmOne optimisation programme to standardise workflows, reduce variation, simplify processes and maximise benefits from the Trust's Electronic Patient Record
- Process automation and workflow redesign, targeting manual and paper-based processes across both Clinical and Corporate services to reduce administrative burden and release staff time
- Microsoft Copilot and Ambient Voice Technology implementation, enabling automation of routine administrative tasks, clinical documentation and information management, allowing colleagues to focus more time on patient care
- Digital infrastructure review and rationalisation, ensuring technologies are either fully leveraged or exited where they no longer provide sufficient value
- Federated Data Platform and enhanced business intelligence capabilities, improving access to real-time information and supporting data-driven operational decision making
- Paperless and digital-by-default ambitions, reducing waste, duplication and inefficiencies associated with analogue processes.

Transformation Portfolio contribution to the Strategic Priority: “Transforming Clinical Pathways and Operating Model”

The Transformation Portfolio for 2026/27 has been designed to act as the primary delivery mechanism for the Trust's strategic priority of Transforming Clinical Pathways and Operating Model. The portfolio brings together pathway redesign, service transformation, quality improvement, digital enablement, productivity improvement and system partnership programmes to support delivery of more integrated, responsive and sustainable models of care. Critically, the portfolio is built around transformation of both clinical pathways and operating models rather than individual projects in isolation, recognising that sustainable pathway redesign requires coordinated change across multiple enablers and services.

At the centre of the portfolio is a significant focus on redesigning care pathways to ensure people receive the right intervention, from the right team, at the right time, whilst reducing unnecessary delays, variation and duplication across services. The portfolio seeks to move beyond incremental improvement and support fundamental changes in how care is organised, delivered and experienced across the Trust and wider System.

The strongest contribution to this strategic priority is through the Patient Flow Programme, which has been established as a comprehensive end-to-end transformation programme spanning inflow, Community assessment, inpatient flow and discharge pathways. The programme aims to improve pathway effectiveness across the whole patient journey by reducing avoidable admissions, improving gatekeeping processes, reducing length of stay, improving discharge arrangements and strengthening Community alternatives to admission. Success will be measured through improvements in nationally recognised indicators including average length of stay (LoS), OoA placements, clinically ready for discharge delays and follow-up after discharge.

Key transformation initiatives supporting pathway redesign include:

- Development of the Neighbourhood Model of Care through the Living Well programme, supporting a shift towards Community-based and preventative approaches
- Development of a 24/7 Neighbourhood Mental Health Centre in Amber Valley, creating new access routes and alternatives to traditional service models
- Operationalisation of the new Mental Health Urgent Assessment Centre, transforming crisis response and urgent care pathways
- Development of a detailed transformation programme for Community and Assessment services, informed through service redesign workshops and pathway reviews
- Development of specialist pathways and engagement with the national Getting it Right First Time programme for Adult Acute Mental Health and Urgent and Emergency Care services.

Beyond Patient Flow, several other programmes support transformation of the operating model:

- The Quality Programme is focused on developing consistent "Waiting Well" approaches and strengthening personalised care planning, supporting a more proactive and person-centred service model
- The Digital Programme enables pathway redesign through digital triage (beseen), Patient Knows Best, e-MHA, Shared Care Records, Federated Data Platform opportunities and workflow automation, providing the digital infrastructure required to support modern pathways of care
- The Estates Programme supports operational transformation through development of facilities including the Mental Health Urgent Assessment Centre and future Neighbourhood Hub infrastructure
- Partnership programmes across Joined Up Care Derbyshire and East Midlands Alliance Provider Collaboratives support pathway transformation beyond organisational boundaries, helping to create more integrated models of care across health and care systems.

Commercial Unit update

Positive Difference Health is clear in its mission and plans. Our mission is to provide: *Compassionate, evidence-based specialist mental health care that helps individuals feel understood, supported, and empowered. We offer personalised, confidential assessment and treatment in a safe and respectful environment, working collaboratively with each person to improve wellbeing, build resilience, and support lasting recovery.*



Our brand highlights the following:

- Treatment and diagnoses that you and your GP can trust
- High quality, NICE and other recommended treatments
- Delivered by registered UK-based clinicians
- All profits go back into the NHS, helping others
- Pay one inclusive cost for your full assessment
- Attend appointments online or in-person.

Progress completed to date includes the first stage of the booking platform build (wireframe), clinician feedback, definition of the first four products, recruitment materials for a psychologist secondment, and branding and visual identity work.

The business is partly ready:

- Finance is in place with a business account, Stripe payments and internal G-code
- Estates requirements have been submitted for three rooms at Ashbourne Centre
- Staffing and onboarding are progressing
- Webpage under development and website copy is currently being developed.

Remaining critical tasks include:

- Finalising the digital clinical safety checks and getting the platform up and running
- Confirm staff commitment and getting them on the bank
- Finalising documents – to include an induction pack, final draft of standard operating procedures, governance guidance, booking platform training and final client/governance policies.

Challenges:

- Time for consultation and feedback from clinical staff to define products
- Clinician commitment to working in the service
- Platform build
- Requirement for operational focus for a period of time.

The first phase of services includes cognitive/neuropsychological functional assessment, trauma treatment, psychological assessment and treatment, a menopause clinic, and a potential contract to deliver reflective practice provision at Foston Hall.

Planned launch date is the autumn (Q2/Q3).

Community Mental Health 24/7 Neighbourhood

Initial property search (via DB Commercial Surveyors) undertaken mid-April 2026 identified six possible options based on the operational requirements and the need to be centrally located in Alfreton.

Additional property (former Public House) identified by the project group and confirmed as the preferred option.

Property valuation undertaken (DB Commercial) early June 2026 to the former Public House – the valuation (£270k) plus likely capital cost of conversion (at least £550k + VAT) meant overall this option was unaffordable and so was subsequently discounted.

A search of available Local Authority properties (via the One Public Estate Lead in June 2026) indicated just one property – Parkwood Day Centre (former Derbyshire County Council daycentre – now closed). This was deemed unviable given its location (15 minutes from Alfreton centre) and not being on an established bus route).

Visits are currently being arranged to three further properties identified on the original property search to check for potential suitability and possible progression to purchase.

Mental Health Urgent Care Assessment Unit

Works are currently ongoing - current situation is:

- Dementia Rapid Response team move from Albany to Kingsway – complete
- Med Annex – move from Radbourne Albany (ground floor) - complete
- Albany (2nd floor) – works ongoing – complete by end July
- Radbourne – works commenced June with completion by end-July.

The following will then happen:

- Crisis Helpline – move from Ripley Town Hall to Radbourne – can happen any time after July
- Crisis Team – Albany to Radbourne – planned for September
- In-Reach Home Treatment team (IRHTT) – move from Albany (ground floor) to Albany (first floor)
- Med Annex – remainder of team move from Radbourne to Albany (ground floor).

Overall costs for the works sits at c£675k, including VAT.

Estates Plan

The 'Estate Plan – 2025-2030' has been finalised, agreed and published on the Trust intranet.

The estate has now been re-surveyed to update the backlog liability – this is now estimated at £12,519,103 (compared to £10,171,258 when last surveyed in 2019).

The backlog figure represents works costs only and so is exclusive of VAT, fees or any other associated costs likely to be incurred when undertaking the work.

Construction tender indices would indicate an estimated inflationary uplift (on the 2019 figure) to somewhere between £12.6m and £14m. Therefore, the increased 2025 figures do not necessarily indicate a 'growing' backlog liability.

The backlog profile shows a near 50/50 liability split across the freehold estate (£6,134,942) and the leased estate (£6,384,161). Wherever possible, investment would be targeted at risk in the clinical freehold estate in the first instance.

The Trust CDEL allocation is yet to be fully agreed and finalised. However, it is likely that around £1m will be available for backlog rectification, plus a further c£290k secured following successful bids to the national 'Estates Safety Fund' (ESF).

The 'High' and 'Significant' backlog ('Critical Backlog') for the freehold estate has been assessed as c£1.28m. This would equate to around £940k of works that can be classed as 'capital' or which cannot be attended to as business as usual (boiler servicing/replacements, etc) or items that can be adequately managed until replacement or until a whole/greater refurbishment can be undertaken (elements of heating/electrical/lighting systems, etc).

Therefore, the capital programme (and some of the ESF funding) will include all schemes necessary to fully remediate this c£940k Critical Backlog works. This includes the 3 High Risk items identified as follows:

- Structural works at Albany House
- Refurbishment of Albany House
- Fire Alarm system at The Hawthorns.

The remaining ESF funding is specifically for replacement of the failed lift at St Andrews (leased) and this will also be carried out this year.

At completion, this would reduce the backlog burden to the freehold estate by £940k, which equates to a 15% reduction.

The estate has also been classified as follows (in line with NHSE requirements):

Core	Good quality, fit for purpose estate aligned to the LTP
Flex	Acceptable quality but not fully aligned to the LTP
Tail	Poor quality estate, not fit for purpose and should be phased out

The estate has also now been provisionally rated for overall condition as follows:

A	Good condition
B	Satisfactory condition
C	Poor condition (requires attention)
D	Unsatisfactory condition (requires urgent attention)

A document indicating the above information together with future intentions for properties, has been circulated separately to the Board as it contains commercially sensitive information. The list will remain under review by the Property Management Group and will be re-assessed once the Clinical Plan is available.

An 'Integrated Development Plan' is currently being finalised – this will build on the strategic intentions noted in the Trust Estate Plan and will incorporate more detailed data relating to the estate and its use, occupation and future suitability to allow informed decision making for the next three years of the Estates Plan.

A property 'De-Carbonisation Plan' is also nearing completion and will provide data, information and supporting detail to allow grant funding submissions to be made to fund work across the estate (essentially the removal/replacement of fossil fuel heating systems). This is expected to be ready in July 2026 and will also feed into the Integrated Development Plan and the Trust green Plan.

The following estate disposals have been agreed (via the Property Management Group) and are currently planned for delivery as follows:

Brooklands – the property is a potential disposal (capital receipt) – pending relocation of the remaining team (ANS) to Ilkeston Resource Centre, the property can be declared surplus.

A valuation is currently being arranged ahead of formal marketing, and a sale could be achieved late 2026/early 2027 depending on interest.

Buxton Health Centre – Older Adult teams to relocate to Queens Court (September 2026) – six months' notice to be given once Queens Court lease is signed.

Corbar View – Landlord (Derbyshire County Council) has served notice on the property, and the Trust has to vacate by 21 Aug 2026. Alternative premises have been sourced (Queens Court) but will require remodelling and refurbishment before occupation with a completion of this work planned for September 2026. Originally the landlord had agreed a rolling month on month occupation at Corbar View (beyond lease-end) but this has now been withdrawn and so alternative temporary provision is being arranged.

Cromwell Business Centre – Crisis teams to relocate to Queens Court – three months' notice to be given once Queens Court lease is signed.

Ripley Town Hall – Crisis team to relocate to Radbourne Unit at completion of Mental Health Urgent Care Assessment Unit project – three months' notice to be given once move date is finalised (likely September/October 2026).

The Ritz – Working Age Adult and Older Adult teams to relocate to new occupation at Trevelyan House – notice has been served and teams to relocate before end September 2026.

Digital Productivity

The Estates and Facilities department recently engaged Wholus to look at options to increase digital productivity across its operations. An initial 'baseline' report has now been completed, identifying seven key areas where further work would benefit productivity, as follows:

- The digital estate is present, but not yet organised as one operating picture
- Estate optimisation is constrained by lack of empirical utilisation evidence
- Soft FM (Facilities Management) has practical paper drag and weak feedback loops
- Compliance evidence exists, but retrieval still looks heavy
- Estates Return Information Collection (ERIC) and management reporting depend on manual collection and reconciliation
- Some value decisions are not yet supported by decision-grade financial evidence
- Digital handover for the new hospitals is a live strategic risk and opportunity.

Managed car parks

Various schemes to improve parking at Kingsway (parking to main drive and around Kingsway House and low level barriers to restrict inconvenient parking) are now complete, and updated main site wayfinding signage has been installed.

A new car park barrier (to control access to the car park and prevent casual public parking) was recently installed at Dale Bank and a new barrier is shortly due to be installed at Dovedale for the same reason.

Proposals to implement a fully managed solution to the Kingsway site have been received (from Group Nexus) and are currently being assessed. The plan would include installation of new barriers and automatic number plate recognition cameras to the site to control parking for pre-registered vehicles (staff) and visitors.

The proposal also provides a managed permit portal function and limited foot-patrols across the site.

Allowing for final agreements and staff consultations, the system could be operational from late 2026/early 2027.

Green Plan and Sustainability update

Based on the Trust's Green Plan programme, significant progress has been made in establishing the foundations required to support delivery of the NHS Net Zero agenda. The Trust has developed a comprehensive Sustainability Strategy and Green Plan which is aligned to the wider Derby and Derbyshire ICB sustainability priorities and System ambitions.

Over the last year, a number of key enabling actions have been completed. A full six-facet condition survey has now been undertaken across the estate, providing a robust evidence base on building condition, backlog maintenance and future investment requirements. This information will be used to inform the Trust's Core, Flex and Tail estate review and long-term disposal and investment strategy. The Trust's Decarbonisation Plan is also in its final stages of development, providing an essential prerequisite for future national funding bids and grant opportunities.

Practical delivery has continued across several workstreams. All owned sites have now been converted to LED lighting, reducing energy consumption and supporting carbon reduction targets. Phase 1 of the Trust's electric vehicle fleet programme has been successfully implemented, supported by the installation of charging infrastructure across relevant sites.

Whilst progress has been strong, the pace of future estate decarbonisation investment is constrained by national CDEL limitations. Nevertheless, the Trust continues to actively pursue external funding and grant opportunities to accelerate delivery where possible.

Looking forward, further work is planned to strengthen sustainability through procurement and estates initiatives, including increasing the use of local suppliers to reduce supply chain emissions and supporting the local economy, alongside additional programmes aimed at waste reduction and resource efficiency across the estate. Sustainable care models and minimising contact points and travel remain another area of continued needed focus. HR is also leading the development of the Trust travel plan which is due for completion by early Q3.

These actions will support continued progress towards the Trust's Green Plan objectives and wider NHS net zero ambitions.

Productive

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



Derbyshire Healthcare
NHS Foundation Trust

Priorities for delivery of success	Roadmap to delivery of success	Q1 Progress Update	Status	Assurance mapped to Q1 papers
	2026-27		Q1 Position	
3.1 Achieve financial sustainability through improved clinical and operational productivity	3.1.1 Deliver the Trust's agreed financial breakeven position by year end 3.1.2 Achieve £14.5 million in CIP with at least 66% recurrent savings by Q4 3.1.3 Establish innovation panel for colleagues to seek funding to deliver service and transformational change - focusing on delivering improved measurable patient outcomes	3.1.1 Financial plan agreed with outturn off track by £300k month 2 and recovery action mobilised. Q1 outturn position not yet available at time of reporting but anticipated to be off plan. Recovery workshop scheduled and working to close CIP gaps through clearing final QEIAs 3.1.2 CIP plan developed with mechanisms established to track and assure delivery . Q1 outturn position not yet available at time of reporting but again anticipated to be off plan. Final plans going through QEIA process and recovery workshops scheduled. 3.1.3 Approach under design and development for innovation panel with mobilisation planned for Q3.	Delivery anticipated to be off plan at end Q1	Agreed assurances considered by Finance and Performance Committee (FPC)
3.2 Transform our clinical pathways and operating model	3.2.1 Agree and implement the CMH 24/7 neighbourhood model 3.2.2 Agree and implement the MH Urgent Care Assessment clinical model	3.2.1 Neighbourhood model of care and 24/7 pilot progressing aligned to strategic intent agreed via Board Development session in April. Opportunities to build out from Living Well under active consideration internally with plan for integration with physical health opportunities being aligned with developing ICB approach. DLN approach on neighbourhood mental health model also being proactively discussed and developed with provider partners. 3.2.2 Programme plan mobilised for opening of Mental Health Urgent Assessment Centre with clinical and workforce model advanced, staff consultation commenced and building works underway. Phased approach to opening and development of service currently planned due to lack of recurrent revenue stream. Build will be ready come September.	Delivery on plan at Q1	Agreed assurances considered by Finance and Performance Committee (FPC) and People and Culture Committee (PCC)
3.3 Optimise our assets and enabling resources to improve services and care	3.3.1 Deliver year 1 priorities Digital Delivery Plan (Psyomics, Patient Knows Best, eMHA by Thalamos, SystmOne Optimisation) 3.3.2 Operationalise and deliver first treatments in Positive Health Difference services	3.3.1 Digital Delivery Plan mobilised over Q1 with all key deliverables on track aligned to highlight report presented to Strategic Portfolio Oversight Group. Digital Futures Day follow up session hosted with staff 18 June 2026 to maintain high engagement and involvement approach. Implementation underway re 3 key projects. 3.3.2 Plan in delivery to mobilise Positive Health Difference services with commencement of trading and delivery of first treatments expected in Q3. Systems developed, finance, comms, website delivered. Ongoing actions re location and clinical resources.	Delivery on plan at Q1	Agreed assurances considered by FPC
3.4 Reduce emissions we control directly (the NHS Carbon Footprint)	3.4.1 Deliver year 2 priorities Estates Plan. This includes progress and disposal of tail estates aligned to Estates plan; Deliver 15% reduction on back log maintenance where sites being retained; Implement solutions for managed car park to improve health and safety across various sites)	3.4.1 Year 2 Estates Plan priorities in delivery with all key milestones on track at Q1. We have the 6 facet survey results to inform our core, flex and tail positions regarding investment and disposal. We have a draft dicarbon plan and have rolled our Led lighting and electric fleet phase 1. CDEL is the limitation to doing more or moving faster	Delivery on plan at Q1	Agreed assurances considered by FPC

Fundamental Standards of Care report (Care Quality Commission (CQC) Domains) (six-monthly)

Purpose of Report

To provide an update on the Trust's current regulatory position, recent CQC activity, Mental Health Act (MHA) visits, Fundamentals of Care reviews, and key quality developments across the CQC domains.

Executive Summary

The Trust remains in a positive regulatory position, with recent CQC inspection outcomes confirming sustained improvement and continued assurance across inspected services. Long-Stay Inpatient Rehabilitation services and Mental Health Crisis services, including Health Based Places of Safety, have both been rated 'Good' overall, with the Safe domain for Crisis services improving from 'Requires Improvement' to 'Good'. CQC provider engagement has reduced from monthly to quarterly from April 2026, reflecting CQC's confirmation of the Trust's low risk profile. The final report and rating for Community Mental Health teams for Working Age Adults are awaited following submission of the Trust's factual accuracy response.

Internal quality assurance activity continues to provide meaningful scrutiny and support improvement through the Quality Assurance Framework, Fundamentals of Care visits, MHA visit responses, Learning the Lessons forums and thematic review of CQC and Fundamentals of Care findings. Fundamentals of Care visits have identified positive practice across services, including strong partnership working, effective co-production, robust governance arrangements and evidence of improved outcomes. Areas requiring further improvement remain under active oversight through Care Group and Divisional governance, with Dove Ward demonstrating an early improving trajectory but requiring continued senior leadership support to embed and sustain practice improvements.

Key quality developments include progress with the medical device management recovery plan, ongoing delivery of actions relating to the Prevention of Future Deaths notice for Mrs HB, establishment of Learning the Lessons forums, launch of the Joined Up Care Derbyshire All Age Carers Strategy, transition of the Mental Health Helpline to NHS 111 mental health option, phased implementation of a crisis text service, and positive external accreditation outcomes including UNICEF Baby Friendly reassessment, Royal College of Psychiatry accreditation for Adult Eating Disorders and retention of the Triangle of Care two-star rating.

The Board is asked to note the positive regulatory and quality assurance position, the evidence of improvement and learning across services and the areas requiring continued oversight. These include the awaited Community Mental Health team's inspection outcome, completion of the Prevention of Future Deaths action plan, delivery of the medical device servicing recovery plan, and sustained embedding of improvements identified through Fundamentals of Care visits and wider assurance activity.

Strategic Considerations		BAF Risk	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X	1A	1.1-1.3
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.			
Productive: We will improve our productivity and design and deliver services that are financially sustainable.			
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.			

Risks and Assurances

- Assurance that the Trust has appropriately responded to the regulatory activity undertaken by the CQC
- The themes identified in this paper align primarily with BAF Risk 1A (risk to safety and effectiveness of care delivery and they have mitigations in place.

Consultation

- CQC Oversight Forum
- Trust Delivery Group
- Divisional Assurance Boards
- Mental Health Act Operational Group
- Mental Health Act Committee.

Governance or Legal Issues

- CQC regulated activity and regulation
- MHA Act 1983
- Mental Capacity Act
- Health and Social Care Act
- Health and Safety Act 1974.

Net Zero Duty Implications

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

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

None.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

No groups are disadvantaged by the application of CQC regulations and standards.

Recommendations

The Board of Directors is requested to:

1. Note the positive regulatory position, the progress made in response to inspection and review findings, and the areas requiring continued oversight through Care Group, Divisional and Quality and Safeguarding Committee governance
2. Receive significant assurance regarding the Trust's ongoing compliance with CQC regulations and fundamental standards of care.

**Report presented and
prepared by:**

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

Care Quality Commission (CQC) inspections

Long-Stay Inpatient Rehabilitation, Cherry Tree Close:

On 20 January 2026, the Trust received a focused CQC inspection of long-stay rehabilitation services, including a two-day on-site visit and supporting data request. The CQC published its assessment report on 24 February 2026, confirming an overall rating of 'Good', with 'Good' awarded across all five domains: Safe, Effective, Caring, Responsive and Well-Led.

Mental Health Crisis services and Health Based Places of Safety:

The CQC inspected the Trust's Mental Health Crisis services and Health Based Places of Safety between 20 and 28 January 2026. The service retained an overall 'Good' rating, with all domains rated 'Good'. The Safe domain improved from 'Requires Improvement' to 'Good' since the previous inspection in 2020.

Community Mental Health teams for Working Age Adults:

The Trust participated in the national Adult Community Mental Health Programme pilot, introduced following the Section 48 review into Nottinghamshire Healthcare and CQC's national commitment to improve assurance in Community Mental Health services. The Trust received the draft inspection report on 23 June 2026. A factual accuracy review has been completed, with the Trust's response submitted to CQC on 10 July 2026. The final report and rating are awaited.

Mental Health Act (MHA) visits

Between January and June 2026, six MHA visits were undertaken. Audrey House, Kingfisher and Wren received their first visits since opening in new buildings. The visits were positive and demonstrated continued improvement in services. Areas for improvement have been addressed, and all submissions were returned to CQC within required timescales.

- Robin Ward, Carsington Unit – January 2026
- Audrey House – February 2026
- Willow Ward – March 2026
- Kingfisher House, Psychiatric Intensive Care Unit – April 2026
- Wren Ward, Carsington Unit – June 2026
- Kedleston Unit, Scarsdale and Curzon Wards – June 2026.

CQC Engagement and Learning

From April 2026, CQC provider engagement meetings moved from monthly to quarterly, reflecting confirmation from CQC of the Trust's low risk profile and providing assurance regarding the current regulatory position. The next provider engagement meeting is scheduled for July 2026.

A thematic review of recent CQC inspections and Fundamentals of Care visits (2025/26) was undertaken to identify recurring themes specifically relating to medical practice, Responsible clinician responsibilities and application of the MHA and Mental Capacity Act. The findings were presented to Medical Senate in February to reinforce learning, strengthen legal compliance and support consistency in clinical documentation and decision-making. Actions have been taken by Medics to address and improve practice.

Fundamentals of Care visits

In January and February 2026, Fundamentals of Care visits were undertaken to Ward 35 and Ward 36 the outcome was positive and no safety concerns were raised.

A Fundamentals of Care visit was undertaken to the Liaison and Diversion service at St Mary's Wharf Police Station in February 2026. The service demonstrated strong multi-agency partnership working across police, courts and probation, with clear pathways and understanding of the criminal justice interface. Compliance with managerial supervision was below the Trust target at the time of the visit and has now been resolved.

Dove Ward:

A follow-up Fundamentals of Care visit was undertaken on 14 April 2026 to test delivery and impact of the Dove Ward Improvement Action Plan:

- Improvement in governance, oversight and core processes is evident, with clearer structures and increased leadership visibility
- Frontline delivery remains inconsistent, particularly in relation to patient engagement, observations and embedding of expected standards
- The ward is currently reliant on senior leadership input, with a clear need for continued guidance and support to stabilise practice
- Workforce capability and confidence remain variable, impacting the consistency of care delivery.

Overall, the ward demonstrates an early improving trajectory. However, improvements are not yet fully embedded and remain dependent on enhanced leadership oversight.

Fundamentals of Care visits were also undertaken across Sycamore, Willow and Oak Wards in the Derwent Unit over two days in April 2026.

Snowdrop Ward, Walton Hospital:

On 24 April 2026, the Trust supported Derbyshire Community Health Services NHS Foundation Trust with a review relating to Snowdrop Ward. The final report and findings were shared with the Trust. Following transfer of the services, the team is progressing areas for improvement and good practice has been shared with the Care Group.

Specialist services:

During June, Fundamentals of Care visits have continued across the Forensic and Rehabilitation, Substance Misuse and Psychology Care Group.

An unannounced visit to the Community Enhanced Rehabilitation team (CERT) provided positive assurance regarding the quality of care and governance arrangements. Strengths included strong multi-disciplinary working, effective co-production with service users and carers, robust oversight of referrals and waiting times, high compliance with care planning (97%), and a clear focus on recovery, independence and community reintegration. Staff also demonstrated a strong learning culture through regular reflective practice and effective incident reporting.

Fundamentals of Care visits continue to include people with lived experience as part of the review team. Reports have been issued to all teams, with improvement actions monitored through Care Group and Divisional governance. Assurance is provided to the Quality and Safeguarding Committee. The programme forms part of the Trust's Quality Assurance Framework and has demonstrated impact on quality and safety through reduced need for external oversight and improvement in outcomes.

Safe

The Trust has appointed Medecon, through the NHS Supply Chain Framework, to provide a full medical device management system from 1 February 2026. A recovery plan has been developed to complete servicing and calibration of medical devices and accompanying equipment, prioritising high-risk devices, Inpatient services, Community premises and physical healthcare equipment. The plan remains on track for completion by the end of August 2026. Progress was reported to the Quality and Safeguarding in June 2026.

The Trust received one Prevention of Future Deaths notice during 2025/26 relating to Mrs HB. Five of eight actions have been completed, two are partially complete and one remains outstanding. The remaining actions are expected to be completed and reported back to HM Coroner by the August 2026 deadline.

Learning the Lessons Forums:

Learning the Lessons forums are now established across each Care Group and at Trust-wide level, with consistent terms of reference and agendas. The forums meet every eight weeks and have met twice since establishment. Two meetings have taken place since the establishment of these groups.

The Trust-wide forum provides strategic oversight to Care Group meetings, supporting triangulation and dissemination of learning and enabling improvement initiatives to be approached collaboratively.

Caring

The Joined Up Care Derbyshire All Age Carers Strategy was launched during Carers Week, 8–14 June 2026. The five-year partnership strategy has been co-produced with carers and partners and focuses on improving outcomes for carers of all ages across Derby and Derbyshire.

The strategy is structured around three priorities: recognising carers as equal partners; providing timely, accessible and tailored support; and enabling carers to maintain wellbeing, independence and life opportunities.

Delivery will be achieved through joint ownership across partner organisations, with each organisation identifying and implementing its respective actions.

Responsive

Complex Case Discussion Forum:

The Trust has a well-established forum in Acute services, meeting fortnightly to discuss patients with complex needs in Community or Inpatient settings. The forum brings together senior clinicians from different specialties to support formulation, risk management, discharge planning, partnership working and senior clinical decision-making.

The Mental Health Helpline has transitioned to a single access point through NHS 111 mental health option. As of 1 July 2026, the previous 0800 number has been deactivated. This change is intended to strengthen the Trust's ability to respond swiftly and effectively to people experiencing mental health crisis. The Trust launched a crisis text service on 1 July 2026. The service is being rolled-out in phases and is currently available to adults actively on the caseload of Community teams. Demand and feedback are being monitored through weekly deployment reviews, with a view to wider expansion over time.

Effective

Clinical effectiveness:

Work is ongoing to review clinical audits in line with clinical effectiveness and effective use of resources across all professional groups. The aim is to ensure services are high quality, aligned to National Institute for Health and Care Excellence standards and focused on patient and clinical outcomes. A central repository of clinical audits will support prioritisation based on national, regional and organisational requirements, with actions monitored through Care Group governance structures. Medics and non-medics across the organisation will be encouraged and supported to participate in clinical audit and quality improvement projects.

UNICEF Baby Friendly reassessment:

In May 2026, the 0–19 Children's services in Derby City were reassessed against the UNICEF Baby Friendly standards for the first time under the enhanced standards. The service passed at the first attempt, scoring above expected benchmarks in both the Mother and Staff Audits. Assessors noted this as a significant and uncommon achievement under the updated criteria.

Royal College of Psychiatry Accreditation:

In May 2026, the Adult Eating Disorders service received confirmation that it had been awarded Royal College of Psychiatry eating disorders accreditation.

Triangle of Care:

The Trust submitted its Triangle of Care self-assessment and received feedback in May 2026 confirming retention of the two-star rating. Assessors provided positive feedback on the quality of the submission, including examples of teams clearly articulating current practice, acknowledging challenges and identifying meaningful areas for improvement.

Well-Led

Given that the Trust's last Well-Led inspection was undertaken in 2020, there is recognition that a further assessment may be due. Therefore, preparation activity has been aligned to strengthen organisational readiness and ensure a consistent, evidence-led narrative.

Progress to date includes:

- Delivery of a Board Strategy and Development Session
- Commissioning of AQUA as a critical friend review, providing independent challenge and supporting the Trust
- Alignment of existing assurance mechanisms to the Well-Led framework governance domains
- Development of supporting materials and resources, including briefing slides, guidance and prompts for leaders, to ensure consistent understanding and preparation across the organisation
- Meetings held with Committee Chairs to support Well-Led interview preparation and assurance articulation
- The CQC Operations Manager delivered a Well-Led Masterclass to the Board on 15 April, providing direct insight and external perspective on Well-Led expectations and lines of enquiry
- Well Led event for senior leaders was delivered on 30 April 2026
- A Band 7 Well-Led preparation session has been scheduled for 30 July to further support operational leaders in understanding the CQC Well-Led framework.

Freedom to Speak Up (FTSU)

FTSU indicates that staff continue to value a confidential and independent route for raising concerns, with 60.3% initially requesting confidentiality and anonymous reporting remaining stable at 13.2%. Nursing staff are the largest group using the route and workers from ethnic minority backgrounds continue to access the service representing 19.1% of concerns raised during the reporting period between April and June 2026. Concerns raised have informed management review, escalation, wellbeing support, workplace practice reviews, patient safety and governance actions and wider organisational learning.

Quality Assurance Framework

Following ratification of the Quality Assurance Framework at the Quality and Safety Committee in February 2026, a one-page summary has been developed for display across ward and team areas to support wider visibility, consistency and staff engagement with the framework.

Outcome of Board Stories of lived experience from patients, carer and staff experiences to Trust Board (annual)

Purpose of Report

To provide an overview of the Board stories that have been brought to the Trust Public Board between March 2024 and November 2025.

Executive Summary

This paper brings together patient, service user and staff stories presented to Board between March 2024 and November 2025.

Collectively, the stories demonstrate the value of hearing directly from people with lived experience and from staff and show how individual experience is being used to shape learning, improvement and service development across the Trust.

The themes strongly align to the Trust Strategic priorities. They support the Patient Focused priority by highlighting compassionate, personalised, trauma-informed and accessible care, including the need to improve communication, reasonable adjustments, waiting times and continuity across pathways.

They support the People priority by showing the importance of inclusive recruitment, staff wellbeing, supervision, reasonable adjustments and creating a culture where staff feel supported to thrive and belong.

They support the Productive priority through examples of redesigned pathways, improved referral and assessment processes, quality improvement work and more effective use of resources to reduce delay and improve outcomes.

They support the Partnerships priority by demonstrating the importance of working with carers, universities, voluntary and community organisations, employment services, local authorities and System partners to improve access, inclusion and recovery.

Strategic Considerations		BAF Risk	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X	1A	1.1-1.4
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X	2A; 2B	2.1-24
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 governance in place to ensure that lived experiences are captured, shared and responded to, overseen by the Director of Nursing, AHPs, Quality and Patient Experience.

Consultation

Patient Experience team

Governance or Legal Issues

- The Trust Strategy ensures that lived experience informs, supports learning and delivery of quality care
- The essential standards of quality and safety consist of 28 regulations (and associated outcomes) that are set out in two pieces of legislation: the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Net Zero Duty Implications

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

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

None.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

No groups were disadvantaged by capturing lived experiences.

Recommendations

The Board of Directors is requested to receive full assurance that lived experience stories provide a direct line of sight between lived experience, organisational learning and delivery of the Trust Strategy, particularly in relation to quality, equity, workforce culture, service improvement and partnership working.

Report presented and prepared by:

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

Date	Storyteller	Service	Brief overview including	Actions following story
Mar-2024	Dr Ian Watkiss, Service Lead	Dr Ian Watkiss, Service Lead	The improvement journey within the Derbyshire Autism Assessment team over the past 12 months. The service moved from a position of low productivity, long waits, staff burnout, sickness absence and vacancies to a more productive, stable and motivated team	Key changes included improving referral management, streamlining pre-assessment processes, reducing unnecessary delays, introducing shorter and more efficient reports, making better use of wellbeing navigators and developing a wider cohort of autism assessors across the Trust
May-2024	Laura Hawksworth	IPS and CMHT	Laura, who lives with several mental health conditions and neurodiversity, was supported by her Occupational Therapist and the IPS employment team to explore work despite not feeling ready or confident. With encouragement from an Employment Specialist, she applied for and secured a Peer Support Worker role, which she describes as a turning point in her recovery. Laura wanted her story to help in tackling mental stigma	The Individual Placement and Support team continues engagement with multi-disciplinary teams, community settings, job centres and employment events, as well as focused work to reach ethnically diverse communities and address potential barriers linked to language, culture, stigma and differing perceptions of mental health
Oct-2024	Alex Balcon	Registered Nurse	Alex Balcon's journey from being a mental health patient to becoming a Mental Health Nurse and how reasonable adjustments enabled him to sustain and thrive in the career he had fought so hard to achieve	Jill Smith, a Ward Manager, saw his strengths rather than his barriers and supported adjustments such as micro-breaks, supervision, reflection time and compassionate support. The Trust has strengthened the staff Wellbeing Offer and Occupational Health support to support staff and managers in the organisation
Nov-2024	Jill's story	Derbyshire Recovery Partnership (DRP)	The story is about Jill's recovery journey from harmful alcohol use to sustained sobriety, supported by the DRP and later Recovery Through Nature (RTN). In short, Jill describes how she initially did not see herself as having an alcohol problem, but after seeking help for her mental health, she was encouraged to address her drinking. Through DRP, she received compassionate, face-to-face support from Ann, her keyworker, counselling and eye movement desensitisation and reprocessing therapy to help process past trauma	Jill's story - the importance of personalised, trauma-informed care, being listened to and the role of ongoing recovery support through nature-based activities. The Trust is enhancing the approach in trauma informed approach, through the care plans, training and personalised interventions

Jan-2025	Faisal, on behalf of himself, Abirami, Ansha, Athira, Sona, Riya and Rakhi	Inpatient services: International recruitment of Nurses	This story is about the experience of internationally educated Nurses recruited by the Trust in 2024, mainly from India and Pakistan. It follows their journey from recruitment through to becoming registered Nurses in England. The Nurses' main challenges were adapting to a new country, culture, healthcare system and mental health practice	The story of the internationally recruited Nurses and their experiences have influenced the approach taken by the Trust when recruiting abroad. The Trust has used the learning in the recruitment of Medics and other staff members from other countries. The learning has also informed how staff from other counties can be supported to adjust and settle
Mar-2025	Richard	Derby well-being service	Richard's story narrates his recovery journey through the Derby Well-being service, describing how he moved from feeling low, socially anxious and uncertain about his mental health. After earlier experiences with substance and alcohol use, to gaining confidence, developing coping strategies, understanding himself better, and beginning to rebuild his life supported by the Derby Living Well service	The Living Well model has now been embedded in the organisation and continues to work with the community, voluntary sector, families, carers and the health system to support people with their mental wellbeing and health in the community
Jun-2025	Alyson Akers, Trainee Advanced Clinical Practitioner, ND services/Adam Chilcott, Strategic Health Facilitator Assistant, Neuro-developmental (ND) services	Easy Read Project ND services	Adam and Alyson presented an Easy Read project to the Board in June 2025. Many people using Trust services may have communication difficulties and staff may not always realise this. The NHS and the Trust need to make information easier for everyone to understand through health literacy, plain English and reasonable adjustments	The Easy Read project continues. In March 2026, a group of people with lived experience is working to ensure that the Trust meets the NHS accessible information standards. There are three sub-groups, Clinical; Systems and Patient Experience Groups. The Group reports to CQC oversight groups. Outputs from the group are expected to be reported on by the end of the year
Jul-2025	Kelly Thompson, Named Nurse Children in Care/Clinical Lead	Community Paediatric and ND services	The story is about an eight-year-old child in care whose ND needs had been recognised for several years but who experienced repeated delays because of moves between areas, waiting lists and fragmented referral pathways. The story highlighted that children in care can be disadvantaged by system boundaries and long waiting lists.	The Transformation team is supporting the team with continuous improvement initiatives. The progress on waiting lists being tracked in the NHS Oversight Framework. The initiatives taking into account lived experience and co-production of interventions. Recruiting to locum post. 200 new referrals to be seen. Increasing medical new assessments – 40 per month (trainees and increased capacity)

Sep-2025	Anna Fisher Operational Lead/ Nicola Ruston Clinical Lead	The Children's Occupational Therapy team	Anna Fisher and Nicola Ruston are explaining how the team responded to significant waiting times, inequity across local areas and sustainability pressures by redesigning how the service works. They introduced triage, group assessments, clearer care pathways, clinic-based models, intermittent caseloads, job planning, caseload reviews, supervision, audits and stronger documentation	The Trust is encouraging innovation to reduce waiting times. In July 2026, the Trust launched various initiatives to share learning from Quality Improvement projects to share learning
Nov-2025	Rosie	Rosie, Student Nurse	The story is about Rosie's journey from being a mental health inpatient to becoming a student mental health Nurse	The Trust continues to work with local universities to grow the future workforce and support students from all backgrounds

Winter Plan on a Page - 2026/27

Purpose of Report

To present the Derbyshire Healthcare NHS Foundation Trust Winter Plan on a Page 2026/27 for Trust Board review and assurance. The paper sets out the Trust's current planning position, key winter risks, controls in place, System support required and areas requiring continued oversight ahead of onward System submission and Board reporting.

Executive Summary

The Integrated Care Board (ICB) has requested all providers complete a Winter Plan on a Page to support System winter planning for 2026/27. The Trust has developed a draft plan covering the core requested areas: anticipation of winter pressures, System support required, prevention controls and actions to improve flow, capacity and workforce resilience. The plan is intended to support System submission and provide Board with early assurance on the Trust's preparedness position.

The central issue for the Trust is flow and effective capacity. Demand is expected to increase over winter, but the main constraint is the Trust's ability to move patients safely and consistently through pathways when discharge, placements, housing, community capacity and acute interfaces are under pressure. Therefore, the plan focuses on maximising existing capacity through length of stay (LoS) governance, Performance Improvement Plans (PIPs), active management of clinically ready for discharge (CRfD) patients, discharge profiling, crisis alternatives and system escalation routes.

The Trust has established controls across prevention, infection prevention and control (IPC), vaccination planning, crisis pathways, discharge oversight, workforce planning and escalation. These controls provide operational grip, but they do not remove the risk created by sustained winter pressure or System delays. Delivery impact remains dependent on timely System response, particularly in relation to discharge, placements, Local Authority support, community capacity and acute provider interfaces.

Workforce resilience is a key part of the winter plan. Current controls include weekly workforce planning meetings to identify hotspots, forward e-rostering to review staffing gaps in advance, Executive oversight for Bank Holiday periods and a planned flexible "bubble" staffing model of approximately 10 staff by Christmas to support Inpatient services where pressure is highest. The Trust Board is asked to receive assurance on the controls in place, note the remaining System dependencies, and support continued monitoring through existing governance routes.

Strategic Considerations		BAF Risk	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X	BAF 1: Quality & Safety	Safe, high-quality care; improving patient experience and outcomes
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X	BAF 3: Workforce	Workforce sustainability, staff wellbeing and engagement
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X	BAF 2: Finance and Performance	Financial sustainability; effective use of resources
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	BAF 4: System Working	Integrated Care and System Collaboration

Risks and Assurances

The Trust can take assurance that winter planning controls are in place across key areas. The plan includes prevention and IPC controls, vaccination planning, crisis alternatives, discharge and LoS governance, CRfD management, workforce planning, e-rostering, escalation routes and System co-ordination. The Trust has also strengthened the plan with operational detail from discussions with clinical, workforce, physical health and operational colleagues.

The main assurance is that the Trust has identified flow as the central winter constraint and has aligned actions to improve effective capacity rather than relying on additional physical beds. LoS governance, PIPs for Older Adults and Working Age Adults, CRfD monitoring, daily discharge profiling, board rounds, ward rounds and system escalation are all positioned as controls to improve flow and reduce avoidable delay.

The key risks are:

- **Flow risk:** delayed discharge, housing, placements, section 117 decisions and Community capacity may reduce effective bed capacity
- **Workforce risk:** sickness, vacancies, rota gaps, seasonal leave and peak demand may affect safe staffing and continuity
- **Infection risk:** flu, respiratory syncytial virus (RSV), norovirus and other seasonal infections may disrupt flow, staffing and safe transfer arrangements
- **System dependency risk:** some barriers to capacity sit outside Trust control and require timely System response
- **Assurance risk:** controls are visible, but delivery impact may not be fully realised until winter pressure tests the System.

The recommended assurance position is **significant assurance with identified limitations**. There is a generally sound system of control in place for winter planning, but delivery remains at risk where system dependencies, discharge barriers or workforce pressures limit the Trust's ability to convert controls into sustained improvement.

Consultation

The Winter Plan on a Page was requested through the System winter planning route. The request was received from the ICB and passed to the Trust for completion and onward review. The Director of Operations asked the Business Managers to pull the work together, with Executive Leadership Team and Board awareness required.

The draft plan has been informed by operational input, previous winter planning material, physical health and vaccination planning information, IPC content, workforce and flow updates and review comments from relevant colleagues. The Associate Director of Physical Health and Quality provided flu planning material to support the vaccination and IPC section.

Governance or Legal Issues

The paper supports winter preparedness, System planning and internal operational governance. The plan should be considered through the Trust Delivery Group (TDG) as part of the Trust's assurance on winter readiness, patient flow, workforce resilience, infection prevention and System dependencies.

Relevant governance routes include TDG, Emergency Preparedness, Resilience and Response (EPRR), LoS and patient flow governance, PIP oversight, workforce planning, IPC governance and System winter planning meetings. System dependencies should continue to be escalated through the appropriate operational, Trust and System routes where provider-level action cannot resolve the constraint.

There are no specific legal decisions requested in this paper. The plan does have governance and compliance implications in relation to safe care, discharge, IPC, workforce planning, vaccination and System escalation.

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:

Minor impact expected. The plan focuses on optimising existing capacity, improving flow, using existing governance routes and reducing avoidable escalation or transfers where possible. No quantified emissions impact is available at this stage.

Potential positive impacts may include better use of existing estate and capacity, reduced avoidable patient movement and use of digital or remote coordination where appropriate. No major capital, travel, procurement or estates change is proposed through this cover sheet.

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:

Winter pressures may affect access, timeliness and experience for people with protected characteristics and vulnerable groups, including older adults, people with disabilities, clinically vulnerable people, people in Inpatient settings, people requiring timely discharge and staff working under sustained pressure.

The plan mitigates these risks through crisis access routes, IPC controls, vaccination planning, LoS and discharge governance, workforce planning and escalation through System routes. Specific equality considerations remain relevant for vaccination access, discharge to care homes, Inpatient flow, Community capacity and the impact of delayed pathways on patients and carers.

The plan does not identify a single adverse equality impact requiring a separate decision at this stage, but equality impact should remain under review as the winter plan develops and as detailed operational plans are confirmed.

Recommendations

The Board of Directors is requested to:

- Note the Derbyshire Healthcare NHS Foundation Trust Winter Plan on a Page 2026/27 and the assurance position set out in this cover sheet
- Receive significant assurance that winter planning controls are in place across flow, prevention, workforce planning, IPC, vaccination and escalation, noting identified limitations linked to System dependencies
- Support continued monitoring of LoS, CRfD, workforce hotspots, PIP delivery and System discharge barriers through existing governance routes
- Note that delivery impact remains dependent on timely System response across discharge, placements, Local Authority support, Community capacity and Acute interfaces
- Agree any further actions required before onward System submission or Board reporting.

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

Report prepared by: **Lee Ryan-Doyle**
 Director of Operations

Sifo Dlamini
Business Manager

Derby and Derbyshire ICB Derbyshire Healthcare NHS FT Winter plan on page 2026/27

June 2026

1. Anticipate and assess

What are your key winter pressure drivers?

- Sustained system pressure across UEC, including ED demand, ambulance conveyance delays and constrained acute flow
- Continued growth in mental health demand across ED, crisis pathways and inpatient services
- Seasonal increase in respiratory illness (flu, RSV, norovirus) impacting admissions, infection risk and workforce absence
- Workforce constraints including sickness, vacancies and seasonal leave
- Persistent system flow constraints, particularly discharge delays, placements and community capacity

What demand do you expect over winter and how does this relate to your capacity?

- Demand expected to increase in line with previous winter trends, with peaks during Christmas, New Year and school holidays
- Inpatient, crisis and community services expected to operate at or near full capacity during peak periods
- Surge capacity is available but will be limited by workforce availability and flow constraints
- Service pressure will be driven not only by demand, but by inability to move patients through pathways at required pace

What are your risks over winter 26/7

- **Flow risk:** delayed discharge and pathway delays will reduce effective bed capacity and limit responsiveness
- **Access risk:** increased crisis presentations may exceed pace of response across liaison, CRHTT and inpatient pathways
- **Workforce risk:** sickness, vacancies and rota gaps impacting safe staffing and continuity
- **Infection risk:** seasonal illness disrupting patient flow and workforce resilience
- **System dependency risk:** Trust controls are in place, but recovery of flow is dependent on system action on discharge, placements and community capacity

2. What help is requested from system partners to enact your Winter plan

System support required

- **Local Authority and ICB support on discharge and flow:** Timely resolution of discharge delays, including S117, complex packages, housing and placements, to enable patient progression and release inpatient capacity
- **System-wide focus on reducing discharge delays (CRFD):** Coordinated action across health and social care to reduce the volume and duration of clinically ready for discharge patients
- **Acute provider support to improve ED interfaces and patient flow:** Improved transfer and escalation pathways for mental health patients in ED to reduce delays, risk and length of stay
- **EMAS support to maximise direct pathways and reduce avoidable conveyance:** Increased use of alternative pathways, including direct access to mental health services, to avoid unnecessary ED attendance
- **System escalation and coordination through Operational Co-ordination Centre (OCC) and tactical forums:** Responsive system escalation to unblock capacity constraints that cannot be resolved at provider level during peak pressure

System dependency statement

- Trust controls are established across crisis response, flow and inpatient pathways
- Delivery of winter resilience is dependent on timely system response, particularly in discharge, placements and community capacity
- Without system action, flow will remain constrained and capacity gains will not translate into improved access or performance

3. Prevent the likelihood of occurrence and effects of any such issues

What steps are you taking to prevent and manage infection inc. vaccination; patient/staff testing over Winter?

- The Trust will actively manage IPC across inpatient, crisis and community pathways to mitigate flu, RSV, norovirus and seasonal infection risks
- Cohorting, isolation and safe transfer processes will be flexed to protect capacity and reduce transmission
- Staff and patient testing will be maintained in line with national guidance to identify and respond to infection risk early
- IPC performance will be monitored with escalation where infection impacts flow, staffing or patient safety

In light of NHSE guidance will you have an accessible occupational health vaccination offer to staff throughout the entire flu campaign, including onsite bookable and walk-in appointments.

- Yes – the Trust will provide an accessible vaccination offer throughout the campaign
- Delivery will be peer vaccinator led, supported by the Trust physical health team
- The offer will include digital booking, access to DCHS vaccination sites and local peer vaccination within teams
- Vaccine supply, storage and handling will be managed through the Trust pharmacy team

Are you confident you will have a fully developed plan for improving flu vaccine uptake for NHS staff by the end of Q1, incorporating a stretching target percentage increase on last year's uptake.

- Staff flu uptake improvement plan will build from the 2025/26 baseline of 43.6%, with a presumed 5 percentage point improvement ambition
- Plan development will be overseen through the staff physical health, workforce and pharmacy planning route
- Uptake will be supported by clear communications, proactive engagement with frontline teams and physical health champions

For Winter in light of recent guidance will you offer vaccination on discharge to any patients going into a care home?

- Vaccination for eligible long-term inpatients and patients being discharged to care homes is recognised as an area requiring further confirmation
- Eligible patients will be offered vaccination where appropriate, with weekly review of uptake and outstanding actions
- The model will be reviewed through the Trust flu planning meeting in July 2026
- Final arrangements will align with ICB guidance and local vaccination pathways

Do you have actionable infection prevention and control (IPC) strategy in place for Winter?

- Yes – an established IPC strategy is in place and will be actively managed throughout winter
- Controls include surveillance, outbreak management, isolation processes and workforce guidance
- IPC escalation routes are embedded within operational and EPRR governance to respond to emerging risks

Do you have identified cohorting spaces ready to be actioned, for direct admission of flu patients into community bedded capacity?

- Cohorting arrangements are in place across relevant inpatient settings and will be activated as required
- Capacity will be flexed in response to infection risk and demand pressures
- Cohorting will support infection control while maintaining safe flow through inpatient pathways

	Describe the benefit	Timescale
What are your key actions to reduce demand on services ?		
- Maximise use of 111 Mental Health Option 2 (including the new Text Service) and Crisis Line to provide direct access and reduce avoidable ED attendances; - Strengthen crisis alternatives including safe havens, crisis houses and community-based provision to support admission avoidance	Reduced avoidable ED presentations and admissions, protecting inpatient and crisis capacity and improving patient flow across pathways	In place and scaled ahead of Winter (Q2–Q3), with continuous operation through peak period
Have you set stretching local performance targets for daily pathway 0,1,2 and 3 discharges and do you profile them through the week pathway and agreed with the LA?		
- Implement daily discharge profiling to take advantage across pathways 0–3 with agreed trajectories aligned with system partners - Strengthen daily flow meetings and ward rounds to drive early discharge planning and reduce delays	Increased discharge rates and reduced delays, releasing effective bed capacity and improving flow through inpatient pathways	Timescale: Profiling agreed by Q2, fully embedded and monitored through Winter
What are your key actions to increase capacity over Winter? Does this include increasing Virtual wards, SDEC including direct ambulance off-loading at specialty facilities?		
- Optimise use of existing inpatient, crisis and community capacity through improved flow and reduced length of stay - Maximise use of alternatives to admission, including crisis pathways and community provision	Increased effective capacity without reliance on additional physical beds, improving responsiveness and flow across crisis and inpatient services	In place ahead of Winter (Q2–Q3), with escalation arrangements during peak demand
What additional beds are you opening and what are the time scales? What are your plans to eliminate corridor waits /MSFT reduction/Mental Health waits		
- No material increase in base bed numbers; focus on maximising effective capacity through flow and discharge - Strengthen processes to reduce inappropriate out of area placements and waiting times for inpatient admission	Reduced waits for admission and improved flow into inpatient beds, increasing usable capacity and reducing risk associated with delays and out of area placements	Ongoing through Winter, with trajectory monitored through governance
How will you improve processes and ways of working over Winter via transformation and efficiency plans to improve flow and reduce LOS?		
- Implement standardised flow processes including daily ward rounds, discharge tracking and defined escalation routes - Deliver LOS improvement through established governance including Patient Flow Delivery Oversight Group, PIPs across Older Adults and WAA, and clinically ready for discharge (CRFD) management aligned to LOS improvement expectations including reduction in long stay cohorts (45 & 60-day patients)	Reduced length of stay and variation, with improved conversion of clinically ready patients into discharge, increasing effective capacity and flow	Fully implemented by Q3, with continuous optimisation through Winter
What are your strategic enhancements in staffing over Winter especially over Xmas/New Year?		
- Strengthen winter staffing plans including rota resilience, bank/agency cover and targeted support over Christmas and New Year - Implement weekly workforce planning meetings to identify and respond to staffing hotspots - Use forward e-rostering to identify gaps early and proactively redeploy staff to pressure areas - Introduce a flexible “floating” staffing model (c.10 staff) to support inpatient services and respond to demand pressures across the Trust - Executive oversight in place for Bank Holidays and peak periods to maintain operational grip	Improved staffing resilience, enabling sustained patient flow and safe utilisation of available capacity during peak demand	Plans in place by Q2, with full delivery across Winter peak

4. Prepare by having appropriate mitigating actions, plans and management structures in place. What are your key actions /schemes to address any forecast capacity shortfalls for Winter 2026/7.Please list the mitigation/actions below together with expected benefit for each action together with timescale for each action.	Describe the benefit	Timescale
How will your support staff well- being over Winter ?		
Implement a structured winter wellbeing offer including visible leadership, welfare support and access to occupational health services	Improved staff resilience and reduced fatigue, enabling sustained safe staffing levels and maintaining patient flow during peak demand	In place ahead of Winter (Q2–Q3), with targeted support during peak pressure periods
Ensure protected breaks, local support offers and targeted interventions in high-pressure areas		

5. Respond and recover by enacting plans and contingencies as required

Do you have escalation triggers and actions in place for Winter as part of your Winter plan?

- Action**
- Yes – escalation triggers aligned to OPEL levels, demand, capacity and flow indicators are defined and actively monitored
 - Clear operational escalation actions are in place, including internal response and system escalation via coordination forums
- Benefit**
- Early identification and response to deterioration in flow or capacity, reducing risk and maintaining operational control
- Timescale**
- Embedded and actively managed throughout Winter

Do you have contingency/surge plan especially during Xmas/New Year as part of your Winter plan?

- Action**
- Yes – contingency and surge plans are in place to respond to peak demand, including capacity flex, staffing escalation and operational command structures
 - Enhanced operational grip in place over Christmas and New Year, including senior clinical and managerial cover
- Benefit**
- Maintains service continuity and flow during peak periods, protecting capacity and reducing risk of system destabilisation
- Timescale**
- Plans in place by Q2, enacted during peak Winter periods

What approach are you taking for residents, patient and staff communications over Winter

- Action**
- Deliver a coordinated winter communications approach, including vaccination messaging, service access routes and frontline engagement through physical health champions
 - Use internal channels, team-level engagement and campaign materials to support uptake, access and awareness
- Benefit**
- Improved public and staff awareness of appropriate access routes, reducing avoidable demand and supporting smoother patient flow
- Timescale**
- Communications plan in place ahead of Winter, with ongoing delivery throughout peak period

Fit and Proper Persons Test (FPPT) - Chair’s Annual Declaration

Purpose of Report
To inform the Board of the Board members compliance against the FPPT Framework.

Executive Summary
NHS England developed an FPPT Framework in response to recommendations made by Tom Kark KC in his 2019 review of the FPPT. This also takes into account the requirements of the Care Quality Commission (CQC) in relation to Board Directors being fit and proper for their roles. It is confirmed that DHcFT Trust Board member references/pre employment checks (where relevant) and full FPPT, including the annual self-attestation have been completed and are satisfactory for each Trust Board member.
A summary of the checks is included at **Appendix 1**.
It is the responsibility of the Chair to discharge the requirement placed on the Trust to ensure that all Board Directors meet the fitness test and do not meet any of the ‘unfit’ criteria. Under the new FPPT Framework, the Chair is required to complete a review of the whole Board annually and submit a template confirming compliance to NHS England. This has been sent off by the 30 June deadline. The Chair’s declaration covers 2025/26 and is included at **Appendix 2**.

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

Risks and Assurances

- The Board can receive assurance that due process has been followed in line with the Trust’s FPPT Policy to ensure that all relevant post holders meet the fitness test and do not meet any of the ‘unfit’ criteria
- That comprehensive files have been established and maintained for each relevant post, evidencing compliance and that proactive processes have been set in place to monitor the filing system.

Consultation

This report has not been considered by other groups/committees. However, confirmation of FPPT compliance for Non-Executive appointments is reviewed by the governor Nomination and Remuneration Committee, and confirmation of compliance with FPPT requirements have been overseen by the Remuneration and Appointments Committee for Executive Director appointments made in-year.

Governance or Legal Issues

- It is a requirement of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that NHS bodies undertake a 'fit and proper person test'
- The regulations have been integrated into the CQC's registration requirements and falls within the remit of their regulatory inspection approach.

Net Zero Duty Implications

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

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

Nothing specific for this declaration.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

Recommendations

The Board of Directors is requested to:

1. Receive full assurance from the Chair's declaration that that all Board Directors meet the fitness test and do not meet any of the 'unfit' criteria and that the Board is fit and proper
2. Note the compliance against the national FPPT Framework.

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

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

Appendix 1

Fit and Proper Person Checks introduced as part of Fit and Proper Persons Test (FPPT) framework.

1. All new appointments are subject to a full FPPT that includes:
 - 1.1. Standard employment checks as per the Trust's Recruitment and Selection Procedure.
 - 1.2. References, using the Board member reference template that cover a six-year continuous employment history.
 - 1.3. An enhanced DBS for a person who will be acting in a role that falls within the definition of a 'regulated activity'.
 - 1.4. Search of insolvency and bankruptcy register.
 - 1.5. Search of Companies House register to ensure that no board member is disqualified as a Director.
 - 1.6. Search of the Charity Commission's Register of Removed Trustees.
 - 1.7. Employment Tribunal Judgement check.
 - 1.8. Web/social media search.
 - 1.9. Satisfactory completion of the self-attestation form.
2. For annual assurance, the FPPT includes:
 - 2.1. Annual completion of the self-attestation form.
 - 2.2. Annual Declaration of Interest for Directors in post.
 - 2.3. DBS check at least every three years.
3. All Board leavers:
 - 3.1. Completed Board Member exit reference based on template to be kept on file, irrespective of whether a reference is requested from another NHS employer.

Requirement to hold certain FPPT data in the Electronic Staff Record (ESR)

New data fields in ESR will hold individual FPPT information for all Board Members. A privacy notice is issued to all Board members.

Appendix 2 - NHS FPPT submission reporting template

NAME OF ORGANISATION	TYPE OF ORGANISATION <i>Select organisation</i>		NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:
Derbyshire Healthcare NHS Foundation Trust		Trust	Selina Ullah	2025/26
	X	Foundation Trust		
		ICB		

Part 1: FPPT outcome for board members including starters and leavers in period

Role**	Total Number Count	Confirmed as fit and proper?			Leavers only	
		Yes	No	How many Boad Members in the 'Yes' column have mitigations in place relating to identified breaches? *	Number of leavers	Number of Board Member References completed and retained
Chair/NED board members	7	X		None	2	2
Executive board members	7	X		None	1	1
Partner members (ICBs)	n/a					
Total	14	14			3	3

* See 3.8 'Breaches to core elements of the FPPT (Regulation 5)' in the Framework.

** Do not enter names of board members.

Have you used the Leadership Competency Framework as part of your FPPT assessments for individual board members?	Yes- within appraisals	
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Part 2: FPPT reviews / inspections

Use this section to record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews, etc.

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
None – Chair submits annual declaration to the Board				

Part 3: Declarations

DECLARATION FOR DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST 2025/26				
For the SID/deputy chair to complete:				
FPPT for the chair (as board member)	Completed by: Senior Independent Director	Ralph Knibbs	9.3.2026	Fit and proper? Yes
For the chair to complete:				
Have all board members been tested and concluded as being fit and proper?	Yes	If 'no', provide detail:		
Are any issues arising from the FPPT being managed for any board member who is considered fit and proper?	No	If 'yes', provide detail:		
As Chair of Derbyshire Healthcare NHS Foundation Trust, I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.				
Chair signature:				
Date signed:	1.6.2026			
For the regional director to complete:				
Name:				
Signature:				
Date:				

Patient and Carers Race Equality Framework (PCREF)

Purpose of Report

To provide an update on progress, key developments, and next steps in relation to the PCREF Steering Group across March and April 2026 meetings.

Executive Summary

The PCREF Steering Group continued to progress implementation of the national framework aimed at improving equity of access, experience, and outcomes for racially diverse populations.

Key developments included:

- High ethnicity data completeness (~96%), with targeted work to address areas below 95%
- Approval and publication of the Trust-wide PCREF self-assessment, with commitment to a detailed, co-produced action plan
- Agreement on a pilot approach focusing on specific wards/services to enable meaningful implementation and learning
- Continued work to strengthen service user and carer representation, particularly from diverse communities
- Ongoing development of race-based data analysis, including Mental Health Act and restrictive practice data
- May 2026 meeting was cancelled due to annual leave and sickness.

The programme remains at an early implementation stage, with a focus on governance, data quality, engagement, and pilot delivery.

Strategic Considerations		BAF Risk	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X	1A	1.4
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X	2A	2.3
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X	3A	3.2
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X	4A	4.1

Risks and Assurances

Key Risks

- PCREF Lead not yet appointed resulting capacity issues. Limited capacity in Business Intelligence (BI) team to support meaningful data and clinical interpretation
- Data quality and consistency risks remain, particularly around ethnicity coding and completeness in some services
- Challenges in securing representative service user/carer involvement, particularly from racially-diverse communities
- Fragmented population health data, limiting benchmarking and comparative analysis
- Early stage of implementation, with reliance on pilot sites to inform future scaling.

Assurances

- Executive Medical Director had discussion with Transformation Lead for more support from BI team
- The data quality issues are being discussed at the Executive Leadership Team
- Strong governance via PCREF Steering Group
- Executive-level approval of self-assessment
- Defined action plans and pilot programme in development.

Ongoing collaboration with System partners and Public Health.

Consultation

Engagement has taken place with:

- Derby Health Inequalities Partnership (DHIP)
- Community Action Derby
- Local Authority and Public Health partners.

Further work is underway to strengthen co-production and community engagement arrangements.

Governance or Legal Issues

PCREF implementation aligns with national NHS requirements on race equality.

Oversight is provided through the PCREF Steering Group, with escalation to Executive-level governance as required.

Consideration is being given to aligning PCREF oversight with wider health inequalities governance to avoid duplication.

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 identified within the reporting period
- Future workstreams (eg service redesign and community engagement models) may consider sustainable delivery approaches.

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 PCREF programme directly supports the Trust's statutory duties under the Equality Act by:

- Addressing racial inequalities in access and outcomes
- Improving data quality to identify and mitigate disparities
- Embedding co-production with diverse communities.

Risks relating to representation and data gaps are recognised and actively being managed.

Recommendations

The Board of Directors is requested to:

1. Note the progress made in implementing the PCREF framework
2. Support continued development of the PCREF pilot programme and action plan
3. Endorse the focus on improving data quality, community engagement, and partnership working
4. Recognise the risks relating to capacity (awaiting appointment of PCREF Lead and BI team capacity), data completeness and representation and support mitigating actions
5. Receive limited assurance on progress made so far.

**Report presented and
prepared by:**

**Dr Girish Kunigiri
Executive Medical Director**

Strategic Plan 2026/27: Quarter 1 (Q1) progress update

Purpose of Report

To update the Board of Directors on progress in delivery of the Strategic Plan at the end of Q1, 2026/27.

Executive Summary

The Strategic Plan 2025-2028 was originally approved by the Board on 4 March 2025. Following a robust process of review and revision at the close of the first year, refined 2026/27 deliverables were approved by the Board on 19 May 2026.

The enclosed report provides an update at the end of Q1, 2026/27 on delivery of priorities and deliverables within the Year 2 roadmap

This quarter has seen significant mobilisation across all priorities, with most deliverables progressing in alignment with agreed ambition. Of the 15 strategic priorities, 12 are currently on plan, with key achievements including:

- Learning from incidents arrangements fully established, with Trust-wide learning forums operational and reporting through governance committees
- Violence and Aggression Collaborative established with co-produced action plans in delivery
- Complaints backlog from 2025 cleared and improvement plan continuing
- Community safer staffing review launched across all 11 Community teams
- Transfer of Snowdrop Ward, Dementia Day services and Neurodevelopmental services from Derbyshire Community Health Services NHS FT to Derbyshire Healthcare NHS FT completed
- Workforce vacancy reduction programme progressing, with strong Healthcare Support Worker recruitment outcomes
- STRIVE Leadership Programme delivered to plan and organisational change programme Phase 1B operationalised
- Mental Health Urgent Assessment Centre programme mobilised, with consultation commenced and building works underway
- Neighbourhood Mental Health Model and 24/7 pilot progressed in line with Board direction
- Digital Delivery Plan mobilised with key programmes on track, including Patient Knows Best, Psyomics, eMHA and SystmOne Optimisation
- Positive Health Difference service mobilisation progressed ahead of planned launch
- Estates Plan Year 2 priorities delivered to plan, including LED lighting and electric fleet initiatives
- New ICB governance arrangements responded to, ensuring Trust representation across emerging structures
- Adult Social Care Living Well contract hosting proposal agreed, supporting sustainability of the model
- East Midlands Provider Collaborative plan approved, including transition to a single commissioning hub and expansion of Gambling Harms services.

At the end of Q1, the following three deliverables are currently off-track and represent a risk to achievement of annual delivery commitments:

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

Whilst published Q1 data is not yet available tracking has identified trajectories are off-plan for reducing out of area placements and length of stay reduction. Rapid reviews have been implemented of action plans, along with enhanced oversight arrangements for key deliverables by the Executive team. Alignment with BAF risk 26/27 1A.

2.4 Be recognised as a Trust that supports and promotes the wellbeing of our people

Action plan trajectories for improving long term sickness are off plan at month 2 with enhanced oversight through the Trust Delivery Group, Executive Leadership Team and People and Culture Committee. Alignment with BAF risk 26/27 2A.

3.1 Achieve financial sustainability through improved clinical and operational productivity

Published outturn position for Q1 is not available at the time of reporting but anticipated to be an off-plan delivery position for both the financial and efficiency plans. Alignment with BAF risk 26/27 3A.

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

Risks:

- Risks to delivery of the Strategic Plan are recognised and managed via the Board Assurance Framework (BAF)
- Alignment of off plan areas with BAF risks is set out within the cover sheet.

Assurances include that:

- The Strategic Plan aligns with and seeks to enact the Trust Strategy
- The source and forum for assurance is defined for each Strategic Plan priority
- The enclosed report demonstrates significant assurance on successful delivery of Q1 Strategic Plan ambitions with specific areas of under delivery recognised and discussed through prior quarterly reports and overseen by respective sub committees.

Consultation

- The Strategic Plan was developed through engagement and consultation through two Board Strategy and Development Sessions, the Staff Conference and the Leadership forum
- The Strategic Plan refresh for 2026/27 was considered through multiple forums, including the Executive Leadership Team and Board Strategy and Development conversations
- The quarterly delivery report has been received by the Strategic Portfolio Oversight Group with assurances considered and adjustments agreed.

Governance or Legal Issues

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

Net Zero Duty Implications

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

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

The Strategic Plan directly supports statutory commitments to achieve net zero by reducing carbon output associated with care delivery, estates, travel, supply chains and operational processes.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

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

Recommendations

The Board of Directors is requested to confirm the level of assurance secured in delivery of Strategic Plan ambitions at Q1, 2026/27. The recommended level is significant assurance: There is a generally sound system of control designed to meet the system's objectives. However, some weakness in the design or inconsistent application of controls put the achievement of particular objectives at risk.

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

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

Strategic Plan 2025 - 2028

Progress Update: Q1 2026-27



Patient focused

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

Priorities for delivery of success	Roadmap to delivery of success	Q1 Progress Update	Status	Assurance mapped to Q1 papers
	2026-27		Q1 Position	
1.1 Improve safety and effectiveness in line with our quality ambitions	1.1.1 Improve safety and reduce harm: timely learning from incident, review of Datix, PISRF reviews in line with Trust Policy 1.1.2 Reduce restrictive practices incidents (seclusion, restraint, rapid tranquilisation) by 10% through targeted clinical interventions 1.1.3 Learning from Incidents - all SI learning themes reported to ELT and QSC with action tracking 1.1.4 Reduce incidents of violence and aggression towards staff by 10%	1.1.1 Plans in delivery to develop learning approach with Care Group level and Trust wide Learning the Lessons meetings now fully operational. In Q1 the group shared learning on National alerts, themes on care planning, complaints and PSIRF reviews. Learning has been shared with the divisions 1.1.2 Action plan in delivery to reduce restrictive practice with oversight through QSC. There reduction in restrains, and prone restrains and increased support for the female wards set targets yet to achieved by Q1 1.1.3 Mechanism established to report all SI learning themes through ELT and QSC along with tracking of associated action plans. Learning lessons group met in June, set objectives to share learning with divisions met in Q1 1.1.4 Violence and aggression collaborative established with co-produced action plans in delivery intended to support achievement of trajectory. 4 areas of priority have been formulated Physical aggression, Sexual Safety, Anti-racism and Police Partnership. 2 sessions have been completed with staff .	Delivery on plan at Q1	Agreed assurances considered by Quality and Safeguarding Committee (QSC)
1.2 Improve experience for, and empower, service users patients and carers	1.2.1 Patient and Carer Race Equality Framework - coproduction of an action plan and having 3 pilot sites for implementation 1.2.2 Improve participation and improve scores in Community Mental Health Feedback 1.2.3 Deliver engagement and co-production plan (in continuous improvement and care delivery) 1.2.4 Closer Look Complaints to be responded within 90 days	1.2.1 Steps being mobilised for co-production of action plan with pilot sites for implementation to be identified. PCREF has been recruited 1.2.2 Action plan designed and in delivery to improve participation and feedback scores for Community Mental Health services. 28% increased has been realised in Q4 in 25/26 improvement plans are taking effect 1.2.3 Engagement and co-production plan in delivery with milestones on track at Q1 2026-27. Carer event held in June, Trust retained 2 star for Triangle of Care 1.2.4 Improvement plan in delivery for improving complaints response with progress being overseen by QSC. The backlog of complaints from 2025 has been cleared. Complaints Improvement plan remains in place	Delivery on plan at Q1	Agreed assurances considered by QSC
1.3 Develop effective quality governance systems and processes that facilitate shared learning and support a positive safety culture	1.3.1 Deliver a minimum of 3 operational NOF performance standards 1.3.2 Develop and deliver Clinical Plan with set deliverables to be delivered in year 1 1.3.3 Develop and deliver community safer staffing models in community services 1.3.4 Provide assurance and oversight of nursing and AHP roster, safer staffing and associated budgetary spend meet the national agency and bank usage targets	1.3.1 NOF framework for 2026-27 now published and improvement plans established for challenged metrics. Segmentation for Q1 expected to be published in September 2026. 1.3.2 Clinical Plan in final draft and to be progressed through governance mechanisms for approval over Q2. 1.3.3 Approach designed for community safer staffing review with implementation underway. Methodology has been approved by TDG and review meetings have been set up will all 11 community teams 1.3.4 Assurance mechanisms established for oversight of roster, safer staffing and associated agency and bank spend with oversight through ELT and QSC. HCA agency ban has been implemented. Roster improvement Plan now in place with combined oversight from Nursing, finance and HR	Delivery on plan at Q1	Agreed assurances considered by QSC
1.4 Improve access to our services and achieve all target wait times	1.4.1 Deliver the Trust's OOA bed reduction plan 1.4.2 Reduce LOS by 10% as set out nationally in the Trust's plan	1.4.1 Out of area bed reduction plan established and in delivery aligned to Operational Plan trajectory. Increase in OOA female PICU and appropriate OOA utilisation seen in Q1 with rapid review implemented of action plan progress being overseen by Patient Flow Delivery Group. 1.4.2 Length of stay reduction plan reviewed and refreshed with data driven approach across interventions. LoS not reduced aligned to plan with Medical Director led working group established to refocus on 72-hour reviews, MDT, LOS and 3-day leave, MHUAC clinical design completed, consultation launched and building work commenced. Caseload management transformation programme launched for community services. Transfer of OA Snowdrop ward, dementia day service and ND services from DCHS to DHcFT completed 1 June which will support longer term improvements in patient care and improved access	Delivery anticipated to be off plan at end Q1	IPR assurance considered by Finance and Performance Committee (FPC)

Priorities for delivery of success	Roadmap to delivery of success	Q1 Progress Update	Status	Assurance mapped to Q1 papers
	2026-27		Q1 Position	
2.1 Be recognised for attracting and retaining the best people	2.1.1 Improve recommendation as a place to work and staff engagement scores (Pulse check ins to assess progress) 2.1.2 Reduction in medical and key clinical vacancies (focus on remaining 39.72 TE HCSW inpatient vacancy and 26.69 FTE RMN inpatient vacancy) 2.1.3 Improvement in general recruitment processes 2.1.4 Improvement in teams with turnover above 10% to reduce variance and bring in line with trust thresholds 2.1.5 Improvement in eRoster efficiency to support overall reduction in 10% bank usage and 30% agency usage (alongside elimination of all HCSW agency usage)	2.1.1 Staff survey action plans are now being implemented across the Trust, with a clear focus on improving colleague experience and engagement. Pulse surveys scheduled throughout 2026/27 will provide early evidence of progress and enable targeted action where improvement is required. 2.1.2 Vacancy reduction remains on track, with sustained recruitment activity strengthening workforce capacity in priority clinical areas. Early progress is improving service resilience and reducing reliance on temporary staffing, with Healthcare Support Worker recruitment delivering particularly positive results 2.1.3 Recruitment processes have been streamlined, enabling faster appointments into vacant posts and reducing delays to services. Early improvements are supporting a more responsive recruitment experience for candidates and managers. 2.1.4 Teams with higher turnover have been identified and targeted interventions are underway. This proactive approach is expected to improve retention, reduce avoidable turnover and strengthen workforce stability in priority areas. 2.1.5 eRoster project established with targeted actions implemented over Q1 designed to realise immediate bank and agency benefits. Detailed scope and implementation plan in development for next phase of work and medium-term plan for optimising eRoster system.	Delivery on plan at Q1	Agreed assurances considered by People and Culture Committee (PCC)
2.2 Be recognised for supporting and developing our people to work confidently in their roles	2.2.1 Reduction in length of time for formal ER cases (measurement through regular reporting via TDG) 2.2.2 Reduction in inappropriate formal ER cases (utilising the respectful resolution policy to reduce formal ER cases) 2.2.3 Continue to deliver Leadership Development Programme 2.2.4 Deliver organisational change aligned to efficiency plan and organisational priorities	2.2.1 A focused improvement programme is underway to reduce the duration of formal employee relations cases, enabling earlier resolution for colleagues and managers while improving organisational efficiency and reducing the impact of prolonged processes. 2.2.2 Early improvements are supporting greater confidence and consistency in applying the Respectful Resolution Policy, increasing the proportion of concerns resolved informally and fostering a more restorative workplace culture. 2.2.3 STRIVE Leadership Programme in delivery aligned to agreed schedule with good feedback from participants. 2.2.4 Organisational change plan designed and in delivery with all milestones on track at Q1 and efficiency plan target expected to be fully delivered by year end.	Delivery on plan at Q1	Agreed assurances considered by PCC
2.3 Be recognised by our people for our values driven and inclusive culture	2.3.1 Deliver all elements of EDI Plan for 2026-27	2.3.1 Delivery of the Equality, Diversity and Inclusion Plan remains on track, strengthening inclusive leadership, improving staff experience and supporting the Trust's ambition to create a culture where everyone feels they belong.	Delivery on plan at Q1	Agreed assurances considered by PCC
2.4 Be recognised as a Trust that supports and promotes the wellbeing of our people	2.4.1 Improvement in long term sickness absence rates (to support an overall reduction of 0.5% in the annual sickness absence rate) 2.4.2 Reduction in sickness absence across teams above trust average, reduction of variance to within 1%	2.4.1 Enhanced oversight of long-term sickness absence is supporting earlier interventions and improved recovery planning. While improvements will take time to be reflected in overall absence rates, the strengthened approach is expected to improve colleague wellbeing and reduce prolonged absence.. 2.4.2 Detailed analysis has identified teams requiring targeted support, enabling tailored interventions to address local absence drivers. This data-led approach will improve consistency across services and contribute to sustainable	Delivery anticipated to be off plan at end of year	Agreed assurances considered by PCC

Priorities for delivery of success	Roadmap to delivery of success	Q1 Progress Update	Status	Assurance mapped to Q1 papers
	2026-27		Q1 Position	
3.1 Achieve financial sustainability through improved clinical and operational productivity	3.1.1 Deliver the Trust's agreed financial breakeven position by year end 3.1.2 Achieve £14.5 million in CIP with at least 66% recurrent savings by Q4 3.1.3 Establish innovation panel for colleagues to seek funding to deliver service and transformational change - focusing on delivering improved measurable patient outcomes	3.1.1 Financial plan agreed with outturn off track by £300k month 2 and recovery action mobilised. Q1 outturn position not yet available at time of reporting but anticipated to be off plan. Recovery workshop scheduled and working to close CIP gaps through clearing final QEIAs 3.1.2 CIP plan developed with mechanisms established to track and assure delivery . Q1 outturn position not yet available at time of reporting but again anticipated to be off plan. Final plans going through QEIA process and recovery workshops scheduled. 3.1.3 Approach under design and development for innovation panel with mobilisation planned for Q3.	Delivery anticipated to be off plan at end Q1	Agreed assurances considered by Finance and Performance Committee (FPC)
3.2 Transform our clinical pathways and operating model	3.2.1 Agree and implement the CMH 24/7 neighbourhood model 3.2.2 Agree and implement the MH Urgent Care Assessment clinical model	3.2.1 Neighbourhood model of care and 24/7 pilot progressing aligned to strategic intent agreed via Board Development session in April. Opportunities to build out from Living Well under active consideration internally with plan for integration with physical health opportunities being aligned with developing ICB approach. DLN approach on neighbourhood mental health model also being proactively discussed and developed with provider partners. 3.2.2 Programme plan mobilised for opening of Mental Health Urgent Assessment Centre with clinical and workforce model advanced, staff consultation commenced and building works underway. Phased approach to opening and development of service currently planned due to lack of recurrent revenue stream. Build will be ready come September.	Delivery on plan at Q1	Agreed assurances considered by Finance and Performance Committee (FPC) and People and Culture Committee (PCC)
3.3 Optimise our assets and enabling resources to improve services and care	3.3.1 Deliver year 1 priorities Digital Delivery Plan (Psyomics, Patient Knows Best, eMHA by Thalamos, SystmOne Optimisation) 3.3.2 Operationalise and deliver first treatments in Positive Health Difference services	3.3.1 Digital Delivery Plan mobilised over Q1 with all key deliverables on track aligned to highlight report presented to Strategic Portfolio Oversight Group. Digital Futures Day follow up session hosted with staff 18 June 2026 to maintain high engagement and involvement approach. 3.3.2 Plan in delivery to mobilise Positive Health Difference services with commencement of trading and delivery of first treatments expected in Q3. Systems developed, finance, comms, website delivered. Ongoing actions re location and clinical resources.	Delivery on plan at Q1	Agreed assurances considered by FPC
3.4 Reduce emissions we control directly (the NHS Carbon Footprint)	3.4.1 Deliver year 2 priorities Estates Plan. This includes progress and disposal of tail estates aligned to Estates plan; Deliver 15% reduction on back log maintenance where sites being retained; Implement solutions for managed car park to improve health and safety across various sites)	3.4.1 Year 2 Estates Plan priorities in delivery with all key milestones on track at Q1. We have the 6 facet survey results to inform our core, flex and tail positions regarding investment and disposal. We have a draft dicarbon plan and have rolled our Led lighting and electric fleet phase 1. CDEL is the limitation to doing more or moving faster	Delivery on plan at Q1	Agreed assurances considered by FPC

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.

Priorities for delivery of success	Roadmap to delivery of success	Q1 Progress Update	Status	Assurance mapped to Q1 papers
	2026-27		Q1 Position	
4.1 Build partnerships that deliver on the needs of our communities	4.1.1 Develop relationship with ICB Executive team to keep DHcFT positioned positively as a key partner in the new cluster 4.1.2 Become a lead provider for mental health services in Derby and Derbyshire 4.1.3 Deliver priorities for Community and Stakeholder Engagement Plan – Deaf and Black communities 4.1.4 EM Provider Collaborative: Move from 2 to 1 Commissioning Hub, expand Gambling Harm service by 10% 4.1.5 Optimise DLN cluster opportunities: Integrate Living Well in Neighbourhoods offer, undertake system wide strategic review of Children's services, embed Right Care Right Person (RCRP) ways of working	4.1.1 Proactive approach established to development of relationships with ICB Executive team and with partners across the DLN cluster. New governance structure recently released by ICB with action being progressed to mobilise DHcFT representation and full participation across this. 4.1.2 Action agreed in Q1 for DHcFT to host the Adult Social Care contract for the Living Well service as an enabler to offer stability to the model and programme. Development of this approach being actively progressed with ICB. ICB cluster reviewing Living Well model with a view to decision regarding future commissioning arrangements in September 2026. Ongoing compliance with national target for 2 plus contacts. 4.1.3 Year 2 of Community and Stakeholder Engagement Plan in delivery aligned to priorities agreed through Board Development session with bi-annual progress update scheduled. Workshop hosted in Q1 focused on black communities. 4.1.4 East Midlands Alliance Provider Collaborative plan approved and in delivery for 2026-27 which includes move to single commissioning hub and expansion of Gambling Harm service aligned to new funding stream through gambling levy. 4.1.5 Active work stream progressing with DLN partners to develop approach on neighbourhood model of care alongside internal development of Living Well model. Children's service review being progressed through Provider Collaborative workstream led by DHcFT CEO: commenced internal discussions with staff in 0-19 service, children's continence service and paediatric therapies. RCRP partnership continues to develop and identify opportunities for ongoing development with a recent focus on learning in action from review of calls into the Police Control Room and development of a DLN transformation bid to support collaborative service development opportunities.	Delivery on plan at Q1	Agreed assurances considered by the Finance and Performance Committee and the Board of Directors
4.2 Excel in our role as an anchor organisation	4.2.1 Collaborate with our partners to deliver an inclusive wellbeing economy - business as usual	4.2.1 Anchor ambitions as an employer, a procurer, as a holder of property and assets, as a partner, and in sustainability all in delivery and fully embedded through Delivery Plans. Progress with actions and metrics being overseen by sub-committees and Board through oversight of People Plan, Estates Plan, Green Plan, and Community and Stakeholder Engagement Plan. Focus in Q1 on analysis and action plan from newly released Carbon Footprint Data on the Federated Data Platform and development of system estate plans through the Strategic Estates Group.	Delivery on plan at Q1	Agreed assurances considered by the Sub Committees and Board of Directors
4.3 Achieve University Hospital Trust status	4.3.1 Continue to develop our strategic partnerships with academic institutions and deliver year 2 plan to develop – business as usual	4.3.1 Strategic partnership agreement signed with University of Derby with associated agreed plan in delivery to develop and strengthen research capability and support ambition to achieve University Hospital status. Progress being reported to and overseen by Board of Directors. OD programme delivered by UoD across a number of service areas including inpatient wards, crisis teams	Delivery on plan at Q1	Agreed assurances considered by the Board of Directors

Medical Job Planning - Performance and Assurance Plan (six-monthly update)

Purpose of Report

This report provides six monthly update on Medical Job Planning Performance and Assurance Plan in the Trust.

Executive Summary

Data is presented showing Trust compliance with NHSE job planning targets for 2025/26.

The Trust is compliant with current NHSE target of 90% of Consultant and SAS job plans complete.

New priorities defined by NHSE are outlined including a focus on service level job planning, an increase in completed job plan rates to 95% for 2026/27 and ability to demonstrate 98% delivery of job planned activity.

The Trust approach to meeting the NHSE requirements is outlined.

The Executive Medical Director is involved in the development of national guidance on Medical Job Planning in mental health that is due to be launched in July 2026.

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

Risks and Assurances

- Acknowledgement of risks to compliance related to:
 - Increased compliance rates set by NHSE
 - Recent appointment of Community Clinical Director has left Community job planning round delayed
- Mitigations in place through the Trust's approach to the 2026/27 job planning round including training.

Consultation

- The medical body has been consulted on job planning through training and discussion at medical senate
- People and Culture Committee, 2 July 2026..

Governance or Legal Issues

Annual job planning is a contractual requirement for substantively-employed medical staff.

Net Zero Duty Implications

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

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

No impact.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

No impact.

Recommendations

The Board of Directors is requested to:

1. Note significant assurance on compliance with the job planning for all Doctors in the Trust
2. Note potential delay in the completion of job plans in 2026/27 for Adult Community services due to Clinical Director vacancy which has been recruited since June 2026
3. Support the progress on elements related to measuring productivity going forward.

Report presented by: **Deborah Good**
 Non-Executive Director

On behalf of **Ralph Knibbs**
 Chair, People and Culture Committee

Report prepared by: **Dr Mark Broadhurst**
 Deputy Medical Director

Medical Job Planning in Derbyshire Healthcare NHS Foundation Trust (DHcFT)

1. Background

It is a contractual requirement for all substantively employed doctors to have an annual job plan. Job plans are prospective and should be set/reviewed annually by line managers. The job planning process was relaxed during COVID and a renewed focus on job planning has occurred in subsequent years. Compliance with job plan sign off rates for Consultants and SAS doctors is monitored by NHS England on a monthly basis. DHcFT compliance has increased steadily during the monitoring period.

NHSE priorities for job planning in 2025/26 job planning round focussed on gaining 90% compliance with signed off job plans.

For the 2026/2027 job planning round, NHSE have set priorities for:

- 95% compliance with signed off job plans
- 98% of job planned activity to be delivered
- A focus on service level (rather than isolated individual) job planning.

2. Situation in DHcFT

Job plans are recorded on an electronic system, namely L2P. The majority of substantively-employed DHcFT doctors are gaining familiarity with the job planning platform and it is relatively intuitive to use with good support from the platform's provider.

The process of setting/reviewing job plans for the new job planning year is carried out on an annual basis by clinical and operational line managers. Following the recent DHcFT operational restructure, job plans will be carried out by Clinical Directors and Care Group Operational Managers in the Care Group triumvirates.

Job plans should be completed prospectively and signed off by April of each year.

DHcFT has held annual job planning training for the last two years. This has been provided for both managers involved in job planning and Doctors who are contractually obliged to have a job plan. The training sessions are separated into the principles of job planning and the practicalities of the use of L2P to document the job plan. The most recent training sessions were held on 22 January and included a presentation by Dr Jyothi Nippani, NHSE Clinical Lead for Medical Productivity, and part of the National Job Planning Group, who spoke about the priorities for job planning in 2026/27 and beyond. The Executive Medical Director is part of national task and finish group and involved in the development of national guidance on medical job planning in mental health that is due to be launched in July 2026.

3. Job planning data

The data presented below shows the percentage of DHcFT Consultants and SAS Doctors with a completed job plan.

Consultants

	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Headcount	81	81	79	80	81	81	81
Signed off	71	71	71	71	75	78	78
%	88%	88%	90%	89%	93%	96%	96%

SAS

	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Headcount	30	32	37	37	40	44	44
Signed off	29	31	36	36	39	41	41
%	97%	97%	97%	97%	98%	93%	93%

Incomplete job plans for the 2026/27 job planning round are being completed and will be signed off in next couple of months.

4. Plans to continue to improve the robustness of job planning processes within DHcFT

Development to DHcFT's job planning processes will be based on the guidance and priority areas set by NHSE.

For this year the focus will be on:

- 95% compliance with signed off job plans
- 98% of job planned activity to be delivered
- A focus on service level (rather than isolated individual) job planning.

We have delivered training on the process for service level job planning to job planning managers (with excellent uptake) and all substantive Doctors. The training is recorded and thus available to those who were unable to attend.

The job planning round for 2026/27 included a service level job planning meeting in all the Care Groups, except in the Adult Community Division (due to lack of Clinical Director; currently recruited and in place from June 2026).

Care Group Operational Managers considered data to inform capacity and demand discussions in service-level job planning meetings.

Individual job planning meetings were held during March/April for completion and sign off in advance of April where possible. A Clinical Director vacancy in the Community triumvirates has led to delayed job planning in that Care Group. This vacancy was recruited to in June 2026 and the delayed job planning for those Doctors will now begin.

All Medical managers will be asked to contribute to completion of delayed Community job plans.

Measures of productivity will be decided in Care Groups by the triumvirates working collaboratively with Doctors. At least two strategic objectives will be set to reflect markers of productivity/activity. One of these will be a direct measure of delivered activity (eg the number of a specific clinical activity that should be undertaken each year). The other will be a "proxy measure" such as a team performance indicator, eg waiting lists. Delivery of job planned activity will be assessed by a six month review of all individual job plans by the job planning managers.

Clinical Directors in their triumvirates are formulating these two measures and Dr O Williams, HST, is supporting and will work with L2P on transferring the objectives into job plans.

5. Risks to job planning compliance for the 2026/27 job planning round

DHcFT has reached a compliant position with NHSE for 2025/26. However, it is noted that the compliance requirements are increased to 95% for 2026/27. We are making progress towards achieving the increased compliance rates for 2026/27 and our compliance will improve now that the Community Care Group Clinical Director is in place.

However, it is felt likely that the service level job planning process will help to engage those Doctors who have struggled to engage until now. Service-level job plans will help in aligning Trust strategic objectives to that of service and to individual job plans. Furthermore, there has been a renewed focus on job planning as a result of the DHcFT structural reorganisation as well as the reset due to new NHSE guidance.

It should also be acknowledged that the structural reorganisation has introduced a large proportion of new job planning managers and reduced the time available for the current job planning round. While it is hoped that this will aid enthusiasm and engagement, it must be recognised that significant time and energy is required for job planning and there is a risk that new managers may not have sufficient recognition of this as yet. This risk is being mitigated through training but it is possible that there will be an initial impact on completed job plan numbers.

A vacancy in the Community Clinical Director post until this month has resulted in delays with Community job plans.

Work is ongoing to meet the challenge of identifying productivity measures for our job plans while awaiting national guidance to support this approach specifically for Mental Health Trusts which is due in July 2026.

Learning From Deaths annual report

Purpose of Report

The 'National Guidance on Learning from Deaths' requires each trust to collect and publish specified information on a quarterly and annual basis. This report covers the period 1 April 2025 to 31 March 2026.

The Quality and Safeguarding Committee accepted 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

*Generated through use of Microsoft Copilot

This annual Learning from Deaths report 2025/26 sets out Derbyshire Healthcare NHS Foundation Trust's mortality data, learning activity and improvement work for the period 1 April 2025 to 31 March 2026. The Trust reports continued compliance with national Learning from Deaths guidance and has further strengthened its governance arrangements through new Trust-wide and Care Group Learning the Lessons forums, the embedding of mortality red flag identification within the Electronic Patient Record, and ongoing audit processes to improve oversight and dissemination of learning.

During the reporting period, the Trust received 2,067 death notifications, with overall mortality figures broadly consistent with the previous year. Of these, 255 deaths were reported on Datix, with 28 case record reviews and seven patient safety incident investigations commissioned; the report notes that 86.3% of deaths reviewed through completed Incident Review Tools did not identify concerns requiring a further learning response. There were seven Inpatient deaths, 37 learning disability deaths, and two deaths of patients with autism, with most deaths continuing to reflect expected patterns of age-related mortality.

The report identifies recurring learning themes from closed learning responses, particularly around risk assessment and management, care planning and documentation, communication and coordination, governance and accountability, and staff training and supervision. In response, the Trust has introduced or progressed several improvement initiatives, including mandatory suicide prevention, risk assessment and safety planning e-learning, strengthened cross-check and quality monitoring processes, development of an Incident Review Tool Audit Group, and wider quality improvement work through the new AMaT audit platform and Learning the Lessons governance structure.

The report also highlights that one death within 2025/26 met the criteria for Duty of Candour, alongside four cases from the previous year confirmed during this period, with improvement work focused on risk recognition, escalation, communication and policy adherence. In addition, the Trust received one Prevention of Future Deaths notice, with most required actions already completed or in progress. Overall, the report indicates that the Trust has demonstrated clear evidence of actions being taken to strengthen safety, governance and organisational learning.

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

Risks and Assurances

This report provided limited assurance to the Quality and Safeguarding Committee that the Trust is following recommendations outlined in the National Guidance on Learning from Deaths.

Consultation

- Reviewed by the Medical Director and colleagues within the Medical Directorate meeting
- Quality and Safeguarding Committee, 16 June 2026.

Governance or Legal Issues

- The report indicates limited adherence to the Patient Safety Incident Response Framework and National Guidance on Learning From Deaths
- Outcome 4 (Regulation 9) Care and welfare of people who use services
- Outcome 14 (Regulation 23) Supporting staff
- Outcome 16 (Regulation 10) Assessing and monitoring the quality of service provision
- Duty of Candour (Regulation 20).

Net Zero Duty Implications

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

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

There are no expected implications in relation to net zero duty.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Data scrutinised through a health inequalities lens shows that DHcFT's incident profile in respect to patient demographics is in keeping with that established in research and national data and there are no clear causes for concern identified in patient safety incident data. However, gaps in the recording of patient demographic data are evident, which hinder the reliability of the data.

Recommendations

The Board of Directors is requested to:

1. Accept this report with limited assurance of the Trust's approach
2. Agree for the report to be published on the Trust's website as per national guidance.

Report presented by: **Lynn Andrews**
 Chair, Quality and Safeguarding Committee

Report prepared by: **Tom Larder**
 Interim Patient Safety Lead

Learning from Deaths

Annual Report

2025/26



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1. Background

In line with the Care Quality Commission's (CQC) recommendations in its review of how the NHS investigates patient deaths, the National Quality Board published a framework for NHS Trusts - 'National Guidance on Learning from Deaths'. The purpose of the framework is to introduce a more standardised approach to the way NHS trusts report, investigate, and learn from patient deaths, which should lead to better quality investigations and improved embedded learning. To date, the Trust has met all the required guidelines.

In line with this national guidance, the trust is required to publish annual reports to public board meetings on to key performance statistics and figures.

This report presents the data for 1 April 2025 to 31 March 2026.

2. Current position and progress

This section of the report will provide an overview of Derbyshire Healthcare NHS Foundation Trust's (DHcFT's) current position and areas of progress in relation to its mortality review process and procedure.

- Cause of death information is currently being sought through the coroner offices in Chesterfield and Derby but only a very small number of cause of deaths have been made available
- Medical examiner offices at acute trusts provide independent scrutiny of non-coronial deaths including those in the community. They carry out a proportionate review of medical records and liaise with doctors completing the Medical Certificate of Cause of Death (MCCD). They give families and next of kin an opportunity to ask questions and raise concerns. There is an agreement in place for cause of death information to be released to the DHcFT patient safety team for patients open to our service in the six months prior to their death. This agreement is in place with UHDB and Chesterfield Royal Hospital via working relationships between the corresponding Patient Safety teams

This has been slow to come into force due to numerous technical issues for the varies EPR systems and a shortage of medical examiners. We have escalated the delay to the Integrated Care Board (ICB) Patient Safety Lead, who will explore this issue with their contacts to see if a resolution can be found

- Regular audits continue to be undertaken to ensure compliance with policy and procedure for the reporting of Red Flag deaths. This includes auditing complaint data against names of deceased patients to ensure this meets the requirements specified in the National guidance. The last audit was completed 7 May 2026. Red flag deaths are clinical 'red flags' determined through the National Learning from Deaths guidance that indicate the need for care reviews or investigations to determine if the death was potentially avoidable
- A process is now embedded within the Electronic Patient Record, which aids staff in identifying deaths which meet the threshold for Datix reporting. This process fulfils stage one of the Learning from Deaths procedure
- In line with changes being made to the assurance and oversight of learning post-incident, the Trust Mortality Committee was stood down and has been superseded by Trust-wide and Care Group Learning the Lessons meetings, which aim to triangulate learning across a broader spectrum of sources, including mortality, patient safety incidents, patient experience, clinical audit and clinical research. The Trust-wide Learning the Lessons forum holds oversight and governance for the dissemination and embedding of learning post-incident and will feed intelligence and directives to the Care Group Learning the Lessons groups to inform and drive forward quality improvement programmes across the Trust.

The first Trust-wide meeting took place on 11 May and will continue on an eight-weekly basis.

- DHcFT's Patient Safety team has re-established the Regional Mortality Review Networking as of March 2026 and the first meeting received great representation from other external partner agencies across the region. A further meeting is being arranged for July 2026 and will focus on shared learning and practice around integration of Learning from Deaths guidance and procedure with the Patient Safety Incident Review Framework
- We are developing an Incident Review Tool (IRT) Audit Group 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 the broader PSIRF requirements.

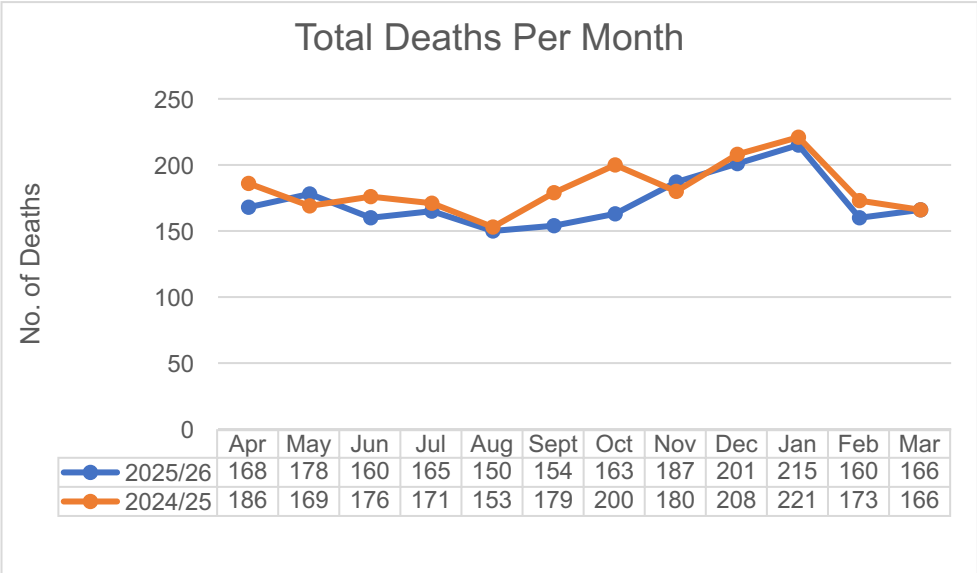
3. Data summary of all deaths

The following table outlines the number of notification of deaths received for the period 1 April 2025 to 31 March 2026:

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Total Deaths Per Month	168	178	160	165	150	154	163	187	201	215	160	166
LD Referral Deaths	3	1	3	4	1	5	1	1	5	4	4	5

*Correct as at 18 May 2026
 *Please note that Inpatient and Learning Disability (LD) data is subject to additional scrutiny based upon whether a) the patient was an open Inpatient, and b) there is an open LD referral at time of death regardless of whether the Trust has seen the patient.

Between 1 April 2025 to 31 March 2026, the Trust received 2,067 notifications of death of patients who had been in contact with our services or discharged within six months of the incident. Of these deaths, 1,103 patients were male, 961 female and three of unknown gender, 1,625 were white British and 41 Asian British. The youngest age was zero years, the oldest age recorded was 105. The Trust has reported 37 LD deaths in the reporting timeframe and two deaths of a patient with a diagnosis of autism.



Comparing data from 2025/26 against that of last year's report for 2024/25 shows relatively consistent mortality figures across both years, but with less deaths in the month of September & October 2025 compared to data from 2024.

4. Review of deaths

Only deaths which meet the clinical 'Red Flags' (laid out in National Learning from Deaths Guidance) are reported through the Trust incident reporting system (Datix). These deaths are reviewed through processes outlined within the Trust's *Incident Reporting and Investigation Policy and Procedure*.

The table below lists the number of deaths reported through the Datix Incident Reporting System and those that met the criteria for reviewed by the organisation:

Total number of deaths between 1 April 2025 to 31 March 2026 reported on Datix	202 "Unexpected deaths"
	33 "Suspected Suicide deaths"
	20 "Expected - end of life pathway"
	<i>NB some expected deaths do not meet the criteria for reporting and have therefore been rejected from the Datix Incident Reporting System. These rejected incidents are not included in the above figure.</i>
Incidents assigned for a review	220 incidents assigned to the Operational Incident Group.
	32 incidents assigned to the Executive Incident Group.
	Three incidents to be confirmed.

The list below details the criteria for which notification of deaths should be recorded through the Trust's incident reporting system:

Any patient, open to services within the last six months, who has died and meets the following:

- Homicide – perpetrator or victim
- Domestic homicide - perpetrator or victim
- Suicide/self-inflicted death, or suspected suicide
- Death following overdose
- Death whilst an inpatient
- Death of an inpatient who died within 30 days of discharge from a DHcFT hospital
- Death following an inpatient transfer to acute hospital
- Death of patient on a Section of the Mental Health Act or Deprivation of Liberty Safeguards (DoLS) authorisation
- Death of patient following absconsion from an Inpatient unit
- Death following a physical restraint
- Death of a patient with a learning disability
- Death of a patient where there has been a complaint by family/carer the Ombudsman or where staff have raised a significant concern about the quality-of-care provision
- Death of a child (this will also be subject to scrutiny by the Child Death Overview Panel)
- Death of a patient open to safeguarding procedures at the time of death, which could be related to the death
- Death of a patient with historical safeguarding concerns, which could be related to the death
- Death where a previous Coroner's Regulation 28 has been issued
- Death of a staff member whilst on duty
- Death of a child under the age of 18 of a current or previous service user who has died in suspicious circumstances
- Where an external organisation has highlighted concerns following the death of a patient, whether they were open to the Trust at time of death or not
- Death of a patient with autism
- Death of a patient who had a diagnosis of psychosis within the last episode of care
- Death of a patient who had a diagnosis of an eating disorder within the last episode of care or within six months of discharge
- Death of a patient open to Crisis Home Resolution team or equivalent at the time of death.

5. Inpatient deaths

A total of seven Inpatient deaths were reported during the period of April 2025 to March 2026.

- Two deaths were expected and related to patients who were being cared for through an end-of-life pathway
- Three deaths were unexpected but related to a medical condition or natural causes. Review of these deaths identified the following:

- The care and treatment of all three patients were found to be of a good standard
- One case has highlighted responsiveness of the duty doctor as an area for improvement.
- One case has generated learning in respect to the consideration of multiple physical health comorbidities in the review of RESPECT forms
- One death was unexpected and related to morphine toxicity. Review of the death found that care and treatment met expected standards, however generated some learning in relation to strengthening the alignment of care plans, risk assessments and safety planning, particularly during periods of leave
- One death was reported to be a suspected suicide. A patient safety incident investigation (PSII) is currently underway and will in due course identify if there is any learning or areas for improvement.

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 made as to whether a further Learning Response is required.

Financial Year	Datix	Case Record Review	PSII
2023/24	119 deaths	39	16
2024/25	141 deaths	23	3
2025/26	255 deaths	28	7

Please note: Seven deaths are currently awaiting a decision.

This indicates that for **86.3%** of the total deaths within the period of 2025/26 the completed Incident Review Tools provided assurance that there were no concerns with care that warranted the commissioning of a learning response.

The author notes that there is a significant difference in deaths reported through Datix between 2024/25 and 2025/26. Further exploration and analysis of the data will be undertaken to determine the contributing factors behind this. Any discrepancies or inaccuracies in data will be updated in future publications of this report.

7. Duty of Candour (DoC) for 1 April 2025 to 31 March 2026

DoC refers to the Trust's obligation under Regulation 20 of the Health and Social Care Act 2008 to be open, honest and transparent with patients (or their families) when mistakes occur in care or treatment that result in significant harm.

Between 1 April 2025 to 31 March 2026, there was one death which met the criteria for DoC. It should be noted there are Learning Responses for this period which remain active therefore DoC figures change. The below provides a brief narrative around the nature of DoC and improvement actions:

No	Incident Date	Date DoC confirmed	Narrative
1	Jun-2025	Nov-2025	DoC was identified following the conclusion of a Case Record Review. An apology was offered to the family in November 2025. The nature of the DoC related to the immediacy of the patient's risks not having been fully recognised and not receiving a timely response. Improvement works are underway in relation to strengthening multidisciplinary discussion and escalation, particularly outside of normal working hours.

Some catastrophic incidents can be subject to a patient safety learning response (ie PSII or Case Record Review). DoC for these incidents can be assessed at the date of the report being signed off by the Executive Incident Group.

The date of which DoC can be assessed for incidents subject to a patient safety learning response can therefore sit outside of the reporting period for which the incident occurred.

Four deaths have been identified during this financial year as DoC having occurred during 2024/25. The Trust continues to support the families involved in engagement with patient safety incident response. The table below provides an overview with narrative around the nature of the DoC and improvement work in place to address this.

No	Incident Date	Date DoC confirmed	Narrative
1	Apr-2024	Sep-2025	DoC was identified following the conclusion of a PSII. An apology was offered to the family in October 2025. Areas for improvement were identified relating to adherence to trust policy around clinical risk assessment and therapeutic observations levels, and the development of a Personality Disorders Pathway. The PSII report is due to be finalised, following which improvement actions will be loaded to our incident reporting system.
2	Dec-2024	Oct-2025	DoC was identified following review at the Trust's Operational Incident Review Group meeting. The nature of the DoC related to harm reduction advice and guidance in relation to illicit substance use not meeting expected standards. The Trust was unable to offer an apology owing to the patient being deceased and having no identified next of kin. Improvement actions generated from the learning have been completed and embedded into practice.
3	Feb-2025	Apr-2026	DoC was identified following the conclusion of a case record review and an apology was offered in April 2026. The nature of the DoC related to gaps in monitoring and follow up from Drug and Alcohol services in Derby City. These services are no longer provided by DHcFT and the learning and improvement actions identified from the Case Record Review have been handed over to the new service providers to inform service delivery moving forward.
4	Feb-2025	Oct-2025	DoC was identified following completion of a PSII and an apology was offered in December 2025. The nature of the DoC related to shortfalls in communication around falls risks during transfer between services and areas for improvement identified in relation to adherence to relevant policy and procedure. 25 of the improvement actions identified from this case have been completed, with learning embedded into practice. Seven broader improvement actions are in progress relating to updates to service policy and procedure.

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 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 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. 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

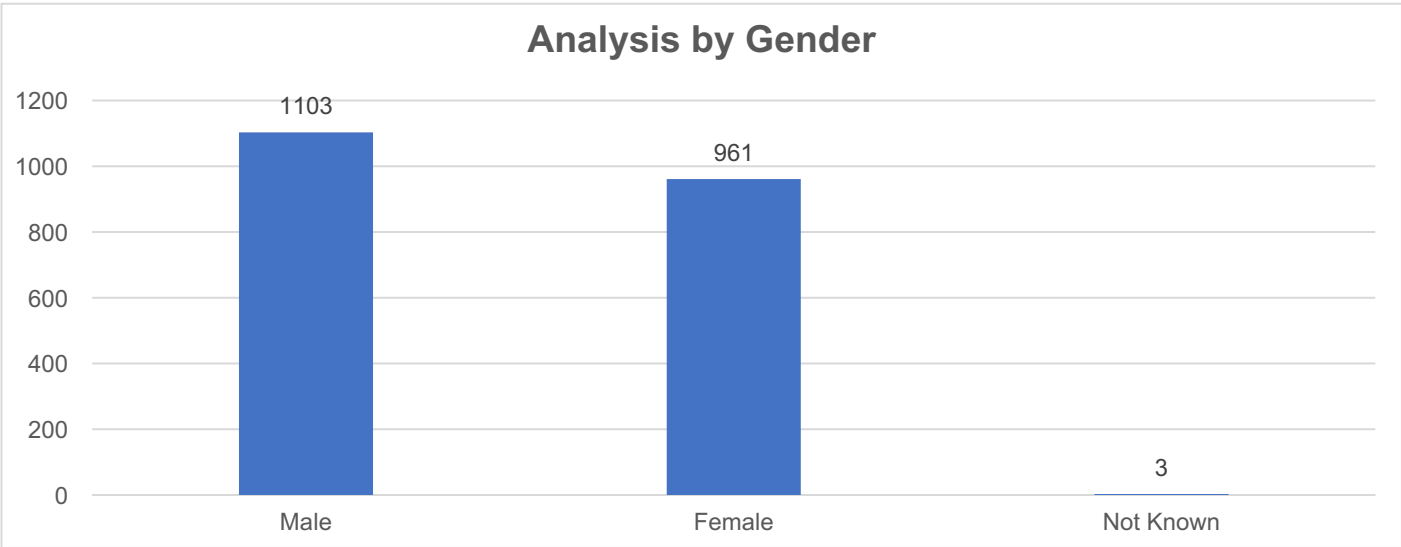
9.1. Analysis per notification system since 1 April 2025 to 31 March 2026

System	Number of Deaths
SystmOne	2,065
IAPT	2
Grand Total	2,067

The data above shows the total number of deaths reported by each notification system. All of the death notifications apart from two were pulled from SystmOne. This clinical record system is aligned to our largest population of patients and a population at greatest risk of death due to the proportion of older people in our care.

9.2. Analysis by gender

The data below shows the total number of deaths by gender 1 April 2025 to 31 March 2026. There is very little variation between male and female deaths; 961 female deaths were reported. compared to 1,103 males:

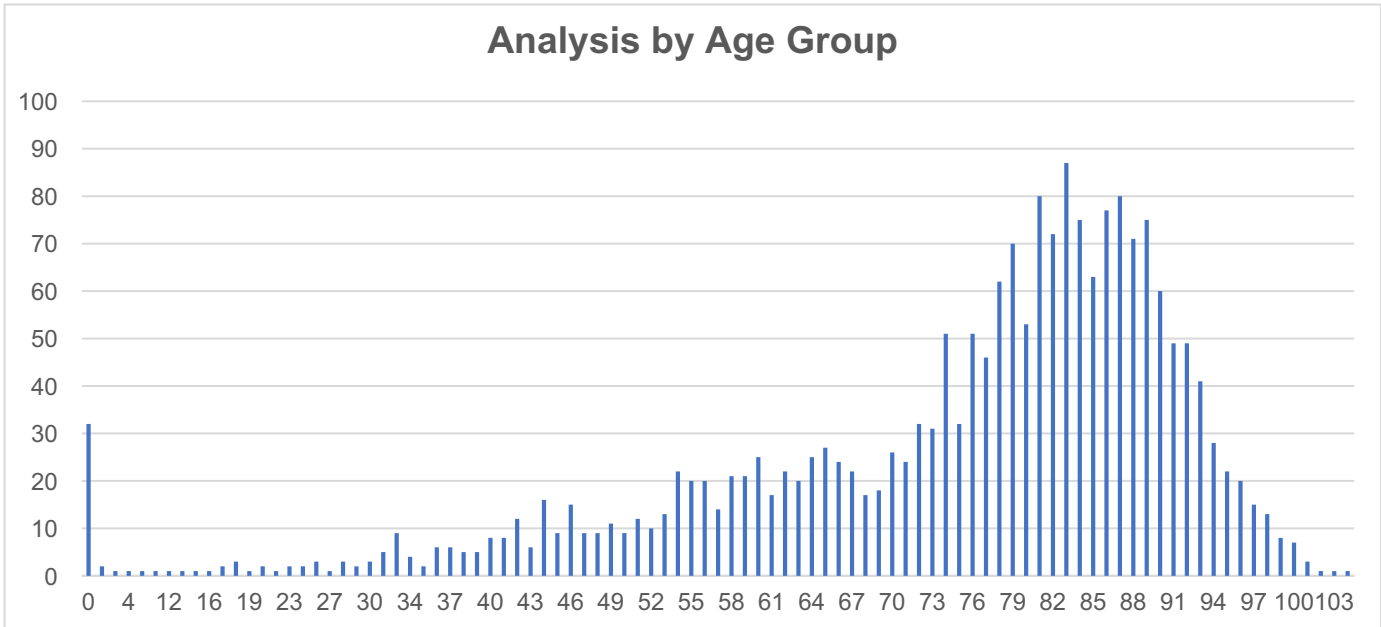


Gender	Number of Deaths	%	Open Referrals to DHcFT	Increase/Decrease from 2024/25
Male	1,103	53.4%	43%	-3.6% decrease
Female	961	46.5%	53%	-7.1% decrease
Not Known	3		-	-
Grand Total	2,067			

The data shows more deaths for men than women, despite more women being open to DHcFT services. However, this data is consistent with national statistics and research which reflect that men have a lower life expectancy than women (see Office for National statistics data, 2020).

9.3. Analysis by age group

The youngest age was classed as zero, and the oldest age was 105 years. Most deaths occurred within the 79 to 89 age groups – this is largely consistent with our 2024/25 report.



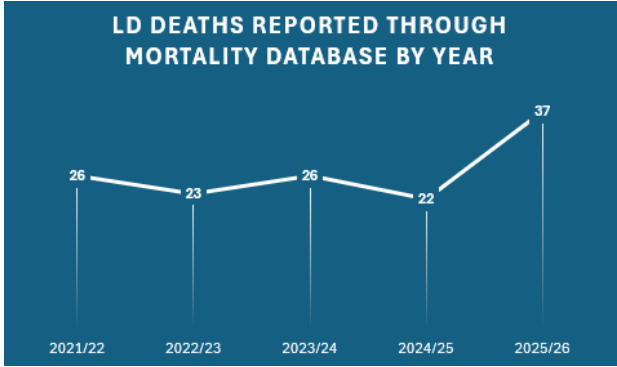
The data indicates that most reported deaths correlate with mortality rates related to natural aging. When compared to data relating to open referrals to DHcFT, ages 70+ are the joint highest age group currently open to our services (alongside ages 30-39yrs).

9.4. Learning Disability (LD) deaths

The Trust reviews all deaths relating to patients diagnosed with an LD. The Trust also currently sends all LD deaths that have been reported through the Datix system to the Learning Disabilities Mortality Review (LeDeR) programme:

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
LD Deaths	3	1	3	4	1	5	1	1	5	4	4	5
Autism	0	0	1	0	1	0	0	0	0	0	0	0

During 1 April 2025 to 31 March 2026, the Trust has recorded 37 Learning Disability deaths. Of these 37 deaths, 21 were reported through the Trust's Datix system:



Comparing the data to last year's report, there has been an increase in LD deaths of 68% (from 22 in 2024/25 to 37 in 2025/26). However, liaison with Derbyshire's LeDeR programme has revealed static figures for 2024/25 and 2025/26, indicating that this increase has not been reflected in overall LD deaths in Derbyshire, but they have similarly seen more reports from DHcFT. It is felt that the increase in reporting by DHcFT may be attributed to improved reporting practices by the organisation.

Review of Datix incident reporting data indicates that deaths of patients with an LD were mainly associated with advanced physical illness, complex comorbidity, dysphagia-related risk, infection and end-of-life care needs.

The most prominent organisational themes relate to waiting lists, staffing pressures, triage, escalation and communication across services, rather than evidence of direct harm caused by Specialist LD teams. The learning identified is largely focused on strengthening systems, timely review, and co-ordination between services.

DHcFT's Speech and Language Therapy services (SaLT) have an improvement project in place to address waiting lists for people accessing these services. They are also supporting a greater number of their SaLT Therapists to complete their dysphagia training so that the Trust can enhance its offer to patients with a learning disability who present with respiratory conditions that may affect their breathing and swallowing. Over the last year the Trust's Neurodevelopmental services have also been offering outreach to care homes to increase awareness of dysphagia and promote earlier identification and referral into services.

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.

The Trust receives annual reports from Derbyshire's LeDeR programme which highlights national good practice and identified learning; this is shared with our ND service leads and will be disseminated through the Trust's Learning the Lessons meetings, which have now been established in our Neurodevelopmental services to support the dissemination of learning to improve practice and reduce avoidable deaths moving forward.

9.5. Analysis by ethnicity

White British is the highest recorded ethnicity group with 1,625 recorded deaths; 114 deaths had no recorded ethnicity assigned. The following chart outlines all ethnicity groups, representing the number of deaths, the percentage of total deaths, and a comparison to the number of total open referrals to DHcFT:

Ethnicity	Number of Deaths	%	Open referrals to DHcFT
White - British	1,625	78.62%	74.58%
Other Ethnic Groups - Any other ethnic group	212	10.26%	11.53%
Not Known	96	4.64%	-
White - Any other White background	37	1.79%	2.19%
Asian or Asian British - Indian	19	0.92%	1.31%
Not stated	18	0.87%	3.74%
Asian or Asian British - Pakistani	16	0.77%	1.43%
White - Irish	13	0.63%	0.37%
Black or Black British - Any other Black background	7	0.34%	0.60%
Black or Black British - Caribbean	5	0.24%	0.73%
Mixed - White and Black Caribbean	5	0.24%	0.86%
Mixed - Any other mixed background	5	0.24%	0.59%
Asian or Asian British - Any other Asian background	4	0.19%	0.63%
Asian or Asian British - Bangladeshi	2	0.10%	0.07%
Black or Black British - African	1	0.05%	0.67%
Other Ethnic Groups - Chinese	1	0.05%	0.11%
Mixed - White and Black African	1	0.05%	0.15%
Grand Total	2,067		

The data shows that deaths by ethnicity are proportionate with the demographic profile of all patients open to DHcFT and there is no indication of health inequalities contributing to deaths.

9.6. Analysis by religion

Christianity is the highest recorded religion group with 810 recorded deaths, 1,079 deaths had no recorded religion assigned. The chart below outlines all religion groups compared to the religious profile of patients with an open referral to DHcFT:

Religion	Number of Deaths	%	Open Referrals
Christian	783	37.88%	32.11%
Not religious	616	29.80%	34.44%
(blank)	316	15.29%	26.83%
Patient religion unknown	139	6.72%	-
Church of England, follower of	50	2.42%	-
Church of England	40	1.94%	-
Christian religion	27	1.31%	-
Muslim	16	0.77%	1.70%
Roman Catholic	13	0.63%	-
Sikh	11	0.53%	0.76%
Methodist	10	0.48%	-
Religion not given - patient r	8	0.39%	1.62%
Catholic religion	8	0.39%	-
Religion NOS	4	0.19%	-
Pagan	3	0.15%	0.39%
Baptist	3	0.15%	-
Catholic: non Roman Catholic	3	0.15%	-
Jehovah's Witness	3	0.15%	-
Buddhist	2	0.10%	0.39%
Atheist	2	0.10%	-
Protestant	2	0.10%	-
Atheist movement	2	0.10%	-
Protestant religion	1	0.05%	-
Greek Orthodox	1	0.05%	--
United Reform Church	1	0.05%	
Rastafarian movement	1	0.05%	-
Anglican	1	0.05%	-
Jehovah's Witness religion	1	0.05%	-
Grand Total	2,067		

There is discrepancy between databases regarding religious categories used which creates challenges in contrasting different data sources. While people within the 'Christian' religious group are represented 5% higher than in DHcFT open referral data, overall the comparison of religious groups represented in mortality data against that in open referrals to DHcFT does not indicate any significant inequalities warranting further exploration.

9.7. Analysis by sexual orientation

Heterosexual or straight is the highest recorded sexual orientation group with 1,482 recorded deaths, 569 have no recorded information available. The chart below outlines deaths in all sexual orientation groups compared against open referrals to DHcFT:

Sexual Orientation	Number of Deaths	%	Open Referrals
Heterosexual	1,482	71.70%	50.71%
(blank)	466	22.54%	36.45%
Sexual orientation not given - patient refused	55	2.66%	1.69%
Sexual orientation unknown	36	1.74%	5.00%
Not stated (person asked but declined to provide a response about their sexual orientation)	10	0.48%	2.28%
Homosexuality NOS	6	0.29%	0.40%
Bisexual	6	0.29%	1.67%
Homosexual	2	0.10%	0.08%
Person asked and does not know or is not sure (about their sexual orientation)	1	0.05%	0.76%
Unknown	1	0.05%	0%
Female homosexual	1	0.05%	0.65%
Male homosexual	1	0.05%	0.30%
Grand Total	2,067		

The data suggests that heterosexual people are much more highly represented in mortality data than in DHcFT open referral data (+21%). However, there is a significant proportion of people for whom sexual orientation is unknown in both mortality and open referral data (27.47% and 46.18% respectively), reducing the validity of this data and making it difficult to analyse with any degree of confidence.

This raises the question as to how reliable data collection practices are, particularly in referral data for DHcFT. These findings will be distributed through the Trust-wide Learning the Lessons forum to promote greater understanding of the challenges to data capture and to inform improvements to future data collection.

9.8. Analysis by disability

This section of the report usually focuses on analysis of data relating to the representation of disabilities in mortality data. Unfortunately, recent changes to data capture relating to disabilities within the SystmOne Electronic Patient Record mean that this data is not currently extractable for the mortality database. Regrettably we are unable to provide valid data in this report.

This has been escalated to our colleagues in the Information Management, Technology and Records (IMT&R) team and we aim to see this resolved for future publications of this report.

9.9. Data quality improvements

As has been noted within the data of this report, there are discrepancies in regard to how demographic data is recorded across different databases (SystmOne EPR, Datix system, mortality database).

Early discussions have already taken place with Risk Systems and IMT&R colleagues regarding improving data quality within the Datix system. Unfortunately, solutions to automate the generation of patient demographic data through the Trust's Electronic Patient Record system are cost prohibitive. The Datix system relies on users to populate patient demographics and is therefore, subject to human error. Efforts to introduce additional checks and procedures around Datix quality are likely to be cumbersome to frontline staff.

Therefore, the proposed solution moving forward will be to use the NHS numbers from the Datix system and mortality database and provide these to the IMT&R team with a request to extract the data from the Electronic Patient Record system (which is noted to have a much higher rate of data quality). This will ensure that demographic data is being sourced from the same system and will improve the validity of data analysis moving forward.

10. Closed learning response outcomes for the period

There have been 34 learning responses approved for closure through the Executive Incident Review Group.

The following table details an executive summary of the key learning themes that have emerged from patient safety learning responses that were approved by the Executive Incident Review Group over the period of April 2025 to March 2026, mapped against improvement initiatives that are currently underway.

Theme	Learning	Improvement Initiatives
Risk assessment and management	There were repeated findings that risk was not reviewed dynamically, important warning signs were missed or underestimated, and decisions or escalation plans were not clearly documented.	As of March 2026, all four Suicide Prevention, Risk Assessment and Safety Planning e-learning modules are now live and considered mandatory training for clinical employees. Positive progress is being made in completion rates and is monitored on a quarterly basis through the Patient Safety report. There are plans for the Trust's Suicide Prevention Lead to facilitate some face-to-face follow-up training for teams who have been identified through patient safety learning responses.
Care planning and documentation	Records were often incomplete, inconsistent, or outdated, reducing the quality of clinical decision-making and continuity of care.	The Trust has been embedding higher standards of care documentation quality through the introduction of frequent 'cross-check' meetings for each service line, increasing accountability for service and clinical leads in demonstrating timely improvement in quality metrics. In addition to this, the Trust has introduced 'Fundamentals of Care' visits as an additional quality monitoring mechanism. The visits function similarly to a 'mock' CQC inspection, where teams are reviewed by peer services who provide feedback around areas of good practice and areas for improvement. The Trust is also investing in a new digital clinical audit platform called 'AMaT'. This platform will promote greater consistency in clinical audit standards and practices across the organisation and provide clearer data analysis to evidence the effectiveness of quality improvement initiatives.
Communication and co-ordination	Problems were noted both within multi-disciplinary teams and with patients, families, carers and partner agencies, leading to missed opportunities to share critical information and respond effectively.	Improvement actions have been targeted towards specific teams identified within learning responses to enhance their governance and processes around multi-disciplinary working and escalations. The Trust's Suicide Prevention Lead will also be leading a piece of work around developing greater governance and structure around multi-disciplinary risk management through developing standardised procedures to support risk strategy meetings. The Trust continues to drive adherence to the 'Triangle of Care' scheme to increase collaborative working with patients, families and carers in the delivery of care, and this is being directly scrutinised through the aforementioned cross-check meetings and Fundamentals of Care visits. The Trust is also partnering with Experts by Experience to undertake the '15 steps challenge' – a quality improvement initiative that places the experience of patients and carers at the core.

		DHcFT utilises the SystmOne Electronic Patient Record system, which is largely utilised by GPs within Derbyshire. However, improvement initiatives have targeted GP surgeries and partner agencies who do not utilise SystmOne to make them aware of risks related to poor information sharing and to promote good information sharing practices. Conversations also continue within the Derbyshire Integrated Care System in relation to voluntary, community and social enterprise partner organisations, who provide key aspects of Derbyshire's Crisis Alternative Support services, accessing SystmOne.
Governance, oversight and accountability	A further theme is the need for stronger governance, oversight and accountability, including clearer pathways, better action tracking, more robust audit and assurance processes and improved recording of multi-disciplinary team discussions and clinical rationale.	As referenced previously, the Trust is investing in the AMaT platform to strengthen governance and accountability in relation to clinical audit standards and practices. The Trust-wide Learning the Lessons forum was launched in May 2026, which serves as a parent forum to the Care Group Learning the Lessons subgroups. The Trust-wide Learning the Lessons forum provides oversight and governance for the dissemination and embedding of learning and improvement throughout the organisation and aims to triangulate learning from a variety of sources (learning from deaths, patient safety incidents, patient experience, clinical audit, clinical research, etc) to inform quality improvement initiatives. The Trust's Transformation team continue to develop the organisation's staff and leaders through Quality Improvement training and through promoting quality improvement methodology and use of the LiveQI system to develop and support QI projects and evidence outcomes.
Training, supervision and staff support	There is an emphasis on the role of training, supervision, and staff support, particularly to help staff manage complex presentations, embed Trust policies in practice and improve safeguarding, clinical decision-making and risk formulation.	As referenced previously, all four Suicide Prevention, Risk Assessment and Safety planning modules are now live and follow-up face-to-face training offers are being planned for teams who have been identified within learning responses. Additionally, the organisation has been through a recent restructure and redefining of leadership roles. This is anticipated to result in greater clarity and emphasis on the role of Clinical Leads to develop and deliver regular training at service level.
Less common themes	Additional learning points include the need to strengthen safeguarding and professional curiosity, improve medication and physical health monitoring, address delays and handover failures, and ensure better carer involvement and individualised safety planning.	Individual learning actions have been developed for specific teams involved in these patient safety incidents and continue to be monitored through the Learning the Lessons meetings and Care Group Performance meetings.

Learning themes have been directly fed back to service leaders and involved staff. They will also be added to the agendas for the Care Group Learning the Lessons forums for dissemination and to incorporate into quality improvement projects.

11. Prevention of Future Death Notices (PFDs)

The Trust received one PFD notice within the period 2025/26 relating to Mrs HB (Datix Incident Ref. W103255) the completion of which is due to be reported back to HM Coroners by August 2026. **Five out of eight** of these actions have been completed. A further two actions are partially complete, pending launch of the Perinatal services 'micro-site' and a confirmed date for their next state stakeholder event. Only one action remains outstanding. The remaining three actions are expected to be completed by the August 2026 deadline.

The main learning from this death pertained to the patient's GP utilising a different electronic patient record system to that of the Trust's Perinatal services, which resulted in important information not being shared, in addition to vital information recorded in the baby's notes not being added to the mother's record.



Quality Account - 2025/26

Purpose of Report

To present the Quality Account 2025/26 to the Trust Board.

Executive Summary

The Quality Account is an annual public report produced by all NHS provider organisations that describes the quality of services delivered over the previous financial year. It is intended to provide transparency, demonstrate accountability to patients and the public, and set out priorities for improving the quality of care.

The production of a Quality Account is a legal requirement under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010. The report is published annually alongside the Trust's Annual Report.

As there is no Board meeting held in June, approval of the Trust Quality Account was delegated to the Trust Quality and Safeguarding Committee as it must be published by 30 June. The Committee approved the Quality Account in May. The document includes:

- A statement from the Chief Executive confirming the accuracy of the report
- Information on how the Trust measures and improves quality across the three domains of:
 - Patient Safety
 - Clinical Effectiveness
 - Patient Experience
- Progress against the quality priorities identified in the previous year's Quality Account
- Quality improvement priorities for the forthcoming year, including measurable objectives
- Performance against nationally mandated quality indicators and locally agreed measures
- Information on participation in national clinical audits, research, patient safety initiatives and quality improvement programmes.

Prior to publication, the Quality Account was shared with key stakeholders for review and comment, including:

- The Integrated Care Board (ICB)
- Healthwatch
- The Local Authority Health Scrutiny Committee.

Statements are published within the Quality Account.

The key quality risks and priorities for 2026/27, include responding to service demand and acuity, supporting workforce sustainability, improving access and flow, reducing unwarranted variation, managing digital dependency, advancing equality and inclusion, and ensuring consistency of experience. These priorities will guide our quality improvement and assurance activities over the coming year.

To support accessibility and transparency, a one-page summary of the Quality Account has been developed in plain English, with input from the Speech and Language service to support accessibility for the public. Additionally, a glossary has been included to help interpret Health Service jargon within the document. These enhancements reflect our commitment to making information about our services understandable and accessible to all.

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

Risks and Assurances

Risks

- Rising demand and acuity impacting patient safety, flow and continuity of care
- Workforce pressures affecting wellbeing, morale and service resilience
- Delays in urgent and inpatient pathways, including risk of out-of-area placements
- Variation in patient, carer and lived experience across services
- Digital dependency and optimisation risks affecting safety and staff experience
- Safeguarding, sexual safety and professional boundary risks in inpatient care
- Violence, abuse and aggression impacting staff safety and retention.

Assurances

- Patient Safety Incident Review Framework (PSIRF) embedded, with strong learning from incidents and 100% in-period Duty of Candour compliance
- Suicide and Self-Harm Prevention Plan in place, with personalised safety planning and training
- Patient Flow Programme and Mental Health Urgent Assessment Centre strengthening access and flow
- Sustained reduction in restrictive practices supported by trauma-informed care and governance
- High safeguarding assurance
- Strengthened workforce assurance through safer staffing oversight, Freedom to Speak Up and Wellbeing programmes
- Digital Delivery Plan and clinically governed use of contactless patient monitoring
- Robust Quality Assurance Framework, including Board visits, accreditation and use of data.

Consultation

- Director of Nursing, AHPs, Quality and Patient Experience
- Deputy Director of Nursing and Patient Safety
- Deputy Director of AHPs and Patient Experience
- Assistant Directors of Safeguarding
- Heads of Clinical Practice
- Matrons
- Service/professional Leads
- Quality and Safeguarding Committee, 14 April 2026 and 7 May 2026.

Governance or Legal Issues

- NHS Quality Accounts Regulations – Statutory requirement for the Trust to publish an annual Quality Account reporting on safety, effectiveness and experience
- Care Quality Commission (CQC) Single Assessment Framework – External regulatory framework informing inspection, Mental Health Act monitoring and organisational assurance
- Mental Health Act 1983 (as amended) – Including CQC Mental Health Act monitoring visits and associated governance and learning arrangements
- Health and Social Care Act 2008 (Regulated Activities) Regulations – Including compliance with Regulation 20 (Duty of Candour)
- PSIRF – Governing the Trust's approach to learning from incidents, deaths and harm
- Learning from Deaths Framework – Supporting mortality review, escalation and assurance processes
- Statutory Safeguarding Duties (Children and Adults) – Including Section 11 safeguarding arrangements and the Safeguarding Adults Assurance Framework (SAAF)
- NHS England Sexual Safety Framework and Sexual Safety in Healthcare Charter – Informing sexual safety governance, improvement and monitoring
- NICE Guidance and National Quality Standards – Supporting clinical effectiveness, audit, research and quality improvement
- Royal College of Psychiatrists Accreditation Standards – Providing external validation and quality assurance across services
- Equality Act 2010 and Human Rights Act 1998 – Underpinning equality, inclusion, cultural safety, dignity and least restrictive practice
- Patient and Carer Race Equality Framework (PCREF) – Guiding anti-racist practice and experience improvement
- Freedom to Speak Up (FTSU) Framework – Supporting workforce voice, culture and organisational learning
- NHS People Promise – Informing workforce experience and wellbeing priorities
- NHS Information Governance Frameworks and 'What Good Looks Like' (Digital) – Providing assurance for digital, data protection and information governance
- Trust Quality Assurance Framework and Board Assurance Framework – Enabling triangulated assurance, risk oversight and escalation
- Trust Strategy 2024–2028 and Quality Delivery Plan – Aligning quality priorities with Board-approved strategic objectives.

Net Zero Duty Implications

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

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

N/A.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Equality-Related Risk	Key Mitigation / Control
Inequalities in access, experience or outcomes for people from ethnic minority and marginalised groups	Delivery of the Patient and Carer Race Equality Framework (PCREF), anti-racist practice, routine monitoring of experience and outcomes
Variation in experience and safety for autistic people, people with learning disabilities and those with complex needs	Autism-informed and trauma-informed care models, least-restrictive practice, strengthened care planning and reasonable adjustments
Disproportionate impact of increased service demand and acuity on vulnerable groups	Patient Flow Programme, Suicide and Self-Harm Prevention Strategy, prioritisation of high-risk groups through quality governance
Risk of racism, discrimination, sexual harm or boundary violations	Sexual Safety Framework, safeguarding governance, Violence, Abuse and Aggression prevention programme, staff training and incident monitoring
Digital exclusion linked to increased digital and data dependency	Inclusive digital design, oversight of digital quality impacts, assurance through information governance processes
Workforce inequality impacting culturally safe and personalised care	Freedom to Speak Up arrangements, culture and inclusion programmes, monitoring of workforce experience and equality indicators
Unwarranted variation across services affecting equality of care	Quality Assurance Framework, triangulation of data, lived experience, audits and targeted improvement actions

Recommendations

The Board of Directors is requested to note the publication of the Trust Quality Account 2025/26.

Report presented by: **Lynn Andrews**
Chair, Quality and Safeguarding Committee

Report prepared by: **Joseph Thompson**
Associate Director of Physical Health and Quality

2025/26 Quality Account



Derbyshire Healthcare
NHS Foundation Trust



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Statement from Chief Executive - Mark Powell



I am pleased to introduce Derbyshire Healthcare NHS Foundation Trust's Quality Account for 2025/26. This report reflects our continued commitment to providing safe, high quality, compassionate and inclusive care for the people of Derbyshire, and offers a transparent account of what we have achieved, what we have learned, and where we will focus our improvement efforts in the year ahead.

During 2025/26, the Trust has made sustained progress against our Quality Ambition and the priorities set out in our Trust Strategy 2024–2028.

This has been achieved in the context of increasing demand, growing acuity and ongoing workforce and system pressures across mental health and community services. I remain proud of the professionalism, resilience and dedication shown by our colleagues throughout the year, and grateful for the trust and engagement of patients, carers and partners.

We have maintained an overall Good rating from the Care Quality Commission, with all inspected services rated Good. This reflects consistent performance across safety, effectiveness and experience, supported by strong clinical leadership, proactive quality governance and continued focus on learning and improvement. Key achievements during the year include further embedding of the Patient Safety Incident Response Framework, sustained oversight of restrictive practices, strengthened safeguarding and sexual safety arrangements, and full compliance with the Duty of Candour during the reporting period

Significant progress has also been made in improving the quality of care environments and the overall patient experience. Through the Making Room for Dignity programme, we have delivered major new inpatient facilities designed to improve privacy, safety and therapeutic care, and to reduce reliance on inappropriate out of area placements. Alongside this, the development of a new Model of Care has strengthened our focus on purposeful admission, trauma informed practice and personalised support.

Improving experience and involvement remains central to our approach. During 2025/26 we strengthened patient, carer and lived experience involvement through clearer governance, increased co production, sustained Triangle of Care compliance and expanded peer support roles. The Culture of Care Programme has been a particular area of progress, embedding trauma informed, autism informed and anti

racist practice across inpatient services and supporting meaningful improvements in ward environments, therapeutic activity and staff and patient experience.

I am also encouraged by the continued development of our digital and improvement capability. Advances in digital maturity, including use of a single electronic patient record, electronic prescribing and contactless patient monitoring, are supporting safer care, improved observation and better use of clinical intelligence. Our LiveQI platform has strengthened quality improvement capability across the organisation, enabling colleagues to lead structured, data driven improvement at pace.

We are clear, however, that challenges remain. Pressures relating to workforce sustainability, access and flow, digital dependency, unwarranted variation and health inequalities require sustained attention. The priorities set out for 2026/27 reflect these risks and align closely to national and system expectations, including improving urgent and crisis care, reducing inappropriate out of area placements, strengthening suicide prevention and continuing to embed equity, inclusion and anti racist practice through frameworks such as The Patient and Carer Race Equality Framework (PCREF).

As Chief Executive, I remain committed to open, compassionate and accountable leadership. We will continue to listen carefully to staff, patients and carers, use data and lived experience to inform decisions, and ensure that learning is translated into visible improvement. Quality and safety will remain at the heart of every decision we make.

I would like to thank our colleagues across Derbyshire Healthcare, our partners across the Derbyshire system, and the people who use our services for their continued commitment, challenge and support. I am confident that this Quality Account provides a fair, balanced and accurate reflection of our performance in 2025/26, and that the Trust is well placed to continue improving care, experience and outcomes in the year ahead.

Statement from Executive Director of Nursing, Patient Experience and Allied Health Professionals - Tumi Banda



I am pleased to present Derbyshire Healthcare NHS Foundation Trust's Quality Account for 2025/26. This report reflects the collective efforts of our patients, carers, staff and partners, and sets out how we have continued to make progress in delivering safe, compassionate and high-quality care in a challenging and pressured environment.

During the year, the Trust has maintained an overall Care Quality Commission rating of Good, all the services inspected in this period showed improvement. This provides important external assurance that our governance arrangements, leadership and frontline practice continue to support safe and effective care. We have further strengthened our quality oversight through full embedding of our Quality Assurance Framework in the delivery of the Trust's strategic objective: Patient Focused. The Quality Assurance Framework has been key in delivery of the Quality Delivery Plan, enabling better triangulation of data, lived-experience insight and direct observation to inform continuous improvement.

A key highlight of 2025/26 has been the delivery of the Culture of Care Programme across multiple inpatient wards. This has supported tangible improvements in ward environments, therapeutic activity, patient involvement and staff experience, embedding trauma-informed, autism-informed and anti-racist practice. Alongside this, significant investment through the Making Room for Dignity Programme has transformed our inpatient estate, improving privacy, safety and dignity, reducing reliance on out-of-area placements and moving us closer to the eradication of dormitory accommodation.

Patient safety has remained a core priority. We have embedded the Patient Safety Incident Response Framework, achieved 100% Duty of Candour compliance for incidents, strengthened learning from deaths, and implemented a Trust-wide Suicide and Self-Harm Prevention Plan aligned to national guidance. Safeguarding and sexual safety arrangements have continued to provide strong assurance, supported by high training compliance, robust governance and positive external validation.

Listening to and improving experience has been a central theme throughout the year. We have strengthened carer and lived-experience involvement through a dedicated Patient, Carer and Lived Experience leadership, sustained Triangle of Care compliance and increased co-production across services. Complaints handling has improved, with clearer processes, better timeliness and stronger use of learning to

drive service change. There is room for improvement on seeking feedback and responding to the feedback in all its forms and plans are in place for the year ahead to work on this. Patient feedback continues to highlight compassionate, respectful care delivered by our teams.

Our workforce remains our greatest asset. Staff experience continues to perform at or above benchmark compared to similar organisations, with strengths in teamwork, compassion and inclusion. At the same time, we recognise pressures on morale, wellbeing and psychological safety. In response, we have prioritised action to support staff voice, strengthen leadership capability, improve working lives and sustain an open culture through enhanced Freedom to Speak Up arrangements.

Looking ahead to 2026/27, our focus is on sustaining improvement, addressing identified risks and reducing unwarranted variation. Priorities include workforce wellbeing, access and flow across urgent and inpatient care, further reduction in restrictive practice, digital optimisation and continued delivery of our Quality Delivery Plan aligned to the Trust Strategy 2024–2028.

I would like to thank our patients, carers and families for their trust and feedback, our staff for their dedication and professionalism, and our partners for their collaboration and challenge. Together, we remain committed to making a positive difference in everything we do and to continuously improving the quality, safety and experience of care for the communities we serve.

Statement from Medical Director – Girish Kunigiri



As Executive Medical Director, I am pleased to reflect on the quality and safety of care provided by Derbyshire Healthcare NHS Foundation Trust during 2025/26. This has been the first full year of delivering our Trust Strategy 2024–2028, and it has taken place against a backdrop of rising demand, increasing clinical complexity and ongoing system pressures.

Despite these challenges, I am consistently impressed by the compassion, professionalism and commitment shown by our medical workforce and multidisciplinary teams. Colleagues across the Trust continue to put patients, carers and families at the heart of care, and this Quality Account captures both the progress we have made and the areas where we must continue to learn and improve.

Patient safety remains my foremost priority. During 2025/26, we have made important progress in embedding the Patient Safety Incident Response Framework (PSIRF).

This has allowed us to move towards more meaningful, system focused learning from incidents, involving patients, families and frontline teams more effectively and supporting a culture of openness.

I am reassured that the Trust achieved 100% Duty of Candour compliance for incidents occurring within the reporting period, reflecting our commitment to being honest and transparent when harm occurs. Our learning from deaths processes have been strengthened and aligned to PSIRF, improving consistency and oversight. While reported deaths reduced compared with the previous year, every death is treated with the seriousness and compassion it deserves, and continuous learning remains essential.

Suicide and self harm prevention continues to be a key clinical priority. The implementation of a Trust wide prevention plan, aligned to national guidance, has strengthened personalised safety planning, staff confidence and our focus on high risk transition points such as admission, leave and discharge.

Safeguarding remains strong, supported by high training compliance, effective partnership working and positive external assurance. Sexual safety and professional boundaries have continued to receive focused attention, alongside ongoing work to reduce restrictive practices through trauma informed approaches and improved risk screening.

Clinical effectiveness has been strengthened through active research, audit and accreditation. Supporting over 35 National Institute for Health and Care (NIHR) studies and achieving multiple Royal College of Psychiatrists accreditations reflects the clinical leadership and pride within our services.

The Making Room for Dignity and Culture of Care programmes have made a real difference to our inpatient environments, therapeutic culture and patient experience. I have seen firsthand how these changes have improved dignity, safety and engagement.

Our Quality Assurance Framework, together with positive CQC oversight, gives me confidence in the robustness of our governance and our understanding of care quality at every level of the organisation.

Looking forward to 2026/27, my focus will remain on sustaining safety improvements, reducing unwarranted variation, supporting staff wellbeing, improving access and flow, and ensuring digital transformation genuinely supports better care.

I would like to thank all colleagues for their dedication and commitment during the year. It is a privilege to work alongside such skilled and compassionate professionals, and I

remain confident that, together, we will continue to improve outcomes, safety and experience for the people and communities we serve.

Statement from Trust Chair – Selina Ullah



As Trust Chair, I am pleased to present Derbyshire Healthcare NHS Foundation Trust's Quality Account for 2025/26. This report provides a transparent and comprehensive account of the quality of care we provide, the improvements we have delivered, and the areas where we continue to focus our efforts to ensure services remain safe, effective and compassionate.

Throughout 2025/26, the Board has maintained a clear and unwavering focus on quality, supported by robust governance, strong clinical leadership and active engagement with patients, carers, staff and partners. The Trust has sustained its overall Good Care Quality Commission rating, with all inspected services rated Good, reflecting consistent performance across safety, effectiveness and experience. As a Board, we take reassurance from this position while recognising that regulation provides a baseline, not a ceiling, for our ambitions.

This year has seen tangible progress against the Trust's Quality Ambition and strategic priorities. Notable achievements include continued oversight of restrictive practice, strengthened safeguarding and sexual safety arrangements, embedding of the Patient Safety Incident Response Framework, and delivery of major estate investments through the Making Room for Dignity programme. These developments are not only improving safety and outcomes, but also dignity, privacy and therapeutic environments for people receiving care.

The Board has been particularly encouraged by the Trust's continued focus on culture and lived experience. The Culture of Care Programme, increased coproduction, strengthened carer involvement, and expanded peer support all reflect our commitment to trauma informed, autism informed and inclusive care. We have also seen strong examples of staff compassion, professionalism and innovation recognised through internal and national awards, reinforcing the values that underpin high quality care.

At the same time, we are open about the challenges that remain. Demand and acuity continue to place pressure on services, workforce wellbeing requires sustained attention, and access and flow across urgent, crisis and inpatient pathways remain system wide priorities. Digital dependency, unwarranted variation and health inequalities are also areas where ongoing vigilance and improvement are essential.

The Board has reviewed these risks in detail and is assured that clear priorities, mitigations and governance arrangements are in place for 2026/27.

As Chair, I regularly visit services alongside fellow Non Executive Directors, speak directly with colleagues and people using our services, and review triangulated assurance through Board reports, quality visits and external intelligence. These activities give me confidence that the Board has appropriate sight of quality at ward, team and service level, and that concerns are identified, escalated and acted upon in a timely way.

I would like to thank our patients, carers and communities for their trust, our partners across the Derbyshire system for their collaboration, and above all, our staff for their unwavering commitment in a demanding year. Their professionalism, compassion and resilience continue to be the Trust's greatest strength.

On behalf of the Board, I am satisfied that this Quality Account provides a fair, accurate and balanced reflection of Derbyshire Healthcare NHS Foundation Trust's quality of care in 2025/26, and I am confident that the organisation is well placed to continue improving outcomes, experience and safety for the people we serve in the year ahead.

Statement from Derby and Derbyshire Integrated Care Board



Derby and Derbyshire Integrated Care Board (DDICB) welcomes the opportunity to respond to the Derbyshire Healthcare NHS Foundation Trust's (DHCFT) 2025/26 Quality Account. DDICB has continued to work with DHCFT throughout the year to ensure commissioned services met statutory safety and effectiveness standards with learning and improvement embedded into local assurance.

DHCFT's information aligns with ICB quality monitoring findings. Commissioners agree the Quality Account reflects the Trust's commitment to high-quality care, coproduction, and engagement with patients, experts, families, and carers. The 2024–2028 strategy maintains these priorities as a central focus. The NHS National Oversight Framework (NOF) monitors NHS Trust performance and during 2025-26, DHCFT progressed from segmentation 4 to 3 in 2025/26. Access, effectiveness, and workforce metrics remain below average for 2026 with these areas prioritised for improvement by the Trust.

Care Quality Commissioner (CQC)

The Regulator has carried out comprehensive inspections of DHCFT services this year, confirming that the overall rating for the Trust remains "Good," with all inpatient services similarly rated as "Good".

Trust improvement priorities for 2025/26

The Trust continues to implement its strategic plan for 2025-2028. This continues a positive focus, tested through workshop-style Board Development sessions during the year. The 4 P's framework has enabled the Trust to focus its quality improvement work appropriately towards patients, people, productivity and partnerships.

The Quality Account outlines quality improvements made during 2025-26. Commissioners monitored progress on these through reports submitted to assurance meetings chaired by the ICB. Key achievements included the implementation of the Patient Safety Incident Response Framework (PSIRF) and a sustained reduction in restrictive practices. Significant estate enhancements were accomplished under the *'Making Room for Dignity' programme*, resulting in new adult acute facilities, a male Psychiatric Intensive Care Unit, and a female Enhanced Care Unit. These developments decrease out-of-area placements, enabling individuals to remain closer to home as evidenced by the information provided in the Quality Account which demonstrates the important work undertaken to avoid use of out of area placements. Linked to this Commissioners note the effective work undertaken to reduce Out of Area placements.

Across 2025-26 priorities, Commissioners acknowledge the progress reported by the Trust Quality Account to deliver on these. It is noted that the Trust recognises ongoing workforce, service demand, and system challenges as areas that require ongoing improvement. However, as with previous years, it would be useful for the Quality Account to identify where priorities were not fully met and outline plans for carrying these forward into 2026-7.

Internal quality assurance and effectiveness

Commissioners note the positive work undertaken by the Trust during 2025/26 to successfully embed its Quality Assurance Framework as a key organisational achievement, providing a structured and triangulated approach to understanding and improving the quality of care people received. Updates on the development of this framework and its implementation and findings have been welcomed by Commissioners at assurance meetings. During these discussions the Trust has been able to demonstrate how it has usefully implemented quality improvement as clinical care level and detect early warning signs where intervention is required to enhance care and maintain safety. Linked to this, it is extremely positive to note that 91 Fundamentals of Care quality visits have been undertaken across all care groups, comprising a combination of both planned and targeted, intelligence-led reviews.

Evidence of this assurance process and the positive impacts have been noted through Commissioner led quality visits and assurance meetings. Commissioners will continue to support further development on further development to strengthen and expand the involvement of lived experience partners within these Quality Assurance Frameworks in 2026-27.

The Quality Account notes that the Trust has strengthened clinical effectiveness through research, audit and evaluation with multiple services achieved or retained Royal College of Psychiatry accreditation, demonstrating alignment with nationally recognised quality standards.

Patient, family and carer experience

The Quality Account provides a summary of complaints and compliments made to the Trust. It is positive to note that care, compassion and empathy feature as highest compliment themes. It is also important to acknowledge that these same themes appear as the most common complaints which demonstrate further work is required as already noted by the Quality Account.

It is helpful that the Quality Account includes patient stories to demonstrate the positive difference the Trust has made to the patients it cares for. Their stories provide real examples. Linked to this Commissioners support the Trusts ambition to co-produce with the people the Trust serves which will further empower people to share positive and not so positive stories to help the Trust continue to improve, listen and learn. Linked to this, it is positive to note that the Trust has again retained its Triangle of Care with positive and constructive feedback to our most recent submission. This supports the Trust's commitment to support family and carers. To support this commitment, commissioners acknowledge the work undertaken this year to develop the carer dashboard, enhance carer champion roles and launch a carer hub on the Trust website.

Commissioners note that care planning has remained a top complaint theme across a number of years with a small decrease noted. Commissioners will be keen to discuss with the Trust how further decrease of complaints about care planning can be achieved via targeted action connected to Trust priorities for 2026-27

Keeping People Safe

Commissioners note that extensive staff training that has been undertaken in relation to the Patient Safety Incident Response Framework (PSIRF). As a national framework PSIRF enhances learning and improvements following incidents and supports a focus on priorities via a Patient Safety Incident Response Plan (PSIRP). These priorities are explained in the Quality Account and commissioners support the identified improvements which include learning from incidents. It is important and positive to note 100% Duty of Candour compliance for incidents within the reporting period.

Inpatient Environments

Commissioners note the extensive estates work that has been underway through the 'Making Room for Dignity' programme with a number of new units open which eradicate dormitory provision and enhance environments for patients and staff. Whilst much of this work is complete further work continues into 2026/27 to refurbish the Radbourne Unit. The new Trust Psychiatric Intensive Care Unit for Males and Enhanced Care Unit for Females will remove the need for people to travel outside of Derbyshire to receive this support. Commissioners also continue to discuss with the Trust how these new units are being supported to embed new models.

Commissioners acknowledge positive work undertaken in previous years to align to CQC ligature risk reduction principles and tools. This work continues, noting DHCFT has not yet fully embedded this process. Commissioners note that the suicide and self-harm prevention plan maintains a strong focus on inpatient safety and ligature reduction which is supported by the new enhanced inpatient environments under the Trust 'Making Room for Dignity' programme.

Workforce and staff experience

Commissioners would like to express their congratulations to DHCFT staff as 2025 HSJ (Health Service Journal) winners of two Digital Awards, recognising the organisation's commitment to digital innovation and the transformative impact of digital technology on patient care and population health across Derbyshire. Celebrating national recognition for two of its leaders. Congratulations also to Selina Ullah as Trust Chair who has once again been named by the Health Service Journal (HSJ) as one of the 50 most influential Black, Asian and Minority Ethnic people in health.

The national staff survey shows staff experience is above comparator averages, with strengths in compassionate leadership and line management. However, it is important to acknowledge that a number of scores have declined from last year. The Quality Account could have explained more about these declines, outlining planned actions, and including relevant findings from the quarterly pulse survey for context.

Commissioners commend the progress in embedding Freedom to Speak Up (FTSU) throughout the organisation, as observed during ICB quality visits to DHCFT Services. Commissioners support further action identified by the Trust through targeted leadership support, mediation, strengthened monitoring and the implementation of the "A Kind Life programme".

Looking ahead into 2026/27

This Quality Account (2025–2026) confirms the Trust's commitment to high-quality care in all services. For 2026–2027, DHCFT will focus on maintaining progress, mitigating risks, reducing variation, and improving safety, experience, and outcomes for the local population. These priorities support the NHS Medium Term Planning Framework 2026–2029 and the 10 Year Health Plan, targeting quality, access, productivity, and equity. Commissioners support these priorities and agree these will strengthen local

governance, reduce variations in patient experience and enhance co-production within the organisation. The Trust will also focus on improving patient safety oversight and learning by fully embedding PSIRF, as well as continually working to improve access and patient flow. Further efforts will involve promoting equality, anti-racism, and sexual safety frameworks, while also supporting workforce wellbeing, leadership development, and psychological safety. The ICB and cluster will continue to work with the Trust to monitor these improvements via ICB lead assurance meetings.

Looking forward, Commissioners anticipate continued positive and collaborative engagement with the Trust as, together, we advance the three key priorities set out in the NHS 10 Year Plan. Oversight of these initiatives will be provided through the newly established Derby, Lincoln, and Nottingham ICB clustering arrangements.

Rosa Waddingham

Executive Director of Quality (Nursing)

On behalf of Derby and Derbyshire Clinical Integrated Care Board

30th April 2026

Statement from Trust Council of Governors

Figure 1: Some of the DHCFT Trust Governors



As representatives of the public, patients, carers and members, the Council of Governors welcomes this Quality Account for 2025/26 and confirms that it provides a clear, transparent and balanced account of the quality of care delivered by Derbyshire Healthcare NHS Foundation Trust during the year.

Throughout 2025/26, Governors have met regularly with the Trust Chair, Executive and Non-Executive Directors, attended Trust committees, participated in service visits, and engaged with local communities, patients and carers. These activities have enabled the Council of Governors to gain assurance over the Trust's performance against its quality priorities, and to provide constructive challenge where risks and pressures have been identified.

The Governors are encouraged by the Trust's continued overall Care Quality Commission rating of 'Good', with all inspected services rated Good, and by the positive outcomes of Mental Health Act monitoring visits. We have received clear assurance that patient safety remains a core priority, with sustained progress in embedding the Patient Safety Incident Response Framework, strong Duty of Candour compliance, and demonstrable learning from incidents and deaths.

We recognise and commend the significant investment made through the Making Room for Dignity programme, which has delivered new inpatient facilities that improve privacy, dignity, safety and therapeutic environments, while reducing reliance on out-of-area placements. Governors have seen first-hand the positive impact of these new environments on both patient and staff experience. This represents a major step forward in the Trust's quality programme.

The Council of Governors also welcomes the Trust's strong focus on safeguarding and sexual safety, including high training compliance, positive external assurance and the implementation of Trust-wide improvement programmes to strengthen professional boundaries and promote a zero-tolerance culture. We have been assured that safeguarding governance arrangements are robust and that learning is shared effectively across services.

We are encouraged by the Trust's continued commitment to listening to and learning from patients, carers and people with lived experience. The strengthening of co-production, peer support, carer involvement and lived experience participation within quality assurance and improvement activity is a clear area of progress. Governors value the Trust's transparency in reporting feedback, complaints and concerns, and its use of learning to drive improvement.

The Council of Governors recognises the dedication, compassion and professionalism of the Trust's staff despite the pressures faced by colleagues. Governors welcome the Trust's open approach to staff feedback, the embedded Freedom to Speak Up arrangements, and the clear priorities set out to support wellbeing, morale and psychological safety.

We are reassured that the Trust is realistic about the challenges ahead, including increasing demand, workforce pressures, access and flow across urgent and inpatient care, and digital dependency. The pressures generated by increased patient demand and a challenging financial environment are real. The Key Quality Risks and Priorities for Improvement for 2026/27 reflect issues that have been appropriately identified and discussed with Governors, and we are satisfied that clear plans and governance arrangements are in place to manage these risks.

Looking ahead, the Council of Governors will continue to work closely with the Board to maintain oversight of quality, safety and experience, and to represent the voices of our communities. We thank patients, carers, staff and partners for their ongoing contribution to improving services, and we support the Trust's ambition to deliver safe, effective, compassionate and inclusive care for the people of Derbyshire.

On behalf of the Council of Governors, we confirm our support for this Quality Account and our commitment to continued engagement and assurance throughout 2026/27.

Statement from Healthwatch Derbyshire



Healthwatch Derbyshire (HWD) is an independent voice for the people of Derbyshire. We listen to the experiences of local people using health and care services and give them a stronger say in influencing how services are provided.

We gather experiences from patients and members of the public using a variety of methods including face-to-face engagement, social media, and direct feedback from telephone conversations, emails, through our website and letters.

The Patient experience feedback we receive is fed through to health and care organisations throughout the year to give an independent account of what is working well, and what could be improved. We routinely share feedback with the Patient Experience Team at the Trust. We send feedback that needs a response weekly and feedback that doesn't require a response quarterly.

We carry out themed engagement work to explore topics in greater detail. The findings of themed engagement work are analysed and written up into reports, including recommendations for improvement. Service providers and commissioners are then asked to respond to these recommendations. All our reports, including the responses we receive, are published on our website and the Public and Patient Insight Library.

On reading the Quality Account, we recognise the challenges faced by the NHS, and the work done at DHCFT to continue to deliver quality services.

We would like to thank DHCFT for supporting our themed engagement work. We regularly visit the Carsington, Derwent and Radbourne units to gain patient feedback. This feedback is shared with DHCFT twice per year. There have been many positive changes made from the patient feedback we collected at our engagements at the units.

We will continue to share patient feedback and look forward to working with the Trust in the year ahead.

Quality Account 2025/26 – One Page Summary



Who we are

We offer a wide range of services across Derbyshire. These include mental health, neurodevelopmental and children's services.

We want to make a positive difference in everything we do.



How we are doing

We are:

- Rated "Good" by CQC
- Using systems well to help keep people safe
- Being open and honest when things go wrong
- Using less restrictive practice
- Working to help staff feel positive and included
- Offering more safety, privacy and dignity on our wards



How we are keeping people safe

We have:

- Improved how we learn from incidents
- Put strong plans in place to support safeguarding, sexual safety and suicide prevention
- Improved safety, privacy and dignity on our wards
- Improved how we involve patients, carers and people with lived experience



How we are supporting our staff

- Our staff survey results are the same or better than average
- The survey shows we are good at teamwork, compassion and inclusion
- Freedom to Speak up is helping create a safe and open culture



What else have we been doing

- There are fewer local people on wards outside Derbyshire
- We have opened a Mental Health Helpline and Urgent Assessment Centre
- We are using digital tools to improve safety and joined-up care



What is next for 2026/7?

- Keep listening to our staff, patients and carers
- Make it easier for people to access our services
- Keep working to make sure people are safe and happy with our care

Quality Account 2025/26 – What Does It Mean?

Neurodevelopmental	Conditions where the brain works in a different way. For example, autism and learning disability.
CQC	Care Quality Commission. They check NHS services and give a rating about how well we are doing.
Restrictive Practice	Stopping a person from doing something that could be dangerous to them or others. For example, holding someone's arms.
Privacy	Having control over your own space, body and information.
Dignity	Being shown respect and treated as important.
Incident	An unexpected event that causes harm or could have caused harm.
Safeguarding	Protecting people who might be at risk of harm.
Sexual safety	Protecting people from sexual abuse.
Suicide prevention	Stopping people from ending their lives.
Lived experience	People who have experience of using our services or supporting people who use them.
Compassion	Kindness and understanding.
Inclusion	Making people feel welcome, respected and part of a group.
Freedom to Speak Up	Supporting staff to tell someone when there are problems without worrying they will get in trouble.
Open culture	A place where people are honest and feel comfortable to speak up.
Digital tools	Technology that we use in the workplace. For example computer systems or AI.
Joined-up care	Working together and sharing information with other people to give the best care to a patient.

Part 2: About our Trust and our Quality Ambition

Our Board



DHCFT is proud of its vision, values, and culture. The vision and values have been shaped through the involvement and engagement of everyone who interacts with the Trust, including patients, carers and staff members. This quality account will be reflective of the Trust Strategy for 2024 - 2028.

Our Services

DHCFT provides a range of clinical services that are structured within the following Care Groups:

Acute Mental Health and Psychiatric Intensive Care

- Inpatient Mental Health Ward Services
- Psychiatric intensive care unit (PICU) (Male)
- Enhanced Care Unit (Female)

Community Mental Health Services and Assessment Services for Adults of Working Age

- Community Mental Health Team Services/Living Well
- Early Intervention in Psychosis Services
- Outpatient Clinic Services
- Individual Placement Support.
- Crisis and Home Treatment Services
- Liaison Services
- Mental Health Helpline.

Forensic and Mental Health Rehabilitation Services and Specialist Care Services

- Community and Inpatient Forensic Services
- Criminal Justice Team
- Liaison and Diversion Services
- Placement Review Team
- Community and Inpatient Rehabilitation Services.
- Perinatal Inpatient and Community Services
- Eating Disorder Services
- Gambling Harms Service
- Substance Misuse Services

Mental Health Services for Older People

- Community Services
- Inpatient Services
- In Reach Home Treatment Services
- Dementia Rapid Response Services
- Memory Assessment Services.

Children's Services and Neurodevelopmental Services

- Child and Adolescent Mental Health Services
- 0 - 19 Universal Child Health
- Complex Health and Pediatric Therapies.
- Autism Assessment and Treatment Teams
- Integrate Support Team
- Strategic Health Facilitation Team
- Community Support Team
- Case Management Team.

Trust Strategy 2024-2028

Derbyshire Healthcare NHS Foundation Trust's Trust Strategy 2024–2028 launched in October 2024 was developed through a collaborative approach including Trust colleagues partners governors and representatives of patient service users and carers with a draft version of the strategy shared with external stakeholders for feedback. The strategy sets out a clear ambition to “*make a positive difference in everything we do*”, with a strong focus on improving quality, safety, access, outcomes and experience for the people who use our services, while ensuring the Trust remains a sustainable and inclusive organisation.



Our Quality Ambition and Clinical Priorities

The first year of the Strategy (2024/25) was positioned as a foundational year, focused on establishing the conditions required to deliver sustained quality improvement over the life of the Strategy. This included:

- Embedding a patient-focused approach to care, underpinned by the Quality Delivery Plan and a clear commitment to safety, effectiveness and experience.
- Laying the groundwork for service transformation, including new models of care, greater use of digital technologies, and a shift towards care closer to home, in line with national priorities to move from hospital to community settings and from analogue to digital services.

- Progressing plans for modern, therapeutic environments, including new inpatient facilities designed to improve privacy, dignity and safety, and to address long-standing estate challenges.
- Strengthening the culture of accountability, inclusion and belonging, through the introduction of new Trust values and the Personal Accountability Charter, co-produced with colleagues, service users and carers.
- Establishing enabling plans (including Clinical, Digital, People, Estates, Transformation and Quality Delivery Plans) to support delivery of the Trust's four strategic priorities: Patient Focused, People, Partnerships and Productive.

Overall, 2024/25 was intended to focus on clarity of direction, engagement, and infrastructure, recognising increasing demand, growing complexity of need, and financial constraints across the system.

The Trust Strategy was developed through a collaborative approach, involving Trust colleagues, partners, governors and representatives of our patients, service users and carers. A draft version of the strategy was also shared with external stakeholders for feedback.

A strategic plan for 2025-2028 has been developed, based on the outputs of a Board Development session in October 2024, and the dialogue on transformational opportunities hosted at the staff conference. The initial strategic plan was reviewed and tested through a further workshop-style Board Development session throughout 2025.

Strategic priorities – the four Ps

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

The priorities are all of equal focus and importance. Each will remain in place for the three years this Trust Strategy covers (Winter 2024 – Spring 2028) and will have a set of key deliverables which set under each priority. These will be reviewed on an annual basis to monitor progress, completion and to identify any new deliverables that reflect the changing environment in which we work.

A number of key plans and documents will support delivery of the strategic priorities, as outlined on the subsequent pages. Where these documents are not in place, they will be developed during the life of this Trust Strategy.

Our strategic priorities will be known as our four Ps:

Patient focused

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

People

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

Productive

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

Partnerships

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



NHS
Derbyshire Healthcare
NHS Foundation Trust



Quality improvement in 2025/26 is explicitly aligned to the Strategy's four Ps, ensuring that improvements in care quality are delivered with patients, through our people, in partnership, and in a way that is productive and sustainable for the future. To strengthen colleagues' personal accountability to demonstrate the behaviours our values expect. The personal accountability charter sits alongside the Trust strategy.



The Trust Clinical Ambitions are that the Services we Provide:

- Be person-centred and prevent ill health
- Provide care at home or in the community where possible, through a partnership approach to promote individual and community resilience
- Ensure any admission to hospital is within Derbyshire and kept to the shortest effective period of time
- Be compassionate and take account of trauma-informed practice
- Involve people who use our services in designing their care and treatment, to meet personal goals throughout their lives.

In order to meet the clinical elements of the strategic plan, a Quality Delivery Plan was developed in 2025

Quality Delivery Plan

This summarises how we will meet the **patient focused** strategic priorities outlined in the Trust strategy

Three key pillars of quality care:



Our patient focused strategic priority (one of the Trust's 4Ps) is: **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.**

In the plan...

- There are objectives and delivery measures outlined for each of the three key pillars
 - There are a series of co-produced pledges that underpin the plan, together with examples of real-life experiences from patients and staff
 - Digital is seen as a key enabler of the plan.
- The plan also sets out our quality approach with some principles and pledges.

Patient Focused Elements of the Strategic Plan

Patient focused		Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.		NHS Derbyshire Healthcare NHS Foundation Trust	
Priorities for delivery of success	Roadmap to delivery of success 2025-26	Q4 Progress Update		Status Q4 Position	Assurance mapped to Q4 papers
1.1 Improve safety and effectiveness in line with our quality ambitions	1.1.1 Develop and implement Quality Delivery Plan, agree improvement ambitions and measures, and establish associated governance 1.1.2 Monitor performance and implement action plans to address any identified improvement opportunities 1.1.3 Implement national initiatives including Culture of Care inpatient quality improvement programme and Patient Carer Race and Equality Framework	1.1.1 Quality Delivery Plan approved and published in Q2 including roadmap to delivery and measures of success. 1.1.2 Quality monitoring continuously developed over Q4 with mechanisms fully embedded, action plans delivered as appropriate to address identified areas of improvement and assurance overseen by QSC. Impact demonstrated through reduction in bank and agency reliance leading to more consistent care, improved CQC inspection outcomes published across four services, and proposed reduction in BAF risk rating for Q1 of 2026-27. 1.1.3 Progress maintained in Culture of Care programme with self assessment completed Q4. Forward approach for 2026-27 defined with local ward ambitions to be supported through continuous improvement projects. PCREF lead commenced in post and self assessment workshop hosted in Q4 with outputs informing forward action plan.		Delivery on plan at Q4	Agreed assurances considered by Quality and Safeguarding Committee (QSC)
1.2 Improve experience for, and empower, service users patients and carers	1.2.1 Define and agree experience measures across all services 1.2.2 Review and refine feedback mechanisms across all services 1.2.3 Monitor feedback and implement plan to address any identified improvement aligned to transformation and continuous improvement portfolio 1.2.4 Develop and agree framework for empowerment 1.2.5 Design and launch education programme 1.2.6 Develop and implement engagement through to co-production framework	1.2.1 Measures of experience defined through Quality Delivery Plan with dashboard developed and operationalised to track and assure delivery aligned to year 1 ambitions and roadmap. 1.2.2 Feedback mechanisms further developed over Q4 with focus on standardisation and effective co-ordination and escalation across all services. 1.2.3 Feedback monitoring maintained over Q4 with identified need to accelerate improvement in responsiveness to feedback and complaints and action plan progress overseen by QSC. 1.2.4 Approach defined within Quality Delivery Plan and action plans in delivery aligned to newly appointed remunerated lived experience roles across all services and renewed patient and carer experience meeting. 1.2.5 Education programme now focused on addressing identified need in physical health with delivery phase of CPD programme launched Q4 in partnership with DCHS. 1.2.6 Work plan for advancing coproduction and participation delivered with lived experience partners now fully embedded within evaluation of quality of care through fundamental care standards and '15 Steps' quality visits.		Delivery on plan at Q4	Agreed assurances considered by QSC
1.3 Develop effective quality governance systems and processes that facilitate shared learning and support a positive safety culture	1.3.1 Review, refresh and embed quality governance systems aligned to new Quality Delivery Plan 1.3.2 Refine Learning Culture and Safety Group as a mechanism to develop and assure a positive safety culture 1.3.3 Agree preferred model and design plan for transition from Care Programme Approach to support safe care co-ordination	1.3.1 Quality Assurance Framework developed aligned to year 1 Quality Delivery Plan ambitions and roadmap. Enhanced governance arrangements operationalised and embedded aligned to new operating model. Impact demonstrated through tested alignment with Well Led framework over Q4. 1.3.2 Development plan for learning and safety culture in delivery aligned to Quality Delivery Plan with Q4 focus on alignment and connection of approach and learning mechanisms under new operating model. 1.3.3 Decision agreed to implement new NHSE Personalised Care Framework. Delayed final framework and guidance now expected to be published in 2026-27 with risk based decision not to proceed on current draft guidance.		Delivery behind plan at Q4 due to delay in NHSE Framework	Agreed assurances considered by QSC
1.4 Improve access to our services and achieve all target wait times	1.4.1 Launch and deliver year 1 Clinical Services Delivery Plan with a focus on improving access and on understanding and addressing health inequalities 1.4.2 Design framework for disproportionate allocation of resources based on needs of our population 1.4.3 Agree and monitor achievement of target waiting times across all services with a year 1 priority focus on eradication of inappropriate out of area (OOA) placements through 'end to end' pathway optimisation	1.4.1 Clinical Services Delivery plan remains in development with forward approach refreshed by new Medical Director and a draft due to be consulted upon and presented for approval in Q1 of 2026-27 1.4.2 Framework for disproportionate allocation of resources in development aligned to 1.4.1 above. 1.4.3 Achievement in year of a number of targets including perinatal access, dementia diagnoses, children and young people eating disorder access, and individual work placement support access. Improvement action plans to reduce out of area placements and increase crisis 24 hour face to face response resulted in Q4 achievement of Operational Plan trajectories. Continued focus on other challenged access targets including LoS and Community waiting times.		Publication due Q1 26-27 Access recovery in specific services beyond 25-26	Due once final draft plan agreed IFR assurance considered by Finance and Performance Committee (IFC)

Part 3 – Quality at a Glance: What Improved in 2025/26 and looking ahead to 2026/27

Headline Quality Achievements

During 2025/26, Derbyshire Healthcare NHS Foundation Trust made sustained progress in delivering its Quality Ambition, with clear improvements across safety, experience, workforce, access, digital delivery and inclusion. This section provides a high-level summary of the most significant quality improvements achieved during the year. More detailed evidence and supporting data are set out in Parts 4 and 5 of this Quality Account.



Keeping People Safe

The Trust maintained an overall CQC rating of Good, with all inspected services rated Good during 2025/26, supported by proactive governance, learning from inspection feedback and sustained CQC readiness.

Patient safety systems were further strengthened through embedding the Patient Safety Incident Response Framework (PSIRF), improving learning from incidents and deaths, and achieving 100% Duty of Candour compliance for incidents within the reporting period.

There was a continued reduction in restrictive practices, including sustained reductions in chemical restraint and seclusion, supported by improved risk screening, observation practice and trauma-informed care.

Safeguarding and sexual safety assurance remained strong, with high training compliance, positive external assurance and targeted improvement work to strengthen professional boundaries and safety in inpatient settings.



Providing Effective, Person-Centred Care

Significant estate investment through the Making Room for Dignity programme delivered new and improved facilities, improving privacy, dignity, safety and therapeutic environments while reducing reliance on out-of-area placements.

Clinical effectiveness was strengthened through research, audit and evaluation, with over 35 NIHR studies supported and research embedded within service improvement activity.

Multiple services achieved or retained Royal College of Psychiatry accreditation, demonstrating alignment with nationally recognised quality standards.



Listening to and Improving Experience

The Trust strengthened its organisational approach to patient, carer and lived experience involvement, including clearer governance, improved co-production and sustained Triangle of Care compliance.

Complaints, compliments and concerns handling was improved, with clearer processes, improved timeliness for responses and better use of learning to drive service improvements.

Patient feedback continued to demonstrate high levels of appreciation for compassionate, respectful and supportive care.



Supporting and Valuing Our Workforce

Staff experience remained at or above benchmark levels compared to similar organisations, with strengths in teamwork, compassion and inclusion.

Freedom to Speak Up arrangements were strengthened, with increased staff confidence to raise concerns and improved use of intelligence to identify and address local cultural issues.

Colleagues and teams delivering outstanding care were recognised through the HEARTS Awards, reinforcing a positive, values-led culture.



Improving Access, Flow and Urgent Care

The Trust made progress in reducing inappropriate out-of-area placements through a comprehensive Patient Flow Programme focused on purposeful admissions, improved reviews and safer discharge.

The Mental Health Helpline continued to provide vital access to crisis support, with technical improvements made to support service reliability and development of the Mental Health Urgent Assessment Centre progressed with an ambition to establish a new model to improve timely access to urgent mental health assessment and reduce pressure on Emergency Departments.



Using Digital and Innovation to Improve Quality

The Trust continued to advance digital maturity, including use of a single electronic patient record, electronic prescribing and improved business intelligence.

Contactless patient monitoring was implemented across inpatient services using a clinically governed approach, strengthening observation, night-time safety and physical health monitoring.

Quality improvement capability was further embedded through LiveQI, supporting staff to deliver structured, data-driven improvement across clinical and corporate services.



Addressing Inequalities and Promoting Inclusion

Health inequalities considerations were developed inline with quality improvement work, including actions linked to the Patient and Carer Race Equality Framework, autism-informed care, SEND services and targeted support for vulnerable groups. Dedicated work supported improved access, experience and outcomes for children and young people, carers, and people from disadvantaged or marginalised communities.



Looking Ahead

While progress has been made, the Trust recognises ongoing challenges related to workforce pressures, demand for services and system constraints. Priorities for 2026/27 focus on sustaining improvements, addressing identified risks, reducing unwarranted variation, and continuing to improve safety, experience and outcomes for the populations we serve.

National and Local Priorities (2026/27)

The NHS Medium Term Planning Framework 2026–2029 sets out a national direction for mental health services, aligned to the Ten-Year Health Plan and a renewed focus on quality, access, productivity and equity.

- Improving access and outcomes in community mental health care
- Reducing inappropriate out-of-area placements.
- Strengthening crisis and urgent mental health care
- Reducing reliance on inpatient care for people with a learning disability and autistic people.
- Improving productivity and flow within mental health services
- Strengthening suicide prevention and patient safety
- Supporting digital transformation

Patient Focused Strategic Priorities

Continued focus on the 2024-2028 Trust strategy

1.1 Improve safety and effectiveness in line with our quality ambitions

- Develop and implement Quality Delivery Plan, agree improvement ambitions and measures, and establish associated governance
- Monitor performance and implement action plans to address any identified improvement opportunities
- Implement national initiatives such as Patient Carer Race and Equality Framework.

1.2 Improve experience for service users, patients and carers

- Define and agree experience measures across all services
- Review and refine feedback mechanisms across all services
- Monitor feedback and implement plan to address any identified improvement aligned to transformation and continuous improvement portfolio.

1.3 Effective quality governance systems and processes that facilitate shared learning and support a positive safety culture

- Review, refresh and embed quality governance systems aligned to new Quality Delivery Plan
- Refine Learning Culture and Safety Group as a mechanism to develop and assure a positive safety culture
- Agree preferred model and design plan for transition from Care Programme Approach to support safe care co-ordination.

1.4 Strengthen patient and carer empowerment

- Develop and agree framework for empowerment
- Design and launch education programme.

Overview of Key Quality Risks and Priorities for Improvement 2026/27

Key Quality Risks and Priorities for Improvement 2026/27

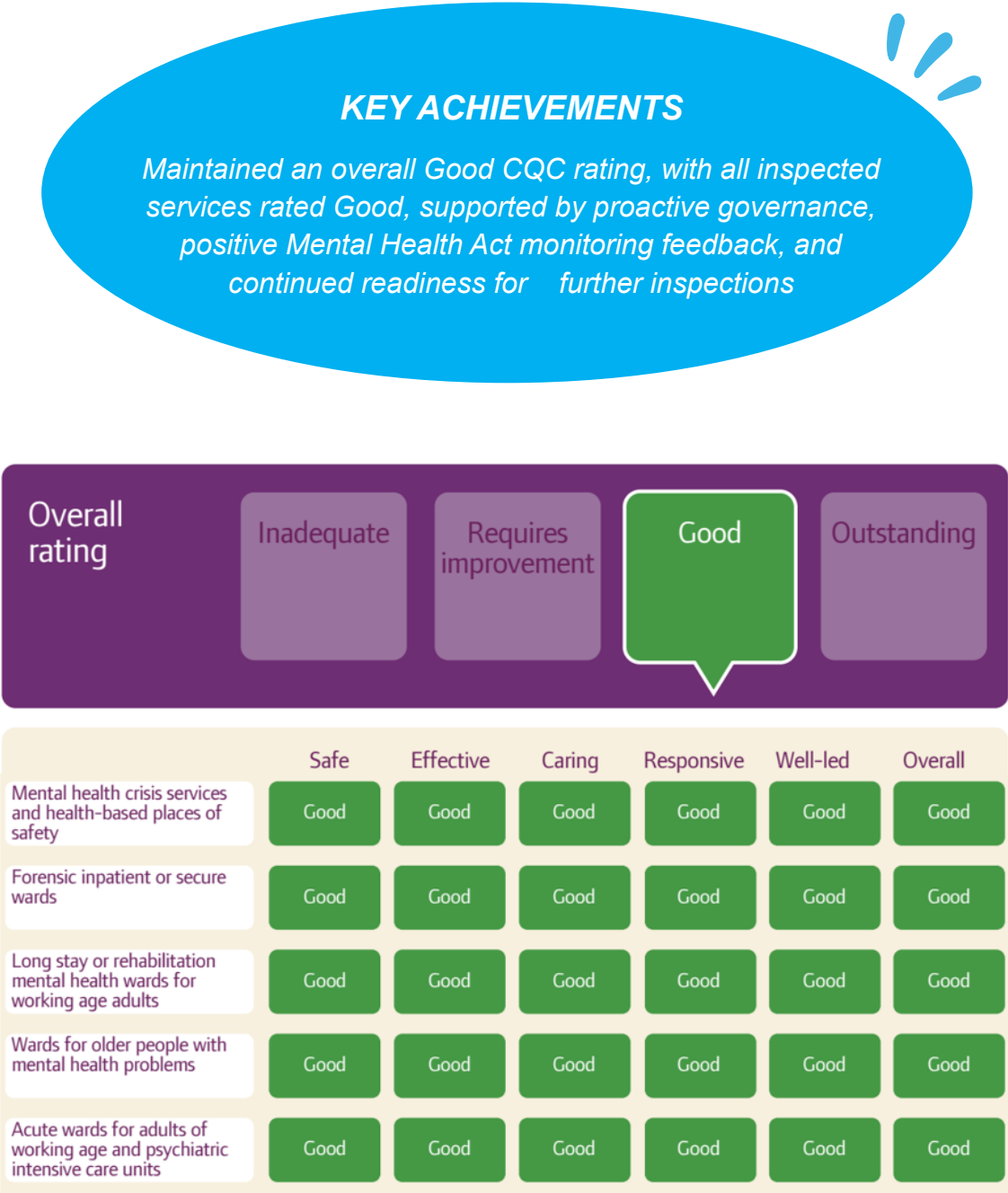
Key Quality Risk	Potential Impact	Priority for Improvement 2026/27
Increasing service demand and acuity across inpatient, crisis and community services	Increased risk to patient safety, including suicide and self-harm risk, pressure on observation practice, restrictive interventions, delayed discharge and inconsistent continuity of care	Strengthen patient safety through full embedding of PSIRF, delivery of the Suicide and Self-Harm Prevention Plan, continued reduction of restrictive practices, improved observation reliability and safer discharge processes
Workforce sustainability, morale and wellbeing pressures	Risk of burnout, increased turnover and sickness absence, reduced capacity and potential variation in quality and consistency of care	Support and sustain the workforce through activity focused on wellbeing, morale and psychological safety, strengthened leadership capability, safer staffing oversight and embedding inclusive, compassionate cultures
Access, flow and pathway delays across urgent, crisis and inpatient care	Delays in assessment and treatment, pressure on emergency departments and continued risk of inappropriate out-of-area placements	Improve access and flow through delivery of the Mental Health Urgent Assessment Centre, continued implementation of the Patient Flow Programme and further reduction of inappropriate out-of-area placements
Variation in patient, carer and lived experience	Reduced satisfaction, increased complaints and concerns, and risks to engagement, recovery and trust in services	Enhance patient and carer experience by improving care planning and communication, strengthening the learning from feedback and complaints, and expanding co-production within quality assurance and improvement activity
Digital dependency and optimisation risks	Risk to safety, efficiency and staff experience if digital systems are not optimised or consistently used	Maximise digital as an enabler of quality through delivery of the Digital Delivery Plan, optimisation of the electronic patient record, safe and effective use of contactless patient monitoring and reduction of digital burden

Equality, inclusion and cultural safety risks	Inequalities in experience and outcomes for people from marginalised communities; risk of harm related to racism, discrimination, sexual safety and violence, abuse and aggression	Embed equality, inclusion and anti-racist practice through implementation of PCREF, strengthened safeguarding and sexual safety arrangements, and delivery of the Violence, Abuse and Aggression Prevention Collaborative
Unwarranted variation in quality and practice across services	Inconsistent standards of care and reduced assurance at ward, team and service level	Reduce unwarranted variation through targeted quality improvement, accreditation programmes, strengthened governance and assurance, and improved use of data and intelligence to drive improvement

Part 4 – Delivering Our Quality Ambition: Key Achievements 2025/26

(Examples of Quality Ambition–related achievements)

CQC – Care Quality Commission Oversight and Assurance (2025/26)



During 2025/26, the CQC have continued to undertake targeted inspections and assessments across the Trust’s services in line with the Single Assessment Framework.

Inspection of Crisis services and Health-Based Places of Safety (January 2026), Inpatient Services, including Long Stay and Rehabilitation Wards (January 2026), Forensic Services (August 2025) and Older People's Mental health wards (April 2025), all resulted in Good ratings. The Trust's overall rating remains Good. At the time of publication, the Trust is awaiting the outcome of the Community Mental Health services for adults of working age.

CQC activity has reflected an increased emphasis on triangulated evidence, system partner feedback, and culture and leadership.

The Trust has continued to respond proactively to feedback, with a focus on patient safety, care planning, learning from incidents and workforce pressures, supported by established governance arrangements and improvement plans.

Mental Health Act monitoring

During 2025/26, the CQC undertook 12 Mental Health Act monitoring visits across the Trust's inpatient services. These visits focused on the application of the Mental Health Act, including patient rights, documentation and compliance with the Code of Practice.

Feedback from visits has been used to support ongoing improvements in documentation, patient experience and staff understanding of the Mental Health Act, with actions overseen through established governance arrangements.

Results and feedback from CQC visits:



Good

Mental Health Crisis & Health Based Places of Safety – Rated Good

- Compassionate, responsive care with overwhelmingly positive patient feedback; individuals felt listened to, respected and supported in crisis
- Effective crisis assessment and home treatment model, providing timely interventions and reducing need for hospital admission
- Strong multidisciplinary working and system coordination, supporting safe transitions and continuity of care
- Robust risk assessment and safety planning, with personalised, holistic plans developed with patients and carers
- Established learning culture, with incidents reviewed and learning embedded to improve practice and patient safety
- High-quality, evidence-based care aligned to national guidance, with a wide range of interventions available to support recovery
- Effective partnership working with health, social care and third sector organisations to support holistic patient needs

- Visible, supportive leadership with a focus on staff wellbeing, continuous improvement and service development
- Staff skilled, compassionate and committed, with positive team culture and strong supervision and support arrangements
- Improvements in safety and governance since previous inspection, particularly in risk assessment and training compliance



Good

Long Stay / Rehabilitation Mental Health Wards (Cherry Tree Close) – Rated Good

- Safe, clean, and well-maintained therapeutic environment supporting recovery and independence
- High-quality, personalised care with a wide range of interventions (psychological, vocational, educational)
- Strong focus on rehabilitation and community reintegration, with patients making measurable progress
- Positive patient feedback, with individuals feeling empowered and involved in decision-making
- Visible, supportive leadership with a focus on innovation, continuous improvement, and staff wellbeing
- Staff felt valued and enabled to deliver high-quality care



Good

Older Adult Mental Health Services – Rated Good

- Person-centred care tailored to the needs of older adults, including those with cognitive impairment
- Caring and compassionate staff interactions consistently observed
- Safe care delivery with appropriate clinical oversight and monitoring
- Good involvement of families and carers in care planning and decision-making
- Supportive ward environments promoting dignity and comfort
- Strong MDT working contributing to effective care delivery



Good

Forensic Services – Rated Good

- Robust risk management and strong focus on safety and security
- Skilled staff with clear understanding of relational and procedural security
- Structured care pathways supporting rehabilitation and progression
- Positive staff-patient relationships supporting engagement and recovery
- Effective leadership and governance supporting safe service delivery

- Evidence of least restrictive practice and patient involvement in care

Mental Health Act Visit feedback

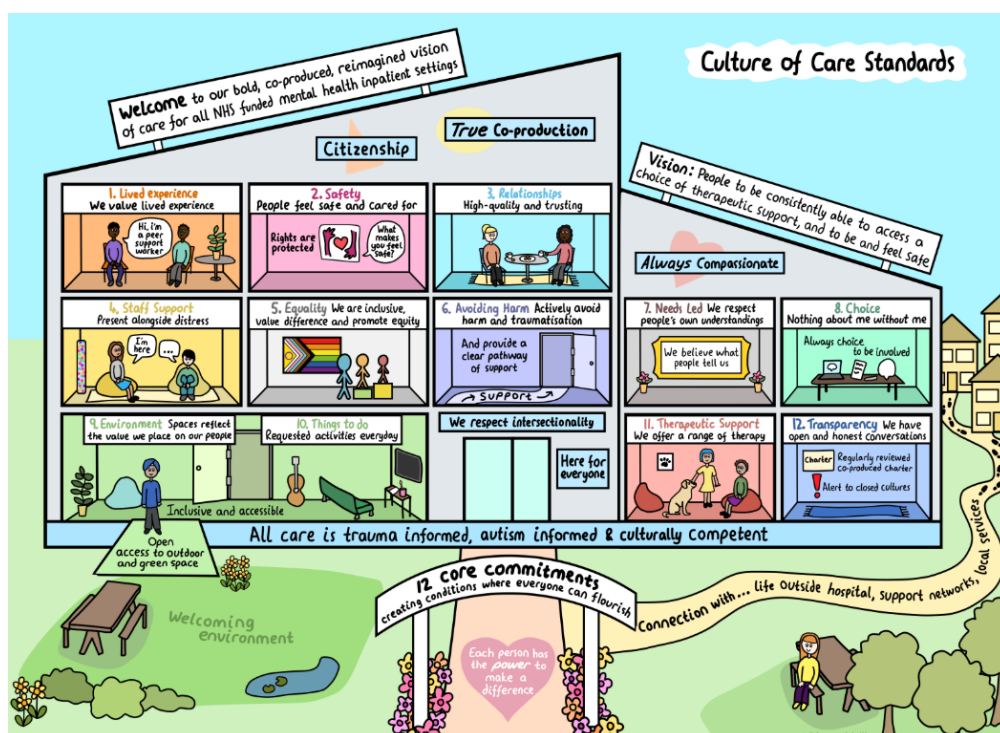
- Patients reported being treated with dignity and respect
- Positive feedback regarding staff kindness, compassion, and availability
- Patients felt involved in decisions about their care and treatment
- Access to advocacy services, supporting patient voice and rights
- Care plans were generally person-centred and recovery-focused
- Risk assessments in place and regularly reviewed, supporting safe care delivery
- Evidence of multidisciplinary involvement in care planning and decision-making
- Wards were observed to be clean, safe, and well-maintained
- Good relational security, with staff demonstrating awareness of patient risk and needs
- Staff had a clear understanding of observation levels and patient safety requirements

Culture of Care Programme

KEY ACHIEVEMENTS

Successfully delivered the Culture of Care Programme across multiple inpatient wards, embedding trauma-informed, autism-informed and anti-racist practice with demonstrable improvements in ward environments, therapeutic activity and patient involvement

The Culture of Care Programme at Derbyshire Healthcare NHS Foundation Trust is a key component of NHS England's Quality Transformation Programme, focused on strengthening therapeutic, safe and equitable cultures within inpatient mental health, learning disability and autism services. Delivered between March 2024 and March 2026 and supported by the National Collaborating Centre for Mental Health (NCCMH) and partner organisations, the programme embeds trauma-informed, autism-informed and anti-racist approaches, with lived experience central to design and delivery.



Progress has been made across multiple wards through strong multidisciplinary engagement, leadership development and co-production with service users. Dedicated ward-level project teams have been established on Willow, Robin, Oak and Ward 36, supported by regular external coaching, expert-by-experience input and Trust-wide links to data, transformation and specialist clinical services. A monthly executive-sponsored steering group and quarterly learning network events have further strengthened oversight, shared learning and momentum.

Change Idea, Status, Principles, Standards, Population focus, Summary and/or change idea story, Organisation and ward

Change Idea	Status	Principles	Standards	Popula tion focus	Organisat ion
Creating Faith room	✓ Implemented	Autism-informed, Racial equity, Trauma-informed	2. Safety, 6. Avoiding harm, 7. Needs-led, 11. Therapeutic support	Patient	Derbyshire - Robin war
Having locked doors working well to make the ward less restrictive	✓ Implemented	Trauma-informed	2. Safety, 6. Avoiding harm, 7. Needs-led	Patient	Derbyshire - Robin war
improving patients access to outdoor spaces	✓ Implemented	Autism-informed, Trauma-informed	2. Safety, 9. Environment, 10. Things to do, 11. Therapeutic support	Patient	Derbyshire - Robin war
Engaging carer engagement - open door invite to ward activities	● Testing	Autism-informed, Trauma-informed	2. Safety, 3. Relationships, 6. Avoiding harm	Carer, Patient	Derbyshire - Robin war
Funding for rec worker/Amending HCA post to REC worker	● Testing	Autism-informed, Racial equity, Trauma-informed	2. Safety, 7. Needs-led, 8. Choice, 10. Things to do, 11. Therapeutic support	Patient	Derbyshire - Robin war
Increasing patient's accessibility to information such as inpatient guides, or proformas by leaflet holders or to access them digitally (e.g QR code)	● Testing	Autism-informed, Trauma-informed	2. Safety, 7. Needs-led, 12. Transparency	Patient	Derbyshire - Robin war
Learning from others good practice	● Testing	Autism-informed, Racial equity, Trauma-informed	4. Staff support, 6. Avoiding harm	Staff	Derbyshire - Robin war
Peer support worker on the ward	● Testing	Autism-informed, Racial equity	1. Lived experience, 2. Safety, 6. Avoiding harm, 7. Needs-led	Patient	Derbyshire - Robin war
Reducing the number of professionals present in an MDM	● Testing	Autism-informed, Trauma-informed	1. Lived experience, 2. Safety, 6. Avoiding harm, 7. Needs-led, 12. Transparency	Patient	Derbyshire - Robin war
Using patient, staff and carer feedback review MDMs as a whole	● Testing	Autism-informed, Racial equity, Trauma-informed	2. Safety, 3. Relationships, 6. Avoiding harm, 7. Needs-led, 9. Environment, 11. Therapeutic support, 12. Transparency	Patient	Derbyshire - Robin war
1 hr MDM for patients to have enough time to address concerns	● To test				Derbyshire - Robin war
Fairly allocate out patient leaves through daily meeting	● To test	Autism-informed, Racial equity, Trauma-informed	5. Equality, 6. Avoiding harm, 7. Needs-led, 8. Choice, 10. Things to do, 12. Transparency	Patient	Derbyshire - Robin war
Improving activities on the ward by improving patients access to gym	● To test	Autism-informed, Trauma-informed	7. Needs-led, 10. Things to do	Patient	Derbyshire - Robin war

The programme has translated into tangible improvements in ward practice. Each participating ward has implemented quick wins and tested a wide range of change ideas aligned to the national Culture of Care standards, including improvements to ward environments, patient involvement in multidisciplinary discussions, therapeutic activity, communication, equity and personalised support. Several wards are actively testing or progressing multiple change ideas simultaneously, demonstrating sustained engagement with quality improvement methodology and co-production principles.

Investment through national funding has enabled the introduction of a Recreational Coordinator role, recruited in December 2025, to enhance therapeutic engagement, meaningful activity and recovery-focused care, while also building staff capability to sustain improvements beyond the funding period. Leadership capability has also been strengthened through participation in the Foundation of Nursing Studies Ward Manager Leadership Development Programme, supporting person-centred and inclusive ward cultures.

The Trust has established robust monitoring and evaluation arrangements, including monthly proxy measures (such as restrictive practices and workforce indicators), national benchmarking submissions, and patient and staff surveys to track experience and wellbeing. Staff feedback has already informed escalation and planned review of digital and documentation pressures, demonstrating responsiveness to learning and continuous improvement. Despite the programme finishing in March 2026, the Trust has an appetite to continue to embed a Anti Racist, Autism Informed and Trauma Informed Culture With a celebration and sustainability event planned for June 2026.

Quality Assurance and Quality Improvement Framework

KEY ACHIEVEMENTS

Fully embedded the Quality Assurance Framework, strengthening triangulated assurance through Board visits, Fundamentals of Care reviews and lived-experience input, providing clearer insight and stronger organisational oversight

Quality Assurance Framework



Derbyshire Healthcare
NHS Foundation Trust

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

Our different quality visits



During 2025/26, the Trust has successfully embedded its Quality Assurance Framework (QAF) as a key organisational achievement, providing a structured and triangulated approach to understanding and improving the quality of care. The framework brings together intelligence from data, feedback and direct observation, with a particular strength being the meaningful integration of lived experience, ensuring the voices of patients, carers and families inform assurance and improvement activity. This has continued to develop over the year, including the use of approaches such as the 15 Steps Challenge to capture immediate impressions of care environments and experiences.

As part of the QAF, Executive and Non-Executive Directors have maintained a strong visible presence in services through Board visits, with 152 visits undertaken over the last 12 months across clinical, operational and corporate services. These visits provide an important opportunity for direct engagement with staff and patients, enabling Board members to gain real-time insight into the lived experience of care, observe culture and environment firsthand, and strengthen organisational visibility, transparency and connection between frontline services and senior leadership.

In addition, 91 Fundamentals of Care (FoC) visits have been undertaken across all care groups, comprising a combination of both planned and targeted, intelligence-led reviews. Planned visits provide routine oversight and support consistency of standards across services, while targeted visits focus on areas of identified risk, variation or emerging concern. Together, these visits offer a detailed and standardised assessment of care quality at ward and team level, with a focus on patient experience, safety, environment and care delivery. Findings inform clear action planning and are triangulated with other sources of assurance, supporting timely improvement and strengthening organisational oversight.

Looking ahead to 2026/27, a key area of further development will be to strengthen and expand the involvement of lived experience partners within the Quality Assurance Framework, increasing the breadth and consistency of co-production within assurance activity to further enhance insight, challenge and improvement.

Making Room for Dignity – Improving Privacy, Safety and Environment

KEY ACHIEVEMENTS

Delivered major new inpatient facilities (including PICU and enhanced care units) improving privacy, safety and dignity, reducing out-of-area placements and progressing towards the eradication of dormitory accommodation

In 2020, the Government made a bold commitment to eradicate dormitory accommodation from mental health inpatient facilities, pledging more than £400m nationally to transform environments and improve the safety, privacy and dignity of people experiencing mental illness. Derbyshire benefitted significantly from this investment, receiving £80m for mental health estates, which has underpinned a £150m programme of new and refurbished facilities across the county.

Building on this commitment, and as set out in the previous Quality Account, the Trust successfully opened a number of major developments during 2024/25, including:

- **Bluebell Ward**, Walton Hospital, Chesterfield – a 12-bedded older adults ward, opened in January 2025
- **The Derwent Unit**, Chesterfield Royal Hospital site – a 54-bedded adult acute unit, opened in March 2025
- **The Carsington Unit**, Kingsway Hospital, Derby – a 54-bedded adult acute unit, opened in May 2025

During 2025/26, Derbyshire Healthcare NHS Foundation Trust continued to build on this momentum through its *Making Room for Dignity* programme, delivering further high-quality, purpose-built inpatient services that address long-standing gaps in local provision. These include:

- **Kingfisher House**, Kingsway Hospital, Derby – a 14-bedded Psychiatric Intensive Care Unit (PICU) opened in July 2025. This new male PICU enables people to receive highly specialised care closer to home and eliminates the need for out-of-area placements for this group.

THE DEVELOPMENT OF KINGFISHER HOUSE

Derbyshire Healthcare NHS Foundation Trust

VISION: To provide a 14-bed male Psychiatric Intensive Care Unit (PICU), reducing the need for out-of-area placements.

2021
MAKING ROOM FOR DIGNITY
 WE WORKED WITH PEOPLE WITH LIVED EXPERIENCE TO:
 • Improve privacy and dignity
 • Give people choice over their environments
 • Create open and therapeutic spaces for recovery
 • Create facilities focused on people, not illnesses.

“By providing a local Psychiatric Intensive Care Unit, the Trust is addressing a long-standing inequality in service provision.”
 Selina Ullah, Trust Chair

Outdoor space is seen as being an important aspect of recovery.

2022
‘MAKING ROOM FOR DIGNITY’ IS BORN
 The programme name was developed and chosen by our staff and people who use our services.
 Kale Smith, who designed the logo for the ‘Making Room for Dignity’ programme, is an artist with lived experience of mental ill health.

2023
THE UNIT HAS A NAME
 Trust Chief Executive, Mark Powell, announces the name chosen by colleagues, service users and carers.

A ground-breaking ceremony marked the beginning of the new building.

2024
KEEPING EVERYONE INVOLVED
 We welcomed colleagues and partners to tour the new building.
 Mark Powell shows the progress to Derby North MP, Catherine Atkinson.
 Governor, Angela Kerry, visiting with Trust colleagues.
 A tour with The Lord-Lieutenant of Derbyshire, Mrs Elizabeth Fothergill.

2025
THE UNIT OPENS ITS DOORS
 ...on 22 July 2025, with an official opening ceremony taking place on 7 November 2025.
 Official opening ceremony.
 Moving in day.

WE MAKE A POSITIVE DIFFERENCE IN EVERYTHING WE DO



- **Audrey House**, Kingsway Hospital, Derby – an eight bedded Enhanced Care Unit for female patients, opened in August 2025, with an official opening ceremony held in November 2025. This bespoke service similarly reduces reliance on out of area placements and improves access to the right care at the right time.



All new developments have been shaped by meaningful engagement with service users, carers and staff, and designed in line with national guidance to deliver safe, therapeutic, single room environments. Collectively, these facilities significantly enhance patient experience, promote dignity and privacy, support recovery, and strengthen transitions between different levels of inpatient care. They represent a major step forward in delivering compassionate, high quality mental health services for people with the most complex needs across Derbyshire.



**Making Room
for Dignity**

**THE DEVELOPMENT
OF AUDREY HOUSE
ENHANCED CARE
UNIT**

NHS
Derbyshire Healthcare
NHS Foundation Trust

VISION: A full refurbishment of Audrey House to create an enhanced care unit, designed to support up to eight women with complex mental health needs in a safe, therapeutic environment.

“We want everyone who comes to Audrey House to feel safe, supported and hopeful. Our team is here to help each person on their journey to recovery.”

Lisa, Audrey House



Sensory environments and outdoor access place therapeutic care at the heart of the new facility.







Audrey House was a part of the Making Room for Dignity programme which has delivered new and refurbished facilities in Derbyshire, removing dormitory accommodation to improve safety, privacy, dignity, and embed therapeutic-based care in recovery.

WE WORKED WITH PEOPLE WITH LIVED EXPERIENCE TO:

- Improve privacy and dignity
- Give people choice over their environments
- Create open and therapeutic spaces for recovery
- Create facilities focused on people, not illnesses.

Kate Smith designed the logo for the 'Making Room for Dignity' programme.

“It is fantastic to have a new service where women with enhanced mental health needs can receive the right care and support.”



“By providing a local enhanced care unit, the Trust is addressing a long-standing inequality in service provision.”

Solima Ullah, Trust Chair

Moving in day.



A member of the Derbyshire Mental Health Carers Community Forum



Access to outdoor space plays an important role in people's recovery.

THE UNIT OPENS
...on 22 July 2025, with an official opening ceremony taking place on 7 November 2025.

Official opening ceremony with The Lord-Lieutenant of Derbyshire, Mrs Elizabeth Fothergill.







To complement these modern environments and further enhance patient experience, the Trust has also developed and implemented a new Model of Care. Co produced with Experts by Experience, the model places a strong emphasis on purposeful admission, trauma informed practice and sensory based interventions, ensuring care is both personalised and recovery focused.

The final phase of the programme is now underway, with the refurbishment of two 17 bed adult acute wards at the Radbourne Unit, Derby Royal Hospital. On completion, this will fully realise the ambition of the Making Room for Dignity programme and eradicate all dormitory accommodation from the Trust's mental health inpatient estate—marking a significant achievement for patients, staff and the wider system.



Strengthening Carer and Lived Experience Involvement

KEY ACHIEVEMENTS

Strengthened carer involvement through the establishment of a dedicated Patient, Carer and Lived Experience function, sustained Triangle of Care compliance, improved governance, and increased co-production across services

Carer Engagement

The last year has seen the development of a Deputy Director post for Patient, Carer and Lived Experience. The establishment of a Patient Carer and Lived Experience Team has seen improvements in communication, governance and passion for patient and carer involvement.

Carers, Trust staff, Carers Champions, stakeholders and partners from the local Health and Social Care sector continue to attend monthly Carer Engagement Group meetings. The Carer Engagement Group workplan is aligned to the Trust's Patient and Carer Experience Plan and the fourth pledge of the plan, to "Increase Carer Involvement". The work also aligns to the Trust Quality Plan and ensuring we provide a personalised, compassionate, respectful, and dignified experience for Patients, Carers and Families.

Where there are specific pieces of collaborative work e.g. the Team's Carer Letter on SystemOne, extraordinary meetings are convened to focus on successful completion. This model has also been used to develop and refine the indicators for the Carers Survey that we continue to prioritise within the Carers Engagement Workplan. Triangle of Care / Carer Awareness Training continues to hold steady at 85% compliance and is consistently well-evaluated.

Carers have welcomed the development of the Trust's inpatient services and Psychiatric Intensive Care Unit and Carers are actively involved in the "15 Steps" initiative.

In September 2025 a Carer, a Trust Carers Champion and the Trust's Carer Involvement Lead presented to the Trust Leadership Team Forum to illustrate what good looks like in terms of Carer involvement and gave a good practice example of the Early Intervention Team's Friends and Family Skill Share Group. Carers Champions are actively sharing and learning from each other to improve the team's offer to Carers.

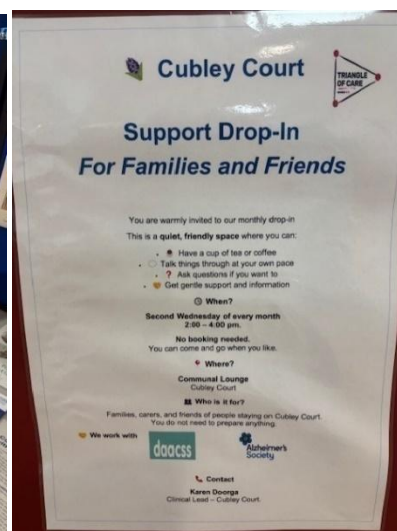
Triangle of Care

We are delighted to announce that, following the submission of its Triangle of Care Annual Report in February 2026, the Trust has proudly retained its prestigious Triangle of Care two-star status. This achievement is a testament to the continued dedication and hard work of our staff, carers, and partners, reflecting our unwavering commitment to carer involvement and support. Maintaining this nationally recognised standard is a source of great pride for everyone involved and serves as further motivation to build upon our successes in the year ahead.



The Carer's Trust Triangle of Care National Leads continue to provide support and guidance to the Trust and are present in the Triangle of Care Regional meetings that are currently led by colleagues in Nottinghamshire Healthcare Trust. Derbyshire Healthcare remains committed to the Triangle of Care as a framework for Teams to continuously reflect on, and improve, their engagement with Carers and Families.

A Carer Dashboard is now available to clinical staff on SystmOne. Compliance is improving and work is ongoing with operational and clinical leads, Information Management and Technology and Clinical Digital colleagues, to improve compliance. The Carers and Families Hub on the Trust website continues to be updated as changes and developments occur. A short piece of work is anticipated in 2026, updating the Support for Carers Leaflet that was published in December 2024.



In the past year the Trust “Working with and Supporting Carers” Policy has been significantly reviewed in collaboration with Carer representatives. It emphasises the importance of reaching out to Carers from minority and disadvantaged populations and Young Carers. Membership of the Derby Health Inequalities Partnership is important in this endeavour.

Partnerships

We value the relationships and partnerships that have been formed with stakeholders, sometimes over many years. In the current climate of organisational change across the health and care sectors these partnerships are vital in terms of progress and sustainability. The Trust relies on and values good working relationships and collaboration with partner services and this is particularly so in Carer engagement.

The last year has seen Trust involvement in the development of the first joint Derby and Derbyshire Carers Plan that will be launched in the Spring of 2026. We look forward to continuing our involvement to ensure the Plan is recognised across services.

The recent introduction of the Patient and Carer Race Equality Framework (PCREF) is welcomed and, whilst in the early stages, there is learning from NHS early implementers that will guide our progress to reduce racial inequalities in our services.



The PCREF is mandatory for all NHS mental health trusts and providers. It sets out clear actions they must take to reduce racial inequalities in their services – and forms part of Care Quality Commission (CQC) inspections. The framework focuses on three areas:

1. Leadership and governance – trust boards will lead on creating and monitoring plans to reduce health inequalities.
2. Data – trusts must publish new data on progress in reducing health inequalities, and include ethnicity information in all existing core data sets.
3. Feedback – trusts must put clear, visible ways in place for patients and carers to give feedback, and show how that feedback leads to action.

We greatly appreciate and value the active support of the Trust's Chief Executive Officer, Chair of the Trust Board, Non-Executive Carer Champion member of the Trust Board and Council of Governors Carer lead.

We also welcome and value relationships with partner organisations across the County and City areas, these include local authorities, the Integrated Care Board, 3rd Sector providers and, most importantly, Carer Representatives from local forums and groups. We appreciate the time given by Carer Representatives who engage with us, as critical friends, to improve our services and support better care for everyone. During 2025 Derbyshire All Age Carers Support Service has run the H-Connect Hospital Discharge Project pilot in two wards and in partnership with ward staff. Everyone involved has appreciated this collaborative piece of work.

2025 saw some Trust Carers Champions, the Carers and Families Project Lead and the Care Standards and Carers Involvement Lead nominated for these awards. Even more worthy of note, the latter won their category of Partnership and Collaboration having been nominated by a Social Care Commissioning partner.

Plans for the next year include continued improved compliance with regard to the Carer Dashboard on SystmOne, the introduction of the Carer Survey and a continued focus on Young Carers and increasing the Cultural Competence of Trust Teams to meet the needs of the populations they serve.

15 Steps Challenge

The 15 Steps Challenge is an NHS England–developed quality improvement approach designed to understand the quality of care from a patient and carer perspective, based on the principle that first impressions of care environments are powerful indicators of overall quality. It uses short, structured walkarounds undertaken by teams of staff and people with lived experience to capture what it *feels like* to enter and experience an inpatient ward, focusing on early signals of safety, care and organisation.



The Challenge is not an audit or performance management tool, but a collaborative method to support continuous improvement. Feedback is structured around four key domains aligned to CQC expectations: Welcoming, Safe, Caring and Involving, and Well Organised and Calm. Observations are used to identify good practice, highlight opportunities for improvement, and support rapid sharing and action at ward and organisational level.

During 2025, the 15 Steps Challenge was launched and embedded across Derbyshire Healthcare NHS Foundation Trust mental health inpatient services, led by the Trust's EQUAL group. This work established a consistent, values-based approach to ward walkarounds that strengthens patient and carer involvement, supports quality assurance, and provides qualitative evidence to inform improvement activity, CQC readiness, and Quality Account reporting.

The EQUAL group is a collective group of experts by experience, carers and staff with expertise and experience to ensure their voices are heard within the Trust. As part of this there is visibility from EQUAL within the wards which also support patients on the wards.



Part 5 – Quality Improvements Against National and Local Priorities

Section A: Our People and Our Culture

Celebrating Staff Excellence

KEY ACHIEVEMENTS

Recognised excellence, compassion and innovation through the HEARTS Awards, with high engagement and national recognition for staff and teams delivering quality care

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

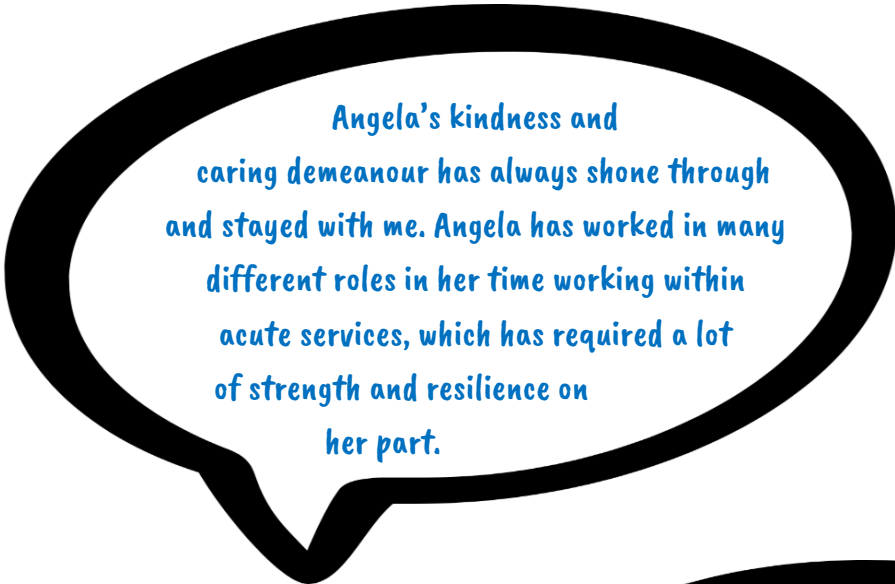
The awards ceremony, hosted by members of the Trust's Board of Directors and sponsored by Hill Dickinson, Kier Construction and Arden Partnership, recognised individual Trust employees and teams who have gone above and beyond the call of duty and performed at a consistently high level over the last year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



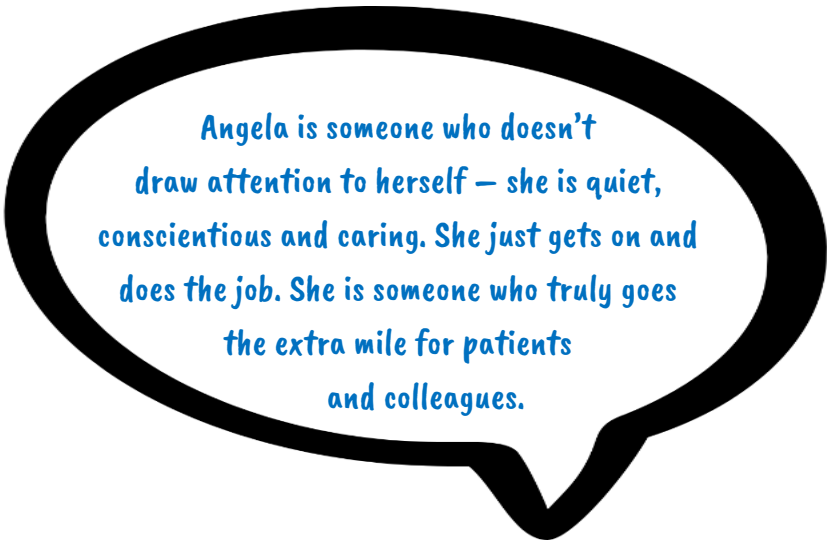
Angela Rafferty – Lead Nurse for the Electroconvulsive Therapy (ECT) Suite team – received with the ‘Derbyshire Healthcare Lifetime Achievement’ award for dedicating 48 years of service to the NHS.

Angela was described as having shown “dedication” and “compassion” throughout her career. Her reliability, quiet leadership and pride in her work have made a lasting impact in acute mental health care and ECT services.

Lexine Price, Senior Nurse working in the ECT team, has worked closely with Angela for many years and submitted the nomination for her colleague. She collected Angela’s award on the night and said: “Angela and I have crossed career paths many times over the years. I first met her in 1984 when I was a naïve anxious student nurse on my very first placement. Angela took me under her wing and guided me.”



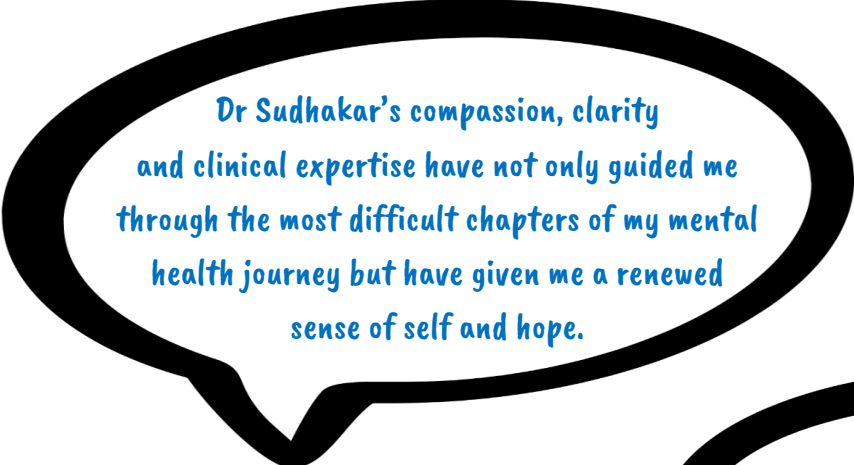
Angela's kindness and caring demeanour has always shone through and stayed with me. Angela has worked in many different roles in her time working within acute services, which has required a lot of strength and resilience on her part.



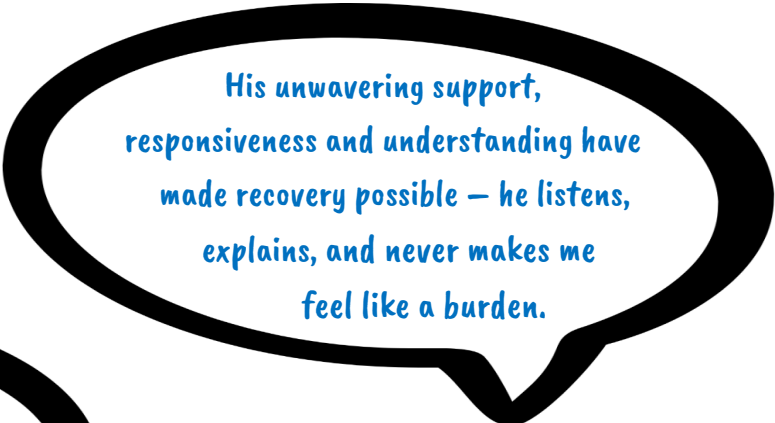
Angela is someone who doesn't draw attention to herself – she is quiet, conscientious and caring. She just gets on and does the job. She is someone who truly goes the extra mile for patients and colleagues.

The 'Outstanding Care and Compassion' award was presented to an individual for working effectively for the wider benefit of the Trust and patients, demonstrating ambition and a desire to support patients and people. This award went to Dr Saladi Sudhakar, a consultant psychiatrist with the Erewash Community Mental Health Team.

Dr Sudhakar won this award after being nominated by a patient, who praised Saladi's consistent and compassionate care, describing how his understanding, responsiveness and tailored support have made a real difference in the patient's recovery. In the nomination, the patient said:



Dr Sudhakar's compassion, clarity and clinical expertise have not only guided me through the most difficult chapters of my mental health journey but have given me a renewed sense of self and hope.



His unwavering support, responsiveness and understanding have made recovery possible – he listens, explains, and never makes me feel like a burden.



He is caring and extremely knowledgeable in his role and has led me to multiple services which have been life changing. I believe he hasn't just saved my life but many others.

"If only I could show the world where I was a few years ago compared to today, it would really highlight his extreme compassion for helping individuals in the community. My words can't do justice to how amazing he is. I have huge respect for him, and he is giving me another shot at life."



Dr Sudhakar was pleased to be celebrated on the night, he said: "It's incredibly rewarding to see the positive changes in my patient – not just in their mental health, but in the way they carry themselves, how they speak, how they dress. To witness someone rediscover their confidence and sense of self is a privilege. It reminds me why I do this work."

This year's awards included a new category, the 'Patient Focus' award, which recognises a team or individual who demonstrates exceptional respect for, and responsiveness to, the needs and values of our service users, patients, children, families, and carers. This commitment is reflected through positive feedback, improved service outcomes, and consistently high levels of satisfaction.

The Children in Care and Adoption team, who offer confidential support and advice to children in care in Derby city, and their foster carers, won this award for their commitment to co-production, peer support and continuous improvement which has led to high satisfaction rates.

The nomination, which was submitted by a member of staff at the NHS Derby and Derbyshire Integrated Care Board (ICB) read: "The Children in Care and Adoption team places children at the heart of every decision, building relationships rooted in trust and empathy, while consistently delivering outstanding support shaped by lived experience and emotional insight. From the way they answer a phone call to navigating emotionally complex conversations, the team embodies respectful, responsive, and inclusive practice at every level."

Dr Achana Marudkar, Associate Specialist, and Kelly Thompson, Named Nurse attended the ceremony to represent the team, and said: "We were genuinely thrilled just to be nominated – to win was an unexpected and deeply meaningful moment for all of us. This recognition means a great deal, especially given the emotional intensity of the work we do with vulnerable children and young people. It's a real team effort – from our doctors and nurses to our admin colleagues – and we're proud of the way we support each other every day. We're a close-knit team, and this award reflects the compassion and commitment that goes into everything we do."

Other award categories included the 'Partnership and Collaboration' award, which celebrates an individual that has gone to significant lengths to involve experts by experience, members of our communities or system partners in shaping their services or their work.

The award winner was Lynn Dunham, Care Standards Co-ordinator and Carer Involvement Lead, who was chosen for this award for her efforts to advocate for carers and improve partnership working across the Trust and wider system. Her inclusive approach has strengthened service development, supported engagement and improved outcomes for carers and families.

The nomination, which was submitted by a representative of Derby City Council, read:



Lynn was honoured to receive his award, she said: "I was genuinely shocked to receive a HEARTS Award. For me, this doesn't feel like work – I'm simply doing what I love. It's a privilege to advocate for carers and help shape services that truly reflect their voices."

Mark Powell, Chief Executive at Derbyshire Healthcare, congratulated colleagues who were successfully named as winners and finalists, as well as all those who were nominated.

Mark said: "It's a privilege to celebrate the dedication, compassion and excellence shown by our colleagues across Derbyshire Healthcare. Whether recognised as winners, finalists or nominees, everyone has made a meaningful difference to the lives of those we care for, and that's what the HEARTS Awards are all about.

"These awards reflect the values we hold as a Trust – putting people first, working together, and striving for continuous improvement. I'm incredibly proud of the commitment shown by our staff and grateful for the positive impact they make every day as representatives of this Trust. I'm also very grateful to our sponsors, Arden Partnership, Hill Dickinson and Kier, for making these awards possible."

A full list of winners from our HEARTS Awards are:

- Clinical Team of the Year Award – *a team award category - for rising to the challenge of working in ever-changing circumstances and delivering compassionate, safe, responsive and effective care to patients.*



WINNER – Bolsover Older Adult Community Mental Health Team (CMHT)

- Non-Clinical Team of the Year Award – *a team award category - for working effectively for the wider benefit of the Trust and patients, demonstrating ambition and a desire to support our patients and our people.*



JOINT WINNERS – Capital Projects & Making Room for Dignity Programme team; and Estates and Facilities department

- Making a Positive Difference Award – *for a team or individual that has made a positive difference to the lives of the people we serve or work with every day by creating a positive culture and by embodying our values: Caring, Inclusive, Collaborative, Ambitious, Belonging.*



WINNER – Amanda, Occupational Therapist, Forensic Community Mental Health Team (CMHT)

- Patient Focus Award – *for a team or individual that excels in being respectful of, and responsive to, the needs and values of our service users, patients, children, families and carers, resulting in positive feedback or service outcomes and high levels of satisfaction.*



WINNER – Children in Care and Adoption team

- Productivity and Innovation Award – *showcasing a team or individual that has found new ways to deliver projects or services that demonstrate best value for our population, encourage prevention and self-care, embrace technology and/or result in efficiencies.*



WINNER – Erica Screatton and the Occupational Therapy team at the Derwent Unit

- Outstanding Care and Compassion Award – *for an individual who goes the extra mile to ensure their service is caring and compassionate and makes a difference to the lives of patients, service users, carers and colleagues.*



WINNER – Dr Saladi Sudhakar – Consultant Psychiatrist, Erewash Community Mental Health Team (CMHT) – Outpatients

- Partnership and Collaboration Award – *for an individual that has gone to significant lengths to involve experts by experience, members of our communities or system partners in shaping their services or their work.*



WINNER – Lynn Dunham, Care Standards Co-ordinator and Carer Involvement Lead

- Rising Star Award – *individual award category - this award recognises outstanding performance within the organisation and celebrates growing talent at Derbyshire Healthcare NHS Foundation Trust. This person will be new to the NHS or their profession and have made exceptional and ambitious contributions to their team and service.*



WINNER – Oluyomi Ladapo – Registered Nurse, Cubley Court Male older adult dementia inpatient service

- Inclusive Leader Award – *individual award category (DHCFT staff nominations only) - for showing real care and compassion for colleagues, recognising and celebrating the positive impact of inclusion and diversity and creating a sense of belonging. Open to colleagues from all levels of the organisation.*



WINNER – Nicole Ellis – Mobilisation Project Manager, Making Room for Dignity programme team

- Lifetime Achievement Award – *individual award category (Derbyshire Healthcare staff nominations only) - this award seeks to recognise colleagues with over 40 years' service who have dedicated their career to the NHS. They will truly reflect the Trust values and will have demonstrated a commitment to providing support and care to both patients and staff.*



WINNER – Angela Rafferty – Lead Nurse, Electroconvulsive Therapy (ECT) Suite team

Derbyshire Healthcare NHS Foundation Trust is celebrating national recognition for two of its leaders. Chair, Selina Ullah, has once again been named by the Health Service Journal (HSJ) as one of the 50 most influential Black, Asian and Minority Ethnic people in health. Consultant Psychiatrist, Dr Subodh Dave, has also been named a Rising Star for his work with the Royal College of Psychiatrists and Doctors in Distress.

Selina Ullah, Chair since 2021 and one of the first Muslim female NHS trust chairs in the country, has been honoured for a second time for her leadership in advancing Board diversity and workforce inclusion. Under her leadership the Trust has won many awards for Equality, Diversity and Inclusion including Trust of the Year. Her extensive career includes roles as regional lead on mental health policy for the National Institute for Mental Health. Leading a high-profile portfolio including community safety and community cohesion strategic partnerships, civil contingencies and emergency planning and commissioning third sector domestic abuse, drug and alcohol initiatives for Bradford Council, and serving as a Non-Executive Director at Local and Bradford Teaching Hospitals NHS Foundation Trust. Selina is also a lay Board member at the General Pharmaceutical Council and the Vice Chair and Senior Independent Director at NHS Providers.



Selina said: “Being recognised alongside other leaders is an honour. The HSJ’s recognition of equality, diversity, and inclusion in health and social care highlights the ongoing priorities for our Trust. I plan to continue using my position to promote a culture that supports colleagues from diverse backgrounds, focusing on creating safe spaces within our workforce where everyone can bring their whole self to work and give their best to our patients.”

Dr Subodh Dave, Consultant Liaison Psychiatrist at Derbyshire Healthcare, Dean of the Royal College of Psychiatrists, and Trustee of Doctors in Distress – which promotes the mental health of healthcare workers, has been named a Rising Star for setting standards for education and training.

He is also a professor of psychiatry at the University of Greater Manchester and Deputy Director of Undergraduate Medical Education at Derbyshire Healthcare.

Subodh said: “I am honoured to be recognised as a Rising Star by the HSJ. Supporting colleagues, especially during challenging times, and championing inclusion and compassion in healthcare remain at the heart of my work. I am grateful for the opportunity to contribute to make positive changes and help create a culture where every member of our workforce feels valued and supported,”

Mark Powell, Chief Executive at Derbyshire Healthcare NHS Foundation Trust, congratulated the two on their achievement and said: “The Trust is proud to see both Selina and Subodh recognised for their dedication and leadership, which continue to inspire colleagues and improve healthcare for communities across Derbyshire and beyond.”

Derbyshire Healthcare NHS Foundation Trust is proud to announce that it has been named the winner in two categories at the 2025 HSJ (Health Service Journal) Digital Awards, recognising the organisation’s commitment to digital innovation and the transformative impact of digital technology on patient care and population health across Derbyshire.



At a ceremony on 26 June, the Trust won the coveted ‘Digital Organisation of the Year’ award and its School Nursing team claimed the ‘Generating Impact in Population Health through Digital’ award.

The 'Digital Organisation of the Year' award celebrates the Trust's implementation of an organisation-wide Digital Plan, including the rollout of an integrated and future-proof electronic patient record (EPR) system that enables seamless information sharing across services and with GPs, empowering clinicians and patients alike to make informed decisions without delay. The Trust has also introduced electronic prescribing, resulting in the safer and more consistent management of medicines. The second award win, for the 'Generating Impact in Population Health through Digital' award, highlights the work of the Trust's School Nursing Team in transforming the way they identify children's health needs in the city of Derby. In partnership with The Lancaster Model (TLM) and Aire Innovate Limited, the team digitised the Health Needs Assessment process, using a digital questionnaire to find out about children and young people's health at various ages. The survey results help the school nursing team to plan services for the future for all children, and to give each child the health and wellbeing support they need as early as possible. Through the questionnaire, the team have heard from 85% of Year 6 students, 70% of Year 9 students and, in a pilot, 94% of a group of Year 12s, revealing a range of potential health needs that can now be addressed more quickly.

The approach has enabled the team to shift from a reactive, safeguarding-focused model to a proactive, child-centred public health approach. This transformation has already made a meaningful difference to the health and wellbeing of over 15,000 young people and their families across Derby city.

Mark Powell, Chief Executive at Derbyshire Healthcare, said: "We are delighted to have won not one, but two national awards that recognise the dedication and innovation of our teams. These achievements reflect our Trust's strategic focus on digital transformation to improve outcomes, reduce inequalities, and deliver safer, more responsive care to our communities.

"I understand that these wins come at a time of record-breaking participation in the HSJ Digital Awards, with over 430 entries submitted and 205 projects shortlisted. This clearly shows Derbyshire Healthcare's success through the power of collaboration, clinical leadership, and a shared vision for a digitally enabled NHS."

The Trust was also shortlisted in a third category for 'Driving Prevention and Early Intervention through Digital' which also highlighted leadership in digital health innovation in our school nursing service.

Staff Survey Results

KEY ACHIEVEMENTS

The Trust continues to perform at or above the benchmarking group across indicators, demonstrating a consistently positive staff experience relative to comparable organisations.

2025 NHS Staff Survey
Results Summary

The national NHS Staff Survey presents feedback from colleagues aligned to the seven themes of the NHS People Promise. These themes are areas that are central to improving colleagues’

People Promise

experiences at work. Our Trust results are presented across these themes below, in addition to the Trust’s overall scores for staff engagement and morale.

NHS
Derbyshire Healthcare
NHS Foundation Trust



Colleagues feedback

Thank you to everyone who completed the NHS Staff Survey in 2025.

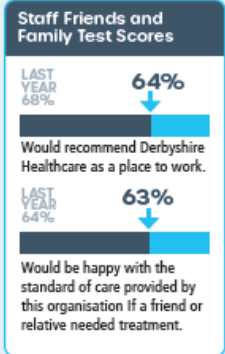
The Trust is committed to making ongoing improvements in response to the feedback we have received from colleagues.

Your feedback continues to rate the Trust higher than average when benchmarked against other comparable organisations.

Team-level feedback has been shared, with a small number of local actions being identified that will make the most difference in your local areas of work.

This is in addition to Trust-wide actions, which include:

- Making the Trust a better place to receive care
- Making the Trust a better place to work.



We have been scored against each element compared to the average from the 28 other organisations in our benchmarking group

All elements are scored on a 0-10 scale, where a higher score is more positive than a lower score. The People Promise scores are generated by grouping the results from each question into sub-themes.

The Trust continues to perform at or above the benchmarking group across indicators, demonstrating a consistently positive staff experience relative to comparable organisations.

Response rates have remained strong at 64%, reflecting continued engagement with the survey and confidence that staff feedback will be heard and acted upon.

Strengths are evident in:

- **We are a team (7.33)** – indicating strong teamworking and collaboration across services
- **We are compassionate and inclusive (7.68)** – reflecting a positive and supportive organisational culture
- **We work flexibly (7.05)** – demonstrating continued progress in supporting flexible working arrangements

However, the survey shows a gradual decline over time in several indicators, particularly:

- **Morale (6.25)**
- **We are safe and healthy (6.44)**
- **We each have a voice that counts (6.93)**

While these scores remain above benchmark, the downward trend indicates areas requiring focused attention.

Actions to address areas of concern

In response to the survey findings and wider listening channels, the Trust has prioritised the following areas:

- **Making the Trust a better place to receive care** – making sure Derbyshire Healthcare is a place colleagues would recommend to their families and friends as a place to receive care, and that colleagues see patient care as our number one priority.
- **Making the Trust a better place to work** - making sure that colleagues feel supported, valued and safe while they are at work; that people want to stay working for Derbyshire Healthcare, and that the Trust is a place new colleagues want to come and work.

Future priorities and targets

The Trust has identified the following key priorities to improve staff experience:

- **Improving morale and wellbeing**, with a focus on psychological safety and workload pressures

- **Enhancing staff voice and involvement**, ensuring colleagues feel able to contribute to improvements
- **Embedding a positive and inclusive culture**, aligned to the NHS People Promise

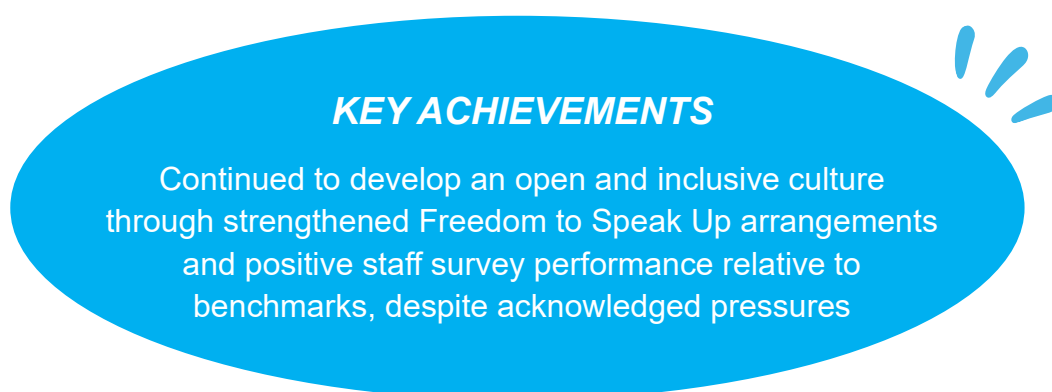
Monitoring and assurance

Progress against these priorities will be monitored through:

- Annual NHS Staff Survey results
- National Quarterly Pulse Survey data
- Workforce metrics (including turnover, sickness absence, and retention)
- Local team-level survey data and action plans
- Regular reporting through Trust governance structures

The Trust will continue to use these insights to drive continuous improvement and ensure that staff experience remains a central priority.

Freedom to Speak Up



During 2025/26, the Trust continued to strengthen its Freedom to Speak Up (FTSU) arrangements, with a sustained focus on improving accessibility, responsiveness and organisational learning from staff concerns. This work supports a positive, open safety culture and enables early identification of risks to patient safety, quality of care and staff wellbeing.



Progress and Impact

Engagement and visibility of the FTSU function increased throughout the year. The Freedom to Speak Up Guardian (FTSUG) undertook proactive engagement with staff through team meetings, inductions and targeted sessions for resident doctors, students and preceptees. Communication was strengthened through intranet updates, blogs and social media, supported by a network of 43 FTSU Champions who provide local visibility and signposting.

Speaking up activity increased significantly, with 268 cases recorded in 2025/26, representing a 49.7% increase compared with 2024/25. This increase is considered a positive indicator of growing staff confidence and awareness of routes to raise concerns, including use of the Focus portal.

Feedback processes for staff who speak up continued to improve. Although timeliness remains an area for further development, feedback from staff remains positive, with 83.7% of respondents reporting that they would speak up again. This demonstrates increasing confidence in the support provided through the FTSU process.

Speaking up data has been used more effectively to identify themes and areas of concern, including indicators of closed cultures within specific teams. Targeted interventions, including staff engagement activity and cultural reviews, have supported local improvements in openness, psychological safety and team culture.

Governance, Oversight and Managing Concerns

The Trust has clear processes to ensure that concerns relating to patient safety, quality of care and workplace behaviours are acted upon promptly. Patient safety and quality concerns raised via the FTSUG are escalated immediately to the Executive Director of Nursing, AHPs, Quality and Patient Experience and, where appropriate, the Executive Medical Director.

Concerns relating to bullying, harassment or inappropriate behaviours are shared, with consent, with relevant leaders and the Employee Relations team to ensure appropriate support, investigation and intervention. FTSU activity is triangulated with other intelligence sources to identify emerging risks and barriers to speaking up. Regular reporting is provided to the Trust Board (six-monthly), Audit and Risk Committee and People and Culture Committee, strengthening executive and non-executive oversight of themes, trends and organisational learning.

Protecting staff from Detriment

The Trust remains committed to ensuring that staff who speak up do not suffer detriment. All perceived detriment cases are recorded and escalated to the Executive Lead for Speaking Up (Chief Executive). Ongoing communication reinforces expectations that speaking up is encouraged and should not result in reprisals, with action taken where concerns are identified.

Key challenges and priorities

The continued growth in speaking up activity has placed pressure on the current part-time FTSUG resource, impacting response times and feedback. Strengthening capacity remains a priority for 2026/27.

Bullying, harassment and inappropriate behaviours continue to be a significant theme, with approximately 40% of concerns including aspects of these issues. The Trust has responded through targeted leadership support, mediation, strengthened monitoring and the implementation of the *A Kind Life* programme; however, further work is required to ensure consistent behavioural standards and psychologically safe environments across all services.

In relation to equality, diversity and inclusion, further work is required to strengthen the Trust's response to racism and discrimination. Key developments during the year included the introduction of a Trust-wide Anti-Racism Position Statement, classification of racism-related incidents as Major Incidents, establishment of a Race Equality Working Group and closer working between FTSU and EDI teams.

Looking ahead

The Trust has continued to make progress in strengthening its speaking up culture during 2025/26. Priorities for the coming year include increasing FTSU capacity, improving timeliness of responses, strengthening EDI-related actions and embedding learning from concerns into sustained Trust-wide cultural change and leadership accountability.

Section B: Patient Safety and Effectiveness

Patient Safety and PSIRF

KEY ACHIEVEMENTS

Embedded PSIRF principles, achieved 100% Duty of Candour compliance for in-period incidents, strengthened learning from deaths processes, and improved systems for incident reporting and learning

Embedding of the Patient Safety Incident Response Framework (PSIRF)

The Trust entered the early adopter phase of the Patient Safety Incident Response Framework in 2020. The framework has now been rolled out nationally, and all providers are adapting to new ways of working. The framework has supported a move towards a more proactive approach to learning from incidents, emphasising higher quality, more proportionate responses to patient safety incidents. This allows us to develop systems which focus on areas where there is the greatest opportunity for learning and improvement.

This has all lead to an improvement in the management of incidents and developing a culture learning and engagement in support of patients and their families post incident. There has been a move towards embedding a collaborative approach to incident management and review to gain early learning and direct engagement with clinical teams in identifying ways to improve the safety of services.

The trust continues to monitor return on its Local Priority incidents and planned thematic analysis. Plans are in place to strengthen operational engagement and ownership over learning identified through the PSIRF process.

Learning the Lessons Meetings

Processes continue to develop across the trust, with a current focus on post incident response by services, enhanced oversight and accountability and the identification of learning in a proactive and timely manner. Areas of improvement include the establishment of learning the lessons meetings within the new care groups; and divisional oversight groups which will feed into and out of the patient safety incident corporate functions.

The main priority for these forums will be to ensure the effective and timely implementation of learning from all incidents. Oversight groups are being established

operationally to ensure these meetings remain compliant with their main function and to ensure effective flow of information in and out of the incident process. The Trust Executive Incident Review group will have oversight and maintain challenge over these groups. Work is in progress to enhance reporting structures and escalation processes where standards are not being met.

Improvement of PSIRF Processes

We received an independent audit of our incident response and learning processes which has highlighted areas for improvement around adherence to PSIRF. The learning and recommendations from this have been developed into an improvement plan which will be monitored by the trust audit committee with completion by August 2026.



Duty of candour

Duty of Candour

The following is a summary of Duty of Candour compliance from 1/4/2025 to the year end. The Trust achieved 100% (20/20) compliance with Duty of Candour (Regulation 20).

Number of incidents assessed as Duty of Candour within this reporting period where the date of incident sits outside of this reporting period.

Some catastrophic and major incidents can be subject to Case Record Review (CRR) or Patient Safety Incident Investigation (PSII). Duty of Candour for these incidents can be assessed at the date of the report being signed off by the Executive Incident Group. The date of which Duty of Candour can be assessed for incidents subject to CRR or PSII can therefore sit outside of the reporting period for which the incident occurred.

Therefore, for transparency this report will include the number of incidents assessed as Duty of Candour within this reporting period where the date of the incident sits outside of this reporting period.

There were 6 incidents assessed as Duty of Candour within this reporting period (from 1/5/2025 until 23/2/2026).

The Trust achieved 67% compliance rate (4/6) with Duty of Candour (Regulation 20) for these incidents assessed as Duty of Candour within this reporting period where the date of incident sits outside of this reporting period.

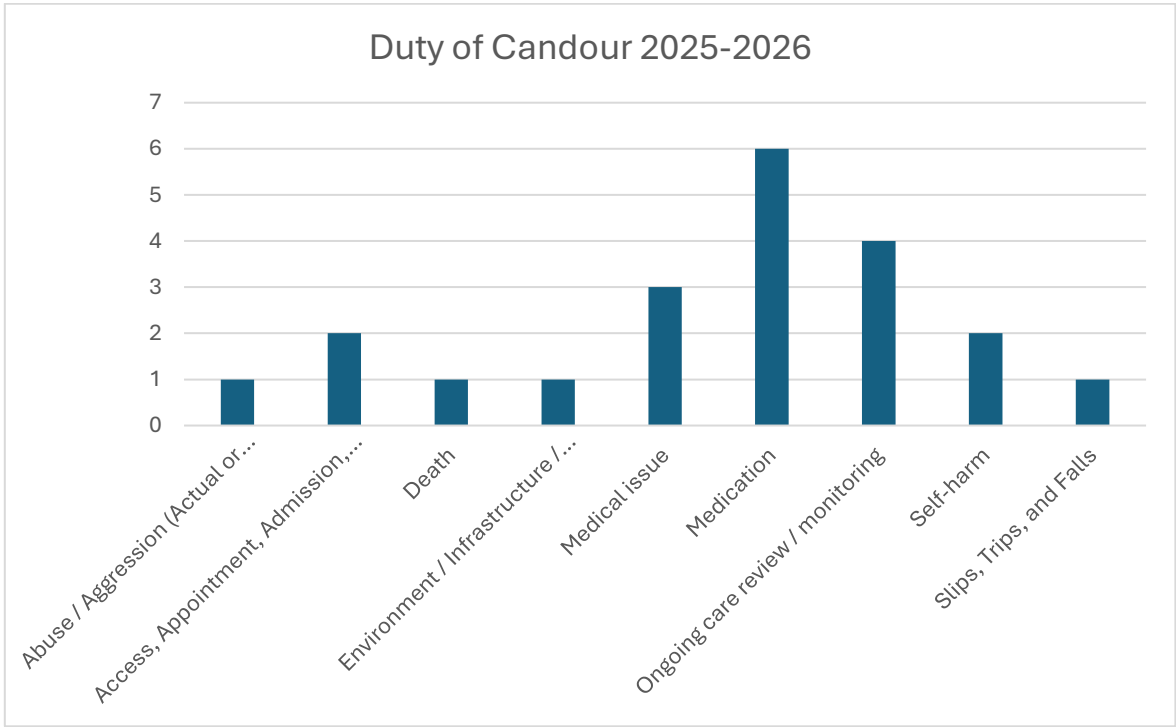
Incidents where regulation 20 was not met

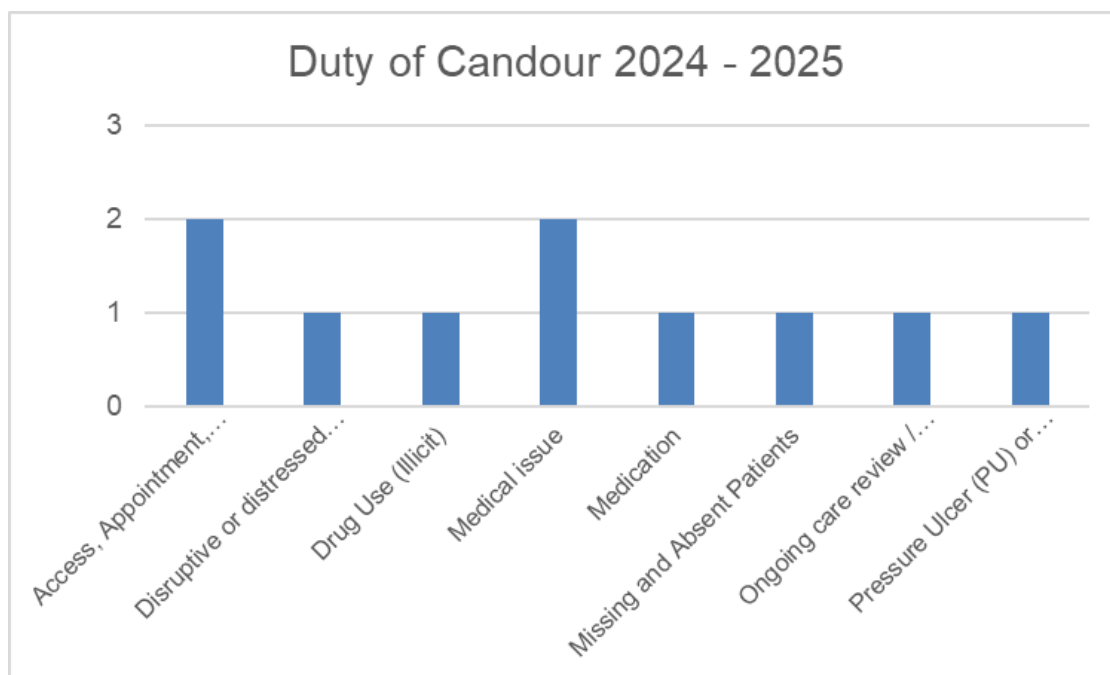
There are two incidents where regulation 20 was not met.

- The first attempted to engage the former patient in the process but this was declined.
- For the second, the Patient was deceased and the family members were estranged.

Note that some incidents remain under review (e.g., deaths subject to Case Record Review or PSI investigation), and data is subject to change. This reflects a dynamic approach to incident management, with continuous monitoring and reassessment.

There were a total of 21 incidents meeting requirements for Duty of Candour from 01/04/2025 – 23/02/2026. The bar charts below show the difference in incident categories from the period of 2025-26 (above) compared to the period of 2024-25 (below).





Lived Experience Participation

Family Liaison and Engagement throughout patient safety incident response continues to improve and plans are being explored as to how we can further involve our patients and their families in the learning from incidents. This, in part, will involve our new dedicated Patient Safety Partner. The Patient Safety Partner role exists to represent the voice of patients, carers and family in the design and improvement of safety systems and processes, and of clinical practice and care.

Systems and processes to manage the flow of incidents have been improved to support better governance through DATIX and allow for the early detection and feedback on themes emerging from incidents.

Training

We have been in the process of rolling out comprehensive training courses relating to suicide prevention, risk assessment and safety planning. 3 of 4 modules have been made available to all clinical staff to complete. The final module has been edited and will be made available to staff within the very near future.

We are also in the process of working with an external partner to develop internal training packages relating to all level of incident management, review and learning Response. This aims to upskill our clinical workforce in adhering to Trust policy & procedure and develop a greater understanding of the human factors that can contribute to safety incidents.

In addition to this, work will begin to develop a comprehensive internal Patient Safety Incident Investigation training package to equip clinicians with the skills and knowledge required to respond to and investigate patient safety incidents through the

lens of systems and processes, in line with PSIRF. We currently have one session available from an external training provider that will be offered to DHCFT colleagues once the organisational restructures are complete, to strengthen the new leadership structures in their knowledge and skills in relation to Patient Safety Incident Response.

A review of current skill mix and capacity within operations will be completed in relation to learning responses post re-structure, and we will utilise peer learning & mentoring approaches to draw upon the knowledge and wisdom of professionals more experienced in leading patient safety incident responses.

Learning From Patient Safety Events (LFPSE)

We have now integrated our incident reporting systems with the national NHS Learn from Patient Safety Events (LFPSE) service, a centralised system for the recording and analysis of patient safety events in health and care (this replaced the National Reporting and Learning System, or NRLS). The Strategic Executive Information System (SEIS) currently remains active as the LFPSE continues to develop.

Table - Incidents reported to LFPSE (Learning from Patient Safety Events) in 2025/26

	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26	Total
Self-harm	520	617	396	194	1727
Medication	226	254	299	84	863
Slips, Trips, and Falls	149	163	131	54	497
Abuse / Aggression (Actual or Alleged) - Patient to Patient	100	185	154	41	480
Missing and Absent Patients	113	159	109	42	423
Access, Appointment, Admission, Transfer, Discharge	79	104	115	44	342
MH / MC Act process	80	48	77	27	232
Medical issue	52	60	68	25	205
Environment / Infrastructure / Facilities issue on Trust premise (incl. team base)	47	104	34	12	197
Ongoing care review / monitoring	45	67	55	19	186
Record Keeping Standards	30	42	42	15	129
Data Security and Missing Records	32	39	37	14	122
Drug Use (Illicit)	35	22	22	6	85
Alcohol Use	13	17	27	8	65
Accident	14	18	17	7	56
Equipment issue (medical device)	10	30	8	4	52
Death	12	5	12	4	33
Security	10	6	10		26
Infection Control	7	10	4		21
Pressure Ulcer (PU) or Moisture Associated Skin Damage (MASD)	8	1	4	1	14
Disruptive or distressed behaviour	2	6	3	2	13
Equipment issue (non-medical device)	3	4	3		10
IT systems / service issue	3	2	4		9
Manual Handling	3	1	5		9
Fire	1	3	1	1	6
ECT Treatment	2	1	1	1	5
Abuse / Aggression (Actual or Alleged) - DHCFT Staff to Patient	1	2	1	1	5
Other - see 'Description' field for details		3	1		4
Police & DHCFT: Section 136 Pathway		1	1	1	3
Inoculation			1		1
COVID-19 case	1				1
Total	1598	1974	1642	607	5821

This represents a **2.7% increase** in the number of incidents reported from 2024-2025.

Total Number of Incidents Resulting in Severe Harm/Death reported on to the Trust Incident Reporting System, Datix 1 April 2025- 18 Feb 2026

	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26	Total
Severe harm	11	6	5	6	28
Fatal (Death)	37	24	39	21	121
Total	48	30	44	27	149

This represents an **18% decrease** in the number of deaths reported from 2024-2025.

Total Number of Incidents Resulting in Severe Harm/Death (Reported to LFPSE)

	Q1 2025/26	Q2 2025/26	Q3 2025/26	Q4 2025/26	Total
Severe harm	6	4	4	6	20
Fatal (Death)	12	4	12	4	32
Total	18	8	16	10	52

This represents a **13% increase** in incidents resulting in severe harm/death reported to LFPSE from 2024-2025.

Total Number of Incidents reported on to STEIS (Strategic Executive Information System – the NHS system used to report and monitor the progress of serious incident investigations). STEIS is used to report incidents that meet a Patient Safety Incident Investigation threshold.

Row Labels	▼ Apr	May	Jun	Jan	
Reported by DHCFT	2	1	3	1	7
Total	2	1	3	1	7

There was a total of 3 incidents reported to STEIS in 2024-2025.

Learning from Deaths – Process

The Trust Mortality process was subject to review and alignment to the Trust Incident Management and Investigation processes under PSIRF. This has resulted in more effective management of deaths and improved use of resources. Weekly audits against the mortality database (which draws its information from the national NHS Spine and local ERP systems) continue. This monitors compliance of Stage 1 Mortality reviews and supports staff to identify deaths which meet Trust and National

red flags for incident reporting. These deaths are then reviewed and managed through the patient safety incident response framework.

The Trust has received notification of 1799 deaths of patients through the NHS Spine since 01 April 2025 to 18 February 2026:

Differences may occur between mortality figures recorded on internal Trust systems and those identified through the national NHS Spine due to variations in data sources, update timings, and reporting methodologies. Internal systems are used for operational and clinical purposes, while the NHS Spine receives information through national demographic and civil registration processes, which may capture deaths differently or at different times. The Trust routinely reviews and reconciles data from multiple sources to support accurate reporting and learning from deaths, and small discrepancies between local and national datasets are expected as part of normal data quality assurance.

Month	Number of Deaths Recorded
April	168
May	177
June	158
July	165
August	150
September	153
October	162
November	187
December	200
January	209
February	70

This represents a **17.5%** decrease in notification of deaths from 2024-2025.

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 that meet the Trust ‘red

flag' will have an Incident review Tool completed. This is then reviewed and a decision made as to whether a further learning response is required.

Year	Number of Deaths	PSII	CRR
2023-2024	117	15	37
2024-2025	95	5	27
2025-2026	137	6	23

*Please note- 55 deaths are currently awaiting a decision

In 2025/26, 36 learning reviews were completed and closed. When a learning response is commissioned, the review team is independent of the team concerned/ involved in the patient's care. Plans are in place to enhance the way we develop and implement recommendations for improvement post learning response, to ensure that the voice and perspectives of the family and of frontline staff are represented.

Coroner Regulations 28 Conclusions - Prevention of Future Death Reports

The Trust has received one Regulation 28 within the financial period of 2025/26 which related to a death recorded January 2025. The learning identified was focussed on communication and information sharing. More specifically to the knowledge held by agencies or organisations of increasing contacts which were impacted by 1) not having the same record system; or 2) the relevant information was put into another record – the patients' child – rather than the patient's record (or repeated). The evidence at court was that there was nothing specific in the contact that caused a clinical concern but rather the fact that there was increasing contact suggested the patient was struggling. In that context, there was a lack of knowledge within partner agencies as to what could and should be shared. The Trust has responded to matters within its control which includes SystmOne 'alert' and Information leaflet to GPs on referral.

Local Learning Priorities

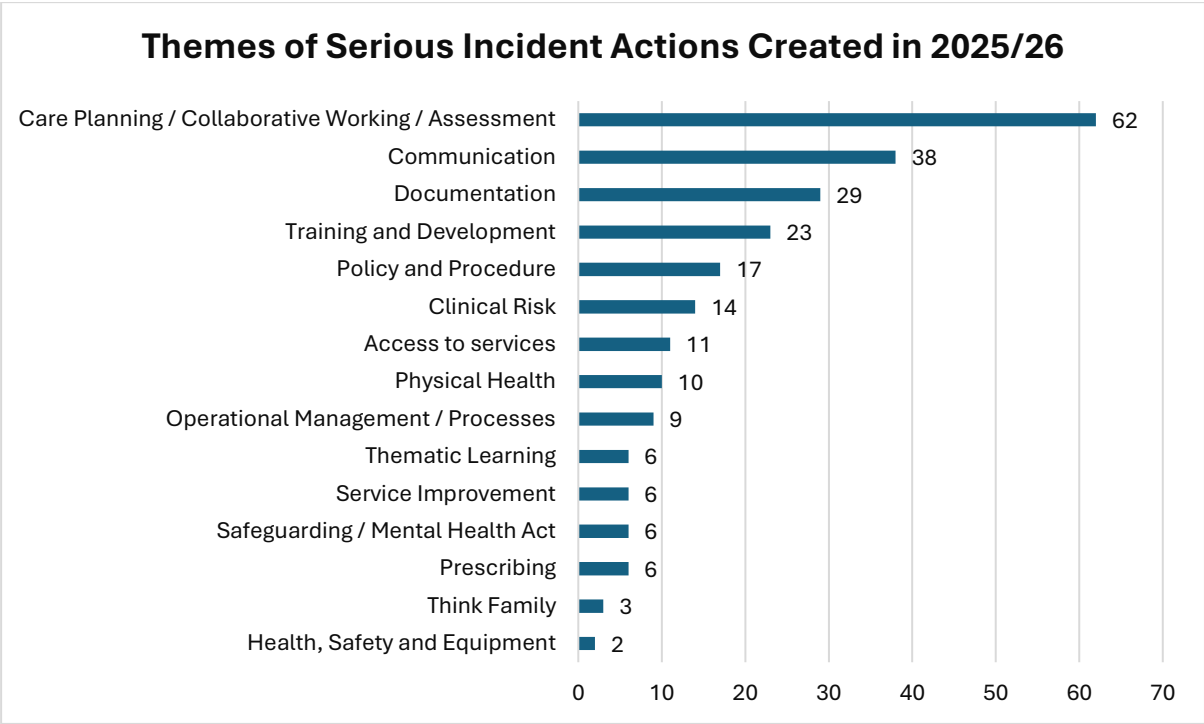
As part of our commitment to continuous improvement and patient safety the Trust has identified the following local learning priorities. These priorities guide our ongoing efforts to enhance care delivery and address systemic issues:

- Improving Risk Management to ensure that comprehensive risk assessments are completed and reviewed and that these accurately reflect the patient needs, particularly in complex/ high-risk patients and working to identify and mitigate risks early. This aligns to the development of the Trust Risk

Assessment, Safety Planning and Suicide Prevention works which includes a training package and revised Suicide Prevention Plan with a Suicide Prevention lead now in place.

- Ensuring that care plans are individualized and reflect the holistic needs of patients, including their psychological, emotional, and physical wellbeing.
- Improving Communication and Teamwork, a re-occurring theme which identifies the need to enhance communication between multidisciplinary teams (MDTs) and the importance of open and transparent communication with patients and families, particularly around critical decisions and care pathways. Promoting the importance of respecting patient preferences and involving patients and their families in care decisions.
- Supporting Staff with complex case management by identifying gaps in training and guidance, particularly related to safeguarding, risk management, and clinical decision-making to support staff in being equipped with the skills and knowledge they need to deal with complex cases.
- Patient Safety thread and Incident Reporting, to encourage a culture of openness where all incidents, near misses, and concerns are reported and acted upon. Ensuring that incidents are appropriately managed and responded too to support the dissemination of learning to reduce risk to patients.

In the table below Themes arising from incident learning responses provides more detail in relation to themes and improvement needs.



Suicide and Self-Harm Prevention

KEY ACHIEVEMENTS

Implemented a Trust-wide Suicide and Self-Harm Prevention Plan aligned to national guidance, embedding personalised safety planning, training and system learning

Derbyshire Healthcare NHS Foundation Trust (DHCFT) has an established Suicide and Self-Harm Prevention Plan (2025–2028) which sets out how the Trust will reduce suicide risk, improve care quality and strengthen system-wide prevention across Derbyshire. The Plan aligns with the NHS National Suicide Prevention Strategy 2023–2028, NICE Self-Harm Guidance (NG225) and recommendations from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH), translating national policy into locally delivered actions.

Suicide prevention is recognised as a shared responsibility, requiring a whole-system and trauma-informed approach. The Plan is underpinned by learning from serious incidents, lived experience, staff feedback and research, and is aligned to the Patient Safety Incident Response Framework (PSIRF), focusing on system learning rather than individual blame.

The Plan is structured around eight strategic priorities:

1. Improving data quality, intelligence and evidence use, including near-real-time surveillance, Datix and research partnerships.
2. Delivering tailored, targeted support for priority and high-risk groups, including people who self-harm, children and young people, autistic people, middle-aged men, people in contact with the justice system and those bereaved by suicide.
3. Addressing common risk factors such as trauma, deprivation, substance misuse, social isolation and physical health inequalities.
4. Promoting online safety and responsible media portrayals, with explicit assessment of digital risk in clinical care.
5. Strengthening cross-sector crisis support, including integrated crisis pathways, liaison services and voluntary sector partnerships.

6. Reducing access to the means and methods of suicide, with a strong focus on inpatient safety, ligature reduction and safer prescribing.
7. Providing effective bereavement and postvention support for families, carers and staff.
8. Making suicide prevention everyone's business through staff training, community engagement and stigma reduction.

Across all services, the Trust has embedded collaborative risk formulation and personalised safety planning, moving away from predictive risk scoring, in line with national best practice. A new suicide and self-harm prevention training programme is being delivered to clinical staff, strengthening confidence in assessment, formulation and compassionate care. Particular emphasis is placed on safe transitions, especially at points of inpatient discharge and leave, which are recognised as higher-risk periods.

The plan places strong emphasis on staff wellbeing and postvention, recognising the impact of suicide on staff and the importance of timely, compassionate support and learning. Clear procedures are in place for family liaison, learning following deaths, and ongoing audit and review.

Progress against the Plan is monitored through quality governance arrangements, including incident review, audit, training compliance and partnership reporting. The Plan is a live document, reviewed regularly to ensure responsiveness to emerging risks, population need and national guidance.

Safeguarding and Sexual Safety

KEY ACHIEVEMENTS

Maintained high safeguarding assurance with strong external validation, robust training compliance and a clear Trust-wide programme to improve sexual safety and professional boundaries

Safeguarding remains a core priority for Derbyshire Healthcare NHS Foundation Trust, with statutory responsibilities for children, young people and adults at risk embedded across all services through a *Think Family* approach. The Trust maintains strong multi-agency partnerships with local safeguarding boards and consistently meets its public protection duties through effective governance, assurance reporting,

and system-wide engagement. Safeguarding Children and Adults Operational Groups provide oversight and escalate risks through the Quality and Safeguarding Committee to the Trust Board, supported by regular performance dashboards and a bi-monthly safeguarding information report that ensures learning, legislation, and guidance are disseminated across the organisation.



Performance data for 2025/26 demonstrates sustained safeguarding activity across children's and adults' services, including high volumes of advice calls, strategy discussions, Multi-Agency Risk Assessment Conference (MARAC) involvement, and multi-agency risk management activity. Domestic abuse and neglect continue to feature prominently as safeguarding themes, reflecting both system pressures and improved professional confidence in identifying and responding to risk. Safeguarding supervision remains stable and accessible through a flexible delivery

model, supporting timely advice and consistent practice across inpatient and community services.

The Trust continues to provide assurance through strong compliance with safeguarding training requirements, with safeguarding children and adults training levels consistently above 90%. External assurance has been positive, including full or near-full compliance with Section 11 safeguarding arrangements and the highest level of assurance achieved through the Safeguarding Adults Assurance Framework (SAAF), providing confidence in the Trust's safeguarding leadership, governance, and workforce capability.



Sexual safety is a Trust quality priority, with visible and ongoing improvement work to strengthen professional boundaries and promote a zero-tolerance culture. A Sexual Safety Working Group has been established to deliver a data-led action plan aligned to the NHS England Sexual Safety Framework and the Sexual Safety in Healthcare Charter. Sexual safety incidents within inpatient services are monitored through the safeguarding adults dashboard, enabling oversight of

trends and targeted learning. Sexual safety training is being delivered across the organisation, with positive feedback, and the programme is supported by strong executive leadership and reporting through People and Culture, Quality and Safeguarding Committee, and Trust governance structures.

Collectively, these arrangements provide assurance that the Trust continues to meet its safeguarding and public protection responsibilities, actively addresses sexual

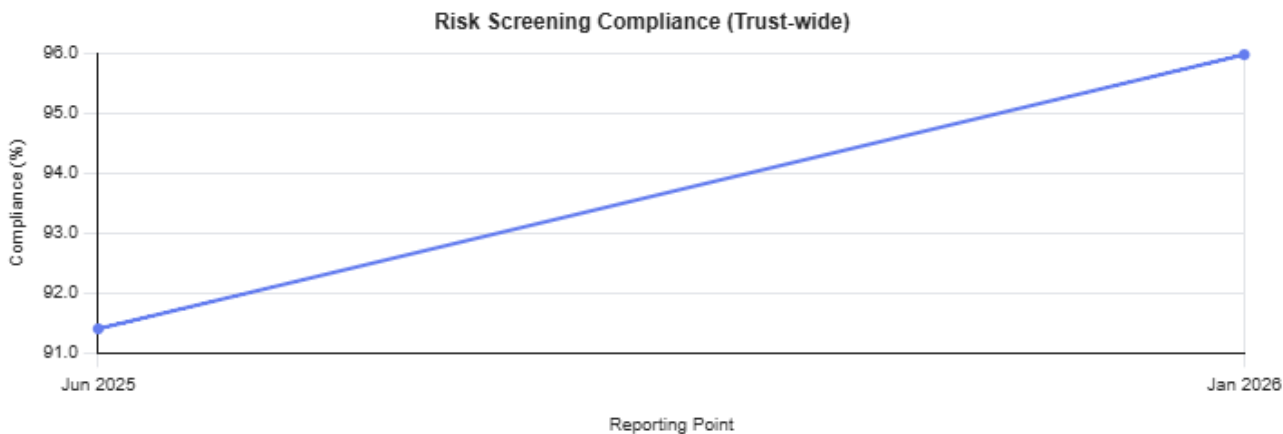
safety risks, and uses data, learning from reviews, and workforce development to drive continuous improvement and safe, person-centred care.

Reducing Restrictive Practices

KEY ACHIEVEMENTS

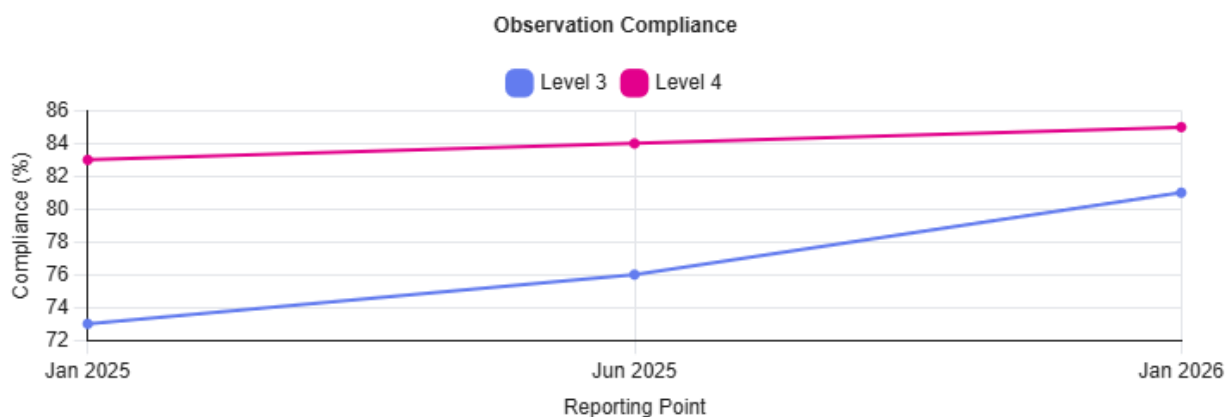
Risk screening compliance has improved, and strengthened governance to support least-restrictive, trauma-informed care

Over the past year, the Trust has made steady and demonstrable progress in reducing restrictive practices, supported by strengthened governance, updated policies aligned with national guidance, and a continued focus on trauma-informed, autism-informed and anti-racist care. Risk screening compliance has significantly improved, exceeding the Trust target and providing stronger assurance that risks are identified and managed early, supporting least-restrictive approaches to care.



Absconson rates have remained consistently low, supported by the controlled-access model, which has been positively recognised through the Right Care Right Person programme.

Observation practice has continued to improve, with measurable increases in compliance for higher-level observations, supported by a Trust-wide quality improvement programme addressing digital, training and operational barriers. At the same time, the Trust has maintained strong audit and post-incident review processes to ensure learning from restrictive interventions is embedded into practice.



Areas requiring continued focus remain, particularly training compliance for Positive and Safe Breakaway modules, digital challenges affecting observation reliability, and an increase in prone restraint, which has been linked to higher levels of acuity and use of rapid tranquilisation. In response, the Trust has strengthened reporting arrangements from early 2026 to better distinguish prone-only restraint and has set a clear ambition to eliminate prone-only restraint, supported by targeted quality improvement and enhanced governance oversight.

Overall, the Trust continues to demonstrate a positive trajectory towards safer, more consistent and least-restrictive care, with clear actions in place to address remaining risks and sustain improvement.

Tackling Violence, Abuse and Aggression Towards Staff

KEY ACHIEVEMENTS

Established a Trust-wide Violence, Abuse and Aggression Prevention Collaborative, translating staff lived experience into clear, governed improvement actions across safety, sexual safety, anti-racism and partnerships

Violence, Abuse & Aggression Action Group *in summary*



Organisational data relating to incidents of **violence, aggression and racism** shows that these experiences continue to affect staff across a range of settings, roles and services

Not all incidents of violence or aggression can be viewed in the same way, and that a **compassionate, trauma-informed** and proportionate approach is essential.



Session	Lead	Time
Welcome	Mark Powell	09:30 - 09:40
Introduction to the day	Joe Thompson	09:40 - 10:20
Brainstorming Conversation	Joe Thompson & Lucy Moorcroft	10:20 - 11:20
Break		11:20 - 11:35
Campaign Ideas and Design	Joe Thompson & Lucy Moorcroft	11:35 - 12:35
Lunch		12:35 - 13:20
Supporting and managing patients	Joe Thompson & Girish?	13:20 - 14:00
Review & Summary	Joe Thompson & Lucy Moorcroft	14:00 - 15:00



The Action Group will bring together staff from across the organisation to collaboratively address incidents using a **co-production** approach.

The group will draw on staff experience, organisational data and practical insight to develop actions that are **realistic, proportionate and appropriate** to mental health services.



Session 1

By the end of the programme, the action group will have produced a clear, **co-produced set of outcomes**, including actions, longer-term recommendations, and defined next steps



The group will operate as a **time-limited programme**, consisting of four facilitated, action-focused sessions, delivered through a mix of in-person and online meetings.

The Trust has established a Violence, Abuse and Aggression Prevention Collaborative to address the ongoing impact of violence, verbal abuse, racist behaviour and other forms of unacceptable behaviour directed towards staff. This programme recognises that these issues are systemic rather than isolated, and require a coordinated, organisation-wide response grounded in staff experience and supported by clear leadership accountability.

The collaborative adopts a co-production and organisational development approach, bringing together colleagues from across clinical, operational and corporate services to share lived experience, identify root causes and jointly design practical solutions. Early sessions focused on creating psychologically safe spaces for staff to speak openly, highlighting themes including inconsistency in responses, normalisation of abuse, variable post-incident support, and a lack of clarity around expectations, escalation and consequences.

Building on this insight, the Trust has moved deliberately from listening to action. The programme is structured to **translate staff feedback into tangible organisational improvements**, supported by clear ownership and governance. Action planning is organised around four interconnected pillars:

- **Physical violence** – improving prevention, response and consistency, including post-incident support.
- **Sexual safety** – strengthening implementation of the Sexual Safety Charter and support pathways.
- **Anti-racism** – embedding the Trust's Anti-Racism Statement into everyday practice, with clear responses to racist abuse.
- **Police and system partnerships** – improving consistency, escalation and joint working with external agencies.

Across all pillars, there is a strong and explicit focus on:

- **Prevention and clear boundaries**, including consistent expectations of behaviour.
- **Simpler and more meaningful reporting**, linked to learning and visible action.
- **Proactive, trauma-informed post-incident support**, including meaningful debriefing, protected time and leadership validation.
- **Visible leadership ownership and accountability**, ensuring staff confidence that concerns are taken seriously and acted upon.

The outputs of the collaborative are being consolidated into a Trust-wide improvement plan, with identified owners, defined actions and agreed governance arrangements to monitor delivery and impact. This approach reflects the Trust's commitment to moving beyond policy statements and campaigns alone, towards consistent, practical action that improves staff safety, wellbeing and experience.

Section C: Patient and Carer Experience

Patient Experience

KEY ACHIEVEMENTS

Strengthened organisational focus on experience by aligning Patient Experience, Carer and Lived Experience teams, progressing co-production, peer support and expanding the use of patient surveys and feedback mechanisms

Work continues on our Patient and Carer Experience pledges which is being reviewed in April 2026; it was published in April 2024 so this is the halfway mark. We are reviewing our four key areas within the Plan, reflecting on the work achieved so far and reviewing our goals for the next year:

- Improve communication
- Improve patient experience from referral to discharge
- Increase co-production
- Increase carer involvement

Progress has been made in respect, and the patient survey is being rolled out

In April 2025, the Patient Experience Team joined with the Trust Carer Leads, Volunteers Lead and Peer Support Worker Lead, and the team are managed by the Chief AHP and Deputy Director of Patient, Carer and Lived Experience. The team sits within the Nursing and Quality Directorate bringing together all the Corporate teams supporting the patient and carer experience and ensures that we have an overarching approach to improving the experience for people who use our services. All the teams support the monthly Trust Induction for new starters.

Peer support

Peer support in mental health refers to a model of care where individuals with lived experience of mental health challenges provide support to others who are currently using services. This approach is built on shared understanding, mutual respect, and the belief that recovery is possible. Peer support workers use their personal

experiences to offer empathy, reduce stigma, and help individuals feel less isolated, while also supporting them to develop coping strategies and navigate services.

At Derbyshire Healthcare NHS Foundation Trust, peer support was formally established in 2021 and has grown to become an integral part of community mental health services. The role has expanded significantly and is now embedded across a range of specialist areas, including Perinatal services, Individual Placement and Support (IPS), Eating Disorder services, and Child and Adolescent Mental Health Services (CAMHS).

More recently, the *Making Room for Dignity* transformation programme has further strengthened this approach by creating five new peer support roles within inpatient services. This development has expanded the Trust's unique peer support offer, ensuring that individuals receiving care in inpatient settings can also benefit from lived experience support alongside clinical care.

The inclusion of peer support within our services reflects a broader shift toward recovery-focussed and person-centred care. Peer support workers contribute to improved engagement, increased hope, and more collaborative relationships between service users and professionals. As a result, peer support is now recognised as a key component in enhancing the quality and effectiveness of community mental health provision within Derbyshire Healthcare.

DHCFT Peer support team pictured with Trust CEO



Compliments, Complaints and Concerns

KEY ACHIEVEMENTS

Improved responsiveness and transparency in complaints handling, reduced overall contacts compared with the previous year, and increased use of learning to drive service improvement

In the first instance, we ask people to raise any concerns or queries they may have with the clinical team involved in their care, as staff can respond swiftly to resolve any issues that arise. If this is not possible, the Trust’s Patient Experience Team is the central point of contact for people to provide feedback and raise concerns about the services provided by the Trust. The team’s aim is to provide appropriate responses to concerns or queries raised through Quick Resolution complaints with responses from the local team when appropriate, or through a thorough Closer Look investigation when required. Closer Look complaints receive a comprehensive written response, including being informed of any actions taken.

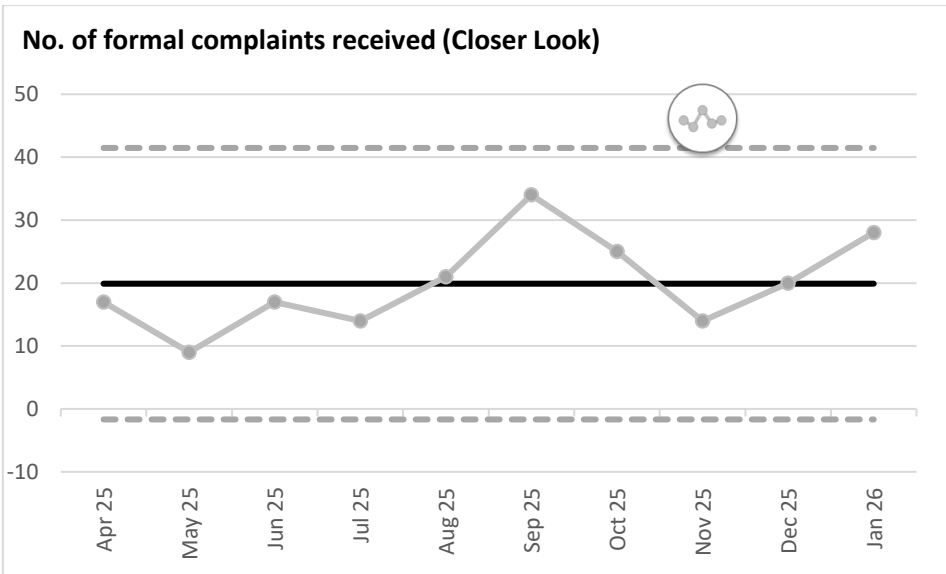
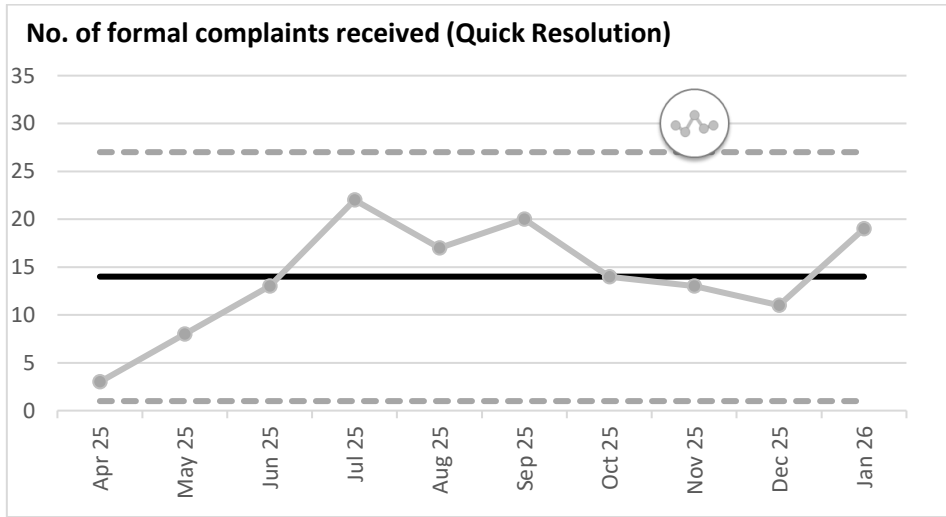
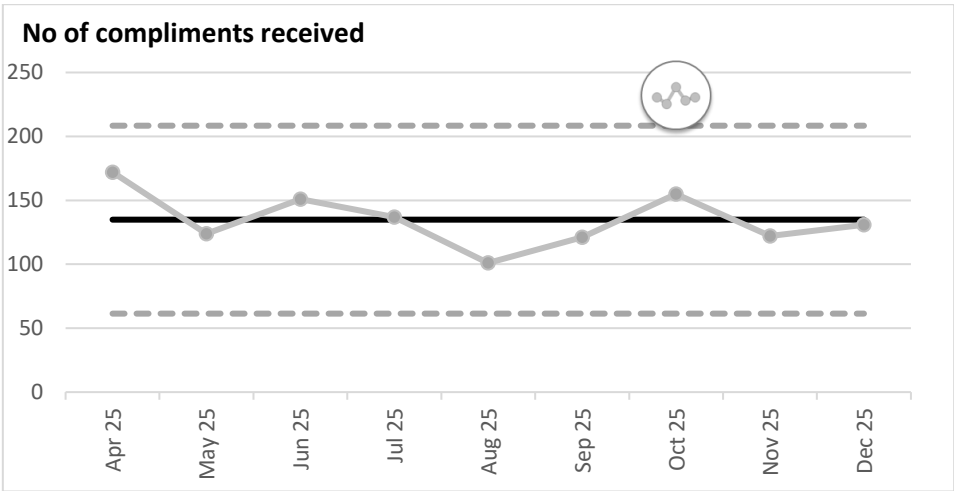
The Patient Experience Team are working with our Transformation team and with Senior Managers to reduce the length of time investigations are taking and for reports waiting to be drafted. Changes have been made to our processes, and we now aim to respond to all Closer Look complaints within 90 working days. Our progress is monitored and reported on, in quarterly reports to the Patient and Carer Operational Group and Quality and Safeguarding Committee. We also aim to reduce the number of Quick Resolution complaints taking longer than 10 working days to complete.

We provide real-time data on our Trust website on the numbers of complaints, concerns, compliments, and Friends and Family Test responses.

Comparison of Contacts Through the Year

	2024/25	2025/26*
Complaint	430	339
Quick Resolution (Yellow)	241	140
Closer Look (Orange)	163	169
Closer Look (Red)	26	30
Compliment	1791	1346
Concern	86	72
Enquiry	1697	1570
Total	4004	3327

*data up to 31/01/2026.



Comparison of Concerns, Complaints and Compliments by Top Issues Raised

Top 3 issues raised in Concerns		Top 3 issues raised in Complaints	
2024/25	38	2024/25	342
Unprofessionalism by staff	10	Care planning	183
Availability of Services / Activities / Therapies	7	Unprofessionalism by staff	86
Appointments (e.g. delays and cancellations)	7	Availability of Services / Activities / Therapies	73
		2025/26	338
2025/26	33	Care planning	173
Other	15	Engagement	87
Unprofessionalism by staff	12	Unprofessionalism by staff	78
Breach of confidentiality	6	Total	680
Total	71		

* From 1 April 2024, concerns are only logged directly by staff.

Compliments

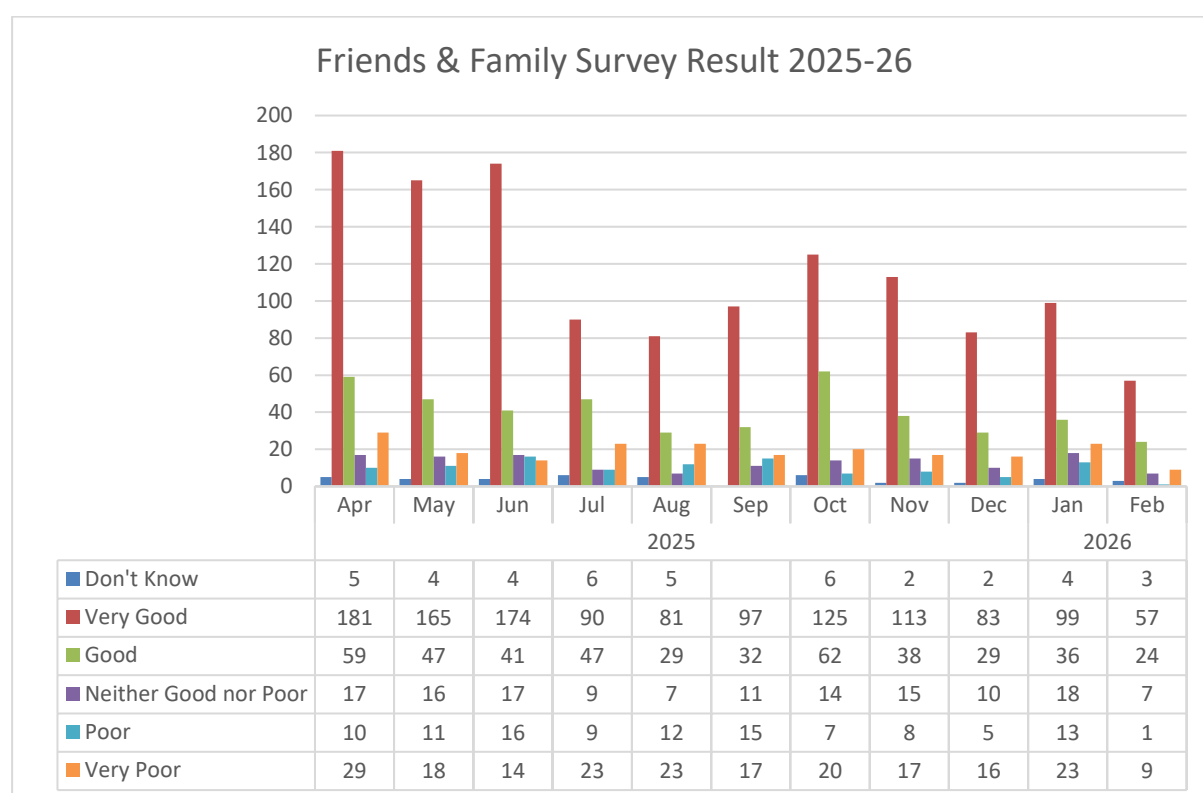
Most of the 1346* compliments received during 2025/26 reflected people's general gratitude for the care, support and help that staff had provided. Individual subjects commented on are noted in the list below.

	2024/25	2025/26*
Care	1065	847
Compassion	862	712
Empathy	619	520
Environment	221	200
Facilities	175	166
General gratitude	1380	1030
Information/Advice	712	486
Kindness	900	703
Listening	826	618
Responsiveness	685	528
Support/Help	1269	944
Other - see description	57	34

* figures from 31/1/2026 they will need to be adjusted

Friends and Family Test

The Friends and Family Test asks, 'Thinking about the service we provide; overall, how was the service user's experience with our service'? It offers a range of responses to choose from, and when combined with supplementary follow-up questions, provides an indicator of good and poor patient experience. The results of the Friends and Family Test are published each month by NHS England. To increase our feedback, we have incorporated the Friends and Family Question into our Electronic Patient Surveys that are asked at regular intervals after appointments. Most people reported that their care was good or very good.



Section D: Improving Access, Flow and Urgent Care

Mental Health Helpline

KEY ACHIEVEMENTS

Delivery of a high-demand service with technical improvements to support access, alongside preparation for transition to NHS 111 as a single point of access

The Mental Health Helpline continues to be well utilised, with sustained growth in demand since the inception of the service. Whilst it is acknowledged that there are challenges to improving the handled call rate, the service is committed to working through these improvements to improve patient care and experience. Over recent months there has been improvement to the telephone systems to improve historical technical difficulties. The national directive to close the 0800 line and move to one single point of access via NHS 111 is being worked through which will result in less variance around access making access more straightforward.

Mental Health Urgent Assessment Centre

KEY ACHIEVEMENTS

Development of the Mental Health Urgent Assessment Centre model to provide timely, therapeutic crisis assessment, reduce pressure on emergency departments and improve urgent care pathways

The Mental Health Urgent Assessment Centre (MHUAC) is a specialist facility designed to provide immediate, calm and safe assessment and support for adults experiencing a self-defined mental health crisis. The service aims to reduce pressure on the acute emergency department by offering timely access to skilled mental health clinicians in a more appropriate therapeutic environment.

The MHUAC will be delivered from the medical annex of the Radbourne Unit, which will be refurbished to provide four assessment rooms, a clinical room, offices and a reception area. The Crisis Resolution and Home Treatment Team will be based at the Radbourne Unit, with the Mental Health Helpline team located on the ground floor of the medical annex.

Benefits

- **For patients**, the MHUAC will provide timely access to mental health assessment and interventions, a therapeutic and low-stimulus environment, private and confidential assessment spaces, faster assessment (within four hours) and an improved overall experience for adults aged 18 and over.
- **For staff**, the model supports more streamlined and rapid assessment processes and closer working between urgent assessment services, bringing teams together within a single centre.
- **For carers**, the centre will offer appropriate space for family members, friends or carers to wait with the person being supported, alongside improved privacy, dignity and outcomes.
- **For the Derbyshire system**, the MHUAC will provide essential support for people in mental health crisis while reducing demand on traditional emergency departments. The service will support joined-up urgent and emergency care pathways, enable data-informed planning and investment, strengthen partnership working, and ensure clear accountability through identified clinical leadership.

The first phase of the MHUAC is due to launch in July 2026 as a 24/7 service. Initial referrals will be limited to liaison from the Royal Derby Hospital Emergency Department to manage demand and allow activity and outcomes to be monitored. Referral routes are expected to expand to include crisis and mental health helpline teams following initial implementation

Patient Flow and Reducing Inappropriate Out-of-Area Placements

The Trust has established a comprehensive Patient Flow Programme to improve end-to-end mental health care pathways across inflow, flow and outflow, ensuring that people who require acute inpatient mental health care receive timely access to appropriate services as close to home as possible. The programme is designed to improve quality, safety and experience while reducing avoidable delays and system pressures across the pathway.

The programme is aligned to national mental health priorities and is underpinned by a clear set of national value and tracking indicators, including average length of stay, delayed discharges, bed occupancy, inappropriate out-of-area placements, timely follow-up after discharge and long length of stay for adult and older adult inpatients. These measures are used to track progress and inform improvement activity across community, crisis and inpatient services

Delivery is overseen through established Trust governance arrangements, with executive leadership, senior clinical oversight and dedicated programme leadership. Improvement activity is structured through inflow (community and crisis), flow and

outflow (inpatient) workstreams, supported by transformation, improvement and performance expertise to ensure sustained change and system-wide impact.

A key feature of the programme is the application of continuous improvement methodology, including structured 30/60/90-day rapid improvement cycles. This approach enables the Trust to test, evaluate and embed interventions at pace, with progress reviewed weekly through operational flow escalation processes and learning applied iteratively to strengthen delivery.

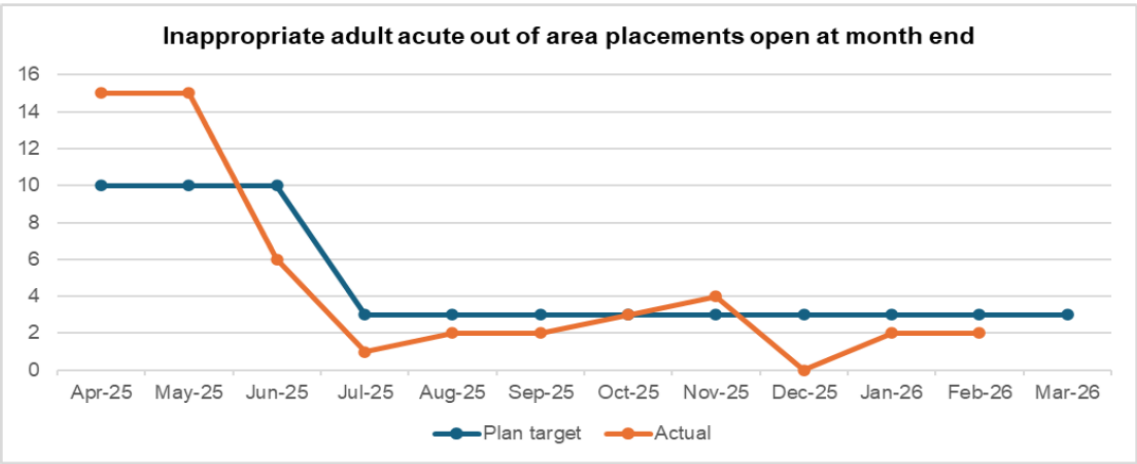
The improvement cycle plan has been aligned to delivery of the ten high-impact actions for mental health discharges with key interventions such as the 72hr review and rapid review process (Red2Green) supporting achievement across multiple high impact actions. The mapping of actions is demonstrated below:

High Impact Action	Mapping to Improvement Cycle Plan
1. Identify the purpose of the admission, set an expected date of discharge (EDD) for when this purpose will be achieved, and communicate this with the person, family/carers and any teams involved in the person's care post-discharge, e.g. CMHT/CRHTT	Action 4. Purposeful admission and 72hr review
2. Complete care formulation and care planning at the earliest opportunity with the person, and within a maximum of 72 hrs	Action 4. Purposeful admission and 72hr review
3. Identify any potential barriers to discharge early on in admission and take action to address these. Where appropriate action cannot be taken, escalate this to the ICB Discharge Lead.	Action 4. Purposeful admission and 72hr review
4. Conduct daily reviews, such as the 'Red to Green' approach, to ensure each day is adding therapeutic benefit for the person and is in line with the purpose of admission.	Action 5. Rapid review (Red2Green) evaluation
5. Hold Multi Agency Discharge Events (MADE) with key partners on a regular basis, to review complex cases	Action 7. MaDE
6. Ensure partnership working and early engagement with the person, family/carers and teams involved in the person's post-discharge support; agree a joint action plan with key responsibilities, for example for social care, housing, PC, CMHT etc.	Action 4. Purposeful admission and 72hr review
7. Apply 7-day working to enable people who are clinically ready for discharge to be discharged over weekends and bank holidays, and allow people who require admission timely access to local beds.	Action 4. Purposeful admission and 72hr review Action 5. Rapid review (Red2Green) evaluation
8. Identify common reasons and solutions to people being delayed in hospital, e.g. housing support/accommodation. Start by reviewing: a) Those who are clinically ready for discharge but occupying beds and b) Adults and older adults with a long length of stay (over 60/90 days for adult/older adult admissions).	Action 7. MaDE
9. Communicate notice of discharge at least 48 hours prior to the person being discharged, to the person, their family/carers and any ongoing support services.	Action 4. Purposeful admission and 72hr review Action 5. Rapid review (Red2Green) evaluation
10. Follow up to be carried out with the person by the CMHT or CRHTT at the earliest opportunity and within a maximum of 72 hrs of discharge, to ensure the right discharge support is in place.	In place

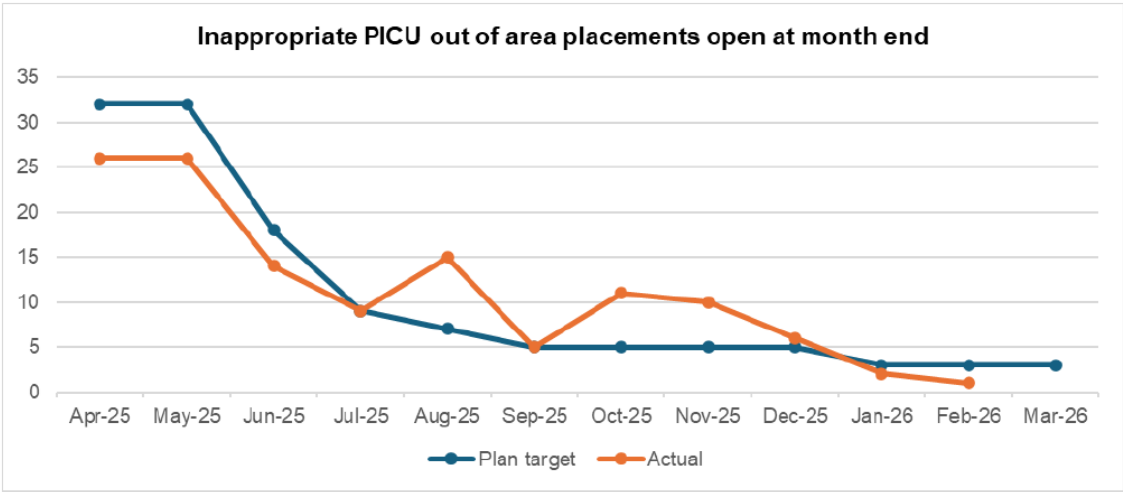
Priority interventions include strengthening purposeful admissions and 72-hour reviews, improving the consistency and effectiveness of daily clinical reviews, enhancing multi-agency discharge events (MADE), and improving the identification and management of people who are clinically ready for discharge. The programme is explicitly aligned to the ten national high-impact actions for mental health discharges, supporting improved flow, reduced length of stay and safer, more timely discharge.

The programme takes a data-driven approach, using detailed analysis of length of stay, delayed discharges, ward-level variation and system demand to inform improvement hypotheses and track impact. Early evidence demonstrates a reduction in inappropriate out-of-area placements, with continued focus on securing sustainable improvement through ongoing measurement and learning.

The inappropriate out of area position achieved at the 28 February 2026 month end was 2, below the Operational Plan trajectory of 3.



The inappropriate out of area position on 28 February 2026 was 0, with 1 appropriate male OOA patient and 2 female continuity of care placements, below the revised plan trajectory.



AVERAGE LENGTH OF STAY TO DISCHARGE													
Average of Length of Stay (Days)													
Month J													
2025													
Bed type	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Older adult	120	86	105	67	90	141	95	80	87	100	97	81	
Adult acute and PICU	49	47	60	54	41	58	54	53	60	58	50	35	
Grand Total	64	54	71	57	49	70	62	59	65	65	59	43	

AVERAGE LENGTH OF STAY IF DISCHARGED WHEN CLINICALLY READY													
Average length of stay to discharge rea Month J													
2025													
Bed type	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Older adult	84	50	70	45	56	106	61	73	61	58	64	63	
Adult acute and PICU	46	45	52	49	40	55	49	48	55	54	49	35	
Grand Total	54	45	56	48	43	62	51	54	56	54	52	39	

Table 1: Current LoS

Analysed by Older Adult; Adult acute and PICU; and overall LoS (Grand total)

Table 2: LoS if zero CRfD delays

Analysed by Older Adult; Adult acute and PICU; and overall LoS (Grand total)

Alongside rapid improvement activity, the Trust is developing a longer-term transformation plan for patient flow, informed by external reviews and national improvement support. This includes work to redesign community and crisis pathways, strengthen neighbourhood-based models of care and ensure services are aligned to future system and population needs, supporting the delivery of the Trust's strategic objectives for quality, access and equity.

2026-27
Review ambitions and quality measures based on year 2 Quality Delivery Plan Monitor performance and implement action plans to address any identified improvement
Evaluate and refine measures across all services for year 2 Develop and establish a framework for feedback across all services Monitor feedback and implement action plans as required aligned to transformation and continuous improvement portfolio Implement framework for empowerment and evaluate progress Embed consistent and proactive approach to engagement through to co-production
Self assess quality governance systems, re-evaluate ambitions and implement update or refinement as appropriate Deliver transition from Care Programme Approach to agreed model support safe community practice
Deliver year 2 of Clinical Services Delivery Plan with a focus on improving experience and reducing racial inequalities aligned to PCREF Implement framework for disproportionate allocation of resources Evaluate access across services, define improvement ambitions and deliver year 2 plan

Section E: Digital, Research and Enablers of Quality

Digital Transformation and Quality Improvement

KEY ACHIEVEMENTS

Advanced digital maturity through a single electronic patient record, e-prescribing and business intelligence improvements, positioning digital as a core enabler of quality and safety

Derbyshire Healthcare NHS Foundation Trust recognises that digital transformation is a key enabler of high-quality, safe and person-centred mental health care. The Trust's Digital Delivery Plan (2026–2028) sets out how digital investment and innovation will support improvements in patient safety, clinical effectiveness, experience of care and staff productivity, while addressing health inequalities and supporting system integration.

Digital transformation is positioned as a quality improvement programme, aligned to the Trust's strategic priorities, Quality Delivery Plan and the ambitions of Joined Up Care Derbyshire. The focus is on maximising the benefits of existing digital systems while accelerating improvements that directly impact patient care.

Progress to Date

Over recent years, the Trust has made significant progress in its digital journey. This includes the implementation of a single Electronic Patient Record, electronic prescribing, expanded use of digital consultations, and improved access to self-help and digital support tools. These developments have strengthened information sharing, reduced duplication, and improved continuity and safety of care across services.

More recent progress includes the development of enhanced business intelligence capability, improved integration with partner organisations, and pilots of emerging technologies designed to reduce administrative burden and support clinical decision-making. Collectively, these improvements provide a strong foundation for further quality improvement.

How Digital Transformation Improves Quality

The Trust's digital vision is aligned to the mental health care pathway, from prevention and early identification through to discharge and ongoing support. Digital developments are being used to:

- Improve access and timeliness of care, including triage and assessment
- Support joined-up assessment and care planning, reducing repetition for patients
- Strengthen transitions and discharge planning, improving safety and continuity
- Increase patient and carer involvement, including access to information and two-way communication
- Support self-management and prevention, particularly for people with long-term mental health needs

This approach supports a digital-first mindset, while ensuring that inclusion, safety and personalised care remain central to service delivery.

Engagement and Co-production

The Trust is committed to involving staff and patients in shaping digital priorities. A Trust-wide Digital Futures engagement event brought together colleagues from across services to explore how digital solutions could improve safety, responsiveness and patient experience along a fictional patient journey. The insights gained have directly informed the priorities within the Digital Delivery Plan and support cultural readiness for change.



Digital Priorities and Quality Impact

The Digital Delivery Plan is structured around four strategic ambitions, each with a clear quality impact:

- **Empowering patients digitally** – improving access to information, supporting involvement in care and helping to address health inequalities
- **Equipping and supporting staff** – improving safety through better information at the point of care and reducing administrative burden
- **Building a connected digital ecosystem** – strengthening partnership working and safer transitions across health and social care
- **Streamlining processes** – freeing up staff time to focus on direct patient care

Key areas of focus include optimisation of the Electronic Patient Record, expansion of patient portals, improved digital triage, and targeted work towards paper-light services.

Governance and Assurance

Delivery of the Digital Delivery Plan is overseen through established Trust governance arrangements, with Board-level oversight. Progress, benefits and risks are monitored through a defined programme management and benefits realisation

framework, ensuring that digital initiatives are assessed on their impact on quality and outcomes, not solely technical delivery.

Regular reporting provides assurance that digital risks are identified and managed, and that investment continues to support safe, effective and high-quality care.

Measuring Success

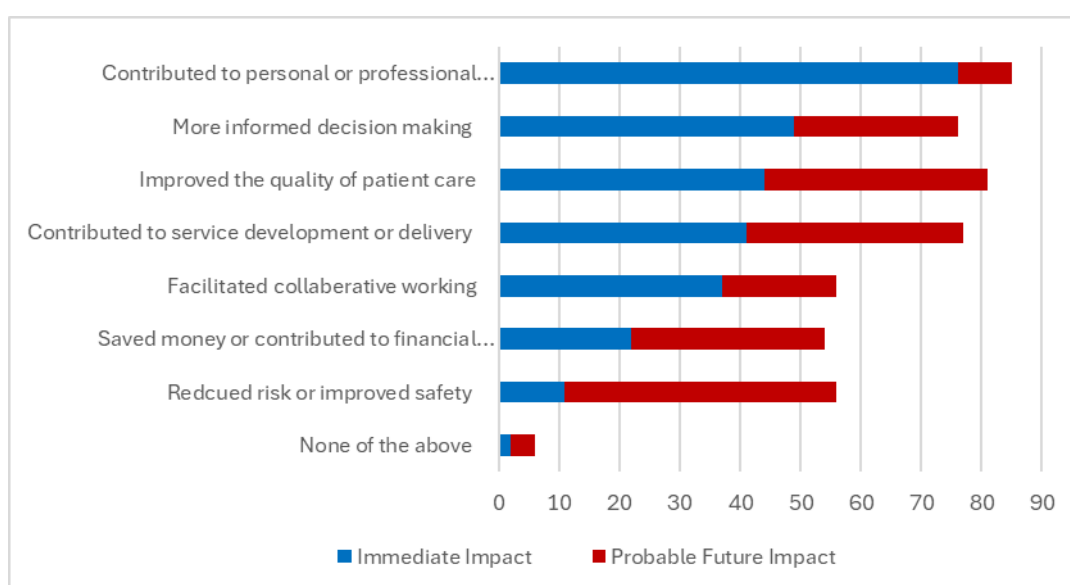
Success will be measured through improvements in digital maturity, adoption and optimisation of digital systems, and alignment with national standards such as the What Good Looks Like framework. These measures will support ongoing monitoring of quality impact over the life of the plan.

Expected Impact on Quality

By 2028, delivery of the Digital Delivery Plan is expected to contribute to:

- Safer, more coordinated care with improved information sharing
- Increased patient access to information and involvement in care
- Improved staff experience, efficiency and capacity
- Stronger partnership working across the health and care system

These outcomes directly support the Trust's Quality Account priorities and its commitment to continuously improving patient safety, effectiveness and experience of care.



Contactless Patient Monitoring

KEY ACHIEVEMENTS

Implemented contactless patient monitoring across inpatient settings using a clinically governed model, strengthening, safety and night-time care

As part of the Trust's ongoing commitment to improving patient safety and the quality of inpatient care, contactless patient monitoring has been implemented across 72 rooms across adult inpatient wards, the Psychiatric Intensive Care Unit (PICU), and the Health-Based Place of Safety (HBPoS), with deployment tailored to the clinical purpose and physical layout of each area.



The installation followed a structured five-stage implementation model designed to ensure safe, effective and clinically governed adoption. This included pre-installation engagement and site surveys; Trust-led preparatory works such as cabling, secure housing installation and standard operating procedure (SOP) development; installation and commissioning of contactless patient monitoring hardware and IT infrastructure

by the supplier; a period of blind running to configure and optimise system performance in live clinical environments; and a supported launch with staff training and operational sign-off.

All contactless patient monitoring-enabled rooms are fitted with secure, tamper-resistant housing units containing a camera and infrared illuminators, designed to meet recognised safety and durability standards. User interfaces, including fixed touchscreens and portable devices, have been installed to support staff access while maintaining clinical workflow efficiency. The supporting IT infrastructure has been implemented within Trust environments, with defined requirements for power, cooling, network connectivity and cyber security to ensure system reliability and resilience.

Detailed site surveys and room layout assessments were undertaken prior to installation to identify any environmental factors that could affect system performance. Where potential limitations were identified, these were addressed through configuration, blind-running optimisation, or agreed mitigations, ensuring that the system operates safely and as intended within each clinical area.

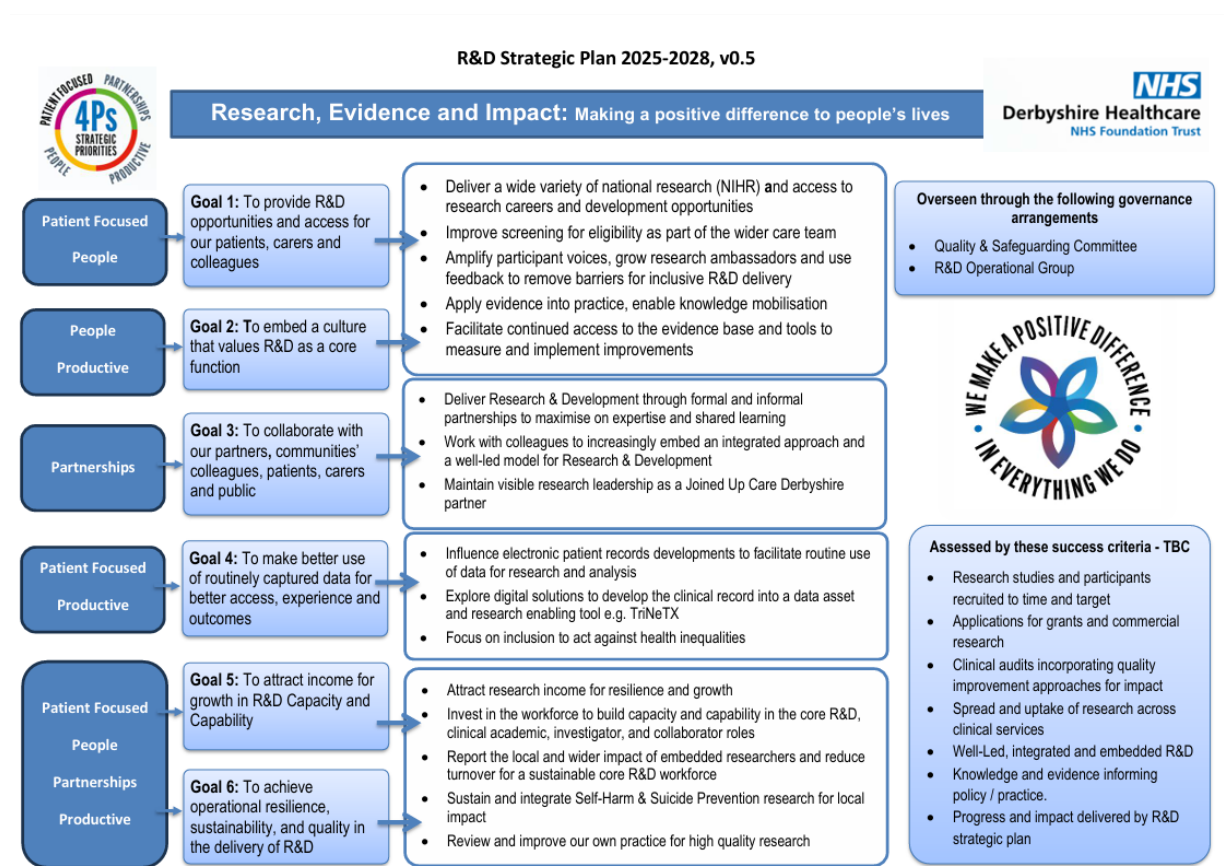
Overall, the contactless patient monitoring installation journey has been delivered through a clearly defined, clinically informed and assurance-led process, supporting the Trust's wider quality priorities around patient safety, observation, and the use of digital technology to enhance care delivery in inpatient mental health and specialist settings. Contactless monitoring is used as a safety adjunct within a clinically governed framework and does not replace therapeutic observation or staff-patient interaction.

To ensure the trust are using the contact list patient monitoring correctly alerts on how often staff have used the system are received weekly, recorded clear video can only be viewed by authorised staff if there is a safety incident and must be requested within 24 hours with the patient having the right to be informed if this happens. The video footage is only kept for 24 hours and then is automatically deleted and data is handled following NHS data handling protocols.

Research and development

KEY ACHIEVEMENTS

Delivered a strong research programme supporting over **35 National Institute for Health and Care Research Studies** and embedding research, audit and evaluation into service improvement, directly informing quality, safety and sustainability



Research and Development 2025/26

During 2025/26, the Trust delivered impactful research supporting service improvement, patient experience, and evidence-based practice. The Clinical Research Team facilitated over with more than **400 participants**, alongside extensive audit and evaluation efforts. Research aligned with organizational priorities and the Research & Development Strategic Plan 2025–2028.

*** Goal 1: Expand R&D access**

A range of accessible research opportunities was provided across multiple services, with studies like ANTLER 75+, COBALT, ADAPT, CONTACT-GAD, and Snacktivity enabling inclusive participation. Participant feedback informed ongoing improvements; ethnicity data was monitored to address under-representation.

*** Goal 2: Foster an R&D culture**

Research and audits were integrated into routine care, achieving 90% participation in eligible national audits and robust local audit alignment. Findings drove quality improvements, tracked through governance channels.

*** Goal 3: Strengthen collaboration**

The Trust collaborated with academic, clinical, and voluntary partners, involving patients and the public directly—especially in projects like the Multicentre Study of Self-harm—enhancing research relevance and governance.

*** Goal 4: Utilize routine data**

Embedded evaluators helped services use operational data for quality improvements, such as redesigns and effectiveness assurance. Examples included frequent-caller pathway evaluations and data-driven upgrades in several service areas.

*** Goal 5: Grow R&D capacity**

Evidence-based evaluation supported financial sustainability and secured funding, notably for the Alcohol Care Team, with outcomes shared nationally.

*** Goal 6: Ensure resilience and quality**

Strong governance continued for research and knowledge services; all criteria of the Knowledge and Library Services Quality Improvement Framework were met, reinforcing safe and effective care.

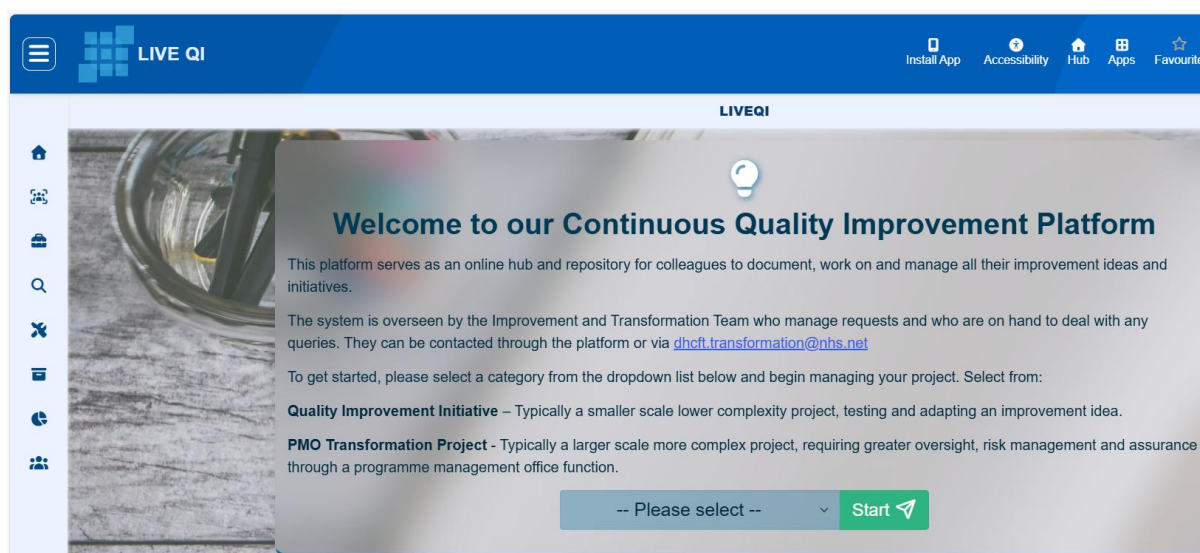
Overall Impact

Research and development activities in 2025/26 advanced patient experience, service quality, clinical effectiveness, and system sustainability, aligning with strategic goals and national priorities.

Continuous Quality Improvement

LiveQI has been in operation for the last year and is a workspace and repository for quality improvement projects. It has now also been further developed to incorporate larger transformation projects which typically were managed in the Derbyshire system ePMO. This additional functionality went live in January 2026 ahead of the 2026-27 transformation programme. There are plans to further develop the platform later in 2026 to accommodate strategic transformation reporting and research and audit management.

LiveQI currently holds 98 QI and transformation projects which all trust staff can access and view. There are inbuilt and downloadable and up loadable templates for progressing and supporting projects. There are analytical pages for evaluating data and there is ongoing work in relation to reporting functionality. The platform helps to quickly identify the stages of a project whether it be 'in progress', 'completed', 'stalled' or have become dormant. It also enables the improvement team to provide support and guidance to those colleagues that are looking to get involved in a QI project.



There are a number of QI projects currently live. These focus on improvement initiatives in:

- LIO Oxehealth Oxevision contactless+monitoring medical G2 device as enabler for patient care, safety and experience.
- Culture of Care: Staff care and development, Bluebell Older Adults 2026
- Culture of Care, Staff Care and Development, Kedleston Unit
- Culture of Care programme aimed at compassionate and inclusive care and improved patient and staff experience. Aligns with the national strategy of delivering and improving care and our new model of care.

- Children's physio bookable clinics
- Culture of Care Staff Care and Development Cubley Court 2025-26 Improve team working and promote outcomes for staff and Service users
- Occupational Therapy Referral Process
- CMHT Carer Involvement
- Are we following the MHRA guidelines for our patients on valproate
- QI predictability tool for risk and reduce harm in Substance Misuse population in DHCFT
- Experience Based Co-design of Psychosis Centred Integrated Care Services for Ethnically Diverse People with Multimorbidity (CoPICS)
- Transformation Model of Care: Purposeful admission, Trauma informed care and sensory interventions. DHCFT New Model of Care delivery, as part of the Making room for Dignity programme for existing staff and new recruits in acute inpatient mental health settings by March 2026
- Updates to Resident Doctors' Handbook
- On Call Monitoring
- Improving Patient and Staff Experience of Ward Rounds on The Beeches
- Diversion and Wellbeing Hub
- Enhancing Completion Rates of Occupational Therapy Assessments: An older adult community mental health team
- Induction for HST Doctors
- Improve collaborative working between inpatient wards and OT

Examples of work supported by the improvement team using a quality improvement model include:

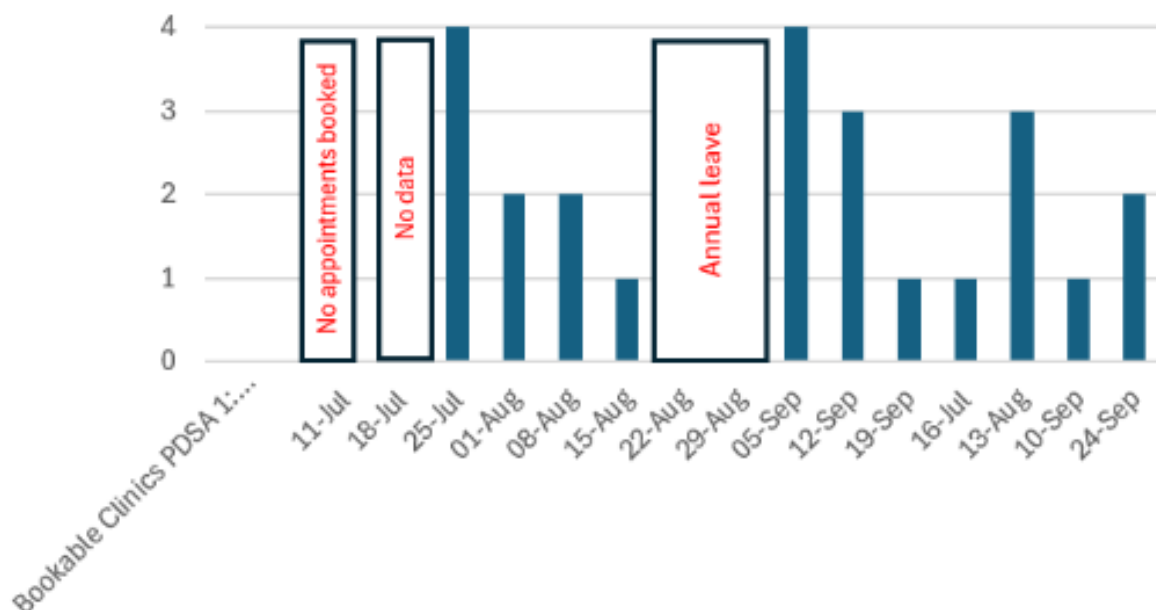
- During 2025, the Trust's Improvement Team supported a range of quality improvement (QI) initiatives focused on improving access, safety, experience and clinical effectiveness across services. These programmes demonstrate the use of structured QI methodologies, including driver diagrams and Plan–Do–Study–Act (PDSA) cycles, to address identified risks and opportunities and to deliver measurable improvement.

- In Paediatric Physiotherapy, a QI programme was implemented to address significant waiting times for children and families. The service undertook pathway redesign, capacity and demand modelling, and targeted testing of change ideas, including revised job planning, partnership working to deliver additional clinics for children with the longest waits, and the introduction of bookable clinics across multiple sites. Early PDSA testing showed reductions in the overall waiting list and provided learning to inform further scaling and refinement of the model, alongside continued focus on managing risk within the existing caseload and addressing workforce constraints

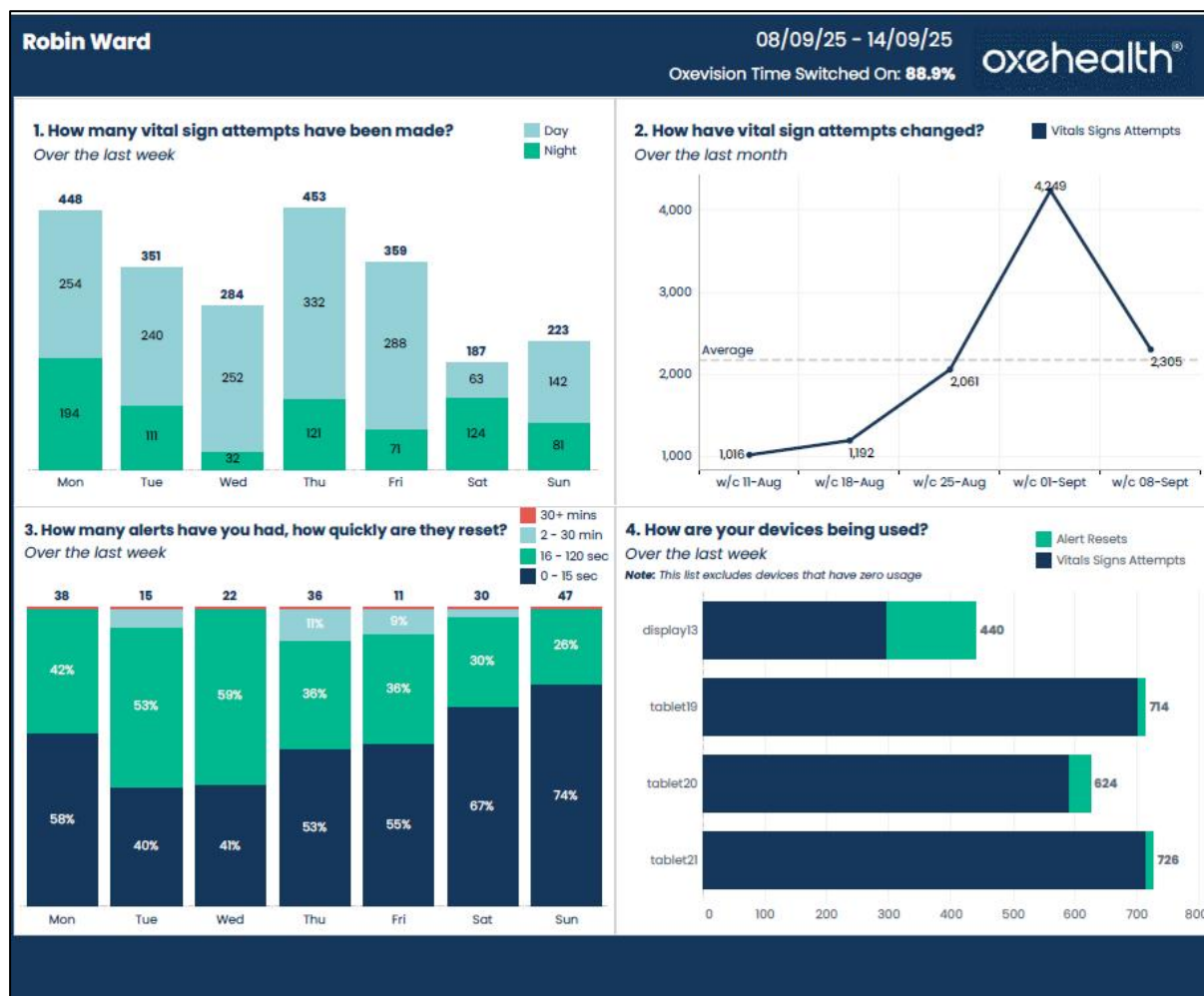
PDSA Worksheet

Team: Paediatric Physio	Date: 11/6/2025	PDSA Cycle No. 1
Specific Aim: <i>We aim to do what, by how much, by when.</i> PDSA 1 Aim: Establish processes, understand baseline clinic delivery metrics and DNA rate for bookable clinics in the Paediatric Physiotherapy team by end of September 2025 Project aim: All clinicians will have a minimum of 1 day per week that is a <u>rebookable</u> diary, with a minimum of 3 patient facing appointments, by end of September 2025, in order to support increased clinical capacity and productivity, and to reduce DNA rates by allowing a degree of choice around appointments.		

Bookable clinics PDSA 1: Ilkeston appointments completed



The Trust has also continued to invest in digital innovation to improve inpatient care through the implementation of the Contactless patient monitoring programme. This initiative supports safer care environments by improving physical health monitoring, reducing falls and self-harm risk, enhancing night observations, and enabling more data-informed clinical decision-making. Roll-out has been supported by extensive staff training, multi-disciplinary engagement, and regular use of activity and usage data to inform governance and clinical practice.



Collectively, these programmes demonstrate the Trust's commitment to using quality improvement approaches, partnership working and digital innovation to improve patient access, safety and experience, while embedding a culture of continuous improvement and data-informed care.

Pharmacy services

KEY ACHIEVEMENTS

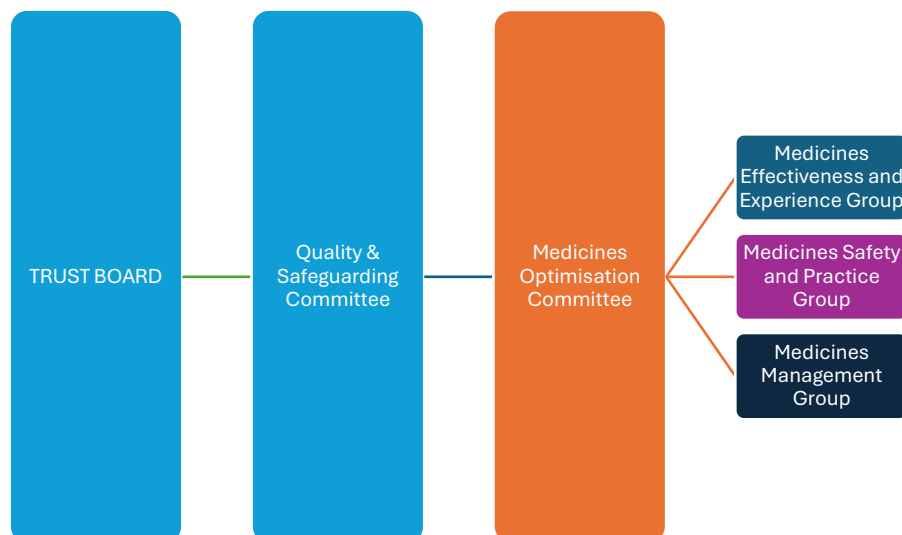
Strengthened medicines safety, clinical pharmacy capacity and financial governance, supporting safer prescribing, improved assurance and a more sustainable workforce

The Trust’s Pharmacy Team has continued to evolve in line with national changes to the pharmacy professions and workforce, guided by the Pharmacy Plan 2025–29. A strong focus has been maintained on medicines safety, workforce sustainability, and assurance through robust governance arrangements



Governance, Assurance and Oversight

A quarterly departmental assurance meeting is embedded to review key performance metrics, with agreed actions escalated as required. Highlights are shared with the Medical Director, providing senior clinical oversight. In addition, the Chief Pharmacist produces an annual report for the Quality and Safeguarding Committee, supplemented by escalation and assurance updates through the Medicines Optimisation Committee.



Clinical Pharmacy and Patient Care

Clinical Pharmacy services continue to support safe and effective medicines use for individual patients. Medicines reconciliation is completed for all inpatient admissions, and the team contributes to the NHS England Discharge Medicines Service. The specialist and advanced mental health pharmacist workforce has stabilised, strengthening support to Community Mental Health Teams. Three advanced mental health pharmacists are now prescribing in community settings, increasing patient choice and clinical capacity.



Medicines Safety and Risk Management

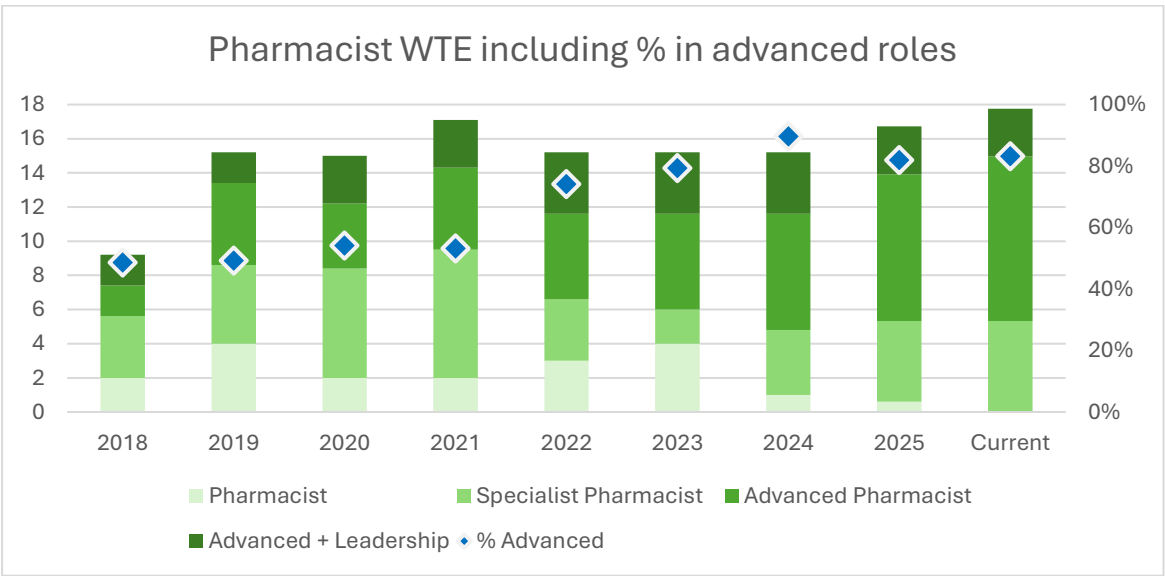
Medicines safety remains a core focus. The Trust is supported by a designated Medicines Safety Officer, who promotes medication incident reporting and learning through regular safety newsletters. The pharmacy team works collaboratively within the Trust, across the Integrated Care System, and with regional mental health providers to identify and address medicines-related risks. Robust arrangements are in place to manage national medicines recalls and supply shortages, including system-wide responses to significant disruption, such as shortages of long-acting antipsychotic injections.

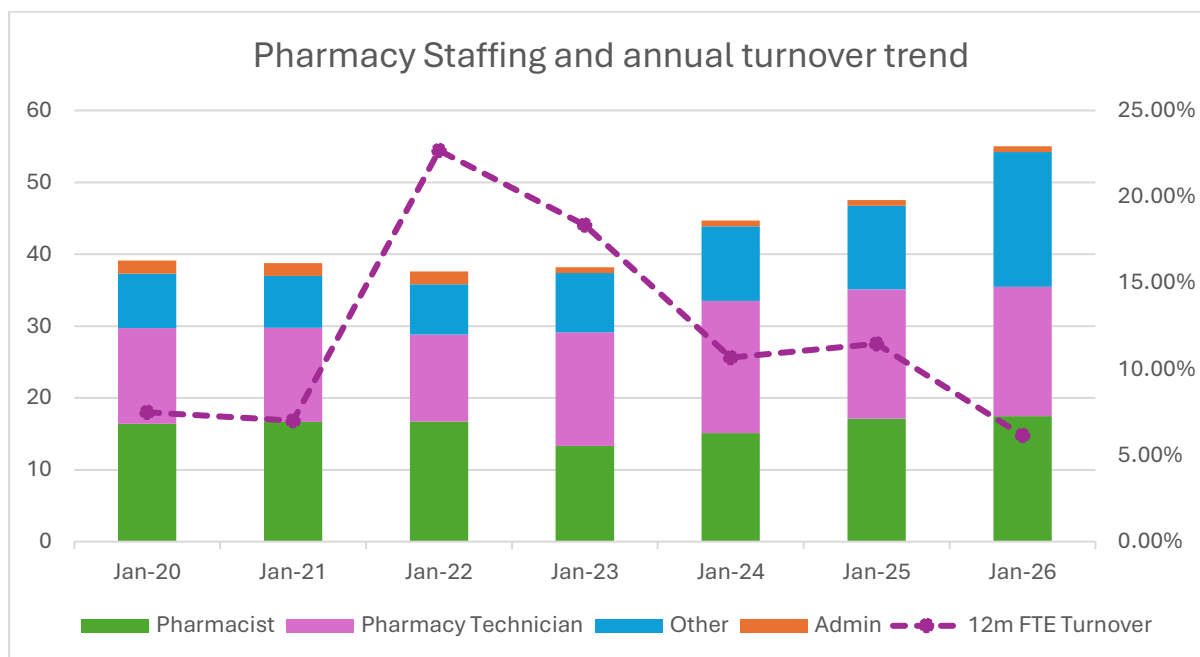
Medicines Optimisation and Financial Stewardship

The Pharmacy Team maintains strong oversight of medicines procurement and expenditure, using digital analytic tools to support cost efficiency and benchmarking against peer organisations. In 2025, medicines procurement activity increased, with off-contract overspend remaining below national targets and improving compared to the previous year. Service changes, including repatriation of dispensing activity, generated recurrent cost savings while supporting new inpatient services.

Workforce Development and Sustainability

A strategic approach to workforce planning has supported stability and resilience across pharmacy roles. This includes skill-mix optimisation, benchmarking of workforce data, and the successful development of internal training pipelines for pharmacists, pharmacy technicians, and support workers. The Trust continues to contribute to regional and national workforce development programmes, including foundation year training and apprenticeships, while recognising emerging funding pressures. Overall staff turnover has reduced as a result of this approach.





Audit, Improvement and Learning

The Pharmacy Team completes regular audits of medicines handling, storage, and controlled drugs across inpatient wards and community bases. Audit results are made available via the Trust's data hub to support local improvement. Clinical audits, including those relating to rapid tranquilisation, are also supported. A recognised area for development is the systematic collection of patient experience data relating to pharmacy services, which is being addressed through the Pharmacy Plan.

Through strong governance, a skilled and sustainable workforce, effective medicines safety systems, and prudent financial management, the Pharmacy Team provides assurance that services are safe, effective, and responsive to changing organisational and patient needs. The service continues to adapt to national policy, workforce, and service delivery requirements while maintaining a clear focus on quality and safety.

Section F: Children and Young People

KEY ACHIEVEMENTS

Delivered strong assurance for Children in Care and SEND responsibilities, achieving high compliance with statutory requirements and national quality expectations

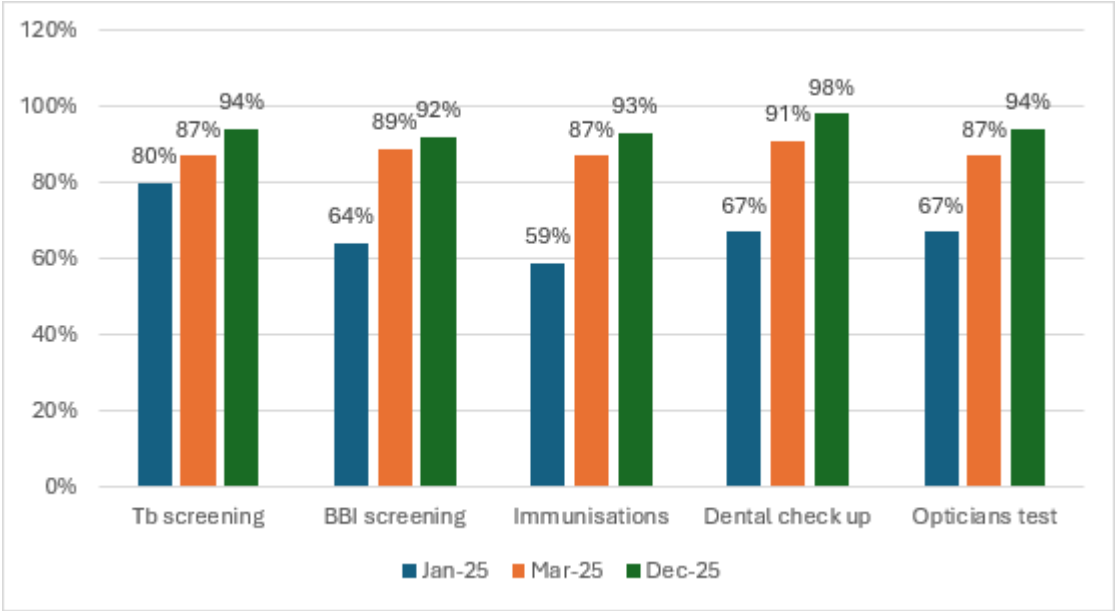
Children's and Young People's Services - Children in Care 2025-2026

The Markers of Good Practice is a self-assessment tool which the team complete yearly to provide Derby and Derbyshire Integrated Care Board with assurance that the needs of our Children in Care are being identified and met in line with Statutory Guidance Promoting the Health and Well-Being of Looked After Children (2015). The Markers of Good Practice (MOGP) is the support/challenge performance management tool used to seek assurance for the ICB Quality Schedule. DDICB requires that all Health Providers complete the self- assessment tool for the Markers of Good Practice to ensure that they remain compliant with the standards required, highlight and celebrate improvements and success. The tool will also inform the ICB if there are any areas of non-compliance or areas of risk identified within your organisation in a supportive and constructive manner. The tool is RAG rated by the Children in Care Service and after submission is RAG rated by DDICB with comments for improvement if required. Some examples of the evidence submitted includes clinical audits, quality audits, feedback from children and young people, social workers, carers and other services who may be involved, training and assurance of roles and responsibilities.

The Children in Care Team were nominated for the Hearts Award and won the category of Patient Focus Award in October 2025. Delivering trauma-informed, inclusive care within strong emotional wellbeing structures, this team was nominated for their commitment to co-production, peer support and continuous improvement which has led to high satisfaction and positive outcomes for vulnerable children and their carers.

An Annual Report is submitted yearly to the Quality Safeguarding Committee along with a child friendly version to receive assurance of the work within DHCFT around Children in Care and young people and the continued partnership working to ensure the best outcome is achieved for this vulnerable group of children and young people.

We have a Trauma Informed Navigator role within the Children in Care team. The new appointed Trauma Informed Navigator joined the team in December 2024. The role is to support our Unaccompanied Asylum Seeker Children and Young people (UASC) with their health needs. It is evidenced in the graph below the significant impact made by the Trauma Informed Navigator in supporting our UASC to attend their health appointments to ensure their outstanding health needs are being met by specialist services.



Special Educational Needs and Disabilities (SEND) 2025-2026

The SEND Reforms have been in place since the Children’s and Families Action (2014). Since this time Health Providers have been work with Derby and Derbyshire integrated Care Board (ICB) have been developing pathways and processes to ensure we are compliant with our statutory duties. Initial the focus was on children’s services, but this has now been developed to include all services who see young people under the age of 25. This has been through the development of the SEND annual report and self-assessment.

For the first time this year the ICB has RAG rated the Trust to ensure compliant with the standards required, highlight and celebrate improvements and success. The tool will also inform the ICB if there are any areas of non-compliance or areas of risk identified within the organisation in a supportive and constructive manner. This was followed by the first quality assurance meeting in July 2025, which found that the Trust provided a high level of assurance. This includes 100% compliance with statutory deadline for EHC Health needs assessment reports, despite the significant increase in requests. Clinical audit results showed 98-100% report compliance across all services which complete more than 10 reports per year. The Trust are fully compliant with code four areas for the code of practice, with the four remaining areas we had made good progress towards full compliance. Compliance with SEND

training which had only recently been introduced at the time of the report, will significantly improve our position. Outstanding issues primarily relate to system working with local authorities and will be addressed through continued collaborative engagement.

Children's Occupational Therapy Service redesign



The Children's Occupational Therapy Service undertook a service redesign to improve equity, sustainability and quality in response to increasing demand, long waits and variation in access across Derbyshire. Key improvements included the introduction of group assessments, a triage and online booking system to improve referral appropriateness and engagement, expanded self-help resources via the service website, clinic-based provision for short-term needs, intermittent caseloads for children with long-term conditions, and clear care pathways to ensure consistent intervention regardless of location. Productivity was strengthened through job planning, structured student training, and improved caseload oversight, alongside enhanced clinical assurance through regular audits, supervision and twice-yearly caseload reviews. These changes have resulted in significantly reduced and sustained waiting times, improved equity of access, better engagement with children

and families, and improved staff wellbeing, supporting the delivery of a high-quality and sustainable Children's Occupational Therapy service.

Outcomes and Impact

- **Waiting times significantly reduced and sustained**, with an average wait of approximately **seven weeks** for initial appointments.
- **Equity of access improved** across Derbyshire.
- **Improved engagement** of children, young people and families, demonstrated through audit of the triage process.
- **Improved staff wellbeing**, clarity of role and caseload management.
- **Positive patient and family feedback**, highlighting improved outcomes, advocacy, clarity of advice and impact on children's functional development.

Section G: Accreditation and External Validation

Royal College of Psychiatry Accreditation

KEY ACHIEVEMENTS

Secured and retained multiple Royal College accreditations across services, demonstrating adherence to nationally recognised quality standards

Teams with current accreditation:

- **Perinatal Services** - The Beeches were accredited on 05/02/2025 and the Community Team on 30/12/2024. Both teams have mid-point peer reviews booked in for May 2026.
- **Electroconvulsive Therapy Service** - Accredited in March 2025 with commendations in monitoring and follow up, training and research, and documentation)
- **Psychiatric liaison team North** - Following the peer review for accreditation by the Psychiatric Liaison Accreditation Network (PLAN) in April 2024, the team provided the final evidence submission requested for accreditation in August 2025 and were accredited on the 25th of September 2025

- **Psychiatric liaison team South** - The team provided the first round of supplementary evidence requested by PLAN in August 2025 following a Peer review in February 2025. A final piece of evidence was submitted in October 2025. This was reviewed at their panel in March and Confirmation of accreditation was awarded in March 2026.

Teams Currently Working Towards Accreditation

- **Child and Adolescent Mental Health Services (CAMHS)**- had a Peer review in June 2024 and are currently working towards meeting the required standard. There is a further peer review booked for May 2026. In the meantime, the service has continued to participate in peer reviews for other services.
- **Forensic Inpatient Services** - The Kedleston Unit received feedback from their Peer review in April 2025 with supplementary information submitted in August 2025. A meeting to discuss next steps took place in January 2026 and due to the Medical vacancies and challenges with leadership in the unit a decision was collaboratively taken with the Royal College of Psychiatry to pause work towards accreditation and revisit this in September 2026. However, in the interim the unit continues to use the quality standards as a benchmark.

Part 6 – Patient and Staff Stories



C was referred for peer support in the Trust Living Well service as he identified that he wanted someone to chat with regularly and help him explore ways to move forward in his life. C was facing several challenges, including anxiety about leaving the house alone, low motivation, and a sense of disconnection from working life after being unemployed for some time.

We began by having informal conversations where I shared some of my own past struggles. These open discussions helped build a strong rapport between us. C often said he found me easy to talk to and appreciated my honesty when it came to discussing mental health.

During one of our chats, I mentioned how much running had helped me personally. At first, C was sceptical that something like running could make a difference, but he told me he was willing to “try anything.” That determination sparked something within him, and we decided to give it a go together.

We started with the Couch to 5K nine-week running plan designed for beginners. It's a programme I had completed myself in 2021 while recovering from knee surgery, and it's what first got me hooked on running.

Because running is a high-impact sport, it wasn't easy for C at first. Having never run before, his body took some time to adjust, and he experienced a few injuries, including knee pain and an ankle issue. This meant the programme took longer than expected but, thanks to my superiors, we were able to extend his support while he completed the course.

As the weeks went by, I saw a real change in C. His self-belief and motivation began to grow, and he started thinking more about his goals for the future. He became less anxious about leaving the house and even began doing some of his runs independently at the weekends. Towards the end of the programme, C shared some wonderful news, he had found a job and was preparing to start work soon. We completed our first 5K jog together, and soon after, C felt confident enough to sign up for Parkrun, a weekly 5K community event held at his local park with 200-400 participants. I'm delighted to say that he completed his first Parkrun with around 300 people in just under 40 minutes. At the finish line, he told me he didn't feel any anxiety at all, everyone had been so supportive that he simply enjoyed the experience.

Although I was there to support C, I believe the real credit belongs to him. His determination, commitment, and willingness to step outside his comfort zone made this journey possible. It's been a privilege to work alongside him, and I wish him all the very best for the future.

Andrew



NHS
Derbyshire Healthcare
NHS Foundation Trust

Andrew is a 12-year-old boy, diagnosed with ASD by our paediatrician at 4, referred to the continence team and not attending school, parent struggling too as unable to work due to caring for him. Support by clinician and GP commenced an intensive medication regime.

Within a month annual review of his EHCP completed incorporating his health care plan, he returned to school and has got his confidence back, mum has also been able to return to work fulltime.

Charlotte



NHS
Derbyshire Healthcare
NHS Foundation Trust

Charlotte, aged 17, started attending CAMHS for support due to mood issues linked to her physical health medication.

Initially resistant to sharing personal experiences, she displayed significant emotional distress in sessions and struggled with trust.

Over time, Charlotte showed improvement, engaging more in therapy and expressing hopes of becoming a paramedic, indicating her potential for continued positive development.

Pauline

NHS
Derbyshire Healthcare
NHS Foundation Trust



For patients like Pauline, one of the hardest things about being admitted to a mental health unit, was the noise.

However, that has since changed with the opening of the Trust's new Bluebell Ward in Chesterfield.

With single en-suite rooms and calm break-out spaces for patients, Bluebell Ward is one of six new or refurbished facilities in the Making Room for Dignity programme.

Claudia

NHS
Derbyshire Healthcare
NHS Foundation Trust



Living with an eating disorder is hard enough but the festive period can be an especially triggering time of year.

For 25-year-old Claudia, that nightmare was all too real, having spent last Christmas in the throes of anorexia nervosa mixed with anxiety and depression.

Just 12 months on and with thanks to the support from Derbyshire Eating Disorders Service, Claudia has found a route back to full time employment and self-sufficiency whilst fighting the ongoing battle with her eating disorder.

Staff stories

NHS

Derbyshire Healthcare

NHS Foundation Trust

“

When we embrace diversity and foster an inclusive culture, we enhance our ability to understand and meet the diverse needs of our patients. This leads to better health outcomes and a more supportive and empathetic care environment.

”

Sarah

NHS

Derbyshire Healthcare

NHS Foundation Trust

“

Communities are at the heart of what we do. Social workers foster solidarity, mutual support, and empowerment, particularly in marginalised groups. We champion human rights, tackle inequalities, and help build stronger social bonds.

”

Paul

NHS

Derbyshire Healthcare

NHS Foundation Trust

“

Inclusion in nursing means recognising and valuing the unique contributions of every nurse, regardless of gender, background, or experience. It's about creating a healthcare environment where everyone has equal opportunities to thrive and provide the best care possible.

”

Rebecca





Derbyshire Healthcare NHS Foundation Trust HQ
Ashbourne Centre, Kingsway Hospital, Derby DE22 3LZ

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FORWARD PLAN - BOARD - 2026/27		19-May-2026	21-Jul-2026	22-Sep-2026	24-Nov-2026	26-Jan-2027	23-Mar-2027
Deadline for Approved Papers		07-May-2026	09-Jul-2026	10-Sep-2026	12-Nov-2026	14-Jan-2027	11-Mar-2027
DoCA/TS	Declarations of Interest	X	X	X	X	X	X
DoN	Patient/Board Story	X	X	X	X	X	X
CHAIR	Minutes/Matters Arising/Action Matrix	X	X	X	X	X	X
CHAIR	Board review of meeting effectiveness	X	X	X	X	X	X
CHAIR	Board Forward Plan (for information)	X	X	X	X	X	X
CHAIR	Summary of Council of Governors meeting (for information)	X	X		X	X	
CHAIR	Chair's update	X	X	X	X	X	X
CEO	Chief Executive's update	X	X	X	X	X	X
PD, PC, JUCD	Joined Up Care Derbyshire Provider Collaborative	X			X		
OPERATIONAL PERFORMANCE							
DCEO/CDO/DoN/ DoF/DPODI	Integrated Performance report (Operations, Finance, People and Quality)	X	X	X	X	X	X
Committee Chairs	Board Committee Assurance Summaries	X	X	X	X	X	X
DCEO/CDO	Emergency Preparedness, Resilience and Response (EPRR) Core Standards			X			
DCEO/CDO	ICB Joint Forward Plan (ad hoc inclusion with CEO update)						
DoF	Medium-term Plan response (compliant with conditions; linked to activity and performance)	X					
Executive Lead	Strategy Deep Dive (4Ps - People; Productive; Patient; Partnerships)	People	Productive	Patient	Partnership		
DoF	Year-end Financial Position 2025/26	X					
Receipt of Reports (for noting following assurance at Quality and Safeguarding Committee (QSC)):							
DoN/MD	Safer Staffing annual review (QSC Jul)			X			
QUALITY GOVERNANCE							
DoN	Assertive Outreach Treatment - Community Mental Health Action Plan update	X			X		
DoN	Fundamental Standards of Care report (CQC Domains) (six-monthly)		X			X	
MD	Medical Job Planning (annual) (PCC Jul/Jun)		X				
DoN	Outcome of Board stories (annual, Jun)		X				
DCEO/CDO	Transformation and Continuous Improvement (six-monthly)	X			X		
DCEO/CDO/MD/DoN	Winter Plan		X	X			
Receipt of Reports (for noting following assurance at People and Culture Committee (PCC)):							
MD	10 Point Plan to Improve the Lives of Resident Doctors (PCC - Nov)				X		
MD	Guardian of Safe Working Hours report (PCC quarterly / annual report Jan Sep)	X	Deferred to Sep-2026	Deferred from Jul-2026	X	X	
MD	Medical Appraisal and Revalidation - annual report (PCC Apr)	X					
Receipt of Reports (for noting following assurance at Quality and Safeguarding Committee (QSC)):							
DoN	Delivery of Same Sex Accommodation (QSC Oct)				X		
DoN	Infection Prevention and Control annual report and IPC BAF (QSC Oct)				X		
MD	Learning from Deaths/Mortality report for approval (QSC quarterly)		AR		X	X	X
DoN	Looked After Children - annual report (QSC Sep)				X		
DoN	Quality Account (QSC - May)		X				
MD	Research and Development (QSC Jul (AR) and Dec)			AR		X	
DoN	Safeguarding Children and Adults at Risk - annual report (QSC AR Sep)				X		
DoN	SEND - Special Educational Needs and Disabilities annual report (QSC May/Jun)	X					
STRATEGIC PLANNING AND CORPORATE GOVERNANCE							
DoF/DCEO/CDO/DPODI	2026/27 Plan (annual)	NHSE Feedback to Medium-Term Plan					
DoCA/TS	Annual Review of Register of Directors' Interests	X					
DoCA/TS	Board Assurance Framework update	X		X	X		X
DCEO/DCO	Clinical Digital Plan update (six-monthly)				X		
DoCA/TS	Continuation of Services Condition 7 - Provider Licence	X					
DoCA/TS	Council of Governors - Composition and Elections			X			
CHAIR	Fit and Proper Person Declaration		X				
FTSUG	Freedom to Speak Up Guardian report (six-monthly)			X			X
MD	Patient and Carers Race Equality Framework (six-monthly)		X			X	
DoCA/TS	Trust Sealings (six-monthly - for information)	X			X		
DCEO/CDO	Trust Strategic Plan (quarterly update, to include 4Ps Delivery Plans)	X	X	X		X	
DPODI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) request for Board delegated authority for People and Culture Committee meeting Sep to approve the October submissions			X			
DPODI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Strategic implications (retrospective sign-off on assurance at People and Culture Committee Sep)			X			
Receipt of Reports (for noting following assurance at Audit and Risk Committee (ARC)):							
DoCA/TS	Year-end Governance reporting from Board Committees and approval of Terms of Reference (ToRs) (ARC Apr)	X					
Receipt of Reports (for noting following assurance at People and Culture Committee (PCC)):							
DPODI	2025/26 Flu Campaign annual report (PCC Jul-Sep)			X			
DPODI	Annual Approval of Modern Slavery Statement (PCC Apr/May, to be published on Trust website on approval)	X					
DPODI	Annual Gender Pay Gap report for approval (data for previous year reporting deadline Mar - PCC Jul)	X					
DPODI	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 Officer
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)
AMaT	Audit Management and Tracking (audit/governance system (real-time reporting for clinicians, wards, audit departments and healthcare organisations))
AMM	Annual Members' Meeting
AMHP	Approved Mental Health Professional
ANP	Advanced Nurse Practitioner
ANPR	Automatic Number Plate Recognition
AO	Accountable Officer
AO	Assertive Outreach
AOVPN	AlwaysOn VPN (secure network access)
APC	Annual Physical Health
APNA NHS	Asican Professionals' National Alliance
APOM	Activity Participation Outcome Measure
ARAF	Annual risk Acknowledgement Form
ARMS	At Risk Mental State
ARRS	Additional Roles Reimbursement Scheme
ASC	Adult Social Care
ASD	Autism Spectrum Disorder
ASM	Area Service Manager
ATR	Alcohol Treatment Requirement
ATU	Acute Treatment Unit
B	
BAF	Board Assurance Framework
BAME	Black, Asian and Minority Ethnic
BCF	Better Care Fund
BCO	Building Control Officer
BCP	Business Continuity Plan
BI	Business Intelligence
BIA	Business Impact Analysis
BLS	Basic Life Support (ILS Immediate Life Support)
BMA	British Medical Association
BILD	British Institute of Learning Disabilities
BME	Black and Minority Ethnic group

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Abbreviation	Term in Full
BoD	Board of Directors
BPD	Borderline Personality Disorder
BPPC	Better Payment Practice Code
C	
CAARMS	Comprehensive Assessment of At-Risk Mental States
CAD	Community Action Derby
CANSAS	Camberwell Assessment of Need Short Appraisal Schedule
CAMHS	Child and Adolescent Mental Health Services
CASSH	Care and Support Specialised Housing
CBT	Cognitive Behavioural Therapy
CBRN	Chemical, Biological, Radiological and Nuclear
CCG	Clinical Commissioning Group (defunct from 1 July 2022)
CCCG	Collaborative Commissioning and Contracting Group (East Midlands Alliance)
CCQI	College Centre for Quality Improvement
CCT	Community Care Team
CDEL	Capital Departmental Expenditure Limit
CD-LIN	Controlled Drug Local Intelligence Network
C.DIFF	Clostridioides difficile
CDM	Construction Design and Management
CDMI	Clinical Digital Maturity Index
CE	Chief Executive
CEO	Chief Executive Officer
CER	Clinical Establishment Review
CERT	Community Enhanced Rehabilitation team
CESR	Certificate of Eligibility for Specialist Registration
CETR	Care, Education and Treatment Review
CFFSR	Counter Fraud Functional Standard Return
CGA	Comprehensive Geriatric Assessment
CGL	Change Grow Live
CHANNEL	Confidential, voluntary, multi-agency safeguarding programme that provides early intervention to protect vulnerable children and adults who might be susceptible to being radicalised
CHIME	Connectedness, Hope, Identity, Meaning, Empowerment recovery
CHPPD	Care Hours Per Patient Day
CIC	Children in Care
CIN	Children in Need
CIP	Cost Improvement Programme
CMDG	Contract Management Delivery Group
CMHF	Community Mental Health Framework
CMHT	Community Mental Health Team
CMO	Chief Medical Officer
CNST	Clinical Negligence Scheme for Trusts
COAT	Clinical Operational Assurance Team
COD	Cause of Death
COF	Commissioning Outcomes Framework
CoG	Council of Governors
COO	Chief Operating Officer
CP	Child Protection
CPA	Care Programme Approach
CPD	Continuing Professional Development
CPN	Community Psychiatric Nurse
CPR	Child Protection Register

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Abbreviation	Term in Full
CPRG	Clinical Professional Reference Group
CQC	Care Quality Commission
CQI	Clinical Quality Indicator
CQRG	Clinical Quality Review Group
CQUIN	Commissioning for Quality and Innovation
CRD	Clinically Ready for Discharge
CRG	Clinical Reference Group
CRH	Chesterfield Royal Hospital
CRHT	Crisis Resolution and Home Treatment
CROMS	Clinician Reported Outcome Measures
CRR	Case Record Reviews
CRS	(NHS) Care Records Service
CRS	Commissioner Requested Services
CSC	Commonwealth Scholarship Commission
CSDS	Community Services Data Set
CSF	Commissioner Sustainability Fund
CSPR	Child Safeguarding Practice Review
CSTF	Core Skills Training Framework
CSU	Commissioning Support Unit
CTO	Community Treatment Order
CTR	Care and Treatment Review
CUF	Cost Uplift Factor
CYP	Children and Young People
D	
DAG	Divisional Assurance Group
DAR	Divisional Assurance Review
DARD	Drugs and Alcohol Related Deaths
DASP	Drug and Alcohol Strategic Partnership
DAT	Drug Action Team
Datix	Trust's electronic incident reporting system of an event that causes a loss, injury or a near miss to a patient, staff or others
DBS	Disclosure and Barring Service
DBT	Dialectical Behavioural Therapy
DDME	Deputy Director of Medical Education
DfE	Department for Education
DCHS	Derbyshire Community Health Services NHS Foundation Trust
DCO	Designated Clinical Officer
DDCCG	Derby and Derbyshire Clinical Commissioning Group
DDSAB	Derby and Derbyshire Safeguarding Adult Board
DDSC	Designated Doctor Safeguarding Children
DDSCB	Derby and Derbyshire Safeguarding Children Board
DDSCP	Derby and Derbyshire Safeguarding Children Partnership
DEED	Delivering Excellence Every Day
DHcFT	Derbyshire Healthcare NHS Foundation Trust
DHR	Domestic Homicide Review
DHSC	Department of Health and Social Care
DISCO	Diagnostic Interview for Social and Communication Disorders (assessment)
DIT	Dynamic Interpersonal Therapy
DLN Cluster	Derbyshire, Lincolnshire, Nottinghamshire Cluster
DME	Director of Medical Education
DNA	Did Not Attend
DoC	Duty of Candour

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Abbreviation	Term in Full
DoF	Director of Finance
DoH	Department of Health
DoL	Deprivation of Liberty
DoLS	Deprivation of Liberty Safeguards
DoN	Director of Nursing
DPA	Data Protection Act
DPI	Director of People and Inclusion
DPIA	Data Protection Impact Assessment
DPR	Divisional Performance Review
DPS	Data Protection and Security
DQMI	Data Quality Maturity Index
DRR	Drug Rehabilitation Requirement
DRRT	Dementia Rapid Response Team
DSCRO	Data Services for Commissioners Regional Offices
DSFS	Derbyshire Support and Facilities Services
DS&P	Data Security and Protection
DSPT	Director of Strategy, Partnerships and Transformation
DTOC	Delayed Transfer of Care
DV	Domestic Violence
DVA	Derbyshire Voluntary Action (formerly North Derbyshire Voluntary Action)
DWP	Department for Work and Pensions
E	
EAP	Employee Assistance Programme
EbE	Expert by Experience
ECT	Enhanced Care Team
ECT	Electroconvulsive Therapy
ECW	Enhanced Care Ward
ED	Emergency Department
EDS2	Equality Delivery System 2
EHA	Early Help Assessment
EHCP	Education, Health and Care Plan
EHIC	European Health Insurance Card
EHR	Electronic Health Record
EI	Early Intervention
EIA	Equality Impact Assessment
EIP	Early Intervention In Psychosis
EIS	Early Intervention Service
e-LfH	e-Learning for Healthcare
ELT	Executive Leadership Team
EMDR	Eye Movement Desensitising and Reprocessing Therapy
EMPH	East Midlands Provider Collaborative
EMR	Electronic Medical Record
EPC	Energy Performance Certificate
EPMA	Electronic Prescribing and Medicine Administration
ePMO	Electronic Programme Management Office
EQIA	Equality Impact Assessment
EPR	Electronic Patient Record
EPRR	Emergency Preparedness, Resilience and Response
ERIC	Estates Return Information Collection
ESF	Estates Safety Fund
ESR	Electronic Staff Record
ETOC	Enhanced Therapeutic Observation and Care

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Abbreviation	Term in Full
ETP	Electronic Transfer of Prescriptions
EUPD	Emotionally Unstable Personality Disorder
EWTD	European Working Time Directive
F	
FBC	Full Business Case
FCMHT	Forensic Community Mental Health
FDP	Federated Data Platform
FFT	Friends and Family Test
FGM	Female Genital Mutilation
FIG	Feedback Intelligence Group
FOI	Freedom of Information
FOT	Forecast Out-Turn
F&P	Finance and Performance
FReM	Government Financial Reporting Manual
FSR	Full Service Record
FT	Foundation Trust
FT ARM	Foundation Trust Annual Reporting Manual
FTE	Full-time Equivalent
FTN	Foundation Trust Network
FTSU	Freedom to Speak Up
FTSUG	Freedom to Speak Up Guardian
FWS	Future NHS Workforce Solution
FYE	Full Year Effect or Financial Year End
5YFV	Five Year Forward View
G	
GAM	Group Accounting Manual
GB0	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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Abbreviation	Term in Full
HSCIC	Health and Social Care Information Centre
HSE	Health and Safety Executive
HSSC	Health and Safety Security Committee
HST	Higher Specialty Training
HV	Health Visitor
HWB	Health and Wellbeing Board
I	
I&E	Income and Expenditure
IAPT	Improving Access to Psychological Therapies
Icare	Increase Confidence, Attract, Retain, Educate
ICB	Integrated Care Board
iCIMS	Internet Collaborative Information Management System
ICM	Insertable Cardiac Monitor
ICO	Information Commissioner's Office
ICS	Integrated Care System
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IDVAs	Independent Domestic Violence Advisors
IFRS	International Financial Reporting Standards
IIC	Inclusive Inter-cultural Communication
IG	Information Governance
ILS	Immediate Life Support (BLS – Basic Life Support)
IMHA	Independent Mental Health Advocacy
ImmForm	UKHSA ImmForm system – used to order medical products and collect vaccine uptake data
IMST	Information Management Systems and Technology
IMT	Incident Management Team
IMT&R	Information Management, Technology and Records
INQUEST	Official, public inquiry to discover the facts about a death. An inquest is conducted by a coroner to determine who the deceased was, and how, when, and where they died, especially in cases of sudden, violent, or unexplained deaths
IPC SAG	Infection Prevention and Control Strategic Action Group
IPP	Imprisonment for Public Protection
IPR	Integrated Performance Report
IPS	Individual Placement and Support
IPT	Interpersonal Psychotherapy
IQVIA	I (for IMS Health), Q (for Quintiles) and VIA (meaning 'by way of')
IRG	Incident Review Group
IRHTT	In-reach Home Treatment Team
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Abbreviation	Term in Full
KSF	Knowledge and Skills Framework
L	
LA	Local Authority
LAC	Looked After Children
LCFS	Local Counter Fraud Specialist
LA – CYPD	Local Authority – Children and Young People Divisions
LADO	Local Authority Designated Officer
LCSPR	Local Child Safeguarding Practice Review
LD	Learning Disabilities
LD/A	Learning Disability and Autism
LeDeR	Learning Disabilities Mortality Review
LFPSE	Learning from Patient Safety Events
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender and Queer or Questioning, Intersex, Asexual
LHP	Local Health Plan
LHRP	Local Health Resilience Partnership
LHWB	Local Health and Wellbeing Board
LNC	Local Negotiating Committee
LOS	Length of Stay
LPS	Liberty Protection Safeguards
LSU	Long-Term Service Use
LTFT	Less Than Full-Time
LTP	Long Term Plan
LTS	Long Term Segregation
LTWP	Long Term Workforce Plan
LWSTO	Living Well Short-Term Offer
M	
M&E	Mechanical and Electrical
MADE	Multi-agency Discharge Event
MAPPA	Multi-agency Public Protection Arrangements
MARAC	Multi-agency Risk Assessment Conference (meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors)
MARS	Mutually Agreed Resignation Scheme
MAS	Memory Assessment Service
MASH	Multi-Agency Safeguarding Hub
MaST	Management and Supervision Tool
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Abbreviation	Term in Full
MFA	Multi-Factor Authentication
MFF	Market Forces Factor
MHA	Mental Health Act
MHAC	Mental Health Act Committee
MHIN	Mental Health Intelligence Network
MHIS	Mental Health Investment Standard
MHLDA	Mental Health, Learning Disabilities and Autism
MHLT	Mental Health Liaison Team
MHOST	Mental Health Optimal Staffing Tool
MHPS	Maintaining High Professional Standards
MHRA	Medical and Healthcare products Regulatory Agency
MHRT	Mental Health Review Tribunal
MHRV	Mental Health Response Vehicle
MHSDS	Mental Health Services Data Set
MHUAC	Mental Health Urgent Assessment Centre
MiCAD	Reporting system for medical device service and repair
MIND	The leading mental health charity in England and Wales
MMaSP	Medicine Management Safety and Practice
MMC	Medicine Management Committee
MOC	Medicine Optimisation Committee
MoSCoW	Must have, Should have, Could have and Won't have (methodology)
MoU	Memorandum of Understanding
MPAC	Multi-Professional Approved Clinician
MRSA	Methicillin-resistant Staphylococcus aureus
MSC	Medical Staff Committee
MSK	Musculoskeletal (conditions)
MSP	Medicines Safety and Practice
MST	Multisystemic Therapy
MSU	Medium Secure Unit
MTFP	Medium-Term Financial Plan
N	
NAI	Non-Accidental Injury
NCISH	National Confidential Inquiry into Suicide and Safety
NCRS	National Cancer Registration Service
ND	Neuro-development
ND	Neurodiversity
NECS	North of England Care System Support
NED	Non-Executive Director
NETS	National Educational Training Survey
NFI	National Fraud Initiative
NGO	National Guardian's Office
NHIS	Nottingham Health Informatics Service
NHS	National Health Service
NHSC	NHS Confederation
NHSCFA	NHS Counter Fraud Authority
NHSE	National Health Service England
NHSI	National Health Service Improvement
NHSEI	NHS England and NHS Improvement
NHSP	NHS Providers
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NIMS	National Immunisation Management System

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Abbreviation	Term in Full
NIMS	National Incident Management System
NIVS	National Immunisation and Vaccination System
NOF	NHS Oversight Framework
NPS	National Probation Service
NPSA	National Patient Safety Alert
NQB	National Quality Board
NR	Non-Recurrent
NRLS	National Reporting and Learning System
NROC	Non-Resident On-Call
O	
OBC	Outline Business Case
OBD	Occupied Bed Days
ODG	Operational Delivery Group
OoA	Outside of Area
OPMO	Older People's Mental Health Services
OP	Outpatient
OSC	Overview and Scrutiny Committee
OSCE	Objective Structured Clinical Examination
OT	Occupational Therapy
P	
PAB	Programme Assurance Board
PAG	Programme Advisory Group
PALS	Patient Advice and Liaison Service
PAM	Payment Activity Matrix
PARC	Psychosis and the reduction of cannabis (and other drugs)
PARIS	This is an electronic patient record system
PbR	Payment by Results
PCC	Police & Crime Commissioner
PCC	People and Culture Committee
PCF	Personalised Care Framework
PCLB	Provider Collaborative Leadership Board
PCN	Primary Care Networks
PCOG	Patient and Carer Operational Group
PCREF	Patient and Carers Race Equality Framework
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Abbreviation	Term in Full
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
PRN	Prescribed as necessary / Pro re nata
PROMS	Patient Reported Outcome Measures
PSED	Public Sector Equality Duty
PSF	Provider Sustainability Fund
PSII	Patient Safety Incident Investigations
PSIRF	Patient Safety Incident Response Framework
PSIRP	Patient Safety Incident Response Plan
PSQG	Patient Safety and Quality Group
PSR	Provider Selection Regime
PTU	Psychiatry Teaching Unit
PYE	Part Year Effect
Q	
QAG	Quality Assurance Group
QASI	Quality Assurance Serious Incidents
Q&SC	Quality and Safeguarding Committee
QEIA	Quality and Equality Impact Assessment
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity Programme
QNCC	Quality Network for Community CAMHS
QOF	Quality and Outcomes Framework
QSIR	Quality, Service Improvement and Redesign
R	
RAID	Rapid Assessment, Interface and Discharge
RAP	Recovery Action Plan
RAVS	Record a Vaccination Service
RCGP	Royal College of General Practitioners
RCI	Reference Cost Index
RDF	Resident Doctor Forum
RDOG	Research and Development Operational Group
REGARDS	Race, Economic disadvantage, Gender, Age, Religion or belief, Disability and Sexual orientation
ReQoL	Recovering Quality of Life
RFI	Request for Information
ROAG	Responsible Officer Advisory Group
RoDP	Recognition of Deteriorating Patient
ROM	Reported Outcome Measure

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Abbreviation	Term in Full
RPOG	Restrictive Practice Oversight Group
RRN	Restraint Reduction Network
RRP	Recruitment Retention Proposal
RSD	Rejection Sensitive Dysphoria
RSV	Respiratory Syncytial Virus
RTS	Real Time Surveillance
RTT	Referral to Treatment
S	
s132	Section 132 of the Mental Health Act: As soon as a patient is detained under the Act the patient must be given their rights orally and in writing unless it is not practicable at that time. If this is the case, it must be documented in the patient's electronic care record
s136	Section 136 of the Mental Health Act: Police can use emergency powers if they think you have a mental disorder, you're in a public place and need immediate help. They can take you or keep you in a place of safety, where your mental health will be assessed.
SAAF	Safeguarding Adults Assurance Framework
SAB	Safeguarding Adults Board
SAF	Single Assessment Framework
SAM	Self-Administered Medication
SAR	Safeguarding Adult Review
SAS Doctor	Specialist, Associate Specialist and Specialty Doctor
SAT	Specialist Autism Team
SBARD	Situation, Background, Assessment, Recommendation and Decision (SBARD) tool
SBS	Shared Business Services
SCPHN	Specialist Community Public Health Nurse
SEIPS	Systems Engineering Initiative for Patient Safety
SEND	Special Educational Needs and Disabilities
SFI	Standing Financial Instructions
SI	Serious Incidents
SIG	Serious Incident Group
SID	Senior Independent Director
SIDS	Sudden Infant Death Syndrome
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement
SLaM	South London and Maudsley NHS Trust
SLR	Service Line Reporting
SLRDE	Senior Lead for Resident Doctor Experience
SMI	Severe Mental Illness
SNOMED CT	Systemised Nomenclature of Medicine – Clinical Terms
SOAD	Second Opinion Appointed Doctor
SoBS	Survivors of Bereaved by Suicide
SOC	Strategic Options Case
SOF	Single Operating Framework
SoCI	Statement of Comprehensive Income
SO	Standing Order
SOP	Standard Operating Procedure
SPF	Social Partnership Forum
SPOA or SPA	Single Point of Access
SPOE	Single Point of Entry
SPOG	Strategic Portfolio Oversight Group
SPOR	Single Point of Referral

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS

NHS Abbreviation	Term in Full
SSQD	Specialised Services Quality Dashboards
SSRB	Senior Salaries Review Board
STEIS	Strategic Executive Information System
STAH	St Andrew's House
StEIS	Strategic Executive Information System
STF	Sustainability and Transformation Fund
STOMP/STAMP	Stopping The Over-Medication of children and young People with a learning disability, autism or both / Supporting Treatment and Appropriate Medication in Paediatrics
STP	Sustainability and Transformation Partnership
SUI	Serious (Untoward) Incident
SW	Social Worker
SWARM	A swarm is a rapid learning response immediately following an adverse patient safety incident or "near miss", where a diverse team of medical professionals converges to handle a specific task simultaneously
SWW	Support While Waiting
SystemOne	Electronic patient record system
T	
10YHP	10-Year Health Plan
TAV	Team Around the Family
TARN	Trauma Audit and Research Network
TBT	Tobacco Dependence Team
TCP	Transforming Care Partnerships
TCS	Transforming Community Services
TDA	Trust Development Authority
TDG	Trust Delivery Group
TDT	Tobacco Dependence Team
TIC	Trauma Informed Care
TLT	Trust Leadership Team
TMAC	Trust Medical Advisory Committee (now Medical Senate)
TMT	Trust Management Team
TMTC	Trust Medical Training Committee
TOIL	Time Off In Lieu
TOOL	Trust Operational Oversight Leadership
ToRs	Terms of Reference
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
U	
UHDB	University Hospitals of Derby and Burton
UEC	Urgent and Emergency Care
V	
VARM	Vulnerable Adult Risk Management
VCOD	Vaccination as a Condition of Deployment
VCP	Vacancy Control Panel
VCSE	Voluntary, Community and Social Enterprise organisations
VdTMoCA	Vona du Toit Model of Creative Ability (<i>a practical guide for Acute Mental Health Occupational Therapy Practice</i>)
VfM	Value For Money
VO	Vertical Observatory
VTE	Venous Thromboembolism
VUCA	Volatility, Uncertainty, Complexity, Ambiguity
W	

**GLOSSARY OF NHS AND
DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS**

NHS Abbreviation	Term in Full
WAP	Wireless Application Protocol
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent
Y	
YP	Young Person
YTD	Year to Date

10 July 2026

Report from the Council of Governors meeting held on 19 May 2026

The Council of Governors has met once since the last report, on 19 May 2026. The meeting was conducted as a hybrid meeting.

Chief Executive's update

The Chief Executive's report presented to Public Board that morning was included in the papers for this meeting for information.

Report from Governors' Nominations and Remuneration Committee held on 5 May 2026

In the absence of the Trust Chair, Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary, presented an overview of the matters discussed at the last Governors Nominations and Remuneration Committee on 5 May which covered the following business:

- The appraisals for the Trust Chair and the Non-Executive Directors (NEDs)
- Year-end governance reports, specifically:
 - Time commitment, balance of skills, committee membership and succession planning
 - Year End Report 2025/26
 - Annual review of Terms of Reference before submission to the Council of Governors.

The Council of Governors:

- Received assurance from the Committee that satisfactory appraisals have taken place for the Trust Chair and Non-Executive Directors
- Approved the Chair's objectives as set out in the report
- Noted the year-end report 2025/26
- Approved the Committee's Terms of Reference.

Council Of Governors Annual Effectiveness Survey

The Council of Governors approved the recommendation that the survey is undertaken in September 2026.

Escalation items to the Council of Governors from the Governance Committee

It was noted that there were no escalation items for this meeting.

Staff Survey Results

Rebecca Oakley, Director of People, Organisational Development and Inclusion, presented the staff survey results which shows the current position of the Trust for the 2025 NHS staff survey.

Non-Executive Directors' Report

Two Non-Executive Directors, Andrew Harkness and Ralph Knibbs presented their reports which summarised their role and activities.

Verbal summary of Integrated Performance Report (IPR)

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

Report from Governance Committee held on 21 April 2026

The Co-Chair of the Governance Committee presented a report of the meeting held on 21 April 2026.

The Council of Governors approved the governor statement for the Quality Account which was included in the report.

Review Governor Membership Engagement Action Plan

The Membership and Involvement Manager provided an update on the Governor Membership Engagement Action Plan which was developed to increase engagement with members and to promote the governor role.

Governor training and development

The Membership and Involvement Manager gave an overview of sessions that have taken place and also referred to the free of charge mental health awareness training sessions provided by Derbyshire County Council.

RECOMMENDATION

The Trust Board is asked to note the summary report from the Council of Governors meeting held on 19 May 2026.