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Derbyshire Healthcare
NHS Foundation Trust

Public Board Meeting

Agenda

Date: Tuesday, 24 November 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	Patient Story – Volunteering service *During this session, the presenter will share their experience(s), the content of which some people may find upsetting. Anyone affected by the issues raised can find support via the Trust website*	Tumi Banda
3	10.00	Minutes of the Board of Directors meeting held on 30 September 2026	Selina Ullah
4		Action Matrix and Matters Arising	
5		Questions from members of the public	
6	10.10	Chair's update – verbal	Selina Ullah
7	10.20	Chief Executive's update	Mark Powell
OPERATIONAL PERFORMANCE			
8	10.30	Integrated Performance report, including Quality, Operations, People and Finance	Tumi Banda/Vikki Ashton Taylor/Rebecca Oakley/James Sabin
		8.1 Board Committee Assurance Summaries, Committee Chairs to give assurance alongside presentation of the performance sections; stand-alone update for Audit and Risk Committee	Committee Chairs
BREAK 11.05am			
TRUST STRATEGY DEEP DIVE			
9	11.15	Partnerships	Vikki Ashton Taylor/ Anna Shaw
QUALITY GOVERNANCE			
10	11.30	Assertive Outreach Community Mental Health treatment	Tumi Banda
11	11.40	Thirlwall Inquiry	Tumi Banda

STRATEGIC PLANNING AND CORPORATE GOVERNANCE			
12	11.50	Strategic Plan – mid-point review	Vikki Ashton Taylor
13	12.00	Trust Clinical Plan – 2026-2029 (for approval)	Girish Kunigiri
14	12.10	Board Assurance Framework (BAF) update	Justine Fitzjohn
REPORTS FOR NOTING AND/OR APPROVAL FOLLOWING ASSURANCE AT BOARD COMMITTEES			
15	12.20	<u>Quality and Safeguarding Committee</u> 15.1 Children in Care/Looked After Children annual report – 2025/26 15.2 Delivery of Same Accommodation (for approval) 15.3 Infection Prevention and Control annual report and IPC BAF 15.4 Learning from Deaths/Mortality report for approval	Lynn Andrews
CLOSING BUSINESS			
16	12.25	Consideration of any items affecting the Board Assurance Framework (BAF)	Selina Ullah
17		Meeting effectiveness	
FOR INFORMATION			
Board Forward Plan - 2026/27 Glossary of NHS Acronyms Summary of Council of Governors (CoG) meeting held 22 September 2026 Trust Sealings			

Next meeting:

Date:	**Time:**	**Location:**
Tuesday, 26 January 2027	9.30am	Conference Rooms A&B, Research and Development Centre, Kingsway, Derby, DE55 3LZ. Arrangements will be notified on the Trust website seven days in advance of the meeting.

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

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

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

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

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

Strategy on a page

Derbyshire Healthcare
NHS Foundation Trust

We make a positive difference in everything we do

Our vision

Our strategic priorities

Patient focus

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

Caring

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

Inclusive

We respect and include everyone in all we do.

Partnerships

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

Ambitious

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

WE MAKE A POSITIVE DIFFERENCE • IN EVERYTHING WE DO •

Belonging

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

People

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

Collaborative

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

Productive

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

Our values



Find out more

derbyshirehealthcareft.nhs.uk/about-us/strategy

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

DECLARATION OF INTERESTS REGISTER 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 *from 01-Jun-2026*	(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 *until 31-Jul-2026*	(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 *until 31-Oct-2026*	(d) (e)

James Sabin
Director of Finance
	• Spouse works at Sheffield Health & Social Care NHS Foundation Trust as:
	  ○ Head of Capital and Therapeutic Environment
	  ○ Trustee of Sheffield Hospitals Charitable Trust
		
		(e)
		(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).

v1.0 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

Wednesday, 30 September 2026

MEETING HELD IN PUBLIC

Commenced: 9.30am Closed: 12.47pm

PRESENT	Selina Ullah	Trust Chair
	Lynn Andrews	Non-Executive Director
	Ralph Knibbs	Senior Independent Director
	Chioma Akpom	Non-Executive Director
	Deborah Good	Non-Executive Director
	Jo Hanley	Non-Executive Director
	Andrew Harkness	Non-Executive Director
	Mark Powell	Chief Executive
	Vikki Ashton Taylor	Deputy Chief Executive and Chief Delivery Officer
	Tumi Banda	Director of Nursing, Allied Health Professions (AHPs), Quality and Patient Experience
	Justine Fitzjohn	Director of Corporate Affairs and Trust Secretary
	Dr Girish Kunigiri	Medical Director
	Rebecca Oakley	Director of People, Organisational Development and Inclusion
	James Sabin	Director of Finance
IN ATTENDANCE	Anna Shaw	Associate Director of Communications and Engagement
	Jo Bradbury	Corporate Governance Officer
DHCFT2026/075	Becki Priest	Deputy Director of Patient Experience
DHCFT2026/075	Georgie Lazzari	Peer Support Co-ordinator
DHCFT2026/075	Georgina Hambleton	Peer Support Worker
DHCFT2026/075	Rachel Finn	Peer Support Worker
DHCFT2026/087	Tam Howard	Freedom to Speak Up Guardian
OBSERVERS	Leanne Walker*	Project Support Officer
	Mark Pridmore	Senior Business Development Manager, VitalHub UK Limited

* denotes on-line attendance

DHCFT/ 2026/074	**CHAIR'S WELCOME, OPENING REMARKS, APOLOGIES FOR ABSENCE AND DECLARATION OF INTERESTS** Selina Ullah, Trust Chair, welcomed Board colleagues, observers and guests for today's Board Story. The Declaration of Interests Register for 2026/27 was noted and there were no declarations of interest.
DHCFT/ 2026/075	**BOARD STORY - PEER SUPPORT IN INPATIENT SERVICES** Reflecting on the previous Board Story, Becki Priest, Deputy Director of Patient Experience, advised that the Clinical team and the Executive Directors were working through the complex and systemic issues identified. It was noted that an update would be provided with the annual Board Story update in July 2027.

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	It was advised that Georgie Lazzari, Peer Support Co-ordinator, Georgina Hambleton and Rachel Finn, Peer Support Workers (PSWs), were to present today's story. Georgie explained that PSWs used their own experience of mental health challenges and recovery in a purposeful way to build relationships based on shared understanding, mutual respect, hope and connection. It was noted that since 2021, the Trust's Peer Support offer had expanded to approximately 26 directly employed workers across Community and Specialist services, with five Inpatient roles funded through the Making Room for Dignity programme across the Psychiatric Intensive Care Unit, Audrey House, Carsington Unit, Radbourne Unit and Derwent Unit. Georgina and Rachel described how a non-clinical, non-judgemental approach enabled patients to discuss practical matters and difficult personal experiences in a safe space. They gave examples of building trust through informal contact, activities and group work and of using their own Inpatient experience to support reflection and recovery. They confirmed that peer supervision, supportive managers and escalation routes were available when serious concerns arose. Georgie recognised the risk of role drift; where a PSW was the only such worker in a unit and advised that work was continuing to improve staff understanding of the role through promotional materials and other communications. Jo Hanley, Non-Executive Director, welcomed the insight provided and asked whether further support was required. Georgina responded that increased peer capacity would enable the team to meet more regularly and learn from colleagues with greater experience, while confirming that ward staff were supportive. Highlighting the differing terms, including PSW, champion and advocate, Dr Girish Kunigiri, Medical Director, acknowledged this could cause confusion for patients. He stressed the importance of clear relationships and appropriate boundaries. Georgina highlighted that weekends were particularly difficult for patients because fewer sources of support were available. James Sabin, Director of Finance, asked how awareness of the service could be increased. Rachel supported the use of posters and highlighted the practical needs of some patients at discharge, including access to food and charitable support. Georgie confirmed that a promotional leaflet for Inpatient and Community settings was being developed for completion by the end of 2026. The possibility of current PSWs engaging with prospective applicants was suggested by Ralph Knibbs, Senior Independent Director. Georgie advised that vacancies were recruited through the usual route, agreeing that contribution from existing team members would enhance the process. Although development opportunities remained limited, Georgie pointed out that two higher-banded research posts had recently been created within the Emotional Regulation Pathway. Becki confirmed that NHS-funded peer training was available and suggested that the role should be considered further within implementation of the Personalised Care Framework (PCF). The progress was welcomed by Mark Powell, Chief Executive, who proposed that PSWs contribute to Trust Learning and Engagement sessions and sharing events. He also suggested using anonymised patient stories to demonstrate impact and that consideration be given to submitting the work for awards. Thanking the team, Selina emphasised the importance of the role in providing a beacon of hope to people receiving Inpatient care. **RESOLVED: The Board of Directors was greatly encouraged by the progress demonstrated and the positive impact of PSWs for Trust patients.**
DHCFT/ 2026/076	**MINUTES OF THE LAST BOARD OF DIRECTORS MEETING** The draft minutes of the last meeting held on 21 July 2026 were accepted as a correct record.

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DHCFT/ 2026/077	**ACTION MATRIX AND MATTERS ARISING** The Board reviewed and closed the completed actions. Selina drew attention to the below actions: DHCFT/2026/047: Tumi Banda, Director of Nursing, AHPs, Quality and Patient Experience, advised that Mark had formally written to the CEO of the Integrated Care Board cluster to seek an update on the strategic intent for commissioning of Assertive Outreach (AO) services in the future. It was noted that the Board Assurance Framework (BAF) had been updated accordingly and the escalation was currently sat with the Mental Health Board. DHCFT/2026/063: Rebecca Oakley, Director of People, Organisational Development and Inclusion, confirmed strengthened triangulation between the People team, Organisational Development team and Freedom to Speak Up intelligence, which would be reported into the People and Culture Committee.
DHCFT/ 2026/078	**QUESTIONS FROM MEMBERS OF THE PUBLIC** No questions had been received.
DHCFT/ 2026/079	**CHAIR'S UPDATE** Selina provided the Board with her reflections on activity since the previous Board meeting on 21 July 2026 and drew attention to the below points: The breadth of recent service visits and the strong emphasis on organisational culture was highlighted. Visited teams had discussed openly where arrangements were not as they should be and had demonstrated ownership, innovation and a willingness to address challenges. Positive examples of teamworking, speaking up and continued delivery of effective patient care during significant transformation and service pressure were noted. Selina thanked staff and Executive Directors for maintaining care through the period of change. It was noted that Angela Kerry, Public Governor, Amber Valley, had been impressed by colleagues' willingness to ask questions. Visits undertaken with Mark and James had provided assurance that leaders had the appropriate approach following substantial transformation and change. It was suggested that examples of teams 'trying, testing, learning from failure and improving' could be shared more widely. Discussions with Kathy McLean, Chair of the Derbyshire, Lincolnshire and Nottinghamshire (DLN) Integrated Care Board (ICB) cluster were referenced, concerning the AO service, the Nottingham inquiry and sustainable funding. The ICB had recognised this as a risk requiring consideration alongside finite resources. The Board noted that the Care Quality Commission (CQC) Well-Led inspection was scheduled for 3–5 November 2026 and that preparations were under way to demonstrate the Trust's work. On 9 September, Selina had been invited to 10 Downing Street to attend a Muslim Round Table. It was noted that Florence Eshalomi MP, Minister of State (Minister for Homelessness, Democracy, Communities and Faith) and Baroness Merron, Parliamentary Under-Secretary of State (Minister for Women's Health and Maternity), had been in attendance, enabling an opportunity to discuss the experiences of Muslim staff and patients, faith and belief literacy and other issues of concern within the health service. **RESOLVED: The Board of Directors considered the content of this report.**
DHCFT/ 2026/080	**CHIEF EXECUTIVE'S UPDATE** 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, serving to horizon scan for risks and opportunities that may affect the organisation.

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	Mark was delighted to confirm that the Mental Health Urgent Assessment Centre (MHUAC) at the Radbourne Unit had opened as planned on Monday, 28 September 2026. He thanked the Estates, Clinical and Operational teams for the significant work undertaken and advised that patient numbers would increase through a phased approach. The Board considered the implications of the Thirlwall Inquiry report and its far-reaching recommendations. Lynn Andrews, Non-Executive Director, questioned whether sufficiently detailed information was being received in a timely-enough manner to support effective oversight. Mark acknowledged the need to examine both the longstanding systemic issues referenced in the report and the forward-looking response, including whether comparable failings could occur within the Trust. It was noted that there would be further consideration through the relevant committees and at the next public Board meeting. **Post-meeting note, Forward Plan updated**. Mark advised that NHS guidance on implementation of the Equality and Human Rights Commission Code of Practice had not yet been received. Therefore, individual trusts were required to interpret its application. He also confirmed that preparations for the CQC Well-Led inspection, scheduled for 3–5 November 2026, were being led by Tumi and Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary, with leaders meeting weekly. The Board Strategy and Development Session on 14 October 2026 would provide further preparation while maintaining a business-as-usual approach. Reporting on engagement with Amanda Sullivan, Chief Executive, DLN ICB cluster, concerning AO funding, Mark recognised the need to balance commissioned activity against finite resources. He advised that further work was required where agreement had not yet been reached. Lynn welcomed the extent of stakeholder involvement by Mark and Selina, noting the emerging impact. It was highlighted that agreement had been secured with the ICB to meet one-off set-up costs associated with responding to the closure of the Sheffield Neurodevelopmental waiting list route, noting the importance of sustained relationships in shaping patient care. **RESOLVED: The Board of Directors noted the update.**
DHCFT/ 2026/081	**<u>INTEGRATED PERFORMANCE REPORT (IPR) AND BOARD COMMITTEE ASSURANCE SUMMARIES</u>** The IPR provided a high-level view of performance against a number of Quality, Operational, People and Financial metrics, and assurance regarding actions being taken to improve performance up to the end of July 2026 for internal measures and to the end of May 2026 where the data source is NHS England (NHSE). The Board Committee Assurance Summaries from recent meetings were considered alongside the IPR, with attention drawn to key points by Executive Directors and Committee Chairs during the discussions. <u>Quality</u> Progress in responding to complaints was highlighted, with most now completed within 90 working days and more constructive and timely feedback. Deborah Good, Non-Executive Director, sought assurance that the improved trajectory would be sustained and that learning would inform the wider culture work. Tumi advised that complaints, compliments and Freedom to Speak Up themes were reviewed through Divisional Assurance Boards. Lynn reported that the Quality and Safeguarding Committee remained focused on progressing from limited to significant assurance, with complaints, patient safety, Learning from Deaths and the triangulation of flow, absence and acuity data receiving detailed scrutiny. The Board noted that implementation planning for the PCF was in development and would be considered by the Executive Leadership Team on 21 October 2026. Tumi confirmed that the Care Programme Approach would remain in place until a safe transition had been completed. **Action,**

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following completion of the relevant governance process, the PCF implementation trajectory and associated risks to be reported at the next Board meeting.

In response to concern raised about increased assaults on staff, Tumi advised that incidents were receiving greater emphasis as high-risk events, staff support had been strengthened, legislation was being used where appropriate and the Positive and Safe team was being deployed to higher-risk areas.

Jo challenged whether the flu vaccination ambition was sufficiently stretching and whether supply constrained delivery. Rebecca confirmed that the Trust's 49% target was five percentage points above its previous performance, that some flexibility existed within the agreement with Derbyshire Community Health Services and that all available routes, including vaccinations delivered through general practice, would be promoted. It was emphasised that the Trust should aim to exceed the minimum target. Ralph confirmed that the People and Culture Committee had received significant assurance on the delivery model.

Operations

Strong operational performance in several areas was reported, including Individual Placement Support. Vikki Ashton Taylor, Deputy Chief Executive and Chief Delivery Officer, confirmed that the MHUAC at the Radbourne Unit would provide assessment in a calmer and more appropriate environment than an Emergency Department.

It was noted that demand continued to exceed commissioned capacity in some services, while the lack of a female Psychiatric Intensive Care Unit in Derby and Derbyshire resulted in out-of-area (OoA) placements.

Jo highlighted the interdependency between community capacity, admission avoidance, discharge, transformation and finance.

Vikki reported improved Mental Health helpline performance, support for emergency services through the professional helpline, continued delivery of the unfunded mental health response vehicle with East Midlands Ambulance Service and a wider roll-out of the text service.

In relation to those people experiencing lengthy waits, Tumi advised that the Waiting Well Policy had been scrutinised by the Quality and Safeguarding Committee, who had received limited assurance and acknowledged that contacts within Working Age Adult Community services were not always taking place when required. Lynn confirmed that the Committee was sighted on the associated incidents and was satisfied that active management plans were in place.

People

Rebecca identified sickness absence as the principal workforce risk, with the July rate at 6.8%, comprising 4.3% short-term and 2.5% long-term absence. Anxiety, stress or depression-related illness remained the leading causes. She described action to strengthen consistent case management, dedicated absence support, Occupational Health responsiveness and assurance at Divisional and Care Group level. It was advised that a clear trajectory and milestones were being developed, while Mark cautioned that performance could initially deteriorate and that sustained improvement might take six to 12 months. Ralph confirmed that the People and Culture Committee would monitor both delivery against the trajectory and whether staff were managed fairly, robustly and sensitively, including the appropriate use of reasonable adjustment passports.

Finance

James reported an adjusted deficit of £1.0m at 31 July 2026, £0.1 million behind plan, driven principally by OoA expenditure, Inpatient acuity and gaps in efficiency delivery, partly offset by underspends. Cash remained above plan and there were no debt-recovery concerns.

Jo highlighted the need for best- and worst-case scenarios and the effect of bank expenditure, OoA placements and transformation requirements.

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	Lynn questioned at what point the BAF risk should be escalated higher and what contingency would apply if efficiencies were not achieved. James advised that the Trust remained on plan at the date of the meeting, but that pressure was expected to increase in quarter three. He emphasised that reducing clinically ready for discharge delays would materially improve the position. Mark did not consider that sufficient evidence had been presented to change the risk rating at that stage. He challenged Executive Directors to provide more detailed and coherent assumptions so that committees could give the appropriate assurance. Although positive outcomes were becoming clearer, Andrew Harkness, Non-Executive Director, observed the increasing challenge required stronger articulation of outputs, tangible impact and joined-up decision-making across Executive and committee oversight. Whilst the Audit and Risk Committee had approved the current BAF, Chioma Akpom, Non-Executive Director, expected it to be reviewed to reflect current risks, alongside work arising from the AQUA recommendations and further consideration of risk appetite and tolerance. **RESOLVED: The Board of Directors accepted limited assurance on current performance across the areas presented.**
DHCFT/ 2026/082	**EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) ANNUAL REPORT AND CORE STANDARDS** Vikki provided an overview of the works completed within the EPRR portfolio and the substantial compliance for the August submission of the core standards, with four partial areas remaining across the 58 standards. It was confirmed that the Trust was in a good position and that work was continuing to address the partial areas and complete final ratification of the relevant documentation. The Board noted the significant number of incidents managed by the organisation during the preceding 12 months, alongside normal operational delivery. Vikki reported that the Incident Response team had worked collectively to maintain safe services and that learning from previous events had strengthened resilience and contingency arrangements. Ongoing development and monitoring would continue through the EPRR Strategic Leadership Group. **RESOLVED: The Board of Directors:** **1. Received the updated report** **2. Was fully assured of ongoing work to maintain the Trust's level of compliance with the EPRR core standards.**
DHCFT/ 2026/083	**TRUST STRATEGY DEEP DIVE – PATIENT FOCUSED** Tumi presented the third deep dive against the Trust's four strategic priorities, focusing on what it meant for the organisation to be patient focused. He reported that the Quality Delivery Plan and supporting Quality Assurance Framework provided a coherent approach to quality control, assurance and continuous improvement. Delivery was embedded through established governance, Fundamentals of Care reviews, service accreditation, patient feedback, Board visits and improvement programmes. The evidence included 91 Fundamentals of Care visits and 152 Board visits during 2025/26, alongside positive regulatory findings and improvements in patient and carer experience. Therefore, Tumi recommended significant assurance against delivery of the strategic priority. Lynn reported that the Quality and Safeguarding Committee had provided feedback on the paper and recognised the difficulty in clearly demonstrating the achieved impact. She added that the report identified measurable evidence of delivery and improvement, while recognising that sustained Executive and Committee oversight remained necessary in relation to long waits, complaints timeliness, outcome measurement, care-plan reviews, violence and aggression, restrictive practice, length of stay, digital capacity and implementation of the PCF.

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	Selina suggested the inclusion of specific timescales and actions would provide greater clarity on the areas requiring improvement. The Board noted that the identified areas were visible through established governance routes and subject to targeted improvement, and that the developing Clinical Plan was expected to provide the next stage of delivery by the end of 2026. **RESOLVED: The Board of Directors:** **1. Received significant assurance on the delivery of the Patient Focused strategic priority and noted areas of improvement and focus** **2. Noted that the Clinical Plan, as a key driver for the strategic priority, is at an advanced stage of development and will be in place by end 2026.**
DHCFT/ 2026/084	**<u>WINTER PLANNING – 2026-27</u>** Vikki presented the Winter Plan and associated Board Assurance Statement (BAS), which had been scrutinised by the Finance and Performance Committee and completed in accordance with the national template. She advised that the Trust remained exposed to identifiable risks, including sustained community demand, constraints on effective capacity, delayed discharge, workforce availability and wider System dependencies. However, established business-as-usual controls were in place, including discharge optimisation, flow governance, urgent mental health pathways, workforce resilience, infection prevention and control, and operational escalation arrangements. It was highlighted that operational pressures were not confined to winter and could arise across Christmas, New Year, summer periods and heatwaves. Vikki confirmed that the Trust was experienced in planning for and managing such pressures and would continue to monitor demand and respond through daily operational arrangements. No material operational capability gap or requirement for additional investment had been identified, and the remaining work related principally to assurance validation and completion of the approval process. **RESOLVED: The Board of Directors:** **1. Received significant assurance regarding the Trust's preparedness to maintain effective capacity, patient flow and operational performance throughout winter 2026/27** **2. Noted that delivery of the Winter Plan is expected through existing business-as-usual arrangements and that no material operational capability gap has been identified** **3. Noted the principal risks to productivity, effective capacity and operational performance arising from sustained demand, discharge constraints, workforce pressures and System dependencies** **4. Noted that no additional financial investment had been identified as a requirement for delivery of the Winter Plan and that implementation will be managed through existing operational resources and governance arrangements** **5. Supported progression of the BAS following a governance route through the Finance and Performance Committee ahead of final NHSE submission.**
DHCFT/ 2026/085	**<u>BOARD ASSURANCE FRAMEWORK (BAF), ISSUE 2, VERSION 2.3, 2026/27 UPDATE</u>** Justine advised that a review would be undertaken to ensure the BAF reflected the Trust's current risk position, inviting additional Board comments at the end of the agenda. **RESOLVED: The Board of Directors:** **1. Reviewed and approved Issue 2 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 priorities** **2. Agreed to receive updates in line with the forward plan for the Trust Board.**
DHCFT/ 2026/086	**<u>PROVIDER CAPABILITY SELF-ASSESSMENT</u>** The 2026 self-assessment was presented for Board approval, with confirmation that Executive Directors and Committee Chairs had contributed to its development.

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	It was noted that the assessment had been prepared at short notice and had drawn on the collective judgement of those involved, supported by headline rationales and evidence against the six CQC domains. The proposed ratings were Green for Strategy, Leadership and Planning and for Financial Performance and Oversight, with the remaining four domains rated Amber-Green. The Board noted significant assurance in relation to the Trust's governance processes and limited assurance regarding the factors determining its current NHS Oversight Framework segmentation. It was recognised that NHSE might request further evidence, particularly in relation to performance. Justine emphasised that the submission should describe how the Trust would work with commissioners and System partners on matters outside its direct control. She confirmed that the language had been moderated to support constructive relationships and avoid attribution of blame. Mark considered the assessment reflective of the Trust's current position and welcomed the breadth of input, while recognising the inherently subjective nature of the exercise. **RESOLVED: The Board of Directors:** **1. Confirmed the proposed ratings, narrative, evidence, identified development areas and actions across all six domains and approved the 2026 Provider Capability Self-Assessment** **2. Authorised the Chair and Chief Executive to sign it on behalf of the Board for submission to NHSE by 5.00pm on Friday 2 October 2026** **3. Noted the requirement that the Trust has to notify NHSE of any subsequent material in-year change affecting the Trust's capability assessment.**
DHCFT/ 2026/087	**<u>FREEDOM TO SPEAK UP GUARDIAN (FTSUG) REPORT (SIX-MONTHLY)</u>** Tam Howard, FTSUG, presented the six-monthly FTSU report covering January to June 2026 and warmly acknowledged the support provided by Lynn as the FTSU Non-Executive Director. A total of 125 cases had been recorded, compared with 116 during the equivalent period in 2025. Worker safety and wellbeing remained the most frequently reported themes, alongside inappropriate attitudes and behaviours, bullying and harassment and patient safety and quality. The Board noted the continued activity of the 45-member Speaking Up Champions network and that 75% of respondents had indicated that they would speak up again. Tam advised that c18% of respondents had indicated they might speak up again. In relation to those teams from which no concerns had been raised, Tam confirmed that gap analysis is undertaken to compare intelligence from other reporting routes, but this was not yet triangulated. She agreed that this could be explored. It was emphasised that ownership for triangulation rested with the Divisions and Executive leads rather than solely with the FTSUG. Lynn requested clearer visibility of agreed interventions and measurable impact, including the management of anonymous reports. It was noted that the reduction in cases raised by Nursing staff was neither inherently positive nor negative and that the position was comparable with the national average. There had been greater reporting from AHPs, which aligned with a period of change for those professions. The Board was advised that Tam used a red, amber and green rating methodology, which had recently been included in reports, and that whistleblowing concerns could be raised through the FTSU route or other available channels. Selina requested greater Board visibility of whistleblowing matters. Welcoming the level of activity, Chioma sought stronger focus on themes, actions and triangulation with staff absence, patient safety and other organisational intelligence. Tam acknowledged that response rates and reporting could be improved.

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	It was suggested that further practical measures, including body-worn cameras, would support staff safety and accountability. **RESOLVED: The Board of Directors:** **1. Noted the contents of the report, including the 125 FTSU cases recorded during January–June 2026, the themes identified, the associated learning and the actions underway** **2. Supported the continued development of the Trust's speaking-up culture through the mechanisms described in the report, including FTSU visibility and engagement, the Speaking Up Champions network, Culture Collaborative activity, staff-group engagement and triangulation with wider organisational intelligence** **3. Agreed the level of assurance that actions arising from FTSU concerns are appropriately owned, monitored and reviewed, with clear escalation where concerns remain unresolved or recurring** **4. Supported the continued independence, accessibility and confidentiality of the FTSU function, including appropriate Board oversight.**
DHCFT/ 2026/088	**REPORTS FOR NOTING AND/OR APPROVAL** **Emergency Powers of the Chair and Chief Executive** The Board was informed that the Chair and Chief Executive had exercised emergency powers on 24 July 2026, following consultation with Jo and Andrew, Non-Executive Directors, to approve entry into the Nottinghamshire Health Informatics Service (NHIS) Service Level Agreement and Partnership Agreement. Emergency approval had been required because no scheduled Trust Board meeting fell before the NHIS Board meeting on 29 July 2026. Deferral would have risked disruption to the agreed Arden and GEM Commissioning Support Unit transition timetable, governance assurance, recruitment and service mobilisation. **RESOLVED: The Board of Directors noted the exercise of emergency powers by the Chair and Chief Executive as set out in the summary above.** Thes following reports were received for information/noting and/or approval, having previously provided assurance to the People and Culture and Quality and Safeguarding Committees. **PEOPLE AND CULTURE COMMITTEE** **Guardian of Safe Working Hours (GoSWH) annual report and quarterly report** The Board considered the annual report and the quarterly report covering 1 June to 7 August 2026. The reports provided assurance that compliance with the 2016 Resident Doctor contract was monitored by the Guardian of Safe Working Hours Medical Lead, with issues escalated through the Joint Local Negotiating Committee and established governance routes. Ralph highlighted the overlap between the Guardian's remit and the NHSE 10 Point Plan. The reports confirmed that the two arrangements had been aligned to support consistent oversight. A working group led by the Deputy Director of Medical Education for the south had reviewed on-call pressures. **RESOLVED: The Board of Directors noted the content of the report and the mitigation planned or put in place to manage the increase in exception reporting.** **10 Point Plan to improve the lives of Resident Doctors** The Board noted significant progress in implementing the 10 Point Plan, with compliance increasing from 65% at baseline to 77% at the 12-week review. From October 2026, compliance would be monitored through the Education Quality Framework, provider self-assessment and BAF.

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RESOLVED: The Board of Directors:

1. **Noted the progress on NHSE 10 Point Plan for Improving the Working Lives of Resident Doctors in the Trust**
2. **Noted significant compliance in regard to the Board Assurance Framework September 2026.**

Flu Campaign – 2026/27

The Board noted that delivery would be led by Peer Vaccinators, supported by the Physical Health Hub, Pharmacy, Communications and Engagement, People services, Divisional leadership and the Derbyshire Community Health Services' agreement.

RESOLVED: The Board of Directors received significant assurance that a comprehensive delivery model is in place to support achievement of the Trust's 2026/27 frontline healthcare worker flu vaccination ambition of 49% and that the plan recognises the operational challenges to delivery and through the flu steering group these will be actively managed.

Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports, following sign-off at People and Culture Committee

Ralph reported that the 2025/26 WRES and WDES reports demonstrated positive progress in representation and data quality, while identifying continuing disparities in recruitment, progression, senior representation and staff experience. He advised that the Committee had requested a more focused plan for the following 12 months and would receive a future action plan.

RESOLVED: The Board of Directors:

1. **Approved the WRES and WDES reports**
2. **Approve the WRES and WDES Action Plans**
3. **Agreed for the reports to be published on the Trust website.**

QUALITY AND SAFEGUARDING COMMITTEE

Learning From Deaths/Mortality report – Quarter 1, 2026/27

The Board considered the report, which covered 1 April to 30 June 2026, noting that mortality trends remained stable and the available data did not indicate significant health inequalities.

The Committee had accepted limited assurance because 40 learning responses remained active, of which 22 were overdue by an average of 142 days, creating a risk that learning and improvement opportunities would not be identified promptly. However, the Board noted a 55% reduction in overdue learning recommendations and the continued strengthening of oversight through audits, the Trust-wide Learning the Lessons Forum and development of a Patient Safety Dashboard.

RESOLVED: The Board of Directors:

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

Safeguarding Children and Adults annual report

The report provided significant assurance that the Trust continued to discharge its statutory safeguarding responsibilities through effective governance, risk management, workforce development, quality assurance and partnership working. Risks were reviewed through the Safeguarding Children and Safeguarding Adults Operational Groups and escalated to the Quality and Safeguarding Committee and relevant system safeguarding boards where strategic oversight was required.

RESOLVED: The Board of Directors received and approved the Safeguarding Children and Adults annual report, which was offered by the Executive Lead with significant assurance regarding the fulfilment of legal and statutory duties.

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	Safer Staffing annual review The review evidenced that Inpatient staffing arrangements had remained within safe parameters, with no staffing category falling below the 80% fill-rate threshold. **RESOLVED: The Board of Directors:** **1. Received and noted the Safer Staffing annual review and the assurance provided in relation to compliance with National Quality Board guidance and CQC Regulation 18** **2. Approved the recommendation to maintain current Inpatient funded establishments at this stage, with no immediate reductions, recognising that professional judgement, acuity, dependency, enhanced observation requirements, ward configuration, and quality and safety intelligence do not support reducing establishments despite some lower Mental Health Optimal Staffing Tool outputs** **3. Received limited assurance on the ongoing actions being taken to address the issues highlighted.** **Research and Development annual report** The report demonstrated sustained delivery and impact across clinical research, Library and Knowledge services, embedded service evaluation and clinical audit. During 2025/26, 450 participants had consented to 40 National Institute for Health and Care Research studies and approximately £1.14m of external research funding and investment had been secured. The Operational Group had continued to provide effective governance and escalation through the Quality and Safeguarding Committee. **RESOLVED: The Board of Directors:** **1. Received the R&D annual report – 2025/26 and accepted significant assurance from the evidence of sustained delivery, impact, governance oversight and progress against the Trust's R&D strategic priorities. Significant assurance is suggested** **2. Approved the annual review of the R&D Operational Group Terms of Reference, noting that the Group is operating effectively as the governance and assurance forum for research, clinical audit, and Library and Knowledge services. It was also expanding membership in 2026/27** **3. Noted the first six-monthly Trust Board research activity, performance and income report proposed, including the significant assurances provided, the identified delivery risks, issues and mitigations.**
DHCFT/ 2026/089	**STANDING FINANCIAL INSTRUCTIONS (SFIS) POLICY AND PROCEDURE** James presented the annual review of the SFIs, advising that the proposed amendments were limited in scope and had been considered through the Trust Delivery Group and agreed by the Audit and Risk Committee in July 2026, before presentation to the Board for final ratification. **RESOLVED: The Board of Directors ratified the SFis Policy and Procedure.**
DHCFT/ 2026/090	**CONSIDERATION OF ANY ITEMS AFFECTING THE BOARD ASSURANCE FRAMEWORK (BAF)** Mark suggested that the workforce risk around sickness absence required clearer articulation and explicit linkage to the associated financial and quality risks. **ACTION, Rebecca, James and Tumi to review how sickness absence is articulated and triangulated with financial and quality risks within the BAF**. Lynn suggested the inclusion of a triangulation summary with the IPR to enhance oversight.
DHCFT/ 2026/091	**MEETING EFFECTIVENESS** Lynn observed that the meeting would be more effective if discussion remained focused on outcomes, with less commentary and greater emphasis on the implications and impact of the matters considered. Selina agreed that greater discipline was required in the conduct of the meeting.

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	In his capacity as observer, Mark Pridmore, Senior Business Development Manager, VitalHub UK Limited, recognised the good engagement and supported the need for more concise commentary.
The next meeting to be held in public session will be held in person on Tuesday, 24 November 2026 at 9.30am in Conference Rooms A and B, Centre for Research and Development, Kingsway, Derby.	

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ACTION MATRIX - BOARD OF DIRECTORS - NOVEMBER 2026							
Date	**Minute Ref**	**Item**	**Lead**	**Action**	**Completion Date**	**Current Position**	
19-May-2026	DHCFT/2026/047	Assertive Outreach (AO) Treatment - Community Mental Health Action Plan update	Tumi Banda	Further articulation and re-escalation to the Integrated Care Board (ICB) around the requirement for a stand-alone AO service.	~~24-Jul-2026~~ ~~30-Sep-2026~~ Ongoing	On 02-Sep-2026, Mark Powell, CEO, formally wrote to the CEO of the ICB Cluster to update on Derbyshire Healthcare NHS FT's position regarding the provision of an AO service offer, to request funding to mitigate risks identified by the Trust and to seek an update on the ICB's strategic intent for Commissioning AO services in the future. Awaiting a response. There is an update report regarding the AO Community Mental Health Treatment Self-Assessment Tool included on the November Board agenda.	Amber
21-Jul-2026	DHCFT/2026/063	Integrated Performance Report (IPR)	Lead Executives and Lead Non-Executive Directors	To consider the levels of assurance agreed during Committee meetings - further clarity on what is needed to move from limited to significant and/or significant to full assurance. To be covered at a Board Strategy and Development Session, in conjunction with the review of the Board Assurance Framework review, risk appetite and confidence in recovery plans.	24-Nov-2026	Committees are now providing additional challenge on levels of assurance at meetings and being more specific on what is needed to improve. These areas have also been identified in the AQUA Well-Led report and will be progressed.	Green
30-Sep-2026	DHCFT/2026/081	Integrated Performance Report (IPR)	Tumi Banda	Following completion of the relevant governance process, the Personalised Care Framework implementation trajectory and associated risks to be reported.	24-Nov-2026	A project plan has been drawn to transition from the Care Programme Approach to the PCF. The Plan was supported by the Strategic Oversight Group on 01-Oct-2026. The plan will be taken to the Executive Leadership Team on 21-Oct-2026 for approval and an update will be sent to the Quality and Safeguarding Committee and the Board in November 2026.	Green
30-Sep-2026	DHCFT/2026/090	Consideration of any items affecting the Board Assurance Framework (BAF)	Rebecca Oakley, James Sabin, Tumi Banda	Review of how sickness absence is articulated and triangulated with financial and quality risks within the BAF.	02-Oct-2026	02-Oct-2026: Workforce risks have been completely overhauled, and Rebecca has updated all wording around the sickness absence risk. This will be reflected in Issue 1, quarter 3.	Green

Key:					
	Action Overdue	RED		**0**	**0%**
	Action Ongoing/Update Required	AMBER		**1**	**25%**
	Resolved	GREEN		**3**	**75%**
	Agenda item for future meeting	YELLOW		**0**	**0%**
				4	**100%**

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

Chief Executive's update

Purpose of Report

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

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

National and regional context

Protecting confidential patient information

NHSE has written to NHS organisations following reports nationally of staff accessing confidential patient information without a legitimate reason, reinforcing a zero-tolerance approach to unauthorised, inappropriate and unjustifiable access. We have reviewed our arrangements and are reassured that our existing disciplinary policy and confidentiality requirements address these circumstances, with serious breaches of confidentiality capable of being considered as gross misconduct following a fair and appropriate investigation. We will continue to reinforce these expectations with colleagues and strengthen our arrangements for responding consistently and promptly to any concerns, helping to protect patient confidentiality and the trust people place in our services.

Independent review of mental health, attention deficit hyperactivity disorder (ADHD) and autism services

The final report of the independent review of mental health, ADHD and autism services, led by Professor Peter Fonagy, Psychoanalyst and Clinical Psychologist, was published in October. The review responds to increasing demand for Mental Health and Neurodevelopmental services and makes a series of recommendations for reform. These include moving towards a more needs-led approach to support, providing more integrated mental health and neurodevelopmental assessment, strengthening specialist services, developing workforce capacity and improving the use of digital technology, data and evidence.

The direction set out in the review is significant for us as a mental health and learning disability provider. In particular, it reinforces the importance of earlier intervention and supporting people according to need, alongside access to specialist assessment and treatment for those who need it. We will consider the recommendations alongside our existing work to improve access, develop our neurodevelopmental pathways and strengthen Community-based services, whilst recognising that the resources we have available continue to be constrained and reduced year on year.

Autumn Budget 2026

The government published its Autumn Budget on 28 October. The Budget confirmed the existing NHS funding settlement and provided a further £190m to support winter pressures during 2026/27. We will work with NHSE and System partners to understand the local distribution of winter funding and the implications for future revenue, capital, workforce and efficiency planning. The overall direction reinforces the need to maintain financial discipline, deliver our efficiency programme and demonstrate how investment in prevention, Community services and digital transformation improves outcomes and productivity.

The Budget also announced an independent review of the opportunities presented by artificial intelligence and technology to improve NHS productivity, together with further investment in technology and innovation. The review is expected to report in early 2027 and will help inform the next Spending Review.

Other measures with potential implications for us as a Trust include the increase in the National Living Wage from April 2027, changes to tax-free mileage rates and continuing constraints on public-sector capital expenditure. The government has also signalled that prevention will have a more explicit place within future spending arrangements.

Equality Act Code of Practice

Earlier this year, the Equality and Human Rights Commission updated the Equality Act code of practice following the UK Supreme Court ruling that 'sex' in equality law means 'biological sex' rather than the gender someone identifies as, while confirming trans people retain protections under gender reassignment. NHSE has now issued updated guidance on single-sex patient accommodation and staff facilities and has asked NHS Boards to review their local policies, practices and environments.

We are reviewing what this means for our Trust and whether any changes are needed to our current policies or ways of working. These are sensitive and complex issues, and we will continue to ensure that our approach is lawful and that we endeavour to provide safe, compassionate and respectful care which protects the privacy, dignity and safety of all our patients and staff.

Mental Health Personalised Care Framework

NHSE recently published its new Mental Health Personalised Care Framework, setting out a more personalised and outcome-focused approach to care for adults and older people with severe mental health problems. The framework builds on and modernises the Care Programme Approach, with a stronger focus on personalised care planning, continuity through a named worker, timely review and re-access to support and the experience and outcomes of people receiving care. We have established a programme to support the safe and consistent implementation of the framework across our services. A detailed update on our approach, including implementation and assurance arrangements, will be brought to a Board meeting in the new year.

Integrated Care Board (ICB) cluster and future arrangements

NHSE has confirmed that decisions on the future merger and footprint arrangements for the Derbyshire, Lincolnshire and Nottinghamshire ICBs will be deferred until summer 2027, with any changes now expected to take effect from 1 April 2028. Therefore, existing cluster arrangements will continue throughout 2027/28. The revised timetable reflects the government's commitment to align public service boundaries with strategic authorities and the developing devolution arrangements. This does not change current joint working across the cluster, and we will continue to work with System partners on agreed priorities and transition planning.

Resident doctors

NHSE has published further guidance to support implementation of the national Resident Doctors' deal. This includes moving locally employed Doctors towards substantive contracts, reimbursement of eligible examination fees and strengthened appraisal and development arrangements. We are reviewing the guidance and progressing the requirements locally, supporting our wider commitment to the development, experience and retention of our Medical workforce.

Paused Industrial action

The British Medical Association (BMA) has announced that it is pausing the planned industrial action by Consultant Doctors, due to take place on 25 and 26 November, to enter into negotiations with the government.

Our Incident Management Team will be stood down while these negotiations are held.

Local context

Well-Led assessment

The CQC visited the Trust early in November to undertake our Well-Led assessment. This is the first Well-Led inspection the Trust has received since 2020, when we were given a good rating.

The aim of a CQC Well-Led inspection is to review and assess our leadership, management and governance to ensure that we can deliver high-quality, person-centred care. I'm pleased to say the initial feedback we have received from the inspection team was very complimentary about the enthusiasm and motivation of all involved. We were told that our values are expressed consistently, that we have a positive organisational culture, people are well connected to our strategic priorities (4Ps) and that there is a clear connection to patient care in all we do.

There will be some areas of development and we expect these to be focused on the need to further embed our new people, processes and ways of working. We now wait for the draft report to arrive – which I am likely to receive early next year. There will then be a period of factual accuracy checking before the report is published and we receive a rating for Well-Led.

Good rating for Perinatal services

Congratulations to our Perinatal teams, who received a good rating in their recent CQC inspection. The team (which includes The Beeches Mother and Baby Unit, together with two Perinatal Community teams) received a good rating in every domain. The report outlines how our skilled teams provide a high standard of care using a range of innovative interventions, treating people with kindness and respect to support them to achieve their goals and develop greater independence.

This is the eighth service in a row that has been rated good by the CQC, which is a fabulous Team Derbyshire Healthcare achievement.

New Mental Health Urgent Assessment Centre (MHUAC) open in Derby

I am pleased to confirm that our new MHUAC opened to patients on 28 September and is now supporting patients in a mental health crisis who present at the Emergency Department (ED) at the Royal Derby Hospital.

With referrals facilitated by our Liaison team, the multi-disciplinary team based at the MHUAC in the Radbourne Unit will support individuals who have mental health needs that could be better supported by the MHUAC than by ED. This aims to avoid unnecessary waits in the ED, providing a quicker response to people attending the hospital in crisis. Individuals who require support from our Liaison team in addition to their physical health needs will continue to be supported in the hospital.

NHSE Provider Review Meeting (PRM)

On 29 October, together with Executive Directors, I attended the latest PRM which is chaired by NHSE. We set out the Trust's position across quality, performance, workforce and finance, as well as our preparations for the CQC Well-Led assessment and findings from the independent AQUA Well-Led Development Review. The meeting provided a useful opportunity to reflect on progress and the areas outlined in the National Oversight Framework (NOF) where continued focus and improvement are needed.

Annual Members Meeting

Our Annual Members Meeting (AMM) was held on 30 September. Thank you to members who joined and heard presentations from our services including our Specialist Psychology team, the importance of shared activities for patients staying in our facilities and our Community Enhanced Rehabilitation team.

Congratulations to the following winners of our art competition on the theme 'A ray of hope': Saffron Bishop-Powell, Sophie Lightfoot, Emily Keeler, Lizzy James, Erin Hinchcliffe, Martha Hinstridge, Clare Exley, Sally B, Karen Sangha, Alveera Zafar, the Sewa Ladies Group, Let's Make It Craft Group and patients at Cherry Tree House.

Recent achievements

Congratulations to Fern Tucker, Early Discharge Nurse, North Crisis team, who was the DEED winner for September. Fern was nominated in recognition of the exceptional commitment, compassion, and professionalism she demonstrates in her role.

Alex Unwin, Employment Specialist, Community Mental Health teams, was the DEED of the month for August. Alex was nominated by a service user, who praised her support and kindness in getting them back to work.

A number of colleagues received a certificate of merit at the Asian Professionals' National Alliance (APNA) NHS Awards in October, including:

- APNA Champion of the Year (Clinical) Award - Dr Saladi Sudhakar
- Rising Star - Asaam Nadeem
- Emerging Leader - Oluyomi Ladapo
- Excellence in Equality, Diversity and Inclusion - Chetna Mistry
- Excellence in Equality, Diversity and Inclusion - Clem Thompson
- APNA Champion of the Year (Non-Clinical) - Nadeem Mirza.

It was fantastic to have a record seven Derbyshire Healthcare finalists recognised across a range of categories at the Derbyshire and Nottinghamshire Apprenticeship Awards. Congratulations to Nathaniel David and Niamh Kerry who were both winners in their category – and well done to all our finalists; Phoebe Louise Fullerton, Modupeola Falase, Ben Chapman, Kerry-Anne Doyle and Laura Bevington.

Congratulations to Tracey Cooper Smith, Clinical Lead, Health Visiting team, who was recently made a Queen's Nurse. This is public recognition of excellence in Community Nursing.

Rosie May, Individual Placement and Support (IPS) Team Leader, won the national Lived Experience Award at the IPS Grow Awards in October, for using her own experiences to help people recognise their strengths and take positive steps towards employment.

Professor Subodh Dave, Consultant Psychiatrist, is included in this year's Health Service Journal (HSJ) most influential Black, Asian and minority ethnic people in health for his role as President of the Royal College of Psychiatrists.

Joshua Ige, Divisional Lead Occupational Therapist for Inpatient services, Crisis, Corporate and Children services, has undertaken a piece of research titled 'An exploration into how people living in secure hospitals experience work'. This has recently been published in the British Journal of Occupational Therapy.

Staff engagement

New Perkbox app to support wellbeing

In September, we launched the Perkbox app, as part of our wider wellbeing offer, providing a range of staff benefits including access to an online/virtual GP alongside wider wellbeing support along with virtual Physiotherapy support for aches, pains and musculoskeletal concerns. Perkbox also increases opportunities for staff reward and recognition alongside a wide range of staff discounts, savings and benefits.

HEARTS awards

Congratulations to all colleagues who were recognised at this year's HEARTS awards, held for the first time at Makeney Hall thanks to the sponsorship received from our partners at Patchwork, LIO, Hill Dickinson, Thalamos, Browne Jacobson and Arden Partnership. It was great to hear about the fabulous achievements of all our finalists and to celebrate the winners in each category.

The quality of award entries this year was exceptionally high. I know the judging panel found it very difficult to shortlist our finalists and agree the winners, given the standard of nominations we received.

The winners were:

- Clinical Team of the Year Award - Specialist Memory Assessment and Dementia Support service
- Non-Clinical Team of the Year Award - Derwent Unit and Radbourne Unit Reception teams
- Making a Positive Difference Award **-** Megan Moorhouse, Occupational Therapy, Kingfisher House
- Patient Focus Award **-** Infant Feeding team and 0-5 Health Visiting teams
- Productivity, Sustainability and Innovation Award – Mental Health Liaison team
- Partnership and Collaboration Award - Psychiatry Teaching Unit
- Outstanding Care and Compassion Award - Augustina Sunday, Cherry Tree Close
- Rising Star Award – Niamh Kerry, Inpatient Dietetics team
- Inclusive Leader Award - Emelie Anekwu, Mental Health Physiotherapy Team – Bluebell Ward and Derwent Unit
- Lifetime Achievement - Audrey Williamson, David Hackett, Helena Goodwin, Kulbeer Basran, Lesley Newton Griffiths, Susan Coxon.

Team visits

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

- Carsington Unit on 29 September
- Kingfisher House on 29 October
- Board Visit to the Equality, Diversity and Inclusion team on 12 November
- Pharmacy team on 17 November.

I have also met with colleagues from the Integrated Care Board and NHSE as part of my routine external relationship building.

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

- Vikki Ashton Taylor, Deputy Chief Executive and Chief Delivery Officer, has visited these sites:
    - Dementia Rapid Response Team (DRRT) and In Reach Home Treatment Team (IRHTT) in the High Peak, Bakewell on 1 October.
    - Walk and Talk for Mental Health at the Kingsway site on 9 October.
    - DRRT South in Kingsway House on 30 October.
    - Dietetics Team at Kingsway on 23 November.
- Rebecca Oakley, Director of People, Organisational Development and Inclusion, attended a Board Visit to Snowdrop Ward at Walton Hospital on 17 September and visited staff governors at St Mary's Gate in Chesterfield on 25 September, our Estates Team at Kingsway House on 16 October, and the Radbourne Unit on 13 November.
- James Sabin, Director of Finance, has visited the following locations:
    - St Andrews House, Dovedale Day Hospital and London Road Resource Centre on 7 October.
    - Dove Ward at the Carsington Unit on 8 October.
    - Erewash Adults of Working Age CMHT at Ilkeston Resource Centre on 15 October.
- Tumi Banda, Director of Nursing, Allied Health Professionals, Quality and Patient Experience, has visited the following locations:
    - Kedleston Unit on 22 September.
    - Physical Teaching Hub/Undergraduate Education Team on 7 October.
    - Physical Health Hub on 12 November.
    - Board Visit to Ward 35, Radbourne Unit on 19 November.

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

Raising awareness and community engagement

2026 saw the 39th Black History Month, with the theme of 'honouring our communities'. During the month we explored the work of our Patient and Carer Race Equality Framework (PCREF), as well as discussing the strengths that come from the diversity of our Board of Directors.

A series of Walk and Talk events were held at Kingsway Hospital in Derby to mark World Mental Health Day on 10 October. We know that fresh air and physical exercise provide a wide range of benefits for our mental health and emotional wellbeing.

October was also Freedom to Speak Up Month. I want all colleagues to feel confident to speak up about any concerns – it is important we learn and improve from people's feedback. Speaking up can also act as an early warning sign to catch risks, fix errors and improve the quality and people's experiences of the care we provide. We pledge to show colleagues that listening is an active, compassionate responsibility, with leaders acting on feedback.

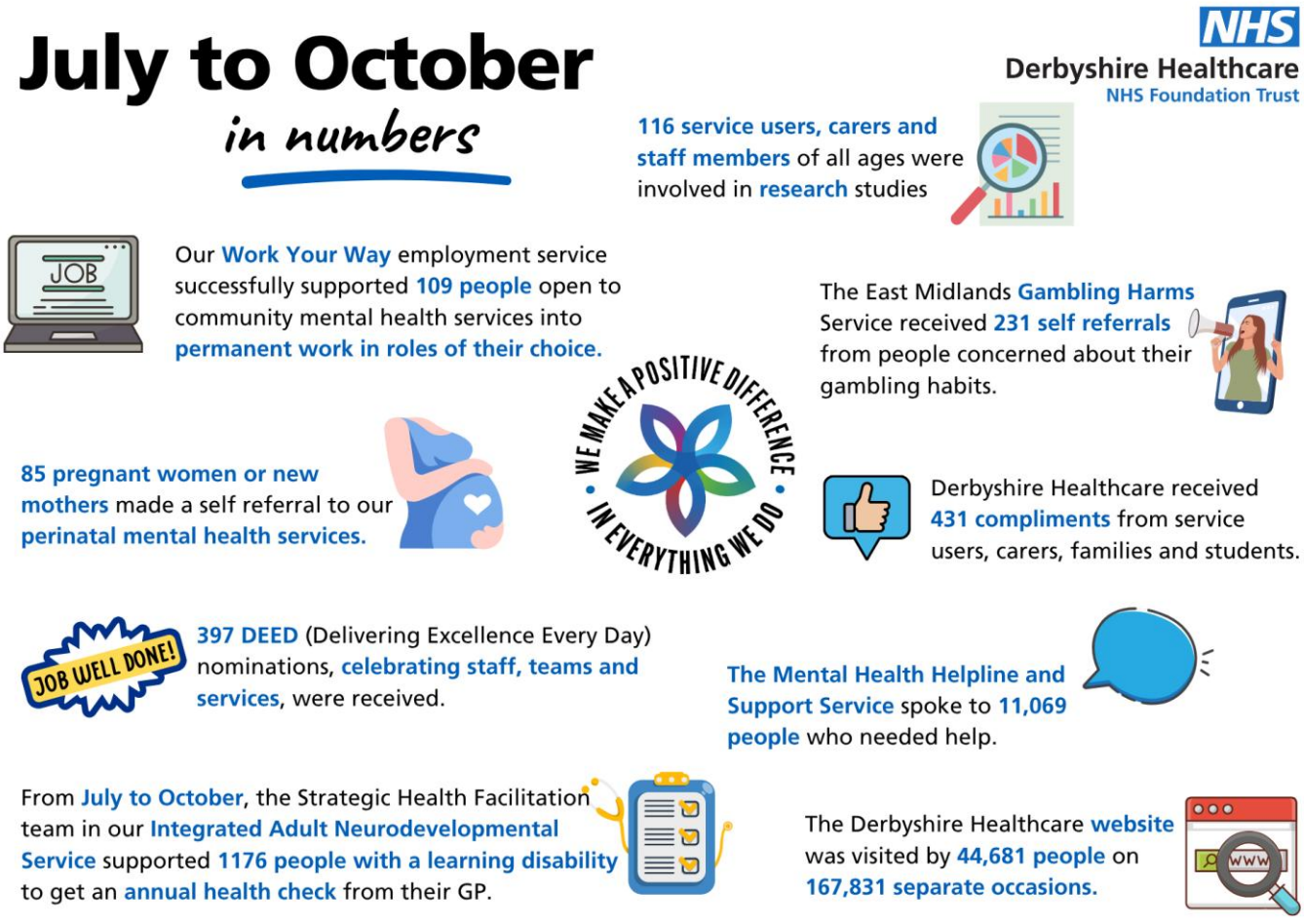
During organ donation week it was moving to read about the experiences of Yvonne, a Trust Occupational Therapist whose life has been transformed by two kidney transplants.

In November, our Armed Forces Network marked Armistice Day, with a special reflection event taking place in the Trust's memorial garden.

Memorial events

On 29 September people met in our memorial garden at Kingsway Hospital to remember and pay tribute to colleagues **Richard Day**, **Sally Morton** and **Deborah Rogers**, who we sadly lost this year.

Recent activity data



Strategic Considerations		BAF Risk(s)	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X	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 require 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 September 2026 for internal measures, and to the end of August 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 Performance

This section summarises performance across key quality, safety, patient experience and flow measures for August and September 2026, alongside the latest published tobacco treatment and flu vaccination measures.

Overall performance was mixed. Falls, ligature and absconding incidents remained within improvement thresholds, and Duty of Candour (DoC) requirements were met for the September incident. Seclusion, physical and prone restraint, patient-to-patient violence and assaults on staff reduced but remained above ambition. Continued Board oversight is required for complaints timeliness, medicines-management risks, Care Programme Approach (CPA) reviews, discharge barriers and patients not seen for over 12 months. Established governance arrangements support oversight, but the two-month position does not demonstrate sustained improvement.

Areas of assurance

Absconding remained below ambition, with 16 incidents in August and 17 in September against a threshold of 21 or fewer. Monitoring continues through inpatient governance routes.

Seclusion and physical restraint reduced from 35 to 21 episodes and 152 to 140 incidents respectively between August and September. Both remained above ambition; oversight continues through the Reducing Restrictive Practice Group and Safer Steps Programme.

Violence and aggression reduced, with patient-to-patient incidents falling from 38 to 27 and assaults on staff from 45 to 39. Both measures remained above ambition, requiring continued focused monitoring and staff support.

Prone restraint reduced from nine incidents in August to seven in September. The zero target was not achieved; individual incident review and targeted ward support continue through the Positive and Safe team.

Falls remained stable and within ambition at 35 in both months against a threshold of 39 or fewer. Most resulted in low or no harm, but significant injuries, including fractures, occurred; falls prevention and Care Group oversight continue.

Ligature incidents remained within ambition at 45 in August and 46 in September against a threshold of 55 or fewer. No fixed-point incidents were recorded in either month. A fatal non-fixed ligature incident in August 2026 prompted an organisational review to identify learning, and improvement actions were implemented as required. Non-fixed ligatures remain the predominant risk, with individualised risk management and Ligature Risk Reduction Group oversight.

DoC requirements were met for the one incident reported in September, with an apology letter issued; none were reported in August. Some incidents remain under review and the data may change.

Tobacco treatment met target and governance remains established. The latest published supported quit-attempt measure was 50%, meeting target, although further periods are needed to confirm sustainability. Specialist groups, Divisional reviews, Care Group meetings and multi-agency escalation provide ongoing oversight.

Areas of risk

Complaints timeliness remains below target, improving from 50% in August to 72.2% in September against 100%. Sustained compliance has not been achieved; the complaints improvement plan and Patient Experience oversight remain in place.

Restrictive practice remains above ambition despite reductions. September physical restraint was 140 against 88 or fewer, seclusion was 21 against 18 or fewer and prone restraint was seven against zero. Ward variation and repeated interventions require continued targeted action.

Patients not seen for over 12 months remain a material risk, increasing from 308 in August to 311 in September against a zero target. Access, safety and regulatory risks require continued service improvement plans, divisional business review and care group operational oversight.

Assaults on staff remain above ambition at 39 in September against 24 or fewer, despite reducing from 45 in August. Activity remains concentrated in Older People's Inpatient wards and the Psychiatric Intensive Care Unit (PICU). The No Excuse for Abuse approach supports monitoring and staff support.

Medication incidents remain above ambition at 135 in August and 133 in September against 122 or fewer. Predominantly low reported harm does not remove recurring administration, documentation, controlled-drug and post-rapid-tranquillisation monitoring risks. Pharmacy reviews, ward action plans and medicines governance continue.

Patient-to-patient violence remains above ambition at 27 incidents in September against 19 or fewer, despite reducing from 38 in August. Concentration in the PICU and a small number of Inpatient wards requires continued focused review through the Reducing Restrictive Practice Group.

CPA compliance declined and flu vaccination remains below target. CPA annual reviews reduced from 80.4% in August to 79.2% in September against 95%, requiring targeted Divisional oversight. The current flu vaccination rate is 28.6% against a Trust target of vaccinating 49% of frontline healthcare workers by the end of the campaign in March 2027. Campaign oversight continues through the Trust plan and People and Culture governance.

Discharge flow remains constrained, with the proportion clinically ready for discharge increasing from 6.9% in August to 7.6% in September against 3.5% or less. Housing, funding and social care barriers remain subject to twice-weekly multi-agency discharge meetings.

Operational Performance

Overall operational performance is mixed: several clinical access, safety and outcome measures remain strong, while sustained demand-capacity gaps, workforce pressures and inpatient flow constraints continue to drive material risk. The recommended assurance level remains limited. Priority actions are as follows: maintain grip on crisis response and helpline recovery; reduce out of area (OoA) placements, length of stay (LoS) and discharge delays; accelerate Community Paediatrics and Neurodevelopmental backlog plans; stabilise workforce capacity and sickness; embed consistent outcome measure completion; and secure System partner action on commissioning, accommodation, discharge and sustainable capacity.

Areas of assurance

The 72-hour post-discharge follow-up standard continues to be exceeded, placing the Trust among the top providers nationally, and the 14-day mental health readmission rate is in the best-performing segment

Early intervention in psychosis has exceeded target for eight consecutive months; Individual Placement and Support activity is 31% above target; and Derby and Derbyshire performs strongly for dementia diagnosis and specialist Perinatal access rate.

Mental Health Helpline answer times are among the quickest in the Midlands, with call abandonment reducing substantially. Older Adult LoS is within trajectory, Paediatric Physiotherapy has cleared waits over 52 weeks and the 0–4 Community Paediatrics backlog has reduced markedly

Areas of risk

Urgent crisis face-to-face contact within 24 hours remains below national performance, although October data show improvement. Demand continues to exceed commissioned capacity in the Mental Health Helpline, Community Paediatrics, autism, attention deficit hyperactive disorder (ADHD) and other Neurodevelopmental pathways, resulting in long waits and poor access rankings. Inpatient services remain pressured with a number of female PICU OoA placements, and Adult Acute LoS above trajectory. Paired outcome-measure completion is particularly weak for children and young people (CYP), while national methodology continues to overstate CYP waits over 104 weeks by including adults first referred before age 18. Perinatal access is above the national standard but below the Integrated Care Board's much more stretching local trajectory.

People Performance

People performance remains strong across compulsory training, turnover and clinical supervision, with all three measures meeting or exceeding their respective targets. Principal workforce risks remain with high sickness absence levels and appraisal compliance being below target. Vacancy levels continue to fall, and agency usage remains low, supported by strengthened oversight and vacancy-filling activity.

Areas of assurance

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

Compulsory training compliance remains robust at 95.7% and continues to perform above the 95% target.

Annual turnover remains healthy at 10.6%, in line with national and regional benchmarks and below the Trust's 12% upper tolerance, indicating a relatively stable workforce.

Clinical supervision compliance remains above target at 96% and management supervision slightly below target at 94.5%.

Areas of risk

Sickness absence remains a key concern and priority area of focus within the Trust. The September 2026 monthly absence rate was 6.9%, comprising of 2.7% short-term absence and 4.2% long-term absence. Anxiety, stress or depression-related illness remains the leading cause, reinforcing the need for sustained focus on wellbeing, early intervention and strengthening managers skills in supporting staff and managing sickness absence.

Annual appraisal compliance has remained in the high eighties over the past five months, consistently below the revised 95% target. Key areas of focus remain to understand the reasons for decline and addressing appraisals that are overdue or approaching renewal. Agency usage remains low compared with the previous year as work continues to reduce this further.

Financial Performance

At the end of September, there is a deficit of £0.9m, which has been adjusted for the IFRS16 PFI adjustment, bringing the adjusted financial position to a deficit of £0.8m which is better than the plan by £0.1m. The deficit position is mainly driven by OoA expenditure and acuity on the Inpatient wards, which has been partly mitigated by other underspends.

Areas of assurance

The plan includes an efficiency requirement of £14.8m with the plan assuming 72% is delivered recurrently. At the end of September efficiencies have delivered £6.7m against a plan of £6.7m.

The forecast assumes the full efficiency programme will be delivered.

Capital is below plan at the end of September by £1.9m. The forecast includes additional expenditure related to nationally-funded schemes not in the plan.

Cash at the end of September was £33.3m (£34.5m last month) against a plan of £23.5m, £9.8m above the plan. There are no concerns in relation to debt recovery.

The Better Payment Practice Code (BPPC) sets a target for 95% of all invoices to be paid within 30 days. BPPC is measured across both invoice value and volume of invoices. At the end of September, the volume and value of invoices was above target at 95.3% and 97.9% respectively.

Areas of risk

Agency expenditure at the end of September 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 September by £0.9m and is forecast to be over plan by £1.4m by the end of the financial year.

At the end of September, OoA expenditure is above plan by £1.6m. The current forecast is based on a reducing trajectory which brings the forecast overspend to £1.6m by the end of the financial year.

Strategic Considerations		**Board Assurance Framework (BAF) 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

Derbyshire Healthcare
NHS Foundation Trust

Integrated Performance Report

24 November 2026

www.derbyshirehealthcareft.nhs.uk
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Director of Nursing, Allied Health Professions, Quality and Patient Experience:
Tumi Banda

Responsible Committee: **Quality and Safety Committee**

Executive Summary

This update focuses on performance during August and September 2026. Measures are reviewed against the 2026/27 improvement ambitions in the Quality 2026 scorecard and the supporting Quality Dashboard. The period shows a mixed position: seclusion, physical restraint, prone restraint, assaults on staff and ligature incidents reduced, while falls remained stable and Duty of Candour (DoC) compliance was maintained. However, complaints timeliness, restrictive practice, medication incidents, Care Programme Approach (CPA) reviews and discharge flow require continued targeted action and Board oversight. Governance and mitigation remain in place through Care Group and Divisional performance reviews, specialist safety groups, patient experience and patient safety processes, and multi-agency discharge arrangements.

Overview

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

Performance remained below the 100% target, with 50.0% of complaints responded to within 90 working days in August and 72.2% in September. September showed improvement, but sustained compliance has not yet been achieved. The complaints improvement plan remains in place, with oversight through the Patient Experience team, Care Group performance meetings and the quarterly Patient Experience report.

Seclusion episodes per month (Target: ≤18)

Seclusion episodes reduced from 35 in August to 21 in September. Both months remained above the improvement ambition of 18 or fewer, although September activity was 40% lower than August. Activity remained concentrated in the Psychiatric Intensive Care Unit (PICU) and the Radbourne Unit. Oversight continues through the Reducing Restrictive Practice Group, seclusion reviews and the Safer Steps Programme.

Physical restraint incidents per month (Target: ≤88)

Physical restraint reduced from 152 incidents in August to 140 in September, a 7.9% reduction, but remained above the improvement ambition of 88 or fewer in both months. Activity continued to vary between clinical areas and was influenced by repeated interventions involving a small number of unwell patients. Positive and Safe teamwork compliance was 91% and supplementary training continues, with oversight through the Training and Education Committee and Reducing Restrictive Practice Group.

Physical restraint by prone position (Target: 0)

Prone restraint reduced from nine incidents in August to seven in September but remained above the zero target. The reduction provides positive evidence of movement away from higher-risk restrictive interventions. The targeted prone-reduction project continues on female wards and PICU, with individual incident review and ward support provided by the Positive and Safe team.

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

Incidents reduced from 38 in August to 27 in September, a 28.9% reduction, but remained above the improvement ambition of 19 or fewer in both months. The Quality Dashboard identifies concentration in PICU and a small number of inpatient wards. Most incidents resulted in low or no harm. Oversight continues through the Reducing Restrictive Practice Group.

Assaults on staff by patients (Target: ≤24)

Assaults on staff reduced from 45 in August to 39 in September, a 13.3% reduction, but remained above the improvement ambition of 24 or fewer. The improvement follows the July high point, although activity remains concentrated in Older People's Inpatient wards and PICU. Monitoring continues through the Reducing Restrictive Practice Group and the Trust's No Excuse for Abuse approach; race-related abuse remains a staff safety and equality concern.

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

Ligature incidents were 45 in August and 46 in September, both below the improvement ambition of 55 or fewer and broadly stable. No fixed-point incidents were recorded in either month, meeting the target of three or fewer. A fatal non-fixed ligature incident in August 2026 prompted an organisational review to identify learning, and improvement actions were implemented as required. Non-fixed ligatures remain the predominant risk, with oversight through the monthly Ligature Risk Reduction Group, individualised risk management and ward-level environmental safety plans.

Medication incidents per month (Target: ≤122)

Medication incidents remained above the improvement ambition, at 135 in August and 133 in September, although they reduced slightly and were predominantly no harm or insignificant harm. Recurring themes include administration and dose errors, missed or undocumented doses, controlled-drug governance, prescribing and medicines reconciliation, storage monitoring and incomplete post-rapid-tranquillisation monitoring. Mitigations include targeted education, strengthened ePMA use, ward action plans, pharmacy Datix reviews and escalation through medicines governance groups.

Falls on Inpatient wards (Target: ≤39)

Falls were stable at 35 in both August and September, meeting the improvement ambition of 39 or fewer. Incidents remained concentrated in Older People's Acute Inpatient services. Most resulted in low or no harm, although significant injuries, including fractures, occurred. Oversight continues through the Falls Lead, clinical leadership, bi-weekly falls prevention meetings and monthly Care Group performance review.

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

Incidents increased slightly from 16 in August to 17 in September but remained below the improvement ambition of 21 or fewer in both months. The dashboard reports common cause variation with no emerging pattern of harm; monitoring continues through inpatient governance routes.

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

No DoC incidents were reported in August, and one was reported in September. The Quality Dashboard confirms that DoC requirements were met for the September incident, with an apology letter issued. Some incidents remain under review and the data may change.

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

CPA annual review compliance reduced from 80.4% in August to 79.2% in September, remaining below the 95% target. Variation between divisions requires targeted oversight through Divisional performance reviews, Care Group Fundamentals of Care meetings and service action plans. The Trust is preparing to transition to the mental health Personalised Care Framework, while CPA indicators remain in place until implementation is complete.

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

The proportion remained above the 3.5% threshold, increasing from 6.9% in August to 7.6% in September. The principal causes remain unavailable suitable housing, funding arrangements and social care placements. Twice-weekly multi-agency discharge event meetings continue to escalate and resolve barriers.

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

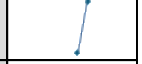
The number increased slightly from 308 in August to 311 in September, following the earlier improving trajectory. Performance remains materially above the zero target and continues to represent an access, safety and regulatory risk. Oversight is maintained through divisional business meetings, Care Group operational meetings and service performance improvement plans.

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

The latest published position is 50%, meeting the 50% target. As this is an NHS England (NHSE) measure with limited published data, further periods are required to confirm sustained performance.

NHS Oversight Framework 2026/27 healthcare worker flu vaccination rate (Target: 49%)

The current flu vaccination rate is 28.6% against a Trust target of vaccinating 49% of frontline health care workers by the end of the campaign in March 2027. The 2026/27 campaign commenced in October, with delivery and equity actions monitored through the approved Trust flu vaccination plan and People and Culture governance arrangements.

Measure	Target	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	
No. of complaints responded to within 90 working days (rolling 24 months)	100%	27%	20%	23%	44%	43%	44%	42%	43%	43%	74%	50%	72%	
Seclusion episodes per month	18	28	15	26	17	16	27	14	31	34	35	35	21	
Physical restraint incidents per month	88	89	72	75	112	146	139	129	151	170	154	152	140	
Prone restraint incidents per month	0	14	14	14	10	19	3	11	10	16	8	9	7	
Incidents of violence and aggression between patients per month	19	34	27	19	18	19	15	23	39	35	23	38	27	
Assaults on staff by patients per month	24	26	24	22	23	26	29	33	45	57	69	45	39	
Ligature incidents per month	55	47	65	35	77	31	73	60	52	90	75	45	46	
Ligature incidents per month involving fixed points	3	4	5	4	4	0	4	1	2	5	3	0	0	
Medication incidents per month	122	162	179	163	162	131	129	113	158	162	162	135	133	
Falls per month	39	32	33	40	43	44	38	49	47	46	45	35	35	
Abscond, escape and fail to return incidents	21	18	23	21	24	20	29	13	19	8	8	16	17	
Duty of candour incidents	0	4	0	1	3	2	5	0	4	3	1	0	1	
Care programme approach (CPA) annual reviews	95%	79%	79%	82%	82%	80%	76%	76%	76%	79%	80%	80%	79%	
Proportion of patients clinically ready for discharge	3.5%	12%	11%	11%	11%	9%	12%	9%	9%	9%	8%	7%	8%	
Patients open to mental health services but not seen for over 12 months	0	460	433	399	408	401	401	421	384	426	366	308	311	
NOF percentage of inpatients referred to and seen by an in-house tobacco treatment service who make a supported attempt to stop smoking[1]	50%							0%	50%					
NOF healthcare worker flu vaccination rate[1]	54%							44%	44%					

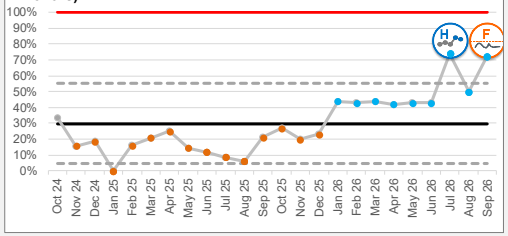
[1]NHS England data

Target

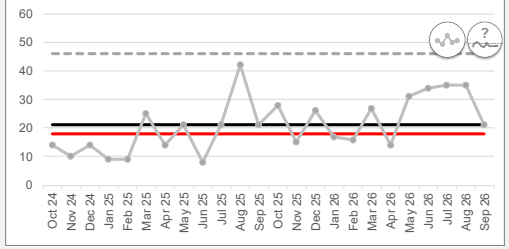
Mean over the past 24 months

Quality Key Performance Indicators – Statistical Process Control Charts

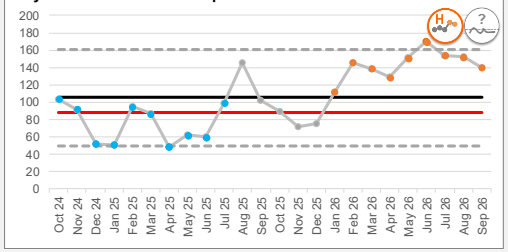
Complaints responded to within 90 working days (rolling 24 months)



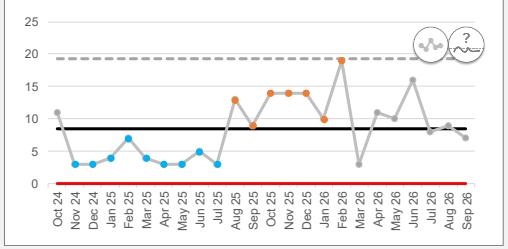
Seclusion episodes per month



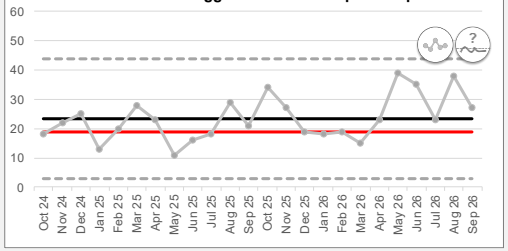
Physical restraint incidents per month



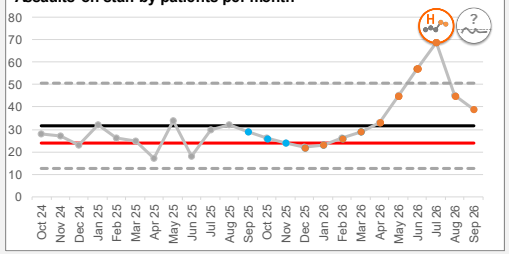
Physical restraint by prone only position per month



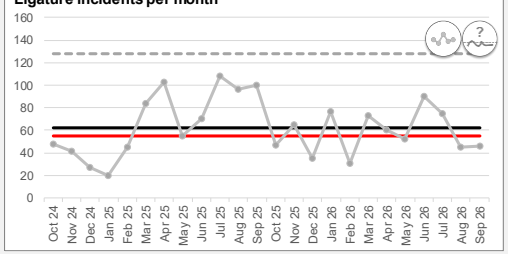
Incidents of violence and aggression between patients per month



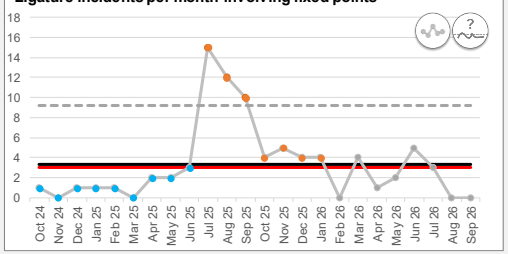
Assaults on staff by patients per month



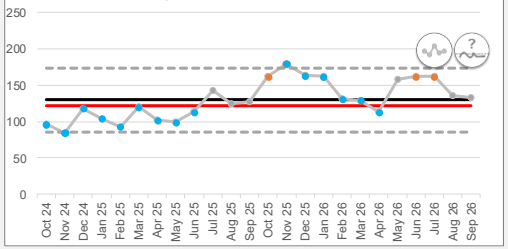
Ligature incidents per month



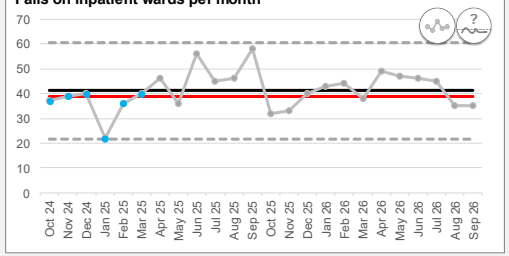
Ligature incidents per month involving fixed points



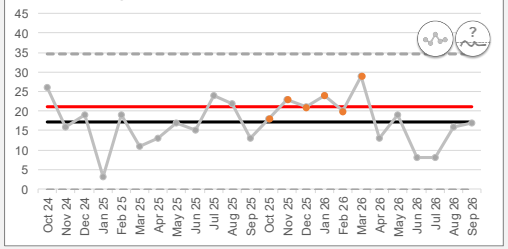
Medication incidents per month



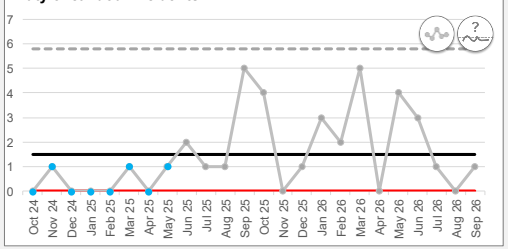
Falls on inpatient wards per month



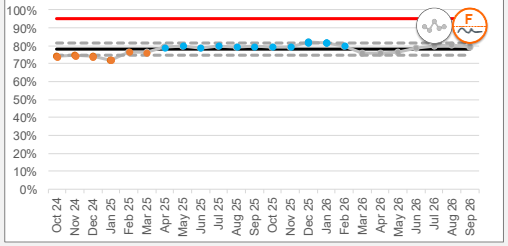
Abscond, escape and fail to return incidents



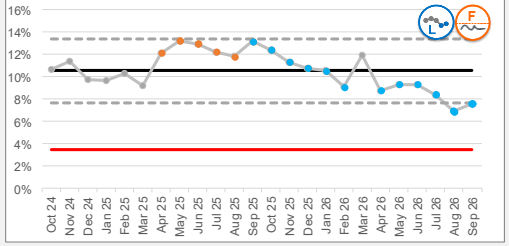
Duty of candour incidents



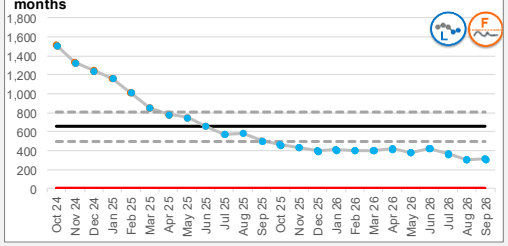
Care programme approach (CPA) annual reviews



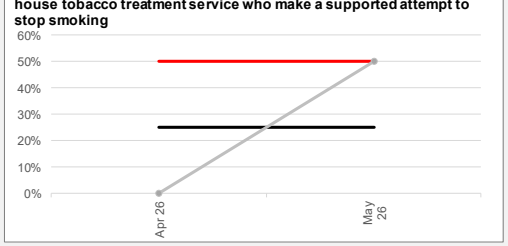
Proportion of patients clinically ready for discharge



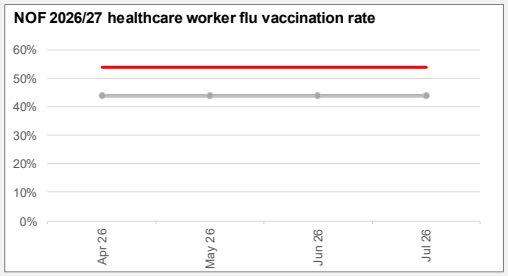
Patients open to mental health services but not seen for over 12 months



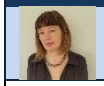
NOF 2026/27 percentage of inpatients referred to and seen by an in-house tobacco treatment service who make a supported attempt to stop smoking



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

NHS oversight framework

The Quarter 2 (Q2) rankings and scores are yet to be published. From internal analysis it is forecast that the overall result will be very similar to Q1 and again place in segment 3, with the usual caveat that it is not possible to predict with certainty. The notable changes in Q2 include: the percentage of urgent crisis response patients to receive face-to-face care within 24 hours dropping from 71% (segment 2) to 60% (segment 3); the percentage of clinical trials set up within 90 days dropping from 100% (segment 1) to 50% (Segment 4); sickness absence increasing by from 6.1% to 6.4%, dropping into segment 4 from segment 3; and the percentage of inpatients referred to and seen by an in-house Tobacco Treatment service who make a supported attempt to stop smoking increasing from 0% (segment 4) to 40% (segment 1).

Inflow

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

This is an NHS Oversight Framework (NOF) measure of the proportion of urgent referrals made to Crisis teams and Mental Health Single Points of Access who were seen face to face within 24 hours. In the latest published data (August 2026), the service achieved 60% against the national average of 73.6% and placed in the worst performing 25% of providers.

A full performance improvement plan is in place, and October to date the position has improved to 76.6%. There are a number of factors contributing to the recent decline. Vacancy factor particular in the city and county south has reduced capacity. 5.0 whole time equivalent (WTE) Band 6 have now been recruited to, reducing the gap. Short-term and long-term sickness as well as employee relations cases are also contributing to reduced staffing capacity. A weekly escalation meeting is in place chaired by the Deputy Director of Operations and Head of Practice to support the remedial actions needed. A workforce assurance meeting has also been agreed (chaired by the Director of People) to ensure oversight and grip on the broader workforce issues. Medium-term work is needed across all adult services to understand the demand and capacity on the service in greater detail and ensure appropriate decisions and escalations on service delivery can be made, as well as future-proofing service delivery.

Mental Health Helpline

From the latest official statistics published by NHSE (August 2026), the proportion of calls to the helpline which were abandoned (callers hung up) after interactive voice response call steering was third highest in the Midlands at 25%. However, this has improved significantly from 40% in March 2026 and fell just below the national average of 26%. The Trust's speed to answer calls was the second quickest in the Midlands, at 68 seconds. This was considerably quicker than the national average of 220 seconds.

Demand for the service continues to remain high, with call volumes for the professional line being up to 200 per week and the helpline being up to 800 per week. The service remains focused on delivery of the performance improvement plan, with weekly performance cross check meetings which have been reviewed by the new team leadership in place following operational phase 1b. The service continues to provide daily mental health practitioner support to East Midlands Ambulance Service (EMAS) colleagues in respect of the Mental Health Response Vehicle, and have also prioritised this as a service necessity, which in turn impacts on the wider pathway of Emergency Department avoidance and hospital admission. A consultation relating the relocation of the helpline is complete, the team will relocate in November to the Mental Health Urgent Access Centre alongside Crisis teams which will support better integration of urgent services.

- The Mental Health Text Message service was successfully implemented on 1 July 2026 following completion of testing and staff training. The service is now operational and forms part of the wider offer to improve accessibility and choice for people seeking support but is currently receiving an average of just six texts per week.

This has been a phased implementation plan, currently operational for all known patients to Working Age Adult services. A slight pause in the wider roll-out occurred owing to the consultation and move. However, with this now complete, further roll-out to the public (adults) is planned to be realised by the end of November with communication and engagement plans being worked through currently. Access for Children and Young People (CYP) services is also still being worked through. It is essential that the pathway is robust clinically as the urgent services operate differently to adult services, and it essential that the right escalation routes are enabled from the text to business as usual services

- Engagement with the Integrated Care Board (ICB) regarding the future service specification continues. Discussions remain focused on ensuring that commissioning arrangements accurately reflect current service demand of all services provided by the helpline and support service activity and workforce requirements
- Whilst improvements have been made, demand continues to exceed commissioned capacity. This remains a risk to performance and service delivery and continues to be highlighted through commissioning discussions and performance assurance processes. Funding for two WTE Band 6 posts reinvestment into the helpline was agreed. However, this is currently stalled as the funding is no longer available.

Adult Community Mental Health team (CMHT) waits

There are currently 1,230 patients waiting on the various Adult CMHT external waiting lists. The average wait is 10 weeks (median seven weeks). 213 patients have been waiting over 18 weeks (17%) and 13 have been waiting over 52 weeks (1%). A performance improvement plan is in place. The plan aims to reduce waiting lists in line with the agreed recovery trajectory while keeping patients safe during their wait.

Main priorities:

- Strengthen waiting well compliance: require monthly audits; standardise SystmOne documentation; and increase management and governance scrutiny
- Prioritise patients at greatest risk: ensure plans are in place for people waiting over 52 weeks and those with higher complexity, escalating risk or safeguarding concerns
- Reduce backlogs and improve flow: review high-volume pathways, particularly single points of access, and introduce targeted outpatient recovery actions in Amber Valley, Erewash and Derby City
- Address capacity constraints: protect management time, review staffing and skill mix, escalate system barriers and monitor staff wellbeing
- Improve assurance: cleanse waiting-list data monthly, strengthen digital reporting, review referral and triage processes, and report progress through governance forums.

Mental health 14 day readmission rate

The rate of readmissions to Adult Acute, Older Adult or PICU beds within 14 days of discharge has reduced to 5% which places in the best performing segment of the NOF and is below the national average of 5.8%.

Reduce Accident and Emergency (A&E) referrals to Liaison teams of patients known to Mental Health services

This is one of three mental health sector priority targets set this financial year. To date there is no data published. However, NHSE has advised that the data is currently in testing phase.

Outflow

Inappropriate out of area (OoA) Adult Acute and PICU placements

At the end of September there were zero Older Adults, one Adult Acute, one male PICU and 13 female PICU inappropriate OoA. The ICB recognises a maximum of three female PICU placements. From an acute bed perspective, at the end of September there were 13 patients placed in acute OoA continuity of care placements.

A mental health sector priority has been set to reduce Adult Acute inappropriate OoA placements by 50% from the March baseline (excluding PICU placements). As there was only one patient out of area in March, this means that the Trust must effectively eliminate inappropriate acute placements by year end if the target is to be achieved.

The Clinical Bed Manager is in post and is providing clinical oversight to PICU female patients. There is ongoing work via gatekeeping including a new performance improvement plan being drafted to capture the short to long term improvements needed around gatekeeping, aiming to reduce inappropriate admissions and ensure Getting it Right First Time (GiRFT) principles are being followed around purposeful admission.

Average Length of Stay (LoS) for Adult Acute and PICU mental health beds (rolling three months)

From July to September the average (mean) LoS was 58 days against the medium term plan target of 48.5 days. During the three months there have been a number of discharges of people with unusually long LoS of over 200 days, which is positive, but means that average LoS gets worse before it can start to get better. If excluding those discharges, the mean LoS would have been just 45.2 days. (Median LoS of all discharges was 36.5 days). LoS has also been impacted by delays to discharge when clinically ready, which inflated mean length of stay by 4.7 days. In total the discharged patients experienced 1,191 delayed bed days at a cost of £956.3k.

Changes to Patient Flow Delivery Group have been made to ensure the improvements made within flow have more stringent oversight and are impactful. Ongoing emphasis and iterative changes to the GiRFT)/LoS meeting are happening to ensure the correct outputs in terms of reduction in LoS are being achieved. Changes planned this month to that process include building in an escalation for any ward holding over 25% of patients with 60 days plus LoS (who are not clinically ready for discharge) and revising the terms of reference to ensure correct triumvirate oversight and grip.

Average LoS for Older Adult mental health beds

From July to September the average (mean) LoS was 75.6 days, achieving the medium-term plan target of 80.3 days. Delay to discharges when clinically ready has inflated average LoS by 14.4 days, which is significant. In total the discharged patients experienced 1,242 delayed bed days at a cost of £1.2m. A revised performance improvement plan for Older Adult LoS reduction and improved flow has been implemented. Weekly reporting remains in place regarding performance against a suite of Older People inpatients Fundamentals of Care metrics, including LoS.

Adult Acute and Rehabilitation discharges followed up within 72 hours

The national standard for follow-up after inpatient discharge continues to be consistently exceeded, ensuring patients get support at the time they are most vulnerable, and placing the Trust in the top nine of providers nationally. This process continues to be tightly monitored on a daily basis by the Trust's Performance Analyst to ensure the safety of patients.

Discharges from CMH services with a paired outcome score

A new NOF metric for this financial year is a measure of the proportion of people discharged from CMH services who had a paired outcome measure completed. This means completion of an outcome measure at the start of their episode of care, then repeating the same outcome measure at discharge in order to enable comparison of the scores at the start and end of treatment as a measure of effectiveness. For adults, this is patient reported outcome measures, ie outcome measures completed by the patients themselves, and for children this can be patient or clinician reported. In the latest official data the completion rate for adults was 14%, placing in the top 16 of trusts, and for children was 9%, placing 49th out of 54 NHS providers.

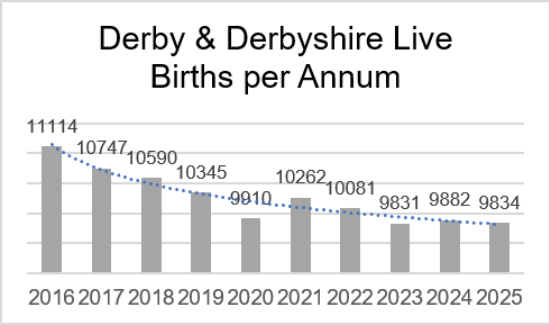
Action is being taken to revise the relevant standard operating procedures. Work across the Adult and CYP teams has started with a review of the current outcomes being used, with a view of standardising the measures where possible. Paired outcomes have been added to the productivity transformation workplan as it requires a whole service approach to ensure that the outcomes measures are embedded in practice and we have the right clinical, Information Management, Technology and Records (IMT&R) and operational framework for sustainability of the programme.

Elective/access

Women accessing specialist Perinatal Mental Health service

The current access rate remains above the national 10% target at 11.7% and again placed NHS Derby and Derbyshire ICB in the top eight performers nationally, with Nottinghamshire placing 20th and Lincolnshire placing 18th.

The NHS long-term plan target is for 10% of mothers to access services. However, live births have fallen year-on-year since this target was set based on 2016 births, and in the latest data covering 2025, births were 11.5% lower than the target year.



The fall in live births means that to meet the target of 1358 mothers accessing the service, 13.8% of mothers need to be seen, which is a considerably higher target than the 10% long-term plan requirement, and higher than the targets set for our peers. The targets were set prior to the live births data being published, with the Trust's target being based on median performance over a 12 month period.

ICB	Live births 2025	Target	% of births
Derby & Derbyshire	9834	1358	13.8%
Nottingham & Nottinghamshire	10483	1315	12.5%
Lincolnshire	6004	720	12.0%

Rolling 12 months access has fallen below this challenging target for the last three months. Referral demand remains sufficient to meet target, but workforce capacity is limiting recovery.

Recruitment across both Community teams is expected to finish by October 2026, with the revised performance improvement plan tracking assessments, waiting times, workforce capacity and recovery actions; assurance remains partial and further discussions will need to take place with the ICB and NHSE to ensure we are being measured on par with other providers in the cluster.

Community waits over 52 weeks and waits under 18 weeks

The position continues to improve, and September saw a reduction to 40% of children waiting over 52 weeks to be seen. At the time of writing, this has further reduced to 30%. The majority of the long waits are for Community Paediatric autistic spectrum disorder (ASD) assessment and/or attention deficit hyperactive disorder (ADHD) assessment. Demand for Community Paediatrics over the past six years has been as high as 450% above capacity and remains to date at 250% above. There has been limited system ownership to prevent flow into health services. There has been no increase in funding to match increased demand or population increase of 10% over the past 15 years.

Good progress has been made on the CYP Community waits. Paediatric Physiotherapy has cleared all waits over 52 weeks, including the 52 to 104 weeks waiting cohort. This has been achieved through additional Code 5/6 clinics, validation of the waiting list, extra staffing, pathway changes, improved job planning using NHS demand and capacity calculator and use of centralised re-bookable clinics. There remain 27 children still waiting over 18 weeks. These children are reviewed weekly and a revised recovery plan is in place with a trajectory for achieving the 18 week waits by February 2027. Risks to achieving this remain around staffing/sickness, etc. However, the plan is to pull in additional capacity from across the Care Group and wider teams to mitigate this risk if needed.

The 0–4 and 5–16 pathways have now been separated. This protects capacity for younger children and gives a clearer view of both waiting lists. The 0–4 cohort waiting over 52 weeks has reduced from 962 in April 2026 to 21 children. Appointments have been allocated where capacity allows and the remaining cases are being actively managed for treatment by the end of November 2026. A further 600 CYP remain over 18 weeks on the Community Paediatricians Unit, and the team is currently working on a trajectory of March 2027 to achieve the 18 week target.

The assurance on achieving this target is supported that all Medical vacancies have now been filled, additional Consultant and locum capacity is in place, and further substantive capacity is due to start in November. Weekly recovery meetings, daily tracking of the remaining cases, increased clinical contacts supported by a revised standard operating procedure prescribing expected activity and protected new-patient capacity provide assurance that there is clear grip on the position which helps with the forecasting of our position.

CYP mental health waits for help that are over 104 weeks

This is a new NOF metric for 2026/27 and an NHS medium-term plan target to eliminate waits over 104 weeks by financial year end. “Help” is defined by NHSE as an attended appointment, completion of an outcome measure, plus completion of a clinical intervention. In the latest official data 13% of CYP are reported as waiting over 104 weeks, which is a total of 180 against the medium-term plan target of 71. Only 71 of the 180 reported are actually children. So in reality, the trajectory has been achieved. The remaining cohort are patients open to Adult Mental Health services and Adult Neurodevelopmental services, the eldest being 41 years old. Unfortunately, NHSE count anyone as a child if they were aged under 18 at the time their episode of care started and have recently confirmed that they will not be changing this approach.

A performance improvement plan has been devised and is in implementation phase. Work across the Adult and CYP teams has started with a review of the current outcomes being used, with a view of standardising the measures where possible. Outcomes have been added to the productivity transformation workplan as it requires a whole service approach to ensure that the outcomes measures are embedded in practice and we have the right clinical, IMT&R and operational framework for sustainability of the programme.

Early intervention in psychosis

The Early Intervention services and At Risk Mental State (ARMS) Services assess people who are suspected of experiencing a first episode of psychosis. The national standard is to undertake an assessment and assign a Care Co-ordinator within two weeks of people being referred into the service (target 60%). For the last eight months the target has been exceeded.

Individual work placement support

Over the last 12 months the number of people using CMH services in Derbyshire who have been supported to find work and stay in work by the *Work Your Way* team has increased by 26%, and the target has been exceeded by 31%.

Dementia diagnosis

Data are available at ICB-level only, and NHSE are now publishing the data quarterly. In Q1, nationally 66.2% of patients had a recorded diagnosis. At 69.6%, NHS Derby & Derbyshire ICB placed 10th best in the country.

CYP mental health referrals receiving a full clock stop within four weeks: this is one of three new mental health sector priorities for 2026/27. The target is to achieve 50% by financial year end, which is a significant increase from current performance. Prior to the introduction of this metric, the Trust was working to a three-year plan as agreed with the ICB to achieve the four-week target.

This metric has historically applied to the Mental Health Support teams which are commissioned to achieve this target. In Derbyshire, this contract is delivered by a private provider `Compass`. Applying this metric to tier 3 Child and Adolescent Mental Health services is a challenge and we are currently reporting an average 20 week wait. Work is currently underway to review the performance improvement plan to work towards this revised target.

Collaboratives

Transforming care programme

For adults, the Trust and system have agreed a trajectory for 2026/27 to reduce from 32 inpatients in Q1 down to 28 in Q4. As of September 2026, there were 18 adult inpatients with autism, which is two above trajectory, and 16 adults with a learning disability and autism (LD&A), which is in line with trajectory, giving a total of 34 adults in total, two over the trajectory of 32. The agreed target threshold for CYP inpatients is static at three per month, and currently there are three CYP inpatients, which is in line with trajectory.

The LD&A Patient Review team, with the ICB Escalation team, continues to strengthen the transforming care pathway. The primary challenges with the LD&A patient cohort is appropriate care and accommodation pre- and post-admission alongside System tolerance of risk often leading to out of hours admissions. A performance improvement plan is in place and shared with System partners to address these issues with the aim to achieve the target of LD&A admissions of 28 by March 2027.

Living Well

Living Well delivery remains broadly on track, with Adult Social Care funding now confirmed in principle and several practice and operational improvements underway. The main risks relate to workforce capacity, leadership resilience, ICB governance transition and sustainability beyond March 2027. The Strategic Living Well Practitioner role was agreed for substantive recruitment to support ongoing work within Living Well, especially with the transition to Neighbourhood models. Continued support is required to finalise contractual arrangements, maintain System oversight during ICB transition and agree longer-term programme capacity and governance arrangements.

Measure	Target	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	
Medium term plan metrics														
Inappropriate adult acute & PICU mental health out of area placements at month end^ **	6	4	7	4	7	3	6	6	11	7	9	9	15	
Women accessing specialist perinatal mental health services (rolling 12 months)* ^^	1358	1360	1365	1360	1355	1385	1395	1365	1365	1320	1290	1295		
Perinatal access rate (ICB)*	10%	12.3%	12.4%	12.3%	12.2%	12.5%	12.7%	12.5%	12.5%	12.0%	11.7%	11.7%		
Individual work placement support access (rolling 12 months)*	750	780	810	805	845	845	860	885	910	935	955	985		
NHS oversight framework trust operational services scoring metrics for 2026/27														
Proportion of patients waiting over 52 weeks for community care ***	0.5%	66%	62%	66%	62%	63%	51%	52%	54%	55%	48%	44%	40%	
Proportion of patients waiting less than 18 weeks for community care ***	82%	16%	18%	20%	23%	20%	27%	25%	26%	27%	35%	37%	34%	
Children and young people's (CYP) mental health waits for help that are over 104 weeks* ***	11%	10%	10%	10%	11%	12%	13%	13%	12%	13%	13%	13%		
Number of CYP mental health waits for help that are over 104 weeks* **	71	120	125	130	160	180	190	180	175	185	190	180		
Adults discharged from community mental health services with a paired outcome score* ***	12%							14%	13%	13%	13%	14%		
CYP discharged from community mental health services with a paired outcome score* ***	20%							10%	8%	8%	8%	9%		
Mean length of stay for adult acute mental health and PICU patients (latest 3 months)**	49.5	51.6	55.0	55.7	56.9	55.9	52.3	51.3	54.0	54.1	53.5	51.7	58	
Mean length of stay for older adult acute mental health patients (latest 3 months)**	80.7	107.2	101.3	86.0	87.0	93.3	95.7	94.8	88.7	78.9	75.4	76.8	76	
Adult acute and rehabilitation discharges followed up within 72 hours (latest 3 months) ***	71%	86%	91%	86%	91%	92%	89%	90%	88%	88%	91%	88%	93%	
Mental health 14-day readmission rate (latest 3 months)* ***	10%	5%	1%	2%	3%	5%	3%	4%	5%	6%	6%	5%		
Percentage of patients in crisis to receive face-to-face contact within 24 hours* ***	71%	76%	75%	76%	78%	81%	71%	78%	68%	68%	62%	60%		
Data quality maturity index ***	95.2%	99%	99%	99%	98%	97%	97%	98%	98%	98%	98%	98%	98%	
Key operational measures														
Children & young people eating disorder routine referrals seen within 4 weeks	95%	100%	100%	100%	100%	100%	100%	100%	100%	96%	96%	100%	100%	
Children & young people eating disorder urgent referrals seen within 1 week	95%	#N/A	#N/A	#N/A	100%	#N/A	#N/A	#N/A	100%	#N/A	#N/A	#N/A	#N/A	
Dementia diagnosis rate - the data are now published quarterly only (ICB)*	68%	68.9%	68.8%	68.9%	68.7%	68.7%	69.8%			69.2%				
Early intervention in psychosis 2 week waits from referral to treatment - complete	60%	85%	56%	78%	41%	67%	73%	70%	88%	72%	63%	68%	81%	
Mental health sector priorities 2026/27														
Reduce adult acute out of area placements by 95% from March 26 baseline (1 patient)	0							0	2	1	1	1	1	
Reduce A&E referrals to Liaison teams of patients known to mental health services*	tbc							NHSE data is currently in test phase						
Children & young people mental health referrals receiving a full clock stop within 4 weeks*	50%							7%	5%	4%	2%	3%		

Data not available yet - awaiting publication by NHS England

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

* Data source = NHS England

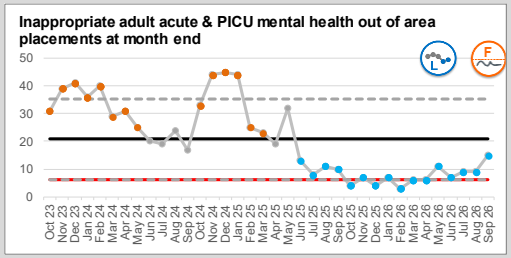
^^ Perinatal and maternal mental health services

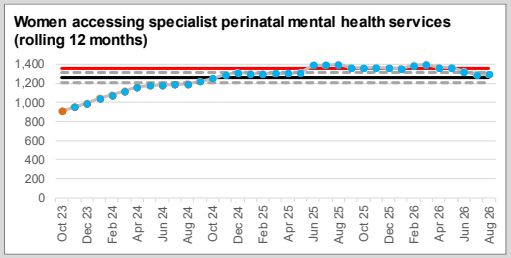
** Target is the level set in the medium term plan trajectory for the latest month.

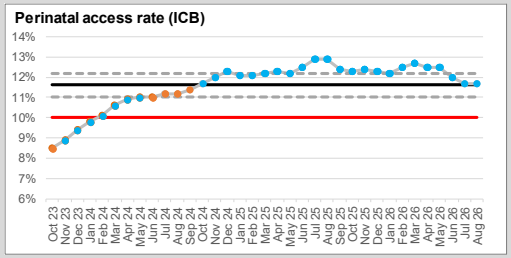
*** Target set is the threshold for achieving segment 2 in the latest NOF quarterly rankings

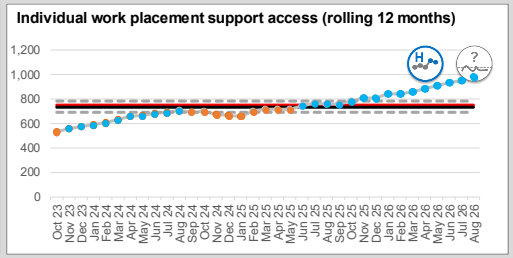
For more information regarding the NOF 2026/27 see: https://www.england.nhs.uk/nhs-oversight-framework/

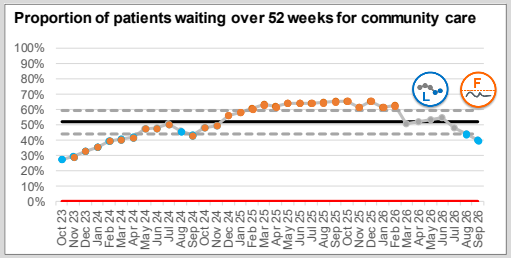
Operational Key Performance Indicators – Statistical Process Control Charts

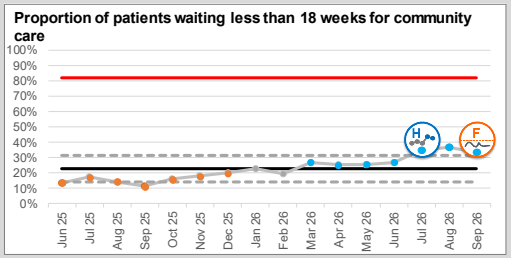


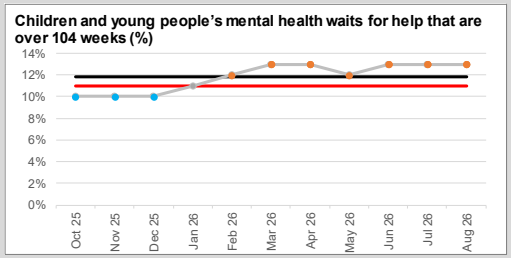


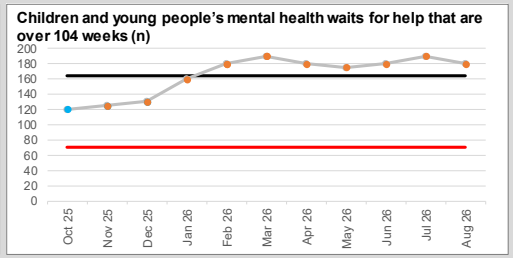


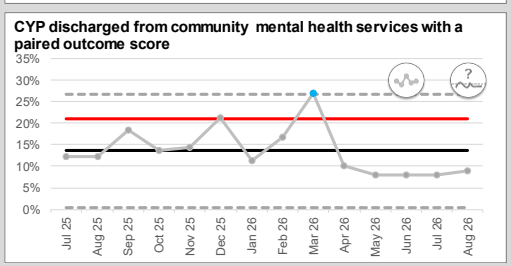


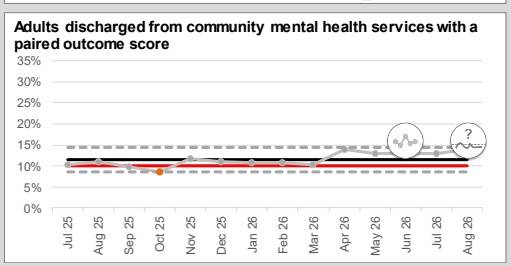


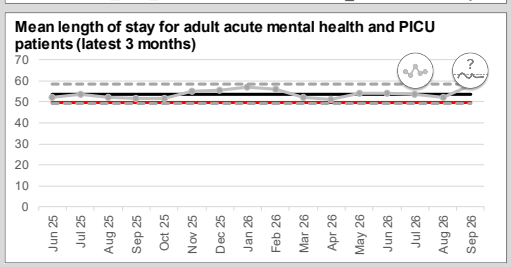


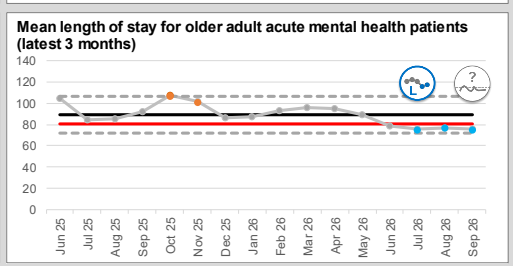


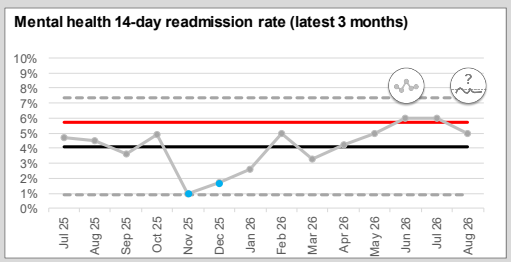


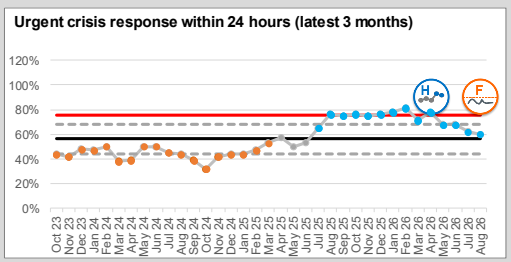


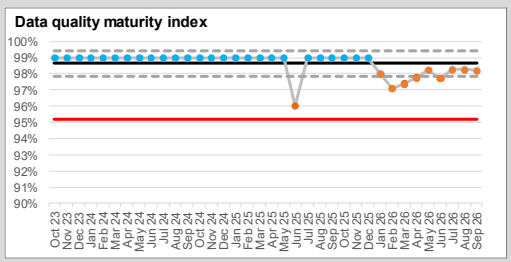


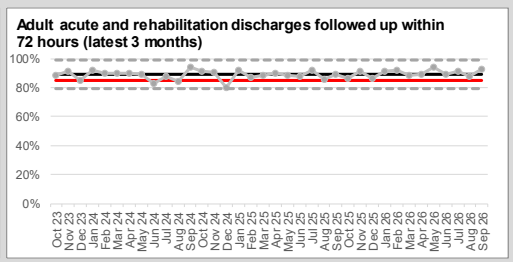


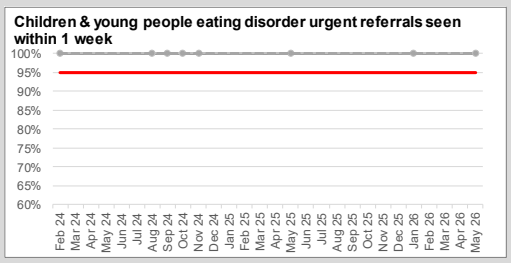


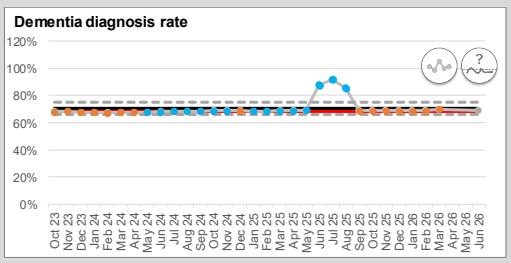


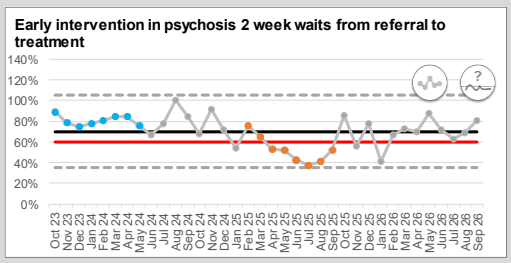


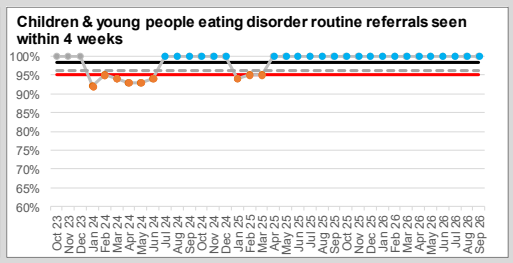






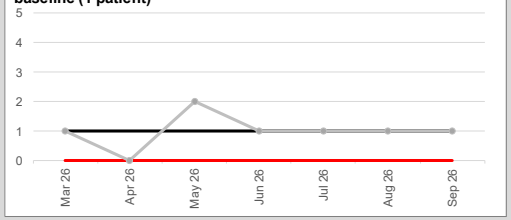




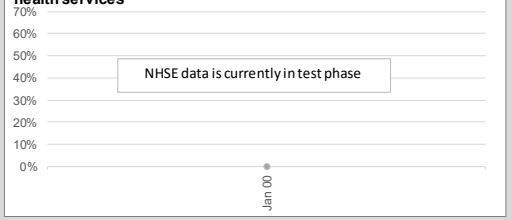


Operational Key Performance Indicators – Statistical Process Control Charts

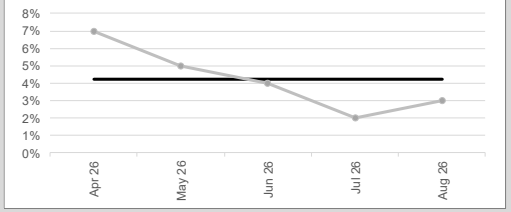
Reduce adult acute out of area placements by 95% from March 26 baseline (1 patient)



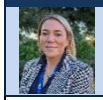
Reduce A&E referrals to Liaison teams of patients known to mental health services



Children & young people mental health referrals receiving a full clock stop within 4 weeks



PEOPLE PERFORMANCE



Director of People, Organisational Development and Inclusion:
Rebecca Oakley

Responsible Committee: **People and Culture Committee**

Executive Summary

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

Overview

Annual appraisal

Compliance has fallen by 1% compared to the previous month to 87%, which is below the revised 95% target. During September, 265 appraisals expired, while appraisals completed during the month helped maintain compliance in the high 80s. Actions continue to focus on understanding the decline and addressing appraisals that are overdue or approaching renewal. The People and Inclusion team continues to raise awareness with managers to ensure they hold appraisals in a timely manner and to ensure systems are updated when the appraisal takes place.

Annual turnover

Turnover rate remains in line with national and regional comparators at 10.6% and has remained below the Trust's 12% upper tolerance for the last year.

Compulsory training

Compliance remains high at 95.7% and continues to exceed the 95% target. Work continues to address training that is overdue or approaching renewal to maintain performance.

Sickness absence

The September 2026, monthly sickness absence rate was 6.9%, an increase of 0.1% compared to the previous month. Short-term absence accounted for 2.7%, an increase of 0.3% compared to the previous month and long-term absence accounted for 4.2%, a decrease of 0.2% compared to the previous month. Long-term sickness absence continues to drive the current high levels of sickness absence, along with a seasonal increase in short-term sickness absence. Anxiety, stress or depression-related illness remains the highest reason for sickness absence. Efforts continue to support our people to remain well at work including ongoing work to support long term absence cases, which is starting to show a slight improvement. Short-term absence requires further dedicated focus and intervention.

Vacancy rate

The September 2026, rate was 2.8% which is a significant improvement from the beginning of the financial year. The vacancy rate is calculated by taking the funded full-time equivalent (FTE) posts less staff in post FTE at month end.

Agency usage

Usage has reduced significantly compared to the previous year and remains low. Agency workers continue to be used for a small number of Medical roles and Registered Mental Health Nurses. The Agency Reduction Panel meets fortnightly to review vacancies and temporary staffing usage, in particular to ensure appropriate approval of agency use remains in place.

Supervision

Compliance targets were reset to 95% to align with comparable mental health trusts and provide a sustainable benchmark. Following alignment of the supervision system with the revised policy, clinical supervision compliance remains within target at 96.0% and management supervision compliance at 94.5%, slightly under target.

NOF Staff Survey

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

NOF staff standards

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

PEOPLE KEY PERFORMANCE INDICATORS

Measure	Target	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	
People Performance														
Annual appraisals[4]	95%	91%	91%	91%	91%	92%	92%	91%	88%	86%	87%	88%	87%	
Annual turnover (target 8-12%)	12%	10.4%	10.7%	10.8%	10.7%	10.8%	10.5%	10.5%	10.3%	10.4%	10.4%	10.2%	10.6%	
Compulsory training	90%	94.8%	94.5%	94.6%	94.5%	95.0%	94.8%	95.4%	95.5%	95.7%	95.5%	95.8%	95.7%	
Vacancy	5%	8.9%	8.5%	6.7%	6.4%	5.8%	5.6%	8.0%	7.9%	4.3%	4.3%	3.9%	2.8%	
Bank staff use	5%	4.5%	5.2%	4.7%	4.2%	4.7%	5.2%	5.7%	4.3%	5.4%	4.5%	5.1%	4.4%	
Agency staff use	1.9%	0.5%	0.4%	0.5%	0.4%	0.5%	0.7%	0.4%	0.4%	0.5%	0.3%	0.4%	0.3%	
Management supervision - staff compliant with supervision policy[3]	95%	88%	86%	89%	88%	85%	94.8%	96%	95%	95%	95%	95%	94.5%	
Clinical supervision - staff compliant with supervision policy[3]	95%	85%	86%	88%	88%	89%	96%	96%	96%	96%	96%	96%	96%	
NHS oversight framework														
NHS Oversight Framework (NOF) sickness absence rate	5%	6.6%	6.6%	6.3%	6.0%	6.2%	6.1%	6.3%	6.3%	6.3%	6.8%	6.8%	6.9%	
Long term sickness (28 days plus)	n/a	3.6%	3.9%	3.7%	3.2%	3.2%	3.5%	3.7%	3.8%	3.9%	4.3%	4.4%	4.2%	
Short term sickness (<28 days)	n/a	2.9%	2.6%	2.6%	2.8%	2.9%	2.6%	2.6%	2.5%	2.4%	2.5%	2.4%	2.7%	
NOF annual NHS staff survey - raising concerns sub-score[1]	6.64	6.76	6.76	6.76	6.76	6.76	6.64	6.64	6.64	6.64	6.64	6.64	6.64	
NOF annual NHS staff survey engagement theme score[1]	7.02	7.07	7.07	7.07	7.07	7.07	7.02	7.02	7.02	7.02	7.02	7.02	7.02	
NOF annual NHS staff survey advocacy rate[1]	6.87	6.02	6.02	6.02	6.02	6.02	6.02	6.02	6.02	6.02	6.02	6.02	6.02	
NOF annual NHS staff standards sub score[1]	7.77							7.82	7.82	7.82	7.82	7.82	7.82	
NOF national education and training survey overall satisfaction score[2]	77.4%	78.9%	78.9%	78.9%	78.9%	78.9%	79.4%	79.4%	79.4%	79.4%	79.4%	79.4%	79.4%	

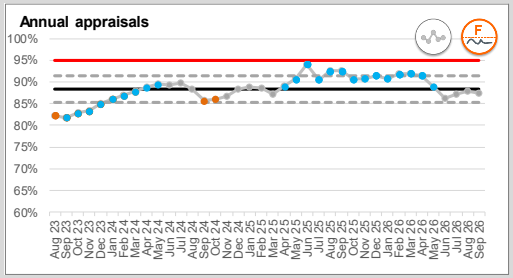
[1]2025 survey results were published in March 2026. Target = national average (2024 raising concerns = 6.74, and 2024 engagement = 7.07).

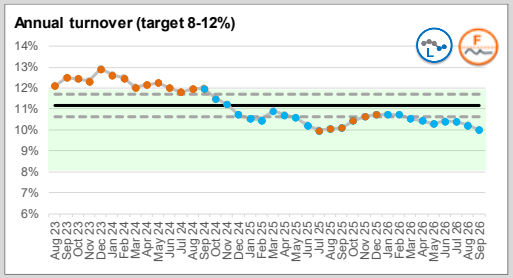
[2]2025 survey results were published in March 2026. Target = national average.

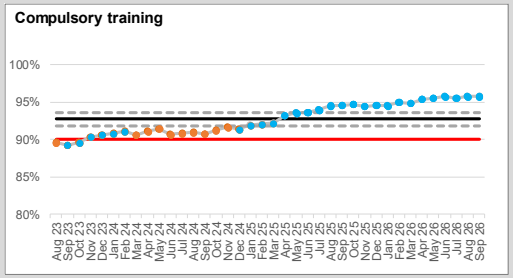
[3]System changes implemented from March 2026

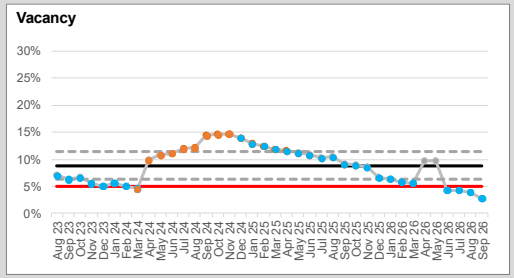
[4]Target increased from 90% in April 2026

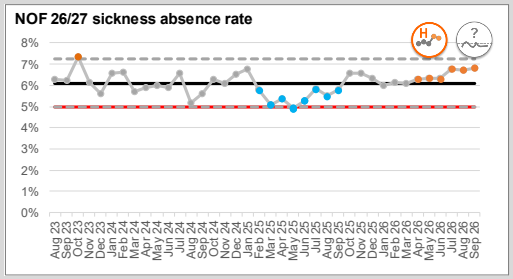
People Key Performance Indicators – Statistical Process Control Charts

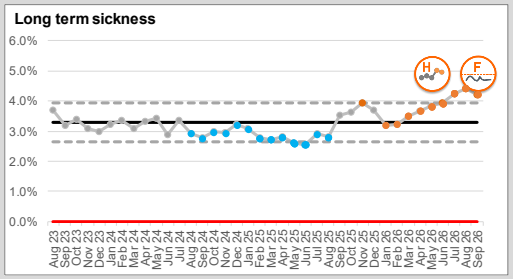


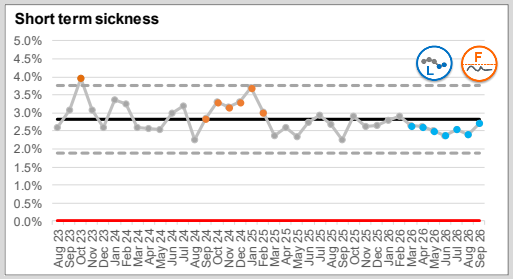


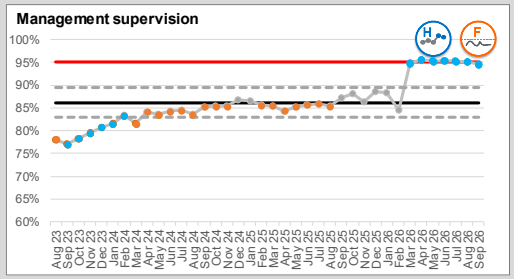


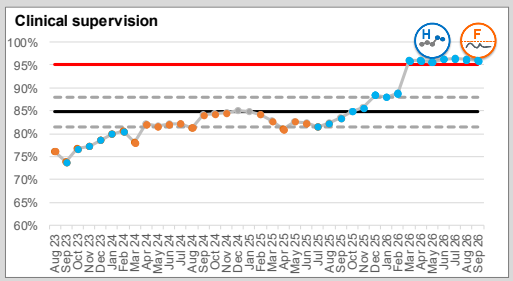


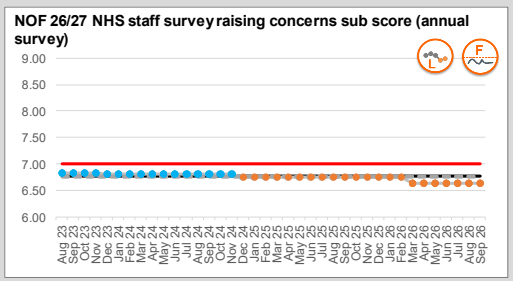


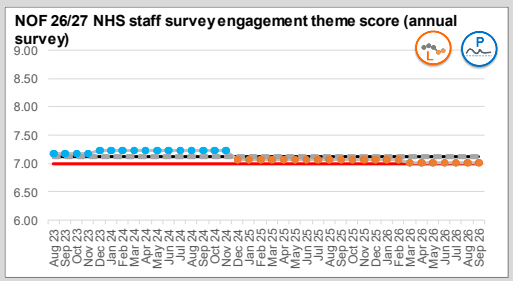


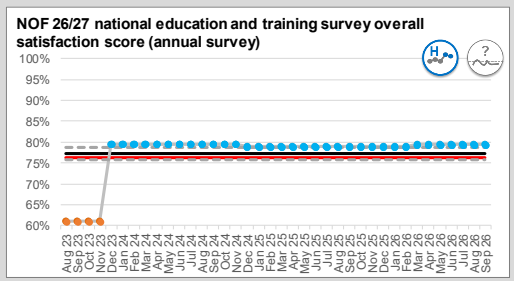


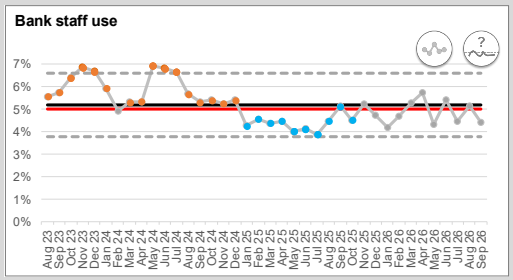


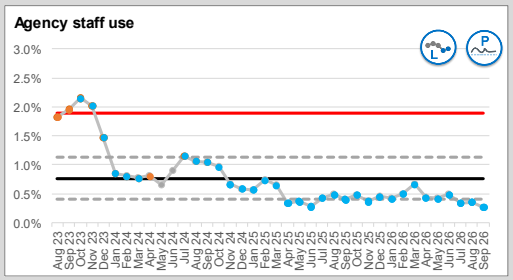


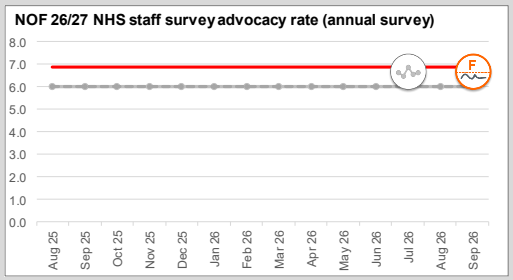


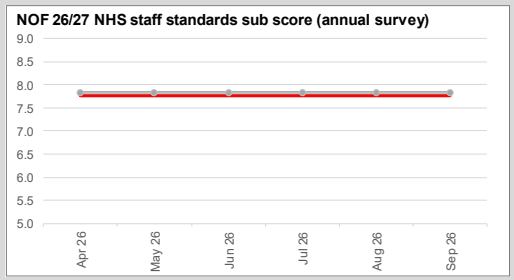












FINANCIAL PERFORMANCE



Director of Finance:
James Sabin

Responsible Committee: **Finance and Performance Committee**

Executive Summary

Overall

At the end of September, there is an overall deficit of £0.9m, 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 £0.8m which is better than plan by £0.1m. The deficit position is mainly driven by out of area expenditure and acuity on the Inpatient wards, 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 OoA expenditure and managing other cost pressures in year.

Efficiencies

The plan includes an efficiency requirement of £14.8m with the plan assuming 72% is delivered recurrently. At the end of July, efficiencies have delivered £6.7m against the plan of £6.7m, 67% has been delivered recurrently against a plan of 64% year to date. The forecast assumes that the full efficiency programme will be delivered, with 76% of savings delivered recurrently against a plan of 72%.

Temporary staffing

Agency expenditure at the end of September 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. In September agency expenditure was 0.7% (0.8% last month) of total pay expenditure which is lower than the plan of 0.9%. Bank expenditure is above plan at the end of September by £0.9m 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. Bank expenditure is currently running at 4.6% (4.4% last month) of total pay expenditure. against a plan of 4.0%.

Adult Acute OoA placements

At the end of September, OoA expenditure is above plan by £1.6m. The current forecast is based on a reducing trajectory which brings the forecast overspend to £1.6m by the end of the financial year. However, if the current run rate continues spend could be as high as £5.8m which could lead to an overspend of £3.7m.

Capital expenditure

Capital is below plan at the end of September by £1.9m. The forecast assumes spend of £8.2m against the plan of £7.6m which includes additional national funding of £0.9m which was not in the original plan.

Cash

Cash at the end of September was £33.3m (£34.5 last month) against a plan of £23.5m, £9.8m above the plan which is due to timing of cash receipts. There are no concerns in relation to debt recovery.

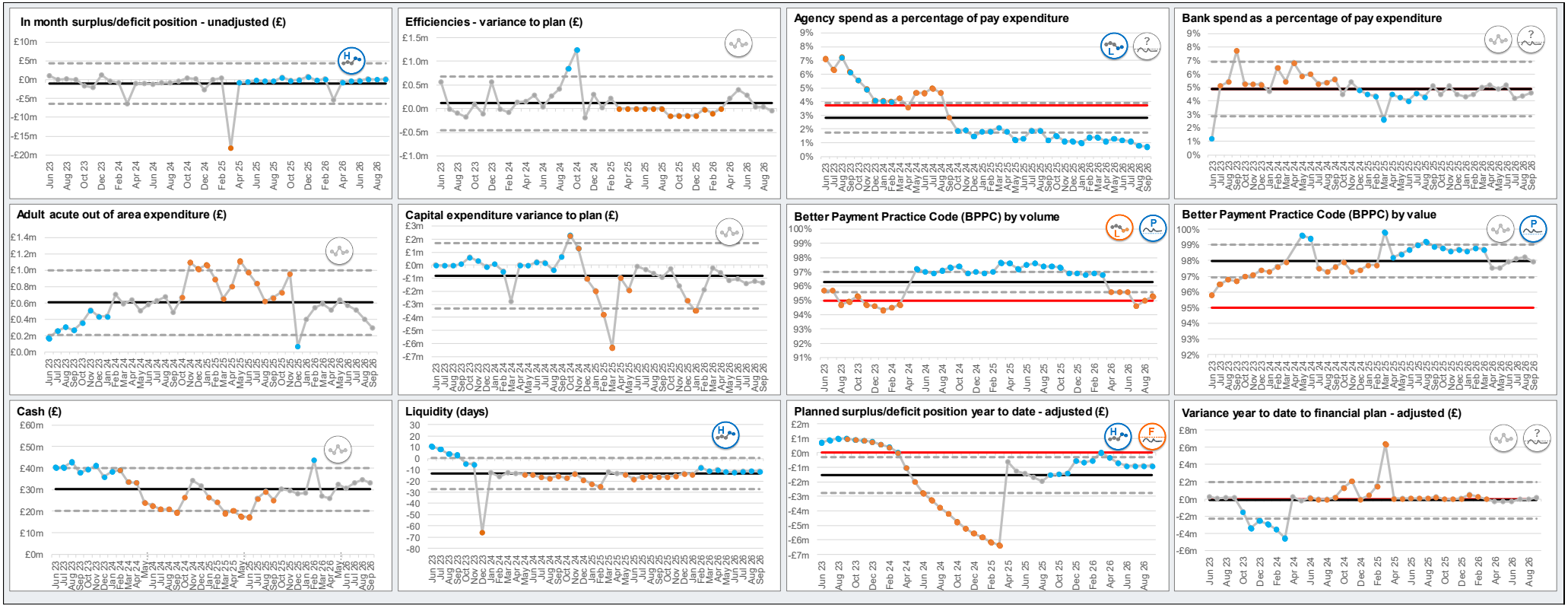
Better Payment Practice Code (BPPC)

The BPPC sets a target for 95% of all invoices to be paid within 30 days. BPPC is measured across both invoice value and volume of invoices. At the end of September, the volume and value of invoices was above target at 95.3% and 97.9% respectively.

FINANCIAL KEY PERFORMANCE INDICATORS

Measure	Target	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	
Financial Performance														
In month surplus/deficit position - unadjusted (£)	-	-£ 224,055	-£ 16,211	£ 792,384	-£ 181,752	£ 105,378	-£ 5,302,531	-£ 660,307	-£ 341,136	-£ 255,919	£ 187,903	£ 29,293	£ 129,525	
Efficiencies - variance to plan (£)	-	£ 2,000	£ 1,000	-£ 150,000	-£ 17,000	-£ 96,000	£ -	£ 213,000	£ 400,000	£ 281,000	£ 28,000	£ 30,000	-£ 47,000	
Agency spend as a percentage of pay expenditure	3.7%	1.5%	1.0%	1.1%	1.0%	1.4%	1.4%	1.1%	1.3%	1.2%	1.1%	0.8%	0.7%	
Bank spend as a percentage of pay expenditure	4.9%	4.5%	4.9%	4.5%	4.3%	4.5%	5.0%	5.2%	4.9%	5.2%	4.2%	4.4%	4.6%	
Adult acute out of area expenditure (£000)	-	£ 727	£ 956	£ 60	£ 399	£ 543	£ 592	£ 513	£ 637	£ 564	£ 513	£ 401	£ 289	
Capital expenditure variance to plan (£)	-	-£ 274,000	-£ 1,606,000	-£ 2,719,000	-£ 3,479,000	-£ 1,905,000	-£ 244,000	-£ 583,500	-£ 1,167,000	-£ 1,058,000	-£ 1,432,000	-£ 1,249,000	-£ 1,324,000	
Better Payment Practice Code (BPPC) by volume	95%	97.3%	96.9%	96.9%	96.8%	96.9%	96.8%	95.6%	95.6%	95.6%	9460.0%	95.0%	95.3%	
Better Payment Practice Code (BPPC) by value	95%	98.8%	98.6%	98.7%	98.6%	98.8%	98.7%	97.5%	97.5%	97.9%	9810.0%	98.2%	97.9%	
Cash (£000)	-	£ 30,338	£ 29,717	£ 27,969	£ 28,403	£ 43,653	£ 26,925	£ 25,834	£ 32,492	£ 30,704	£ 33,241	£ 34,544	£ 33,264	
Liquidity (days)	-	-16	-16	-13	-14	-8	-11	-10	-12	-12	-12	-11	-12	
NHS oversight framework 2026/27														
Planned surplus/deficit year to date - adjusted (£)	£ -	-£ 1,472,000	-£ 1,421,000	-£ 557,000	-£ 669,000	-£ 521,000	£ 11,000	-£ 343,000	-£ 678,000	-£ 908,000	-£ 912,000	-£ 903,000	-£ 893,000	
Variance year to date to financial plan - adjusted (£)	tbc	£ 5,116	£ 6,456	£ 33,609	£ 496,585	£ 240,026	£ 11,000	-£ 296,000	-£ 271,000	-£ 275,000	-£ 52,000	-£ 1,000	£ 140,000	
Relative difference in costs	<100%									85.7%			85.7%	
Temporary staffing cost relative band	1									4				

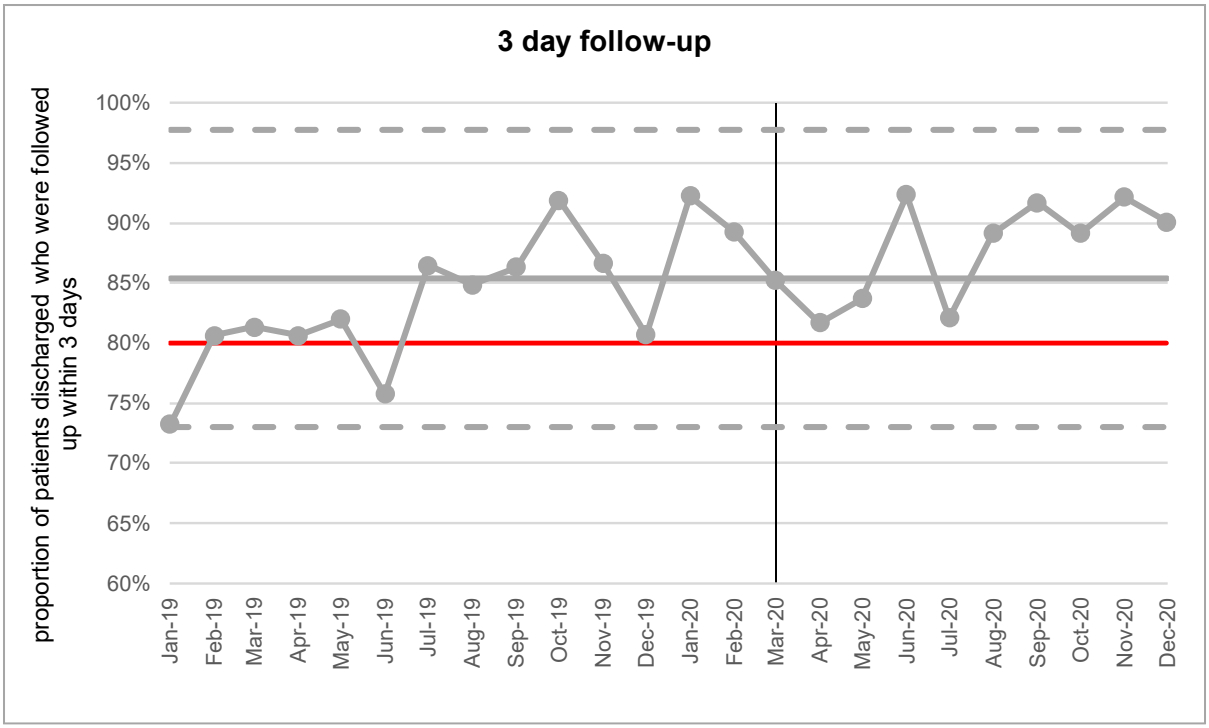
Financial Key Performance Indicators – Statistical Process Control Charts



Appendix 1

Statistical Process Control Chart (SPC) Guidance

Example SPC chart:



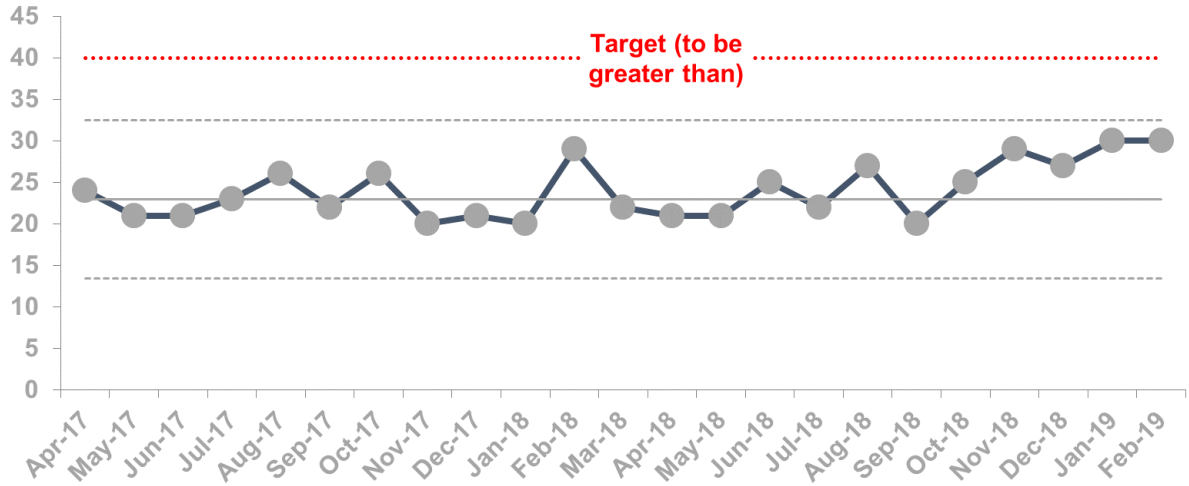
- The red line is the target
- The grey dots are the actual performance each month. They are coloured grey as performance each month is normal in this example
- The solid grey line is the average (mean) of all the grey dots
- The grey dotted lines are called process limits, or control limits.

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

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

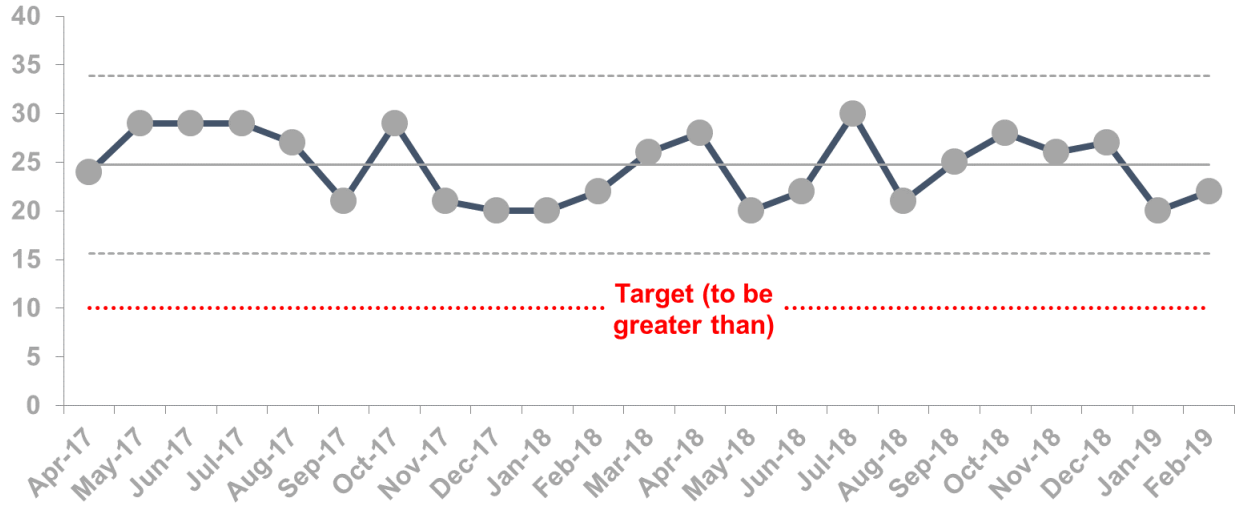
Things to look out for:

1. A process that is not working:



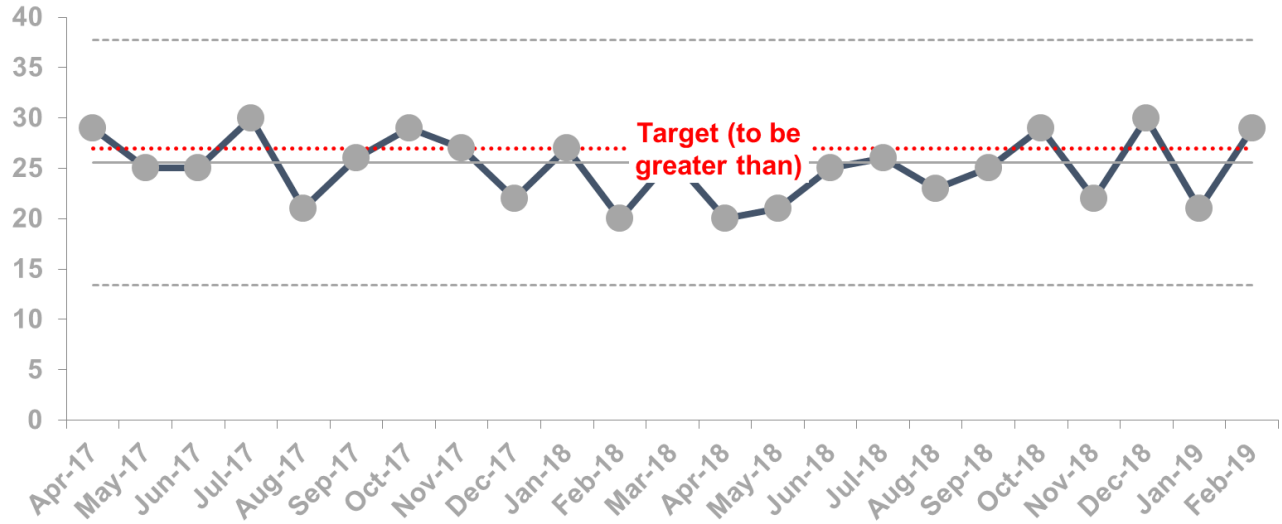
In this example the target is higher than the upper dotted grey line. This means that the target will never be achieved. To achieve the target, we need to change how we do things.

2. A capable process:



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

3. An unreliable system:

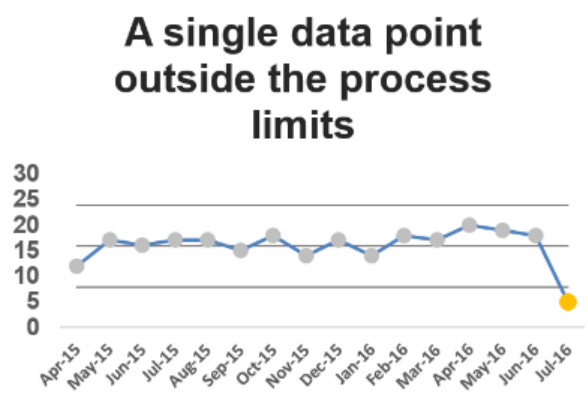
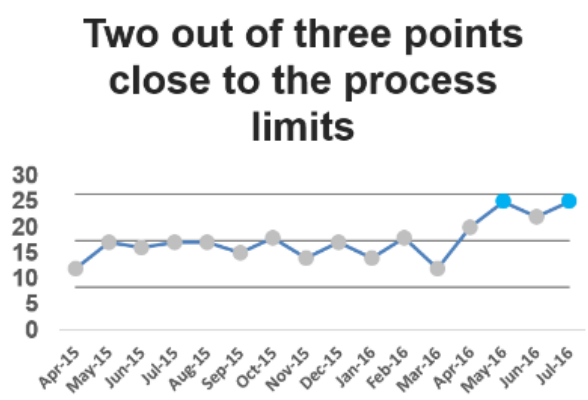


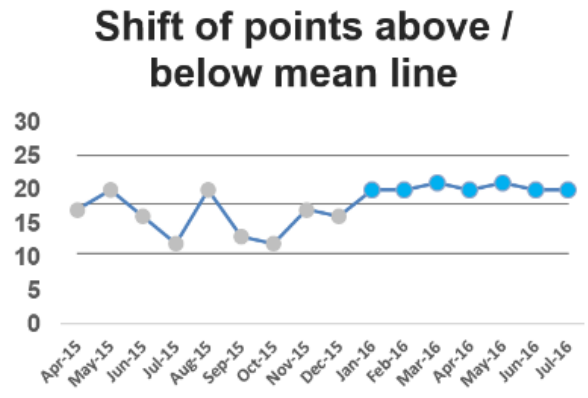
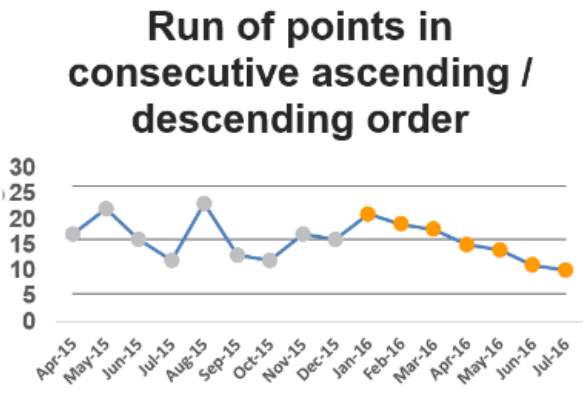
In this example, the target line sits between the two grey dotted lines. As it is normal for the grey dots to fall anywhere between the two dotted grey lines, this means that it is entirely random as to whether or not the target will be achieved. So, this system is unreliable and needs to be redesigned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

4. Unusual patterns in the data

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

There are four scenarios where this can happen:

	
In this example the July 2016 perfomance is significantly lower than expected and falls beneath the lower grey dotted line.	Two out of three points close to one of the grey dotted lines is statistically significant, in this case they are blue, indicating better than expected performance.

	
A run of seven points above or below the average line is significant. In this example it might indicate that an improvement was made to the process in Jan 2016 that has proven to be effective.	A run of seven points in consecutive ascending or descending order is significant. In this example things are getting worse over time.

Frequently seen in the NHS:

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

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

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

Appendix 2

Assurance Ratings

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

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

The following summaries cover key items discussed at the meetings that have been held since the last public Board meeting held on 22 September 2026 and are received for information.

- Finance and Performance Committee – 11 September 2026 and 11 November 2026 (verbal)
- Quality and Safeguarding Committee –8 October 2026 and 12 November 2026
- Audit and Risk Committee – 22 October 2026
- People and Culture Committee – 5 November 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 – 11 September 2026	
	Assurance on delivery of Estate Plan **Significant assurance** was received on delivery of the Estates Plan, with most actions complete or substantially in progress. The refreshed six-facet survey increased the recorded backlog from approximately £10.2m to £13.5m, mainly due to updated construction prices. £4.7m of significant backlog is targeted through work at the Radbourne Unit and planned exit from St Andrews House. Future reporting will be stepped down to annual due to assurance, with interim escalation where risks move off track.
	Radbourne Unit – next ward development Accepting **significant assurance**, the Committee approved competitive re-procurement through an approved framework to test the market and improve value for money. Value engineering has reduced the estimate by approximately £780k to £15.4m, with the current proposal still around £2m above expectations. The Board should be sighted on the expected delay to the completion dates regardless of contractor or re-procurement due to build timeline impacting continued use of dormitories and associated quality and regulatory consequences.
	Digital Plan **Significant assurance** was agreed on delivery of the Digital Delivery Plan 2026-2028, with 13 of 16 deliverables at the expected stage and three at risk before the end of Quarter 2. Further development is required on sustainable capacity, benefits realisation, adoption and evidence of patient safety, quality, productivity and financial benefits. Future reporting will consider combining transformation strands and focusing on exceptions. Key questions continued to push for a digital literacy focus to maximise staff productivity

	Financial governance and performance – month 4 finance report The Committee noted that the Trust was £0.1m behind plan and approximately £1m in deficit year to date. Efficiency delivery was close to plan, but bank expenditure remained substantially above target, linked to acuity and enhanced observations. Forecast pressures around out of area and continued Inpatient overspends could lead to a year-end deficit of approximately £4m. As break-even was unlikely, **limited assurance** was accepted, with a Board discussion requested on operational levers, delivery capacity and risk acceptance.
	Refreshed year three financial plan The refreshed plan provided the Committee with **limited assurance**. The submission identified a possible £4m deficit this year, a minimum estimated saving requirement of approximately £9m next year and a potential £12.8m savings plan that could still leave a £3.3m deficit. A return to break-even may not occur until 2028/29 and will require genuine cost reduction and service transformation. Further work is required over the next three months to develop a credible recovery programme. Potential exit costs also remain a key barrier to short term financial balance.
	National Cost Collection submission (post-submission) The Committee approved the processes supporting the mandated Cost Collection submission with **significant assurance**, noting two areas of ongoing non-compliance: • insufficiently granular consultant job plans • incomplete allocation of floor areas to services. Data quality was reported as generally strong compared with other mental health trusts. National publication and benchmarking are awaited, with the follow-up action moved to the end of March.
	Discussion on charitable funds position The Committee discussed options for establishing the Trust's own charity. Current arrangements are managed through neighbouring organisations and the proposed move to an independent University Hospitals of Derby and Burton charity has been delayed by governance and legacy record issues. It was noted that a paper covering capacity, governance and the potential need for a subcommittee will be presented to the Executive Leadership Team..
	New commercial unit – progress report The update provided the Committee with **significant assurance** on Positive Difference Health. A planned launch on 26 October 2026 was highlighted, noting that an initial commercial opportunity had been secured, involving preparation of a service for Foston Hall. Future reports will include target markets, income projections and expected growth.
	Procurement update Accepting **significant assurance** the Committee agreed to reduce the frequency of separate reports. Procurement will be incorporated into regular finance updates, with future reporting focused on new tenders, material contract risks, procurement law challenges and matters requiring escalation.
	Operational performance Length of stay for Older Adults and Acute Adults was on track for the Quarter 2 trajectory, while Crisis services and 24-hour face-to-face review performance remained inconsistent. Community Therapy services were on track to eliminate waits over 52 weeks by the end of November, but ADHD and ASD assessment waits were not. The Committee accepted **limited assurance**, noting that a Board Strategy and Development Session will consider workforce issues, uncommissioned services and whether services should continue, stop or be capped at commissioned levels.

	Deep Dive into new Care Group performance The presentation was received for information sharing purposes.
	Winter Plan – 2026/27 Reflecting expected demand peaks, lessons from the previous winter and the recent regional exercise, the plan provided the Committee with **significant assurance**, whilst noting that sustained demand, discharge constraints, workforce pressures and System dependencies are continued risks. No additional financial investment need or expectation was identified and delivery will be managed through existing resources and governance arrangements. The Committee approved plan for submission.
	Business environments **Significant assurance** was received across the provider collaborative and wider business environment. Work continued towards a February transfer of the 0-19 Children's service, subject to due diligence and final Board approval. The Committee noted risks relating to the Mental Health Urgent Assessment Centre and endorsed a staged approach to the Neighbourhood Mental Health Model, subject to business cases, affordability, partner co-design and decision gateways.
	System updates: Integrated Care Board (ICB) Finance Committee/System Directors of Finance The System financial position and relevant updates were considered within the Month 4 finance report.
	Updates from Strategic and Partnership System meeting and forums Updates were considered through the Business Environments report.
	Board Assurance Framework (BAF) 2026/27 risks overview The Committee noted the two risks within its remit, covering delivery of revenue and capital plans and digital. Members considered whether discussions and decisions from the meeting required updates to the framework.
	Key matters for Board attention • The forecast year-end deficit risk and the need for a Board discussion on operational levers, delivery capacity and the balance between financial recovery and patient care • The Radbourne Unit re-procurement, including the delay, continued dormitory use and associated quality and regulatory consequences • The scale of the medium-term financial challenge and the requirement for a credible transformation and recovery programme • A Board Strategy and Development Session on workforce pressures, uncommissioned services and choices about service scope and capacity.
	Overall assurance Split assurances. **Significant assurance** was received on estates, digital, winter preparedness and the wider business environment. **Limited assurance** was received on the current financial position, the refreshed three-year financial plan and operational performance.

	Items for discussion at Board or other Board committees: • Board visibility of the Radbourne Unit timeline, continued dormitory exposure and associated quality and regulatory consequences • Board discussion on the forecast financial position, operational levers, delivery capacity and risk acceptance • Board Strategy and Development Session on workforce issues and uncommissioned services • People and Culture Committee consideration of the relationship between sickness absence, vacancies, establishment and bank and agency expenditure, where appropriate. **Items added to the BAF:** None. **Next scheduled meeting:** 11 November 2026.
Committee Chair: Jo Hanley	**Executive Lead: James Sabin, Director of Finance**
Quality and Safeguarding Committee – key assurance levels for items – 8 October 2026	
	Inpatient Acuity update – triangulation of observation demand, restrictive interventions and workforce pressures The revised analysis compared admissions in 2024/25 and 2025/26 and indicated increased Inpatient acuity and complexity, including greater clinical, physical health and social needs, alongside increased demand for enhanced observations and restrictive interventions. It was agreed that the reports evidence provided a clearer basis for activity, workforce and financial planning. The Committee noted interim staffing mitigations and that discussions would be initiated with the Integrated Care Board (ICB) regarding a sustainable funding approach.
	Director of Nursing update The update covered preparations for the forthcoming Care Quality Commission Well-Led review, the broadly positive Perinatal inspection and the Trust's response to the Thirlwall Inquiry. Improvements relating to risk assessment, safety planning and person-centred care planning were being progressed while the formal inspection report was awaited. Members noted the wider organisational implications of the Inquiry, including Freedom to Speak Up and whistleblowing arrangements and emphasised that the resulting action plan should demonstrate measurable improvements in patient care and outcomes. The potential impact of the planned transfer of 0–19 services on safeguarding resources was also noted.
	Medical Director update The Committee noted the approach to supporting continuity of care where patients or families requested private referral to Psychological Services, and that local shared-care arrangements for ADHA and the prescribing of Lithium remained in place with any refusals to be recorded and monitored. Updates on proposed changes to the Child and Adolescent Psychiatry and other specialties Consultant on-call rota were received.
	Children in Care annual report The Committee received **significant assurance** noting the positive progress in improving access to health assessments and wider physical and mental healthcare, supported by the substantive Trauma-Informed Health Navigator role. The service's strong performance and partnership working was recognised, while noting continuing risks relating to missed appointments, dependency on external partners, staffing pressures and continuity of specialist care when children moved between areas.

Infection Prevention and Control (IPC) annual report and Board Assurance Framework (BAF) update

It was noted that the assurance review by NHS England Midlands, had moved the Trust from enhanced to routine monitoring following recognised improvements in cleaning standards, local ownership and governance, with no immediate patient safety risks identified by NHS England Midlands review.

The requirement for continuous improvement across environmental standards, audit compliance, staff training and immunisation assurance was highlighted.

Accepting **significant assurance**, acknowledgement was given to the strengthened accountability and joint working arrangements, the proportionate risk-based approach to personal protective equipment and fit testing, and preparations for a sustainability review within nine months.

Medicine Optimisation Committee 3As report (quarterly)

The Committee received an update on valproate prescribing compliance and implementation of the national clozapine protocol. **Limited assurance** was agreed, recognising the progress made, with further work required to address recording gaps and strengthen the reliability of compliance data. Therefore, the valproate risk would remain high-rated pending a full monitoring cycle and repeat audit. Existing clozapine arrangements were considered safe and compliant, while work continued to align Trust guidance with national best practice.

Risk report (quarterly)

The Committee noted substantial improvement in the currency, ownership and governance of organisational risks. Members welcomed the strengthened scrutiny and escalation arrangements, while highlighting continuing concerns regarding waiting-list oversight, compliance with the Waiting Well policy and recurring workforce pressures, including medical recruitment. Future reports would provide clearer evidence of whether mitigating actions were reducing risk levels and improving outcomes.

Significant assurance was accepted.

Sexual Safety report

Progress in implementing the NHS Sexual Safety Charter and strengthened governance, reporting and leadership arrangements provided the Committee with **significant assurance**. However, **limited assurance** was accepted around the residual risks, gaps in training, data triangulation, specialist support and evidence of cultural impact. Continued oversight with measurable outcomes reported through established governance routes was requested.

Delivery of same sex accommodation

The Committee was **fully assured** that environmental and procedural improvements had addressed the previous year's concerns, with no mixed-sex accommodation breaches recorded during the reporting period.

The strengthened arrangements supporting compliance and the Trust's response to the April 2025 Supreme Court ruling were noted, including updated policy and a risk-based approach pending national guidance.

Divisional Assurance Boards (six-monthly)

The presentation confirmed the governance arrangements established across Care Groups and Divisions, including performance monitoring, escalation routes and improvement planning.

The Committee welcomed the framework, noting examples of improvement activity, while seeking stronger evidence that organisational learning was consistently embedded, communicated to frontline teams and delivering measurable benefits for patients.

	Transformation and Continuous Improvement Framework (annual) The paper updated on progress across the Trust's strategic transformation portfolios, along with continuing risks relating to patient flow, waiting lists, data quality, digital infrastructure, capacity and efficiency delivery. While progress was welcomed, the Committee requested to see sufficient evidence of measurable benefits for patients and wider organisational priorities including assurance on organisation-wide process ownership or the management of potential unintended consequences, including inequalities. Further assurance reporting was requested.
	Deprivation of Liberty Safeguards (DoLS) Policy **Significant assurance** was received that the updated policy represented the law as it presently stood.
	Review of Quality and Safeguarding Board Assurance Framework (BAF) Risks Progress in patient safety leadership and the reduction in outstanding serious incidents was acknowledged; however, members determined that the patient safety risk rating should remain unchanged pending further evidence that actions and learning were embedded and delivering improved patient outcomes.
	Items for discussion at Board or other Board committees: None. **Items added to the Board Assurance Framework:** None. **Next scheduled meeting:** Thursday, 12 November 2026.
Committee Chair: Lynn Andrews	**Executive Lead: Tumi Banda, Director of Nursing, AHPs, Quality and Patient Experience**

Quality and Safeguarding Committee – key assurance levels for items – 12 November 2026	
	Director of Nursing update The Committee noted the key points: • 'Good' Care Quality Commission rating for Perinatal services across all domains with some actions to strengthen care planning, risk assessments and governance assurance • Changes to East Midlands Ambulance Service safeguarding referral arrangements to ensure clinical responsibility would not result in a significant impact for the Trust • The Same Sex Accommodation Policy had been updated and implemented following NHS England (NHSE) guidance. The Board declaration paper had been amended accordingly.
	Medical Director update - verbal NHSE's recent report on people with severe mental illness was discussed. The Trust, in conjunction with Public Health, will examine five years of data to investigate differing suicide trends within Derby and Derbyshire among people with severe mental illness and inform whether further review of access to services was required. Immediate interventions and strengthened discharge processes had supported patient flow and temporary accommodation had enabled some discharges, incurring additional costs rather than direct savings. Implementation challenges relating to updated inpatient accommodation requirements were noted, along with potential Pharmacy workforce pressures. Recruitment arrangements were being progressed.

	Ligature Risk Reduction report Following an inpatient fatality, the Committee was advised that the Patient Safety Incident Response Framework (PSIRF) review remained ongoing and initial learning on observation practice had been shared. The Trust is reporting a reduction in fixed-point ligature incidents, good governance arrangements and having addressed all estates task issues. It was noted that consistent observation practice, individual risk assessment and environmental improvements with old estate remained necessary. Staff post-incident support has been strengthened. Additional training sessions were being arranged to meet the planned compliance trajectory. It was highlighted that to reach significant assurance this would require sustained improvements in consistent application of practice, training compliance and the old estate environment upgrades. **Limited assurance** was accepted.
	Patient Safety report (quarterly) The report provided a deep dive on all patient safety related issues. Significant improvements in patient safety processes, timeliness and governance were reported which enabled the committee to reduce the risk register rating from 'high' to 'moderate'. The focus now turns to reducing overdue learning responses and safety recommendations to enable lessons learnt to be shared promptly. Abuse and aggression incidents and self-harm incidents had increased. Recurring learning themes included family engagement, risk assessment and communication. A focus on inequalities presented showed no evidence of over-representation of any ethnic group within insignificant-moderate incident data. However, White British groups continue to be overrepresented within major and catastrophic incidents. The Committee sought clearer evidence that learning translated into effective controls and sustained improvements. Work was underway to strengthen improvement monitoring and feedback, although Patient Safety team capacity constraints required prioritisation. **Limited assurance** was received in respect to the continued application of PSIRF throughout the organisation.
	Quality Dashboard – July to September 2026 Receiving **limited assurance** on progress towards clinical performance targets, the Committee was advised that restrictive practices remained high, while commissioning gaps, waiting times and bed and staffing pressures continued to affect patient flow and access to care. It was noted that complaint response timeliness and absconding had improved, whilst care planning and risk assessment required further improvement. Work continued to strengthen therapeutic activity, community pathways and responsiveness ahead of winter. Further discussion to consider achievable performance, investment priorities and risk acceptance was proposed, recognising that longstanding challenges could not be resolved quickly.
	Triangle of Care update The interim assurance report addressed strengthened Carers Trust requirements to maintain two-star status ahead of the full annual submission in June 2027. The report centred on the theme of 'confidence' in governance, people and carers. It was confirmed that governance arrangements had strengthened, but timely responses to carers' feedback and updated team self-assessments remained priorities. A task-and-finish group and an audit period from December 2026 to March 2027 were proposed. Discussion emphasised early, meaningful carer involvement and greater awareness of the Staff Carers Network. The Committee received **significant assurance** on performance against the standards and recommended the report for submission to the Carers Trust at the beginning of December 2026.

	Clinical Plan 2026-2029 for approval It was noted that the Plan had been developed through stakeholder consultation, aligned with the Trust Strategy and four Ps and supported a shift towards preventative, integrated, community-based and outcomes-focused care. Discussion highlighted implementation risks, resource dependencies and the need for measurable outcomes combining patient feedback with clinical assessment. Baselines and targets would be established in the first year, followed by phased implementation over two years. Collaborative planning expectations concerned offering patients involvement rather than required participation. The Committee **approved** the Plan and agreed for its submission to the Trust Board for final approval.
	Learning from Deaths (including Learning Disabilities Mortality Review (LeDeR) / Mortality report – Quarter 2, 2026/27 The Committee noted fewer deaths than in the previous quarter, reduced overdue learning responses and actions and no concerning health inequalities findings. Recurring learning themes included risk assessment, family and carer involvement, communication and access to services. Further reductions in outstanding responses and actions, stronger improvement oversight and better feedback remained priorities. Delayed cause-of-death information from partner organisations was considered a data-quality issue requiring monitoring rather than a significant learning concern. The report was accepted with **limited assurance** of the Trust's approach, noting the need to reduce outstanding learning responses and actions further and strengthen oversight of improvement work to progress assurance to significant.
	Personalised Care Framework Plan – verbal update It was highlighted that the Personalised Care Framework transition affected approximately 15k patients. The transition plan had been approved by the Executive Leadership Team and submitted to the Integrated Care Board and NHSE. It was acknowledged the implementation plan requires coproduction and a key transformation piece of work for effective change. Implementation remained at an early stage, with resources being reprioritised and staffing arrangements incomplete. Co-production and engagement were planned.
	Quality and Equality Impact Assessment (QEIA) - verbal update Due to staff unavailability, the QEIA update had been delayed. It was acknowledged that reliance on one individual had highlighted a governance weakness, with consideration given to strengthening arrangements.
	Suicide and Self-Harm Prevention Plan (six-monthly) The refreshed Plan had been informed by national evidence and local learning. Priorities included individual safety planning, staff training, post-discharge safety and stronger post-incident support. The progress and compliance provided the Committee with **full assurance** on plans to date. It was agreed that the three-year plan would include milestones and six-monthly trajectories when next presented and that future reporting was to focus on outcomes and evidence of assurance.
	Policy review The Committee **ratified** the Safeguarding Individuals Vulnerable to Extremism (Contest, Prevent and Channel) Policy and Procedure, which focused on information flows within the revised two-Division governance structure; operational detail remained unchanged.
	Board Assurance Framework (BAF) – key risks identified: The Committee noted the patient-safety risk reduction.

Items for discussion at Board or other Board committees: Due to the submission deadline, the Assertive Outreach self-assessment paper being presented to the Board would incorporate the assessment and previous Committee discussion, including Fundamental Standards of Care. Some scores had been reduced to better reflect strategic risk.

Items added to the Board Assurance Framework: None.

Next scheduled meeting: Thursday, 10 December 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 – 22 October 2026

Review of Board Assurance Framework (BAF), Issue 3, Version 3.1, 2026/27

The Committee **approved** Issue 3 of the BAF, noting substantial revisions, particularly in relation to cyber security and emerging artificial intelligence (AI) related risks.

The need for clearer presentation of changes to risk appetite and tolerance was emphasised, including their rationale and implications. The Board's collective responsibility for considering and challenging proposed changes was reaffirmed.

Further discussion covered the wording of assurances relating to AI, the escalation of persistent high-rated risks and the longstanding valproate prescribing risk.

Actions were agreed to improve the cover sheet and executive summary, clarify relevant wording and rationale and to obtain an update on the Pharmacy risk.

Operational Risk Management (quarterly update)

The Committee noted full compliance with the previous audit recommendations, strong performance in risk reviews and record keeping, and no overdue clinical risk reviews.

Members sought assurance on the impact of the operational restructure on risk ownership, training and oversight. It was confirmed that targeted training and proactive support were in place, although further work was required as new arrangements continued to embed and timely notification of staffing changes remained important.

Risk Management Strategy - 2026-2028

It was confirmed that the objectives, training targets and reporting requirements of the Risk Management Strategy remained on track.

Members discussed the targeted approach to training and sought assurance that current performance measures were sufficiently robust, particularly for high and extreme risks and the length of time risks remained open. It was agreed that broader indicators, trends and escalation triggers would be considered through the ongoing risk management development work.

Annual Report and Accounts – review of 2025/26 production

The review confirmed that production had progressed smoothly, supported by early planning, learning from the previous cycle and effective collaboration between Trust teams, internal and external auditors.

No significant concerns were identified, providing assurance regarding the robustness of the underlying processes and controls.

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

The final independent review was received, noting the proposed approach to aligning its development actions with existing strategic and improvement plans, avoiding duplication and identifying new priorities.

The importance of clear ownership, evidence and oversight, particularly for longer-term actions was emphasised.

	Commercial insurance options appraisal The Committee supported the continued procurement of property insurance for the new Inpatient buildings, noting the financial exposure arising from the NHS Resolution limit and agreeing that the position should remain under review. Following consideration of existing oversight, the control environment, claims experience and potential financial exposure, it was agreed not to procure separate cyber or data protection breach insurance. It was noted that previous national discussions had not secured a change to the property coverage limit. **Significant assurance** was received that the Trust was actively monitoring its insurance risks and making commercially-informed decisions.
	Data Security and Protection (DS&P) report The Committee received **significant assurance** on the Trust's DS&P arrangements. Completion of the 2025/26 Toolkit audit action was noted, along with progress towards Toolkit Version 9 requirements, high training compliance and strong subject access request performance, despite increasing demand and complexity. The planned transition of support to Nottinghamshire Health Informatics Services, incident themes and cyber risks were discussed. It was confirmed that monitoring, targeted learning and strengthened controls remained in place, with preventative action taken in response to a national cyber alert and no identified breach.
	Implementation of the Freedom to Speak Up (FTSU) Policy Framework (six-monthly) Effective implementation of the FTSU framework; activity, themes and learning from January to June 2026, was noted. The increasing maturity of the Trust's approach was recognised, while highlighting the need for future reporting to provide stronger qualitative evidence of staff confidence, organisational responsiveness and the impact of actions taken, particularly in relation to anonymous reporting, perceived detriment and recurring concerns. Actions were agreed to strengthen feedback and closure arrangements, introduce anonymised reporting on outcomes and incorporate FTSU themes within Divisional cultural dashboards. The paper provided the Committee with **significant assurance**.
	Internal Audit progress report Significant assurance from the Fit and Proper Person Test review was noted to identify robust controls and two low-risk administrative findings. Progress against the 2026/27 Internal Audit Plan was highlighted. The timing and scope of the BAF review, expected to report in January 2027, was discussed, noting that the annual survey would be repeated after planned refinements had been implemented.
	Counter Fraud progress report Progress against the 2026/27 counter fraud plan was discussed, including planned fraud awareness activity and the replacement of the controlled-drugs review with a proactive review of consultant job planning in response to emerging risks. The Committee noted the position on active and closed investigations, associated recoveries and the reduction in referrals following previous working-while-sick work. It was highlighted that the next National Fraud Initiative data release would provide an updated view of potential cases.

	External Audit progress report The report informed of progress in planning the 2026/27 external audit, including the engagement letter, indicative timeline and anticipated audit strategy memorandum. The forthcoming external audit event was noted, which would provide an opportunity to consider specialist perspectives on the potential benefits and risks of artificial intelligence within the NHS.
	Clinical Audit annual report and latest Clinical Audit programme The 2025/26 Clinical Audit annual report and progress against the 2026/27 programme was reviewed, noting that the programme had supported changes in practice but that delivery and implementation of learning remained affected by capacity, competing priorities and delays. The Committee queried the alignment of audits with organisational risks, that they were completed promptly and translated into measurable improvement. Planned improvements included strengthened work planning, wider participation, clearer Care Group ownership, enhanced oversight and more consistent recording and linkage of audit-related risks within Datix. Due to inconsistent application of controls and associated delays in achieving objectives and learning, **limited assurance** was received.
	Intellectual Property Policy and Procedures The Committee **ratified** the document.
	Items for discussion at Board or other Board committees: None. **Items added to the Board Assurance Framework**: None. **Next scheduled meeting:** Thursday, 21 January 2027.
Committee Chair: Chioma Akpom	**Executive Lead: Justine Fitzjohn, Director of Corporate Affairs and Trust Secretary**
People and Culture Committee – key assurance levels for items – 5 November 2026	
	Director of People update The Committee noted the main points of the update: • Preparations were underway for the Consultant Doctors' industrial action scheduled to take place between 25 and 26 November • Immigration sponsorship changes were being reviewed, with affected numbers of staff awaited and a support plan in development • The Trust had not been selected for the Staff Safety Pioneer Programme but remained interested in future participation and learning • The People Portal Programme remained on track for Gate 2 by 13 November. Payroll accuracy was the principal risk; organisation-wide governance, staff engagement and communication were emphasised.

People and Inclusion Assurance Dashboard

The Committee reviewed current performance. The main points were:

Flu Campaign: vaccination uptake was 32.8% and ahead of the equivalent point the previous year, with ongoing targeted improvement activity.

Staff Survey: participation was 42%, which was confirmed as lower than the previous year, with targeted improvement activity taking place.

Attendance and Absence: sickness absence was 6.93%. It was noted that Occupational Health (OH) waiting times exceeded the 10-working-day target. Mitigations included additional OH capacity and strengthened absence monitoring.

Appraisals: compliance was 87.55% against a 95% target, with improved recording being progressed.

Temporary Staffing Usage: agency usage had improved, with tighter scrutiny of bank staffing being introduced. The Committee emphasised operational ownership, oversight of combined workforce risks and continued capacity reviews.

Significant assurance was accepted for mandatory training, staff turnover and Freedom to Speak Up and **limited assurance** for vacancies and recruitment, attendance and absence, supervision and appraisals.

Organisational Change – Lessons Learned Phase 1b

The consultation had affected 108 staff, of which seven staff had been redeployed and compulsory redundancies avoided. Effective partnership working with Staff Side and dedicated communication channels had supported the process.

Clear communication, staff wellbeing and sufficient capacity were identified as priorities for future change programmes. Staff feedback had informed adjustments to the new model, with ongoing evaluation supporting implementation and stability.

The Committee accepted **significant assurance** that lessons learned had been thoroughly undertaken following the conclusion of Phase 1b of the operating model and agreed that these would be retained for future organisational change and transformation programmes.

Sickness Absence Management Exception report

The Committee noted the September 2026 absence rate of 6.93%, against a 5% target and 4.1% long-term ambition. Long-term absence remained the largest contributor, with anxiety, stress and depression accounting for approximately 39% of recorded absence.

Targeted case reviews, improved reporting and manager support were being strengthened, with an initial focus on four priority teams. Proposed policy changes aimed to improve consistency, while an OH improvement plan had been requested to address appointment delays.

Strengthened absence-management arrangements and performance exceptions were highlighted.

Accepting **limited assurance**, the Committee emphasised preventative wellbeing support, equitable flexible working and evaluation of interventions.

Leadership Development – THRIVE Programme

It was noted that the Trust's leadership and management development programme for 150 leaders, aligned with Stage 2 of the NHS Leadership and Management Framework. The 18-month programme was planned to commence in January 2027 across three cohorts, with engagement informing its design.

Evaluation measures included 360-degree feedback and regular review points. Participation was expected for the designated leaders, with a minimum attendance requirement of 90%. The Committee emphasised Executive support to protect attendance from operational pressures, supported by attendance monitoring and follow-up.

Significant assurance was received on progress in developing and co-designing THRIVE, noting the proposed structure, target audience, delivery model and wider development offer.

	Temporary Staffing Workforce - Agency Substantial reductions in agency usage and expenditure were reported, with the Trust remaining on track with the elimination of Healthcare Support Worker agency usage and to achieve the national 30% reduction in agency. Increased reliance on bank staffing and overtime was being monitored, with sickness absence remaining a significant driver of last-minute cover. The Committee sought assurance on Consultant recruitment and progress towards eliminating Consultant agency usage. Targeted staffing and recruitment measures were also underway to stabilise higher-usage wards.
	Review of People and Culture Committee Board Assurance Framework (BAF) Risks Leadership development controls and the strengthened sickness absence narrative were discussed. Progress through THRIVE and STRIVE was considered, and a consolidated leadership and management development pathway was requested. The relationship between sickness absence, temporary staffing and financial risk was highlighted. The Committee emphasised local ownership of controls and mitigation, with inconsistent application and ownership remaining the principal sickness absence risk.
	Items for discussion at Board or other Board committees: None. **Items added to the Board Assurance Framework**: None. **Next scheduled meeting:** Wednesday, 13 January 2027

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

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

Trust Strategy Deep Dive - Partnerships

Purpose of Report

To provide a deep dive into progress against the Partnership deliverables within the Strategic Plan, highlighting evidence of impact, key delivery risks and the development of System, community, regional and academic partnerships.

Executive Summary

The enclosed paper offers an overview of progress in delivery of the Partnership priorities defined within the Strategic Plan. It presents evidence of collaboration and emerging benefits, while recognising that partnership outcomes are long term, influenced by multiple organisations and not readily attributable to the Trust alone.

DHcFT is strengthening relationships within the Derbyshire, Lincolnshire, Nottinghamshire (DLN) cluster and progressing representation in emerging Integrated Care Board (ICB) Cluster governance arrangements. Work is underway to establish the Trust as host of the Living Well Adult Social Care contract and develop its broader lead-provider role. Neighbourhood mental health development, a System-wide Children's services review and joint work on Right Care Right Person demonstrate shared direction, with increasing Section 136 detentions remaining a focus for partnership action.

Community engagement is supporting more accessible services and trusted relationships through co-designed information, accessibility reviews and collaboration with community organisations. A detailed review of the Community and Stakeholder Engagement Plan is scheduled via a forward Board Development session, with opportunities for community partners to contribute directly to assessing progress.

Regional collaboration is progressing towards a single East Midlands commissioning hub, with a Director Lead job description agreed and preparations for staff consultation advanced. The Gambling Harms service received above target referrals in Quarter 1, 2026/27, with referrals from every East Midlands locality. Referral pathways, prevention partnerships, self-help resources and lived-experience involvement are being strengthened with published recovery stories providing evidence of positive outcomes.

Anchor ambitions are embedded within existing delivery plans, with examples spanning local recovery support, apprenticeships, sustainable estate and transport, shared use of assets and co-ordinated dementia support.

The signed University of Derby partnership agreement supports research capability and the ambition for University Hospital status, with organisational development and collaborative research providing practical examples of its contribution to service development and safer care.

Delivery remains dependent on evolving ICB Cluster governance, partner alignment and capacity amid operational and financial pressures. Assurance should draw on a balanced combination of performance data, milestones, lived experience, professional insight and case studies, recognising emerging benefits without overstating attribution or quantified impact.

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

Risks and Assurances

- Emerging ICB governance and transition arrangements may delay decisions, representation and mobilisation. Delivery also depends on sustained partner commitment, alignment and timely agreement across organisations
- Operational and financial pressures, competing system priorities and limited capacity may constrain implementation and sustained community engagement, creating reputational risk where delivery falls short of expectations
- Assurance is supported by delivery milestones, regional service activity, community engagement and case studies, with anchor delivery and academic partnership progress overseen through existing committees and the Board. A detailed engagement review will include community partners' perspectives on progress.

Consultation

- The paper describes engagement with System partners, community organisations and academic partners, alongside staff involvement in neighbourhood care development and the Children's services review
- Community partners will have opportunities to contribute to the planned engagement review via a future Board Strategy and Development Session. Preparations for staff consultation on the single East Midlands commissioning hub have been discussed and agreed through the East Midlands Alliance governance architecture.

Governance or Legal Issues

Governance developments include mobilisation of DHcFT representation in new ICB structures, work to host the Living Well Adult Social Care contract and transition towards a single regional commissioning hub. Existing committees and the Board oversee anchor and academic partnership delivery.

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 anchor partnership priority supports progress towards net zero through completed sustainability and light emitting diode (LED) lighting projects across Trust-owned estate, a fully electric fleet and installed electric vehicle (EV) charging infrastructure. Partnership work to optimise estate use and develop community-led neighbourhood provision supports shared use of assets.

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:

Community engagement is informing accessibility reviews, co-created signposting information, awareness training and improved understanding of how communities access mental health information and support. Funding pressures may limit sustained engagement and adoption of improvements. The forward planned Board Strategy and Development Session will enable community partners to contribute evidence on progress.

Recommendations

The Board of Directors is requested to:

1. Note progress against the Strategic Plan Partnership deliverables and the evidence of collaboration, emerging benefits and regional impact presented in the paper
2. Consider the key delivery risks and whether the evidence presented provides sufficient assurance, recognising the limits of outcome attribution and the planned opportunity for community partners to contribute to the detailed engagement review
3. Confirm the level of assurance secured in progress with achievement of Strategic Plan Partnership deliverables. 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**
Chief Delivery Officer and Deputy CEO

Anna Shaw
Associate Director of Communications and Engagement

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

Anna Shaw
Associate Director of Communications and Engagement

NHS
Derbyshire Healthcare
NHS Foundation Trust

Trust Strategy Deep Dive: Partnerships

November 2026



Strategic Plan 2026/27 Partnership Deliverables

Derbyshire Healthcare NHS Foundation Trust

Priorities for delivery of success	Roadmap to delivery of success 2026/27
Build partnerships that deliver on the needs of our communities	Develop relationship with the Integrated Care Board (ICB) Executive team to keep DHcFT positioned positively as a key partner in the new cluster Become a lead provider for Mental Health services in Derby and Derbyshire Deliver priorities for Community and Stakeholder Engagement Plan – Deaf and Black communities East Midlands Provider Collaborative: Move from two to one Commissioning Hubs, expand Gambling Harms service by 10% 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
Excel in our role as an anchor organisation	Collaborate with our partners to deliver an inclusive wellbeing economy - business as usual
Achieve University Hospital Trust status	Continue to develop our strategic partnerships with academic institutions and deliver year 2 plan to develop – business as usual

Overview of Progress

Derbyshire Healthcare NHS Foundation Trust

- Our partnership ambitions are deliberately broad, interconnected and long-term. Therefore, their impact may be difficult to isolate or demonstrate through quantitative measures alone, particularly where outcomes are influenced by multiple organisations, wider system pressures and changing local circumstances

- Assessment should draw on a balanced range of evidence; including performance data (where available), milestone delivery, lived experience perspective, professional insight, case studies and evidence of improved collaboration. This does not reduce accountability. It recognises the partnership contribution without claiming sole responsibility and builds a clear picture of progress and impact over time

- In support of this, a more detailed review of progress against the Community and Stakeholder Engagement Plan is scheduled via a forward Board Development session, offering community partners the opportunity to contribute directly to the assessment of progress

- The content over pages 4 to 10 following provides a balanced assessment, applying the approach set out above and drawing on the evidence available for each deliverable

- Key risks to delivery are highlighted at page 11.

Derbyshire, Lincolnshire, Nottinghamshire (DLN) Partnership

Derbyshire Healthcare NHS Foundation Trust

Strategic Plan deliverable: Develop relationship with ICB Cluster Executive team to keep DHcFT positioned positively as a key partner in the new cluster

- Progress: CEO participation on the DLN Partnership Board. Proactive approach established to development of relationships with ICB Cluster Executive team and with partners across the DLN cluster. New governance structure recently released by ICB Cluster with action being progressed to mobilise DHcFT representation and full participation across this
- DHcFT continues to strengthen its position within the new ICB Cluster through successful delivery of regional priorities, including the Mental Health Urgent Assessment Centre and the East Midlands Gambling Harms service, being awarded the SAANs waiting list contract and funding for developing the mental health neighbourhood model, demonstrating our ability to work effectively with system partners, secure investment, deliver at scale and provide leadership on priority mental health transformation.

Strategic Plan deliverable: Become a lead provider for Mental Health services

- Progress: Work with the ICB Cluster is progressing in 2026/27 to establish DHcFT as host of the Living Well Adult Social Care contract, supporting service stability. Our neighbourhood mental health approach builds on Living Well's success and has received positive feedback from partners, demonstrating our ability to shape System priorities and lead mental health transformation through partnership working. Dialogue ongoing to build on lead provider approach for broader Living Well service offer with the ICB Cluster formally supporting this approach through their internal governance.

Community and Stakeholder Engagement Plan

Derbyshire Healthcare NHS Foundation Trust

Strategic Plan deliverable: Deliver priorities for Community and Stakeholder Engagement Plan – Deaf and Black communities

- Engagement plans and processes are in place, with productive working relationships developing with priority communities
- A new Deaf Focus Group has been in place for one year
- We are reviewing Deaf service offers and accessibility
- Exploring work placement opportunities to increase employee representation
- Roll-out of deaf awareness training
- Exploration of interpretation services including booking processes and data captured
- A new deaf signposting webpage and British Sign Language (BSL) video has been co-created with the Deaf community
- Derby City is now represented by a new deaf governor, following this engagement work
- Two-way trusted relationships are being built with the Deaf community.

Community and Stakeholder Engagement Plan

Derbyshire Healthcare NHS Foundation Trust

Strategic Plan deliverable: Deliver priorities for Community and Stakeholder Engagement Plan – working with local Deaf and Black communities

Collaborative work has commenced with Community Action Derby (CAD) and community groups that represent and engage with existing, new and emerging Black communities to:

- Create new and improved relationships, building trust and partnerships (direct engagement is shaping a co-designed project)
- Map our population together, to gain a shared understanding of our local Black communities
- Learn how to reach people to increase awareness of mental health services, helping to tackle stigma
- Understand how people access information and how this can improve early access to Mental Health services.

Colleagues representing this engagement work plan to attend a future Board Strategy and Development Session to share progress and extend direct engagement with the Board of Directors.

East Midlands Alliance Partnerships

Derbyshire Healthcare NHS Foundation Trust

Strategic Plan deliverable: Move from two to one Commissioning Hubs

- Progress: Job description defined and agreed by East Midlands Alliance (EMA) provider organisations for single hub Director Lead. Readiness developed for staff consultation process with next steps discussed and agreed via EMA Strategy Directors meeting in September 2026.

Strategic Plan deliverable: Expand the Gambling Harms service by 10%

- Progress: The service received 169 referrals in Quarter 1 (Q1), 2026/27, with activity above the annual target range and referrals from every East Midlands locality. This demonstrates sustained demand and broad regional reach, alongside achievement of the 2025/26 stretch target.
- Improvement Focus: The service is strengthening referral pathways, prevention partnerships, self-help resources and lived-experience involvement to improve awareness, access and engagement
- Multiple recovery stories have been published over 2026 demonstrating positive outcomes from the service and our success as a regional provider of a highly specialised NHS service, extending impact beyond Derbyshire boundaries.

Derbyshire Partnerships

Derbyshire Healthcare NHS Foundation Trust

Strategic Plan deliverable: 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

Progress:

- Active work stream progressing with DLN partners to develop approach on neighbourhood model of care alongside internal development of Living Well model. Presentation made to Health and Wellbeing Board September 2026 with positive feedback from partners. Clinical workshop hosted with a focus on transforming the clinical care model in alignment with strategic intent. Progress demonstrates shared direction on neighbourhood care and foundation for closer integration
- Children's service review being progressed through Provider Collaborative workstream led by DHcFT CEO. Internal discussions commenced with staff in 0-19 service, Children's Continence service and Paediatric Therapies, demonstrating collaborative leadership and staff involvement in shaping more co-ordinated services for children and families
- RCRP partnership continues to develop and identify opportunities for ongoing development with a current focus on understanding and developing joint action plans to address the increase in Section 136 detentions. Ongoing collaboration demonstrates shared responsibility for improving crisis responses, with the aim of ensuring people receive the right care from the right service.

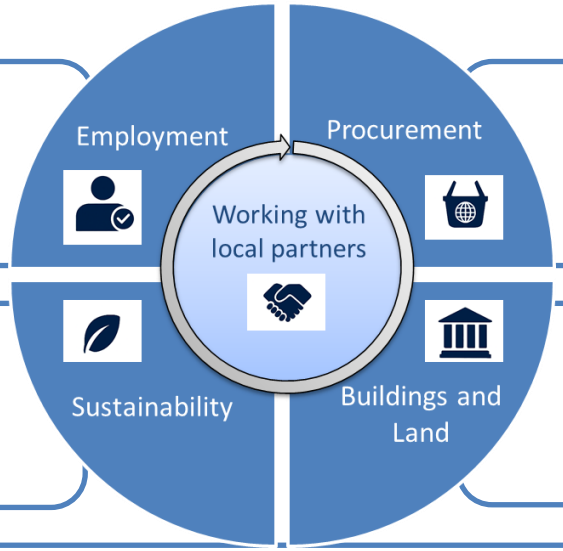
Anchor Partnership

Derbyshire Healthcare NHS Foundation Trust

Strategic Plan deliverable: Collaborate with our partners to deliver an inclusive wellbeing economy - business as usual

- Progress: Anchor ambitions are 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. Highlights across ambitions at Q2, 2026/27 include:

Progress Highlight: Healthcare Support Worker apprenticeships offering routes into permanent NHS roles and career progression. Seven colleagues shortlisted for the 2026 regional apprenticeship awards, demonstrating active investment in local workforce development and career progression.



Progress Highlight: Derbyshire Dales Community Mental Health team completed Active Confidence with High Lea Farm, Matlock, in August 2026, demonstrating how resources directed through a local organisation support recovery and wellbeing while strengthening community assets.

Progress Highlight: Sustainability and LED lighting projects completed across all Trust-owned estate. Fully electric fleet and electric vehicle charging infrastructure installed, demonstrating active investment in reducing environmental impact and progressing towards Net Zero.

Progress Highlight: Collaborative work progressed to optimise utilisation of Derbyshire estate. Partnership approach applied to development of 24/7 Neighbourhood Mental Health Centre including VCSE and community-led services, demonstrating a shared approach to using Trust assets for community benefit.

Progress Highlight: Dementia Hub hosted in June 2026 at Pride Park Stadium in collaboration with a range of local services and community partners. This initiative improved access to advice, support and community resources for people affected by dementia and their carers, demonstrating how partnership working can provide practical, visible benefits for local communities through a co-ordinated and accessible offer.

University of Derby (UoD) Partnership

Derbyshire Healthcare NHS Foundation Trust

Strategic Plan deliverable: Continue to develop our strategic partnerships with academic institutions and deliver year 2 plan to develop – business as usual

- Progress: Strategic partnership agreement signed with UoD 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
- Organisational Development programme delivered by UoD across a number of service areas, including Inpatient wards, Crisis teams with highly positive feedback from frontline teams
- A collaborative research project was recently delivered by UoD and the Derbyshire Recovery Partnership on solitary drug use, recognised to increase overdose risk because nobody can call for help or give naloxone, a medicine that reverses opioid effects. Findings included that people often understood the risks, but stigma, fractured relationships and inconsistent services contributed to using alone. Rural transport barriers and isolation compounded risk. Participants called for wider naloxone access and respectful, realistic safety planning. The research provides evidence to inform improved prevention and service practice within the Derbyshire Recovery Partnership, with the aim of reducing preventable deaths. This demonstrates how our academic partnership strengthens our research capability and informs safer care.

Key Risks to Delivery

Derbyshire Healthcare NHS Foundation Trust

- **ICB Cluster governance and transition:** Emerging structures, roles and decision-making arrangements may delay agreement, representation and mobilisation.
  Mitigation: Working collaboratively with other DLN MH providers to agree shared representation
- **Competing System priorities:** Operational and financial pressures may reduce partner capacity to progress shared ambitions.
  Mitigation: Ongoing proactive management of relationships and internal prioritisation as appropriate
- **Community Engagement:** Funding pressures may limit sustained improvements, adoption of new ways of working and wider community engagement, with reputational risks if delivery falls short of expectations.
  Mitigation: Ongoing proactive management of relationships and ensuring consistency of representation
- **Reliance on partners:** Delivery depends on sustained commitment, alignment and timely decisions across organisations.
  Mitigation: Utilising developed relationships with partners and making ourselves easy to work with
- **Capacity and capability:** Limited resources may constrain the pace and scale of implementation.
  Mitigation: Agreed organisational leads supported by dynamic review of leadership capacity
- **Demonstrating impact:** Partnership outcomes are often long term and influenced by multiple factors, making attribution and quantification difficult.
  Mitigation: Seek ongoing feedback from partners and triangulate with our Strategic Delivery Plan and associated timelines

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

Assertive Outreach (AO) Community Mental Health Treatment

Purpose of Report

To inform and request retrospective sign-off from the Board of Directors about the outcome of the Midlands Intensive and AO Self-Assessment Tool, submitted to Midlands Mental Health team, NHS England (NHSE) on 4 November 2026.

Executive Summary

This report updates the Board on AO provision within Community Mental Health teams (CMHTs) and seeks retrospective approval of the Midlands Intensive and AO Self-Assessment Tool, reviewed and agreed by the Executive Leadership Team before submission on 4 November 2026. Overall, quality and safety assurance remains limited following the July 2026 whole-caseload review, which identified documentation that did not consistently demonstrate up-to-date, personalised care and gaps in face-to-face contact for a small number of patients. Since August, monitoring has included monthly audits of 25% of the AO caseload, monthly whole-caseload performance monitoring and weekly identification of patients without face-to-face contact for more than four weeks. Requirements for documentation review at least every three months and whenever risks or needs change, and escalation arrangements are incorporated into the amended Assertive and Intensive Support Policy, presented for ratification in September 2026.

Quarterly AO System meetings have strengthened governance and clarified eligibility, step-up/step-down arrangements and caseload expectations. The Management and Supervision Tool (MaST) and the Divisional scorecard support caseload and contact oversight, while a shared action plan supports System accountability and escalation through the Adults of Working Age Divisional Board, with Board and Integrated Care Board (ICB) involvement where required. Weekly AO supervision supports clinical co-ordination, complex case discussion and learning. Partnership work and patient and carer engagement arrangements are progressing, although gaps in carer involvement remain recognised. The Quality and Safeguarding Committee continues to monitor quality and safety assurance quarterly.

The November self-assessment records lower scores than May in partnership working, workforce, community-based care, and key workers and caseload management; the remaining six categories are unchanged. The assessment and Board Assurance Framework reflect the unresolved commissioning gap: the Trust does not have a commissioned, stand-alone AO service, and funding constraints limit progress towards dedicated, multi-disciplinary teams. Diverting resources from already stretched CMHTs is affecting caseload manageability, waiting times, patient experience and outcomes. Anticipated demand threatens to exceed current capacity. This risk was escalated to the ICB in September 2025, with subsequent follow-up in September 2026. Strengthened oversight has not resolved the capacity and commissioning risks or changed the limited assurance position. The Board is requested to discuss the report and retrospectively approve the self-assessment submitted on 4 November 2026.

Strategic Considerations		BAF Risk	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X	1a	1.1-1.3
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X	2a	2.4
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

- Risks identified are supported by an action plan under review by the chairs of the Group with escalation as required
- Governance and oversight are in place in the community team to manage caseloads using MaST and Fundamentals of Care standards are in place to monitor quality of care
- Due to the projection of more referrals that will require AO offer, the current resources will not be adequate
- Staff are likely to be overwhelmed which will have a negative impact on service users due to staff sickness or staff managing high AO caseloads.

Consultation

- Care Group Leadership
- Executive Leadership Team.

Governance or Legal Issues

The self-assessment is being carried out in line with direction from NHSE to all ICBs and mental health trusts.

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:

Access to services and health inequalities consideration.

Recommendations

The Board of Directors is requested to discuss the report and retrospectively approve the Midlands Intensive and AO Self-Assessment Tool, which was submitted on 4 November 2026.

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

Fundamentals of Care Standards

In September 2026, the Quality and Safeguarding Committee received an update on the quality and governance of Assertive Outreach (AO) care within Community Mental Health teams (CMHTs). The overall assurance position remains limited. The assurance was position was driven by whole-caseload review from July 2026, which identified that documentation compliance did not consistently demonstrate up-to-date, personalised care. A small number of patients had not received face-to-face contact at least every four weeks, highlighting gaps in oversight of care quality and engagement.

Governance has been strengthened through a continuous quality monitoring cycle introduced in August 2026. Monthly audits cover 25% of the AO caseload, providing full coverage every four months, alongside monthly whole-caseload monitoring of key performance indicators. Weekly reports identify patients without face-to-face contact for more than four weeks for clinical follow-up. Care documentation must now be reviewed at least every three months and whenever risks or needs change, with audit findings reported through Care Group performance arrangements and significant concerns escalated to clinical leadership.

These requirements have been incorporated into the amended Assertive and Intensive Support Policy, presented to the Quality and Safeguarding Committee for ratification in September 2026. The Quality and Safeguarding Committee continues to monitor quality and safety assurance quarterly.

AO Self-Assessment

The Trust submitted the Midlands Intensive and AO Self-Assessment Tool on 4 November 2026. The assessment was reviewed and agreed by the Executive Leadership Team before submission. The assessment consideration included the Board discussions from May 2026 to align the strategic risk in the commissioning and delivery of the service and the escalation that the Board submitted to the Integrated Care Board (ICB) in September 2025 and subsequent follow ups.

The governance and oversight remaining in place in the Community teams and there is caseload oversight using the Management and Supervision Tool (MaST), caseload management in the teams. The Fundamentals of Care Standards are in place to ensure quality and safety.

AO System oversight

Quarterly AO System meetings have strengthened System-wide governance, clarified the service model and improved oversight across the Trust. The principal unresolved issue is the gap between current capacity and anticipated demand, with funding constraints limiting progress towards dedicated, multi-disciplinary AO teams.

Progress and delivery

- **Service model:** Eligibility, step-up/step-down arrangements and caseload expectations have been clarified. Full-time AO practitioners generally have an expected caseload of up to 15 people
- **Identification and oversight:** MaST supports identification of people who may meet AO criteria. Contact timeliness is monitored through the Divisional scorecard, improving visibility of variation between localities
- **System accountability:** A shared action plan and action log support oversight of workforce, housing, physical health, carers and service development. Escalation is through the Adults of Working Age Divisional Board, with Board and ICB involvement where required
- **Partnership and practitioner support:** Wider partners are engaged in addressing barriers beyond CMHT provision. Weekly AO supervision complements strategic oversight through complex case discussion, clinical co-ordination, learning and staff support
- **Carer involvement:** Gaps in engagement have been recognised, with work on carer information, feedback and dashboard reporting. Working with carer and families is being supported by carer and patient engagement meetings and champions in the teams.

The Board Assurance Framework and the self-assessment have been aligned to note the strategic risk of commissioning gap. The Trust does not have a commissioned, stand-alone AO service. The consequence of moving resources away from already stretched CMHTs has impacted our ability to ensure that clinicians have a manageable caseload and resulted in increasing waiting times for this service.

We have evidence that this reduction in resource is impacting patient experience and outcomes across the CMHTs. The self-assessment has been submitted, and scores were reassessed as below:

Midlands Intensive and Assertive Outreach Self-Assessment Tool Summary		
Category	**May score**	**November score**
Partnership working	25	23 ↓
Workforce	14	13 ↓
Community-based care	45	35 ↓
Key Workers and caseload management	16	11 ↓
Out of hours provision	11	11 -
Care delivery	39	39 -
Information sharing	9	9 -
Families and carers	8	8 -
Demonstrating impact	18	18 -
Governance and oversight	5	5 -

Self-Assessment

Scoring Criteria progression to assurance				
1	2	3	4	5
Not in place/ significant gaps	Making forward progress but significant gaps still exist	Some aspects in place but incomplete	80% in place	In place and functional

Partnership Working

Identified challenges (September 2025 Review Summary)	Systems face persistent challenges in developing effective partnership approaches. •Engagement remains inconsistent engagement across key across some partners, particularly social care and Primary Care Networks. •Fragmented, non-interoperable information systems hinder real-time data sharing. •Workforce pressures, including unstable Section 75 agreements, affect multi-agency continuity. Sustainable funding for VCSE contributions remains uncertain despite their recognized value.

Areas of Focus	We have no clear partnership working or governance structure in place for this patient group		We have some elements of partnership and governance in place, but they are inconsistent, informal or still developing		We have strong and embedded partnership and governance arrangements in place to support this patient group	Additional Comments
Access to housing/ relationships across housing stakeholders includes this cohort.		YES				HACT review completed, this is ongoing and a housing workstream is in place across system partners. Some housing providers have representation within MDT meetings. There is limited housing availability in Derby City area, AO patients regularly use hostels, sometimes long term. We do have good links with housing providers, however we reach out to them. Ongoing lack of S117 aftercare follow up from social care. There is shortage of housing and placements for patients with significant risk and MAPPA involvement. This contributes to long length of stay if admission is required.
Primary Care are engaged and involved		YES				Ongoing challenges with GP's accepting shared care arrangements, lack of physical health assessments within primary care. This is a particular issue for people open to EIP services and people with assertive and intensive care needs where GP's will not continue prescribing on discharge from the service - datixes being completed each incident. This is variable across the county and some GP practices and PCN's where we are working in partnership well. GP's provide repeat prescriptions in the main and review physical health needs when patients supported. Can be difficult to get appointments for AO patients at some surgeries, however some are helpful. (AO patients routinely not online, some don't have access to a phone or will not attend without CPN taking)
VCFSE are incorporated into our support offer				YES		Within community services we work jointly with VCSE, some areas where this is limited accessibility for those with assertive outreach needs primarily linked to how these people present and limited engagement.
We actively engage with social care and other partners (eg) Police				YES		Overall there are good working relationship with the police and social care. Limited engagement with the police regarding information sharing and links with the police to be able to proactively work together for people disengaging and deteriorating mental state increasing risk to others and self. We do have the professional line which the police and Emas can make contact with to link in with services, often finding that the response is limited when MH services contact the police with concerns re risk to others. Relies on care co to liaise. Police tend to get in touch with helpline/ out of hours services or send a PPN. Social care less engaging.
We have real time data sharing across our key partnerships			YES			Our EPR provider does not provide live integrated data and can often be 24-72 hours delay for data exports. Patient detail info - We do have access to Derbyshire Shared Care records however minimal information is shared and the Trust and most GP's use the same EPR with some delay in data sharing. National Spine again with limited information. Still waiting for the reasonable adjustments digital flag in EPR's nationally. Data shared on SystmOne, however, no access to that from social care, housing, police
Are we looking at our response /interventions as part of a whole pathway? For example,		YES				

1. Looking at those people with first episode psychosis (first three years of care) and				YES		CBTp and family therapy available, limited physical health assessment and interventions. IPS, psychosocial interventions, psychoeducation.
2. Those people with long-term psychosis.		YES				Access to psychology however long delays, people with assertive outreach needs clinicians are able to meet with psychology colleagues to develop a formulation, AO clinicians encouraged to complete training in Motivational Interviewing. No access to CBTp for people with long term psychosis.IPS, psychosocial interventions, psychoeducation. AOT is considered with people with long term psychosis and additional complexities
Additional Areas of Focus (Please enter here)						
Workforce						
Identified challenges (September 2025 Review Summary)	· Fragile workforce capacity · Recruitment and retention difficulties across psychology, advanced practitioner, and peer support roles. Training and competency development. · Gaps in carer support, autism/LD awareness, and engagement skills. · Caseload expectations (eg ≤15 patients per worker) are frequently unachievable without additional resources.					
Areas of Focus	We have significant gaps in assurance processes relating to staffing for this patient group		We have some systems in place, but they are incomplete, inconsistently applied, or under development		We have robust systems in place and embedded to ensure safe and competent staffing for this patient group	Additional Comments
We have sufficient access to:						
Psychological therapy for this cohort and are aware of the length of waits to access		YES				EIP have access to psychological interventions and have recruited into relevant posts with small waiting times, once a person transitions to the Long Term Offer/CMHT there is a gap in psychological provision for people with long term psychosis and assertive and intensive support needs. Psychology formulation sessions have been set up for clinicians to have psychological support with managing their caseloads. The Trust does not have a commissioned, stand-alone Assertive Outreach service The consequence of moving resources away from already stretched community mental health teams has impacted our ability to ensure that clinicians have a manageable caseload and resulted in increasing waiting times for this service.
Peer support		YES				EIP have a good peer support network and roles in place to support people accessing the service. Staff have regular peer support as clinicians. For AO clinicians a peer supervision group occurring monthly is in place and embedded whilst acknowledging limited dedicated peer support worker roles in the teams. We have evidence that this reduction in resource is impacting patient experience and outcomes across the CMHTs
Our staff are able to access the knowledge and skills to support people in this cohort along the pathway.				YES		Staff have good peer support, training has been identified but challenges with training availability and staff accessing this to upskill. Variable access to other professionals. We have evidence that this reduction in resource is impacting patient experience and outcomes across the CMHTs
We are providing training and development for staff to support our AO community (this includes our autism & LD community)		YES				CAARMS training - staff booked and facilitator has not attended on a number of occasions. Requests for in-house training regarding people with LD/ASD. CBT training for people providing AO approaches due to lack of supervisors If time could allow we do feel other teams would benefit from training around AO capabilities particularly social care. Generic training is offered to CMHT staff to allow them to cover AO and CMHT, because there are no specific commissioning and the resources hav eto be spread across all the staff. staff have been provided with the standards of practice and metrics in the management of AO caseloads
Our training and development input supports staff to be culturally competent and aware (PCREF)			YES			Workstream specifically relating to PCREF in place. All staff cultural sentivity training. Care plans have section called my care plan that enables us to document their needs including cultural and spiritual needs.
Additional Areas of Focus (Please enter here)						
Community-based Care						
	· Workforce shortages, funding gaps.					

Identified challenges (September 2025 Review Summary)	· Difficulties sustaining small, intensive caseloads limit consistent implementation. · Fragmented IT systems and poor interoperability hinder real-time monitoring and cohort tracking. Variations in service models, governance, and resource availability across localities create inequities in care

Areas of Focus	We have no formal local policies or governance arrangements in place to support access to community services.		We have some policies and governance arrangements but they are inconsistently applied, under development, or lack full alignment with best practice		We have comprehensive, embedded, and routinely monitored policies and governance arrangements in place to ensure access, support, and safe transitions.	Additional Comments
We understand /know the individuals within our current caseload who require IAO					YES	We embedded MaST, gives an overview of AO Caseload and support in identifying people who require an AO approach. We do monthly supervision with all AO Workers in that they report their caseload size. MaST can identify people who are eligible for AO, those people will be discussed in MDM for appropriate allocation. If time could allow we do feel other teams would benefit from training around AO capabilities particularly social care.At present, 145 service users are supported under the Assertive Outreach caseload. However, through the MaST system, an additional 108 service users have been identified as meeting the criteria for Assertive Outreach input. For Derbyshire Healthcare, the provision of an effective Assertive Outreach offer remains one of our most significant strategic and operational risks.
Have we integrated / utilised the findings from the Special Review of MH Services at Nottinghamshire NHSFT to consider our service provision in the context of:						The Trust have proactively worked with System Partners to continuously review their special review of mental health services at Nottingham and implemented an action plan which was approved at Board Level. Risk strategy meeting held prior to any discharge planning. MDT is within wider CMHT and not specific to AO. Repeated use of locum psychiatrist and CMHT psychiatrists not always understand of AO patient's needs can create issues with medicine management and rapid response. The consequence of moving resources away from already stretched community mental health teams has impacted our ability to ensure that clinicians have a manageable caseload and resulted in increasing waiting times for this service We have evidence that this reduction in resource is impacting patient experience and outcomes across the CMHTs For Derbyshire Healthcare, the provision of an effective Assertive Outreach offer remains one of our most significant strategic and operational risks.
· joint discharge planning			YES			
· multidisciplinary team working			YES			
· dynamic risk management				YES		
· Medicines management				YES		
Our data dashboard sights staff to where people are accessing or not engaging with our services along the pathway				YES		MaST supports us to have a robust oversight. The consequence of moving resources away from already stretched community mental health teams has impacted our ability to ensure that clinicians have a manageable caseload and resulted in increasing waiting times for this service We have evidence that this reduction in resource is impacting patient experience and outcomes across the CMHTs For Derbyshire Healthcare, the provision of an effective Assertive Outreach offer remains one of our most significant strategic and operational risks.
We are able to track our interventions to support individuals once identified by our data management tool (eg) MaST				YES		MaST can identify people who are eligible for AO, those people will be discussed in MDM for appropriate allocation. If time could allow we do feel other teams would benefit from training around AO capabilities particularly social care.At present, 145 service users are supported under the Assertive Outreach caseload. However, through the MaST system, an additional 108 service users have been identified as meeting the criteria for Assertive Outreach input.
Interoperability of our IT is not a barrier to track this cohort				YES		There is a slight delay of reporting data to MaST which can be up to 72 hours.
We create opportunities for friends and families to engage and input to plans and interventions				YES		Carers Group set up in different parts of the county, but not everywhere, done lots of work with Teams re our ability to listen to carers and family. Carers Dashboard in place, need to ensure everyone is using this. Have a project with Clinical Leads around how to engage with families. Monthly casenote audits around family engagement.
Additional Areas of Focus (Please enter here)						

Key Workers and Caseload Management

	· Most key workers continue to carry caseloads of 25–40 patients per key worker, limiting the ability to provide personalised, proactive support.

Identified challenges (September 2025 Review Summary)	· High caseloads compromising contact frequency and personalised engagement. · Potential increase to risk of disengagement and missed early intervention in relapse. · Additionally, ongoing community transformation, organisational change, and contractual shifts, such as Section 75 arrangements, place further pressure on services, creating uncertainty in workforce models and risking increased demand without corresponding resources.					
Areas of Focus	We have no oversight or monitoring mechanisms in place to ensure key worker allocation or to monitor caseload appropriateness		We have some oversight in place, but we are not able to fully monitor key worker allocation or caseload appropriateness		We have robust and embedded oversight and monitoring systems in place, giving us clear oversight and assurance of key worker allocation and caseload management	Additional Comments
Our organisation is sighted to current caseload size and frequency of contact on an ongoing basis					YES	We have MaST in place and internal reporting around conducts and 365 Reports that help us to have robust oversight of all intensive AO caseload, however, we still have some areas where staff are working to higher caseloads and EI Teams does not use MaST. Reduced caseloads for AO workers - get emails weekly regarding contact figures •For Derbyshire Healthcare, the provision of an effective Assertive Outreach offer remains one of our most significant strategic and operational risks
We have a clear understanding of the proportion / number of people requiring assertive outreach input within our CMHTs			YES			Please include: approx. IAO numbers per CMHT, proportion of people with IAO needs per CMHT AO functionality is ringfenced. We have AO standard Operation Policies and EI Teams in place.
we are able to monitor/review our assertive outreach prevalence numbers for our local population		YES				Through the use of MaST in population health data and regular reviews in MDMs. The Trust does not have commissioned AO service, the Trust has set a high criteria to receive the service. The trust reviews patients that are referred and declined and are waiting for the service.
We are applying the principles set out in the Personalised Care Framework for our IAO population	YES					The Personalised Care Framework was published in July 2026. The Trust has developed a transformation plan that will be mobilised from November and expected to last 18 months across all the services
Additional Areas of Focus (Please enter here)						
Out of Hours Provision						
Identified challenges (September 2025 Review Summary)	· Workforce and funding pressures restrict proactive support. · Cohort may not present via ED or 999, they risk being deprioritized · Out-of-hours responses are often reactive rather than proactive. · Role clarity - external partners, including ambulance, police, and voluntary sector staff, uncertain about responsibilities during out-of-hours episodes.					
Areas of Focus	We have no formal arrangements in place for multi-agency coordination outside of core hours		We have some arrangements in place, but they are inconsistently applied, informal, or lack full system engagement		We have clear, formalised, and embedded arrangements in place to enable effective multi-agency coordination outside of core hours	Additional Comments
External partners coming into contact with people harder to engage have been supported to understand their responsibilities during out of hours episodes			YES			Some aspects are in place, eg we are reaching out to the Police. There is always variation due to how the Police work but we are currently waiting for them to set up an intelligent database which we can contribute to, We are currently using the Reasonable Adjustment Tab in System One to highlight to the GPs that the person is on AO needs. The Trust also works with the Ambulance Services to man the ambulance response vehicle with EMAS. In the event that the current conduct with the AO patient, the MH Workers in the response vehicle will be able to access System One for the most up to date plan of care for that service user.
Our out of hours provision enables a focus beyond ED and 999				YES		Notes added previously. There is currently work to implement the MH Unit Assessment Centre due to go live in July 2026. This will be able to divert people who do not need to be seen in ED but they are in a crisis that can be supported for the person to go back into the community. The turnaround of the MH Assessment Centre is 4 hours. We have the MH Helpline in place.

We are able to make provision for continuity of care at weekends/evenings?				YES		We have the Crisis and Home Treatment Teams which the AO Workers can refer onto if they need the service users to be supported during weekends and evenings. However they need to meet the Crisis and Home Treatment criteria. AO workers are Monday to Friday 9-5. Patients can call helpline out of hours however unlikely to do so and wouldn't be continuity of care as would depend on who is on shift as to whether they have any knowledge of the patient. Crisis team rarely support AO patients again due to lack of engagement and them requiring consent to refer. Recently added on front page of system 1 reasonable adjustments - this has had a positive response with a GP surgery.
Additional Areas of Focus (Please enter here)						
Care Delivery						
Identified challenges (September 2025 Review Summary)	· Care plan quality is variable, with updates and co-production inconsistent. · Limited PROMs use hinders measurement of impact and experience. · Workforce skills gaps in psychosis, risk formulation, and family interventions · Engagement challenges - some service users struggle to participate in co-production or outcome measures, while assertive approaches to engagement remain resource-dependent and inconsistently applied.					
Areas of Focus	We have no consistent oversight to ensure that our care delivery for this cohort indicates that their needs are comprehensively assessed / have care plans		We have some oversight mechanisms in place, but they are inconsistently applied or not fully embedded across services		We have robust and embedded oversight arrangements in place to ensure care plans are in place and holistic needs are assessed and addressed	Additional Comments
Our review of care delivery includes:						
whether care is delivered as planned					YES	We regularly audit AO caseloads and use of MaST. Care delivered depends on patients response at that time which fluctuates
Medication concordance					YES	We have MaST in place and also work closely with our Community Pharmacists. Concordance regularly reviewed
How frequently people were reviewed when risks increased					YES	Increased visits from Care Co-coordinators, regular discussions in MDT and Safety Huddles. However, we do not have dedicated AO Consultant time which can cause a slight delay in review in some areas.
If our care plans have been developed, delivered and reviewed by a MDT?				YES		Inconsistent depending on which other members of MDT are involved with patient as we currently do not have an AO team
We are able to demonstrate that our response to serious incidents for our IAO cohort incorporates the principles set out in the Patient Safety Incident Response Framework (PSIRF)					YES	Thematic analysis conducted alongside SI investigations.
Our Serious Incident Review Process:						Please include: (eg) Frequency of any routine review / the number of people flagged in the last quarter. We have got the SI Group Meeting that takes place on a weekly basis to review all Serious incidents reported in the Trust. Cases will be allocated accordingly for further investigation or full investigation in line with PSIRF Guidelines. In the event that there is an AO reported case, this will be further discussed in our monthly supervisions with AO Workers for shared learning and support for AO Workers with a Risk Management Formulation.
We review our serious incidents (SIs) involving people with psychosis as part of our continuous improvement plan for Intensive and Assertive Outreach					YES	
We have a process in place that flags any of our SI reviews with potential learning/missed opportunities regarding people with IAO needs.					YES	
We monitor the number of SIs that we flag where people have AO needs to support a true understanding of our current service for this cohort					YES	
Additional Areas of Focus (Please enter here)						
Information Sharing						

Identified challenges (September 2025 Review Summary)	· Fragmentation of IT systems and lack of interoperability between platforms - preventing different agencies from accessing and contributing to a single, coherent patient record. · Inconsistent application of GDPR and wider information governance rules, leaving many staff uncertain about what can be legally shared. · Despite strong safeguarding frameworks, there are still gaps in information exchange with primary care, education, and VCSE providers, which means some partners remain disconnected from crucial aspects of patient care. · Reliance on information sharing via personal contacts and informal processes, rather than being embedded in robust, system-wide mechanisms. · Timeliness of information exchange particularly during crisis episodes or care transitions, when delays can have the most serious consequences for patient safety and outcomes.					
Areas of Focus	We have no formal information sharing protocols in place, or existing protocols are not used in practice.		We have some protocols or agreements but they are inconsistently applied or not embedded across all partners		We have clear, formalised, and consistently applied information sharing protocols in place across all relevant partner organisations	Additional Comments
Strategic partners are engaged and focused to resolve the interoperability challenges between different platforms				YES		Systematic systems are different. Operational Policies in services are not always in sync. However, there is still ongoing work to see how we can work with the Police and also teams are promoting setting up Risk Strategy Meetings that will facilitate information sharing where IT systems may not be able to support us, eg if we are dealing with a complex housing issue, we would need to invite Housing Association Teams to support those MDMs. Some have more understanding than others, can be inconsistencies
Our review of SI's gives an indication of where the lack of information sharing has contributed and the causes.					YES	Picked up as part of the PSIRF process and any actions will be part of a Safety Action Plan.
Additional Areas of Focus (Please enter here)						
Families and Carers						
Identified challenges (September 2025 Review Summary)	· Systematic monitoring is limited: · Some providers lack formal procedures to audit family and carer contact · Feedback is not consistently used to inform service change. · Consent and confidentiality barriers restrict meaningful involvement, as families are often excluded when patients withhold consent. · Staff approaches to balancing confidentiality and engagement vary. · The quality of engagement is uneven - involvement not always proactive or meaningful · Carers feeling underheard, particularly around discharge planning and crisis pathways.					
Areas of Focus	We have no formal mechanisms in place to gather, monitor, or respond to family and carer feedback		We have some arrangements in place but they are inconsistently applied, informal, or lack clear governance		We have clear, embedded arrangements and processes in place to routinely capture and respond to family and carer feedback	Additional Comments
We provide a flexible range of opportunities for families and carers to contribute and tell us what works for them and what doesn't					YES	We have got the Friends and Family Questionnaire in place and also the Electronic Patient Records Survey. The plan is to be sent every 6 months and at the point of discharge. AO System Meetings we have invited people with lived experience, although engagement is low for them, we are keen to get feedback from them. We have got a representative from the Carers Engagement Meeting in our AO Meetings (Equal). We have got carers groups in most of the teams which will help us to proactively engage with families and we have Carers Champions in teams which attend Carers Engagement Meetings. Individual care co-ordinators maintain links with family where patient has consented. Carer support groups/ assessment are external to the Trust and we can signpost there but wouldn't get feedback.
We are learning more about what works and what doesn't in engaging with families and carers and in capturing their feedback			YES			Karen Billyard to provide feedback. Teams have been informed to increase use of carers dashboard and friends and families test, however can be difficult with AO patients who often do not have family or friends or they are not involved
Additional Areas of Focus (Please enter here)						
Demonstrating Impact						
Identified challenges (September 2025 Review Summary)	· Absence of cohort-specific KPIs. · PROMs - not consistently used to drive improvement. · Wide variation across ICBs and Trusts in metrics, reporting quality, and co-production.					

Areas of Focus	We have no formal processes to measure or monitor the effectiveness of local services		We have some processes in place but they are inconsistent, incomplete, or lack full integration across services		We have comprehensive and embedded processes in place to systematically measure, monitor, and demonstrate service effectiveness	Additional Comments
Our data capture helps us to measure how well we identify, maintain contact with, and meet the needs of our IAO population ?					YES	MaST in place and we have the supportive Policies.
We make use of evidence based tools (eg) DACT to benchmark our delivery and progression to meeting the needs of this cohort					YES	The AO Policy is based around the DACT Model.
Our patient reported outcomes are utilised to adapt and improve our service provision for this cohort.				YES		The AO Workers have reported the challenges of engagement by AO patients. Patients reported outcome measures. They are asking for the use of dedicated AO outcomes such as Bexley Engagement Measure.
Our review informs our understanding of how accessible the service is to different elements of our local population				YES		The Trust is advocating for having dedicated AO Teams and an AO Option Paper was submitted to the Board which is advocated for dedicated AO Teams.
Additional Areas of Focus (Please enter here)						
Governance and Oversight						
Our Executive teams are satisfied that effective processes are in place to provide them with robust assurance that the needs of this cohort are met.					YES	Regular reporting to Board and Committees. There is Exec oversight. The Execs have oversight of the MaST Dashboards. Our new Operational Meeting Structure have clear pathways of reporting floor to Board. For Derbyshire Healthcare, the provision of an effective Assertive Outreach offer remains one of our most significant strategic and operational risks
Additional Areas of Focus (Please enter here)						

Thirlwall Inquiry

Purpose of Report

- Inform the Board of the publication and principal findings of the Thirlwall Inquiry
- Present an initial assessment of the recommendations most relevant to the Trust
- Identify implications for safeguarding, patient safety, mortality governance, workforce, professional standards, leadership accountability, Freedom to Speak Up (FTSU) and regulatory assurance.

Executive Summary

This paper presents an initial assessment of the Thirlwall Inquiry and its implications for the Trust. Although the Inquiry arose from neonatal services, its learning is relevant across the Trust's services, particularly safeguarding, patient safety, mortality governance, leadership accountability and FTSU. The central message is that patient safety must take precedence over organisational reputation, professional hierarchies and employment disputes, supported by a culture of professional curiosity, effective challenge and timely escalation.

The report identifies Recommendations 4, 6, 9, 13, 16 and 17 as most relevant to the Trust. Existing arrangements provide a foundation for assurance, including safeguarding policies and training, People in Positions of Trust processes, joint safeguarding and Employee Relations reviews, mortality and patient safety governance, the Quality Assurance Framework and the Personal Accountability Charter. The Board-approved FTSU Plan 2026–2029, established reporting routes and committee oversight to support the response to concerns. However, the existence of policies and processes alone does not demonstrate their effectiveness in recognising and responding to potential harm.

The most significant, immediate implication is Recommendation 9 on a Suspicion of Deliberate Harm Protocol: credible concerns must trigger a co-ordinated safeguarding and patient safety response, alongside fair employment processes and external escalation where appropriate. The Safeguarding team has commenced an initial review and is considering how further learning can be incorporated into training. The Board is invited to reflect on whether similar failures could occur within the Trust and consider the adequacy of current safeguards. Continued embedding and development of leadership programmes, the operating model and patient safety arrangements remain necessary to sustain assurance.

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	2.1;2.2
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.	X	4a	4.1

Risks and Assurances

- There safeguards in place to monitor and prevent harm using the accountability charter, safeguarding procedures, patient safety frameworks and FTSU routes
- There is a risk that staff may not adhere to the safeguards and safeguards may not be able to prevent harm in all cases.

Consultation

- Employee Relations
- Safeguarding team
- FTSU.

Governance or Legal Issues

- Care Quality Commission Regulation
- Mental Health Act, Mental Capacity
- Health and Social Care Act 2008
- Health and Safety Act
- Care Act 2014
- Children's Act 2004
- Public Interest Disclosure Act
- Human Rights Act 1998.

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 will be disadvantaged by the finding of the inquiry and implementations of the recommendations

Recommendations

The Board of Directors is requested to:

1. Reflect on whether similar failures could occur within the Trust and consider the adequacy of current safeguards
2. Receive limited assurance that the safeguards in place are able to prevent all harm the Inquiry highlighted, the Trust has safeguards that are yet to embedded and mature.

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

Report prepared by: **Tina Ndili**
Associate Director of Safeguarding Children

Purpose of the Thirlwell Inquiry report

The Thirlwall Inquiry report was published on 15 September 2026. NHS England (NHSE) subsequently confirmed that the learning is not limited to organisations providing neonatal services and should be considered by every NHS trust and Integrated Care Board (ICB). The Thirlwall Inquiry examined events at the Countess of Chester Hospital between 2015 and 2018 and their wider implications. Its recommendations address the systems through which healthcare organisations identify risk, listen to concerns, safeguard patients, respond to unusual patterns of harm and hold leaders to account.

NHSE directed that every Trust and ICB to review the Thirlwall report and to consider its findings at a public Board meeting: Boards should reflect on whether it would have been possible for similar events to occur at their own organisation and seek assurance that sufficient measures are in place to keep the babies and children in their care safe, no matter what setting. Central to this is a culture of professional curiosity, where both Board members and staff feel empowered, supported, and confident to speak up, challenge concerns, and raise issues without fear. Any risks to this must be urgently discussed with the regional team.

The Thirlwall Inquiry identified serious failures in management, governance, safeguarding and organisational responses to concerns about patient safety and deliberate harm. Although many recommendations arise from neonatal services, several have wider relevance across Mental Health, Learning Disability, Perinatal, Substance Misuse, Community and Inpatient services.

The recommendations assessed as most relevant to the Trust are Recommendations 4, 6, 9, 13,16 and 17. These collectively strengthen expectations concerning:

- Safeguarding training and contractual responsibilities
- Identification and escalation of suspected deliberate harm by healthcare staff
- Mortality surveillance and escalation of unusual patterns
- Access to independent clinical and professional scrutiny
- Medical Examiner and child death review arrangements
- Accountability, conduct and regulation of managers
- Care Quality Commission (CQC) scrutiny of safeguarding and patient safety effectiveness
- Freedom to Speak Up (FTSU) and protection of those raising concerns
- Listening and responding to patients, families and carers.

Within the Trust, the Safeguarding team has commenced an initial review. Safeguarding trainers have also considered how the learning can be incorporated into adult and children's safeguarding training. Current children's training already addresses harm by professionals, Local Authority Designated Officer, Persons in a Position of Trust (PiPoT), transferable risk and escalation routes. Adult Level 3 training includes PiPoT, FTSU, professional bodies and alternative escalation routes.

Organisational culture and accountability

The Inquiry identifies organisational culture as a significant contributing factor in the failure to respond appropriately to concerns. It highlights the risks associated with defensive leadership, professional hierarchies, organisational loyalty and the failure to challenge established assumptions.

The Inquiry also considers the limitations of approaches to organisational culture that place insufficient emphasis on individual responsibility and accountability. While recognising the importance of learning from mistakes and supporting staff to raise concerns, it reinforces the need for organisations to distinguish between genuine error, poor performance, inappropriate conduct and deliberate wrongdoing.

The Trust has established programmes of work intended to strengthen organisational culture, including its Personal Accountability Charter, respectful and restorative approaches and wider culture and leadership development activity. The Trust's Just Culture Checklist is clear on the need for accountability, it states the following:

'In a just culture, accountability is still vitally important. Our people are required to perform their duties in accordance with their professional codes, Trust values and our accountability charter. Our people are accountable not only for providing exceptional, safe patient care and experience but also for how they treat each other. Treating each other with respect and civility is expected from all our people and is at the heart of how we work'.

The Trust's approach supports openness, fairness, compassion and learning while maintaining clear expectations of professional conduct and personal accountability.

Leadership and management accountability

The Inquiry identifies significant failures in the response of senior leaders to concerns raised by clinical staff, including insufficient challenge, ineffective escalation and a failure to recognise the potential safeguarding implications.

The findings reinforce the responsibility of all managers, both clinical and non-clinical, to recognise concerns that may affect patient safety and to take appropriate action, irrespective of professional relationships, hierarchy or organisational pressures.

Recommendation 13 proposes strengthened arrangements for the accountability and regulation of NHS managers, including a national barring system, additional safeguards concerning the movement of senior managers between organisations and an individual duty of candour. The Inquiry also recommends strengthening the NHS Leadership and Management Framework to make the primacy of patient safety explicit.

The Trust has its leadership development, management standards, recruitment processes, appraisal arrangements and accountability frameworks reflect these expectations. This includes consideration of the Trust's implementation of national leadership and management standards, its Fit and Proper Person Test arrangements and processes for addressing concerns about the conduct or capability of managers.

FTSU and the response to concerns

The Inquiry identifies serious weaknesses in the way concerns raised by staff were received, considered and escalated. The findings reinforce that the existence of speaking-up policies and designated roles does not, in itself, provide assurance that staff concerns are appropriately addressed.

The Inquiry also highlights the potential for individuals who raise concerns to experience adverse treatment and for employment processes to become a source of additional difficulty for those seeking to raise patient safety concerns.

Recommendation 16 proposes transferring the functions of the National Guardian's Office to the Parliamentary and Health Service Ombudsman, with enhanced powers concerning the handling of whistleblowing complaints.

The Trust has established FTSU arrangements and existing mechanisms for receiving concerns through management, professional, safeguarding and Employee Relations routes. The Trust continues to demonstrate a strong commitment to fostering a culture where staff feel safe and confident to speak up. Established processes ensure that concerns are listened to, responded to in a timely manner and used as a driver for learning and improvement. Reporting levels remain above national averages, particularly in relation to patient safety, quality concerns and cases of bullying and harassment, indicating both awareness of and engagement with FTSU arrangements:

- FTSU Plan 2026-2029 approved by the Board
- NHSE FTSU Reflection and Planning Tool completed and adopted by the Board. FTSU action and improvement plan regular reported to the Audit and Risk Committee
- FTSU Non-Executive Director works closely with the FTSU Guardian
- Wrap around health and wellbeing support for FTSU Guardian, including clinical supervision through Psychology team
- Board supported mandating speak up training, promotes Listen Up training and completes Follow Up training
- Significant number of FTSU Champions throughout the services and an open culture that allows speaking up to managers, colleagues, professional leads
- Board and Executive regularly updated on national cases or inquiries via the FTSU Guardian
- FTSU Guardian is a member of the Trust Delivery Group – to ensure they are sighted on in advance of significant organisational changes
- Increased engagement mechanisms to hear the voice of our colleagues, including our staff networks, regular face to face drop-in sessions by FTSU Guardian and Chief Executive, the quarterly pulse survey and quality visits

- Staff Survey scores
- Leadership development programmes which promote a culture of compassion, inclusion and listening
- New staff induction covers FTSU in detail- bespoke video with Trust staff
- The Board received assurance on FTSU every six months and the last report to Board was September 2026. In the report the Board seeks assurance on FTSU activities, themes, responsiveness and impact
- The Trust has a clear and defined FTSU Policy and Procedure that staff demonstrate awareness of through its usage and this is supported by training
- The Trust values FTSU and has been able to demonstrate impact through speaking up, Employee relations have been implemented when reports indicated staff were not adhering to Trust values which have led to cultural reviews, review of staffing levels or deployment like when staff spoke up about implementation of breaks in Acute services, a different approach was taken to address staff concerns whilst addressing the legal requirement to have breaks.

Employee Relations, grievances and disciplinary processes

The Inquiry identifies how concerns about potential patient harm became entangled with employment processes, including the handling of a grievance raised by the employee concerned.

The grievance process contributed to a change in organisational focus, with attention directed towards the treatment of the employee and the conduct of those who had raised concerns. The underlying patient safety concerns were not appropriately addressed through the relevant safeguarding and investigative arrangements.

The Inquiry demonstrates the risks associated with treating serious clinical or safeguarding concerns primarily as employment disputes, particularly where allegations of unfair treatment, discrimination or counter-grievances arise during an investigation.

The findings do not diminish the importance of fair employment processes, procedural safeguards or employees' rights. Rather, they reinforce the need for employment procedures to operate alongside clear and effective safeguarding and patient safety arrangements.

The Trust has effective working relationships between the Employee Relations team and the Safeguarding team with joint review groups to consider concerns when they are raised. The internal PiPoT process is well-established and a recent review of the process and who is involved has taken place. A flow chart has been produced to ensure clarity. In 2025/26, there were two substantiated PiPoT referrals within the Trust.

The Trust has a just and fair culture that will consider the potential harm to balance with the need for Employee Relations process. The review of such reports of potential harm are jointly reviewed by Employee Relations, clinical experts, safeguarding, health and safety and any other expertise that is required. There are processes that are in place from fat finding to full scale investigations that are put in place for each report with Executive oversight of the processes and Executive Team Leadership if required.

Safeguarding and the management of concerns about staff

A central finding of the Inquiry is that safeguarding action was not initiated appropriately when concerns arose that a member of staff may have deliberately harmed patients.

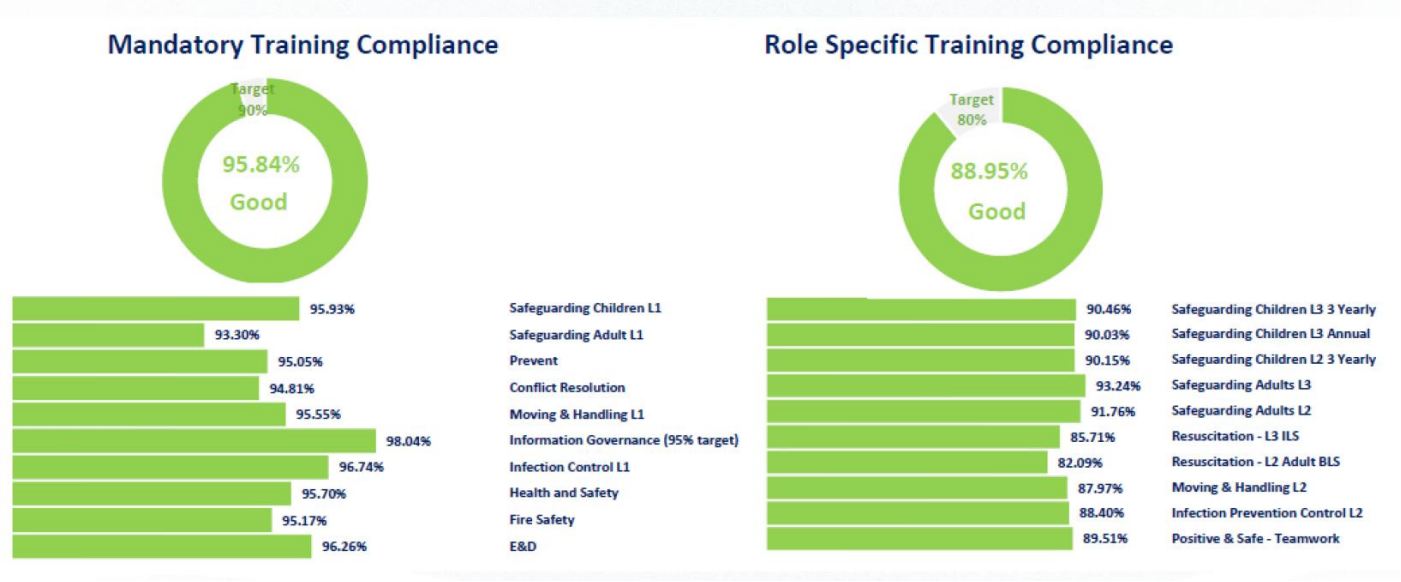
The Inquiry emphasises that safeguarding responsibilities arise when credible concerns or suspicions are identified and do not depend on an organisation having established that wrongdoing has occurred.

Recommendation 9, concerning a Suspicion of Deliberate Harm Protocol, represents the most significant immediate safeguarding and governance implication. The Trust should ensure that any concern about possible deliberate harm by a healthcare worker initiates a coordinated response involving patient safety, safeguarding, operational management, People services, professional standards, FTSU and, where appropriate, external agencies.

The Trust is not starting from a position of no assurance. Existing arrangements include safeguarding policies, PiPoT processes, incident reporting, patient safety learning, FTSU routes and training. The current Safeguarding Adults Policy and Procedures - updated February 2026, requires concerns to be reported promptly and identifies serious alleged or actual mistreatment by anyone working for the Trust as requiring safeguarding and incident-reporting consideration.

The Trust's Managing Allegations (PiPoT) for Staff also provides for safeguarding, employment and police processes to run concurrently and describes suspension as a neutral act where this is required to protect patients and support an investigation.

Recommendation 4 addresses safeguarding training for staff and Board members and proposes changes to employment contracts to reinforce employees' obligations to follow relevant safeguarding guidance. The Trust has robust training for safeguarding and high level of training compliance both under mandatory training for role specific training. The Trust has the Safeguarding team that offers advice, review cases and works with the local authority Safeguarding Boards to ensure high level quality of care and patient safety. The Quality and Safeguarding Committee receives assurance on a quarterly basis and assurance levels for both safeguarding children and adults stand at significant with significant assurance level for the Section 11 compliance assessed annually by the ICB.



9. Workforce intelligence and organisational assurance

The Inquiry highlights the consequences of failing to recognise patterns of concern and of considering information in isolation rather than bringing together intelligence from different sources.

For People and Culture, this reinforces the importance of triangulating workforce information to identify services or teams where multiple indicators may suggest underlying leadership, cultural or organisational risks.

The Trust has in place the Quality Assurance Framework that reviews the quality of services in line with evidence-based care and regulations standards using Fundamental Standards of Care, Board Visits, 15 Steps Challenge, Service Accreditations, complaints, compliments and other sources of feedback. This is triangulated against performance indicators and people performance indicators. The people performance indicators are qualitative and quantitative, using set metrics, such as sickness rate, vacancy rates and qualitative feedback from cultural reviews, staff feedback, complaints and grievances with input from staff side as well. The governance in place allows the performance and intelligence to be triangulated in the services up to the Board.

Patient Safety Incident Review Framework (PSIRF)

- Mortality surveillance and escalation of unusual patterns
- Access to independent clinical and professional scrutiny
- Medical Examiner and child death review arrangements.

The Trust uses PSIRF to ensure that these areas are addressed. There is set governance for mortality review and the assurance is received by the Quality and Safeguarding Committee and the Board. Safeguarding processes support PSIRF in the cases of the death of a child or young person and Section 37 procedures are followed with the CQC if indicated.

The Trust has a number of established arrangements relevant to the Inquiry's findings, including:

- The Personal Accountability Charter and wider culture improvement programme
- The implementation of respect and resolution approaches
- Leadership and management development arrangements
- FTSU processes and governance
- Employee Relations policies and case management arrangements
- Safeguarding policies, training and escalation procedures
- Joint working between the Employee Relations and the Safeguarding teams
- Workforce assurance meetings and reporting to the People and Culture Committee
- Staff survey reporting and organisational development activity
- PSIRF
- Culture reviews.

Conclusion

The Thirlwall Inquiry identifies significant and far-reaching learning for NHS organisations, particularly concerning leadership accountability, organisational culture, safeguarding, speaking up and the management of employment matters. The Trust is able to demonstrate that it has the governance, and support to meet the challenges that the Thirlwall Inquiry identified. It has to be acknowledged that some of the mitigations such as the development programmes, the operating model and patient safety arrangements need embedding and continued development.

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

Strategic Plan - mid-point review: draft version (for assurance)

Purpose of Report

To present the draft mid-point review of delivery against the Trust Strategic Plan 2025-2028, summarising progress, impact, outcomes and the delivery position across the four strategic priorities.

Executive Summary

The Trust Strategy was launched in October 2024, supported by the Strategic Plan 2025-2028 approved by the Board in March 2025. The plan sets out the priorities and delivery roadmap for achieving the Trust's four strategic ambitions: Patient Focused, People, Productive and Partnerships.

The mid-point review provides an 18-month assessment of the progress across key deliverables, the impact and outcomes achieved, and the current delivery position for each strategic priority.

Overall delivery is progressing well, with most priorities on-plan. Four deliverables illustrate how progress across strategic ambitions is translating into practical benefits for patients and staff:

Patient Focused – Reduction of out-of-area (OoA) placements: OoA placements have reduced from a high of circa 30 in 2025 to consistently fewer than three, with delivery trajectories achieved and improvement sustained. Withdrawal from the 16 appropriately commissioned beds is also currently on track. Caring for patients in Derbyshire keeps them connected to family, carers and established community support, makes visiting and involvement in care planning easier and supports continuity with local clinical teams. It also enables discharge planning to begin earlier with local housing, social care, primary care and voluntary-sector partners, reducing avoidable delays and supporting safer, more sustainable recovery closer to home. For staff, locally delivered care improves communication and shared decision-making across the pathway, strengthens clinical oversight and reduces the time and complexity involved in co-ordinating care with distant providers.

People – Leadership Development Programme: The STRIVE programme, Leadership Roadmap and developing talent pathways have increased participation in leadership development and reflective learning. Staff are being supported to lead with greater confidence, manage change effectively and create more inclusive, compassionate and accountable team cultures. Stronger leadership improves the quality and consistency of supervision, decision-making and support available to frontline colleagues, helping teams address concerns earlier, maintain wellbeing and retain skilled staff. For patients and families, improved leadership and more stable teams support safer care, clearer communication, more consistent practice and a better overall experience. The programme is also strengthening succession planning and internal career pathways, building organisational resilience and reducing disruption when leadership roles change.

Productive – Making Room for Dignity: The programme is now fully operational, and benefit evaluations have been completed. The improved inpatient environment offers patients greater privacy, dignity and personal space, with modern, therapeutic facilities designed to support safety, recovery and individual needs. More appropriate spaces for meaningful activity, quiet time and contact with families and carers can reduce distress and support a more positive inpatient experience. For staff, the redesigned environment improves observation, workflow and access to suitable clinical and therapeutic spaces, enabling safer and more efficient care. It also supports multi-disciplinary working, reduces avoidable operational pressures and gives colleagues facilities that better reflect the standard of care they are expected to provide.

Partnerships – Lead Provider of the Gambling Harms service: The Trust has strengthened its lead-provider role across the East Midlands. The service received 651 referrals during 2025/26, performing above the annual target range of 368–517 referrals. A further 169 referrals were received in Quarter 1 (Q1), 2026/27, demonstrating sustained demand; if this level continues, referrals are expected to exceed the previous year. This activity reflects growing awareness of the service and the continued development of referral pathways across the region. A clearer regional pathway is extending access to specialist, evidence-based support for people affected by gambling harm, including those who may not previously have recognised the impact or known where to seek help. Co-ordinated provision enables earlier intervention, reduces variation in access and supports people and families with the wider mental health, relationship and financial consequences associated with gambling harm. For staff and partners, the lead-provider model creates clearer referral routes, stronger clinical co-ordination and more consistent standards across the region. It also supports shared learning, workforce expertise and better use of specialist capacity, enabling local services to identify risk earlier and connect people to the right support more quickly. Success is strengthening the Trust's partnership position as a regional provider of a highly specialised NHS service.

The review completed is aligned with the latest quarterly Strategic Plan update and highlights the actions required during the remainder of 2026/27 to maintain progress, address off-plan and at-risk areas, strengthen benefits and outcome measurement, and ensure delivery remains aligned with the Trust's strategic ambitions and Board Assurance Framework (BAF).

Areas requiring enhanced oversight are:

1.4 Improve access to our services and achieve all target waiting times

A zero position has been achieved for Adult Acute and Older Adult OoA placements. Female Psychiatric Intensive Care Unit use remains above the Integrated Care Board plan, with no commissioned service in Derbyshire, and length of stay (LoS) remains challenged. Continued pathway redesign and focused oversight through the Patient Flow Delivery Group are required. Recovery plans are in delivery, supported by enhanced Executive oversight of the key deliverables. Linked BAF Risk 26/27 1A: *There is a risk that the Trust will fail to provide standards for safety, and effectiveness as required by our patients, regulators, partners and our Board. There is also a risk of poor patient experience and outcomes.*

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

The trajectory for reducing long-term sickness absence remains off-plan. Recovery delivery is subject to enhanced oversight through the Trust Delivery Group, Executive Leadership Team (ELT) and People and Culture Committee. Linked BAF Risk 26/27 2B: *There is a risk that we do not have an adequate supply of a skilled and diverse workforce in critical clinical roles, including inpatient nursing and support staff, limiting the Trust's ability to deliver safe staffing, reduce reliance on temporary workforce solutions, and meet safety, quality and financial priorities.*

One further area is expected to be on plan at quarter 2 but at risk for quarter 3:

3.1 Achieve financial sustainability through improved clinical and operational productivity

Published Q2 outturn is not available at the time of reporting but current forecasts indicate that the financial plan will be on plan and the efficiency programme will be close to target. This position is at risk for Q3, requiring focused ongoing action and continued oversight. Linked BAF Risk 26/27 26/27 3A: There is a risk that the Trust fails to deliver its revenue and capital financial plans for 2026/27.

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

Risks and Assurances

- The review confirms that most strategic priorities remain on plan, with established governance and assurance routes supporting oversight of delivery
- Key delivery risks relate to LoS, sickness absence, the financial and recurrent efficiency position, restrictive practice, and violence and aggression
- Mitigating actions will continue through the relevant Executive, committee and programme governance arrangements, with material strategic risks escalated through the BAF.

Consultation

- The mid-point review has been informed by updates from Executive leads and the established governance forums responsible for oversight of each strategic priority
- The draft review has been presented to the ELT for consideration before onward discussion and assurance through the Board of Directors.

Governance or Legal Issues

The Trust Strategy and Strategic Plan were approved by the Board. The mid-point review supports the Board's continuing oversight of delivery, impact, risk and accountability and does not introduce any new legal obligations.

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:

Strategic priority 3.4 directly supports the Trust's net zero duties through delivery of the Sustainability and Estates Plans, including estate rationalisation, energy efficiency, electric fleet and charging infrastructure, travel planning and development of the decarbonisation plan.

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, diversity and inclusion are embedded across the Strategic Plan, including delivery of the Patient and Carers Race Equality Framework, Workforce Race Equality Standard and Workforce Disability Equality Standard improvement plans, inclusive leadership and engagement with Deaf and Black communities. Continued monitoring of access, experience, workforce and outcome data will support identification and mitigation of differential impacts.

Recommendations

The Board of Directors is requested to:

1. Note the progress, impact and outcomes achieved during the first 18 months of the Strategic Plan
2. Consider the areas identified as off-plan or at risk and confirm that the proposed mitigating actions and governance arrangements provide sufficient assurance.

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

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

NHS
Derbyshire Healthcare
NHS Foundation Trust

Strategic Plan 2026-28

Mid-Point Review



1. 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		18-Month Delivery, Impact & Outcomes
	2025-26	2026-27 (Reviewed and refreshed May 2026)	
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 including Culture of Care inpatient quality improvement programme and Patient Carer Race and Equality Framework	Improve safety and reduce harm: timely learning from incident, review of Datix, PISRF reviews in line with Trust Policy Reduce restrictive practices incidents (seclusion, restraint, rapid tranquilisation) by 10% through targeted clinical interventions Learning from Incidents - all SI learning themes reported to ELT and QSC with action tracking Reduce incidents of violence and aggression towards staff by 10%	**Key deliverables:** Embedded the Quality Delivery Plan, Culture of Care and PCREF arrangements; established care-group and Trust-wide Learning the Lessons meetings; introduced After Action Review and MDT incident reviews; strengthened incident, complaint and PSIRF action tracking. **Impact and outcomes:** CQC outcomes improved across four services and a lower BAF risk rating agreed. Overdue Incident Review Tools improved 76% from Q4 2025–26, overdue Patient Safety Actions 46%, and overdue Learning Responses 21% since Q1 2026-27; restraint and prone restraint also reduced. **Delivery position: On plan** overall, but restrictive practice and violence and aggression remain above the 10% reduction targets; further targeted actions and No Excuse for Abuse delivery continue through 2026-27.
1.2 Improve experience for, and empower, service users patients and carers	Define and agree experience measures across all services Review and refine feedback mechanism s across all services Monitor feedback and implement plan to address any identified improvement aligned to transformation and continuous improvement portfolio Develop and agree framework for empowerment Design and launch education programme Develop and implement engagement through to co-production framework	Patient and Carer Race Equality Framework- coproduction of an action plan and having 3 pilot sites for implementation Improve participation and improve scores in Community Mental Health Feedback Deliver engagement and co-production plan (in continuous improvement and care delivery) Closer Look Complaints to be responded within 90 days	**Key deliverables:** Implemented the experience dashboard, paid lived-experience roles, refreshed patient and carer forum, fundamental care standards and 15 Steps visits; appointed the PCREF Lead and Co-Chair, confirmed three pilots and established ethnicity-data triangulation. **Impact and outcomes:** Ethnicity recording exceeded 95%; Community Mental Health feedback participation increased 28%; the 2025 complaints backlog has been cleared, 70% of complaints now receive a response within 90 days, and Triangle of Care retained two-star status. **Delivery position: On plan**; co-production advisory panels and alternative feedback methods will broaden participation, while complaint performance on track to rise from 70% to the full 90-day standard.
1.3 Develop 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	Deliver a minimum of 3 operational NOF performance standards Develop and deliver Clinical Plan with set deliverables to be delivered in year 1 Develop and deliver community safer staffing models in community services Provide assurance and oversight of nursing and AHP roster, safer staffing and associated budgetary spend meet the national agency and bank usage targets	**Key deliverables:** Embedded the Quality Assurance Framework and new clinical governance model; improved the NOF segmentation position and performance across key metrics; progressed the Clinical Plan to final consultation; implemented the HCA agency ban and reviewed staffing across all 11 community teams. **Impact and outcomes:** Well-Led testing and joint nursing, finance and HR oversight strengthened assurance, learning, roster control and temporary-staffing governance. Agency use continues to reduce, and separating AHP rosters increased therapeutic activity and ward programmes. **Delivery position: On plan**; secure Clinical Plan approval, complete evidence-based community staffing models and address challenged NOF metrics, with segmentation currently capped at 3 due to financial deficit.
1.4 Improve access to our services and achieve all target wait times	Launch and deliver year 1 Clinical Services Delivery Plan with a focus on improving access and on understanding and addressing health inequalities Design framework for disproportionate allocation of resources based on needs of our population 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	Deliver the Trust's OOA bed reduction plan Reduce LOS by 10% as set out nationally in the Trust's plan	**Key deliverables:** Achieved access standards for perinatal care, dementia diagnosis, CYP eating-disorder services and IPS; met earlier OOA and 24-hour crisis trajectories; transferred older adult, dementia day and neurodevelopmental services; deployed OOA and LOS plans, GIRFT workshops and Medical Director oversight. **Impact and outcomes:** Service transfers created a stronger access platform, sustained improvement in Adult Acute and Older OOA placements; withdrawal from appropriately commissioned beds remains on track at August 2026, and Derby Mental Health Urgent Assessment Centre opened aligned to target in September 2026 alongside community care model transformation. **Delivery position: Off plan** at Q2: Zero position achieved for Adult Acute and Older Adult beds. Female PICU use remains above the ICB plan with no commissioned service in Derbyshire. Length of stay remains challenged; Patient Flow Delivery Group action and oversight and continued pathway redesign are required.

2. People

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

NHS Derbyshire Healthcare NHS Foundation Trust

Priorities for delivery of success	Roadmap to delivery of success		18-Month Delivery, Impact & Outcomes
	2025-26	2026-27 (Reviewed and refreshed May 2026)	
2.1 Be recognised for attracting and retaining the best people	Improve our recruitment and retention processes and systems to provide assurance on the experience of our people Support managers to support our people to fulfil their potential and deliver new roles Further mature and embed our workforce planning approach and develop multi-year Trust strategic workforce plan which reflects our role as system partner.	Improve recommendation as a place to work and staff engagement scores (Pulse check ins to assess progress) Reduction in medical and key clinical vacancies (focus on remaining 39.72 TE HCSW inpatient vacancy and 26.69 FTE RMN inpatient vacancy) Improvement in general recruitment processes Improvement in teams with turnover above 10% to reduce variance and bring in line with trust thresholds Improvement in eRoster efficiency to support overall reduction in 10% bank usage and 30% agency usage (alongside elimination of all HCSW agency usage)	**Key deliverables:** Embedded staff-survey, stay, exit and workforce insight in local retention plans; completed the national workforce submission; sustained priority and HCSW recruitment; streamlined appointments; strengthened recruitment KPI governance and launched targeted eRoster actions. **Impact and outcomes:** Vacancy reduction remains on track, HCSW recruitment is strengthening service resilience, appointment delays are reducing and the workforce pipeline is more stable, with early reductions in temporary-staffing reliance. **Delivery position: On plan**; deliver the next eRoster optimisation phase and quantify movement in vacancies, teams above 10% turnover, staff recommendation scores and remaining clinical gaps.
2.2 Be recognised for supporting and developing our people to work confidently in their roles	Launch roadmap for leadership development and roll out year 1 plan including senior leadership programme Embed talent management and succession planning framework Develop standards and governance for advanced professional practice across roles Develop learning culture for all staff including regular career conversations	Reduction in length of time for formal ER cases (measurement through regular reporting via TDG) Reduction in inappropriate formal ER cases (utilising the respectful resolution policy to reduce formal ER cases) Continue to deliver Leadership Development Programme Deliver organisational change aligned to efficiency plan and organisational priorities	**Key deliverables:** Launched and sustained STRIVE; progressed CMI accreditation, talent pathways and the advanced-practice framework; introduced a Leadership Roadmap from aspiring to executive leaders; progressed THRIVE and maintained organisational-change milestones. **Impact and outcomes:** Development and reflective-learning participation increased, Respectful Resolution is enabling more informal resolution and a more restorative culture, and the efficiency-plan target is expected to be fully delivered by year end. **Delivery position: On plan**; complete the focused ER improvement programme and evidence shorter formal cases, consistent management practice and stronger succession readiness.
2.3 Be recognised by our people for our values driven and inclusive culture	Embed personal accountability charter within the people management and appraisal framework and develop competence of managers in restorative just culture Deliver year 1 plan to develop EDI framework with a focus on diversity in recruitment and development offer, and equipping leaders with skills and data to improve Refresh and deliver improvement plans for Workforce Race Equality and Disability Equality Standards	Deliver all elements of EDI Plan for 2026-27	**Key deliverables:** Embedded the Personal Accountability Charter through A Kind Life; maintained active anti-racism, EDI, WRES and WDES plans; strengthened Race Equality Plan accountability and staff-network oversight. **Impact and outcomes:** Values-led behaviour, accountability and inclusive leadership are more consistently built into people management, supporting staff experience and clearer routes for challenge and assurance. **Delivery position: On plan**; develop the wider EDI framework in Q3–Q4 2026-27, sharpen impact measures and evidence improvement in staff-survey, race-equality and disability-equality outcomes.
2.4 Be recognised as a Trust that supports and promotes the wellbeing of our people	Embed a flexible working culture, supporting colleagues to balance home and work life and support delivery of services ,with clear action plans for delivery within one year Continue to embed annual health and wellbeing assessment and deliver year 1 development plan Develop psychology support and offer for staff Review and refine attendance management policy and approaches to support colleagues and managers	Improvement in long term sickness absence rates (to support an overall reduction of 0.5% in the annual sickness absence rate) Reduction in sickness absence across teams above trust average – reduction of variance to within 1%	**Key deliverables:** Established flexible-working processes, enhanced long-term absence oversight, a specialist psychological-support pathway and an emerging in-house wellbeing model; completed detailed analysis of local absence drivers. **Impact and outcomes:** Managers now intervene earlier, improve recovery planning and target tailored support to high-absence teams, strengthening prevention and consistency across services. **Delivery position: Off plan** at Q2; convert earlier intervention into a sustained reduction against the 0.5% annual absence ambition and narrow high-team variance to within 1%.

3. Productive

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

NHS Derbyshire Healthcare NHS Foundation Trust

Priorities for delivery of success	Roadmap to delivery of success		18-Month Delivery, Impact & Outcomes
	2025-26	2026-27 (Reviewed and refreshed May 2026)	
3.1 Achieve financial sustainability through improved clinical and operational productivity	Agree core priorities and deliverables for 25-26, to include reduction of OOA and premium spend Deliver agreed financial plan on pathway towards financial balance and sustainability Deliver year 1 plan for international medical recruitment on path to eradicate medical agency spend Understand productivity and sustainability across all services and plan for optimisation or consider exit Implement data flow for new national currency model Develop literacy of our people in financial, capacity and activity planning	Deliver the Trust's agreed financial breakeven position by year end Achieve £14.5 million in CIP with at least 66% recurrent savings by Q4 Establish innovation panel for colleagues to seek funding to deliver service and transformational change - focusing on delivering improved measurable patient outcomes	**Key deliverables:** Maintained the 2025–26 financial plan, CIP and bank and agency controls; progressed international medical recruitment and productivity governance; recovered the early 2026–27 deficit by month five; established CIP tracking, assurance, QEIAs and recovery workshops. **Impact and outcomes:** £45m of system deficit support enabled partner break-even in 2025–26; Q2 financial and CIP outturns were anticipated to be on or very close to plan, strengthening the route to lower premium spend and productivity improvement. **Delivery position: At risk** of falling off track in Q3; close remaining CIP gaps, resolve difficult estates and property savings and mobilise a minimally funded innovation panel.
3.2 Transform our clinical pathways and operating model	Establish vision and ambitious transformation plan for integrated 'end to end' pathway and model of care across community and acute services and align to partnership development approach Design and implement new operating model and accountability framework for delivery of services Design and launch transformation plan for corporate services Implement year 1 of agreed transformation programme Implement transformation and improvement framework Develop population health approach within the clinical transformation programme	Agree and implement the CMH 24/7 neighbourhood model Agree and implement the MH Urgent Care Assessment clinical model	**Key deliverables:** Implemented phases one and two of the operating model through triumvirate teams; embedded transformation governance and service deep dives; progressed the 24/7 neighbourhood pilot, specialist-care redesign and Derby Mental Health Urgent Assessment Centre. **Impact and outcomes:** Neighbourhood, urgent-care and community pathways are more integrated and aligned to population need; Derby phase one Mental Health Urgent Assessment Centre opened on track September 2026, and national funding secured for a further Chesterfield centre. **Delivery position: On plan**; deliver Mental Health Urgent Assessment Centre phased openings and 24/7 Neighbourhood Centre opening within recurrent-funding constraints, design and deliver programme plan for Living Well and Neighbourhood model of care.
3.3 Optimise our assets and enabling resources to improve services and care	Deliver and track realisation of intended benefits from the Making Room for Dignity programme Launch and deliver year 1 of agreed Estates Plan Launch and deliver year 1 of agreed Digital Plan with a focus on consolidating gains from existing assets including EPR and design of 'end to end' digital workflow	Deliver year 1 priorities Digital Delivery Plan (Psyomics, Patient Knows Best, eMHA by Thalamos, SystmOne Optimisation) Operationalise and deliver first treatments in Positive Health Difference services	**Key deliverables:** Making Room for Dignity fully operational and completed benefit evaluations; progressed the Estates Delivery Plan; strengthened programme leadership; hosted Digital Futures Day, designed and mobilised Digital Delivery Plan launched beseen digital triage; completed core Positive Health Difference systems, resources and facilities preparation. **Impact and outcomes:** The first new digital deployment is live, delivery has moved from planning to operational infrastructure, and Positive Health Difference is ready to begin trading and first treatments once rooms are completed. **Delivery position: On plan**; launch eMHA and Patient Knows Best, optimise SystmOne, commence treatments in Q3 and use the 12-month review to evidence sustained care benefits.
3.4 Reduce emissions we control directly (the NHS Carbon Footprint)	Deliver year 1 of agreed Sustainability Plan and achieve a reduction on emissions in 2025-26 on course for 80% long term target	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)	**Key deliverables:** Approved the Sustainability Plan; progressed EV charging; completed LED rollout and electric-fleet phase one; kept Year 2 Estates Plan milestones on track; completed six-facet estate surveys and developed the draft decarbonisation plan. **Impact and outcomes:** The Trust now has stronger evidence to classify core, flex and tail estate and direct investment, maintenance and disposal decisions toward lower energy demand and the long-term carbon target. **Delivery position: On plan**, but quantified emissions and backlog-maintenance reductions are not yet reported; complete the Travel Plan and prioritise high-impact work within CDEL constraints.

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.

NHS Derbyshire Healthcare NHS Foundation Trust

Priorities for delivery of success	Roadmap to delivery of success		18-Month Delivery, Impact & Outcomes
	2025-26	2026-27 (Reviewed and refreshed May 2026)	
4.1 Build partnerships that deliver on the needs of our communities	Develop our partnership within the East Midlands Alliance, to enable the best mental health, learning disability and autism care and support for the people of the East Midlands and deliver year 1 plan across the priorities for: 1.Quality improvement and productivity 2. Enabling safe care 3. Developing our workforce 4. Improving population health and 5.Reducing inequalities Develop our role as Perinatal Lead Provider and in leading Gambling Harm services within the East Midlands. Develop our strategic partnership with University of Derby and associated implementation plan Develop partnerships within the JUCD Provider Collaborative with a year one focus on collaboration across services for Children and Young People Deliver Community and Stakeholder Engagement Plan with year 1 priority focus on the deaf community, black communities and new migrant families Proactively engage with regional and national learning collaboratives Work in partnership to develop financial model and full business case for income generating business unit	Develop relationship with ICB Executive team to keep DHcFT positioned positively as a key partner in the new cluster Become a lead provider for mental health services in Derby and Derbyshire Deliver priorities for Community and Stakeholder Engagement Plan – Deaf and Black communities EM Provider Collaborative: Move from 2 to 1 Commissioning Hub, expand Gambling Harm service by 10% 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	**Key deliverables:** Activated all five East Midlands Alliance priorities and JUCD work across corporate services and clinical pathways; signed the University partnership; progressed Deaf and Black community plans; mobilised ICB governance participation and DHcFT hosting of the Living Well adult social-care contract. **Impact and outcomes:** Gambling Harm referrals and activity increased and performed above target in Q2 with positive recovery stories strengthening DHcFT's lead-provider position; Living Well maintained the national two-plus-contact standard with plan developed for ongoing transformation; Deaf and Black community involvement is helping shape more accessible, inclusive services. Joint working through Derbyshire Partnerships is shaping more coordinated neighbourhood, children's and crisis care. **Delivery position: On plan**; secure Living Well commissioning decisions, deliver the single hub and Gambling Harm expansion, progress the CEO-led children's-services review and address rising Section 136 detentions through RCRP partnership.
4.2 Excel in our role as an anchor organisation	Apply datasets alongside local demographics to establish baseline position and inform actions to develop our role across five domains: as an employer, a procurer, as a holder of property and assets, as a partner, and in sustainability	Collaborate with our partners to deliver an inclusive wellbeing economy - business as usual	**Key deliverables:** Aligned anchor ambitions across employment, procurement, property and assets, partnership and sustainability; completed the baseline stocktake; progressed the 2028 impact framework and embedded measures across People, Estates, Green and engagement plans with Board oversight. **Impact and outcomes:** Careers Derbyshire is producing measurable outcomes, while new Federated Data Platform carbon-footprint analysis and Strategic Estates Group planning strengthen evidence-led decisions on local social, economic and environmental value. Evidence that local collaboration is improving access to support and NHS careers, alongside investment in sustainability. **Delivery position: On plan**; convert new data into tracked outcomes across all five anchor domains and accelerate wider system partnership delivery.
4.3 Achieve University Hospital Trust status	Develop our strategic partnerships with academic institutions and deliver year 1 plan to develop research capability Design and implement year 1 of action plan to be a centre for education across disciplines and achieve University Hospital Trust status	Continue to develop our strategic partnerships with academic institutions and deliver year 2 plan to develop – business as usual	**Key deliverables:** Signed and activated the University of Derby partnership, research capability plan and University Hospital Trust action plan, with progress overseen by the Board; extended the University organisational-development programme into inpatient wards and crisis teams. **Impact and outcomes:** The partnership has moved from agreement to practical workforce and service development, with governance and academic infrastructure now established. Collaborative research is informing safer care, supported by staff development with positive frontline feedback **Delivery position: On plan**; build measurable research activity and education capacity and complete the milestones I the year 2 delivery plan.

Clinical Plan – 2026-2029 (for approval)

Purpose of Report

The paper presents the Clinical Plan 2026-2029 following the consultation with staff, patient groups and wider stakeholders across the System.

Executive Summary

The Clinical Plan 2026-2029 sets out Derbyshire Healthcare NHS Foundation Trust's strategic framework for delivering high-quality, evidence-based, personalised care over the next three years. The Plan supports the Trust Strategy and NHS strategic priorities, including the shift from hospital to community care, treatment to prevention and analogue to digital service delivery. It describes how the Trust will improve outcomes, reduce unwarranted variation, address health inequalities and deliver more integrated neighbourhood-based care for the populations it serves.

The Plan has been developed around four delivery pillars aligned to the Trust Strategy: Patient Focused, People, Productive and Partnerships. Through these pillars, the Trust aims to improve clinical outcomes and recovery, deliver care closer to home, strengthen prevention and early intervention, reduce health inequalities and develop a sustainable, skilled and digitally-enabled workforce.

Extensive engagement has been undertaken with clinical leaders, the Medical Senate, Care Groups, Allied Health Professionals, people with lived experience, transformation and equality leads and System partners. This was via a Trust-wide questionnaire and having engagement meetings, including presentation at the Primary and Secondary Care Interface meeting and Clinical and Professional Leadership meeting, attended by System-wide senior leaders. In addition, it was discussed in detail in the Joint Board and Senior Leadership meeting at the Trust.

Feedback has been consistently supportive of the overall direction of the Clinical Plan but has highlighted several areas requiring strengthening that is included in Appendix 1. These include:

- Greater emphasis on quality, safety, effectiveness and patient experience
- Stronger implementation of personalised care and collaborative care planning
- More explicit co-production and lived experience involvement in service design and evaluation
- Improved focus on workforce sustainability, capability and supervision
- A clearer outcomes and measurement framework
- Stronger alignment to the Patient and Carers Race Equality Framework (PCREF), NHS England’s Core20PLUS5 and health inequality priorities
- The ongoing development of the Adult Community Mental Health Transformation, neighbourhood delivery models and partnership working and to focus on prevention
- Better use of performance, quality and workforce intelligence data through integrated dashboards
- Stronger emphasis on trauma-informed, recovery-focused and culturally competent care.

The revised Clinical Plan reflects this feedback and includes strengthened commitments around personalised care, co-production, workforce development, outcome measurement, health inequalities, trauma-informed practice, integrated neighbourhood services and the use of digital technology and artificial intelligence to support clinical effectiveness and productivity whilst maintaining professional judgement.

This paper has been presented to the Quality and Safeguarding Committee for discussion and approval, to then be presented to the Trust Board for final approval.

Strategic Considerations		BAF Risk(s)	Strategic Delivery Plan Reference
Patient Focus: Our care and clinical decisions will be respectful of and responsive to the needs and values of our service users, patients, children, families and carers.	X	25-26 1A	1.1
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X	25-26 2B	2.1
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X	25-26 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.	X	25-26 4A	4.1

Risks and Assurances

The Clinical Plan establishes the key focus and priorities for clinical delivery over the next three years, aligned to the priorities of the Integrated Care Board (ICB) and supported by the Trusts' key enabling plans.

Risks:

- Workforce capacity and capability
- Ability to measure impact
- Variation in implementation
- Complexity of transformation leading to delays
- Partnership dependency
- Digital Infrastructure and readiness.

Assurances:

- Clinical Plan Delivery Framework
- Care Group ownership
- Trust-wide Outcomes Framework
- Governance and oversight
- Integrated dashboards
- Annual review and refresh as required.

Overall assurance:

The principal risks relate to workforce, delivery capacity, partnership dependency and measurement of impact. The revised Clinical Plan strengthens governance, Care Group accountability, outcome measurement and enabling strategies to mitigate these risks and support successful delivery over the next three years.

Consultation and Timeline

- Various key stakeholders consulted on the draft version of the Clinical Plan and their feedback has been incorporated into this version
- The clinical plan was approved by the Executive Leadership Team on 9 November, presented to the Quality and Safeguarding Committee on 12 November and will be presented to Trust Board on 24 November 2026 for approval.

Governance or Legal Issues

The Clinical Plan is a key element in delivering the Trust Strategy and fully aligned with the existing Trust plans for each area long with the Care Group plans.

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:

Having a Clinical Plan that focusses on getting it right first at the right time, right place and with right intervention using technology will support Trust Green Plan.

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 Clinical Plan supports Trust ambition of providing care that is equitable to all communities with different sociodemographic needs and protective characteristics.

Recommendations

The Board of Directors is requested to discuss and approve the Clinical Plan 2026-2029.

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

Jo Leitner
Business Development Manager

Report prepared by: **Dr Ritu Gupta**
Deputy Medical Director

Jo Leitner
Business Development Manager

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NHS Foundation Trust

Trust Clinical Plan

2026–2029

DRAFT



About us

- Derbyshire Healthcare is a provider of NHS mental health, learning disabilities and substance misuse (drug and alcohol) services in Derby city and Derbyshire county.
- We also provide a wide range of children's health services, and we run the East Midlands Gambling Harms Service.
- We employ approx. 3,500 people delivering services from a number of community bases across the whole of Derbyshire and from inpatient units in Derby and Chesterfield.
- Across the county and the city, we serve a combined population of approximately one million people.

Our services

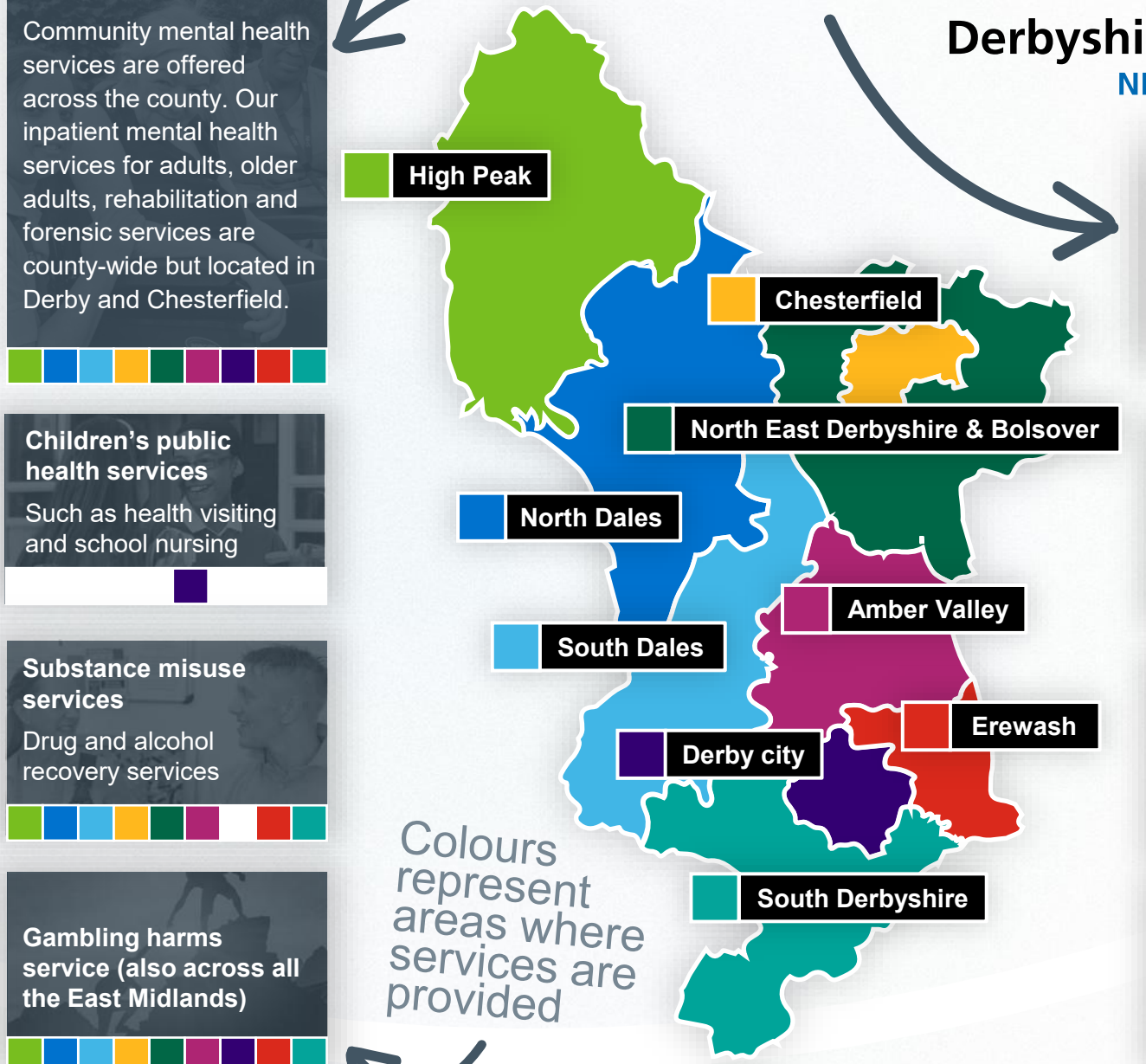
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Mental health services
Community mental health services are offered across the county. Our inpatient mental health services for adults, older adults, rehabilitation and forensic services are county-wide but located in Derby and Chesterfield.

Children's public health services
Such as health visiting and school nursing

Substance misuse services
Drug and alcohol recovery services

Gambling harms service (also across all the East Midlands)



Colours represent areas where services are provided

Children's complex health services
Supporting children with neurodevelopmental, behavioural and physical and movement needs

Adult learning disability/ neurodevelopmental services*

Child and adolescent mental health services (CAMHS) and children's eating disorders services

Eating disorders services for adults

Clinical Plan Summary:

Derbyshire Healthcare
NHS Foundation Trust

- **Our Ambitions**
  - Improve Outcomes
  - Reduce Inequalities
  - Deliver care closer to home
- **Priority Populations**
  - Children and Young People
  - People with Serious Mental Illness
  - Learning disabilities and Neurodevelopment such as autism
  - Older Adults
  - Deprived communities
  - Substance misuse and addiction
  - Deaf community
- **How we will Deliver**
  - Through the Four Priorities of: Patient Focused / People / Productive / Partnerships
- **How will we know we are succeeding:**
  - Better Outcomes / Better Patient and Carers Experience / Improved Workforce Experience
  - Measured Reduction in Health Inequalities
  - More Integrated Care / Care Closer to Home/ Triangle of Care framework fully implemented

Introducing our Clinical Plan:

Derbyshire Healthcare
NHS Foundation Trust

- Our Clinical Plan is the Trust's framework for translating its strategy into high-quality clinical care. It sets out the clinical outcomes we want to achieve over the next 3 years, the populations we will prioritise, the model of care we will provide, the changes required in clinical practice and how we will measure whether those changes improve outcomes, safety, experience and equity.
- The Clinical Plan acts as a blueprint for how we will deliver evidence-based care with improved outcomes for our patients, whilst meeting the growing demands on our services and creating a healthier future for our communities.
- We are transforming the way we deliver services, in response to the needs of our communities and the way they want to access care.
- With advances in digital technology and artificial intelligence, detailed health data, and the growing emphasis on prevention and integrated care, we have developed this plan to better meet our patients' needs, alongside our focus on providing evidence-based services maximising local expertise including third sector, primary, community and secondary care.

Clinical Plan Strategic Ambitions – 2026-28

Derbyshire Healthcare
NHS Foundation Trust

- Improve **Mental and Physical health Outcomes and Recovery**
- Improve **Access and Reduced Health Inequalities**
- Deliver more **integrated care in the community and neighbourhood-based services**
- Shift to **proactive, preventative community care**
- Transform **care models and end-to-end care pathways**
- Develop a **sustainable, skilled and digitally enabled Workforce**

What are the Drivers for Change?

Derbyshire Healthcare
NHS Foundation Trust

- We serve a large, diverse and ageing population which is predicted to grow. This means increased demands on services across the community we need to adapt our care to integrate new technologies and better meet the needs of our population.
- We will use advances in digital technology and artificial intelligence (AI) to improve how we deliver our services where appropriate and safe to do so.
- We will use population health approaches to inform us of those areas where we can make the biggest improvements to the health and wellbeing of the community and our patients.
- We will work with our partners across health, social care and third sector agencies to provide more coordinated care and tackle health inequalities across our local communities.
- We will coproduce our future service offer together with our patients and their carers that is evidence based and best practice.
- We will measure the impact and outcomes of service delivery.

The Drivers:

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10 year NHS Plan	ICB (DLN) Priorities Population Health	Trust Strategy	What Good Looks Like (WGLL) Framework	Needs of our Patients & their Carers	Needs of our People
The Health & Care vision is one of prevention and provision of and community-based services by 2035. The plan seeks to address this by shifting resources from acute hospitals to local 'neighbourhood health services'	The (DLN) ICB Population Health strategy has been developed to provide a coordinated approach for care delivery across our local system, informed by lived experience, expectations and priorities of citizens across the cluster. They have directly shaped the development of the 5-Year Population Health Strategy and those insights and priorities are reflected throughout DCHFT's Clinical Plan.	Our Trust strategy is built around our Four P's: •**Patient Focused** •**People** •**Productive** •**Partnerships**	The WGLL framework provides a blueprint to digitise, connect, and transform services, aiming to improve patient care through seven key success measures that includes ensuring data-driven, safe, and efficient care. This framework, used alongside the NHS Impact Improvement Programme will support our clinical leaders to deliver high-quality, efficient, and consistent care.	Our Quality Delivery Plan is a key enabler to support the achievement of ambitions through three pillars of quality care – effectiveness, safety and experience. Our patients require us to better enable them to take an active role in managing their health and wellbeing. Key also is our Digital Plan which will provide the ability to interact with us digitally, to access and contribute to their health and care records.	This clinical Plan is created to ensure that clinical colleagues across all disciplines identify and explore opportunities for delivering high quality effective clinical care and the role of key enablers to achieve this.

Enabling plans



Transformation & Improvement Framework | Green Plan | Comms Plan | Community and Stakeholder Engagement Plan | People Plan | Estates Plan | R&D Plan | Digital Delivery Plan | Quality Delivery Plan | Clinical Plan

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WE MAKE A POSITIVE DIFFERENCE IN EVERYTHING WE DO

Our four strategic priorities are supported by our enabling plans









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Clinical Plan alignment with care models and our key strategic priorities for delivery:

PATIENT FOCUSED:

Personalised Care

Recovery Focused Care

Co-Production

Measured improved experience of patients and Carers

Reducing Inequalites

PEOPLE:

Workforce Capability

Leadership and Development,

Wellbeing & Retention

Research & Learning

Workforce sustainability

PRODUCTIVE:

Outcomes and Quality

Innovation and Digital

Continuous Improvement

Care standards and clinical effectiveness

PARTNERSHIPS:

Integrated Care

Neighbourhood hub alignment

Prevention and population wellbeing

Living Well and ARRs

Prevention and early intervention



Clinical Plan Key Priorities: The 4 "P"s

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NHS Foundation Trust

- **Patient Focused: Delivering personalised, co-produced care that improves outcomes, experience and equity.** Patients are the centre of everything we do, patient empowerment, family involvement, focussed on individual needs including cultural, involved in decision making, health inequality

- **People: Develop a skilled, compassionate workforce that supports prevention, early intervention and recovery**. Enable and support delivery of proactive approaches to care delivery. Trust is outward facing – clinicians supporting primary care and voluntary sectors, police/school, housing… in managing patients if they don't have to come to secondary care. Work with Public health in prevention - basically reaching out who need the service

- **Productive: Using Evidence, outcomes and continuous improvement to deliver high-quality care**. Using Clinical Audit processes to measure and evidence clinical outcomes against standards and to continuously learn from clinical audits and further improve quality, focussing on improving health results and patient experience. Evaluate clinical practice and NICE guidance to implement standards

- **Partnerships: Work within the Trust and with system partners to deliver seamless, integrated pathways of care.** Work with system partners using a neighbourhood model, covering 24/7 care to ensure delivery of seamless integrated care.

The Clinical Plan will support the development and alignment of future care pathways and models across our clinical services that are evidence based, outcome focused, utilising digital first philosophy and practices where clinically appropriate.

Clinical plan alignment with the Trust strategic priorities

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Patient Focused	People	Productive	Partnerships
Deliver personalised, co-produced, trauma-informed and recovery-focused care	Develop a skilled, compassionate, sustainable workforce	Improve outcomes, quality and value through innovation and continuous improvement	Work with patients, carers, communities and partners to improve population health

Clinical plan supports the delivery of quality care

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Safety	Effectiveness	Experience	Equity	Personalisation
Reduce harm and unwarranted variation	Deliver evidence-based care and improve outcomes	Ensure people feel listened to, respected and involved	Tackle health inequalities and improve access	Support people to achieve goals that matter to them
Learn from incidents, complaints and feedback, working with patients, families and carers	Use outcomes data to drive improvement	Strengthen collaborative care planning	Deliver PCREF and Core20PLUS5 priorities	Implement personalised and co-produced care
Embed trauma-informed approaches	Reduce variation in care and outcomes	Improve patient and carer experience	Improve outcomes for underserved communities	Focus on recovery, independence, participation and quality of life

Priority Themes

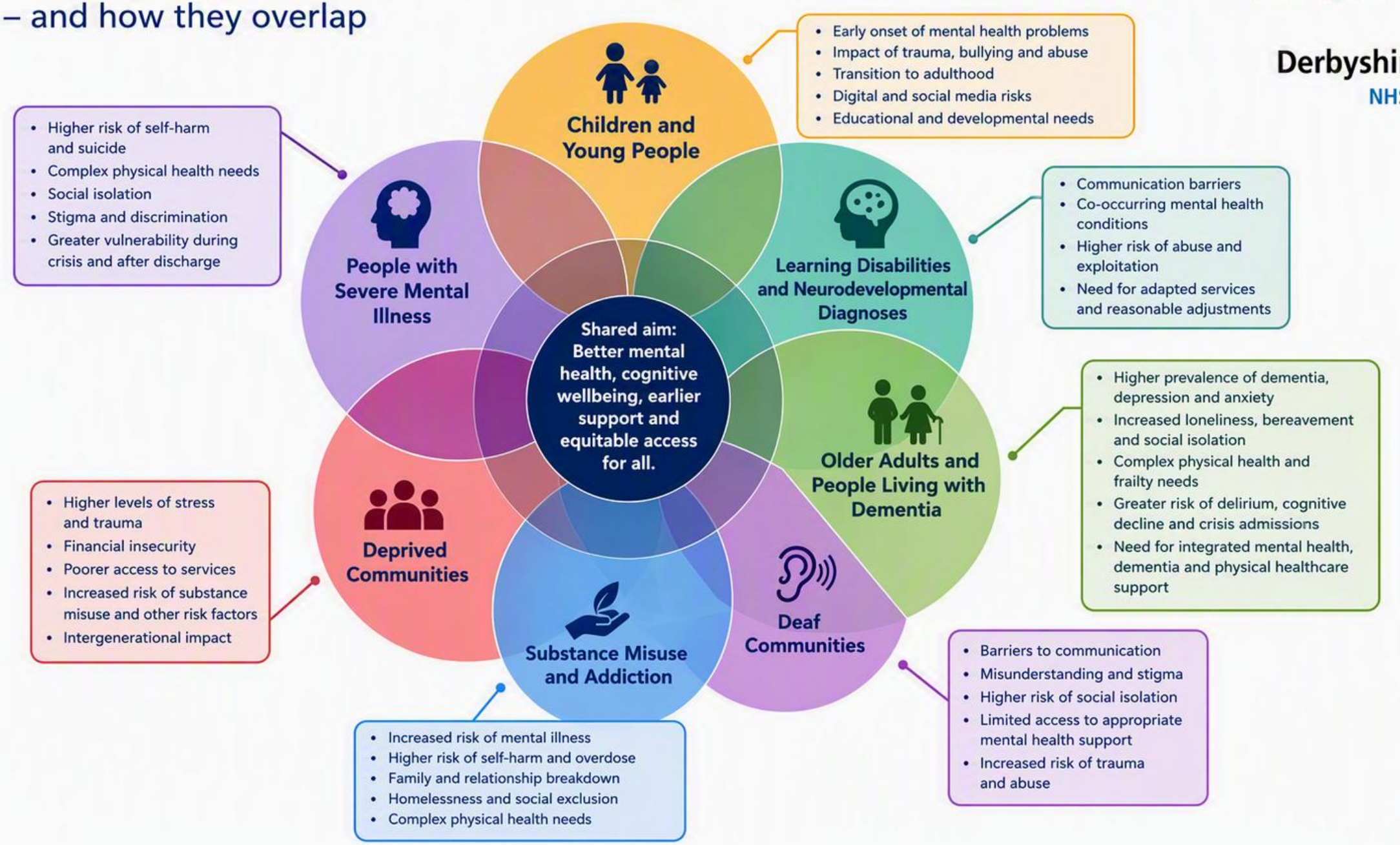
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- **Improving Population Health & Inequalities**
  - Tackling deprivation and early onset ill-health aligning with Core20PLUS5
  - Targeting high-need populations
  - Aligning to ICB population priorities
  - PCREF Implementation
  - Reducing inequalities for underserved populations.
- **Personalised Care, Lived Experience, Carers input and Co-Production**
  - Shared Decision Making
  - Lived Experience involvement in Design and Evaluation
  - Collaborative Care Plans and Safety Plans
- **Data informed, Clinically led, Outcomes Driven**
  - Analogue to digital- Digital Outcome Collection Pilots using PROMs
  - Adopt a common outcomes framework aligned to the National Outcomes Framework
  - Outcomes visible through Trust-Wide Dashboards
  - Establish core set of outcome measures used consistently across care groups
- **Shifting Care Models**
  - Inpatient → community-based care
  - Reactive → preventative care
  - Fragmented → integrated pathways

Priority Populations for Mental Health Needs
– and how they overlap

Different experiences. ***Shared challenges.*** ***Better together.***

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Clinical Plan Implementation: Patient Focused

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Trust 4 'P's	Clinical Pillar	2026/7 Year 1	2027/8 Year 2	2028/9 Year 3
Patient Focused	**Patient Centred Care**	**Establish, pilot, and initiate change**	**Expand and operationalise improvements**	**Full implementation and measurable impact**
	• Patient and Carers Race Equality Framework (PCREF)	PCREF action plan (in 3 pilot sites) Establish Baseline Data	Extending the pilot to at least one service in each care group	Rolling PCREF across the organisation and all care groups. Full alignment with PCREF framework.
	• Ensure genuine co-production is integral to service design	Undertake mapping exercise of coproduction across the organisation	Establish co-production based on the mapping exercise in at least 2 care groups.	Embedded co-production across all Care Groups with evidence that lived experience has influenced service design and evaluation.
	• Collaborative care plans and safety plans • Implementation of the personalised care framework	Baseline audited data for % of collaborative care plans and Safety plans Implementation of the personalised care framework	Staff awareness campaign to ensure collaboration work Ensure integration with Systm1	100% documented offer to all patients to complete collaborative care plans and safety plans
	• Trauma and recovery (T&R) focused care integral to care delivery • Meeting Triangle of Care Principles	T & R Training module and guidance to be developed together with an implementation programme. Specific training rolled for Older Adults.	Roll out the training programme across 3 care groups. Develop an evaluation tool to assess the impact of trauma and recovery training across teams	Ensure embedding of learning arising from T & R training findings within governance reporting structures across care groups

Clinical Plan Implementation: People

Derbyshire Healthcare
NHS Foundation Trust

			2027/8	2028/9		
People	Proactive Care	Establish, pilot, and initiate change	Expand and operationalise improvements	Trust 4 'P's	Clinical Pillar	2026/7
	• Safer staffing and support across all services.	• Establish baseline workforce capacity for each area. • Ongoing Safer staffing including medical staff • Ensuring supervisions and appraisals standards. • Revised support for staff health and wellbeing	• Safer staffing in line with the new models of care. • Utilise outcomes from our clinical audits, national benchmarking to inform safe staffing across service.	• Evaluate safe staffing levels aligned with emerging care models across services. • Improvement in staff survey indicators relating to wellbeing and engagement.		
	• Strengthened Clinical Leadership capability • Clinically Led improvement • Clinical governance using data to drive improvement • Research	• Establish baseline leadership development offers across all staff groups. • Identify Clinical Leaders for key priorities and care pathways • Standard clinical outcome and quality dashboards available • Baseline participation in clinical academic activity established	• Dedicated time for Clinical Leadership and development. • Data informed clinical leadership in QI, Audit and transformation programmes. • Increased participation in Research and innovation	• Clinical Leadership embedded in evaluation of service changes • Consistent service lead continuous improvement across all care groups. • Evidence of reduced variation and improved outcomes • Research and innovation embedded in service Development.		
	• Improve staff competency based on care models and care pathways. • Clinical governance using data to	• Co-Production and lived experience input to the care models and care pathways. • Improving staff digital skills, aligned with Trust Digital strategy and delivery plan	• Dashboards developed to evidence improvements in implementation of care models/pathways.	• Empowering staff in the evaluation of the care models/pathways • Improved Supervision / Appraisal Compliance • Increased Research Participation • Improved Retention and Wellbeing		

Clinical Plan Implementation: Productivity

Derbyshire Healthcare
NHS Foundation Trust

Trust 4 'P's	Clinical Pillar	2026/7	2027/8	2028/9
Productivity	**Clinical Effectiveness**	**Establish, pilot, and initiate change**	**Expand and operationalise improvements**	**Full implementation and measurable impact**
	• **Measurable improved Outcomes Framework aligned to National Outcomes Frameworks and standards**	• Develop Trust wide Clinical Outcome Frameworks aligned to NOF and implement in all care groups. • Established baseline data for LoS, Wait times, Access Times and Outcome	• Clinical Outcome Framework Measures embedded across all services • services collecting outcome measures • Productively measured through Outcomes, Quality and Patient Experience	• Integrated use of NOF outcome measures in service development • Dashboards in place showing outcome measures
	• **Develop Dashboards to schedule and evidence progress**	• Development Routine Use of Dashboards for service improvement • Establishment of team dashboards incorporating workforce and care standards data	• Outcomes drive clinical service design • Improve the timeliness, responsiveness and ease of access to care. • Routine use of dashboards to provide workforce and care standards intelligence.	• Sustaining improvements using clinical effectiveness programme. • Continuous evaluation to improved care.
	• **Expected Impact**	• **Baseline Established**	• **Evidence of improvement demonstrated**	• **Reduce Unwarranted variation** • **Improved Recovery outcomes** • **More services benchmark above national standards**

Clinical Plan Implementation: Partnerships

Derbyshire Healthcare
NHS Foundation Trust

Trust 4 'P's	Clinical Pillar	2026/7	2027/8	2028/9
Partnerships	**Care Models**	**Establish, pilot, and initiate change**	**Expand and operationalise improvements**	**Full implementation and measurable impact**
	• To facilitate joint ownership between services / organisations based on care models/Pathways that produce the best patient centred care and outcomes • Ensuring seamless care transitions within the Trust incorporating a trusted assessor model. • Ensuring a trusted assessor model is incorporated throughout the trust.	• Agree priority pathways with external partners and plan care models / pathways • Map VCSE and Community Assets • Continued Alignment of Living well and Partner services • Identify all services which benefit from joined up care within the Trust and plan implementation	• implement the change ensuring benchmarks for joined up care • Community Pathways embedded into care models. • Joined up care pathways operating within the Trust	• Evaluation of the impact of joined up care models and pathways at organisational and system level • Demonstrable reduction in reliance on hospital-based care • Increased community alternatives and prevention support
	• Ensuring people receive seamless sustainable care from the right team, in the right time, at the right place.	• Integrating GiRFT principles into care models/pathways in priority areas.	• Establishing GiRFT principles in majority of services.	• Establishing GiRFT principles in all services. • Compare performance with nationally available benchmarking data
	• **Expected Impact**	• **Priority Care Pathways Established internally and Externally** • **Embedding of GIRFT principles**	• **Evidence of improvement demonstrated**	• **Patients experience seamless care pathways both within and across organisational boundaries.** • **Services benchmarked above national standards**

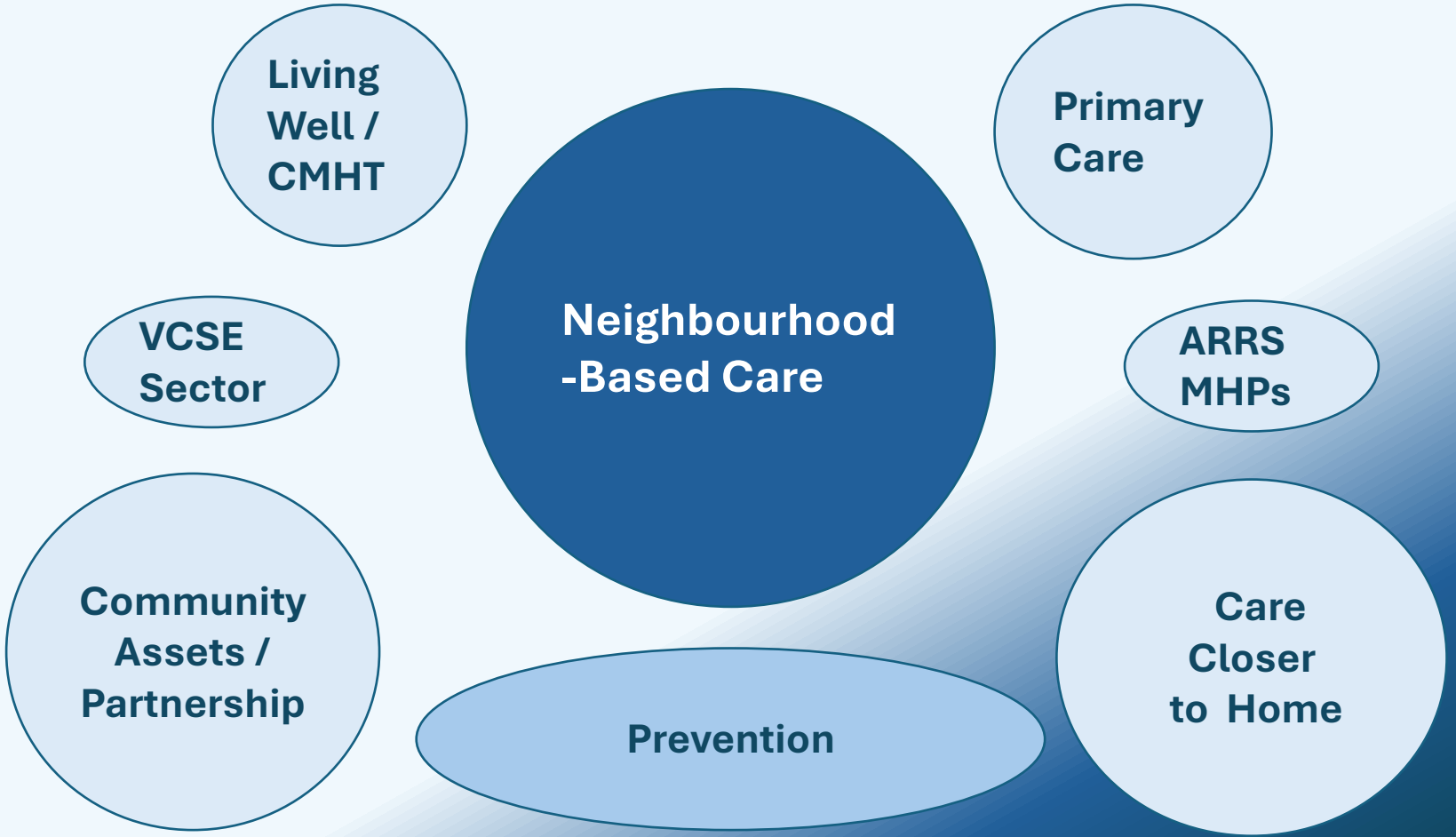
Delivering Care through Neighbourhood Hubs:
Our Future Model of Care:

Derbyshire Healthcare
NHS Foundation Trust

Community Mental Health Transformation	Living Well Model	Primary Care Integration	Mental Health Practitioners in primary care	VCSE and Community Sector Partnerships
• Integrated, person-centred pathways • Improved access and continuity of care • Reduced service fragmentation • Stronger recovery-focused support	• Earlier intervention and support • Short-term and targeted interventions • No Wrong door Approach • Enhanced self-management and recovery	• Closer alignment with GP practices and Primary Care Networks • Shared approaches to prevention and population health • Improved coordination between primary and secondary care	• Enhanced mental health support within primary care • Earlier identification and intervention • Improved access to specialist advice and support	• Stronger collaboration with community and voluntary organisations • Better use of local expertise and community resources • Improved social prescribing opportunities
Community Assets and Prevention	**Care Closer to Home**	**Implementation of Triangle of Care Framework**		
• Greater use of community resources and support networks • Early intervention and prevention-focused approaches • Supporting health, wellbeing and independence	• Reduced reliance on hospital-based care • Improved continuity across services • Flexible care delivered in the most appropriate setting • Alignment with Neighbour Hubs	• Strengthening the identification, involvement and support of carers, drawing on co-production principles and recognised good practice including the Triangle of Care.		

Delivering Care through Neighbourhood Hubs: Our Future Model of Care:

Derbyshire Healthcare
NHS Foundation Trust



Improved Outcomes

Improved Experience

Reduced Inequalities

Better Value

What will success look like? Strategic success measures:

Derbyshire Healthcare
NHS Foundation Trust

- **Patients:**
  - Improved clinical Outcomes
  - Better measurable Patient Experience
  - Reduced Variation
  - Improved Patient Reported and Clinical Outcome Measures
- **Communities**
  - Reduced Inequalities
  - Earlier intervention and prevention
  - Identification and use of community alternatives to prevent admission / support earlier discharge
- **Services**
  - More care delivered closer to home
  - Improve Access
- **Workforce**
  - Improved Staff experience
  - Improved retention
- **Organisation**
  - Embedding Evidence based Practice
  - Increased Productivity
  - Financial Sustainability

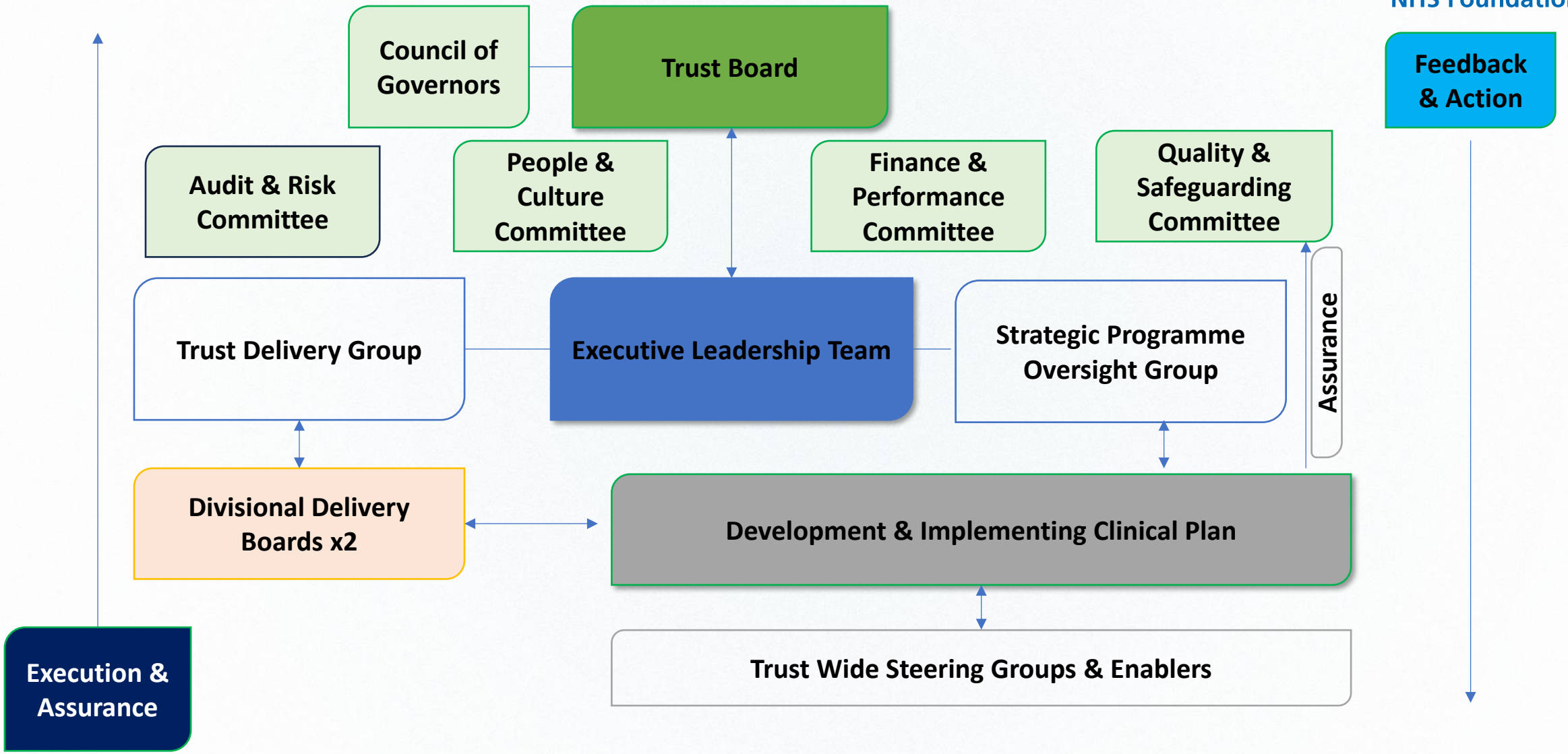
What will success look like for Patients?

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NHS Foundation Trust

- **By 2029 Patients will :**
  - **Receive care closer to home**
  - **Wait less and access support earlier**
  - **Be more involved in decisions about their treatment**
  - **Experience less variation in care quality**
  - **Experience seamless transitions of care**
  - **Have outcomes routinely measured and used to improve services**

Leadership & Governance supporting the Clinical Plan

Derbyshire Healthcare
NHS Foundation Trust



<u>Appendix 1:</u> Clinical Plan - 2026-2029: Summary of consultation feedback and update

Feedback from	Summary of feedback
Transformation team	Request clearer articulation of neighbourhood working and the Community Transformation.
Occupational Therapy	Greater emphasis on recovery, occupation, independence, quality of life, supervision and professional development.
Lived Experience representatives	Clearer definition of co-production and stronger evidence of Lived Experience influence.
PCREF leads	Stronger focus on race equality, Core20PLUS5, cultural competence and anti-racism.
Medical Senate	Stronger focus on quality, workforce sustainability, outcomes and deliverability.
Acute and PICU services	Greater emphasis on flow, purposeful admission, trauma-informed care, dashboards and alternatives to admission.
Children, Perinatal, Maternity and Neurodevelopmental services	Better recognition of existing achievements and stronger outcomes measurement.
Older Adult's services	Stronger focus on dementia pathways, care closer to home and access inequalities.
Working Age Adult services	Greater clarity on community transformation, neighbourhood services and workforce implications.
DCHS	Greater focus on including physical health and overall wellbeing outcomes incorporated into mental health interventions.
Carers groups	An explicit request to incorporate Carers into Priority groups. I didn't do so as I see them embedded through the plan (Cross cutting group) rather than a specific clinical population.

In addition, a questionnaire was sent to all staff to provide feedback. There were engagement meetings including presentation to a Primary and Secondary Care Interface meeting and Clinical and Professional Leadership Group meeting attended by System-wide senior leaders. The Clinical Plan was discussed in detail at the Trust Joint Board and Senior Leadership meeting.

Overall, feedback was that the Clinical Plan was highly aligned with the Trust's Strategy, with the Care Groups own plans and the existing area plans. The strategic direction of the Plan was not challenged. Instead, stakeholders and colleagues requested greater clarity regarding delivery, measurement and implementation.

Key amendments made following consultation:

1. Stronger Personalised Care Framework: The Patient Focused section has been expanded to include:

- Collaborative care planning
- Collaborative safety planning
- Personalised Care Framework implementation
- Greater emphasis on co-production and patient involvement.

2. Enhanced focus on Trauma and Recovery: The update now includes:

- Trauma and recovery-focused care
- Workforce development programmes
- Specific reference to older adults trauma-informed care where they are leading in practice
- Evaluation and implementation milestones.

3. Workforce sustainability: The People pillar has been strengthened through:

- Safer staffing
- Workforce baselines
- Staff competence and capability
- Digital capability
- Supervision and wellbeing.

4. Outcome measurement and dashboards: New commitments include:

- Trust-wide outcomes framework
- Team dashboards. Consultant dashboards
- Workforce indicators
- Care standards measures
- Use of outcome measures across all Care Groups to drive care development.

5. Health inequalities and equity: The Plan now incorporates:

- Patient and Carers Equality Framework (PCREF) implementation
- Priority population approach
- Deprivation focus
- Learning disabilities and autism
- Deaf communities
- Serious mental illness and dementia populations.

6. Improved Integration and Partnership Working: The Partnerships section has been strengthened through:

- Joined-up care pathways
- Trusted assessor approaches
- Getting it Right First Time principles
- Integrated neighbourhood working
- System partnership models.

Overview of the slide deck

Clinical vision and strategic context

Slides 1-7 establish the case for change and set out how the Clinical Plan aligns with:

- NHS 10-Year Plan
- Derbyshire population health priorities
- Trust Strategy
- Quality priorities
- Digital Transformation aims.

One Transformation

The Clinical Plan is positioned as the framework/mechanism that brings together all major enabling plans and strategies including:

- Quality
- Digital
- Workforce
- People
- Research
- Estates
- Sustainability
- Community engagement plans into a single transformation framework.

Four Pillars of Delivery

The Plan is structured around four interconnected pillars:

- Patient Focused
- People
- Productive
- Partnerships

These core pillars are the basis of the Trust Strategy which provide the structure for implementation and future care model development.

Priority Themes

Cross-cutting priorities include:

- Personalised care and co-production
- Data-informed care
- Outcomes and dashboards
- Population health
- Health inequalities
- Community transformation
- Prevention and early intervention.

Priority Populations

The Plan identifies populations experiencing the greatest inequalities and where focused improvement effort is required:

- Children and young people
- Serious Mental Illness
- Older Adults and dementia
- Learning Disabilities and Neurodevelopmental conditions
- People living in deprivation
- Substance misuse
- Deaf communities.

Three-year delivery approach

The implementation framework uses a structured three-year approach:

Year 1

- Establish baselines
- Pilot approaches
- Build capability.

Year 2

- Scale implementation
- Embed improvements.

Year 3

- Demonstrate impact
- Measure outcomes
- Sustain improvements.

This approach is reflected across all four pillars through detailed implementation plans.

Governance and assurance

Delivery will be overseen through existing Trust governance arrangements including:

- Trust Board
- Executive Leadership Team
- Quality and Safeguarding Committee
- Finance and Performance Committee
- People & Culture Committee.
- Strategic Programme Oversight Group.

Areas for further development

1. Introduce an explicit Quality Framework built around Safety, Effectiveness, Experience, Equity and Personalisation.
2. Strengthen PCREF alignment (ongoing).
3. Clarify the future neighbourhood and community transformation model, including Living Well and Community Mental Health Transformation (ongoing).
4. Further develop the Trust-wide outcomes framework and associated dashboard measures.
5. Clarify how lived experience will contribute to implementation and ongoing evaluation.

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

Board Assurance Framework (BAF), Issue 3, Version 3.3, 2026/27 (for review and approval)

Purpose of Report

To meet the requirement for Boards to produce an Assurance Framework. This report details the current BAF risks, Issue 3, version 3.3 for 2026/27.

Executive Summary

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

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

For this issue, as a result of feedback from the Audit and Risk Committee, Directors were specifically asked to check the following:

- Internal and external assurances – some of what's listed as assurance is activity, eg regular meetings with external bodies. It may be that assurance is gained as a result of these meetings but it is more informative to cite the reports/outcomes from these meetings as positive assurance
- Risk appetite – to be reviewed against each risk by the Director Lead: Does it map to the risk rating and tolerance and if not is there reasonable explanation in the rest of the narrative?
- Summary of progress – is it current and does it map clearly to meeting the measures to close the gaps in control?

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

Summary of updates

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

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

The key gaps in control have been added to, to include the gaps in commissioned services.

The key gap in control relating to Care Programme Approach has been fully updated as the Trust transitions to the Personalised Care Framework.

Further work is being undertaken on the Suicide Prevention Plan following feedback by clinicians. Progress is being made on all measures to close the gaps in control and it is expected that this will be completed in Quarter 4, 2026/27.

People - Derbyshire Healthcare is a great place to work

Risk 2A: There is a risk that the Trust is unable to sustain a positive, inclusive and compassionate culture, staff wellbeing, morale and engagement during a period of significant organisational and financial change, due to inconsistent leadership and management practice, variable ownership of people policies and insufficient embedding of the Trust's culture and behavioural expectations. This may result in increased sickness absence, employee relations concerns, reduced retention and discretionary effort, and reduced organisational capacity to deliver safe, high-quality services

The title has been updated to reflect the current risks.

Two key gaps in control have updated wording to reflect the current status, these relate to sickness/absence management and to adverse impact of organisational change. The actions to close those gaps, measures and progress against them have been fully reviewed. This meets the request made at Trust Board in September to clearly articulate the sickness related risks and explicitly link to associated financial and quality risks.

The Director of People, Organisational Development and Inclusion (DPOI) has removed one key gap in control linked to the Making Room for Dignity (MRfD) programme, the rationale being:

MRfD has transitioned into business-as-usual organisational development and culture activity. The remaining risk is not specific to MRfD and is therefore incorporated within the wider 2A strategic risk concerning organisational culture, leadership, morale and the impact of organisational change. Future assurance will be provided through the Trust's culture/organisational development programme, targeted cultural reviews, staff experience measures and relevant workforce indicators - as agreed in the People and Culture Committee

Risk 2B: There is a risk that the Trust is unable to attract, develop and retain a sufficiently skilled, diverse and sustainable workforce in critical roles, resulting in workforce gaps, increased reliance on temporary staffing and reduced ability to deliver safe, high-quality and financially sustainable services

The title has been updated to reflect the current risks.

Several key gaps in control have updated wording to reflect the current status. The actions to close all the gaps in control, measures and progress against them have all been fully reviewed.

One key gap in control linked to MRfD has been removed with the same rationale as above.

Another key gap in control (effectiveness of recruitment policy, practice and processes) has been removed as this is covered in the key gap in control that relates to workforce diversity, recruitment and retention and career progression, which has an improved RAG rating, going from red to amber.

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

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

The assurances on control, internal and external controls have been completely updated.

Two of the actions to close key gaps in control have been re-worded to reflect the current status and outstanding actions. Progress updates have been logged against them.

Both actions to close key gaps in control retain an amber RAG rating, the rationale being:

Transition from Arden & Gem to Nottinghamshire Health Informatics Service (NHIS). The action remains amber while onboarding, contractual arrangements, baseline validation and transition controls are still being completed

Incomplete visibility of the technology estate/unsupported devices: The action remains amber pending completion of onboarding discovery, reconciliation of records and agreed remediation of any exceptions identified

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

All key controls have been completely updated to reflect the current situation and the entire content of the key gaps in control, actions to close the gaps, measures and progress updates has been fully updated.

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

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

Internal and external assurances have been updated.

An additional root cause has been added relating to General Practice's perception of access to Trust services. A relating action has also been added and a progress update against the key gap in control has been provided.

Operational risks

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

Removed – Risk 23501: Risk to Service Delivery - Patient Safety team

Reviewed by the Interim Patient Safety Lead, down-rated to moderate.

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

Down-rated to moderate by the Risk Handler.

BAF reporting cycle/format

All changes/updates to this issue of the BAF, compared with Issue 2, 2026/27, are shown in tracked changes. All text that has been stricken through will be removed from the next issue (Issue 4, 2026/27).

The Issue 3 cycle is:

Executive Leadership Team (ELT) for full collective review: Version 3.1	21 October 2026
Audit and Risk Committee for approval: Version 3.2	22 October 2026
Board for review and approval: Version 3.3	24 November 2026

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

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	All	All
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X		
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X		
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X		

Risks and Assurances

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

Consultation

The BAF report is reviewed and updated by:

- Executive Directors
- Deputy Directors
- Managing Director
- Professional Leads
- Risk and Assurance Manager (on behalf of Operational Risk Handlers).

The BAF is presented quarterly to the ELT for full collective review, the Audit and Risk Committee for approval and Board for review and approval.

Governance or Legal Issues

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

Net Zero Duty Implications

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

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

The production of the BAF report, and the risk management system (Datix) do not use artificial intelligence (AI). There are significant climate and air pollution impacts from AI's energy and resource consumption so by not contributing to that we are in line with the NHS move towards net zero.

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

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

Specific elements within each BAF risk and associated actions are addressed by the relevant lead Director in taking forward.

Recommendations

The Board of Directors is requested to:

1. Review and Approve Issue 3 of the BAF for 2026/27 and the assurance the paper provides of the process of the review, scrutiny and update of the BAF in seeking to identify and mitigate risks to achieving the Trust's strategic priorities
2. Continue to receive updates in line with the forward plan for the Trust Board.

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

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

Board Assurance Framework Report 2026/27 – Issue 3.3 Board November 2026

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

Risks to Trust Strategic Priorities 2026/27

Ref	Risk	Director Lead	Risk Rating	Responsible Committee
Patient Focused - Our services will deliver safe and high-quality care				
26/27 1A	There is a risk that the Trust will fail to provide standards for safety, and effectiveness as required by our patients, regulators, partners and our Board, There is also a risk of poor patient experience and outcomes	Director of Nursing, AHPs, Quality and Patient Experience (DON) / Medical Director (MD)	**MODERATE**	Quality and Safeguarding Committee
26/27 1B	There is a risk that the Trust does not deliver key regulatory and strategic requirements related to dormitory eradication and that the Trust estate is not maintained sufficiently well to comply with regulatory and legislative requirements	Director of Nursing, AHPs, Quality and Patient Experience (DON)	**MODERATE**	Quality and Safeguarding Committee
People - Derbyshire Healthcare is a great place to work				
26/27 2A	There is a risk that the Trust is unable to sustain a positive, inclusive and compassionate culture, staff wellbeing, morale and engagement during a period of significant organisational and financial change, due to inconsistent leadership and management practice, variable ownership of people policies and insufficient embedding of the Trust's culture and behavioural expectations. This may result in increased sickness absence, employee relations concerns, reduced retention and discretionary effort, and reduced organisational capacity to deliver safe, high-quality services	Director of People, Organisational Development and Inclusion (DPOI)	**HIGH**	People and Culture Committee

	~~There is a risk that we are unable to sustain a positive, inclusive and compassionate culture with high levels of staff morale and engagement while delivering multiple, concurrent change and efficiency programmes, leading to increased sickness absence, employee relations cases, loss of discretionary effort and reduced capacity to deliver strategic priorities safely~~			
26/27 2B	There is a risk that the Trust is unable to attract, develop and retain a sufficiently skilled, diverse and sustainable workforce in critical roles, resulting in workforce gaps, increased reliance on temporary staffing and reduced ability to deliver safe, high-quality and financially sustainable services ~~There is a risk that we do not have an adequate supply of a skilled and diverse workforce in critical clinical roles, including inpatient nursing and support staff, limiting the Trust's ability to deliver safe staffing, reduce reliance on temporary workforce solutions, and meet safety, quality and financial priorities~~	Director of People, Organisational Development and Inclusion (DPOI)	**HIGH**	People and Culture Committee
Productive - Our services will be productive, demonstrate best value for our population and be cost effective				
26/27 3A	There is a risk that the Trust fails to deliver its revenue and capital financial plans for 2026/27. There is also the added risk of a Capital Departmental Expenditure Limits (CDEL) breach linked to following through on the Making Room for Dignity dormitory eradication programme	Director of Finance (DOF)	**HIGH**	Finance and Performance Committee
26/27 3B	There is a risk that the Trusts increasing dependence on digital technology to deliver safe, timely and integrated care increases exposure to major system outages or cyber incidents, impacting patient safety, service continuity and strategic delivery	Chief Delivery Officer (CDO)	**MODERATE**	Finance and Performance Committee
Partnerships - Our organisation will identify new ways of working, through new collaborative approaches				
26/27 4A	There is a risk of reputational damage if the Trust is not viewed as a strong partner both within the Derby and Derbyshire Integrated Care System (ICS) and more broadly within the East Midlands Mental Health Provider Alliance	Chief Delivery Officer (CDO)	**MODERATE**	Trust Board

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

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

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

Root causes:

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

BAF Ref: 26/27 1A	**Director Lead**: Tumi Banda (DON) / Girish Kunigiri (MD)	**Responsible Committee**: Quality and Safeguarding Committee

Board Assurance Framework Report 2026/27 – Issue 3.3 Board November 2026

Key Controls										
Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Tolerance**	**Risk Appetite**
High	Likelihood 4	Impact 4	Moderate	Likelihood 3	Impact 4	Moderate	Likelihood 3	Impact 4	Tolerated	Low

Preventative – Quality governance structures, teams and processes to identify quality related issues; mandatory training; Duty of Candour processes; clinical audits and research; health and safety audits; risk assessments; physical health care screening and monitoring; monitoring and effective responses to infection and control guidance, EQUAL unannounced visits to services and anonymised bright ideas service improvement ideas. Feedback intelligence from independent advocacy, Director visits in and out of hours and Board visits. Adherence to the Trust's Quality Assurance Framework

Detective – Quality dashboard reporting; Board visits virtual clinical service contact visits; incident, complaints and risk investigation; clinical audit; Fire Safety Regulations (FSR) compliance checks; mortality review process; physical health care monitoring clinics pilots; safety check log; Head of ~~Nursing~~ Clinical Practice and Matron compliance visits, reviewed model of announced and unannounced visits to service throughout the 24-hour period; Quality Assurance Framework; Fundamental Standards of Care visits; quality cross-checks: Inpatient and Community; 15 Steps challenge commencing in inpatient services; patient survey; friends and family test

Directive – Trust Strategy; Quality Delivery Plan; Joint Child Adult and Family Safeguarding Strategy; Patient and Carer Experience pledges and associated workplans; Patient Safety Incident Response Plan (PSIRP); clinical strategies; policies and procedures available via Trust intranet; Central Alerting System (CAS) alerts; Risk Management Strategy; clinical sub committees of the Quality and Safeguarding Committee

Assurances on controls – Internal	Assurances on controls – External
Trust quality and performance dashboards	National enquiry into suicide and homicide
Scrutiny of Quality Account by committees	NHS Litigation Authority (NHSLA) scorecard demonstrating low levels of claims
Programme of physical healthcare and other clinical audits and associated plans	Safety Thermometer identifies positive position against national benchmark
Infection Control Board Assurance Framework reported to NHS England	Trust fully compliant with National Quality Board Learning from Deaths guidance
Positive and Safe self-assessment	Engagement meetings with CQC taking place
Quality Assurance Framework	Patient Safety Incident Response Framework (PSIRF) implementation
Board visits and out of hours visits	CQC comprehensive review 2020 Trust rated Good
Fundamental Standards of Care visits	CQC inspections: Acute and PICU December 2024 rated Good; Wards for older people with mental health problems, July 2025 rated Good; Forensic inpatient or secure wards, September 2025 rated Good; Rehab and long stay unit, January 2026 rated Good, Crisis and Health Based Place of Safety, January 2026 Rated Good
Clinical audits	Quarterly CQC regulation oversight
Incident reporting and monitoring systems through Datix	Regular NOF Level 3 meetings with NHS England (NHSE) and Integrated Care Board (ICB)
Quality and safeguarding workplan	ICB local review to ensure there are clear policies in place to meet the needs of people in Derbyshire with severe mental health illness
Patient, family and carer feedback	Adult and Children Safeguarding Boards (Derby City and Derbyshire County)
Trust risk registers and scrutiny of the Risk Management Strategy by Board committees	ICB Clinical Quality ~~System~~ Reference Group for Integrated Care System (ICS) quality system monitoring
Divisional governance structure is in place	
Quarterly review of the Strategic Priorities in Strategic Priorities Oversight Group	

		Advisory support provided by the Trust to the system on bedded care standards for Learning Disability in-patient services Triangle of Care 2 star rating Infection Prevention and Control NHSE oversight: Routine monitoring			
Key gaps in control	**Actions to close gaps in control**	**Impact on risk to be measured by**	**Expected completion or (review)**	**Summary of progress**	**Action rating**
Gaps resulting from under-commissioned services resulting in risks to~~in~~ adherence with operational ~~ing~~ standards ~~-~~and clinical risks for acute and community mental health services	Improvement of both inpatient and community care settings – Environments need to be improved New internal performance improvement process and oversight in place Performance Improvement Plans for areas where Trust constitutional standards are not being met [ACTIONS OWNER: DON] Set out improvement plans to achieve Royal College of Psychiatrists (RCP) accreditation across services [ACTION OWNERS: MD/DON/CDO] Implement Community Mental Health Framework (CMHF) Improve the out of area (OOA) placements and facilitate care closer to home Improve access to services Work with commissioning partners to address identified gaps in commissioned services [ACTIONS OWNERS: CDO/DON]	Improve working with carers and families Improving risk assessment and care planning for patients in community settings Deliver the assertive outreach pathway to support patients with complex care needs. Provision is part of the CMHT with a specialist service Improvement in operating standards compliance to be overseen by Quality and Safeguarding Committee Adherence to the Trust Assurance Framework across all the services to review and monitor quality of care Implemented Mental Health Community Framework (CMHF) to Quality and Safeguarding Committee Achieving waiting time access targets Improvement in performance of constitutional standards and NHS	~~(30.09.26)~~ (31.12.26)	~~Increased performance management scrutiny and unannounced site visits undertaken with compliance checks~~ Monitoring Fundamental Standards of Care and the quality measures through the Quality Dashboard Quality Assurance Framework in place to monitor quality and safety Triumvirate leadership in the place across divisions and care groups to take collective responsibility for quality and safety ~~Governance structure to review, monitor, improve quality and give assurance to the Board is in place following implementation of the new operating model~~ Implement and monitor the ten High Impact Actions including MADE	AMBER

		National Oversight Framework (NOF) metrics Recovery action plans in place in all required areas Increased commissioned activity – Commissioners' contract for identified commissioning gaps Development and implementation of a co-produced plan to transition to Personalised Care Framework		events and working with system partners. Inappropriate OOA bed use has significantly reduced Performance Improvement Plans in place and monitored Ongoing conversations with ICB cluster regarding appropriate funding to meet increased demand CQC oversight engagement meeting changed to Quarterly ~~ICB Clinical Quality Reference Group reviewed from monthly to quarterly~~ Get it Right First Time (GIRFT) meetings established with the inpatient wards to review NOF metrics Group in place to review NOF metrics supported by executive team ~~Recent update to NHSE for Assertive Outreach via Trust governance sign-off, ongoing working group to provide oversight and assurance. A financial gap (system) remains in terms of the ideal model~~	

				Formal escalation to the ICB on Assertive Outreach risk and funding gaps CMHF: Current discussion with the ICB for the Trust to manage the contract and in turn the contract with both local authorities and the VCSE offer. The Trust is working with the ICB around outcome measures/benefits Gaps in commissioned services identified and quantified. Engagement commenced with commissioners to agree how we commence work to close those gaps	
Gap in operating standards and clinical risks for Learning Disabilities and Autism (LD&A) services	The community Intensive Support Team and Learning Disability models require improvement Improvements are required in rapidly returning inpatients who access Learning Disabilities and Autism (LD&A) services to local care to enable them to live in the least restrictive manner, as close to home as possible. Continue to work on developed delivery improvement plan, owned by system partners [ACTIONS OWNERS: CDO/DON/MD]	Review all models of support offered by the Intensive Support Team (IST) completed and improvement made Implement and embed delivery improvement plan to ensure focussed system action on existing inpatients who are placed inappropriately and out of area Enhancing and reviewing Listening and Engagement Active Partnerships (LEAP) procedures Improvement plans in admission avoidance, crisis alternatives to admission, including	~~(30.09.26)~~ (31.12.26)	ICB have presented to both providers on how to ensure community offers are enhanced further through the review of pathway offers where resource is disproportionately allocated ~~TUPE for LD services completed 01 June 2026~~ ~~New Dynamic Support Pathway (DSP) launched following cross-agency redesign work~~	AMBER

		improvement in the use of Dynamic Support Registers as a means of admission avoidance Reduction in delayed discharges in units across the country resulting in NHSE escalations		Enhanced escalation process established to avoid admission where clinically appropriate Quarterly performance monitoring ~~The Trust with the ICB continues to meet with NHSE on a quarterly basis to monitor performance~~, focussing on those patients with a long length of stay and who are Clinically Ready for Discharge	
Learning from independent and national forums on current issues affecting patient safety outcomes and experience	Participate in collaborative local and regional forums to gather learning Revisit all assurances and scrutinise practice, gathering intelligence and implement an improvement plan to enable all services to provide the highest standard of care which would be expected Monitor and implement the lessons from CQC Section 48 from other providers Patient safety incidents and patient experience and effectiveness to be triangulated in providing assurance on quality as set out in the Quality Delivery Plan [ACTIONS OWNERS: DON/MD]	Ensuring that staff are aware of how to raise concerns and speak up Implement the Accountability Framework Strengthen out of hours, weekends and night announced and unannounced visits. To promote access to multiple managers, relationships, so colleagues feel empowered to report any concerns Professional leads are in place and supported by Employee Relations to ensure that registered professional staff are aware of the requirements to practice in line with their professional codes Uphold safeguarding standards including PIPOT	~~(30.09.26)~~ (31.12.26)	Options for staff to have conversations about care delivery and raise concerns available include Trust-wide and divisional engagements, Freedom to Speak Up, Schwartz Rounds Improvements in engagement of temporary staff identified Robust oversight of patient safety incidents, concerns, complaints, and compliments with scrutiny from independent partners, e.g. Healthwatch and experts by experience being core members of Patient and Carer Experience Committee External partnership working including Healthwatch and	AMBER

		Timely investigation and response to concerns and complaints Patient safety team and patient safety lead working collaboratively to effectively evaluate risk and quality and identify learning and improvement Quarterly self-assessment of Assertive Outreach of quality and safety matrix as reported to Quality and Safeguarding Committee		advocacy services within safeguarding and secure services. The Trust provides assurance and participates in external reviews alongside the ICB and Adult Safeguarding Board Trust-wide Learning, Culture and Safety Group established, providing oversight of teams/services with repeating patterns for improvements to be made ~~Culture of Care Programme ended March 2026. The Trust will continue with Models of Care~~ Action plan in place to improve responses to complaints and patient feedback Significant Level of assurance received in 2025 from ICB on the Safeguarding Accountability and Assurance Framework review and Section 11 compliance	
~~Clinical improvement in the current use and transformation of Care Programme Approach (CPA), to support safe community practice~~	~~Identify the Trust's preferred alternative model to replace CPA~~ Establish transition plan which includes communications and training strategy and clear timeline for go live of the new	~~Review of changes to national policy to replace CPA~~ ~~Safe and effective practice is in place~~	~~(30.09.26)~~ (31.12.26)	CPA training continues at present ~~Personalised Care Framework (PCF) - Modern CPA launched~~	AMBER

Implementation of the Personalised Care Framework and transitioning from the Care Programme Approach (CPA) using the latest guidance in mental health care	system and detailing when use of CPA will cease Implement an improvement plan to enable all services to provide the highest standard of care [ACTIONS OWNERS: DON/MD]	~~Improve patient safety risk assessment, care planning and CPA review compliance in community services~~ Development and implementation of a co-produced plan to transition to Personalised Care Framework		~~nationally in July 2026 - DON/MD reviewing with an implementation plan~~ CPA policy has been ratified to cover the period of transition and has been communicated to clinicians	
Review of the new Major Conditions Strategy and Suicide Prevention Strategy for England: To be considered as Trust Clinical Plan developed	Scrutinise new policy direction and develop new plans Routinely review incidents for learning in suicide prevention including cluster analysis and benchmarking [ACTIONS OWNERS: DON/MD]	Adjust strategy and policy to meet requirements Undertake a cluster analysis of in-patient and acute care pathway deaths	~~(30.09.26)~~ (31.12.26)	~~Review of new strategy for Major Conditions and Suicide Prevention PSIRF priorities focusing on prevention and oversight incorporated into the Trust's updated Suicide and Self Harm Prevention Strategy~~ Suicide Prevention Lead – Post ended in July 2026. ~~The functions have been reviewed and devolved into existing operational structures~~ New risk assessment, safety planning and suicide awareness training now in place, mandatory for all clinical staff Trust Suicide and Prevention Strategy ~~published March 2026~~under secondary review Cluster analysis is being undertaken by Suicide Prevention Lead, Research and	GREEN

				Development and Patient Safety Larder from patient safety – Expected completion is 31.01.27	
Review of Patient Carer Race and Equality Framework (PCREF) and develop implementation plan	Establish PCREF Steering Group Complete Self-assessment on PCREF Development of PCREF Champions – Scope to identify relevant service user and carer representative Improving data quality to ensure it reflects the community we serve Develop an annual report and project plan for the next three years [ACTIONS OWNER: MD]	Complete action plan on PCREF implementation Involvement of service users and carers in developments Identify PCREF Champions Validation of data quality Annual report production Pilot sites to be implemented in line with national requirement	~~(30.12.26)~~ (31.12.26)	PCREF Steering Group established. Central oversight in place by Mental Health Act Committee PCREF Lead is reviewing the action plan with service users to evolve it if necessary. Action plan implementation is ongoing ~~PCREF Lead appointed.~~ Ongoing work to identify Champions Submission for Trust Annual Report completed and now annual BAU Three pilot sites implemented in 2026; implementation of PCREF is behind the national target; work is ongoing	AMBER

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

ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating
22790	Corporate Services – Pharmacy	Prescribing Valproate: Failure to comply with MHRA patient safety regulations	02.03.26: Awaiting go-live of questionnaire on SystmOne to allow consultants to record their valproate caseload. This is intended to give more transparent oversight of our level of assurance of adherence to safety guidance and will allow the level of risk to be reassessed 07.07.26: Questionnaire live on SystmOne. Audit of quality/accuracy of completion will be undertaken in the autumn by the Pharmacy team. The potential outcome from valproate affecting a pregnancy will remain a catastrophic outcome, so mitigation is about reducing the likelihood 10.09.26: Interim assessment of consultant use of the valproate dashboard is due to be presented to the Medicines Optimisation Committee. Currently there is no information to support a change in the risk rating for the Trust's lack of assurance about safe prescribing of valproate	28.02.22	10.12.26	HIGH

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

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

Impact:
Low quality care environment specifically related to dormitory wards at the Radbourne Unit
Crowded staff environment
Patient safety and dignity risks associated with dormitory in-patient bedded care at the Radbourne Unit
Non-compliance with statutory care environments at the Radbourne Unit
Non-compliance with statutory health and safety requirements at the Radbourne Unit
Final ward refurbishment cost unknown until we receive the final Guaranteed Maximum Price (GMP) in Quarter 2 of 2026/27
Completion of the full Dormitory eradication programme has been delayed until late Quarter 3 2027/28

Root causes:

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

BAF Ref: 26/27 1B	**Director Lead**: Tumi Banda (DON)	**Responsible Committee**: Quality and Safeguarding Committee

Key Controls

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

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

Detective – Reporting progress against Premises Assurance Model (PAM) to the Executive Leadership Team (ELT); Dormitory Eradication Board reports into Trust Board; Quality dashboard reporting; Board visits virtual clinical service contact visits; incident, complaints, and risk investigation
Directive – Capital Action Team (CAT) role in scrutiny of capital projects; IPC policy and procedure; Continuous Improvement Plan; Estates Plan; Trust Strategy; Physical Health Care Strategy; Safeguarding Strategy; Suicide Reduction Strategy; clinical strategies; policies and procedures available via Trust intranet; Central Alerting System (CAS) alerts; Risk Management Strategy

Assurances on controls – Internal	Assurances on controls – External
IPC risk assessments Health and safety audits Premises Assurance Model System (PAMS) reporting Trust quality and performance dashboards Bed Management processes Scrutiny of Quality Account by committees Programme of physical healthcare and other clinical audits Infection Control Board Assurance Framework reported to NHSE Positive and Safe self-assessment Quality Assurance Framework Cleaning and maintenance schedules Continuous Improvement Plan Estates and facilities management internal audit	Mental Health Capital funding secured External authorised reports for statutory health and safety requirements Regional reporting and NHSE oversight Gateway review process – Positive feedback from first stages Safety Thermometer identifies positive position against national benchmark Mental Health Benchmarking data identifies higher than average qualified to unqualified staffing ratio on inpatient wards CQC comprehensive review 2020 Trust rated Good CQC inspections: Acute and PICU December 2024 rated Good; Wards for older people with mental health problems, July 2025 rated Good; Forensic inpatient or secure wards, September 2025 rated Good; Rehab and long stay unit, January 2026 rated Good Patient Safety Incident Response Framework (PSIRF) implementation Monitoring of IPC standards compliance and reporting – ICS IPC Team IPC monitoring by NHSE has been revised to routine from enhanced

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Lack of adherence to national guidance and policy requiring the elimination of dormitory style inpatient facilities	Radbourne Unit dormitory eradication refurbishment to provide two 17-bed wards with single room en-suite, with additional staffing and new model of care, to complete dormitory eradication in Southern Derbyshire [ACTIONS OWNER: DON/CDO]	Delivery of approved business case Completion of the units at the Radbourne Unit CQC approval and sign off	30.06.28	FBC and revenue funding approved by ICS. National PDC capital funding approved by NHSE Making Room for Dignity Programme refurbishment of Radbourne Unit expected completion early 2027/28	AMBER

				Annual review of the delivery of same sex accommodation was completed and published by the Board in November 2025; The Trust is compliant with the guidance	

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

People - Derbyshire Healthcare is a great place to work

There is a risk that the Trust is unable to sustain a positive, inclusive and compassionate culture, staff wellbeing, morale and engagement during a period of significant organisational and financial change, due to inconsistent leadership and management practice, variable ownership of people policies and insufficient embedding of the Trust's culture and behavioural expectations. This may result in increased sickness absence, employee relations concerns, reduced retention and discretionary effort, and reduced organisational capacity to deliver safe, high-quality services

~~**There is a risk that we are unable to sustain a positive, inclusive and compassionate culture with high levels of staff morale and engagement while delivering multiple, concurrent change and efficiency programmes, leading to increased sickness absence, employee relations cases, loss of discretionary effort and reduced capacity to deliver strategic priorities safely**~~

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

Root causes:

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

BAF Ref: 26/27 2A	**Director Lead**: Rebecca Oakley (DPOI)	**Responsible Committee**: People and Culture Committee

Key Controls

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

Preventative – Freedom to Speak Up Guardian (FTSUG) self-assessment and six monthly reports; actions taken from staff survey results, people performance reviews and actions, training and education meeting, Equality, Diversion and Inclusion (EDI) working group, staff networks, health and wellbeing network, operating model structure
Detective – National staff survey, Quarterly Pulse Checks, FTSUG log and escalations; staff network engagement; WRES, WDES, wellbeing champion network, executive led engagement sessions; non-executive, executive and deputy visits to teams
Directive –National People Plan; strategic people priorities

Board Assurance Framework Report 2026/27 – Issue 3.3 Board November 2026

Assurances on controls – Internal	Assurances on controls – External
National staff survey and reporting into board, ELT and divisions Quarterly pulse check and action planning process Exit interview analysis and reporting People Plan	Benchmarking in mental health Trusts and at system level Staff survey analysis and reporting

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Lack of planned leadership development growth, stretch programmes and opportunities including coaching and mentoring	Leadership section of the People Plan to align to organisational leadership needs Delivery of the People Plan priority: To be recognised for supporting and developing our people to work confidently in their roles Review and development of Trust leadership offer and impact [ACTIONS OWNER: DPOI]	Percentage of leaders with development plan as part of objectives Percentage of employees accessing leadership development programmes	~~(30.09.26)~~ (31.12.26)	THRIVE middle management programme commissioned and designed for delivery commencing in January with alignment to the national Management and Leadership Development Framework STRIVE – Senior leadership programme currently being delivered in partnership with Kings Fund, Chartered Management Institute and Derby university Leadership development (delivered via a service level agreement with DCHS) notice served on contract, from July a new team and service will be situated within DHCFT. As part of the transition a full review of the current offer and any gaps taking place will be completed People Plan presented and signed off at People and Culture Committee (PCC) November 2025 – Includes clear direction on leadership development	AMBER

Lack of progress across EDI including staff networks and reporting (WRES/WDES/gender pay gap)	Staff networks have an embedded operating framework through which to maximise the impact of staff networks Clear measurable EDI plan that includes all national reporting and Trust level actions Support to bi-monthly network Chairs meetings through DPI, Head of EDI and EDI Manager Delivery of People Plan priority: To be recognised by our people for our values driven and inclusive culture [ACTIONS OWNER: DPOI]	Clarify on role and function of staff network chairs and objectives for each network – Reviewed twice a year Annual updates by network Chairs of engagement undertaken to be included in annual reports Year on year change WRES/WDES, staff surveys and lived experience of staff through staff networks	~~(30.09.26)~~ (31.12.26)	EDI working group reestablished and governance embedded Framework, including clear actions to progress and signed off at PCC Race equality plan developed in conjunction with BME network and supports key actions in WRES Staff network conference planned took place in May 2026 EDI plan developed and presented at PCC in March 2026 – Combines all WRES/WDES/gender pay gap actions EDI working group in place	AMBER
~~Lack of ownership and embedded models of care and cultures across MRfD workforce resulting in retention and turnover challenges and inconsistency of approach across MRfD programme~~	~~Review of all commissioned and in house owned programmes both clinical and non-clinical to be clear of the 'ask' and the 'why'~~ ~~Clear framework to ensure alignment across all programmes~~ ~~Comprehensive plan of delivery and outcome measures~~ ~~[ACTIONS OWNER: DPOI]~~	~~Delivery against plan including attendance on programmes~~ ~~Staff survey measures~~ ~~Bespoke MRfD surveys to measure awareness and impact of programmes~~	~~(30.09.26)~~	~~Revised programme board and workstreams to ensure alignment and learning from gateway review~~ ~~Wider organisational plan for acute wards in development, where appropriate cultural reviews are being commissioned~~ ~~All wards completed the programme, six month follow-up with each ward now commenced~~ ~~Culture reviews completed on wards where triangulation of~~	~~RED~~

				~~data has highlighted cultural risks~~	
Not yet embedded the Trust personal accountability framework and inconsistent support for Employee Relations (ER) informal and formal cases	Fully embed Trust personal accountability framework across all teams and individuals to have ownership of their own behaviours Development and delivery of ER training for managers on cases and investigations Establish new ER services in Trust (currently in a shared service) [ACTIONS OWNER: DPOI]	Reduction in length of cases Reduction in formal cases Attendance at training by managers on cases and investigations Establishment of new ER in-house team	~~(30.09.26)~~ (31.12.26)	A kind life just culture training programme commenced, incorporating personal accountability framework – 150 colleagues have already attended Active Bystander training being rolled out Reduction in formal cases across Respect and Resolution policy	RED
Inconsistent approach to flexible working impacting on staff morale	Develop and embed a clear approach to flexible working that supports service delivery and staff Develop a clear and consistent way of recording and reviewing flexible working that supports both managers and staff [ACTIONS OWNER: DPOI]	Ability to record and track number of flexible working arrangements in place Staff engagement measures via staff survey and pulse check	~~(30.09.26)~~ (31.12.26)	Design of flexible working system linked to ESR to record requests for flexible working and approved requests in progress – This will focus recording in one place Flexible working group in place and currently designing training for the roll out of the system	AMBER
Inconsistent application and ownership of the Sickness Absence Policy (support and care for staff policy) and associated processes ~~Lack of robust absence management policy and processes that support both managers and staff~~	Strengthen management ownership and consistent application Identify hotspot areas and hold divisions to account; Targeted support for long-term and repeated short-term absence review Occupational Health utilisation and management capability ~~Review and relaunch a new absence management policy~~	Reduction in overall absence ~~management~~ and across both long and short term absences Reduction in Occupational Health DNAs and improvement in utilisation of Occupational Health All absence cases are actively managed, with each team maintaining clear data on the number of staff at each stage of the absence process ~~Staff survey and pulse check~~	~~(30.09.26)~~ (31.12.26)	Absence plan developed and presented to PCC and ongoing scrutiny with further deep dive January 2026 Oversight working group established Workforce assurance meetings in place at executive and divisional level Independent review of Absence sickness policy and recommendations for	RED

	~~Review support provided to managers to review and move forward long term sickness absence cases~~ ~~Review Occupational Health access, support and usage to ensure maximising service and being used to~~ ~~Delivery of People Plan priority: To be recognised as a Trust that supports and promotes the wellbeing of our people~~ [ACTIONS OWNER: DPOI]	Improvements as part of NOF segment data		improvements being implemented	
Organisational change continues to create risk to morale, engagement and wellbeing ~~Lack of a stable positive culture due to high levels of organisational change impacting on morale~~	Maintain post-implementation review of the operating model Targeted wellbeing and organisational development support for affected teams Strengthen change-management capability and communication [ACTIONS OWNER: DPOI] ~~Review and develop organisational change policy to ensure clear and supportive approach for managers and staff~~ ~~Clear wellbeing processes for occupational health and other support mechanisms~~ ~~Effective, clear and open communication channels~~	Staff survey and pulse check engagement scores ~~Financial balance~~ Improved absence rates	~~(30.09.26)~~ (31.12.26)	Review of phase 1a and 1b commenced with initial feedback and discussions held with staffside colleagues Culture collab established to triangulate intelligence and data across workforce, staffside, quality, operations and Freedom to Speak Up to identify teams ~~Fast track process for Occupational Health in organisational change~~ ~~Phase 1a operating model programme completed~~ ~~Phase 1b consultation concluded~~	RED

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

Board Assurance Framework Report 2026/27 – Issue 3.3 Board November 2026

People - Derbyshire Healthcare is a great place to work

There is a risk that the Trust is unable to attract, develop and retain a sufficiently skilled, diverse and sustainable workforce in critical roles, resulting in workforce gaps, increased reliance on temporary staffing and reduced ability to deliver safe, high-quality and financially sustainable services

~~**There is a risk that we do not have an adequate supply of skilled and diverse workforce in critical clinical roles, including inpatient nursing and support staff, limiting the Trust's ability to deliver safe staffing, reduce reliance on temporary workforce solutions, and meet safety, quality and financial priorities**~~

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

Root causes:

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

BAF Ref: 26/27 2B	**Director Lead**: Rebecca Oakley (DPOI)	**Responsible Committee**: People and Culture Committee

Key Controls

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

Preventative – Alliance, system and national Human Resources forums for sharing best practice and risk mitigation, website, workforce plan
Detective – People Performance Report in TLT, ELT and PCC; Bank and Agency Improvement Group; Combined Delivery Group with multi-disciplinary team (MDT) input; Medical Staffing Group, Sustainability Meeting; FTSU culture; exit interview process stay interview process
Directive – JUCD Careers Team; JUCD and People and Inclusion meeting; recruitment policy and procedure; TRAC recruitment system; safe staffing plans

Assurances on controls – Internal	Assurances on controls – External
People Performance Report at ELT and PCC People Dashboard in PCC PCC forward plan and deep dive plan Workforce plan People Plan	Healthcare Support Workers (HCSW) submissions System operational planning process Safe staffing report Regular NOF Level 3 meetings with NHSE and ICB

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Workforce planning and pipelines are not yet sufficiently mature to address critical workforce gap ~~An integrated workforce plan and planning process that feeds into pipeline plans and ensures we have the right people in the right place with the right skills~~	Develop a Trust Workforce Plan linking demand and capacity, workforce redesign to ensure a fully funded workforce Develop vacancy rate data and breakdown variances in vacancy data Delivery of all People Plan priorities: Attracting a high skilled and diverse range of applicants to our roles Retaining our diverse talent through growth and development Staff are delivering at the top of their professional standards Opportunities for professional and career development [ACTIONS OWNER: DPOI]	Reduced vacancy rates Time taken to fill vacant posts Transformational posts, e.g. apprenticeships all identified Reduction in agency costs Improved retention rates	~~(30.09.26)~~ (31.12.26)	Executive-led vacancy control meeting takes place every week for approval of all vacancies and workforce expenditure increases, i.e., job evaluation Divisional workforce planning session ~~taking~~ took place in July 2026 Finance led workforce plans triangulated and signed off at regional level Revised agency control group in place Workforce assurance meetings in place at each division to review vacancy, recruitment and bank/agency usage Three year workforce plan developed and presented at September 2026 People and Culture Committee	AMBER
Retention and succession arrangements are not consistently embedded, particularly in identified hotspot roles and newly qualified workforce ~~We do not have an effective and embedded succession talent management processes~~	Develop a Talent Management Strategy Pilot career conversations for senior leaders and roll out career conversations for all colleagues ~~Work as a system to develop system-wide approach to talent management and align where best for the Trusts~~	Career conversations taking place Internal appointments/promotions Reduction in turnover rate Key staff survey measures	~~(30.09.26)~~ (31.12.26)	Succession plan in place for executive leadership team Talent Strategy finalised Talent programme for senior executive leadership completed – To be run for senior leadership team following finalised operating model	RED

	Delivery of all People Plan priorities: Attracting a high skilled and diverse range of applicants to our roles Retaining our diverse talent through growth and development [ACTIONS OWNER: DPOI]			Talent and succession planning part of every Executive Director's objectives	
~~Onboarding and retention process and planning needs to be embedded (this includes MRfD and challenges on retention of high numbers of newly qualified nurses)~~	~~Understand the key retention issues for posts/teams/professions with the highest turnover to deliver People Plan priorities to attract and retain newly qualified nurses~~ ~~Ensure 'stay conversations' form part of regular 1:1s~~ ~~Develop NHS retention framework for nursing~~ ~~[ACTIONS OWNER: DPOI]~~	~~Improvements to turnover~~ ~~Staff survey engagement scores~~	~~(30.09.26)~~	~~Additional posts added to the preceptorship team to support retention of high numbers of newly qualified staff~~ ~~Stay Surveys launched at months 3, 6 and 12~~ ~~Revised induction commencing from May 2026~~	~~AMBER~~
Workforce diversity is not consistently reflected across recruitment, progression and senior leadership ~~Lack of inclusive recruitment practices and actions to consider the needs of people from different backgrounds, to support our commitment to embedding an inclusive culture~~	All chairs of recruitment panels have undergone inclusive chairs recruitment training Data driven recruitment practices Delivery of People Plan priority: To be recognised by our people for our values driven and inclusive culture [ACTIONS OWNER: DPOI]	WRES and WDES data shows year on year improvement, staff survey and lived experience of staff Increase the proportion of applications from ethnic minority groups, increase likelihood of shortlisting and reduce disparity in all areas	~~(30.09.26)~~ (31.12.26)	Job evaluation national assessment completed and work programme to improve efficiency of the process in place and presented to PCC National nursing profiles review – Working group in place with staffside representation Inclusive recruitment for chairs training: Ongoing roll out Cultural competence training commissioned rolled out, initially focusing on acute wards and now expanding wider. Board have also completed the training	~~RED~~ AMBER
~~Effectiveness of recruitment policy, practice and processes~~	~~Review and develop existing recruitment Key Performance Indicators (KPIs) to ensure fit for purpose~~	~~Time to recruit~~	~~(30.09.26)~~	~~A range of recruitment methods are deployed to~~	~~AMBER~~

	~~Where appropriate move away from TRAC to advertise jobs and use fast track processes, e.g. Indeed/MSforms~~ ~~Develop cohort recruitment for key posts~~ ~~Improve the multidisciplinary working (HR, communications and recruiting managers) to enable better planned and executed campaigns~~ ~~[ACTIONS OWNER: DPOI]~~	~~Number of applicants applying and successfully shortlisted~~ ~~Campaign impact and reach~~ ~~Financial savings through cohort recruitment~~		~~ensure we attract a diverse range of applicants~~ ~~Revised Service Level Agreement and KPIs in place for recruitment service~~	
Agency and bank usage control measures and reduction	Ensure bank and agency usage is controlled by clear processes and measures with accountability at team level on spend Agency off framework usage is managed with clear expectations Plan in place to reduce and align to agency price cap for all posts Bank staff are recognised and rewarded appropriately [ACTIONS OWNER: DPOI]	Agency and bank usage reduction Agency off framework nil return Agency price cap achieved Bank usage is appropriate and available to support where needed	~~(30.09.26)~~ (31.12.26)	Ongoing weekly agency approval in place for approval of all agency requests Working group in place focusing on improvements in vacancy reduction across key posts, agency elimination and improvements in bank utilisation	AMBER

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

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

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

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

Root causes:

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

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

BAF Ref: 26/27 3A	**Director Lead**: James Sabin (DOF)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Tolerance**	**Risk Appetite**
Moderate	Likelihood 2	Impact 5	High	Likelihood 3	Impact 5	Moderate	Likelihood 2	Impact 5	Not Accepted	Low

Preventative – Operating plan and financial plan agreed for 2026/27 in line with national requirement. Integrated Care Board (ICB) signed off and fully support the dormitory eradication programme and are supporting this through to completion as a pre-commitment. High quality business cases. Regular meetings with NHSE on programme progress. Meaningful stakeholder engagement (internal and external). Robust cash flow forecasting and delivery. Multi-disciplinary development of financial plans for new of work. System sign-off and appropriate governance arrangements for new programmes of work: Budget training, segregation of duties, management of commissioning risk through system engagement and leadership, mandatory counter fraud training and annual counter fraud work programme: Enhanced cash management and forecasting aligned to large capital and transformational programmes. Action plans in place and recovery plans for areas of focus. Deep dives commissioned via F&P Committee
Detective – Risk logs and programme-reporting (capital/transformation) informs ongoing financial risk assessment: Audits (internal, external and in-house); scrutiny of financial delivery, bank reconciliations; continuous improvement including cost improvement planning (CIP) and efficiency / QI delivery; contract performance, local counter fraud scrutiny
Directive – Business plans and templates set out clear financial plans and assumptions: Standing financial instructions; CIP Monitoring, Performance management reviews, Treasury management procedures, budget control, delegated limits, recruitment approval processes; business case approval process; invest to save/Quality Improvement methodology and protocol and Plan Do Study Act. Risk and gain share agreements

Assurances on controls – Internal	**Assurances on controls – External**
Operational plan; financial planning including CIP planning, processes and delivery monitoring CIP reporting to Trust Delivery Group, Executive Leadership Team and F&P Committee CIP programme group under review to strengthen oversight. Further work and governance changes planned to drive the transformational plans and monitor progress Vacancy control process in place with Executive oversight	~~Weekly reporting into NHSE, in addition to~~ Routine monthly reporting into NHSE and across the system ~~All CIP plans and progress reporting into the EPMO for shared system oversight across the ICB~~ NHSE feedback throughout progress of dormitory eradication Programme and business cases in programme Systems Finance Performance meetings System DOF meetings Internal Audits – Financial integrity and key financial systems audits

Performance management processes in place ~~and being refreshed to add to assurance levels~~. Now also established and in place for corporate functions Appropriate monitoring and reporting of financial delivery – Trust overall and programme-specific Assurance levels gained at Finance and Performance Committee (F&P) Delivery of Counter fraud and audit work programme with completed and embedded actions for all recommendations Independent assurance via internal auditors including HFMA checklist, external auditors and counter fraud specialist that the figures reported are valid and systems and processes for financial governance are adequate Strategic Portfolio Oversight Group	External Audits – Strong record of high-quality statutory reporting with unqualified opinion National Fraud Initiative – No areas of concern Local counter fraud work – Referrals show good counter fraud awareness and reporting in Trust and no material losses have been incurred. Use of risk-based activity in new counter fraud standards Information Toolkit rating – Evidencing strong cyber risk management Regular NOF meetings with NHSE and ICB A clean year-end position and clean Value for Money (VFM) assessment as part of our year end audit

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Trust cash and capital risks related to national funded capital programme: Increased cost pressure now aligned to final refurbishment project	~~We will not have a~~ Guaranteed Maximum Price (GMP) for Radbourne ~~Until late~~ now received as of Quarter 2 ~~of~~ 2026/27. This shows the costs are higher than expected and a review of costs and value for money is required. Options under evaluation [ACTION OWNER: DOF]	Cash and capital reporting as part of finance reporting into F&P and Board forecasting evidence of plan delivery and/or indicates areas of required management action	~~(30.09.26)~~ (31.12.26)	Regular oversight of capital and cash position. Reporting to Trust Programme meetings and Committees on risks and mitigations Significant cost pressures on Radbourne Unit Refurb. The decision and affordability question of the second ward will be worked up ~~in Quarter 2 aligned to~~following the receipt of the GMP	AMBER
Some partners moving away from business case assumptions and previous agreements Re-costing service provision, increasing Service Level Agreements (SLA) Added pressure re SLA from Chesterfield Royal Hospital and other costs such as rates	Close partnership working with ICB and system partners Need to quantify impact and raise with commissioners [ACTIONS OWNER: DOF]	Monitoring and reporting of income allocations and expenditure in year Transparent reporting of position shared with ICB/NHSE to reduce challenge and ensure joint understanding and support This forms part of understanding our underlying deficit drivers and cost pressure impacting sustainability	~~(30.09.26)~~ (31.12.26)	MHLDA DB agreed to oversee revenue delivery contained within programme spend Still working through inter-Trust charges with Chesterfield Royal Hospital. Some concerns flagged to date as costs have risen well above baseline inflation	AMBER

Insufficient substantive staffing into vacancies and temporary staffing costs for bank and agency staff do not reduce	Continued workforce strategies progressed to reduce agency and increase bank reducing risk ~~Enhanced bank and agency costs reported as part of wider financial and workforce reporting~~ Agency actions and controls are working and costs continue to reduce Implementation of bubble teams will reduce agency and bank usage [ACTIONS OWNERS: DPOI/DOF]	Continued reduced run rates evidence in spend Continued reduction in breaches in rates and framework providers Compliance with non-nursing (HCSW national ban) Direct impact and outcome of bubble team leads to reducing bank usage	~~(30.09.26)~~ (31.12.26)	~~Further work underway to comply with new mandate to ban use of band 2/3 health care support worker agency use~~ Impact of bubble teams on bank usage will be monitored from November 2026, post October launch	AMBER
Financial cost pressures created both internally and by system first decisions leading to the requirement for mitigations to close both the internal gap and the system financial gap	Additional 'stretch' management action required to reduce other cost and mitigate impact to achieve overall financial position Additional CIP plans needed to close the CIP gap Close monitoring and oversight of Arden & Gem IT support transition to Nottinghamshire Health Informatics Service. Minimise cost pressure Long list of unpalatable options drawn up and supported in principle by Board for further review. These are for consideration post planning nationally due to potential to impact patients and core Trust NHS offer. Need to develop these into costed and prioritised plans with clarity of patient and wider staff impact [ACTIONS OWNERS: DOF/MD/DON/CDO]	Alignment with our financial plan Reduction of pay run rate in line with delivering on a planned headcount reduction Reduction in CIP gap and non-delivery. Extent to which solutions are non-recurring Reduction in cost pressure linked to IT transition and CSU demise	~~(30.09.26)~~ (31.10.26)	Financial plan for 2026/27 is concluded but we need to continue to work on reducing the deficit as part of our longer term financial sustainability All new investments to follow governance processes with business cases via TDG, ELT, F&P and Board where appropriate and will require wider system support. All investments need a clear source of funding as increased CIPs beyond 6% is not credible Weekly CIP returns monitoring progress recently been stepped down by NHSE but monthly reporting remains	AMBER

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

Board Assurance Framework Report 2026/27 – Issue 3.3 Board November 2026

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

There is a risk that the Trust's increasing dependence on digital technology to deliver safe, timely and integrated care increases exposure to major system outages or cyber incidents, impacting patient safety, service continuity and strategic delivery.

Impact:
There is a risk that the Trust's digital infrastructure, systems, or data may be compromised due to an outage or failure to maintain adequate cybersecurity measures. This could lead to significant disruption to clinical services, compromise of sensitive patient or staff data, financial loss, reputational damage, regulatory breaches, and potential harm to patients

Root causes:

a. Increasing reliance on a single electronic patient record and other interconnected digital services
b. ~~Increasing use of video software for the direct provision of care and operational purposes~~
~~c.~~b. Increasing electronic collaboration across health, social care and voluntary sector partnering organisations
~~d.~~c. Increasing global instability and risk from state supported cyber attacks
d. Increase in locally developed system solutions to support DHCFT and partner operations and performance
e. Increasing use of cloud, video, mobile and locally developed solutions to support care and organisational performance

BAF Ref: 26/27 3B	**Director Lead**: Vikki Ashton Taylor (CDO)	**Responsible Committee**: Finance and Performance Committee

Key Controls

Initial Risk Rating			**Current Risk Rating**			**Target Risk Rating**			**Risk Tolerance**	**Risk Appetite**
Moderate	Likelihood 3	Impact 4	Moderate	Likelihood 3	Impact 4	Moderate	Likelihood 2	Impact 4	Tolerated	Moderate

Preventative – Use of NHS-provided and approved services, including Microsoft 365, NHSmail and the Health and Social Care Network (HSCN). Mandatory data security and protection training at induction and annually, supported by regular cyber-awareness and phishing communications. Cyber, information governance, network and technical controls are overseen through the Commissioning Support Units (CSU) transition programme and established Trust governance. Device and software lifecycle management, patching, multi-factor authentication, endpoint protection and supplier security requirements are applied. Software monitoring planned for the initial Nottinghamshire Health Informatics Service (NHIS) onboarding to improve discovery and baseline visibility of end-user devices and technology across DHCFT and all partnering organisations
~~Trust utilises NHS provided solutions as widely as possible, i.e., Office 365, NHS Mail to ensure compliance with mandated requirements. Use of the secure Health and Social Care Network (HSCN) specified by NHS Digital. Mandatory staff training on data security and protection at induction and annual refresher. Regular all staff communications regarding safe ways of working and phishing emails. Contract with NHS Arden and Greater East Midlands Commissioning Support Unit provides information governance and security services, includes review of risks and addressing of vulnerabilities. Subscription with NHS Digital Care Certification Programme highlights cyber vulnerabilities and monitors Trust's compliance against them~~
Detective – Microsoft Defender security monitoring, NHS England Cyber Security Operations Centre alerts and high-severity alert processes, vulnerability scanning, penetration testing, cyber-hygiene reporting and routine review of unsupported devices, software and inactive accounts. Cyber risks and actions are reviewed through Trust governance, NHIS assurance arrangements and the Nottingham Cyber Associates Network (NCAN)

~~Cyber essentials framework: NHS Digital encourage all organisations to comply. Advanced Threat Protection (ATP) monitors every server and device to highlight threats and software vulnerabilities~~
Directive – Cyber Assessment Framework (CAF) aligned Data Security and Protection Toolkit, NHS England cyber requirements and relevant Trust and NHIS security, network, incident response, business continuity and disaster recovery policies. Major technology changes are subject to architecture, clinical safety, information governance and change-control processes ~~Compliance with NHS Digital requirements. Monthly rigor review meeting with NHS Arden and Greater East Midlands Commissioning Support Unit. Security and Protection Policies and Procedures. Business continuity policy and procedure;~~
Digital Plan and complementary Cyber Plan – In development and aligned to the Trust Strategy

Assurances on controls – Internal	Assurances on controls – External
~~IM&T~~Digital Strategy and plan delivery update ~~to F&P – Annual~~ Digital Delivery Group (DDG) Monthly Digital and Cyber update to Trust Board Annual Embedded programme of software and hardware upgrades Live testing of business continuity plans Digital Plan and Cyber – In development and aligned to the Trust Strategy	NHIS Cyber Security Assurance Programme Board and cyber workplan reporting Membership of the Nottingham Cyber Associates Network (NCAN) NHS England Cyber Security Operations Centre alerts, monitoring and nationally provided security services Annual independent penetration testing and external cyber review DSP Toolkit submission and independent audit assurance Increased standards for external third-party organisation compliance via the DSP toolkit ~~Templar Cyber Organisational Readiness Report (CORS)~~ ~~Annual external cyber review and penetration test commissioned (vulnerability scan)~~ ~~Data Security and Protection (DSP) annual review by Internal Audit~~ ~~Compliance with DSP Toolkit; high levels of training compliance~~

Key gaps in control	Actions to close gaps in control	Impact on risk to be measured by	Expected completion or (review)	Progress against action	Action rating
Arden & GEM CSU will cease to provide the current service beyond 31 March 2027. Transition to NHIS creates a time-limited risk relating to service continuity, knowledge transfer, capacity, contractual readiness, financial clarity and maintenance of effective cyber and technical controls across shared Derbyshire infrastructure	Deliver the joint CSU transition programme with DCHS, the ICB, primary care, Arden & GEM CSU, NHIS and other relevant partners. Organisational onboarding: Technical discovery, due diligence, service mapping, knowledge transfer, contract/SLA and partnership agreement, financial and workforce arrangements Software monitoring during onboarding to establish and validate the end-user device and technology baseline, identify	Safe transfer of support services to NHIS by the required date Approved SLA and partnership arrangements with clear responsibilities and escalation routes Completed onboarding and validated asset/technology baseline	(31.12.26)	DHCFT and DCHS continue to progress a coordinated transition because of extensive shared infrastructure, network, domain and operational dependencies DHCFT, DCHS, primary care and the ICB are entering the initial NHIS onboarding process. Software monitoring planned to support discovery and	AMBER

~~NHS 10 year plan to abolish Commissioning Support Units (CSU). Arden GEM CSU will not exist beyond 31 March 2027 and DHCFT no longer and to benefit from respective cyber, network and technical services and support~~	unsupported/unmanaged assets and inform remediation plans Align cyber governance, risk registers, policies, incident response, business continuity, access, patching and monitoring arrangements with NHIS Track delivery through the IMT & Records senior team, CSU transition governance, Technical Design Authority and Trust committees ~~CSU transition project in place and joint initiative alongside DCHS, ICB, Arden GEM, North of England Care System Support and Nottingham Health Informatics Services.~~ ~~Tracked by IMT+Records senior team and CSU transfer task and finish group~~ ~~National changes tracked via regional forum and Technical Design Authority and task and finish group~~ [ACTIONS OWNER: CDO]	Agreed remediation plans for unsupported/unmanaged or non-compliant assets No material deterioration in cyber controls, service availability or incident response during transition ~~Transfer of support services to a new entity~~		validation of the current end-user device and technology estate The SLA and partnership agreement remain under joint review, supported by finance, legal, technical and subject-matter workstreams Technical workshops and due-diligence activity are supporting secure knowledge transfer and service migration DHCFT and DCHS are now members of NCAN, strengthening access to regional cyber assurance, threat intelligence, shared learning and alignment with NHIS governance ~~Quarterly review leading to deadline in spring 2027~~ ~~Due to significant links and sharing with DCHS across all levels of infrastructure, process, network, domain, DHCFT is looking to be in lockstep with DCHS in terms of joint approach to new ICT supplier~~ ~~New preferred supplier Service Level Agreement and partnership agreement under joint review alongside DCHS~~	

				~~Dedicated finance subgroup commissioned to help with open book and transparent approach to transition costs~~ ~~Subject Matter Expert and technical workshops taken place to support secure transfer of services from Arden GEM to new supplier~~	
Incomplete visibility of the technology estate, together with unsupported, unmanaged or ageing end-user devices, servers and software, may create security vulnerabilities and delay effective cyber response ~~Unsupported IT devices are a potential security risk~~	Maintain a routine lifecycle programme for hardware, operating systems, applications and network components Use current management information and the NHIS onboarding discovery tools to identify devices, software and ownership, reconcile asset records and prioritise remediation Ensure unsupported assets are upgraded, replaced, isolated, removed or covered by a documented risk assessment and agreed compensating controls Continue account and device ownership reviews, patching oversight, vulnerability management and supplier assurance Escalate material exceptions through cyber, operational risk and Trust governance ~~Routine review and update of Trust assets. Ongoing cycle to refresh kit and update assets to comply with security updates~~ ~~Routine rigour technical meeting with Arden GEM supplier to monitor and review compliance~~	Improved accuracy of asset and configuration records Reduction in unsupported or unmanaged devices, servers and software Improved compliance with patching and security baselines Documented ownership, risk assessment and remediation plan for material exceptions Timely response to NHS England and supplier security alerts ~~Compliance with monthly rigour and service reviews~~ ~~Removal of any unsupported devices/assets with each wave of security updates~~	~~(30.09.26)~~ (31.12.26)	Windows 10 remediation has reduced the Trust's exposure, with continued lifecycle activity required for future support deadlines and remaining exceptions Initial NHIS onboarding will provide an opportunity to validate DHCFT and shared Derbyshire device and technology records Cyber hygiene, patching, unsupported-technology and account information continues to be reviewed through Trust and NHIS governance National and regional updates continue to emphasise prompt remediation of unsupported Windows Server versions and full deployment of appropriate endpoint and identity protection ~~DHCFT the first Trust in the midlands to be fully compliant and phase out~~	AMBER

	~~Routine asset management in place for all managers and staff to view and update staff owned assets such as laptop, mobile phone~~ ~~Routine ownership, membership prompts for staff and managers to confirm whether devices are still used and needed (otherwise disabled)~~ [ACTIONS OWNER: CDO]			~~Windows 10 devices. Cycle will repeat with next wave of security updates~~ ~~Ongoing - Monthly rigour and service review meetings with IT service supplier~~ ~~Testing in progress for new Microsoft Defender for Identity (MDI) and on track for completion ahead of government policy mandate to be in place before Autumn 2026~~	

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

ID	Service Line	Title	Risk: Summary of Progress	Date Risk Created	Date of Next Review	Residual Risk Rating
21620	IT, IM and Patient Records	IT system collapse due to cyber attack	06.01.26: Cyber Security Operations Centre (CSOC) released high severity alert for need to update network switches nationally 03.11.26: Reviewed as part of the new DSP toolkit in September 2026: Top three cyber security risks that could impact patient/service user care and the ability to deliver services: Risk 21620 - IT system collapse due to cyber attack Risk 3113 - Risk of supplier of Trust services being involved in a cyber incident Risk 23466 - Data Accuracy and Cyber Security Risk - Azure Management of Services Many subject matter experts (SMEs) from Arden GEM confirmed to have secured role within NHIS to help with smooth transition and especially with support around the DSP toolkit and cyber security There is still a significant dependency on current IT supplier Arden GEM CSU and transition to NHIS planned early December 2026	08.02.19	02.02.27	HIGH

			As such new review date given 31 March 2027 to allow for transition and some transformation work within IMT&R and Cyber function			

Partnerships - Our organisation will identify new ways of working, through new collaborative approaches
There is a risk of reputational damage if the Trust is not viewed as a strong partner both within the Derby and Derbyshire Integrated Care System (ICS) and more broadly within the East Midlands Mental Health Provider Alliance

Board Assurance Framework Report 2026/27 – Issue 3.3 Board November 2026

Impact:
May have detrimental impact on patient experience and quality of care provided for people accessing services.

Root causes:

a) Silo working within the organisation
b) Not actively engaging enough as part of a broader multi-agency partnership at Place and community level
c) Increasing national expectations in provider collaboration and multi-disciplinary delivery model
~~c)~~d) Some elements of general practice perceive that some of our services are not easily accessible

BAF Ref: 26/27 4A	**Director Lead**: Vikki Ashton Taylor (CDO)	**Responsible Committee**: Trust Board

Key Controls

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

Preventative – Active membership in each Place Alliance; Active participation in Integrated Place Executive; Meaningful stakeholder engagement (internal and external); Multi-disciplinary and cross organisational development and implementation of services
Detective – Quality Improvement (QI) delivery; Contract performance; Continuing engagement in all Joined up Care Derbyshire governance from DHCFT representatives
Directive – Integrated Care Strategy; Joint Forward Plan (JFP); Trust Strategy; National Neighbourhood Health Framework

Assurances on controls – Internal	**Assurances on controls – External**
Positive feedback and improvements identified from ~~R~~regular Trust Delivery Group (TDG) and ELT updates and discussions ~~NED Board members on JUCD committees~~ Developing collaborative plans with system partners to recognise and mitigate gaps within the system for ADHD and ASD diagnostics	Mental Health and Learning Disability assurance meetings with ~~NHSE~~ICB cluster ~~-~~County and City Places to JUCD Place Executive Patient surveys conducted by Healthwatch CEO on ICB Cluster Board and ~~Integrated Care Partnership (ICP)~~Derbyshire Provider Collaborative Leadership Board Regular NOF Level 3 meetings with ~~NHSE and~~ ICB

Key gaps in control	**Actions to close gaps in control**	**Impact on risk to be measured by**	**Expected completion or (review)**	**Progress against action**	**Action rating**

System partners report that DHCFT is inward looking and not easy to work with	To build stronger working relations and build stronger integrated ways of working and be more accessible, both from an organisational and service perspective To deliver integrated care and neighbourhood model of care Addressing gaps identified by general practice [ACTIONS OWNER: CDO]	Increased delivery of integrated services Established mental health 24/7 neighbourhood hub Expand Living Well service offer to meet national requirements Improved perception of access to DHCFT services by general practice	(30.09.26)	Collaborative development of community mental health 24/7 pilot alongside partner organisations - Alfreton location confirmed and potential building to deliver services from identified Regular system partner meetings to increase collaborative working to improve access to services, for example, MADE events to reduce length of stay and Clinically Ready For Discharge numbers DHCFT are progressing three connected transformation programmes in relation to neighbourhood working, these being extending the Living Well model, establishing 24/7 neighbourhood mental health centres and opening two mental health urgent assessment centres ~~Active membership of all Neighbourhood (Place) Alliance Groups~~	GREEN

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

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

Board Assurance Framework Report 2026/27 – Issue 3.3 Board November 2026

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

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

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

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

Action Owners

CEO	Chief Executive Officer
DOF	Director of Finance
MD	Medical Director
CDO	Deputy Chief Executive / Chief Delivery Officer
DON	Director of Nursing, AHPs, Quality and Patient Experience
DPOI	Director of People, Organisational Development and Inclusion
DCA	Director of Corporate Affairs and Trust Secretary

Definitions

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

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

Children in Care annual report – 2025/26

Purpose of Report

The purpose of this report is to provide Derbyshire Healthcare NHS Foundation Trust (DHcFT) an overview of the progress, challenges, opportunities, and future priorities to support and improve the health and wellbeing of Children in Care in Derby City. This is an assurance report to provide the Board with scrutiny of this on how this service is discharging its legal duties and clinical standard requirements.

Executive Summary

- The report includes all cohorts of children in care that Derby City local authority is responsible for, no matter where they live
- The report provides significant assurance on the provision, performance and outcomes for children in the service. All health performance has been maintained to ensure outcomes for our children
- It is recognised that the Children in Care health team has core competencies, specialist skills, knowledge and attitudes to act as advocates, undertake health assessments and identify and manage health needs
- The Children in Care team acknowledges, adapts and responds to the many changes in demographics of children in care and understands that different ethnicities are changing. The Children in Care team is dedicated to ensuring that the care offered is culturally adapted to each ethnicity demographic and offer a culturally competent service
- Abuse and neglect remain the most dominant reason for children/young people coming into care, with absent parenting being the second main reason
- It is clear from the comparative data between January 2025, (prior to Trauma-Informed Navigator being fully in post), March 2025 and the data collection in December 2025 that the role holder is having a significant impact on supporting Unaccompanied Asylum-Seeking Children (UASC) having their screening and dental/eye health checks. It is evident that UASC needs an additional level of health navigation and support from the Trauma Navigator, as a collaborative approach with the local authority, Support Workers
- The admin team continues to provide an excellent service and ways of improving. Despite being down to two administrative staff, work continues to be completed to a high standard. The administrative team always looks at ways the service they deliver can be improved
- An audit was completed in December 2025 to audit the number of Mother and Baby forms the Children in Care team receives. The audit aimed to evaluate the process of obtaining Mother and Baby forms for children's health information. Mother and Baby forms provide crucial health and developmental data vital for adoption decisions and agency reporting. The audit showed that since reintroducing the updated pathway, the number of Mother and Baby forms received did increase. However, there was still a number outstanding. The reason for the forms not being received or delayed was due to Social Workers not requesting the forms or once the forms are requested, it can take up to six weeks for the hospital to process and return the forms; impacting timely processes and causing workflow disruptions. Findings were shared with relevant agencies and a re-audit will be completed in 2026/27
- There has been a decrease in the number of reports at the agency decision maker stage during 2025/26 compared to 2024/25. There has been an increase in adult medical reports, which includes reports for fostering, adoptive parents, kinship, short break and respite. The adoption activity data is provided by the Children in Care team (from 1 April 2025 to 31 March 2026)

- The Children in Care team were nominated for a Hearts Award for the Patient Focus Award. One of the Doctors and I attended the Awards event and were very happy to win the category. The feedback was for 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.

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

Risks and Assurances

- The organisation will assure measures are put into place in accordance with the service specification
- Maintain working relationships with other partner agencies/services
- The statutory timescales will be monitored and evidence is provided and scrutinised, in order, to achieve outcomes
- Training compliance will be scrutinised to ensure competency of staff to the right level.

Consultation

- This report has been developed by the Named Nurse for Children in Care with information that is held by both provider and local authority
- Various members of the wider Children in Care team have contributed to the report
- A child-friendly annual report will be developed in a leaflet form
- Quality and Safeguarding Committee, 10 October 2026..

Governance or Legal Issues

- The Trust meets statutory obligations and legal duties regarding: Mental Health Act [1983]; Mental Capacity Act [2005]; The Care Act [2014]; Children and Families Act [2014]; Human Rights Act [1998] Domestic Violence, Crime and Victims Act [2004] and our internal systems, structures and processes are joined up and effective
- The Trust meets the required standards for our Regulators and our Professional Regulatory bodies Codes of Practice, ie Safe, Caring, Effective, Responsive, Well-led and Safeguarding are one of the gold threads that runs throughout. We apply national guidelines and evidence based best practice, eg NICE, DoH, National Statistics
- The Trust contributes as an equal partner in multi-agency forums, eg MAPPA; MARAC; Channel; Child and Adult Safeguarding Boards and subgroups and takes part in peer assessment, benchmarking and self-assessment and assurance
- The Trust invests in staff across multiple agencies and services to ensure high levels of competence and confidence and achieve consistently good practice that is constantly updated and refreshed within a culture of learning from both successful and adverse situations.

Net Zero Duty Implications

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

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

- The use of digital platforms to support safeguarding meetings and Children in Care professional meetings, eg S47 strategy meetings, multi-agency reviews and supervision, continues to reduce travel requirements and associated carbon emissions, supporting sustainable models of care
- The Children in Care team travels to some home visits. However, to minimise travel, they try to undertake home visits within the same areas, eg Nottingham, Derby City, Southern Derbyshire, in order to reduce travel requirements and associated carbon emissions, supporting sustainable models of care.

Public Sector Equality Duty & Equality Impact Risk Analysis

In compliance with the Equality Delivery System (EDS2), reports must identify equality-related impacts on the nine protected characteristics age, disability, gender 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:

- Empowerment - of the individual to make decisions
- Protection - support and representation for those in need
- Prevention - of abuse/neglect as well as helping the person to reduce the risks of harm and abuse that are unacceptable to them
- Proportionality - responses should be least restrictive to the person’s rights
- Partnerships - working collaboratively to prevent, identify and respond to harm
- Accountability - and transparency in delivering safeguarding.

Recommendations

The Board of Directors is requested to:

1. Accept the annual report
2. Receive significant assurance of the work within DHcFT around Children in Care and Young People in Care and the continued partnership working to ensure the best outcome is achieved for this valuable group of children and young people.

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

Report prepared by: **Kelly Thompson**
Named Nurse and Clinical Lead for Children in Care

Derbyshire Healthcare
NHS Foundation Trust

Annual report for Derby city Looked after Children provision

2025/26

www.derbyshirehealthcareft.nhs.uk

DHCFT DERBYSHCFT NHS_DERBYSHIREHEALTHCARE

WE MAKE A POSITIVE DIFFERENCE IN EVERYTHING WE DO

Contributors:

Kelly Thompson (Named Nurse for Children in Care – DHcFT)
Dr S Mehta (Medical Advisor for Children in Care and Adoption – DHcFT)
Dr M Ishfaq (Medical Advisor for Children in Care – DHcFT)
Lisa Ogden (Admin Coordinator – DHcFT)



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Section 1: Introduction and context

The purpose of this report is to provide Derbyshire Healthcare NHS Foundation Trust (DHcFT) an overview of the progress, challenges, opportunities, and future plans to support and improve the health and wellbeing of looked after children in Derby City. This includes all cohorts of looked after children that Derby City Local Authority are responsible for, no matter where they live (see section 4 for explanation of the differing cohorts).

1.1. The report will outline how Commissioners, Designated Professionals, Local Authority and Health Providers have worked together in partnership to meet the health needs of children in care in Derby City; in line with the statutory guidance 'Promoting the health and wellbeing of looked after children' (DH, 2015).

It will summarise key improvements, service performance; along with setting out the objectives and priorities for the next financial year (2025/26) for children in care in Derby City.

1.2. This report has been compiled in partnership with the Named Nurse for Children in Care (CIC), the Medical Advisors and Specialist CIC Nurses and admin.

1.3. Within all national and local policies and guidance the service is known as Looked after Children. However, within Derbyshire Healthcare NHS Foundation Trust, the service is known as Children in Care.

Context

1.4. **Definition of a looked after child/ child in care**

A child that is being looked after by the Local Authority; they might be living with:

- Foster parents
- At home with their parents under the supervision of Children's Social Care
- In Local Authority or private residential children's homes
- Other residential settings such as schools or secure units.

They might have been placed in care voluntarily by parents struggling to cope, or Children's Social Care may have intervened because a child was at significant risk of harm.

Health and wellbeing of looked after children

1.5. It is well recognised that children's early experiences have a significant impact on their development and future life chances. As a result of their experiences and blended effects of poverty, poor parenting, chaotic lifestyles, abuse and neglect, looked after children often are at greater risk and have poorer health than their peers (DfE, DH, 2015).

Ref: Promoting the health and well-being of looked-after children, March 2015, Department for Education and Department of Health

1.6. The Royal College of Paediatrics and Child Health (2020) states that looked after children and young people have greater mental health problems, along with developmental and physical health concerns such as speech and language problems, bedwetting, coordination difficulties and sight problems. Furthermore, the Department for Education and Department of Health (2015) argue that almost half of children in care have a diagnosable mental health disorder and two thirds have special educational needs. When there are delays in identifying or meeting the emotional and mental health needs this can have a detrimental effect on all aspects of their lives leading to unhappy unhealthy lives as adults.

Ref: Promoting the health and well-being of looked-after children, March 2015, Department for Education and Department of Health

Ref: Looked after children: Knowledge, skills and competencies of health care staff, Intercollegiate Role Framework, December 2020, Royal College of Paediatrics and Child Health

Section 2: Statutory Framework, Legislation and Guidance

The statutory guidance focused around Looked after Children is in abundance; the key documents and legislation are outlined as follows:

2.1 **Children Act (1989)**
Under this Act a child is defined as being 'looked after' by the local authority if the child or young person is in their care for a continuous period of more than 24 hours by the authority.

There are four main groups:

- **Section 20** children who are accommodated under a voluntary agreement with their parents
- **Section 31 and 38** children who are subject to an interim care order or care order
- **Section 44 and 46** children are subject to emergency orders
- **Section 21** children who are compulsory accommodated including children remanded to the care of the local authority or subject to criminal justice supervision with a residence requirement.

2.2 **Adoption and Children Act (2002)**

This Act modernised the law regarding adoptive parenting in the UK and international adoption. It also enabled more people to be considered by the adoption agency as prospective adoptive parents. This Act also places the needs of the child being adopted above all else.

2.3 **Children and Young People's Act (2008)**

The purpose of the Act is to extend the statutory framework for children in care in England and Wales and to ensure that such young people receive high-quality care and services which are focused on and tailored to their needs.

2.4 **Children and Families Act (2014)**

This Act strengthens the timeliness of processes in place to ensure children are adopted sooner. Due regard is given to the greater protection of vulnerable children including those with additional needs.

2.5 **Promoting the health and wellbeing of looked after children (March 2015)**
This guidance was issued by the Department of health and Education. It is published for Local Authorities, Clinical Commissioning Groups now Integrated Care Boards - ICB, Service Providers and NHS England.

2.6 **Looked after children: Knowledge, skills and competences of health care staff intercollegiate role framework (December 2020)**

This document sets out specific knowledge skills and competencies for professionals working in dedicated roles for looked after children.

2.7 **The Children and Social Work Act (2017)**

Improves decision making and support for looked after and previously looked after children in England and Wales:

- Improve joint work at local level to safeguard children and enabling enhanced learning to improve practice in child protection
- Enabling the establishment of new regulatory regime for the social work profession
- Improve the provision of relationship and sex education in schools

Section 3: Looked after Children data and profile

National and local data

3.1 The number of looked after children has increased steadily over the past eight years. There were 83,840 Looked after Children on 31 March 2023, an increase of 2%, compared to 31 March 2022. (Department for Education DfE, Department of Health DH, 2023).

3.2 **Number of children looked after in England from 31 March 2015 to 2026**

2015	**69,540**
2016	**70,440**
2017	**72,670**
2018	**75,420**
2019	**78,150**
2020	**80,080**
2021	**80,850**
2022	**82,170**
2023	**83,840**
2024	**83,630**
2025	**81,770**
2026	**82,000 (approx.)**

Ref: Data made available from Derby City Local Authority Informatics Department (approx data). The official statistics for the year ending March 2026 are provisional and will be published by the Department for Education in November 2026.

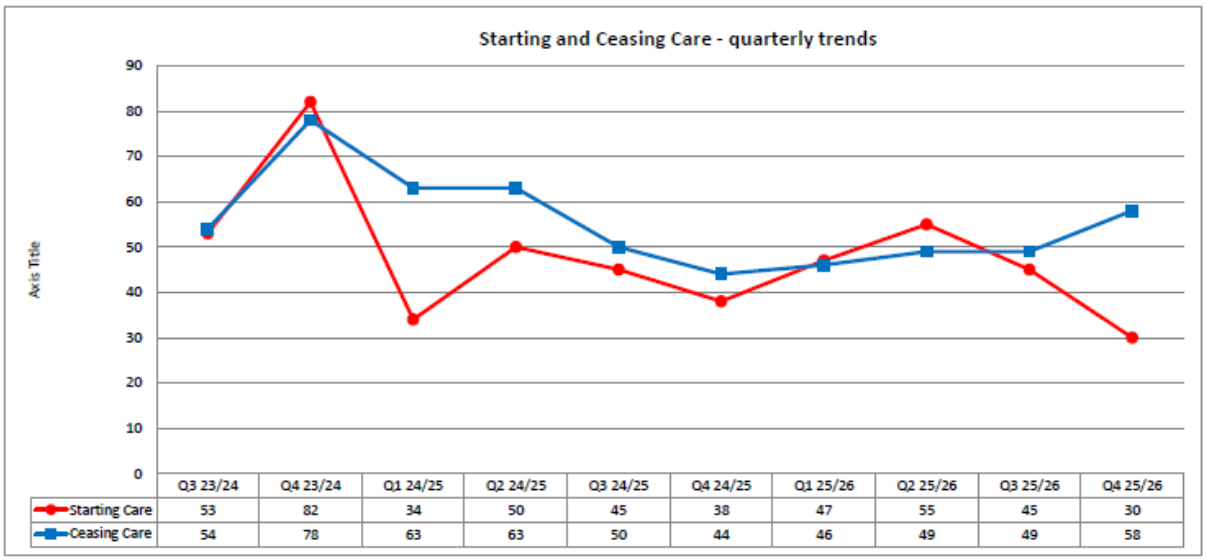
3.3 **Number of children looked after in Derby from 31 March 2017 to 31 March 2026**

2017	**448**	**0.8% decrease from 2016**
2018	491	8% increase from 2017
2019	562	12% increase from 2018
2020	588	4.6% increase from 2019
2021	642	9.4% increase from 2020
2022	627	2.3% decrease from 2021
2023	621	1.1% decrease from 2022
2024	598	3.7% decrease from 2023
2025	545	8.9% decrease from 2024
2026	512	6.1% decrease

Ref: Data made available from Derby City Local Authority Informatics Department

At the end of the year on 31 March 2026, Derby had 512 children in care. This represents a decrease from the 545 children recorded at the end of the previous year which equates to a 6.1% decrease.

3.4 **Children in Care - starting and ceasing care - quarterly trends.**



	Q3 23/24	Q4 23/24	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26
Starting Care	53	82	34	50	45	38	47	55	45	30
Ceasing Care	54	78	63	63	50	44	46	49	49	58

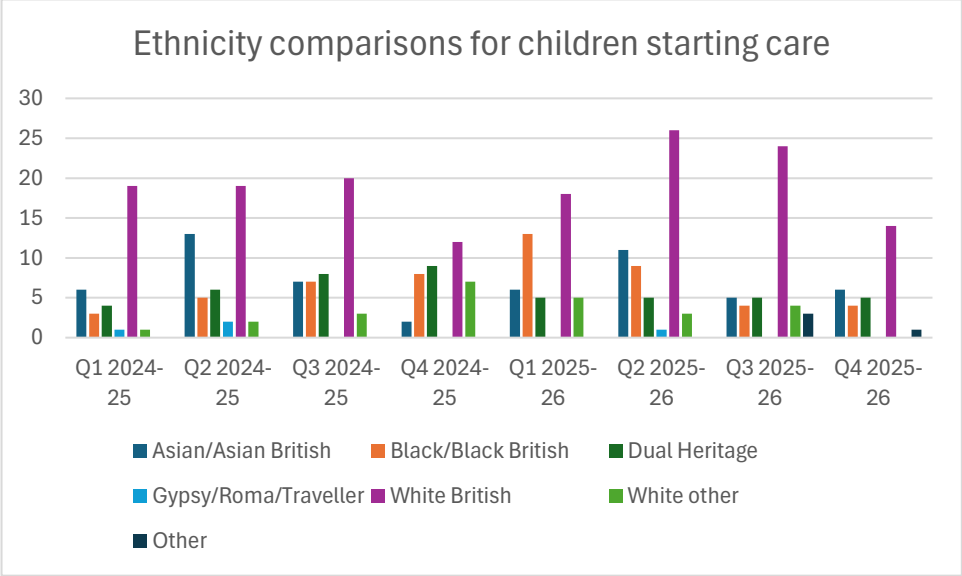
Ref: Data made available from Derby City Local Authority Informatics Department

During the second quarter of the 2025/26 period, Derby City experienced an increase in the number of children entering care. This upward trend in entrants highlights a shift in the dynamics of children requiring support and protection during this time frame.

Conversely, in the fourth quarter of 2025/26, there was a notable decrease in the number of children entering care. Alongside this reduction, the number of children ceasing care increased, suggesting a period where more children were able to leave the care system, possibly due to reunification with families or transitions to other forms of support.

Profile of looked after children in Derby City

3.5 **Ethnicity comparisons over the last three years:**



Ref: Data made available from Derby City Local Authority Informatics Department

The CIC team acknowledge, adapt, and respond to the many changes in demographics of children in care, and understand that different ethnicities are changing. The CIC team is dedicated to ensuring that the care offered is culturally adapted to each ethnicity demographic and offer a culturally competent service.

The placement team try to match ethnicity/culture where they can, however this is not always possible due to the balancing of availability and timings. Culture and identity are always discussed at Looked after Children reviews and plans are put in place to ensure the child's needs are being met and fulfilled. The Review Health Assessment pre-checklist has a section to prompt the nurses to confirm the ethnicity and to consider if care offered is culturally adapted and offers a culturally competent service.

Unaccompanied Asylum-Seeking Children (UASC) leaflets (gender specific and general health) are available in different languages for our children in care.

Derby City Local Authority are linked to the East Midlands Migration group. Any relevant information is distributed to the Designated Nurse for Looked after Children and shared with the CIC team.

The Local Authority have employed a specific UASC team, in order, to support the continuity and cultural compatibility.

The CIC team have a Trauma-Informed Navigator, employed by Derbyshire Healthcare Foundation Trust, in the team. The role of the Trauma Informed Navigator is to support our UASC and Young People with their health needs by signposting to specialist services.

White British remains the most dominant ethnicity of our children in care. There was an increase of Black/Black British children and young people who entered care during quarter 1 (Q1). There was an increase of Asian/Asian British children and young people who entered care during Q2.

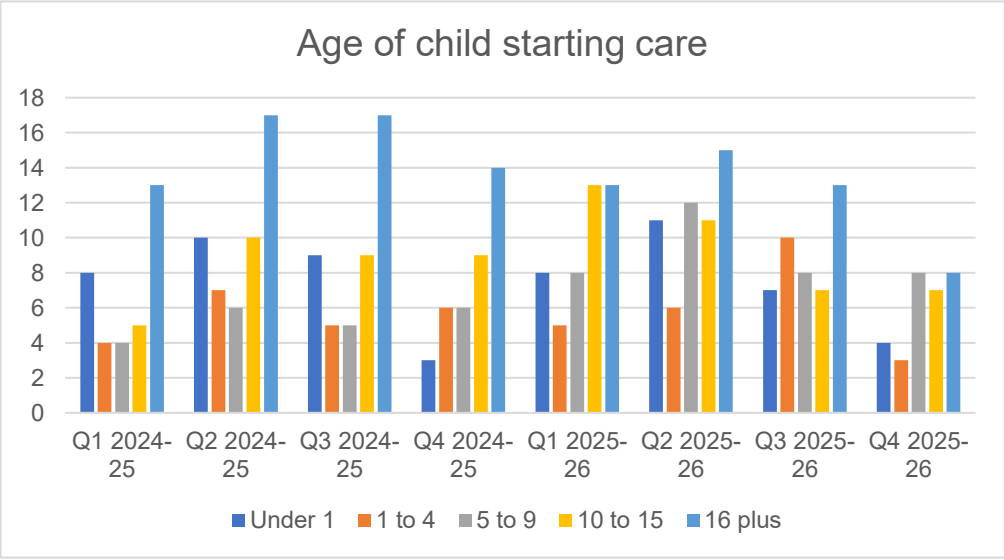
3.6 **Gender of looked after children in March 2026**

Gender	
Male	54%
Female	46%

Ref: Provisional data made available from Derby City Local Authority Informatics Department

As of 31 March 2026, there were a total of 612 children in care, comprising 276 males, 234 females, and two individuals whose gender was recorded as indeterminate. This reflects a gender distribution of 54% male and 46% female within the looked after children cohort.

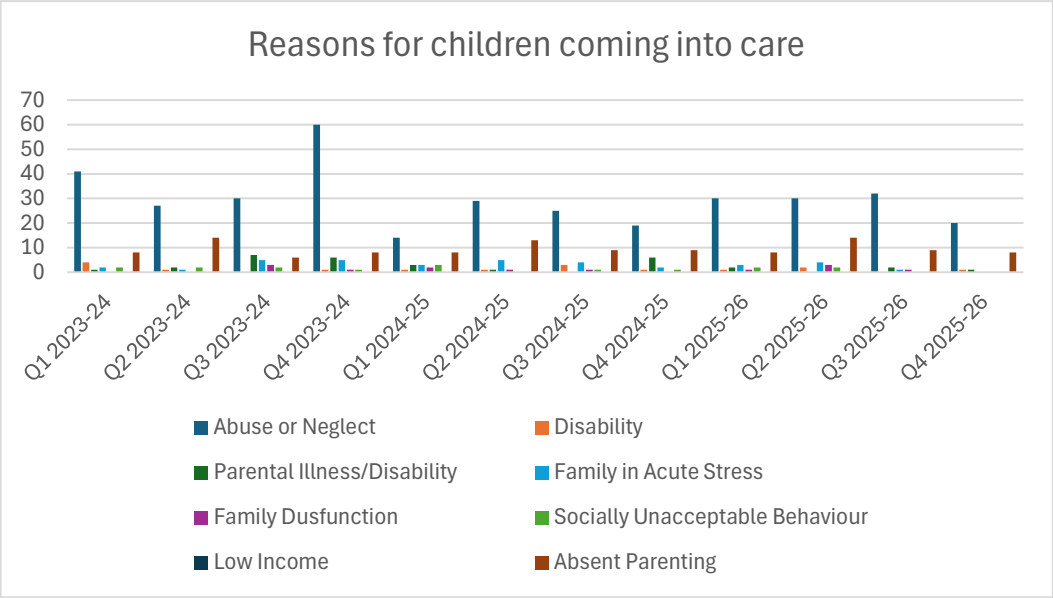
3.7 **Age comparisons over the last two years:**



Ref: Data made available from Derby City Local Authority Informatics Department

During 2025/26 in Q2 there was an increase of children aged under 1 and 1-4 years, 5-9 years and 16 plus. During Q3 there was an increase of children aged 1-4 years. In Q4, 2025/26, eight young people aged 16-17 entered care, accounting for 27%, which is slightly lower than the previous quarter's figure of 29%.

3.8 **Reasons for children coming into care and ceasing care – comparison per quarter over the last three years:**

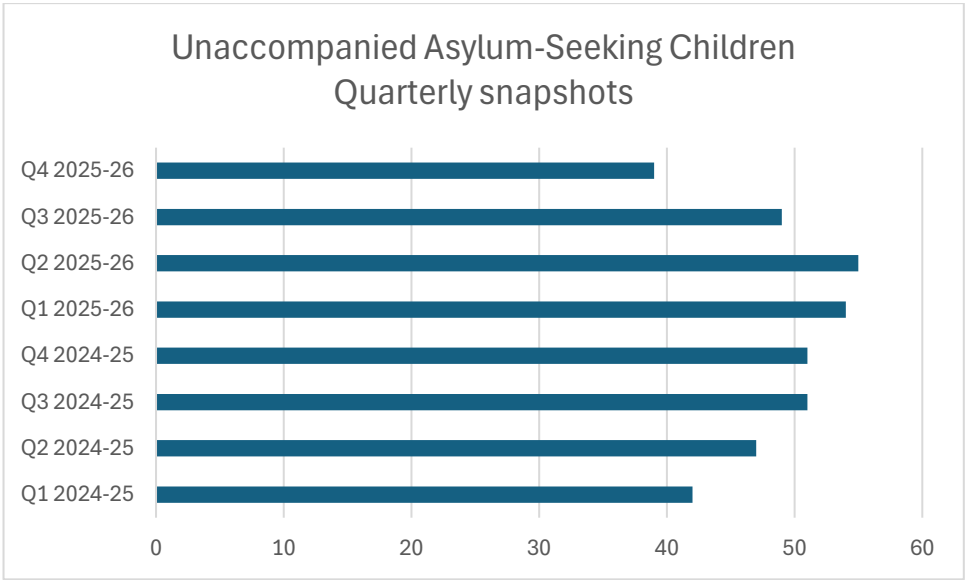


Ref: Data made available from Derby City Local Authority Informatics Department

Abuse and neglect remain the most dominant reason for children/young people coming into care, with absent parenting being the second main reason.

3.9 **Unaccompanied Asylum Seeker Children (UASC) 2024/26**

There were 39 UASC in care on 31st March 2026. This equates to 7.6% of the overall cohort. This is a decrease from 49 UASC seen in the previous quarter.

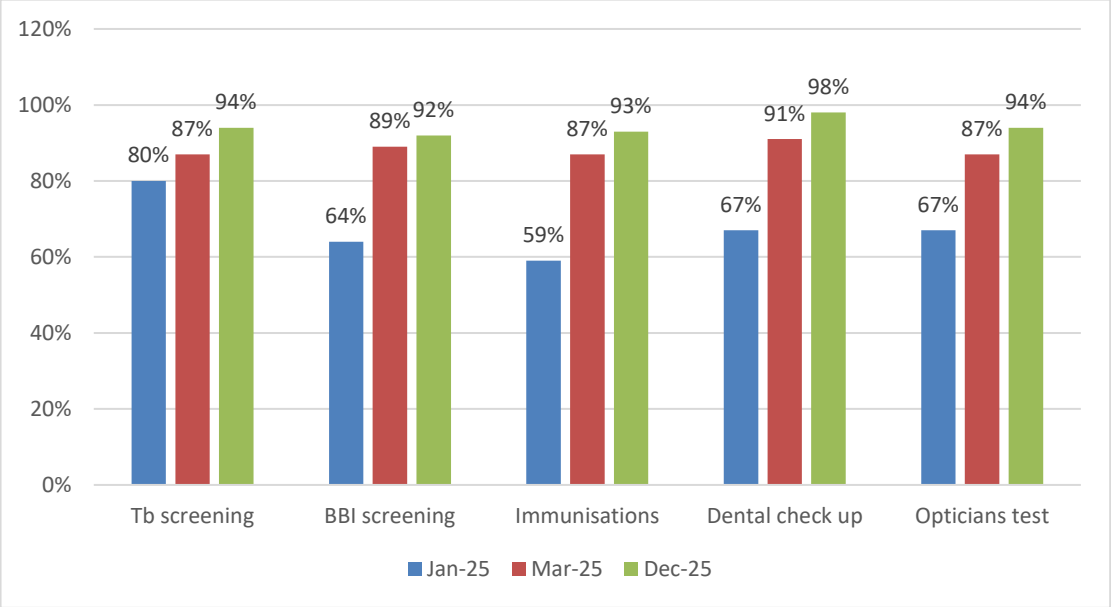


Ref: Data made available from Derby City Local Authority Informatics Department

In December 2024 the team were successful in recruiting a Trauma-Informed Navigator to support the UASC. The role is a substantive role to offer an additional level of health navigation for our UASC.

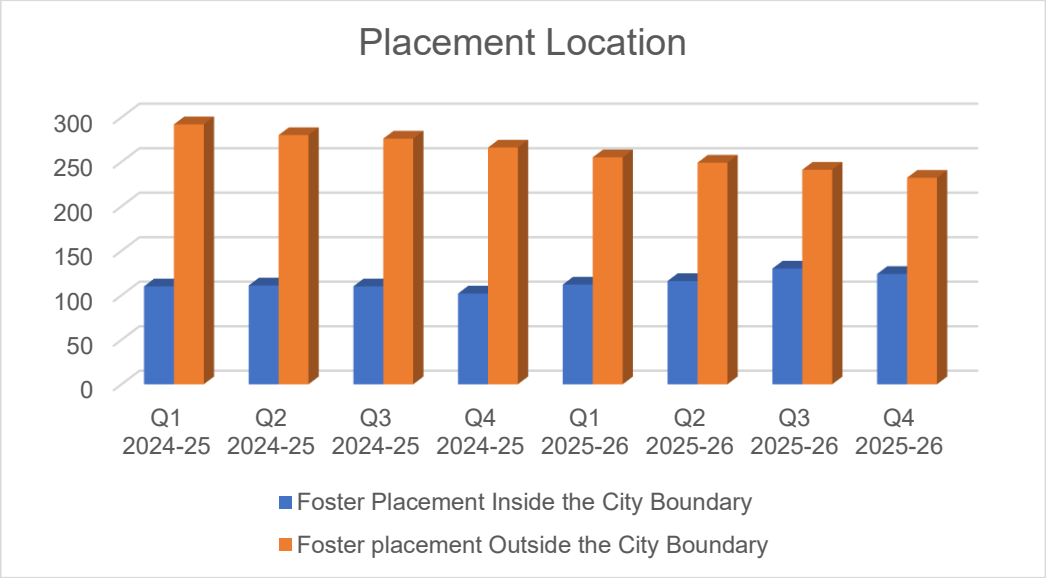
Part of their role will be to facilitate the young people making informed choice and having a full understanding of the need for the screening, suggested screening/interventions suggested and to have their immunisations in the UK, even if they consider themselves fully immunised in their country of origin. The Trauma-Informed Navigator had a six-week induction with the CIC team prior to starting fully into the role in February 2025.

Below is a graph to evidence the improvements made with UASC attending screening/health appointments following on from the Trauma-Informed Navigator's support and signposting to health services.



It is clear from the comparative data between January 2025, (prior to Trauma-Informed Navigator being fully in post), March 2025 and the data collection in December 2025, that the role holder is having a significant impact on supporting UASC having their screening and dental/eye health checks. It is evident that UASC need an additional level of health navigation and support from the Trauma Navigator, as a collaborative approach with the Local Authority, Support Workers.

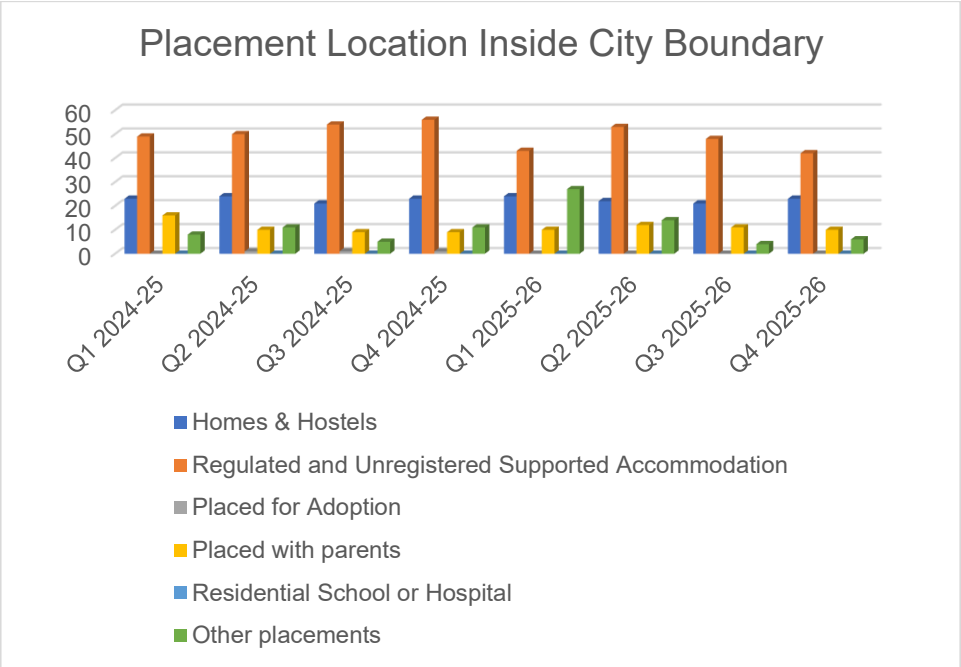
3.10 Location of Placement



Ref: Data made available from Derby City Local Authority Informatics Department

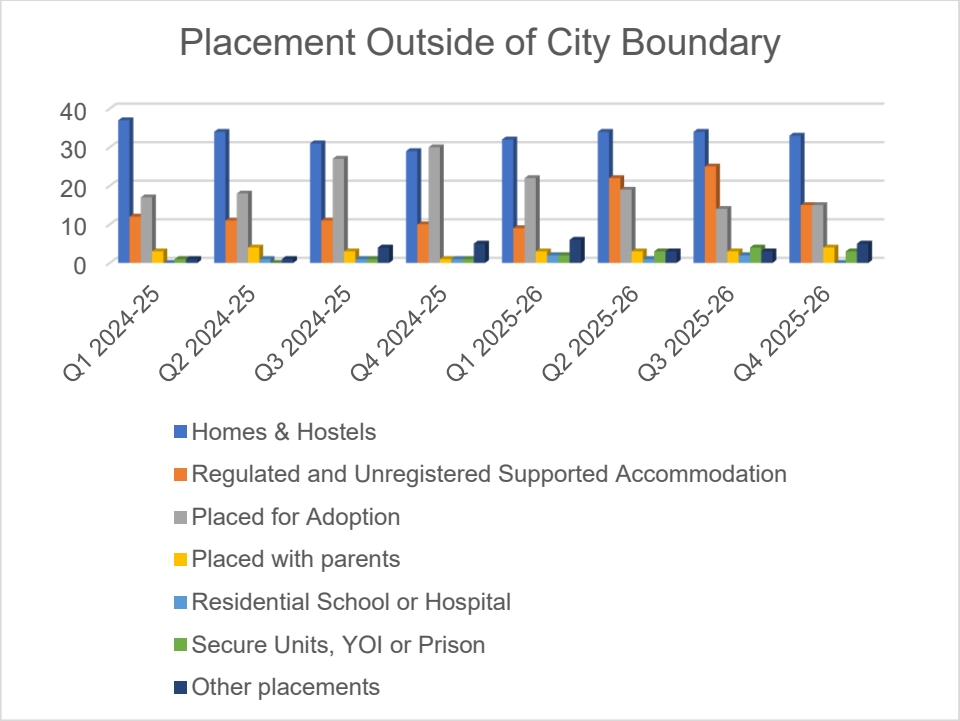
The data demonstrates a clear trend towards increasing the proportion of foster placements made within the city boundary. Between Q1 2024/25 and Q4 2025/26, placements within the city increased while placements outside the city deceased steadily.

Although, the majority of foster placements continue to be outside the city boundary, the gap has narrowed significantly over the reporting period, suggesting progress in supporting children in care to remain closer to their local communities and services.



Ref: Data made available from Derby City Local Authority Informatics Department

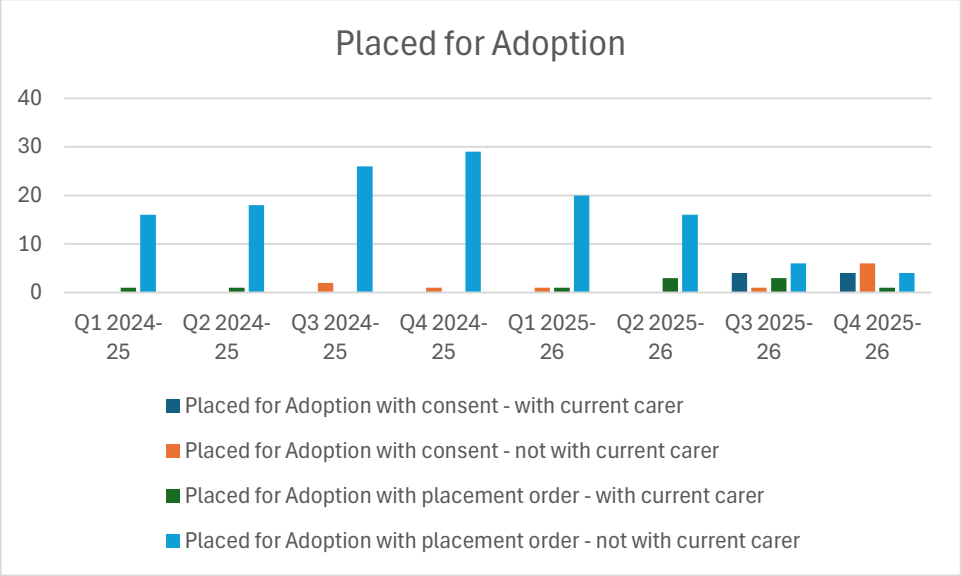
Within city placements continue to be dominated by regulated and unregistered supported accommodation, although the number of these placements has reduced during 2025/26 following a peak in 2024/25. Over the same period, there has been a gradual increase in the use of homes and hostels and residential school or hospital placements. Placements with parents have shown a downward trend, while placement numbers for adoption and other placement categories have remained comparatively low and stable. Overall, the data suggests a changing profile of local placements, with a broader range of accommodation types being utilised within the city boundary.



Ref: Data made available from Derby City Local Authority Informatics Department

Over the reporting period, there has been a positive shift towards increasing the number of children placed within the city boundary and reducing reliance on external placements.

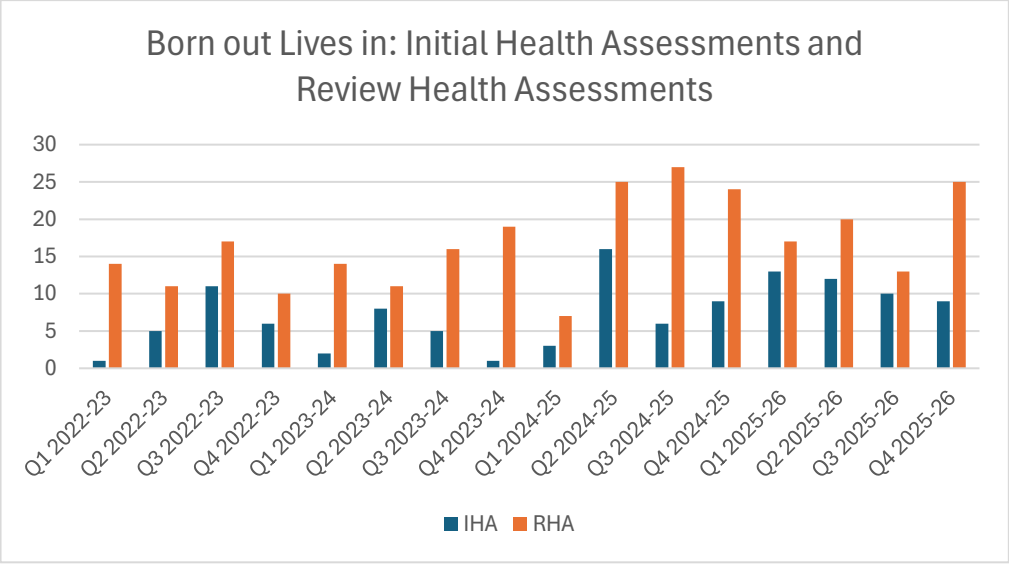
However, a significant proportion of placements outside the city continue to be homes and hostels, reflecting ongoing demand for specialist residential provision that may not be available locally. The use of supported accommodation outside of the city increased during 2025/26, while placements for adoption outside the city declined from levels seen in 2024/25. Overall, the data suggests progress in achieving more local placements, although challenges remain in securing sufficient local capacity for children with more complex placement needs.



Ref: Data made available from Derby City Local Authority Informatics Department

Adoption placements during the reporting period were predominantly children placed under a placement order with adoptive carers who were not their current carers. This category increased during 2024/25, peaking in Q4 before declining steadily throughout 2025/26. Placements for adoption with current carers remained low across the reporting period, as did placements based on parental consent. Overall, the data indicates a reduction in adoption placement activity during 2025/26 following higher levels recorded in the previous year.

3.10 **Children in Care – Born out Lives in Derby City**



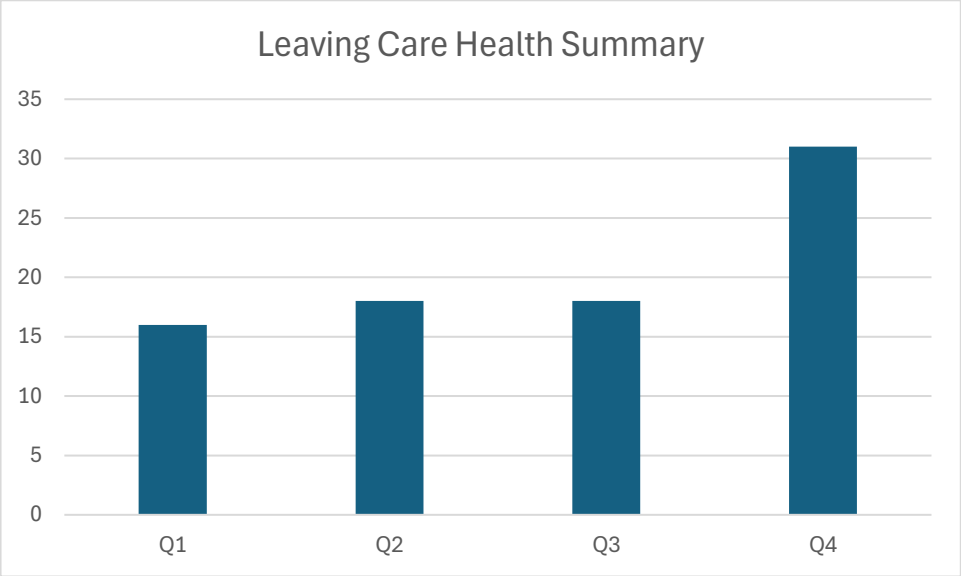
Ref: Data made available from Derby City Children in Care Quarterly Dashboard

BORN OUT, LIVES IN – Looked after Children that were born in another area outside of Derby City (or taken into care by an external Local Authority) but reside in Derby City. Children in care placed in Derby City from other Local Authorities are supported by the 0-19 service. Derby City CIC team will undertake Health Assessments on behalf of other local authorities upon request. There was an increase in requests for Initial Health Assessments in 2025/26 in Q1 and Q2.

In 2025/26 from Q4 there has been an increase in requests for Review Health Assessments to be completed by the CIC team. The number of 'was not brought' to appointments for children born out living in Derby in 2025/26 were 15 for the Initial Health Assessments compared to 20 in 2024/25. The CIC admin team started to notify foster carers of their Initial Health Assessment appointments from May 2025 which may have contributed to the reduction in 'was not brought'. There were 16 'was not brought' to appointments for children born out living in Derby for the Review health Assessments compared to 32 in 2024/25. This shows an improvement in 'was not brought' to appointments for the children in care born out living in Derby for 2025/26. It is the responsibility of the originating Local Authority to ensure children and young people placed in Derby City have an Initial Health Assessment and Review Health Assessment within the statutory requirement.

3.11 **Children in Care – Leaving Care Health Summary**

All children in care will receive a leaving care health summary following from their final Review Health Assessment between the ages of 17 and 18 years. During the Review Health Assessment between ages 16 and 17 years the Leaving Care Health Summary will be discussed with the young person and verbal consent will be obtained for the nurse to complete a leaving care health summary following on from their last Review Health Assessment, these are sent to the Local Authority to provide a copy to the young person. During 2025/26 the Trauma-Informed Navigator and the Designated Nurse CiC developed a Leaving Care Health Summary specifically for the UASC. The number of leaving care health summaries completed during 2025/26 is shown below:



Ref: Data made available from Derby City Children in Care Quarterly Dashboard

Section 4: DHcFT service provision for Looked after Children

4.1 The DHcFT CIC health team have core competencies, specialist skills, knowledge, and attitudes to act as advocates, undertake health assessments, identify, and manage health needs and provide support/training to Foster Carers and Children's homes (in line with the Intercollegiate Role Framework, RCN, RCGP, 2020). The team also contribute to health care plans for all looked after children including children with special educational needs and/or disabilities.

4.2 The team continues to improve their offer for children in care by including the delivery of health promotion to children and young people, support for care leavers, development of a robust system to collate health histories for care leavers, improved identification of risk of child exploitation (including boys/young men) and provision for children who have special needs and/or disability.

4.3 The staffing levels for the health team at the end of the financial year (March 2026) were as follows:

Designation	Hours	WTE
Designated Doctor	2 PAs	0.2
Designated Nurse (DDICB)	37.5 hours	1
Named Nurse	30 hours	0.8
Specialist Nurse	37.5 hours	1
Specialist Nurse	26 hours	0.7
Specialist Nurse	22.5 hours	0.6
Specialist Nurse	15 hours	0.4
Specialist Nurse	7.5 hours	0.2 from March 2026
Trauma-Informed Navigator	37.5 hours	1
Band 4 Admin Co-ordinator	30 hours	0.8
Band 3 Administrator	30 hours (fixed)	0.8 from January 2026 for five months
Band 3 Administrator	26 hours	0.7

4.4 BORN IN, LIVES IN – Looked after Children born in Derby City (or taken into care by Derby City Local Authority) and reside within the City.

BORN IN, LIVES OUT (placed near home) – Looked after Children that were born in Derby City (or taken into care by Derby City Local Authority) but reside within approximately 20 miles away from Derby City in another Local Authority area.

BORN IN, LIVES OUT (at a distance) – Looked after Children that were born in Derby City (or taken into care by Derby City Local Authority) but reside in another Local Authority area over 20 miles away from Derby City.

BORN OUT, LIVES IN – Looked after Children that were born in another area outside of Derby City (or taken into care by an external Local Authority) but reside in Derby City. Children in care placed in Derby City from other Local Authorities are supported by the 0-19 service. Derby City CIC team will undertake Health assessments on behalf of other Local Authorities upon request.

Section 5: Children in Care and Adoption Administrators

The CIC administrative team comprises of one Administrator Co-ordinator (Band 4) and two Administrators (Band 3). The team is currently looking at recruiting a Band 3 Administrator to replace the vacancy following a team member recently leaving the role.

The primary purpose of these roles is to provide a comprehensive administrative support service to the CIC Health team, ensuring that all administrative requirements are met and that processes and procedures operate efficiently. The team is responsible for responding to enquiries, making decisions where appropriate, and following up on actions from health professionals across both local and external services.

Given the sensitive nature of information shared regarding these vulnerable children, all work is carried out with the utmost confidentiality, discretion and professionalism. The administrative team has also established strong working relationships with the local authority, enabling the delivery of a high-quality and effective service.

The admin team continues to provide an excellent service and ways of improving. Despite being down to two administrative staff, work continues to be completed to a high standard, and the administrative team always looks at ways the service they deliver can be improved. Admin have worked further in gaining Mother and Baby gorms back and continue to monitor this and are hoping to continue improving the amount received back.

Compliance continues to be challenging with a significant rise in children becoming looked after in April/May 2026 – Admin and CICA Doctors have worked hard to add extra clinics in to help with compliance and continue to monitor this.

Streamlining the spreadsheets used by admin has considerably helped with keeping track of compliance. Also retrieving information from the spreadsheets has been made easier and more accurate.

Section 6: Health Data and Performance for Year 2025/26

6.1 Health data and Local Authority performance is a mandated submission to the Department for Education on a yearly basis, and the table below summarises the performance over the last five years:

** Please note all health data for 2025-2026 is provisional until submitted to the Department for Education**

Health Data Indicator	Year 2021/22	Year 2022/23	Year 2023/24	Year 2024/25	Year 2025/26
Annual health assessments	92.6%	92.9%	93.8%	95.3%	90.7%
Dental checks	77%	90.6	85.3%	87.8%	86.4%
Immunisations up to date	94.1%	95.3%	96.1%	94.1%	94.7%
Development checks (two RHAs in the 12 months for under 5 years old)	86.9%	98.6%	94.1%	96.8%	95.6%

NB: the data is only mandatory for those children/young people in care for a period of 12 months or more.

6.2 **Annual Health Assessments** – The performance for Health Assessments increased slightly during Q4 from 89.9% to 90.7%. The local target is 90%. The latest comparator authority average for 2024/25 was 92.1% so Derby is performing slightly below this.

Dental Checks – The performance for Dental checks increased during Q4 from 56.9% to 86.4% This is above the 2024/25 comparator authority average of 83.3%. Performance is expected to continue to improve during the year.

Immunisations - The performance for up-to-date Immunisations has increased from 87.2% to 94.7%. The local target is 92%. The comparator authority average for 2024/25 was 90.1% so Derby is slightly above this.

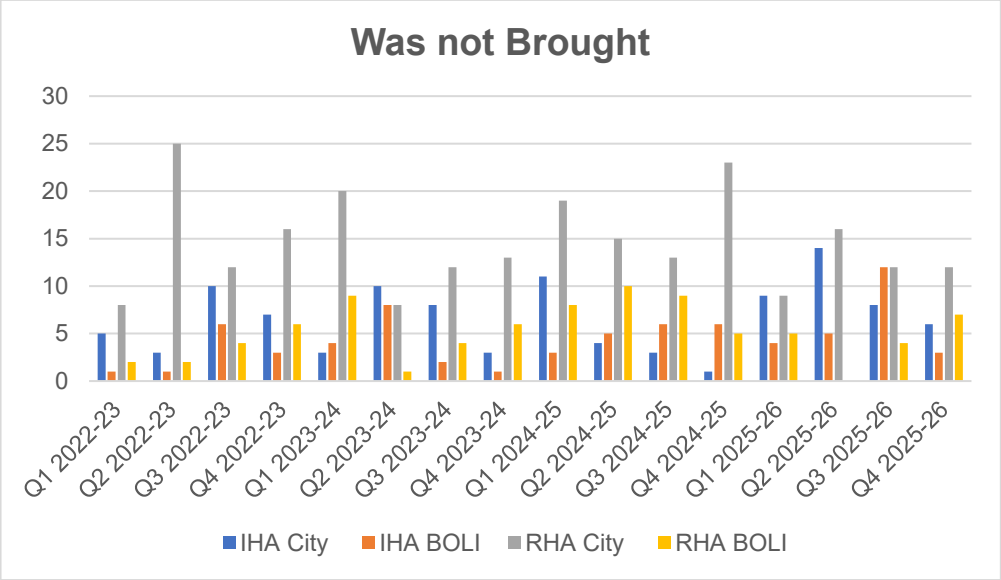
Development Checks - The performance for Health Development Checks has increased during Q4 to 95.6% from 83.7% at Q3. The comparator authority average for 2024/25 was 93% so Derby is currently performing above this.

Ref: Data made available from Derby City Children in Care Quarterly Dashboard

6.3 The CIC team has both access to and the means to update the Liquid Logic system, which is the Local Authority's IT platform. As a result, the accuracy of health data for children in care has seen significant improvements.

To ensure that all relevant information is properly recorded, the Named Nurse for CIC and the Designated Nurse for CIC hold quarterly meetings. During these meetings, they review the data to confirm that it is complete and correct. Any outstanding information identified is then passed on to the CIC Nurses and administrative staff, who are responsible for following up and ensuring the information is obtained and entered on the system.

6.4 Shown in the table below are the number of children in care who were not brought to their health assessments during 2022-2026.



Ref: Data made available from Derby City Children in Care Quarterly Dashboard

The above includes children born in Derby living within a 20-mile radius (city) and children from out of area placed within Derby City (BOLI).

Some of the reasons for 'was not brought' to their appointment during 2025/26 are shown below:

- Young person refused to attend
- Foster carer not aware of the appointment – it is the responsibility of the social worker to inform the foster carer of the Initial Health Assessment appointment date and time
- Foster carer forgot to cancel
- Child placed with parent
- Foster carer did not receive the appointment letter
- Foster carer mislaid the appointment letter.

Any 'was not brought' or cancellation of the health assessment appointment, for whatever reason, can have a huge impact on our compliance. The CIC team has a 'was not brought' pathway to follow if a child is not brought to their appointment. If the child/young person refuses to attend the CIC team has a refusal pathway to follow.

It is the responsibility of the social worker to inform birth parents and foster carers of the Initial Health Assessment appointments. However, due to the number of 'was not brought' to appointments for children placed in Derby City from another Local Authorities in 2024/25 the CIC admin also started to notify foster carers of the appointment from May 2025.

Two years ago, the CIC team changed to hybrid printing, this is a more efficient way of sending appointment letters out for Review Health Assessments, the aim is to prevent carers not receiving the appointment letter in a timely manner resulting in a decrease in 'was not brought'.

Despite the change to hybrid printing of appointment letters, there is still a high number of 'was not brought' in quarter two for the Derby City Review Health Assessments and the Derby City Initial Health Assessments. The Named Nurse CiC will continue to work closely with the Designated Nurse CiC, the Local Authority and the team to look at the reasons for 'was not brought' and how we can reduce the numbers over 2026/27.

Section 7: Analysis of Adoption and Medical Adviser Activity

This section is compiled by Dr Sujata Mehta and Dr Mehwish Ishfaq, Derby City Medical Advisers, CIC and Adoption team, Derby City

This section of the report has been prepared based upon the information available from DHcFT data and data provided by the Local Authority regarding adoption related work.

ADOPTION ACTIVITY

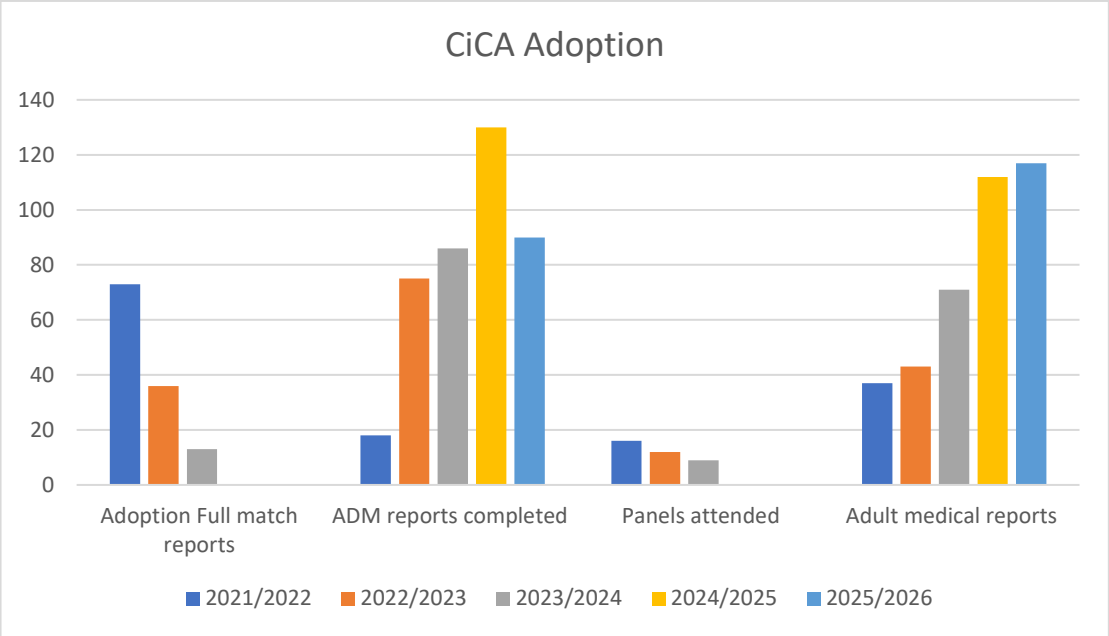
The format of the reports provided for agency decision maker (ADM) has been working well over the past year and the feedback from the agency has been positive. This has proved to be helpful to the medical advisers who provide the report and to the readers of these reports as they are more comprehensive and nicely summarised in the beginning of the report. The workload has also been more streamlined with designated time and clinic slots to complete these reports and reports have generally been going out on time, meeting strict deadlines.

7.1 There have been two Medical Advisors contributing to the Adoption work for Derby city over the past year. The Adoption Support Specialist Liaison Nurse has been contributing to the adoption work by preparing the reports for those coming up for adoption at the ADM and matching stage. The medical advisors have also been contributing written advice to Adoption panels since June 2025. However, attending Adoption panels has not been happening since January 2024 due to shortage of staff.

7.2 The Regionalised Adoption service (Adoption East Midlands) continues to work incorporating four neighbouring regions of Derby City, Derbyshire, Nottingham City and Nottinghamshire. The cases for matching the Derby City children continue to be heard at any of the panels within the region, attended by different medical advisers. An efficient and timely liaison between different medical advisers is needed to explore and clarify any issues in advance of panel, which may get affected by the capacity issues, requiring Medical Advisers to be available all the time as queries may arise from any panel.

7.3 The following adoption activity data is provided by Adoption East Midlands (from 1 April 2025 to 31 March 2026):

- Total number of adoption children's medical reports (Matching reports) – 0
- Total number of ADM Reports – 90
- Total number of adult medical reports – 117 including Fostering, Adoption, Kinship, Short break and respite
- Total number of panels where written advice was provided- 11
- Total number of panels attended (advice provided by Derby City medical advisers) – 0
- Number of Prospective adopter consultations undertaken – 0.



There has been a decrease in the number of reports at the ADM stage during 2025/26 compared to 2024/25. There has been an increase in adult medical reports which includes reports for fostering, adoptive parents, kinship, short break and respite. The above adoption activity data is provided by the CIC team (from 1 April 2025 to 31 March 2026).

We continue to invite questions in writing from adopters via the Social Worker, which are responded to in writing, included on the report if possible or separately if received later, also the report format is very comprehensive and includes any history and implications in detail.

A telephonic consultation is only provided in selected cases, if requested, to answer any specific queries which remain or if the child has a very significant or complex medical condition.

7.4 The training sessions by Medical Advisors for prospective adopters, foster carers and Social Workers, incorporating training on common clinical issues in an adoption scenario, ie impact of maternal smoking, alcohol and drug misuse in pregnancy and Blood Borne Infection screening in vulnerable and high-risk children, has not happened last year due to staff shortages. It is hoped that this activity will restart once staffing levels have improved in the future.

7.5 The Medical Advisors attend regular quarterly AEM meetings with other Medical Advisors and panel advisors (plus commissioners if appropriate). They also attend panel training days twice a year.

7.6 The Named Doctor for CIC and the Named Nurse for CIC also deliver a training lecture on CIC and Adoption as part of the GP vocational training course in Derby.

Section 8: Derby and Derbyshire Development Day

8.1 The Named Nurses for CIC for Derby City and Derbyshire and the Designated Nurses for CIC for Derby and Derbyshire Integrated Care Board held a development day for Derby City and Derbyshire CIC teams.

8.2 The DECC (Emotional Wellbeing Service) provided an update on their service model. Their offer is from September 2025–2030. They informed us about their new duty service available to professionals for advice, information on their website and their referral and screening recommendation process and their 18-24 leaving care offer.

8.3 Clinicians were divided into groups to take part in an action learning set on vaping. Research articles were provided to support each group in gathering information and feeding back their findings.

8.4 There was an opportunity for networking, with nurses, doctors and administrative colleagues working in groups to discuss challenges, share best practice and identify priorities for the year ahead.

8.5 The Named Nurse CiC and Designated Nurse delivered a session on wellbeing on behalf of our wellbeing champion. This included two interactive games.

8.6 The day concluded with a reflective session, allowing participants to consider key learning from the day and how this could be applied in practice.

Section 9 Summary of achievements in year 2025/26

During the period of 2025/26 the CIC health team have continued to experience some changes and it has been acknowledged despite this the Specialist Nurses, Medical Advisors and Administration team have shown innovation and marked improvements within their service delivery.

The following are an indication of the progress made and not an exhaustive list of achievements:

9.1 The end of year Health Performance Data continues to remain positive as shown in section 6.

9.2 The Designated Nurse, Designated Doctor, Named Nurse and Administrator Co-ordinator have continued to strengthen local and regional relationships with key professionals, partners and agencies. This has supported improved information sharing, health outcomes and the voice of the child, including children placed out of area.

9.3 Access to the Liquid Logic Child Social Care system continues to support improved information sharing between agencies in the best interests of looked after children. It also has a positive impact on the accuracy and validity of health data reported to the Department for Education. Health information is uploaded to Liquid Logic at the end of each quarter, with any missing information followed up by the CIC team.

9.4 Reporting and assurance into the DDICB Quality and Performance Committee have been strengthened via quarterly reporting of performance and quality of the CIC service. This has allowed the Named Nurse for CIC the opportunity to access and interrogate health data more robustly internally within the Trust, using relevant and useful reporting systems. This in-depth provision of evidence has enabled a more robust way of working at both team and service level and influenced improvements.

9.5 The Specialist Nurses for CIC continues to act as link nurses for Local Authority Residential Children's Homes, with two Specialist Nurses linked to each home. During 2025/26, they have continued to offer health drop-in sessions on topics selected by each home, based on the needs of the children and young people living there. These sessions have been delivered either by the Specialist Nurses or jointly with other health services. Although young people do not always engage, the sessions provide an opportunity for the Specialist Nurses to remain visible and available, while also supporting residential staff with any health-related concerns.

9.6 The CIC team was nominated for a Hearts Award for the Patient Focus Award. One of the doctors and I attended the Awards event, and we were very happy to win the category. The feedback was for 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.

9.7 The Named Nurse from Derby City and Derbyshire held a successful development day for both CIC teams which was funded by Derby and Derbyshire Integrated Care Board. There were a variety of presentations on the day as discussed in section 8.

9.8 A Specialist Nurse for CIC, the CIC administration team and the Trauma-Informed Navigator were all nominated for a DEED during 2025.

9.9 Enhanced Case Management meetings have continued. These are a multi-disciplinary meeting focusing on certain topics appropriate to the young person using an outcomes-based tool.

9.10 The CIC team participated in a quality visit with the Trust. Positive feedback was received alongside advice and recommendations on any improvements that could be made and support offered within the Trust to make these improvements.

9.11 An audit was completed in December 2025 to audit the number of Mother and Baby forms the CIC team receives. The audit aimed to evaluate the process of obtaining Mother and Baby forms for children's health information. Mother and Baby forms provide crucial health and developmental data vital for adoption decisions and agency reporting. The audit showed since reintroducing the updated pathway the number of Mother and Baby forms received did increase, however there were still a number outstanding. The reason for the forms not being received or delayed were due to Social Workers not requesting the forms or once the forms are requested it can take up to 6 weeks for the hospital to process and return the forms. Impacting timely processes and causing workflow disruptions. Findings were shared with relevant agencies, and a re-audit will be completed in 2026/27.

9.12 As discussed in section 3.9 the CIC team has a Trauma-Informed Navigator in the team who supports the UASC whilst they are in care. The team was successful in recruiting a new Trauma-Informed Navigator in December 2024.

9.13 The CIC team has a Wellbeing Champion within the team to support the team's wellbeing. One of the Specialist Nurses for CIC has successfully attended training for this and delivers wellbeing sessions once a month during lunchtime. The sessions have included some wellbeing interactive sessions and discussions. The Wellbeing Champion will provide updates through email approximately once a week which include any Trust wellbeing updates, wellbeing quotes and general check in. The team appreciates these sessions and updates.

Section 10: Priorities for Year 2026/27

10.1 **DHcFT Provider key priorities for 2026/27:**

- To ensure a safe team and delivery of service despite the current challenges and changes within the ICB and the Trust
- To continue to deliver health promotion within the Local Authority Residential Children's Homes
- To continue to represent health at the Enhanced Case management Meetings and Health Meetings with the Local Authority Children's Residential Homes
- Focus on improving attendance of health drop-in sessions for foster carers
- Identify learning to improve outcomes for young people and foster carers
- To continue to provide Health Passports and Leaving Care Health Summaries
- To finalise the Review Health Assessment paperwork ensuring feedback is gathered from children and young people
- To continue to work closely with the County CIC team working towards the Joined-up Care Derbyshire approach
- To build relationships with the leaving care team to improve support around transition
- To submit the Markers of Good Practice Assurance Tool.

Derbyshire and Derby City Children in Care

Markers of Good Practice

Year: 2025-2026

Health Provider: Derbyshire Healthcare NHS Foundation Trust

Date completed: 16.02.26

By whom: Kelly Thompson Named Nurse and Clinical Lead for Children in Care



"Children are the world's most valuable resource and it's best hope for the future."- JFK

For 2025-2026 as part of the safeguarding children assurance process, Derby and Derbyshire Integrated Care Board would like to obtain assurances from our Health Providers that the needs of Looked After Children 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.

The documentary evidence requested may be utilised to provide assurance across more than one area of compliance. NB: not all the standards will apply to every Health Provider.

The process for completion of the MOGP is as follows:

- Completion of the self-assessment tool including RAG rating.
- Feedback following self-assessment rating, including a peer review for each provider (which may include a visit as appropriate).
- Designated professional to complete the evidence submitted section and address ongoing development.
- Action to be taken by Providers regarding addressing national and local priorities.
- Providers to ensure compliance with Promoting the Health and Well-being of Looked After Children (2015).

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.

RAG Rating:

The RAG rating system relates to how an organisation assesses itself and how it plans to make improvements. This will be followed with a ICB peer reviewed RAG rating, following review of evidence and/or visit.

	The necessary arrangements are in place, up to date and meets or exceeds the required minimum standard
	Significant progress made from last MOGP but still requires some further improvements
	Some measures are in place but others require review or improvement
	Arrangements need to be developed as soon as possible

Please refer to **appendix 1** for examples of evidence that is suggested for each standard.

Standard 1: Compliance with Statutory Initial Health Assessments Health Providers are required to demonstrate that they are compliant with Statutory Guidance Promoting the health and well-being of Looked After Children (2015) by providing high quality and timely Initial Health Assessments.		
1A	**Providers can demonstrate that the child living in Derbyshire/Derby City (no matter where they originate from) has had their IHA and a Health Care Plan is completed within 20 working days of the child coming into care and is made available to Social Care for the child's first review.**	
Self-assessment RAG rating		Comments: Challenges around IHA compliance are evidenced due to various reasons. Systems are in place and the admin, and doctors work hard to ensure compliance where possible.
ICB / peer review RAG rating	To be completed by ICB	

Evidence submitted:

Pathways:

IHA Flowchart 20 day compliance.doc

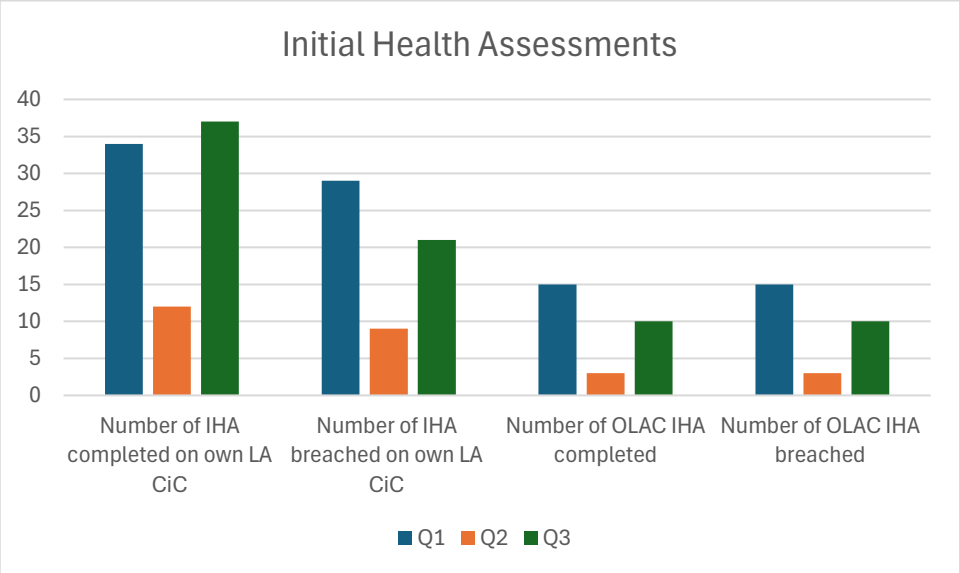
INITIAL HEALTH ASSESSMENTS.docx

IHA Flow Chart.docx

Following the IHA Appointment.docx

Compliance information for City and BOLI (OLAC)

MOGP 25-26 - IHA Info.docx



Mitigation Plan:

There have been some challenges with our compliance over the past year due to long term sickness from December 2024. This has had an impact on our compliance, and a mitigation plan is currently in place. The Integrated Care Board and the Local Authority are aware, and this is on the Trust's risk

register. There is a plan for the doctor and Designated Doctor for Children in Care to return to work, currently awaiting an update.

ICB comments:

Actions required (add additional actions as required):

	Action	By who	By when
1.			
2.			

1B	**Providers can demonstrate for those originating from the aligned Local Authority who are placed at a distance that the IHA is requested in a timely manner from external Health Provider.**	
Self-assessment RAG rating		Comments: See audit – delay in consent forms continues to be a challenge.
ICB / peer review RAG rating	To be completed by ICB	

Evidence submitted:

BILO at a distance:

MOGP - BILO IHA requests 2025-26.dc

CiC admin get notified that a child has come into care and are informed that the child is living out of area. CiCA Admin register the child as per process and request is sent to the social worker via email with the relevant paperwork. Once the relevant paperwork is received from the social worker the request can be sent to the out of area provider to request an IHA to be completed on our behalf.

ICB comments:

Actions required (add additional actions as required):

	Action	By who	By when
1.			
2.			

1C	**Provider can demonstrate that there is a clear escalation process within their organisation to the ICB, where there is a delay for a child, to minimise the impact of any delays.**	
Self-assessment RAG rating		Comments: communication with the Trust and ICB is working well.
ICB / peer review RAG rating	To be completed by ICB	

Evidence submitted:

See pathways in section 1A

IHA overview 2025/26

IHA compliance continues to be challenging due to Doctor sickness, limited appointment availability at times, and the high number of children coming into care. September 2025 was our strongest month for compliance, with 10 children entering care; of these, 6 were booked in line with compliance requirements and returned to the local authority within 20 days. WNB remains an ongoing challenge; however, there has been a notable reduction in BOLI WNB since appointment letters have been sent directly to carers as well as to social workers. Late notifications from the local authority have also impacted compliance, as these children do not always appear on the "starting care spreadsheet," meaning some new children into care can go undetected.

Positively, IHA clinics remain consistent, and there has been an increase in paperwork being returned within required timescales. Doctors continue to work hard in supporting admin to ensure paperwork is completed and returned on time.

The admin team continue to liaise with the Designated Nurse for Children in Care, informing of any challenges around IHA compliance. This information is regularly discussed with managers and plans are put in place as required.

ICB comments:

Action required (add additional actions if required):

	Action	By who	By when
1.			
2.			

1D	**Provider's arrangements are that Initial Health Assessments are completed by an appropriately skilled and knowledgeable Medical Practitioner and in line with the Intercollegiate Guidance level 4 competencies (Autumn 2025)**	
Self-assessment RAG rating		Comments: We have a skill mix of doctors within the CiC Team
ICB / peer review RAG rating	To be completed by ICB	

Evidence submitted:

The intercollegiate document has been updated and circulated following consultations. The intercollegiate document is a guidance document which outlines core competencies for all professionals who work within the Children in care Service. The updated version has changed to 'Safeguarding children and young people & looked after children and young people: Competencies for Healthcare Staff'.

Skill matrix- Specialist doctor in Community Paediatrics and Named Doctor for Adoption, Associate Specialist Doctor, Named doctor for Children in care.

The Children in Care doctors receive mandatory training as per Trust policy, this training includes Safeguarding Children and Adults, Mental Capacity Act, SEND, Data Security and Paediatric and Adult Resuscitation, Infection Control and Fire Safety. Other training is specific to their specialism.

There have been no trainee doctors this financial year within the Children in Care Team.

Doctor one: SM
Training from April 2025- till date
April 3- Transitions and working with young adults
April 4- Secondary trauma and staff well being
April 29- Adoption moving forward course
April 30- Adoption panel training event
June 26- Managing stress and boosting mental fitness
July 9- RCPCH course- UASC
August 11- Planning for retirement
October 1- Adoption panel members training
October 16- Leadership skills for SAS doctors- practical applications

Revalidation date 6.12.2025

Last Appraisal date 4.03.2025

Safeguarding Level 3 training date- compliant when appraisal completed on 4.03.2025 and have booked it again on 12 March this year.

Doctor two: DK
CPD Record Summary (Appraisal Period)
Internal CPD Meetings
- Safeguarding peer review — 11 Mar 2025 — 1.5 points
- Monthly departmental training and safeguarding peer review — 8 Apr 2025
- Monthly departmental training and safeguarding peer review — 13 May 2025
- Monthly departmental meeting and safeguarding peer review — 17 Jun 2025
- Monthly departmental training and safeguarding peer review — 8 Jul 2025
- Monthly departmental training and safeguarding peer review — 9 Sep 2025
- Monthly departmental training and safeguarding peer review — 14 Oct 2025
- Monthly departmental training and safeguarding peer review — 11 Nov 2025

External CPD Meetings
- West Midlands Neurodisability Study Day — 10 Jun 2025
- Paediatric Neurodisability Diploma Online Group Learning Session – Day 1: Introduction to Childhood Disability — 2 Oct 2025

Training as Medical Educator
- SAS Doctors as an Educator — 11 Jul 2025

Teaching and Facilitating Learning
- GPVTS Training — 30 Sep 2025

Seminars / Workshops (External)
- E-learning module: Reflection Matters — 25 Oct 2025
- E-learning module: What is Disability? — 25 Oct 2025
- E-learning module: See the Person (Celebrate Abilities) — 26 Oct 2025

- E-learning module: Communication Basics — 28 Oct 2025
- E-learning module: Communication Matters in Health — 28 Oct 2025
- E-learning module: Communication Support Tools — 28 Oct 2025
- E-learning module: Three-way Communication Matters — 28 Oct 2025
- E-learning module: Understanding Matters for Effective Communication — 28 Oct 2025

Seminars / Workshops (Internal)
- E-learning module: Disability, Cultures and Languages — 26 Oct 2025
- Derby and Derbyshire Children in Care Development Day — 26 Nov 2025

02/05/2027 revalidation date.

2026 appraisal meeting booked on 29/01/2026
Appraisal 2025 submission date - 28/02/2025

Doctor three: MI
Last Appraisal : 27.08.2025.
Revalidation Due on: 08.03.2026

Safeguarding Children Training Level 3 completed on 23.04.2025 Valid until 22.04.2028

Training from April 2025- till date

April 4- Sleep in Children with Neurogenetic Disorders: Improving Outcomes for Families
April 29- Adoption moving forward online conference
April 30- Adoption panel training event
June 19- Job planning Training
July 9- RCPCH full day course- UASC
August 26- Pan African Neuropsychiatry: An Approach to Functional Neurological Disorders
September 23, 24 -Two-day Course on Paediatric Medical Emergencies
September 25 - Poverty and the paediatrician: what can you do?" with Dr Ian Sinha
October 1- Adoption panel members training
October 23 - Improving opportunities for physical activity for care-experienced children and young people
November 7- Challenges from primary to secondary care

More Dr's skill matrix AM – awaiting information

There have been no trainee doctors during 2025-2026.

ICB comments:

Action required (add additional actions if required):

	Action	By who	By when
1.			
2.			

1E	**Providers can demonstrate that consent for IHA is gained from parental responsibility holder or directly from the child if he/she is competent to do so**

Self-assessment RAG rating		Comments: The consent form has been updated during this year and we have added a separate consent for our UASC.
ICB / peer review RAG rating	To be completed by ICB	

Evidence submitted:

Copy of consent form updated in November 2025:

New IHA form Nov 25.docx

A copy of the UASC consent form is shown below:

UASC IHA form Jan 25.docx

It is the social workers responsibility to ask birth parents for consent (depending on parental responsibility). If the consent is received verbally then it is expected that the social worker writes this on the consent form and signs the form. For example: Telephone conversation with birth mum, on the date it took place, who consents (ensure correct options are chosen) signed and dated by the social worker. If a young person is 16 and over and has capacity to consent the doctor will accept the consent form to be signed by the young person. It was agreed that we required a separate consent form for our UASC.

ICB comments:

Action required (add additional actions if required):

	Action	By who	By when
1.			
2.			

1F	**Providers have a process to gain relevant information from other professionals to assist the IHA assessment process, including parental health and maternity/birth information where available**		
Self-assessment RAG rating			Comments: Improvements have been made over the past year to obtain the M&B forms.
ICB / peer review RAG rating	To be completed by ICB		

Evidence submitted:

Copy of consent form included parental health information:

New IHA form Nov 25.docx

A separate UASC consent form is shown below:

UASC IHA form Jan 25.docx

See MOGP 204-2025 for information prior to this.
Following on from last year's MOGP an audit was carried out on the Forms M&B to collate the number of requested Forms M&B since the new process had been shared v how many returned to the team. The audit discussions commenced in September 2025, information was collated, and the plan is to complete the write up of the audit by January 2026. This was shared at the CiCA Operational meeting on the 20.01.26. Plans are to share with the Adoption Team and Local Authority.

Audit findings Mother and Baby Fo

Forms MB Audit template version 2.d

ICB comments:

Action required (add additional actions if required):

	Action	By who	By when
1.			
2.			

1G	**Providers can demonstrate the assessment is holistic and child centred, with evidence of assessment of physical, emotional, developmental progress and voice of every child (demonstrating equality and diversity provision eg: SEND, UASC, non-verbal children, sexuality, gender identity, ethnicity, culture)**	
Self-assessment RAG rating		Comments: Outcome of audit is positive with evidence of feedback through the survey monkey.
ICB / peer review RAG rating	To be completed by ICB	

Evidence submitted:

The Initial Health Assessment form used currently is attached below. The doctors started using the updated forms which were uploaded onto SystmOne from July 2025.

IHA - UASC new version - July 2025.d

IHA - 0-5 yrs new version July 2025.do

IHA - 5-10 yrs new version July 2025.do

IHA - 10-18 yrs new version July 2025.do

An audit was completed by our Designated Nurse CiC to look at the quality of Initial Health Assessments following the roll out of the new updated versions of the initial health assessment forms:

IHA audit Dec 25.docx

The findings were deemed to be more favourable in comparison to the quality audit completed in September 2024. This may indicate the positive impact of the quality workshop delivered in November 2024 along with simplified / improved documentation.

Quality Audit:

IHA Reports Quality Audit 2025 Final.ppt

Survey monkey feedback 2025-2026:

Data Survey Monkey 2025.pdf

Q3 data.pdf

ICB comments:

Action required (add additional actions if required):

	Action	By who	By when
1.			
2.			

Standard 2: Compliance with Statutory Review Health Assessments

Health Providers are required to demonstrate that they are compliant with Statutory Guidance Promoting the health and well-being of Looked After Children (2015) by providing high quality and timely Review Health Assessments.		
2A	**Providers can demonstrate that the child living in Derbyshire/Derby City (no matter where they originate from) has had their RHA and a Health Care Plan is completed within the RHA due date. Annual RHA for children turned 5 years old up to 18 years, every 6 months for those under 5 years old**	
Self-assessment RAG rating		Comments: There have been some issues with timeliness for the OLAC living in Derby City over the year, however as of the end of March all OLAC children will have been offered an appointment for their Review Health Assessments.
ICB / peer review RAG rating	To be completed by ICB	

Evidence submitted:

Children in Care Born out Lives in RH

Review health assessments for LAC

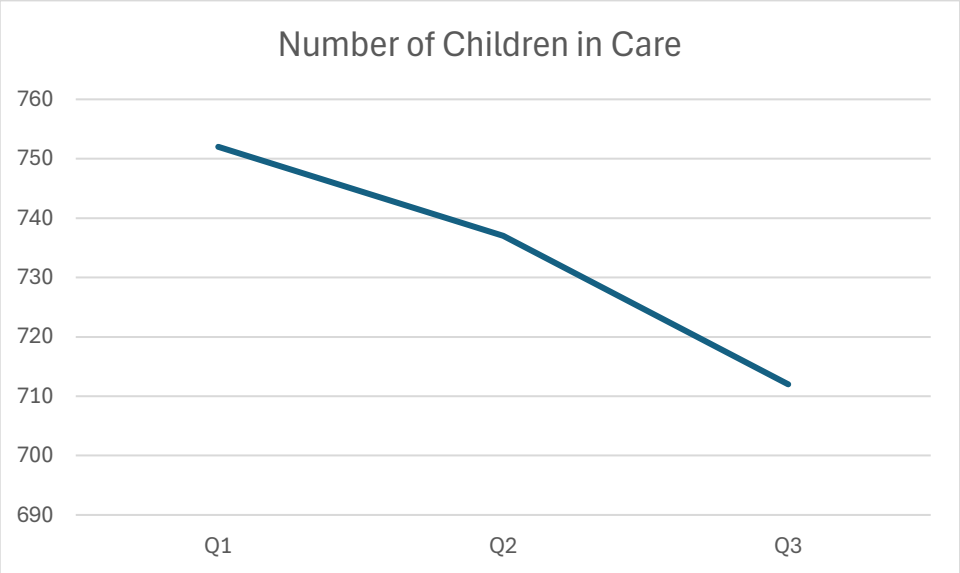
Refusal Pathway.docx

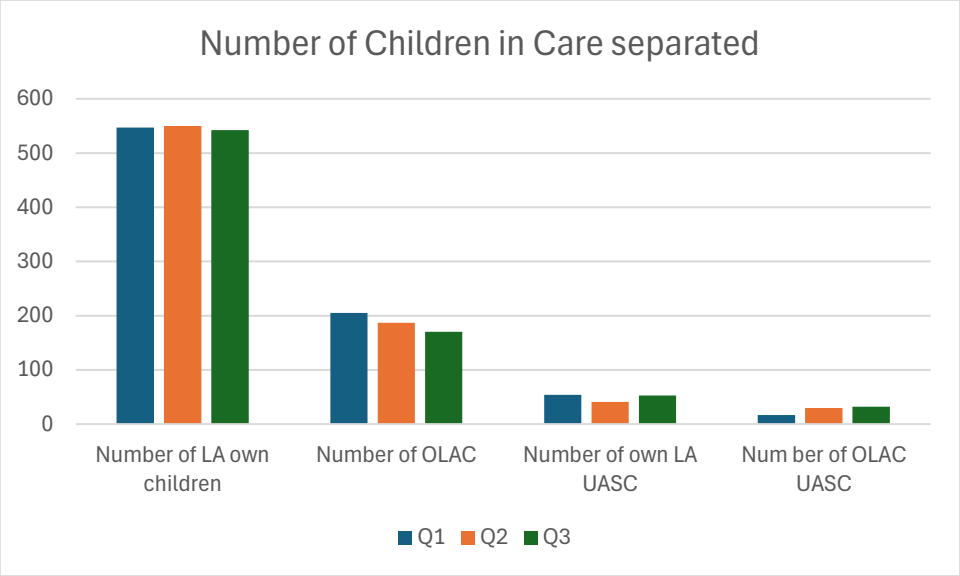
Was Not Brought Dec2025.docx

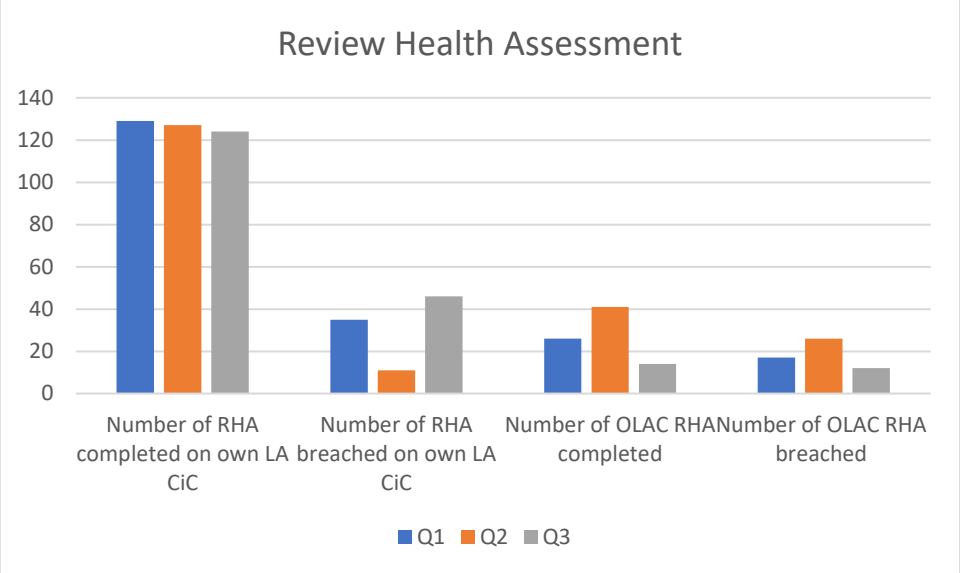
Timeliness audit for BILI and BILO 20 miles radius:

Review Health Assessments.docx

Quarter four only 4 records were audited due to the time the MOGP was due for submission.

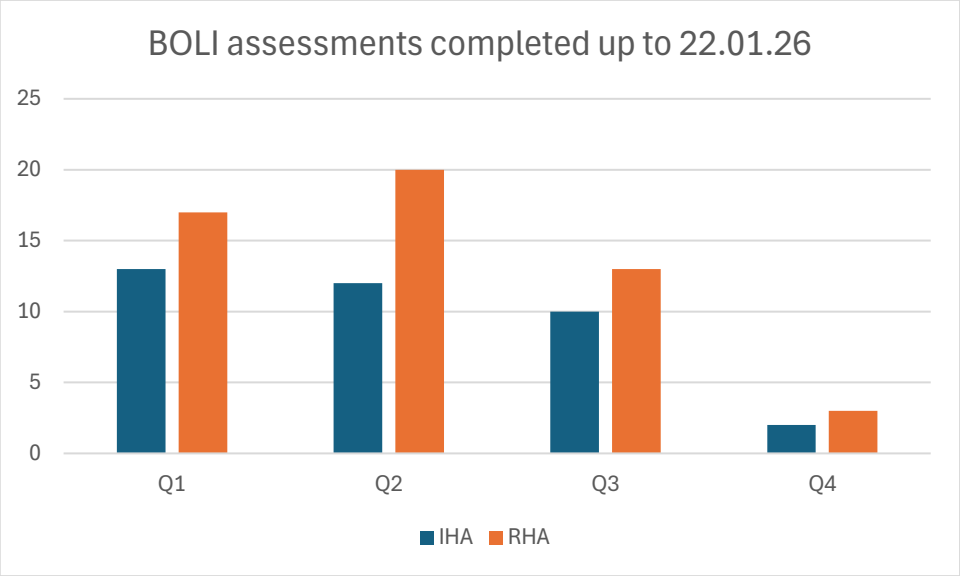






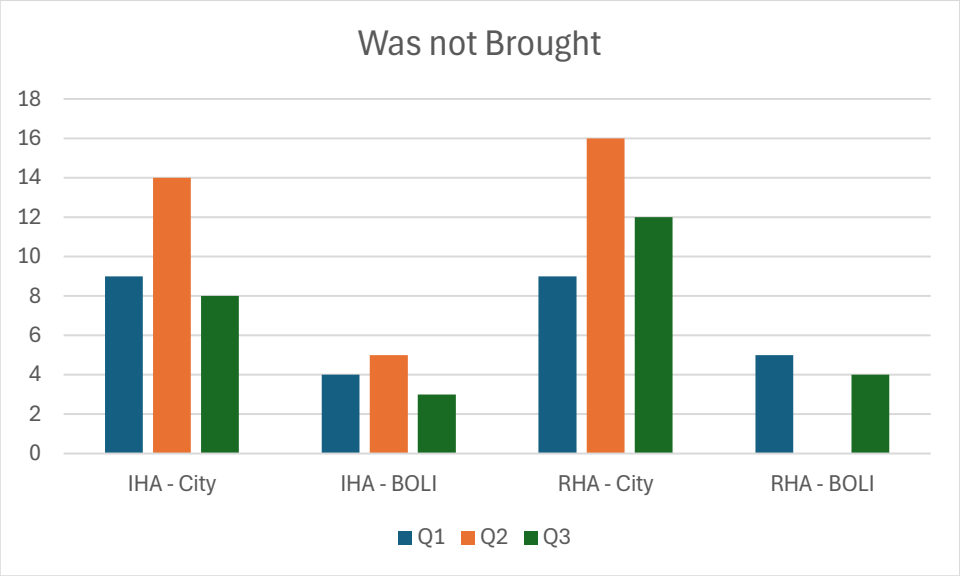
BOLI Audit:

MOGP - BOLI RHA - 2025-26.docx



The Born-out Lives in Review Health Assessments are undertaken as requested. The expectation is that the request is sent at least 12 weeks before the due date to allow time to plan and allocate. The CiC Team offer additional hours which are consistent over the year to undertake these appointments, and these should be funded through the low volume activity. There has been an increase in requests for BOLI Review Health Assessments over 2025-26, therefore at times the service have struggled to meet the demands of this increase. This has been escalated through managers and the Trust. Plans are put in place when these struggles occur, and the team have worked hard to ensure the health assessments are completed with minimal delay. We have a high number of was not brought which can also impact on the delay. Currently we are just about up to date with our BOLI waiting list. All BOLI children on the waiting list will be offered an appointment by the end of the financial year for those that are due.

Was not brought audit:



Leaving Care Health Summary:

Since August 2024 one of admin has been running a monthly clinical report to identify any outstanding leaving care health summaries and those that are due. This has helped support the timely completion of health history summaries.

Leaving Care Health Summary numbers are shown below from April 2025 – 22.01.26:

HH summaries	Quarter	Number
	Q1	16
	Q2	18
	Q3	18
	Q4	9

ICB comments:

Action required (add additional actions if required):

	Action	By who	By when
1.			
2.			

2B	**Providers can demonstrate for those originating from the aligned Local Authority who are placed at a distance that the RHA is requested in a timely manner from external Health Provider (according to agreed pathway)**	
Self-assessment RAG rating		Comments: There is a clear process in place to request health assessments for children placed at a distance. Admin work hard to ensure requests are sent in a timely manner, some challenges around late requests the main one being change of placement.
ICB / peer review RAG rating	To be completed by ICB	

Evidence submitted:

Review health assessments for LAC

MOGP - BILO RHA request 2025-26.doc

When a child/young person moves placement, this can result in a delay in the Review Health Assessment being completed depending on when the notification is sent to the team and a further request needing to be sent to the new provider.

During 2025-2026 if there has been a significant delay in a review health assessment being completed by an out of area provider, where possible, the Derby City Nurses have completed the health assessment over the telephone with the carer. This is only considered, if possible, for children placed at a distance who are 5 and under.			
ICB comments:			
Action required (add additional actions if required):			
	Action	By who	By when
1.			
2.			
2C	**Provider can demonstrate that there is a clear escalation process within their organisation to the ICB, where there is a delayed RHA for a child, to minimise the impact of any delays**		
Self-assessment RAG rating		Comments: We have a clear escalation pathway.	
ICB / peer review RAG rating	To be completed by ICB		
Evidence submitted:  Guidance for the management of esc  IRO Escalation Dec 25.docx  Was Not Brought Dec2025.docx **See was not brought audit in section 2A**			
ICB comments:			
Action required (add additional actions if required):			
	Action	By who	By when

1.			
2.			

2D	**Provider's arrangements are that Review Health Assessments are completed by appropriately skilled, knowledgeable and trained nurses and in line with the Intercollegiate Guidance level 3 competencies (Autumn 2025)**		
Self-assessment RAG rating			Comments: The team is a good skill mix. Mandatory training is supported by the Trust and external training is offered to further development
ICB / peer review RAG rating		To be completed by ICB	

Evidence submitted:

Skill mix of nurses:
Currently we have two health visitors, a school nurse, and a learning disability nurse in the CiC Team, all Specialist Nurses for Children in Care are Band 6. The whole-time equivalent is 2.69wte for the Specialist Nurses following a retire and reduce in October 2025 we now have a vacancy which has gone out to advert twice internal only for the gap of 0.2wte. We have a full time Band 4 Trauma Informed Navigator to support UASC. There was a gap of one admin during 2025, however we successfully recruited for a 6-month period, and they started with the team in January 2026. We have two Band 3 administrators, and one Band 4 Admin Coordinator equates to 2.3wte. There is one Named Nurse for CiC, Clinical and Operational Lead equivalent to 0.8wte.

Training:

Each Specialist Nurse completes their mandatory training as per Trust Policy. Training can be delivered face to face, on MS Teams or as E-Learning. Examples of the training includes Safeguarding Children Level 3, Safeguarding Adults including prevent, DOLS and Mental capacity Act, Paediatric and Adults Resuscitation, Infection Control, Fire Safety, Practice Supervisor and Assessor, Oliver McGowans Training, Data Security, Record Keeping, Moving and Handling.

Additional Training:
Goals based outcome training was delivered to the team to provide an opportunity to capture and measure outcomes through the electronic health record on SystmOne,

Quality Improvement Fundamentals session was planned as recommended from our Quality Visit in October however due to sickness in the team this was rearranged and is now planned for 03.02.26.

Training compliance
Mandatory training

Name	Compliance Percentage
Ailsa Kinson	93.5
Clare Pickering	96.8
Emma Fennell	93.5
Janette Beard	96.3
Kelly Thompson	87
Kimia Rezaei	95.2
Satvieer Dutton	83.9

Both Satvieer and Kelly have training booked over the next 3 weeks which will increase their compliance.

Development Day:
We held a development day in November 2025 which was kindly funded by the ICB for the Derby City and Derby County Children in Care Teams.

The agenda for the day is shown below:

FINAL Derby and Derbyshire CIC Dev I

The feedback from the day is shown below:

Evaluation data from Children in Cai

ICB comments:

Action required (add additional actions if required):

	Action	By who	By when
1.			
2.			

2E	**Providers can demonstrate that consent for RHA is gained from parental responsibility holder or directly from the child if he/she is competent to do so**	
Self-assessment RAG rating		Comments: Consent is available within the child's/young person's electronic health record and is checked prior to each Review Health Assessment.
ICB / peer review RAG rating	To be completed by ICB	

Evidence submitted:

Those who are aged 16 will normally be regarded as fully competent to discuss health needs. The Mental Capacity Act (2005) will be considered when obtaining consent for 16–18-year-olds. Competence of those under this age will be determined by the health professional that should satisfy him or herself that the young person is of sufficient age and understanding to be able to give informed consent before proceeding with any treatment. (Gillick Competence)

Questionnaires for competence and capacity to consent are available within SystmOne and once completed are documented within the child'/young person's electronic health record.

Below are screenshots taken for each questionnaire:

Record capacity to consent

Assessment or Treatment?

- ◯ Assessment
- ◯ Treatment

2 Details of decision to be agreed (e.g. Community Care Plan, treatment etc...)

Determining Impairment or disturbance of mind or brain

Guidance: every individual aged 16 and over should be assumed to have the capacity to make a decision unless it is proved that they lack capacity.

Q1 Is there an impairment of, or disturbance in the functioning of the patient's mind or brain? (For example, symptoms of alcohol or drug use, delirium, concussion following head injury, conditions associated with some forms of mental illness, dementia, significant learning disability, long term brain damage, confusion, drowsiness or loss of consciousness due to a physical or medical condition)

- ◯ Yes
- ◯ No

Assessment

Date:

Competent to consent to health assessment

1 Does the young person understand what their assessment, plan of care or treatment entails?

- ◯ Yes
- ◯ No

2 Does the young person have the maturity to make their own decisions and understand the implications of those decisions?

- ◯ Yes
- ◯ No

3 Do you consider the young person able to understand the information relevant to the decision and that this information has been provided in a way that the young person is most probably able to understand?

- ◯ Yes
- ◯ No

4 Do you consider the young person able to retain the information for long enough to use it in order to make a choice or an effective decision?

- ◯ Yes
- ◯ No

5 Do you consider the young person able to weigh that information as part of the process of making that decision?

- ◯ Yes
- ◯ No

6 Do you consider the young person able to communicate their decision?

- ◯ Yes
- ◯ No

7 Assessed to be competent to consent to own assessment / treatment?

- ◯ Yes
- ◯ No

ICB comments:

Action required (add additional actions if required):

	Action	By who	By when
1.			
2.			

2F	**Providers have a process to gain relevant information from other professionals to assist the RHA assessment process, including social workers, carers, previous health assessments, 0-19 service as appropriate**	
Self-assessment RAG rating		Comments: The children in care team have good working relationships with internal and external professionals who they liaise with when required.
ICB / peer review RAG rating	To be completed by ICB	

Evidence submitted:
An aide memoir is available to all Children in Care Nurses to complete prior to the Review Health Assessment being undertaken. This helps the nurse to gather any relevant information before undertaking the health assessment. It is the responsibility of the Specialist Nurse CiC to gather any relevant information that is needed by the social worker prior to the health assessment appointment. The Specialist Nurse for Children in Care should liaise directly with the social worker following the health assessment if required.

Aide Memoir Pre.docx

Currently we send a form out to carers with the appointment letter to gather some health information for them to bring to the appointment:

over 2 form RHA.pdf

From January 2026 we have decided as a team to use the CoramBAAF pre appointment information sheets to send out with each appointment depending on the age of the child.

For young people aged 11-16 we also send out an Adolescent Wellbeing Questionnaire to be completed prior to the appointment. The carer/young person brings the completed questionnaire to their appointment to be discussed as necessary:

Adolescent Wellbeing 11-16.pd

It was agreed as a team that the Adolescent Wellbeing Questionnaire should be completed prior to the appointment to allow the young person to complete this in their own time and not feel pressured at the appointment. However, we agreed this will need to be monitored to ensure if not completed prior to the appointment then the offer to complete this during the appointment remains.

We continue to use the below pathway between the health visiting service and the children in care team which looks at health and development reviews which are completed at touch points for all children aged 0-5 years. This was developed to support both services when completing a development review on each child and to prevent duplication. It provides clear guidance on roles and responsibilities when a child is seen by both services. The pathway below has been agreed by the Clinical Lead for 0-5 years and the Named Nurse and has been approved at our Children's Reference Group and by Area Service Managers.

CIC and HV Integration Process.

The Specialist Nurses for CiC receive the minutes from each CiC review and any health actions from these should be carried out, or the nurse should signpost on to the relevant health service.

ICB comments:

Action required (add additional actions if required):

	Action	By who	By when
1.			
2.			

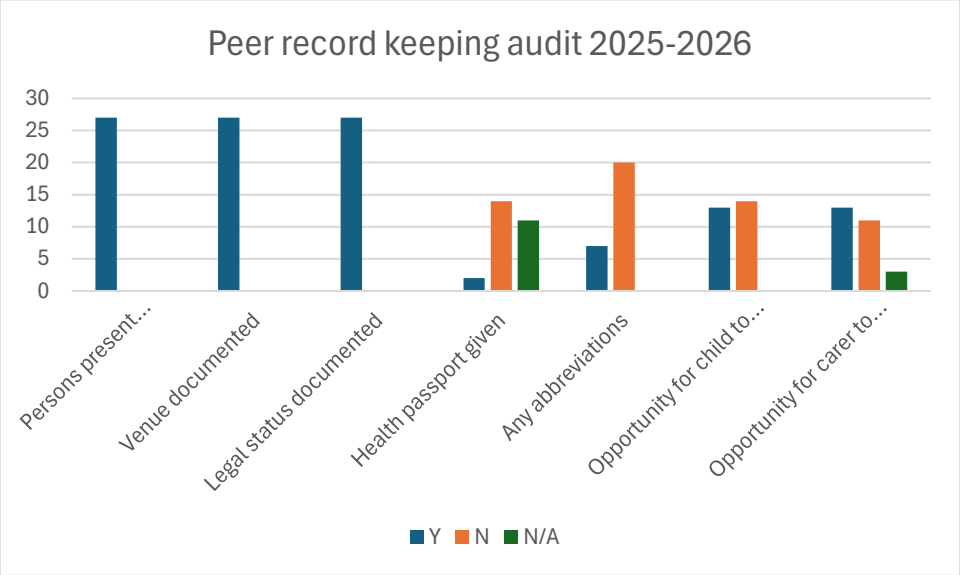
2G	**Providers can demonstrate the assessment is holistic and child centred, with evidence of assessment of physical, emotional, developmental progress and voice of every child (demonstrating equality and diversity provision eg: SEND, UASC, non-verbal children, sexuality, gender identity, ethnicity, culture). Ensuring information is considered regarding immunisation, oral health, optician checks**	
Self-assessment RAG rating		Comments: The assessment is holistic and child centred. There will be a review of the peer record keeping audit paperwork once the updated review health assessment paperwork is finalised.
ICB / peer review RAG rating	To be completed by ICB	

Evidence submitted:

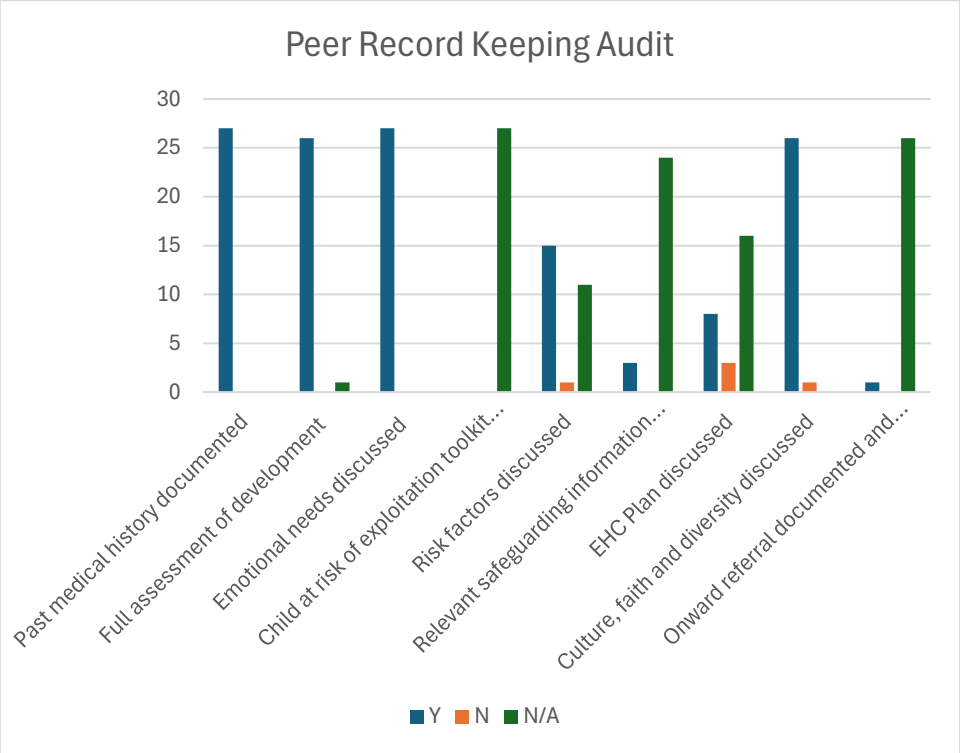
Peer Record Keeping blank upda

This was reviewed and updated in September 2025. There will be a review of the peer record keeping audit paperwork once the updated review health assessment paperwork is finalised.

Results

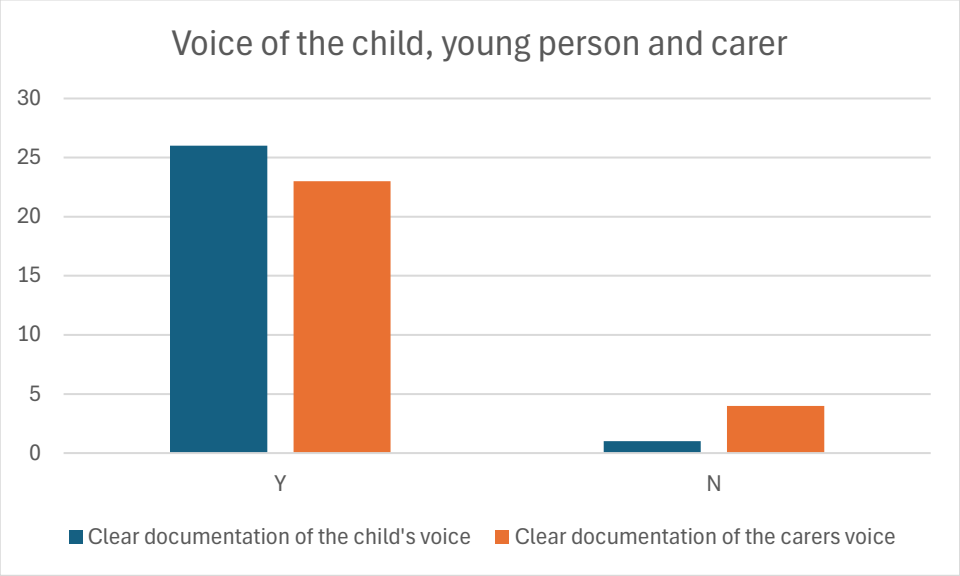


- Plan to discuss the health passports with all the team as a reminder to give these out when applicable
- Abbreviations used are known medical abbreviations for example ADHD, GP and ECG
- The reasons for the child not being offered to be seen alone was because this was not appropriate due to their age or the appointment was undertaken over the telephone. Two children were not offered to be seen alone due to their additional needs.
- The reasons for the carer not being offered to be seen alone was due to the age of the child or the young person attended alone.

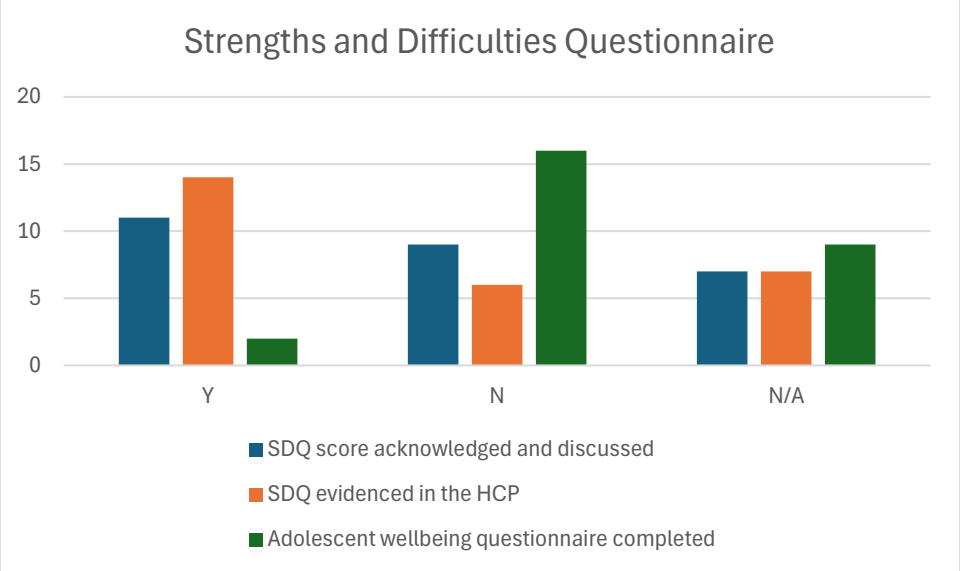


- A full assessment of development was discussed, the one that said not applicable had a note of development discussed in the Review Health Assessment about ASD and ADHD.

- Risk factors were discussed in 26 health assessments, however there was one health assessment where sexual health was not discussed, comment added sensitive subject.
- In the records where the EHC Plan was not discussed there were no comments for two of the records audited, one comment said EHC Plan information was not available.

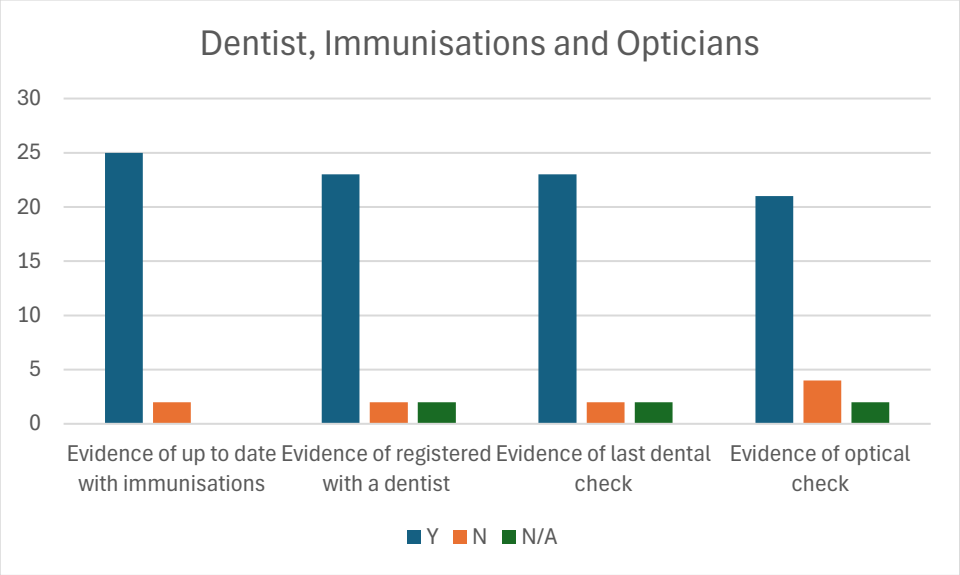


- The child's voice that was not captured was due to wishes and feelings being expressed through carer.
- There were 4 health assessments that did not capture the voice of the carer, 1 was due to the young person being seen alone, the carer was asked if they wanted to share any views however declined. The other 3 did not have reasons documented on the audit.

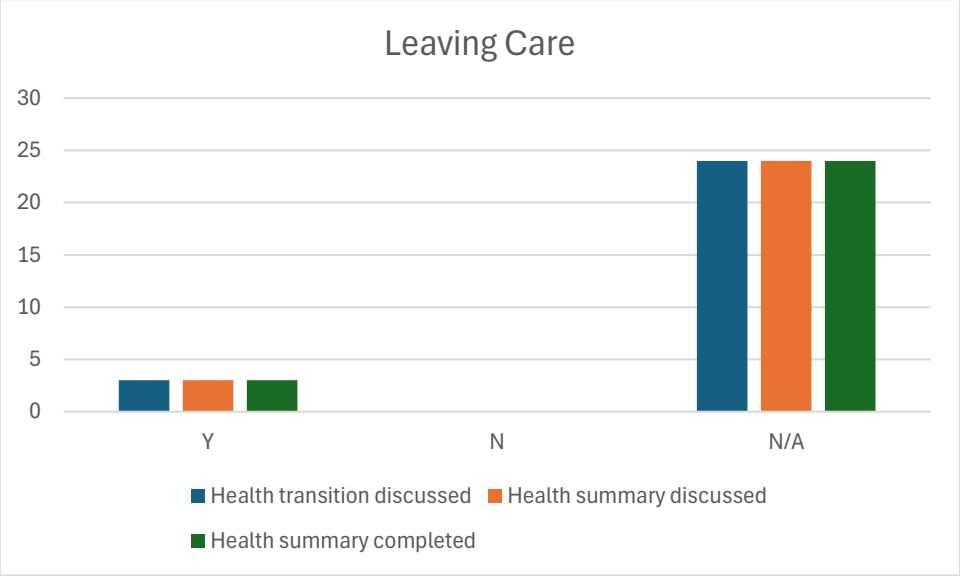


- The strengths and difficulty questionnaire score was shown to be available for 11 out of 20 review health assessments. The remaining 7 were not applicable due to the age of the child or young person.
- There was evidence of the strengths and difficulty questionnaire within the health care plan for 14 out of 20 review health assessments.
- There were only 2 out of 18 adolescent wellbeing questionnaires completed to inform the review health assessment. These forms are sent with the appointment letter for the child/young person to complete prior to the appointment and to bring the completed form with

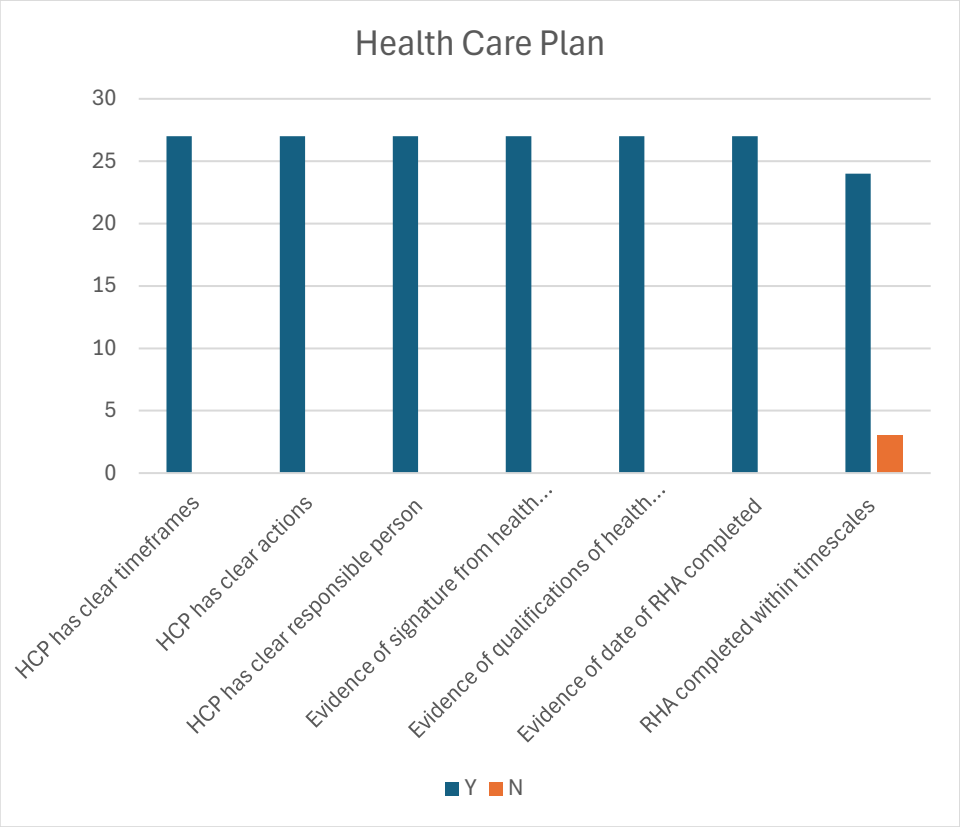
them. If it is felt that the questionnaire needs to be completed and discussed it is the responsibility of the Specialist Nurse CiC to request this is completed during the health assessment if not completed prior to the appointment. Out of the 16 not completed the adolescent wellbeing questionnaire was not returned and no concerns were raised during the health assessment.



- There was evidence of the immunisations being up to date for 25 records reviewed. For the 2 that showed immunisations were outstanding an action was evidenced in the health care plan.
- There were two health assessments where the child was not registered with a dentist, advice was given to carer.
- There were 21 health assessments that showed evidence of having an appointment with the Opticians. Out of the ones outstanding two had an appointment booked and one had declined.



- Health transition discussed where applicable and leaving care health summary discussed and completed.



- One health assessment was not completed within timescales due to a was not brought to their first appointment. There was no comment for the remaining two that were not completed within timescales.

Survey monkey:

Data Survey Monkey 2025.pdf

Q3 data.pdf

Other snapshot audits completed by the Designated Nurse CiC are shown below:

Outsanding actions from IHA to RHA Ma

IHA audit Dec 25.docx

ICB comments:

Action required (add additional actions if required):

	Action	By who	By when
1.			
2.			

Standard 3: Leadership and Working Collaboratively Designated Professionals for Looked After Children should provide advice support and supervision to Named and Specialist Professionals for Looked After Children. Working collaboratively is paramount in meeting the needs of Looked after Children and should include all partners in the Corporate Parenting responsibilities		
3A	**Named and specialist professionals working with children in care should have access to advice and support from the Designated Professionals for LAC, including both medics and nurses**	
Self-assessment RAG rating		Comments: Support is offered by the Designated Professionals and colleagues within the team as required.
ICB / peer review RAG rating	To be completed by ICB	

Evidence submitted:

Due to the continued long-term absence from our Designated Doctor the County Designated Doctor has kindly offered to support the Children in Care Doctors when required. Currently the previous Designated Doctor who had retired and returned to Community Paediatric work continues to support the Children in Care Team to quality assure the out of area Initial Health Assessments. There have been no trainee doctors to support during this financial year.

The Named Nurse for Children in Care receives quarterly Clinical Supervision from the Designated Nurse for Children in Care. The Designated Nurse for Children in Care supports all the team with any queries or concerns they may have about a child in care. If anything needs escalating from the provider to the ICB or the Local Authority this is done through the Designated Nurse CiC.

The Adoption Specialist Liaison Nurse is supported by the Named Nurse for Children in Care who provided managerial and clinical supervision as per Trust Policy and the Adoption Doctors also support and provide guidance.

The Designated Nurse for Children in Care attends our Children in Care Operational meetings which are held quarterly. The Designated Nurse CiC updates the attendees on information that is relevant during that quarter, for example numbers of children coming into care, performance and compliance, updates on projects/services relevant to children in care.

Examples of support and advice.

A Specialist Nurse for CiC was asked to complete a review health care assessment for a BOLI for a young person with complex health needs and an intellectual disability and communication difficulties. Having completed the review health care assessment for this young person for the past 3 years, I was aware it was going to be complicated and time consuming to complete and to write up, due to his ongoing complex health needs and numerous health appointments in both Derby and in Nottingham.
My previous review health care assessments completed, have been returned requesting further information to be added to the review health care assessment. This has been very time consuming to provide and, in most cases, I was not able to provide any further information than I had already sent.
The Specialist Nurse for CiC asked the Designated Nurse to check the review health care assessment before sending it, and to highlight any areas/ further information I had not provided as the Designated Nurse CiC completes Quality Assurance Checks for out of area health assessments.
The Designated nurse CiC carefully checked the review health assessment and asked me to provide further information and asked me to provide clarity on some of the areas completed.
The report once altered was then sent.
Having the Designated Nurse CiC check the report prior to being sent and them asking me to provide further information was invaluable and as a result the report did not come back for alterations. This

resulted in a reduction overall in the clinic time spent liaising with the Designated Nurse, resulting in the report being sent with no return and the amount of time taken to alter the report.

A Specialist Nurse CiC had help from both Mehwish and Sujata (CiC Drs) regarding a query concerning foetal alcohol syndrome and a pathway for diagnosis. It led to possibly more joined up work between the drs and nurses with regards to attending training/meeting for specific concerns and information sharing.

A Specialist Nurse CiC also had support from Heather (Designated Nurse CiC) regarding residents at one of the residential children's homes for complex needs and engagement of services for one young person leaving their care and another who had numerous concerns and required careful planning for further care.

The Named Nurse CiC got advice and support from the Designated Nurse CiC when concerns were raised by the two Specialist Nurses CiC who are link nurses for a residential children's home for complex needs. Support was also offered by the Safeguarding Unit at UHDB. Relevant escalations were followed to provide assurance to the Named Nurse CiC, the Designated Nurse CiC and the Named Nurse for Safeguarding Children at UHDB around actions to be followed to ensure the safety of the children living within the home and what training should be offered to the care workers.

ICB comments:

Action required (add additional actions if required):

	Action	By who	By when
1.			
2.			

3B	**The Designated Nurse for LAC should provide a minimum of six-monthly supervision for Named Nurses for children in care**	
Self-assessment RAG rating		Comments: Supervision is provided by the Designated nurse CiC
ICB / peer review RAG rating	To be completed by ICB	

Evidence submitted:

The Named Nurse for Children in Care receives quarterly Clinical Supervision from the Designated Nurse for Children in Care. The supervision covers wellbeing, team updates, other work/discussions, training, challenges/risks, case discussions and reflections.
The Designated Nurse CiC will arrange to meet with the Specialist Nurses for CiC at least twice a year.

Dates of supervision with the Designated Nurse CiC:
8th of April 2025, 14th of August 2025 and 22nd of October 2025 one planned for February 2026

ICB comments:

Action required (add additional actions if required):			
	Action	By who	By when
1.			
2.			

3C	**Specialist Nurses for LAC should receive specialist supervision (eg: safeguarding / case management / clinical). NB: this should also apply to Health Visitors completing RHAs as part of their service provision**		
Self-assessment RAG rating			Comments: Supervision is provided as Trust Policy
ICB / peer review RAG rating		To be completed by ICB	

Evidence submitted:

Supervision_Policy_and_Procedure.docx

Supervision:

Team	No. of Staff	Managerial Supervision % Compliance *	Clinical Supervision % Compliance *	Safeguarding Children % Compliance *
CICA_Admin	3	100.0%	N/A	N/A
CICA Team	5	100.0%	100.00%	100.0%
Total	**8**	**100.0%**	**100.00%**	**100.0%**

Group Safeguarding Supervision is provided to the team by the Named Nurse CiC on a three-monthly basis. Safeguarding is also discussed as part of management and clinical supervision. The team know that in any cases safeguarding can be discussed as it occurs and if the Named Nurse is not available, we have a duty line for the Safeguarding Children's Team DHcFT.

Some examples and themes for safeguarding children supervision:
01.04.25 – we discussed the DDSCP Vision. We discussed the CRE and strategy meetings process. Positive feedback around GP's being more receptive of tasks and making appointments.
ACORN Pass discussed – a nurse gave a scenario for a BOLI.
Discussed layering and criminality and not getting caught.
Discussed a recent strategy meeting for two little ones.

18.09.25 – We discussed a case of a young person who was at risk of exploitation and used the safeguarding tools to help us identify the concerns and any support in place to identify any gaps and if there is any more than can be done to support this young person.

02.12.25 - Discussed a residential children's home for children with complex needs and update on recent incidents, escalation, actions and plans. Discussed transition. Discussed UASC and healthy eating and lifestyle. We looked at a Local Child Safeguarding Practice Review from February 2024.

The Trauma Informed Navigator (TIN) has managerial and clinical supervision from a Specialist Nurse CiC as per Trust Policy. The TIN is invited to our group safeguarding supervision sessions.

Appraisals:
Appraisals are undertaken on a yearly basis for all staff. Dates are shown below -
Ailsa Kinson: 11.02.25 booked for the 21.01.26 – completed
Clare Pickering: 07.05.25
Emma Fennell: 08.01.26
Janette Beard: 02.04.25
Kimia Razaei: 22.12.25
Satvieer Dutton: 04.02.25 booked for the 21.01.26 – completed

ICB comments:

Action required (add additional actions if required):

	Action	By who	By when
1.			
2.			

3D	**Organisations can demonstrate how they access the Designated Nurse and Doctor for Children in Care and that there is an understanding of the roles and responsibilities**	
Self-assessment RAG rating		Comments: There is a plan in place to cover the long-term absence of the Designated Doctor.
ICB / peer review RAG rating	To be completed by ICB	

Evidence submitted:

Also see section 3A.

A new Designated Doctor for Children in Care was appointed in Oct 2024, with a view to start at the end of November/beginning of December. Our Named Doctor for Children in Care was successful in being appointed for this role. There had been a gap in the Designated Doctor role for approx. 18 months prior to appointing the new Designated Doctor CiC. During this time the previous Designated Doctor who had retired and returned to Community Paediatric work was supporting the Children in Care Team to quality assure the out of area Initial Health Assessments. The Named Doctor for Children in Care took on the role in supporting and supervising any trainee doctors we had during this period.

The Designated Doctor for CiC has been on long term sick leave therefore a mitigation plan is in place where the County Designated Doctor has kindly offered to support the Children in Care Doctors when required. Currently the previous Designated Doctor who had retired and returned to Community Paediatric work continues to support the Children in Care Team to quality assure the out of area Initial Health Assessments. There have been no trainee doctors to support during this financial year.

The agreed plan is for the Designated Doctor for CiC to do a phased return when a date for return has been agreed.

ICB comments:			
Action required (add additional actions if required):			
	Action	By who	By when
1.			
2.			
3E	**Provider can evidence that there is collaboration between Local Authority, Independent Reviewing Officer Service, other partners (eg: CAMHS, emotional health wellbeing services, specialist care, police, education) and across the LAC Derbyshire footprint in the best interest for the child**		
Self-assessment RAG rating		Comments: All feedback from professionals, carers and young people is gathered and any compliments are recorded on our Trust intranet compliments database.	
ICB / peer review RAG rating	To be completed by ICB		

Evidence submitted:

Feedback collated:

Feedback for MOGP 2025-26.docx

Feedback received from a carer following a Specialist Nurse CiC supporting a young person around healthy lifestyle:

Yes, I thought it went really well.

The young person is booked in with the GP on the 3rd of Feb at 3.30 🙂

They spoke very highly and positively of you. And came away beaming from the meeting. I think that's broken the barrier down a bit that they were able to feel vulnerable and felt heard.

All feedback is recorded on our Trust compliments site.

ICB comments:			
Action required (add additional actions if required):			
	Action	By who	By when
1.			
2.			

3F	Provider can evidence that they foster a culture of supporting their staff (within the CIC / Health Visitor teams) in relation to their emotional resilience, health/wellbeing and flexible working, in order to ensure the staff have psychological safety.	
Self-assessment RAG rating		Comments: Staff wellbeing is supported by the Trust, and we have a wellbeing champion in the children in acre team and have regular wellbeing sessions planned throughout the year.
ICB / peer review RAG rating	To be completed by ICB	

Evidence submitted:

Wellbeing Champion –

We are very fortunate to have a wellbeing champion in our team. See below some information around the role of the wellbeing champion.

A paragraph provided from our wellbeing champion:
I have continued with the role of well-being champion over the last year and continue to enjoy being able to share Trust updates to our team via regular emails, usually fortnightly. I put these together to reach out to the team, to check in, ask if anyone needs anything and add some mindfulness quotes, affirmations and any pieces of advice that have been shared via the Trust or through champion meetings/champion channel (through MST). I have shared information about managing stress, daily movement, grounding techniques and am always encouraging staff to look at what sessions are available to book on over the month via the Trust.

As part of my emails, I try and do a 'light-hearted blog', often citing briefly what I have been up to. I just try and be down to earth, humorous and offer a bit of reading for the team to encourage them to 'take 5' out of their day to have a read, have a laugh and have access to information they might find useful.

I try to set dates over the year for monthly sessions which can be face to face or via MST. These are well received by staff.

It is planned over the next couple of months to offer a session on self-massage that I attended through the Trust myself and really valued and I thought it would be nice to offer out to the team with the recording I have from my session.
The team seem keen to do this 😊

I continue to try and keep the wellbeing board updated with the Trust information and sessions available on the seasonal timetable and change things round a little every once in a while.

I am also planning to start a wellbeing 'pamper basket' in the office: To start a collection of small items that might be nice for staff to have access to, to take whatever they might need at the time, whether it be hand cream, a chocolate bar, tissues, or a tea bag for a much needed brew. Just a little basket of 'thoughtfulness' to help keep the team looking after themselves.

I offered a slideshow presentation to my lead and designated nurse to deliver at the development day in November and some extras to make it fun.

Further sessions that I plan to book into the diary for this year include:

- Deep breathing
- Creative session (art/painting)
- Quiz
- Tea/coffee and cake

- Bingo
- Walk

The Trust offer support to all staff members through groups and counselling. They have a wellbeing team which all staff have access to.

We also have a freedom to speak up guardian with champions throughout the Trust, and training on this is part of our mandatory training passport.

ICB comments:

Action required (add additional actions if required):

	Action	By who	By when
1.			
2.			

Standard 4: The child's experience and journey
Health providers can demonstrate the 'voice of the child' and have arrangements in place to promote a culture, where looked after children are listened to and take into account their views according to their age and understanding.
Children and young people's vulnerabilities and risks are considered, acted upon and followed up in line with local safeguarding procedures and statutory guidance.

4A	**The provider can evidence that feedback has been sought from children and young people about the experience of having a health assessment (both IHAs and RHAs) and forms any improvements following feedback and/or suggestions**	
Self-assessment RAG rating		Comments: we continue to offer the survey monkey to gather feedback for both Initial and Review Health Assessments. Currently the Trust are reviewing the friends and family questionnaire for gathering feedback from service users.
ICB / peer review RAG rating	To be completed by ICB	

Evidence submitted:

Survey monkey – see previous sections for data from the survey monkey questionnaire.

See previous feedback attached in section 3E

The Trust is currently working on improving how it gathers and uses feedback. As part of this, the existing Friends and Family questionnaire used to collect feedback from service users is being reviewed.

Staff survey – staff are asked to complete the staff survey yearly and feedback is provided and distributed to all staff on what is going well and areas for improvement. We discuss this at our Lead meetings which take place monthly.

ICB comments:

Action required (add additional actions if required):			
	Action	By who	By when
1.			
2.			

4B	**The provider can demonstrate that children and young people (and carers, where appropriate) have been consulted if there are any changes to service delivery or introduction of new child centred services**	
Self-assessment RAG rating		Comments: The child friendly annual report has been shared with the Local Authority. More improvements could be made to consult children and young people. The plan is to gather feedback from children and young people about the updated Review Health Assessment paperwork once drafted.
ICB / peer review RAG rating	To be completed by ICB	

Evidence submitted:

Child annual report

Child annual report 2024-25.pub

Annual Report 2024-2025

2024-2025 Final Annual Report for D

The Named Nurse and Designated Nurse for CiC attend the Corporate Parenting Committee meeting once year to present information around the Annual Report.

The annual report is feedback at the Corporate Parenting Committee, representation from the Children in Care Council attend this meeting.

ICB comments:

Action required (add additional actions if required):			
	Action	By who	By when
1.			
2.			

4C	The provider can demonstrate that young people leaving care receive a final RHA within timescales and a Leaving Care Health History Summary	
Self-assessment RAG rating		Comments: Health History Summaries are monitored, and a process is in place to ensure health history summaries are completed within a timely manner. A process is in place to track LCHS to ensure none are missed.
ICB / peer review RAG rating	To be completed by ICB	

Evidence submitted:

Due to the MOGP being submitted before the end of Q4 I have captured the number of leaving care health history summaries up to the 22.01.25:

Leaving Care Health Summary numbers are shown below from April 2025 – 22.01.26:

HH summaries	Quarter	Number
	Q1	16
	Q2	18
	Q3	18
	Q4	9

We complete all LCHS for children and young people born in Derby City wherever they are placed. Since August 2024 one of our admin has been running a monthly clinical report to identify any LCHS that are due or have not been completed. This has helped improve the numbers of completed LCHS and identified ones that have been missed. The leaving care team have also sent reminders over the past year for any that we have missed.

ICB comments:

Action required (add additional actions if required):

	Action	By who	By when
1.			
2.			

4D	The organisation can demonstrate and provide assurance that the Children in Care Health Teams/Health Visiting Teams are able to identify safeguarding/risk, adhere to relevant policies and procedures and act in the best interest of the child and recorded on the child's record	
Self-assessment RAG rating		Comments: Safeguarding supervision is undertaken as per Trust Policy.
ICB / peer review RAG rating	To be completed by ICB	

Evidence submitted:

Safeguarding supervision is provided to all CiC Nurses by the Named Nurse using a cascade model. Group Safeguarding Supervision is provided on a 3 monthly basis and safeguarding will also be discussed at each managerial and clinical supervision where relevant. We always use an open-door method when it comes to safeguarding and the CiC Nurses are encouraged to discuss any

safeguarding concerns they may have as they arise. See section 3C for some themes discussed during group safeguarding supervision.

The Named Nurse has safeguarding supervision on a 3 monthly basis with the Head of Safeguarding Children DHCFT.

Dates for Named Nurse:
24.02.25
19.05.25
22.07.25
18.08.25
24.11.25

Risk Assessment:
Representatives from Children's Services have been involved in a working party to adapt a Risk assessment which has been added to S1 clinical tree – the plan is for the risk assessment to be completed after each contact and updated and each contact. To be used from Jan 2025. This will be evaluated to identify and improvements to this template.

Relevant safeguarding policies can be found on the Derby and Derbyshire Safeguarding Children Partnership website – staff are aware and will use this if required.

ICB comments:

Action required (add additional actions if required):

	Action	By who	By when
1.			
2.			

4E	**The organisation can demonstrate their service provision is flexible and adapts to the individual needs of the child, young person**	
Self-assessment RAG rating		Comments: Flexibility is offered where possible and adjustments are made on individual needs.
ICB / peer review RAG rating	To be completed by ICB	

Evidence submitted:

The Children in Care Nursing Team provides flexibility in both timing and location to support children and young people in completing statutory health assessments or interventions.

Initial Health Assessments (IHA)
These are carried out by a medical advisor in a clinic setting. In exceptional situations, such as when a young person declines a face-to-face appointment, a telephone or virtual consultation may be offered, followed by a physical examination at a later date or signposted to their GP. If the young person continues to refuse to attend a paper review will be completed by the medical advisor. Chaperones are available if needed for a face-to-face contact during a physical examination.

Review Health Assessments (RHA)
These are usually completed face to face, either in a clinic or home setting, unless an alternative venue is necessary. If a young person prefers a telephone or virtual appointment, the Specialist

Nurse for Children in Care will determine whether this is appropriate based on individual circumstances and will arrange any required follow up in a clinic setting.

If an interpreter is needed the social worker will typically arrange this.

All professionals involved must ensure that any additional needs are considered before appointments are scheduled.

The service acknowledges that some children and young people may require appointments outside of standard hours, particularly during exam periods or other critical stages of their education. While we strive to accommodate these requests wherever possible, our ability to do so is limited by existing working hours and staff patterns. Priority will be given to those with exceptional educational needs, and all requests will be considered on a case-by-case basis. Therefore, in January 2026 the named nurse and the admin coordinator drafted a paragraph to add to appointment letters as below:

'If your appointment needs to be rearranged, please be aware that an after-school appointment is not always possible. Should the school require evidence of the appointment, kindly provide them with a copy of the appointment letter as confirmation.'

An email has been sent to the virtual schools to inform and to request any information they may have around schools marking down on attendance due to health appointments. Awaiting a response.

Feedback can be seen in section 3E

ICB comments:

Action required (add additional actions if required):

	Action	By who	By when
1.			
2.			

4F	**The organisation can demonstrate the impact of their service provision on the health outcomes and/or management of risk and additional vulnerabilities for children and young people**	
Self-assessment RAG rating		Comments: All meetings where an invite is received is attended by a health representative. We have joint pathways with the DHCFT Children's Safeguarding Unit to ensure these meetings are represented by health.
ICB / peer review RAG rating	To be completed by ICB	

Evidence submitted:

Number of strategy meeting numbers:

Q1	15
Q2	27

Q3	11

Number of vulnerable children meetings attended:

Q1	15
Q2	13
Q3	6

Pathway with the safeguarding team on attendance at strategy meetings:


Born Out Live In Strategy Pathway (B(


Children in Care Strategy Meetings f(

A Health Exchange Form is completed prior to any strategy meetings. All minutes received are attached to the child's electronic health record.

The Specialist Nurses CiC will attend child at risk of exploitation meetings when invited and will provide health reports prior to the meetings. All minutes received are attached to the child's electronic health record.

ICB comments:

Action required (add additional actions if required):

	Action	By who	By when
1.			
2.			

Standard 5: Governance, quality assurance and clinical audit
Health providers can demonstrate appropriate organisational governance, assurance that the needs of Looked After Children are being met by producing clear data collection and audit and analysis of care provided

5A	**The organisation can provide evidence of the clinical governance arrangements which demonstrates that the LAC service is considered, evaluated and that the performance is monitored in line with the Service Specification and statutory guidance**	
Self-assessment RAG rating		Comments: Discussions continue regarding the low volume activity. This issue has been escalated within the Trust
ICB / peer review RAG rating	To be completed by ICB	

Evidence submitted:

Dashboard information – a quarterly dashboard is submitted by the Trust to the Integrated Care Board.

Discussions have taken place regarding the low volume activity to ensure appropriate funding is allocated for Initial Health Assessments and Review Health Assessments completed for children placed within a 20-mile radius, as well as children who are born out living in (OLAC). We have seen an increase over the past few years particularly for born out lives in children, and further discussions have been held to review demand versus capacity. This issue has been escalated within the Trust.

Annual Report

2024-2025 Final Annual Report for D

The Named Nurse attends the CiC Commissioning meetings held by the Local Authority where performance is discussed as a standard agenda item. The Named Nurse CiC attends the Safeguarding Operational Meetings, the Children's Clinical Reference Group and the Named and Designated meetings.

ICB comments:

Action required (add additional actions if required):

	Action	By who	By when
1.			
2.			

5B	**The organisation can provide evidence of clinical audit arrangements to assure the quality of the health services for LAC and demonstrate the impact of these audit findings, implementing recommendations for LAC outcomes or experience**	
Self-assessment RAG rating		Comments: Audits continue throughout the year. The doctors are keen to take part in audits during 2026-2027
ICB / peer review RAG rating	To be completed by ICB	

Evidence submitted:

See previous audit.

Audit template - UASC health needs .

Gps and rel audit Jan 25 (002).docx

Outsanding actions from IHA to RHA Ma

ICB comments:

Action required (add additional actions if required):

	Action	By who	By when
1.			
2.			

5C	**The Provider can provide evidence their adherence to General Medical Council (GMC), Nursing Midwifery Council (NMC), Health and Care Professionals Council (HCPC) and NHS guidance on record keeping, information governance and sharing of information**		
Self-assessment RAG rating			Comments: Quality of record keeping is audited through the continuous quality audits through the Trust Dashboard. There is guidance around information sharing available to all staff and processes in place.
ICB / peer review RAG rating	To be completed by ICB		

Evidence submitted:

The Trust have continuous quality audits which are completed by each service to audit the quality of record keeping. Five audits are completed by each service monthly through a dashboard of set questions. Themes for improvement are identified after completing each individual audit. The themes are feedback to the Children's Head of Nursing with actions for improving record keeping. The updated audit questions have been available through the dashboard over the past year and is completed monthly. The main areas for improvement identified over the last year are for groups and relationships to be up to date, ensuring any historical groups and relationships that are no longer relevant are ended. If another organisation has added the groups and relationships you need to end, a request must be sent to the organisation to ask them to end the historical groups and relationships that are no longer applicable.

During each health assessment it is the responsibility of the health professional to discuss information sharing and obtain consent to share information, which is relevant, appropriate on a need-to-know basis. Even if someone consents to sharing information, the child/young person can ask for parts of it to be kept private. Private means that only a small number of people can see this information. The health care professional can talk to them about this, and who could then see the information. All children and young people need to be informed that if there are any safeguarding risks identified that these will be shared appropriately with the relevant professionals. The health care plan is shared with the Local Authority, GP, carer, child, and young person following a health assessment.

Previously, the admin would task the GP if they're on S1 to let them know they have uploaded an RHA/IHA – this has changed, and admin now task the safeguarding lead if there is an option to do so due to the number of tasks the GP receives. If it's a letter for the GP and they're on S1 admin

electronically send it direct to them. If not on S1 admin hybrid mail it. If admin is requesting a share from the GP, they will call the GP and get their email address and then request a share via email.

Any information to be shared with the Social Worker is sent via email direct to them as they have secure emails.

Sharing information can be found on the Trust intranet accessible to all who work within DHcFT.

The Trust are currently working towards the phase 2 rollout of CPIS.

ICB comments:

Actions required (add additional actions as required):

	Action	By who	By when
1.			
2.			

Delivery of Same Sex Accommodation (for noting and approval)

Purpose of Report

The report provide assurance on the Delivery of Same Sex Accommodation against the regulation and report on incidents for the year 2025/26.

Executive Summary

This report provides assurance on the Trust's compliance with national requirements for delivering same-sex accommodation during 2025/26.

No mixed-sex accommodation breaches were recorded between 1 April 2025 and 31 March 2026. Four related complaints were received concerning the Trust's approach following the April 2025 Supreme Court ruling and alleged discrimination; all were investigated and none were upheld.

Compliance is supported through proactive bed management, strengthened escalation arrangements, regular review of capacity and demand, incident monitoring, local quality audits and practice observations. Incidents are reviewed under the Patient Safety Incident Review Framework, with safeguarding review where required. The Trust has updated its relevant policy following the Supreme Court ruling.

NHS England's Privacy, dignity and safety in hospital accommodation guidance was published on 15 October 2026, which replaces the 2019 Delivering Same Sex Accommodation guidance. The Trust policy has been updated in line with the new guidance.

The Board of Directors is asked to take full assurance on the Trust's delivery of same-sex accommodation and recommend the annual Declaration of Compliance to the Board.

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

There is lack of clear guidance and following the change in the law, this has been mitigated by setting out clear escalation and legal support when required.

Consultation

- Patient Experience team
- Care Groups
- Clinical Quality Directorate
- Patient Safety team
- Quality and Safeguarding Committee, 10 October 2026.

Governance or Legal Issues

- CQC regulation
- Equality Act 2010
- Privacy, Dignity and Safety in Hospital Accommodation.

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:

- There is lack of guidance following the changes in the law
- Reviews are conducted on an individual case informed by risk assessment to ensure that risk of discrimination is minimised.

Recommendations

1. The Board of Directors is requested to receive full assurance on the Delivery Same Sex Accommodation in the Trust
2. Approve the publication of the Declaration of Compliance.

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

Report prepared by: **Libby Runcie**
Deputy Director of Nursing and Patient Safety

Delivery of Same Sex Accommodation

The purpose of this report is to provide the Board of Directors with a summary of the Trust position for the financial year 2025/26 regarding compliance with NHS England (NHSE) requirements to eliminate Mixed Sex Accommodation (MSA) breaches within all inpatient areas and compliance with national 'Delivering same-sex accommodation' guidance (NHS, 2019) and assurance against the regulations.

Proactive bed management strengthened escalation processes and consistent review of capacity and demand pressures are in place with clear lines of escalation to the executive triumvirate. Learning from each incident is conducted through the Patient Safety Incident Review Framework and this is supported by safeguarding reviews where required.

Mixed sex accommodation breaches 2025/26

Maintaining same sex accommodation is central to safe, respectful and person-centred Inpatient care.

Between the period 1 April 2025 and 31 March 2026, there have been zero breaches.

Patient experience

The Trust has a policy entitled "Policy for Community and Inpatient services on the Care and Support of Transgender and Gender Non-conforming Service Users and Staff". The Policy was based on national guidance Delivery of Same Sex Accommodation (2019). The policy was updated following the Supreme Court ruling in April 2025 Women Scotland v Scottish Ministers.

There were four complaints related to same sex accommodation in the period between 1 April 2025 and 31 March 2026. The complaints were due to dissatisfaction with the Trust approach in line with the Supreme Court ruling and alleged discrimination. All four complaints were investigated and they were not upheld.

NHS England's Privacy, dignity and safety in hospital accommodation guidance was published on 15 October 2026, which replaces the 2019 Delivering same-sex accommodation guidance. The guidance sets out expectations for NHS organisations to provide hospital accommodation that protects every patient's privacy, dignity, safety and wellbeing, while meeting individual care needs. It supports the NHS Constitution's pledge to eliminate mixed-sex accommodation and provides a framework for staff making accommodation decisions.

The related policy; the Policy for Community and Inpatient Services on the Care and Support of Transgender and Gender Nonconforming Service Users and Staff, has been updated and is now in use.

Declaration of compliance

The Board is required to publish an annual declaration on the Delivery of Same Sex Accommodation. The Board of Directors is requested to review the declaration and publish as recommended by the Quality and Safeguarding Committee:

Declaration of Compliance

Derbyshire Healthcare Foundation Trust is pleased to confirm that we are compliant with the Government's requirement to eliminate mixed-sex accommodation. We continue to offer and improve our Inpatient facilities, resources and culture to ensure that patients that are admitted to our hospitals and specialist Inpatient units will only share the room where they sleep with members of the same sex and that same-sex toilets and bathrooms will be close to their bedroom area where there are no ensuite facilities.

The organisation has mixed gender wards and the accommodation is compliant in the delivery of same sex accommodation requirements.

How do we monitor compliance of our standards?

We monitor compliance through a variety of local and service line actions, these include, bed management and gate keeping, monitoring of Datix incidents and reports, local quality audits and observations within practice.

What do I do if I think I am admitted to accommodation that does not comply with the Government standards?

Talk to your named Keyworker. If this does not resolve your concerns, you can ask to speak to the Patient Experience team, dhcft.patientexperience@nhs.net.

Executive Director of Nursing, Allied Health Professions, Quality and Patient Experience.

Infection Prevention and Control (IPC) update and Board Assurance Framework (BAF)

Purpose of Report

The purpose of this paper is to provide assurance to the Board of Directors that effective IPC arrangements are in place across the Trust.

Executive Summary

This paper provides assurance on IPC arrangements across the Trust, drawing on the May and August 2026 IPC meetings and the NHS England (NHSE) Midlands IPC assurance review undertaken on 21 September 2026. The review resulted in de-escalation from enhanced to routine monitoring and support, identified no immediate risk to patient safety and confirmed that a sustainability review will take place within six to nine months.

The identified improvements relate to environmental and estates controls and consistent hand hygiene and Bare Below the Elbows compliance. A Matron-led action plan will be monitored through the Trust IPC meeting and aligned to the IPC BAF and the Health and Social Care Act Code of Practice.

Audit oversight identified compliance risks requiring continued action. In August, 14 of 90 teams were overdue for hand hygiene audits and eight of 63 Community teams were overdue for IPC audits, largely linked to outdated assurer details and process clarity. Recurring themes included sharps-box misuse, wristwatches and jewellery and inconsistent waste segregation. Actions include updating assurer registers, clarifying clinical and non-clinical audit requirements, moving Inpatient audit frequency from weekly to monthly through Nexus and strengthening visual guidance and escalation.

Preparedness and infrastructure have strengthened. DRLC Ltd is now appointed as the Trust's Authorising Engineer for ventilation, providing independent technical advice and assurance against HTM 03-01.

All medical devices have been serviced, highly communicable infections disease (HCID) response kits are being deployed to key sites, and FFP3 fit testing will initially focus on Inpatient Band 6 and 7 staff before wider rollout. The 2026/27 flu campaign has a frontline healthcare worker uptake ambition of 48.6%, rounded to 49%, representing a five percentage point improvement on 2025/26 uptake of 43.6%.

Delivery will be Peer Vaccinator-led, supported by the Physical Health Hub, Pharmacy, the existing Derbyshire Community Health Services service level agreement, central and roving clinics and targeted communications.

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	1E	1.1
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X	1E	
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X	1E	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	1E	4.1

Risks and Assurances

Risks

- **Audit compliance:** 14 teams were overdue for hand hygiene audits and eight Community teams were overdue for IPC audits in August 2026; outdated assurer details contributed to non-completion
- **Sharps and waste management:** Recurrent incorrect disposal and low waste-management training compliance require clearer guidance, training oversight and monitoring
- **External review findings:** NHSE Midlands identified further improvement requirements relating to environmental cleaning, estates maintenance, water safety, storage arrangements, signage, waste management and consistent hand hygiene and Bare Below the Elbows compliance across all professional groups. Although no immediate patient safety risk was identified, sustained delivery is required ahead of the planned sustainability review
- **Workforce immunisation:** Outstanding immunisation and screening requirements remain, and exposure data requires continued triangulation between Occupational Health and incident systems
- **Seasonal and HCID readiness:** Fit testing and HCID-kit access require completion. Flu delivery risks include timely release of Peer Vaccinators, cold-chain capacity, vaccine transport to sites without daily deliveries, stock visibility across multiple fridges, data reconciliation and the consistent recording of vaccination offers to eligible inpatients and patients discharged to care homes.

Assurances

- **Infection surveillance:** One *C. difficile* case and no MRSA cases were reported in Q1 2026/27, with records confirmed as accurate and up to date
- **Training:** Mandatory IPC training compliance is 97%, with Level 2 IPC training compliance at 88%
- **Medical-device assurance:** All devices have been serviced, with drop-in arrangements for missed equipment and an annual programme in place
- **Emergency preparedness:** HCID equipment kits have been assembled for key sites and trained fit-testing capacity is available to support phased FFP3 rollout
- **External IPC assurance review:** NHSE Midlands recognised strong ward-level ownership and accountability, compassionate and patient-centred care, and generally clean and welcoming clinical environments. Improvements since the previous review resulted in de-escalation from enhanced to routine monitoring and support, and the findings were assessed as presenting no immediate risk to patient safety

- **Improvement oversight:** A comprehensive Matron-led action plan will address all areas for improvement, with progress monitored through the Trust IPC meeting and aligned to the IPC BAF and the Health and Social Care Act Code of Practice. A sustainability review is planned within six to nine months
- **Seasonal vaccination:** The 2026/27 programme has a 48.6% frontline healthcare worker uptake ambition, rounded to 49%. ESR identifies 1,876 frontline staff, equating to approximately 919 staff vaccinations at the planned uptake level. A total of 1,200 doses has been ordered, providing capacity for projected staff uptake and eligible patient vaccination, subject to active stock and wastage monitoring.

Consultation

- Health Protection Unit
- Heads of Clinical Practice
- Matrons
- NHSE Midlands IPC assurance review team
- Quality and Safeguarding Committee, 10 October 2026.

Governance or Legal Issues

- IPC Board Assurance Framework (BAF)
- Health and Social Care Act 2008 code of practice
- Water safety HTM 04-01
- Ventilation safety HTM 03-01
- National IPC guidance from the United Kingdom health Security Agency and NHSE (UKHSA/ NHSE),

Net Zero Duty Implications

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

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

N/A.

Public Sector Equality Duty & Equality Impact Risk Analysis

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

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

The report does not identify any direct equality or health inequality impacts. IPC arrangements, audits and controls apply consistently across all services and staff groups. No adverse impact on protected characteristics has been identified.

Recommendations

The Board of Directors is requested to:

1. Receive the outcome of the NHSE Midlands IPC assurance review and note the Trust's de-escalation to routine monitoring and support
2. Agree the proposed significant assurance rating and ongoing monitoring through routine IPC reporting arrangements, including preparation for the sustainability visit within six to nine months.

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

Report prepared by: **Joseph Thompson**
Associate Director of Physical Health and Quality

Infection Prevention and Control (IPC) update and Board Assurance Framework (BAF)

This paper reports measurable IPC outcomes, current gaps and delivery controls against the IPC BAF, national guidance and statutory standards.

External IPC assurance review

Outcome: NHS England (NHSE) Midlands undertook an IPC Assurance Review visit on 21 September 2026 across the Radbourne, Carsington and Tissington Units. The review recognised strong ward-level ownership and accountability, compassionate and patient-centred care, and generally clean and welcoming clinical environments. Improvements since the previous review resulted in the Trust being de-escalated from enhanced to routine monitoring and support, with a sustainability review planned within six to nine months.

Areas for improvement include environmental cleaning, estates maintenance, water safety, waste management and storage, signage and consistent compliance with hand hygiene and Bare Below the Elbows standards across all professional groups. These findings present no immediate risk to patient safety. A comprehensive action plan will be developed by the Trust's Matrons and monitored through the Trust IPC Meeting to provide assurance that actions are implemented and sustained in alignment with the IPC BAF and the Health and Social Care Act Code of Practice. It is expected these improvements will in place and reflected at the sustainability review.

Water, ventilation and environmental safety

Outcome:

- DRLC Ltd has been appointed as Authorising Engineer for ventilation, providing independent assurance against HTM 03-01
- Bluebell ventilation and mould concerns have been resolved, with continuous fan operation and ongoing monitoring
- Patient-Led Assessments of the Care Environment inspections will cover all sites between 1 September and 23 November 2026
- A heatwave response plan is being developed for implementation before summer 2027, with consideration of vulnerable groups and sustainable cooling solutions.

IPC risks and assurance

Measured position: 51 of 53 IPC BAF domains are compliant and two are partially compliant, supporting Substantial Assurance. Mandatory IPC training is 97% and Level 2 IPC training is 88%. Priority improvement areas are Level 2 training, audit completion, environmental controls and workforce immunisation.

Workforce outcome: 259 immunisation or screening requirements were outstanding in Q1, 2026/27, including 160 pre-placement cases. Future reporting will separate current staff from pre-placement requirements. 10 blood and body-fluid exposure incidents were managed within required timescales; Occupational Health and incident data are being reconciled.

The IPC BAF has been reviewed by the Quality and Safeguarding Committee.

Q1 2026/27 surveillance	April–June 2026	Assurance position
Clostridioides difficile	1	Single case reported on Bluebell Ward; no outbreak concern identified.
MRSA bacteraemia	0	No cases reported.
Reporting assurance	Confirmed	Communicable-disease log reconciled with incident reporting and assessed as accurate and current.

Audits and compliance

Measured position: 14 of 90 teams were overdue for hand-hygiene audits and eight of 63 Community teams were overdue for IPC audits in August 2026. Assurer details are being corrected, overdue teams followed up and persistent non-compliance escalated. Inpatient audit frequency is changing from weekly to monthly to improve completion and proportionality.

Sharps and waste management: Audit themes remain incorrect sharps disposal, watches and jewellery, and waste segregation. Controls are refreshed visual guidance, Pharmacy clarification on medicine disposal, spot checks and escalation. Waste-management training is approximately 20%; scope and mandatory status are being clarified for routine reporting.

Preparedness and equipment: Highly contagious infection diseases (HCID) kits are assembled for five key sites and more than 160 trained fit testers are recorded. FFP3 rollout will start with Inpatient Band 6 and 7 staff. All identified medical devices have been serviced, with annual servicing and catch-up arrangements in place.

Policy and governance updates

Policy outcome: IPC policies are being consolidated into core and enhanced documents covering standard precautions, outbreaks, isolation, HCID response, FFP3 responsibilities and kit locations. Completion is monitored through quarterly IPC governance. All policies are in date.

Flu campaign

Measured ambition: Increase frontline healthcare-worker uptake from 43.6% to 48.6% (rounded to 49%). The denominator is 1,876 staff, requiring approximately 919 vaccinations. The Trust has ordered 1,200 doses.

Delivery outcome: The campaign runs from 1 October 2026 to 31 March 2027, with most vaccinations planned by 30 November. Peer Vaccinators, walk-in and bookable clinics, roving support and Derbyshire Community Health Services (DCHS) access will provide local and shift-compatible delivery.

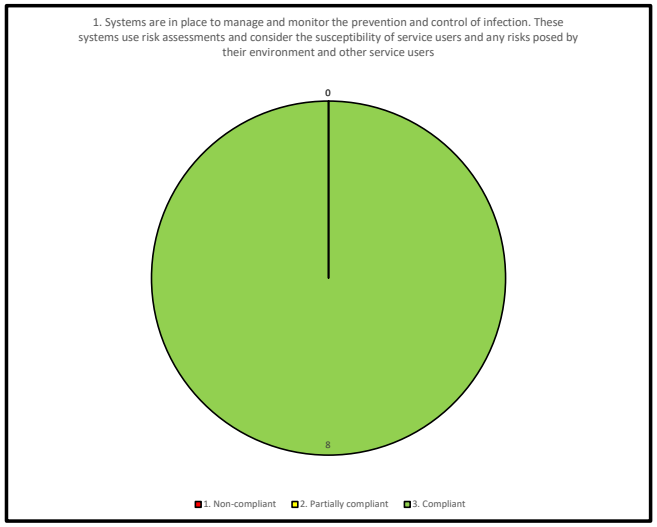
Monitoring: Uptake will be reviewed weekly during peak delivery through record a vaccine services (RAVS), ESR, federated data platform (FDP) and local reconciliation. The trajectory is 20% by end October, 34% by end November, 42% by end December, 46% by end January and 48.6% by end February, maintained through March.

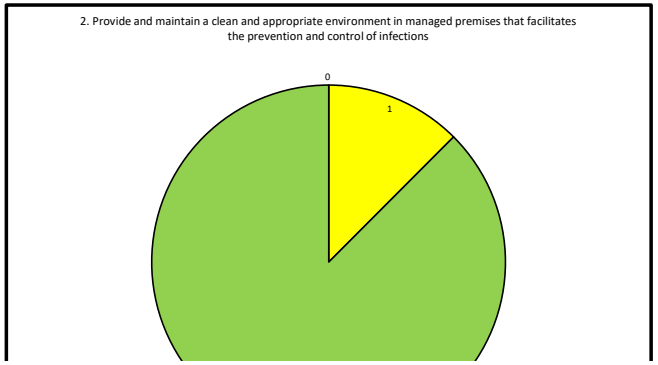
Controls: Pharmacy and the Flu Vaccination Steering Group will monitor stock, cold chain, transport, wastage and data quality. Eligible long-stay inpatients and patients discharged to care homes will have vaccination offers and outcomes recorded through ward review, discharge documentation and planned SystmOne functionality.

Flu campaign measure	2026/27 position
Frontline staff uptake ambition	48.6%, rounded to 49%, compared with 43.6% in 2025/26.
Planning denominator	1,876 frontline healthcare workers; approximately 919 vaccinations required to achieve 49%.
Vaccine supply	1,200 doses ordered for projected staff uptake and eligible patient vaccination, subject to active stock, transport and wastage monitoring.
Delivery period	1 October 2026 to 31 March 2027, with the majority of vaccinations planned by 30 November 2026.
Indicative cumulative trajectory	20% by end October; 34% by end November; 42% by end December; 46% by end January; 48.6% by end February; maintained through March.
Delivery model	Peer vaccinators, local and roving clinics, walk-in and bookable appointments, Physical Health Hub support and DCHS access.
Governance and reporting	Weekly peak-period oversight through the Flu Vaccination Steering Group, using RAVS, ESR, FDP and local reconciliation, with escalation through Trust Delivery Group and relevant governance routes.

Infection Prevention and Control board assurance framework v5.0

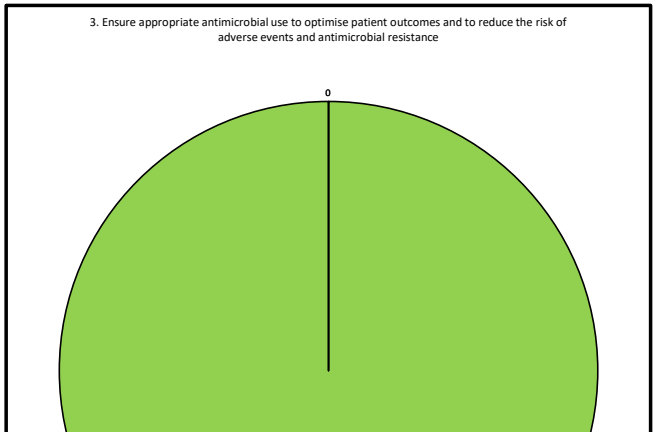
	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them						
Organisational or board systems and process should be in place to ensure that:						
1.1	There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	The Trust has a quarterly Infection Control Committee, chaired by the Trust's Associate Director of Physical Health and Quality (ADPHQ). This committee reports to the Quality and Safeguarding Committee.	None	The System IPC SAG and regional NHSE IPC meetings are attended by the ADPHQ. Updates, findings and regional assurance requirements are	N/A	3. Compliant
1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	Infections are reported through the DATIX system.	None.	The System IPC SAG and regional NHSE IPC meetings are attended by the	N/A	3. Compliant
1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	Incidents are reported through the DATIX system, and IPC incidents are flagged to the IPC link nurse for support. Clinical records are reviewed in liaison with the nursing and medical teams.	None.	Incidents reported via the pathology laboratory or other sources are checked by the IPC team to ensure they are logged on DATIX.	N/A	3. Compliant
1.4	They implement, monitor, and report adherence to the NIPCM.	Clinical records are reviewed in liaison with the nursing and medical teams. Incidents are shared with and overseen by colleagues in IPCSAG,	None.	IPCSAG and CQRG provide feedback on Trust compliance	N/A	3. Compliant
1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	Surveillance is routinely undertaken, and AMR prescribing and infection rates are monitored at Trust and system level.	None	IPCSAG provides feedback on Trust compliance and reporting standards. The AMR monitoring group and Schedule 4 reports also	N/A	3. Compliant
1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	An audit framework is in place, with oversight by PHCIC and IPCSAG.	None	IPCSAG provides feedback on Trust compliance and reporting standards. The AMR monitoring group and Schedule	N/A	3. Compliant
1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	All staff undertake Level 1 training, and clinical staff undertake Level 2 training.	None		A Matrons' IPC masterclass was held in January 2026, facilitated by NHSE to support knowledge and development.	3. Compliant
1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings)	The Physical Health Hub and ADPHQ are available to support teams in undertaking local risk assessments. Infection control link nurses also provide local support.	None	The infection link worker forum is embedded.	N/A	3. Compliant
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections						
System and process are in place to ensure that:						
2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	National Cleaning Standards are displayed as per guidance for all ward areas.	None	N/A	N/A	3. Compliant
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.	The programme was undertaken in 2025/26 and is scheduled for delivery in 2026/27.	None	N/A	26/03/2026: Site visits were undertaken in 2025; a good standard was met, as reported in February 2026.	3. Compliant
2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	The equipment cleaning policy identifies roles and responsibilities for cleanliness, and audits provide assurance against compliance with standards.	Recent audits have highlighted gaps in frequency of checks.	Enhanced oversight o	Gaps are still identified in repeat	2. Partially compliant



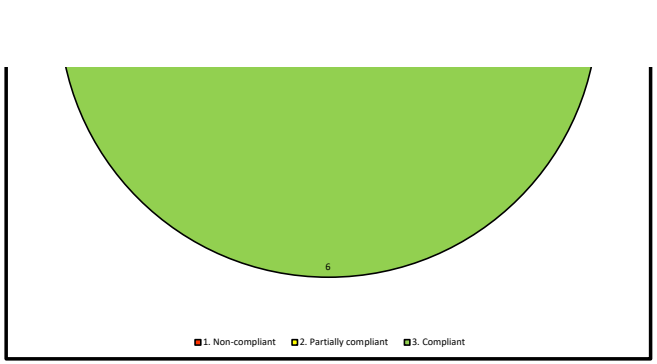


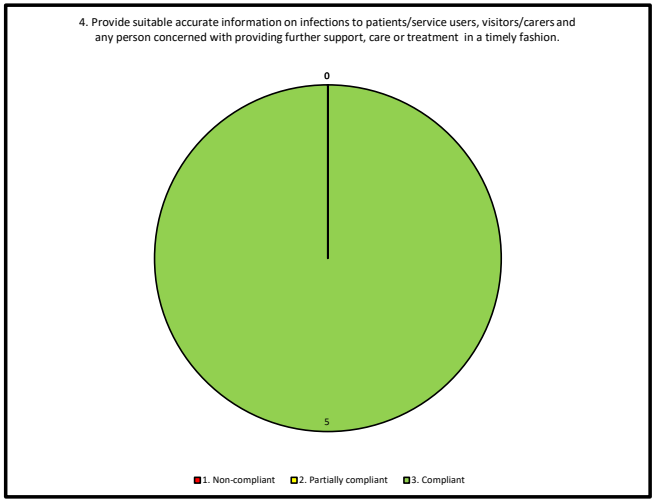
2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	Monitored by the estates and facilities team; assurance checks are reported to the Statutory standards meeting as of 2026 and escalated to the Health and safety lead. oversight is done vis the ADPHQ via the IPC meeting.	None	N/A	N/A	3. Compliant
2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	The IPC lead is included in the Radbourne Unit development programme, and assurance checks for key stages of building development are requested and reviewed as required.	None	N/A	N/A	3. Compliant
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	The laundry contract is managed by an external provider and reviewed by housekeeping services, with input from thephysical health Clinical lead	None	N/A	N/A	3. Compliant
2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	Safe disposal of healthcare waste is managed in accordance with current regulations.	None	N/A	N/A	3. Compliant
2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06.	N/A to DHCFT setting	N/A	N/A	N/A	0. Not applicable
2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.	Processes are in place for the labelling and storage of foodstuffs brought in for service users, and these are checked by staff. Food hygiene training (Levels 2 and 3) is available, and attendance and compliance are monitored.	N/A	Review of incidents a	N/A	3. Compliant
3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance						
Systems and process are in place to ensure that:						
3.1	Ensure clarity of responsibility for AMR within governance responsibilities, including how antimicrobial stewardship (AMS) aspects of Care Quality Commission (CQC) Regulation 12 to prevent individuals from receiving unsafe care and treatment and prevent avoidable harm or risk of harm.	The Trust attends the regional AMS group, reports to the Schedule 4 oversight group for AMS prescribing and attends IPCSAG. The Medicines Management Committee and IPC Committee also review performance, with a biannual oversight report (within the physical health update paper) sent to QSCG.	None	N/A	N/A	3. Compliant
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.	Included within the Medicines Management and PH/IPC annual reports.	None	N/A	N/A	3. Compliant
3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan. A formal operational lead for AMS is in post with time in their job description. Monitor patterns and trends of sentinel infections and antimicrobial use, the impact of early, accurate diagnosis and intervention upon outcomes and lengths of stay. Where there is variation with other providers which requires attention, develop plans to address unwarranted variation and to support National AMR Plan ambitions.	The Medical Director is the identified lead for AMR prescribing.	None	N/A	N/A	3. Compliant



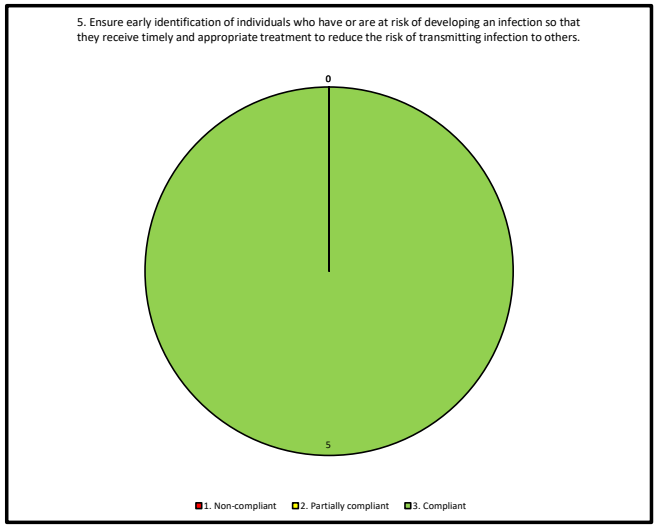


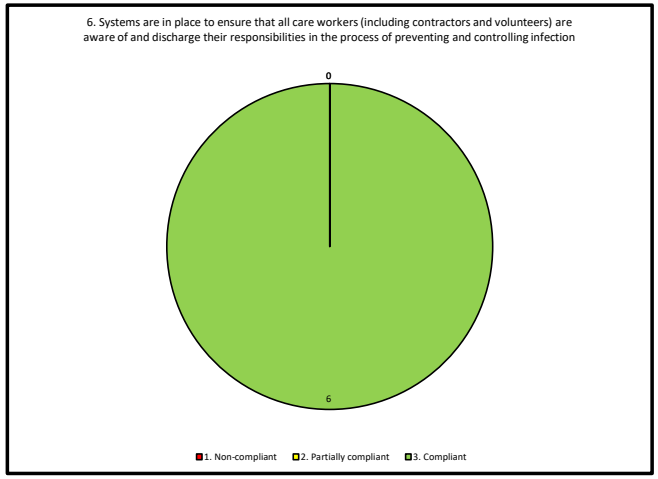
3.4	To optimise patient outcomes and minimise inappropriate prescribing: • Monitor and improve compliance with NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' • Ensure adherence to the principles of Start Smart, Then Focus is implemented and monitored in secondary care. • Ensure AMS is included in mandatory training using national materials such as 'Start Smart, Then Focus' and 'Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET)'.	The Trust is a low-volume prescriber; however, tracking streams are utilised in accordance with locally agreed system-level priorities.	None	N/A	N/A	3. Compliant
3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMS are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: • total antimicrobial prescribing. • broad-spectrum prescribing. • intravenous route prescribing. • treatment course length.	Schedule 4 compliance is monitored via the system-level CQRG.	None	N/A	N/A	3. Compliant
3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)	DHCFT works with local partners and reports against locally agreed high-priority areas.	None	None	Incident levels within the Trust a	3. Compliant
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion						
Systems and processes are in place to ensure that:						
4.1	Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	IPCSAG and the AMR group coordinate locally agreed annual action plans and areas of high incidence or prevalence. DHCFT monitors performance in accordance with these local targets.	None	N/A	N/A	3. Compliant
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (eg digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate.	Information leaflets related to treatment or conditions are provided and available in a range of formats.	None	N/A	N/A	3. Compliant
4.3	The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.	Local signage and community meetings are used to discuss locally implemented IPC measures. Face masks and hand hygiene facilities are available for service users as required.	None	N/A	N/A	3. Compliant
4.4	Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include: •hand hygiene, respiratory hygiene, PPE (mask use if applicable) •Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (eg cleanliness) •Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. •Provide published materials from national/local public health campaigns (eg AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors and advocates to minimise the risk of transmission of infections.	Cleaning standards are displayed. PPE and IPC support measures are available and checked, signage is in place, and community meetings are used to discuss local measures or provide advice. Community rates are monitored, with escalation plans in place if an increased risk of transmission is detected.	HCID PPE requirements are being explored across mental health providers to identify the most appropriate and proportionate approach.	Community meetings and proactive contact take place when an infection is identified. The Trust is working with NHSE and local providers to ensure HCID preparedness complies with the training package released in 2025.	N/A	3. Compliant



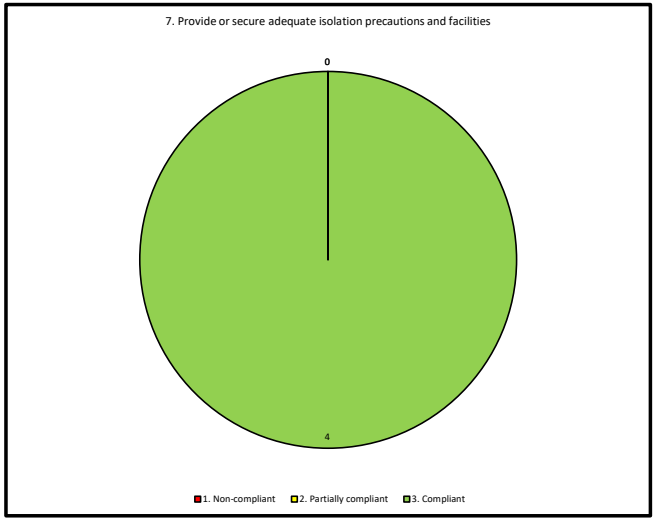


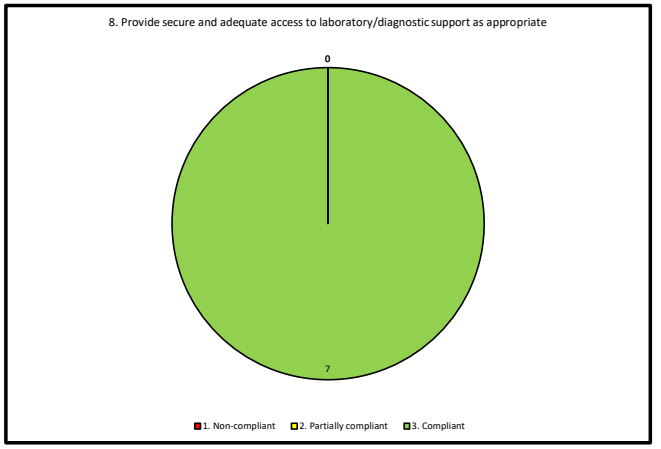
4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.	Signage and emergency signage are available at all sites. Service user care plans are implemented as required when a suspected or confirmed infection is detected.	None	N/A	N/A	3. Compliant
5.Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.						
Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM:						
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.	Screening processes are in place on admission to inpatient care settings.	None	N/A	N/A	3. Compliant
5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes. The Isolation prioritisation tool is available to assist in patient placement and ongoing isolation decisions.	NEWS2 and symptomatic monitoring are undertaken by the clinical team providing care to the patient.	None	N/A	**N/A**	3. Compliant
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	Pertinent clinical information is handed over when a patient transfers to or from the organisation.	None	The SBARD system is	N/A	3. Compliant
5.4	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	Signage appropriate to the care setting is displayed.	none	Signage checks again	The care setting is mental health	3. Compliant
5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	Infectious incidents are monitored and traced by HPU with oversight and monitoring processes implemented accordingly.	None	N/A	Pre-emptive monitoring is provi	3. Compliant
6.Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection						
Systems and processes are in place to ensure:						
6.1	Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	IPC training, link nurses and policies are all focused on improving understanding of SICPs and when to escalate to TBPs, based on local dynamic risk assessment.	None	Regular communicati	N/A	3. Compliant
6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	IPC training is monitored via performance reports across all divisions.	None	N/A	N/A	3. Compliant
6.3	Monitoring compliance and update IPC training programs as required.	As above	None	N/A	N/A	3. Compliant
6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	As above	None	N/A	N/A	3. Compliant
6.5	That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	Staff who undertake AGP procedures are routinely fit tested as per H and S requirements.	None	N/A	Changes to national guidance resulted in the removal of the requirement for all inpatient staff to undergo FFP3 mask fit	3. Compliant
6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	Any additional training requirements are identified and supported by the Training and Development Team.	None	N/A	N/A	3. Compliant
7. Provide or secure adequate isolation precautions and facilities						
Systems and processes are in place in line with the NIPCM to ensure that:						

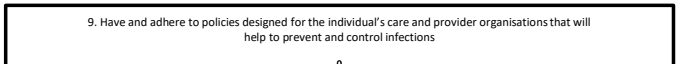




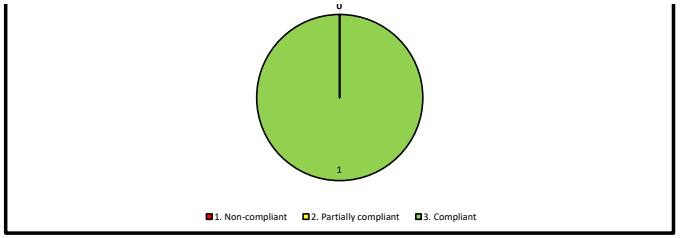
7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	Screening and support processes are in place, with advice available from HPU regarding the treatment, cohorting and management of individuals and groups as required.	None.	Post-incident reviews	N/A	3. Compliant
7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: •single rooms are in short supply and if there are two or more patients with the same confirmed infection. •there are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	Appropriate cohorting arrangements are available across all areas, with flexibility to support either infectious patients or those who need enhanced protection (e.g. NMABS-eligible patients), proportionate to the risks presented.	None	N/A	N/A	3. Compliant
7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	TBP measures are available to be stepped up as required in all settings.	None	N/A	N/A	3. Compliant
7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	DHCFT is compliant with this guidance, in accordance with national and locally agreed protocols.	None	N/A	N/A	3. Compliant
8.Provide secure and adequate access to laboratory/diagnostic support as appropriate						
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:						
8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	DHCFT is compliant with this guidance.	None	N/A	N/A	3. Compliant
8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	DATIX records are cross-referenced with pathology laboratory records for patients involved with DHCFT. The local IPC network supports reviews of patients who have moved between providers to identify the lead provider	None	N/A	N/A	3. Compliant
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.	Pathology laboratory services are provided by a local acute provider; specialist monitoring for clozapine blood tests is provided under a separate contract.	None	N/A	N/A	3. Compliant
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	DHCFT is compliant with current testing protocols.	None	N/A	N/A	3. Compliant
8.5	Patients/service users who develops symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.	DHCFT is compliant with current testing protocols.	None	N/A	N/A	3. Compliant
8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens.	DHCFT is compliant with current testing protocols and has arrangements in place through IPCSAG and EPRR to step up testing when required or directed.	None	N/A	N/A	3. Compliant
8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	DHCFT is compliant with current testing protocols.	None	N/A	N/A	3. Compliant
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections						

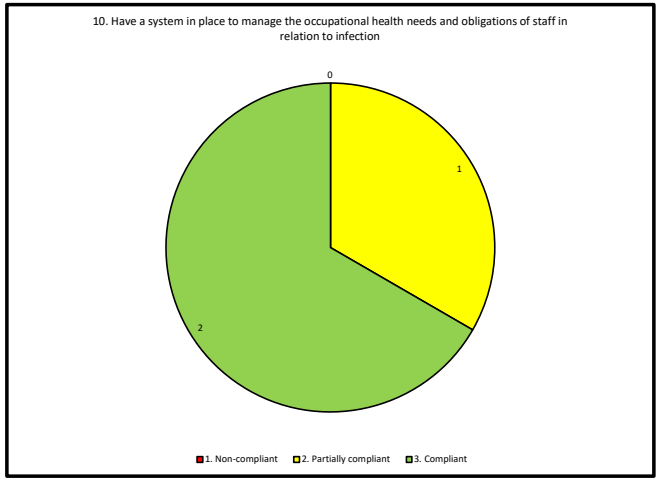






9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA, NIPCM including the NHSE A to Z pathogens list). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident by the registered provider. The SICPs monitoring tool can be applied to aid this process.	DHCFT has policies in place for common and known infections. EPRR processes are in place for new and emerging infections.	The new and emerging virus policy is under review and requires completion and sign-off.	Policy in place.	N/A	3. Compliant
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection						
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:						
10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	Processes are in place with local management teams and are supported by OH services in accordance with current national protocols.	None	N/A	N/A	3. Compliant
10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	Processes are in place with local management teams and are supported by OH services in accordance with current national protocols.	None	N/A	N/A	3. Compliant
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	Processes are in place with local management teams and are supported by OH services in accordance with current national protocols.	MMR checks identified a number of colleag	N/A	N/A	2. Partially compliant





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

Learning from Deaths report – Quarter 2 (Q2), 2026/27

Purpose of Report

The 'National Guidance on Learning from Deaths' requires each trust to collect and publish specified information on a quarterly and annual basis. This report covers the period Q2, 2026/27.

The Board of Directors is requested to accept this report as assurance of the Trust's approach and agree for the report to be published on the Trust's website as per national guidance.

Executive Summary

This report provides an overview of mortality and learning from deaths during Q2, 2026/27. The Trust received 466 notifications of deaths, representing a reduction from the previous quarter. Of deaths reported through Datix, 37 were unexpected, nine were suspected suicides and three were expected/end-of-life deaths.

The report provides evidence of continued improvement in the Trust's Learning from Deaths processes. 18 learning responses were completed during the quarter, identifying recurring learning around dynamic risk assessment, transitions and clinical ownership, access and waiting pathways, information sharing, family and carer involvement, management of complex needs, clinical documentation and mental capacity.

There has been a continued reduction in the backlog of learning responses, with overdue responses reducing from 22 to 12, alongside reductions in both the average and longest periods overdue. Overdue patient safety recommendations have also reduced by 40%, with no outstanding recommendations remaining from before 2025.

Overall, the report demonstrates improving operational oversight of mortality reviews, learning responses and resulting actions. However, outstanding learning responses and delays in obtaining cause-of-death information from partner organisations remain areas requiring continued oversight. Therefore, the Board is asked to accept the report with limited assurance and agree its subsequent publication.

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

Risks and Assurances

- This report provided limited assurance to the Quality and Safeguarding Committee that the Trust is following recommendations outlined in the National Guidance on Learning from Deaths, owing to delays in learning response completion and overdue learning recommendations. This presents a risk that opportunities for learning and improvement are not identified in a timely manner
- No concerns have been noted in relation to mortality data.

Consultation

- Learning themes and improvements around learning response and safety recommendation have been presented to the Medical Directorate referenced within the Patient Safety report for Q2, 2026/27, which contains commentary and analysis of all patient safety incidents, whereas this report speaks only of deaths
- This report has been reviewed by the Executive Medical Director, and areas of feedback have been addressed prior to submission
- Quality and Safeguarding Committee, 12 November 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.

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

Derbyshire Healthcare
NHS Foundation Trust

Learning from Deaths report

Quarter 2, 2026/27

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WE MAKE A POSITIVE DIFFERENCE IN EVERYTHING WE DO

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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 July 2026 to 30 September 2026.

2. Current Position and Progress

This section of the report will provide an overview of DHcFT's current position and areas of progress in relation to its mortality review process and procedure.

- As reflected through the data contained within this report, the Trust is demonstrating continuous improvement in reducing overdue learning responses and patient safety recommendations resulting from deaths
- Cause of death information is currently being sought through the coroner offices in Chesterfield and Derby but only a very small number of cause of deaths have been made available
- Medical examiner offices at acute trusts provide independent scrutiny of non-coronial deaths, including those in the community. They carry out a proportionate review of medical records and liaise with doctors completing the Medical Certificate of Cause of Death (MCCD). They give families and next of kin an opportunity to ask questions and raise concerns. There is an agreement in place for cause of death information to be released to the DHcFT Patient Safety team for patients open to our service in the six months prior to their death. This agreement is in place with University Hospitals of Derby and Burton (UHDB) and Chesterfield Royal hospital (CRH) via working relationships between the corresponding Patient Safety teams

  This has been slow to come into force due to numerous technical issues for the varies electronic patient record (EPR) systems and a shortage of medical examiners. We have escalated the delay to the Integrated Care Board (ICB) Patient Safety Lead. Plans are still being pursued to meet with the representatives from UHDB and CRH to seek a resolution. If the issue remains unresolved, the Patient Safety team will escalate this to the Director of Nursing to be raised on the ICB Risk Register
- Regular audits continue to be undertaken to ensure compliance with policy and procedure for the reporting of red flag deaths. This includes auditing complaint data against names of deceased patients to ensure this meets the requirements specified in the national guidance. The last audit was completed 15 October 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 EPR, which aids staff in identifying deaths which meet the threshold for Datix reporting. This process fulfils stage one of the Learning from Deaths procedure
- Trust-wide and Care Group Learning the Lessons meetings aim to triangulate learning across a broader spectrum of sources, including mortality, Patient Safety Incidents (PSIs), Patient Experience, clinical audit and clinical research. The Trust-wide Learning the Lessons forum hold oversight and governance for the dissemination and embedding of learning post-incident and feed key information and directives to the care group Learning the Lessons groups to inform and drive forward quality improvement programmes across the Trust
- The Learning the Lessons meeting Terms of Reference are due to be reviewed to iterate and improve this governance meeting in light of stakeholder feedback
- DHcFT's Regional Mortality Review Network continues to see great representation from other external partner agencies across the region. Our last meeting focused around use of AI to support learning from mortality data and PSIs.

3. Data Summary of all Deaths

The following table outlines the number of notification of deaths received for the period:

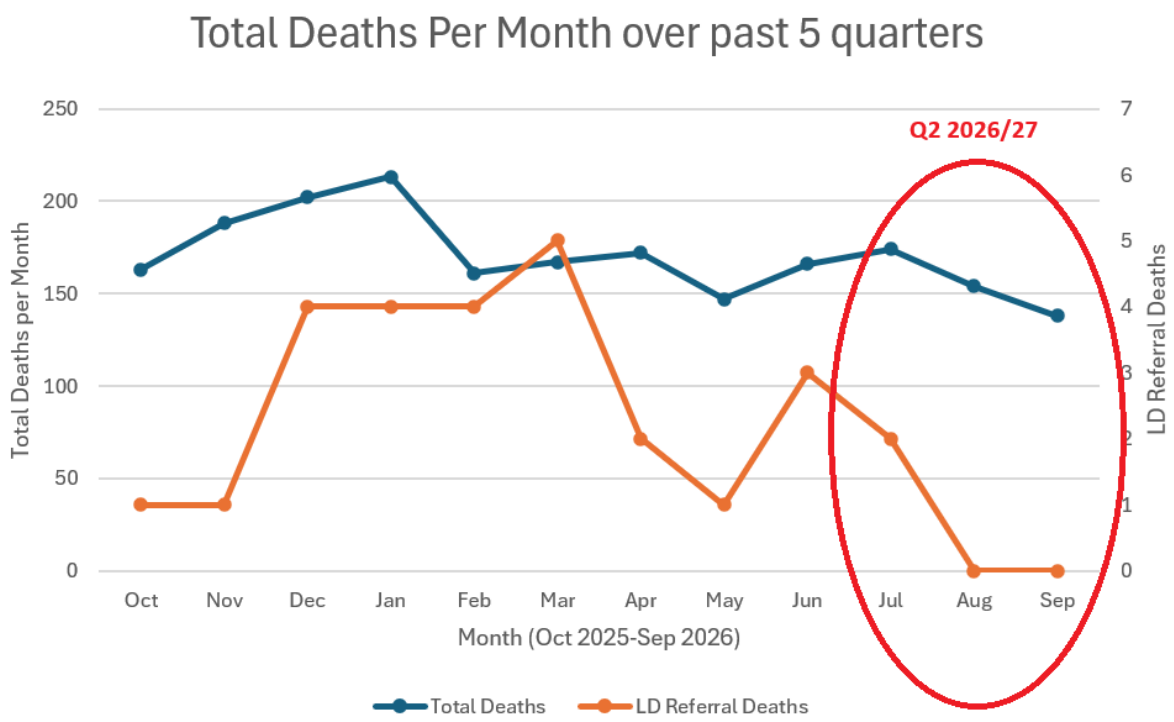
	Jul	Aug	Sep
Total Deaths Per Month	174	154	138
LD Referral Deaths	2	0	0

*Correct as of 19 October 2026

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

Between 1 July 2026 to 30 September 2026, the Trust received 466 notifications of death of patients who had been in contact with our services or discharged within six months of the incident. Of these deaths, 243 patients were male, 223 female. 368 were white British and 42 Other Ethnic Groups. The youngest age was zero years (in Community Paediatrics), the oldest age recorded was 99. The Trust has reported two LD deaths in the reporting timeframe.

The chart below demonstrates total deaths (blue line, left axis) and LD referral (orange line, right axis) over the period of October 2025-September 2026:



Overall, total deaths for Q2, 2026/27 are 4% lower than compared to Q1, 2025/26 and LD referral deaths have been 66% lower than Q1, 2025/26. Total deaths reported across the past five quarters show a reducing rate since the winter period. LD death data has increased from previous reporting periods over December 2025 to March 2026 as our Mortality database has been updated.

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 July 2026 to 30 September 2026 reported on Datix.	37 “Unexpected deaths”
	Nine “Suspected Suicide deaths”
	Three “Expected - end of life pathway” *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.*
Incidents assigned for a review.	41 incidents assigned to the Operational Incident Review Group (IRG).
	Eight incidents assigned to the Executive IRG.

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

Four inpatient deaths were reported during the period of 1 July 2026 to 30 September 2026:

Incident form Ref	Incident Subcategory	Outcome of Patient Safety Review:
W124092	Expected death - end of life pathway	Lady in her mid-80s. receiving end of life care for Alzheimer's disease. 'Incident Review Tool' reviewed by Operational Incident Review Group. Incident closed to Patient Safety team as natural progression of illness/condition.
W125624	Suspected suicide - ligature	Reviewed by Operational Incident Review Group. Patient Safety Incident Investigation (PSII) commissioned. Due date of 3 February 2027 set.
W124105	Suspected suicide - overdose	Reviewed by Operational Incident Review Group. Patient had been discharged from the Acute Inpatient ward one month prior to death. Case Record Review commissioned. An extension date has been approved for the learning response to be submitted by 19 November 2026.
W125154	Unexpected death - medical condition/natural causes	Gentleman in his late-70s, presentation of mixed Alzheimer's and vascular dementia. 'Incident Review Tool' reviewed by Operational Incident Review Group. Patient had been transferred to the acute hospital in response to physical deterioration before the death. Incident closed to Patient Safety team with assurance having been provided that the ward team responded appropriately to physical deterioration.

Learning from commissioned patient safety learning responses will be reflected in future publications of this report.

6. Learning Responses for 1 July 2026 to 30 September 2026

The table below outlines the number of deaths that have been recorded through the Trust incident reporting system Datix and the learning response that has been commissioned. All deaths reported through the Datix system meeting the Trust 'red flag' will have an Incident Review Tool completed. This is then reviewed, and a decision made as to whether a further Learning Response is required.

Financial Year	Datix	Case Record Review	Patient Safety Incident Investigation	After Action Review	MDT Review	Assurance Review	Other Patient Safety
2023/24	119 deaths	39	16				
2024/25	141 deaths	23	3				
2025/26	255 deaths	28	7				
2026/27	100 deaths	9	5	3	2	3	1

Please note: two deaths are currently awaiting a decision.

This indicates that for 77% of the total deaths so far within the period of July to September 2026 the completed Incident Review Tools provided assurance that there were no concerns with care that warranted the commissioning of a Learning Response.

7. Duty of Candour (DoC) for 1 July 2026 to 30 September 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 July 2026 to 30 September 2026, there were no deaths which met the criteria for DoC. It should be noted there are Learning Responses for this period which remain active and therefore, DoC figures change.

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

One death has been identified during this financial year as DoC having occurred during 2025/26. The Trust continues to support the families involved in engagement with patient safety incident response. The table below provides an overview with narrative around the nature of the DoC and improvement work in place to address this:

No	Incident Date	Date DoC confirmed	Narrative
1	23/06/2025	31 July 2026	**Has regulation 20 been completed?** Yes, apology, explanation and Patient Safety Incident Investigation were shared with patient's sister on 31 July 2026. The Trust has offered to meet with the family to apologise in person and feedback the learning and improvement actions from the incident. Patient safety improvement areas: • Review and update risk assessment pro forma relating to risk formulation to ensure guidance aligns with Trust training. • Strengthen multidisciplinary participation in clinical decision making. • Strengthen induction processes for newly qualified staff, preceptees and international recruits. • Strengthen staff awareness of fundamental policy & procedure. • Strengthen staff confidence around confidentiality and consent to share or receive information with/from families.

8. Learning from Deaths Procedure

Following implementation within the EPR which aids staff in identifying deaths which meet the threshold for Datix reporting, the Patient Safety team continues weekly random audits for deaths against the red flags to provide assurance that the new process is working as intended. This process fulfils stage one of the Learning from Deaths in that all deaths are considered for red flags as identified under the national Learning from Deaths procedure.

The Patient Safety team has developed an Incident Review Tool (IRT) audit process which will be allocated to Medical 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.

This proposal is due to be presented to the Medical Senate for agreement and to establish a plan around implementation. We expect this to be up and running by the end of November 2026. Once live, data from this audit process will be reflected within future publications of this report.

9. Analysis of Data

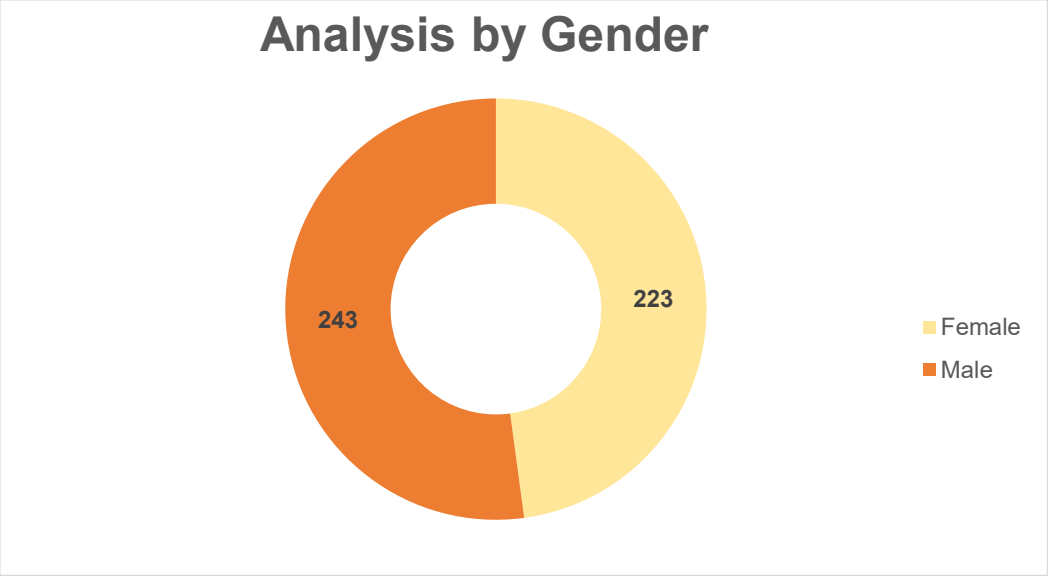
9.1. Analysis per notification system since 1 July 2026 to 30 September 2026

EPR System	Number of Deaths
SystmOne	466
Grand Total	**466**

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

9.2. Analysis by Gender

The data below shows the total number of deaths by gender 1 July 2026 to 30 September 2026. 223 female deaths were reported. compared to 243 males:

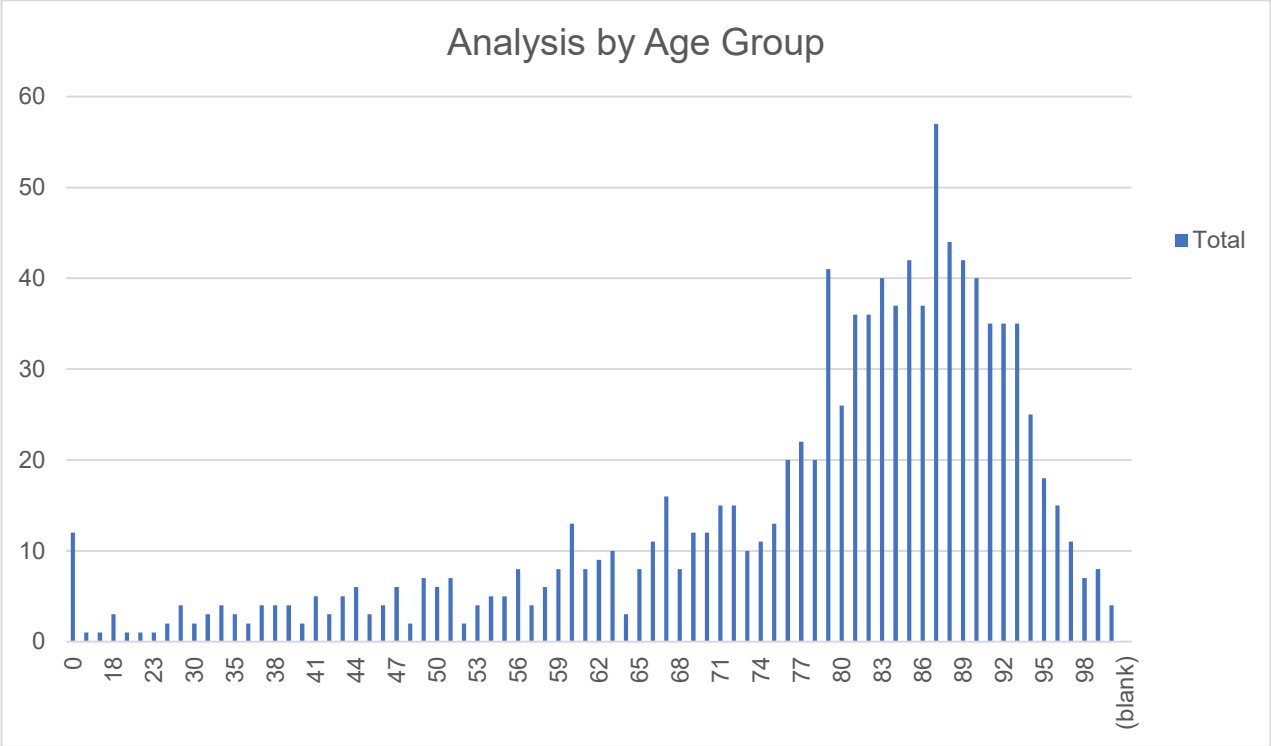


Gender	Number of Deaths	%	Open Referrals to DHcFT
Male	243	54%	48%
Female	223	46%	52%
Grand Total	**466**		

There has been very little variation in data from the previous publication of this report, with males having a marginally higher mortality rate than females. The data indicates that males are marginally over-represented in mortality data for Q2, 2026/27 compared with open referrals to DHcFT. This will be further monitored in future publications of this report, with consideration for deeper analysis should the trend continue.

9.3. Analysis by Age Group

The youngest age was classed as zero (in Community Paediatrics), and the oldest age was 99 years. Most deaths occurred within the 83 to 89 age groups – this is largely consistent with our previous report.

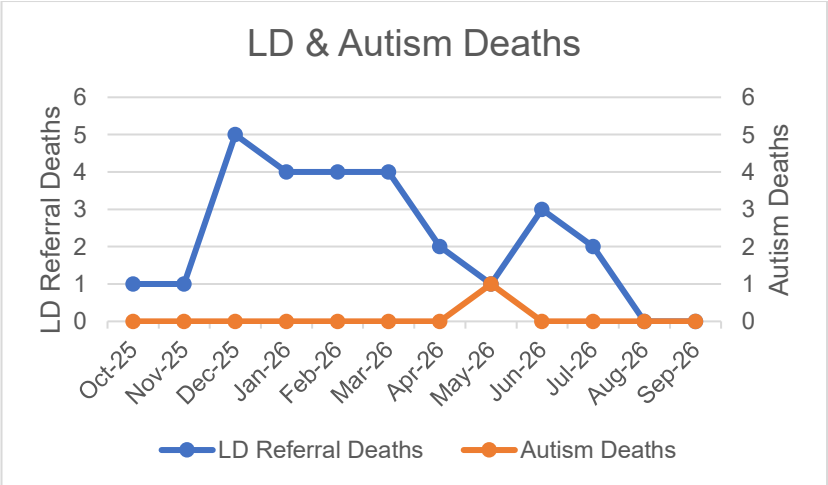


The data indicates that most reported deaths correlate with mortality rates related to natural aging. 12 deaths were associated with babies aged zero years and under, and only nine of these were associated with Trust's Health Visiting services. These cases related to babies who were open to Health Visiting services in anticipation of transfer from Midwifery services provided by another organisation but were not actively receiving care from the Trust.

9.4. Learning Disability (LD) Deaths

The Trust reviews all deaths relating to patients diagnosed with a 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.

	Jul	Aug	Sep
LD Deaths	2	0	0
Autism	0	0	0



During, 1 July 2026 to 30 September 2026, the Trust has recorded two LD deaths. Of these two deaths, one was reported through the Trust's Datix system.

Data over the past four quarters shows consistently low numbers of LD and Autism deaths, with greater variation observed in the LD deaths over time.

9.5. Analysis by Ethnicity

White British is the highest recorded ethnicity group with 368 recorded deaths; 42 deaths were from Other Ethnic Groups. The following chart outlines all ethnicity groups, representing the number of deaths, the percentage of total deaths and a comparison to the number of total open referrals to DHcFT:

Ethnicity	%	Open referrals to DHcFT
Asian or Asian British - Any other Asian background	0%	1%
Asian or Asian British - Bangladeshi	0%	0%
Asian or Asian British – Indian	1%	1%
Asian or Asian British - Pakistani	1%	1%
Black or Black British – African	0%	1%
Black or Black British - Any other Black background	1%	0%
Black or Black British - Caribbean	0%	0%
Mixed - Any other mixed background	0%	1%
Mixed - White and Asian	0%	1%
Mixed - White and Black African	0%	0%
Mixed - White and Black Caribbean	0%	1%
Not Known	5%	4%
Not stated	1%	1%
Other Ethnic Groups - Any other ethnic group	10%	15%
Other Ethnic Groups – Chinese	0%	0%
White - Any other White background	2%	2%
White – British	78%	71%
White – Irish	2%	0%

The data shows that deaths by ethnicity are largely proportionate with the demographic profile of all patients open to DHcFT, with the exception of White British groups who are slightly over-represented mortality data.

9.6. Analysis by Religion

Not religious is the highest recorded religion group with 159 recorded deaths, 156 deaths were from the religion Christianity. The chart below outlines all religion groups compared to the religious profile of patients with an open referral to DHcFT:

Religion	%	Open referrals to DHCFT
Buddhist	0%	0%
Christian	38%	23%
Declines to Disclose	0%	1%
Hindu	0%	0%
Jain	0%	0%
Jewish	0%	0%
Muslim	0%	1%
None	36%	36%
Not Recorded	16%	29%
Other	1%	2%
Pagan	0%	0%
Sikh	0%	0%
Unknown	8%	8%

People within the 'Christian' religious group appear overrepresented in mortality data. This aligns with research findings that attribute this to Christians largely being an older age population and therefore, more represented in death rates (Sherwood, 2022). There is no overt indication of any health inequalities in mortality data relating to deaths.

9.7. Analysis by Sexual Orientation

Heterosexual or straight is the highest recorded sexual orientation group with 355 recorded deaths,82 have no recorded information available. The chart below outlines deaths in all sexual orientation groups compared against open referrals to DHcFT:

Row Labels	%	Open referrals
Bi-sexual	0%	2%
Gay/Lesbian	0%	1%
Heterosexual	75%	46%
Not Recorded	17%	44%
Not Stated (PERSON asked but declined to provide a response)	8%	8%
PERSON asked and does not know or is not sure	0%	0%

Mortality data would indicate that heterosexual groups are over-represented compared to open referrals to the Trust. However, in open referral data Heterosexual groups are the most highly represented group, closely followed by patients whose sexual orientation is not recorded. Therefore, it is difficult to draw clear conclusions on any potential health inequalities. It is notable that other sexual orientation categories are proportionate between deaths and open referrals, and therefore, likely that the majority of 'not recorded' data accounts for the heterosexual population.

9.8. Analysis by Disability

Disability Present	%	Open Referrals to DHcFT
No	37%	62%
Yes	63%	38%

The data indicates a much higher prevalence of disability among deaths than compared to open referrals to DHcFT. Further analysis reveals that the highest reported disabilities are 'gross motor disability' (30.4%), 'memory impairment' (27.9%) and 'personal, self-care and continence' (17.4%). Each of these disabilities are commonly associated with biological aging, which provides clear context as to why 'disabilities' appear over-represented in death data.

9.9. Data Quality

A 'demographic comparison report' has been developed by the Information Management, Technology and Records team which allows for the demographic data associated with NHS numbers of reported deaths to be compared to demographic data for all open referrals to DHcFT. Therefore, demographic data in compared and analysed in this report has been generated from the EPR, resulting in greater accuracy and validity.

NB. Please note that our mortality database is continuously updated as deaths are reported to us. Many deaths are reported retrospectively and as such the data is rarely static. Data presented in this report is accurate to the time it was generated but is likely to change over time as further deaths are retrospectively reported.

10. Closed Learning Response outcomes for the period

18 Learning Responses were completed within the last quarter. These consisted of:

- one After Action Reviews
- one Assurance Review
- two Multi-Disciplinary team (MDT) Reviews
- 10 Case Record Reviews
- three PSIIs
- one other Patient Safety Learning Response

The following table details an Executive Summary of the key learning themes that have emerged from Learning Responses that were approved by the Executive IRG over this quarter.

Learning themes have been directly fed back to service leaders and involved staff. They will also be added to the agendas for the Care Group Learning the Lessons forums for dissemination and to incorporate into quality improvement projects.

Learning Theme:	Detail:
1. Dynamic, formulation-led risk assessment	Across the reviews, risk information was often recorded but not always brought together into a dynamic formulation linking psychological, social, physical, historical and environmental factors to safety planning. One review identified repeated risk screening but limited formulation and a disconnect between known suicide risk and the safety plan. Similar learning within Living Well highlighted inconsistent risk management and difficulty recognising deterioration in people previously assessed as lower risk. This should be balanced against recognition that suicide cannot always be predicted, and that good-quality assessment may still be followed by an unexpected deterioration.
2. Transitions, discharge and clinical ownership	Transitions between inpatient, Crisis, Community and Outpatient services emerged as important vulnerability points. Learning included the need for clear clinical ownership, effective handover, updated risk and safety plans, timely post-discharge review and reliable arrangements when the allocated practitioner is unavailable. One review found that risk assessment and safety planning had not been updated following discharge despite continuing psychosocial stressors.
3. Access, triage and waiting pathways	Several reviews identified vulnerabilities before meaningful therapeutic contact was established. The Living Well review highlighted delays in early engagement, variable documentation, incomplete care/safety planning and deterioration among some people initially assessed as lower risk.
4. Multi-agency information sharing and triangulation	Important information was not always readily accessible or integrated into decision-making. The Living Well review identified interoperability problems between clinical and social-care systems, which could result in incomplete information being available at triage. Similar issues were identified where information from other agencies was not consistently available to professionals co-ordinating complex care.
5. Family and carer involvement	Families were frequently an important source of support and safety information. Some reviews demonstrated effective family involvement, while others identified opportunities to better recognise carer roles, incorporate family concerns into assessment and involve carers in safety planning. For example, one review found family members were actively involved in escalation when the patient could not be contacted, but their status as carers had not been explicitly considered.

6. Integrated responses to complex needs	The reviews demonstrate that risk often arose from interacting mental health, physical health, substance misuse and psychosocial problems rather than a single condition. Chronic pain, for example, was closely associated with mental-health deterioration in one substance-misuse case, requiring liaison across Addiction, Primary Care and specialist physical-health services. Another review involving severe frailty and disordered eating highlighted the importance of co-ordinated MDT and multi-agency working across mental and physical healthcare.
7. Documentation as a patient-safety issue	Across the reviews, gaps included unclear clinical rationale, incomplete or outdated care and safety plans, and difficulty locating relevant information. The consequence was reduced visibility of risk, decisions and continuity arrangements.
8. Mental capacity and professional curiosity	Capacity was generally considered appropriately, but some complex presentations highlighted the need for clearer decision-specific assessment and documentation. In the alcohol-related review, learning focused on whether individuals could understand, retain, use and weigh information about the consequences of continued alcohol use and its impact on health and care decisions.

11. Prevention of Future Death (PFD) Notices

The Trust did not receive any PFD notices for this quarter.

12. Active Learning Responses and Recommendations

Moving forward, this report will incorporate the data on Learning Response completion across each quarter (up to a maximum of five quarters) to demonstrate progress over time. Unfortunately, as this data was not captured in previous publications of this report it is not possible to refer to previous quarters' data at this time.

Outstanding Learning Responses for reported deaths:

	Q1, 2026/27	Q2, 2026/27
Investigation awaiting	14	15
Report to be finalised by Patient Safety team	12	3
Amendments	7	3
Allocation	2	1
Cause of death awaiting	2	0
Investigation received	3	2
Total	**40**	**24**

	Q1, 2026/27	Q2, 2026/27
Number of overdue Learning Responses	22	12
Longest overdue	344 days	193 days
Collective average overdue	142 days	80 days
Collective median overdue	119 days	85 days
Collective mode overdue	196 days	14 days

Analysis:

- There are 12 overdue learning responses relating to deaths as of this reporting period. This represents a 45% reduction in overdue learning responses. The data also demonstrates a 44% reduction in the average number of days overdue for overdue learning responses, and significant reduction in the longest number of days overdue

- The data provides assurance that the Trust has good operational grip around overdue Learning Responses and that actions to reduce this are proving effective
- The biggest area of impact has been around improved administration and co-ordination from within the Patient Safety team in reducing the number of Learning Response reports awaiting finalisation and in chasing completion of amendments from learning response leads and final Executive sign-off.

Recommendations post-learning response:

**Please note, it is not possible to separate this data between death and non-death incidents. Therefore, data relating to outstanding learning recommendations also refers to those generated through review of major incidents that did not result in a death.*

Active			
Rating	**Q4, 2025/26**	**Q1, 2026/27**	**Q2, 2026/27**
High Priority – Cause of Incident	6	1	1
Medium Priority – Indirectly related to cause of incident	112	95	120
Low Priority – Not related to cause of incident	63	40	34
Total	**181**	**136**	**155**
Overdue			
Rating	**Q4 2025/26**	**Q1 2026/27**	**Q2, 2026/27**
High Priority – Cause of Incident	3	1	1
Medium Priority – Indirectly related to cause of incident	87	39	29
Low Priority – Not related to cause of incident	37	30	12
Total	127	70	42

The table below summarises the number of current overdue patient safety recommendations by year of which they were uploaded to the Datix system:

Number of overdue recommendations by year as reported in each quarter:			
Year	**Q4, 2025/26**	**Q1, 2026/27**	**Q2, 2026/27**
2020/21	1	1	0
2021/22	2	1	0
2022/23	7	2	0
2023/24	5	0	0
2024/25	47	7	0
2025/26	65	37	8
2026/27	-	22	34

Analysis:

- The total number of overdue recommendations has reduced by 40% since the last quarter and there are no longer any outstanding actions from before 2025**,** demonstrating that the Trust has good operational grip around overdue actions and actions to reduce this are proving effective
- The total number of active recommendations has increased by 14%. This is partly owing to the Trust having expanded the range of Patient Safety Learning Response methods, with the inclusion of After-Action Reviews and MDT Reviews which we reported on within our last quarterly report. These methods provide more proportionate responses to a variety of PSIs, both in terms of scope and timescale, ensuring that incidents are reviewed promptly to identify the correct learning and improvement actions. However, this is also partly owing to increased administrative efforts from within the Patient Safety team to finalise outstanding learning responses, leading to agreed recommendations being loaded to the Datix system

- The Patient Safety team continues to monitor patient safety actions to ensure that:
    - They are linked to existing quality improvement work to avoid duplication
    - They are purposeful and avoid promote ‘safety clutter’
    - They continue to be completed in a timely manner.

References:

- Sherwood, H. (2022). Why is the Christian Population of England and Wales declining? The Guarding. Available online: https://www.theguardian.com/world/2022/nov/29/why-is-the-christian-population-of-england-and-wales-declining

FORWARD PLAN - BOARD - 2026/27		19-May-2026	21-Jul-2026	30-Sep-2026	24-Nov-2026	26-Jan-2027	23-Mar-2027
	Deadline for Approved Papers	**07-May-2026**	**09-Jul-2026**	**19-Sep-2026**	**12-Nov-2026**	**14-Jan-2027**	**11-Mar-2027**
DoCA/TS	Declarations of Interest	X	X	X	X	X	X
DoN	Patient/Board Story	X	X	X	X	X	X
CHAIR	Minutes/Matters Arising/Action Matrix/Public Questions	X	X	X	X	X	X
CHAIR	Board review of meeting effectiveness	X	X	X	X	X	X
CHAIR	Board Forward Plan (for information)	X	X	X	X	X	X
CHAIR	Emergency Powers of the Chair and the Chief Executive (for information, as required)			X			
CHAIR	Summary of Council of Governors meeting (for information)	X	X		X	X	
CHAIR	Chair's update	X	X	X	X	X	X
CEO	Chief Executive's update	X	X	X	X	X	X
PD, PC, JUCD	Joined Up Care Derbyshire Provider Collaborative (six-monthly)	AR			Deferred	Deferred from Nov-2026	
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			
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/Jan)		X				
DoN	Outcome of Board stories (annual, Jun)		X				
DoN	Personalised Care Framework					X	
DoN	Thirlwall Inquiry				X		
DCEO/CDO	Transformation and Continuous Improvement (six-monthly)	X			Deferred	Deferred from Nov-2026	
DCEO/CDO/MD/DoN	Winter Plan		X	X			
Receipt of Reports (for noting following assurance at People and Culture Committee (PCC)):							
MD	10 Point Plan to Improve the Lives of Resident Doctors (PCC - six-monthly Sep and Mar)			X			
MD	Guardian of Safe Working Hours report (PCC quarterly / annual report ~~Jun~~ Sep)	X	Deferred to Sep-2026	Deferred from Jul-2026		X	
MD	Medical Appraisal and Revalidation - annual report (PCC Apr)	X					
Receipt of Reports (for noting following assurance at Quality and Safeguarding Committee (QSC)):							
DoN	Delivery of Same Sex Accommodation (QSC Oct)				X		
DoN	Infection Prevention and Control annual report and IPC BAF (QSC Nov)				X		
MD	Learning from Deaths/Mortality report for approval (QSC quarterly / AR Jun)		AR	X	X	X	X
DoN	Looked After Children/Children in Care - annual report (QSC Sep)				X		
DoN	Quality Account (QSC sign-off Jun)		X				
MD	Research and Development (QSC six-monthly - Feb and Jul; AR Jul)			AR			X
DoN	Safeguarding Children and Adults at Risk - annual report (QSC Sep)			X			
DoN	SEND - Special Educational Needs and Disabilities annual report (QSC May/Jun)	X					
STRATEGIC PLANNING AND CORPORATE GOVERNANCE							
DoF/DCEO/CDO/DPODI	2026/27 Plan (annual)	NHSE Feedback to Medium-Term Plan					
DoCA/TS	Annual Review of Register of Directors' Interests	X					
DoCA/TS	Board Assurance Framework update	X		X	X		X
DCEO/DCO	Clinical Plan update (six-monthly)				For approval		
DoCA/TS	Continuation of Services Condition 7 - Provider Licence	X					
CHAIR	Fit and Proper Person Declaration		X				
FTSUG	Freedom to Speak Up Guardian report (six-monthly)			X			X
DCEO/CDO	IMPACT annual agreement						X
MD	Patient and Carers Race Equality Framework (six-monthly)		X			X	
DoCA/TS	Provider Capability Assessment			X			
DoCA/TS	Trust Sealings (six-monthly - for information)	X			X		
DCEO/CDO	Trust Strategic Plan (quarterly update, to include 4Ps Delivery Plans)	X	X		Mid-point review	X	
Receipt of Reports (for noting following assurance at Audit and Risk Committee (ARC)):							
DoCA/TS	Year-end Governance reporting from Board Committees and approval of Terms of Reference (ToRs) (ARC Apr)	X					
Receipt of Reports (for noting following assurance at People and Culture Committee (PCC)):							
DPODI	2025/26 Flu Campaign annual report (PCC ~~Jul~~ Sep)			X			
DPODI	Annual Approval of Modern Slavery Statement (PCC Apr/May, to be published on Trust website on approval)	X					
DPODI	Annual Gender Pay Gap report for approval (data for previous year reporting deadline Mar - PCC Jul)	X					
DPODI	Staff Survey results (PCC Mar)						X
DPODI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) *request for Board delegated authority for People and Culture Committee meeting Sep to approve the October submissions*						
DPODI	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Strategic implications (retrospective sign-off on assurance at People and Culture Committee Sep)			X			
POLICY REVIEW							
DoF	Standing Financial Instructions Policy and Procedures (31-Oct-2026)			X			

KEY

ARC	Audit and Risk Committee
DCEO/CDO	Deputy Chief Executive and Chief Delivery Officr
DoCA/TS	Director of Corporate Affairs and Trust Secretary
DoF	Director of Finance
DoN	Director of Nursing, Allied Health Professionals, Quality and Patient Experience
DPODI	Director of People, Organisational Development and Inclusion
FTSUG	Freedom to Speak Up Guardian
MD	Medical Director
PCC	People and Culture Committee
PD, PC, JUCD	Programme Director, Provider Collaborative, Joined Up Care Derbyshire
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
AAC	Advisory Appointments Committee (legally required interview panel used to appoint substantive Medical and Dental Consultants in NHS trusts in England, Wales and Northern Ireland)
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
ADM	Agency Decision Maker
ADOS	Autism Diagnostic Observation Schedule (assessment)
AED	Adult Eating Disorder
AED	Automated External Defibrillator
AEO	Accountable Emergency Officer
AfC	Agenda for Change
AFT	Advanced Foundation Trust
AHP	Allied Health Professional
AI	Artificial Intelligence
AIMS	Royal College of Psychiatrists Accreditation for Inpatient Mental Health Services programme
ALB	Arms-length body such as NHS Improvement (NHSI) and NHS England (NHSE)
AMaT	Audit Management and Tracking (audit/governance system (real-time reporting for clinicians, wards, audit departments and healthcare organisations))
AMM	Annual Members' Meeting
AMHP	Approved Mental Health Professional
ANP	Advanced Nurse Practitioner
ANPR	Automatic Number Plate Recognition
AO	Accountable Officer
AO	Assertive Outreach
AOVPN	AlwaysOn VPN (secure network access)
APC	Annual Physical Health
APNA NHS	Asian 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
AVT	Ambient Voice Technology
B	
BAF	Board Assurance Framework
BAME	Black, Asian and Minority Ethnic
BCF	Better Care Fund
BCO	Building Control Officer
BCP	Business Continuity Plan

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
Be Seen (Psyomics)	A digital questionnaire system for service users. The tool aims to improve patient experience, help clinicians identify needs earlier, and support more efficient care pathways.
BI	Business Intelligence
BIA	Business Impact Analysis
BLS	Basic Life Support (ILS Immediate Life Support)
BMA	British Medical Association
BILD	British Institute of Learning Disabilities
BME	Black and Minority Ethnic group
BoD	Board of Directors
BPD	Borderline Personality Disorder
BPPC	Better Payment Practice Code
C	
CAARMS	Comprehensive Assessment of At-Risk Mental States
CAD	Community Action Derby
CANSAS	Camberwell Assessment of Need Short Appraisal Schedule
CAMHS	Child and Adolescent Mental Health Services
CASSH	Care and Support Specialised Housing
CBT	Cognitive Behavioural Therapy
CBRN	Chemical, Biological, Radiological and Nuclear
CCG	Clinical Commissioning Group (defunct from 1 July 2022)
CCCG	Collaborative Commissioning and Contracting Group (East Midlands Alliance)
CCIO	Chief Clinical Information Officer
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
CEG	Carers Engagement Group
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
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
CoSUM	Co-occurring Substance Use and Mental Health Disorders
CP	Child Protection
CPA	Care Programme Approach
CPD	Continuing Professional Development
CPN	Community Psychiatric Nurse
CPR	Child Protection Register
CPRG	Clinical Professional Reference Group
CQC	Care Quality Commission
CQI	Clinical Quality Indicator
CQRG	Clinical Quality Review Group
CQUIN	Commissioning for Quality and Innovation
CRD	Clinically Ready for Discharge
CRG	Clinical Reference Group
CRH	Chesterfield Royal Hospital
CRHT	Crisis Resolution and Home Treatment
CROMS	Clinician Reported Outcome Measures
CRR	Case Record Reviews
CRS	(NHS) Care Records Service
CRS	Commissioner Requested Services
CSC	Commonwealth Scholarship Commission
CSDS	Community Services Data Set
CS	Clinical Supervisor
CSF	Commissioner Sustainability Fund
CSPR	Child Safeguarding Practice Review
CSTF	Core Skills Training Framework
CSU	Commissioning Support Unit
CT	Counter Terrorism
CTO	Community Treatment Order
CTR	Care and Treatment Review
CUF	Cost Uplift Factor
CYP	Children and Young People
D	
DAG	Divisional Assurance Group
DAR	Divisional Assurance Review
DARD	Drugs and Alcohol Related Deaths
DASP	Drug and Alcohol Strategic Partnership
DAT	Drug Action Team
Datix	Trust's electronic incident reporting system of an event that causes a loss, injury or a near miss to a patient, staff or others
DBS	Disclosure and Barring Service
DBT	Dialectical Behavioural Therapy
DDME	Deputy Director of Medical Education
DfE	Department for Education
DCHS	Derbyshire Community Health Services NHS Foundation Trust
DCO	Designated Clinical Officer
DDCCG	Derby and Derbyshire Clinical Commissioning Group

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
DDSAB	Derby and Derbyshire Safeguarding Adult Board
DDSC	Designated Doctor Safeguarding Children
DDSCB	Derby and Derbyshire Safeguarding Children Board
DDSCP	Derby and Derbyshire Safeguarding Children Partnership
DEED	Delivering Excellence Every Day
DHcFT	Derbyshire Healthcare NHS Foundation Trust
DHR	Domestic Homicide Review
DHSC	Department of Health and Social Care
DISCO	Diagnostic Interview for Social and Communication Disorders (assessment)
DIT	Dynamic Interpersonal Therapy
DLN Cluster	Derbyshire, Lincolnshire, Nottinghamshire Cluster
DME	Director of Medical Education
DNA	Did Not Attend
DoC	Duty of Candour
DoF	Director of Finance
DoH	Department of Health
DoL	Deprivation of Liberty
DoLS	Deprivation of Liberty Safeguards
DoN	Director of Nursing
DPA	Data Protection Act
DPI	Director of People and Inclusion
DPIA	Data Protection Impact Assessment
DPR	Divisional Performance Review
DPS	Date Protection and Security
DQMI	Data Quality Maturity Index
DRP	Derbyshire Resilience Partnership
DRR	Drug Rehabilitation Requirement
DRRT	Dementia Rapid Response Team
DSCRO	Data Services for Commissioners Regional Offices
DSFS	Derbyshire Support and Facilities Services
DS&P	Data Security and Protection
DSPT	Director of Strategy, Partnerships and Transformation
DTOC	Delayed Transfer of Care
DV	Domestic Violence
DVA	Derbyshire Voluntary Action (formerly North Derbyshire Voluntary Action)
DWP	Department for Work and Pensions
E	
EAP	Employee Assistance Programme
EbE	Expert by Experience
ECT	Enhanced Care Team
ECT	Electroconvulsive Therapy
ECW	Enhanced Care Ward
ED	Emergency Department
EDS2	Equality Delivery System 2
EHA	Early Help Assessment
EHCP	Education, Health and Care Plan
EHIC	European Health Insurance Card
EHR	Electronic Health Record
EI	Early Intervention
EIA	Equality Impact Assessment
EIP	Early Intervention In Psychosis
EIS	Early Intervention Service

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
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
EPS	Electronic Patient Survey
EPRR	Emergency Preparedness, Resilience and Response
ERIC	Estates Return Information Collection
ESF	Estates Safety Fund
ESR	Electronic Staff Record
ETOC	Enhanced Therapeutic Observation and Care
ETP	Electronic Transfer of Prescriptions
EUPD	Emotionally Unstable Personality Disorder
EWTD	European Working Time Directive
F	
FBC	Full Business Case
FCMHT	Forensic Community Mental Health
FDP	Federated Data Platform
FFP3	Type of face mask for infection, prevention and control (IPC)
FFT	Friends and Family Test
FGM	Female Genital Mutilation
FIG	Feedback Intelligence Group
FOI	Freedom of Information
FOT	Forecast Out-Turn
F&P	Finance and Performance
FReM	Government Financial Reporting Manual
FSR	Full Service Record
FT	Foundation Trust
FT ARM	Foundation Trust Annual Reporting Manual
FTE	Full-time Equivalent
FTN	Foundation Trust Network
FTSU	Freedom to Speak Up
FTSUG	Freedom to Speak Up Guardian
FWS	Future NHS Workforce Solution
FYE	Full Year Effect or Financial Year End
5YFV	Five Year Forward View
G	
GAM	Group Accounting Manual
GBO	Goal Based Outcome
GDPR	General Data Protection Regulation
GGI	Good Governance Institute
GiRFT	Getting it Right First Time
GMC	General Medical Council
GMP	Guaranteed Maximum Price
GoSWH	Guardian of Safe Working Hours
GP	General Practitioner

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
GPFV	General Practice Forward View
H	
HACT	Housing Association Charitable Trust
HBPoS	Health Based Places of Safety
HCA	Healthcare Assistant
HCAI	Healthcare Associated Infection
HCHS	Hospital and Community Health Services (NHS)
HCID	Highly Communicable Infectious Disease
HCP	Healthy Child Programme
H1	First half of a fiscal year (April through September)
H2	Second half of a fiscal year (October through the following March)
HEE	Health Education England
Heidi Health	AI-powered documentation tool that listens to consultations and generates clinical notes, letters, and other records
HES	Hospital Episode Statistics
HFMA	Healthcare Financial Management Association
HIEM	Health Innovation East Midlands
HoNOS	Health of the Nation Outcome Scores
HoP	Head of Practice
HOPE(s)	The HOPE(s) model is an ambitious human rights-based approach to working with individuals in segregation, developed from research and clinical practice
HSCIC	Health and Social Care Information Centre
HSE	Health and Safety Executive
HSSC	Health and Safety Security Committee
HSSIB	Health Services Safety Investigations Body
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
IHI	Institute for Healthcare Improvement
IHR	Ill-Health Retirement
IIC	Inclusive Inter-cultural Communication
IG	Information Governance
ILS	Immediate Life Support (BLS – Basic Life Support)
IM	Intramuscular
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
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
ISA	Information Sharing Agreement
ISL	Immigration Salary List
J	
JCVI	Joint Committee on Vaccination and Immunisation
JDF	Junior Doctor Forum
JLNC	Joint Local Negotiating Committee
JNCC	Joint Negotiating Consultative Committee
JTAI	Joint Targeted Area Inspections
JUCB	Joined Up Care Board
JUCD	Joined Up Care Derbyshire
K	
KLOE	Key Lines of Enquiry (CQC)
KPI	Key Performance Indicator
KSF	Knowledge and Skills Framework
L	
LA	Local Authority
LAC	Looked After Children
LADO	Local Authority Designated Officer
LA – CYPD	Local Authority – Children and Young People Divisions
LADO	Local Authority Designated Officer
LCFS	Local Counter Fraud Specialist
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
LIO	A unified, contactless mental health inpatient platform (previously Oxevision by Oxehealth)
LNC	Local Negotiating Committee
LOS	Length of Stay
LPS	Liberty Protection Safeguards
LSU	Long-Term Service Use
LTFT	Less Than Full-Time

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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
MPAC	Multi-Professional Approved Clinician
MRSA	Methicillin-resistant Staphylococcus aureus
MSaPG	Medicine Safety and Practice Group
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
NAIF	National Audit of Inpatient Falls
NCISH	National Confidential Inquiry into Suicide, Homicide 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
NEWS	National Early Warning Score (standard medical tool used across UK healthcare to track patient vital signs and spot signs of sudden worsening health)
NFI	National Fraud Initiative
NGO	National Guardian's Office
NHIS	Nottinghamshire Health Informatics Service
NHS	National Health Service
NHSC	NHS Confederation
NHSCFA	NHS Counter Fraud Authority
NHSE	National Health Service England
NHSI	National Health Service Improvement
NHSEI	NHS England and NHS Improvement
NHSP	NHS Providers
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NIMS	National Immunisation Management System
NIMS	National Incident Management System
NIVS	National Immunisation and Vaccination System
NOF	NHS Oversight Framework
NPS	National Probation Service
NPSA	National Patient Safety Alert
NQB	National Quality Board
NR	Non-Recurrent
NRLS	National Reporting and Learning System
NROC	Non-Resident On-Call
O	
OBC	Outline Business Case
OBD	Occupied Bed Days
ODG	Operational Delivery Group
OoA	Outside of Area
OPMO	Older People's Mental Health Services
OP	Outpatient
OPEL	Operational Pressures Escalation Levels Framework

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
OSC	Overview and Scrutiny Committee
OSCE	Objective Structured Clinical Examination
OT	Occupational Therapy
P	
PAB	Programme Assurance Board
PAC	Personal Accountability Charter
PAG	Programme Advisory Group
PALS	Patient Advice and Liaison Service
PAM	Payment Activity Matrix
PARC	Psychosis and the reduction of cannabis (and other drugs)
PARIS	This is an electronic patient record system
PbR	Payment by Results
PCC	Police & Crime Commissioner
PCC	People and Culture Committee
PCF	Personalised Care Framework
PCLB	Provider Collaborative Leadership Board
PCN	Primary Care Networks
PCOG	Patient and Carer Operational Group
PCREF	Patient and Carers Race Equality Framework
PDC	Public Dividend Capital
PDF	Portable Document Format
PDSA	Plan, Do, Study, Act
PET	Psychiatric Emergency Team
PFI	Private Finance Initiative
PFF	Probation Feedback Form
PFR	Provider Finance Return
PGD	Patient Group Direction
PHC	Public Health Commissioners
PHCIC	Physical Healthcare and Infection Control Committee
PHE	Public Health England
PHE	Physical Health Equipment
PHSCC	Population Health and Strategic Commissioning Committee
PHSMI	Physical Health Serious Mental Illness
PHSO	Parliamentary and Health Service Ombudsman
PICU	Psychiatric Intensive Care Unit
PID	Project Initiation Document
PiPoT	Persons in a Position of Trust
PJF	Professional Judgement Framework
PKB	Patients Know Best (a secure patient portal that allows people to access information about their care and communicate digitally with healthcare services)
PLACE	Patient-Led Assessments of the Care Environment
PLIC	Patient Level Information Costs
PMF	Performance Management Framework
PMH	Perinatal Mental Health
PMLD	Profound and Multiple Disability
PMO	Project Management Office
PNA	Professional Nurse Advocate
PODG	Programme Oversight and Delivery Group
POEM	Patient-rated Outcome and Experience Measure
PPE	Personal Protection Equipment
PPI	Patient and Public Involvement
PPN	Public Protection Notice

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
PPT	Partnership and Pathway Team
PQN	Perinatal Quality Network
PREM	Patient Reported Experience Measure
PRM	Provider Review Meeting
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
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

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
	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
SPBP	Strategic People Business Partner
SPF	Social Partnership Forum
SPOA or SPA	Single Point of Access
SPOE	Single Point of Entry
SPOG	Strategic Portfolio Oversight Group
SPOR	Single Point of Referral
SSQD	Specialised Services Quality Dashboards
SSRB	Senior Salaries Review Board
STEIS	Strategic Executive Information System
STAH	St Andrew's House
StEIS	Strategic Executive Information System
STF	Sustainability and Transformation Fund
STOMP/STAMP	Stopping The Over-Medication of children and young People with a learning disability, autism or both / Supporting Treatment and Appropriate Medication in Paediatrics
STP	Sustainability and Transformation Partnership

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
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
SystmOne	Electronic patient record system
T	
10YHP	10-Year Health Plan
TAV	Team Around the Family
TARN	Trauma Audit and Research Network
TBT	Tobacco Dependence Team
TCP	Transforming Care Partnerships
TCS	Transforming Community Services
TDA	Trust Development Authority
TDG	Trust Delivery Group
TDT	Tobacco Dependence Team
Thalamos	Digital platform designed to streamline Mental Health Act processes by replacing paper-based workflows
TIC	Trauma Informed Care
TLT	Trust Leadership Team
TMAC	Trust Medical Advisory Committee (now Medical Senate)
TMT	Trust Management Team
TMTC	Trust Medical Training Committee
TOIL	Time Off In Lieu
TOOL	Trust Operational Oversight Leadership
ToRs	Terms of Reference
TRiM	Trauma Risk Management
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
U	
UASC	Unaccompanied Asylum-Seeking Children
UHDB	University Hospitals of Derby and Burton
UEC	Urgent and Emergency Care
V	
VARM	Vulnerable Adult Risk Management
VCOD	Vaccination as a Condition of Deployment
VCP	Vacancy Control Panel
VCSE	Voluntary, Community and Social Enterprise organisations
VdTMoCA	Vona du Toit Model of Creative Ability *(a practical guide for Acute Mental Health Occupational Therapy Practice)*
VfM	Value For Money
VO	Vertical Observatory
VTE	Venous Thromboembolism
VUCA	Volatility, Uncertainty, Complexity, Ambiguity
W	
WAP	Wireless Application Protocol
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent
Y	

GLOSSARY OF NHS AND DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST ACRONYMS	
NHS Abbreviation	**Term in Full**
YP	Young Person
YTD	Year to Date
Z	
ZTAS	National blood monitoring company used by the Trust

13 November 2026

Report from the Council of Governors meeting held on 22 September 2026

The Council of Governors has met once since the last report, on 22 September 2026. The meeting was conducted as a virtual meeting using Microsoft Teams.

Chief Executive's update

In the absence of the Chief Executive, the Deputy Chief Executive and Chief Delivery Officer gave an update on:

- The progress of the Mental Health Urgent Assessment Centre (MHUAC)
- Preparation of the Trust's Winter Plan submission for NHS England
- Achievement of Baby Friendly accreditation for Derby City 0-19 Children's services
- Launch of the Carers Staff Network in July
- The forthcoming Care Quality Commission Well Led Inspection in November.

Presentation of the Annual Report and Accounts and report from the external auditors

The Annual Report and Accounts 2025/26 were presented to the Council of Governors. It was confirmed that they will also be presented, consistent with financial reporting, at the Annual Members Meeting on 30 September 2026.

The representative from Forvis Mazars, the Trust's external auditors, provided a summary of the positive annual report letter and outlined their responsibilities as follows:

- Give an opinion on the Trust's financial statements
- Assess the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (the value for money conclusion).

The representative from Forvis Mazars confirmed that they had not identified any significant weaknesses which would require further work or wider reporting.

Escalation items to the Council of Governors from the Governance Committee

It was noted that there were no escalation items for this meeting.

Non-Executive Director's report

Chioma Akpom, Chair of the Audit and Risk Committee, presented her report updating governors on her activities as a Non-Executive Director since last October when she joined the Trust.

Report from Governance Committee 25 August 2026

The Membership and Involvement Manager presented a report of the meeting held on 25 August 2026. The Council of Governors approved the Governance Committee's recommendation to ratify the Committee's terms of reference for a further year.

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.

Update on the Annual Members Meeting (AMM)

The Membership and Involvement Manager gave an update on the AMM which included an overview of the programme and an update on the art competition. The winners of the art competition will be announced at the AMM.

RECOMMENDATION

The Trust Board of Directors is asked to note the summary report from the Council of Governors meeting held on 22 September 2026.

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

Trust Sealings (for information)

Purpose of Report

This report provides the Trust Board with a six-month update of the authorised use of the Trust Seal since the last report to the Board on 19 May 2026.

Executive Summary

The Trust's Standing Financial Instructions (point 8.16) were revised in September 2024 to allow a more practical process for the signing of contracts, as the size of the organisation's contract values have grown. The authorised signatory limits reflect the delegated expenditure limits in point 3.2.

Now, only deeds and contracts relating to the disposal, acquisition or leasing of land or property need to be executed under the Common Seal of the Trust.

In accordance with the Standing Orders of the Board (section 12 point 6) a report of all sealing shall be made to the Trust Board twice a year. The report will contain details of the seal number, the description of the document and date of sealing. The register will be retained by the Trust Secretary.

A report on use of the seal was last made to the Board on 19 May 2026. Since the last report, the Trust Seal was used as follows:

- DHCFT/141 – (2 July 2026) – Underlease for part of St Oswald's Community Hospital, Clifton Road, Ashbourne, DE6 1DR between 1) Community Health Partnerships Ltd and 2) Derbyshire Healthcare NHS Foundation Trust
- DHCFT/142 – (17 July 2026) – Second Deed of grant relating to site 2 Manor Kingsway Hospital, Derby, DE22 3LZ between 1) Homes and Community Agency, 2) Tilia Partnership Homes Ltd, 3) Derbyshire Healthcare NHS Foundation Trust
- DHCFT/143 – (17 July 2026) – Engrossment Lease Relating to First Floor New Beetwell Street, Chesterfield, S40 1QR between 1) Derwent Rural Counselling Service, 2) Derbyshire Healthcare NHS Foundation Trust
- DHCFT/144 – (28 July 2026) – Lease relating to part of Trevelyan House, Matlock, DE4 3YH between 1) Youth Hospital Association (YHA) (England & Wales) and 2) Derbyshire Healthcare NHS Foundation Trust.

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	N/A	N/A
People: We will attract, involve and retain staff creating a positive culture and sense of belonging.	X		
Productive: We will improve our productivity and design and deliver services that are financially sustainable.	X		
Partnerships: We will work together with our system partners, explore new opportunities to support our communities and work with local people to shape our services and priorities.	X		

Risks and Assurances

Use of the Trust Seal has been undertaken in accordance with the Standing Financial Instructions and Standing Orders of the Board of Directors.

Consultation

N/A.

Governance or Legal Issues

The affixing of the seal is consistent with the Board's responsibilities outlined within the Standing Financial Instructions and Standing Orders of the Board of Directors.

Net Zero Duty Implications

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

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

The Trust amended its standing financial instructions to reduce the number of documents requiring sealing which reduced printing and postage requirements.

Public Sector Equality Duty and Equality Impact Risk Analysis

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

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

Recommendations

The Board of Directors is requested to note the authorised use of the Trust Seal since the last report to the Board on 19 May 2026 and receive full assurance that this has been undertaken in accordance with the Standing Financial Instructions and Standing Orders of the Board of Directors.

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

Report prepared by: **Jo Bradbury**
Corporate Governance Officer

Emma Warrilow
Personal Assistant