

# **Derbyshire Community Health Services NHS Foundation Trust**

## **Annual report and accounts 2020/21**

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**Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of  
the National Health Service Act 2006**

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## Foreword

We are pleased to present this 2020/21 annual report and accounts, covering the most challenging 12 months for our staff, our communities, and the NHS generally as we have pulled together to respond to the Covid-19 pandemic and have maintained essential services for people at their time of need.

This report covers our statutory reporting requirements in full and acknowledges the tremendous efforts of our staff over the past year and what we are doing to support them as we go forward.

At the time of writing we are emerging with hope of something more like normal life being resumed. Our staff, volunteers, health service partners and local communities have been instrumental in the roll-out of the vaccination programme across Derbyshire and Derby which has helped to set us on the path to greater freedom from the threat of Covid-19, for which we are immensely grateful.

But clearly there remains a lot to do with our partners in Joined Up Care Derbyshire to restore health services to pre-pandemic levels. By working together we are able to achieve more. We are proud of the commitment of all our colleagues and to be able, once again, to record that we have met all our statutory obligations as an NHS foundation trust and to have ended the year in a strong organisational position. Thank you to everyone who has contributed to that success in the most challenging year ever.



**Tracy Allen**  
Chief Executive



**Prem Singh**  
Chairman

## Performance report

### Overview

*The purpose of the overview is to give the reader a short summary that provides them with sufficient information to understand the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.*

### **A brief history and statutory background of the organisation**

Derbyshire Community Health Services NHS Foundation Trust is one of the largest providers of specialist community health services in the country, serving a population of over one million people in Derbyshire and Derby. We have operated as a standalone NHS organisation since April 2011 and we became a fully-fledged foundation trust on 1 November 2014. We are rated outstanding overall by the Care Quality Commission following a well-led inspection in September 2019. We remain compliant with all our financial obligations.

### **A statement Tracy Allen, chief executive, providing her perspective on the performance of the trust over the year**

Last year I opened this statement reflecting on an incredibly challenging year, a year which ended with the global Covid-19 pandemic looming large and posing an enormous challenge for society as a whole. We entered 2020/21 with uncertainty, foreseeing an unprecedented year for the NHS, perhaps its most difficult on record. But any hesitancy was matched by confidence in my kind, compassionate and brilliant colleagues right across DCHS.

It's been a fantastic effort in the most difficult of circumstances, while coping with all the uncertainties that Covid-19 has brought into every element of our home and working lives. The community and team spirit is what I'll choose to remember about 2020/21. To say I am proud of our teams would be an understatement – I am incredibly grateful and privileged to work alongside such dedicated and caring people.

We began the year playing our part in the national NHS response to the pandemic, adapting quickly to the new clinical issues and challenges it posed for us in Derbyshire and working as part of a joined-up health and care system. We temporarily stopped some of our non-critical services while adapting others, in line with a nationally-determined prioritisation framework. This was a difficult move to make for our staff and for local people, as it meant

longer waits for some services and routine treatments. The impact of this may well be felt for years to come across the NHS.

At the end of March 2020, the government advised that everyone considered ‘clinically extremely vulnerable’ should shield at home and avoid all face-to-face contact for an initial period of up to 12 weeks. This was subsequently extended – and with it came a number of challenges for the local NHS. Our number one priority was always protecting our most vulnerable colleagues – both their physical and mental wellbeing. With many no longer able to safely support their teammates on the frontline there was a sense of guilt expressed, which we acknowledged while providing the necessary emotional support. We also enabled our shielding colleagues to support our efforts in new ways from the security of their homes.

Our many flexible colleagues volunteered to work in new and unfamiliar areas, using their skills, experience and kindness in different ways to ensure our most pressured services were supported. Many traded their usual positions to support our busy wards and community teams, caring for very poorly patients with Covid-19, some of whom we tragically lost in our care.

Our strong track record of infection prevention and control was given additional and necessary emphasis throughout the pandemic in line with Public Health England guidance to ensure we minimised risk and effectively managed any outbreaks. We significantly increased our cleaning, driving and personal protective equipment (PPE) logistical capacity and we welcomed the support of local volunteers. And from mid-June all staff started wearing face masks in our facilities while visitors were also asked to wear face coverings.

New ways of working were implemented rapidly, making use of all available technology to deliver virtual patient consultations and treatment wherever it was safe and appropriate. We engaged with colleagues in new ways and supported them to connect with each another remotely, given the new ‘Stay home, Protect the NHS, Save lives’ and social distancing guidance from the Government. We bolstered our staff wellbeing offer, doing all we could to look after our frontline colleagues so they could focus on delivering expert patient care. And our corporate services were equipped to deliver their essential support functions from home.

Indeed, each and every one of us played a vital role, maintaining our essential services while doing all we could to keep ourselves, our families and our communities safe and well. Our integrated community services teams maintained their core service provision throughout, despite the increased demand and assortment of pressures on our patient-facing colleagues. Our children’s services teams continued to support young people and their parents, coping with increased complexity as Derbyshire families struggled through lockdown. As the number of new cases gradually fell across the country we started to

recover our non-critical services towards pre-pandemic levels. We acknowledged a loss of confidence in local communities accessing NHS services and shared a clear message that we are doing everything possible to make accessing our services safe – and while it is not business as usual for the NHS, the NHS is still very much open for business.

We applauded some of the fantastic innovation we saw from teams trying to work through significant backlogs and waiting lists, such as our school-age immunisation team. This award-winning group developed a very effective drive-through immunisation facility for local children and their parents which was duly recognised on a national scale. Virtual (online or telephone) consultations also greatly increased, as did our confidence in delivering them.

On 5 July 2020 the NHS turned 72, so we celebrated by saying “thank you” in a short film to our family and friends, fellow key workers and our amazing volunteers who have supported the NHS and kept the whole country going. In the past year NHS Charities Together, the collective body of more than 240 NHS charities nationally, fundraised a simply staggering £457m, while spending more than £1m every day to enhance patient experience. NHS Trusts such as ours also received a proportion of that money to be used on staff wellbeing initiatives. We have worked with colleagues across the organisation to use this additional resource in a variety of ways to support their health and well-being, including the establishment of a Staff Hardship Fund, recognising the increased financial hardship across society as a whole.

The broader societal response was championed by Derbyshire businesses, many of whom were instrumental in supporting our NHS heroes. An incredible amount of goods were donated over many months which we distributed across our sites through a series of ‘wobble rooms’ – quiet rooms that staff can visit if they are feeling overwhelmed – and ‘calm kit bags’ for staff working hard in local communities. For this we are eternally grateful.

As we move forward we are committed to playing a significant role in our communities by contributing to the local economy as an ‘anchor institution’. Anchor institutions are typically non-profit, public sector organisations whose long-term sustainability is tied to the wellbeing of the populations they serve. The term ‘anchor’ refers to our connection to the local population – for us this means jobs for local people as one of Derbyshire’s larger employers, and sourcing services and goods locally to support the county’s businesses.

From September our focus reverted back to managing a rising numbers of cases in a second wave of the pandemic and our local joined-up response. We were able to learn from wave one and despite the very significant pressures on our services and the increased staff absence, all essential services were maintained. Staffing and absence levels posed one of the biggest challenges for us throughout the pandemic, hitting a peak of 16% in wave one with more than 600 colleagues absent due to self-isolation, Covid-related sickness or other

illnesses. Throughout the second wave absence levels hovered around the 7-8% mark which is still around double what we'd normally expect to see.

We planned carefully for the ever-challenging winter months by vaccinating more than 80% frontline staff as part of our annual flu campaign. Frontline colleagues also started twice-weekly staff self-testing for Covid-19 doing everything possible to minimise the risk of outbreaks in our services. DCHS also became the lead provider in the local Covid-19 vaccination programme following the ground-breaking announcement on 2 December that a vaccine had been approved for use in the UK.

The Covid-19 vaccination programme is the largest of its kind ever undertaken by the NHS and as I write this we've just passed the 100 day milestone (8 December 2020 - 17 March 2021). A massive health and care system-wide effort has seen us vaccinate more than 500,000 Derbyshire residents in that time – that's one every 20 seconds – working collaboratively with our partners across Joined Up Care Derbyshire.

Supporting the health and care system to deliver the programme was a major focus of the second half of the year, as we recruited, trained and deployed more than 800 people into new roles. The time, energy and complexity of the effort really cannot be overstated. Hundreds of colleagues were redeployed, many volunteered in their own time, while hundreds more returned from retirement to support the cause. Collectively they provided the clinical, managerial and logistical expertise required

Our partners in general practice have led local vaccination services from accessible community settings, while on 25 January the DCHS vaccination centre opened at Derby Arena – a major step forward for the programme. On 8 February Prime Minister Boris Johnson visited the Arena site and praised the incredible work of everybody involved.

In line with other parts of the country, we have experienced challenges with vaccine hesitancy in some communities, most notably black, Asian and minority ethnic (BAME) groups and an unacceptable inequity in terms of uptake. As a system we prioritised equality of service delivery, working with community and religious leaders and other trusted voices to promote vaccine confidence. We have seen an improvement in uptake but there is still plenty of work to do.

A similar pattern is apparent in Covid-19 vaccine uptake among staff groups, with more than 92% overall uptake yet a 10% discrepancy when it comes to our BAME colleagues. We are working hard to understand the challenges, answer questions, and support colleagues to have greater confidence in the vaccine while promoting wider service equality.

In February 2021 the Government published a White Paper which aims to build on the NHS Long Term Plan, further join up health and care services and embed lessons learned from the pandemic. We welcomed these proposals and they are in line with the direction of travel being planned locally. In particular, the announcement proposed legislation to set out the future of Integrated Care Systems (ICS). Joined Up Care Derbyshire was approved as the ICS for Derby and Derbyshire from 1 January 2021, its four main aims being:

- Improving population health and healthcare
- Tackling unequal outcomes and access
- Enhancing productivity and value for money
- Helping the NHS to support broader social and economic development.

As a system we planned carefully for the UK's departure from the European Union, considering its wider impact on the NHS in terms of staffing, the supply of medicines and other essential goods. The rules governing the new relationship between the EU and UK took effect on 1 January 2021 and to date we've not experienced any notable adverse impact as a result.

2020/21 was a big year for us in many other ways too. We had a 62.5% response from colleagues completing the NHS Staff Survey (slightly up on the previous year's 62.4%) with 75% of those colleagues who responded recommending DCHS as a place to work – an increase of 4% in the past year. 87% (91% in 2019/20) would also recommend DCHS as a place to receive treatment– the highest confidence rate of any community trust in the country. The equivalent question the NHS puts to patients nationally was paused this year due to the pandemic, though at DCHS we routinely see a 97%+ approval rating from our service users.

Overall we scored better than the previous year in seven of the ten measures, remained the same in two, and fell marginally in the 'team working' measure – a largely positive picture in our most difficult year yet. Although the 'DCHS Way' ethos is to never be complacent and we remain fully committed to improving the experience of everyone working here.

Elsewhere we made further progress on our multi-million pound development projects in the towns of Belper, Bakewell and Buxton, with the aim of securing state-of-the-art healthcare facilities for future generations.

I am incredibly proud of what my colleagues have achieved in 2020/21 and how they have responded to the pandemic, but I am not at all surprised. What each and every one of them delivers every day for the people of Derby and Derbyshire is nothing short of amazing. They truly are the embodiment of the 'DCHS Way' and their energy, compassion and commitment will ensure that we are able to play a major role in restoring and recovering the

NHS locally while supporting the great communities we're a part of to face the challenges ahead.

### ***A statement on the purpose and activities of the organisation***

Our purpose is to provide community health services to a patient population of over one million people in Derbyshire and Derby, as part of Joined Up Care Derbyshire. Our services are organised and managed across three divisions: integrated community services, planned care & specialist services, and health, wellbeing and inclusion. Details of the services we provided are included on our website: [www.dchs.nhs.uk](http://www.dchs.nhs.uk). We employ around 4,200 substantive staff, caring for patients in 11 community hospitals and more than 30 health centres, as well as in clinics, GP practices, schools, care homes and, increasingly, in people's own homes and via virtual consultations. During the pandemic response we have led the implementation of public vaccination centres in collaboration with partners across health and social care.

### ***Brief description of the business model and environment***

Health and social care organisations in Derby and Derbyshire have been working closely together for some time, to improve care and services for people and integrating them around local people and communities to make them as efficient and effective as possible. We are fully aligned to this business model and environment, developing services in partnership with other parts of the health and care system which promote a system-level approach as part of Joined Up Care Derbyshire's Integrated Care System. You can find more details here: <https://joinedupcarederbyshire.co.uk/>

### ***Organisational structure***

Our established system of governance and management is organised into three distinct domains as Quality People, Quality Service and Quality Business. Regular reports are provided at each Trust Board meeting from each of the three committees. Within this governance framework we manage and identify risks to our organisation through the Board Assurance Framework (BAF).

Through this structure the Board ensures that relevant metrics, measures, milestones and accountabilities are developed and agreed, to understand and assess progress and delivery of performance.

### ***Objectives and strategies***

Implementation of our 2020/21 operational plan was paused because of the pandemic and the need to prioritise the emerging needs of the Covid-19 response.

This followed a directive on 17 March 2020 to all NHS providers, from Sir Simon Stevens, NHS chief executive, and Amanda Pritchard, NHS chief operating officer, detailing the important and urgent actions the NHS needed to take in response to the Covid-19

pandemic. At the time these measures were introduced, our operational plan for 2020/21 was well developed as we continued to work to support the priorities within the NHS Long Term Plan and Joined Up Care Derbyshire partners.

Throughout 2020/21 we moved from reaction, through to restoration and recovery. We published an operational recovery plan in November 2020 which provided an overview of our planning aims and actions for the remainder of 2020/21, aligned to the planning and ambitions of our Joined Up Care Derbyshire (JUCD) partners.

By taking a phased approach in our planning we were able to safely restore important services for our communities to near-normal levels of non-Covid-related health services during the second half of 2020/21. Detailed business intelligence has supported our recovery and restoration, enabling us to track, record and close the gap as we reduce our backlog waiting lists.

The operational recovery plan also keeps a clear focus on our JUCD commitment to improve population health outcomes for the people and communities we serve and to enable people to:

- Have the best start in life
- Stay well
- Age well
- Die well.

At the forefront of our system plan are five strategic priorities:

- Place-based care
- Prevention and self-management
- Population outcomes
- System efficiency
- System management.

The 2020/21 operational recovery plan is available to view here:

[http://www.dchs.nhs.uk/home/dchs\\_publications/operational\\_plan\\_2020-21](http://www.dchs.nhs.uk/home/dchs_publications/operational_plan_2020-21)

For 2021/22 we are not required to produce an operational plan specific to Derbyshire Community Health Services NHS Foundation Trust but we are finalising the work we will prioritise for the coming year. This will clearly set out how we will both contribute to the JUCD plan as it becomes fully operational as an Integrated Care System and also the work we will undertake to ensure a commitment to continual improvement of our services.

We and our system partners are keen to develop the role of the NHS in Derbyshire as an Anchor Organisation, helping us to deliver on our commitments to address the wider determinants of health and support our communities.

We are working with our partners to support this important priority, including:

- Employment: increasing our apprenticeship offer and promoting local recruitment
- Procurement: continuing to work to our target of 30% spend in the Derbyshire economy
- Environment: developing a sustainable travel approach by investing £50,000 on active travel (walking and cycling) initiatives (released through savings made on travel during the pandemic) and also reviewing our travel and mileage policies. We will also investigate how to develop and use our green space to improve staff health and wellbeing. In addition, we are moving to fully renewable electricity and, working with our Derbyshire partners, we will help to deliver the Derbyshire County and Derby City air quality standard targets.

For 2021/22 we are developing and agreeing specific operational priorities which are linked to national and local planning requirements as well as our own local priorities.

### Financial performance

In a challenging year, given the impact of Covid-19, we have ultimately performed well during 2020/21. We delivered a net surplus of £1.042m, which was in excess of our break-even plan. This reported surplus was delivered to support the Joined Up Care Derbyshire financial position, as we move towards a more system-based way of working within Derbyshire.

The Covid-19 pandemic costs continued to be incurred and were funded accordingly, therefore not impacting on our financial performance in 2020/21. In addition, our Trust took on the lead provider role in delivering the Covid-19 vaccine. In line with the national commitment, these costs were also fully reimbursed to us and therefore did not impact on our financial performance in 2020/21. This table summarises our financial performance for the year:

<b>2020/21 Performance</b>	<b>£'000 plan</b>	<b>£'000 achieved</b>
Surplus	0	1,042
EBITDA (Earnings before interest, tax, depreciation and amortisation)	6,162	7,190
Cash balance at period end	31,262	42,635
Better payment practice code	95.0%	98.7%

Target is to pay 95% of all non-NHS creditors within 30 days of the receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.		
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EBITDA is a way of representing how much of our operating income exceeds our operating costs. Our EBITDA for 2020/21 was £7.2m which equates to 3.7%. This measure demonstrates sound financial health and the efficient use of our resources. The next table details our financial performance and over-achievement on the control total set by NHS Improvement.

	£'000s
Deficit for the year	(392)
Less donated assets depreciation	155
Less gains on transfers by absorption	440
Less impairments charged	845
Adjusted Surplus for the year	1,048
Control Total	0
<b>Performance Against Control Total</b>	<b>1,048</b>

### Capital expenditure

Our capital expenditure for 2020/21 was £5.9m against a capital plan of £6.5m. The £695k we did not utilise on expected capital spending related to deferment of Belper, site developments. The most significant schemes we undertook involved continued investment in our IM&T infrastructure.

The table below summarises our capital expenditure for 2020/21.

<b>Capital expenditure schemes 2020/21</b>	<b>Cost £'000</b>
Estate - General refurbishment	507
Estate – Ilkeston Hospital's decentralisation of boilers	707
Estate – Walton Hospital development	1,082
Estate – Staff cost	423
Estate - Upgrade Ilkeston physiotherapy unit	73
Estate – Ilkeston Hospital boiler replacement	155
Estate – Ilkeston Hospital chillers replacement	112
Estate – Eckington Health Centre wound care clinic upgrade	110
Estate – Manor Stores demolition and site clearance	90
Estate – Purchase of Rhoslan garden	70
Estate – Belper development	146
Estate – Bakewell development	259
Estate – Clay Cross Hospital conversion of office to treatment room	94
Equipment	222
IM&T - desktop renewal and local infrastructure	1,432
IM&T – LAN/WAN Infrastructure	199
IM&T – Digitisation	274
<b>Total capital expenditure</b>	<b>5,955</b>

**Efficiency**

During 2020/21 we generated efficiency savings of £5.29m against a target of £5.1m. A total of £4.24m of the £5.29m are recurrent savings. A summary of our main savings delivered during 2020/21 is shown below:

<b>Service Area</b>	<b>£m</b>
Corporate and estate	£1.31m
Health, wellbeing & inclusion	£1.09m
Planned care and outpatients	£0.36m
Integrated community based services	£0.76m
Other	£1.77m
<b>Total</b>	<b>£5.29m</b>

**Key opportunities and risks****Future financial performance**

As a result of the coronavirus pandemic, temporary funding arrangements that were introduced to NHS organisations throughout the whole of 2020/21 are to continue for a six-month period up until the end of September 2021. The Board of Directors has approved an interim financial plan in response to this which sets out to deliver a break-even revenue surplus supported by a requirement to deliver efficiency savings of £6.6m. Successful delivery of this plan will achieve the maximum Use of Resources rating of 1 against which we will be assessed as an NHS Foundation Trust.

**Financial statements**

Our primary financial statements and supporting notes to the accounts are provided at appendix 1. Our external auditors, Deloitte, have provided an opinion on the accounts. Our annual report and accounts cover the 12 month period from the 1 April 2020 to 31 March 2021. Our accounts have been prepared in accordance with directions given by the Department of Health and NHS Improvement. They are also prepared to comply with International Financial Reporting Standards (IFRS) and are designed to present a true and fair view of our financial activities.

A copy of the full annual report and accounts can be obtained from the Director of Finance and Strategy at Derbyshire Community Health Services NHS Foundation Trust Headquarters, Ash Green Learning Disability Centre, Ashgate Road, Ashgate, Chesterfield, Derbyshire S42 7JE.

### **External audit**

Our auditors for 2020/21 are:

Deloitte LLP  
Four Brindley Place  
Birmingham  
B1 2HZ.

The total fees for external auditors for 2020/21 accounts were £108,255 (plus VAT) in respect of the completion of the statutory audit work, made up of:

Deloitte (appointed auditors) £108,255 (plus VAT)

Due to the coronavirus pandemic, there is no requirement for a Foundation Trust to prepare a quality report and include it in its annual report for 2020/21. Additionally, there is no requirement for a Foundation Trust to commission external assurance on its quality report for 2020/21.

The Audit and Assurance Committee provides the Board with an independent and objective view of arrangements for internal control within our Trust and to ensure the internal audit service complies with mandatory auditing standards, including the review of all fundamental financial systems.

The Governor Governance Group received regular updates in respect of the work of Deloitte. The group also met with Deloitte on 11 February 2021 which allowed Deloitte to report on the cycle of audit work and for the governors to ask questions on points of clarification.

### **Appointment process for external auditor**

The appointment of our external auditors is a matter that requires the approval of the Council of Governors. As a Foundation Trust, the Council of Governors is responsible for appointing auditors. The Audit and Assurance Committee is responsible for making a recommendation to the Council of Governors.

A process for the appointment of auditors was carried out during 2020. On 8 January 2020, the Council of Governors approved a proposal to go out to tender for our external auditors for 2020/21 onwards. Subsequently, the Council of Governors confirmed at their meeting on 11 March 2020 that they were content with the recommendations arising from the process to appoint Deloitte as our external auditors for an initial three year term from October 2020 with the option to extend for a further two years.

The Audit and Assurance Committee review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements.

### **Digital transformation**

Digital transformation is a cornerstone of our efforts to ensure constant improvement in the delivery of our services. The past year has seen a continued push towards digital transformation across and beyond our Trust's boundaries. Much of our digital work has continued to be driven by the Covid-19 pandemic and our response to it. Other areas of digital transformation have taken place outside of the Covid-19 agenda.

The Covid-19 pandemic has driven a number of initiatives around digital transformation. Our aim has been to learn the lessons and embed the best of these ideas into our future service provision. The need to deliver care to our service users at a distance demanded that we provide solutions for remote consultations. While our services already used telephone consultations, we have introduced video consultation at scale over recent months to a position where we now provide around 500 video consultations every week.

As the pandemic closed local schools we transformed the way we delivered our School Aged Immunisation Service to ensure children didn't lose out on important planned vaccinations. This included our first 'Drive Through or Walk To' vaccination service for children in years 8 and 9. This forward planning paid off as it also allowed our vaccination team to support the Covid-19 vaccination programme with no adverse impact on routine vaccinations for children. To support this programme we worked quickly to source and procure an online booking system that would allow parents to book a slot online.

Our rapid digital transformation has also allowed us to play a lead role in the Covid-19 vaccination programme. We have led the establishment of vaccination sites across the county, through which Primary Care Networks and other system partners delivered over a million vaccinations to the people of Derby and Derbyshire by mid-May. We have rapidly deployed staff to the vaccination programme using digital solutions and infrastructure from hardware to booking solutions, learning from our experience with school aged immunisation, to support the vaccination effort.

We have also embedded a number of solutions to ensure that we can maintain our levels of service and staffing throughout the pandemic. We have enabled our staff to work from home providing technical solutions such as the Microsoft Teams collaboration platform. This has minimised the need for face-to-face meetings, reducing costs, travel time and CO2 emissions while enabling us to continue to deliver services for the people of Derbyshire and Derby.

Although the Covid-19 pandemic has been central to our efforts this year, we have also delivered a number of other digital transformation projects.

The introduction of voice recognition software in our musculoskeletal service has enabled clinicians to use voice recognition to write clinical letters without relying on medical secretaries to transcribe letters, reducing delays in letter and report production from 3-6 weeks to nil. The transformation has also saved 20% of medical secretary time which has been reinvested in supporting our clinicians.

We have delivered hand-held electronic observation solutions for our wards, allowing clinicians to easily record and monitor our patients' vital signs. This system also automatically alerts senior clinicians of any changes to the patient, enabling swift action and improving patient care.

We have streamlined and improved our system-to-system record sharing to enable greater communication between services and with GP practices. This enables more effective and secure sharing of information, ensuring that the patient receives the most appropriate care based on the latest and most comprehensive information.

We have developed and implemented an electronic wound clinic referral form across Derby. This has supported improved management, and in the quality of the referral information as well as a reduction of the waiting list. In addition, the wound clinic service is progressing discussions with the Pathfinder (primary care digital solution) which will enhance the referral process further, including the appropriateness and quality of the referrals to the wound clinic service.

We have streamlined our electronic clinical documentation for patients admitted to our hospitals for short stays. The reduced clinical documentation will minimise unnecessary questions, improving a patient's experience of an admission to our wards but still provide a proportionate assessment to safely manage the patient's admission.

### **Managing strategic risks**

The Board Assurance Framework (BAF) is a mechanism for the Board and its sub-committees to focus on its strategic risks and the actions **required** to mitigate the risks to an acceptable level.

In 2020/21 a specific Covid-19 BAF was developed for the first quarter of the year which was aligned to the strategic objectives in managing the major incident of the pandemic. There were 12 strategic risks on the Covid-19 BAF with four high risks within the Quality People domain and one in the Quality Services domain. Rather than being reviewed quarterly the risks were reviewed monthly and as we came out of the first wave of Covid-19 the risks were reviewed and aligned to our Restoration and Recovery objectives. The Restoration and Recovery Corporate Framework was approved by the Board in June 2020.

The BAF has continued to be reviewed throughout the year through the Quality Committees and the Audit and Assurance Committee. The BAF has been more dynamic this year, with more changes, which reflects the nature of the environment we have been operating within. At the end of the financial year, the BAF has 27 strategic risks on it and is more in line with our business as usual BAF. There is risk within the Quality People domain with a focus on ensuring we have an adequate supply of qualified clinical staff. The high risks within the Quality Service domain have been mitigated to medium risks.

### ***Promoting equality of service delivery***

This is a development area for us, and one which we are committed to going forward. To date we have prioritised the promotion of equality and equity of service delivery as follows:

A major project to improve diversity monitoring has been completed during 2020/21 with the aim of promoting equality of service delivery.

It was initiated in 2018 when our equality diversity and inclusion leadership forum (EDILF) consented to an ambitious quality improvement project to revise the monitoring of equality and diversity data for patients. We have historically audited compliance with completing equality and diversity monitoring, and acting on the equity needs assessed, in many different guises including the clinical records audit and the identifying disability audit.

We consistently gained evidence that staff were not confident asking equality and diversity monitoring questions. We were aware that many staff did not understand why they should ask the questions and when they are relevant. It was also a challenge to find documented evidence of care planned or actions taken in response to answers to equality and diversity monitoring questions.

EDILF supported the clinical effectiveness team to lead a quality improvement project to revise the diversity monitoring questionnaire in SystemOne (the electronic patient record):

The aim of the project has been to ensure we:

- Monitor protected characteristics robustly and can support automated reporting
- Support staff in identifying needs arising from monitoring and that these are included in personalised care planning
- Receive regular analysis of the monitoring element matched to local population data to identify areas where we should address inequalities
- Achieve improved completion rates of the monitoring questionnaire by clinicians.

Following consultation with patients, staff and members of the community, the clinical effectiveness team designed a revised diversity monitoring questionnaire in collaboration with the informatics team. In January 2019 EDILF approved the revised questionnaire, which was then piloted by two of our services and evaluated for both staff and patient

experience. The final version of the questionnaire was launched across SystemOne, to all DCHS services (with the exception of integrated sexual health services who use a different electronic patient records system) in September 2020.

In February 2021 EDILF commissioned an equality and diversity reporting group which was launched in May 2021 with responsibility for monitoring and improving the collection of equality and diversity data and monitoring and improving the use of the collected data to ensure it is used to improve the access, experience and outcomes of our patients. The group has a remit to:

- Maintain and develop the diversity monitoring questionnaire to ensure it remains fit for purpose for staff and patients
- Identify training needs and support the design of relevant training to meet those needs
- Analyse compliance data
- Analyse diversity monitoring data
- Manage and co-ordinate task and finish projects e.g. patient self-completion of equality, diversity and inclusion questionnaires.

This group **will meet** every two months and is chaired by the improvement, innovation and effectiveness lead, reporting to EDILF.

### ***Monitoring equality and diversity***

**NHS Friends and Family Test:** since December 2020 equality and diversity monitoring has been an integral part of our NHS Friends and Family Test (FFT) patient feedback. We engaged external IT digital solutions experts, Civica, to provide this via different methodologies, including SMS/text. We had previously only undertaken FFT internally using a postcard.

The revised questionnaire, and new digital ways of being able to ask patients for feedback, is designed to help us understand whether patients are happy with the service provided, or where improvements are needed. It's a quick and anonymous way for patients to give their views after receiving NHS care or treatment.

This initiative is in line with a move by NHS England to make FFT a more effective tool in gathering patient feedback that helps to drive local improvements in healthcare services. The revised FFT reporting was originally due to come into force in April 2020 but was postponed due to the pandemic until the end of the year.

We report the outcomes of FFT so that findings can be analysed and acted upon in terms of service improvements and patient experience.

**NHS Equality Delivery System 2 (EDS2):** We have completed the EDS2 process within a core service area which identified, through this detailed audit process, where issues of equity of access, outcomes and experience could be improved. Whilst focusing on protected characteristics, the work also analysed patient access using deprivation as a factor. The work has subsequently been identified as best practice by colleagues at Public Health England.

As part of our internal operational planning, we aim to use an equity analysis approach to implement the refreshed version of EDS (currently awaiting sign-off by NHS England and NHS Improvement) to understand if any population groups are being detrimentally impacted by our current models of service delivery. Where any inequity in access, outcomes or experience is identified we will take steps to address them. This in turn helps us to review and improve our performance for people with characteristics protected by the Equality Act 2010 and to deliver on the Public Sector Equality Duty. It is aligned to NHS England and NHS Improvement's commitment to an inclusive NHS that is fair and accessible to all.

**Equalities Board:** Our Equalities Board continues to have strategic oversight of the Trust's equality, diversity and inclusion strategy and helped to influence and shape our inaugural very successful 'Delivering Inclusion at DCHS' conference during 2020/21. The Equalities Board meets quarterly and comprises our chairman, chief executive, director of people services and organisational effectiveness, a non-executive director, staff network chairs and a representative from our equality, diversity and inclusion team. Subject experts are invited to present on a range of associated topics.

**Under-represented groups on NHS boards:** In November 2020, we reviewed the associate non-executive director role on our Trust Board and agreed that in future the role would be used to support the next generation of talented people from groups that are currently under-represented on NHS boards. In keeping with our aspirations as an anchor organisation, we aimed to attract candidates to the role that have strong links to Derbyshire. Subsequently we were successful in recruiting two associate non-executive directors that will not only increase the diversity of our Board, but also our connections to local communities.

**Workforce Race Equality Standard (WRES):** We are ranked among the best performing organisations in three of the nine WRES indicators: 5, 6 and 7 which are three of the four indicators based on the NHS Staff Survey questions. Conversely, we are ranked as one of the least well performing organisations for WRES indicator 2, which measures ethnicity gap in recruitment outcomes and promotion opportunities between white and black and minority ethnic (BAME) job applicants. We are analysing our recruitment data for the 12 months to February 2021 to ascertain the issues and determine any interventions deemed to be appropriate. The WRES indicator 9 data showed that our BAME Board voting membership is representative of our overall BAME workforce.

**Workforce Disability Equality Standard (WDES):** We are awaiting publication of the national WDES report, based on the 2020 data, by NHS England and NHS Improvement. Notable improvements in the past year include our colleagues' disability self-declaration rates, enabling DCHS as an employer to provide a greater level of support and intervention. We're also paying attention to colleagues' staff survey responses to understand where and how we can make further improvements.

**Council of Governors:** We acknowledge that our elected Council of Governors (COG) is not entirely representative to the local communities we serve, so in a similar vein to the aforementioned associate NED roles, we're taking steps to address the gap by appointing 'associates to the COG' from underrepresented groups to increase the diversity and our local community connections.

### **Clinical service developments**

New clinical developments during the year help us to provide the right services fairly and accessibly when people need them. A few examples of developments which seek to promote accessible, equitable and responsive service delivery are:

**New clinical model and triage priority for therapy services:** a new therapy service provides a rapid team and a core team which operate seven days a week, delivering therapy services across all pathways, with extended cover to the service operating hours (8am-6.30pm). This is part of our transformational work to support urgent community response and is in line with a national requirement to move to a two-hour crisis response within Integrated Care Systems, as part of which therapy services are expected to play a significant role.

The rapid therapy team flex and cover community urgent referrals, community support beds and community hospital wards. The core team provides a service to non-urgent referrals where the appointments can be planned within the place the patient calls home.

Referrals to community services are streamlined and channelled via the Community Access Point. These referrals are then triaged by experienced clinicians against the agreed guidance to ensure a consistent and appropriate response by the right clinician. Work is allocated to therapists based within the appropriate team, with the added flexibility of therapy staff being able to work across pathways/settings to provide the appropriate response. Areas and teams have been resourced as indicated by data and taking account of local factors e.g. Primary Care Network requirements, geography. A consistent model is now in place across the county, which is equitable and is focused on improving patient experience with the clinically appropriate response.

**Integrated psychological and behavioural health services:** the experience of Covid-19 this year has highlighted for us all how health has mental, physical, emotional, social and cultural aspects and that to provide the best health and social care we can we need to

integrate and work together in new ways. In clinical health psychology services this year we have continued to pursue our aims to integrate psychological and behavioural science approaches across the Trust and the wider Joined up Care Derbyshire system. This allows us to understand, predict and influence human behaviour.

As well as providing direct clinical psychology assessment and intervention, our clinical health psychology team has implemented new roles working with integrated care teams, public health and children's 0-19 services. Our aim is to bring our psychological knowledge and skills to work in collaboration with colleagues in these areas. Together we are developing new approaches to care with a focus on prevention and health inequalities. Our aim is to improve the experiences and clinical outcomes for patients and staff by developing psychologically informed models of care that will build self-awareness, confidence and resilience. Feedback and outcomes have been incredibly positive.

**Derbyshire long Covid-19 assessment clinic and MDT:** we were asked by our commissioners to host and run the Derbyshire long Covid-19 assessment clinic and multi-disciplinary team in December 2020 in response to the emerging new condition known as post Covid-19 syndrome (also referred to as long Covid-19). The clinic quickly recruited a local GP, supported by a system wide multi-disciplinary team consisting of psychology, physiotherapy, occupational therapy, speech and language therapy, respiratory experts and dietetics. The first patients were referred, triaged and contacted in the first week of January 2021. The setting up of the first clinic was rapid and the service is developing as we learn more about the virus and the physical and mental impacts on individual patients. This is a largely virtual assessment service. After assessment patients are referred into the newly established multi-disciplinary team or on to other services. Referrals, for adults and children, come mainly from GPs. The service had received 137 referrals up to early March 2021.

**First Contact Practitioner roll-out:** our outpatient physiotherapy and musculoskeletal (MSK) services have been working with Primary Care Networks to extend MSK First Contact Practitioner services across Derbyshire. First Contact Practitioners have advanced skills in the assessment and diagnosis of musculoskeletal conditions and are able to provide expert advice to people at their first contact with their GP surgery. Getting the right advice quickly can reduce the need for further treatment. Having MSK First Contact Practitioners in Primary Care Networks allows GPs more time to spend with people who present with non-MSK conditions.

**Derbyshire wound care service:** wounds have a significant and detrimental impact on both the quality of life of those affected and the healthcare system. Furthermore, the number of people developing non-healing wounds has continued to increase due to an

ageing population living with complex long-term health conditions and the growth of lifestyle-related diseases.

The complex nature of non-healing wounds necessitates a specialised healthcare service that has the ability to provide timely wound diagnoses and treatment to ensure optimal outcomes and reduce the risk of serious consequences such as infection and wound deterioration. The Derbyshire Wound Clinic Service was established to meet this need and to provide high quality evidence-based wound care to the population of Derbyshire. Providing a seven days a week service, the Derbyshire Wound Clinic Service utilises 30 specialised clinics spread across 20 clinical sites staffed by specialist wound care nurses who have been trained using our award-winning 'Time to Heal' principles which were designed to improve healing rates and patient experience. The Covid-19 pandemic placed several challenges on the service. However, it continued to provide excellent care throughout. Our pandemic response plan included the increased use of technology through telephone and video consultations and select home visits, based on clinical need. The Derbyshire Wound Clinic Service has continued to involve patients in their own care, has robust referral pathways and runs joint clinics with the tissue viability and podiatry teams.

### **New facilities for integrated care**

We are leading service developments in Bakewell, Belper and Buxton which gives us significant opportunities as part of service redesign and investment in the new facilities aligned to Joined Up Care Derbyshire's strategic aims of greater integration of care.

In Bakewell, we have purchased a plot of land which framed part of Newholme Hospital site and we are working with East Midlands Ambulance Service partners to combine the site we have purchased with the current ambulance station site to develop new state-of-the-art facilities and ambulance accommodation. Extensive consultation with the Peak District National Park Authority planning department has resulted in an agreed scheme for the demolition of Riverside Ward and the ambulance station and construction of the new facilities. An application for full and listed planning consent was submitted in December 2020 and was approved in April 2021. Capital funding of £8.58m has previously been secured by way of the Government's sustainability and transformation plan, wave 4, funding and a full business case for the project has been submitted to NHSE/I.

In Belper, we have purchased the Belper Clinic site at Babington Hospital and are working on plans for a £10m new state-of-the-art healthcare facility which will also provide accommodation for East Midlands Ambulance Service and the Derbyshire Constabulary. Extensive consultation has been ongoing with a number of statutory bodies including the Environmental Agency, planning authority, highways and the local authority heritage officer to agree acceptable proposals and we are now in a position to develop the design and then to submit a planning application. The scheme honours all the promises made to local people in the engagement process of 2018 to develop services fit for the 21<sup>st</sup> century in a

sustainable way and in line with the ambitions set out in Joined Up Care Derbyshire to replace outdated facilities at Babington Hospital. Full background information can be accessed on our website here <https://www.dchs.nhs.uk/home/our-services/service-development>.

In Buxton, the outline business case for a proposed new health and community public services hub was nearing completion as the Covid-19 pandemic hit. The outline business case is a vital step in a project of this scale, in evaluating the benefits and costs for the scheme.

We purchased the chosen plot, a 3.5 acre site at the former Buxton Water plant, in January 2018 and the outline planning consent for the community hub has already been granted by High Peak Borough Council. The next step will be to develop a full business case with the senior team of all organisations from across the public who have agreed to be partners in the development. There is no central government funding for the building costs of the project which will require all the organisations to contribute towards the costs.

Significant capital investment has continued to reduce backlog maintenance and to improve sustainability and carbon reduction including LED lighting projects.

### ***A summary of performance to the extent not already covered***

#### **Performance against CQUINs 2020/21**

A total of 1.25% of our total income in 2020/21 was conditional on achieving the nationally set CQUIN measures (Commissioning for Quality and Innovation), as agreed between us and Derby and Derbyshire Clinical Commissioning Group (CCG).

At the start of 2020/21 we had four national CQUINs, agreed with the CCG:

- Malnutrition screening and care planning within Inpatients
- Flu vaccination of frontline staff (90% target)
- Assessment, diagnosis and treatment of lower leg wounds within community nursing
- Assessment and documentation of pressure ulcer risk within inpatients

The total contract value relating to these for 2020/21 was £1.66m. Following the national guidance published on 26 March 2020 in relation to the Covid-19 pandemic, all CQUIN activity and data reporting ceased until June 2020 (later confirmed until March 2021). The associated income was agreed to be paid through wider block payment as outlined in the Stevens/Pritchard letter (17 March 2020).

While the formal CQUIN programme was suspended, it should be noted that screening, assessment, diagnosis and care planning in relation to malnutrition, lower leg wounds and

pressure ulcers continued to be undertaken within inpatient and community nursing services, as part of our business as usual, supporting the delivery of quality care and treatment. Our tissue viability team has previously developed and championed the wound care assessment template on SystmOne, supporting clinicians in recording and care planning for wounds, including lower leg wounds and pressure ulcers. Likewise, a significant amount of work has previously been undertaken to embed the Malnutrition Universal Screening Tool (MUST) within inpatient and community services, identifying those patients at risk of malnutrition and ensuring appropriate care planning. The flu campaign delivered 84.5% against the 90% CQUIN target.

### **Clinical accreditation**

The Trust Board and Quality Service Committee monitor clinical governance via the Quality Always and Clinical Assessment and Accreditation Scheme (CAAS).

CAAS was paused from 17 March 2020 until 28 August 2020 in support of the response required for the Covid-19 pandemic and subsequent operational pressures.

When re-introduced in August 2020 the Quality Always team had undertaken a wide ranging engagement process with operational teams and stakeholders. The outcome was a revised CAAS process suitable for introduction into a Covid-19 environment that adapted to the new norms and the anxieties expressed by operational staff.

The CAAS assessments now take place utilising a blended approach of virtual and face-to-face methods of gathering evidence, observing clinical practice and seeking the perspective of staff.

A total of 35 CAAS assessments have been concluded utilising this process in areas restored to CAAS and who have been identified as “priority” due to continuing to deliver patient services throughout the pandemic. All but one of the services had progressed against their rating pre-pandemic.

Gold accreditation panels were also reintroduced in a virtual format from September 2020 enabling four more community teams to gain gold before a pause was required during high operational escalation levels in December 2020 to March 2021. At the time of writing, a further five teams are pending consideration at gold panel when they are restored again in June 2021.

Earned autonomy self-assessments have also been maintained and expended during this time enabling seven further teams to sustained gold standards and look to introducing their own clinical governance framework matrix as an extension of ownership of quality

assurance. All this development and restoration has been achieved alongside the Quality Always team working in clinical operational services to support patient care throughout.

Our Quality and Safe Care Champions headcount is 1,284; they have been supported by the development of e-learning programmes, including in public health in response to the pandemic.

### **Charitable funds**

The Trust Board acts as corporate trustee for our Charitable Trust, which is a charity registered with the Charity Commission under number 1053329.

These charitable funds have resulted from fundraising activities and donations received over many years by our respective organisations and are used to purchase equipment and other services in accordance with the purpose for which the funds were either raised or donated. The charity also has a general-purpose fund which is used more widely for the benefit of patients and staff.

Following HM Treasury's ruling IAS27, that consolidated and separate financial statements should apply to all NHS bodies for accounting periods from 1 April 2013, we undertook an assessment against the two key criteria of materiality and control. As a result of this assessment we concluded that it was not necessary to consolidate the accounts of the charity with those of the NHS body. The financial activities of the charity for the 2020/21 financial year will continue to be reported within a separate annual report and accounts for the funds held on trust. This report is published on the Charity Commission website.

Our charity has benefitted from funds allocated from NHS Charities Together, following the launch of their Covid-19 Appeal in March 2020 to help support NHS staff nationally in the wake of the pandemic. We are very grateful for the generosity of the public in making donations and of NHS Charities Together for allocating funds to us which have enabled us to support our staff's wellbeing at the most challenging time for health workers.

### **Investments**

We made no investments through joint ventures or subsidiary companies and no other financial investments were made. No financial assistance was given by us.

### **Working capital and liquidity**

Our cash position is maximised through efficient working practices regarding the day-to-day management of our working capital. We have appropriate governance in place to monitor performance in key areas and additional metrics are embedded into the routine reporting to the Quality Business Committee which is chaired by a non-executive director.

### **Accounting policies**

We have detailed accounting policies approved by our Audit and Assurance Committee which comply with the accounting requirements of the Department of Health and Social Care Group Accounting Manual and International Financial Reporting Standards for NHS Foundation Trust accounts. Our accounting policies are detailed in the full set of financial accounts.

### **Insurance cover**

We have insurance cover through the NHS Litigation Authority to cover the risk of legal action against our directors and officers. We also have insurance cover for public and products liability to cover income generating activities.

### **Going concern**

After making enquiries, the directors have a reasonable expectation that the services provided by the NHS Foundation Trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

### **Signed**



**Tracy Allen**  
**Chief Executive**

**15 June 2021**

## Accountability report

### Directors' report

The directors' report has been prepared in accordance with sections 415 to 418 of the Companies Act 2006 (section 415(4) and (5) and section 418 (5) and (6) would not apply to NHS Foundation Trusts) as inserted by SI 2013 (1970), regulation 10 and schedule 7 of the large and medium-sized companies and groups regulations 2008.

### Directors

The following directors were appointed to membership of the Board of Directors, and were in post during the year 1 April 2020 to 31 March 2021:

Designation	Date	Name
Chairman	1 April 2020 to 31 March 2021	Prem Singh
Vice chair	1 April 2020 to 31 March 2021	Kaye Burnett
Chief executive	1 April 2020 to 31 March 2021	Tracy Allen
Director of finance and strategy/deputy chief executive	1 April 2020 to 31 March 2021	Chris Sands
Chief information and transformation officer	1 April 2020 to 31 March 2021	Jim Austin
Director of nursing, allied health professionals and quality	1 April 2020 to 31 March 2021	Michelle Bateman
Director of strategy	1 April 2020 to 29 October 2020	Tim Broadley
Associate director of corporate governance/trust secretary	1 April 2020 31 March 2021	Melanie Curd
Chief operating officer	1 April 2020 to 31 March 2021	William Jones
Medical director	1 April 2020 to 31 March 2021	Dr Ben Pearson
Director of people services and organisational effectiveness	7 September 2020 to 31 March 2021	Darren Tidmarsh
Interim director of people services and organisational effectiveness	31 March 2020 to 4 September 2020	Paul Renshaw

<b>Designation</b>	<b>Date</b>	<b>Name</b>
Non-executive director	1 April 2020 to 31 March 2021	Kay Fawcett
Associate non-executive director	1 April 2020 to 31 March 2021	Richard Harcourt
Non-executive director	1 April 2020 to 31 March 2021	Joy Hollister * currently on sabbatical until January 2022
Non-executive director	1 April 2020 to 31 March 2021	Julie Houlder
Non-executive director	1 April 2020 to 31 March 2021	Ian Lichfield
Non-executive director	1 April 2020 to 31 March 2021	James Reilly

We consider each of the listed non-executive directors to be independent.

Further details about the Board of Directors can be found within this chapter.

### **Ensuring services are well led**

In 2019 the the Care Quality Commission (CQC) conducted their well-led inspection of the Trust and rated the Trust as Outstanding.

You can find details on our approach to mitigating and managing risks, internal control measures and ensuring services are well led in the Annual Governance Statement and also in the Performance Report which gives details of our Board Assurance Framework as a mechanism for the Board and its sub-committees to focus on its strategic risks and the actions taken to mitigate the risks to an acceptable level.

The Quality Report, produced separately this year to an end of June deadline set by DHSC, covers arrangements for monitoring improvements in the quality of healthcare, details of other key quality improvements and information on complaints handling and stakeholder relations. It also covers in greater detail clinical service developments, key elements of which are shared here in the Performance Report, under the heading of clinical service developments.

### **Register of interests for directors and governors**

All directors and governors are required to comply with the Trust's code of conduct and declare any interests that may result in a potential conflict of interest in their role as a director or governor of the Trust.

For the purpose of meeting annual report guidance, we report that our chairman Prem Singh has no significant external interests, and his interests are included in the register.

The register of interests is maintained and available to the public at the following address: Chief Executive's Department, Babington Hospital, Derby Road, Belper, Derbyshire, DE56 1WH and a copy is also published on our Trust's website at the following link <http://www.dchs.nhs.uk/home/about/freedom-of-information1/foi-publication-scheme>.

### **Cost allocation and charging requirements**

We have complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector information guidance.

### **Political and charitable donations**

We did not make any political or charitable donations from our exchequer or charitable funds during 2020/21.

### **Prompt payment practice code**

Our Trust is a signatory to the prompt payment code and committed to paying our suppliers within clearly defined terms. We also commit to ensuring there is a proper process for dealing with any invoices that are in dispute. Our Trust's performance is detailed below:

	<b>NHS</b>	<b>Non NHS</b>
Value	98.91%	98.66%
Volume	98.57%	98.95%

There has been no interest paid under the Late Payment of Commercial Debts (Interest) Act 1998.

### **NHS Oversight Framework**

NHS England and NHS Improvement's NHS Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability (well-led).

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

Derbyshire Community Health Services NHS Foundation Trust is a segment 1 organisation. This segmentation information is the Trust's position as at 19 May 2021. Current segmentation information for NHS Trusts and NHS Foundation Trusts is published on the NHS England website.

### **Income disclosures**

During the year ending 31 March 2021, our Trust generated income of £198.9m for the provision of services, principally to the people of Derbyshire.

Of that total, £178.6m income was for patient care activities, as shown in note three of the accounts. The Trust complied with Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) which requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other services.

In addition to clinical income, our Trust generated other operating income of £20.3m as shown in note four of the accounts. This income related to recharges to other bodies for staff and supplies provided to them, research and development, education and training and many other services that supported healthcare services being provided. This has not impacted on our delivery of services.

### **Disclosure of information to auditors**

So far as the directors are aware, there is no relevant audit information of which the auditors are unaware, and the directors have taken all of the steps that they ought to have taken as directors to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Signed



**Tracy Allen**  
**Chief Executive**

**15 June 2021**

## Annual statement on remuneration 2020/21

This report contains details of how the remuneration of senior managers is determined.

A 'senior manager' is defined as 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Trust. The Trust deems this to be the executive and non-executive members of the Board of Directors.

As chair of the Remuneration and Term of Service Committee I have reviewed the definition of 'senior manager' and can confirm that this covers the members of the Trust Board only. I also confirm that the remuneration report complies with:

- Section 420 to 422 of the Companies Act 2006
- Regulation 11 parts 3 and 5 of schedule 8 of the large and medium-sized companies and groups regulations 2008
- Parts 2 and 4 of schedule 8 of the regulations as adopted by NHS Improvement in this manual
- Elements of the NHS Foundation Trust code of governance.

### Major decisions on senior managers' remuneration

There were no major decisions on senior managers' remuneration made by the Remuneration and Terms of Service Committee in 2020/21.

### Substantial changes to senior managers' remuneration during the year and the context for these

There were no substantial changes to senior managers' remuneration during 2020/21.

Signed



**Prem Singh**  
Chairman

**15 June 2021**

## Senior managers' remuneration policy Future policy table - executive directors

Components:

- A pay point that is benchmarked against similar roles in similar sized NHS organisations
- Cost of living pay rises that are in line with other groups of staff in the NHS.
- In respect of Agenda for Change staff, in line with national agreements, the assumption is one of progression unless an individual is subject to performance measures.

Component	How this operates	How this supports the Trust's short and long term strategic objectives	Maximum that can be paid	Framework used to assess performance and performance measures that apply	Provisions for recovery or withholding of payments
Annual flat-rate salary, taxable benefits and pension benefits reviewed regularly with reference to the wider NHS directors pay and the pay award to other NHS staff in any given year (applies to all executive directors with no specific differences for individual directors).	This is set out below under the section headed 'Remuneration policy'.	It enables executive directors to take a balanced view between short and long term objectives which are based on key items determined by the Annual Plan	Remuneration is based on flat rate salary, benefits in kind and pension related benefits	Performance review is in place. Remuneration is based on flat-rate salary, it is not performance related and measures do not therefore apply	Provision is made for termination of the contract without notice in certain circumstances.

### Notes on future policy table

No new components of the remuneration package have been introduced in 2020/21 nor have any changes been made to existing components.

The differences between the policy on senior managers' remuneration and the general policy on employees' remuneration are set out below under the section headed 'Remuneration policy'. Senior managers are classed as executive directors, excluding associate directors. NHS pay for employees is set nationally within Agenda For Change. Pay for executive directors, who are classed as our senior managers, are set locally following national guidance, through our Remuneration and Terms of Service Committee.

The chief executive was paid £141,484 pro-rata £157,204 during 2020/21 (2019/20: £139,956 pro-rata £155,507). We are satisfied that this remuneration is reasonable having undertaken benchmarking work, both in terms of salaries of chief executive officers of small to medium-sized Trusts and gender equality. The salary paid was approved by both NHS Improvement and the Treasury.

The remuneration of the medical director is directly attributable to his executive director role. He has no clinical duties.

### Non-executive directors

Component	Additional fees	Other remuneration
Annual flat-rate non pensionable fee, with a higher rate payable for the chair of the Trust. The total monetary amount of these fees was £141,750 in 2020/21 (£145,000 in 2019/20)	Not applicable – flat rate fees	Not applicable

### Use of external advisors

Our Remuneration and Term of Service Committee has not used external advisors to provide advice or services on remuneration matters.

### Service contracts for senior managers

The service contract for the chief executive and executive directors is the contract of employment. This is substantive and continues until the director retires; otherwise, the notice period for termination by the Trust is six months and for termination by the director, three months.

The contract does not provide for any other payments for loss of office but does provide for compensation for early retirement and redundancy in accordance with the provisions in section 16 of the Agenda for Change: NHS terms and conditions of service handbook.

Our Trust's approach to executive directors' remuneration is to ensure that the Trust can attract, motivate and retain the high calibre executives it needs through paying a market remuneration package, taking account of our financial condition and providing value for money for tax payers.

The Remuneration and Terms of Service Committee is responsible for ensuring that the remuneration packages that are paid to the executive directors and associate directors are in line with boardroom pay in the NHS and reflect the performance of the organisation and the individual. The exact remuneration package is determined by the committee based on market position to comparable Trusts and our Trust's performance and the individual's contribution. The process for reviewing executive remuneration is as follows:

### **Recruiting executive directors**

- For new appointments we will undertake a market review of salaries with comparable organisations from data available, both nationally and locally
- Before determining the salary we will take into account the salary paid to the previous incumbent and to parity with other executive directors
- For appointments with a salary level of over £150,000 we will follow the requirements to seek Treasury approval.

The Remuneration and Terms of Service Committee determines the remuneration of the executive directors with the aim of attracting and retaining high calibre directors who will ensure the continued success of the Trust in providing the highest quality patient care. Employees are not consulted.

Salary levels are reviewed regularly with reference to the wider NHS directors' pay and the pay award to other NHS staff in any given year.

All non-medical employees at the Trust, including senior managers, are remunerated in accordance with the nationally agreed NHS pay structure, Agenda for Change. Medical staff are remunerated in accordance with the national terms and conditions of service for doctors and dentists.

### **Non-executive directors**

The service contract for non-executive directors is not an employment contract.

Our constitution regarding the non-executive term of office is compliant with the NHS code of governance. In the case of re-appointment of non-executive directors, the chairperson

should confirm to the governors that following formal performance evaluation, the performance of the individual proposed for re-appointment continues to be effective and to demonstrate commitment to the role. Any term beyond six years (eg. two three-year terms) for a non-executive director is subject to particularly rigorous review and takes into account the need for progressive refreshing of the board. Non-executive directors may, in exceptional circumstances, serve longer than six years (eg. two three-year terms following authorisation of the NHS Foundation Trust) but this should be subject to annual re-appointment.

The notice period for termination is one month on either side and the contract does not provide for any other payments for loss of office.

The Council of Governors determines the pay and terms of office of our chair and non-executive directors, on recommendation of the Trust's Nomination and Remuneration Committee and in accordance with national policy.

### Information not subject to audit

#### Details of the service contract for each executive director at 31 March 2021

Name	Title	Service contract start date	*Date of new service contract	Unexpired term (years)		
				0 - 10	11 - 20	21 - 30
Tracy Allen	Chief executive	2 January 2007	17 April 2015		✓	
Chris Sands	Director of finance and strategy/deputy chief executive	1 August 2011	17 April 2015		✓	
William Jones	Chief operating officer	6 June 2011	17 April 2015	✓		
Michelle Bateman	Director of nursing, allied health professionals and quality	16 February 2019	n/a	✓		
Ben Pearson	Medical director	3 June 2019	n/a		✓	
Melanie Curd	Associate director of corporate governance	2 September 2019	n/a		✓	

<i>Tim Broadley</i>	<i>Director of strategy (until 26 November 2020)*</i>	<i>6 January 2020 (retire and return)</i>	<i>n/a</i>	✓		
<i>Jim Austin</i>	<i>Chief information and transformation officer</i>	<i>1 May 2015</i>	<i>n/a</i>		✓	
<i>Paul Renshaw</i>	<i>Interim director of people services and organisational effectiveness (until 30 September 2020)</i>	<i>9 March 2020</i>	<i>n/a</i>		✓	
<i>Darren Tidmarsh</i>	<i>Director of people services and organisational effectiveness (from 7 September 2020)</i>	<i>1 September 2020</i>	<i>n/a</i>			

*\*Tim Broadley's contract ran until 26 November 2020 but his last day at work was 29 October 2020, the difference accounted for by previously untaken annual leave.*

*As default retirement age has been phased out, state pension age has been used to calculate the unexpired term on the assumption that senior managers planned to retire at state pension age.*

*\* Executive directors signed new contracts of employment to incorporate the "duty of candour and fit and proper persons test".*

### **The Remuneration and Terms of Service Committee**

The Remuneration and Terms of Service Committee is chaired by Trust chairman Prem Singh and comprises non-executive directors. The committee has delegated responsibility to determine the remuneration, allowances and other terms and conditions of the executive directors and to oversee any new executive director appointments during the year. The committee met on five occasions during the period 1 April 2020 to 31 March 2021. The membership and attendance at the committee is detailed in the table below.

Attendance at Remuneration and Terms of Service Committee		15 May 2020	2 July 2020	6 August 2020	5 November 2020	7 January 2021
Prem Singh	Chairman	✓	✓	✓	✓	✓
Kaye Burnett	Non-executive director	✓	✓	✗	✓	✓

Attendance at Remuneration and Terms of Service Committee		15 May 2020	2 July 2020	6 August 2020	5 November 2020	7 January 2021
Kay Fawcett	Non-executive director	✓	✓	✓	✓	✓
Richard Harcourt	Associate non-executive director	✓	✓	✗	✓	✓
Joy Hollister* currently on sabbatical until January 2022	Non-executive director	✗	✓	✗	✓	
Julie Houlder	Non-executive director	✓	✓	✓	✓	✓
Ian Lichfield	Non-executive director	✓	✓	✓	✓	✓
James Reilly	Non-executive director	✓	✓	✓	✓	✗

The Remuneration and Terms of Service Committee receives support from the chief executive and executive directors to assist the committee in their considerations of any matters.

During 2020/21 we made one new executive appointment, for our director of people services and organisational effectiveness, following the departure of the previous post-holder to another Trust.

We engaged with NHS Leadership Academy to handle the recruitment process. They undertook a search for candidates on our behalf and we also advertised in the Health Service Journal. The post then had an interview panel and a stakeholder panel.

### Remuneration policy

The Remuneration and Terms of Service Committee determines the remuneration of the executive directors, with the aim of attracting and retaining high calibre directors who will ensure the continued success of the Trust in providing the highest quality patient care.

Remuneration for executive directors, who are voting members of the Board, consists of a salary plus pension contributions. Salary levels are reviewed regularly with reference to the wider NHS directors' pay and the pay award to other NHS staff in any given year.

No director is involved in, or votes in, any matter pertaining to their own remuneration.

Performance is assessed through the annual appraisal process in line with our Trust's policies. The appraisal of all the executive directors is carried out by the chief executive. All the executive directors have a six-month notice period written into their contracts. A summary of the appraisal for the chief executive and other executive directors is presented to the Remuneration and Terms of Service Committee on an annual basis.

The only non-cash element of remuneration is the pension-related benefit which accrues under the NHS Pension Scheme. Contributions are made by both the employee and the employer under the rules of the scheme which are applicable to all NHS staff in the scheme. We do not make termination payments to executive directors in excess of contractual obligations. There have been no such payments during 2020/21.

Non-executive directors, including the chairman, do not hold service contracts and are appointed for between three to four years. Non-executive directors do not receive pensionable remuneration. There were no amounts payable to third parties in respect of the services of a non-executive director and they received no benefits in kind. Expenses properly incurred in the course of the Trust's business were reimbursed in line with the Trust's policies.

## Expenses

Expenses paid to governors, executive and non-executive directors are detailed in this table:

	2020/21			2019/20		
	Number		Expenses £ '00	Number		Expenses £ '00
	Total	Receiving expenses		Total	Receiving expenses	
Directors	9	9	23	9	9	22
Non-executive directors	8	4	9	8	8	12
Governors	28	3	2	28	18	6
Total	45	16	34	45	35	40

## Information subject to audit

### Trust board salaries and allowances

		1 April 2020 to 31 March 2021					
		Salary and fees <i>(bands of £5,000)</i>	Taxable benefits * <i>(Rounded to the nearest £00)</i>	Annual performance related bonuses <i>(bands of £5,000)</i>	Long-term performance related bonuses <i>(bands of £5,000)</i>	All pension related benefits <i>(bands of £2,500)</i>	Total <i>(bands of £5,000)</i>
<i>Name</i>	<i>Title</i>	£0	£0	£0	£0	£0	£0
Prem Singh	Chairman	45-50	-	-	-	-	45-50
Tracy Allen	Chief executive	140-145	41	-	-	110-112.5	255-260
Chris Sands	Director of finance and strategy/deputy chief executive	125-130	41	-	-	32.5-35	165-170
Paul Renshaw	Interim director of people service and organisational effectiveness (01.04.2020 - 04.09.20)	70-75	-	-	-	75-77.5	145-150
Darren Tidmarsh	Director of people services and organisational effectiveness (07.09.20 - 31 March 2021)	60-65	24	-	-	25-27.5	90-95
William Jones	Chief operating officer	115-120	48	-	-	-	120-125
Michelle Bateman	Director of nursing, allied health professionals and quality	105-110	41	-	-	27.5-30	140-145
Ben Pearson	Medical director	135-140	41	-	-	32.5-35	175-180
Jim Austin	Chief information and transformation officer	115-120	7	-	-	27.5-30	145-150
Tim Broadley	Director of strategy (01-04.20 – 29.10.20)	55-60	5	-	-	-	55-60
Mel Curd	Associate director of corporate governance	75-80	-	-	-	45-47.5	125-130

Kaye Burnett	Non-executive director	10-15	-	-	-	-	10-15
Richard Harcourt	Associate non-executive director	10-15	-	-	-	-	10-15
Kay Fawcett	Non-executive director	10-15	-	-	-	-	10-15
Joy Hollister	Non-executive director (Sabbatical 01.01.21 – 31.12.21)	5-10	-	-	-	-	5-10
Julie Houlder	Non-executive director	10-15	-	-	-	-	10-15
Ian Lichfield	Non-executive director	10-15	-	-	-	-	10-15
James Reilly	Non-executive director	10-15	-	-	-	-	10-15

\*relates to car user allowances, shown in £100s

### Information subject to audit

		1 April 2019 to 31 March 2020					
		Salary and fees <i>(bands of £5,000)</i>	Taxable benefits * <i>(Rounded to the nearest £00)</i>	Annual performance related bonuses <i>(bands of £5,000)</i>	Long-term performance related bonuses <i>(bands of £5,000)</i>	All pension related benefits <i>(bands of £2,500)</i>	Total <i>(bands of £5,000)</i>
Name	Title	£0	£0	£0	£0	£0	£0
Prem Singh	Chairman	45-50	-	-	-	-	45 - 50
Tracy Allen	Chief executive	140-145	41	-	-	22.5-25	165-170
Chris Sands	Director of finance and strategy/deputy chief executive Acting chief executive (1.05.19 to 31.08.19)	125-130	41	-	-	32.5-35	165-170
Amanda Rawlings	Director of people services and organisational effectiveness	55-60	10	-	-	5-7.5	65-70
Rick Meredith	Medical director (01.4.19 to 31.05.19)	15-20	7	-	-	-	15-20
William Jones	Chief operating officer	115-120	48	-	-	25-27.5	145-150
Michelle Bateman	Director of nursing, allied health professionals and quality	105-110	45	-	-	157.5-160	270-275

Ben Pearson	Medical director (from 01.06.19)	110-115	34			125-127.5	245-250
Paul Renshaw	Interim director of people services and organisational effectiveness (from 09.03.20)	5-10				35-37.5	45-50
Jim Austin	Chief information and transformation officer	115-120	7			25-27.5	140-145
Tim Broadley	Director of strategy (until 29.10.21)	95-100	14				95-100
Cath Benfield	Acting director of finance (01.05.19 to 31.08.19)	25-30				40-42.5	70-75
Kirsteen Farrar	Trust secretary/associate director of corporate governance (01.05.19 to 31.08.19)	45-50	3	-	-		45-50
Mel Curd	Trust secretary/associate director of corporate governance (from 01.09.19)	40-45				25-27.5	70-75
Kaye Burnett	Non-executive director	10-15	-	-	-	-	10-15
Richard Harcourt	Associate non-executive director	5-10					5-10
Kay Fawcett	Non-executive director	5-10	-	-	-	-	5-10
Joy Hollister	Non-executive director	5-10	-	-	-	-	5-10
Julie Houlder	Non-executive director	10-15	-	-	-	-	10-15
Ian Lichfield	Non-executive director	10-15	-	-	-	-	10-15
James Reilly	Non-executive director	10-15	-	-	-	-	10-15

\*relates to car user allowances, shown in £100s

## Pensions

Certain members do not receive pensionable remuneration therefore there will be no entries in respect of pensions for non-executive directors.

There are no additional benefits that will become receivable by directors in the event that the senior manager retires early. There are no senior managers who have rights under more than one type of pension.

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide.

NHS Pensions are still assessing the impact of the McCloud judgement in relation to changes to benefits in the NHS 2015 scheme. The benefits and related CETVs disclosed do not allow for any potential future adjustments that may arise from this judgement.

### Information subject to audit

The pension benefit table provides further information on the pension benefits accruing to the individual at 31 March 2021.

Name	Title	Real increase in pension at age 60	Real increase in pension lump sum at age 60	Total accrued pension at age 60 at 31 March 2020	Lump sum at age 60 related to accrued pension at 31 March 2020	Cash equivalent Transfer Cash equivalent transfer value at 31 March 2020	Real increase cash equivalent transfer value	Cash equivalent transfer value at 31 March 2020	Employer's contribution to stakeholder pension
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	(bands of £1,000)	(bands of £1,000)	(bands of £1,000)	(bands of £1,000)
Tracy Allen	Chief executive	5-7.5	0-2.5	60-65	135-140	1041	57	1116	20
Chris Sands	Director of finance and strategy/deputy chief executive	0-2.5	-	45-50	95-100	763	419	11978	18
Michelle Bateman	Director of nursing, allied health professionals and quality	0-2.5	5-7.5	45-50	140-145	969	66	1052	26
William Jones	Chief operating officer	0-2.5	0-2.5	55-60	165-170	1275	46	1343	17

Ben Pearson	Medical Director	2.5-5	0-2.5	55-60	125-130	1039	60	1117	20
Mel Curd	Trust secretary/associate director of corporate governance	2.5-5	2.5-5	20-25	35-40	262	44	311	11
Jim Austin	Chief Information and transformation officer	0-2.5	-	15-20	-	163	-	166	17
Tim Broadley	Director of strategy (01.04.20 - 29.10.20)	-	-	-	-	-	-	-	-
Paul Renshaw	Interim director of people services and organisational effectiveness (01.04.20 - 04.09.20)	0-2.5	-	10-15	-	108	24	166	10
Darren Tidmarsh	Director of people services and organisational effectiveness (07.09.20-31.03.21)	0-2.5	-	5-10	-	38	13	61	9

Darren Tidmarsh only has membership in the 2015 scheme. No lump sum will be shown for senior managers who only have membership in the 2015 scheme.

### Cash equivalent transfer value

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme.

They also include any additional pension benefit accrued to the member as a result of purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

### **Real increase in CETV**

This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrual pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

### **Information subject to audit**

#### **Fair pay multiples**

Reporting bodies are required to disclose the relationship between the highest paid director and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director at the Trust during 2020/21 was £160-165k (2019/20 £155-160k); this was 6.6 times more than the median pay of £24,305 (2019/20 6.1 times median pay of £25,171).

The Trust is required to calculate the fair pay multiple based on all staff in post as at the end of March 2021 on an annualised basis. Where staff are employed on a part-time basis, their salary is calculated as if they were in the Trust's full-time employment. This is to ensure that the actual salary cost of part-time staff does not distort the overall median pay value.

On this basis in 2020/21 no employee received remuneration in excess of the highest paid director.

Total remuneration includes salary, non-consolidated performance pay and benefits in kind. It does not include severance payments, employer pension contributions or the cash equivalent transfer value of pensions. During 2020/21, there are no significant changes on either side of the ratio.

Signed



**Tracy Allen**  
**Chief Executive**

**15 June 2021**

## Staff report

It has been the most challenging year on record for our colleagues, alongside everyone working in the NHS and other public services. The early pandemic response often involved swift changes in individual working arrangements and redeployment into different services as we collectively worked towards combating the threat of Covid-19 in our communities. Later in the year, as we began on the restoration and recovery of services which had been paused during the height of the pandemic, we have faced a new set of challenges of restoring services, running vaccination services and addressing waiting lists.

It has never been more important to make sure that our colleagues feel safe and supported at work. Our People Plan 2020/21 had a strong focus on looking after our colleagues, was aligned with service and financial plans and, wherever possible, was developed alongside partners, including social care and public health. During the year, one of our non-executive directors took on a new responsibility as wellbeing guardian specifically to look at our activities from a health and wellbeing perspective.

We employ in the region of 4,200 substantive staff, making us one of the largest specialist community health services in the country, serving a widespread local patient population in both urban and rural parts of Derbyshire and in Derby city.

In addition to our substantive workforce, we have a well-established internal bank, meaning that we have over 1,300 committed bank workers supporting us to deliver high quality patient care and ensuring our agency usage is kept to a minimum.

Details of our staff turnover are published by NHS Digital on this website:

<https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics>

### The workforce plan

Our workforce plan continues to be based on a strong commitment to strengthen our position within the Derbyshire health and care system and particularly within the primary care networks. The move to be a 'system by default' operational model has been the main development as the Derbyshire integrated care system was formally established from April 2021.

The workforce plan has been developed in collaboration where possible, with our health and social care partners, including engagement with private, independent and voluntary providers. We recognise their contribution to developing a sustainable workforce, developing services in partnership with them and working to explore new opportunities for them to make a difference to the wellbeing of our patients. This partnership has further strengthened through the year as services developed to support Joined Up Care Derbyshire.

The main focus of our work during this year has been to support our staff and services through the Covid-19 pandemic and then to focus our attention on restoration and recovery of our services within the context of the integrated care system. We have also been at the forefront of setting up the Covid-19 vaccination centres.

We recognise that our people need to be at the heart of plans for recovery and transformation and our plans reflect the need for staff to get the support, rest and recuperation that they need. Our foremost attention to support the health and wellbeing of staff and taking action on recruitment and retention.

Our People Plan reflects the progress made in 2020/2021 as well as shows greater progress on equality, diversity and inclusion; progress on compassionate and inclusive cultures; and increasing workforce supply. These themes were highlighted as part of the review of local plans in September 2020. All of our workforce actions and priorities are aligned to the NHS People Plan “We are the NHS : People Plan 2020/21 - action for us all” published in July 2020.

### **Looking after our people**

Our staff will need to recover from the demands of the pandemic in different ways, and their safety remains a priority. We have support in place to help our staff, given what they have been through over the past 12 months.

We have provision to support staff to carry over all unused annual leave and offer flexibility for staff to take or buyback unused leave. All staff will be encouraged to take time off to recover, making use of annual leave which may be carried over from 2020/21.

Individual health and wellbeing conversations will be a regular part of supporting all staff with an expectation that a plan is agreed at least annually and should take place over the course of the first half of the year. Staff safety remains a priority and these plans will include risk assessment, flexible working, compliance with infection prevention and control policy, and Covid-19 testing policy, as well as drawing on the range of preventative health and wellbeing support we have made available.

Occupational health and wellbeing support is available for all staff, including rapid access to psychological and specialist support. We will access the national investment made to roll out mental health hubs in each integrated care system and allow our staff time to access this service.

We have developed an optional staff transfer scheme to support staff retention. This will offer staff the option for alternative employment, redeployment and flexible retirement options to achieve alternative employment opportunities where possible to accommodate individual needs.

## **Belonging in the NHS**

Covid-19 has surfaced inequalities that can be harmful to our people and addressing this remains an urgent priority. Derbyshire's black minority and ethnic (BME) population represent 6.7% of the total, as per the Office of National Statistics, and we have plans in place to increase our BME staff to reflect this. We are committed to shaping the culture positively and to promoting behaviour which is fair, diverse and inclusive, with a particular focus on tackling the discrimination that some staff face.

We are supporting this development through our staff networks which offer support and guidance for staff to network with like-minded colleagues and increase quality issues through allyship. Allyship is about building relationships of trust, consistency and accountability with marginalised individuals and/or groups of people. The executive team also provides directives and looks to the groups to support the aims of the Trust, as well as the groups feeding into the executive team where support may be needed to facilitate change.

We have:

- Developed improvement plans based on the latest workforce race equality standards (WRES) findings, including the need to improve diversity through recruitment and promotion practices
- Accelerated the delivery of the model employer goals.

## **New ways of working and delivering care**

During the pandemic, our people adopted innovative ways of working to make best use of their skills and experience to benefit our patients. Progress is now being made to further develop and embed workforce transformations to support recovery and longer-term changes:

- We will further maximise the use of and potential benefits of e-rostering, giving colleagues better control and visibility of their working patterns, supporting service improvements and the most effective deployment of individuals
- We are undertaking a comprehensive review of the e-roster system to ensure that we have the most effective tool to support safe, effective, and efficient rostering of staff. A project group has been established to support this with representation from all directorates
- We have encouraged and supported colleagues to make use of interventions to facilitate flexibility and staff movement, including remote working plans, technology enhanced learning and the option of staff digital passports. We have an interim flexible working guide. This guide sets out how staff can request temporary working arrangements
- We are beginning to look at staff rotations across the system and developing and increase rotational posts.

## **Growing for the future**

During the pandemic we were able to grow our workforce through a range of innovative measures that helped us to deal successfully with Covid-19 while treating patients with a range of other conditions. We will now take steps to increase the size of our workforce sustainably and reduce our vacancies, in line with measures set out in the NHS Long Term Plan. We will:

- Develop and deliver a local workforce supply plan with a focus on recruitment and retention, demonstrating effective collaboration to increase overall supply, widen labour participation in the health and care system, and support economic recovery
- Ensure system plans draw on national interventions to introduce new and extended roles and make use of associated national funding, notably the initiative to increase health care support workers
- Support the recovery of the education and training pipeline by putting in place the right amount of clinical placement capacity to allow students to qualify and register as close to their initial expected date as possible
- Develop and implement robust postgraduate training recovery plans that integrate local training needs into service delivery planning
- Ensure that workforce plans cover all services. The plans will support the major expansion and development of integrated teams in the community, with primary care networks serving as the foundation, assisted to make full use of their additional roles reimbursement scheme funding, including through the options of rotational or joint employment.

## **Diversity and inclusion policies**

In 2020, the urgent work to respond to the ongoing Covid-19 pandemic coupled with lockdown restrictions, service pressures, staff redeployment and the Covid-19 vaccination programme delayed, and in some cases culminated in the suspension of, some planned equality, diversity and inclusion (EDI) work programme including in-person EDI events such as multi-faith tours, Derbyshire LGBT+ conference, Pride events, cohort 2 of our reverse (to be changed to reciprocal) mentoring programme, delivery of equalities training for our quality and safe care champions for dignity and inclusion, to mention a few.

Details of our workforce composition are published in our 2019/2020 Workforce Disability Equality Standard (WDES) datasets and Workforce Race Equality Standard (WRES) datasets. More workforce profiles are available in our Public Sector Equality Duty Report (PSED) 2018/19 as well as our Gender Pay Gap (GPG)\_Report 2020. The Equality and Human Rights Commission (EHRC) recently announced that enforcement of deadlines for the latest instalments of both the PSED and GPG reporting has been delayed for six

months until 5 October 2021 due to the continued impact of the Covid-19 pandemic. Our [WDES](#) and [WRES](#) improvement action plans respectively set out initiatives being considered and/or taken to improve inclusion and workforce diversity as well as incrementally close or narrow disproportionate gaps in experiences, opportunities and outcomes for staff and job applicants between different protected groups.

Despite the challenge presented by the pandemic which restricted access to safe in-person contacts and accelerated the use of online technology for virtual meetings, our staff networks continue to offer a safe space for colleagues, particularly those with protected characteristics, to speak up, share their concerns/experiences and seek support or a listening ear confidentially. All our networks continue to have executive sponsorship. The huge online uptake culminated in growing attendance at network meetings and other engagement events. In addition to our BAME, disabilities and long-term conditions and LGBT+ staff networks, a fourth network, armed forces and veterans' network, set up in 2019, was formally launched during our inaugural EDI conference's plenary segment on 20 October 2020. Colleagues have protected time to attend network meetings and each network chair is offered paid day release per week to focus solely on work for their respective networks.

### **Supporting colleagues' wellbeing**

During Covid-19 the wellbeing team has scaled up the wellbeing support for staff and developed alternative methods of delivery. Along with the existing offer a central website hub was developed as a one stop shop for wellbeing information, a 24/7 phonenumber launched, the Thrive mental health app and clinical psychologist capacity made available.

1:1 wellbeing coaching calls have also been provided giving staff the opportunity to discuss any wellbeing worries, find solutions to current challenges, learn where to access further support and feel connected during a time where normal routines may have been disrupted.

The staff wellbeing team have launched six different virtual support sessions which are delivered on a weekly basis. These include everything from carers, shielders and redeployed staff to parenting, nutrition and physical health sessions. The overarching aim of these sessions is to provide a sense of connection which may have been weakened due to the nature of the pandemic.

Our Schwartz Rounds have taken a refreshed approach through 2020, taking them from physical face to face sessions to becoming virtual. This provided the opportunity to increase awareness and encourage staff to reflect and connect with others. A total of eight have now been delivered and with an average attendance of 40 people each session - aiding towards improving staff morale and communication levels.

During the year we achieved our highest ever staff flu vaccination rate, reaching 84.5%, beating the previous best of 80.7%. Vaccines were delivered via Covid-19 secure clinics across the county, the model acting as a trial run for the Covid-19 vaccination clinics which followed.

The continuation of the Derbyshire-wide system wellbeing group has developed the Derbyshire system staff wellbeing offer, increasing best practice and reducing inequity. This has developed into a system wide 'mental health hub' providing rapid access and assessment for the 50,000 health and social care staff across Derbyshire.

We launched the reproductive and hormone health project which is a dedicated role looking at understanding the key factors affecting women's health at work and launching interventions to make our Trust a best practice employer for women.

The launch of the Thrive mental health app, has provided mindfulness, breathing, relaxation and cognitive behaviour therapy exercises via employees' phones. This was nominated for an award for the use of technology in staff wellbeing at the InsideOut staff wellbeing awards and was announced as the winner in March 2021. The Thrive app has been a staple of our offer and we have been working with the provider to introduce several changes. One of these changes includes a "manager check request." This additional feature enables users to have a better oversight of their personal wellbeing data. This provides a better understanding of staff wellbeing and can be used to offer more targeted wellbeing interventions.

The mediation service was relaunched with 15 new accredited mediators able to provide mediation support which has dramatically increased our capacity. The Resolve service has supported over 10% of the workforce to access counselling, and an average time to appointment of less than two working weeks. Of the staff accessing Resolve support 87% said it helped them not to take time off sick.

These elements, along with the day-to-day offer of bespoke team sessions, coaching and manager support, has seen us increase the NHS Staff Survey wellbeing score, which takes us further beyond the average for similar Trusts than in previous years.

## Information subject to audit

### Our staff

<b>Total staff as at 31 March 2021 *</b>		
<b>Gender</b>	<b>2019/20</b>	<b>2020/21*</b>
Female	3,725	3,757
Male	457	477
<b>Total</b>	<b>4,182</b>	<b>4,234</b>
<b>Executive directors as at 31 March 2021*</b>		
<b>Gender</b>	<b>2019/20</b>	<b>2020/21*</b>
Female	3	3
Male	4	4
<b>Total</b>	<b>7</b>	<b>7</b>
<b>Senior managers as at 31 March 2021*</b>		
<b>Gender</b>	<b>2019/20</b>	<b>2020/21*</b>
Female	18.6	22.51
Male	4.8	7.00
<b>Total</b>	<b>23.40</b>	<b>29.51</b>

\* Based on staff employed at 31 March 2021 as whole-time equivalents.

### Average number of employees (WTE basis)

Our average whole time equivalent (WTE) staff numbers in 2020/21 are based on an accumulation of the total WTE staff throughout the year, divided by 12 to give the average WTE.

**Information subject to audit**

	<b>2020/21 permanent number</b>	<b>2020/21 other number</b>	<b>2020/21 total number</b>	<b>2019/20 total number</b>
Medical and dental	20.40	1.12	21.52	38.73
Ambulance	0	0	0	0
Administration and estates	687.55	22.37	709.91	731.27
Healthcare assistants and other support staff	884.37	19.91	904.28	901.05
Nursing, midwifery and health visiting staff	1,124.71	15.56	1,140.27	1105.05
Scientific, therapeutic and technical staff	548.68	10.05	558.74	572.19
Other	0	0	0	0
<b>Total average numbers</b>	<b>3,265.71</b>	<b>69.01</b>	<b>3,334.72</b>	<b>3,348.30</b>

<b>Staff groups</b>	<b>Average of fixed term temporary staff 2020/21</b>	<b>Average of permanently employed staff* 2020/21</b>
Administration and estates staff	22.37	687.55
Ambulance staff	00.00	00.00
General payments	00.00	00.00
Health care assistants/other support staff	19.91	884.37
Healthcare science	0.25	13.74
Medical and dental staff	1.12	20.40
Nursing, midwifery and health visiting learners	8.08	14.82
Nursing, midwifery and health visiting staff	7.47	1109.90
Scientific, therapeutic and technical staff	9.80	534.94
<b>Total</b>	<b>69.01</b>	<b>3265.71</b>

## **Gender pay gap**

We are committed to developing initiatives and implementing workforce strategies to remove the imbalance relating to pay levels of male and female employees. We monitor our gender pay gap details closely and submit our gender pay gap information for publication annually on the Gov.UK website <https://gender-pay-gap.service.gov.uk> as well as on our website's workforce diversity analysis page:

[http://www.dchs.nhs.uk/home/about/equalityand\\_diversity](http://www.dchs.nhs.uk/home/about/equalityand_diversity)

## **Absences**

Covid-19 has continued to have a substantial impact upon the organisation's sickness absence. Our sickness absence data has all been published by NHS Digital and can be found on this link: [NHS Sickness Absence Rates - NHS Digital](https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates) (<https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates>)

## **Reasons for absences**

The latest figures published by NHS Digital on Covid-19 absence show that the effect it has had on our absence rate is in line with that of other Trusts, both within the Midlands area and nationally.

The trend in Covid-19 sickness continued to mirror the impact of the pandemic nationally, as we moved further into the third wave. The average number of new cases being reported per week during December and January was 17 compared to an average 11 during October and November. However, it should be noted that Covid-19 absence dropped from a peak in January of 108 reported cases to 86 at the beginning of February.

The rolling 12-month sickness absence average stands at 5.16% and the trend associated to this figure shows a stable sickness position, but one that is still unable to meet the Trust's target of 4.5%.

Although absence rates over January and February were at a five-year high a third of this sickness can be attributed to Covid-19. This has highlighted a sharp drop in the number of reported illnesses relating to coughs, colds and flu which may indicate that some managers are recording this type of illness incorrectly as Covid-19.

The latest figures produced by NHS digital show sickness absence related to stress, anxiety, depression and other psychiatric illnesses to be consistently the most reported reason for sickness absence across the NHS. This is reflected in our sickness absence, as once Covid-19 sickness is removed from the data, stress and anxiety continues to be the main reason for sickness. However, it should be noted that this has reduced by approximately 4% when compared to this time last year. Musculoskeletal, chest and respiratory problems follow stress-related sickness as the second and third top reasons.

As the third wave began in early January, resulting in an increase in Covid-19 related absences, there was a risk that we would struggle to manage the demands on service provision during winter pressures. Lateral flow testing has helped to offset this risk in enabling Covid-19 positive staff to be identified quickly and reduce infection rates within teams. Positive lateral flow tests and subsequent PCR tests are being completed in a timely manner to enable staff to return to work wherever PCR negative results are received. The second highest sickness reason is musculoskeletal (MSK). It is acknowledged that as working from home impacts upon staff longer term there will be a risk in this type of sickness increasing. All staff are being encouraged to review their workplace risk assessments and seek support and equipment where required.

### **Freedom to Speak Up**

The Freedom to Speak up agenda has continued to develop during the year and has been particularly active during the Covid-19 pandemic, being one of a number of routes where staff could receive support to speak up if they had concerns.

Areas of concern during the pandemic were shared with the senior leadership team, directly influencing improvements for staff and patients.

The Freedom to Speak up Guardian heard 112 concerns during 2020/21, an increase of 52 from the previous year, when 60 concerns were heard.

This demonstrates a confidence in the FTSU approach and is a reflection of the open and honest and improvement culture within the Trust. Feedback on the process from staff has been extremely positive.

During the year, 18 Freedom to Speak Up Ambassadors were appointed to support the promotion of speaking up and to signpost staff to the guardian where appropriate.

Themes and learning are shared with Trust Board and the Audit and Assurance Committee, as well as more widely within the organisation, to ensure improvements are made.

### **A safe and healthy workplace**

Keeping our teams safe and well has been a priority throughout the last year. Covid-19 has presented us with a huge challenge, but our teams have responded incredibly.

From work to maintain infection prevention and control standards, the procurement and distribution of PPE, as well as supporting colleagues at greater individual risk of serious illness from Covid-19, there has been a great collective effort.

There have been changes to our ways of working, such as testing and screening, social distancing and making our spaces Covid-secure. Many people have been working from home, and we have supported them with additional training and equipment.

Tragically, we lost a colleague to Covid-19 during the year who is missed greatly by everyone who knew them.

Although much focus has been on the pandemic, there has been a lot of work on other areas affecting our health, safety and wellbeing. Violence and aggression, lifting and handling, slips and trips, and sharps injuries remain the most frequent causes of injuries to colleagues, and whilst we have worked hard to reduce them, we still have more to do.

As we recover from the impact of the past year, support for the mental health of our teams is also at the heart of our work.

Overall there were 433 incidents resulting in injury, over half of these were the result of violent behaviour. We reported 24 injuries under RIDDOR (the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013), an increase from the previous year (20 in 2019/20).

Our work during 2021/22 aims to reduce injuries and ill health at work, whilst supporting our teams through the continuing pandemic with both their mental and physical wellbeing.

### **Essential training**

We run a programme of essential training for staff, monitor and report on training compliance in all areas as part of our commitment to meet the statutory requirements, maintain safety and good practice. The figures below show our attempts to maintain our 96% target on training compliance.

We anticipated the impact of Covid-19 emergency response to affect our compliance as we saw a lot of staff redeployments and service disruptions and this is evidenced in our current training figures. As we slowly move into recovery phase for both our staff and services; we are working hard to support staff to ensure their training is renewed and is in date.

All our essential training is accessible via e-learning and staff can access this from anywhere without having to come into a classroom. A lot of focus will be directed at improving fire training, information governance and appraisal compliance and managers are being encouraged to take advantage of the newly introduced technology and new ways of working.

Training programmes	Compliance 31 March 2020	Compliance 31 March 2021	% DCHS target
Essential learning	97.90%	96.32%	96%
Information governance	97.52%	94.84%	96%
Fire training	95.12%	94.82%	96%
Appraisal	89.88%	86.53%	96%

### Disability confident leader



The disability confident scheme has been live since November 2016. It supports the Government's commitment to help one million more disabled people into work within the next ten years.

All employers start at level 1 and progress through the scheme at their own pace. The journey is as follows:

- Level 1: disability confident committed
- Level 2: disability confident employer
- Level 3: disability confident leader.

We are the holders of a disability confident leader award, first awarded to us during 2017/18 by the Department of Work and Pensions (DWP), in recognition of our commitment to ensuring our policies give fair consideration to disabled applicants, promote the continued employment of disabled employees or those who become disabled during their time with us and offer career progression/training for disabled employees. We are also continuing to undertake further work with the DWP and other NHS organisations and stakeholders in sharing our work on attaining leader status, as highlighted in the work undertaken previously to promote this.

Our award is now due to be renewed and we will be working closely with our relevant stakeholders to ensure this is retained.

## Engaging with our staff

We actively encourage staff to get involved in what's happening across the organisation, to be able to express their views and play an active role in how the culture of the organisation develops - and we also want to be able to thank people.

We have a number of established ways in which we provide information to staff on matters of concern to them as employees and also to encourage involvement by individuals in our organisation's performance.

We have a strong staff representation on our Council of Governors involved in making decisions affecting our workforce and the services we provide.

A quarterly Staff Forum brings together staff representatives with executives to discuss matters of interest and concern to staff, on topics chosen by staff.

Leadership Forums are quarterly three-hour sessions for people managers to discuss the latest developments with executives, and then share with their teams.

In addition to these ongoing organisation-wide engagement/information sharing opportunities, we also organise briefing sessions for groups of staff at their places of work to ensure their views can be taken into account on specific developments likely to affect them.

We have a strong culture of training, learning, development and raising concerns which are all designed to promote our approach to staff engagement. We hold topic specific engagement events, which are currently held virtually via Microsoft Teams.

## Saying thank you

We think it is important to celebrate the achievements of individuals and teams whose dedication and commitment shines through, including those who devote decades of their working life to the NHS and to our organisation. Nominees are a combination of colleagues who had been nominated, who were receiving their long service awards and teams who had retained their Gold Quality Always Accreditation.

**#DCHSTTT**

 **thank you,**  
 **time and**  
 **tea**

In the year of the pandemic, we had to get creative to ensure we were still able to recognise and thank our colleagues via our #DCHSTTT – thank you, time and tea party - reward and recognition scheme, as our normal events were postponed. We transformed these events into a virtual alternative and featured colleagues across our social media platforms @DCHStrust, ensuring a certificate, badge (if applicable) and letter were sent to recipients by post. They also received a small treat as they were unable to attend the tea party itself, which was a letter box brownie sourced from a Derbyshire based company.

Following on from the success of this, we were able to develop the #DCHSTTT even further. Nominees, both individuals and teams, received a box of treats including cakes and party poppers, to celebrate with one of our executives and our chairman in a celebratory MS Teams event to acknowledge and discuss their experience and success.

To further support staff engagement, we have been able to reward colleagues via our NHS Charities Together grants throughout the year. All staff received a £20 gift voucher before Christmas, where they had a choice of four options; Chatsworth Farm Shop, Denby, National Trust or a Love2Shop high street voucher.



We held again our 'Seasonal Stars' festive initiative leading up to Christmas. This feel good campaign began in 2018 and was sponsored in part by Thornton's and also a local Derbyshire based company: Charlotte's Chocolates. In 2020, we recognised over 200 colleagues, some of which were featured on our social media channels throughout December.

The Extra Mile Awards had become an established event in our calendar. We had held six award ceremonies prior to 2020. The COVID-19 pandemic meant we were unable to go ahead with our annual award ceremony last year. We plan to host a virtual event towards the end of 2021, so we can continue to recognise those who inspire others and deliver beyond expectations.

### **NHS Staff Survey**

The 2020 NHS Staff Survey was conducted between Monday 14 September and Friday 27 November 2020. A total of 2,528 colleagues from a usable sample of 4,045 completed the survey. This gives a 62.5% response rate, which is slightly above our response rate of 62.4% in 2019.

The annual NHS Staff Survey provides us with valuable feedback on how individuals feel about the NHS and our organisation in particular as a place to work. The results are widely shared and discussed through all our established staff engagement channels, including team talks, executive briefings, leadership and staff forums, to ensure staff at all levels have the opportunity to feed into the conversation about what the results tell us.

The results are grouped together into 10 themes (see below). All the themes cover areas of staff experience, helping to present results in these areas in a clear and consistent way. All of the ten themes are scored on a 0-10 scale, where a higher score is more positive than a lower score. These theme scores are created by scoring question results and grouping these results together. The themes are as follows:

1. Equality, diversity and inclusion
2. Health & wellbeing
3. Immediate managers
4. Morale
5. Quality of care
6. Safe environment – bullying and harassment
7. Safe environment – violence
8. Safety culture
9. Staff engagement
10. Team working.

There is no longer a theme on the quality of appraisals.

Scores for each indicator together with that of the survey benchmarking group community Trusts are presented in the following table. Full survey results are shared on our intranet site, called My DCHS, and via our all staff weekly email, My Download. All these channels help to feed into the detailed action plan to address areas where the survey shows we need to improve.

### Benchmarking with Community Trusts

Theme	2020		2019		2018	
	Trust	Benchmarking group	Trust	Benchmarking group	Trust	Benchmarking group
Equality, diversity and	9.5	9.4	9.5	9.4	9.4	9.3

inclusion						
Health and wellbeing	6.6	6.3	6.3	6.0	6.2	5.9
Immediate managers	7.2	7.2	7.2	7.2	7.0	7.0
Morale	6.7	6.5	6.5	6.3	6.3	6.2
Quality of care	7.7	7.5	7.7	7.4	7.6	7.3
Safe environment – bullying and harassment	8.7	8.5	8.6	8.4	8.5	8.4
Safe environment - violence	9.7	9.7	9.6	9.7	9.6	9.7
Safety Culture	7.2	7.1	7.2	7.0	7.1	7.0
Staff engagement	7.4	7.3	7.3	7.2	7.2	7.1
Team working	6.8	6.9	6.9	7.0	6.9	6.9

It is important to bear in mind that 2020 has not been “business as usual” for the NHS workforce. The impact of the Covid-19 pandemic has had a profound impact across the NHS. However, by measuring staff experience in a consistent way with previous years, the 2020 NHS Staff Survey provides a unique opportunity to understand the impact that the Covid-19 pandemic has had on staff experience.

## Addressing NHS Staff Survey findings

### Team working

We have been addressing the team working result, which was the only theme to score worse than 2019, in terms of people feeling their team had a set of shared objectives and in feeling that their team met often to discuss the team's effectiveness.

In March, we engaged with colleagues in our Staff Forum and with staff network groups, wellbeing champions and via the staff Facebook group to help us understand the reasons for this result.

We found a lot of the comments related to the disconnection caused by the Covid-19 pandemic, as team working was affected by factors such as remote working from home, redeployment into different teams, home schooling children, not seeing colleagues face to face and not having regular one to ones.

At the staff health wellbeing support safety and engagement group on 22 April 2021 it was agreed the main focus for the year ahead will be around team working and progress on this will be reported via this sub-committee.

### Other priority areas arising from the NHS Staff Survey

- **Equality, diversity and inclusion:** our overall score was positive but needs further investigation and analysis. The percentage of staff believing that we provide equal opportunities for career progression or promotion showed a 12.7% difference between how BME and non BME colleagues scored this question, which is also a 10% increase in gap from 2019. A focus on making improvements to our Workforce Race Equality Standard (WRES) data was recommended as one of the key areas for us over the next 12 months, particularly on career progression, and to understand the big gap between BME and non BME respondents.
- **Health and wellbeing:** we are working with the health and safety team to unpick increases in musculoskeletal absences and to target appropriate interventions. This includes exploring patterns in work-related stress from a team level and professional group data.
- **Morale/immediate managers:** we are running focus group/engagement sessions on team working and immediate manager data, correlating with team level staff survey data and cultural intelligence data on absence, turnover, appraisal and training.

- **Bullying and harassment:** we are correlating safety and DATIX data, alongside information provided by our employee relations team and Freedom to Speak Up Guardian, and intelligence from colleagues' perspectives.
- **Safety Culture:** we are working to understand how we increase the communications reach on changes made as a result of incident/error reporting and learning from benchmarking Trusts about how they have achieved top results in this area.

Equality, diversity and inclusion data, including the findings from the WRES and Workforce Disability Equality Standard (WDES), the protected characteristics data and further analysis to narrow down the findings has all now gone over to the equality, diversity and inclusion team to progress with the staff network groups and feed into the wider Equality, Diversity and Inclusion Strategy and action plans. This will be monitored via Equality Diversity and Inclusion Leadership Forum (EDILF).

### **Pulse Checks/NHS People Pulse**

We usually carry out quarterly pulse check surveys, (including the two key Staff Friends and Family Test (FFT) questions), which are circulated to all staff. The pulse checks help to monitor performance and take action where necessary and also to celebrate great results. The Trust did not run a Pulse Check in 2020 due to the Covid-19 pandemic. National guidance allowed postponements, as no information was needed to be recorded for NHS England on Staff FFT. We were also very conscious of the additional Covid-19 pressures faced by our colleagues and teams.

As a Trust we value continued feedback from all our colleagues. As such we decided to run the NHS People Pulse surveys over the summer of 2020. This gave the Trust an opportunity to hear how colleagues were feeling during the pandemic and helped us to understand what we were doing well and what we could do better.

### **Trade union regulations**

We support and value the work of our trade union and professional organisation representatives, promoting a climate of active co-operation between representatives, leadership teams and staff at all levels to achieve real service improvement, best patient care and our desire to be an employer of choice.

The Covid-19 pandemic necessitated significant changes to partnership working processes both collectively where substantive changes to working practices were rapidly implemented and due to the pausing of the volume of formal individual casework. Our Trust and

accredited reps worked together in the spirit of the national Staff Partnership Forum guidance to progress wide-ranging casework and staff concerns outside of formal process wherever possible, recognising that lack of resolution can result in additional uncertainty and anxiety.

As an organisation we recognise that outstanding practice requires an engaged and valued workforce, and we continue to seek to enhance and maintain these excellent employee relations through early involvement, engagement and intelligence sharing with our trade union partners. This has been particularly true with our Covid-19 pandemic response work.

In line with the Trade Union (Facility Time Publication Requirements) Regulations 2017 we have published details of facilities time carried out by our trade union representatives during the 2019/20 year on our website [www.dchs.nhs.uk](http://www.dchs.nhs.uk). This covers duties carried out for trade unions or as union learning representatives in relation to our Trust and staff.

In recognition of the additional workloads that has been placed upon our reps this year resulting from the pandemic, including massively increased clinical and frontline responsibilities and changes in their ways of working and the redeployment of key team members, the detailed data collation has been amended to enable a fair reflection of the time and commitments they have made but without the arduous need to compile detailed annual figures.

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
12	

Percentage of time union officials spent on facility time	Number of employees
0%	0
1-50%	9
51-99%	3
100%	0

### Percentage of pay bill spent on facility time

For the previous reporting period (2019/20) the total time spent on Facility Time (duties and activities) by the 14 reps active within our Trust was 3,733 hours.

Although detailed data has not been collated for 2020/21 evidence would suggest that this figure would be significantly reduced. Evidence to support this includes:

- Reduction in number of active reps (from 14 to 12)
- Massively increased workloads for all reps relating to their substantive frontline roles because of the Covid-19 pandemic, reducing the amount of time they have been able to commit to trade union duties and activities
- The national Social Partnership Forum guidance which recommended curtailing and streamlining of employee processes and decision-making
- The secondment of a rep to the staff partnership administrator role was ended early in the pandemic, enabling this member of staff to return to an alternative role
- A further member of the staff partnership team was redeployed to a role within the pharmacy team for a significant length of time during the year, and all staff partnership team members have taken on additional roles away from the trade union function to support the pandemic response, including administrative support at vaccination centres, PPE and pharmacy deliveries.

### **Paid trade union activities**

In 2019/20 the time spent on paid trade union activities as a percentage of total paid facility time was 4.66% - largely comprised of trade union conference attendance and regional activities. Using all the evidence above, and additional factors such as the wholesale cancellation of conferences, reduction in trade union branch regional and national activities, curtailment of union learning activities and evidence from comparable organisations, this figure for 2020/21 is potentially reduced to 1-2%.

### **Counter fraud/anti-bribery activities**

We support staff to be able to raise any concerns they may have with a dedicated local counter fraud specialist advice service from KPMG. We have developed a comprehensive counter fraud work plan in accordance with guidance received from NHS Protect. We also have a counter fraud policy approved by the Board of Directors. Anyone suspecting fraudulent activities within our services can report their suspicions to our local counter fraud specialist by telephoning the confidential hotline on: 0800 028 4060.

### **Information subject to audit**

#### **Staff costs**

	2020/21			2019/20		
	Total	Permanent	Others	Total	Permanent	Others
	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	105,961	105,951	10	102,677	102,544	133
Social security	9,501	9,501	-	8,945	8,945	-

costs						
Apprenticeship levy	537	537	-	518	518	-
Pension cost - defined contribution plans employer's contributions to NHS pensions	14,178	14,178	-	13,820	13,820	-
Pension cost - other	74	74	-	56	56	-
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	6,160	6,160	-	6,052	6,052	-
Termination benefits	4	4	-	(449)	(449)	-
Other employment benefits	4,624	-	4,624	2,841	-	2,841
Temporary staff - agency/contract staff	1,250	-	1,250	1,937	-	1,937
<b>Total gross staff costs</b>	<b>142,289</b>	<b>136,405</b>	<b>5,884</b>	<b>136,396</b>	<b>131,485</b>	<b>4,911</b>
Total staff costs - included within:						
	<b>2020/21</b>			<b>2019/20</b>		
<b>Costs capitalised as part of assets</b>	423	423	-	365	365	-
Employee expenses - staff	141,866	135,982	5,884	135,477	130,566	4,911
Employee expenses - executive directors	2,360	2,360	-	1,003	1,003	-

<b>Analysed into operating expenditure</b>						
	<b>2020/21</b>			<b>2019/20</b>		
Employee expenses - staff	141,866	135,982	5,884	135,477	130,566	4,911
Employee expenses – executive directors	2,360	2,360	-	1,003	1,003	-
Redundancy	4	4		(499)	(499)	
<b>Total employee benefits excluding capitalised costs</b>	<b>144,230</b>	<b>138,346</b>	<b>5,884</b>	<b>136,031</b>	<b>131,120</b>	<b>4,911</b>

### Expenditure on consultancy

	<b>2020/21</b>	<b>£'000</b>	<b>2019/20</b>	<b>£'000</b>
Spiritdigital ICS digital programme		184		-
Therapy service improvement		112		-
Information technology – SystmOne optimisation		-		196
Community engagement and nursing		27		32
Coaching and development		25		24
Service line reporting system		9		23
International financial reporting standards and VAT financing		20		18
Governance review		-		21
Estate valuation		-		2
Estate management		52		52
Workforce development		18		5
Recruitment		-		41
Other		23		18
<b>Total</b>		<b>470</b>		<b>432</b>

### Off-payroll engagement

The Public Expenditure (PES) paper (2018)13 published by HM Treasury which sets out disclosure on highly paid and/or senior off-payroll engagements.

For all off-payroll engagements as of 31 March 2021, for more than per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2021	-
Of which:	
The number that have existed for less than one year at the time of reporting	-
The number that have existed for between one and two years at the time of reporting	-
The number that have existed for between two and three years at the time of reporting	-
The number that have existed for between three and four years at the time of reporting	-
The number that have existed for four or more years at the time of reporting	-

### New off-payroll engagements

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2020 and 31 March 2021, for more than £245 per day and that last for longer than six months:

	Number
Number of new engagements, or those that reached six months in duration between 1 April 2020 and 31 March 2021	-
Of which:	
Number assessed as within the scope of IR35	-
Number assessed as not within the scope of IR35	-
Number engaged directly (via PSC contracted to trust) and are on the Trust's payroll	-

Number of engagements reassessed for consistency/assurance purposes during the year	-
Number of engagements that saw a change to IR35 status following the consistency	-

Off-payroll arrangements are considered by exception and where there is no practical alternative to employing directly. Our policy covers the process to follow in deciding how to fill a service gap, as below:

- First formal recruitment should be considered
- Only if not suitable should agency then be considered in liaison with the procurement team
- Only if those methods are not appropriate should off-payroll arrangements be considered, following the usual procurement rules
- The addition of a tax status checklist that is required from all contractors employed via that route, to provide assurance
- Practical arrangements for collecting and validating the information necessary to meet HM Treasury's reporting and assurance requirements
- Understanding of consequences of failing to identify correctly whether an individual is an employee in terms of HMRC's employment tests, and
- Documentation maintained to identify the individuals requiring assurance.

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021:

	<b>2020/21 number of engagements</b>
Number of off-payroll engagements of board members, and/or senior officials with significant financial responsibility, during the financial year.	-
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility'. This figure should include both off-payroll and on-payroll engagements.	17*

\*The 17 individuals are the Board members listed in the remuneration report. The number reduced to 16 following the retirement of Tim Broadley on 29 October 2020.

## Exit packages

NHS Foundation Trusts are required to disclose summary information of their use of exit packages agreed in the year, as required by the FReM (paragraph 5.3.27(h)).

The figures disclosed in the accounts relate to exit packages agreed in the year, irrespective of the actual date of accrual or payment. The actual date of departure may be in a subsequent period, and the expense in relation to the departure costs may have been accrued in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of the Agenda for Change NHS terms and conditions. Exit costs in this note are accounted for in full on agreement of departure date. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme.

Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table. There are no payments included in the above outside the NHS terms and conditions. This disclosure reports the number and value of exit packages taken by staff leaving in the year.

## Information subject to audit

### Exit packages

2020-21								
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	No	£	No	£	No	£	No	£
Less than £10,000	8	7,112	3	(3,383)	11	3,729	-	-
£10,000 - £25,000	-	-	-	-	-	-	-	-
£25,001 - £50,000	-	-	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-	-	-
£100,001 - £150,000	-	-	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-	-	-
Over £200,000	-	-	-	-	-	-	-	-
<b>Total</b>	<b>8</b>	<b>7112</b>	<b>3</b>	<b>(3,383)</b>	<b>11</b>	<b>3,729</b>	<b>-</b>	<b>-</b>

2019-20								
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	No	£	No	£	No	£	No	£
Less than £10,000	9	29,882	(2)	(20,747)	7	9,135	-	-
£10,000 - £25,000	(12)	(261,433)	4	51,427	(8)	(210,006)	-	-
£25,001 - £50,000	(5)	(137,452)	1	36,376	(4)	(101,076)	-	-
£50,001 to £100,000	(2)	(147,000)	-	-	(2)	(147,000)	-	-
£100,001 - £150,000	-	-	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-	-	-
Over £200,000	-	-	-	-	-	-	-	-
<b>Total</b>	<b>(10)</b>	<b>(516,003)</b>	<b>3</b>	<b>67,056</b>	<b>(7)</b>	<b>(448,947)</b>	<b>-</b>	<b>-</b>

### Non-compulsory departure payments

2020/21		
Types of other departures	Agreements	Total value of agreements
	No	£,000
Voluntary redundancies including early retirement contractual costs		
Mutually agreed resignations (MARS) contractual costs	2	(3)
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice	-	-
Exit payments following employment tribunals or court orders	-	-
Non-contractual payments requiring HMT approval	-	-
<b>Total</b>	<b>2</b>	<b>(3)</b>
2019/20		
Types of other departures	Agreements	Total value of agreements
	No	£,000
Voluntary redundancies including early retirement contractual costs	-	-
Mutually agreed resignations (MARS) contractual costs	3	67
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice	-	-
Exit payments following employment tribunals or court orders	-	-
Non-contractual payments requiring HMT approval	-	-
<b>Total</b>	<b>3</b>	<b>67</b>

## NHS Foundation Trust Code of Governance

Derbyshire Community Health Services NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012. We have met the disclosures in the 'comply or explain' table in the NHS Foundation Trust Annual Reporting Manual 2020/21.

### Our Board of Directors

The Board of Directors brings a wide range of experience and expertise to their leadership of the Trust and continues to demonstrate the vision, oversight and encouragement required to enable it to thrive.

In 2020/21 the Board membership consisted of the following executive directors:

Name	Title	Date
Tracy Allen	Chief executive	1 April 2020 to 31 March 2021
Jim Austin (non-voting)	Chief information and transformation officer	1 April 2020 to 31 March 2021
Michelle Bateman	Director of nursing, allied health professionals and quality	1 April 2020 to 31 March 2021
Tim Broadley (non-voting)	Director of strategy	1 April 2020 to 29 October 2020
Melanie Curd (non-voting)	Associate director of corporate governance	1 April 2020 to 31 March 2021
William Jones	Chief operating officer	1 April 2020 to 31 March 2021
Ben Pearson	Medical director	1 April 2020 to 31 March 2021
Chris Sands	Director of finance and strategy/deputy chief executive	1 April 2020 to 31 March 2021
Paul Renshaw	Interim director of people services and organisational effectiveness	1 April 2020 to 4 September 2020
Darren Tidmarsh	Director of people services and organisational effectiveness	7 September 2020 to 31 March 2021

The Board included the following non-executive directors: Prem Singh (chairman); Ian Lichfield (non-executive director); James Reilly (non-executive director) and Kaye Burnett (non-executive director and vice chair), Joy Hollister (non-executive director), Kay Fawcett (non-executive director), Julie Houlder (non-executive director) and non-voting associate non-executive director, Richard Harcourt.

Members of the Board have regularly attended Council of Governors meetings to develop an understanding of the views of governors and members. Governors are able to share the views of their constituent members at these meetings.

Members and governors are actively encouraged to attend the public Trust Board meetings, held every two months, to influence discussion and raise awareness of constituents' views. These were held virtually this year because of pandemic social distancing.

Other feedback channels and engagement opportunities for our members and governors are routinely publicised via our regular membership communications, for example, sharing opinion on corporate publications.

### **Trust Board**

The Trust Board leads by undertaking three key roles:

- Formulating strategy
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable
- Shaping a positive improvement culture for the Board and the organisation.

A number of sub-committees, and some individual officers, have delegated powers. These are detailed in our scheme of delegation. The scheme of delegation also includes a statement on the roles and responsibilities of the Council of Governors.

Membership of the Trust Board is balanced, complete and appropriate. We are confident that all the non-executive directors are independent in character and there are no relationships or circumstances which are likely to affect or could appear to affect their judgement.

The Board of Directors has conducted a review of the effectiveness of its system of internal controls, as discussed in the Annual Governance Statement.

The Board of Directors is not aware of any relevant audit information that has been withheld from our auditors, and they take all the necessary steps to make themselves aware of

relevant information and to ensure that this is passed to the external auditors where appropriate.

Our Board of Directors considers that the annual report and accounts, taken as a whole, is fair, balanced and understandable, and that it provides the information necessary for patients, regulators and stakeholders to assess our performance, business model and strategy. The directors' responsibility for preparing the annual report and accounts is outlined in the Accountability Report and Annual Governance Statement.

### **Council of Governors**

Our Council of Governors play a vital role with us - they work with our Trust Board in ensuring the organisation develops services which best meet the needs of patients, families and carers.

Our lead governor is Bernard Thorpe and the deputy lead governor is Lynn Walshaw. You can read the biographies of Bernard and Lynn and all the other members of our governing body on our website: <http://www.dchs.nhs.uk/home/about/governors/meet-our-governors>.

Our governors hold the non-executive directors individually and collectively to account for the performance of the Board of Directors. They play a vital role in representing the views of, and providing a link to our members, public, staff and our partner organisations.

The number of public governors for each constituency reflects the level of services we provide in each area: Amber Valley, Erewash and Southern Derbyshire (six), Bolsover, Chesterfield and North East Derbyshire (five), Derbyshire Dales and High Peak (four), Derby City (two) and Rest of England (one).

As well as the 18 seats for public governors on our Council of Governors, we also have 10 elected staff governors, although this fluctuated slightly with changes in personnel during the year, and we consistently had three appointed governors from partner organisations, rising to four for half of the year. Attendance at meetings is listed in the next table.

During 2020/21 the Council of Governors met **virtually** five times:

- Wednesday 8 July 2020
- Wednesday 24 September 2020
- Wednesday 11 November 2020
- Wednesday 13 January 2021
- Wednesday 10 March 2021.

Governors' statutory roles include:

- Appointing and removing the chair and other non-executive directors
- Agreeing the terms and conditions of the chair and non-executive directors
- Approving the appointment of the chief executive
- Receiving the Trust's annual accounts and annual report
- Commenting on the Trust's strategic planning
- Appointing and removing the external auditors
- Approving changes to the constitution
- Expressing a view on the Board's plans for the Trust, in advance of submitting plans to NHS Improvement
- Taking decisions on non-NHS income
- Taking decisions on significant transactions.

Our Trust has a statement on roles and responsibilities of the Council of Governors which references how any possible disagreement between the Council of Governors and the Board of Directors will be resolved. Should an agreement not be reached the dispute will be referred to the Board of Directors who shall make the final decision. Any final decision by the Board of Directors is without prejudice to the statutory powers of the Council of Governors.

The terms of office and attendance at Council of Governors meetings of all our governors, covering the period from 1 April 2020 to 31 March 2021, are listed in this table:

<b>Elected public Governor</b>	<b>Constituency</b>	<b>Term of office began</b>	<b>Term of office ends</b>	<b>Attendance (actual/possible)</b>
Peter Ashworth	Amber Valley, Erewash & South Derbyshire	1 November 2014 (first term) 1 November 2017 (Second term)	31 October 2020	1/3
Paul Gibbons		1 November 2017 (first term) 20 April 2018 (second term) 1 December 2020 (third term)	30 November 2023	4/5
Tony Marston		1 December 2020	30 November 2023	2/2
Paul Mason		1 November 2016 (first term) 1 November 2019	31 October 2022	4/5

David Mayes		1 December 2020	30 November 2023	1/2
Kevin Miller		1 November 2017	31 October 2020	1/3
Terence Watson		1 November 2017 (first term) 1 December 2020 (second term)	30 November 2023 – although he resigned on 11 January 2021	3/3
Sarah Naylor		1 November 2019	31 October 2022	1/5
Gillian Harvey	Bolsover, Chesterfield & North East Derbyshire	1 December 2020	30 November 2023	2/2
Claire McCann		1 November 2019	31 October 2022	2/5
Lynn Walshaw		1 April 2018 (first term) 1 December 2020	30 November 2023	5/5
Ann Button	Derbyshire Dales & High Peak	1 November 2016 (first term) 1 November 2019 (second term)	31 October 2022	5/5
Stephen Dawes		1 November 2019	31 October 2022	5/5
Jane Dent		1 December 2020	30 November 2023	2/2
John Dick		1 November 2017 (first term) 1 December 2020 (second term)	30 November 2023	3/5
Helen Knight		1 November 2017	31 October 2020	1/3
Bernard Thorpe		City of Derby	1 November 2014 (first term) 1 November 2017 (second term)	31 October 2020* See below for term of office as an appointed governor from 1 November 2020
Ian Beck	24 May 2018 (first term) 1 November 2019 (second term)		31 October 2021	5/5
David Boddy	Rest of England	1 April 2018 (first term) 1 December 2020	30 November 2023	4/5
<b>Elected staff governor</b>	<b>Constituency</b>	<b>Term of office began</b>	<b>Term of office ends</b>	<b>Attendance (actual/</b>

				possible)
Jo Stanhope	Admin and clerical and managers	1 August 2019 (first term) 1 November 2019 (second term)	31 October 2020	2/3
Donna Quinton		1 December 2020	30 November 2023	2/2
Katie Andrew	Nursing	21 July 2019 (first term) 1 November 2019 (second term)	31 October 2022	2/5
Adele Clements		1 November 2019	30 October 2022	2/3
Mandy Grogan		1 November 2019	31 October 2020	0/3
Marie Haywood		1 December 2020	30 November 2023	2/2
Amy Farrington		1 December 2020	30 November 2023	0/1
Wendy Hodgkinson	Healthcare Support, Estates and Facilities	1 November 2016 (first term) 1 November 2019 (second term)	31 October 2022	4/5
Karon Mather		1 November 2019	31 October 2020	0/3
Clare Rowland		1 November 2019	31 October 2020	0/3
Joy Williams		1 December 2020	30 November 2023	2/2
Lynne Bakewell		Other registered professionals	1 November 2016 (first term) 1 November 2019 (second term)	31 October 2022
Sara Nash	Other registered professionals	1 November 2014 (first term) 1 November 2017 (second term) 1 December 2020 (third term)	30 November 2023	3/5
Alex Carberry	Dental and medical	1 April 2018 (first term) 1 December 2020 (second term)	30 November 2023	1/5

The following governors resigned from their post during 2020/21:

<b>Elected public governor</b>	<b>Constituency</b>	<b>Term of office began</b>	<b>Term of office ends</b>	<b>Attendance (actual/ possible)</b>
Terence Watson	Amber Valley, Erewash & South Derbyshire	1 November 2017 (first term)	11 January 2021	3/3
<b>Elected staff governor</b>		<b>Term of office began</b>	<b>Term of office ends</b>	<b>Attendance (actual/ possible)</b>
Adele Clements	Nursing	1 November 2019	16 December 2020	2/3
Claire Rowland	Healthcare Support, Estates and Facilities	1 November 2019	22 June 2020	0/3

One additional appointed governor seat was created in 2020/21 for a maximum period of 12 months. The relevant organisations appointed the following representative.

<b>Appointed governor</b>	<b>Constituency</b>	<b>Term of office began</b>	<b>Term of office ends</b>	<b>Attendance (actual/ possible)</b>
Bernard Thorpe	Previously publically-elected governor	1 November 2020	31 October 2021	5/5

The Lead Governor is also appointed from this group during this period.

### **Governor elections**

In 2020 we held governor elections for 12 public and six staff governors. UK Engage were the electoral agents who managed the process. The ballot stage of the election process closed on Wednesday 26 November 2020 and results were declared on Thursday 27 November 2020. Candidates stood for election with the following results:

Constituency	Number of seats vacant	Number of seats filled
Amber Valley, Erewash and South Derbyshire	4	4 (one has since resigned)
Bolsover, Chesterfield and North East Derbyshire	4	2
Derbyshire Dales and High Peak	2	2
Rest of England	1	1
City of Derby	1	0
Facilities, estates and healthcare support staff	2	2
Medical and Dental	1	1
Nursing	1	1
Other registered professionals	1	1
Administrative, clerical and managers	1	1
Total	18	15

We received the same number of nominations for the number of seats within Facilities and Estates and Healthcare Support Staff, Other Registered Professionals, Administration Clerical and Managers and Medical and Dental and therefore these staff governors were elected uncontested.

Due to a lack of valid nominations seats were not filled within Bolsover, Chesterfield and North East Derbyshire (1), and City of Derby (1) constituencies and as such it was agreed that the vacancies will be held in these constituencies until the planned 2021 elections.

### Contacting the Council of Governors

Members and the public can contact the Council of Governors via email:

[DCHST.Governors@nhs.net](mailto:DCHST.Governors@nhs.net)

### Council of Governors meetings

During the regular meetings the governors are updated on the performance of our Trust. Members of the public can attend and information about these meetings is available on our website: <http://www.dchs.nhs.uk/home/about/governors>

### Governor groups

There are four informal governor sub-groups of the Council of Governors. The groups support governors to be involved in key areas of our organisation's work and to meet with

the executives and non-executives that lead that work. Governors report back to the full council meetings regarding the work of each of the groups.

- **The strategy group** contributed to the review of the strategic and operational plans, oversaw our winter planning arrangements, received updates on commissioning, contracting and capital developments.
- **The quality group** focused on activities to maintain quality and service. This included a deeper understanding of the work of the Quality Service Committee, reviewing patient experience reports, receiving presentations from clinical services, and receiving updates on coroner's inquests.
- **The governance group** activities included reviewing amendments to the constitution, the Council of Governors' self-assessment process including agreeing the areas to be explored and the subsequent responses, reviewing and suggesting amendments to the engagement policy and external auditor plans. The group also observed non-executive directors during Board meetings and sub-committees and fed back to other governors in respect of their performance in holding the Trust Board to account.
- **The engagement group** did not meet during 2020/21 because of the pandemic but has a role in more usual years to build engagement with members, public and patients and provide feedback regarding communications with the membership.

Governors canvass the opinion of our members, patients, carers, staff and the public, as well as from the organisations that our appointed governors represent, on our forward plans, objectives, priorities and strategies. These views are then communicated and shared with the Board of Directors. They canvass the opinion of members via:

- The Council of Governors email address which is publicised to welcome feedback and comments
- Articles in My Community newspaper for public members
- Local health groups and associations, charities, parish councils, social groups, church activities and school governing bodies
- Involvement in our Staff Forum.

## Constitution

Our constitution sets out the standards of conduct for our NHS Foundation Trust and our staff in accordance with NHS values and accepted standards of behaviour in public life.

The Council of Governors provided valuable input to the review of our constitution, the latest version of which is available on our website:

[http://www.dchs.nhs.uk/home/dchs\\_publications/foundation-trust-authorisation](http://www.dchs.nhs.uk/home/dchs_publications/foundation-trust-authorisation)

## **Nominations and Remuneration Committee**

In 2020/21 the duties of the committee included:

- Taking assurance from the completed annual appraisals, including key successes and objectives for the chairman and non-executive directors
- Recommending amendments to the code of conduct for governors
- Monitoring the conduct of governors
- Reviewing the remuneration of the chair and non-executive directors and making recommendations
- Monitoring the process for elections and composition of the committee.

## **Board and governors' relationship**

The Board works closely with the Council of Governors to ensure it understands their views and those of our members.

Chairman Prem Singh also chairs the Council of Governors and is supported at every meeting by the chief executive Tracy Allen and the appointed lead governor Bernard Thorpe. The chairman also chairs the Nominations and Remuneration Committee.

The chairman works closely with the nominated lead governor and also meets regularly with each constituency of governors to discuss matters that interest or concern them.

The senior independent director is Kaye Burnett and the other non-executive directors attend the Council of Governors' meetings, along with all the executive directors, and take part in open discussions that form part of each meeting. Members of the Council of Governors can contact a member of the Board at any time in respect of any concerns they may have.

Council of Governors meetings have a regular agenda item to support and promote their 'holding to account' role whereby each of the non-executive directors, in turn, presents the work of the sub committees which they chair and answer any questions that may arise.

We have an engagement policy for the Council of Governors around their work with the Trust Board, in compliance with the NHS Foundation Trust Code of Governance, which provides the process by which the council can raise concerns related to the overall wellbeing of the organisation, if the need arises.

## **Governor training and development activities in 2020/21**

These activities were conducted virtually in line with social distancing pandemic restrictions:

- An induction programme for new governors to ensure they fully understand their statutory duties. New governors are also paired with a “buddy” governor to ensure they successfully join the council
- A programme of training events for new and established governors
- Development of the knowledge of governors through their chosen areas of interest via involvement with the governor groups.

As part of their self-assessment the Council of Governors can identify training needs or request further training on a particular area as needed.

### Board members attendance at Council of Governors meetings

Name	Attendance (actual/possible)  April 2020 – March 2021
Prem Singh (chairman)	5/6
Tracy Allen (chief executive)	5/6
Kaye Burnett (non-executive director)	5/6
Melanie Curd (associate director of corporate governance)	5/6
Kay Fawcett (non-executive director)	4/6
Richard Harcourt (associate non-executive director)	6/6
Joy Hollister (non-executive director)*	2/6
Julie Houlder (non-executive director)	6/6
William Jones (chief operating officer)	4/6
Ian Lichfield (non-executive director)	2/6
Ben Pearson (medical director)	2/6
Paul Renshaw (director of people services and organisational effectiveness Until September 2020)	0/2

Darren Tidmarsh (director of people services and organisational effectiveness from September 2020)	1/4
James Reilly (non-executive director)	3/6
Chris Sands (director of finance and strategy/deputy chief executive)	3/6
Michelle Bateman (Director of nursing, allied health professionals and quality)	4/6

\*Joy Hollister is currently on sabbatical until January 2022.

\*\* Note regarding attendance during Covid-19 pandemic

During the Covid-19 pandemic the corporate governance framework was suspended which also included the quoracy requirements for meetings. This was to allow staff to focus on delivering the Covid-19 response and attendance at meetings was restricted to limited numbers of staff only.

Governors and non-executive directors work closely together in the governor subgroups. The governance group also attends meetings held by the non-executive directors.

Governors are encouraged to attend our public Board meetings and also our Board subcommittee meetings. These meetings provide governors with the opportunity to reflect on the business discussed by the Board and to ask questions.

## Attendance at Trust Board meetings by executive and non-executive members

		May 2020 public	June 2020	July 2020 public	August 2020	October 20 public	November 2020	Dec 2020 public	January 2021	Feb 2020 public	March 2021
Prem Singh	Chairman	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tracy Allen	Chief executive	✓	✓	✓	✓	x	✓	✓	✓	✓	✓
Kaye Burnett	Non-executive director	✓	✓	✓	x	✓	✓	✓	✓	✓	✓
Melanie Curd	Associate director or corporate governance	✓	✓	✓	✓	x	✓	✓	✓	✓	✓
Kay Fawcett	Non-executive director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Richard Harcourt	Associate non-executive director	✓	✓	✓	x	✓	✓	✓	✓	✓	✓
Joy Hollister * currently on sabbatical until January 2022	Non-executive director	✓	✓	✓	x	x	✓	✓			
Julie Houlder	Non-executive director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
William Jones	Chief operating officer	✓	✓	✓	✓	x	✓	✓	x	✓	✓
Ian Lichfield	Non-executive director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ben Pearson	Medical director	✓	✓	✓	✓	x	✓	✓	✓	✓	✓

		May 2020 public	June 2020	July 2020 public	August 2020	October 20 public	November 2020	Dec 2020 public	January 2021	Feb 2020 public	March 2021
Darren Tidmarsh	Director of people services and organisational effectiveness					✓	✓	✓	✓	✓	✓
James Reilly	Non-executive director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chris Sands	Director of finance and strategy/deputy chief executive	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Michelle Bateman	Director of nursing, allied health professionals and quality	✓	✓	✓	x	✓	✓	✓	✓	✓	✓
Paul Renshaw	Interim director of people services and organisational effectiveness	✓	✓	✓	✓						
Jayne Needham	Associate director: strategy, health and wellbeing						✓	✓	✓	✓	x

### Audit and Assurance Committee

The Audit and Assurance Committee, chaired by Julie Houlder, provides the Board of Directors with an independent review of financial and corporate governance and risk management. It provides an assurance of independent external and internal audit, ensures standards are set and monitors compliance in non-financial, non-clinical areas of our organisation. We have an internal audit function, provided by KPMG, which provides:

- An independent objective opinion to the accounting officer, the Board of Directors and the Audit and Assurance Committee on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives
- An independent and objective consultancy service specifically to help managers improve our risk management, control and governance arrangements.

Recommendations from internal audit reports are tracked by the Audit and Assurance Committee to ensure prompt implementation. The Audit and Assurance Committee monitors the integrity of the financial statements, and any formal announcements relating to the Trust's financial performance, reviewing significant financial reporting judgements contained in them.

The Audit and Assurance Committee provides oversight of data quality and monitors implementation of the data quality improvement plan on a quarterly basis. Data quality is reported on a monthly basis to the Board of Directors, as part of the performance dashboard. The information management and technology strategy group has lead responsibility for data quality. Periodically, the chair and chief executive attend the Audit and Assurance Committee to observe the meeting.

<b>Audit and Assurance Committee members attendance</b>		24 April 2020	10 June 2020	27 July 2020	23 October 2020	22 January 2021
Ian Lichfield	Non-executive director	✓	✓	x	✓	✓
Julie Houlder	Non-executive director	✓	✓	✓	✓	✓
Kay Fawcett	Non-executive director	✓	✓	✓	x	✓

<b>Audit and Assurance Committee other attendees</b>		24 April 2020	10 June 2020	27 July 2020	23 October 2020	22 January 2021
Cath Benfield	Deputy director of finance	✓	✓	✓	✓	✓
Melanie Curd	Associate director of corporate governance	✓	✓	✓	✓	✓
Chris Sands	Director of finance and		✓		✓	✓

<b>Audit and Assurance Committee other attendees</b>					22 January 2021
		24 April 2020	10 June 2020	27 July 2020	23 October 2020
	strategy/deputy chief executive	✓		✓	

### Nominations and Remuneration Committee

The Nominations and Remuneration Committee, chaired by Prem Singh, considers and makes recommendations relating to the appointment, remuneration and other relevant issues, for the chairman and non-executive directors. The committee also considers overall performance issues in the Council of Governors.

The committee works to our equalities commitments in making appointments, as outlined in the EDS2 section of our performance report and our People Plan strategy, as outlined in the staff report section of this report; and stated in our annual governance statement which confirms control measures are in place to ensure that all our organisation's obligations under equality, diversity and human rights legislation are complied with. In line with our aspirations to be an anchor institution, we have recently appointed two associate non-executive directors from under-represented groups on NHS Boards to take up appointment in 2021/22.

<b>Nominations and Remuneration Committee members attendance</b>					
		30 June 2020	12 October 2020	04 November 2020	23 February 2021
Prem Singh	Chair, non-executive director	✓	x	✓	✓
Kaye Burnett	Vice chair	✓	✓	✓	✓
Bernard Thorpe	Appointed governor	✓	✓	✓	✓
Lynne Bakewell	Staff governor – other registered professionals	x	✓	✓	✓

<b>Nominations and Remuneration Committee members attendance</b>		30 June 2020	12 October 2020	04 November 2020	23 February 2021
Lynn Walshaw	Public governor – Bolsover, Chesterfield and North East Derbyshire	✓	✓	✓	✓
Terence Watson	Public governor – Amber Valley, Erewash and South Derbyshire	✓	✓	✓	
David Boddy	Public governor – Rest of England	✓	x	✓	✓
<b>Nominations and Remuneration Committee other attendees</b>		30 June 2020	12 October 2020	04 November 2020	23 February 2021
Melanie Curd	Associate director of corporate governance	✓	✓	✓	✓

## Board members – executive directors

### Chief executive: Tracy Allen

Tracy Allen was appointed as chief executive on 1 April 2011. She was previously managing director when the services operated as an autonomous provider within NHS Derbyshire County Primary Care Trust. She led the creation of Derbyshire Community Health Services and its establishment as an NHS community trust.

She was previously executive director of strategy and service improvement at Sherwood Forest Hospitals NHS Trust, leading strategies which underpinned the organisation's successful authorisation as an NHS Foundation Trust. Tracy is an ex-NHS management trainee and has a wide range of operational and strategic management experience in NHS organisations.

### Chief information and transformation officer - Jim Austin

Jim Austin joined the Trust in April 2015, following a year-long induction through the NHS executive fast track programme, attached to Salford Royal NHS Foundation Trust. Prior to joining the NHS, Jim had accumulated 20 years of experience in the private, non-health

sector and was, for seven years, the sales and customer service director at the AA. There he was responsible for over 2,500 people, the vast majority of whom were customer facing. During his time at the AA, and previously in the financial services sector and telecommunications, he led and implemented wide-spread change and transformation, to improve customer experience and meet demanding financial constraints. Prior to working in the private sector, Jim was a commissioned officer in the Royal Artillery and served both in the UK and abroad. Jim is the board champion for the LGBT+ community within the Trust.

**Director of nursing, allied health professionals and quality: Michelle Bateman**

Michelle Bateman started her registered nurse training in 1985 at St Bartholomew's Hospital in London, following a period of working as a nurse auxiliary at City Hospital, Nottingham, whilst attending college. She then went on to complete her midwifery and health visitor training and after a period of working as a locality manager, which included the development and management of services for older people, she moved back to Nottingham. Since 2000 she has held a variety of posts which have all centred on clinical leadership, quality, risk management and patient experience. She completed an MSc in health policy in organisations in 2002. She held the role of associate director of nursing for community and mental health services within Nottinghamshire until her appointment as chief nurse/director of quality at Derbyshire Community Health Services NHS Foundation Trust in 2019. She is also the vice chair of a BME housing association in Nottingham.

**Director of strategy – Tim Broadley (until retirement in October 2020)**

Tim worked in the NHS for 37 years, more than 20 of which were in community health services in Derbyshire. His background was in planning, operations, strategy and business development, and included extensive Board experience. Before his retirement in October 2020 he was an active member of the East Midlands coaching database, with a strong interest in team and personal development. Until his retirement he led our approach to the evolution of sustainable community-based services, building on the legacy of previous initiatives and organisations to respond to the current needs of the communities we serve.

**Associate director of corporate governance: Melanie Curd**

Melanie Curd has worked in the NHS for 18 years, the majority of her experience has been within community Trusts. Melanie has held a variety of posts within governance, the most recent being our deputy Trust secretary until her appointment as associate director of corporate governance /Trust secretary in September 2019. Melanie has an LLM in health law and a post-graduate qualification in health services management.

**Chief operating officer: William Jones**

William Jones joined us in June 2011 and is responsible for the delivery of all our operational services and leads on emergency planning, security management, capital and estates. He is also the lead for Joined Up Care Derbyshire for capital and estates. His extensive NHS management experience includes previous roles as deputy chief executive for North East Derbyshire Primary Care Trust and chief executive of Derbyshire Health United. He qualified as a podiatrist in 1984 and moved into general management in 1993 having completed the Trent general management training scheme. He is a member of the Institute of Health Service Management. William is a voting member of the Trust Board.

**Medical director: Dr Ben Pearson**

Dr Ben Pearson took up the position of executive medical director in June 2019, having previously held senior medical positions within the University Hospitals of Derby and Burton NHS Foundation Trust. He completed his first degree in zoology at Durham University, before going to Kings College London to study medicine, graduating in 1993. He worked in London, Lincoln, Nottingham and Derby to complete his junior doctor training and his specialisation in geriatrics and general internal medicine. Ben was appointed consultant in acute and general medicine at Derby Hospitals in 2004 and set up the acute medicine service, later working out in the community with GPs and care homes in addition to holding clinical leadership positions. He was the secondary care doctor for the mid-Nottinghamshire Clinical Commissioning Groups for seven years and he remains a council member with the East Midlands Clinical Senate. He has fostered close working ties between health partners in the acute, community and primary care sectors of the NHS as part of improving care for patients.

**Interim director of people services and organisational effectiveness: Paul Renshaw (March 2020 – September 2020)**

Paul Renshaw joined us in March 2020 as the interim director of people services and organisational effectiveness. He has significant Board-level experience having worked within the NHS as an executive director of human resources and organisation development at a number of Trusts since 2013, including Salford Royal NHS Foundation Trust and most recently the South East Coast Ambulance Service. He also has extensive leadership experience within other public sector organisations and the private sector.

**Director of people services and organisational effectiveness: Darren Tidmarsh (from September 2020)**

Darren joined us from United Lincolnshire Hospitals NHS Trust in September 2020 as an experienced HR and organisational development professional with a strong public sector background. During his career he has held executive roles in the further/higher education

sector, leading significant people transformations in a number of high performing organisations, before moving into NHS leadership at the Royal Orthopaedic Hospital NHS Trust in Solihull.

Until recently he was a non-executive director and chair of the board at Learn Sheffield, Sheffield city region's school improvement company, and a trustee of two multi-academy educational trusts. Darren has a master's degree in human resources management and is a science graduate from The University of Nottingham. His earlier career included work for a number of leading international companies including Severn-Trent, Nestle and Zurich Financial Services. He is a champion of learning and development and a strong advocate of continuous improvement. Darren is our board champion for reserivists.

### **Director of finance and strategy/deputy chief executive: Chris Sands**

Chris Sands joined us in August 2011. He is responsible for finance and strategy. He is also our deputy chief executive. Before joining us he was director of finance and compliance for Lincolnshire Partnership NHS Foundation Trust for six years. Chris has over 25 years' experience of working in the NHS in the acute, community and mental health sectors. He is a chartered management accountant and holds an honours degree in economics. Chris is also a member of the Healthcare Financial Management Association and sits on the East Midlands branch committee.

## **Board members – non-executive directors**

### **Chairman - Prem Singh**

Prem has been Chairman of Derbyshire Community Health Services NHS Foundation Trust since Dec 2013. In September 2020, he was appointed to a key leadership role as Independent Chair of the Integrated Care System for Staffordshire and Stoke-on-Trent, to improve outcomes in population health and healthcare; tackle inequalities; improve productivity and make best use of resources and help the NHS to support broader social and economic development.

Prem has significant experience in health and social care management, having served at Board level positions for over 30 years, including as a chief executive of several Primary Care Trusts spanning 11 years. He has a general and psychiatric nursing background, having previously led community, mental health and learning disability services in various senior positions, including as an executive director of nursing and quality.

Prem has developed extensive networks and a national reputation; he is currently the senior independent trustee of the NHS Confederation Board and an invited member of the Chairs Advisory Group of 25 chairs nationally hosted by the chairs of NHS England/Improvement. During 2020, he was invited to join the Midlands Strategic

Transformation and Recovery Board and chaired one of the four working groups, the safe restoration and recovery group. He was previously appointed to take the lead on inclusive leadership on the National Leadership Council and named, in the inaugural HSJ listing, as a (Top 50) BME pioneer. He is a highly experienced leadership mentor and an ILM 7 qualified executive coach. Originally from Malaysia, he is very proud to have been part of the NHS's journey over the past four decades.

**Non-executive director: Kaye Burnett**

Kaye Burnett has held senior roles in the NHS and police service and has over 25 years consultancy experience, delivering leadership development, coaching and major change programmes with diverse clients, including NHS Trusts, local authorities, national charities, international companies and large public administrations overseas. She has an MSc in human resources development, worked for the UK's leading human resourcing organisation, and has continued to focus on person-centred, compassionate leadership development, coaching, employee engagement and change management, including as a policy adviser at national and international level. She is a director of the Health Coaching Academy and a Fellow of the Higher Education Academy, and was a visiting lecturer at Sheffield Hallam University for a number of years. She is a former chair of Health Education East Midlands and previously chaired the transformational programme, 'Better Care Together' in Leicester, Leicestershire and Rutland. She is also a trustee of Growing Points, a charity supporting people with ambition from excluded communities.

**Non-executive director: Kay Fawcett OBE**

Kay Fawcett is a registered nurse, who has over 40 years' experience of nursing, working in clinical leadership and education roles throughout the Midlands, holding several senior positions within NHS Trusts as well as undertaking national advisory and consultancy roles. She was awarded an OBE for services to nursing in 2014. She was executive director of nursing for Derby Hospitals for two-and-a-half years, up until January 2008, and has since held positions as chief nurse at University Hospitals Birmingham NHS Foundation Trust for nearly six years and as interim executive director of nursing at George Eliot Hospital NHS Trust, Nuneaton, for six months until February 2018. Kay runs her own consultancy company and is an accredited coach. She works with Health Education England on development of the unregistered workforce and on supporting the work of volunteers in health and care.

**Associate non-executive director: Richard Harcourt**

Richard Harcourt is a former Derby-based Rolls-Royce director who joined us as an associate non-executive director in September 2018. He retired from Rolls-Royce in July 2018 after 20 years with the company, latterly as director of group operations.

Richard served in executive roles at Rolls-Royce for 10 years and spent the previous decade in senior management roles at the company, including four years in Canada. He is an authority on "lean" processes and principles which support continuous improvements in systems and the development of high performance teams.

**Non-executive director: Joy Hollister**

Joy Hollister was the strategic director of adult care and public health at Derbyshire County Council for three years until her retirement from the council in July 2018. While at the council, she chaired the Place Board for Derbyshire's Sustainability and Transformation Partnership, the strategic body pushing forward on making health and social care services more seamless and integrated across the county. A social worker by background, Joy held senior roles in social care, public health, adult and children's services in London, East Sussex and the East Midlands before returning to Derbyshire in 2015. She worked at executive level for 14 years including at the City of London Corporation and the London Borough of Havering. In March 2019 Joy started as the independent chair of Nottingham City Safeguarding Adults Board. Joy is on sabbatical from her non-executive role with us until January 2022.

**Non-executive director: Julie Houlder**

Julie Houlder is a former West Midlands Centro executive who joined us on 1 October 2018. She brings a unique mix of analytical and soft skills, as a qualified accountant and also a personal development coach with her own consultancy and qualifications in psychological coaching, stress management and NLP (Neuro Linguistic) training. Julie worked at Centro for 32 years in increasingly senior financial positions, serving as head of business management and chief audit executive until 2016, when she left to pursue her consultancy, charitable and health service interests. She is also the vice chair of George Eliot Hospital NHS Trust in Nuneaton, where she has served on the Board since 2016. Julie is chair of Sir Josiah Mason Trust which provides safe, secure and affordable sheltered accommodation, extra care and residential care for adults in their older age and projects supporting young people. She is also an associate providing governance and board development support and a director of Windsor Academy Trust member of their Finance Committee and safeguarding lead.

**Non-executive director: Ian Lichfield**

Ian Lichfield's expertise lies in business transformation. Currently he is the CEO of WHP Engineering, a private equity backed engineering business based in Gateshead. Ian has headed up the award winning business transformation of WHP and achieved significant

growth since he joined in 2016. Prior to this he was a director of Tarmac and headed up Tarmac Building Products, as chief executive (2011 – 2014) and chief financial officer (2008 – 2011). He left the business having successfully turned its performance around resulting in the sale of the company in 2014. He is a qualified chartered accountant with expertise in strategy, restructuring, reorganising, rationalising and growing businesses and has led the acquisition, integration and sale of several companies. He has held several senior finance and commercial roles and has extensive board level management and leadership experience, including managing a number of joint-ventures during his international career in the commercial sector.

**Non-executive director: James Reilly**

James Reilly was chief executive of Central London Community Healthcare NHS Trust, the largest community healthcare organisation in London, from 2011 until his retirement in February 2016. He spent 27 years in local government roles, 10 of these serving as an executive director with responsibilities for social services, council housing, community safety and regeneration. He is an active associate of the Association of Directors of Adult Social Services. James currently serves as a trustee of Methodist Homes for the Aged. He is the independent chair for the Adult Safeguarding Partnership Boards in the London Boroughs of Camden and Islington. He also chairs the Independent Safeguarding Commission of the British Jesuit Province (an order of Catholic Priests).

**Evaluation**

All of our committees and groups undertake an annual review against their terms of reference and a paper on the work of the main sub-committees of the Board is discussed at the Audit and Assurance Committee.

All of our directors and non-executive directors undergo an annual appraisal. The chief executive and directors' appraisals are discussed at the Remuneration and Terms of Service Committee by the non-executive directors. The chair and non-executive directors' appraisals are discussed at the Nomination and Remuneration Committee by our governors.

All of our non-executive directors are considered to be independent according to the criteria set out in NHS Improvement's Code of Governance. The term of office may be terminated by resignation or by the approval of three-quarters of the members of the Council of Governors.

The non-executive directors have the following terms of office:

Name	Role	Appointment date	Expiry date
Prem Singh	Chairman	1 December 2013	30 November 2017  20 January 2017 given extension to <b>30 November 2020</b> (with effect from 1 December 2017)  Extension given to <b>30 November 2021</b> (with effect from 1 December 2020)
Ian Lichfield	Non-executive director	1 April 2015	31 March 2018  1/3/17 second term of office agreed to <b>31 March 2021</b>  Extension given <b>until 31 March 2022</b> on 8 July 2020
Kaye Burnett	Non-executive director	1 August 2016	31 July 2019 Extension given to <b>31 July 2022</b> on 20 June 2019
James Reilly	Non-executive director	1 December 2016	30 November 2019 Extension given to <b>30 November 2022</b> on 20 June 2019
Kay Fawcett	Non-executive director	1 October 2018	30 September 2021
Julie Houlder	Non-executive director	1 October 2018	30 September 2021
Joy Hollister* currently on sabbatical until January 2022	Non-executive director	1 October 2018	30 September 2021
Richard Harcourt	Associate non-executive director	1 September 2018	31 August 2019 Extension given until <b>31 August 2020</b> on 20 June 2019

			Extension given until <b>31 March 2022</b> on 8 July 2020
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## Our membership

We have a steady membership drawn largely from the local communities we serve and from our own staff.

Members are a vital asset in ensuring we remain accountable to the public we serve. Members are kept informed via newsletters, emails and invitations to events. Our annual members' meeting is where we present the annual report and accounts. Members are also routinely invited to our regular Trust Board and Council of Governor meetings.

Our strategy for membership is to maintain our current levels and our representative mix while also looking to extend opportunities for our members to engage in our work and to shape services. We are in contact with a variety of local community groups to encourage further uptake of membership, with a focus particularly on BME related groups, by working with Healthwatch in Derby and Derbyshire and local religious leaders.

During 2020/21 we were not engaged in any specific recruitment targets on our membership numbers, having previously reached the target of membership numbers above 1% of the population we serve in Derbyshire.

The population we serve is just over one million across Derby City and Derbyshire (1,059,996 <https://observatory.derbyshire.gov.uk/population-estimates/>) and our membership remains above the 1% target, with 11,067 public members and 4,300 staff members, as at 31 March 2021.

During 2020/21 we undertook to maintain these membership levels and to ensure our membership remained representative of our communities. There are two membership categories and we strive for a membership that represents the communities we serve:

**Public** – anyone over the age of 12 years old living in England who has an interest in the services that we provide. This includes past and present patients, carers and members of the public.

**Staff** – employees and volunteers of our Trust who are on a contract of at least 12 months, are automatically enrolled as a staff member unless they choose to opt out.

## Membership in 2020/21

Our membership stands at 15,367 members, comprising 11,067 public members and 4,300 staff members\* (figures accurate on 31 March 2021). See below for a breakdown of

constituencies in both public and staff membership and an illustration of constituency boundaries.

Membership profile by constituency (March 2021)

**Public**

Amber Valley, Erewash and South Derbyshire	2,898
Bolsover, Chesterfield and North East Derbyshire	2,469
City of Derby	2,043
Derbyshire Dales and High Peak	1,223
Rest of England	2,434
<b>Total</b>	<b>11,067</b>

**Staff**

Medical and dental	81
Nursing	1,320
Other registered professionals	701
Administrative, clerical and managers	850
Healthcare support staff	53
Facilities and estates	1,295
<b>Total</b>	<b>4,300</b>

\*Staff who are members of our flexible workforce (bank staff) are not included in the staff membership figures.

In my capacity as accounting officer I confirm that the information contained above in the accountability report is an accurate record.

Signed



**Tracy Allen**  
**Chief Executive**

**15 June 2021**

## Becoming a member

You can securely sign up to be a public member online at:

[http://www.dchs.nhs.uk/sign\\_up\\_to\\_be\\_a\\_member](http://www.dchs.nhs.uk/sign_up_to_be_a_member).

You can contact the Council of Governors via email: [DCHST.Governors@nhs.net](mailto:DCHST.Governors@nhs.net).

We are always keen to hear members' views and anyone who wants to find out more or get in touch should contact: The Chief Executive's Office, Babington Hospital, Derby Road, Belper, DE56 1WH. Email: [dchst.members@nhs.net](mailto:dchst.members@nhs.net)

This map shows the constituency boundaries for Derbyshire Community Health Services NHS Foundation Trust membership scheme.



## Statement of accounting officer's responsibilities

Statement of the chief executive's responsibilities as the accounting officer of Derbyshire Community Health Services NHS Foundation Trust.

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given accounts directions which require Derbyshire Community Health Services NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Derbyshire Community Health Services NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the accounting officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the accounts direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust

and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The accounting officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the Foundation Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Signed

A handwritten signature in black ink that reads "Tracy Allen". The signature is written in a cursive, flowing style.

**Tracy Allen**  
**Chief Executive**

**15 June 2021**

## Annual Governance Statement 1 April 2020 – 31 March 2021

### Derbyshire Community Health Services NHS Foundation Trust

#### 1. Scope of responsibility

- 1.1 As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

#### 2. The purpose of the system of internal control

- 2.1 The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to:
- identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives of Derbyshire Community Health Services NHS Foundation Trust,
  - to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.
- 2.2 The system of internal control has been in place in Derbyshire Community Health Services NHS Foundation Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

#### 3. Capacity to handle risk

- 3.1 The Board has the ultimate responsibility for risk management and the review and approval of high-risk treatment options. The Trust's risk management framework encompasses a Risk Management Policy which describes DCHS' approach to risk management including the processes, roles and responsibilities which underpin it.
- 3.2 The Trust has an effective Board, with an appropriate balance of skills and experience and with constructive challenge from the Non-Executive Directors. There is an induction and development programme in place for Board members.
- 3.3 The Chief Executive has overall responsibility for the management of risk by the Trust. The Director of Nursing, AHPs and Quality is responsible for the risk

management strategy and policy. The Executive Team exercise lead responsibility for specific types of risk.

- 3.4 The Quality Services Committee is the lead Committee for ensuring the risk register is robust. The Committee undertakes bi-monthly reviews of risks referred by other Committees of the Board and a quarterly review of the full risk register. During the year a risk review process was undertaken to ensure alignment of risk register reviews across the organisation leading to one agreed version of the risk register by the end of each month.
- 3.5 The Audit and Assurance Committee takes the lead role in ensuring the risk management control system is robust. The Audit and Assurance Committee reviews the Board Assurance Framework at each meeting to ensure risks to the achievement of strategic objectives are being effectively managed.
- 3.6 The Audit and Assurance Committee annually reviews attendance at Trust committees, and will report any concerns around quoracy through to the Board for action
- 3.7 The role of each Executive Director is to ensure that appropriate arrangements are in place for the:
- Identification and assessment of risks and hazards
  - Elimination or reduction of risk to an acceptable level
  - Compliance with internal policies and procedures, and statutory and external requirements
  - Integration and implementation of functional risk management systems and development of the assurance framework.
- 3.8 These responsibilities are managed operationally through corporate managers supporting the Executive Directors and working with designated lead managers within Operational Divisions.
- 3.9 The Trust has a Risk Management Strategy in place. The objectives in the strategy are regularly reviewed during the year to ensure that risk is fully embedded in the day to day management of the organisation and conforms to best practice. The Strategy defines risk and identifies individual and collective responsibility for risk management within the organisation. It also sets out the Trust's approach to the identification, assessment, scoring, treatment and monitoring of risk. The strategy includes a risk appetite statement and this is assessed by the Board across 4 areas:
- People, service delivery and internal systems
  - Propriety, regularity, finance and accountability
  - Reputation

- External.

3.10 In the last year the Trust has followed national guidance on training delivery including the extension of training compliance and guidance on specific training delivery from national bodies i.e. UK Resus Council. Our training delivery models have been reviewed and amended in line with strategies for reducing infection; with an increase in virtual delivery and on-line training. Face to face training has been risk assessed and is only in place for specific clinical skills. All staff complete statutory mandatory and role specific training to ensure the delivery of safe care. This includes:

- Fire safety, health and safety, moving and handling, infection control, information governance and security, resuscitation, management of violence and aggression and clinical skills training
- Training and induction in incident investigation, including documentation, root cause analysis, steps to prevent or minimise recurrence and reporting requirements
- Developing shared understanding of broader business, financial, environmental and clinical risks through collegiate clinical, professional and managerial groups
- Use of a reporting database to support risk management, Datix, which is recognised as best in class.

3.11 The organisation's key strategic risks are identified in the Board Assurance Framework, which is reported to the Board of Directors quarterly. These risks are categorised as Quality Service, Quality People, Quality Business and Governance risks. The appropriate Committee reviews these risks on a bi-monthly basis to ensure the risk assessment is current, and to ensure risks are removed when closed, and added when new risks emerge.

#### **4. The risk and control framework**

4.1 The system of internal control is based upon an on-going risk management process designed to identify the principal risks to the achievement of the organisation's objectives; to evaluate the nature and extent of those risks; and to manage them efficiently, effectively and economically

4.2 The key elements of the Risk Management Strategy are that:

- Risk is a key organisational responsibility
- All staff must accept the management of risks as one of their fundamental duties
- Every member of staff must be committed to identifying and reducing risk

- The management of risk is best achieved through an environment of honesty and openness, where mistakes and untoward incidents are identified quickly and dealt with in a positive and responsive way and lessons learnt are communicated throughout the organisation and best practice adopted.
- 4.3 The tools used to identify, evaluate and control risks are those outlined in ISO 31000 using the 5x5 matrix for consequence and likelihood. The use of this tool ensures consistency of risk assessment across the organisation.
- 4.4 Risks that are assessed as low indicate management by routine procedures. Moderate risks require specific management responsibility and action. High risks require senior management attention. Extreme risks require immediate action, including informing the Board of Directors.
- 4.5 During the year, the Trust has introduced a revised Corporate Governance Framework to respond to the COVID 19 emergency response. This Corporate Governance Framework has been regularly reviewed in year, alongside reviews of the Board Assurance Framework.
- 4.6 The Trust has been part of a National Level 4 Emergency Structure for the full year. Emergency planning arrangements have been put in place which include the establishment of a Command Centre which is able to respond to both national and local directives. Operational Pressures Escalation Levels (OPEL) have been used for the Trust and each of its service lines which has supported the risk assessment process and informed the re-allocation of resources, particularly staffing.
- 4.7 The key ways in which risk management is embedded in the activity of the organisation is through ensuring staff are aware of their responsibilities and accountabilities as set out in the risk management strategy. Assurances on how effectively the Risk Management System is working are through inspections – such as, environmental, infection control, security, workplace and fire safety – and through the health and safety and clinical governance activities.
- 4.8 This is supported through the Trust’s induction programme, training updates and individual training as a result of needs assessments. The Trust has introduced a performance management framework which includes the effective management of risk as a key element. The organisation undertakes Equality and Quality Impact Assessments on all functions it carries out to ensure that service delivery and employment practices comply with legal requirements.
- 4.9 The Trust involves key stakeholders in supporting it in the management of risks through formal meetings, discussions and engagement. This includes:
- Patients and their carers
  - The general public through consultations
  - Council of Governors
  - Trust membership
  - Staff Partnership Committee

- Staff Forum
  - Trust Management Executive
  - Frontline Care Council
  - Mental Health Act Committee (MHAC)
  - Health and Safety Committee (HSC)
  - Operations Senior Management Team
  - Clinical Commissioning Groups (CCGs)
  - Primary Care Networks
  - Local Health Providers
  - Local Authorities (LAs)
  - Improvement and Scrutiny Committee (ISC)
  - Health and Wellbeing Boards
  - Joined Up Care Derbyshire
  - Care Quality Commission (CQC)
  - NHS England and NHS Improvement (NHSEI)
  - Healthwatch.
- 4.10 The Trust has developed an integrated Assurance Framework to ensure that there are proper internal and independent assurances given on the soundness and effectiveness of the system and on the processes in place for meeting its objectives and delivering appropriate outcomes. The Assurance Framework is structured across Quality, People, Business and Governance risks. The Governance section addresses key risks to compliance with the NHS Foundation Trust license condition 4 (FT Governance).
- 4.11 The Board of Directors determines the strategic objectives of the Trust. Achievement of these strategic objectives is performance managed through the Board Committee structure. Strategic risks, which threaten the achievement of strategic objectives, are identified and key controls put in place to manage these risks. The Board is provided with reports to enable it to monitor the effectiveness of each element of the Assurance Framework.
- 4.12 The mitigation of strategic risks has been included as a key element of the operational plan to ensure our risk management processes and operational planning is aligned and that we are focussing our resources on the right things.
- 4.13 The Board of Directors has considered the key controls that are in place to identify risks and has assessed whether these controls are adequate. Where gaps in controls have been identified, action plans have been put in place to address the weaknesses.
- 4.14 The Board of Directors has mapped out how assurances relate to strategic objectives and identified where gaps exist. Action plans are in place to ensure further assurance is given in these areas. The Trust uses external bodies to provide assurance, where available, and targets the internal audit and clinical audit programmes at specific areas to provide assurance.

- 4.15 During the year Internal Audit undertook a number of reviews to test the internal control system and to review risk areas identified by the Trust. There was one limited assurance report which related to e-rostering. The Trust has agreed several recommendations, and these will be implemented within agreed timescales.
- 4.16 The recommendations from internal audit reports are tracked by the Audit and Assurance Committee to ensure prompt implementation. There was one high-risk recommendation identified in-year, relating to a review of e-rostering. The high risk recommendation was to develop a credible and realistic E-Roster action plan with appropriate Board level sponsorship and oversight. The Trust has accepted the recommendation, and the Director of People and Organisation Effectiveness will sponsor the work, with oversight through the Quality People Committee.
- 4.17 The Trust ensures a strong relationship between the assurance framework and risk register. The two documents are cross referenced, with the assurance framework including strategic risks, and the risk register operational risks.
- 4.18 Sections of the assurance framework have been assigned to the Board and its committees to ensure that there is clear oversight of all areas. Where lack of assurance, or gaps in control are identified, these are escalated to the Board of Directors. The Audit and Assurance Committee is responsible for maintaining the overview of the framework.
- 4.19 The Board of Directors uses the assurance framework to provide assurance when signing declarations to third parties.
- 4.20 The Quality Service Committee has responsibility for reviewing assurances over clinical quality. The Board Committees have responsibilities for ensuring assurance is obtained routinely on compliance with CQC registration requirements. The Audit and Assurance Committee maintains an overview of compliance.
- 4.21 The Quality People Committee provides oversight and scrutiny of the Trust's Workforce Plan and reports on safe staffing. This is supported by the Strategic Workforce Group, who ensure that the Workforce Plan matches the needs of individual Divisions and services and develops as the operating environment flexes and changes. All inpatient ward establishments are reviewed every six months by the Director of Nursing, AHPs and Quality. The Trust has developed a Responsive Workforce Staffing model to ensure that we have the right staff to undertake high quality patient care. This is underpinned by our 4,200 strong substantive workforce, who are complimented by a large bank of flexible workers, plus a team of substantive clinical staff who have flexible contracts, allowing them to be deployed into the areas of greatest need at any one time. The Trust has reviewed its workforce planning processes against 'Developing Workforce Safeguards' and believes it to be operating in line with the best practice detailed within this publication.
- 4.22 The Trust has a process in place for the revalidation of medical staff. This process is overseen by the Medical Director.

- 4.23 The Trust also has a process for the revalidation of nurses which is overseen by the Director of Nursing, AHPs and Quality and processes in place for ensuring that all registered clinical staff renew their professional registration. Where staff's registration is at risk of lapsing, this is flagged to the Director of Nursing, AHPs and Quality. This process is overseen by the Director of Nursing, AHPs and Quality
- 4.24 The Trust has a Raising Concerns Policy in place. The policy sets out how concerns will be investigated, with regular updates provided through to the Audit and Assurance Committee and Board. The Trust has appointed a Freedom to Speak Up Guardian who staff can contact directly with any concerns.
- 4.25 Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.
- 4.26 As an employer with staff entitled to membership of the NHS Pension scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.
- 4.27 The Foundation Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.
- 4.28 The Trust has a Major Incident and Business Continuity Plan. This document has been reviewed in-year to reflect the latest guidance from NHS England and the learning from incidents, training and exercises. The Quality Business Committee receives assurance reports on progress with the plan.
- 4.29 The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission.
- 4.30 The Trust has published on its website an up to date register of interests, including gifts and hospitality, for decision making staff (as defined by the Trust with reference to the guidance) within the past 12 months, as required by the "Managing Conflicts of Interest in the NHS" guidance. During the past 12 months, we have seen an increase in gifts being declared principally due to the Covid 19 pandemic. There has been no relaxation of our policy over this period.
- 4.31 For the financial year 2020/21, Deloitte are the Trust's external auditors and KPMG are the internal auditors and providers of Counter Fraud services.

4.32 The Trust has a Director responsible for Security Management and has access to a Local Security Management Advisor. The Quality Business Committee receives an assurance report with progress against the plan.

4.33 There have been no serious clinical incidents in year that were classed as a Never Event.

## **5 Review of economy, efficiency and effectiveness of the use of resources**

5.1 The Trust uses a range of key performance indicators (KPIs) which include non-financial measures, to manage the day to day business. This approach helps to provide a comprehensive and balanced view of performance.

5.2 During the year, the Board of Directors has received regular reports providing information on the economy, efficiency and effectiveness of the use of resources. The reports provide detail on the financial and clinical performance of the Trust during the previous period and highlight any areas through benchmarking or a traffic light system where there are concerns around economy, efficiency and effectiveness of the use of resources. The reports, supplied by general and service managers of the Trust, show the integrated financial, risk and performance management which support efficient and effective decision making by the Board of Directors.

5.3 The Trust has responded to a national emergency from the COVID 19 pandemic and has allocated resources in line with national directives and local needs. The Trust has reviewed the information reported to the Board during the year to reflect the changing operational priorities.

5.4 Internal audit has reviewed the systems and processes in place during the year and has published reports detailing the required actions within specific areas to ensure economy, efficiency and effectiveness of the use of resources is maintained. The internal audit reports provided to the Audit and Assurance Committee throughout the year gave an assessment of assurance in these areas

5.5 The Board of Directors has also received assurances on the use of resources from agencies outside the Trust, including NHS Improvement. The Board of Directors self-assess on a quarterly basis and NHS Improvement score this assessment using its Financial and Governance Risk Ratings. An overall segmentation rating is then provided for each Trust.

## **6 Information governance**

6.1 The Trust has systems and processes in place to govern access to confidential data and to ensure certain standards are followed when data and information is in transit. Any new system or process needs to meet these standards as does any hardware (e.g. computers or software). All system developments whether new or existing need to follow a process and be signed off by the Information Management and

Technology (IM&T) Strategy Group to ensure they meet the required criteria and that hardware and software is compatible.

- 6.2 The Trust monitors its information governance risks through the Information Governance Group. Incidents and risks are managed in accordance with Trust policy and serious risks are escalated through either IM&T Strategy Group or more urgent ones through the Executive Team, Quality Services Committee and Board of Directors.
- 6.3 The Caldicott Guardian (Medical Director) and the Senior Information Risk Owner (Chief Information and Transformation Officer) advise the Board around information and data security risks.
- 6.4 During the financial year, the Trust had no data security breaches at Level 2, which required reporting to the Information Commissioner.
- 6.5 Where Level 2 incidents do occur, these would be reviewed through the Information Governance Group so that learning can be shared and actioned.

## **7 Data Quality and Governance**

- 7.1 The Trust has assigned the Chief Information Officer as the Board Director responsible for data quality and governance.
- 7.2 The Trust receives assurance on data quality through the data quality kitemark to indicate the robustness of service and organisational data. The kitemark assesses service line data against the following six categories before an overall score is provided: audit, timeliness, sign off, relevance, completeness and source. External assessment of data quality is via performance metrics against national quality standards.
- 7.3 To ensure that there are appropriate controls in place to ensure the accuracy of data, the Trust has a data quality improvement plan in place. Key indicators are reviewed through management and audit resource. Progress with improving data quality is reported through the Informatics Strategy Group and then through to the Audit and Assurance Committee.

## **8. Review of effectiveness**

- 8.1 As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn upon performance information available to me. My review

is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, audit and assurance committee, quality service committee, quality people committee and quality business committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

- 8.2 Executive Directors within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by major sources of assurance detailed below.
- 8.3 I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board of Directors, the Audit and Assurance Committee, the Quality Service Committee, the Quality People Committee and the Quality Business Committee. A plan to address weaknesses and ensure continuous improvement of the system is in place.
- 8.4 The processes that have been applied in maintaining and reviewing the effectiveness of the system of internal control include the roles of the following:
- The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. The Head of Internal Audit Opinion for 1st April 2020 to 31st March 2021 is as follows:  
  
Significant assurance with minor improvement opportunities can be given on the adequacy and effectiveness of the Trust's framework of governance, risk management and control.
  - The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its strategic objectives have been reviewed.
  - The Trust's response to the COVID 19 pandemic in terms of how we have continued to provide excellent care and support our staff whilst ensuring resources are used effectively provides further me with evidence on the effectiveness of controls.
  - The Care Quality Commission (CQC) inspection of our services in July 2019, which resulted in an overall rating of "Outstanding", and their rating of "Outstanding " for Well Led, provides me with assurance over our clinical and corporate governance systems and quality of care of the services provided.

- The Trust's development of its Quality Assurance Framework, and Quality Always accreditation, provides me with assurance of the quality of services provided by our services.
- Our categorisation under the Single Oversight Framework (SOF) as a segment 1 Trust (low risk) for both governance and finances provides me with assurance as to our overall governance systems.
- The work of our external auditors to review the arrangements in place for producing the financial accounts, and providing an opinion on them, provides me with assurance.
- The work of our internal auditors in completing their risk-based targeted programme of reviews provides me with assurance on the effectiveness of controls.
- The work of our clinical audit team provides me with assurances of the effectiveness of controls in clinical areas.
- Our Staff Survey results provides me with assurance that our staff feel supported and involved in the work of the Trust, and this triangulates with the findings of the Care Quality Commission Well Led Review earlier in the year.
- The Audit and Assurance Committee provides the Board with an independent and objective view of arrangements for internal control within the Trust and to ensure the Internal Audit service complies with mandatory auditing standards, including the review of all fundamental financial systems.
- The Trust undertook an internal audit against the information governance toolkit, which provided evidence to support the Trust's view that it was compliant with the standards. The Trust continues to take action to ensure the standards of information governance are improved further in line with best practice.
- The Board of Directors has identified the strategic risks facing the organisation during the period and has monitored the controls in place and the assurances available to ensure that these risks are being appropriately managed.

## **9. Significant Control Issues**

- 9.1 During the year, there have been no significant control issues from business as usual.
- 9.2 However, in March 2020, the Trust enacted its business continuity plan with other partners to respond to the COVID 19 Pandemic. This event has caused the Trust to change its normal operational arrangements. The pandemic has required the Trust


to redirect resources to focus upon critical services to support the health and social care system response throughout the year.

- 9.3 The Trust has established a Gold and Silver Command structure that links into local structures feeding the Local Resilience Forum to ensure a coordinated public sector response is provided. The Board has approved a revised Corporate Governance Framework to support and oversee the response, and reviewed this throughout the year. The Trust has followed the national prioritisation tool for community services to inform our Service Delivery Plan for the pandemic.

## 10. Conclusion

- 10.1 My review confirms that Derbyshire Community Health Services NHS Foundation Trust has a generally sound system of risk management and internal control that supports the achievement of its policies, aims and objectives.
- 10.2 The Trust will continue to use the assurance framework to assure the Board of Directors and others that the Trust's key controls to manage strategic risks are being assessed and continuously improved. Where areas of concern are identified, action plans have been put in place to close the gap in control or assurance.

Signed (on behalf of the Board of Directors)



**Tracy Allen**  
**Chief Executive**  
**Independent auditor's report**

**15 June 2021**

Independent auditor's report to the Council of Governors and Board of Directors of Derbyshire Community Health Services NHS Foundation Trust

Report on the audit of the financial statements

Opinion

In our opinion the financial statements of Derbyshire Community Health Services NHS Foundation Trust (the 'foundation trust'):

- give a true and fair view of the state of the foundation trust's affairs as at 31 March 2021 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We have audited the financial statements which comprise:

- the statement of comprehensive income;
- the statement of financial position;
- the statement of changes in equity;
- the statement of cash flows; and
- the related notes 1 to 30.

We have also audited the information in the Remuneration Report and Staff Report that is subject to audit, being:

- the table of salaries and allowances of senior managers;
- the table of pension benefits of senior managers;
- the table of pay multiples; and
- the table of exit packages.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts.

#### **Basis for opinion**

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)), the Code of Audit Practice and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

#### **Conclusions relating to going concern**

In auditing the financial statements, we have concluded that the accounting officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the foundation trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

The going concern basis of accounting for the foundation trust is adopted in consideration of the requirements set out in the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it is anticipated that the services which they provide will continue into the future.

#### **Other information**

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The accounting officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

#### **Responsibilities of the accounting officer**

As explained more fully in the statement of accounting officer's responsibilities, the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the foundation trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the foundation trust without the transfer of the foundation trust's services to another public sector entity.

#### **Auditor's responsibilities for the audit of the financial statements**

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: [www.frc.org.uk/auditorsresponsibilities](http://www.frc.org.uk/auditorsresponsibilities). This description forms part of our auditor's report.

#### **Extent to which the audit was considered capable of detecting non-compliance with laws and regulations, including fraud**

We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulations, including fraud. The extent to which our procedures are capable of detecting non-compliance with laws and regulations, including fraud is detailed below.

We considered the nature of the foundation trust and its control environment, and reviewed the foundation trust's documentation of their policies and procedures relating to fraud and compliance with laws and regulations. We also enquired of management about their own identification and assessment of the risks of non-compliance with laws and regulations.

We obtained an understanding of the legal and regulatory framework that the foundation trust operates in, and identified the key laws and regulations that:

- had a direct effect on the determination of material amounts and disclosures in the financial statements. This included the National Health Service Act 2006.
- do not have a direct effect on the financial statements but compliance with which may be fundamental to the foundation trust's ability to operate or to avoid a material penalty. These included the Data Protection Act 2018 and relevant employment legislation.

We discussed among the audit engagement team including relevant internal specialists such as valuations, IT and industry specialists regarding the opportunities and incentives that may exist within the organisation for fraud and how and where fraud might occur in the financial statements.

As a result of performing the above, we identified the greatest potential for fraud or non-compliance with laws and regulations in the following areas, and our specific procedures performed to address it, are described below:

- Recognition of NHS clinical revenue. We evaluated the recognition of income through the period, including year-end cut-off, and evaluated the results of the agreement of balances exercise. In doing so, we assessed the appropriateness of judgements made and the nature of provisions for disputes and the basis for the position adopted.

In common with all audits under ISAs (UK), we are also required to perform specific procedures to respond to the risk of management override. In addressing the risk of fraud through management override of controls, we tested the appropriateness of journal entries and other adjustments; assessed whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluated the business rationale of any significant transactions that are unusual or outside the normal course of business.

In addition to the above, our procedures to respond to the risks identified included the following:

- reviewing financial statement disclosures by testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described as having a direct effect on the financial statements;
- performing analytical procedures to identify any unusual or unexpected relationships that may indicate risks of material misstatement due to fraud;
- enquiring of management, internal audit and external legal counsel concerning actual and potential litigation and claims, and instances of non-compliance with laws and regulations;
- review of local counter fraud reports produced; and
- reading minutes of meetings of those charged with governance and reviewing internal audit reports.

#### **Report on other legal and regulatory requirements**

##### **Opinions on other matters prescribed by the National Health Service Act 2006**

In our opinion:

- the parts of the Remuneration Report and Staff Report subject to audit have been prepared properly in accordance with the National Health Service Act 2006; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

#### **Matters on which we are required to report by exception**

##### *Use of resources*

Under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006, we are required to report to you if we have not been able to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Our work in respect of the foundation trust's arrangements is not complete at the date of our report on the financial statements. We will report the outcome of our work on the foundation trust's arrangements and include any additional exception reporting in respect of significant weaknesses in our audit completion certificate and our separate Auditor's Annual Report. We are satisfied that the remaining work is unlikely to have a material impact on the financial statements.

##### **Respective responsibilities of the accounting officer and auditor relating to the foundation trust's arrangements for securing economy, efficiency and effectiveness in the use of resources**

The accounting officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the use of the foundation trust's resources.

We are required under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006 to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our work in accordance with the Code of Audit Practice, having regard to the guidance, published by the Comptroller & Auditor General in April 2021, as to whether the foundation trust has proper arrangements for securing economy, efficiency and effectiveness in the use of resources against the specified criteria of financial sustainability, governance, and improving economy, efficiency and effectiveness.

The Comptroller & Auditor General has determined that under the Code of Audit Practice, we discharge this responsibility by reporting by exception if we have reported to the foundation trust a significant weakness in arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021 by the time of the issue of our audit report. Other findings from our work, including our commentary on the foundation trust's arrangements, will be reported in our separate Auditor's Annual Report.

***Annual Governance Statement and compilation of financial statements***

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit; or
- proper practices have not been observed in the compilation of the financial statements.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in respect of these matters.

***Reports in the public interest or to the regulator***

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or a director or officer of the foundation trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

**Use of our report**

This report is made solely to the Council of Governors and Board of Directors (“the Boards”) of Derbyshire Community Health Services NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor’s report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

A handwritten signature in blue ink, appearing to read 'M Ramzan', is positioned above the printed name and title.

Mohammed Ramzan, CPFA (Key Audit Partner)

For and on behalf of Deloitte LLP

Statutory Auditor

Birmingham, United Kingdom

15 June 2021

## Audit certificate issued subsequent to opinion on financial statements

### Independent auditor's certificate of completion of the audit

#### Issue of opinion on the audit of the financial statements

In our audit report for the year ended 31 March 2021 issued on 15 June 2021, we reported that, in our opinion, the financial statements:

- gave a true and fair view of the state of the foundation trust's affairs as at 31 March 2021 and of its income and expenditure for the year then ended;
- had been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and
- had been prepared in accordance with the requirements of the National Health Service Act 2006.

#### Foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

As part of our audit, we are required to report to you if we are not able to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

As at the date of issue of our audit report for the year ended 31 March 2021 on 15 June 2021, we had not completed our work on the foundation trust's arrangements, and had nothing to report in respect of this matter as at that date.

#### Certificate of completion of the audit

In our audit report for the year ended 31 March 2021 issued on 15 June 2021, we explained that we could not formally conclude the audit on that date until we had completed our work in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed our work in this area.

No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave our opinion.

We have nothing to report in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

We certify that we have completed the audit of Derbyshire Community Health Services NHS Foundation Trust in accordance with requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.



Mohammed Ramzan, CPFA (Key Audit Partner)  
For and on behalf of Deloitte LLP  
Statutory Auditor  
Birmingham, United Kingdom  
27 August 2021

**Derbyshire Community Health Services NHS Foundation Trust**

**Annual accounts for the year ended 31 March 2021**

## Foreword to the accounts

### Derbyshire Community Health Services NHS Foundation Trust

These accounts, for the year ended 31 March 2021, have been prepared by Derbyshire Community Health Services NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed

A handwritten signature in black ink that reads "Tracy Allen". The signature is written in a cursive style with a large initial 'T'.

**Tracy Allen**  
**Chief Executive**  
**15 June 2021**

## Statement of Comprehensive Income

		2020/21	2019/20
	Note	£000	£000
Operating income from patient care activities	3	178,595	176,837
Other operating income	4	20,255	18,961
Operating expenses	6, 8	(196,620)	(190,470)
<b>Operating surplus from continuing operations</b>		<b>2,230</b>	<b>5,328</b>
Finance income	11	9	270
Finance expenses	12	(7)	-
PDC dividends payable		(1,832)	(2,067)
<b>Net finance costs</b>		<b>(1,830)</b>	<b>(1,797)</b>
Other (losses)	13	(352)	(346)
(Losses) / Gains arising from transfers by absorption	29	(440)	125
<b>(Deficit) / surplus for the year from continuing operations</b>		<b>(392)</b>	<b>3,310</b>
<b>(Deficit) / surplus for the year</b>		<b>(392)</b>	<b>3,310</b>
<b>Other comprehensive income</b>			
<b>Will not be reclassified to income and expenditure:</b>			
Impairments	7	(8,266)	(197)
Revaluations	17	10,058	459
Other reserve movements		(5)	-
<b>Total comprehensive income for the period</b>		<b>1,395</b>	<b>3,572</b>
<b>Adjusted financial performance (control total basis):</b>			
(Deficit) / Surplus for the period		(392)	3,310
Remove net impairments not scoring to the Departmental expenditure limit		845	990
Remove (gains) / losses on transfers by absorption		440	(125)
Remove I&E impact of capital grants and donations		155	(141)
<b>Adjusted financial performance surplus *</b>		<b>1,048</b>	<b>4,034</b>

\* The financial performance of the Trust is assessed against the surplus or deficit adjusted for impairments, transfer by absorption and donated depreciation. There were no discontinued operations during the year, therefore the above surplus and the following notes relates solely to continuing operations

## Statement of financial position

		31 March 2021	31 March 2020
	Note	£000	£000
<b>Non-current assets</b>			
Intangible assets	14	1,278	1,811
Property, plant and equipment	15	79,912	77,478
Receivables	19	169	191
<b>Total non-current assets</b>		<b>81,359</b>	<b>79,480</b>
<b>Current assets</b>			
Receivables	19	5,811	8,475
Cash and cash equivalents	21	42,635	35,154
<b>Total current assets</b>		<b>48,446</b>	<b>43,629</b>
<b>Current liabilities</b>			
Trade and other payables	22	(17,969)	(15,349)
Provisions	24	(1,034)	(984)
Other liabilities	23	(1,634)	(168)
<b>Total current liabilities</b>		<b>(20,637)</b>	<b>(16,501)</b>
<b>Total assets less current liabilities</b>		<b>109,168</b>	<b>106,608</b>
<b>Non-current liabilities</b>			
Provisions	24	(30)	(30)
<b>Total non-current liabilities</b>		<b>(30)</b>	<b>(30)</b>
<b>Total assets employed</b>		<b>109,138</b>	<b>106,578</b>
<b>Financed by</b>			
Public dividend capital		2,762	1,597
Revaluation reserve		29,990	28,206
Income and expenditure reserve		76,386	76,775
<b>Total taxpayers' equity</b>		<b>109,138</b>	<b>106,578</b>

The notes on pages 130 to 168 form part of these accounts.

### Signed



**Name: Tracy Allen**  
**Position: Chief Executive**  
**Date: 15 June 2021**

**Statement of changes in equity for the year ended 31 March 2021**

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
<b>Taxpayers' and others' equity at 1 April 2020 - brought forward</b>	<b>1,597</b>	<b>28,206</b>	<b>76,775</b>	<b>106,578</b>
(Deficit) for the year	-	-	(392)	(392)
Impairments	-	(8,266)	-	(8,266)
Revaluations	-	10,058	-	10,058
Transfer to retained earnings on disposal of assets	-	(3)	3	-
Public dividend capital received	1,165	-	-	1,165
Other reserve movements	-	(5)	-	(5)
<b>Taxpayers' and others' equity at 31 March 2021</b>	<b><u>2,762</u></b>	<b><u>29,990</u></b>	<b><u>76,386</u></b>	<b><u>109,138</u></b>

**Statement of changes in equity for the year ended 31 March 2020**

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
<b>Taxpayers' and others' equity at 1 April 2019 - brought forward</b>	<b>1,377</b>	<b>28,065</b>	<b>73,344</b>	<b>102,786</b>
Surplus for the year	-	-	3,310	3,310
Impairments	-	(197)	-	(197)
Revaluations	-	459	-	459
Transfer to retained earnings on disposal of assets	-	(121)	121	-
Public dividend capital received	220	-	-	220
<b>Taxpayers' and others' equity at 31 March 2020</b>	<b><u>1,597</u></b>	<b><u>28,206</u></b>	<b><u>76,775</u></b>	<b><u>106,578</u></b>

## **Information on reserves**

### **Public dividend capital**

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

### **Revaluation Reserve**

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

### **Income and expenditure reserve**

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

## Statement of cash flows

	2020/21	2019/20
Note	£000	£000
<b>Cash flows from operating activities</b>		
Operating surplus	2,230	5,328
<b>Non-cash income and expense:</b>		
Depreciation and amortisation	6.1 3,913	3,685
Net impairments	7 1,056	1,879
Income recognised in respect of capital donations	4 -	(263)
Decrease in receivables and other assets	2,608	2,446
Increase in payables and other liabilities	3,892	307
Increase / (decrease) in provisions	50	(534)
Other movements in operating cash flows	(4)	1
<b>Net cash flows from operating activities</b>	<b>13,745</b>	<b>12,849</b>
<b>Cash flows from investing activities</b>		
Interest received	9	270
Purchase of intangible assets	(439)	(466)
Purchase of PPE and investment property	(5,322)	(6,839)
Sales of PPE and investment property	84	23
Receipt of cash donations to purchase assets	-	372
<b>Net cash flows (used in) investing activities</b>	<b>(5,668)</b>	<b>(6,640)</b>
<b>Cash flows from financing activities</b>		
Public dividend capital received	1,165	220
Other interest	(7)	-
PDC dividend (paid)	(1,754)	(2,074)
<b>Net cash flows (used in) financing activities</b>	<b>(596)</b>	<b>(1,854)</b>
<b>Increase in cash and cash equivalents</b>	<b>7,481</b>	<b>4,355</b>
<b>Cash and cash equivalents at 1 April - brought forward</b>	<b>35,154</b>	<b>30,799</b>
<b>Cash and cash equivalents at 31 March</b>	<b>21.1 42,635</b>	<b>35,154</b>

## Notes to the accounts

### Note 1 Accounting policies and other information

#### Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

#### Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

#### Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Due to the COVID-19 pandemic there have been significant changes to the way NHS providers are being funded in 20/21 which has impacted the Trust.

The Trust has a track record of successfully delivering its financial plan and ended the 2020/21 financial year with £42m in its bank account. In response to the changing financial landscape, the Board has approved an interim financial plan for 2021/22 which will deliver a break even position in the first half of the financial year with an assumption that all reasonable costs incurred during this period in responding to the pandemic will be reimbursed. The plan will need to be reviewed once further clarity is given regarding the funding arrangements from October 2021 onwards. It is expected that block funding arrangements will be in place for 2021/22.

The Board of Directors is therefore satisfied and considers it appropriate that the accounts for the year ended 31st March 2021 should be prepared on a Going Concern basis.

#### Note 1.3 Interests in other entities

Activities are considered to be "acquired" only if they are taken on from outside the public sector. Activities are considered to be "discontinued" only if they cease entirely. They are not considered to be "discontinued" if they transfer from one public body to another.

#### Charitable funds

The NHS Foundation Trust is the corporate Trustee to The Derbyshire Community Health Services Charitable Trust. Under the provisions of IAS27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS Bodies are consolidated within the entities returns. In accordance with IAS1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact.

Following Treasury's agreement to apply IAS27 to NHS Charities from 1st April 2013, the Trust has established that as the Trust is the corporate Trustee of the linked NHS Charity, The Derbyshire Community Health Services Charitable Trust, it effectively has the power to exercise control so as to obtain economic benefits. However, the transactions are immaterial in the context of the group and therefore transactions have not been consolidated. Details of the transactions with the charity are included in the Related Parties note.

#### **Note 1.3.1 Joint arrangements**

Arrangements over which the Trust has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the Trust is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts.

#### **Note 1.4 Revenue from contracts with customers**

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

#### **Revenue from NHS contracts**

The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

##### 2020/21

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at a Integrated Care System/Sustainability and Transformation Partnership level. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

##### Comparative period (2019/20)

In the comparative period (2019/20), the trust's contracts with NHS commissioners included those where the trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited

as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

#### **Revenue from research contracts**

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

#### **NHS injury cost recovery scheme**

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

#### **Note 1.5 Other forms of income**

##### **Grants and donations**

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants are used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

##### **Apprenticeship service income**

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

#### **Note 1.5.1 Other income**

The main source of other income for the Trust is provision of facilities management, community pharmacy, catering and recharges.

#### **Note 1.6 Expenditure on employee benefits**

##### **Short-term employee benefits**

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

##### **Pension costs**

###### *NHS pension Scheme*

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

#### **Note 1.7 Expenditure on other goods and services**

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

#### **Note 1.8 Discontinued operations**

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of Whole of Government Accounts are 'machinery of government changes' and treated as continuing operations.

## **Note 1.9 Property, plant and equipment**

### **Recognition**

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

#### *Subsequent expenditure*

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

### **Measurement**

#### *Valuation*

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset-basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

#### *Depreciation*

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

#### *Revaluation gains and losses*

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

#### *Impairments*

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve.

Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

#### **De-recognition**

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition. These are defined further as:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales
- the sale must be highly probable i.e:
  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale'
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

#### **Donated and grant funded assets**

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

In 2020/21 this includes assets donated to the trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

#### **Useful lives of property, plant and equipment**

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	<b>Min life Years</b>	<b>Max life Years</b>
Land	-	-
Buildings, excluding dwellings	5	71
Dwellings	-	-
Plant & machinery	5	15
Transport equipment	7	7
Information technology	5	8
Furniture & fittings	5	10

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

### Note 1.10 Intangible assets

#### Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

#### *Internally generated intangible assets*

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

#### *Software*

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

#### Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

#### Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

#### Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	<b>Min life Years</b>	<b>Max life Years</b>
Software licences	5	10

### **Note 1.11 Inventories**

Inventories are valued at the lower of cost and net realisable value.

In 2020/21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

The Trust has taken the decision to not account for inventory. The majority of the Trust's stock items are held locally by individual departments and not in a central store and are therefore deemed available for immediate use. In addition, the value of these items are not material in the context of the Trust's overall cost base.

### **Note 1.12 Cash and cash equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

### **Note 1.13 Financial assets and financial liabilities**

#### **Recognition**

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

#### **Classification and measurement**

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets and liabilities are classified as subsequently measured at amortised cost.

#### **Financial assets and financial liabilities at amortised cost**

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

### **Impairment of financial assets**

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

### **De-recognition**

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

### **Note 1.14 Leases**

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

#### **The trust as a lessee**

##### *Finance leases*

Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

##### *Operating leases*

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

*Leases of land and buildings*

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

**The trust as a lessor**

*Finance leases*

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

*Operating leases*

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

**Note 1.15 Provisions**

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2021:

		<b>Nominal rate</b>
Short-term	Up to 5 years	0.51%
Medium-term	After 5 years up to 10 years	0.55%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2020:

	<b>Inflation rate</b>
Year 1	1.90%
Year 2	2.00%
Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.95% in real terms.

**Note 1.15.1 Clinical negligence**

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 24.1 but is not recognised in the Trust's accounts.

**Note 1.15.2 Non clinical risk**

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

#### **Note 1.16 Contingencies**

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed as note where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed as a note, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

#### **Note 1.17 Public dividend capital**

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at <https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts>.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

#### **Note 1.18 Value added tax**

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

#### **Note 1.19 Climate change levy**

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

#### **Note 1.20 Foreign exchange**

The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

#### **Note 1.21 Third party assets**

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

#### **Note 1.22 Losses and special payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accrual basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

#### **Note 1.23 Gifts**

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

#### **Note 1.24 Transfers of functions to / from other NHS bodies / local government bodies**

For functions that have been transferred to the trust from another NHS / local government body, the transaction is accounted for as a transfer by absorption. The assets and liabilities transferred are recognised in the accounts using the book value as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain / loss corresponding to the net assets/ liabilities transferred is recognised within income/expenses, but not within operating activities.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation/amortisation balances from the transferring entity's accounts are preserved on recognition in the trust's accounts. Where the transferring body's recognised revaluation reserve balances are attributable to the assets, the trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the trust has transferred to another NHS/local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss/gain corresponding to the net assets/ liabilities transferred is recognised within expenses/income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve.

Adjustments to align the acquired function to the trust's accounting policies are applied after initial recognition and are adjusted directly in taxpayers' equity.

The Trust has not transferred any functions to / from other NBS bodies / local government bodies during 2020/21 and 2019/20.

**Note 1.25 Early adoption of standards, amendments and interpretations**

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

**Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted**

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease. On transition to IFRS16 on 1 April 2022, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of £5,000, a lease liability will be recognised equal to the value of the remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be defined by HM Treasury, Currently this is 1.27% but this may change between now and the adoption of the standard, The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at the current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustment will be made on 1 April 2022 for existing finance leases.

Due to the COVID pandemic, HM Treasury and the Financial Reporting Advisory Board ( FRAB) decided that the implementation of IFRS16 in the public sector will be deferred until 1st April 2022. Due to the need to reassess the lease calculations, together with the uncertainty on expected leasing activity from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is considered impracticable. However the Trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

Due to the COVID pandemic, HM Treasury and the Financial Reporting Advisory Board ( FRAB) decided that the implementation of IFRS16 in the public sector will be deferred until 1st April 2022. Due to the need to reassess the lease calculations, together with the uncertainty on expected leasing activity from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is considered impracticable. However the Trust does expect this standard to have a material impact on non-current assets , liabilities and depreciation.

### **Note 1.27 Critical judgements in applying accounting policies**

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

#### **Accounting for property, plant and equipment**

##### *Modern Equivalent Asset Valuation*

The Trust undertook a full revaluation of its land and building portfolio as at 31 March 2021, adopting the Modern Equivalent Asset (MEA) methodology. This has resulted in the Trust recognising impairments of £845k in the 2020/21 accounts.

Department of Health guidance specifies that the Trust's land and buildings should be valued on the basis of depreciated replacement costs, applying the Modern Equivalent Assets (MEA) concept. The MEA is defined as the "cost of a modern replacement asset that has the same productive capacity as the property being valued". Therefore the MEA is not a valuation of the existing land and buildings that the Trust owns, but a theoretical valuation for accounting purposes.

The Trust is satisfied that the assumptions underpinning the MEA valuation are robust and are based on the Trust's estate strategy. The assumptions allow for the same productive capacity that would enable the Trust to continue to deliver the current range of services. In determining the assumptions to be used for the valuation, the Trust has not opted to exercise the "alternative site" option, with the exception of Buxton combined healthcare facilities.

#### **Accounting for leases**

Judgements have been made regarding whether the risks and rewards of ownership pass to the lessee under lease arrangements.

#### **Consolidation of the associated charity**

Following Treasury's agreement to apply IAS27 to NHS Charities from 1st April 2013, the Trust has established that as the Trust is the corporate Trustee of the linked NHS Charity, The Derbyshire Community Health Services Charitable Trust, it effectively has the power to exercise control so as to obtain economic benefits. However, the transactions are immaterial in the context of the group and transactions have not been consolidated. Details of the transactions with the charity are included in the Related Parties note.

### **Note 1.28 Sources of estimation uncertainty**

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

#### **Compensated absences accrual**

In accordance with IAS19, the Trust accrues for untaken annual leave at the end of the financial year. This accrual is based on a sample which is then extrapolated across the population. Due to the COVID pandemic, employees are able to carry forward any remaining annual leave not taken in 20/21 into the next two financial years. This has been factored into the calculation of the accrual provided for in the 20/21 accounts.

#### **Accounting for doubtful debts**

A general provision is made for doubtful debts. This is based on 100% for expected loss on non-NHS invoices older than 90 days, and 2% on invoices less than 90 days.

#### **Provisions**

The Trust holds a number of provisions where the actual outcome may vary from the amount recognised in the financial statements. The amount recognised is estimated based on the best available evidence at the year-end.

**Note 2 Operating segments**

No segmental analysis is shown as the sole activity of Derbyshire Community Health Services NHS Foundation Trust in 2020/21 was the provision of specialist community services. The "Chief Operating Decision Maker" is deemed to be the Trust Board.

The Board currently receives only high level financial reporting information and does not therefore review information or allocate resources in any way that could be perceived to represent operating segments. This will be reviewed during the course of 2021/22 dependent upon the information received by the Trust Board.

The Trust has five customers that account for more than 10% of its total revenue derived from providing specialist community services. Customers are defined for this purpose as "Clinical Commissioning Groups and NHS England" and Local Authorities. The total income that the Trust received during the period 1 April 2020 to 31 March 2021 was £178m (2019/20: £177m) for the provision of specialist community services.

**Note 3 Operating income from patient care activities**

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

<b>Note 3.1 Income from patient care activities (by nature)</b>	<b>2020/21</b>	<b>2019/20</b>
	<b>£000</b>	<b>£000</b>
<b>Acute services</b>		
Block contract / system envelope income*	6,736	12,733
Other NHS clinical income	-	265
<b>Mental health services</b>		
Block contract / system envelope income*	16,662	16,208
<b>Community services</b>		
Block contract / system envelope income*	126,709	116,241
Income from other sources (e.g. local authorities)	19,906	21,089
<b>All services</b>		
Additional pension contribution central funding**	6,160	6,051
Other clinical income	2,422	4,252
<b>Total income from activities</b>	<b>178,595</b>	<b>176,837</b>

\*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

\*\*The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

**Note 3.2 Income from patient care activities (by source)**

	<b>2020/21</b>	<b>2019/20</b>
	<b>£000</b>	<b>£000</b>
<b>Income from patient care activities received from:</b>		
NHS England	11,931	14,307
Clinical commissioning groups	146,603	140,377
Other NHS providers	5	94
Local authorities	19,558	21,152
Injury cost recovery scheme	203	384
Non NHS: other	295	523
<b>Total income from activities</b>	<b>178,595</b>	<b>176,837</b>
<b>Of which:</b>		
Related to continuing operations	178,595	176,837

**Note 4 Other operating income**

	2020/21			2019/20		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	83	-	83	80	-	80
Education and training	1,932	-	1,932	1,367	-	1,367
Provider sustainability fund (2019/20 only)	-	-	-	2,046	-	2,046
Reimbursement and top up funding	2,002	-	2,002	-	-	-
Receipt of capital grants and donations	-	-	-	-	263	263
Other contributions to expenditure	-	2,412	2,412	-	-	-
Other income	13,826	-	13,826	15,187	18	15,205
<b>Total other operating income</b>	<b>17,843</b>	<b>2,412</b>	<b>20,255</b>	<b>22,772</b>	<b>281</b>	<b>23,053</b>
<b>Of which:</b>						
Related to continuing operations			20,255			18,961

	2020/21	2019/20
	£000	£000
Main items of other income are:		
Clinical service SLA	3,899	3,468
Non-clinical service SLA	1,415	1,293
CCG pass through cost - Dressings	2,637	2,554
People Services - Joint venture income	1,444	1,506
Domestic	1,496	1,156
Speech and language therapy	999	969
CCG pass through cost - Community Pharmacy	619	856

**Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period**

	2020/21 £000	2019/20 £000
Revenue recognised in the reporting period that was included in contract liabilities at the previous period end	168	154
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	2,648	4,010

**Note 5.2 Transaction price allocated to remaining performance obligations**

	31 March 2021 £000	31 March 2020 £000
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:		
within one year	2,648	4,010
after one year, not later than five years	-	-
after five years	-	-
<b>Total revenue allocated to remaining performance obligations</b>	<b>2,648</b>	<b>4,010</b>

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

**Note 5.3 Income from activities arising from commissioner requested services**

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2020/21 £000	2019/20 £000
Income from services designated as commissioner requested services	-	-
Income from services not designated as commissioner requested services	178,595	176,837
<b>Total</b>	<b>178,595</b>	<b>176,837</b>

**Note 5.4 Profits and losses on disposal of property, plant and equipment**

Loss on disposal (Note 13) is mainly on IT equipment due to the roll out of Windows 10, making the equipment obsolete.

**Note 6.1 Operating expenses**

	<b>2020/21</b>	<b>2019/20</b>
	<b>£000</b>	<b>£000</b>
Purchase of healthcare from NHS and DHSC bodies	5,241	6,407
Purchase of healthcare from non-NHS and non-DHSC bodies	2,298	3,086
Staff and executive directors costs	141,862	136,480
Remuneration of non-executive directors	152	160
Supplies and services - clinical (excluding drugs costs)	11,104	9,836
Supplies and services - general	1,318	1,268
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	1,283	2,139
Inventories written down (Note 18)	-	-
Consultancy costs	470	432
Establishment	1,490	2,185
Premises	11,045	9,209
Transport (including patient travel)	3,512	4,543
Depreciation on property, plant and equipment	3,279	3,110
Amortisation on intangible assets	634	575
Net impairments	1,056	1,879
Movement in credit loss allowance: contract receivables / contract assets	(48)	24
Increase/(decrease) in other provisions	-	(20)
Audit fees payable to the external auditor		
audit services- statutory audit	130	74
other auditor remuneration (external auditor only)	-	1
Internal audit costs	86	86
Clinical negligence	783	664
Legal fees	366	260
Insurance	42	38
Education and training	1,320	683
Rentals under operating leases	7,963	6,647
Redundancy	4	(449)
Car parking & security	3	(31)
Hospitality	1	6
Losses, ex gratia & special payments	4	5
Other	1,222	1,173
<b>Total</b>	<b>196,620</b>	<b>190,470</b>
<b>Of which:</b>		
Related to continuing operations	196,620	190,470
Related to discontinued operations	-	-

Included in the analysis above are costs of £5.3m(2019/20:£0.3m) which the Trust incurred in response to the COVID 19 pandemic, and £3.47m in the Trust's role as the lead provider in the rollout of the vaccination for Derbyshire population. These costs have been or will be fully reimbursed during the year by NHS England and Improvement, and a debtor recognised for the balance still to be reimbursed at 31 March 2021. The Trust has recognised the expenditure in its operating expenditure and recognised the income due the reimbursement in "Income from Patient Care Activities".

**Note 6.2 Other auditor remuneration**

	2020/21 £000	2019/20 £000
<b>Other auditor remuneration paid to the external auditor:</b>		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	-	-
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	1
<b>Total</b>	<b>-</b>	<b>1</b>

**Note 6.3 Limitation on auditor's liability**

The limitation on auditor's liability for external audit work is £1 million (2019/20: £1 million).

**Note 7 Impairment of assets**

	2020/21 £000	2019/20 £000
<b>Net impairments charged to operating surplus resulting from:</b>		
Loss or damage from normal operations	-	97
Abandonment of assets in course of construction	211	792
Changes in market price	845	990
<b>Total net impairments charged to operating surplus / deficit</b>	<b>1,056</b>	<b>1,879</b>
Impairments charged to the revaluation reserve	8,266	197
<b>Total net impairments</b>	<b>9,322</b>	<b>2,076</b>

During 2019/20, the Trust revalued its Buxton land and buildings. Specialised buildings were valued at depreciated replacement cost on a modern equivalent asset basis. Where applicable, the valuation loss was recognised initially against the Revaluation Reserve with the balance being recognised as an impairment. This resulted in the Trust recognising impairments of £973k in the Statement of Comprehensive Income, and £17k for other impairments.

During 2020/21 the Trust undertook a full revaluation of its land and building portfolio as at 31 March 2021, refreshing the underlying Modern Equivalent Asset (MEA) methodology. This has resulted in the Trust recognising impairments charged to operating surplus of £845k and impairments charged to revaluation reserve of £8,266 in the 2020/21 accounts.

**Note 8 Employee benefits**

	<b>2020/21</b>	<b>2019/20</b>
	<b>Total</b>	<b>Total</b>
	<b>£000</b>	<b>£000</b>
Salaries and wages	105,961	102,677
Social security costs	9,501	8,945
Apprenticeship levy	537	518
Employer's contributions to NHS pensions	20,338	19,927
Pension cost - other	74	-
Other employment benefits	4,624	2,841
Termination benefits	4	(449)
Temporary staff (including agency)	1,250	1,937
<b>Total gross staff costs</b>	<b>142,289</b>	<b>136,396</b>
Recoveries in respect of seconded staff	-	-
<b>Total staff costs</b>	<b>142,289</b>	<b>136,396</b>
<b>Of which</b>		
Costs capitalised as part of assets	423	365

**Note 8.1 Retirements due to ill-health**

During 2020/21 there were 3 early retirements from the trust agreed on the grounds of ill-health (3 in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £123k (£100k in 2019/20).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

**Note 9 Pension costs**

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at [www.nhsbsa.nhs.uk/pensions](http://www.nhsbsa.nhs.uk/pensions). Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

**a) Accounting valuation**

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as at 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

#### b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations

#### C) NEST pension

As of 1st April 2013 it became a statutory requirement to enrol all eligible staff into a workplace pension scheme. Where employees are not eligible to enrol in the NHS Pension scheme they are enrolled in the NEST Pension scheme as an alternative. The employee can choose to "opt-out" of the scheme after they have been auto-enrolled, this opt out last for three years after which time the Trust will be required to re-enrol the employee. The Trust is required to make employer contributions of 1% of the employee's qualifying salary to the NEST Pension scheme. For the period 1st April 2020 to 31st March 2021 the Trust has contributed £74,445 (2019/20: £56,002)

#### Note 10 Operating leases

##### lessee

This note discloses costs and commitments incurred in operating lease arrangements where Derbyshire Community Health Services NHS Foundation Trust is the lessee.

	2020/21 £000	2019/20 £000
<b>Operating lease expense</b>		
Minimum lease payments	7,963	6,647
<b>Total</b>	<b>7,963</b>	<b>6,647</b>
	<b>31 March 2021 £000</b>	<b>31 March 2020 £000</b>
<b>Future minimum lease payments due:</b>		
- not later than one year;	7,928	7,049
- later than one year and not later than five years;	26,232	24,376
- later than five years.	53,623	51,498
<b>Total</b>	<b>87,783</b>	<b>82,923</b>

The increase in 2020/21 operating lease expense is mainly due to the increase of £482k annual lease payments to Community Health Partnership and £582k to local authorities in relation to operating the vaccination centres as part of the regional coronavirus pandemic response.

The increase in annual lease payments to Community Health Partnership is reflected in the future lease payments.

**Note 11 Finance income**

Finance income represents interest received on assets and investments in the period.

	2020/21
	£000
Interest on bank accounts	9
<b>Total finance income</b>	<b>9</b>

**Note 12.1 Finance expenditure**

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2020/21
	£000
<b>Interest expense:</b>	
Interest on late payment of commercial debt	7
<b>Total interest expense</b>	<b>7</b>
<b>Total finance costs</b>	<b>7</b>

**Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015**

	2020/21
	£000
Amounts included within interest payable arising from claims made under this legislation	7

**Note 13 Other gains / (losses)**

	2020/21
	£000
Gains on disposal of assets	17
Losses on disposal of assets	(369)
<b>Total gains / (losses) on disposal of assets</b>	<b>(352)</b>
<b>Total other gains / (losses)</b>	<b>(352)</b>

Loss on disposal is mainly on IT equipment due to the roll out of Windows 10, making the equipment obsolete.

**Note 14 Intangible assets - 2020/21**

	Software licences £000	Intangible assets under construction £000	Total £000
<b>Valuation / gross cost at 1 April 2020 - brought forward</b>	<b>4,706</b>	<b>147</b>	<b>4,853</b>
Transfers by absorption	-	(240)	(240)
Additions	-	439	439
Reclassifications	237	(237)	-
Disposals / derecognition	(789)	-	(789)
<b>Valuation / gross cost at 31 March 2021</b>	<b>4,154</b>	<b>109</b>	<b>4,263</b>
<b>Amortisation at 1 April 2020 - brought forward</b>	<b>3,042</b>	<b>-</b>	<b>3,042</b>
Provided during the year	634	-	634
Disposals / derecognition	(691)	-	(691)
<b>Amortisation at 31 March 2021</b>	<b>2,985</b>	<b>-</b>	<b>2,985</b>
<b>Net book value at 31 March 2021</b>	<b>1,169</b>	<b>109</b>	<b>1,278</b>
<b>Net book value at 1 April 2020</b>	<b>1,664</b>	<b>147</b>	<b>1,811</b>

**Note 14.1 Intangible assets - 2019/20**

	Software licences £000	Intangible assets under construction £000	Total £000
<b>Valuation / gross cost at 1 April 2019 - as previously stated</b>	<b>4,349</b>	<b>38</b>	<b>4,387</b>
Additions	-	466	466
Reclassifications	357	(357)	-
<b>Valuation / gross cost at 31 March 2020</b>	<b>4,706</b>	<b>147</b>	<b>4,853</b>
<b>Amortisation at 1 April 2019 - as previously stated</b>	<b>2,467</b>	<b>-</b>	<b>2,467</b>
Provided during the year	575	-	575
<b>Amortisation at 31 March 2020</b>	<b>3,042</b>	<b>-</b>	<b>3,042</b>
<b>Net book value at 31 March 2020</b>	<b>1,664</b>	<b>147</b>	<b>1,811</b>
<b>Net book value at 1 April 2019</b>	<b>1,882</b>	<b>38</b>	<b>1,920</b>

## Note 15.1 Property, plant and equipment - 2020/21

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
<b>Valuation/gross cost at 1 April 2020 - brought forward</b>	10,930	62,178	3,713	4,441	17	6,255	1,219	88,753
Transfers by absorption	-	-	-	(779)	-	-	-	(779)
Additions	-	-	5,516	-	-	-	-	5,516
Impairments	(153)	(14,576)	(211)	-	-	-	-	(14,940)
Reversals of impairments	-	2,971	-	-	-	-	-	2,971
Revaluations	1,163	5,582	-	-	-	-	-	6,745
Reclassifications	742	3,168	(6,126)	475	-	1,697	44	-
Disposals / <u>derecognition</u>	-	-	-	(913)	-	(2,375)	(162)	(3,450)
<b>Valuation/gross cost at 31 March 2021</b>	<b>12,682</b>	<b>59,323</b>	<b>2,892</b>	<b>3,224</b>	<b>17</b>	<b>5,577</b>	<b>1,101</b>	<b>84,816</b>
<b>Accumulated depreciation at 1 April 2020 - brought forward</b>	-	4,359	-	3,010	17	2,707	1,182	11,275
Transfers by absorption	-	-	-	(579)	-	-	-	(579)
Provided during the year	-	2,026	-	243	-	979	31	3,279
Impairments	-	(2,647)	-	-	-	-	-	(2,647)
Revaluations	-	(3,313)	-	-	-	-	-	(3,313)
Disposals / <u>derecognition</u>	-	-	-	(823)	-	(2,126)	(162)	(3,111)
<b>Accumulated depreciation at 31 March 2021</b>	-	425	-	1,851	17	1,560	1,051	4,904
<b>Net book value at 31 March 2021</b>	<b>12,682</b>	<b>58,898</b>	<b>2,892</b>	<b>1,373</b>	-	<b>4,017</b>	<b>50</b>	<b>79,912</b>
<b>Net book value at 1 April 2020</b>	<b>10,930</b>	<b>57,819</b>	<b>3,713</b>	<b>1,431</b>	-	<b>3,548</b>	<b>37</b>	<b>77,478</b>

## Note 15.2 Property, plant and equipment - 2019/20

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
<b>Valuation / gross cost at 1 April 2019 - as previously stated</b>	12,030	60,283	2,449	4,426	17	6,707	1,296	87,208
Transfers by absorption	-	-	125	-	-	-	-	125
Additions	-	-	6,251	-	-	-	-	6,251
Impairments	(1,050)	(258)	(792)	-	-	-	-	(2,100)
Revaluations	(27)	560	-	-	-	-	-	533
Reclassifications	-	1,593	(4,320)	623	-	2,104	-	-
Transfers to / from assets held for sale	(23)	-	-	-	-	-	-	(23)
Disposals / <u>derecognition</u>	-	-	-	(608)	-	(2,556)	(77)	(3,241)
<b>Valuation/gross cost at 31 March 2020</b>	<b>10,930</b>	<b>62,178</b>	<b>3,713</b>	<b>4,441</b>	<b>17</b>	<b>6,255</b>	<b>1,219</b>	<b>88,753</b>
<b>Accumulated depreciation at 1 April 2019 - as previously stated</b>	-	2,359	-	3,371	17	4,061	1,201	11,009
Transfers by absorption	-	-	-	-	-	-	-	-
Provided during the year	-	1,950	-	238	-	865	57	3,110
Impairments	-	(24)	-	-	-	-	-	(24)
Revaluations	-	74	-	-	-	-	-	74
Disposals / <u>derecognition</u>	-	-	-	(599)	-	(2,219)	(76)	(2,894)
<b>Accumulated depreciation at 31 March 2020</b>	<b>-</b>	<b>4,359</b>	<b>-</b>	<b>3,010</b>	<b>17</b>	<b>2,707</b>	<b>1,182</b>	<b>11,275</b>
<b>Net book value at 31 March 2020</b>	<b>10,930</b>	<b>57,819</b>	<b>3,713</b>	<b>1,431</b>	<b>-</b>	<b>3,548</b>	<b>37</b>	<b>77,478</b>

**Note 15.3 Property, plant and equipment financing - 2020/21**

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
<b>Net book value at 31 March 2021</b>							
Owned - purchased	12,682	54,980	2,892	1,270	4,017	50	75,891
Owned - donated/granted	-	3,918	-	103	-	-	4,021
<b>NBV total at 31 March 2021</b>	<b>12,682</b>	<b>58,898</b>	<b>2,892</b>	<b>1,373</b>	<b>4,017</b>	<b>50</b>	<b>79,912</b>

**Note 15.4 Property, plant and equipment financing - 2019/20**

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
<b>Net book value at 31 March 2020</b>							
Owned - purchased	10,930	54,492	3,713	1,303	3,548	37	74,023
Owned - donated/granted	-	3,327	-	128	-	-	3,455
<b>NBV total at 31 March 2020</b>	<b>10,930</b>	<b>57,819</b>	<b>3,713</b>	<b>1,431</b>	<b>3,548</b>	<b>37</b>	<b>77,478</b>

**Note 16 Donations of property, plant and equipment**

The Trust did not receive any donated assets during the financial years 2020/21 and 2019/20.

**Note 17 Revaluations of property, plant and equipment**

During the year, the Trust undertook a full revaluation exercise in respect of the land and building assets held. Specialised buildings are revalued at depreciated replacement cost on a modern equivalent asset basis. This is consistent with the NHS accounting policies and principles which are detailed in the Department of Health Government Accounting Manual. Land and non-specialised buildings have been valued at market value for existing use. During 2020/21 two valuations have been transacted. One at the 1 April 2020 resulted in revaluation gain of £5.2m and one at 31 March 2021 resulted in revaluation loss of £4.2m. In both cases, the valuations were carried out by the District Valuer.

**Note 18 Inventories**

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £2,412k of items purchased by DHSC. The full value has been recognised in the income and expenditure for 2020/21.

The deemed cost of these centrally procured inventories was charged directly to expenditure on receipt with the corresponding benefit recognised in income.

As the Trust's policy is to not account for inventories, it is impractical to calculate the value of inventories consumed in any given financial year. All stock items are held locally by individual departments and are treated as being available for immediate use. The overall value of such items is not material in the context of the Trust's overall expenditure levels.

**Note 19.1 Receivables**

	<b>31 March 2021 £000</b>	<b>31 March 2020 £000</b>
<b>Current</b>		
Contract receivables	4,876	7,744
Allowance for impaired contract receivables / assets	(113)	(153)
Prepayments (non-PFI)	943	747
PDC dividend receivable	56	134
VAT receivable	6	3
Other receivables	43	-
<b>Total current receivables</b>	<b>5,811</b>	<b>8,475</b>
<b>Non-current</b>		
Contract receivables	217	251
Allowance for impaired contract receivables / assets	(48)	(60)
<b>Total non-current receivables</b>	<b>169</b>	<b>191</b>
<b>Of which receivable from NHS and DHSC group bodies:</b>		
Current	2,676	4,398

**Note 19.2 Allowances for credit losses**

	<b>2020/21</b>	<b>2019/20</b>
	<b>Contract receivables and contract assets £000</b>	<b>Contract receivables and contract assets £000</b>
<b>Allowances as at 1 April - brought forward</b>	<b>213</b>	<b>189</b>
Prior period adjustments		-
<b>Allowances as at 1 April - restated</b>	<b>213</b>	<b>189</b>
New allowances arising	-	19
Changes in existing allowances	(4)	6
Reversals of allowances	(44)	(1)
Utilisation of allowances (write offs)	(4)	-
<b>Allowances as at 31 Mar 2021</b>	<b>161</b>	<b>213</b>

**Note 19.3 Exposure to credit risk**

	31 March 2021	31 March 2020
	Trade and other receivables £000	Trade and other receivables £000
<b>Ageing of impaired financial assets</b>		
0 - 30 days	2	4
30-60 Days	1	3
60-90 days		
90- 180 days	2	24
Over 180 days	62	67
<b>Total</b>	<b>67</b>	<b>98</b>
<b>Ageing of non-impaired financial assets past their due date</b>		
0 - 30 days	2640	3,055
30-60 Days	28	557
60-90 days	281	828
90- 180 days	16	78
Over 180 days	56	132
<b>Total</b>	<b>3,021</b>	<b>4,650</b>

**Note 20 Non-current assets held for sale and assets in disposal groups**

	2020/21 £000	2019/20 £000
Assets classified as available for sale in the year	-	23
Assets sold in year	-	(23)
<b>NBV of non-current assets for sale and assets in disposal groups at 31 March</b>	<b>-</b>	<b>-</b>

**Note 21.1 Cash and cash equivalents movements**

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2020/21 £000	2019/20 £000
<b>At 1 April</b>	<b>35,154</b>	<b>30,799</b>
Net change in year	7,481	4,355
<b>At 31 March</b>	<b>42,635</b>	<b>35,154</b>
<b>Broken down into:</b>		
Cash at commercial banks and in hand	4	4
Cash with the Government Banking Service	42,631	35,150
<b>Total cash and cash equivalents as in SoFP</b>	<b>42,635</b>	<b>35,154</b>
<b>Total cash and cash equivalents as in SoCF</b>	<b>42,635</b>	<b>35,154</b>

**Note 21.2 Third party assets held by the trust**

Derbyshire Community Health Services NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	<b>31 March 2021 £000</b>	<b>31 March 2020 £000</b>
Bank balances	5	5
<b>Total third party assets</b>	<b>5</b>	<b>5</b>

**Note 22 Trade and other payables**

	<b>31 March 2021 £000</b>	<b>31 March 2020 £000</b>
<b>Current</b>		
Trade payables	4,640	4,508
Capital payables	912	718
Accruals	7,154	4,129
Social security costs	1,553	1,422
Other taxes payable	1,118	929
Other payables	2,592	3,643
<b>Total current trade and other payables</b>	<b>17,969</b>	<b>15,349</b>
<b>Of which payables from NHS and DHSC group bodies:</b>		
Current	3,303	2,818
Non-current	-	-

**Note 23 Other liabilities**

	31 March 2021 £000	31 March 2020 £000
<b>Current</b>		
Deferred income: contract liabilities	1,634	168
<b>Total other current liabilities</b>	<b>1,634</b>	<b>168</b>

**Note 24 Provisions for liabilities and charges analysis**

	Pensions: early departure costs £000	Legal claims £000	Re- structuring £000	Other £000	Total £000
<b>At 1 April 2020</b>	-	80	114	820	1,014
Arising during the year	260	(7)	4	355	612
Utilised during the year	-	(24)	(118)	-	(142)
Reversed unused	-	-	-	(420)	(420)
<b>At 31 March 2021</b>	<b>260</b>	<b>49</b>	<b>-</b>	<b>755</b>	<b>1,064</b>
<b>Expected timing of cash flows:</b>					
- not later than one year;	260	19	-	755	1,034
- later than one year and not later than five years;	-	30	-	-	30
<b>Total</b>	<b>260</b>	<b>49</b>	<b>-</b>	<b>755</b>	<b>1,064</b>

The other provision relates to the potential cost to the Trust of a national legal case and the potential cost in relation to tax for self-employed consultants and potential claw back of VAT reclaimed in relation to software.

The legal provision relates to the Trust liability for 6 cases currently with the NHS Litigation Authority.

**Note 24.1 Clinical negligence liabilities**

At 31 March 2021, £1,943k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Derbyshire Community Health Services NHS Foundation Trust (31 March 2020: £2,410k).

**Note 25 Contractual capital commitments**

	<b>31 March 2021 £000</b>	<b>31 March 2020 £000</b>
Property, plant and equipment	367	-
Intangible assets	-	-
<b>Total</b>	<b>367</b>	<b>-</b>

There are no contractual capital commitments during the year to 31 March 2021 and 31 March 2020.

**Note 26 Financial instruments****Note 26.1 Financial risk management**

Financial Reporting standard IFRS7 requires the disclosures of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking activities. Because of the continuing service provider relationship that the Trust has with its commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply.

The Trust's Treasury Management operations are carried out by the finance department, within the parameters defined formally by the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. The Trust's treasury activities are subject to review by the Trust's Internal Auditors.

**Currency risk**

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency risk.

**Interest rate risk**

The majority of the Trust's financial assets and all of its financial liabilities carry nil or a fixed rate of interest. Bank deposits are subject to a variable rate of interest. Therefore, the Trust is not exposed to significant interest rate risk.

**Credit risk**

The Trust's exposure to credit risk at the reporting date is the carrying value of cash at bank and short term deposits. In the year, the Trust deposited surplus cash with the Government Banking Service (GBS). All cash deposits were in line with the Treasury Management policy agreed by the Board of Directors. The majority of the Trust's income comes from contracts with other public sector bodies, and consequently the Trust has low exposures to credit risk. The maximum exposures as at 31 March 2020 are in short term receivables from customers. No further credit risk provision is required in excess of the normal provision for bad and doubtful debts disclosed in the Trade and other receivables note. With the introduction of IFRS9, the trust has recognised an additional provision of 2% on all Non-NHS debtors that fall within the 90 day aged bracket.

**Liquidity Risk**

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups and NHS England, which are financed from resources voted annually by Parliament. The Trust funds its capital investment plans from internally generated cash resources. The Trust is not, therefore, exposed to significant liquidity risks.

**Note 26.2 Carrying values of financial assets**

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
<b>Carrying values of financial assets as at 31 March 2021</b>				
Trade and other receivables excluding non financial assets	4,932	-	-	4,932
Cash and cash equivalents	42,635	-	-	42,635
<b>Total at 31 March 2021</b>	<b>47,567</b>	<b>-</b>	<b>-</b>	<b>47,567</b>

	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
<b>Carrying values of financial assets as at 31 March 2020</b>				
Trade and other receivables excluding non financial assets	7,779	-	-	7,779
Cash and cash equivalents	35,154	-	-	35,154
<b>Total at 31 March 2020</b>	<b>42,933</b>	<b>-</b>	<b>-</b>	<b>42,933</b>

**Note 26.3 Carrying values of financial liabilities**

	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
<b>Carrying values of financial liabilities as at 31 March 2021</b>			
Trade and other payables excluding non financial liabilities	13,313	-	14,082
Provisions under contract	49	-	49
<b>Total at 31 March 2021</b>	<b>13,362</b>	<b>-</b>	<b>14,131</b>

	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
<b>Carrying values of financial liabilities as at 31 March 2020</b>			
Trade and other payables excluding non-financial liabilities	11,234	-	11,234
Provisions under contract	194	-	194
<b>Total at 31 March 2020</b>	<b>11,428</b>	<b>-</b>	<b>11,428</b>

**Note 26.4 Maturity of financial liabilities**

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	<b>31 March 2021 £000</b>	<b>31 March 2020 restated* £000</b>
In one year or less	14,101	11,398
In more than one year but not more than five years	30	30
<b>Total</b>	<b>14,131</b>	<b>11,428</b>

\* This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

**Note 27 Losses and special payments**

	<b>2020/21</b>		<b>2019/20</b>	
	<b>Total number of cases Number</b>	<b>Total value of cases £000</b>	<b>Total number of cases Number</b>	<b>Total value of cases £000</b>
<b>Losses</b>				
Cash losses	-	-	3	1
Bad debts and claims abandoned	27	5	54	3
<b>Total losses</b>	<b>27</b>	<b>5</b>	<b>57</b>	<b>4</b>
<b>Special payments</b>				
Ex-gratia payments	18	4	3	1
<b>Total special payments</b>	<b>18</b>	<b>4</b>	<b>3</b>	<b>1</b>
<b>Total losses and special payments</b>	<b>45</b>	<b>9</b>	<b>60</b>	<b>5</b>

**Note 28 Related parties**

Derbyshire Community Health Services NHS Foundation Trust is a public benefit corporate authorised by Monitor - the Independent Regulator for NHS Foundation Trusts, established by order of the National Health Services Act 2006.

All NHS Foundation Trusts are independent bodies which are not controlled by the Secretary of State. The Trust has considered whether or not the working relationships it has with any NHS bodies and Government departments and agencies meet the definition of a related part under IAS 24.

**Transactions with Governors**

Dr Emma Pizzey is the CCG partner governor on the DCHS board of governors. She declared that she is the GP governing body member of Erewash Clinical Commissioning Group. Transactions are in the normal course of business and are on an arms-length basis. Transactions with this NHS body are disclosed under 'Transactions with Other Related Parties'.

Stuart Swan declared that he is a South Derbyshire district councillor for Church Greasley ward and county councillor for Swadlincote South Division. He is also a Derbyshire County Council's cabinet support member for health and communities. Transactions are in the normal course of business and are on an arms-length basis. Transactions with this local government body are disclosed under 'Transactions with Other Related Parties'.

Dr Paula Holt is leading the College of Health and Social Care of University of Derby. Dr Paula is also executive lead for regulation. Transactions with the University of Derby are in the normal course of business and are on arms-length basis.

**Transactions with Board Members**

Prem Singh declared that his partner is employed as chief executive of Rotherham, Doncaster and South Humberside NHS Foundation Trust. She has no direct commissioning responsibility for Derbyshire Community Health Services NHS Foundation Trust's contracts. There were no transactions with this NHS body during 2020/21.

Prem Singh declared that he is the managing director of PMS Consulting Ltd. There are no transactions with this company.

Prem Singh declared that he is the independent chair of the Staffordshire and Stoke-on-Trent Integrated Care System.

Tracy Allen declared that her husband is employed as director of primary care with Derbyshire CCGs which commission services from Derbyshire Community Health Services NHS Foundation Trust. Transactions are in the normal course of business and are on an arms-length basis. Transactions with the CCGs are disclosed under 'Transactions with Other Related Parties'.

William Jones, chief operating officer, declared that he is a director of Lift Co South Derbyshire. Transactions are in the normal course of business and are on an arms-length basis.

William Jones, chief operating officer, declared that he is a director of Hucklow.net Ltd. here are no transactions with this company

**Transactions with Other Related Parties**

The Department of Health and Social Care is regarded as a related party. During the year to 31 March 2021 Derbyshire Community Health Services NHS Foundation Trust has had a significant number of material transactions with the department and with other entities for which the department is regarded as the parent entity.

**Note 28 Related parties (continued)**

	Receivables		Payables	
	2020/21	2019/20	2020/21	2019/20
<b>Receivables/payables over £250k</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
Chesterfield Royal Hospital NHS Foundation Trust	35	314	329	319
University Hospitals of Derby & Burton NHS Foundation Trust	844	1,538	370	435
Derbyshire Healthcare NHS Foundation Trust	113	-	361	435
NHS England	1,185	762	603	-
NHS England - Midlands	15	389	-	-
NHS Derbyshire and Derbyshire CCG	292	853	19	60
NHS Property Services	-	26	1,077	817
NHS Arden & GEM CSU	15	10	528	432
Derbyshire County Council	1,749	2,502	1,490	63
<b>Total</b>	<b>4,248</b>	<b>6,394</b>	<b>4,777</b>	<b>2,561</b>

	Income		Expenditure	
	2020/21	2019/20	2020/21	2019/20
<b>Income/expenditure over £1m</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
NHS England	3,601	3,525	-	-
NHS England - Midlands	4,356	7,196	-	-
NHS Derbyshire and Derbyshire CCG	147,916	142,180	120	374
Derbyshire County Council	17,752	19,119	425	297
Derby City Council	2,268	2,277	816	29
University Hospitals of Derby & Burton NHS Foundation Trust	3,117	3,019	3,032	4,110
Derbyshire Healthcare NHS Foundation Trust	3,038	2,943	727	809
Chesterfield Royal Hospital NHS Foundation Trust	724	838	1,094	1,636
Community Health Partnership	668	663	6,066	6,390
NHS Property Services	-	-	1,838	1,616
Health Education England	1,712	1,265	-	-
NHS Arden & GEM CSU	151	158	1,521	1,729
NHS Nottingham and Nottinghamshire CCG	1,942	1,656	-	-
<b>Total</b>	<b>187,245</b>	<b>184,839</b>	<b>15,639</b>	<b>16,990</b>

**Note 29 Transfers by absorption**

The Trust has transferred £200k of Ilkeston Hospital's theatre equipment to University Hospital of Derby and Burton at 31 December 2020 in relation to delivery of consultants lead plan care services.

The Trust also transferred a funding of £240k at 31 March 2021 to Chesterfield Royal Hospitals in relation to Healthcare Record.

**Note 30 Events after the reporting date**

The implications of the global COVID-19 continue to be felt, with the Trust incurring significant costs including as lead provider for the vaccination programme in Derbyshire. All costs incurred in relation to the vaccination programme have been reimbursed in 2020/21. In response to the pandemic, significant changes to the way NHS providers are funded were introduced for the whole of 2020/21. NHSE/I published operational planning guidance for 21/22 in March 2021 which set out the key priorities for 2021/22 and systems are asked to develop plans for the next months. It has been confirmed that funding arrangements similar to those in place during the last six months of 2020/21 will remain in place for the first half of the new financial year. Funding envelopes will be issued at a system/ICS level in a continuation of the block funding arrangements in place during 2020/21. At this stage it has not yet been confirmed what the funding arrangements will be beyond the end of September 2021 and therefore the impact on the financial position of the Trust and the wider Derbyshire system. The Trust will continue to incur costs in relation to the management of the pandemic and in its role as lead provider for the vaccination programme. The expectation is that all reasonable costs incurred will continue to be reimbursed.

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