Derbyshire Community Health Services NHS Foundation Trust

Annual report and accounts 2018/19

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

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Annual report contents

Foreword

Welcome to our 2018/19 annual report and accounts. It provides a detailed look at how we have performed during a challenging year for us and the NHS more widely.

It has been a year in which we have continued to align our people and our plans around a more integrated way of working with our partners in health and social care in Derbyshire.

Our community-based services are at the heart of the sustainability and transformation plans in Joined Up Care Derbyshire and in line with the NHS Long Term Plan and you will read much about how we are taking this work forward.

Both internally and as a system we've made some amazing progress on changing the way services are delivered during 2018/19. It means strengthening our commitment to working in a 'system first, organisation second' way that's relentlessly focused on supporting people in our communities and delivering a person-centred approach.

None of it would be possible without the dedication and commitment of staff colleagues providing care every day in numerous settings and others who support the delivery of frontline care in any number of ways behind the scenes. We are very appreciative of the work which goes on 365 days a year to provide the best possible care to our patients.

As we look back at the achievements of 2018/19 we know the pace of change is going to continue to increase during 2019/20 and it is vital that we focus at least as much on supporting our health and care workforce.

We are pleased to have this opportunity to thank our staff, governors, volunteers, service users and their families for contributing so much to supporting our healthcare community and our shared purpose of putting patients at the heart of that care.

Chris Sands
Acting Chief Executive

Prem Singh
Chairman

Performance report

Overview

The purpose of the overview is to give the user 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.

Derbyshire Community Health Services NHS Foundation Trust is one of the largest providers of specialist community health services in the country, providing in the region of 4,000 patient contacts each day and serving a population of over one million people in Derbyshire and Derby.

Who we are at a glance

- We are rated good overall by the Care Quality Commission and outstanding for caring (May 2016). We have a well-led inspection review visit during July 2019
- We are compliant with all our financial obligations
- We maintained our place in segment 1 of NHS Improvement's Single Oversight Framework, achieving the highest level of autonomy for our performance.

A brief history of our organisation

Derbyshire Community Health Services NHS Foundation Trust has operated as a standalone NHS organisation since April 2011 and we became a fully-fledged foundation trust on 1 November 2014.

We now employ around 4,300 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.

Service transformation and integration, to provide more care in community settings and working jointly across health and social care, has made significant progress during 2018/19, as part of the Joined Up Care Derbyshire sustainability and transformation programme.

The purpose and activities of our organisation

Our purpose is to provide community health services to a patient population of over one million people in Derbyshire and Derby. These services are organised and managed across three divisions: integrated community-based services, planned care and health, wellbeing and inclusion.

Our services

Integrated community-based services

Community nursing, district nursing and matrons
Community therapy (including physiotherapy and occupational therapy)
Discharge facilitation/clinical navigation in local acute trusts
End of life care
Falls rehabilitation
Falls response service
Intravenous (IV) service
Long-term conditions
Rehabilitation (including intermediate bedded care)
Single point of access care
Stroke coordination and rehabilitation
Virtual ward/care at home
Wound care clinics.

Planned care and specialist services

Babington Day Unit
Cardiac rehabilitation
Community podiatry
Consultant outpatients
Consultant day case surgery
Continence services
Heart failure specialist nurses
Learning disability service
Minor injury units
Musculoskeletal services
Neurological and stroke services
Podiatric surgery
Phlebotomy
Older people's mental health services
Outpatient physiotherapy
Outpatient occupational therapy
Respiratory services
Speech and language therapy.

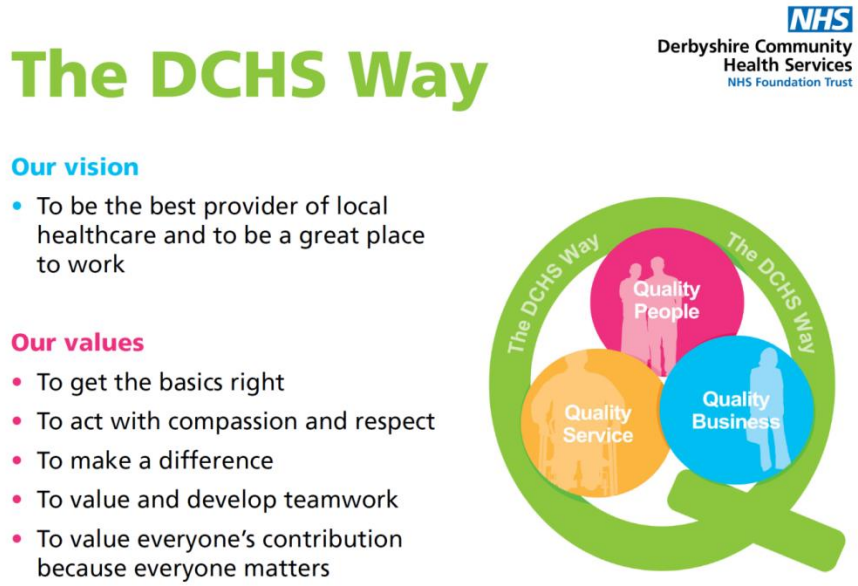
Health, wellbeing and inclusion

Children's school age immunisation services
Children's continence services
Children's services: health visiting and school nursing

Diabetes education services
Family doctor services (general practice)
Health psychology
Infant and toddler nutrition services
Integrated sexual health services
Specialist community and urgent care dental services
Tier 3 weight management services.

The vision and values of our organisation

The DCHS Way is described as “the way we do things around here”. It underpins all our activities and governance structures and is based on an ethos of care for patients and staff.



Objectives and achievements

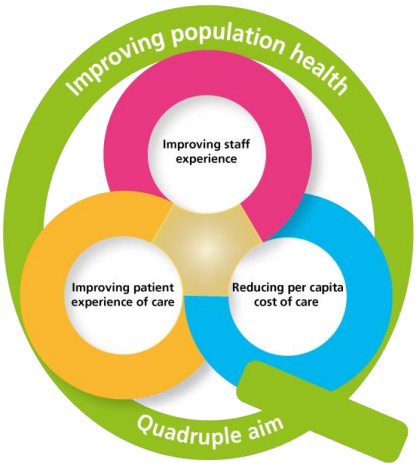
As with many other organisations in the NHS, we have faced and are still facing considerable financial constraints and challenges arising from the economic climate and the growing demand for services. Despite these pressures, we met our objectives and performed well – operationally and financially – during 2018/19. We also achieved ratings consistently above average in a variety of measures which have tested the quality of our care for our patients and the workplace for our staff.

At the last full inspection of our services by the Care Quality Commission (CQC) in 2016 we were rated as ‘Good’ overall and ‘Outstanding’ for the caring domain and in some specific services. The next inspection, including a ‘Well Led’ review, will take place in July 2019.

We have consistently been rated as a Segment One provider in the Single Oversight Framework – the method used by NHS Improvement to monitor all NHS providers.

Segment one is the highest possible rating and affords us a reduced degree of scrutiny, having a demonstrable track record of performance. More details about our financial performance are available in the Performance Analysis section.

We remained focused on the delivery of our clinical strategy, following the Triple Aim approach of 'simultaneously improving the health of the population, enhancing the experience and outcomes of the patient, and reducing the per capita cost of care for the benefit of communities'. Working with colleagues we incorporated an important fourth element – staff experience – evolving our strategic ambitions around a new 'Quadruple Aim'. This remains the cornerstone to our ongoing planning and decision-making.



A key measure of our staff experience is the annual NHS Staff Survey and the response rate in 2018 was our highest yet at 61%. We were pleased to score the same or better than our peers in all but one of the 10 measures, yet resisted the urge to compare ourselves too much as we firmly believe it is what's happening locally that matters the most. The past 12 months have been the most difficult on record for the NHS and our results generally reflect that, particularly when compared to where we were the previous year. You can read more about our results and responsive forward planning in the Staff Report section.

We have spent a lot of time reflecting on the unprecedented change impacting our services, acknowledging a degree of change fatigue across the organisation. We are extremely proud of the resilience, compassion and conscientiousness shown by our colleagues over the past year. Their collective commitment to innovation and improvement has seen many success stories and will continue to create the very best future for our patients and for those who love, care, treat or support them.

How we achieve this is again described thoroughly in our annual operational plan, refreshed for 2019/20 with the help of more than 1,000 colleagues across the Trust as part of a county-wide roadshow of focused events. We considered our role as a specialist community services provider in shaping the future for our patients and staff. We also reflected on the publication of the Government's NHS Long Term Plan, what it meant locally for us, and how we collectively make it a reality. Our operational plan and summary 'plan on a page' are both available here: www.dchs.nhs.uk.

The NHS Long Term Plan was published on 7 January 2019 and set out key ambitions for the health service over the next 10 years, supported by additional

investment of £4.5bn a year for primary care and community services in real terms by 2023/24. Although the NHS Long Term Plan looks positive from a community services perspective, our commissioners remain in financial recovery and so we remain realistic about their ability to invest Derbyshire's share of this money in future.

The original STP 'Joined-up Care Derbyshire', published in October 2016, will also be refreshed in summer 2019. It brings together work that has been taking place across the county to better coordinate services and support people to stay well. We are focused on looking after people in their own home or local area, so they get the targeted care they need at their convenience, instead of concentrating on providing the majority of services from specific buildings.

Joining up care is also about preventing people from getting ill in the first place by helping them to take good care of themselves and be able to deal with issues before they become bigger problems. All NHS and social care partner organisations have signed-up to improving how they work together to help the people of Derbyshire lead happier, healthier lives.

'Place-based systems of care' has been a key system-wide priority and one way we have collaborated successfully with our partners. By working more closely together and managing common resources our teams have made good progress in improving the health and care of the populations we serve.

In 2018/19 we agreed upon eight places (as shown) and have restructured our integrated community services senior team to align to this new geographical model. We're a key partner and have played a major role as part of eight 'place alliances'; the multi-agency groups that oversee planning and delivery in each place.

The NHS Long Term Plan does not replace the STP – it has helped us build upon it. Clinicians and managers from across Derbyshire have proposed a shortlist of priority areas for the STP refresh. The shortlist of priorities was agreed by the Joined-up Care Derbyshire Board, which meets monthly, and builds upon existing work already happening across the system.

Whilst all existing work will be of equal importance, the system agreed that planned care, place and mental health and learning disability, along with system financial sustainability, are the areas which need initial attention as the biggest opportunities for transformation. Towards the end of 2018/19, each workstream was being asked

to write a ‘plan on a page’ to identify their priorities, building on existing work, and this will be the basis of the refresh.

These will be further developed as part of an extensive and inclusive programme of engagement with staff, patients and stakeholders throughout the spring and summer months.

Other focus areas we have been working on during 2018/19

- Developing academic links to support leading-edge service delivery, using innovation and driving best practice
- Building on our success of staff engagement and leadership development, embracing a high performance culture
- Embracing the use of technology and digital solutions to improve our practice, care and productivity
- Building on our service and commercial aspirations to promote service integration and transformation
- Ensuring that we maintain a firm grip on the delivery of our plans and manage ongoing service quality/performance.

Risks and associated controls

Maintaining quality and high performance throughout the year has required careful attention to manage the strategic risks to our delivery during a period of significant change.

During the year we took action to address the key risks we had identified in relation to the aforementioned transformation plans in areas of staffing, clinical services and operational business. The big strategic risks are governed by the Trust Board via the Board Assurance Framework (known as BAF) which also feeds the key strategic priorities of the Trust Board’s sub-committees.

This established system of governance and management is known internally as the DCHS Way and organised into three distinct domains as Quality People, Quality Services and Quality Business, to manage the strategic risks in each area.

The committee with overall responsibility for the BAF is the Audit and Assurance Committee (AAC). Once the BAF has been robustly challenged by the AAC, it is then presented to the Board. Any papers that are presented to the sub-committees ‘for assurance' feature on the BAF and align to one of the strategic risks, demonstrating how the strategic risk is being managed and what proactive controls are in place. The Board Assurance Framework helps the Board to determine if there are any gaps in control or assurance in the management of the risk. The following table shows what we have identified as our key strategic risk areas:

Quality Service
Strategic risks
There is a risk to patient care due to stretched management capacity, and overall service continuity from the processes related to significant service change, resulting in a reduced quality of service.
There is a risk to patient care due to a failure to optimise use of current information systems resulting in reduced time to care and inaccurate management information.
There is a risk to patient care due to a lack of consistent deployment of the Trust's patient quality improvement and assurance framework resulting in care that is less safe and effective.
There is a risk to patient care due to a failure to apply evidence-based practice, learn from clinical governance processes and implement change resulting from audit and feedback resulting in the provision of less effective care.
There is an overarching risk to patient care due to periods of major system change and employment of new governance systems and processes related to place based care resulting in a reduced quality of service.
There is a risk to population health through the failure to fully embed public health principles within DCHS service delivery resulting in an inability to reduce inequalities for our resident communities.
There is a risk to patients due to not consistently considering principles of equality, diversity and inclusion resulting in the way we plan and deliver our services being at odds with what matters to individuals/ service users/ carers.
Quality People
Strategic risks
There is a risk to patient care due to national and local workforce supply shortages resulting in our staff not being able to provide high quality, safe and effective care.
There is a risk to staff and patient care due to the Trust not having sufficient resources and capacity to deliver the volume of training required from service changes resulting in a workforce without the appropriate skill set.
There is a risk to the Trust due to the high volume of organisational and health system change, which is likely to continue to be a feature of our health economy for several years resulting in a reduced organisational performance.
There is a risk to staff due to the uncertain operating environment DCHS is working in resulting in reduced personal engagement, morale, and health and wellbeing of our staff.
There is a risk to staff and patient care due to the volume of organisational change resulting from tenders and service changes resulting in our staff not being able to provide high quality, safe and effective care.
There is a risk to the Trust due to the amount of internal transformation affecting our ability to deliver the ambitions in our leadership strategy resulting in reduced organisational performance.
There is a risk to the Trust due to our inability to continue to establish an open and

transparent organisational culture that demonstrates inclusion, diversity and fairness resulting in staff being unable to achieve their potential and legal/financial sanctions.
Quality Business
Strategic risks
There is a risk to the organisation's performance and achieving our strategic objectives due to inconsistent implementation/organisational support of the Sustainability and Transformation Plan resulting in poor outcomes for patients and poor use of resources.
There is a risk to the effective and efficient provision of DCHS services due to the financial stress experienced by health and social care partners resulting in unfunded activity being directed towards community services, resulting in increasing caseloads and / or increased waiting times and inequitable outcomes/access.
There is a risk to the financial stability of the organisation due to not meeting the future Sustainable Quality Improvement Programme over the next two years (2018/19 and 2019/20) and the loss of service contracts, decommissioning of services and / or unfavourable contract negotiations resulting in unfunded stranded costs.
There is a risk to the organisation due to non-delivery of elements of the IM&T strategy, resulting in the full benefits not being realised and an impact on patient care.
There is a risk to the Trust's resilience, due to an emergency, severe disruption or a cyber-attack, resulting in an impact on patient care, inability to meet targets, loss of revenue.
There is a risk to the organisation, due to failure to align and influence stakeholders resulting in poor relationships that impact on patient care.
There is a risk to the organisation due to the complexity of running multiple significant capital projects resulting in benefits not be delivered in a timely, efficient and effective way.
There is a risk to the organisation due to not being able to undertake transformation at the pace it is required resulting in future loss of patient benefit and resources not being used effectively.
Audit and Assurance Committee
Strategic risks
There is a risk to the organisation due to not having strong corporate governance systems in place resulting in Trust vision not being delivered.
There is a risk to the organisation due to not meeting regulatory, contractual or legal obligations resulting in sanctions.
There is a risk to the organisation due to not having strong risk management controls in place resulting in failure to put effective mitigation plans in place promptly.
There is a risk to the organisation due to lack of comprehensive data quality systems resulting in poor decisions that could affect outcomes and financial loss.
There is a risk to the organisation of ineffective Derbyshire system wide governance arrangements which may impact on the quality of our services, workforce and business arrangements.

Major transformation programmes/the broader environment in which we are working

- **Better Care Closer to Home**

The Better Care Closer to Home (BCCTH) project team, made up of providers, commissioners and other partners, has been working hard on a long-term solution for the number and location of beds specifically across north Derbyshire.

Since the proposed rehabilitation ward at Chesterfield Royal Hospital has proved to be a more complex piece of work than originally anticipated, the BCCTH Project Board and our Trust Board have now both recommended that we retain pathway three beds at Clay Cross (12), and Whitworth (12) Hospitals, in addition to Cavendish Hospital (8).

Alongside these Derbyshire County Council will be providing up to 44 pathway two beds, but the bulk of rehabilitation care will be provided by our staff in patients' own homes.

- **Learning disabilities short break service in north Derbyshire**

Our commissioners are reviewing the way that short break services are offered to people with learning disabilities in north Derbyshire. In December, they confirmed that they will be carrying out further engagement with service users and families to discuss what really matters to them and to fully understand all of their health and social care needs. This will inform potential options for future commissioning arrangements.

- **Joined up care in Belper**

Agreement has been reached to provide brand new facilities in the town of Belper following a thorough public and staff engagement exercise in spring 2018.

The review was prompted by difficulties providing 21st century healthcare services from the existing former workhouse, Babington Hospital, given its maintenance limitations. We're involved in detailed ongoing work with the Clinical Commissioning Group and Derbyshire County Council in realising this development.

- **Planning for a 'no deal' Brexit**

We have been planning for some months to mitigate any supply, employee or demand issues that arise from a no-deal Brexit. We believe we are taking all reasonable steps to ensure that disruption to our patients and other stakeholders is kept to a minimum.

However, given the uncertainties around the impact of a no-deal Brexit, a risk has been placed on our organisation's risk register. This is underpinned by a detailed assessment, which shows only low–medium risk at this stage.

On staffing/workforce, we have risk assessed the impact of a 'no deal' Brexit as being very low. This is due to our very small number of EU employees and no concentration of such employees in any particular department. Currently we employ 30 EU employees in total, half are Irish and not from mainland Europe.

Other areas we are monitoring, but which remain low-medium risk, cover:

- Medicines and vaccines
- Medical devices and clinical consumables
- Non clinical devices and consumables
- Reciprocal healthcare
- Research and clinical trials
- Data sharing processes and access.

Our organisational response to any Brexit related issues will be through our existing business continuity plan. The business continuity plan has been tested using Brexit-related scenarios and the business impact analysis has been reviewed and updated within the context of Brexit. We are following national guidance from the Department of Health and Social Care for all eventualities. The 'EU Exit' webpages are updated regularly with developments: www.england.nhs.uk/eu-exit.

- **Outstanding Way – digital and systems transformation**

Outstanding Way continues to focus on areas that matter most for our clinicians, including the amount of documentation they need to complete. Analysis in October 2018 showed that 4% less time was spent on documentation than in previous years thanks to work done so far – that's the equivalent of releasing 16 staff. This time has been used to support training, development and appraisals to enable staff to do their jobs well.

Early 2019 saw the deployment of new documentation for therapy staff that will result in more time saved and a better, more joined up, clinical record. As we move through 2019 we will be using new functionality in our clinical record systems (SystmOne) and improving the way we use the record – including how we use it to assess the quality of our care.

Work with the quality team in 2018 also saw the deployment of standard kit bags for staff, ensuring all community staff had access to standard observation equipment such as sphygmomanometers, on every visit. This has been a really positive addition for staff and has resulted in the number of core observations taken rising dramatically.

2019 will also see an emphasis on training and support for our staff, to make the use of our electronic patient record an integrated part of any assessment and treatment. This will help GPs and other NHS providers to see shared information where this is appropriate too.

2018 saw a real impact thanks to our Outstanding Way Champions – staff who spend one day per week supporting their colleagues with new changes, helping to design and deploy innovation into their own areas. The local expertise they bring has really helped to embed consistent practice.

A focus on good case load management supported a drastic reduction in waiting times during 2018 and this will be built on during 2019.

- **Freedom to Speak Up**

In June 2018 we received a report from the National Guardian's Office following a case review carried out at our Trust in early 2018 into a case of speaking up. The report made recommendations to help us improve the timeliness and independence of our investigations. The National Guardian's Office went on to ask all NHS trusts to adopt these recommendations for best practice in dealing with cases of speaking up.

The review was a learning experience for us and also commended us for areas of good practice. We ran a large awareness campaign during October 2018, to coincide with national Freedom to Speak Up month. Our campaign set out to ensure everyone working here knows who to tell if they have a concern, are confident they will be taken seriously and that any necessary action will be taken. It included the launch of a series of animated videos to highlight different types of concerns and make sure staff were familiar with how to raise a concern and would feel safe and encouraged to do so. The role of our Freedom to Speak Up guardian, who is a senior trust board member, has been widely publicised, including on local radio, to drive home the message that if staff want to speak up they can do this in a supportive environment.

Statement from the Chief Executive

It has been one of the most difficult years on record for the NHS, across Derbyshire and beyond. Our services have experienced unprecedented change and uncertainty has become part and parcel of the NHS landscape.

Significant financial challenges faced by our clinical commissioning groups and local authorities have led to further contract reductions in 2018/19, predominantly through the decommissioning of services. The political landscape has also seen major change, with a new secretary of state for health being appointed in July 2018 and the publication of the much anticipated NHS Long Term Plan in January this year.

Despite this evolving and challenging environment, our colleagues have continued to show tremendous resilience, commitment, energy and compassion, helping maintain our position as one of the highest performing specialist NHS community trusts in the country.

We have continued to work closely with our health and social care partners and communities to develop alternative models of care across Derbyshire's eight

localities, or ‘places’. This work has unlocked the potential for further integration at a local community level, meaning better and more joined-up services for local people. Indeed, our community-based services are now caring for patients in their own homes more than ever before, minimising the need for hospital stays. Our focus on rehabilitation and working with patients to maximise their best recovery are at the heart of Derbyshire Community Health Services NHS Foundation Trust.

This period of change has not been easy, but collectively we’ve remained focused on doing the right thing for the people of Derbyshire. We’ve continued to improve and innovate, maintained vigilance around quality monitoring and improved the way we support colleagues experiencing change. We are very grateful to our governors, who have quite rightly and ably held us to account in these areas throughout the year.

Most of all, we’re indebted to our magnificent colleagues for their ongoing contribution, touching the lives of almost 4,000 people every day, and doing so with such compassion. It is no surprise to us that they were rated outstanding for their caring by NHS regulators, the Care Quality Commission, at our last full inspection in May 2016. Thanks also to our brilliant support staff for delivering their various and important ‘behind the scenes’ roles so effectively. 2018/19 has been a challenging year, maintaining high standards of care for patients against a backdrop of ongoing service reorganisation and integration as part of the Joined Up Care Derbyshire programme, and budget constraints from commissioners.

Going concern

Derbyshire Community Health Service NHS Foundation Trust’s accounts have been prepared on the basis that we run the Trust as a ‘going concern’. This means that our assets and liabilities reflect the ongoing nature of our activities.

Because risks and uncertainties change over time as an organisation develops and as its operating environment changes, the directors consider a detailed assessment of the evidence supporting our assertion that we are a going concern in the supporting evidence of our accounts submissions each year.

After making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the ‘going concern’ basis in preparing the accounts.

Chris Sands
Acting Chief Executive **22 May 2019**

Performance analysis

Clinical strategy

In the two years since our clinical strategy was launched there have been many changes, nationally and locally within Derbyshire. There have also been changes within our own organisation in terms of our service portfolio as we have shaped and delivered major transformations which have enabled the delivery of care closer to home and the further development and efficient utilisation of the Derbyshire public estate.

In January 2019 the NHS published the Long Term Plan, which sets out the priorities for healthcare over the next 10 years and shows how the NHS funding settlement will be used. The plan ensures that we give everyone the best start in life, deliver world-class care for major health problems such as cancer and heart disease and help people to age well.

In response to these changes we have undertaken a refresh of our clinical strategy – the triple aim. The ambitions of our clinical strategy remain consistent with the vision of our Joined Up Care Derbyshire partners. However, we know that achieving this is directly dependent upon our workforce. Our staff engagement sessions, held across the county, have enabled us to really understand the issues that matter most to our colleagues and therefore we have explicitly developed a strategy to reflect our organisation's commitment to improving staff experience of work. This includes improving our approach to the way we support colleagues experiencing change and ensuring that all colleagues feel motivated, valued and able to influence the high quality care and services they deliver as we shape our future together – **our DCHS Quadruple Aim**

Our Quadruple Aim

'Simultaneously improving the health of the population, enhancing the experience and outcomes of the patient, reducing the per capita cost of care for the benefit of communities and improving staff experience'

Our strategy is supported by a number of key specific clinical strategies. During 2018/19 we have worked to develop these further, such as those for frailty and research and innovation to help us deliver our organisation's overarching clinical strategy through our operational plans.

Quality Always – clinical accreditation

Quality Always is our assessment accreditation system for our clinical care, first introduced in 2014, as part of our Quality Improvement and Assurance Framework. More details about this are included in the Quality Report. Frontline teams who

achieve the highest standards are gold award winners. As this is a continuous process, teams must work hard to maintain their Quality Always gold awards.

Teams who achieved gold awards for the first time during 2018/19 were: Chesterfield and north east outpatients and MSK physiotherapy service; Fenton Ward, Cavendish Hospital; Ripley Community Hospital's outpatient department; Ilkeston Community Hospital's diagnostic and treatment centre, the Trust-wide school age immunisation and vaccination team; Okeover Ward at St Oswald's Hospital, Ashbourne; Bolsover South 0-19 children's service; Heanor outpatient department; Amber Valley outpatients and MSK physiotherapy service and Wheatbridge integrated sexual health service. More details are included in the Quality Report.

Operational plan for 2019/20

In April 2019 we began working towards a one year operational plan to implement the measures set out in the NHS Long Term Plan. All providers must have robust, integrated operational plans for 2019/20 that demonstrate the delivery of safe, high quality services that meet the NHS Constitution standards or delivery of recovery milestones within available resources.

The development of operational plans for 2019/20 enables us to progress against the overall tests set by the government to:

- Improve productivity and efficiency
- Eliminate provider deficits
- Reduce unwarranted variation in quality of care
- Incentivise systems to work together to redesign patient care
- Improve how we manage demand effectively
- Make better use of capital investment.

Our operational plan 2019/20 details our approach to delivering our refreshed clinical strategy, our Quadruple Aim and the actions we are taking to support:

- Quality planning
- Workforce planning
- Financial planning
- Our links to the plans of Joined Up Care Derbyshire (JUCD), our Sustainability and Transformation Plan (STP)
- Membership and elections.

It also details our frontline reinvestment programme, including:

- £1.9m into our wound care service, delivered by specialist nurses in place-based hubs
- £1m into musculoskeletal (MSK) triage, assessment and treatment service

- £500,000 into community nursing, to improve equity, particularly across Derby and Chesterfield and north east Derbyshire.

We have a significant capital funding programme of nearly £14m this year. Financial regulations dictate that capital funds can only be used on long-term investments such as buildings, technology, and equipment. So although that money can't be spent directly on additional staff, it certainly improves both the patient and staff experience of DCHS. Headlines include:

- Ongoing estate developments at Bakewell, Belper and Buxton
- Significant IM&T investment to improve infrastructure and equipment
- Investing in our people in areas such continuous professional development, wellbeing, apprenticeships and leadership development.

The plan doesn't take away from the major financial challenges we collectively face as a health and care system, but it will ensure that we maximise our contribution towards transforming care, improving outcomes and experiences for the people of Derbyshire.

You can access a copy here: http://www.dchs.nhs.uk/operational_plan_2019-20

Derbyshire system operational plan 2019/20

Alongside developing our own operational plan for 2019/20 we have, along with our partners developed a Joined Up Care Derbyshire STP system operational plan, which sets out the priorities for the forthcoming year and will be the foundation for our refreshed five-year STP. Derbyshire Community Health Services NHS Foundation Trust and our partners will take collective responsibility for delivery of the system–level operating plan, working collectively to ensure the best use of their resources to implement the Derbyshire STP vision, to 'deliver the most effective and efficient health and social care system for the citizens of Derbyshire delivered through a place-based care system , which is effectively joined up with specialist services and managed as a whole' (Derbyshire STP, October 2016).

The DCHS Way

Alongside this we have also worked with colleagues to refresh the DCHS Way, ensuring that we meet the vision and the values to reflect how we support each other and also how we work with our partners. As part of this refresh we will continue to develop our approach to raising concerns as we implement the actions as part of the National Guardian's Office (NGO) review.

Our plan reflects the vision for the Joined Up Care Derbyshire (JUCD) STP and how this is being taken forward within our Trust, further demonstrating the organisation's

active role in enabling delivery of the agreed Derbyshire model of care and the system wide transformation priorities.

Our performance against standards and targets

Our performance is monitored against a range of standards and targets. The Board of Directors also monitors performance against our objectives and a range of other measures.

Delivery against our priorities, and all measures of quality, are closely monitored by our Quality People, Quality Service and Quality Business committees which regularly report to the Board of Directors.

This well-embedded and cohesive system of governance, which mirrors our DCHS Way ethos, helps to support linkages in our performance monitoring and analysis across all areas of our activities.

Performance reporting

We summarise our performance in a monthly integrated performance report which is provided to the Board, published on our website and made available to localities, teams and services.

Monitoring our activity and performance against a range of indicators, including national, contractual and local targets, is an important part of ensuring we deliver high quality services.

Significant areas of risk are monitored in more detailed performance reports to the quality committees and any risks which are likely to impact on the delivery of the Trust's strategic goals and objectives is captured in the Board Assurance Framework (BAF)

We currently monitor and report against 300 indicators, which are all aligned to the five Care Quality Commission domains of Safe, Caring, Effective, Responsive and Well-led, which enable us to triangulate our performance across all areas.

Commissioning for Quality and Innovation (CQUIN)

CQUINs are quality-related goals which support ongoing innovations and improvements in care across our clinical services; achievement is linked to a proportion of the organisation's income.

During 2018/19 we continued with five CQUIN measures. These were originally set at a national level in 2017/18. However, following a directive from NHS England regarding the suspension of the Proactive and Safe Discharge CQUIN, we agreed with commissioners to develop an additional local CQUIN.

The themes for the CQUINs were:

- Health and wellbeing: NHS Staff Survey, healthy food, flu vaccination uptake
- Preventing ill health through risky behaviours (i.e. alcohol and tobacco)
- Improving the assessment of wounds
- Improving the degree of personalised care planning for patients with long term conditions
- Using personalised patient goals in the treatment of patients with venous leg wounds (local).

A total of 2.5% of our patient care income in 2018/19 was conditional on achieving nationally and locally set milestones in these areas as agreed between us in Derbyshire Community Health Services NHS Foundation Trust and North Derbyshire and Southern Derbyshire Clinical Commissioning Groups (CCGs) as the lead commissioners on behalf of our four local CCGs. This was part of our contract for the provision of NHS services, through the CQUIN payment framework.
The total contract value relating to these for 2018/19 was £3,416,478 and this was agreed as part of the block contract for our Trust.

Progress update 2018/19
A number of risk assessments were undertaken in relation to the achievement of CQUINs during 2018/19 and we anticipated that some of the targets would be difficult to fully achieve due to the acute care focus and the inability to amend these for a community trust. However, we have maintained a focus on improving the quality of services for patients. As a result significant progress towards milestones in many of these areas has been achieved.

We have continued to evaluate staff wellbeing through the annual NHS Staff Survey, with the CQUIN focusing on responses to those questions related to positive action on health and well-being, and work-related stress.

Despite a dedicated programme of wellbeing support being made available to staff, the results of the 2018/19 survey did not demonstrate the 5% point improvement required in these particular areas. This may be indicative of the high level of organisational change staff have experienced over the past two years.

Our 2018/19 flu vaccination campaign closed with 2,226 out of 3,473 frontline staff vaccinated. This equates to 64.1%. This was short of the 75% target detailed in the CQUIN and slightly behind the 2017/18 total of 68.5%. It does however maintain the momentum achieved in the previous years where the previous highest total had been 51.5% in 2016/17. We are developing a new approach to support the 2019/20 CQUIN and associated 80% target.

Healthy eating options for staff and visitors have been successfully implemented across all Trust sites, with DCHS signing up to the national sugar-sweetened beverage reduction scheme. All of our sites complied with the targets related to providing reduced levels of food and drink high in fat, sugar and salt.

Performance against the preventing ill health CQUIN saw an achievement across all five indicators in quarter four, with inpatient staff undertaking patient screening for alcohol and tobacco use, and providing brief advice and onward referral where appropriate.

The improving wound care CQUIN continued the roll out of the national chronic wound assessment across frontline community services. Compliance of its use has been measured through a bi-annual audit, with a stretched target of 60% for quarter two and 80% for quarter four. Whilst the final audit demonstrated 32% compliance with the wound assessment, in many cases the audit found that only one element prevented the assessment from being 100% completed. Staff continue to be supported by the tissue viability team and wound care auditing will continue to be monitored to ensure the quality of assessments continues to improve.

This year the personalised care planning CQUIN involved a number of key staff receiving personalised care training, and their associated patients receiving dedicated care and support planning conversations and interventions. We achieved 100% of the training target and 88% of patients had evidence of a care conversation taking place against a target of 75%.

In addition to the national personalised care CQUIN, we also developed personalised goal setting for patients with a venous leg ulcer, within a pilot area of community nursing. Following a programme of training for staff, a total of 50% of patients had personalised goals set against an improvement target of 75% following a baseline audit. This work will continue into 2019/20 as part of the continuation of the local CQUIN.

Big 9

Each year we set ourselves stretching improvement targets referred to as the Big 9. The Big 9 are split into the Quality People, Quality Service and Quality Business domains, in line with the DCHS Way.

More details about the Big 9 are available in the Quality Report. Our annual Quality Reports are also published separately and are available online at NHS Choices (www.nhs.uk) and our website (www.dchs.nhs,uk).

We rate our performance against the Big 9 as green, amber or red as a traffic light system to flag where we are not meeting our own stretch targets and for which we produce exception reports.

The latest Big 9 for March 2019 showed us as red rated for the provision of breastfeeding-friendly facilities. Our target was to have breastfeeding-friendly status at 40 of our sites. We have achieved 33. Five of the 40 sites originally listed are no longer open or open to the public. A further two are in the process of achieving breastfeeding-friendly status.

Big 9 - March 2019

	Objective	Priorities 2018/19	Target	Plan to end of March	Achieved to end of March	Forecast
Quality Service	To deliver high quality and sustainable services that echo the values and aspirations of the community we serve	Targeted increase in community nursing staff trained in best practice management of chronic leg ulcers	240 community nurses to be trained in optimum leg ulcer management	240 (100%)	286 (119%) (GREEN)	286 (119%) (GREEN)
		Increase the proportion of services adopting patient related outcome measures	Additional 45 teams will implement the systematic use of patient related outcome measures (implementation October - March)	45 (100%)	45 (100%) (GREEN)	45 (100%) (GREEN)
		Establish breast feeding friendly facilities across our services in Derbyshire and Derby City	40 sites to be registered (implementation October - March)	40 (100%)	33 (83%) (RED)	33 (83%) (RED)
	Objective	**Priorities 2018/19**	**Target**	**Plan to end of March**	**Achieved to end of March**	**Forecast**
Quality People	To build a high performance work environment that engages, involves and supports staff to reach their full potential	Increase the staff engagement score by 10% in teams where engagement is lowest by monitoring it through the National Staff Survey and Pulse Checks	53	53 (10%)	57 (19%) (GREEN)	57 (19%) (GREEN)
		Decrease the number of days our Nursing and Midwifery workforce are absent from work due to mental health conditions by 10%, from baseline of 1,163 days.	1,047	1,047 -(10.0%)	1,074 -(7.7%) (AMBER)	1,074 -(7.7%) (AMBER)
		Improve 12 month rolling average attendance across the Trust by 0.65% to 95.5%	95.50%	95.50%	95.11% (AMBER)	95.11% (AMBER)
	Objective	**Priorities 2018/19**	**Target**	**Plan to end of March**	**Achieved to end of March**	**Forecast**
Quality Business	To ensure an effective, efficient and economical organisation which promotes productive working and which offers good value to its community and commissioners	Demonstration of efficiency across all DCHS services through the delivery of the Sustainable Quality Improvement Plan (SQIP)	Delivery of £6m SQIP Plan	£6.000m (100.0%)	£6.001m (100.0%) (GREEN)	£6.001m (100.0%) (GREEN)
		Delivery of effective services within the Community	75% of records updated within 30 mins of clinical appointment	75%	75.5% (GREEN)	75.5% (GREEN)
		Delivery of safe information systems within the Community	Machines patched with 95% of cyber security patches within last 30 days	95%	88.6% (AMBER)	88.6% (AMBER)

Financial performance analysis

In 2018/19 we delivered a net surplus of £6.175m which was in excess of our original plan of £4.07m by £2.103m. The next table details our financial performance and over-achievement on the control total set by NHS Improvement.

	£000's
Surplus for the year	6,837
Add impact of donated assets	44
Add back impairments charged to I&E	-706
Adjusted surplus for the year	6,175
Control Total	4,072
Performance against Control Total	**2,103**

The year-end surplus figure includes a Provider Sustainability Fund (PSF) of £4.065m. This is made up of core STF. Removing the impact of the PSF, the Trust has over-performed against its control total by £0.2m

	£000's
Adjusted surplus for the year	**6,175**
Less PSF funding	**-4,065**
Adjusted surplus for the year exc PSF	**2,110**
Control Total exc PSF	**1,911**
Performance Against Control Total exc PSF	**199**

Our primary financial statements and supporting notes to the accounts are provided at appendix 1. Our external auditors, PwC, have provided an opinion on the accounts.

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

Financial statements

Our annual report and accounts cover the 12 month period from 1 April 2018 to 31 March 2019. 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.

Going concern

Our accounts have been prepared on the basis that the Trust is a going concern. This means that our assets and liabilities reflect the ongoing nature of our activities. Our directors have considered and declared that: “After making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future”. For this reason, they continue to adopt the going concern basis in preparing the accounts.

External audit

Our auditors for 2018/19 are:
PricewaterhouseCoopers LLP (PwC)
Donington Court
Pegasus Business Park
Herald Way
East Midlands
DE74 2UZ.

The total audit fees in respect of completion of the statutory audit work for 2018/19 were £65,000 (plus VAT), comprising £55,250 for the accounts and £9,750 for the quality accounts.

The total fees for external auditors for 2018/19:
PwC (appointed auditors) £65,000 (plus VAT)

NHS foundation trusts are required to seek external assurance over their annual quality report. The audit work undertaken by PwC in relation to quality reports must be done in accordance with the detailed guidance issued by NHS Improvement. PwC provided non-audit services on the quality accounts. A charge of £9,750 (plus VAT) was made for the quality account audit. The fee for the quality account audit is immaterial in the context of the audit fee to both our Trust and PwC, as the work has no correlation or impact on the financial audit and has an entirely separate scope.

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 Governance Sub-Committee of the Council of Governors had a series of update meetings with PwC. The first of these took place on 26 June 2018, a further two on 23 August 2018 and 21 February 2019. These meetings provide an opportunity for PwC 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 2015/16. In December 2014, the Council of Governors approved a proposal to go out to tender for our external auditors for 2015/16 onwards. Subsequently, the Council of Governors confirmed at their meeting on 9 September 2015 that they were content with the recommendations arising from the process to appoint PwC as our external auditors for an initial three year term from September 2015 with the option of two one-year extensions. The Audit and Assurance Committee recommended the optional extension for a further two years and the recommendation was accepted and approved by the Council of Governors at their meeting on 9 May 2018.

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.

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 2018/19 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.

Financial performance

Despite the current financial difficulties facing the NHS and economy as a whole, we have ultimately performed well during 2018/19. We made a net surplus of £6.175m was which in excess of our original plan of £4.072m by £2.103m.

We have had a number of financial targets to meet and our performance against these is set out here:

2018/19 performance	**£'000**
Surplus	6,837
EBITDA	11,650
Cash balance at period end	30,799
Better payment practice code	97.7%

EBITDA stands for Earnings Before Interest, Tax, Depreciation and Amortisation and in simple terms is a way of representing how much of our operating income exceeds our operating costs. Our EBITDA for 2018/19 was £11,650m which equates to 6.4%. This measure demonstrates sound financial health and the efficient use of our resources.

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.

We ended 2018/19 with a healthy cash balance of approximately £30.8m which equates to 61 days' worth of operating expenditure. We have continued to invest surplus cash in 2018/19 in the National Loans Fund to generate a modest return on investment.

Events after the reporting period

There are no events after the reporting period that will have a material impact upon the financial statements.

Overseas operations

We have no overseas operations.

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 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.

Capital expenditure

Our capital plan for 2018/19 was £7.1m.

The most significant scheme is the purchase of Buxton Health Centre for £2.13m.

In addition to our routine capital investment programme, we successfully bid to secure STP funding to support the development of a new health facility in Bakewell. The total value of the scheme is £8.58m.

During the year, we completed the sale of Bolsover Hospital to Home England for £0.52m.

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The table summarises our capital expenditure for 2018/19.

Capital expenditure schemes 2018/19	Cost £'000
Estate – Purchase of Buxton Health Centre	2,130
Estate – Walton development	1,748
Estate – Bakewell development	457
Estate - general refurbishment	418
Estate - upgrade Castle Street	251
Estate - upgrade New Mills	227
Estate - Belper development	177
Estate - staff cost	268
Equipment	660
IM&T - desktop renewal and local infrastructure	560
IM&T -NHS Wi-Fi	205
IM&T -End user licence	202
Other Schemes	185
Total capital expenditure	**7,488**

NHS pensions and directors' remuneration

The accounting policy in relation to employee pension and retirement benefits is set out in the full set of the financial accounts for 2018/19.

The detail of the directors' remuneration is contained within the remuneration report section of this annual report.

Policy and payment of creditors

The non NHS trade creditor payment policy of the NHS is to comply with both the Confederation of British Industry prompt payment code and government accounting rules.

The government accounting rules state: “The timing of payment should normally be stated in the contract. Where there is no contractual provision, departments should pay within 30 days of receipt of goods and services or on the presentation of a valid invoice, whichever is the later”. As a result of this policy, we ensure that a clear consistent policy of paying bills in accordance with contracts exists, and that finance and procurement divisions are aware of this policy.

- Payment terms are agreed at the outset of a contract and are adhered to
- Payment terms are not altered without prior agreement of the supplier
- Suppliers are given clear guidance on payment terms
- A system exists for dealing quickly with disputes and complaints
- Bills are paid within 30 days unless covered by other agreed payment terms.

Efficiency

During 2018/19 we generated efficiency savings of £6m against a target of £6m. The savings were required to deliver a 4% national efficiency requirement for commissioners. This was a national requirement for NHS providers.
A summary of our main savings delivered during 2018/19 is shown below:

Service area	£m
Corporate and estate	3.24
Health, wellbeing & inclusion	0.86
Planned care and outpatients	0.70
Integrated community-based services	0.64
Other	0.63
Total	**6.00**

Future financial performance

The Board of Directors has set out a detailed financial plan for 2019/20. We intend to achieve a surplus of £3.878m in 2019/20. This will achieve the maximum continuity of service rating of 1 against which we will be assessed as an NHS foundation trust.

Our 2019/20 financial plan is predicated upon the successful delivery of a challenging efficiency requirement of £5.6m. We have taken further measures through 2018/19 to improve our financial governance processes to prepare for the more challenging times ahead.

Our project management office, which was set up in 2012, has become embedded across the Trust to ensure that a structured process is in place for the delivery of our

major change programmes, which will result in future efficiencies. We also continue to improve our financial reporting to ensure we are more forward-looking and have the information to enable us to manage performance proactively.

In our future plans, it is clear that we need to maintain our core business by providing high quality and efficient services to our patients and commissioners. We have produced our quality account in 2018/19 and have plans in place to ensure quality improvements in our services are included, measured and evidenced.

The future economic environment continues to become more challenging as public spending on health and social care services slows. There will be increasing pressure on provider organisations to make further efficiencies and to work in partnership with commissioners and other partners to secure effective and efficient care pathways.

Environmental matters

At Derbyshire Community Health Services NHS Foundation Trust we have a board-approved sustainable development management plan (SDMP) which identifies how we are meeting our corporate and social responsibilities, including our carbon reduction targets and climate change adaptation plan.

Previously, we measured our overall progress across a range of sustainable development areas using the NHS Sustainable Development Unit Good Corporate Citizenship Toolkit. Our scores, using this toolkit, continued to improve across all areas during the last few years.

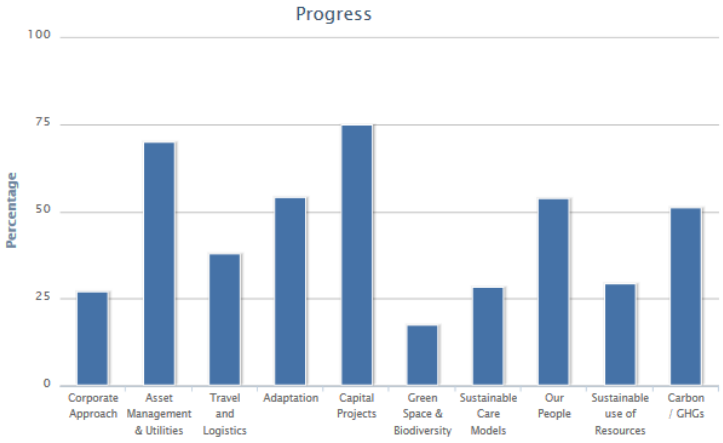
However, this toolkit has now been replaced by the Sustainable Development Assessment Tool (SDAT). This works in much the same way as the old toolkit, but with different questions and a wider range of areas to assess. Going forward we will use this new tool to assess our overall progress across all sustainability areas. This tool has helped us reassess how sustainable we are and provides a benchmark to measure our progress by evaluating sustainability across a range of areas. The chart below shows our new benchmark (July 2018) from which we will measure our future progress.

DERBYSHIRE COMMUNITY HEALTH SERVICES NHS TRUST

Latest assessment score

42%

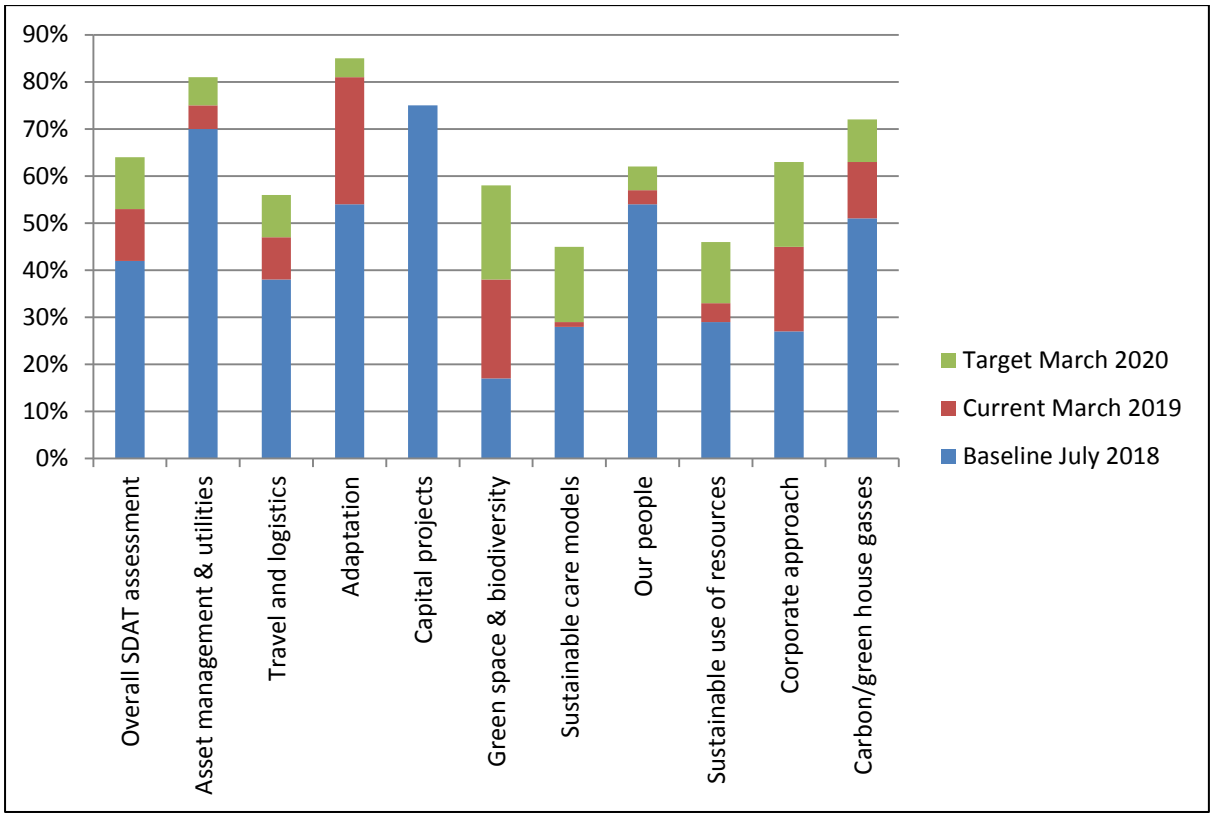
Module	Score
Corporate Approach	27.04%
Asset Management & Utilities	69.84%
Travel and Logistics	37.63%
Adaptation	53.85%
Capital Projects	74.6%
Green Space & Biodiversity	17.39%
Sustainable Care Models	28.21%
Our People	53.76%
Sustainable use of Resources	29.17%
Carbon / GHGs	50.93%



The Sustainable Development Assessment Tool asks a total of 296 questions against these 10 areas. Each question can score up to 3 points (if we are fully doing that action). The scores achieved in each section are shown as a % of the total score available. The overall score is also shown as a % of the total score available across all sections.

Progress in 2018/19

From the July 2018 baseline we set targets for March 2020 (64%) and March 2021 (76%). The March 2020 targets for each section are shown below along with our progress to date. From this it can be seen (first column) that our overall assessment score has increased from 42% to 53% between July 2018 and March 2019.



Carbon reduction

As well as using the SDAT to measure our wider sustainable development progress, we also specifically measure total carbon emissions from our travel, energy, waste and water. We continue to meet or exceed our ongoing sustainability targets, making excellent carbon and cost reductions and putting us on target to achieve 34% carbon reduction emissions by 2020[1].

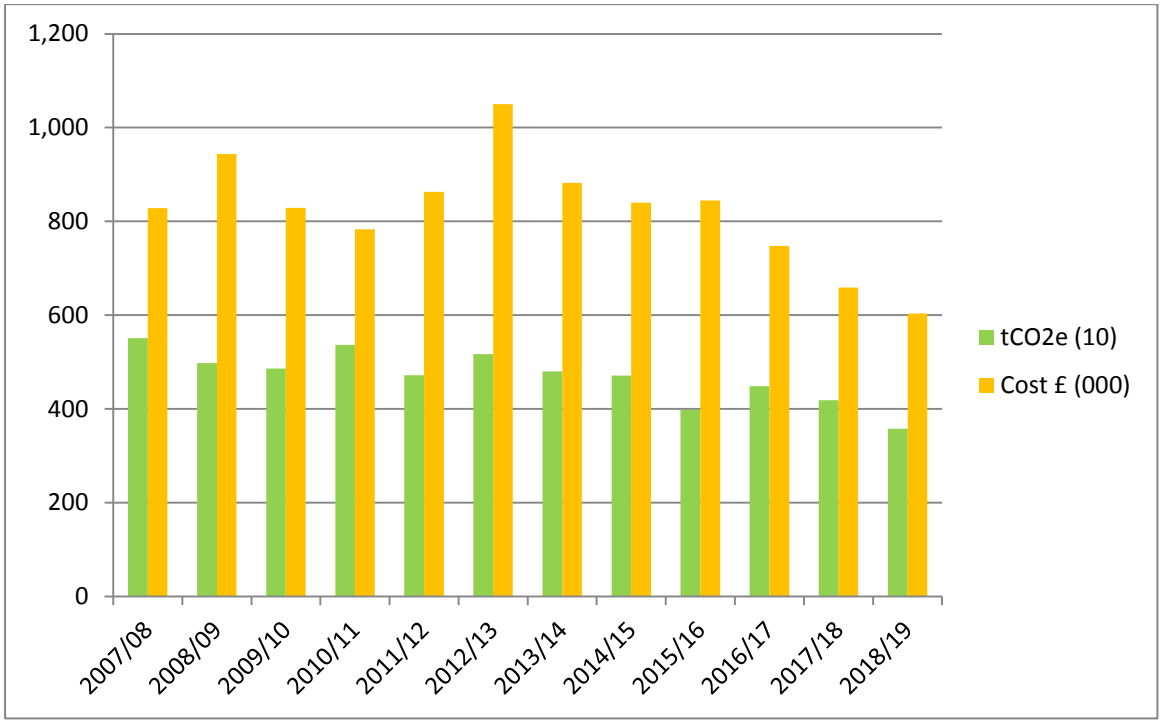
Energy (gas and electricity)

Energy is one of the most difficult assets to manage in a large, complex and diverse organisation like ours. In addition, increasingly unpredictable seasonal temperature changes and oil price volatility make it extremely challenging to stay on course to meet our targets.

Despite this, we are making good and persistent savings year on year and staying on target. This is due to capital investments in recent years and a sustainable culture now embedded within the organisation. The following charts and tables show our overall trends and savings made year on year.

[1] Using 2007/8 baseline

Gas



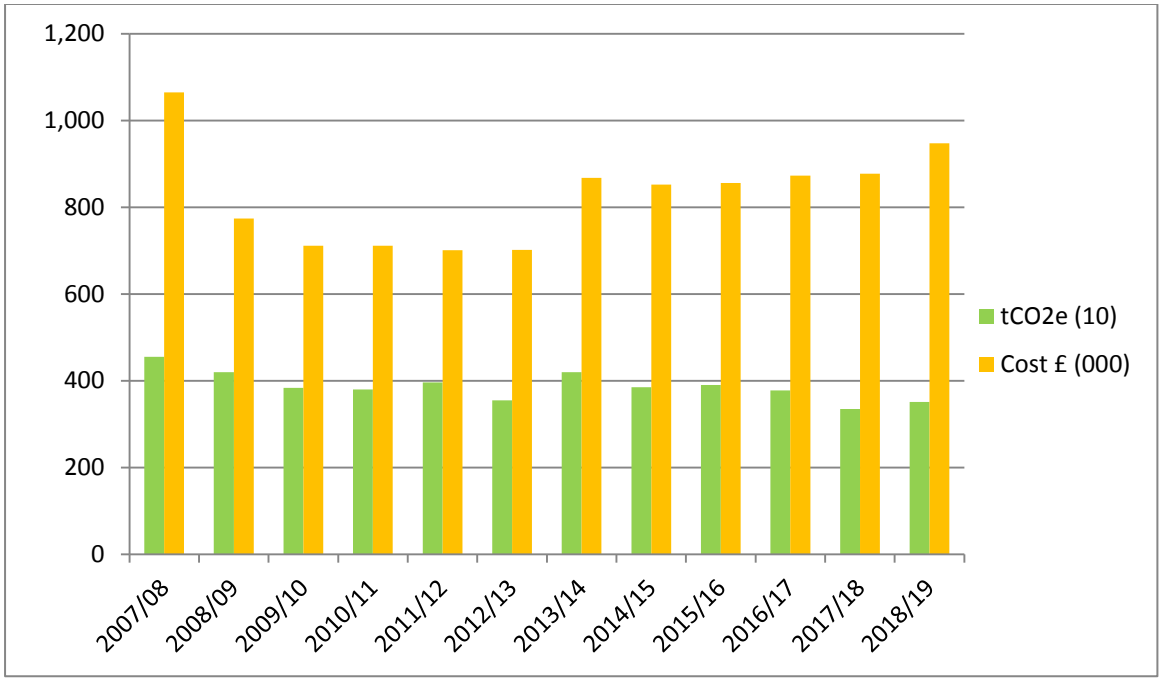
Year	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Gas MWh	29487	26647	25913	28737	25211	27634	25651	25187	21287	23995	22399	19129
tCO2e	5514	4983	4845	5374	4715	5168	4796	4710	3981	4487	4187	3577
Cost £(000)	828	944	829	783	863	1050	882	840	845	748	659	604

Gas CO2 emissions (tCO2e) and cost

The gas consumption, carbon emissions and costs are continuing to decrease year on year since 2007/08. To date net figures are as shown below.

Carbon emissions reduced by 1,937 tonnes (35%), cost reduced by £224,000 (27%).

Electricity



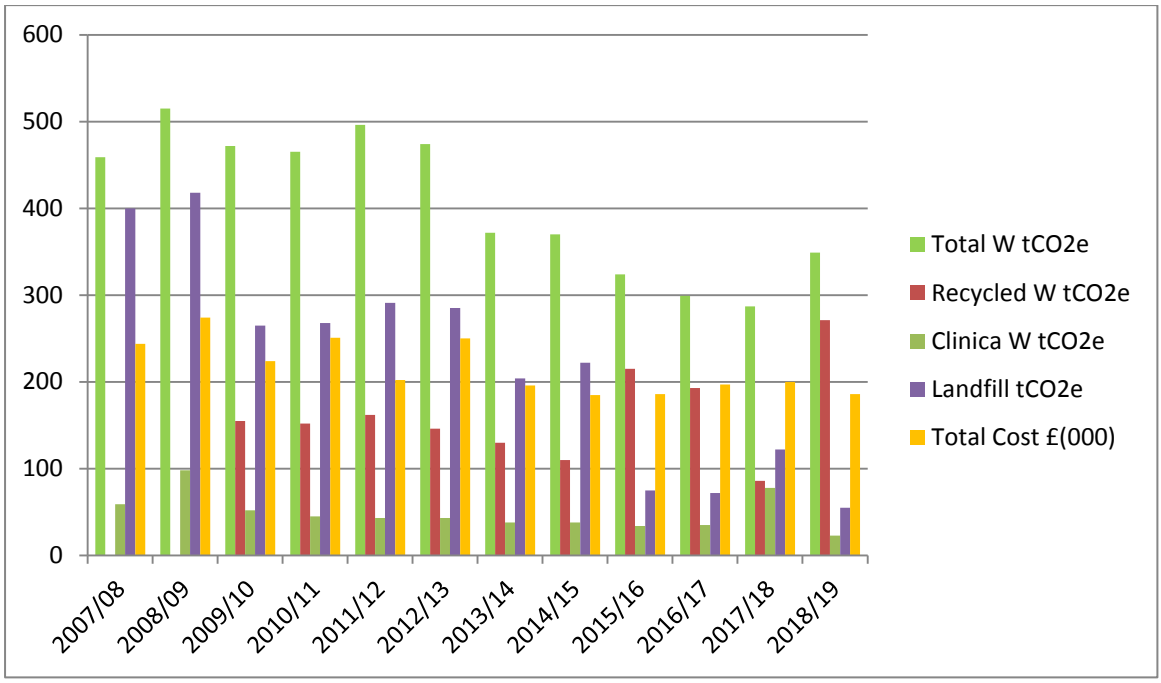
Year	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Elect MWh	8677	8012	7332	7590	7558	6781	8013	7347	7449	7209	6387	6689
tCO2e	4546	4198	3842	3977	3960	3553	4199	3850	3903	3778	3347	3505
Cost £(000)	1065	774	711	711	701	702	868	852	856	872	877	947

Electricity CO2 emissions (tCO2e) and cost

The electricity consumption, carbon emissions and costs have been fluctuating year on year since 2007/08; however the overall trend remains positive. To date net figures are as shown below. Carbon emissions reduced by 1,041 tonnes (23%), cost reduced by £118,000 (11%).

Waste

Good waste management systems are continuing to prevail making sure statutory compliance is met in addition to cost and carbon reductions. Please see ongoing progress details, which follow.



Year	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Total tCO2e	459	515	472	465	496	474	372	370	324	299	287	349
Recyclable tCO2e	0	0	155	152	162	146	130	110	215	193	86	271
Clinical tCO2e	59	98	52	45	43	43	38	38	34	35	78	23
Landfill tCO2e	400	418	265	268	291	285	204	222	75	72	122	55
Total Cost £(000)	244	274	224	251	202	250	196	185	186	197	200	186

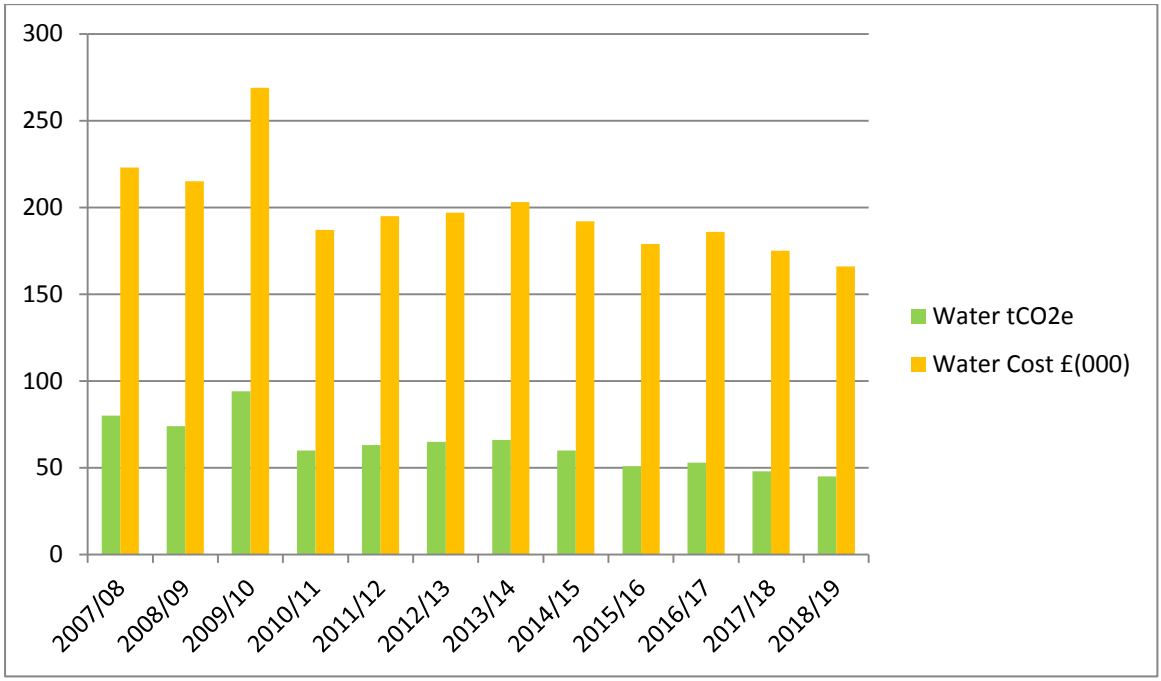
Total waste disposal CO2 emissions (tCO2e) and cost

Since 2007/08 we have reduced our total waste tonnage and cost by 248 tonnes and £58,000 respectively. It also has reduced landfill waste volume from 900 tonnes to 124 tonnes a reduction of 86%. Apart from offensive waste which goes to landfill

(responsible for CO2 emissions) all our waste is either recycled or used as heating fuel.

Water

Due to water industry deregulation for business use since April 2017 official water use data has been difficult to obtain from the newly formed water retailer. Nevertheless, our own water use monitoring and measurements show a healthy water consumption reduction trend, since the start of our carbon reduction programme in 2007/08.



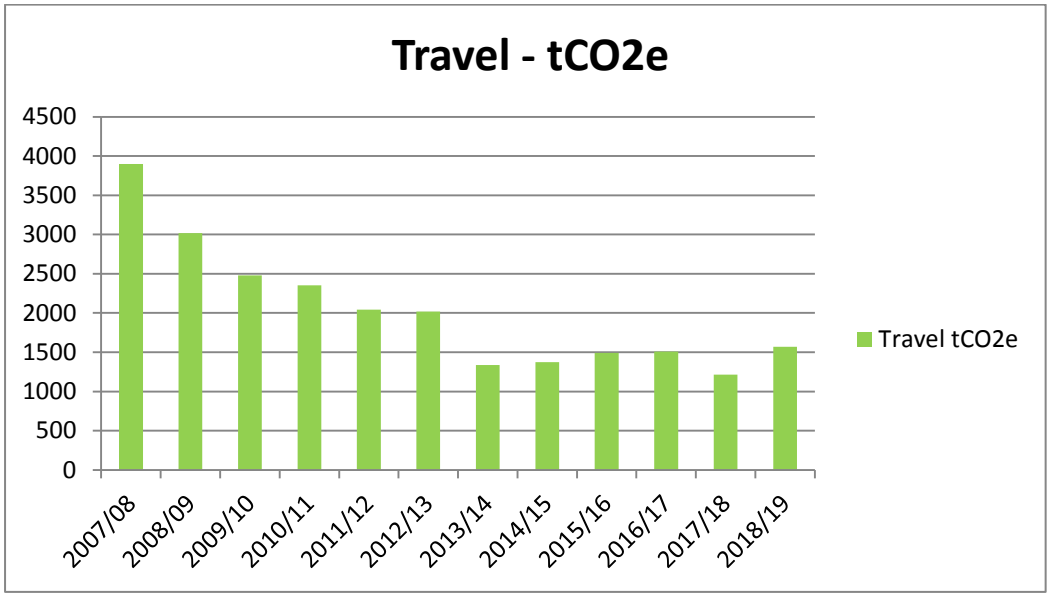
Year	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
tCO2e Water	80	74	94	60	63	65	66	60	51	53	48	45
Cost £(000)	223	215	270	187	195	197	203	192	179	186	175	166

Water CO2 emissions (tCO2e) and cost

The water consumption, carbon emissions and costs are continuing to decrease year on year since 2007/08. To date net figures are as shown below. Carbon emissions reduced by 35 tonnes (44%) cost reduced by £57,000 (26%)

Travel

Historically, accurate and relevant travel data has always been a challenge when it came to accurate reporting. Due to the advent of the electronic mileage claim system, launched few years ago, it is now possible to produce more accurate and various strands of total travel data. However for trend comparison reasons only the grey fleet data is displayed on the following chart.

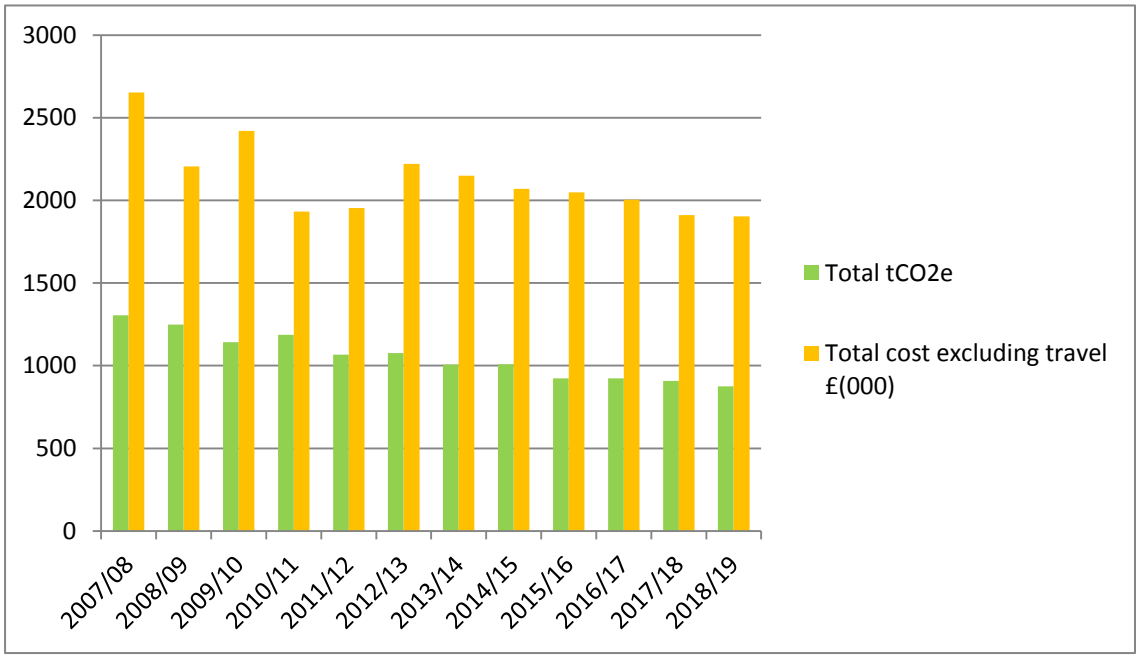


Year	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Miles	12993	12902	10596	10064	8723	8630	4450	4578	4967	5031	4048	5232
tCO2e	3900	3018	2479	2354	2041	2019	1335	1373	1490	1509	1215	1570

Travel CO2 emissions (tCO2e)

During the past few years (since 2015) grey fleet miles per annum have been increasing. However, as can be seen from the figures above, compared with 2007/08 total miles and emissions have dropped by 7.761 million (60%) and CO2 by 2,330 tonnes (60%).

Overall progress



Year	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Total tCO2e	13052	12480	11418	11858	10659	10768	10058	10084	9228	9244	9084	8752
Total Cost £(000)	2652	2206	2421	1932	2220	2149	2070	2070	2048	2004	1911	1903

Total CO2 emissions from energy, travel, waste and water (tCO2e) and costs, excluding travel

The overall carbon and cost reductions since 2007/08 are 4,300 tonnes (33%) and £749,000 (28%), respectively. These are excellent figures and we are only 1% away from our 2020 target of 34%. Further possible capital investment work in the coming year will enable us to exceed our intended target.

Accountability section

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 2018 to 31 March 2019:

Designation	Date	Name
Chairman	1 April 2018 to 31 March 2019	Prem Singh
Vice chairman	1 April 2018 to 31 March 2019	Nigel Smith
Chief executive	1 April 2018 to 31 March 2019	Tracy Allen
Director of finance and strategy/deputy chief executive Acting chief executive	1 April 2018 to 31 March 2019 1 April 2018 to 31 August 2018	Chris Sands
Acting director of finance	8 May 2018 to 31 August 2018	Cath Benfield
Chief operating officer	1 April 2018 to 31 March 2019	William Jones
Director of quality/chief nurse	1 April 2018 to 28 February 2019	Carolyn White
Director of quality/chief nurse	18 February 2019 to 31 March 2019	Michelle Bateman
Acting director of quality/chief nurse	1 April 218 to 29 July 218	Jo Hunter
Director of people and organisational effectiveness	1 April 2018 to 31 March 2019	Amanda Rawlings
Medical director	1 April 2018 to 31 March 2019	Dr Rick Meredith
Associate director of corporate governance/trust secretary	1 April 2018 to 31 March 2019	Kirsteen Farrar
Non-executive director	1 April 2018 to 31 March 2019	Ian Lichfield
Non-executive director	1 April 2017 to 31st October 2018	Chris Bentley

Designation	Date	Name
Non-executive director	1 April 2018 to 31 March 2019	Kaye Burnett
Non-executive director	1 April 2018 to 31 March 2019	James Reilly
Non-executive director	1 October 2018 to 31 March 2019	Kay Fawcett
Non-executive director	1 October 2018 to 31 March 2019	Julie Houlder
Non-executive director	1 October 2018 to 31 March 2019	Joy Hollister
Associate non-executive director	1 September 2018 to 31 March 2019	Richard Harcourt

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

We commissioned an external review against the domains of the NHS Improvement well led framework by Deloitte in 2018. NHS Improvement requires trusts to commission an external review of governance at least every three years.

The findings from Deloitte did not highlight any significant areas of concern, however their report was shared with the Trust's governance groups and the Council of Governors. Any specific recommendations have been considered and acted upon since the publication of the report. More details about the well led review findings are included in the Annual Governance Statement (8.4) and in the Quality Report (3.1.4 and 3.1.5).

Our Trust does not have any other connection with Deloitte, except in providing a two-and-a-half hour executive development session in December 2018 and two Board development sessions, amounting to five hours in total, in November 2018 and February 2019 for the Trust Board.

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 2018/19.

Better payment practice code performance

The better payment practice code requires the payment of undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later, for 95% of all invoices received. We have a policy of paying suppliers within 30 days of receipt of a valid invoice.

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:

Payment of invoices

	31/03/2019 Number	31/03/2019 £'000
Non NHS		
Total bills paid in the year	27,184	34,175
Total bills paid within target	26,729	33,580
Percentage of bills paid within target	**98.3%**	**98.3%**
NHS		
Total bills paid in the year	997	22,432
Total bills paid within target	967	21,752
Percentage of bills paid within target	**97.0%**	**97.0%**

Total		
Total bills paid in the year	**28,181**	**56,607**
Total bills paid within target	**27,696**	**55,332**
Percentage of bills paid within target	**98.3%**	**97.7%**

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

NHS Improvement's Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and providing 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 1 reflects providers with maximum autonomy. A foundation trust will only be in segment 3 or 4 where it has been found to be in breach or suspected breach of its licence.

This segmentation information is the Trust's position at 31 March 2019. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

The finance and use of resources theme is based on scoring in five measures from 1 to 4, where 1 reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2018/19				2017/18			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Financial sustainability	Capital service capacity	1	1	1	1	1	1	1	1
	Liquidity	1	1	1	1	1	1	1	1
Financial efficiency	I & E margins	1	1	1	1	1	1	1	1
Financial controls	Distance from financial plan	1	1	1	1	1	1	1	1
	Agency spend	1	1	1	1	1	1	1	1
Overall score		**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**

Income disclosures

During the year ending 31 March 2019, our Trust generated income of £191.5m for the provision of services, principally to the people of Derbyshire.

Of that total, £173.4m 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 £18.1m 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.

Chris Sands

Acting Chief Executive **22 May 2019**

Annual statement on remuneration

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 2018/19.

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

There were no substantial changes to senior managers' remuneration during 2018/19.

Prem Singh
Chairman **22 May 2019**

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
- A PRP element is in place for executives and for all staff on Agenda for Change. 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 short and long term strategic objectives of the Trust	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	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.

specific differences for individual directors).					

Notes on future policy table

No new components of the remuneration package have been introduced in 2018/19, 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' on page 52. 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.

No senior manager was paid more than £150,000 during 2018/19 (2017/18: £150,000). The chief executive was paid £136,350 during 2018/19 (2017/18: £143,113 pro-rata £151,150). 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	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 is in line with boardroom pay in the NHS, and reflects 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.

Annual report on remuneration

Information not subject to audit

Details of the service contract for each executive director at 31 March 2019

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*			✓
Carolyn White	*Chief nurse/ director of quality*	*2 September 2013*	*17 April 2015*	✓		

Amanda Rawlings	*Director of people and organisational effectiveness*	*10 April 2007*	*17 April 2015*		✓	
Rick Meredith	*Medical director*	*6 June 2011*	*17 April 2015*	✓		
William Jones	*Chief operating officer*	*6 June 2011*	*17 April 2015*		✓	
Michelle Bateman	*Chief nurse/ director of quality*	*16 February 2019*	*n/a*	✓		
Kirsteen Farrar	*Trust secretary/ associate director of corporate governance*	*18 June 1991*	*17 April 2015*		✓	

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 eight occasions during the period 1 April 2018 to 31 March 2019. The membership and attendance at the committee is detailed in the table below.

Attendance at Remuneration and Terms of Service Committee		26 April 2018	31 May 2018	28 June 2018	26 July 2018	27 Sept 18	25 Oct 18	27 Dec 18	31 Jan 19
Prem Singh	Chairman	✓	✓	✓	✓	✓	✓	X	✓
Chris Bentley	Non-executive director	✓	✓	✓	X	✓	✓		
Kaye Burnett	Non-executive director	✓	✓	✓	X	✓	✓	✓	✓

Attendance at Remuneration and Terms of Service Committee		26 April 2018	31 May 2018	28 June 2018	26 July 2018	27 Sept 18	25 Oct 18	27 Dec 18	31 Jan 19
Kay Fawcett	Non-executive director						✓	✓	✓
Richard Harcourt	Associate non-executive director					✓	✓	✓	✓
Joy Hollister	Non-executive director						✓	✓	✓
Julie Houlder	Non-executive director						✓	✓	X
Ian Lichfield	Non-executive director	✓	✓	✓	✓	✓	✓	✓	✓
James Reilly	Non-executive director	✓	✓	X	✓	✓	✓	X	✓
Nigel Smith	Non-executive director	✓	✓	✓	✓	X	✓	✓	✓

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 2018/19 we made a new executive appointment for our chief nurse/director of quality and we also began the recruitment process for a new medical director, to take effect in June 2019, due to the retirement of both previous post-holders.

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. Both posts then had both an interview panel and a stakeholder panel.

For the chief nurse appointment, NHS Improvement provided a technical assessor to assist with long listing and short listing. For the medical director's post we conducted the long listing and short listing ourselves in January 2019.

Use of external advisors on remuneration

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

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 2018/19.

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:

	2018/19			2017/18		
	Number			Number		
	Total	Receiving expenses	Expenses £ '00	Total	Receiving expenses	Expenses £ '00
Directors	9	9	14	7	7	16
Non-executive directors	10	10	14	6	6	7
Governors	30	16	5	28	15	4
Total	49	29	27	42	29	27

Information subject to audit

Trust board salaries and allowances

		1 April 2018 to 31 March 2019					
		Salary and fees (bands of £5,000)	*Taxable benefits* (Rounded to the nearest £00)	*Annual performance related bonuses* (bands of £5,000)	*Long-term performance related bonuses* (bands of £5,000)	*All pension related benefits* (bands of £2,500)	*Total* (bands of £5,000)
Name	*Title*	*£0*	*£0*	*£0*	*£0*	*£0*	*£0*
Prem Singh	Chairman	45-50	-	-	-	-	45 - 50
Tracy Allen	Chief executive	135-140	41	-	-	75-77.5	215-220
Chris Sands	Director of finance and strategy/deputy chief executive Acting chief executive (1.04.18 to 31.08.18)	125-130	41	-	-	32.5-35	165-170
Carolyn White	Chief nurse/director of quality (01.04.18-28.02.19)	100-105	45	-	-	-	105-110

Amanda Rawlings	Director of people and organisational effectiveness	60-65	38	-	-	12.5-15	80-85
Rick Meredith	Medical director	125-130	41	-	-	-	130-135
William Jones	Chief operating officer	115-120	48	-	-	25-27.5	145-150
Michelle Bateman	Chief nurse/director of quality (From 19.02.19)	10-15	1	-	-	40-42.5	50-55
Jo Hunter	Acting chief nurse/director of quality (01.04.18 to 29.07.18)	30-35	2	-	-	27.5-30	60-65
Cath Benfield	Acting director of finance (08.05.18 to 31.08.18)	25-30	-	-	-	45-47.5	70-75
Kirsteen Farrar	Trust secretary/associate director of corporate governance	95 - 100	7	-	-	50-52.5	150-155
Chris Bentley	Non-executive director	5-10	-	-	-	-	5-10
Nigel Smith	Non-executive director	15-20	-	-	-	-	15-20
Ian Lichfield	Non-executive director	10-15	-	-	-	-	10-15
James Reilly	Non-executive director	10-15	-	-	-	-	10-15
Kaye Burnett	Non-executive director	10-15	-	-	-	-	10-15
Kay Fawcett	Non-executive director (From 01.10.18)	5-10	-	-	-	-	5-10
Joy Hollister	Non-executive director (From 01.10.18)	5-10	-	-	-	-	5-10
Julie Houlder	Non-executive director (From 01.10.18)	5-10	-	-	-	-	5-10

		1 April 2017 to 31 March 2018					
		Salary and fees *(bands of £5,000)*	*Taxable benefits* *(Rounded to the nearest £00)*	*Annual performance related bonuses* *(bands of £5,000)*	*Long-term performance related bonuses* *(bands of £5,000)*	*All pension related benefits* *(bands of £2,500)*	*Total* *(bands of £5,000)*
Name	*Title*	*£000*	*£00*	*£000*	*£000*	*£000*	*£000*
Prem Singh	Chairman	45 - 50	-	-	-	-	45 - 50
Tracy Allen	Chief executive	145 - 150	41	-	-	45.0 – 47.5	195 - 200
Chris Sands	Director of finance and strategy/deputy chief executive	125 - 130	41	-	-	27.5 - 30.0	160 - 165
Carolyn White	Chief nurse/director of quality	105 - 110	48	-	-	-	110 - 115
Amanda Rawlings	Director of people and organisational effectiveness	60 - 65	12	-	-	15.0 – 17.5	75 - 80
Rick Meredith	Medical director	125 - 130	41	-	-	-	130 - 135
William Jones	Chief operating officer	110 - 115	48	-	-	***15.0 – 17.5***	**135 –140**
Kirsteen Farrar	Trust secretary/associate director of corporate governance	95 - 100	7	-	-	70.0 – 72.5	165 - 170
Chris Bentley	Non-executive director	10 - 15	-	-	-	-	10 - 15
Nigel Smith	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
Kaye Burnett	Non-executive director	10 - 15	-	-	-	-	10 - 15

Amanda Rawlings, director of people and organisational effectiveness, was also appointed to the Board of Directors of Derbyshire Healthcare NHS Foundation Trust, where her day-to-day operational management responsibility was split equally between our Trust and Derbyshire Healthcare NHS Foundation Trust. The allocation of her remuneration to our trust is shown above and her total remuneration is shown in the next table.

Name	Title	1 April 2018 to 31 March 2019					
		Salary and fees (bands of £5,000)	Taxable benefits (Rounded to the nearest £00)	Annual performance related bonuses (bands of £5,000)	Long-term performance related bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	Total (bands of £5,000)
		£0	£0	£0	£0	£0	£0
Amanda Rawlings	**Director of people and organisational effectiveness**	120-125	38	-	-	12.5-15.0	135-140

Name	Title	1 April 2017 to 31 March 2018					
		Salary and fees (bands of £5,000)	Taxable benefits (Rounded to the nearest £00)	Annual performance related bonuses (bands of £5,000)	Long-term performance related bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	Total (bands of £5,000)
		£0	£0	£0	£0	£0	£0
Amanda Rawlings	**Director of people and organisational effectiveness**	120-125	24	-	-	30.0-32.5	150-155

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.

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 2016	Lump sum at age 60 related to accrued pension at 31 March 2016	Cash equivalent Transfer Cash equivalent transfer value at 31 March 2015	Real increase cash equivalent transfer value	Cash equivalent transfer value at 31 March 2016	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	2.5-5.0	2.5-5.0	50-55.	130-135	839	176	1,041	20
Chris Sands	Director of finance and strategy/deputy chief executive	2.5-5.0	0-2.5	40-45.	95-100.	585	117	720	19
Michelle Bateman	Chief nurse/ director of quality	0-2.5	0-2.5	35-40.	105-110	635	13	766	2
Amanda Rawlings	Director of people and organisational effectiveness	0-2.5	-	30-35.	65-70.	463	77	554	16
William Jones	Chief operating officer	0-2.5	2.5-5.0	50-55.	155-160	1,054	128	1,214	**17**
Rick Meredith *	Medical director	-	-	-	-	-	-	-	-
Kirsteen Farrar	Trust secretary/associate director of corporate governance	2.5-5.0	7.5-10	45-50.	135-140	867	155	1,048	15
Jo Hunter	Acting chief nurse/director of quality (01.04.18 to 29.07.18)	0-2.5	2.5-5.0	35-40	115-120	730	55	921	12
Cath Benfield	Acting director of finance (08.05.18 to 31.08.18)	0-2.5	0-2.5	25-30	70-75	378	35	500	11

* There is no entry for Rick Meredith as he opted out of the NHS Pension 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.

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 2018/19 was £155k-160k (2017/18 £145-150k); this was 6.1 times more than the median pay of £26,275 (2017/18 6.44 times or £24,842).

In 2018/19 one employee (2017/18, one) received remuneration in excess of the highest paid director at £159,854 (2017/18 £156,884) on a full time annualised basis.

The Trust is required to calculate the fair pay multiple based on all staff in post as at the end of March 2019 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 2018/19 one employee received remuneration in excess of the highest paid director, although they only worked for the Trust during the year on a part-time basis. This employee provided medical sessions. Their full time equivalent remuneration would have been £156,884**.**

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 2018/19, there are no significant changes on either side of the ratio.

Chris Sands
Acting Chief Executive **22 May 2019**

Staff report

We employ nearly 4,300 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.

We are committed to staffing our clinical areas with our substantive staff wherever possible, as we firmly believe this is the best way to deliver high quality care.

However, in addition to our substantive workforce, we have a well-established internal bank, meaning that we have 1,200 committed bank workers supporting us to deliver high quality patient care and ensuring our agency usage is kept to a minimum.

This year our agency spend is 0.7% of our total pay bill. We are proud to report this continues to be one of the lowest in the NHS and well below the target set for us by NHS Improvement.

Staff turnover has risen slightly to 8.95% for 2018/19, which is lower than both the national and local East Midlands NHS turnover average which stands at 10.39% (based on most current iView data for East Midlands in December 2018).

Analysis of the reasons staff left us has not highlighted any trends or causes for concern. Currently our vacancy rate is 6.51%.

All of this assures us that Derbyshire Community Health Services NHS Foundation Trust has a largely stable workforce which can only serve to support us in providing the very best care to our patients.

The workforce strategy

Our workforce plan for 2019 sets out the steps we will take to develop our workforce in support of the ambitions of the Derbyshire Sustainability and Transformation Plan (STP). The underlying principle of the plan is based upon the future health and care needs of the local population and requisite skills needed by the workforce to support patients across the system.

We are continuing to develop our workforce planning and development approach to understanding our future workforce requirements. We are utilising population workforce planning methodology to gain a full understanding of our future workforce requirements across both health and social care at ‘place-based’ levels across Derbyshire.

The delivery of the people strategy is based on a strong commitment to excellence and on our continued development as an innovative teaching, learning and research

organisation. Ensuring we have the right workforce means that we will have flexible, well-trained, highly motivated, diverse and responsive multi-disciplinary teams. We will also have teams that can be mobilised quickly to meet urgent and planned changes in healthcare needs: targeting the right skills, in the right place, at the right time, for the benefit of our patients.

We recognise the important contribution that the voluntary and community sector make in the delivery of care and the promotion of social value. We will continue to work with our partners in these areas, recognising 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.

The implementation of our plans will require effective leadership to ensure that we are confident in our aspirations; create coherence across the organisations and wider system; work effectively with partners to co-create solutions and manage complexity whilst leading with courage and conviction.

Leaders will need support and development to help them rise to this challenge and this will need to be underpinned by effective communications and change management. We have embedded the concept of compassionate leadership, reflecting our values and this will be further developed as part of our new leadership strategy in 2019/20.

Key workforce achievements for 2018/19:

- Reviewed and implemented systems and processes to support development of a new shared workforce development function across Derbyshire Community Health Services NHS Foundation Trust and Derbyshire Healthcare NHS Foundation Trust
- Increased the number of advanced clinical practitioner roles, to support the integrated model of community care
- Worked collaboratively to develop an integrated support worker apprenticeship role across health and social care
- Collaborated with Health Education England and the local workforce action board to secure workforce development funding
- Maximised access to learning beyond registration funding to meet service delivery and transformation requirements
- Redesign of our essential learning training programme
- Continued to expand our internship programme for individuals with a learning disability
- Full use of available ‘learning beyond registration’ funding based upon service/business priorities

- Successful Return to Practice project which has resulted in returnees obtaining permanent positions with us
- Successful contribution to supporting practice development in community teams.
- Introduction of competency framework for bands 2 - 5
- Introduction of mathematics and English courses to prepare staff to take up further education/qualifications
- Worked both regionally and nationally as part of a number of apprenticeship trailblazers to develop and enhance our apprenticeship offer. As we develop new services and models of care we will use the apprenticeship levy as a key vehicle to equip our staff with the skills and competencies required, whilst also offering opportunities for career progression
  The first cohort of nine nurse associates qualified in January 2019, all of whom have acquired jobs with us. We have expanded the number of trainee nurse associates to 15, all of whom will commence the programme in March 2019
- We continue to be recognised for the quality of practice placements provided for pre-registration students across clinical disciplines. We are committed to providing a learning environment that supports and enables our workforce to attain the right skills, competence and professional capabilities to deliver excellent care in a challenging and changing environment. We will continue to build upon the good work and seek to extend our placement opportunities over the coming year.

The key workforce priorities for 2019 /20 include:

- Developing clear career pathways across both the clinical and non-clinical workforce
- Complete accreditation process to become an accredited training centre
- Further developing our work experience offer with ambition to achieve quality mark for our work experience programme.
- Enhance the internal training provision for non-clinical staff and allied healthcare professionals
- Sustaining and embedding our leadership work to equip our workforce to lead internally and across the system
- Continue to develop a ‘learning organisation’ approach to ensure we provide high quality education and placements for trainees and students from all disciplines inclusive of school children, people with a learning disability and those who have experienced a period of unemployment
- To increase awareness amongst our workforce of the principles of using a public health approach to the delivery of care and to create capacity and capability to allow them to fully engage with this approach by embedding health coaching and other public health approaches.

- To ensure a continuous supply of a high calibre workforce which is able to work flexibly across the organisation and provide seven-day services
- Work with HEE and with higher education institutes to increase the range of pre-registration training available for local people, including part time/flexible routes into registered professions.
- We will continue to assess the current skills and competency of our staff, and map to future service requirements at 'place' level so as to provide relevant learning and development opportunities
- There will be a need to review available learning and development funds so as to implement innovative training solutions to meet workforce development needs given the significant reduction in health education funding
- We will support our staff to work more efficiently through enhanced use of technology to deliver learning and development. This will include use of online training materials, bespoke e-learning, interactive distance learning, e.g. via WebEx, Skype, podcasts and access to virtual library services
- There is need to review our mentorship model and continue to strengthen our relationship with education providers to meet LDA requirements and offer high quality student placements to attract new recruits
- We will continue to develop apprenticeship opportunities that assist in the development of new workforce models to meet the Government public sector target of 2.3%
- We will continue to work with partners to develop new apprenticeship standards and where successful take part in relevant apprenticeship trailblazers
- Seek new funding streams to support CPD activity
- Develop new workforce roles to meet emerging care models.

Developing and supporting our people the DCHS Way

We are very proud of our Trust's values, which we call 'The DCHS Way'. It was launched in 2013 and underpins everything we do at DCHS. It sets out our vision to ensure that we support our people to be able to deliver the very best of care to our patients whilst making the most efficient use of the resources at our disposal. The DCHS Way mantra of 'Quality People, Quality Service, Quality Business' is well-known amongst our staff and is embedded in our Trust governance processes and employment policies.

We are committed to our vision to be the best provider of local healthcare and a great place to work. We know that our people are our most important asset. We also know that we have a multi-generational workforce, which means that the needs

of our staff change over time. Therefore, during 2018/19, we refreshed our People Strategy to ensure it reflects the current needs of our staff and patients.

Our People Strategy (2018-20) sets out three elements which we believe to be key to achieving our vision:

Attract – We are strengthening our employment brand ensuring we are seen as the first choice place to work. We are developing innovative and targeted recruitment campaigns to reach a diverse range of applicants and provide an employment offer that is flexible and meets the needs of all colleagues at all stages of their career.
Develop – We are offering a flexible approach to induction, preceptorship and development that meets the needs of new joiners; building a flexible career pathway by profession to grow and retain colleagues and ensure that all colleagues have a meaningful and engaging annual appraisal that supports their personal development. We are aligning succession planning with workforce and business planning.
Retain – We are creating a positive and engaging working environment for all our staff. We are listening to staff feedback via the annual NHS Staff Survey and the quarterly pulse checks to drive improvements across the Trust and individual teams, to improve staff engagement and involvement. We are developing a benefits package that supports the needs of staff at every stage of their career. We are creating a compassionate culture that nurtures and supports staff's physical and mental wellbeing.

To **Attract, Develop and Retain** colleagues we recognise that there are two golden threads that enable this and are key to delivery; to be excellent in management and leadership and to provide a positively inclusive culture.

Management and leadership – we are developing our management and leadership skills and capabilities across the Trust ensuring our people and service managers have the skills and knowledge to do their role well.

Inclusion – We are creating a 'positively inclusive' employment offer that supports every member of staff to be the best they can be, supported by a compassionate, engaging and enhancing environment that provides inclusive services and employment.

Attendance
Our average absence rate for 2018/19 is 4.89%, which is slightly lower than the previous year (2017/18 5.06%). The top three reasons for absence remain: stress/anxiety, musculoskeletal conditions and gastrointestinal problems. Staff wellbeing is a central focus for our leadership teams as we know that when our staff are well, patient outcomes are better.

Supporting staff health and reducing absence

The biggest step forward for staff wellbeing at DCHS in 2018 has been the launch of a brand new wellbeing strategy. This puts prevention at the heart of what we are doing and builds upon research that we have completed, in partnership with Sheffield University Business School, exploring the demands on health care staff and what interventions can keep us happy and healthy at work.

The focus of this centres around two key areas: creating 'good work' and supporting staff self-compassion. We have started to roll out service level interventions based on good work and are providing a consultancy service to managers to help them implement positive changes for their staff. This work has been boosted further with two community pilot teams testing out interventions and reporting back on what is working for them. We are also increasing the training and coaching offer for staff around self-compassion. This recognises that staff will always be focused on the patient, yet this care will always be limited by what care they give to themselves in the first instance. This work is being supported with the introduction of wellness action plans to support staff mental health and boost working relationships between staff and managers.

These programmes are supported by a 100 strong network of wellbeing champions. We have placed a real focus on recruiting champions from clinical areas to ensure that the signposting and support they provide is available where operational pressures are most acutely felt.

Our support services continue to provide an excellent safety net for staff where issues have occurred. The Resolve counselling service has increased the amount of staff seen and has now reached 10% of the organisation within the year. Feedback from service users show that this has a significant impact on absence as 75% of those attending Resolve say that it helped them stay in work or prevented sickness absence.

A safe and healthy workplace

We firmly believe that no-one should be injured or suffer ill health as a result of their work. In 2018/19 we have seen a significant reduction in both the overall number of injuries from incidents at work (411 from 525) but also in the number of the more serious injuries reportable under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (16 from 26). However, any injury is one too many and we are committed to reducing these figures further.

We reported 153 near misses in 2018/19, but the majority of those reported related to violence and aggression. We know that we have work to do on other topics too, so

we will be encouraging colleagues to report other unsafe situations so that we can manage them proactively.

We are close to launching a new health and safety strategy for DCHS which will support us in improving consistency across the Trust, providing the right information and training, and improving how we learn from incidents. This will link into our leadership development work, as we recognise that our leaders are vital in improving how we control risk.

Our work for 2019/20 will focus on key topic areas including violence and aggression, musculoskeletal ill health, needlestick injuries and stress, whilst also ensuring that we manage less likely but higher consequence risks effectively.

Essential training

We run a programme of essential training for staff and monitor compliance in all areas as part of our commitment to safety and good practice.

Training programmes reported against a target of 95% of available staff	Compliance 31 March 2018	Compliance 31 March 2019	% DCHS target
Essential learning	87%	96%	*96%*
Information governance	94%	95%	*96%*
Fire training	93%	94%	*96%*
Appraisal	87%	92%	*96%*

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 have also recently undertaken further work with the DWP in sharing

our work on attaining leader status which will be used across the UK to help other organisations who are looking to become leaders.

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 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, on topics chosen by staff.

Each month we meet with staff partnership/union colleagues in a formal sub-committee of the Trust Board. The aim is to provide assurance that we routinely engage, consult and involve staff in the management of change.

Team Talks and Exec Huddles offer an informal drop-in opportunity for staff to find out more about what's planned and raise any questions face-to-face with an executive.

Big Conversations are bi-monthly bookable three-hour sessions which are open to all staff. The agenda is set before the meeting and covers key issues relating to the current climate.

Leadership Forums are quarterly three-hour sessions for people managers to discuss the latest developments with executives, and then share with their teams. In additional 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 appraisals, training, learning, development and raising concerns which are all designed to promote our approach to staff engagement. We also hold topic specific engagement events and also arrange for these to be held at locations across the patch.

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.

This year we launched a new #DCHSTTT - thank you, time and tea party - reward and recognition scheme, hosted by the Board, running every quarter, to celebrate and thank staff by inviting them to take some time out and enjoy tea and cakes with colleagues and friends. Our first 2018 cohort of nominees were a combination of staff who had been nominated, staff who were receiving their long service awards and teams who had retained their gold Quality Always accreditation.

We also introduced a new festive initiative leading up to Christmas. Seasonal Stars was a feel good campaign, sponsored by Thornton's, recognising over 80 colleagues throughout December.

During 2018 we hosted our fifth Extra Mile Awards which are an established event in our calendar, to recognise those who inspire others and deliver beyond expectations.

NHS Staff Survey

The 2018 NHS Staff Survey was conducted between Monday 1 October and Friday 30 November 2018. 2,565 DCHS employees completed the survey giving a response rate of 61%, compared to our response rate of 55% in 2017.

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, Exec Huddles, Leadership Forums and the Staff Forum, to ensure staff at all levels have the opportunity to feed into the conversation about what the results tell us.

From 2018 onwards, the results from questions are grouped to give scores in 10 indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

Scores for each indicator together with that of the survey benchmarking group community trusts are presented below.

	2018/19		2017/18		2016/17	
	Trust	**Benchmarking group**	**Trust**	**Benchmarking group**	**Trust**	**Benchmarking group**
Equality, diversity & inclusion	9.4	9.3	9.4	9.3	9.5	9.4
Health & wellbeing	6.2	5.9	6.3	6	6.5	6.1
Immediate managers	7	7	7	7	7.2	6.9
Morale	6.3	6.2	N/A	N/A	N/A	N/A
Quality of appraisals	5.6	5.6	5.7	5.4	5.9	5.6
Quality of care	7.6	7.3	7.6	7.3	7.8	7.5
Safe environment – bullying & harassment	8.5	8.4	8.6	8.4	8.7	8.4
Safe environment – violence	9.6	9.7	9.6	9.7	9.7	9.7

Safety culture	7.1	7	7	6.9	7.1	6.8
Staff engagement	7.2	7.1	7.2	6.9	7.4	6.9

Full survey results are also shared on our intranet site, My DCHS and via our all staff weekly email, the Weekly Download. All these channels help to feed into the detailed action plan to address areas where the survey shows we need to improve.

Following the findings from the 2018 NHS Staff Survey, we work with Picker Europe, our independent contractor, and other key stakeholders to understand what staff have told us about DCHS as a place to work and deliver care.

Working with colleagues across the Trust we have identified the following areas which will be the key focus for improvement over the year ahead:

1. Leading for improvement
2. Employee wellbeing
3. Appraisals
4. Development opportunities
5. Bullying and harassment
6. Raising concerns
7. Health and safety of employees.

It is important to note that none of these areas are new areas of focus; the 2018 NHS Staff Survey results confirmed what we already knew and have enabled us to scale up and increase the work on these current work streams.

High level plans to address these areas of concern and our actions are shared below:

1 Leadership/leading for improvement: We are increasing the pace of the roll out of our 2018-20 leadership and management strategy, including introduction of:

- Top 70 leaders' programme
- Middle leaders' programme
- Master classes and Aspiring to Be programme
- Leadership induction process and 360 appraisal
- Embed the GROW coaching model and coaching network.

2 Employee wellbeing: Our 2019 wellbeing strategy is being rolled out, aligned to national best practice, including:

- Focus on stress management and resilience training, including resilient leadership sessions
- Package of supportive resources including wellness action plans to enable managers to effectively support staff and manage absence
- Employee wellbeing app and benefits package.

3 Appraisals: We launched a new appraisal process and paperwork on 1 April 2019 with supportive training and an ongoing quality assurance process.

4 Development opportunities: We are focusing on three key areas to improve development opportunities for staff:

- A new workforce plan, investing in new roles and continuous professional development
- Maximising development money e.g. apprenticeship levy
- Introduction of professional development pathways.

5 Bullying and harassment: A new framework and approach has been developed by a cross-organisational working group, which links to our organisational values, as set out in the DCHS Way.

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6 Raising concerns: Raising Concerns (our Freedom to Speak Up strategy) has been finalised with a supporting package for roll out.

7 Health and safety of employees: we are focusing on three areas for action to improve the health and safety of employees:

- Updating and improving our training for staff on the management of violence and aggression
- Exploring best practice for de-escalation and restraint
- Reviewing the data in detail to identify key areas.

Progress on a more detailed action plan of our future priorities and targets to improve staff satisfaction in each of these key areas will be reported bi-monthly to our Staff Health, Wellbeing, Safety and Engagement Group and Quality People Committee. We conduct Pulse Checks three times a year. These results give us added opportunities to monitor and improve staff feedback, details of which are included further on in this chapter.

Pulse Check

Pulse Checks were launched in 2013 to give quick anonymous feedback on how well staff feel they are being managed, engaged and supported. This was later linked with our Staff Friends and Family Test. The positive impact high staff engagement

can have on other key performance indicators – such as attendance, patient safety and productivity – is recognised and well researched. It also shows leaders how well they are engaging with their teams to deliver the results we need, primarily around quality care for our patients.

We run the Pulse Checks three times a year (two full census, one sample). We encourage all our staff to complete the 9-question Pulse Check (that shouldn't take any longer than 5 minutes to complete) to test the mood and wellbeing of employees and teams. This helps us pinpoint where and how we need to give extra support and intervention on a rolling basis to maintain staff morale.

The overall engagement scores for each quarter in 2018/19 are:

- Q1 April – June: 76%
- Q3 October – December: NHS Staff Survey, no Pulse Check
- Q4 January – March 2019: 75%

In recent Pulse Checks these are the responses we received to the following Staff Friends and Family Test questions:

How likely are you to recommend Derbyshire Community Health Services NHS Foundation Trust to friends and family if they needed care or treatment?

- Q1 April to June 2018: 90%.
- Q3 October to December: NHS Staff Survey, no Pulse Check
- Q4 January to March 2019: 90%

How likely are you to recommend Derbyshire Community Health Services NHS Foundation Trust to friends and family as a place to work?

- Q1 April to June 2018: 70%.
- Q3 October to December: NHS Staff Survey, no Pulse Check
- Q4 January to March 2019: 69%

Modern slavery statement 2018/19

This statement is made pursuant to Section 54 of the Modern Slavery Act (2015) and sets out the steps that Derbyshire Community Health Services NHS Foundation Trust has taken and will continue to take to ensure that modern slavery or human trafficking is not taking place within this organisation or those with whom we are affiliated. Modern slavery encompasses slavery, servitude, human trafficking, forced labour, sexual exploitation and forced criminality. We have zero tolerance to any form of abuse and thus modern slavery is incorporated within both children and adults safeguarding work streams.

We are committed to acting ethically, with integrity, requiring transparency in all our business dealings and putting effective systems and controls in place to safeguard against any form of modern slavery across the NHS and associated sectors.

Through implementation of robust recruitment policies and procedures we ensure that comprehensive checks are in place to negate the likelihood of an individual being employed by the organisation who has been trafficked or who is the victim of modern slavery.

Derbyshire Community Health Services NHS Foundation Trust is responsible for providing a range of health services for people living in Derby and Derbyshire. The care we provide is monitored by the clinical commissioning groups across the area through regular compliance visits and processes to ensure that we are compliant with the Modern Slavery Act (2015). More details about our work in this area can be found on our website www.dchs.nhs.uk

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.

As an organisation we recognise that outstanding practice requires an engaged and valued workforce, and we seek to enhance and maintain these excellent employee relations through early involvement, engagement and intelligence sharing with our trade union partners.

In line with the Trade Union (Facility Time Publication Requirements) Regulations 2017 we have published details of facility time carried out by our trade union representatives during the 2018/19 year on our website www.dchs.nhs.uk. This covers duties carried out for trade unions or as union learning representatives in relation to our Trust and staff.

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
19	15.76

Percentage of time union officials spent on facility time	Number of employees
0%	3

1-50%	13
51-99%	3
100%	0

Percentage of pay bill spent on facility time	
Total cost of facility time	£68,085.21
Total cost of pay bill	£117,153,690.66
Percentage of the total pay bill spent on facility time, calculated as: Total cost of facility time divided by total pay bill x 100	0.06%

Paid trade union activities	
Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: Total hours spent on paid trade union activities by relevant union officials during the relevant period divided by total paid facility time hours x 100	11.13%

Armed Forces Covenant - employer recognition scheme

The Defence Employer Recognition Scheme encourages employers to support defence and inspire others to do the same. The scheme encompasses bronze, silver and gold awards for employer organisations that pledge, demonstrate or advocate support to defence and the armed forces community, and align their values with the Armed Forces Covenant.

We were delighted to be to be among the recipients of the 2018 Employer Recognition Scheme silver awards. It's almost a year now since we became the first NHS body in Derbyshire to sign up to the Armed Forces Covenant and this award demonstrates our ongoing commitment to that pledge.

Silver award holders:

- demonstrate support for service personnel issues and employ at least one member of the armed forces community
- actively communicate and uphold a positive stance to their employees via established HR policies and procedures
- show flexibility towards annual training commitments and mobilisation of reservist employees and support the employment of cadet instructors, armed forces veterans (including wounded, injured and sick) and military spouses/partners.

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.

Staffing statistics

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

Staff group	Average of fixed term temporary staff	Average of permanently employed staff*
Administration and estates staff	17.44	742.89
Ambulance staff	00.00	00.00
General payments	00.00	00.00
Health care assistants and other support staff	7.14	939.65
Healthcare science	0.30	15.28
Medical and dental staff	4.26	35.46

Nursing, midwifery and health visiting learners	5.63	8.33
Nursing, midwifery and health visiting staff	8.74	1,097.25
Scientific, therapeutic and technical staff	10.63	553.35
Total	**54.14**	**3,392.21**

Total staff as at 31 March 2019 *	
Gender	**Total**
Female	3,818
Male	461
Total	**4,279**
Executive directors as at 31 March 2019*	
Gender	**Total**
Female	4
Male	3
Total	**7**

Senior managers as at 31 March 2019*	
Gender	**Total**
Female	12.70
Male	5.0
Total	**17.70**

* Based on staff employed at 31 March 2019 as whole-time equivalents.

Staff costs

	2018/19			2017/18		
	Total	**Permanent**	**Others**	**Total**	**Permanent**	**Others**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Salaries and wages	101,965	101,813	152	105,404	103,879	293

Social security costs	8,745	8,745	-	8,882	8,882	
Apprenticeship levy	515	515	-	520	520	
Pension cost - defined contribution plans employer's contributions to NHS pensions	13,821	13,821	-	14,087	14,087	
Pension cost - other	17	17	-	8	8	
Termination benefits	498	498	-	359	359	
Other employment benefits	-	-	-	-	-	
Temporary staff - agency/contract staff	3,315	-	3,315	2,317		3,549
Total gross staff costs	**128,876**	**125,409**	**3,467**	**131,577**	**127,735**	**3,842**
Total staff costs - included within:						
Costs capitalised as part of assets	268	268		229	229	
Employee expenses - staff	127,182	123,715	3,467	130,966	128,356	3,842
Employee expenses - executive directors	1,013	1,013		23	23	

Analysed into operating expenditure						
Employee expenses - staff	127,097	126,630	3,467	130,966	127,124	3,842
Employee expenses – executive directors	1,013	1,013		23	23	
Redundancy	498	498		359	359	
Total employee benefits excluding capitalised costs	**128,608**	**125,141**	**3,467**	**131,348**	**127,506**	**3,842**

Average number of employees (WTE basis)

	2018/19 permanent number	2018/19 other number	2018/19 total number	2017/18 total number
Medical and dental	35.46	4.26	39.72	47.40
Ambulance	0	0	0	0
Administration and estates	742.89	17.44	760.33	765.40
Healthcare assistants and other support staff	939.65	7.14	946.79	1,009.46
Nursing, midwifery and health visiting staff	1,105.58	14.37	1,119.95	1,159.26
Scientific, therapeutic and technical staff	568.63	10.93	579.56	604.32
Other	0	0	0	0
Total average numbers	3,392.21	54.14	**3,446.35**	**3,585.84**
Of which: Number of employees (WTE) engaged on capital projects	5.46	0	5.46	7

Expenditure on consultancy

2018/19	£'000
Service integration	91
Governance review	9
Estate valuation	26

Estate management	35
Workforce development	59
Recruitment	35
Other	12
Total	**267**

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 2019, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2019	46
Of which:	
The number that have existed for less than one year at the time of reporting	3
The number that have existed for between one and two years at the time of reporting	43
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 2018 and 31 March 2019, for more than £245 per day and that last for longer than six months:

	Number
Number of new engagements, or those that reached six	3

months in duration between 1 April 2018 and 31 March 2019	
Of which:	
Number assessed as within the scope of IR35	1
Number assessed as not within the scope of IR35	2
Number engaged directly (via PSC contracted to trust) and are on the Trust's payroll	1
Number of engagements reassessed for consistency/assurance purposes during the year	3
Number of engagements that saw a change to IR35 status following the consistency	0

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 2018 and 31 March 2019:

	2018/19 number of engagements
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	20

responsibility'. This figure should include both off-payroll and on-payroll engagements.	

The 20 individuals are the board members listed in the remuneration report, including an associate non-executive director.

Information subject to audit

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.

Exit packages

Exit packages cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
	2018/19		
£0 - £10,000	(8)	16	8
£10,001 - £25,000	2	8	10
£25,001 - £50,000	(7)	2	(5)
£50,001 - £100,000	5	1	6

£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
Total number of exit packages by type	(8)	27	19
Total resource cost	£145k	£353k	£498k

Exit packages cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
	2017/18		
£0 - £10,000	13	-	13
£10,001 - £25,000	11	-	11
£25,001 - £50,000	9	-	9
£50,001 - £100,000	(1)	-	(1)
£100,001 - £150,000	(1)	-	(1)
£150,001 - £200,000	-	-	-
Total number of exit packages by type	31	-	31
Total resource cost	£359k	-	£359k

Non-compulsory departure payments

2018/19	Agreements Number	Total Value of Agreements £'000
Mutually agreed resignations (MARs) contractual costs	27	353
2017/18		
Mutually agreed resignations (MARs) contractual costs	-	-

Equality report

During 2018/19 there has been a shift to making equality, diversity and inclusion more strategic and embedded across the organisation.

Compliance reports as part of our statutory reporting duties under the Equality Act have been completed in line with national deadlines.

We have begun to embed the national NHS equality improvement tool, called the Equality Delivery System2 (EDS2), and equality standards have been used to frame the corporate approach and evidence continuous improvement.

A key risk and development going forward is to strengthen the Equality Impact Assessment process. This work will be overseen by the Equality Diversity and Inclusion Leadership Forum.

The equality impact assessment process chosen by us at Derbyshire Community Health Services NHS Foundation Trust is less about identifying discrimination and more about how to take account of people's individual needs. By taking a more positive 'needs led approach' we succeed in avoiding discrimination or a 'one size fits all approach' which often comes from ignoring or being ignorant of people's differences and the needs often associated with that difference.

A new campaign on inclusion and fairness was launched on 14 May 2018, which included an infographic wheel demonstrating our commitment to each protected characteristic and a short video from members of the executive team outlining the Trust's approach to inclusion and fairness. A workshop was held on 4 July 2018.

We continued to support and grow our three employee network groups for our lesbian, gay, bisexual and trans (LGBT) employees, our black and ethnic minority employees and our employees with a disability or long-standing condition. Each group has a Board equality champion and is open to all allies irrespective of characteristics.

Our annual workforce race equality submission (WRES) was submitted to NHS England on 10 August 2018 and published on our external website on 24 September in line with Public Sector Equality Duties (PSED) Equality Act 2010.

The new gender pay gap report was approved at our Equality Diversity and Inclusion Leadership Forum and published under the Public Sector Equality Duty (PSED) Equality Act 2010.

Work has begun on the new NHS Workforce Disability Equality Standard (WDES) with the proposed first WDES report to be published by August 2019. Work will commence in autumn 2018 on gathering information to complete the 10 metrics which form the standard.

The annual equality and diversity report has been produced in line with statutory public sector equality reporting requirements in the Equality Act 2010. This includes reporting our workforce and patient profile (as at 31 March 2019) and developing a summary and infographic of workforce data.

A Board development session on inclusive leadership was run by the director of people and organisational effectiveness and led by the head of equality, diversity and inclusion.

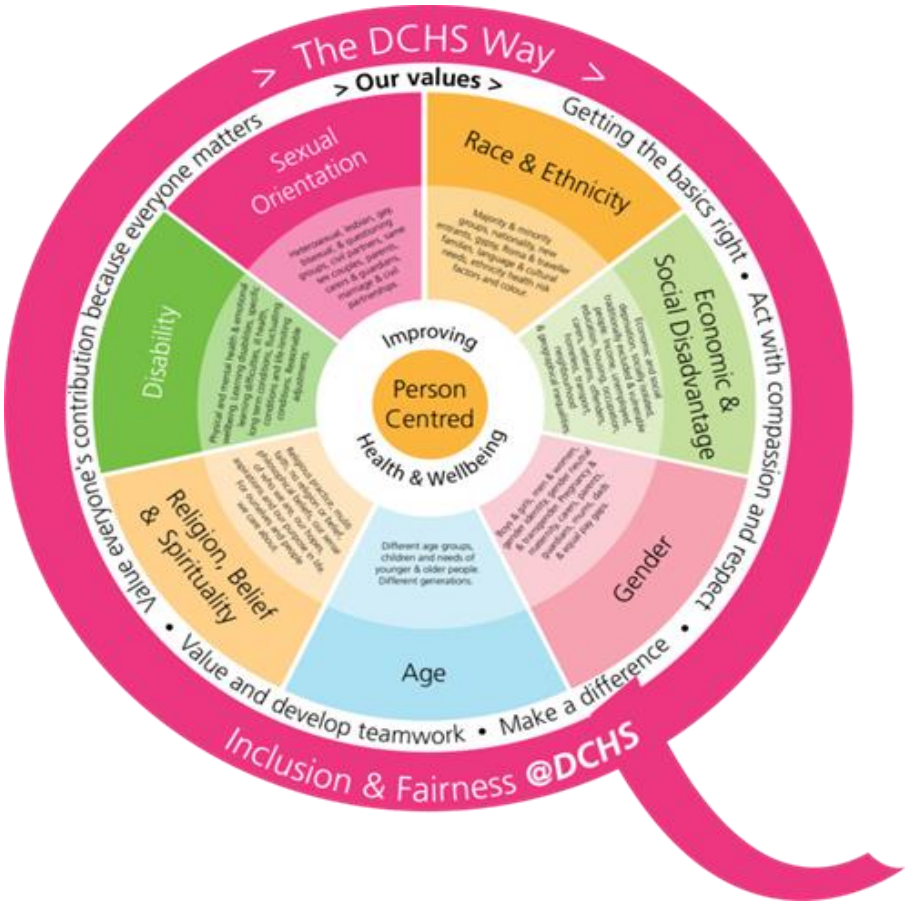
An update of our spirituality and chaplaincy service included the implementation of the voluntary chaplaincy programme, with 83 spiritual end-of-life champions receiving training, and a new spiritual leaflet produced.

The new learning disability improvement standards for NHS trusts were introduced this year. We are taking an organisational-wide approach as well as specifically looking at learning disabilities and autism to evidence that care is provided closer to the home/community for people living with learning disabilities and autism across our services and functions. Work on the development of an audit tool by our clinical effectiveness team is underway to help us measure against the standard. A task group has been set up to oversee the implementation and seek assurance that the standard is embedded in the Trust and identify areas for improvement.

Our Stonewall workplace equality index data was submitted in September 2018 and results published in March 2019 placed us 280 out of 445 organisations. We are working on improving this for 2019/20.

Our Trust is a founder member of a Derbyshire-wide LGBT network with Derbyshire's fire, police and ambulance services as well as Derbyshire County Council and the University of Derby. We participated in a second network conference in June 2019.

We undertook a dementia strategy review to promote a dementia-friendly environment within our older people's mental health service.


The DCHS Way
Our values
Getting the basics right • Act with compassion and respect • Make a difference • Value and develop teamwork • Value everyone's contribution because everyone matters
Inclusion & Fairness @DCHS
Sexual Orientation
Race & Ethnicity
Economic & Social Disadvantage
Gender
Age
Religion, Belief & Spirituality
Disability
Improving
Person Centred
Health & Wellbeing

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 2018/19.

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 2018/19 the Board membership consisted of the following executive directors:

Name	Title	Date
Tracy Allen	Chief executive	1 April 2018 to 31 March 2019
Kirsteen Farrar	Associate director of corporate governance	1 April 2018 to 31 March 2019
William Jones	Chief operating officer Acting deputy chief executive	1 April 2018 to 31 March 2019 1 April 2018 to 31 August 2018
Rick Meredith	Medical director	1 April 2018 to 31 March 2019
Amanda Rawlings	Director of people services and organisational effectiveness	1 April 2018 to 31 March 2019
Chris Sands	Director of finance and strategy/deputy chief executive Acting chief executive	1 April 2018 to 31 March 2019 1 April 2018 to 31 August 2018
Carolyn White	Chief nurse/director of quality	1 April 2018 to 28 February 2019
Michelle Bateman	Chief nurse/director of quality	18 February 2019 to 31 March 2019
Jo Hunter	Acting chief nurse	1 April 2018 to 30 June 2018
Cath Benfield	Acting director of finance	8 May 2018 to 31 August 2018

The Board included the following non-executive directors: Prem Singh (chairman); Chris Bentley (non-executive director until 31 October 2018); Nigel Smith (non-executive director and vice chairman), Ian Lichfield (non-executive director); James Reilly (non-executive director) and Kaye Burnett (non-executive director), Joy Hollister (non-executive director from October 2018), Kay Fawcett (non-executive director from October 2018), Julie Holder (non-executive director from October 2018).

In addition there are two non-voting associate directors in attendance: Jim Austin (associate director of transformation and IT) and Tim Broadley (associate director of strategy) and an associate non-executive director, Richard Harcourt, from September 2018.

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 monthly public Trust Board meetings to influence discussion and raise awareness of constituents' views.

Other feedback channels and engagement opportunities for our members and governors are routinely publicised via our regular membership communications, for example, participation in PLACE (patient led assessments of the care environment) visits and 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 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 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 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 and three appointed governors from partner organisations. Attendance at meetings is listed in the next table.

During 2018/19 the Council of Governors met six times:

- Wednesday 9 May 2018
- Wednesday 11 July 2018
- Wednesday 12 September 2018
- Wednesday 14 November 2018
- Wednesday 9 January 2019
- Wednesday 13 March 2019.

Governors' statutory roles include:

- Appointing and removing the chair and other non-executive directors

- Agreeing the terms and conditions of the chair and the other 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 back 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 2018 to 31 March 2019, are listed in this table:

Elected public governor	Constituency	Term of office began	Term of office ends	Attendance (actual/possible)
Peter Ashworth	Amber Valley, Erewash & South Derbyshire	1 November 2014 (first term) 1 November 2017 (Second term)	31 October 2020	4/6
Valerie Broom		1 November 2014 (first term) 1 November 2016)	31 October 2019	3/6
Paul Gibbons		1 November 2017	31 October 2019	4/5
Paul Mason		1 November 2016	31 October 2019	3/6
Kevin Miller		1 November 2017	31 October 2020	3/6

Terence Watson		1 November 2017	31 October 2020	6/6
Janet Hitchenor	Bolsover, Chesterfield & North East Derbyshire	1 November 2016	31 October 2019	5/6
Julian Miller		1 November 2016 (first term) 1 November 2017 (second term)	31 October 2020	5/6
Julia Ward		1 November 2017	31 October 2020	1/6
Lynn Walshaw		1 April 2018	31 October 2020	4/6
Jacqueline Healy		1 April 2018	31 October 2019	3/6
Ann Button	Derbyshire Dales & High Peak	1 November 2016	31 October 2019	5/6
Andrea Cooke		1 November 2014 (first term) 1 November 2016 (second term)	31 October 2019	6/6
John Dick		1 November 2017	31 October 2020	5/6
Helen Knight		1 November 2017	31 October 2020	6/6
Bernard Thorpe	City of Derby	1 November 2014 (first term) 1 November 2017 (second term)	31 October 2020	4/6
David Boddy	Rest of England	1 April 2018	31 October 2020	5/6
Elected staff governor	**Constituency**	**Term of office began**	**Term of office ends**	**Attendance (actual/possible)**
Hannah Edwards	A&C & managers	1 November 2017	31 October 2020	6/6
Wendy Hodgkinson	Healthcare support staff	1 November 2016	31 October 2019	4/6
Jennifer Kirk	Healthcare support staff	1 April 2018	31 October 2020	6/6
Veronica Hunting-Young	Nursing	12 March 2015 (first term) 1 November	31 October 2019	5/6

		2016 (second term)		
Lynne Bakewell	Other registered professionals	1 November 2016	31 October 2019	5/6
Sara Nash	Other registered professionals	1 November 2014 (first term) 1 November 2017 (second term)	31 October 2020	6/6
Alex Carberry	Dental and medical	1 April 2018	31 October 2020	3/6

The following governors resigned from their post during 2018/19:

Elected public governor	**Constituency**	**Term of office began**	**Term of office ends**	**Attendance (actual/possible)**
Merrilee Briggs	City of Derby	1 November 2017	Removed from Council 9 May 2018	0/1
Elected staff governor	**Constituency**	**Term of office began**	**Term of office Ends**	**Attendance (actual/possible)**
Louise Holmes	Facilities and estates	1 November 2016 (First term) 1 November 2017 (Second term)	Resigned 10 January 2019	1/4
Melanie Baker-Hunt	Nursing	1 November 2017	20 June 2018	1/1
Janine McKnight-Cowan	Nursing	1 November 2016	20 July 2018	1/2
Nominated governor	**Constituency**	**Term of office began**	**Term of office ends**	**Attendance (actual/possible)**
Carol Hart	Derbyshire County Council	1 September 2017	25 June 2018	0/1
Jenny Swatton	Southern Derbyshire Clinical Commissioning Group	22 September 2015	30 September 2018	1/3

Three seats were vacant within the financial year. In accordance with Section 5.3 of the constitution, the vacancies were offered to the candidate who was ranked next highest in the last election for the relevant constituencies. The following successful candidates were announced:

Elected public governor	Constituency	Term of office began	Term of office ends
Ian Beck	City of Derby	24 May 2018	31 October 2019
Elected staff governor	**Constituency**	**Term of office began**	**Term of office ends**
Emma Morris	Nursing	21 June 2018	31 October 2019
Katie Andrew	Nursing	21 July 2018	31 October 2019

Two nominated governor seats became vacant following resignations. The relevant organisations appointed the following replacements:

Nominated governor	Constituency	Term of office began	Term of office ends
Stuart Swann	Derbyshire County Council	4 July 2018	N/A
Dr Katherine Bagshaw	Derbyshire Clinical Commissioning Group	1 October 2018	N/A

Governor elections

No elections were undertaken during 2018/19. The January 2019 Council of Governors, agreed to hold the vacancy in the facilities and estates constituency until the summer 2019 elections.

The March 2018 Council of Governors agreed for the amendment to the appointed Governors to reflect the increasing partnership with the Derby City Council. During the year, the city council members considered the vacancies they held and opted not to appoint to this position at present. Agreement was made for the vacancy to be left unfilled and to be discussed further at Derby City Council's May 2019 meeting.

Contacting the Council of Governors

Members and the public can contact the Council of Governors via email: 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 for 2017/18, 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 feedback from the Care Quality Commission, 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** discussed how to build clear engagement with members, public and patients and provided feedback regarding communications with the membership; agreed the contents and format of the membership leaflet and reviewed the NHS Staff Survey results to discuss the best way to communicate and engage with staff.

Governors were also involved and gained insight into many different activities across the organisation. Some of these were:

- Participation in insight visits to our wards and community teams
- Involvement in important internal groups such as the clinical effectiveness group and patient engagement and experience group

- Participation in PLACE (patient led assessments of the care environment)
- Attendance at meetings and workshops regarding the system transformation programmes for integrated services in north and south Derbyshire
- Providing a governor perspective for our initiatives and events.

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, Frontline Care Council and Team Talks.

Constitution

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

Nominations and Remuneration Committee

In 2018/19 the committee oversaw the recruitment process for the appointment of three non-executive directors. The committee approved the use of a recruitment agency for the appointment process and, after a tender process, Harvey Nash was selected.

There then followed a long listing panel, short listing panel and formal interview panel which including our chairman, acting chief executive, lead governor, staff governor and a stakeholder interview panel including executive and non-executive directors and governors.

As a result of this process, the following non-executive directors were appointed:
Joy Hollister
Julie Houlder
Kay Fawcett.

In addition during the process a candidate had been interviewed who had significant expertise in Lean methodologies, which the interview panel had identified would be

of considerable benefit to DCHS. Richard Harcourt was therefore offered the position of associate non-executive director in September 2018.

Other duties of the committee during the year 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 to 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 Nigel Smith 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 2018/19

- 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
- Participation in workshops, which included strategic developments and membership engagement
- Attendance at national conferences.

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 2018 – March 2019
Prem Singh (chairman)	4/6
Tracy Allen (chief executive)	4/6
Chris Bentley (non-executive director)	1/4
Kaye Burnett (non-executive director)	4/6
Kirsteen Farrar (associate director of corporate governance)	6/6
Kay Fawcett (non-executive director)	2/3
Richard Harcourt (associate non-executive director)	4/4
Joy Hollister (non-executive director)	2/3
Julie Houlder (non-executive director)	2/3
William Jones (chief operating officer)	5/6
Ian Lichfield (non-executive director)	1/6

Rick Meredith (medical director)	3/6
Amanda Rawlings (director of people services and organisational effectiveness)	3/6
James Reilly (non-executive director)	3/6
Chris Sands (director of finance and strategy/deputy chief executive)	4/6
Nigel Smith (non-executive director)	6/6
Carolyn White (chief nurse/director of quality until 28 February 2019)	4/5
Michelle Bateman (chief nurse/director of quality from 18 February 2019)	1/1

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

		April 2018	May 2018	June 2018	July 2018	September 2018	October 2018	November 2018	December 2018	January 2019	February 2019	March 2019
Prem Singh	Chairman	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tracy Allen	Chief executive	x	x	x	x	✓	✓	✓	✓	✓	✓	✓
Chris Bentley	Non-executive director	✓	✓	✓	x	✓	✓					
Kaye Burnett	Non-executive director	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	✓
Kirsteen Farrar	Associate director of corporate	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

		April 2018	May 2018	June 2018	July 2018	September 2018	October 2018	November 2018	December 2018	January 2019	February 2019	March 2019
	governance											
Kay Fawcett	Non-executive director						✓	✓	✓	✓	✓	✓
Richard Harcourt	Associate non-executive director					✓	✓	✓	✓	✓	✓	✓
Joy Hollister	Non-executive director						✓	✓	✓	✓	✓	✓
Julie Houlder	Non-executive director						✓	✓	✓	✓	✓	x
William Jones	Chief operating officer	✓	x	✓	✓	x	✓	✓	✓	✓	✓	✓
Ian Lichfield	Non-executive director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rick Meredith	Medical director	✓	✓	✓	x	✓	✓	✓	✓	x	✓	x
Amanda Rawlings	Director of people & organisational effectiveness	✓	✓	x	✓	x	✓	✓	✓	✓	✓	✓
James Reilly	Non-executive director	✓	✓	x	✓	✓	✓	x	✓	✓	✓	✓
Chris Sands	Director of finance and strategy/deputy chief executive	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	x
Nigel Smith	Non-executive director	✓	✓	✓	✓	x	✓	✓	x	✓	x	✓
Carolyn White	Director of quality & chief nurse	x	x	x	x	✓	✓	✓	✓	✓	✓	
Michelle Bateman	Director of quality & chief nurse (From 18th February 2019)										✓	✓

Audit and Assurance Committee

The Audit and Assurance Committee, chaired by Nigel Smith, 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. Our internal clinical audit function is described in more detail in the quality report.

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.

Audit and Assurance Committee members attendance		20 April 2018	21 May 2018	23 May 2018	20 July 2018	19 October 2018	25 January 2019
Nigel Smith	Chair, non-executive director	✓	✓	✓	✓	✓	✓
Ian Lichfield	Non-executive director	✓	✓	✓	✓	✓	✓
Kaye Burnett	Non-executive director	✓	x	x	✓	✓	x
Julie Houlder	Non-executive director					✓	✓

Audit and Assurance Committee other attendees		20 April 2018	21 May 2018	23 May 2018	20 July 2018	19 October 2018	25 January 2019
Cath Benfield	Acting director of finance		✓	✓	✓		
Kirsteen Farrar	Associate director of corporate governance	✓	✓	✓	✓	✓	✓
Jo Hunter	Acting chief nurse	✓	✓	✓			
Rick Meredith	Medical director	✓	x	x	x	x	x
Chris Sands	Director of finance and strategy/deputy chief executive. Acting chief executive 1.04.18 to 31.08.18	x	✓	✓	x	✓	✓
Carolyn White	Chief nurse/director of quality	x	x	x	✓	✓	✓

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.

Nominations and Remuneration Committee members attendance		24 April 2018	26 June 2018	11 July 2018	11 Sept 2018	30 October 2018	21 February 2019
Prem Singh	Chair, non-executive director	✓	✓	✓	✓	✓	x
Bernard Thorpe	Public governor - City of Derby	✓	✓	✓	✓	✓	✓
Julian Miller	Public governor - Bolsover, Chesterfield and North East Derbyshire	✓	x	✓	✓	✓	✓
Hannah Edwards	Staff governor – administrative, clerical and managers	✓	✓	✓	✓	x	✓

Nominations and Remuneration Committee members attendance		24 April 2018	26 June 2018	11 July 2018	11 Sept 2018	30 October 2018	21 February 2019
Terence Watson	Public governor – Amber Valley, Erewash and South Derbyshire	✓	✓	✓	✓	✓	✓
David Boddy	Public governor – Rest of England		✓	x	✓	✓	✓

(Blue boxes denote times at which individuals were not in post)

Nominations and Remuneration Committee other attendees		24 April 2018	26 June 2018	11 July 2018	11 Sept 2018	30 October 2018	21 February 2019
Kirsteen Farrar	Associate director of corporate governance	✓	✓	x	x	✓	✓
Nigel Smith	Non-executive director		✓				
Kaye Burnett	Non-executive director						✓

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.

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

Chris Sands joined us in August 2011. He is responsible for finance, performance 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 20 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.

Associate director of corporate governance: Kirsteen Farrar

Kirsteen Farrar has worked for us since our inception and previously held a similar role within NHS Derbyshire County Primary Care Trust. She is our appointed Freedom to Speak Up guardian to ensure a culture of speaking up is embedded throughout the organisation.

She started her NHS career in 1983 as a graduate trainee in human resources in Manchester, followed by HR roles in Sheffield and Derby. She has also worked in primary care development, clinical governance and training and development within the NHS in Derbyshire. Kirsteen is a graduate of the Institute of Personnel and Development and has an MSc in healthcare governance. She is a non-voting member of the Trust Board.

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. 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: Rick Meredith

Rick Meredith joined us in December 2012 following a secondment to us. He was appointed clinical director for the integrated community based services division and was our acting medical director from September 2013 until his substantive appointment in November 2014.

Rick has a background in primary care and was a GP in Chesterfield from 1984 to November 2011. Rick has a specific interest in care of the elderly and is very involved in working with partner organisations to integrate and improve services for patients.

Director of people and organisational effectiveness: Amanda Rawlings

Since September 2016 Amanda Rawlings has been in a shared post as the director of people and organisational effectiveness with Derbyshire Healthcare NHS Foundation Trust.

Amanda was appointed as director of human resources and organisational effectiveness with us in April 2011. She was previously the director of human resources and organisational development across NHS Derbyshire County Primary Care Trust and Derbyshire Community Health Services as one statutory organisation.

Amanda joined the NHS in April 2007, having previously spent her career in the private sector; mainly for Caterpillar, Perkins Engines Co Limited and British Sugar.

She has an MSc in management, is a fellow of the Chartered Institute of Personnel and Development and a co-optee of a Peterborough housing association, Cross Keys Homes.

Chief nurse/director of quality: Carolyn White (until 28 February 2019)

Carolyn White retired as our director of quality/chief nurse in February 2019, having held the role since September 2013, following a successful secondment into the post.

She is a registered sick children’s nurse and registered general nurse, specialising in children’s intensive care. Her clinical roles include ward sister in paediatric intensive care at Great Ormond Street Hospital for Sick Children and research nurse for the British Heart Foundation.

Her NHS management career started in 1992 at Royal Hull Hospitals NHS Trust. From 2001 to 2013 she was an executive director for Sherwood Forest Hospitals NHS Foundation Trust, serving as nurse director, and then interim chief executive for nearly two years. She has an MSc in health services research.

Chief nurse/director of quality: Michelle Bateman (from 18 February 2019)
Michelle Bateman trained at St Bartholomew's Hospital, London, having spent time as a nurse auxiliary at City Hospital, Nottingham, whilst attending college. She is trained in midwifery and health visiting and also spent time as a locality manager, which included developing services for older people.

Since 2000 she has held various posts in clinical leadership, quality, risk management and patient experience and gained an MSc in Health Policy in Organisations in 2002. She joins us from Nottinghamshire where she was associate director of nursing for community and mental health services.

Michelle is a Queen's Nurse, regional lead (Midlands and East) for the Chief Nursing Officer's Black and Minority Ethnic Strategic Advisory Group and vice chair of Tuntum, a BME independent housing association in Nottingham.

Board members – non-executive directors

Chairman - Prem Singh
Prem Singh joined us as our chair on 1 December 2013 and for the past year he has also been chair of George Eliot Hospital NHS Trust. He has operated at Board level positions for nearly 30 years and has an operational management and clinical background in health and social care services.

As an experienced chair and previously a chief executive, Prem has extensive expertise in leading high performing organisations. He is politically astute with highly developed leadership and influencing skills and strives to harness whole system leadership. He is an experienced mentor and a qualified ILM 7 executive coach.

He is currently the senior independent trustee on the NHS Confederation Board and a member of the Chairs' Advisory Group of 25 chairs nationally hosted by the chairman of NHS Improvement. He was previously appointed to be the inclusive leadership lead on the National Leadership Council and named a top 50 BME pioneer, in the inaugural HSJ listing.

Prem has worked in the NHS in Derbyshire in senior leadership positions for almost 20 years and has credible relationships with leaders within the health and care sector. Having built on a strong and lasting affiliation with Derbyshire, he holds a

compelling desire and a sense of duty, to help shape health and care services for present and future generations alike. Originally from Malaysia, Prem is proud to have been part of the NHS' journey for the past 43 years, from student nurse to now chair.

Non-executive director: Chris Bentley (until 31 October 2018)
Chris Bentley is a fellow of the Royal College of Physicians and a fellow of the Faculty of Public Health. He qualified as a doctor in 1977 and worked in London teaching hospitals for five years before joining the emergency refugee programme in Somalia, as a government advisor on behalf of UNICEF on issues of primary health care.

On return to the UK, he held directorships in public health in West Sussex, Sheffield and South Yorkshire, and headed up the health inequalities national support team for the Department of Health until 2011. Chris was awarded a visiting chair in public health at Sheffield Hallam University in 2007. He is an independent consultant with contracts in the UK and Europe. In 2014 he was appointed to the national Advisory Committee on Resource Allocation (ACRA).

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. He chairs our Quality Business Committee and sits on the Audit and Assurance Committee.

Non-executive director: Nigel Smith (until 31 March 2019)
Nigel Smith joined us in April 2012. He is a member of the Chartered Institute for Public Finance and Accountancy and has an honours degree in economics from Lancaster University. He worked in a variety of senior executive roles in the Post Office, Consignia and Royal Mail for over 30 years, including regional director of

finance, head of shared services, head of health and safety and head of occupational health.

He has been our senior independent director since April 2016 and our vice chair since April 2017. He chairs our Audit and Assurance Committee. He is treasurer at Age UK in Sheffield.

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 and international companies.

She has an MSc in human resources development, worked for the UK's leading human resourcing organisation, and has continued to focus on leadership development, coaching, employee communication and change management, including as a policy adviser at national and international level. She is a director of the Medical and Health Coaching Academy and visiting lecturer at Sheffield Hallam University. She is a former chair of Health Education East Midlands and led a transformational programme called Better Care Together in Leicester, Leicestershire and Rutland. She chairs our Quality People Committee.

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).

He is a member of the Trust's Quality Services Committee and chairs our Mental Health Act Committee which works to safeguard the interests of all people detained under the Mental Health Act 1983.

Non-executive director: Kay Fawcett (from 1 October 2018)
Kay Fawcett joined us on 1 October 2018. Kay has 41 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 also a non-executive director with the Royal College of Nursing's publishing arm, RCNi, a role she has held for five years. She also works with Health Education England on development of the unregistered workforce and with Helpforce, the national charity supporting the involvement of volunteers in health and care. Kay chairs our Quality Services Committee.

Non-executive director: Julie Houlder (from 1 October 2018)
Former West Midlands Centro executive Julie Houlder 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 for four years 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. She is also a director of Windsor Academy Trust and a member of their Finance Committee.

Non-executive director: Joy Hollister (from 1 October 2018)
Former Derbyshire County Council executive Joy Hollister was the strategic director of adult care and public health 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.

Associate non-executive director: Richard Harcourt (from September 2018)
Former Derby-based Rolls-Royce director Richard Harcourt 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.

Richard, from Warwickshire, manages Broadstreet RFC rugby team, who compete at national level.

Evaluation

As well as the external review which we commissioned from Deloitte on our well led framework, (which we discuss in more detail in the Directors' Report, Annual Governance Statement and in the Quality Report), we have undertaken significant internal 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 **30 November 2020** (with effect from 1 December 2017)
Chris Bentley	Non-executive director	21 November 2011	20 November 2015 21 May 2015 given extension to 31 October 2017 1 March 2017 given 12 months extension to **31 October 2018**
Nigel Smith	Non-executive director	1 April 2012	31 March 2016 21 May 2015 given extension to 31 March 2018 1 March 2017 given 12 months extension to **31 March 2019**
Ian Lichfield	Non-executive director	1 April 2015	31 March 2018 1/3/17 second term of office agreed to **31 March 2021**
Kaye Burnett	Non-executive director	1 August 2016	31 July 2019

James Reilly	Non-executive director	1 December 2016	30 November 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	Non-executive director	1 October 2018	30 September 2021
Richard Harcourt	Associate non-executive director	1 September 2018	31 August 2019

Our membership

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

In 2018/19 wheelchair services were re-tendered and are now no longer provided by us. As a result our staff membership figures were reduced by 23.

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 the year public members of the Trust have been invited to join our readers' panel. The panel comments on documents and patient information before it is published. Members were also involved in our PLACE visits (patient led assessments of the care environment) across our sites during March, April and May. We initially approached individuals who were trained and involved in the visits in previous years, before also opening up the opportunity to other members.

Consultation events were held around the redevelopment of healthcare facilities in Derbyshire during the year which were publicised directly to members, as well as to the general public, as opportunities to give their views.

During 2018/19 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 (1,049,000 https://observatory.derbyshire.gov.uk/population-estimates/) and our membership remains above the 1% target, with 12,009 public members and 4,313 staff members, as at 31 March 2019.

During 2018/19 we undertook to maintain these membership levels and to ensure our membership remained representative of our communities. This is measured and reported every month to the Trust Board.

Membership and engagement is reported through the Council of Governors to Board. The Governors' Membership and Engagement Sub Group proactively looks at relevant activities including input to our members' magazine. One of our priorities for this year is a refresh of our membership strategy which will include actions to address membership recruitment and engagement in any areas of the population which are under-represented.

We have attended faith tours and various other community meetings/health related events and recruited new members as a result. We routinely promote membership through our social media channels, external website and via leaflets and posters at our NHS sites.

The Board of Directors monitor how representative our membership is by:

- Receiving details about the membership as part of performance reporting
- Approving the membership strategy and monitoring progress against it.

The Board of Directors monitor the level and effectiveness of member engagement via:

- Its established sub-committee reporting structure
- Via the governor engagement sub-group which meets every two months.

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 2018/19

Our membership stands at 16,322 members, comprising 12,009 public members and 4,313 staff members* (figures accurate on 31 March 2019). See below for a breakdown of constituencies in both public and staff membership and an illustration of constituency boundaries.

Membership profile by constituency (March 2019)

Public	
Amber Valley, Erewash and South Derbyshire	3177
Bolsover, Chesterfield and North East Derbyshire	2679
City of Derby	2259
Derbyshire Dales and High Peak	1318
Rest of England	2576
Total	**12,009**

Staff	
Medical and dental	77
Nursing	1306
Other registered professionals	691
Administrative, clerical and managers	856
Healthcare support staff	969
Facilities and estates	414
Total	**4,313**

***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.

Chris Sands
Acting Chief Executive **22 May 2019**

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
Trust members and members of the public who wish to contact the Council of Governors can do so via email**:** DCHST.Governors@nhs.net

Constituency boundaries

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

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.
Telephone: 01773 525065 Email: dchst.members@nhs.net

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, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, 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 financial statements on a going concern basis.

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 him/her 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.

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

Chris Sands
Acting Chief Executive **22 May 2019**

Annual Governance Statement 1 April 2018 – 31 March 2019

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 2019 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

Derbyshire Community Health Services NHS Foundation Trust's 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 and a formal and rigorous evaluation of Board effectiveness has been undertaken.

3.3 The chief executive has overall responsibility for the management of risk by the Trust. The director of quality/chief nurse 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 takes the lead committee role for ensuring the risk register is robust. The committee reviews the "Top X" risk register at every meeting, and undertakes quarterly reviews of the full risk register.

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.

3.10 Staff are equipped to manage risk in a variety of ways and at different levels of strategic and operational functioning. These include:

- Formal in-house training for staff as a whole in dealing with specific everyday risk, e.g. fire safety, health and safety, moving and handling, infection control, information governance and security
- 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 quarterly 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 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 is through inspections – such as, environmental, infection control, security, workplace and fire safety – and through the health and safety and clinical governance activities.

4.6 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 Impact Assessments on all functions it carries out to ensure that service delivery and employment practices comply with legal requirements.

4.7 The Trust involves key stakeholders 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)
- Local Health Providers
- Local Authorities (LAs)
- Improvement and Scrutiny Committee (ISC)
- Health and Wellbeing Boards
- Care Quality Commission (CQC)
- NHS England
- NHS Improvement
- Healthwatch.

4.8 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).

4.9 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.

4.10 The mitigation of strategic risks have 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.

4.11 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.

4.12 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.

4.13 The recommendations from internal audit reports are tracked by the Audit and Assurance Committee to ensure prompt implementation. During the year there was one high risk recommendation identified. Although the Trust uses standard NHS terms and conditions for contracts which have been updated for General Data Protection Regulation (GDPR), the Trust does not having a process in place for undertaking appropriate ongoing due diligence on GDPR compliance of all Trust contracts. The Procurement Manual will be updated to reflect the new process and implementation will be monitored and evidenced by the Head of Procurement.

4.14 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.

4.15 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.

4.16 The Board of Directors uses the assurance framework to provide assurance when signing declarations to third parties.

4.17 The Directors are required to satisfy themselves that the Trust's Annual Quality Account is fairly stated. In doing so the Trust is required to put in place a system of internal control to ensure that proper arrangements are in place. The Trust has appointed a member of the Board, the Director of Quality / Chief Nurse, to lead, and advise on all matters relating to the preparation of the Trust's Annual Quality Account. To ensure that the Trust's Quality Account presents a properly balanced view of performance over the year, the Quality Services Committee provides scrutiny and challenge over Trust clinical performance. The Trust also has quarterly Quality meetings with its main commissioner.

4.18 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.

4.19 The Trust routinely reports on data quality to the Board of Directors on a monthly basis as part of its performance Dashboard. The Audit and Assurance Committee provides Board oversight of data quality and monitors implementation of the data quality improvement plan on a bi-annual basis.

The Information Management and Technology (IM&T) Group has lead responsibility for data quality.

4.20 The Quality People Committee provides oversight and scrutiny of the Trust's Workforce Plan. 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. 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 4500 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 consistently achieved its NHSI agency staff usage target over the past few years and reports its Safe Staffing data to NHS England on a monthly basis. 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.

4.21 The Trust has a process in place for the revalidation of medical staff. This process is overseen by the Medical Director.

4.22 The Trust also has a process for the revalidation of nurses which is overseen by the Chief Nurse 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 Chief Nurse / Director of Quality. This process is overseen by the Chief Nurse/Director of Quality.

4.23 The Trust has a Raising Concerns Policy in place. The policy sets out how these concerns will be investigated. The Trust has also developed a "Raising Concerns the DCHS Way" App.

4.24 Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

4.25 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 in to 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.

4.26 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 Adaption Reporting requirements are complied with.

4.27 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.

4.28 The foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

4.29 The Trust has published an up to date register of interests for decision making staff within the past 12 months, as required by the “Managing Conflicts of Interest in the NHS” guidance.

4.30 For the financial year 2018/19, PwC are the Trust’s external auditors and KPMG are the internal auditors and providers of Counter Fraud services.

4.31 The Trust has a Director responsible for Security Management and has access to a Local Security Management Advisor as required by NHS Protect. The Quality Business Committee receives an assurance report with progress against the plan.

4.32 There has been one serious clinical incident in year that was classed as a No Harm Never Event. A patient had entered first stage recovery area in paediatric theatres following completion of dental treatment under general anaesthetic. Examination of the mouth after removal of the laryngeal mask revealed the presence of one green throat pack on the patient’s tongue. This was immediately removed from the mouth, and the mouth was checked visually by the dentist and the anaesthetist for the presence of any other remaining packs, none were found. The patient was then moved into second-stage recovery area once sufficiently awake and no further intervention was required. No patient harm was caused. A full root cause analysis of this incident has been completed, and lessons learnt.

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. More information about KPIs can be read in our Quality Report.

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 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.

5.4 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 one data security breaches at Level 2, which was reported to the Information Commissioner. In September 2018 a member of staff's car was stolen from their driveway. In the boot of the car was an encrypted laptop and paper documentation containing patient names and task details, but no full health records. All patients that could be identified as possibly affected were contacted to inform them of the incident. The car was subsequently found by the police and all paper documentation recovered.

6.5 Where Level 2 incidents do occur, these are reviewed through the Information Governance Group so that learning can be shared and actioned.

7 Annual Quality Report

7.1 The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of Annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

7.2 The Directors are required to satisfy themselves that the Trust's Annual Quality Report is fairly stated. In doing so the Trust is required to put in place a system of internal control to ensure that proper arrangements are in place. The Trust has appointed a member of the Board, the Director of Quality/Chief Nurse, to lead and advise on all matters relating to the preparation of the Trust's Annual Quality Report.

7.3 To ensure that the Trust's Quality Report presents a properly balanced view of performance over the year, the Quality Services Committee provides scrutiny and challenge over Trust clinical performance. The Trust also has quarterly Quality meetings with its main commissioner, and submits quarterly information to Monitor as part of the Governance Risk Rating review.

7.4 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, such as elective waiting time data, are reviewed through management and audit resource. Progress with improving data quality is reported 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 the content of the quality report attached to this Annual report and other 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 2018 to 31st March 2019 is as follows: **Significant assurance can be provided that there is a generally sound system of internal control, designed to meet the organisations objectives, and that controls are generally being applied consistently.**
- 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 Care Quality Commission (CQC) inspection of our services in May 2016, which resulted in an overall rating of "Good", and their unannounced visits and reports in 2018/19, provides me with assurance over our clinical 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 Trust "Green" for governance and "low risk" for finances provides me with assurance as to our overall governance systems
- An independent review of leadership and governance across the Trust by Deloitte, using the Well Led Framework, provides me with assurance that it is effective. In particular, Deloitte noted the following areas of good practice:
    - Strongly embedded vision and values
    - A highly respected Executive Team
    - Positive culture
    - Focus on assurance and risk management.
- The work of our external auditors to review the arrangements in place for producing the quality report, and to advise us of best practice to inform our development in this area, provides me with assurance
- 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
- The quarterly governance returns to the Board provide me with assurance that the trust met the requirements of its License conditions
- Our performance, in keeping our spend significantly below our agency cap issued by NHS Improvement for 2018/19, provides me with assurance that controls are robust and we are using resources effectively
- 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.

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)*

Chris Sands
Acting Chief Executive

Derbyshire Community Health Services
NHS Foundation Trust

Derbyshire Community Health Services

NHS Foundation Trust

Annual Quality Report 2018/19

Contents

PART 1 - INTRODUCTION

Welcome to the 2018/19 annual quality report

It is my pleasure to introduce our annual quality report for 2018/19. This report describes in detail the work we have been undertaking during the year to improve the quality of the services we provide and achieve our vision of being the best provider of local healthcare and a great place to work.

Within our clinical strategy 2018, the term Quadruple Aim is used to describe a vision of 'simultaneously improving the health of the population, enhancing the experience and outcomes of the patient, and reducing the per capita cost of care for the benefit of communities; whilst ensuring staff have the best possible experience of work.' This provides a framework for the work described within this quality account.

2018/19 has seen increasing pressure on our health and social care community. We continue to be challenged with increasing patient numbers and pressure on our resources and therefore it becomes more and more important that we have a strong focus on quality assurance and continuous quality improvement.

During the year we have continued to embed our Quality Always clinical assessment accreditation programme and it is always rewarding to hear the patient focused initiatives teams have led to achieve their gold awards. This programme allows us to drive quality improvements from a frontline service level and ensure that changes are sustainable. 2018/19 saw the creation and launch of the DCHS Quality Improvement Faculty which to date has 75 members. The faculty are colleagues from all parts of DCHS who have an interest in, and dedication to improving services for our patients.

The management of chronic wounds including pressure ulcers, leg ulcers, diabetic foot wounds and complex surgical wounds continues to utilise a significant amount of our community nursing teams and it is therefore gratifying to see the impact that the introduction of the Time to Heal chronic wound management programme is having on patients and staff. The programme was the overall winner of the 2018 Leading Healthcare Award.

Other highlights of the year have included:

- 98.3% of the 26,778 patients we surveyed recommending our Trust to their family and friends

- Achieving a score above the national average for all six elements of the patient led assessments of the care environment (PLACE) audit
- Our Time to Heal programme tackling chronic wounds and in particular significantly reducing healing times for patients with debilitating leg ulcers
- Implementing the agreed changes following the Clinical Commissioning Group led Better Care Closer to Home consultation, minimising the impact of change on patients, their families and our staff
- Once again being recognised as a great place to work, as reported by our staff within the national NHS Staff Survey where our colleagues reported performance that was average or above average against 9/10 key areas, compared with our peer community trusts
- A score of 7.2 out of 10 for overall staff engagement compared to a national average for community trusts of 7.1 out of 10, despite the significant changes in services in year
- The launch of the new staff wellbeing strategy aiming to create a step change for staff experience at DCHS. The strategy focuses on three key areas; prevention, resilience and support.

This report reflects on our achievements and challenges in improving quality during 2018/19 and where we have not always got things right how we have learned from this.

We hope that you will agree that much progress has been made as a result of the great commitment of our staff and I would like to take this opportunity to recognise and thank them for their continued dedication.

As we look forward to 2019/20 we recognise that there continues to be significant change ahead and an ongoing fiscal challenge. We will continue to strive to improve services for our local people and support our most valuable asset, our staff.

Quality Always, our clinical quality assessment and accreditation programme and Outstanding Way, our approach to service improvement, will be fundamental in how we monitor and assess our progress and provide assurance that the Trust continues to provide the very best quality of care for its patients.

Our staff are our greatest asset and we recognise that to provide great services we need to look after them well and to continue to recruit the very best calibre staff. During 2019/20 we will continue to develop our leadership strategy and use the findings from the annual NHS Staff Survey to work with our teams to build on our vision of being a great place to work.

I can confirm on behalf of the Trust's Board that to the best of our knowledge and belief, the information contained in this annual quality report is accurate and represents our performance in 2018/19 and our priorities for continuously improving quality in 2019/20.

Chris Sands, Acting Chief Executive **22 May 2019**

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Part 2 - PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

2.1 Priorities for improvement

This quality report demonstrates our achievements for the year 2018/19, describes the areas where we would still like to make improvements and our quality objectives for the coming year.

Each year Derbyshire Community Health Services NHS Foundation Trust (DCHS) sets itself stretching improvement targets referred to as the Big 9. The Big 9 are split into three domains - Quality People, Quality Service, and Quality Business - in line with the DCHS Way.

During 2018/19 we set three new quality priorities focusing the whole organisation on quality improvement in areas of patient safety, clinical effectiveness and patient experience. Progress on all three objectives was monitored through the Big 9 report section of the performance report to the Board of Directors.

These priorities in detail were:

Priority 1 Patient safety - reduction in the number of chronic leg ulcers being managed across community services through improved training of clinical staff.

Rationale: Audit results and staff activity analysis (BRAVO) have highlighted that leg ulcers account for the most significant element of community nursing team work (10%). Leg ulcers can be very debilitating for patients and if not managed effectively can become chronic in nature, causing loss of independence and costing significant amounts in terms of dressings and staff resources. The tissue viability team has developed a care pathway to ensure that all patients receive optimum treatment.

Target: To train 240 community nurses in optimum leg ulcer management.

Twenty registered community nurses per month to undertake two-day training in the care and treatment of leg ulcers.

Monthly trajectory: 20 nurses per month to successfully complete leg ulcer management training.

Table 1: Monthly trajectory of nurses undertaking training

Month	April	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Number of Attendees	26	30	24	22	20	22	19	26	22	23	19	25	**278**

Priority 2 Clinical effectiveness - To increase the proportion of services adopting patient related outcome measures.

Rationale: 2017/18 was the first year the Trust had worked to develop a broad range of patient related outcome measures with a target of 37 adopting specific measures. Good progress was made during 2017/18 however embedding of this as routine practice has yet to be established.

We are proposing continuing this priority for a second year to ensure that improvements can be sustained.

Target: An additional 45 teams will implement the systematic use of patient related outcome measures.

Table 2: Monthly trajectory for team to implement patient related outcome measures

Month	1	2	3	4	5	6	7	8	9	10	11	12
Trajectory cumulative number of teams including baseline 37 2017/18	Consolidation of year 1 work			40	45	52	55	60	67	70	75	82

Priority 3 Patient experience - To establish breast feeding friendly facilities across our services in Derbyshire and Derby City.

Rationale: The 0-19 year's team have worked hard for us to be recognised as a UNICEF breast feeding friendly organisation and on 7 March 2019 successfully applied for the Quality Always Gold accreditation.

In support of this, and recognising that breast feeding mothers can access any part of our service, we are proposing running an internal breast feeding friendly accreditation scheme. Identified areas would be asked to identify a suitable area to offer a breast feeding mother, reception staff would have support training and on satisfactory completion of both the area would be designated breast feeding friendly and a certificate/poster awarded. This proposal complements our inclusion agenda.

Target: A total of 40 sites based on seven hospitals, 29 health centres and four general practice sites.

- Year end target is to have all 40 sites registered.

Table 3: Monthly trajectory for breast feeding friendly accreditation

April	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Implementation phase			5	8	12	18	23	28	33	38	40	**40**

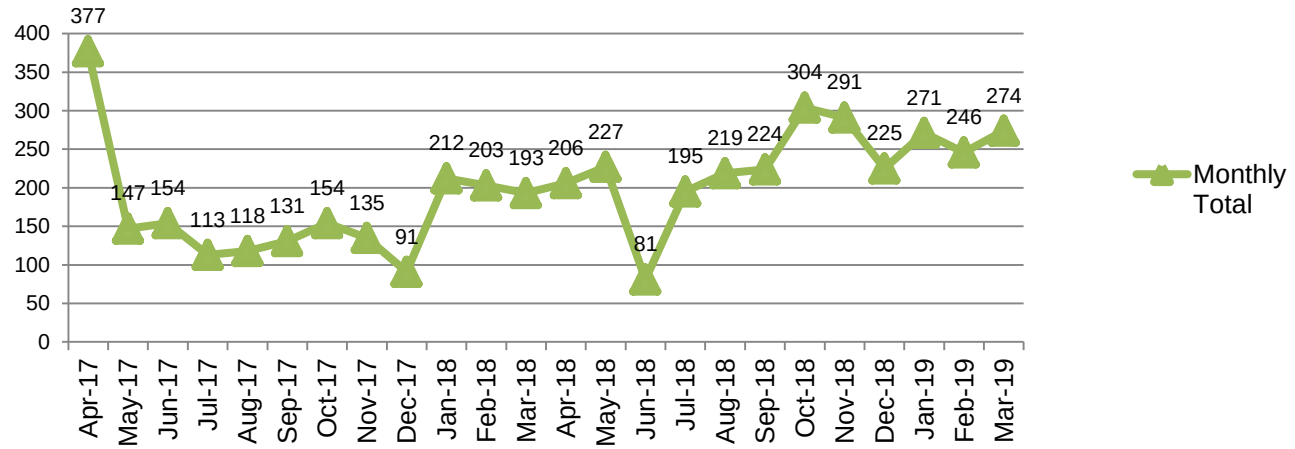
Table 4: Quality Big 3

Quality Big 3	Objective	Priorities	Target	Achieved end Mar	Forecast year end
Quality Service	To deliver high quality and sustainable services that echo the values and aspirations of the community we serve	Targeted increase in community nursing staff trained in best practice management of chronic leg ulcers	240 community nurses to be trained in optimum leg ulcer management	**286 (119%) GREEN**	**286 (119%) GREEN**
		Increase the proportion of services adopting patient related outcome measures	Additional 45 teams will implement the systematic use of patient related outcome measures	**45 (100%) GREEN**	**45 (100%) GREEN**
		Establish breast feeding friendly facilities across our services in Derbyshire and Derby City	40 sites to be registered	**33 (83%) RED**	**33 (83%) RED**

The establishment of 40 breast feeding friendly areas has been impacted by the rationalisation of our estates and we did not achieve this target by year end. This is due to some areas originally identified as patient areas now being decommissioned and not having direct management responsibility of staff in other areas where we work as part of a multi-agency team. Opportunities for new areas to be supported in Baby Friendly status continue to be explored.

One of our targets for 2017/18 was to identify 75% of carers who accessed our services. We actually achieved 70% and PEEG has continued to monitor the number of carers each month that have been identified through SystmOne as can be seen in graph 1 below.

Graph 1: Number of patients who have caring responsibilities identified on SystmOne by month: 2017-2019



2.1.2 Things we want to do better in 2019/20

We are continually striving to improve the quality of the services we provide and to learn from things that did not go so well. In identifying improvement goals for this year we have listened to feedback from our patients, staff and governors about what concerns them and have discussed suggestions made via staff meetings to identify those issues where we feel we can make the most difference. For 2019/20 our Board of Directors has agreed three new strategic quality improvement priorities which will be reported monthly via our Big 9 performance report to Trust Board:

Priority 1 - Patient safety

Improving the identification of sepsis and recognition of the deteriorating patient

Background: Sepsis is a significant cause of death in both adults and children. It is estimated that there are 31,000 cases of severe sepsis in England and Wales every year, and the number of cases is rising. Approximately 30% to 50% of people with severe sepsis will die because of the condition. Recognition of sepsis is an important part of the recognition of the deteriorating patient. NEWS2 has now received formal endorsement from NHS England and NHS Improvement to become the early warning system for identifying acutely ill patients - including those with sepsis - in hospitals in England. It has been agreed that from April 2019 we will be introducing NEWS2 across integrated community services. NEWS2 is based on a simple aggregate scoring system in which a score is allocated to physiological measurements, already recorded in routine practice, when patients present to, or are being monitored in hospital.

Currently community teams have access to all the relevant equipment to undertake NEWS2 with the exception of pulse oximeters which monitor oxygen saturation. The DCHS critically ill patient prevention group has endorsed the move to NEWS2 as it is nationally recognised best practice. The medical devices group is currently working with procurement to source the most effective pulse oximeters for use in the community and the funding has been secured via the capital and estates group.

Proposal: The roll out of the pulse oximeters will take place in Quarter 1 and Quarter 2 of 2018/19 with all being issued to community teams by 30 September 2019.

Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Target	233	233	233	233	233	233

Once the role out and associated training is complete there will be monthly reporting from SystmOne to determine if the provision of this equipment has increased the number of baseline observations recorded, ensuring oxygen saturations are measured in line with NEWS2. The current position is 0% as the equipment is not used in community and it is proposed that a target of 80% is both stretching and reasonable.

Month	Oct-19	Nov-20	Dec -19	Jan-20	Feb-20	Mar-20
Target	13%	26%	40%	55%	70%	80%

A random audit in Quarter 4 of cases where the where NEWS2 was five or more will be undertaken to ensure that the UK Sepsis Trust screening tool was completed and actioned.

Priority 2 Clinical effectiveness

Increasing participation in National Institute for Health Research (NIHR) across DCHS services

Supporting Information:

- Vision for growing DCHS as a 'researching' Trust (DCHS strategy)
- NHS Constitution commitment and pledge 'to inform you of research studies in which you may be eligible to participate'
- Inclusion in CQC monitoring and inspection programme – well led domain requirement for integrated clinical research
- Published evidence around the correlation between involvement in high quality research and better patient outcome
- 87% of patients had a good experience of taking part in research (n = 4,312**).** NIHR Report of the Patient Research Experience Survey 2017/18
- 83% of respondents (public) said that health research is very important (n= 1,014). Survey of the general public: attitudes towards health research 2017 Health Research Authority
- Access to £20,000 incentive funding for organisations, clinical research capability funding, for recruiting minimum 500 participants to NIHR research in a financial year.

Table 5: **Target**: Aspire to recruit minimum 500 participants in total between 01/04/2019-31/03/2020

Month	1	2	3	4	5	6	7	8	9	10	11	12
Target	38	80	122	164	206	248	290	332	374	416	458	500

This is a challenging target and is aimed to achieve the £20,000 research capability incentive. However, it is recognised that this will depend on availability of relevant research studies throughout the year. Therefore a target range of a total annual target between 250 and 500 participants can be set but we would not receive £20,000 if the minimum 500 was not achieved.

In 2017/18, there were 10 potential studies which we could have participated in but were unable to do so for various reasons including a lack of local collaborators and principal investigators. In 2018/19 there are currently 14 studies we could have participated in but have been unable to do so. In 2018/19 we trained 15 research envoys/principal investigators to become research ready.

Process to be set up to support the Big 9

In 2019/20, we will set up a formal (virtual) research review group involving the research champions, research envoys and principal investigators, service managers etc. Every potential NIHR research study will be reviewed formally by the group and cascaded internally to relevant services with the expectation that every relevant research study will be opened in 2019/20 i.e. we will open approximately 10 to 14 new research studies in 2019/20. Each newly opened research study will have an agreed realistic participant recruitment target. Any relevant research studies that are not opened will need to be formally agreed and recorded following acceptance of valid reasons as not being feasible. There will be an expectation for the review of potential studies and expressions of interest to be conducted within two weeks of published deadline. Studies which are opened will need to meet set up target times of 40 days (maximum) and the first participant must be recruited within 30 days of recruitment beginning. All agreed study targets will be monitored for achievement.

Please be aware that we cannot ensure that the studies available to us will be evenly spread across DCHS services. It is likely some services will receive more potential research studies than others.

Priority 3 Patient experience

Improving the dementia friendly environment and culture across DCHS

Background

People with dementia access all services that are provided to adults in Derbyshire. Community services need to be accessible for people whose cognitive and communication abilities are affected by dementia. Services for children are concerned with the whole family, which may include adults with dementia. Dementia affects people in different ways, and there is no single step that will make a service more accessible for all people with dementia. The principle of making services, information and environments more dementia friendly needs to be considered alongside person-centred approaches – asking people 'what matters to you?'

In response to the Healthwatch Derbyshire dementia report (2018) the health, wellbeing and inclusion division proposed to address three aspects of dementia friendly-ness:

- Environments
- Accessible information
- Staff awareness.

DCHS has resources and advice on each of these areas from the dementia lead, care environments lead, patient involvement officer and quality and safe care champions. Although the Big 9 requires a single set of metrics that can be reported on monthly throughout the year, a single approach to improving dementia friendly services is probably not appropriate (there is a different need and baseline for diverse services such as health visiting vs minor injuries units or wards).

Proposal

There are over 100 quality and safe care champions for dementia across our services. We need to cover all services with a dementia champion. This could be achieved by having more champions in services that are regularly used by people with dementia, and champions covering more services where people with dementia are less frequent patients.

1. Target: all services are linked to a dementia champion through Quality Always team. Champions to carry out a brief self-assessment of dementia friendly-ness of their service; environment, information and staff awareness. The self-assessment could include: PLACE assessment criteria, accessible information standard, dementia friends training uptake
2. Target: all champions have completed the self-assessment and agreed an action that will result in improved experience for people with dementia
3. Target: all services have submitted a planned improvement action via their champion
4. Target: champions will audit that their action has been implemented and submit evidence.

Metrics:

Numerator = 97 services

Target = 100% of services (97) will have a completed dementia friendly improvement action by year end.

Metrics: shading has been used to indicate a single reportable measure per month.

Table 6: Targets for dementia friendly improvement action

Month	Baseline Q4	1	2	3	4	5	6	7	8	9	10	11	12
Services with a dementia champion	43	50	70	97									
Services with a dementia friendly improvement action					25	50	97						
Services with a completed dementia friendly action								5	10	20	50	80	97

These 3 indicators will be monitored and reviewed via bi-monthly reports to the Trust Quality Service Committee.

2.2 Statements of assurance from the Board

2.2.1 Contracted services

This section of the report includes text and reports mandated by NHS England and NHS Improvement.

- During 2018/19 DCHS provided and/or sub-contracted 41 relevant health services
- DCHS has reviewed all the data available to them on the quality of care in 100% of these relevant health services
- The income generated by the relevant health services reviewed in 2018/19 represents 100% of the total income generated from the provision of relevant health services by DCHS for 2018/19.

2.2.2 National audits

To ensure that the services we provide achieve meaningful outcomes for patients and carers, we undertake a range of clinical effectiveness activities, and clinical audit is one. Our focus is to ensure that all clinical audit activity results in learning, and improvements in care. Participation in clinical audit enables us to provide effective, responsive and safe care.

During 2018/19 eight national clinical audits and two national confidential enquiries covered relevant health services that DCHS provides.

During that period DCHS participated in 86% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that DCHS was eligible to participate in during 2018/19 are below in table 7.

The national and clinical audits and national confidential enquiries that DCHS participated in during 2018/19 are below in table 7.

The national clinical audits and national confidential enquiries that DCHS participated in, and for which data collection was completed during 2018/19, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The reports of three national clinical audits were reviewed by the provider in 2018/19 and DCHS intends to take the following actions to improve the quality of healthcare provided. See table 7 below for outcomes and actions.

Table 7: National audits

Title	Participated	% submitted	Actions
Learning Disability Mortality Review programme (LeDeR)	Yes	100%	1) Mortality review group (MRG) receives quarterly LeDeR report from the Derbyshire LeDeR steering group 2) Critically ill patient prevention group (CIPP) continuing to scope training for learning disability staff on sepsis 3) DCHS continuing to develop IT updates for identifying patients with learning disability on SystmOne.
National Audit of Care at the End of Life (NACEL)	Yes	100%	Report not available until May 2019
National Audit of Intermediate Care (NAIC)	No	0%	Organisational decision not to take part due to burden it would add to clinicians' work load
National Diabetes Foot Care Audit	Yes	100%	1) Discharge reason: review how this is recorded, including separating DNAs, deaths and outcomes. 2) Deep dive on interval from referral to appointment
National Core Diabetes Audit	Yes	100%	National report not yet available
National Diabetes Transition	Yes	100%	National report not yet available
Sentinel Stroke National Audit programme (SSNAP)	Yes	100%	CCG aware of lack of six month assessment - Derby City ESSD are due to participate in the Compass research study which will explore psychology provision for ESSD for cognitive support - recruitment of staff. Amber Valley, Erewash Team Leader is going to reflect on case studies that were carried on beyond the six week period to demonstrate the gap in specialist services and ongoing therapy patient needs in context of the current waiting times for

Title	Participated	% submitted	Actions
			neurology outpatient services.
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	100%	National enquiry – no report produced
UK Parkinson's Audit: (incorporating occupational therapy speech and language therapy, physiotherapy elderly care and neurology)	Yes	100%	Ensure training package on PD UK is linked to Neuro Portal when this goes live in DCHS. Need to develop PD group in High Peak & Dales. Need to develop and advertise specialist neuro interest group in DCHS to ensure access to specialist advise. Need to clarify and agree consistent process across teams for discharge process. Guidelines for newly diagnosed pathway implemented and follow up audit in 2019 should demonstrate reduction in number of years from diagnosis to therapy intervention. Group agreed that BERG and Lindop should be used as standard OMs for all areas for PT and aim to use PDQ39 for all review patients.

The reports of 22 local clinical audits were reviewed by the provider during 2018/19 and we intend to take the following actions to improve the quality of healthcare provided. See table 8 below for outcomes and actions.

Clinical effectiveness and audit programme 2018/19

The programme of 48 clinical effectiveness projects has progressed well in 2018/19 with 20 projects undertaking a full cycle through to the successful completion of the improvement action plan. The remaining 28 audits are all progressing as planned. The 20 completed projects are listed in table 8 below.

The clinical effectiveness and audit programme consists of clinical projects which review the quality of the services that we provide. These projects include a blended methodology of audit, questionnaire, surveys and focus groups. We compare practice against agreed and recognised standards to ensure our patients receive care of the highest quality. These projects also include participation in the national audit programmes including adult diabetes, diabetic foot care, stroke and dementia. Projects to date include the following:

Table 8: clinical audit programme

	Project Title	Purpose	Outcome	Actions
1	003.3 Q1 2018/19 Controlled drugs audit	To ensure safe storage and management of controlled drugs	100% compliance with all security questions. Administrative errors found in CD registers	1) Audit report has been shared with all wards, MIU and Diagnostic and Treatment Centre. 2) Ward manager to check registers on weekly basis for 1 month 3) Ward manager to discuss at team meeting 4) Ward manager to speak to individuals 5) Pharmacy to produce information / education poster to be displayed on CD cupboard.
2	005.2 Q1&2 Omitted doses (part of the treatment card audit)	To ensure safe administration of medication	Alton, Baron, Butterley, Fenton, Heanor, Hopewell, Oker and Okeover are on SystmOne and achieved 100% for omitted codes. Hillside Ward also achieved 100%. Walton Unit did have some missing omitted dose codes but a system has been introduced to drug rounds which should help reduce these in future. Out of 362 regular doses only eight (2%) had no code or signature in the administration box.	1) Audit report has been shared with all wards 2) Continue to follow up on individual ward action plans 3) Ensure the process for checking 'due medication' at the end of every drug round on e-prescribing wards 4) Consider expanding the audit to look at approved codes for omitted doses eg. out of stock, patient refused etc.
3	016.3 18/19 Emergency equipment audit	To ensure standardised provision of well-maintained emergency equipment	• Overall compliance for DCHS is 96.27%, which is an improvement from the January 2018 audit when it was 95.36%. Of the 77 audits of emergency equipment 39 (51%) achieved 100% compliance	1) Complete a spot check audit of non-compliant areas in January to ensure action has been taken 2) Infograph to include instructions about the need to document on the weekly check that

	Project Title	Purpose	Outcome	Actions
			• 38 (49%) sites were less than 100% compliant but the vast majority of issues reducing compliance were minor and posed no clinical risk.	there is a procedure in place for the checking of emergency call bells. 3) Infograph to include instructions about the need to add a sticker to items with no printed expiry date to state expiry is three years hence date of manufacture 4) Infograph to be sent to all GMs and to the named responsible clinician and responsible equipment checker.
4	022.2 Mental Capacity Act phase 2 re-audit (Adult rehab wards and day hospitals)	To monitor compliance with the Mental Capacity Act	a) Capacity assessments: slightly fewer were correctly recorded in the clinical notes b) Independent Mental Capacity Advocates (IMCA): where a best interests decision met the criteria for involvement of an IMCA a referral to the IMCA service was not made c) Past preference: recording this decreased in the adult rehab wards d) Least restrictive decision: recording this decreased in the day hospitals. e) Deprivation of Liberty rationale: recording why an application should not be made when a best interests decision included degrees of restriction was missing for several cases f) Deprivation of Liberty applications: the local authority had not responded to any of the applications in this sample.	1) Communicate the results and improvement actions to staff 2) Escalate local authority delays in approving DoL applications 3) Ensure Mental Capacity Act (MCA) documentation is rolled out to all SystmOne users in a fully reportable format, with staff training available, before a new audit is set up.
5	037.1 Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) implementation evaluation	The project will provide data to support the implementation of the ReSPECT documentation, and to evaluate the effectiveness of its roll-out and use with patients.	a) Some entries suggest a ReSPECT form is in place but that the patient declined discussions about emergency health care planning b) Report cannot show outcomes of discussions or detail of free text entered by clinicians c) Further work needed to evaluate the content and quality of ReSPECT forms.	1) Re-audit the use of the ReSPECT template on SystmOne in both inpatient and community settings 2) Share findings and learning from SystmOne audit and staff survey with relevant staff groups across DCHS 3) Develop case notes review to assess the quality of the content of ReSPECT forms which have been completed in DCHS.

	Project Title	Purpose	Outcome	Actions
6	036.1 Audit of referrals made by DCHS GP practices to Live Life Better Derbyshire smoking cessation service	There is a risk to population health through the failure to fully embed public health principles within DCHS service delivery impacting on the ability to reduce inequalities in access and outcomes for our populations.	No specific improvement actions identified. Governance group agreed to close project but CET to work with division to create clearer project which identifies with the quality conversations agenda	Whilst the audit provided useful information, it identified a need to refine the audit question to gather more detailed information in future. There is work on-going in the division around quality conversations which is due to be rolled out in DCHS GP practices in February 2019
7	001.3 Improving the assessment of wounds Commissioning for Quality and Innovation (CQUIN) audit Q2 2018/19	Failure to complete a full assessment can contribute to ineffective treatment which therefore delays the rate of wound healing for patients. This has significant consequences for patients in respect of their quality of life as failure to treat wounds correctly can lead to delays in healing or failure to heal. Aims to increase the number of wounds which have failed to heal after four weeks that receive a full wound assessment.	Documentation of information given to patients regarding their wound care has reduced to 52% compared with 61% in Q4 2017/18, despite including this element in the manual notes review as well as the SystmOne report to capture any information being documented elsewhere in the patient record. Completion of the clinician's declaration that 'all fields have been considered' has fallen to 91% this quarter, compared with 100% in Q4. Only 36 of the 150 patient records had 100% of the required information completed, but a further 57 records were only missing one element of information.	1) Results to be broken down by team to enable targeted training and support 2) Share audit findings with participating teams, to support development/improvement 3) Tissue viability matron to liaise with deputy chief nurse to develop a communication to integrated community manager (ICM) and integrated community team lead (ICTL) to gain their support and ask them to identify any barriers to compliance.
8	002.1 Pilot survey of people who have recently experienced the death of a significant person in the care of DCHS community nursing teams	DCHS priority to provide qualitative information relating to the patients' and their families' experience of end of life care.	17 respondents felt that community staff gave them appropriate advice regarding what to do after the death. All respondents said that the care provided was delivered with dignity and respect. 22 respondents said that they and the person being cared for felt involved in decisions about the treatment and care being delivered at home by the community nursing team. Several respondents have made additional comments, referring to the professionalism and care of the teams supporting them. Two people have specifically commented on the positivity of their loved one being able to be cared for at home.	1) DCHS to complete the pilot bereavement survey in the community, and the clinical effectiveness team to interview participating teams to identify concerns or benefits to the project, prior to a decision regarding how to consult bereaved relatives in the future 2) Decision made at End of Life (EoL) group that an appropriate person will be identified to conduct a deep dive records review where respondents to the survey have given negative comments.
9	006.5 Q1 2018/19 End of Life audit	Identify unexpected deaths and trigger an in-depth review of the circumstance by MRG.	Need to ensure lessons learned from the EoL audit including thematic analysis is shared with front line staff. 25 auditors report not	1) Audit report, improvement plan and infographic to be shared with Quality Always team, ICM and matrons meeting, DN forum

	Project Title	Purpose	Outcome	Actions
		Identify areas where practice can be improved and share the findings across the services. Identify areas of good practice and share this across the service. Start to review qualitative information relating to the patients' and their families' experience of end of life care Triangulate end of life information with other sources – Quality Always, training, Friends and Family Test, complaints and comments.	being aware of GP palliative care meeting. Inpatient clinical teams will be encouraged to consider how the needs of the family can be better documented. Decline in the response rate for community teams	and to all auditors 2) Q&SCC to create 'you said, we did' boards to evidence how they change practice as a result of lessons learnt 3) Work with teams and service leads to identify issues with attending palliative care meetings 4) Identify lead to help encourage teams to consider and document the needs of the family. 5) Devise communications plan to inform community teams when, how and why to complete an end of life audit.
10	006.6 Q2 2018/19 End of Life audit	Identify unexpected deaths and trigger an in-depth review of the circumstance by MRG. Identify areas where practice can be improved and share the findings across the services. Identify areas of good practice and share this across the service. Start to review qualitative information relating to the patients' and their families' experience of end of life care Triangulate end of life information with other sources – Quality Always, training, Friends and Family Test, complaints and comments.	Inpatients: communication with patients and carers has continued to improve - 97% of patients had an individualised care plan. Community: overall response rate increased to 40.9% 92% of patients who died were on the GP palliative care register. Improvement in communication between staff and patient and involvement in decision making.	1) Infograph and end of life training to include reminders to staff to explicitly document that they have had discussions with patients and families/carers about their care 2) Work with IT team to add functionality on audit tool that helps improve data quality for the audit 3) Feedback to quality lead for EoL at CCG that we are informed that GP palliative care meetings are not being held with required frequency 4) Attendance and reasons for non-attendance at palliative care meetings to be reported team by team in future.
11	009.1 Susceptibility to medications	To reduce the number of falls caused by effects or side effects of medication.	59% of patients audited had a primary reason of fall for admission. Of these patients 19% suffered a fall during admission. 12.2% of all the patients audited had presented with a new onset of confusion. Results are limited due to lack of evidence related to medication reviews.	1) Inclusion of the clinical records audit within the monitoring section of the policy. This is a key area of monitoring compliance with falls documentation 2) Policy clarification added regarding exemption of mobility wristbands for LD and OPMH services in regard to documentation 3) Updated policy regarding consideration of foot care to reflect amendments to policy documentation and current NICE guidance

	Project Title	Purpose	Outcome	Actions
				4) Audit findings and written report to be shared with OPMH inpatient matrons and ward managers 5) Cascaded for action for all clinical staff including medical.
12	024.1 Frailty audit	Audit the effectiveness of the frail elderly early discharge and admission avoidance pilot between the DCHS, Chesterfield Royal Hospital and North Derbyshire and Hardwick CCGs.	a) There is a wide diversity of community referrers b) Teams respond very quickly to acute referrals c) There is an 80% level of success in achieving admission avoidance or facilitated discharge (D2AM) d) Adoption of a standard frailty assessment tool. DCHS has now adopted the Rockwood frailty measure. This was a DCHS Big 9 strategic objective for 2016/17 e) Effective care plans: Making sure that care plans in SystmOne are: - Specific to the patient's individual requirements and reflecting their assessments - Clear, realistic & measurable patient led outcomes - Achievable within a clear time frame with recovery plans if the time limit may slip - Providing clarity of how patients are using appropriate pathways for their presenting problems e.g. falls, continence, medication reviews, delirium and end of life pathways f) Personal Care Plans: Making sure care plans reflect the patient's wishes and objectives, and are in easy to understand language.	1) Share infographic with participating teams 2) Feedback specific data and results to relevant groups 3) Rockwood scale: feedback scores data from uptake report to dementia and frailty group. Informatics team to be asked to improve reporting of this data for January 2019 meeting, then to make this a direct report to the group. 4) Re-audit to be planned once frailty view on SystmOne is in place
13	025.1 Pressure ulcer - SSKIN self-assessment	Audit of compliance against key standards for DCHS prevention and	Overall engagement with the Trust-wide audit appears to have improved, with a particularly	1) Improve documentation and compliance with key standards

	Project Title	Purpose	Outcome	Actions
		management of pressure ulcer policy and the SSKIN bundle pressure ulcer prevention plan/pathway	significant increase in returns from community teams. More work is needed relating to the documentation of advice and discussion with patients in both inpatient and community. Further work is needed in community teams to document discussions with patients/carers to demonstrate they are involved in planning their care and treatment. Documentation needs to demonstrate that patients understand the information they are given.	2) Reduce inconsistencies in approaches to meeting prevention and wound management standards 3) Support pressure ulcer improvement groups (PUIGs) to monitor progress, celebrate good practice and focus on areas for improvement 4) Work with information management and technology (IM&T) colleagues to develop a means of monitoring key standards and run reports from SystmOne during 2019.
14	028.1 A Re-audit to measure the impact of improvement actions on the diagnosis and management of Catheter Associated Urinary Tract Infections (CAUTI).	To measure compliance with NICE guidelines for the diagnosis, management and treatment of CAUTI.	Out of 33 Datix incidents, 29 CAUTI patients had a set of observations documented, four had their pain assessed, four had a bowel review, one had their blood sugars measured and 19 were advised to increase their fluid intake. The re-audit indicated that urinalysis dipstick is still being used within DCHS to help diagnose a CAUTI. The reporting suggests overall reduction in the number of clinicians performing urinalysis. These figures should not be taken in isolation as it is evident that the overall management of patients with a CAUTI has improved immensely. Clinicians are changing the catheter, obtaining a catheter specimen urine (CSU) from the clean catheter which is sent to microbiology for culture prior to commencing antibiotics. 90% of CAUTIs reported during Q3 2017/18 were treated with antibiotics. It should be noted that the Datix report does indicate that all of these infections were symptomatic.	Continue to respond to all Datix but not to focus on the use of dipstick urinalysis if the catheter has been changed, a CSU taken from the clean catheter and the CSU has been sent for culture.
15	038.1 Use of personalised goal questions in the assessment of patients	Enable individuals living with a wound to achieve their potential and improve the overall experience.	• Eight of the 27 patients had not received a lower limb assessment. No other rationale for diagnosis found • Some of the issues identified from the	1) Tissue viability team to continue to provide targeted training and support for staff to understand how to complete outcomes of goals

	Project Title	Purpose	Outcome	Actions
	with venous leg ulcer wounds (CQUIN) Q2 2018/19		manual notes review where the lower limb template (LLT) was not completed are as follows: - Patient declined any assessments – it is not clear whether the staff member discussed further with the patient to attempt to understand their reason for declining - LLT completed in April 2018, VLU diagnosed, but patient admitted to hospital in the interim. Wound was not reassessed and LLT was not reviewed when the patient was discharged and came back under community care. Diagnosis appears to have been taken from original LLT in April - Two instances where patient is also under the care of another service, e.g. dermatology, who have diagnosed VLU, but no rationale from our community nursing team re diagnosis, and no evidence of any liaison with the dermatology team - Notes and wound assessment suggestive of a different diagnosis but VLU still selected. No LLT.	2) Improve staff understanding of aetiology of wounds, the importance of reviewing a wound if there is any change or interruption in care, and importance of demonstrating clinical reasoning 3) Develop roll-out plan to other community nursing teams and leg ulcer clinic 4) Plan improvement trajectory, for re-audit to be completed in Q4.
16	011.1 Stopping over-medication of patients with learning disabilities (STOMPwLD) review	The aim of this audit is to establish a baseline of current prescribing practice of all psychotropic medication in our specialist learning disability service (outpatient and inpatient)	Prescriptions were generally not backed up by documentation of the process standards. The best score of 24% compliance was for recording clinical indicators. No assurance can be taken from the results for recording the process standards when initiating or reviewing a prescription.	1) Design an 'aide memoire' for all outpatient consultations and inpatient review meetings involving psychotropic medication, to improve recording of prescribing standards in medical notes 2) Include next planned psychotropic medication review date in next outpatient meeting form, and include as a medication review flag on SystmOne 3) Investigate whether specialist pharmacy support for psychotropic medication is

	Project Title	Purpose	Outcome	Actions
				available.
17	017.1 Identifying disability	Demonstrate that reasonable adjustments are made for people with a learning disability to allow improved access to all DCHS community services.	a) Only 6.5 % of first contacts in SystmOne in October 2016 had an E&D questionnaire started b) Of the audit sample of 80 started E&D questionnaires, eight (10%) failed to answer Q3 about disabilities, but 56 (70%) identified at least one disability, suggesting that staff do not complete the questionnaire unless they see a disability c) A total of 79 disabilities were identified, but there was evidence of some staff confusing long term medical conditions with disabilities d) In 40 out of the 56 (71%) the record ended there, with no account of what sort of adjustment was needed. For five patients it was clear that no adjustments were needed for identified disabilities. Only 11 records had an entry for a reasonable adjustment e) Care planning for reasonable adjustments and evaluation of the care plan actions was non-existent in the audit sample f) This is similar to the results of the previous two years results from the identifying learning disability audit.	1) Review the E&D questionnaire 2) Staff training.
18	020.1 National Audit of Dementia (community hospitals pilot)	This will also allow us to measure our performance against the national standards for inpatient dementia services.	a) No dementia lead b) No pathway for dementia c) Staff very positive about personalised care d) Dementia training strategy embedded.	1) Dementia flag to be introduced to electronic patient record to support identification of patients who have dementia 2) Development of DCHS dementia strategy is underway 3) New dementia training pathway has been developed 4) Work progressing to include patient/carer representatives at dementia and frailty group meetings.

	Project Title	Purpose	Outcome	Actions
19	027.1 VTE podiatric surgery	To ensure that all relevant planned care patients are risk assessed for VTE and a clinical decision made and documented as to the necessity for prophylaxis taking into account the overall risks and benefits for individual patients. To ensure that patients have been treated appropriately following the VTE risk assessment. To identify if any areas have not followed the NICE guidance and DCHS VTE policy.	• Limited evidence of quality of verbal advice given to patients • Lack of clarity of term 'prophylaxis' and what form this might take - could be advice, pharmaceutical or mechanical • Limited scope of audit, no comparable data from other services • 95% of patients were offered verbal and written information on VTE prevention as part of the pre-surgical assessment process. 63% of patients were documented to have received an assessment of their VTE and bleeding risk prior to surgery. 90% of patients at risk of VTE were offered VTE prophylaxis.	1) Ensure all staff/services are using the updated screening form and that any older versions are removed 2) Discuss with teams regarding clear documentation of advice given to patients 3) Review definition of 'prophylaxis' and update screening tool to identify the type of prophylaxis given 4) Audit to be rolled out to other podiatric surgery services in DCHS in March 2019.
20	039.1 VTE screening audit diagnostic & treatment centre (DTC)	To ensure that all relevant planned care patients are risk assessed for VTE and a clinical decision made and documented as to the necessity for prophylaxis taking into account the overall risks and benefits for individual patients. To ensure that patients have been treated appropriately following the VTE risk assessment. To identify if any areas have not followed the NICE guidance and DCHS VTE Policy	• None of the screening tools which were audited were fully completed – none had any information completed on page two of the screening tool • There is some evidence that verbal and written advice is given to patients about VTE and how to reduce risk, but this is limited and further work is needed to encourage staff to provide evidence in patient records that they have discussed this with patients/carers • Out of date screening forms were widely in use, and had not been updated.	1) Communications to staff to inform of importance of completing the tool fully 2) Communication and sharing of the DCHS VTE prophylaxis policy and screening tool with consultant team to ensure visiting consultants are aware of the process 3) Clear process of who should complete each element of the screening tool, and when, to be agreed across the outpatients and DTC teams and shared with all relevant staff as a standard operating procedure (SOP). 4) Ensure the correct, up-to-date version of the screening tool is being used in all areas and any out of date forms are removed.

2.2.3 Research

The number of patients receiving relevant health services provided or sub-contracted by DCHS in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee is 145; this is six less recruits when compared to 2017/18 activity.

2.2.4 Commissioning for Quality and Innovation (CQUIN)

CQUINs are quality-related goals which are agreed with our commissioners each year. The goals are linked to a proportion of our income which we receive on achievement of the targets. The targets support ongoing innovation and improvement in care across our clinical services.

During 2018/19 we agreed five CQUIN measures; the themes for our CQUINs included:

- Health and wellbeing: staff survey, healthy food, flu vaccination uptake
- Preventing ill health through risky behaviours (i.e. alcohol and tobacco)
- Improving the assessment of wounds
- Improving the degree of personalised care planning for patients with long term conditions
- Using personalised patient goals in the treatment of patients with venous leg wounds (local).

A proportion of our income in 2018/19 was conditional upon achieving quality improvement and innovation goals agreed between DCHS and any person or body we entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2018/19 and the for the following 12 month period are available in section 3.

The total CQUIN value available for 2018/19 was £3,416,478 and this was agreed as part of the block contract for DCHS. The monetary total for the associated payment in 2017/18 was £3.42m.

Areas of under achievement

We have continued to evaluate staff wellbeing through the annual NHS Staff Survey, with the CQUIN focusing on responses to those questions related to positive action on health and wellbeing, and work-related stress. Despite a dedicated programme of wellbeing support being made available to staff, the results of the 2018/19 survey did not demonstrate the 5% point improvement required in these particular areas. This may be indicative of the high level of organisational change staff have experienced over the past two years.

The uptake of flu vaccinations for frontline clinical staff was 64.1%. This is deterioration from the 2017/18 position (68.5%) and below the national target of 75%. Work to support uptake of the vaccination will continue and will be monitored through the DCHS quality schedule in 2019/20.

Performance against the preventing ill health CQUIN saw an achievement in the majority of indicators; however, due to the low number of patients involved, the threshold for one indicator was missed by a small percentage. This CQUIN has an acute pathway focus which was challenging to fit within a community inpatient service. It should be noted that data capture has continued to improve in terms of achievement and accuracy over the two years of this CQUIN.

Healthy eating options for staff and visitors have been successfully implemented across all Trust sites. All our Trust sites complied with the targets related to providing reduced levels of food and drink high in fat, sugar and salt. We have also signed up to the national sugar-sweetened beverage reduction scheme.

This year the personalised care planning CQUIN involved a number of key staff receiving personalised care training, and their associated patients receiving dedicated care and support planning conversations and interventions. We achieved 100% of the training target and the average activation score of the relevant patient cohort increased from 0.96 to 1.46, indicating a positive impact on patients' engagement with, and confidence in, their own health and wellbeing.

The improving wound care CQUIN continued the roll out of the national chronic wound assessment across frontline community services. Compliance of its use has been measured through a bi-annual audit, with a stretched target of 60% for Q2 and 80% for Q4. Whilst the final audit result did not meet the 80% compliance target, in many cases the audit found that only one element prevented the assessment from being 100% completed, and the overall quality of wound assessments has significantly increased, demonstrating the value that support from the tissue viability team has added to clinical interventions.

In addition to the national personalised care CQUIN, DCHS, in conjunction with the CCG, also developed a local CQUIN on personalised goal setting for patients with a venous leg ulcer. Following a programme of training for staff in a pilot area of community nursing, a total of 50% patients had personalised goals set against an improvement target of 75% following a baseline audit. The implementation plan and wider roll-out of this CQUIN is now being refined and developed, as part of the 2019/20 CQUIN programme

2.2.5 Care Quality Commission (CQC)

DCHS is required to register with the CQC and its current registration status is registered. DCHS has no conditions on registration.

The CQC has not taken enforcement action against DCHS during 2018/19.

DCHS has not participated in any special reviews or investigations by the CQC during 2018/19.

2.2.6 Ratings for primary care services

The three GP practices continue to be rated good overall. See our GP Survey ratings at appendix 2.

2.2.7 Secondary uses service data

DCHS submitted records during 2018/19 to the secondary uses service (SUS) for inclusion in the hospital episode statistics, which are included in the latest published data. The percentage of records in the published data

- which included the patient's valid NHS number was:
  - 100% for admitted patient care
  - 100% for outpatient care
  - 100% for accident and emergency care.

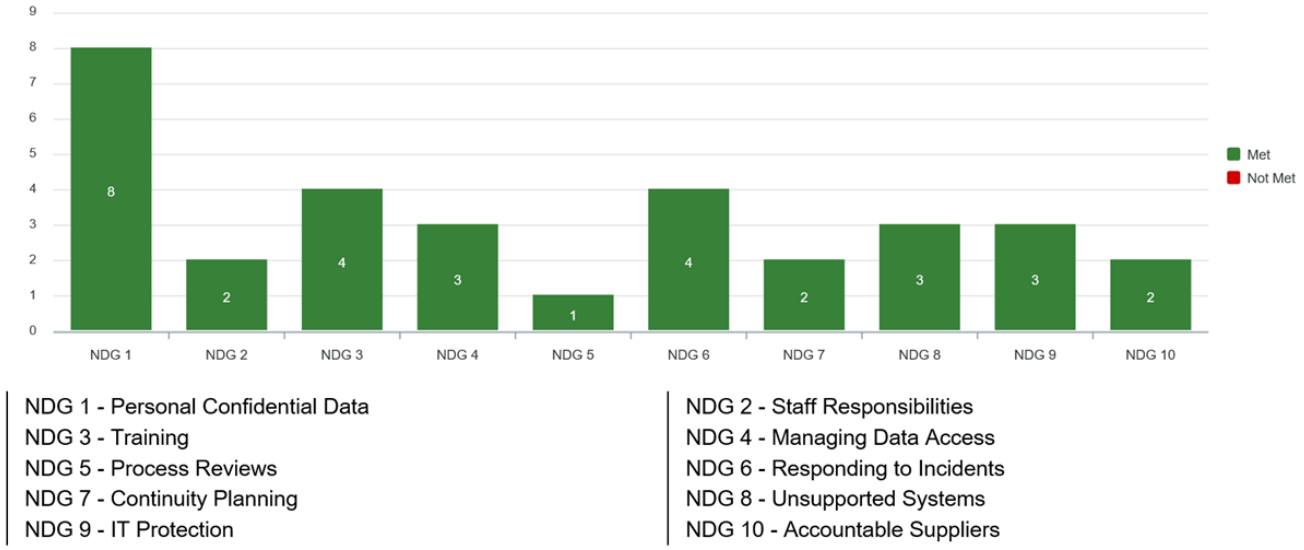
- which included the patient's valid general medical practice code was:
  - 100% for admitted patient care
  - 100% for outpatient care
  - 100% for accident and emergency care.

2.2.8 Information governance

DCHS' data security and protection toolkit overall rating for 2018/19 was Standards Met with all mandatory assertions having been completed.

Graph 2 below shows DCHS compliance against the 10 national data guardian standards detailed in the toolkit:

Graph 2: DCHS compliance



NDG 1 - Personal Confidential Data
NDG 2 - Staff Responsibilities
NDG 3 - Training
NDG 4 - Managing Data Access
NDG 5 - Process Reviews
NDG 6 - Responding to Incidents
NDG 7 - Continuity Planning
NDG 8 - Unsupported Systems
NDG 9 - IT Protection
NDG 10 - Accountable Suppliers

2.2.9 Payment by Results

DCHS was not subject to the Payment by Results clinical coding audit during 2018/19 but did initiate its own internal audit, which measured the accuracy of clinical coding, the results of which are detailed in table 9 below.

Table 9 Clinical coding

Coding Field	DCHS percentage correct 2018/19	DCHS percentage correct 2017/18	DCHS percentage correct 2016/17	IG Req 505 Level 2	IG Req 505 Level 3
Primary diagnosis	91.00%	96.50%	92%	90%	95%
Secondary diagnosis	91.09%	92.26%	93.53%	80%	90%
Primary procedure	93.94%	98.92%	96.84%	90%	95%
Secondary procedure	90.21%	92.66%	93.71%	80%	90%

NB. It is important that results should not be extrapolated beyond the actual sample audited.

DCHS will be taking the following actions to improve data quality:

- The clinicians within the Trust and the clinical coding team members will develop an ongoing and regular process for reviewing activity data, how this is best represented in the clinical coding and what measures need to be put in place to ensure this can be maintained and effectively monitored. This will include the development of any local policies required during the process. Another outcome should be an improvement in the documentation that the clinical coders use to extract information from.

- The department will engage with clinicians to formalise a local policy to support the effective recording of the type of cataracts. This could incorporate a chart for abbreviations and acronyms that are used and the most appropriate code for it. This could also be carried out in conjunction with discussion around the structure of the pro-forma used and how it could be improved to support data quality.

2.2.10 Learning from deaths analysis (schedule 27)

Schedule 27.1

The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure.

The data provided in this report in relation to number of deaths and case note reviews/investigations are derived from our End of Life care audit, the monthly IT in-patient mortality report to the clinical effectiveness team and our mortality tracker respectively.

During 2018/19, 908 of DCHS patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

Table 10: Quarterly reporting of deaths

	Q1	Q2	Q3	Q4
Patient deaths 2018/19	176	202	220	310

Schedule 27.2

The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.

By 31 March 2019, eight case record reviews and three investigations have been carried out in relation to 908 of the deaths included above.

In one case a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

Table 11: Quarterly reporting of case reviews

	Q1	Q2	Q3	Q4
Case note review	5	3	0	0
Investigation	1	0	1	1

Schedule 27.3

An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges, as a result of the review or investigation, were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.

Four, representing 0.4% of the patient deaths during the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of: zero representing 0% for the first quarter; zero representing 0% for the second quarter; three representing 1.4% for the third quarter; one representing 0.3% for the fourth quarter.

There is currently no prescribed methodology for case note reviews in community trusts. We have developed a hybrid of the community section of the global trigger tool and a root cause analysis (RCA) tool to be used as a template for the case record reviews. We used the Royal College of Physicians (RCP) structured judgement review avoidability scale to determine the level of avoidability although in

year this has been revised to ask whether 'the death is thought to be more likely than not due to a problem in care'.

Schedule 27.4

Information requirement: a summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3.

The information gathered will continue to inform themes and trends as data increases, this information will be shared with the MRG through a bi-annual paper. Patients discussed at the MRG these are the emerging trends:

- Excellent monitoring and timely escalation of when people deteriorate - share excellent example of observations
- HCA exemplary performance - not performing inappropriate cardiopulmonary resuscitation (CPR)
- Medication reviewed on regular basis and patient needs addressed promptly with additional doses as required
- Good liaison between community team and GP
- Involvement of multi-disciplinary team to address changes in patients' needs
- High quality of record keeping
- Team followed sepsis guidelines
- Antimicrobial prescriptions in line with antimicrobial prescribing guidelines
- Multidisciplinary review of patient undertaken to support patient's wish to die at home
- Example of excellent practice – good use of objective tool for validating frailty - Rockwood clinical scale.

Opportunities for quality improvement

- Recognising deteriorating patients and escalating care as appropriate
- Wound assessment documentation not completed fully
- Ensuring timely follow up on referrals
- Timely escalation of failed access on planned visits
- Staff recognising delirium
- Recognition of risk of C diff and appropriate actions being taken
- Greater level of alertness to monitoring compliance with professional recommendations in care homes subject to safeguarding proceedings.

Schedule 27.5

Information requirement: a description of actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 27.4)

Quality improvement actions

1. 'Failed visit' standard SOP has been developed. SOP is proceeding to clinical safety group (CSG) for approval and will be launched once approved
2. Handover process reviewed to include specific discussion of patients with ongoing diarrhoea symptoms and appropriate mitigation implemented e.g. stool sample, diaries, continence assessment, diet, medication review
3. Summary sheet documentation to be updated to include infection control section to enable issues and specialist requirements to be highlighted to receiving ward/team
4. Delirium task and finish group to continue and conclude all outstanding actions.

Schedule 27.6

Information requirement: an assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.

Staff are clearer about the mechanisms for seeking and obtaining the additional support and advice as highlighted within the lessons learned. One case was referred to a neighbouring acute trust for further review.

Table 16 in section 3.1.8 Medical devices, shows the increase in staff monitoring base line observations in patients which was identified as an emerging theme through the MRG meetings.

Schedule 27.7

The number of case records or reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period.

45 case record reviews and zero investigations were completed after 1 April 2018 which related to deaths which took place before the start of the reporting period.

Schedule 27.8

An estimate of the number of deaths included in item 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.

Five, representing 11% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the methodology outlined in 27.3.

Schedule 27.9

A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant documents for that previous reporting period, taking into account of the deaths referred to in item 27.8.

Zero representing 0% of the patient deaths during the previous reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.3 Core indicators

Since 2012/13 all NHS foundation trusts are required to report performance against a set of core indicators using data made available to them by NHS Digital. Many of the core indicators are not relevant to community services. Those that are applicable to DCHS appear in table 12 below. For completeness the full set of core indicators can be found at appendix 6.

Table 12: Core indicators applicable to DCHS

	Prescribed information	Related NHS outcomes framework domain & who will report on them	2016/17	2017/18	2018/19
21	The data made available to the Trust by NHS Digital with regard to the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.	4: Ensuring that people have a positive experience of care **Trusts providing relevant acute services**	87.5%	82%	82.8%
DCHS considers that this data is as described for the following reasons: we have worked actively with our staff to engage them in service development and delivery. DCHS has reported consistently excellent staff survey results for the last three years.					
DCHS intends the following actions to improve this percentage score and so the quality of its services, by continuing to actively engage with staff and to build upon its well-developed staff engagement processes and to continue its roll-out work related to staff wellbeing.					
Comparative data taken from NHS England Staff Friends and Family Test website When asked whether, if a friend or relative needed treatment, they would be happy with the standard of care provided by their organisation, 82% of staff agreed or strongly agreed (the average for community trusts is 73%) (data for 2016/17 = 86%).					
21.1	Friends and Family Test – patient. The data made available to the trust by NHS Digital for all acute providers of adult NHS funded care, covering services for inpatients and patients discharged from Accident and Emergency (types 1 and 2). *Please note: there is not a statutory requirement to include this indicator in the quality accounts reporting but NHS provider organisations should*	4: Ensuring that people have a positive experience of care **Trusts providing relevant acute services**	98%	97.8%	98.2%

	Prescribed information	Related NHS outcomes framework domain & who will report on them		2016/17	2017/18	2018/19
	consider doing so.					
DCHS considers that this data is as described for the following reasons: we have worked with our patients to ensure effective and robust feedback from across the breadth of our services and this is monitored by our patient experience and engagement group.						
DCHS has taken the following actions to improve this percentage score: engage with patients and carers, actively seek feedback, encourage completion of FFT cards, collate the findings from feedback and report on changes through our patient experience and engagement group. Develop patient engagement groups for specific service areas and undertake engagement events on key issues. During 2019/20 DCHS will explore options for electronic recording of patient feedback to increase capture of data.						
Comparative data taken from NHS England Friends and Family Test data website Data for 2017/18 shows average of 97.8% of patients would recommend their local community services to friends and family.						
23	The data made available to the Trust by NHS Digital with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	5: Treating and caring for people in a safe environment and protecting them from avoidable harm **Trusts providing relevant acute services**		99.6%	99.9%	99.6%
DCHS considers that this data is as described for the following reasons: DCHS has trained its staff well and has clear clinical policies.						
DCHS has taken the following actions to improve this percentage score and so the quality of its services by reviewing in detail any venous thromboembolism case to ensure any learning is shared throughout the organisation.						
Comparative data for community trusts is not available.						
25	The data made available to the Trust by NHS Digital with regard to the number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	**All trusts** 5: Treating and caring for people in a safe environment and protecting them from avoidable harm	**Total - Patient safety incidents**	10,002	10,018	7,221
			Severe harm or death	7	9	4
			% severe harm or death	0.07%	0.08%	0.05%
DCHS considers that this data is as described for the following reasons: DCHS has a culture of high reporting of clinical incidents as reported by the National Reporting & Learning Scheme (NRLS). There has been a focus during the year on improving the timeliness of reporting.						

	Prescribed information	Related NHS outcomes framework domain & who will report on them	2016/17	2017/18	2018/19
DCHS has taken the following actions to improve this rate and so the quality of its services, by developing a supportive reporting culture and ensuring that lessons learned from clinical incidents are shared organisation wide. Due to the reporting of inherited pressure damage and unwitnessed falls in community no longer requiring reporting there has been a significant drop in the total number of finally approved incidents.					
Comparative data NRLS April–Sept 2017 DCHS remains as having the highest reporting culture rate per 1000 bed days compared with 17 NHS community trusts. <1% of incidents in this period were reported as resulting in severe harm or death.					

PART 3 - REVIEW OF QUALITY IMPROVEMENTS 2018/19

This section of our annual quality report provides information on performance against our quality and performance indicators agreed internally by the Trust and also performance against relevant indicators and performance thresholds set by our regulators.

The Trust has chosen to include performance against a broad range of quality and performance indicators which are reported to the Board of Directors rather than specifically selecting three patient safety, three clinical effectiveness and three patient experience indicators. Performance against this range of indicators is included in table 12 below. Where possible we have included benchmarking information to show how we compare to other NHS organisations and comparative year on year performance. On a monthly basis a balanced score card of performance indicators is presented to the Board of Directors and, where there is underperformance, exception reports are provided which include actions that are being taken to improve outcomes.

Data quality kite mark scoring

Accurate information is fundamental to supporting the delivery of high quality care; we therefore strive to ensure all data is as accurate as possible. Our data quality kite mark scoring enables us to ensure that each indicator on the integrated performance summary dashboard is assessed against six dimensions of data quality, given as a summary of the quality of the indicator data. Using data collected following interview sessions with service staff each system has been marked on the criteria of audit, timeliness, sign off, granularity, completeness and source/process. A system can score as not sufficient, sufficient or exemplary in each of the six areas. These areas make up the outer segments of the data quality kite mark shield e.g. a score of sufficient or exemplary marks the system as green on the kite mark shield for that section; and a score of not sufficient marks the system as red.

Where an indicator has not yet been assessed a white symbol is used. These dimensions and the definitions of the ratings are outlined here:

Key to colour coding – data quality kite mark scoring

	Indicator/measure has met or exceeded target
	Indicator/measure has not met target but is within acceptable tolerances. An action plan is in place and is being monitored.
	Indicator/measure has not met target and is beyond accepted tolerances. Immediate action and investigation has been instigated. An action plan is in place and is being monitored.
	Indicator/measure is not available, in development, or not applicable

Key to symbols

↑	Performance has improved/is above target
↓	Performance has declined/is below target
↔	Performance is stable and on target to be delivered

Each system will receive a data confidence score calculated by the total overall scoring given by four key members of staff relating to the specified system from information, performance and within the service. Each contact is asked to give the system a confidence rating out of five to state how accurately the system data reflects service activity, where five is complete confidence and one is no confidence. The total of the four scores will be displayed in the centre of the data quality kite mark shield. The Audit and Assurance Committee (AAC) receives quarterly reports on data quality.

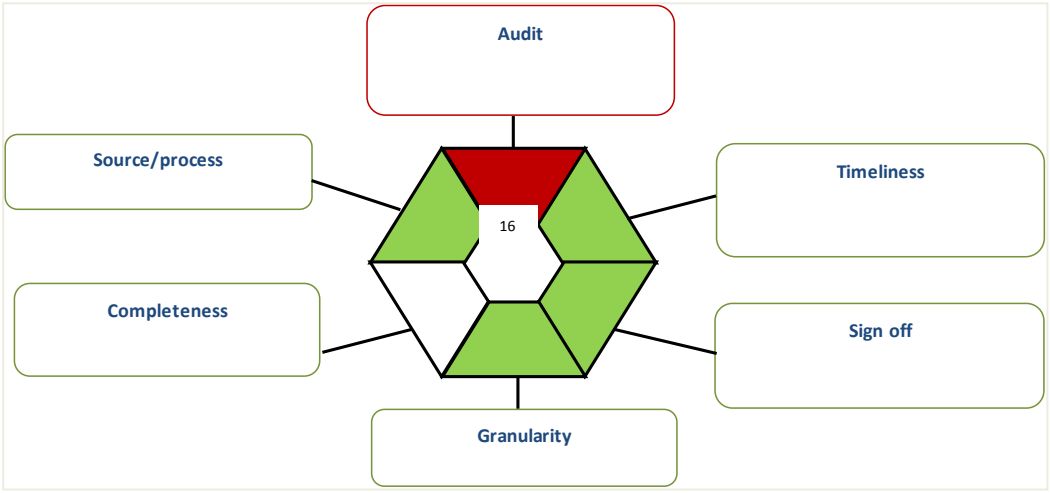


Table 13: Range of indicators

Key performance indicator (KPI)	Primary data source	Data quality score	Target 18/19	Average monthly score 16/17	Average monthly score 17/18	Average monthly score 18/19	Year-end data	Benchmarked performance**
Friends and Family Test scores	Datix	14	98%	97.9%	97.8%	98.3%	98.3%	95.8%
Complaints – number received	Datix	14	No target	11	13	11	131	-
Complaint cases completed within agreed timescale	Datix	14	80%	73%	84%	73%	66.4%	80%
Number of responses from Friends and Family Test	Datix	N/A	No target	2,101	2,428	2,231	26,778	-
Turnover %	ESR	12	14%	9.9%	8.5%	8.9%	8.9%	14.40%
Total sickness rate	ESR	12	3%	4.7%	5.2%	4.9%	4.9%	4.3%
Sickness long term	ESR	12	No target	2.7%	3.2%	2.9%	2.9%	-
Sickness short term	ESR	12	No target	2%	2%	2%	2%	-
Vacancy rate %	ESR	12	No target	6.8%	5.6%		6.51%	-
Annual reviews (staff appraisals) carried out %	ESR	12	96%	92%	87%	93.6%	93.6%	88.4%
Clinical supervision %	Internal spread sheet	N/A	100%	59.29%	65.51%***	83%	83%	100%
Mandatory training	ESR	12	96%	96%	89%	97.1%	97.1%	88.4%
Mandatory training - information governance %	ESR	12	96%	93%	95%	95.9%	95.9%	96%
Medication errors causing serious harm (no.)	Datix	14	0	0	0	0	0	-
Never Events (no.)	Datix	14	0	0	0	0	1	-
Avoidable grade 2, 3 & 4 pressure ulcers developed or deteriorated in Trust care (no.)	Datix	14	34	5	5	Data no longer collected 2019	30	-
Pressure ulcers which meet SI criteria	Datix	14	0	n/a	n/a	3	34	34
Clostridium difficile incidence	Internal spread	N/A	0	0.5	0.2	0.1	1	10

Key performance indicator (KPI)	Primary data source	Data quality score	Target 18/19	Average monthly score 16/17	Average monthly score 17/18	Average monthly score 18/19	Year-end data	Benchmarked performance**
	sheet							
MRSA bacteraemia incidence	Internal spread sheet	N/A	0	0	0	0	0	0
Total grade 3 & 4 pressure ulcers developed or deteriorated in Trust care (no.)	Datix	14	0	7	4	Data no longer collected 2019	27	-
Safety thermometer all harms - % harm free care *	ST Tool	14	94%	93%	92%	Data no longer collected 2019	--	94%
STEIS serious incident reporting – open serious incidents	STEIS	14	No target	20	18	15.3	184	-
OPMH mental health delayed transfers of care - % attributable to the Trust	BI	14	3.5%	1.7%	3.8%	4.3%	4.3%	3.5%
Inpatients – delayed transfers of care	BI	14	3.5%	10.5%	8%	5.9%	5.5%	3.5%
OPMH & inpatients – delayed transfers of care	BI	14	3.5%	8.4%	7.1%	5.6%	5.3%	3.5%
A&E 4 hour wait for A&E attendances (%) (MIUs)	BI	16	95%	100%	99.9%	99.9%	99.9%	95%
RTT waits - admitted patients seen within 18 weeks - (2a) (%)	SystmOne	16	No target	93%	95%	86.1%	86.1%	-
RTT waits - non admitted patients seen within 18 weeks - 95% (target) (1B)	SystmOne	16	95%	95.2%	93.4%	91.1%	91.1%	n/a
RTT waits - incomplete pathway - 92% (target) (2) (%)	SystmOne	16	92%	96%	95%	95%	95%	96.7%
Minimising mental health delayed transfers of care	BI	16	3.5%	1.7%	3.8%	5.6%	5.3%	3.5%
Mental health data	SystmOne	16	97%	100%	100%	100%	100%	-

Key performance indicator (KPI)	Primary data source	Data quality score	Target 18/19	Average monthly score 16/17	Average monthly score 17/18	Average monthly score 18/19	Year-end data	Benchmarked performance**
completeness: identifiers								
Certification against compliance with requirements regarding access to health care for people with a learning disability	EDILF report	n/a	Yes	Yes	Yes	Yes	Yes	Yes
Data completeness: community services - referral to treatment information	CIDS	16	95%	92%	97%	100%	100%	95%
Data completeness: community services - referral information	CIDS	16	95%	91%	96%	99.2%	99.2%	95%
Data completeness: community services - Treatment activity information	CIDS	16	95%	91%	96%	99.2%	99.2%	95%

**Data not collected*

******Benchmarked performance data taken from October 2016 aspirant ft benchmarking group*

****Clinical supervision data is currently not available for Q3 & Q4, the process for collection changed mid-year. From 1 April 2018 this data is being collected via ESR.*

Trust risk ratings (single oversight framework (SOF))

As a foundation trust we are required to meet certain conditions including those in respect of:

- Continuity of services – a measure of financial sustainability and resilience. The purpose of this measure is to identify any significant risks to the financial sustainability of the Foundation Trust which would endanger the delivery of key services. From 1 April 2016 to 30 September 2016 continuity of service was measured on a scale of 1 to 4 with 1 being the highest risk and 4 the lowest risk

- From 1 October 2016 a new SOF became effective and replaced the previous continuity of services risk rating with a finance and use of resources metric. A rating of 1 now represents the lowest financial risk with a score of 4 being the highest risk

- Governance – how a foundation trust oversees care for patients, delivers national standards, and remains efficient, effective and economic. Trusts are rated from green (low risk) to red (high risk). This rating was in place from 1 April 2016 to 30 September 2016.

- From 1 October 2016, under the new SOF, the governance rating was replaced with a segment rating. Trusts are segmented based upon the scale of issues faced by individual providers, with segment 1 providers having maximum autonomy, and segment 4 providers being those in special measures.

We are given a rating for continuity of services/use of resources and a rating for governance/segment to indicate where there is a cause of concern and to determine the extent of any intervention required by NHS Improvement.

We have performed in line with our annual plan during 2018/19 and have achieved consistently good ratings and continue the success of the previous year see table 14.

There have been no formal interventions in year.

Table 14: **Table of analysis**

2018/19	Annual plan	Q1	Q2	Q3	Q4
Continuity of service rating	Low risk	1	1	1	1
Finance and use of resources	Low risk	1	1	1	1
Governance rating	Green	Green	Green	Green	Green
Segment	Segment 1	Segment 1	Segment 1	Segment 1	Segment 1

2017/18	Annual plan	Q1	Q2	Q3	Q4
Continuity of service rating	Low risk	1	1	1	1
Finance and use of resources	Low risk	1	1	1	1
Governance rating	Green	Green	Green	Green	Green
Segment	Segment 1	Segment 1	Segment 1	Segment 1	Segment 1

2016/17	Annual plan	Q1	Q2	Q3	Q4
Continuity of service rating	Low risk	4	4		
Finance and use of resources	Low risk			1	1
Governance rating	Green	Green	Green		
Segment	Segment 1			Segment 1	Segment 1

3.1 WHAT HAVE WE DONE TO IMPROVE PATIENT SAFETY?

The provision of healthcare by its nature is a risky business and so one of our key clinical governance priorities is the provision of safe care and the management of risk. The following section provides examples of work undertaken by the patient safety team during the year to improve and monitor patient safety across the trust.

3.1.1 Sign up to Safety

Sign up to Safety is a national patient safety campaign intended to harness the commitment of staff across the NHS in England to make care safer for patients. We formally signed up to the campaign on 3 July 2015. The national campaign officially ended on 31 March 2019; however, DCHS have committed to continue to work towards the pledges made. The continuing Sign up to Safety pledges are listed in table 15.

The focus of Sign up to Safety has evolved over the years with the realisation of the importance and influences of human factors, staff health and well-being which have a pivotal role in keeping patients safe. In addition we have emphasised the importance of learning from all care and not just when there has been an error. This is something that has been and continues to be embraced and built on in DCHS with the following initiatives:

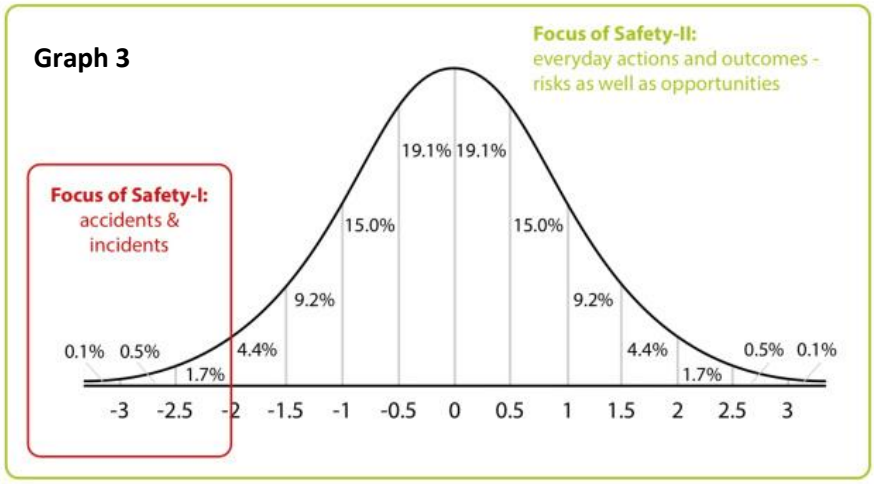
- **Appreciative inquiry** was used as the basis for staff team discussions (mini kitchen table discussions) held with teams across DCHS throughout 2017/18. Building on this during 2018/19 we have introduced 3I Dialogue Forums. The 3Is stand for Included, Involved and Inspired - evidence shows that staff who are included and involved become inspired. 3I has also been used with allied health professionals (AHPs) when setting the vision for their contribution to service in DCHS.

- **Shout Out** was launched in September 2018 to facilitate all staff being able to capture and celebrate excellence occurring across the Trust. Any staff member can submit a Shout Out for a colleague or team who have delivered an excellent service within DCHS. From these submissions, issues where the organisation can learn from excellence are selected and shared with the Lessons Learnt Panel to share best practice organisationally. This enables us to shift the focus of learning to that of all care and not just when errors have occurred.

- **Safety-I to Safety-II** The patient safety team has embraced the need to move from Safety-I to Safety-II (Erik Hollnagel, 1 November 2015).

  Safety-I represents a concern for managing events with unacceptable outcomes. This is done by trying to explain how things go wrong in order to prevent any reoccurrence. The current focus on things that go wrong in practice excludes everything else. The Datix system and NRLS lends itself to this and even though we should be uncovering the lessons learnt, because it is only triggered from a patient safety incident, the learning is limited to that area depicted in red in graph 3.

There is national recognition of the need for further focus on learning from incidents. This has led to the current development of a new database, the patient safety incident management system, to replace both the NRLS and StEIS. The launch date of this is yet to be confirmed.



Safety-II looks at all events regardless of their outcomes, but in particular at the events that occur frequently that lead to the expected outcomes and which therefore are seen as 'normal' (in Safety-I these are, ironically, described as situations where 'nothing happens').

Table 15: **Sign up to Safety pledges and progress to date**

Pledge	Progress made
Pledge 1 **Putting safety first** - commit to reduce avoidable harm in the NHS by half and make public our locally developed goals and plans.	Continence services have been working in collaboration with NHS Improvement on two initiatives to improve the care of patients with an indwelling catheter. 1) to reduce the number of catheters within the University Hospitals Derby & Burton by implementing the HOUDINI (a catheter removal protocol). 2) to develop national documents for use with patients with a catheter. These include a national patient catheter passport and catheter documents to use within the hospital setting. Additionally, the continence team have reviewed the education/training for catheters and are facilitating two days per month inclusive of the Foundations in Care. This includes a clinical skills session on catheterisation and catheter management and addresses their initial pledge to address inappropriate use of antibiotics for UTIs. Through the DCHS falls prevention strategy the safe care movement team aimed to achieve a 5% reduction in the rate of harmful falls per 1,000 occupied bed days in a hospital inpatient setting during the period of 2018/19.

Pledge	Progress made
	Tissue viability team's Time to Heal programme has achieved astounding results for patients requiring chronic wound management – see item 3.1.17.
Pledge 2 **Continually learning** - make our organisation more resilient to risks, by acting on the feedback from patients and staff and by constantly measuring and monitoring the safety of our services.	All patient safety incidents are reviewed by the patient safety team and all staff incidents are reviewed by the health and safety team to ensure that as an organisation we learn from the incidents investigated. Feedback is given to the Lessons Learned Panel, as well as to the investigating manager so that local and Trust wide dissemination of information can occur.
Pledge 3 **Being honest** - be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.	The patient safety team continues to ensure that duty of candour is exercised when serious harm occurs and those patients and their advocates are informed of any lessons learnt. The RCA training now incorporates patient experience and duty of candour elements to provide an insight into the relationship between being open and honest and its reduction in possible complaints.
Pledge 4 **Collaborate -** work closely with our commissioner stakeholders and the serious incident network so that wider learning can occur. Actively consult with our workforce and nurture an open attitude to health and safety issues, encouraging staff to identify and report and suggest innovative solutions so that we can all contribute to creating and maintaining a safe working environment.	The patient safety team meets regularly with the commissioner stakeholders and the serious incident networks to ensure wider learning occurs. The Medical Devices group have pledged to ensure that all frontline community staff are equipped with standardised equipment to take clinical observations (BP, temperature, oxygen saturations) to meet the requirement of NEWS2
Pledge 5 **Being supportive** - help our people understand why things go wrong and how to put them right. Give them the time and support to improve and celebrate progress.	We continue to strive to create a positive health culture. This is embedded into our policies and procedures. Human contributory factors are incorporated into RCA training so that during incident investigations there is further understanding of the crux of the problem and our staff are provided with training, support and confidence to learn and improve.

3.1.2 Risk management

Reporting and managing risks effectively helps us to recognise issues which pose either a threat or an opportunity for improvement, and helps us to track new or under-recognised safety issues. Clusters of patient safety incidents, particularly those occurring more frequently, may represent an important trend that needs a response (e.g. more transport or admissions-related problems). The patient safety team monitors incident trends to ensure that any related risk has been considered and registered on our risk management system (Datix) and that there are robust governance processes in place to address associated concerns.

3.1.3 Risk review

Risks are reviewed on a regular basis by managers through established governance meetings in accordance with our risk policy. To assist rating of a risk, a 5x5 risk grading matrix (see table 16) is used to identify the likelihood of a risk occurring against its resulting consequence.

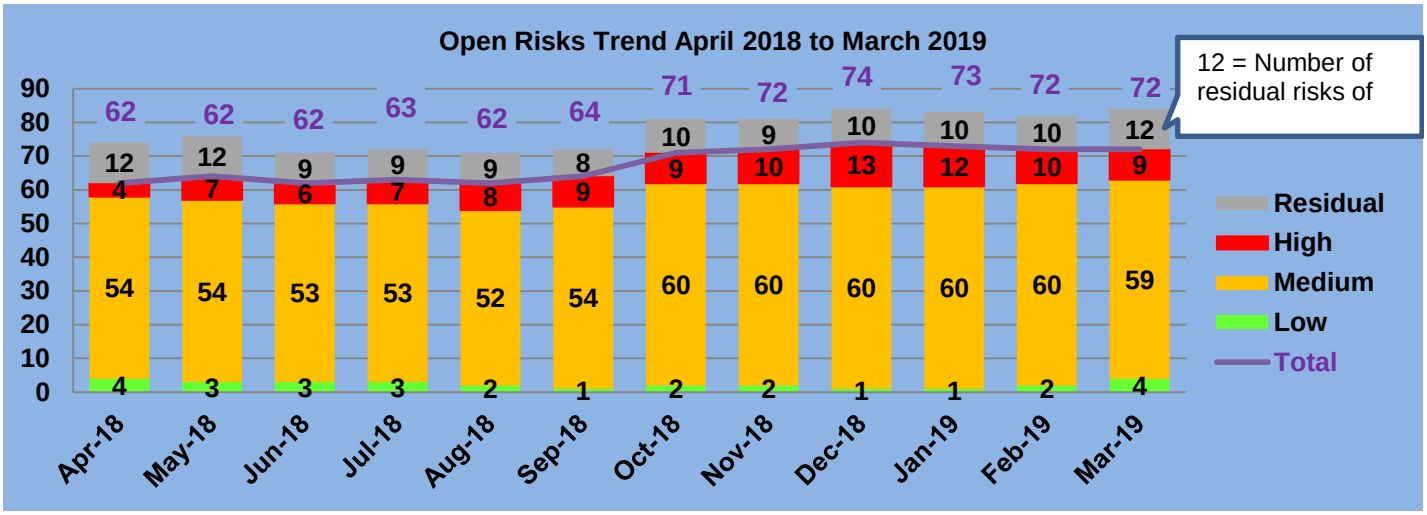
Table 16: Risk grading matrix

LIKELIHOOD						
	Almost certain	5	10	15	20	25
	Likely	4	8	12	16	20
	Possible	3	6	9	12	15
	Unlikely	2	4	6	8	10
	Rare	1	2	3	4	5
		INSIGNIFICANT 1	MINOR 2	MODERATE 3	MAJOR 4	CATASTROPHIC 5
		CONSEQUENCE				

To ensure overview of all risks the Trust's Board review all risks rated 10 and above on a monthly basis, the Quality Service Committee (QSC) review all risks rated 10 and above bi-monthly. Risks 9 and below are reviewed by the QSC on a quarterly basis.

There have been no risks overdue a review for 23 consecutive months at the final review and reporting stage. Risks form a standing agenda item discussed at each divisional governance meeting. An overall trend line of risks through the financial year is shown in graph 4.

Graph 4: Risk trend line April 2018 to March 2019



3.1.4 Risk assurance

The Trust's Board have taken significant assurance regarding risk management throughout the year. DCHS has effective mechanisms in place to ensure that risks are identified and managed right across the organisation. The risk management team continue to provide support and guidance as and when required. The effectiveness of the risk management strategy and policy have been recognised by the Board, Deloittes in the well led review (2018) and the CQC during their last inspection.

3.1.5 Risk maturity

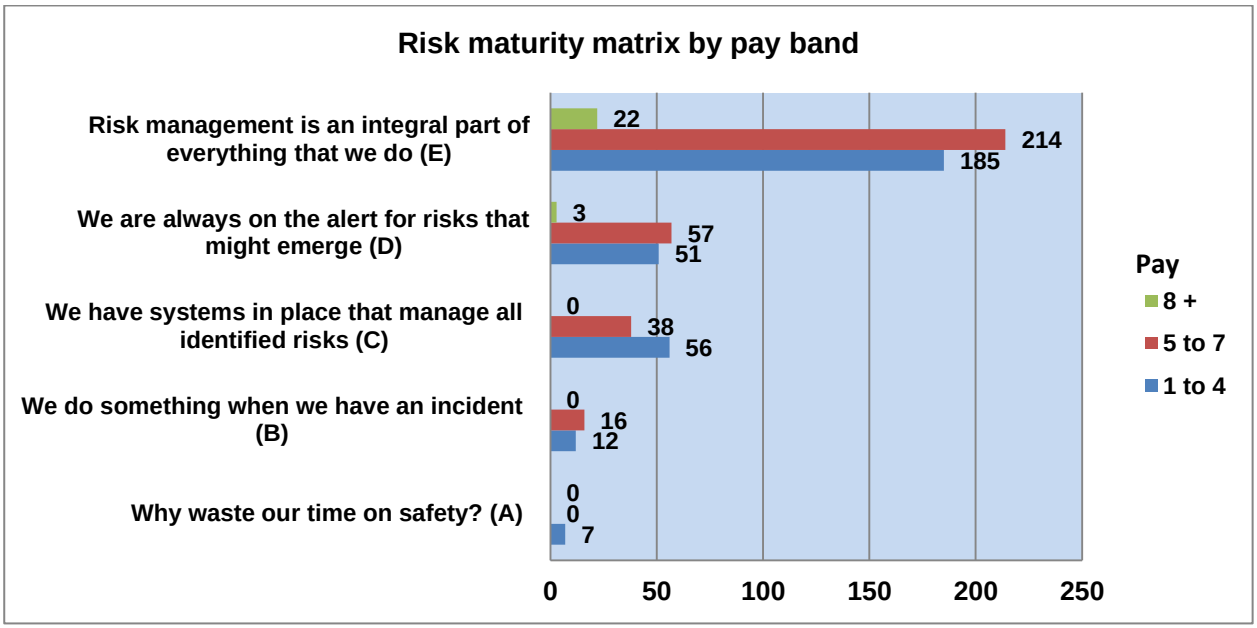
There is evidence of increasing risk maturity across DCHS. This was remarked on positively during the Deloittes well led visit. The maturity is demonstrated regularly within the risk register i.e. risks appear more fluid and better described in the controls and further controls sections when compared to previous years.

For 2018/19 the aim was to continue to promote and provide further support for improved awareness of risk management across the Trust with particular emphasis on improving awareness of risk management at a more junior team level. From 1 April 2017 the risk management team have used a simple matrix of five questions to gain staff responses in terms of levels of risk maturity as detailed in table 16. This provides staff an opportunity to identify and indicate what importance is placed on risk management in their workplace.

Measurements are now well established and provide the risk management team with an opportunity to bolster training and conversations around specific aspects of risk management. The data yielded in 2018/19, consisting of 661 responses from 777 issued questionnaires, shows that there is a positive culture of risk management. The responses yielded an 85% return and of

these 64% rated risk management as an integral part of everything that we do. This data enables the risk management team to identify the effectiveness of existing risk management training and awareness.

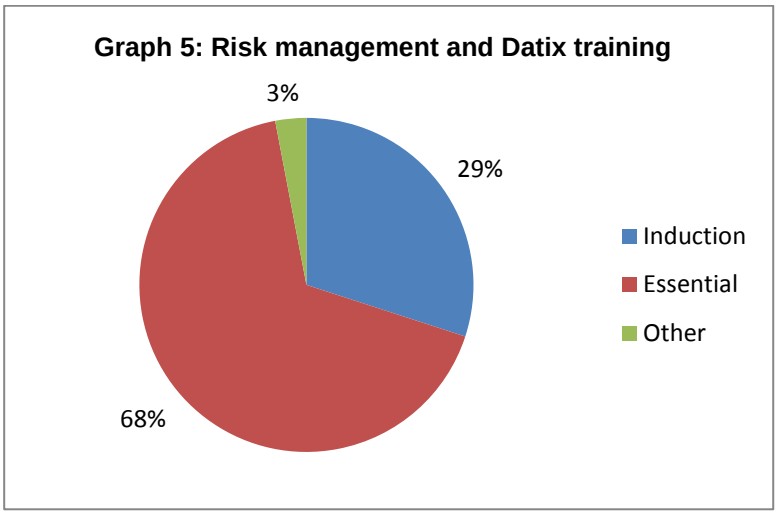
Table 17: Responses during April 2018 to March 2019



3.1.6 Risk training

During 2018/19 the risk management team provided risk management training to 1,322 members of staff. This is approximately 30% of staff employed by DCHS. This is based on a total of 4,416 substantive staff as recorded in the 2017/18 annual quality report. Training includes induction, essential, preceptorship and risk management training. This is supplemented by bespoke individual or team training.

Graph 5: Breakdown of risk management and Datix training



3.1.7 Clinical policies, guidelines and procedures (referred to as 'clinical documentation')

Clinical documentation is at the core of every patient encounter. In order to be meaningful it must be accurate, timely, and reflect the scope of services provided. For this report the different type of documents that are identified in table 17 will be referred to generically as 'clinical documentation'.

We recognise our public accountability, and have established and maintain two central clinical documentation sites to ensure compliance with relevant legislation, taking into account professional guidance and standards and reflecting best practice. These two sites - clinical policies site and clinical documentation site - are managed by the safe care team.

It is of paramount importance to ensure information is efficiently managed, and that all clinical documentation has gone through the correct governance and approval process as this, together with management accountability and structures, provides a robust governance framework for information management.

3.1.7.i Current numbers of all clinical documentation

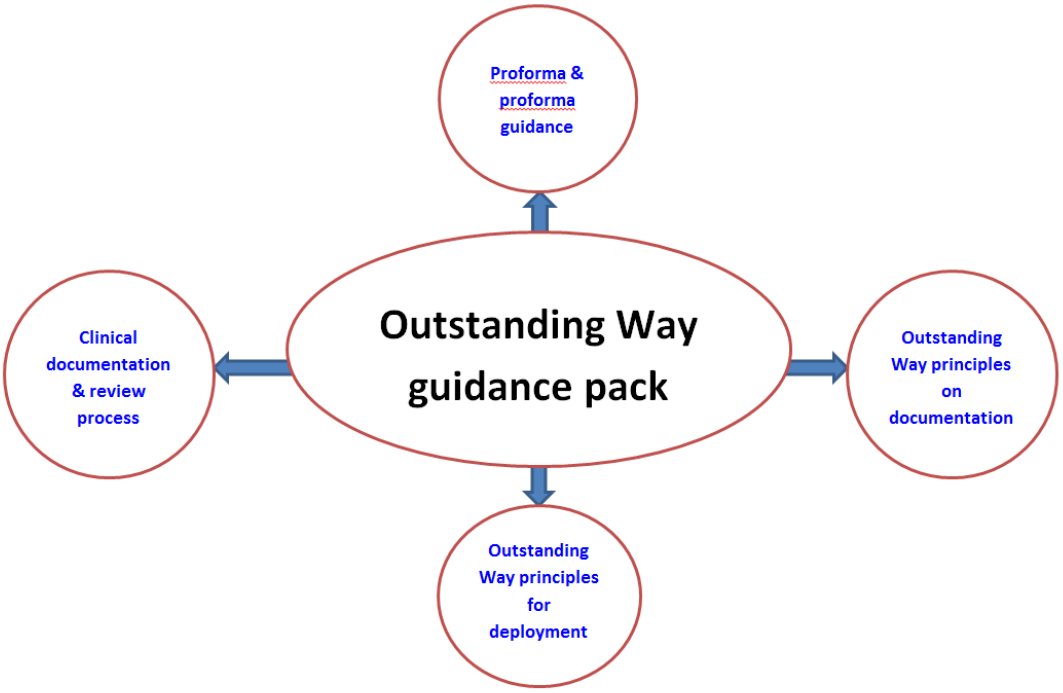
Table 18: Clinical documentation numbers

Type of document	DCHS stand-alone clinical document	Appendix in another document	None DCHS document	Total	Pending archiving
Policies	66	0	0	66	0
Guidelines	43	26	0	69	0
Procedures and protocols	31	14	0	45	0

Leaflets	120	60	2	182	0
Forms	13	0	0	13	0
Documentation paper	172	104	34	310	13

3.1.7.ii Documentation review process

The review of clinical documentation is a dynamic process and the numerous changes that occur due to new documents being developed and older ones archived or replaced are actioned within a timely manner. The Outstanding Way guidance pack below has been developed to support clinicians with the agreed process.



Clinical documentation is generally approved for three years and the safe care team advises teams nine months prior to the review date that they are due for review. To achieve this a rolling clinical documentation database has been created which monitors review dates.

The clinical documentation group is well established and has been running since 2014. The overall aim of the group is to provide assurance to CSG that the Trust is meeting its contractual obligations and expectations of external bodies such as the CQC, NHS Resolution and NICE in respect of clinical policies and guidance (collectively known as clinical documentation). The group will support DCHS to improve the quality and safety of care across our services by ensuring that clinical documents are effective, safe and in line with best national practice and that professional standards are clearly outlined and embedded in clinical records and documentation to prevent harm.

The clinical leaflets group was established in July 2018 and is a sub group of the clinical documentation group. The group's overall aim is to provide assurance to the clinical documentation group and its parent group, CSG, that the Trust is meeting its contractual obligations and the expectations of external bodies such as the CQC, NHS Resolution and NICE in respect of clinical leaflets.

3.1.7.iii Compliance

Currently 100% of all clinical documentation has been reviewed and is within their review date.

3.1.7.iv Number of clinical documentation approved/archived and new between March 2018 and March 2019

Table 19: Clinical documentation approved/archived/new

Type of document	Approved	Archived	New
Policies	14	10	2
Guidelines	28	14	10
Procedures and protocols	20	9	14
Leaflets	87	7	45
Forms	1	0	1
Documentation paper	62	72	11

3.1.7.v Governance of information systems

The data security and protection toolkit (DSP) (formerly the IG Toolkit) is completed annually, with backing evidence confirming compliance, and submitted by 31 March each financial year. The toolkit contains several assertions related to the governance and security assurance of our electronic information systems:

- **Managing data access -** personal confidential data is only accessible to staff who need it for their current role and access is removed as soon as it is no longer required. All access to personal confidential data on information technology (IT) systems can be attributed to individuals.
- **Unsupported systems -** no unsupported operating systems, software or internet browsers are used within the IT estate.
- **IT protection -** a strategy is in place for protecting IT systems from cyber threats which are based on a proven cyber security framework such as cyber essentials. This is reviewed at least annually.
- **Accountable suppliers -** IT suppliers are held accountable via contracts for protecting the personal confidential data they process and meeting the National Data Guardian's data security standards.

The information governance (IG) team are reviewing and updating our information asset register (a list of our information systems) to ensure this information is evidenced and held centrally for each system.

Our DSP toolkit compliance is monitored by the IG and records management group and the IM&T strategy group. A full action plan is taken to each meeting of the IG and records management group and compliance is reported through to QSC in the summary report following each meeting.

We are also audited annually on our DSP Toolkit compliance; the audit by KPMG took place in November 2018 and reported to the Audit and Assurance Committee.

3.1.8 Medical devices

There has been extensive work completed with regards to the standardisation of medical devices within community teams to ensure that all staff working in the trust have access to standardised equipment, which has been approved through a well governed process.

The provision of baseline kit (tympanic thermometer and sphygmomanometer) for community nurses and therapists was commenced in September 2017 and continued through 2018. This resulted in a truly significant year on year increase in baseline observations (taking into account the 10% increase in clinically-relevant patients during 2018) as detailed in table 20.

Table 20: Vital signs reporting 2017/18

Community nursing			Community therapists		
% increase on vital signs reporting from previous year			% increase on vital signs reporting from previous year		
Observation:	**2017**	**2018**	**Observation:**	**2017**	**2018**
Lying diastolic blood pressure	169.84	70.60	Lying diastolic blood pressure	147.97	25.15
Lying systolic blood pressure	186.33	61.97	Lying systolic blood pressure	149.45	24.26
O/E - pulse rate	133.50	37.07	O/E - pulse rate	128.83	60.7
O/E - rate of respiration	132.58	37.83	O/E - rate of respiration	116.33	68.61
Sitting diastolic blood pressure	122.77	34.11	Sitting diastolic blood pressure	104.45	60.50
Sitting systolic blood pressure	123.12	34.16	Sitting systolic blood pressure	104.36	60.31
Standing diastolic blood pressure	235.75	9.65	Standing diastolic blood pressure	109.26	41.72
Standing systolic blood pressure	224.58	8.83	Standing systolic blood pressure	109.20	42.31
Temperature	86.24	64.27	Temperature	120.02	87.37
Grand total	**126.78**	**40.47**	**Grand total**	**114.40**	**58.82**

This is being further developed with the provision of pulse oximeters to meet the requirements of the revised national early warning score (NEWS2). This has been recognised in the Quality Big 3: improving the identification of sepsis and recognition of the deteriorating patient and has been detailed in section 2.1.2.

3.1.9 National reporting and learning system (NRLS)

All patient safety incidents reported onto Datix which meet the reporting requirements are communicated to NHS England's NRLS through an established coding system (with NRLS guidance) set up within Datix and administered by the patient safety team. Incidents shared at this national level feed into national trends and promoting national improvements.

During the period 1 April 2018 to 31 March 2019, there have been a total of 7,994 patient safety incidents reported (excluding 689 rejected reports); of these 7,033 have already been communicated to the NRLS. Please note that the NRLS do not require all patient safety incidents to be communicated to them. At the time of reporting there were 188 (180 last year) patient incidents in the Datix system in the review process i.e. 109 (92 last year) awaiting review by manager, 33 (27 last year) actively being reviewed by manager and 46 (61 last year) waiting follow-up by the patient safety team. This is

showing a slight delay in responsiveness by the incident managers, which is reflected on the corporate risk register, but still an improvement compared with 2016/17.

Table 21: Patient incidents in Datix

	April 2016-March 2017	April 2017-March 2018	April 2018-March 2019
In holding area, awaiting review	**240**	**92**	**109**
Being reviewed	**70**	**27**	**33**
Awaiting final approval	**94**	**61**	**46**

Table 21 compares incident rate by severity classification. This is a much improved picture compared with previous years. There have been zero major harm incidents and a reduction from nine to four catastrophic incidents reported. The mortality review process ensures these are reviewed to determine if our clinicians provided reasonable care in foreseeable situations. Due to the reporting of inherited pressure damage and unwitnessed falls in community no longer requiring reporting, there has been a significant drop in the total number of finally approved incidents.

Table 22: Incidents by severity

Incidents by severity comparable data	2016/17	2017/18	2018/19
No injury or harm	3,574	3,905	3,558
Minor harm/injury	5,897	5,851	4,105
Significant harm/injury	344	253	141
Major harm/injury including permanent disability	2	0	0
Death/multiple deaths or catastrophic event (e.g. flood/fire)	5	9	4
Totals:	10,002	10,018	7,808

The catastrophic events comprise one each of: cardiac arrest on attendance to MIU; suspected suicide in patient's home; subdural haematoma post unwitnessed fall in a care home and an unexpected death in a residential home which has been referred to the coroner.

3.1.10 Never Events

Never Events are defined as incidents that are wholly preventable. Never Events are revised and relisted on an annual basis by NHS England. The revised list was launched in January 2018 where there have been a small number of changes which the patient safety team is in the process of incorporating onto the Datix system. During 2018/19 there has been one Never Event reported by the Trust which met the NHS England's Never Events listed fields.

The incident pertained to a dental green pack left in situ when it should have been removed. This was noticed before the end of the procedure in the recovery area and did not cause harm. In the spirit of transparency and learning, DCHS reported this incident as a No Harm, Never Event i.e. that unnoticed this may have caused harm and that the learning was great. The learning was shared through all relevant departments; guidelines were updated and distributed to enhance learning.

Table 23: The top five reported incidents and trends over the past three years

2016 /17		2017/18		2018/19	
Pressure relief care	**4,507**	Pressure relief care	**5,180**	Pressure relief care	**3,291**
Slips, trips and falls (patient)	**974**	Slips, trips and falls (patient)	**931**	Slips, trips and falls (patient)	**713**
Ambulance/taxi/ transport issue	**603**	Medication	**699**	Medication	**634**
Medication	**545**	Discharge problem	**509**	Discharge problem	**484**
Discharge or transfer problem	**419**	Safeguarding adults	**469**	Safeguarding adults	**444**
Totals:	**7,048**	Totals:	**7,788**	Totals:	**5,566**

Part of the impact on the figures for 2018/19 for pressure relief and slips, trips and falls (patient) is attributed to the cessation of incident reporting of inherited pressure damage and unwitnessed falls in community. This change was made because these incidents do not pertain to care delivered by DCHS. These are now captured on the electronic patient record in SystmOne.

Managing the transfer of patients safely between different health care facilities is essential. The patient safety team sends details of all discharge/transfer incidents to our acute trust partners. Responses are shared through our risk reporting system to the relevant manager so that any lessons learned are communicated. Due to this focused work the number of discharge/transfer incidents needing to be raised is gradually decreasing year on year.

Safeguarding adults incidents are those reported by our staff who have raised concerns which they have observed when administering care to patients. These incidents are usually related to influences external to the Trust and as such are not further communicated to the NRLS. The notification system within Datix allows the safeguarding teams to be aware of an incident as soon as it is reported.

3.1.11 Central alert system and strategic executive information system (STEIS)

The central alert system is a national reporting system which distributes alerts from NHS England, alerting health organisations of safety issues. During the financial year of 2018/19 a total of 110 alerts were received compared with 128 in the previous financial year. Each alert is reviewed for its relevance to our Trust and distributed to the services where the alert applies. All alerts were responded to within the required time frames and the implementation of any required actions is followed up by the patient safety team to ensure it has been executed.

Serious incidents requiring investigation in healthcare are rare, but when they do occur, everyone must make sure there are systematic measures in place to respond. We report incidents under the following severity of harm: no harm/minor/moderate/significant/major/death. Serious incidents are those considered when harm caused is moderate or significant and in the majority of cases, will require further investigation and reporting to commissioners via STEIS. These measures must protect patients and ensure that robust investigations are carried out, which result in organisations learning from serious incidents to minimise the risk of the incident happening again. When an incident occurs it must be reported to all relevant bodies.

The patient safety team processes all serious incidents and checks that, where appropriate, learning is shared across the organisation.

Table 24: Incidents reported on STEIS

Category	STEIS incidents 2016/17	Category	STEIS incidents 2017/18	Category	STEIS incidents 2018/19
Pressure ulcers	60	Pressure ulcers	62	Pressure ulcers	51
Slips, trips and falls	23	Slips, trips and falls	4	Slips, trips and falls	14
Delayed diagnosis	1	Medication	2	Treatment/Diagnosis Delay	2
Pending review	2	Infection prevention and control	1	Medication	1
Medical equipment	1	Sub-optimal care	1	Sub-optimal care	1
Sub-optimal care	1	Pending review	0	Surgical/Invasive procedure	1
				Medical equipment – devices	1 Never Event
Total	**88**		**70**		**71**

3.1.12 Serious incident

During October 2017 we were informed that a serious incident had occurred in the operating theatres at Ilkeston Hospital. A surgeon had received a letter from a pathologist at University Hospitals of Derby and Burton (UHDB) informing him that two histopathology (tissue) samples had been transposed resulting in surgery being carried out on one patient who did not need surgery and surgery not being carried out on one patient who did need surgery.

The two patients had both had elective procedures carried out in Ilkeston and tissue samples were sent from both patients to Derby. These samples revealed that one patient had pre-cancerous changes in the sample and she was booked for further surgery under a general anaesthetic; again samples were sent for histological examination in Derby. These samples proved normal and on review of the original samples the transposition was identified.

Both patients had appointments with the surgeon and the surgeon personally notified the patients of the error. The duty of candour process was comprehensive and the patients both received an apology from UHDB. The patients were also able to question a senior doctor from the pathology service. The full incident report has now been received from UHDB and the conclusions shared with the patients. An offer has been made for a further meeting with the medical director and head of patient safety.

The investigation confirmed that the multi-organisational pathway of care did not contribute to the error. We have carefully reviewed our procedures for labelling and transporting samples to ensure that these are as safe as possible.

3.1.13 Human factors (HF)

The principles and practices of HF focus on optimising human performance through better understanding the behaviour of individuals, their interactions with each other and with their environment. By acknowledging human limitations, HF offers ways to minimise and mitigate human frailties, so reducing medical error and its consequences. The system-wide adoption of these concepts offers a unique opportunity to support cultural change and empower us to put patient safety and clinical excellence at its core.

The patient safety team are making changes to the report form on Datix to enable the capture of HF from the perspective of the reporter and the incident manager to ensure that all incident investigations consider and address the 12 main areas highlighted in the DuPont's Dirty Dozen of Human Factors which are:

A lack of: communication, resources, assertiveness, awareness, team work, knowledge.

An abundance of: stress, pressure, norms, fatigue, distraction, complacency.

It is recognised that when any one of these contributory factors are present then an error can occur and that when three or more are present significant harm is more likely to be the outcome.

3.1.14 Duty of candour

We expect that our staff will always be open and honest with the patients and families they care for. This is especially important where care does not go as planned and where serious harm has occurred.

The Trust is committed to providing an open and honest explanation to patients and a sincere apology where serious harm has happened. During the reporting period 2018/19 there have been 71 incidents meeting the duty of candour criteria. Patients have been contacted and a full explanation provided following investigation.

Duty of candour is a thread throughout Trust induction, essential training, RCA training and incident managers' Datix training as well as being identified in our Sign up to Safety pledges.

References:

From Safety-I to Safety-II – A White Paper, Erik Hollnagel, 1 November 2015

https://www.england.nhs.uk/signuptosafety/wp-content/uploads/sites/16/2015/10/safety-1-safety-2-whte-papr.pdf

NHS England: Human factors in healthcare. A concordat from the National Quality Board

https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-hum-fact-concord.pdf

3.1.15 End of life care

We continue to work on the delivery of our three year end of life care strategic implementation plan which aims to improve and develop the quality and safety of patient care, supported through the development of our staff or service. In 2018/19 we saw the first end of life care training programme that was bespoke to meet the needs of our AHPs, to value and recognise their contribution to end of life care. We continue to support and develop our safe care Quality Always end of life care and spirituality champions who support and disseminate best practice in their individual areas. We proactively supported engagement of our staff and services with the key themes during the 2018 national Dying Matters week through local displays and a cross organisation event. Current work streams include the development of a DCHS directory of end of life care services to bring together all services that support end of life care into one easily accessible place for staff to use. Introduction of an electronic palliative care co-ordination system (EPaCCS), which aims to improve communication and co-ordination of care, will be implemented as a pilot in one area of DCHS and then rolled out to further areas across the organisation throughout 2019.

3.1.16 Allied health professions and end of life care

Our allied health professions contribute significantly to the multidisciplinary and holistic care of patients in their final year of life. This is a relatively new clinical role for these professions. Nationally, professional bodies have not published role descriptions to inform the development of competency frameworks or training needs.

In 2017, our end of life care strategy group noted the lack of take up of internal end of life training days. The end of life care facilitator was asked to develop an offer that would meet the needs of AHPs. This was co-produced with therapists working in clinical posts, along with local experts in partner organisations.

40 therapists attended a pilot study day delivered in north and south locations in November 2018. Evaluation of the courses took the form of a pre and post course questionnaire to assist the staff to reflect on their own learning.

In response to the question ‘did you feel that the day met your expectations?’ 29 out of 40 responded they were fully or partially met. Additional content was suggested to enhance the impact of the day for future attendees.

The new post of specialist lead trainer for end of life care and dementia has a sound foundation on which to develop the contribution of our AHPs to multi-disciplinary end of life care.

3.1.17 Time to Heal

Our Time to Heal leg ulcer improvement initiative was set up to:

1) Expand and redesign existing leg ulcer and wound management training
2) Appoint a chronic wound specialist nurse to review patients from the leg ulcer audit who had been on caseloads for more than 200 days.
3) Second leg ulcer specialist nurses to support community teams to review patients with lower limb wounds
4) Embed knowledge and skills acquired on training and assess competencies
5) Develop a clinical leadership programme which included health coaching to ensure quality conversations and patient focused plans of care.

Patient outcomes: chronic wound specialist reviews at 12 weeks: 32% healed and discharged. Leg ulcer specialist reviews 42% healed and discharged.

Table 25: **Patient outcomes**

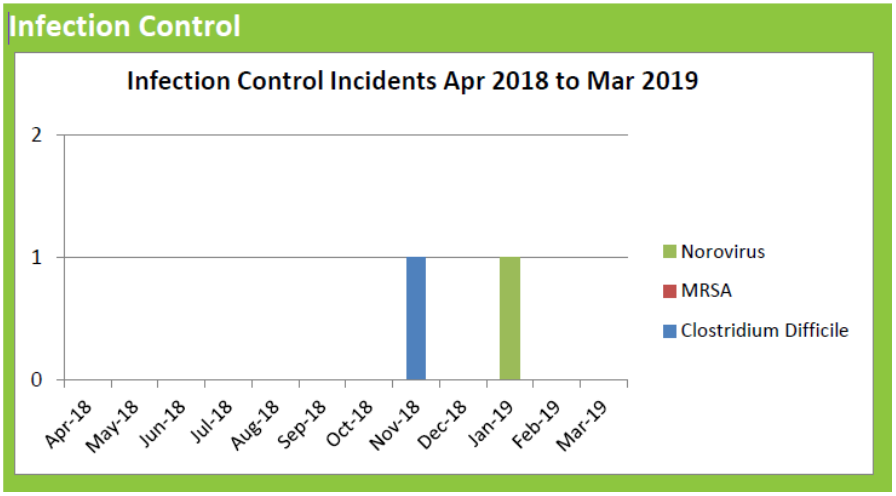
	6 week review	12 week review	18 week review	Total
Wound healed	207 (26%)	91(16%)	61 (18%)	359
Wound improving	272 (34%)	146 (25%)	112 (33%)	530
No change	105 (13%)	99 (17%)	71 (21%)	275
Wound deteriorating	47 (6%)	44 (8%)	20 (6%)	111
Has capacity refusing treatment	25 (3%)	18 (2%)	10 (3%)	53
In hospital	27 (3%)	21 (4%)	7 (2%)	55
No longer in DCHS care	24 (3%)	19 (3%)	6 (2%)	49
Deceased	24 (3%)	20 (3%)	15 (4%)	59
Impact on community nursing teams	At 6 weeks	At 12 weeks	At 18 weeks	
Reduction in nursing visits per week	268	165	160	593

For 138 patients that healed at six weeks the suboptimal care cost prior to leg ulcer specialist intervention was £435,646.14. This was reduced to £44,861.04. Potential cost savings for 138 patients if optimal care pathway was followed are £390,785.01

3.1.18 Infection prevention and control (IP&C)

Infection, prevention and control remains a high priority for us and our good performance is reliant on the continued commitment of the team in promoting best practice, alongside the commitment of staff, patients and visitors in ensuring that we keep healthcare associated infections (HCAIs) as low as possible. Again, this year we can report that our infection rates have remained low with three cases of Clostridium difficile infection and no blood stream infections (bacteraemia) reported.

Graph 6: **Infection control incidents April 2018 – March 2019**



We have been involved in improving awareness of sepsis across the Trust, including the recognition of early signs and symptoms and its management.

The work to reduce E. coli bacteraemia in the community has been ongoing and the IP&C team have continued to collaborate with the CCG and other partners in the wider health economy.

Patient story – Freddie's story

Amanda, school nurse told the story of Freddie, 9 years old. Freddie had poor personal hygiene and low school attendance (82%) due to frequent sickness and diarrhoea. As a subsequence of his absences the relationships with his peers were not as strong as they could have been. Amanda offered him and his family support around handwashing. The initial presentation of the session to the Freddie's family went well with everyone engaging and singing along to a cartoon.

Amanda offered to present a handwashing session to Freddie's school year of around 50 students. This was done with a view to improve Freddie's self-esteem and interaction with his peers and he agreed to be her 'assistant' to present the session.

During the session we had a hands up quiz; used glitter and handshakes to visually demonstrate the transmission of bacteria; used a lightbox to check handwashing techniques which also captured the children's attention. Freddie co-presented the session brilliantly. In addition, a colleague was able to join in and following watching the session they were able to present the second session.

Following the sessions that were presented by Freddie, the school reported that absences for diarrhoea and sickness had dramatically declined. Since the training Freddie has only had authorised absences due to medical appointments.

3.1.19 Patient manual handling and bariatric care

This year the team has supported 159 new patients (bariatric and complex) in community hospitals, transfers to community beds from acute hospitals and in their own homes. Patient records are now managed electronically allowing better communication with clinicians and data collection.

The team works with partner agencies to improve the flow of the patients' journey for people with bariatric needs from acute hospital to community beds or discharge ensuring the availability of appropriate equipment and staff to provide safe, high quality care.

We have been working with IP&C, occupational health, health and safety and tissue viability teams to support community nursing services with equipment and advice to reducing the occurrence of injury to staff from prolonged poor postures, due to low level working for leg dressings in the home and the complex wound clinics.

We have continued to review and audit personal handling equipment throughout the Trust to ensure safety and availability. The programme to replace mobile passive hoists is due for completion this financial year and will reduce the risk from different systems. Flat lift equipment (Hovermat and jacks) is being deployed across the Trust to enable safer and more comfortable lifting of people from the floor and transferring from bed to bed.

Compliance with mandatory patient manual handling continues to increase through bespoke training to teams and through the key trainer system. E-learning packages are soon to be available for staff for bed rail and bed area training and the provision of further training being provided at induction.

3.1.20 Falls prevention assessment and care planning

Inpatient areas have been utilising the new falls risk assessment documentation designed to enhance risk identification and improve care planning documentation standards. A follow up audit of falls risk documentation will be carried out, when the implementation of electronic patient records has been rolled out across all inpatient areas. Community services have undergone a transformation of a suite of patient assessments including falls prevention. Falls prevention specialists will continue to support staff across all clinical areas to ensure clinical assessments and interventions are representative of best practice.

3.1.21 Falls management

This year we have focused on the DCHS deliverable elements of the Derbyshire wide falls and fracture pathway, working alongside colleagues in social care, health and voluntary sectors across Derbyshire and Derby City and begun to outline a new service framework to offer to commissioners. We will continue to have a vital role which focuses on providing rehabilitation to improve strength and balance, restore function and independence and minimise the impact of recurrent falls and fall-related injuries on our elderly population across all clinical services.

3.1.22 Food texture descriptors

Dysphagia is the medical term for swallowing difficulties and a sign or symptom of disease, which may be neurological, muscular, physiological or structural. Dysphagia affects people of all ages in all types of care settings. Food texture modification is widely accepted as a way to manage dysphagia.

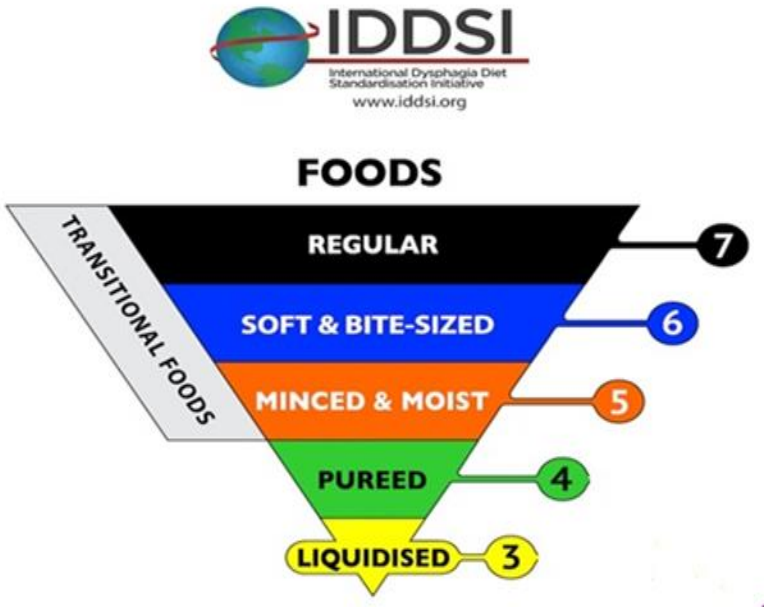
Historically the terms relating to food textures and fluid thickening, such as ‘custard thickness’, have varied locally. In 2011 a national standard terminology for modified food texture, including terms such as ‘fork-mashable’ were developed and widely adopted by the hospital catering industry and many clinical settings. However, local variations have persisted for food and fluid texture, confusing patients, carers and healthcare staff. In June 2018 a national safety alert (NHS/PSA/RE/2018/004) was issued to all organisations providing NHS funded-care for patients who have dysphagia or need the texture of their diet modified for other reasons advising the standard use of the international dysphagia diet standardisation initiative (IDDSI). The campaign was to be started immediately and be completed by 1 April 2019.

A review of NRLS incidents over a recent two-year period identified seven reports where patients appear to have come to significant harm because of confusion about the meaning of the term ‘soft diet’. As a result of the review the IDDSI developed a standard terminology with a colour and numerical index to describe texture modification for food and drink. Manufacturers were required to change their labelling and instructions accordingly, with an aim to complete this by April 2019.

Transition from the current range of food and drink texture descriptors to IDDSI framework for people with dysphagia required careful local planning to ensure it happened as soon and as safely as possible. A senior clinical leader was identified who brought together key individuals (speech and language therapists, dietitians, nurses, medical staff, pharmacists and catering services) to plan and co-ordinate the safe and effective transition to the IDDSI framework and eliminate use of imprecise terminology including soft diet across DCHS. A local implementation plan was developed, which included revising systems for ordering diets, amending inpatient menus local training, clinical procedures and protocols, posters and guidelines and patient information.

Through a local communications strategy (newsletters and local awareness campaign) all relevant staff were given opportunity to be aware of the IDDSI resources and importance of eliminating imprecise terminology. Local posters were created along with resource packs for use by appropriate staff and professionals. This work is now completed.

Graph 7: **International dysphagia diet standardisation initiative**



3.1.23 Diabetes specialist nurses (DSN)

The specialist nurses have received additional funding from transformational monies to increase their service. This has led to additional joint clinics being run within GP surgeries supporting practice staff to increase their expertise.

Additional specialist nurse support has been given at Whitworth Hospital in the specialist foot clinic supporting patients to improve their diabetes control, improve health outcomes and reduce referral to secondary care services. Average HbA1c* before DSN started treating them was 9.91%, the average latest figures were 8.56% so there was a mean average 1.35% decrease in HbA1c which is a significant improvement. An additional foot clinic is also supported in Buxton.
*HbA1c is your average blood glucose (sugar) levels for the last two to three months

The DSNs have been using Flo telehealth to support patients when starting insulin as a short term intervention; this allows monitoring of glucose levels remotely and potential reduction of face to face contacts. The DSNs continue to provide training for staff in diabetes and have supported use of new e-learning diabetes education tool - the Cambridge diabetes education programme.

3.1.24 DCHS Quality Improvement (QI) Faculty

2018 saw the creation and launch of the DCHS Quality Improvement Faculty. Already up to 75 members strong and growing, the faculty are a band of staff from all parts of DCHS who have an interest in, and dedication to improving services for our patients. Through their experience, commitment and skills they help to support our staff to identify areas for improvement and begin a change cycle to test and embed change. They are aided by a group of improvement advocates with extensive knowledge of NHS and social care systems. A DCHS library of quality improvement will also ensure that we learn from what has gone before and help spread good practice.

3.1.25 Ligature management work

In October 2017 we invited our internal auditors (360 Assurance) to support and advise us in the review and revision of our ligature management policy and associated risk assessment and survey tool which resulted in the following action areas:

- Revision of the compound risk scoring capability to include a score for the ligature point itself reflecting its position and design (i.e. is it ‘anti-ligature’ or not, is it accessible and weight bearing?)
- Review of the compensation factors making up the compound risk in order to establish more robust coherence between room function, security over access and relative remoteness within an area
- The resulting policy needs to incorporate a ‘survey tool’ for completion
- The new policy and risk survey tool should be widely publicised and accessible
- Staff should be supported in how to use the tool and that one or two individuals from an area should be involved in carrying out the survey (especially important where staff have not had to use this type of survey approach in their areas)

- The identification of an appropriate committee within our governance framework which will have oversight and monitoring responsibilities for the implementation of the policy, the associated ligature risk surveys and the progression of any identified remedial works that are recommended. This responsibility will also include an escalation route e.g. in the case of where difficulties are experienced within a service in having remedial works progressed.

The revised policy was presented at the mental health oversight group (MHOG) in January 2018 where both the policy and the tool were endorsed and subsequently approved by CSG on 2/2/2018.

CSG agreed to become the oversight and monitoring committee for this process and routinely receives an update report at its meetings. In parallel with its approval by CSG, work was undertaken with the communication and engagement team to formally publicise and launch the new policy and survey tool across DCHS utilising the My DCHS intranet pages.

The tool was used for the first time to survey the new Heanor Memorial Health Centre**;** this enabled a number of functionality issues to be identified in the survey tool and for these to be resolved. A schedule was developed which identified 17 areas of service across DCHS for initial survey. In all, 19 surveys were completed during 2018 across all inpatient services, MIUs and the OPMH day hospitals. The remedial works identified from each survey were costed and presented to CSG and the QSC and a schedule of works was agreed for 2018/19 with the remaining works agreed for 2019/20.

3.1.26 Prevention and management of violence and aggression (PMVA)

In December 2017, a working group was assembled to carry out a comprehensive review and revision of the management of violence and aggression policy. The initial purpose was to review and revise the current policy in light of a 360 Assurance action plan relating to the policy and its procedures. We undertook our review considering the following guidance:

- Positive and proactive care - reducing the need for restrictive interventions (Gov.uk 2014) – reduce uses of physical restraint in care settings
- British Institute for Learning Disabilities – adoption of trauma aware approaches to PMVA
- MIND - movement away from combative styles of PMVA
- NHS England – outlaw the use of prone restraint
- Care Quality Commission – attention on PMVA practices as part of their inspections
- MHA 1983 code of practice (2014) – least restrictive principles
- NICE guidance NG10 – short-term management of violence and aggression – proactive and inclusive care planning
- Positive behavioural support planning
- The Use of Force Act (Mental Health Units) 2018.

The current policy will not be fit for purpose moving forward and a re-write and review of associated procedural tools has commenced:

- With the oversight of CSG – monitoring the working group
- Consultation with MHAC members
- Consultation with safeguarding colleagues.

The new policy brings with it key robust safeguards for patients:

- Designed to ensure that all uses of physical restraint will only follow after all least restrictive measures have been considered thoroughly
- That during physical restraint, measures are taken to monitor carefully the patient's physical condition so that their safety can be properly supported
- That when used, review of the circumstances which led to its use and the techniques employed will take place as part of a formal investigation process
- That effective debriefing of service users and staff takes place and appropriate support is provided
- That ensures incidents of physical restraint will be effectively recorded and reported so that we can draw on this information to inform over strategic objectives of reducing use.

3.1.27 Safeguarding service

Safeguarding children, young people and adults from abuse and harm is everybody's business, is an important part of everyday healthcare practice and should be an integral part of patient care. We have a dedicated safeguarding team of nurses, health professionals and administration staff to provide advice, support and training to our staff and other care providers within Derbyshire.

All staff working within DCHS who have a responsibility for the care, support and protection of children and vulnerable adults should ensure that those at risk are safe. If staff witness or have suspicions of abuse or neglect, they are under an obligation to report it without delay even if they have not witnessed the abuse or neglect themselves. The safeguarding service seeks to protect children, young people and adults through training, supervision and advice.

The safeguarding service promotes a Think Family focus throughout all child and adult safeguarding work to promote the importance of listening to the voice of the child so that their experience is heard and for the adult to ensure that safeguarding is made personal.

3.1.27i Key legislation

The Children's Act 2004 (Section 10 and 11) requires each local authority to make arrangements to promote cooperation between the authority, relevant partners and such other persons or bodies working with children in the local authority's area as the authority considers appropriate. The

arrangements are made with a view to improving the wellbeing of all children in the authority's area, which includes the need to safeguard and protect from harm and neglect.

Working Together to Safeguard Children (2018) continues to be the guidance which covers the legislative requirements and expectations on individual services to safeguard and promote the welfare of children and provides a clear framework for Local Safeguarding Children Boards (LSCBs) to monitor the effectiveness of local services.

The Care Act of 2014 continues to direct the statutory duties of all agencies in relation to safeguarding adults to ensure that services are reactive, proactive and responsive. There is now increased importance placed on making safeguarding personal for individuals who require safeguarding advice and support. To achieve this professionals and agencies must work in partnership and promote the wellbeing of both individuals and their families/carers to reduce inequalities, risk and harm from abuse.

3.1.27ii Quality assurance

There has been a change in the safeguarding self-assessment; the markers of good practice (MOGP) has been replaced by the Section 11 audit. This audit reflects safeguarding children responsibilities as directed by section 11 of the Children Act 2004. The outcome of the process informs the Trust Board, CCG and the Derbyshire Safeguarding Children Board (DSCB) of the processes in place to safeguard local children and young people and acts as a benchmark of compliance.

The section 11 site visit and MOGP for looked after children by the CCG was completed on the 7 December 2018. The outcome being that suitable arrangements are in place, consistent with the standards as set out in the national guidance.

The visit/audit reflects the organisational arrangements for looked after children and that the needs of children are being met and identified in line with statutory guidance: Promoting the health and wellbeing of looked after children (2015).

The CCG carried out a visit on 31 October 2018 to review the completed safeguarding adults assurance framework (SAAF). They were reassured that:

> "The DCHS safeguarding team continue to provide an excellent service across DCHS. The team has developed a variety of expertise and leadership which act to benefit both clinical and non-clinical staff. There is awareness within the team that safeguarding requires ongoing scrutiny and evaluation. You have continued to seek opportunities to enhance the service and improve outcomes for adults at risk from abusive behaviours and practice."

The safeguarding team's core responsibilities are providing advice and support, delivering training and safeguarding supervision to DCHS and on occasion to partner agencies.

3.1.27iii Training delivery

The team deliver training to all DCHS staff that have contact with patients, volunteers, and governors. The level of training required is decided by the intercollegiate document for safeguarding children and young people January 2019 and adult safeguarding August 2018.

Table 26: Safeguarding and Prevent training compliance

Safeguarding training compliance	2018-19
Safeguarding adults level 1	98.00%
Safeguarding adults level 2	97.54%
Safeguarding children level 1	97.96%
Safeguarding children level 2	97.37%
Safeguarding children level 3	**86.77%**
Safeguarding children level 3a	**94.59%**

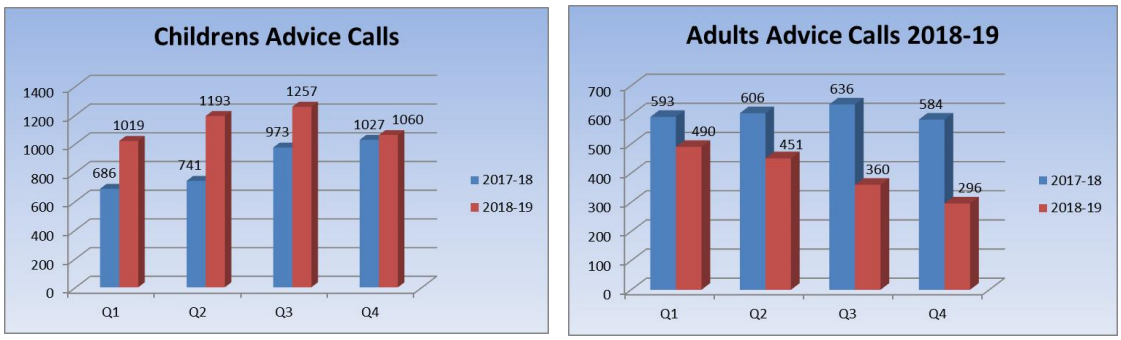
Prevent training compliance	2018-19
WRAP training (clinical staff level 2 and above)	**96.7%**
BPAT training (non-clinical staff level 1)	**88.6%**

3.1.27 iv Advice and support

The volume of advice calls to the safeguarding children team has increased for each quarter from the previous year. The safeguarding adult team's advice call activity has dropped. We are exploring whether this is due to more appropriate recording on the safeguarding electronic record along with improved knowledge of staff through training, increased debriefs with frontline staff and the delivery of

safeguarding supervision by the safeguarding adult team. The adult safeguarding team continue to be extremely busy, supporting DCHS staff with an ever increasing number of complex cases.

Graph 8: Calls made to safeguarding service (children and adults)



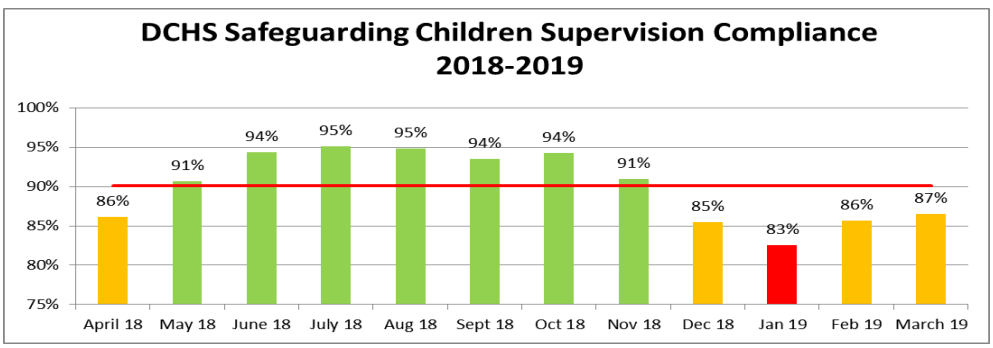
3.1.27v Safeguarding supervision

The delivery of safeguarding supervision is a statutory requirement for the safeguarding children team which we record to ensure compliance. The adult safeguarding team provides supervision to teams that are recognised as having 'high risk' clients i.e. learning disability, older people's mental health. Often, when a Think Family approach is required supervision is delivered jointly by a named nurse safeguarding children and a named nurse safeguarding adult.

December to March 2018/19 saw a decrease in the number of safeguarding supervision sessions delivered by the safeguarding children team; this was due to sickness within the team and increased activity caused by the writing of serious case reviews and serious learning incident reviews.

The safeguarding team remain committed to the protection of all children and vulnerable adults within Derbyshire.

Graph 9: **Safeguarding children supervision compliance**



3.1.27 Modern slavery statement

This statement is made pursuant to Section 54 of the Modern Slavery Act (2015) and sets out the steps that DCHS has taken and will continue to take to ensure that modern slavery or human trafficking is not taking place within this organisation or those with whom we are affiliated. Modern slavery encompasses slavery, servitude, human trafficking, forced labour, sexual exploitation and forced criminality. We have zero tolerance to any form of abuse and thus modern slavery is incorporated within both children and adults safeguarding work streams.

We are committed to acting ethically, with integrity, requiring transparency in all our business dealings and putting effective systems and controls in place to safeguard against any form of modern slavery across the NHS and associated sectors.

Through implementation of robust recruitment policies and procedures we ensure that comprehensive checks are in place to negate the likelihood of an individual being employed by the organisation who has been trafficked or who is the victim of modern slavery.

DCHS is responsible for providing a range of health services for people living in Derby and Derbyshire. The care we provide is monitored by the Clinical Commissioning Groups (CCGs) across the area through regular compliance visits and processes to ensure that we are compliant with the Modern Slavery Act (2015). More details about our work in this area can be found on our website www.dchs.nhs.uk.

3.2 ENSURING SERVICES ARE CLINICALLY EFFECTIVE

As well as our developing clinical audit programme we continue to develop mechanisms for improving and evaluating the effectiveness of care of patients. This section provides examples of how we have achieved this across our range of services.

3.2.1 BRAVO

BRAVO is an excel-based tool undertaken annually which captures clinician activity in 10 minute slots, including detailed clinical procedures, travel, and break time. It was developed by DCHS in response to an ever growing requirement to capture detailed information on the type and volume of activity which community nurses and other clinicians undertake: predominantly clinical but also associated non-clinical activity. This information includes the acuity and dependency of the patients in our care.

The tool has been used by DCHS over the last four years to support local and strategic workforce planning. We have continued to refine the capability of the tool to ensure it remains fit for purpose and has the flexibility to capture the information the organisation needs.

In the past BRAVO data has been used to support the development of leg ulcer clinics and has enabled managers to review and respond to local priorities within clinical teams in terms of skill mix and best practice, supporting the development of staffing for safe caseloads in the community.

During 2018/19 information extracted from the BRAVO audit has supported discussions with commissioners regarding the development of the district nursing specification for 2019/20.

3.2.2 Clinical Effectiveness Showcase

The Clinical Effectiveness Showcase 2018 (Quality conversations to improve outcomes - using clinical effectiveness to support staff and benefit patients) took place on Thursday 4 October 2018 at Post Mill Centre. This year we focused on the way in which we can use clinical effectiveness methodologies to improve the outcomes for our patients, with an overarching theme about how we can engage patients by the way we communicate with them. 92 people attended, the day was vibrant and energetic, it evaluated extremely well and led to DCHS staff going on to showcase their work at external quality improvement events.

3.2.3 Research and innovation strategy implementation

We have made significant progress in implementing this strategy through the development and delivery of a research programme across the Trust that is rigorously governed and which results in quality improvements for our patient population. We have delivered a variety of studies relevant to the

clinical priorities of the research strategy and have begun to develop research competencies with staff across the Trust including developing a research leadership development programme for principal investigators funded in partnership with the Clinical Research Network. The appointment of research champions within each of the three operations divisions has been key to promoting and embedding research which is relevant to our clinical services. DCHS has established a partnership with Derbyshire NHS library and knowledge service. This provides our staff with access to a full and comprehensive service including literature search service, training, knowledge sharing service and access to library resources across three sites.

A research survey was undertaken during 2018 which demonstrated that 15% of staff within operations divisions who responded to the survey had actively engaged in research in the last two years. A further 66% of those not yet involved in research expressed an interest to be involved. This demonstrates an appetite within the Trust to further develop research capabilities and opportunities.

The research and innovation strategy was refreshed in February 2019 and outlines the strategic priorities below:

- Increasing patient and public participation, involvement and engagement in the research and innovation agenda
- Ensuring our staff have the skills and support they need to enable them to develop research and innovation capacity and capability
- Promoting and embedding a culture of research and innovation to improve the quality of care in service delivery and to drive a process of continuous quality improvement throughout the Trust
- Using research and innovation to deliver evidence based practice while making the best use of resources
- Working collaboratively with other organisations to identify and develop new opportunities in research and innovation
- Ensuring research and innovation enables us to contribute to an improvement in the health of our population and reduce inequalities.

During 2018/19, we have continued to develop our research capacity and capability. This year the research and innovation team has introduced two new posts: a research nurse and a research assistant. These roles are instrumental in supporting our research officer to grow the research ambition at DCHS. The research and innovation team and divisional research champions provide support and mentorship to colleagues who want to become involved in research. They support the uptake of clinical studies and opportunities for staff and patients to participate in research and they facilitate research, resolve barriers and share good practice

Key research and innovation successes this year include:

- One of our health visitors/practice teacher has become the Institute for Health Visiting research champion for the East Midlands
- A community dentist has successfully been awarded an NIHR in-practice fellowship

- One of our speech and language therapists has successfully applied for the Health Education England/NIHR bronze clinical scholar award
- Three physiotherapists from integrated community services presented their posters at the DCHS Clinical Effectiveness Showcase
- A poster presentation was submitted to the East Midlands Clinical Research Network Research Forum titled 'Evaluation of the training nursing associate pilot in Derbyshire'.
- Special care dentistry successfully applied for a small grant research prize through the British Society for Disability and Oral Health on the research topic of 'Qualitative assessment of oral health related quality of life in patients receiving community-based psychiatric care in Derbyshire'. This grant of up to £5,000 will enable the team to pursue a research topic in the area of special care dentistry.
- A health visitor has successfully presented the Five Guide - a training package and approach to support education delivered to women following a caesarean section. This innovation has gained the interest of the Royal College of Nursing and Public Health England.

Collaboration

Another area of development in research this year has focused on building and strengthening our strategic partnerships with research networks, universities and other NHS providers.

- Ongoing work to develop a partnership between DCHS and Huddersfield University
- Research work is continuing between DCHS and researchers from the University of Derby to discuss possibilities for a leg ulcer research proposal
- Exploratory meeting was held with the Health and Social Care Research Centre, University of Derby and members of the research and development team from Derbyshire Healthcare NHS Foundation Trust to discuss collaboration and potential bid development for research projects
- Established links between DCHS and a senior lecturer with an interest in palliative and end of life care at the Health and Social Care Research Centre
- DCHS was represented at the community trust alliance (CHART) meeting in Birmingham which aims to provide a forum for discussion and action to increase research participation in community trusts
- Attendance at the Derbyshire CCGs research forum, which sets out to connect health and social care organisations across Derbyshire and to increase research activity
- Clinical research network has invested in research posts and the professional development of our staff.

Research activity

DCHS portfolio studies opened in 2018/19. Definition: the National Institute for Health Research clinical research network (NIHR CRN) portfolio is a database of high-quality clinical research studies that are eligible for support from the NIHR clinical research network.

Table 27: Research Studies opened 2018/19

Research title	Research summary
Metronidazole versus lactic acid for treating bacterial vAginosis–VITA	A randomised controlled trial to assess the clinical and cost effectiveness of topical lactic acid gel for treating second and subsequent episodes of bacterial vaginosis.
PrEP (pre-exposure prophylaxis) impact trial	HIV pre-exposure prophylaxis (PrEP) is the use of anti-HIV medicines by HIV negative people in order to prevent them from becoming HIV positive if exposed to HIV. The PrEP Impact Trial will make PrEP available to 10,000 people over three years to help find out how many people will need PrEP, how many will want to take PrEP, and how long they will stay on PrEP.
Development of a patient decision aid and patient information resource for the management of decayed primary teeth: supporting parents and children to make the right choice for them	The aim of the study is to develop a patient decision aid to support parents and children to make the right choice for them for the management of their child's decayed baby teeth. This will be done through conducting interviews with parent/child pairs who have already been referred to Derbyshire community dental service (CDS) and using this information to design a patient decision aid (PDA) which will then be evaluated and adapted by experts, parents and children.
CREATE - training for OTs in advising on fitness for work	Comparing a reusable learning object with face-to-face training for occupational therapists in advising on fitness for work.
Scaling the Peaks	Understanding the barriers and drivers to providing and using dementia friendly community services in rural areas: the impact of location, cultures and communities in the Peak District National Park on sustaining service innovations.
Finch (falls in care homes)	A multi-centre cluster randomised controlled trial investigating the impact of implementing the guide to action care home (GtACH) fall prevention programme in old age UK care homes.
The psychosocial impact of diabetes and severe mental illness: DAWN-SMI	A survey of people with severe mental impairment (SMI) and diabetes, their carers and healthcare professionals to examine the psychosocial impact of diabetes in SMI including diabetes distress, quality of life, and factors affecting diabetes self-management.
HCP training in assistive technology	A survey of healthcare professionals' knowledge, experiences and training needs in assistive technology.
Public preferences for vascular treatment: is health outcome all that matters?	A survey looking at public preferences for vascular treatment and what factors are important in providing that care.
Radicalisation and general practice	A survey to scope current primary care attitudes, awareness and practice in the areas of identifying radicalisation such that the workforce can be better supported in addressing the threat posed to communities by extremism.
RSV and vaccination in pregnancy	A questionnaire-based study of pregnant women and healthcare staff to help identify factors that might affect their understanding of Respiratory Syncytial Virus (RSV) and attitudes to being involved in hypothetical future trials and receiving the RSV vaccination.

DCHS non-portfolio research activity. Definition: These are studies that do not meet the criteria for adoption by National Institution for Health Research.

Table 28: **Non-portfolio studies opened in 2018/19**

Research title	Research summary
How do school nurses identify and work with children at risk of child abuse and neglect?	A mixed-methods design to support a comprehensive understanding of the role of the school health nurse in identifying and working with school-aged children at risk of child abuse and neglect.
Cognitive management pathways in stroke services (COMPASS): The identification and management of cognitive problems by community stroke teams	The identification and management of cognitive problems by community stroke teams.
Following up patients who last used the tier 3 weight management service in Derbyshire over two years ago	Following up patients who last used the tier 3 weight management service in Derbyshire over two years ago
Micronutrient supplement effects on cognitive outcomes in TBI	The aim of the study is to investigate the efficacy of low-cost multivitamin supplementation with post-acute head injured patients and potential benefits this may have on cognitive rehabilitation. The study is a trial which will compare cognitive task performance of three matched traumatically brain injured patient groups: one taking a multivitamin supplement, one taking an omega-3 supplement and a control group. The findings should inform nutritional supplementation post head-injury.
Peer mentoring for acquired brain injury study (PAIRS)	Many people don't receive the help they need after brain injury. One way to help is to pair them up with a more experienced brain injury survivor who understands their problems, can provide support and help them take part in activities. This PhD project aims to find out if it is possible to recruit mentors and mentees, match them together, get them to meet and achieve activity goals.
How does the microbiome change in a diabetic foot infection after a week of treatment with antibiotics and is this change a result of the treatment?	Diabetic patients are typically prescribed systemic antibiotics. Often, these antibiotics do not resolve the infection. There will be a collection of tissue from patients who present with diabetic foot infections. Bacteria will be harvested from the tissue and from samples taken after treatment of antibiotics. The data will provide insight on how the bacteria in the foot ulcer change in type and amount after a week of treatment with antibiotics.

Research title	Research summary
What are caregivers experiences of supporting stroke survivors with graded repetitive arm supplementary programme (GRASP) self-management in the community?	Graded repetitive arm supplementary programme (GRASP) is a homework-based programme to improve arm function after stroke.
Attendance at clinical health psychology appointments	A multilevel analysis of patient-level predictors and therapist effects on attendance at clinical health psychology appointments.

Table 29: **showing the current number of participants recruited for participation in portfolio research projects for the year 2018/19.**

Research title	Recruitment 2018/19
Metronidazole versus lactic acid for treating bacterial vAginosis–VITA	4
PrEP (pre-exposure prophylaxis) impact trial	49
Development of a patient decision aid and patient information resource for the management of decayed primary teeth: supporting parents and children to make the right choice for them	74
CREATE - training for OTs in advising on fitness for work	2
Scaling the Peaks	1
Finch (falls in care homes)	0 (non-recruiting)
The psychosocial impact of diabetes and severe mental illness: DAWN-SMI	1
HCP training in assistive technology	2
Public preferences for vascular treatment: is health outcome all that matters?	12
Radicalisation and general practice	0
RSV and vaccination in pregnancy	0 (non-recruiting)
	Total 145

Research governance and reporting

We have made considerable progress towards meeting the minimum data set targets outlined by the clinical research network. The data set relates to the portfolio management system (EDGE). The minimum data set project is in place to ensure quality and consistency in reporting on the capacity and capability approval process for trusts. There has been a steady rise in compliance to the minimum data set definition from 73% in July 2018 to 99% in January 2019.

3.2.4 Dementia and frailty

Dementia

The current focus on dementia, both globally and nationally, has highlighted how much has been achieved in the development of dementia care since the launch of the national dementia strategy in 2009/10. However, dementia care remains a national challenge. In response to this, DCHS has worked extensively with our staff, patients and carers of people with dementia to develop the DCHS dementia strategy.

Our strategic objectives are to:

- Provide comprehensive education and training for all staff working within the Trust to empower teams to champion and deliver the very best, person-centred, compassionate, safe and effective care
- Provide early specialist support to people who have just been diagnosed with dementia to aid them and their carers to live well with dementia
- Provide targeted support to people with moderate dementia to continue to live well, through the delivery of programmes of cognitive stimulation therapy
- Refresh our approach to communication by listening to, involving and engaging with people with dementia and their carers to improve dementia care
- Care and support for the carers and friends of people with dementia
- Raise the standards of care by promoting activities that improve the wellbeing of people with dementia and their carers
- Continue to develop our Trust as a Dementia Friendly organisation with environments that promote better outcomes and which are safe
- Continue to develop partnerships to improve collaborative working and improved integration of the pathways of care.

Our strategic objectives will be delivered in keeping with the following principles:

- Parity of esteem between physical and mental health
- Dementia care is everybody's business
- All relevant staff to have generic dementia management skills and competencies
- Dementia friendly environment is embodied not only in concrete buildings and infrastructure but also in the attitude and culture exhibited by staff as we move to a care closer to home model of care delivery
- Reduction in hand-off points in the care of people with dementia
- A clear understanding of the relationship and interdependencies between dementia and the frailty syndromes both in terms of pre-disposition/causation as well as exacerbation.

Frailty:

Around 10% of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85 years (Collard *et al*, 2012). The DCHS frailty strategy sets out our approach to the care of older people living with frailty. It will be applicable to all people who are cared for in DCHS inpatient settings, within the community and by DCHS-led primary care services. It is informed by national guidance and is set in the context of the Derbyshire-wide Sustainability and Transformation Plan. It articulates the Trust's strategic aims in response to an ageing population and addresses the unique challenge of frailty: treating older people as individuals who need coordinated, person-centred care rather than as a collection of morbidities.

Our strategy is aligned with the Joined up Care Derbyshire community frailty model with the stated vision of Derbyshire Healthier Futures.

The goal – to enable all older people to live healthy independent lives for as long as possible in their own home or the place they call home reducing the need for escalation of care to non-home settings by 2020.

The DCHS frailty strategy has three main objectives:

1. Frailty as a long term condition in its own right, rather than merely a label.
2. Pro-active care through timely identification, comprehensive assessment and person-centred, holistic care planning
3. Community based, person-centred, coordinated care.

3.3 CARING – UNDERSTANDING AND IMPROVE THE PATIENT EXPERIENCE

Patient story - Phil's story by Sue from DTC.

Phil suffers from severe hospital phobia and had not been inside a hospital in twenty years. His mother had died in hospital and he hadn't been able to visit her due to the extent of his phobia. Although his sight was deteriorating rapidly, he felt he could not come to hospital to have his cataract surgery. The team agreed how to gradually expose Phil to the hospital by phone contact initially and after several months he agreed to meet Caroline, the manager, in the car park and then eventually in the hospital café. Over a period of time Phil attended his outpatient tests in the eye clinic. It was a lengthy process as there were times when Phil felt he simply could not come in.

When Phil first attended the DTC he was introduced to a designated nurse who showed him round the department, into the theatre where he would have his surgery and explained in detail what would happen on the day of his procedure. She assured Phil that she would be with him at every step during his treatment. The team were able to put to rest many of his anticipated anxieties.

On the day of surgery the whole team was united in ensuring Phil had a positive experience. The operation was a success. Cataract surgery has an important and almost immediate impact on the lives of patients and Phil expressed his gratitude to all the staff for achieving 'the impossible'.

None of the above would have happened had we not had in place the pathway for working together closely and the staff with the drive, professionalism and passion to deliver the best service possible to our patients.

It was a pleasure to be able to feed this back to our teams both as a learning outcome but also as a massive success for the patient.

3.3.1 Patient engagement and Involvement

We measure and monitor people's experiences in different ways to help us improve services. This includes general feedback, complaints, concerns, compliments, the NHS Friends and Family Test (FFT), surveys and online sources such as NHS Choices and Care Opinion (previously known as Patient Opinion) as well as social media. We have also heard many patient and carer stories this year.

98.3% of people would recommend our services to their friends or family if they needed similar care or treatment. *(*FFT results 2018-19)*

3.3.2 The Friends and Family Test (FFT)

The FFT is an important feedback tool that asks a patient “How likely are you to recommend our (ward/service) to friends and family if they needed similar care or treatment?” on a scale from extremely likely to extremely unlikely. The FFT helps us to identify good and poor patient experiences.

Throughout the year we have monitored responses to the FTT and the reasons why people have given higher or lower scores. We follow the national guidance for undertaking and scoring of the FFT results and report on our performance monthly so that we can benchmark our results.

The FFT feedback has been overwhelmingly positive with comments describing high quality services, compassionate and empathetic staff as well as satisfactory overall patient experiences where often expectations are exceeded.

26,778 patients completed the FFT between April 2018 and March 2019 (8% decrease from last year, 29,141 cards). We also continue to perform well above the local and national FFT results.

Whilst the overall feedback given is positive about the care provide to patients, their relatives and carers, we also often get suggestions for improvement. Most typically this has related to improving communication, extending service opening times, reducing waiting times and making some service environments more comfortable (e.g. with better seating and refreshments).

3.3.3 Involvement

We have a network of over 40 groups which consist of local people who use our services. We have worked with these groups to develop our services in the last year. Our most successful example of working in partnership with local people is around the development of our dementia strategy. A focus group helped us shape the development of this strategy.

We will continue to work with the general practice patient participation groups (PPGs) to support our three practices and improve opportunities to gather patient feedback and respond to feedback in the GP annual survey.

Service users were involved in the selection of our chief nurse and a new medical director during the year.

Patient story - from campaigner to 'expert by experience' patient partner

After the loss of his wife Val in 2015 from dementia, Keith Horncastle became a great supporter of his local community in Buxton offering support for families with a loved one diagnosed with dementia. When the Better Care Closer to Home (BCCtH) changes in local community hospitals came about, a group of concerned community members from Buxton and High Peak got together and made a film to highlight their concerns and in support of their needs as families whose members may use the new Walton Unit in Chesterfield in future. This is on YouTube: https://www.youtube.com/watch?v=g99JKv3bmXc

After a request from the chair of our BCCtH implementation group, we contacted Keith as the main spokesperson for the local community group and he agreed to work with us. Keith was able to share with us his own story of caring for his wife with dementia, and their experiences of care in our community hospital at Buxton. Due to his close links with the community he was also able to share what was most important to families living with dementia. We have been able to develop an understanding of the impact of BCCtH proposals and the following changes are being followed up:

- The Walton Unit has developed a carers support group called friends and family group.
- A member of staff is leading on the involvement of any patients from the High Peak locality
- We are developing information on services
- Consideration of the importance of continuity of care for patients and carers by both DCHS and Derbyshire Healthcare NHS Foundation Trust
- Flexibility in visiting times to accommodate individual family needs, which is especially important for those with longer journeys from home
- Refurbishment of a carers room so that family members can make drinks, and stay overnight
- Improvements in signage to make visits to the Walton Unit easier.

We are very proud of our relationship with Keith and delighted that he has continued to work with us.

Keith is now one of our 'expert by experience' network members and he also provides Dementia Friends training for our staff members – 25 staff members have attended Keith's training so far with more sessions booked in for 2019. Some of the comments we have received from staff:

"Everybody in healthcare should attend one of these sessions."

"I wanted to let you know how valuable I found the Dementia Awareness session with Keith, and thank you for letting me attend. It was very engaging and how he shared his own personal experiences was very humbling."

"Very informative, I now have a better knowledge, excellent. Helpful for both work + personal."

"Heartfelt presentation, great insight. Thank you." " Clear, informative, interesting, interactive, practical – applicable. Here for personal and work. Thanks for organising the session."

Keith was nominated for an Unsung Hero award for 2019.

3.3.4 Responding to patient feedback

The pulmonary rehab group is a twice weekly, six week programme which is delivered in unused ward space at Walton Hospital. Members of the group fed back that the room was 'not really fit for purpose': it got very hot and cramped when doing the various exercises, and when the carers joined for the education part chairs had to be found and moved around. Observations showed that there was insufficient space for all the activities in the room without having to go into the corridor. This compromised dignity and equity of service. Concerns were expressed by patients, carers and staff regarding the room conditions. We reported these concerns through our patient engagement and experience group (PEEG). A capital and estates proposal was approved.

The patient involvement officer, Lisa Brightmore, visited the pulmonary rehab group again in November 2018. It was evident that the new space on Peter McCarthy suite at Walton Hospital was a much improved facility. We received feedback regarding other aspects of attending this group such as timing and parking, but not one report of the room being unfit for purpose was received, and it was noted that the new room provided a much better area for people to complete their exercises and for the facilitators to deliver their support and education sessions.

The added benefits of providing this programme were expressed by group members as:

- The ability to share stories and information between themselves
- Those nearing the completion of the programme described significant improvements to their pulmonary function
- One gentleman in his 80s on the last day of the programme explained how his confidence has grown since starting the programme. He was proud he had managed to cut the lawn once again.

3.3.5 Patient led assessments of the care environment (PLACE)

PLACE is a system for assessing the quality of the care environment and involves local people and Council of Governor representatives working alongside Trust staff in assessing the quality of patient areas across a range of criteria, including privacy and dignity, food cleanliness and general building maintenance. For the first time this year the assessments have covered the ways we can demonstrate that we are meeting the needs of patients with disabilities.

The percentage scores for each category shown in table 30 below have been awarded by the NHS information centre based on the information returned by us for our 2018 assessments. All assessments were delivered through self-assessment. The programme was undertaken between March and May 2018.

Table 30: PLACE scores 2016-2018

Hospital	Cleanliness			Food			Privacy and dignity		
	2016	2017	2018	2016	2017	2018	2016	2017	2018
Ash Green	100	100	100	96.72	95.44	79.35	91.51	93.86	88.79
Babington	100	99.70	100	98.96	96.13	74.75	86.41	92.5	82.14
Bolsover	100	100	--	96.13	96.40	--	83.91	84.18	--
Cavendish	99.87	100	100	96.6	93.49	79.59	85.9	92.24	85.17
Clay Cross	98.42	99.28	98.56	90.70	94.21	93.81	76.27	82.75	78.13
Ilkeston	99.01	99.59	100	99.09	94.95	98.06	76.41	91.79	83.33
Newholme	99.80	99.91	--	97.9	96.38	--	84.22	78.85	--
Ripley	100	100	99.62	96.56	94.47	96.73	94.39	91.04	89.80
St Oswald's	98.24	96.92	96.15	98.31	96.10	96.67	84.57	93.75	93.29
Walton	100	99.81	100	95.87	95.98	94.61	91.82	89.72	98.37
Whitworth	100	99.85	100	97.03	94.69	97.06	84.55	83.49	69.83

Hospital	Condition and maintenance			Dementia			Disability		
	2016	2017	2018	2016	2017	2018	2016	2017	2018
Ash Green	98.05	98.10	99.05	82.36	82.60	83.44	92.90	87.75	93.94
Babington	98.64	96.57	96.62	82.21	73.57	75.35	92.02	87.06	91.16
Bolsover	97.32	98.99	--	86.61	80.37	--	93.46	88.48	--
Cavendish	98.0	98.54	97.92	77.57	82.73	79.38	85.55	91.84	95.42
Clay Cross	99.01	95.40	96.61	79.7	83.96	82.59	94.05	96.69	96.88
Ilkeston	93.84	98.06	90.93	76.46	81.99	75.28	83.08	91.09	86.20
Newholme	94.57	94.63	--	83.24	69.38	--	81.38	78.13	--
Ripley	98.83	99.25	98.69	79.76	85.76	84.97	85.75	95.25	96.44
St Oswald's	99.36	98.26	100	79.72	90.24	87.57	90.69	94.52	96.98
Walton	99.82	97.89	99.04	86.66	85.59	89.29	91.0	91.93	96.08
Whitworth	100	98.99	99.03	82.64	84.14	82.78	84.85	94.24	94.19

Additional elements were included within all sections of the 2018 assessments and this should be considered when comparing last year's scores against this year's.

Some of the elements we look for under disability within the PLACE assessment include:

- Are there handrails in corridors?
- Is there at least one toilet big enough to allow space for a person in a wheelchair and their carer?
- Where there are steps to the reception area, is there a ramp to assist those with mobility difficulties?
- Is there space in reception areas for people in wheelchairs?
- Is there a hearing loop at the reception desk?
- Where appropriate, have kerbs been adapted to facilitate wheelchair access?
- Are car parking spaces for disabled people appropriately located closest to the building entrances?
- Is there an audible/verbal appointment alert system for people who have visual impairments?
- Is there a visual appointment system for people who have hearing impairments?

Table 31: **PLACE: DCHS scores against national average scores *(Data source PLACE audit results)***

	Cleanliness	Food	Privacy and dignity	Condition and maintenance	Dementia	Disability
DCHS 2018	99.35%	91.73%	85.74%	97.21%	82.32%	93.72%
DCHS 2017	99.51%	95.29%	88.63%	97.66%	81.59%	90.57%
DCHS 2016	99.57%	96.65%	84.81%	97.81%	81.47%	88.36%
National average score 2018	98.5%	90.2%	84.2%	94.3%	78.9%	84.2%

DCHS have achieved a score above the national average for all six elements of the PLACE audit.

Some issues that have been identified at various sites during the PLACE audits and require ongoing works are:

- No contrasting fittings in bathroom
- Hand rails in corridors repainting as they do not contrast with the wall colour
- Drain covers made of bricks (trip hazard) to be replaced
- Taps identified as not being dementia friendly
- Alarm bell cord broken
- Walls requiring redecoration
- Yellow lines in car park need relining
- Garden requiring attention and not currently suitable for patient use.

An estates action plan has been prepared which is monitored and updated on a regular basis and some items are monitored through contract review meetings.

3.3.6 GP Patient Survey results

The GP Patient Survey is an independent survey run by Ipsos MORI on behalf of NHS England. The survey is sent out to over a million people across the UK. The results show how people feel about their GP practice.

Top lines

- Castle Street was rated above the CCG and national averages in all aspects of the survey
- Creswell and Ripley had both improved overall; increasing 8% and 9% respectively with patients describing their overall experience of the GP practice as good
- The aggregate scores for the service were above the national average for 13 out of 18 aspects of the survey
- Ripley had made excellent progress over the last 12 months in relation to the time patients wait before they are seen. Their score increased by 22% against the previous year (waited 15 minutes or less after their appointment time to be seen at their last general practice appointment).

3.4 ENSURING OUR SERVICES ARE RESPONSIVE TO PATIENTS' NEEDS

We are continually reviewing the provision of services to understand how we can ensure that our services are responsive to the needs of our patients, and patient stories enable us to do this.

3.4.1 Patient stories

Patient stories provide a very powerful and human account of the way that the care we deliver impacts on individual people, carers and families. Every meeting of our Trust Board, Quality Services Committee, Council of Governors, patient experience and engagement group, end of life care group and dementia and frailty group starts with a story.

The stories are either told by a member of staff or by a person who used our services. We aim to hear about the positive impact of our services (for example a patient who was supported during their gender transition) as well as where improvements are needed to be made (for example where our services identified improvements in the way we manage and care for pressure ulcers).

Members of the Board or Committee that hear the story are often challenged and moved by what they hear, lessons are identified and actions agreed.

The telling of the story at the start of the meeting sets the tone for the remainder of the agenda, 'putting the patient in the room', and ensuring that the patient is at the centre of everything we do. Our Quality People Committee also presents a staff story at the start of each of their meetings. These stories help us to understand better the issues and challenges that our staff face and how we can support them and become a better employer.

Patient stories - dementia

Lisa from speech and language therapy services (SLT) shared three different stories of people with dementia.

Dorothy's story - Dorothy had been living in a care home, with a dementia diagnosis for a number of years. She had been struggling with eating and drinking for some time but no one in the care home recognised this and so she was not referred to the SLT for specialist assessment and advice. This meant that Dorothy often didn't finish her meals or her snacks and had been losing weight over several months.

Care home staff tried to encourage her to have her supplement drinks, but she really disliked these and most of them were thrown away. She sometimes coughed and choked when eating and drinking which meant she couldn't enjoy her food and she became frightened to eat and drink as it was so unpleasant for her. She also became isolated from other residents as she was embarrassed to eat in the dining room and someone kept telling her to stop coughing all over them.

Dorothy had a few chest infections but no one realised this was because food and drink was going the wrong way, into her lungs. She ended up in hospital twice with aspiration pneumonia, and once after a really frightening choking episode. This was not only distressing for Dorothy but also for the people looking after her. She spent 25 days in hospital in total and had required six GP visits in the last six months because of her chest infections, dehydration and weight loss. Very sadly, Dorothy died during the last acute hospital admission.

Sid's Story - Sid is a man with long standing dementia, which included significant behaviour issues, and very limited communication. He had a right sided chest infection and had not been seen by SLT in the past and wasn't on any specific recommendations to support eating and drinking.

The SLT assessed Sid and noted that he presented with subtle signs of aspiration; texture and fluid modifications were recommended and advice about the eating environment was provided. He enjoyed his meals more as he was no longer coughing, and was able to eat more during meal times. His chest infection resolved, he remained an inpatient on the ward, due to difficulties identifying an appropriate placement. Sid subsequently deteriorated with regard to his swallowing difficulties, and developed another severe chest infection. However, the staff were quick to notice the signs of deterioration and contacted SLT for further support.

Liaison between SLT and other members of the multi-disciplinary team (MDT), including medics, resulted in decisions being made regarding a best interest plan which included Sid's family. The family were able to be reassured about the issues relating to his swallowing difficulties and how this could be best supported.

Staff were aware of how to support Sid in terms of positioning, how to manage if he coughed, to provide safest consistencies and support an end of life process that enabled Sid to remain comfortable, minimise distress for everyone, and continue to enjoy the taste of small amounts of food. Sid was able to die in a familiar supportive environment, with minimal distress, both for him, the staff and his family.

Terry's Story - Terry was referred to the adult community SLT by a neurologist, asking for some help and information in diagnosing Terry's condition. Terry was experiencing word finding difficulties and slowed cognitive processing and was frightened by his new symptoms. Terry was happy to complete some language and cognition assessments with the SLT and was reassured that someone was interested in helping him. Terry's wife was able to contribute to the assessments and gave valuable information, informing the assessment process.

Terry was diagnosed with primary progressive aphasia, a specific form of dementia which involves a progressive loss of language function. Terry and his wife were obviously frightened by this diagnosis and relied on the SLT for information and support. His wife was helped to support and maximise Terry's communication by learning supported conversation techniques.

Terry started to use a specialist SLT computer software programme to allow him to practice useful words such as family names and places. This meant that Terry could independently control how much therapy he wanted to do, to help to maintain his retrieval of functional words. Terry and his wife

benefitted from finding out about local support services, and met other people for peer support, with the help of the SLT.

Terry began to put in place some long term strategies to help him to cope with the progression of his disease, for example, he started to use a diary as a record and communication support tool and started to make a collection of photographs to help him to be able to communicate with new people. Terry and his wife feel able to call the SLT for help with new communication challenges as they occur and Terry said 'you are an absolute star and always help me' the last time the SLT saw him.

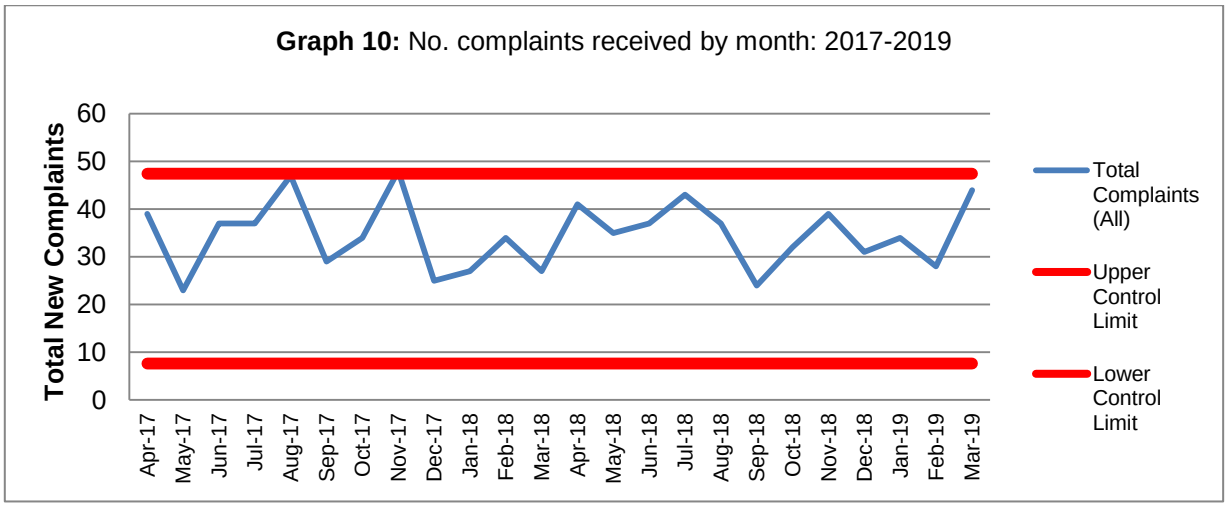
3.4.2 Complaints and concerns

We know that sometimes people's experiences may be poorer than expected. This can be as a result of a lot of different factors. It is important for us to hear about people's experiences, so that we have the opportunity to find out what happened and to put things right if needed.

We have complaints handling processes to ensure that patients, relatives and carers have the opportunity to tell us about their care and treatment and to let us know when things go wrong. Listening and learning from complaints is very important to us. We make every effort to ensure the complaints process is accessible to all. Complaints can be made by telephone, email, through our website, in writing or in person.

Leaflets are available throughout our services describing the process, contact details and support available. When we are contacted by someone who needs help with their complaint, we provide clear contact details for the local NHS complaints advocacy services, which can provide support and make the complaint on a person's behalf. Complaint response letters can be provided in different formats to accommodate needs, for example large fonts and alternative languages.

During 2018/19 a total of 424 complaints (all types) were received; this is a 4% increase compared to the previous year. We have seen a significant increase in type one complaints, which do not require a full investigation and these concerns are resolved by services very quickly.



Graph 10 above shows the variation in complaints received each month over a two year period.

We have monitored the increase in complaints throughout the year and we have concluded that the reason for this has been a result of some of the internal changes we have made to our complaints reporting systems, as well as greater awareness amongst service users of how to raise their concerns as a result of our marketing and publicity efforts.

Subjects of complaints

The main reasons for complaints have usually been a result of poor communication. We are trying to address this through greater awareness and staff training around 'words matter' and improving the patient experience. On review of patient experience data year to date the following three areas have shown to be the most important to people when sharing their concerns. We will continue to monitor these areas to identify any specific learning for individual teams.

- Clinical treatment
- Values and behaviours
- Access to treatment.

Learning from complaints – an example from minor injuries units

Investigations often identify learning and suggested improvements that services should implement. A number of complaints about diagnosis of fractures in our minor injuries units were highlighted during the year. Several patients believed that they had not had the appropriate access to x-ray to reach a diagnosis and appropriate treatment. Those complaints were not upheld on investigation. The following learning and an improvement action was identified as follows:

Learning: patients did not always understand our x-ray protocol and that the initial diagnosis given to them in MIU is tentative pending confirmation by x-ray. Sometimes patients do not retain information given verbally during their attendance at MIU.

Improvement: a leaflet for patients with a suspected fracture or severe sprain explaining the protocol the minor injuries unit and recommendations of how to treat their injury has been developed.

Responding to complaints

We aim to respond to all complaints that require investigation within 40 working days. We identified an inaccuracy in the way we reported our performance against this standard in our last quality report (2017/18). This was reported as 84% compliance and it should have been reported as 83%. This year we responded to only 66.4% of complaints in that timeframe. In 2018/19 we are challenging ourselves to provide timely responses to people who have raised a concern with us.

3.4.3 Complaints review panel

In February 2019 we undertook a review of the formal complaints process for the third year. The panel that undertook the review consisted of chief nurse, assistant director for patient experience, an assistant director for integrated community services, a staff governor, a public governor and patient involvement officer. Ten closed and completed complaints were randomly selected and the panel were given specific actions or processes to look for within the record. Although this is a relatively small number of formal complaints that have been managed by the Trust over the previous year it did give evidence of themes that would benefit from further review.

Initial review of the comments showed that there is a consistently high quality approach to how the Trust responds to a formal complaint however there are themes identified:

- Quality of the investigation
- Demonstrating learning from the investigation.

The outcome of the panel review will be discussed at governance meetings within the organisations and actions will be taken forwards both within the patient experience team as well as within teams that undertake the investigations. This review will be repeated annually.

3.4.4 Carers

We acknowledge the significant contribution of informal carers to the health and wellbeing of local people. We recognise the additional efforts that are needed to ensure that carers of our patients and patients with caring responsibilities are met.

2763 people using our services identified that they also have caring responsibilities this year. The graph on page six shows that we have a system in place to record this and to signpost them for appropriate support.

3.4.5 Healthwatch

We continue to work in partnership with both Healthwatch Derbyshire and Healthwatch Derby. Our partners play a valuable role engaging with local communities, particularly those whose voices may not otherwise be heard, and ensuring that the patient perspective is actively shaping our services. We receive regular feedback from Healthwatch; this is shared with the service lead for response.

Examples this year include:

- We continue to support Healthwatch Derbyshire with their training of enter and view volunteers .
- We have supported the development and sharing of a STOP poster for people with learning disabilities to help them have more control when care may cause them discomfort (for example in our dental services)
- Healthwatch Derby provided us with valuable feedback on our Integrated sexual health services and on our Derby specialist dental services from their own engagement events
- Healthwatch Derbyshire undertook a report on the experiences of people with dementia using the full range of services, including those provided by DCHS.

3.4.6 An inclusive organisation

Over the last year, there has been a strategic shift to embed equality, diversity and inclusion across the Trust. We are working to strengthen shared understanding and accountability across the functions so that we will be able to demonstrate evidence based decision making as business as usual. We have completed all national compliance reports as part of our statutory duties under the Equality Act within deadlines.

That work has begun to embed the national NHS equality improvement tool called the Equality Delivery System 2 (EDS2). Equality standards have been used to frame our corporate approach and to evidence continuous improvement across the four goals:

Goal 1: Better health outcomes for all

Goal 2: Improved patient access and experience

Goal 3: Representative and engaged workforce

Goal 4: Inclusive leadership and governance at all levels.

We have over 40 network groups which consist of local people and service users. We have worked with these groups to co-design and develop our services in the last year. Our most successful example of working in partnership with local people is around the development of our dementia strategy. We held a successful focus group where people had the opportunity to share their experiences and help shape the development of this strategy.

We hope to continue our work with the general practice patient participation groups (PPGs) to develop new initiatives to support our three practices and improve opportunities to gather patient feedback and improve our performance on the annual survey.

3.4.7 Pastoral care in DCHS

We recognise the importance of meeting people's pastoral and spiritual needs as part of our holistic care of patients. We work in partnership with Derby City Centre Chaplaincy who are experienced in providing volunteer chaplains to come alongside people who are using our services. We recognise that life can be challenging and that people are faced with a range of worries and questions especially at times of loss – for example at times of change in their lives. Volunteer chaplains are available for patients in any locality to provide a comforting and confidential listening ear. Chaplains are supporting patients with end of life care, terminal illness, new diagnoses, living with long term conditions, bereavement, with fears about forthcoming treatments, making difficult decisions or about a desire to connect with family. The service is able to connect patients of any faith, or none, with an appropriate person to support them. The chaplaincy service is also helping us to develop our spiritual care to patients at the end of their lives.

3.4.8 Minor injuries unit (MIU) waiting times

We have four MIUs providing urgent care as part of the wider out of hours and emergency care pathway across the health community. Ensuring our patients receive timely care is a key priority. This is measured against a four-hour standard set by the Department of Health. As the table below illustrates, we have performed well in this area.

DCHS considers that this data is as described for the following reasons**:** there are proper internal controls for the collection and reporting of this measure of performance and the controls are subject to quality assessment using the trusts data kite mark quality assurance system.

This data is governed by standard national definitions.

Table 32: MIU four hour waits Ⓐ

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Full Year
2018/19 Ⓐ	100%	100%	100%	100%	100%	99.8%	99.7%	100%	99.8%	99.9%	99.9%	100%	99.9%
2017/18	99.9%	99.9%	100%	99.9%	99.9%	99.9%	99.9%	100%	99.9%	100%	100%	100%	99.9%
2016/17 Ⓐ	100%	100%	99.9%	99.9%	100%	100%	99.9%	100%	100%	100%	100%	100%	100%

Data Source Systm1 PAS

Ⓐ *these figures were independently audited*

We will continue to monitor the quality of our services using our quality improvement and assurance framework. We will work with the wider health community to maintain the high performance within our MIUs.

3.4.9 Comparative data A&E four hour wait

It should be noted that our emergency provision is limited to four MIUs and that comparative data includes data from type 1 accident and emergency departments.

Table 33: **Comparative A&E 4 hour wait data**

Period	Performance	Rank	Total In cohort	National average	Highest	Lowest
2018/19	100%	Joint 1st	235	86.6%	50 trusts	Norfolk And Norwich University Hospitals NHS Foundation Trust
2017/18	100%	Joint 1st	238	85.0%	58 trusts	Princess Alexandra Hospital NHS Foundation Trust
2016/17	100%	Joint 1st	241	99.9%	56 trusts	Princess Alexandra Hospital NHS Foundation Trust
2015/16	100%	Joint 1st	237	91.9%	65 trusts	Tameside Hospital NHS Foundation Trust

Source NHS England February 2019 A&E wait figure

Criteria for percentage of patients with a total time in minor injuries unit of four hours or less from arrival to admission, transfer or discharge

The Trust uses the following criteria for measuring the indicator for inclusion in the quality report:

The indicator is expressed as the percentage of unplanned attendances at minor injuries units (whether admitted or not) in the year ended 31 March 2019 that have a total time in minor injuries unit of four hours or less from arrival time (as recorded by the clinician (nurse or doctor) carrying out initial triage, or minor injuries unit reception, whichever is earlier) to admission, transfer or discharge home.

3.4.10 Referral to treatment times Ⓐ

When our patients need care we aim to see them and undertake their treatment as quickly as possible. The table below reports on our performance in year against the 18 week referral to treatment times and demonstrates that performance has been consistently good in all areas.

DCHS considers that this data is as described for the following reasons: there are proper internal controls for the collection and reporting of this measure of performance and the controls are subject to quality assessment using the Trust's data kite mark quality assurance system.

Table 34: Referral to treatment times (RRT)

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Full Year
Referral to treatment times Incomplete pathway (where treatment is part of a pathway) against a standard of 92%													
2018/19 Ⓐ	95.4%	96.2%	96.4%	96.1%	95.3%	95.2%	95.4%	95.2%	94.8%	93.3%	92.3%	94.7%	95%
2017/18 Ⓐ	96.9%	97.3%	96.7%	95.8%	93.9%	95.3%	94.7%	93.9%	95.0%	95.1%	95.5%	95.0%	95.4%
2016/17 Ⓐ	97.69%	97.35%	95.66%	93.20%	97.87%	97.24%	95.95%	95.54%	94.58%	94.60%	96.68%	97.60%	96.00%
RTT waits - admitted patients seen within 18 weeks - 90% (target) (%)													
2018/19	91.6%	84%	64.7%	59.2%	78.6%	81.8%	100%	100%	100%	80%	100%	100%	86.1%
2017/18	96.9%	96.5%	96.6%	97.3%	91.4%	92.4%	94.7%	95.5%	93.1%	93.1%	95.2%	92.9%	94.6%
2016/17		95.1%	90.9%	91.4%	94.8%	95.7%	90.7%	87.8%	89.8%	95.0%	94.0%	96.0%	92.8%
RTT waits - non admitted patients seen within 18 weeks - 95% (target) (%)													
2018/19	89.7%	91.2%	90.9%	90.9%	93.7%	92.1%	92.9%	90.7%	91.4%	90.4%	91.1%	86.5%	94.1%
2017/18 Ⓐ	94.9%	94.3%	94.3%	95.0%	95.3%	93.2%	93.6%	93.8%	91.8%	90.8%	92.5%	91.0%	93.4%
2016/17	97.1%	98.9%	95.4%	97.3%	97.4%	95.8%	95.1%	95.3%	93.7%	92.1%	94.3%	91.3%	95.2%

Data Source Systm1 PAS

Criteria for percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period

The Trust uses the following criteria for measuring the indicator for inclusion in the quality report:

- The indicator is expressed as a percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period;
- The indicator is calculated as the arithmetic average for the monthly reported performance indicators for April 2018 to March 2019;
- The clock start date is defined as the date that the referral is received by the Foundation Trust, meeting the criteria set out by the Department of Health guidance; and
- The indicator includes only referrals for consultant-led service, and meeting the definition of the service whereby a consultant retains overall clinical responsibility for the service, team or treatment.

Criteria for percentage of non-admitted seen within 18 weeks at the end of the reporting period

The Trust uses the following criteria for measuring the indicator for inclusion in the quality report:

- The indicator is expressed as a percentage of non-admitted patients seen within 18 weeks for patients on non-admitted pathways at the end of the period;
- The indicator is calculated as the arithmetic average for the monthly reported performance indicators for April 2018 to March 2019;
- The clock start date is defined as the date that the referral is received by the Foundation Trust, meeting the criteria set out by the Department of Health guidance; and
- The indicator includes only referrals for consultant-led service, and meeting the definition of the service whereby a consultant retains overall clinical responsibility for the service, team or treatment.

3.4.11 Delayed transfers of care (DTOC)

A delayed transfer of care (DTOC) occurs when a patient is ready for discharge from one of our community hospitals to home or a residential care setting yet is still occupying one of our hospital beds. We work to minimise DTOCs through effective discharge planning and joint working between services to ensure safe, person-centred transfers. This year we have differentiated between DTOCs resulting from delays identifying ongoing social care and delays which are purely related to NHS care.

We consider that this data is as described for the following reasons**:** there are proper internal controls for the collection and reporting of this measure of performance and the controls are subject to quality assessment using the trusts data kite mark quality assurance system.

Comparative data - DTOC monitor compliance calculation is not available.

This data is governed by standard national definitions.

Table 35: Total DTOC: inpatients including older people's mental health (OPMH)

Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Full Year
2018/19 3.5%	5.3%	5.1%	4.1%	3.6%	5.8%	8.7%	4.9%	6.7%	5.2%	6.4%	4.5%	3.4%	5.3%
2017/18 3.5%	7.6%	12.4%	9.8%	11.3%	8.8%	4.8%	4.9%	3.8%	5.6%	5.0%	5.3%	5.0%	7.0%
2016/17 5.5%	6%	7.9%	10.1%	7.6%	8.4%	9.5%	6.1%	8.0%	10.6%	7.5%	9.1%	9.8%	8.4%

Data Source Systm1 PAS

Table 35: Total DTOC: OPMH data:

Target	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Full year
2018/19	1.8%	0.0%	0.0%	1.8%	5.1%	14.9%	2.9%	3.4%	5.1%	4.8%	6.7%	4.8%	4.3%
2017/18 3.5%	0%	1.7%	1.3%	2.0%	7.0%	3.5%	4.0%	2.7%	4.1%	4.8%	13.1%	8.5%	3.8%
2016/17 5.5%	0%	3%	0.9%	0%	1.2%	0%	0%	3.2%	5.7%	3.2%	2.3%	0%	1.7%

Data Source Systm1 PAS

Key	
Less than target	
Greater than target by up to 0.5%	
Greater than target by more than 0.5%	

Although we have not met the revised national target of 3.5% DTOC in 2018/19 for the year in totality, working with partners across Derbyshire we have made further significant improvements and are currently one of the leading health economies for DToC in England. During 2018/19 we introduced statistical process control analysis to better analyse and understand our position and in tandem with real time reports to key stakeholders we achieved the 3.5% target in March 2019 and this position has continued into early 2019/20. This improvement has been achieved against a backdrop of reduced bed capacity which has amplified the impact of any patients in delay across our inpatient setting.

Table 37: DTOC: OPMH (NHS delays only):

Target	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Full year
2018/19	0.0%	0.0%	0.0%	1.8%	4.6%	14.9%	2.9%	3.4%	5.1%	4.8%	6.7%	4.8%	4.2%
2017/18	0.0%	0.0%	0.7%	1.0%	5.4%	3.0%	2.6%	1.6%	3.5%	4.6%	13.1%	8.5%	3.0%
2016/17	0.0%	1.6%	0.9%	0.0%	1.2%	0.0%	1.0%	1.1%	2.3%	2.7%	0.0%	0.0%	0.9%

Data Source Systm1 PAS

Table 38: DTOC Inpatients (NHS delays only):

Target	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Full year
2018/19	3.3%	4.4%	4.6%	1.6%	4.6%	5.4%	3.8%	5.0%	3.6%	5.1%	3.4%	2.7%	4.0%
2017/18	3.7%	6.8%	4.4%	6.1%	5.0%	2.1%	3.7%	3.8%	3.8%	3.0%	2.3%	3.5%	4.0%
2016/17	2.9%	5.4%	7.0%	4.0%	3.6%	4.6%	3.8%	3.1%	3.3%	2.8%	4.9%	4.9%	4.2%

Data Source Systm1 PAS

Table 39: DTOC: OPMH and inpatients (NHS delays only)

Target	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Full year
2018/19	2.8%	3.6%	3.8%	1.7%	4.6%	7.2%	3.7%	4.8%	3.9%	5.0%	3.9%	3.0%	4.0%
2017/18	2.9%	5.2%	3.4%	4.7%	5.1%	2.3%	3.5%	3.3%	3.8%	3.3%	3.8%	4.0%	3.8%
2016/17	2.3%	4.5%	5.5%	3.1%	3.0%	3.4%	3.1%	2.6%	3.0%	2.8%	3.9%	3.9%	3.4%

Data Source Systm1 PAS

Criteria for Delayed Transfers of Care (DToCs)

The Trust uses the following criteria for measuring the indicator for inclusion in the quality report:

- A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed
- A patient is ready for discharge / transfer when: 1) a clinical decision has been made that the patient is ready for transfer and 2) a multi-disciplinary team decision has been made that the patient is ready for transfer and 3) a decision has been made that the patient is safe to transfer
- The numerator is the number of delayed bed days for acute and non-acute patients whose transfer of care was delayed in the month
- The denominator is the total number of occupied bed days in the month.

3.5 ENSURING OUR SERVICES ARE WELL LED

3.5.1 Professional leadership for nursing

Nurses form the majority of the diverse clinical workforce across DCHS. Professional leadership is provided by the chief nurse and deputy chief nurse.

This year we have been delighted to welcome the first eight registered nursing associates (RNA) to the Trust with an additional nine in training. This role is a new addition to the nursing family and designed to bridge the gap between health care assistants (HCAs) and registered nurses.

The NMC registered RNA role will provide a route into nursing and a career ladder for the health care support workforce, enhancing the quality of hands-on care offered through defined and funded training and development, and strengthening the support available to nursing staff, releasing them to focus on care planning and management, advancing their practice and using their high level skills.

RNAs are qualified at level 5 (foundation degree or equivalent) and nursing associate (RNA) is a protected title in England. The NMC is clear that the full suite of regulatory functions will apply to RNAs as it does to nurses and midwives.

Revalidation is the way that nurses and midwives show they are meeting their professional obligations and that they continue to be fit to practise. Revalidation will require nurses and midwives to demonstrate every three years, at the point of renewal of their registration, that they are meeting the Nursing and Midwifery Council (NMC) professional standards as laid out in the revised code (2014).

Revalidation aims to:

- Increase public confidence in nurses and midwives by requiring them to demonstrate on an on-going basis that they are fit to practise
- Enable nurses and midwives to be accountable for demonstrating their continuing fitness to practise
- Promote a culture of professionalism and accountability.

The first full cycle of nurse revalidation was completed in March 2019. In 2018/19 410 nurses were due to revalidate and only four (0.48%) failed to do so, and now all but one of them is restored to the register. Each of these cases has been as a result of significant ill health and the nurses in each case have been supported through this personally difficult time by line managers and the deputy chief nurse.

We are working to strengthen the development of advanced practice in nursing roles and ensuring that all the roles have competencies which are strongly aligned to practice. As the NHS landscape changes it is essential that the nursing workforce is equipped to deliver the clinical and professional changes that working in integrated care systems will require.

3.5.2 Allied health professions

We have a diverse clinical workforce. Over 600 staff are registered with the Health and Care Professions Council as physiotherapists, occupational therapists, speech and language therapists, podiatrists, paramedics or operating department practitioners. These six professions are covered by the umbrella of allied health professions or AHPs. Under the professional leadership of an assistant director they work operationally across planned care and specialist services and integrated community services. DCHS recognises the key contributions that AHPs make to patient outcomes and integrated services. In addition a number of AHPs work in advanced practice roles, extending their skills to provide easy patient access to specialist diagnostics and treatment.

In 2018/19 the DCHS vision for AHPs was co-produced by colleagues across the Trust. This brings together the ambitions of our clinical strategy (the Quadruple Aim – reference page two); the NHS Long Term Plan and AHPs into Action (NHS England's strategy for AHPs).

The headlines of the AHP vision are shown below:

DCHS vision for AHPs

AHPs and our role in improving the health of the population:

- People and communities take up AHP support to improve their health
- AHPs and the people we serve are able to influence decisions about the future of services to enable better patient outcomes.

AHPs' experience as DCHS employees

- The unique skills of AHPs are utilised to provide excellent services for patients and staff
- DCHS leaders value and develop AHPs to provide high quality services
- DCHS attracts AHPs to pursue their careers in Derbyshire.

AHPs contributing to improving the experiences patients have of healthcare:

- People are empowered to make informed choices about interventions provided by AHPs, and their wider health
- People have the information they need about AHP services
- People are able to access AHP interventions as part of flexible, joined up services.

AHPs' role in reducing costs and adding value in delivering care:

- AHPs take responsibility for efficient and effective practice to meet people's needs
- People living with long term conditions are enabled by AHPs to live the best life they can
- AHPs use evidence-based interventions, equipment and technology to add value and improve outcomes
- Innovation led by AHPs is shared effectively.

Staff story – Tracy

Tracy initially went into physiotherapy as a mature student, graduating from Coventry University in 1999. Prior to this she had worked as a physiotherapy assistant. Once qualified her rotations were completed in a large inner city hospital. In time her first child came along, followed by twins, and more children inevitably meant more challenges. It was at this point that she made the decision to leave physiotherapy.

Tracy had considered returning to physiotherapy in the past, but had not felt ready and though her confidence to return was still low she decided to take a quick look online at what opportunities were available. Tracy realised she needed to do 30 days supervised clinical practice.

Tracy found a link on the Health Education England website which asked, 'Thinking of Returning to Practice?' Within half an hour she was chatting on the telephone with Paul Chapman who, of all places throughout the whole of the UK, was based at Walton Hospital. They talked at length and Paul explained that a pilot programme had been set up supporting potential returnees. Paul also convinced Tracy that she had a lot to offer and that there were many trusts in the area that would like to help her to return. The employment route was immediately attractive as, though she wanted to return, the prospect of a period of time without a wage would be a definite barrier. The intention was to apply for band 5 posts, working her period of supervised practice paid at Band 4. Tracy applied for band 5 posts with Bev (placement support) supporting her from behind the scenes.

Tracy was offered a role by the Amber Valley integrated community based team, based at Belper.

Before she knew it she had completed her return to practice period, she applied to the Health and Care Professions Council for re-registration and it was quickly approved.

Tracy admitted that having 10 years away from the NHS brought with it many challenges, but as long as the returnee goes into the process with an open mind, a 'can do' attitude and a good support network, it can be done.

3.5.3 Clinical supervision

We are committed to ensuring clinical supervision supports clinical practice and underpins the maintenance and improvement of standards of patient care.

DCHS recognises that clinical supervision has an important role to play in contributing to the reduction of clinical risk by ensuring safe clinical practice.

We provide opportunities for differing forms of clinical supervision, reflective practice and developmental activities which give staff the opportunity to learn from their experience and develop their expertise within clinical practice, which could contain the following:

- Clinical supervision (group and individual)
- Individual and group reflection sessions
- Restorative supervision
- Development coaching
- Peer review within sessions
- Safeguarding supervision
- Caseload supervision
- Brief and boundaried/action learning
- Reflective practice.

The DCHS policy is that all non-medical patient facing staff have a minimum of three x one hour sessions of clinical supervision in a rolling 12 month period.

Medical colleagues do not have dedicated clinical supervision sessions, but have an annual appraisal and regular one to one meetings with their professional lead where matters relating to clinical supervision are discussed. In 2018/19 83% of eligible staff completed their minimum of three sessions. In 2019/20 we are committed to improving the data collection methodology to ease reporting.

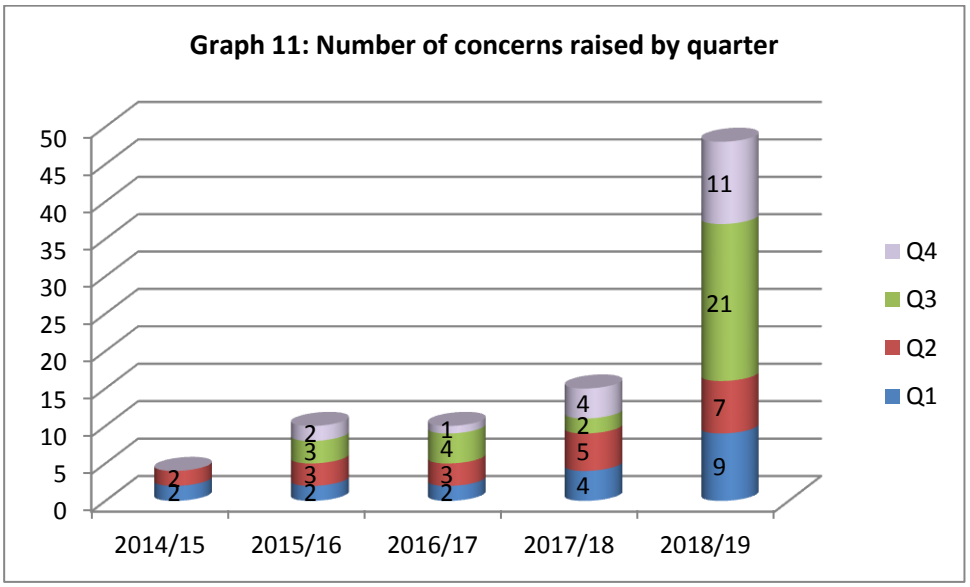
3.5.4 Raising concerns (Freedom to Speak Up)

In 2018 we were delighted to welcome the National Guardian's Office into the Trust to review our speaking up arrangements; this enabled us to reflect on what we were doing well and areas where we needed to strengthen our arrangements. One of the key outcomes was a new raising concerns policy and we have developed and implemented a robust communications plan to ensure all our staff are aware of how they can raise issues of concern and what they should expect in return.

We have updated our raising concerns dedicated website and facilitated drop in sessions across the organisation as well as developing some dedicated training materials. All our staff receive dedicated training as part of their Induction to DCHS.

To help our staff understand the kind of issues they can raise we have created animation videos of five scenarios. These were launched weekly during the first national Speaking Up month in October 2018. During the month we also used social media and local radio to help spread key messages.

During the last year we have seen an increase in the number of issues raised through the raising concerns policy and this can largely be attributed to the huge amount of publicity the initiative has had. The figures are given in graph 11 below.



We have launched a raising concerns newsletter, which will enable us to share the learning from issues that staff have raised with us as well as providing key information on a regular basis.

There has been some key learning from the issues that have been reported and this includes:

- Ensuring that staff who are subject to changes in their workplace are provided with continual support and receive consistent messages regarding how the changes will impact on them
- Ensuring our leaders to consistently behave in a way that reflects the organisation's vision and values
- Ensuring staff are aware of the facilities and equipment that are available to them and that they are used appropriately.

One of our priorities for the next year will be to launch our Freedom to Speak Up strategy: to support its development we held a focus group with key members of staff to explore:

- What currently works well
- What the barriers are to staff raising a concern
- What needs to change.

The outcomes from the session will be reflected in the final document and will help shape our priorities for the coming year.

3.5.5 Quality Always (QA) – our quality assurance and improvement scheme

We want each person to experience high quality healthcare, whenever they use our services – delivering Quality Always. To support our clinical services to deliver this ambition our Trust clinical accreditation scheme known as Quality Always continues to be implemented across the Trust:

1. **Clinical assessment and accreditation scheme (CAAS) -** CAAS is a process of assessment, review and accreditation. An assessment template is used, based on a range of clinical standards. Teams develop and implement an improvement plan and repeat assessments are then carried out, with the frequency being determined by their overall score. Teams can apply for Gold accreditation once the required level of quality has been reached and sustained over a 12 month period.
2. **Quality and safe care champions -** Quality and safe care champions embed best practice identified within the CAAS standards. They are nominated members of front-line staff who receive support to carry out their role throughout the year.
3. **Dashboard -** The dashboard facilitates efficient CAAS assessment and has been developed to identify hot spots and areas of best practice. It also enables in-depth data analysis for staff from Board to front-line clinician level. Regular reports run from the dashboard allow identification of the main improvements achieved by the team against the standards and those areas requiring further work or targeted development.

Progress in 2018 - CAAS

- Throughout 2018 the QA team carried out 125 assessments in 69 teams/services covering all DCHS localities and divisions
- On average during 2018 the team have undertaken 10 assessments each month, an increase from 2017 of two per month
- The team were set a KPI of assessing 18 new areas during 2018 and by the end of December 2018, despite carrying out more assessments in 2018, the actual total of new teams assessed was 15. Please see table 40 below:

Table 40

Division/area 2018	ICS Inpatients	ICS Community	Planned care outpatients	Planned care specialist services	HWBI various	HWBI Children's 0-19
Number of assessments	10	48	27	18	14	8
Number of new assessments	0	8	3		2	2
Total per division	58 (ICS)		45 (PC)		22 (HWBI)	

Below is a table summarising assessment ratings to the end of December 2018.

Table 41: CAAS ratings

	CAAS rating				
Division	**Red**	**Amber**	**Green**	**Gold**	**Multiple Gold**
ICS	1	16	4	0	6
Planned Care	0	3	9	6	10
HWBI	0	2	6	4	2
Totals (56)	3	21	19	10	18

Gold panels

Six gold accreditation panels have taken place during 2018**.** Support for the panel process including refining the detail and expectations has been gratefully received from executive and non-executive colleagues, public governors, assistant directors, staff partnership, previous gold award achievers and heads of service and quality.

The teams presenting to the panels have continued to impress with the diversity of their presentations and the commitment to excellence in patient centred quality care. There are a total of 28 teams who are currently achieving the gold accreditation standard.

Table 42: New gold achievers in 2018

Month	Gold accreditation awards in 2018
Jan	Chesterfield and North East outpatient and MSK physiotherapy service
March	Fenton Ward
May	Ripley outpatient department Diagnostic and Treatment Centre, Ilkeston Hospital School age immunisation and vaccination team
July	Okeover Ward Bolsover South 0-19 Children's service Heanor outpatients department
September	Amber Valley outpatient and MSK physiotherapy service
December	Wheatbridge integrated sexual health service

Table 43: Teams maintaining gold in 2018

After 12 months of accreditation	Learning disabilities community team Adult speech and language therapy service Whitworth Minor Injury Unit Chesterfield and North East dental service Chesterfield and North East podiatry Heanor Ward Butterley Ward Hopewell Ward
After 24 months of accreditation	Valley View Rockley Way Robertson Road Amberley Court Orchard Cottage Baron Ward

Teams who did not retain their gold status

Four teams did not retain their gold status, and one team was deferred by the accreditation panel.

All teams have returned to the CAAS assessment process and are currently rated as amber and green.

Quality and responsive summits

During 2018 quality and responsive summits were arranged to support teams and their leaders with the development of a robust plan to move them forward with their quality improvement journey. The table below shares the details of the team who undertook support from either a quality or responsive summit.

Table 44: **Quality/responsive summit**

Type of summit	Month 2018	Team
Quality summit	February	Amber Valley SPA Clay Cross ICT (integrated community team)
	May	Linacre Ward
	December	Derbyshire Dales South ICT
Responsive summit	January	Dronfield ICT
	April	High Peak and Dales ICT
	May	Erewash 0-19
	June	Belper ICT
	August	Buxton high risk podiatry outpatients and theatre
	September	Ripley Minor Injuries Unit Hillside Ward Oker Ward
	October	Alton Ward Buxton outpatients South Erewash ICT
	November	Clay Cross ICT East Chesterfield ICT

Quality and safe care champion (QSCC) programme

20 training sessions facilitated by the QA improvement leads and specialist leads/practitioners for safe and person-centred care have been held for the champions across the following subjects:

Continence	Infection control and prevention	Nutrition	Patient experience and dignity	Tissue viability
Safeguarding	Falls forum	End of life care and Spirituality	Dementia	Pain

373 champions have attended, estimated to be 40**%** QSCC registered to attend the sessions provided in 2018 from the total head count of 793 QSCC registered as of December 2018.

QSCC have also become influential members of several key clinical groups in the Trust, such as the nutrition steering group and the end of life care group, where their input has been valued.

QSCC hub and Facebook group

The QA team have developed an on-line hub for QSCC to obtain detailed up to date information, examples of service evaluation tools and also to share their ideas with each other; this has been really well received. QSCC continue to engage with the Facebook group posting suggestions ideas and examples of the quality improvement developments being implemented.

QA dashboard and reporting tools

Significant progress has been made in 2018 developing the assessment reporting tool on the quality dashboard page and the informatics lead has developed a range of reports that can be accessed by all leaders and teams. This is enabling teams, specialist leads and the QA assessors to drill down on all the data held within the system to identify achievement, hots spots and themes and trends against the clinical standards. Quarterly reports regarding the top rating themes and trends from assessments are now circulated widely across DCHS to inform improvement actions.

National and local events

An article written by the clinical lead for QA called Designing and implementing a trust-wide quality assurance programme, was published in the Journal of Community Nursing in April 2018. The QA team took part in the Trust Clinical Effectiveness Conference.

Seb's story

In 2017 DCHS were invited by Chesterfield College to offer an internship for three learning disability students for a year, to support them with real life business skills, confidence and people skills, whilst learning hands on what qualities someone needs to progress within the world of work. This was the third cohort of such students DCHS had hosted. Of the six candidates interviewed three were successful, one being Seb.

The wider workforce coordinator arranged for the students to work on a rotational basis with various teams across the Chesterfield area including the patient safety and risk management team. Seb joined the team initially on 6 and 7 December 2017. Seb continued his further placements within DCHS before requesting to return to the patient safety and risk management team for the remainder of the placement. As a result he re-joined the team for two days each week from the 14 March 2018 until 28 June 2018.

Seb recognised that because of the sensitivity and nature of the work he would have limited opportunity to participate in all areas of work. However, Seb demonstrated an immediate interest in the work he was introduced to and was enthusiastic to assist or be involved in the work where he could.

During initial conversations it was identified that Seb has an interest and aptitude for IT work and systems of work. Seb became involved in various work streams and established himself as part of the team whilst Carl Ramsdale, the risk manager, mentored and managed him.

Seb's work included the de-commissioning of medical devices, maintenance of training registers and the compilation of community staff clinical baseline kitbags.

During his time with the team Seb's confidence grew and together we worked on his communication and presentation skills, initially presenting to individuals and finally progressing to staff groups in excess of thirty people.

At the conclusion of Seb's placement he was recruited to the DCHS staff bank in order that he could continue and complete his work with the patient safety and risk management team. Seb has also worked with a clinical team providing administrative support.

At Chesterfield College Seb has become somewhat of a celebrity through the recognition of his success whilst at DCHS. This was evident on 14 June 2018 when Carl was invited to attend the college achievement awards evening in order to present Seb with his college certificate. The majority of staff, parents and students were aware and clearly impressed by Seb as there were frequent references to his achievements.

Carl shared what a pleasure it has been to continue working with Seb and that he has become an outstanding ambassador for DCHS. Seb continues to build on the experience he has gained during the past year and he is confident this has assisted him going forward with his studies and personal development.

Carl Ramsdale was awarded Leader of the Year – admin and clerical at the Unsung Hero Awards on Friday 1 March 2019.

3.5.6 Learning disability improvement standards for NHS Trusts

The new standards have been designed to help NHS trusts measure the quality of care they provide to people with learning disabilities, autism or both.

There are four standards, which include:

1) respecting and protecting rights
2) inclusion and engagement
3) workforce
4) learning disability services standard (aimed solely at specialist mental health trusts providing care to people with learning disabilities, autism or both).

We have undertaken a gap analysis and also contributed to the national survey. In terms of autism we have established a basic awareness programme which 82.82% of staff have completed.

We have also provided staff with easy to use communication guides in the way of posters and cue cards for lanyards. LD services are commissioning a specialist training programme for autism as well.

Patient story - Max's story was presented by Emma, SLT for autism. Max is a six year old boy. He attends an enhanced resource unit at a local mainstream school, and before this attended a mainstream school and nursery.

When it became apparent that Max was still struggling with his communication the SLT service began to look for an iPad with appropriate software.

Max used pictures to communicate as a pre-schooler. Max was loaned a communication aid which uses a recorded voice and can carry up to 100 messages. Max's parents and the SLT service began to look at sources of funding for devices.

Subsequently, Max was provided with equipment from the electronic assistive technology service (EATS) which he can keep for as long as he needs. The iPad has had a profound impact on Max's communication skills and he has shown extensive and significant communication skills.

After an extremely stressful time for Max's mum, Max has now been placed in a mainstream school where he has been able to thrive. The provision of the iPad has allowed Max to really show his skills. He is a bright boy.

This year Max was able to ask for the kind of birthday party that he wanted; he could tell his mum that he loved her as she dropped him at school; he could develop relationships with the wider family as he finally had a system of communication which met his needs, and now the icing on the cake, he has two voices, his iPad and his own. Max has recently joined the school choir and is singing his newly learnt songs to his family.

Staff story - Tim, healthcare assistant, shared his story to raise awareness about the challenges people with a stammer encounter in their day to day lives.

Tim started stammering at around five years' old and doesn't have a memory of speaking without a stammer, so it's all he has ever known. He stammered all the way through school, and back then times were very different; people really didn't have a lot of awareness about stammering and the support he needed.

For Tim, school was about as horrendous as it can get. He was bullied because of his stammer, and people often underestimated the emotional scars this leaves in later life.

Tim's time working in DCHS has been on the whole a very positive experience. He works in a good, close team who even socialise occasionally outside of work. They all have a really good rapport with each other and excellent banter which makes our working environment a great place to be.

Tim doesn't feel that he is treated differently by his team because of his stammer, however on occasions he has experienced a clear lack of awareness and understanding around how people communicate with him and is of the opinion that this is an honest ignorance and people are not knowledgeable or aware of how to change their communication to support someone who has a stammer.

He has found when speaking to others they will often finish his sentences or jump in with words to complete what he is saying. What they don't realise is that this type of behaviour takes his voice away and discourages him from speaking up.

Appendix 1 - Workforce - 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, on topics chosen by staff. Each month we meet with staff partnership/union colleagues in a formal sub-committee of the Trust Board. The aim is to provide assurance that we routinely engage, consult and involve staff in the management of change.

Team Talks and Exec Huddles offer an informal drop-in opportunity for staff to find out more about what's planned and raise any questions face-to-face with an executive.

Big Conversations are bi-monthly bookable three-hour sessions which are open to all staff. The agenda is set before the meeting and covers key issues relating to the current climate.

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

During 2017/18 we held a series of executive-led briefing sessions around the Joined Up Care Belper review and Better Care Closer to Home consultation, both commissioner-led projects for the future shape of care with an impact on our staff, which it was important for us to share directly with staff.

We have a strong culture of appraisals, training, learning, development and raising concerns which are all designed to promote our approach to staff engagement. We also hold topic specific engagement events and also arrange for these to be held at locations across the patch.

Saying thank you

We think it is important to celebrate the achievements of individuals and teams who dedication and commitment shines through, including those who devote decades of their working life to the NHS and to our organisation.

This year we launched a new #DCHSTTT – thank you, time and tea party - reward and recognition scheme, hosted by the Board and

running every quarter, to celebrate and thank staff by inviting them to take some time out and enjoy tea and cakes with colleagues and friends. Our first 2018 cohort of nominees were a combination of staff who had been nominated, staff who were receiving their long service awards and teams who had retained their Gold Quality Always accreditation.

We also introduced a new festive initiative leading up to Christmas - Seasonal Stars. This was a feel good campaign, sponsored by Thorntons, recognising over 80 colleagues split each day throughout December.

During 2018 we hosted our fifth Extra Mile Awards which are an established event in our calendar, to recognise those who inspire others and deliver beyond expectations.

Staff story - James

Following an accident, James sustained an injury and ligament damage to his right hand and right thumb. This involved him having to take time off sick from his job as a health care assistant, working on a ward with patients that have mental ill health and highly challenging behaviours. He was unable to carry out his role as an HCA due to wearing a splint. He was severely limited with carrying, moving and handling safely, and was restricted with carrying out personal care due to wearing the splint and not being able to employ adequate infection control precautions. Further to this he could compromise work colleagues, patients and himself as he was not able to employ restraint or breakaway techniques if and when required.

Following a meeting with his line manager as part of James managing his sickness, a mutually agreed and alternative job role on the ward was found, working with the ward clerk, carrying out admin work in the office.

The passport and alternative arrangements enabled James to return to work from sickness whilst his hand was recovering in a splint and he worked in the office carrying out admin for three weeks. This prevented him from a protracted length of sickness. Being able to return to work had a positive impact on his wellbeing. James said, “I haven’t felt anxious and preoccupied about sickness time or felt guilty for not being able to come to work. I have felt accomplished in my temporary role which has helped to build my self-esteem and confidence, whilst still being a valued member of the unit team. Further to this I have been able to gain a greater understanding of my peers’ jobs, namely the work carried out by the RNs and ward clerks.”

NHS Staff Survey

The 2018 NHS Staff Survey was conducted between Monday 1 October and Friday 30 November 2018. 2,565 DCHS employees completed the survey giving a response rate of 61%, compared to our response rate of 55% in 2017.

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, Exec Huddles, Leadership Forums and Staff Forum, to ensure staff at all levels have the opportunity to feed into the conversation about what the results tell us.

From 2018 onwards, the results from questions are grouped to give scores in 10 indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

Scores for each indicator together with that of the survey benchmarking group, community trusts, are presented in table 45 below:

Table 45: Benchmarking group scores

	2018/19		2017/18		2016/17	
	Trust	Benchmarking group	Trust	Benchmarking group	Trust	Benchmarking group
Equality, diversity and inclusion	9.4	9.3	9.4	9.3	9.5	9.4
Health and wellbeing	6.2	5.9	6.3	6	6.5	6.1
Immediate managers	7	7	7	7	7.2	6.9
Morale	6.3	6.2	N/A	N/A	N/A	N/A
Quality of appraisals	5.6	5.6	5.7	5.4	5.9	5.6
Quality of care	7.6	7.3	7.6	7.3	7.8	7.5
Safe environment – bullying and harassment	8.5	8.4	8.6	8.4	8.7	8.4
Safe environment – violence	9.6	9.7	9.6	9.7	9.7	9.7
Safety culture	7.1	7	7	6.9	7.1	6.8
Staff engagement	7.2	7.1	7.2	6.9	7.4	6.9

Full survey results are also shared on our intranet site, My DCHS, and via our all staff weekly email, the Weekly Download. All these channels help to feed into the detailed action plan to address areas where the survey shows we need to improve.

Using the findings from the NHS Staff Survey 2018, we are focusing on seven key areas for improvement during 2019:

1. Leading for improvement
2. Employee wellbeing
3. Appraisals
4. Development opportunities
5. Bullying and harassment
6. Raising concerns
7. Health and safety of employees.

Progress on a more detailed action plan of our future priorities and targets to improve staff satisfaction in each of these key areas will be reported bi-monthly to our staff health, wellbeing, safety and engagement group and Quality People Committee. We conduct Pulse Checks three times a year. These results give us added opportunities to monitor and improve staff feedback, details of which are included further on in this chapter.

Pulse Check

Pulse Checks were launched in 2013 to give quick anonymous feedback on how well staff feel they are being managed, engaged and supported. This was later linked with our Staff Friends and Family Test.

The positive impact high staff engagement can have on other key performance indicators – such as attendance, patient safety and productivity – is recognised and well researched. It also shows leaders how well they are engaging with their teams to deliver the results we need, primarily around quality care for our patients.

We run the Pulse Checks three times a year (two full census, one sample). We encourage all our staff to complete the nine question Pulse Check (that shouldn't take any longer than five minutes to complete) to test the mood and wellbeing of employees and teams. This helps us pinpoint where and how we need to give extra support and intervention on a rolling basis to maintain staff morale.

The overall engagement scores for each quarter in 2018 / 19 are:

- Q1 April – June: 76%
- Q3 October – December: NHS Staff Survey, no Pulse Check
- Q4 January – March 2019: 75 out of 100

In recent Pulse Checks these are the responses we received to the following Staff Friends and Family Test questions:

How likely are you to recommend Derbyshire Community Health Services NHS Foundation Trust to friends and family if they needed care or treatment?

- Q1 April to June 2018: 90%.
- Q3 October to December: NHS Staff Survey, no Pulse Check
- Q4 January to March 2019: 90%

How likely are you to recommend Derbyshire Community Health Services NHS Foundation Trust to friends and family as a place to work?

- Q1 April to June 2018: 70%.
- Q3 October to December: NHS Staff Survey, no Pulse Check
- Q4 January to March 2019: 69%

Staff wellbeing update

The launch of the new staff wellbeing strategy aims at creating a step change for staff experience at DCHS. The strategy focuses on three key areas; prevention, resilience and support. The previous model was heavily focused on supporting staff once difficulties had happened, as opposed to tackling up stream issues. The existing support structures, such as Resolve and occupational health are

continuing to be developed and are linked into the preventative work. The prevention element focuses on staff self-compassion and supports this through staff training and management consultancy offers. There is also a focus on areas where we know things to be more challenging, such as in LD or OPMH services, and are providing bespoke support to these teams.

Wellbeing figures

The staff wellbeing team have delivered 210 training sessions in the past year, compared to 155 for the same period the previous year. The majority of these sessions focus on stress to resilience or bespoke team building. The sessions receive 98.5% average satisfaction and recommendation scores.

Table 46: Wellbeing training sessions

Month	Training sessions delivered 2017	Training sessions delivered 2018
Total	155	210

Resolve figures

Satisfaction

- 100% of clients rated the overall service received by Resolve as good or excellent
- 100% of clients felt that the counselling they received helped them to deal more effectively with their issues
- 98.5% of clients would use the Resolve service again, if they needed to
- 85.5% of clients reported feeling more productive at work as a result of the counselling they received from Resolve
- 68% of clients felt that coming to counselling prevented them from taking time off sick.

Table 47: Key performance indicators

KPI	Target	2018/19 half year	2017/18 full year
Uptake of counselling (in % of DCHS workforce headcount)	4%	8.5-9% (projected)	9%
Offer first assessment appointment within two weeks (14 calendar days)	100%	89%	83%
Client felt more productive at work	90%	85%	80%
Client would recommend the service/come again	90%	98.5%	99%
Client felt that Resolve counselling helped prevent them from taking sickness absence (where relevant)	90%	68%	72%

Last year there were 408 referrals into Resolve and early indications are that this year will be about the same.

2018/19 Flu campaign

The flu campaign successfully vaccinated 2,226 of 3,473 frontline staff which equates to 64.1%.

This is marginally below the 68.5% achieved last year. However a key success of the campaign was ensuring as many clinical staff as possible were vaccinated at the beginning of the campaign, through the use of pre-booked clinic slots. This has resulted in a reduction in absence due to flu of 5% compared to the previous winter.

APPENDIX 2 - GP PATIENT SURVEY RESULTS

Table 48: Patient Survey results

Service line request	Castle Street 2018	Castle Street 2017	Creswell 2018	Creswell 2017	Ripley 2018	Ripley 2017	Service total	National average
Find it easy to get through to this GP practice by phone	86%	91%	81%	86%	71%	73%	79	9
Find the receptionists at this GP practice helpful	93%	91%	90%	84%	91%	82%	91	1
Are satisfied with the general practice appointment times available^	79%	86%	64%	77%	61%	68%	68	2
Usually get to see or speak to their preferred GP when they would like to	65%	81%	25%	40%	33%	29%	41	-9
Were offered a choice of appointment when they last tried to make a general practice appointment*	74%	--	53%	--	52%	--	60	-2
Were satisfied with the type of appointment they were offered*	89%	--	73%	--	66%	--	76	2
Took the appointment they were offered*	97%	--	93%	--	91%	--	94	0
Described their experience of making an appointment as good	82%	92%	57%	71%	63%	58%	67	-2
Waited 15 minutes or less after their appointment time to be seen at their last general practice appointment	80%	79%	69%	70%	62%	40%	70	1
Say the healthcare professional they saw or spoke to was good at giving them enough time during their last general practice appointment**	90%	89%	91%	87%	87%	86%	89	2
Say the healthcare professional they saw or spoke to was good at listening to them during their last general practice appointment**	93%	92%	91%	88%	94%	88%	93	4
Say the healthcare professional they saw or spoke to was good at treating them with	88%	94%	94%	89%	91%	87%	91	4

Service line request	Castle Street 2018	Castle Street 2017	Creswell 2018	Creswell 2017	Ripley 2018	Ripley 2017	Service total	National average
care and concern during their last general practice appointment**								
Were involved as much as they wanted to be in decisions about their care and treatment during their last general practice appointment^^	99%	93%	90%	77%	95%	84%	95	2
Had confidence and trust in the healthcare professional they saw or spoke to during their last general practice appointment	98%	99%	94%	97%	96%	95%	96	0
Felt the healthcare professional recognised or understood any mental health needs during their last general practice appointment*	91%	--	82%	--	84%	--	86	-1
Felt their needs were met during their last general practice appointment*	100%	--	93%	--	95%	--	96	1
Say they have had enough support in the last 12 months to help manage their long-term condition(s)*	88%	--	60%	--	76%	--	75	-4
Describe their overall experience of this GP practice as good	89%	92%	81%	73%	81%	72%	84	0

* No comparator for 2017

** 2017 data – aggregated from separate GP and nurse results from 2017

^ 2017 data - % of patients who are satisfied with the surgery's opening hours

^^2017 data - % of patients who say the last GP they saw or spoke to was good at involving them in decisions about their care

Key

Above average	1-10 below average

Quality outcomes framework (QOF)

The quality and outcomes framework (QOF) is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results. It is a set of 77 quality indicators which indicate how well practices look after people, particularly those with long term conditions such as heart or lung disease. All of our practices have improved their scores during the last year as illustrated below:

Table 49: QOF results 2017 – 2019

Practice	Points (out of 559)	Percentage 2017	Percentage 2018	Percentage 2019
Castle St	538.56	91%	98%	96.3%
Ripley	540.34	98%	99.5%	96.7%
Creswell	553.47	96%	99.2%	99%
Service aggregate is 97.3%				

Derby and Derbyshire Clinical Commissioning Group

APPENDIX 3 - THIRD PARTY STATEMENTS – CCGS/HEALTHWATCH

Annual Quality Report 2018/19

Derbyshire Community Health Services FT

Commissioner Statement

General Comments

The Derby and Derbyshire Clinical Commissioning Group (DDCCG) welcome the opportunity to provide a statement in response to the presented draft Quality Account (QA) from Derbyshire Community Healthcare Services NHS Foundation Trust (DCHS). The CCG have worked closely with Derbyshire Community Healthcare Services NHS Foundation Trust throughout 2018/19 to gain assurances that the services delivered were safe, effective and personalised to service users. The data presented has been reviewed and is in line with data provided and reviewed through the regular contractual performance meetings and quality assurance meetings.

Measuring and Improving Performance

Commissioners agree that the Quality Account provides a good overview of the overall Trust's Strategy, Vision, Values and work that is making a difference in services that DCHS provides to the local population. The three quality priorities in 2018/19 were focused on quality improvement in patient safety, clinical effectiveness and patient experience. Commissioners note the improvements made, especially within the 0-19 year's team to achieve the UNICEF breast feeding friendly organisation accreditation. In 2019/20 the identified quality improvements continue to reflect national travel (Sepsis & Dementia) for the benefit of the local population.

Achievements against the national Commissioning for Quality and Innovation (CQUIN) schemes for 2018/19 were lower than expected due to a range of factors. Whilst some improvements were noted, especially in for the locally agreed schemes it was disappointing to note the decline in Flu vaccination rates amongst frontline staff. Whilst this CQUIN is to be continued in 2019/20 (with a stretch improvement trajectory of 80%) it would have beneficial to have more detail as to how the Trust will improve the uptake rates amongst frontline staff.

Providing the best outcomes for Patients

The national and local challenge to recruitment of healthcare staff against a background of increased demand is reflected within the QA, throughout the year the Trust have looked at and implemented a range of alternative employment methods. This includes the introduction of new roles such as the Nursing Associates (RNA) and AHPs working in advanced practice roles. The Trust encourage staff involvement through a range of opportunities including staff representation on Council of Governors, Big Conversation sessions and the introduction of a new 'Raising Concerns Policy'.

The Trust recognises the importance of ensuring that all clinical audit activity is meaning and purposeful and results in learning, and improvements in care. The vision for developing DCHS as a 'researching' Trust (DCHS Strategy) is reflected within the organisations commitment as this is one of the three quality priorities for the forthcoming year. In the previous two years the organisation has continued to increase the number of studies participated in and the training of 15 research envoys / principal investigators in 2018/19 will hopefully sustain this increase in forthcoming years.

Positive Experience

Patient experience is clearly outlined within the Quality Account and how the Trust measure and monitor patient and carers experiences to help improve services. In 2018/19 the overall feedback was satisfactory, despite an 8% reduction in the number of responses. It was also noted that the Trust did not meet one of the key priorities rolled over from the previous year in relation to the identification of 75% of carers who accessed services. The overall numbers have remained static and below the peak at the start of 2017. In both these cases it would have been beneficial to understand why there had been either a decrease or no movement and the outline of any plans aimed at improvement.

There is an open and transparent culture within the organisation in relation to the reporting of incidents and an appetite to learning from investigations. Using the national framework the trust has shown transparency and learning to strengthen their internal processes to ensure that patients are safe.

Additional comments

This 2018/19 Quality Account provides an annual report to members of the public with the objective of demonstrating that the Trust is committed to ensuring it assesses and provides a high quality of care across its commissioned services. Within this statement the CCG would like to acknowledge and thank Derbyshire Community Healthcare Services NHS Foundation Trust for working positively and collaboratively with commissioners and key stakeholders to ensure our patients receive a high

quality of care at the right time and in the right care setting. We look forward to continuing to work with the Trust and the people it serves over the coming year and beyond.

Brigid Stacey

Chief Nursing Officer

On behalf of Derby and Derbyshire Clinical Commissioning Group

24th April 2018

"The Committee welcomes the opportunity to consider the Quality Account Report for 2018/19. It notes that the document still required information from the Independent Auditors and will seek to receive this information when it becomes available. The Committee will continue to monitor and offer challenge to DCHS in the provision of its services over the coming months and years."

Derbyshire County Council's Health Scrutiny Committee

21st May 2019

Derbyshire Community Health Services NHS Foundation Trust

Governor statement

21 May 2019

Quality Account 2018/19

Derbyshire Community Health Services NHS Trust Council of Governors are appreciative of the opportunity to review the Quality Account 2018/19 at both the Council of Governors and at the Quality Subgroup with the opportunity for a confirm and challenge approach. From this we are pleased to be able to comment as follows:

Governors are confident in both monitoring and supporting the trust in attaining the highest quality outcomes for patients, despite the significant challenges the NHS faces both locally and nationally and this is demonstrated with this well constructed comprehensive and honest account of where the trust is with regards to meeting quality outcomes.

The Quality Account 2018/19 gives a clear overview of the broad breadth of clinical areas covered, range of indicators used and work undertaken with some excellent examples of its successes as well as highlighting those areas requiring further support to attain the required outcomes identified, all elements have clear action and delivery plans offering assurance of attainment of required targets whilst clearly ensuring the patient remains at the centre of service provision.

The Quality Account clearly demonstrates the successful approach of the triangulation method across operational services and peer review clearly feeding into the assurance framework.

Acknowledgement is made with regards to the continued efforts of all staff within the Trust in achieving continued high quality of care and provision of services.

Bernard Thorpe
Lead Governor

Lynn Walshaw
Public Governor
Chair of Quality Sub-Group

As an independent organisation which asks local people to share their experiences of services with the aim of helping to improve and better understand overall local Health and Social care, it is important that the service providers are prepared to listen and where necessary act upon patient voice. Healthwatch Derby have found DCHS to be open and responsive to the feedback we have provided throughout the year and the team have found staff very helpful in the planning and outreach work we have undertaken. We especially found this with the work into local emergency dentistry provision and sexual health services. The organisation has acted in a manner which displays that they are interested in improving the experience of their services and are actively searching for ways to engage with their service users. Healthwatch Derby is will continue to work in partnership to help DCHS better understand the impact of their work.

James Moore MBA, Assoc CIPD

Chief Executive Officer

Healthwatch Derby

Healthwatch Derbyshire (HWD) is an independent voice for the people of Derbyshire. We listen to the experiences of Derbyshire residents using health and social care services and give them a stronger say in influencing how local health and social care services are provided. All of the experiences we collect are shared with the providers and commissioners of the services, who have the power to make change happen.

Experiences from patients and members of the public are collected through our engagement team, which is supported by volunteers. We undertake engagement in two ways:

1) General engagement in which we collect a variety of different experiences on a number of services. Experiences from our general engagement are shared with providers on a regular basis to provide an independent account of what is working well, and what could be improved.

   Anyone who shares an experience with HWD is able to request a response, and we encourage organisations to consider responses carefully and indicate where learning has taken place as a result of someone's experience.

2) Themed engagement is where we explore a particular topic in more detail and the findings from our themed engagement are analysed and written up into reports which included recommendations for improvement. Service providers and commissioners are asked to respond to the recommendations outlined in the reports.

All of our reports are published onto our website.

We have read the quality account for 2018/19 prepared by the Trust with interest. We have considered if, and how the content reflects some of the themes which have emerged in the feedback that HWD has collected during the past year.

The quality account details improving the dementia friendly environment and culture across the Trust. HWD welcomes this priority, following the publication of the HWD dementia report in May 2018, patients and members of the public explained how important it is to raise awareness and understanding of dementia and to also, create a culture that is inclusive of all.

The quality account also refers to the partnership working between the Trust and HWD. We regularly provide feedback to the Trust in terms of comments and we have also undertaken several pieces of themed engagements, to provide the Trust with independent patient feedback. This includes, the HWD dementia report, cataract report and enter and view visit reports. DCHS also supported the development and sharing of the 'STOP! I have a learning disability' poster. These provide examples of how HWD and the Trust can work closely together to develop and improve patient experience.

By way of summary, during the period April 2018-March 2019, a total of 82 comments were received about the Trust with a fairly equal split between positive comments (37), negative comments (23) and mixed comments (22). The most frequent negative comments were regarding information and communication. The most frequently made positive comments were in relation to the quality of treatment, quality of care provided by members of staff and positive and welcoming environments.

Hannah Morton

Intelligence and Insight Manager

Healthwatch Derbyshire

Regulation 5 – No changes have been made to the final quality account after receipt of the statements referred to above.

APPENDIX 4 - STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY ACCOUNT

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare quality accounts for each financial year.

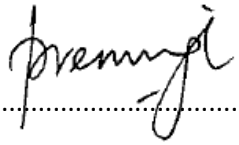
NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- The content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2018/19 and supporting guidance
- The content of the quality report is not inconsistent with internal and external sources of information including:
    - Board minutes for the financial year, April 2018 and up to the date of this statement
    - Papers relating to quality report reported to the Board over the period April 2018 to the date of this statement
    - Feedback from the commissioners dated 24 April 2019
    - Feedback from governors dated 21 May 2019
    - Feedback from local Healthwatch Derby and Derbyshire organisations dated 2 May 2019 and 3 May 2019
    - Feedback from Health Scrutiny Committee dated 21 May 2019
    - The Trust's 2017/18 complaints report (presented to the Patient Experience Engagement Group on 26 June 2018) and bi-monthly 2018/19 complaints reports to the Patient Experience and Engagement Group
    - The 2018 national GP patient survey, dated August 2018
    - The latest NHS Staff Survey 2018
    - The head of internal audit's annual opinion over the Trust's control environment, dated April 2019
    - Care Quality Commission inspection report, dated 23 September 2016
- The quality report presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- The performance information reported in the quality report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- The quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality account's regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board

22 May 2019 Date.....  .....**Chairman**

22 May 2019 Date.....  .....**Acting Chief Executive**

APPENDIX 5 - INDEPENDENT AUDITORS

Independent Auditors' Limited Assurance Report to the Council of Governors of Derbyshire Community Health Services NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Derbyshire Community Health Services NHS Foundation Trust to perform an independent assurance engagement in respect of Derbyshire Community Health Services NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance (the "specified indicators") marked with the symbol Ⓐ in the Quality Report, consist of the following national priority indicators as mandated by Monitor (operating as NHS Improvement) ("NHSI"):

Specified Indicators	*Specified indicators criteria*
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period	Section 3.4.10 - Referral to treatment times
Percentage of patients with a total time in Minor Injuries Unit of four hours or less from arrival to admission, transfer or discharge	Section 3.4.9 - Minor Injury Unit (MIU) waiting times

The three mandated indicators for community foundation trusts to choose from were:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period;
- Emergency re-admissions within 28 days of discharge from hospital; and
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

As the Trust does not receive emergency readmissions to its inpatient rehabilitation beds and does not provide diagnostic and treatment services for patients with cancer, the latter two indicators were not considered relevant for the Trust. Therefore, only the indicator for 'Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period' was tested from the mandated indicators.

As we are required to provide limited assurance on two indicators, the Trust's Council of Governors selected the following alternative indicator:

- Percentage of patients with a total time in Minor Injuries Unit of four hours or less from arrival to admission, transfer or discharge.

Respective responsibilities of the Directors and Auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the 'Detailed requirements for quality reports 2018/19' issued by NHSI. The Directors are also responsible for the conformity of the specified indicators criteria with the assessment criteria set out in the FT ARM and the 'Detailed requirements for external assurance for quality reports 2018/19' issued by NHSI and for reporting the specified indicators in accordance with those criteria, as referred to on the pages of the Quality Report listed above.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the 'Detailed requirements for quality reports 2018/19';
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the criteria set out in the FT ARM and the 'Detailed requirements for external assurance for quality reports 2018/19'.

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM and the 'Detailed requirements for quality reports 2018/19'; and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially consistent with the following documents:

- Board minutes for the financial year, April 2018 and up to the date of signing this limited assurance report ("the period");
- Papers relating to quality reported to the Board over the period April 2018 to the date of signing this limited assurance report;
- Feedback from the Commissioners, NHS Derby and Derbyshire CCG, dated 24th April 2019;
- Feedback from Governors dated 21st May 2019;
- Feedback from local Healthwatch Derby and Derbyshire organisations dated 2nd May 2019 and 3rd May 2019;
- Feedback from Health Scrutiny Committee dated 21st May 2019;
- The Trust's 2017/18 complaints report (presented at the Patient Experience Engagement Group on 26th June 2018) and bi-monthly 2018/19 complaints reports to the Patient Experience and Engagement Group;
- The 2018 national GP patient survey dated August 2018;
- The latest national staff survey 2018; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated April 2019.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

Our Independence and Quality Control

We complied with the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics, which includes independence and other requirements founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour.
We apply International Standard on Quality Control (UK) 1 and accordingly maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Use and distribution of the report

This report, including the conclusion, has been prepared solely for the Council of Governors of Derbyshire Community Health Services NHS Foundation Trust as a body, to assist the Council of Governors in reporting Derbyshire Community Health Services NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Derbyshire Community Health Services NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000 (Revised)'). Our limited assurance procedures included:

- reviewing the content of the Quality Report against the requirements of the FT ARM and the 'Detailed requirements for quality reports 2018/19';
- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
- performing limited testing, on a selective basis, of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the FT ARM and 'Detailed requirements for quality reports 2018/19'.

The nature, form and content required of Quality Reports are determined by NHSI. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by Derbyshire Community Health Services NHS Foundation Trust.

Basis for disclaimer of Conclusion – Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period

The indicator 'Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period' is calculated each month based on a snapshot of incomplete pathways and reported through the Unify2 portal. The data reported is subsequently updated by the Trust for any identified errors through a monthly validation process. The process is, however, not applied to the whole data set, as it focuses only on cases which have breached the indicator.

In our testing, we found a number of instances where the clock had not been stopped at the end of the applicable month end. Therefore, some patients had been incorrectly included in the indicator, until they were picked up by the validation team at a later stage. The Trust was not able to review and update the whole dataset. Therefore, we were unable to access accurate and complete data to check the waiting period from referral to treatment reported across the year.

Basis for disclaimer of Conclusion – Percentage of patients with a total time in Minor Injuries Unit of four hours or less from arrival to admission, transfer or discharge

We found a number of instances where the reported clock stop times did not agree to the information contained within the patient records. In one instance, the clock stop time on the system differed by four minutes to the discharge time recorded on the patient record. In another instance, the reported clock stop time was actually the time of triage from the patient record and we were unable to assess what the actual clock stop time should have been. In both cases, it appears that the clock stop time on the system was retrospectively updated with no explanation included in the patient record for the update.

The Trust cannot prove that there are no other instances like this in the population, therefore we are unable to obtain reliable evidence in relation to the clock stop times for the indicator 'Percentage of patients with a total time in Minor Injuries Unit of four hours or less from arrival to admission, transfer or discharge'.

Conclusion

Because of the matters described in the 'Basis for disclaimer of conclusion' paragraphs above, we have not been able to form a conclusion on the indicators 'Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period' or 'Percentage of patients with a total time in Minor Injuries Unit of four hours or less from arrival to admission, transfer or discharge'.

Based on the results of our procedures:

- nothing has come to our attention that causes us to believe that for the year ended 31 March 2019, the Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the "Detailed requirements for quality reports 2018/19"; and
- nothing has come to our attention that causes us to believe that for the year ended 31 March 2019 the Quality Report is not consistent in all material respects with the documents specified above.

PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP
PricewaterhouseCoopers LLP, Donington Court, Pegasus Business Park, Castle Donington, DE74 2UZ

28 May 2019

The maintenance and integrity of the Derbyshire Community Health Services NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

APPENDIX 6 - THE CORE QUALITY ACCOUNT INDICATORS

Where the necessary data is made available to the NHS Trust and non NHS bodies by the Health and Social Care Information Centre, a comparison of the numbers, percentages, values, scores or rates of the Trust and non NHS bodies (as applicable) should be included for each of those listed in the table with

a) The national average of the same; and
b) With those NHS trusts and NHS foundation trusts with the highest and lowest of the same for the reporting period.

Table 49: Complete list of core indicators.

	Prescribed information	Type of trust	2016/17	2017/18	2018/19
12	(a) The value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period; and (b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	**Trusts providing relevant acute services**	n/a	n/a	n/a
13	The percentage of patients on care programme approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period.	**Trusts providing relevant mental health services**	n/a	n/a	n/a
14	The percentage of category A telephone calls (red 1 and red 2 calls) resulting in an emergency response by the trust at the scene of the emergency within 8 minutes of receipt of that call during the reporting period.	**Ambulance trusts**	n/a	n/a	n/a
14.1	The percentage of category A telephone calls resulting in an ambulance response by the trust at the scene of the emergency within 19 minutes of receipt of that call during the reporting period.	**Ambulance trusts**	n/a	n/a	n/a
15	The percentage of patients with a pre-existing diagnosis of suspected ST elevation myocardial infarction who received an appropriate care	**Ambulance trusts**	n/a	n/a	n/a

	Prescribed information	Type of trust	2016/17	2017/18	2018/19
	bundle from the trust during the reporting period.				
16	The percentage of patients with suspected stroke assessed face to face who received an appropriate care bundle from the trust during the reporting period.	**Ambulance trusts**	n/a	n/a	n/a
17	The percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period.	**Trusts providing relevant mental health services**	n/a	n/a	n/a
18	The Trust's patient reported outcome measures scores for— (i) groin hernia surgery (ii) varicose vein surgery (iii) hip replacement surgery, and (iv) knee replacement surgery, during the reporting period.	**Trusts providing relevant acute services**	n/a	n/a	n/a
19	The percentage of patients aged - (i) 0 to 15; and (ii) 16 or over readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.	**All trusts**	n/a	n/a	n/a
20	The Trust's responsiveness to the personal needs of its patients during the reporting period.	**Trusts providing relevant acute services**	n/a	n/a	n/a
21	The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	**Trusts providing relevant acute services**	87.5%	82%	82.8%
21.1	Friends and Family Test – patient. The data made available by National Health Service Trust or NHS Foundation Trust by NHS Digital for all acute providers of adult NHS funded care, covering services for inpatients and patients discharged from accident and emergency (types 1 and 2).	**Trusts providing relevant acute services**	98%	97.8%	98.2%

	Prescribed information	Type of trust	2016/17	2017/18	2018/19
	Please note: there is not a statutory requirement to include this indicator in the quality accounts reporting but NHS provider organisations should consider doing so.				
22	The Trust's 'Patient experience of community mental health services' indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.	**Trusts providing relevant mental health services**	n/a	n/a	n/a
23	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	**Trusts providing relevant acute services**	99.6%	99.9%	99.6%
24	The rate per 100,000 bed days of cases of C difficile infection reported within the Trust amongst patients aged two or over during the reporting period.	**Trusts providing relevant acute services**	n/a	n/a	n/a
25	The number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	**All trusts**	10,002 7 0.07%	10,018 9 0.08%	7,221 4 0.05%

Glossary

AHPs	-	Allied Health Professions
BAF	-	Board Assurance Framework
Bariatric	-	Medical terminology for branch of medicine dealing with causes prevention and treatment of obesity
BRAVO	-	Baseline recording of activity for valued outputs
CAS	-	Central Alerting System
CAUTI	-	Catheter Associated Urinary Tract Infection
CCG	-	Clinical Commissioning Group
CFT	-	Community Foundation Trust
CSG	-	Clinical Safety Group
CQC	-	Care Quality Commission
CQUIN	-	Commissioning for Quality and Innovation
DCHS	-	Derbyshire Community Health Services NHS Foundation Trust
DoLS	-	Deprivation of Liberty Safeguards
DTC	-	Diagnostic and Treatment Centre
EoL	-	End of Life
ERE	-	Erewash
ESR	-	Electronic Staff Record
GP	-	General Practice
HCA	-	Health Care Assistant
HCAI	-	Healthcare Associated Infection
HCCG	-	Hardwick Clinical Commissioning Group
HSE	-	Health and Safety Executive
ICM	-	Integrated Community Manager
ICTL	-	Integrated Community Team Lead
IG	-	Information Governance

IM&T	-	Information Management and Technology
KLOE	-	Key Lines of Enquiry
KPIs	-	Key Performance Indicators
LD	-	Learning Disabilities
LeDeR	-	Learning Disabilities Mortality Review
LoS	-	Length of Stay
MCA	-	Mental Capacity Act
MIU	-	Minor Injury Unit
MoGP	-	Markers of Good Practice
MRG	-	Mortality Review Group
MRSA	-	Methicillin-resistant Staphylococcus aureus
NA	-	Nursing Associate
NDCCG	-	North Derbyshire Clinical Commissioning Group
NACEL	-	National Audit of Care at the End of Life
NAIC	-	National Audit of Intermediate Care
NED	-	North East Derbyshire
NEWS2	-	National Early Warning Score (Revised)
NHS	-	National Health Service
NICE	-	National Institute for Health and Care Excellence
NMC	-	Nursing and Midwifery Council
NRLS	-	National Reporting and Learning Scheme
NUH	-	Nottingham University Hospital
OT	-	Occupational therapist
OPMH	-	Older People's Mental Health
PLACE	-	Patient-Led Assessments of the Care Environment
QSC	-	Quality Service Committee

RCA	-	Root Cause Analysis
RN	-	Registered Nurse
RTT	-	Referral to Treatment Times
SDCCG	-	Southern Derbyshire Clinical Commissioning Group
SHOT	-	Serious Hazards of Transfusion
SLT	-	Speech and Language Therapy
SSNAP	-	Sentinel Stroke National Audit programme
STP	-	Sustainability and Transformation Partnership
TV	-	Tissue Viability
UHDB	-	University Hospitals of Derby and Burton NHS Foundation Trust
VTE	-	Venous Thromboembolism
WTE	-	Whole Time Equivalents

Independent Auditors' Report to the Council of Governors of Derbyshire Community Health Services NHS Foundation Trust

Report on the audit of the financial statements

Opinion

In our opinion, Derbyshire Community Health Services NHS Foundation Trust's financial statements (the "financial statements"):

- give a true and fair view of the state of the Trust's affairs as at 31 March 2019 and of the Trust's income and expenditure and cash flows for the year then ended; and
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2018/19.

We have audited the financial statements, included within the Annual Report and Accounts 2018/19 (the "Annual Report"), which comprise: the Statement of Financial Position as at 31 March 2019; the Statement of Comprehensive Income for the year then ended; the Statement of Cash Flows for the year then ended; the Statement of Changes in Equity for the year then ended; and the notes to the financial statements, which include a description of the significant accounting policies.

Basis for opinion

We conducted our audit in accordance with the National Health Service Act 2006, the Code of Audit Practice and relevant guidance issued by the National Audit Office on behalf of the Comptroller and Auditor General (the "Code of Audit Practice"), International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities under ISAs (UK) are further described in the Auditors' responsibilities for the audit of the financial statements section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Independence

We remained independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, which includes the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

Our audit approach

Context

The Trust provides community healthcare services across Derbyshire. It is funded predominantly by local Clinical Commissioning Groups ("CCGs") and NHS England.

Our audit for the year ended 31 March 2019 was planned and executed having regard to the fact that the Trust's operations and financial stability were largely unchanged in nature from the previous year. In light of this, our approach to the audit in terms of scoping and key audit matters was largely unchanged, apart from revenue and financial instruments where we undertook additional procedures to ensure the correct accounting treatment has been applied in light of the new accounting standards for revenue and financial instruments.

Overview

- Overall materiality: £3.792 million (2018: £3.977 million) which represents 2% of total revenue.

- Our audit was scoped by obtaining an understanding of the entity and its environment, including internal control. The Trust does not have any subsidiaries and is structured as a single reporting unit and so the whole foundation trust was subject to a full audit scope. All work was performed by a single audit team who assessed the risks of material misstatement, taking into account the nature, likelihood and potential magnitude of any misstatement and determined the extent of testing we needed to do over each balance in the financial statements.

Our key audit matters were:

- Risk of fraud in the recognition of fraud in revenue and expenditure; and
- Valuation of property, plant and equipment.

The scope of our audit

As part of designing our audit, we determined materiality and assessed the risks of material misstatement in the financial statements. In particular, we looked at where the directors made subjective judgements, for example in respect of significant accounting estimates that involved making assumptions and considering future events that are inherently uncertain.

As in all of our audits we also addressed the risk of management override of internal controls, including evaluating whether there was evidence of bias by the directors that represented a risk of material misstatement due to fraud.

Key audit matters

Key audit matters are those matters that, in the auditors' professional judgement, were of most significance in the audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by the auditors, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters, and any comments we make on the results of our procedures thereon, were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. This is not a complete list of all risks identified by our audit.

Key audit matter	*How our audit addressed the key audit matter*
Risk of fraud in the recognition of revenue and expenditure ***See note 1 to the financial statements for the directors' disclosures of the related accounting policies, judgements and estimates relating to the recognition of income and expenditure and notes 3-6 for further information.*** We focused on this area because there is a heightened risk as: • The Trust reported exceeding its control total of £4.07 million surplus with an outturn of £4.27 million surplus (before additional Provider Sustainability Funding). Given the pressure to deliver the planning control total there is an incentive to increase reported income. • There is an incentive not to recognise expenditure in 2018/19 relating to the current year, to improve the financial result. Expenditure relating to judgemental	We read the accounting policy for revenue and expenditure recognition and found it to be consistent with the requirements of the Department of Health and Social Care Group Accounting Manual 2018/19. **Income from Activities** For a sample of healthcare income, we obtained and agreed the income received during the year to a signed contract with the counterparty. For a sample of income recognised in relation to under / over performance against contract we agreed these to contract variations were signed by the relevant counterparty and the Trust. No issues were identified from the work performed. We used the mismatches report provided by NHS Improvement to auditors to identify any differences between the Trust's income, expenditure, receivables and payables balances reported by other NHS organisations. We checked that management had investigated all disputed amounts over £0.3 million. We read correspondence with the counterparties, and then considered the impact, if any, that the remaining disputed amounts would have on the Trust's

estimates, including provisions and accruals could be under-estimated in order to improve reported performance.
- The service level agreements with the Trust's commissioners are renegotiated annually and consist of standard monthly instalments with a settlement for under / over performance against agreed contract levels. Over / under performance is negotiated with commissioners and is, therefore, subject to management judgement regarding its value and recoverability.

Given these incentives, we focussed our work on the elements of income and expenditure that are most susceptible to manipulation, being:

- year-end healthcare income settlements with commissioners;
- items of expenditure where the value is dependent upon estimates, in particular provisions and accruals; and
- non-standard journal transactions; and unrecorded expenditure and liabilities.

financial statements and determined that there was no material impact.

Provisions

We obtained an understanding of the movement for each category of expenditure provision and performed testing on the restructuring provision by agreeing the provision to supporting evidence, confirming the accuracy of the provision calculations and that the Trust had a constructive obligation at 31 March 2019. We considered the completeness of provisions by testing cash payments made after the year end and assessing the completeness of lower value provisions.

Expenditure Accruals

We agreed a sample of accruals back to the supporting evidence available. In addition, we confirmed whether it was appropriate for our sample of accruals over one year old to be recognised within the financial statements.

Where invoices had not been received at the time of our audit, we obtained details of how the accrual had been calculated and confirmed the accuracy of the calculation. We also obtained the information that had been used to form the estimate in order to substantiate the accrual. Significant balances relate to the holiday pay accrual and the sleep in accrual. We considered the completeness of accruals by testing cash payments made after the year end and assessing the completeness of lower value accruals.

We raised an adjustment to reclassify the sleep in accrual as a provision as it is more akin to the definition of a provision.

Other Year End Procedures

For a sample of transactions recognised during the year and around the year-end (both before and after), we confirmed that income and expenditure had been recognised in line with the Trust's accounting policies and in the correct accounting period by agreeing transactions to the supporting invoice and cash receipts/payments where appropriate. We found no material issues.

Manipulation of journal postings to the general ledger

Our journals work was carried out using a risk based approach across the general ledger used by the Trust. We used data analysis techniques to identify the journals that had higher risk characteristics.

We tested a sample of journal transactions that had been recognised in both income and expenditure, focussing in particular on those that

- were raised by senior members of the finance team; and
- that used unusual account combinations.

We agreed the journal entries to supporting documentation, for example invoices and cash transactions. Our testing found that they were supported by appropriate documentation and that the income and expenditure was recognised in the appropriate accounting period.

Valuation of property, plant and equipment

See note 1 to the financial statements for the directors' disclosures of the related accounting policies for Property, Plant and Equipment and note 14 for further information.

We focussed on this area because Property, Plant and Equipment (PPE) represents the largest asset balance

We assessed the assumptions and the estimates used in the valuation and considered the reasonableness of these using our valuation expertise and consideration of wider industry trends. We have also considered the professional capabilities of the Trust's external consultant who has provided the indices.

We identified that the indices had been applied to the depreciated replacement cost of the building assets which is a

in the Trust's Statement of Financial Position and the valuation of land and buildings requires significant levels of judgement and technical expertise in choosing appropriate assumptions. Therefore, our work has focused on whether the methodology, assumptions and underlying data used to determine the value of Property, Plant and Equipment were appropriate and correctly applied.

The Trust's PPE at 31 March 2019 had a net book value of £76.199 million, of which £69.954 million relates to land and buildings, which are subject to revaluation.

Following a full revaluation of PPE undertaken in 2017/18, in 20181/9 the Trust has applied indices as the basis of updating the valuation of its land and buildings.

Our specific areas of focus were:

- accuracy and completeness of detailed information on assets used as the input data for each valuation;
- whether the Trust's assumptions underlying the classification of properties were appropriate;
- the basis of revaluation, assumptions and underlying data; and
- the accounting transactions resulting from this valuation were accurately recorded in the financial statements.

simplistic method of valuation. The indices should have been applied to the gross replacement cost and then one year of depreciation factored into the value. In light of this method of calculation, our valuation specialists proposed an alternative percentage increase should have been applied to the Trust's PPE, this is based on a judgemental range and the Trust chose not to adjust their valuation to reflect this amount.

We have checked the accuracy and completeness of the detailing land and building records being used as the basis of valuation.

We checked that the valuation information has been correctly input into the revaluation calculations and, consequently, that the accounting treatment has been recorded appropriately in the Trust's financial statements. We identified that the Trust had not accounted for revaluation gains which could be used to offset impairments which had been recognised in the Income and Expenditure statement in previous years.

We inspected the repairs and maintenance expense codes to confirm that there had been no significant alterations to the existing value and use of assets.

We determined that there were no further key audit matters relating to the financial statements of the Trust or the Trust's arrangements for securing economy, efficiency, and effectiveness in the use of resources to communicate in our report.

How we tailored the audit scope

We tailored the scope of our audit to ensure that we performed enough work to be able to give an opinion on the financial statements as a whole, taking into account the structure of the Trust, the accounting processes and controls, and the environment in which the Trust operates.

In establishing our overall approach we assessed the risks of material misstatement, taking into account the nature, likelihood and potential magnitude of any misstatement. Following this assessment, we applied professional judgement to determine the extent of testing required over each balance in the financial statements.

Derbyshire Community Health Services NHS Foundation Trust prepares individual Trust accounts. We conducted the audit work on the Trust financial statements at Walton Hospital, which is where the finance function is based.

Our risk assessment included consideration of management's analysis of the United Kingdom's withdrawal from the European Union on page 13, but the terms on which this may occur are not clear, and it is difficult to evaluate all of the potential implications on the Trust's activities, patients, suppliers and the wider economy.

Materiality

The scope of our audit was influenced by our application of materiality. We set certain quantitative thresholds for materiality. These, together with qualitative considerations, helped us to determine the scope of our audit and the nature, timing and extent of our audit procedures and to evaluate the effect of misstatements, both individually and on the financial statements as a whole.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Overall materiality	£3.792 million (2018: £3.977 million)
How we determined it	2% of revenue was used as the basis in both 2019 and 2018.
Rationale for benchmark applied	Consistent with last year, we have applied this benchmark, a generally accepted auditing practice, in the absence of indicators that an alternative benchmark would be appropriate.

We agreed with the Audit and Assurance Committee that we would report to them misstatements identified during our audit above £190,000 (2017/18: £194,000) as well as misstatements below that amount that, in our view, warranted reporting for qualitative reasons.

Conclusions relating to going concern

ISAs (UK) require us to report to you when:

- the directors' use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

We have nothing to report in respect of the above matters.

However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Trust's ability to continue as a going concern. For example, the terms on which the United Kingdom may withdraw from the European Union are not clear, and it is difficult to evaluate all of the potential implications on the Trust's activities, patients, suppliers and the wider economy.

Reporting on other information

The other information comprises all of the information in the Annual Report other than the financial statements and our auditors' report thereon. The directors are responsible for the other information. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except to the extent otherwise explicitly stated in this report, any form of assurance thereon.

In connection with our audit of the financial statements, 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 audit, or otherwise appears to be materially misstated. If we identify an apparent material inconsistency or material misstatement, we are required to perform procedures to conclude whether there is a material misstatement of the financial statements or a material misstatement of the other information. 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 based on these responsibilities.

With respect to the Performance Report and the Accountability Report, we also considered whether the disclosures required by the NHS Foundation Trust Annual Reporting Manual 2018/19 have been included.

Based on the responsibilities described above and our work undertaken in the course of the audit, ISAs (UK) and the Code of Audit Practice require us also to report certain opinions and matters as described below.

Performance Report and Accountability Report

In our opinion, based on the work undertaken in the course of the audit, the information given in the Performance Report and Accountability Report for the year ended 31 March 2019 is consistent with the financial statements and has been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2018/19.

In light of the knowledge and understanding of the Trust and its environment obtained in the course of the audit, we did not identify any material misstatements in the Performance Report or Accountability Report.

In addition, the parts of the Remuneration and Staff reports to be audited have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2018/19.

Responsibilities for the financial statements and the audit

Responsibilities of the directors for the financial statements

As explained more fully in the Accountability Report set out on page 116, the directors are responsible for the preparation of the financial statements in accordance with the Department of Health and Social Care Group Accounting Manual 2018/19, and for being satisfied that they give a true and fair view. The directors are also responsible for such internal control as they determine 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 directors are responsible for assessing the 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 the directors either intend to liquidate the Trust or to cease operations, or have no realistic alternative but to do so.

The Trust is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Auditors' 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 auditors' 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. This description forms part of our auditors' report.

We are required under Schedule 10 (1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report to you where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We have undertaken our work in accordance with the Code of Audit Practice, having regard to the criterion determined by the Comptroller and Auditor General as to whether the Trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice. Based our on risk assessment, we undertook such work as we considered necessary.

Use of this report

This report, including the opinions, has been prepared for and only for the Council of Governors of Derbyshire Community Health Services NHS Foundation Trust as a body in accordance with paragraph 24 of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Other required reporting

Arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report, by exception, if we conclude we are not satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

The scope of our work in respect of arrangements for securing economy, efficiency and effectiveness in the use of resources

The scope of our work is determined by the requirements outlined in Auditor Guidance Note 3 'Auditors' Work on Value for Money Arrangements' ("AGN 03") issued by the National Audit Office in November 2017. We tailored the scope of our work to address the evaluation criterion specified in AGN 03, that in all material respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people.

Key matters

Under AGN 03 we are required to report those matters that, in the auditors' professional judgement, were of most significance in forming the conclusion on whether the Trust had in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources and include the most significant assessed risks of failing to put in place proper arrangements that were identified by the auditors, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters, and any comments we make on the results of our procedures thereon, were addressed in the context of our work on arrangements to secure value for money as a whole, and in forming our conclusion thereon, and we do not provide a separate opinion on these matters. This is not a complete list of all risks identified relating to this work.

Financial Sustainability and delivery of cost savings

The Trust has a red rated risk included on its Board Assurance Framework around the financial stability of the organisation and not meeting future Sustainable Quality Improvement Programmes over the next two years.

In previous years, the Trust's performance on in achieving cost savings has been good, but the ongoing health economy faces financial challenge, and the financial health of other NHS bodies in Derbyshire creates increased concern over the impact the health economy position might have on the Trust's future contractual negotiations, including service cuts.

With pressures expected to heighten, and the added challenge of delivering the conditions associated with future receipt of PSF funding from the Department of Health and Social Care, this was an area of focus for our audit, including in relation to our conclusion on economy, efficiency and effectiveness.

In response to the identified risk, the following specific procedures were performed:

- Understood the 2018/19 financial outturn position and the Trust's performance against its 2018/19 cost savings target;
- Read the Trust's 2019/20 budget and SQIP plans;
- Understood the Trust's the medium term financial strategy and the sensitivities around this; and
- Understood the wider Derbyshire healthcare environment and the current commitments which the Trust has made to support the 'Joined Up Care' initiative.

Based on our risk assessment and work performed, we have summarised the following outcomes from our VFM assessment:

- The Trust is in a relatively strong financial position given it has exceeded its control total in 2018/19 and has reported a surplus. The Trust has also exceeded its planned cost savings target in 2018/19, although there is an over-reliance on non-recurrent schemes compared with the budgeted position.
- The latest CQC inspections, published September 2016, rated the Trust overall as "good". All services were rated as good or outstanding with the exception of the Sexual Health Services which was rated as "requires improvement".
- The NHS Improvement's Single Oversight Framework has continually rated the Trust in the highest rating as '1' in all areas.
- The Trust has budgeted for a surplus and agreed a control total with NHSI of £3.9 million for 2019/20. It has developed plans and is in the process of executing delivery of cost savings schemes to achieve its control total.
- Whilst the Derbyshire healthcare environment remains challenging, the Trust continues to participate in creating plans for a future risk sharing arrangement aimed at operating in a more collaborative approach to the delivery of services to patients across Derbyshire.

As a result of our work, we have no matters to report as a result of this requirement.

Other matters on which we report by exception

We are required to report to you if:

- The statement given by the directors on page 90, in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance, that they consider the Annual Report taken as a whole to be fair, balanced and understandable, and provides the information necessary for patients, regulators, and other stakeholders to assess the Trust's performance, business model, and strategy is materially inconsistent with our knowledge of the Trust acquired in the course of performing our audit.
- The section of the Annual report on page 101, as required by provision C.3.9 of the NHS Foundation Trust Code of Governance, describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.
- The Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 or is misleading or inconsistent with our knowledge acquired in the course of performing our audit. We have not considered whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.
- We have referred a matter to Monitor under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was

unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

- We have issued a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006.
- We have not received all the information and explanations we require for our audit.

We have no exceptions to report arising from this responsibility.

Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Code of Audit Practice.

Alison Breadon (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Donington Court
Castle Donington
East Midlands
28 May 2019

Derbyshire Community Health Services NHS Foundation Trust

Annual accounts for the year ended 31 March 2019

Foreword to the accounts

Derbyshire Community Health Services NHS Foundation Trust

These accounts, for the year ended 31 March 2019, 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 

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Name **Chris Sands**
Job title **Acting Chief Executive**
Date **22nd May 2019**

Statement of Comprehensive Income

For the year ended 31 March2019

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	173,444	180,930
Other operating income	4	19,770	17,911
Operating expenses	6, 8	(184,633)	(207,101)
Operating surplus/(deficit) from continuing operations		**8,581**	**(8,260)**
Finance income	11	190	68
PDC dividends payable		(2,075)	(1,834)
Net finance costs		**(1,885)**	**(1,766)**
Other gains	12	141	881
Surplus / (deficit) for the year from continuing operations		**6,837**	**(9,145)**
Surplus / (deficit) for the year		**6,837**	**(9,145)**
Other comprehensive income / (expense)			
Will not be reclassified to income and expenditure:			
Impairments	7	(741)	(12,383)
Revaluations	16	(170)	16,350
Total comprehensive income / (expense) for the period		**5,926**	**(5,178)**

Statement of Financial Position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	13	1,920	2,236
Property, plant and equipment	14	76,199	72,737
Receivables	17	170	151
Total non-current assets		**78,289**	**75,124**
Current assets			
Receivables	17	11,044	10,461
Cash and cash equivalents	19	30,799	26,619
Total current assets		**41,843**	**37,080**
Current liabilities			
Trade and other payables	20	(15,644)	(14,784)
Provisions	22	(1,518)	(875)
Other liabilities	21	(154)	(129)
Total current liabilities		**(17,316)**	**(15,788)**
Total assets less current liabilities		**102,816**	**96,416**
Non-current liabilities			
Provisions	22	(30)	(20)
Total non-current liabilities		**(30)**	**(20)**
Total assets employed		**102,786**	**96,396**
Financed by			
Public dividend capital		1,377	913
Revaluation reserve		28,065	29,050
Income and expenditure reserve		73,344	66,433
Total taxpayers' equity		**102,786**	**96,396**

The notes on pages 290 to 331 form part of these accounts.

Signed .....

NAME **CHRIS SANDS**
POSITION **ACTING CHIEF EXECUTIVE**
DATE **22ND MAY 2019**

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	**913**	**29,050**	**66,433**	**96,396**
Surplus for the year	-	-	6,837	**6,837**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	(22)	22	**-**
Impairments	-	(741)	-	**(741)**
Revaluations	-	(170)	-	**(170)**
Transfer to income and expenditure reserve on disposal of assets	-	(52)	52	**-**
Public dividend capital received		-	-	**464**
	464			
Taxpayers' equity at 31 March 2019	**1,377**	**28,065**	**73,344**	**102,786**

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**243**	**25,162**	**75,499**	**100,904**
Prior period adjustment	-	-	-	**-**
Taxpayers' equity at 1 April 2017 - restated	**243**	**25,162**	**75,499**	**100,904**
Deficit for the year	-	-	(9,145)	**(9,145)**
Impairments	-	(12,383)	-	**(12,383)**
Revaluations	-	16,350	-	**16,350**
Transfer to income and expenditure reserve on disposal of assets	-	(79)	79	**-**
Public dividend capital received		-	-	
	670			**670**
Taxpayers' equity at 31 March 2018	**913**	**29,050**	**66,433**	**96,396**

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.

Statement of Cash Flows for the year ended 31 March 2019

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus / (deficit)		8,581	(8,260)
Non-cash income and expense:			
Depreciation and amortisation	6.1	3,840	3,459
Net impairments	7	(706)	17,947
Income recognised in respect of capital donations	4	(76)	(228)
Increase in receivables and other assets		(1,005)	(2,615)
Increase / (decrease) in payables and other liabilities		237	(1,375)
Increase / (decrease) in provisions		653	228
Other movements in operating cash flows		5	(1)
Net cash generated from / (used in) operating activities		**11,529**	**9,155**
Cash flows from investing activities			
Interest received		190	68
Purchase of intangible assets		(269)	(302)
Purchase of property, plant and equipment		(6,652)	(6,170)
Sales of property, plant and equipment		520	4,231
Net cash used in investing activities		**(6,211)**	**(2,173)**
Cash flows from financing activities			
Public dividend capital received		464	670
PDC dividend paid		(1,602)	(2,435)
Net cash used in financing activities		**(1,138)**	**(1,765)**
Increase / (decrease) in cash and cash equivalents		**4,180**	**5,217**
Cash and cash equivalents at 1 April - brought forward		**26,619**	**21,402**
Cash and cash equivalents at 31 March	19.1	**30,799**	**26,619**

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 2018/19 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

Note 1.1.1 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, and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The Trust has reviewed its working capital requirements for the next twelve months. Under a set of reasonable sensitivities, it can be demonstrated that the Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, the Trust continues to adopt the going concern basis in preparing the 2018/19 accounts.

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 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 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 1.4.1 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). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

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 main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

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.

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.

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 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 1.4.2 Revenue grants and other contributions to expenditure

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.

The value of the benefit received when accessing funds from the 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, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4.3 Other income

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

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.5 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. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at 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 for Health 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.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those 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:

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 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 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.

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. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 1.6 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 1.7 Property, plant and equipment

Note 1.7.1 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.

Note 1.7.2 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.

Land and buildings 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.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet 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 and, where capitalised in accordance with IAS 23, borrowings costs. 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.

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.

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 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 income.

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.

Note 1.7.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

• 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 ie:

- 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' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned 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. 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.

Note 1.7.4 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.

Note 1.7.5 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:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	16	100
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 1.8 Intangible assets

Note 1.8.1 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 only where all of the following can be demonstrated:

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
• the Trust intends to complete the asset and sell or use it
• the Trust has the ability to sell or use the asset
• how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset and
• the Trust can measure reliably the expenses attributable to the asset during development.

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.

Note 1.8.2 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 under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

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.

Note 1.8.3 Useful economic life 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:

	Min life Years	**Max life Years**
Software licences	5	10
Licences & trademarks	5	10

Note 1.9 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 1.10 Financial assets and financial liabilities

Note 1.10.1 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.

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.

Note 1.10.3 Derecognition

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 1.11 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.

Note 1.11.1 The Trust as 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 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. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability 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.

Note 1.11.2 The Trust as 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 1.12 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 the discount rates published and mandated by HM Treasury.

Clinical negligence costs

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 22.1 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

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 1.13 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 the accounts where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed as note to the accounts, 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 1.14 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.

At any time, 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, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

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 thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.15 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 1.16 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 1.17 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.18 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 accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However 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 1.19 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 1.20 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 assets and liabilities transferred are recognised in the accounts 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 recognised revaluation reserve balances 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.

Note 1.21 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's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Accounting for property, plant and equipment

The Trust applies industry recognised indices (provided by a Chartered Surveyor). Indices are applied to property using the DRC method of valuation.

Accounting for leases

Judgements have been made regarding whether the risks and rewards of ownership pass to the lessee under lease arrangements.

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.

Accounting for doubtful debts

A general provision is estimated for doubtful debts . This is based on 100% for non-NHS invoices older than 90 days. 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.

Note 1.22 Sources of estimation uncertainty

There are no 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:

Note 1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1.24 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2018-19. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2019-20, and the government implementation date for IFRS 17 still subject to HM Treasury consideration

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2018-19. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2019-20, and the government implementation date for IFRS 17 still subject to HM Treasury consideration

Standard	Accounting Standards	Financial year for which the standard first applies
IFRS 16	Leases	Application required for an entity's first annual financial statements for periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRS 17	Insurance Contracts	Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRIC 23	Uncertainty over Income Tax Treatment	Application required for accounting periods beginning on or after 1 January 2019.

The adoption of IFRS 16 Leases are expected to be significantly impacted by the changes in the new lease requirements. This is especially the case where leased properties form a significant part of the Trust's business model. The Standard requires the Trust to recognise most leases on the balance sheet, but this standard has not yet been adopted for the public sector by HM Treasury and may be subject to interpretation and/or adaptation. As such, it is not currently possible to estimate the potential impact.

The remaining new standards are not anticipated to have a future material impact.

Note 2 Operating Segments

No segmental analysis is shown as the sole activity of Derbyshire Community Health Services NHS Foundation Trust in 2018/19 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 2019/20 dependent upon the information received by the Chief Operating Decision Maker.

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 1st April 2018 to 31st March 2019 was £173m (2017/18: £181m) 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 1.4.1

Note 3.1 Income from patient care activities (by nature)	2018/19 £000	2017/18 £000
Acute services		
Elective income	3,906	4,474
Non elective income	-	32,611
First outpatient income	1,973	2,618
Follow up outpatient income	3,385	2,991
A & E income	5,453	5,050
Other NHS clinical income	337	-
Mental health services		
Block contract income	16,769	9,956
Community services		
Community services income from CCGs and NHS England	112,656	96,280
Income from other sources (e.g. local authorities)	21,146	22,681
All services		
Agenda for Change pay award central funding	2,005	-
Other clinical income	5,814	4,269
Total income from activities	**173,444**	**180,930**

There is a change in re-classification of 2018/19 income from acute services non elective income as community services income from CCGs and NHS England, resulted in 2017/18 figures not being directly comparable.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2018/19 £000	2017/18 £000
NHS England	6,855	8,596
Clinical commissioning groups	142,651	148,576
Department of Health and Social Care	2,005	-
Other NHS providers	5	96
Local authorities	21,146	22,681
Injury cost recovery scheme	230	280
Non NHS: other	552	701
Total income from activities	**173,444**	**180,930**
Of which:		
Related to continuing operations	173,444	180,930

	2018/19	2017/18
	£000	£000

Note 4 Other operating income

	2018/19	2017/18
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	84	87
Education and training (excluding notional apprenticeship levy income)	1,671	1,113
Provider sustainability / sustainability and transformation fund income (PSF / STF)	4,065	4,061
Other contract income	13,874	12,422
Other non-contract operating income		
Receipt of capital grants and donations	76	228
Total other operating income	**19,770**	**17,911**
Of which:		
Related to continuing operations	19,770	17,911

Note 5.1 Additional information on revenue from contracts with customers recognised in the period

	2018/19
	£000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	129
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	3,857

Note 5.2 Transaction price allocated to remaining performance obligations

	31 March 2019
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	£000
within one year	4,010
after one year, not later than five years	-
after five years	-
Total revenue allocated to remaining performance obligations	**4,010**

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 license 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:

	2018/19	2017/18
	£000	£000
Income from services designated as commissioner requested services	-	-
Income from services not designated as commissioner requested services	173,444	180,930
Total	**173,444**	**180,930**

Note 5.4 Profits and losses on disposal of property, plant and equipment

Following relocation of delivery of all services from Bolsover Hospital to other sites, it was declared surplus on the Government ePIMS surplus property portal. As the site is no longer in use and there is no clear plan to bring the asset back into use, it was revalued under International Financial Reporting Standard 5 (IFRS5) Assets Held for Sale. This meant revaluing the total asset at the lower of carrying amount and fair value less costs to sell, which resulted in a valuation of £375k and recognising an impairment of £1m.

The asset was subsequently sold for £520k, generating a surplus of £145k.

Note 6.1 Operating expenses

	2018/19	2017/18
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	8,657	9,682
Purchase of healthcare from non-NHS and non-DHSC bodies	3,284	3,516
Staff and executive directors costs	128,110	130,989
Remuneration of non-executive directors	155	127
Supplies and services - clinical (excluding drugs costs)	11,432	11,810
Supplies and services - general	1,305	1,411
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	2,178	2,262
Consultancy costs	267	175
Establishment	1,803	2,115
Premises	8,726	8,927
Transport (including patient travel)	4,078	4,437
Depreciation on property, plant and equipment	3,255	2,858
Amortisation on intangible assets	585	601
Net impairments	(706)	17,947
Movement in credit loss allowance: contract receivables / contract assets	10	
Movement in credit loss allowance: all other receivables and investments	-	(28)
Audit fees payable to the external auditor		
audit services- statutory audit	68	56
other auditor remuneration (external auditor only)	10	4
Internal audit costs	91	106
Clinical negligence	573	436
Legal fees	248	209
Insurance	39	18
Education and training	1,224	784
Rentals under operating leases	7,843	6,962
Redundancy	498	359
Car parking & security	43	74
Hospitality	9	4
Losses, ex gratia & special payments	2	3
Other	846	1,257
Total	**184,633**	**207,101**
Of which:		
Related to continuing operations	184,633	207,101

Note 6.2 Other auditors' remuneration

	2018/19	2017/18
	£000	£000
Other auditors' remuneration paid to the external auditor:		
Other non-audit services	10	4
Total	**10**	**4**

Note 6.3 Limitation on auditors' liability

The limitation on auditor's liability for external audit work is £1m (2017/18: £1m).

Note 7 Impairment of assets

	2018/19	2017/18
	£000	£000
Net impairments charged to operating surplus / (deficit) resulting from:		
Changes in market price	(706)	17,947
Total net impairments charged to operating surplus / (deficit)	**(706)**	**17,947**
Impairments charged to the revaluation reserve	741	12,383
Total net impairments	**35**	**30,330**

Following relocation of delivery of all services from Bolsover Hospital to other sites, it was declared surplus on the Government ePIMS surplus property portal. As the site is no longer in use and there is no clear plan to bring the asset back into use, it was revalued under International Financial Reporting Standard 5 (IFRS5) Assets Held for Sale. This meant revaluing the total asset at the lower of carrying amount and fair value less costs to sell, which resulted in valuation of £375k and recognising an impairment of £1m (2017/18: £17.9m).

During 2017/18, the Trust revalued its land and buildings. Specialised buildings were valued at depreciated replacement cost on a modern equivalent asset basis. Land and non-specialised buildings have been valued at market value for existing use. Where applicable, the valuation loss was recognised initially against the Revaluation Reserve with the balance being recognised as an impairment. This has resulted in the Trust recognising impairments of £30.3m in the 2017/18 Accounts

Note 8 Employee benefits

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	101,965	104,172
Social security costs	8,745	8,882
Apprenticeship levy	515	520
Employer's contributions to NHS pensions	13,821	14,087
Pension cost - other	17	8
Other employment benefits	2,440	2,808
Termination benefits	498	359
Temporary staff (including agency)	875	741
Total gross staff costs	**128,876**	**131,577**
Total staff costs	**128,876**	**131,577**
Of which		
Costs capitalised as part of assets	268	229

Note 8.1 Retirements due to ill-health

During 2018/19 there were 5 early retirements from the trust agreed on the grounds of ill-health (3 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £461k (£127k in 2017/18).

The cost of ill-health retirements is borne by the NHS Business Services Authority - Pensions Division.

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. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health 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.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those 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 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 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. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process

b) 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 2018 to 31st March 2019 the Trust has contributed £16,715 (2017/18: £8,227)

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.

	2018/19	2017/18
	£000	£000
Operating lease expense		
Minimum lease payments	7,843	6,962
Total	**7,843**	**6,962**

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease payments due:		
- not later than one year;	7,718	7,304
- later than one year and not later than five years;	23,960	2,519
- later than five years.	65,941	6,331
Total	**97,619**	**16,154**

Increase in future lease payments due:
Operating lease arrangements completed during the year where Community Health Partnership is the lessor:

- not later than one year;	5,192	5,192
- later than one year and not later than five years;	20,769	-
- later than five years.	60,525	-
	86,486	**5,192**

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2018/19	2017/18
	£000	£000
Interest on bank accounts	190	68
Total finance income	**190**	**68**

Note 12 Other gains / (losses)

	2018/19	2017/18
	£000	£000
Gains on disposal of assets	145	949
Losses on disposal of assets	(4)	(68)
Total gains / (losses) on disposal of assets	**141**	**881**

Note 13 Intangible assets - 2018/19

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	**4,154**	**38**	**4,192**
Additions	-	269	**269**
Reclassifications	269	(269)	**-**
Disposals / derecognition	(74)	-	**(74)**
Valuation / gross cost at 31 March 2019	**4,349**	**38**	**4,387**
Amortisation at 1 April 2018 - brought forward	**1,956**	**-**	**1,956**
Provided during the year	585	-	**585**
Disposals / derecognition	(74)	-	**(74)**
Amortisation at 31 March 2019	**2,467**	**-**	**2,467**
Net book value at 31 March 2019	**1,882**	**38**	**1,920**
Net book value at 1 April 2018	**2,198**	**38**	**2,236**

Note 13.1 Intangible assets - 2017/18

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	**3,668**	**222**	**3,890**
Additions	-	302	**302**
Reclassifications	486	(486)	**-**
Valuation / gross cost at 31 March 2018	**4,154**	**38**	**4,192**
Amortisation at 1 April 2017 - as previously stated	**1,355**	**-**	**1,355**
Provided during the year	601	-	**601**
Amortisation at 31 March 2018	**1,956**	**-**	**1,956**
Net book value at 31 March 2018	**2,198**	**38**	**2,236**
Net book value at 1 April 2017	**2,313**	**222**	**2,535**

Note 14.1 Property, plant and equipment - 2018/19

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**10,824**	**57,019**	**1,501**	**4,718**	**17**	**6,055**	**1,296**	**81,430**
Additions	1,414	1,156	4,731	-	-	-	-	**7,301**
Impairments	-	(1,842)	-	-	-	-	-	**(1,842)**
Reversal of impairments	-	1,013	-	-	-	-	-	**1,013**
Revaluations	167	(337)	-	-	-	-	-	**(170)**
Reclassifications	-	2,511	(3,783)	485	-	787	-	**-**
Transfers to / from assets held for sale	(375)	-	-	-	-	-	-	**(375)**
Disposals / derecognition	-	-	-	(777)	-	(135)	-	**(912)**
Valuation/gross cost at 31 March 2019	**12,030**	**59,520**	**2,449**	**4,426**	**17**	**6,707**	**1,296**	**86,445**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**211**	**-**	**3,954**	**17**	**3,382**	**1,129**	**8,693**
Provided during the year	-	2,179	-	193	-	811	72	**3,255**
Impairments	-	(794)	-	-	-	-	-	**(794)**
Disposals / derecognition	-	-	-	(776)	-	(132)	-	**(908)**
Accumulated depreciation at 31 March 2019	**-**	**1,596**	**-**	**3,371**	**17**	**4,061**	**1,201**	**10,246**
Net book value at 31 March 2019	**12,030**	**57,924**	**2,449**	**1,055**	**-**	**2,646**	**95**	**76,199**
Net book value at 1 April 2018	**10,824**	**56,808**	**1,501**	**764**	**-**	**2,673**	**167**	**72,737**

Note 14.2 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	**15,645**	**69,406**	**1,393**	**4,621**	**17**	**5,203**	**1,458**	**97,743**
Additions	1,779	-	4,418	8	-	-	-	**6,205**
Impairments	(6,605)	(26,254)	-	-	-	-	-	**(32,859)**
Revaluations	49	10,829	-	-	-	-	-	**10,878**
Reclassifications	110	3,038	(4,310)	175	-	987	-	**-**
Transfers to / from assets held for sale	(154)	-	-	-	-	-	-	**(154)**
Disposals / derecognition	-	-	-	(86)	-	(135)	(162)	**(383)**
Valuation/gross cost at 31 March 2018	**10,824**	**57,019**	**1,501**	**4,718**	**17**	**6,055**	**1,296**	**81,430**
Accumulated depreciation at 1 April 2017 - as previously stated	**-**	**6,514**	**-**	**3,795**	**17**	**2,638**	**1,166**	**14,130**
Provided during the year	-	1,698	-	209	-	852	99	**2,858**
Impairments	-	(2,529)	-	-	-	-	-	**(2,529)**
Revaluations	-	(5,472)	-	-	-	-	-	**(5,472)**
Disposals / derecognition	-	-	-	(50)	-	(108)	(136)	**(294)**
Accumulated depreciation at 31 March 2018	**-**	**211**	**-**	**3,954**	**17**	**3,382**	**1,129**	**8,693**
Net book value at 31 March 2018	**10,824**	**56,808**	**1,501**	**764**	**-**	**2,673**	**167**	**72,737**
Net book value at 1 April 2017	**15,645**	**62,892**	**1,393**	**826**	**-**	**2,565**	**292**	**83,613**

Note 14.3 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019								
Owned - purchased	12,030	54,771	2,449	1,055	-	2,646	95	**73,046**
Owned - donated	-	3,153	-	-	-	-	-	**3,153**
NBV total at 31 March 2019	**12,030**	**57,924**	**2,449**	**1,055**	**-**	**2,646**	**95**	**76,199**

Note 14.4 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018								
Owned - purchased	10,824	53,901	1,501	764	-	2,673	167	**69,830**
Owned - donated	-	2,907	-	-	-	-	-	**2,907**
NBV total at 31 March 2018	**10,824**	**56,808**	**1,501**	**764**	**-**	**2,673**	**167**	**72,737**

Note 15 Revaluations of property, plant and equipment
During the year 1st April 2018 to 31st March 2019, the Trust received donated assets totalling £Nil (2017/18: £8k)

Note 16 Revaluations of property, plant and equipment

The last full revaluation of the Trust's Land and Buildings was undertaken as at 31st March 2018.

The Foundation Trust applies industry recognised indices (provided by a Chartered Surveyor). Indices are applied to property using the DRC method of valuation. A full physical valuation is undertaken when there has been significant expenditure in the year on a particular property to ensure that any impairment is recognised as soon as the new/upgraded property is brought into use.

Economic Lives of Plant, Property, Equipment and Intangible Assets

	Minimum Life (years)	Maximum (years)
Software Licences	5	10
Licences and Trademarks	5	10
Buildings excl. Dwellings	16	100
Plant and Machinery	5	15
Transport Equipment	7	7
Information Technology	5	8
Furniture and Fittings	5	10

The Trust uses economic lives for buildings as advised by the District Valuer during his periodic reviews
The Trust applies these lives upon the initial recognition of a non-current asset. Where an asset is transferred to the Trust then the remaining useful life is adopted as the new minimum life.

Note 17.1 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	10,112	-
Trade receivables*	-	4,654
Capital receivables	109	38
Accrued income*	-	3,857
Allowance for impaired contract receivables / assets*	(141)	-
Allowance for other impaired receivables	-	(140)
Prepayments (non-PFI)	763	766
PDC dividend receivable	127	601
VAT receivable	37	369
Other receivables	37	316
Total current trade and other receivables	**11,044**	**10,461**
Non-current		
Contract receivables*	218	-
Allowance for impaired contract receivables / assets*	(48)	-
Allowance for other impaired receivables	-	(45)
Other receivables	-	196
Total non-current trade and other receivables	**170**	**151**
Of which receivables from NHS and DHSC group bodies:		
Current	7,402	6,975
Non-current	-	-

*Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 17.2 Allowances for credit losses - 2018/19

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2018 - brought forward		**185**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	185	(185)
New allowances arising	8	-
Changes in existing allowances	2	-
Utilisation of allowances (write offs)	(6)	-
Allowances as at 31 Mar 2019	**189**	**-**

Note 17.3 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All receivables
	£000
Allowances as at 1 Apr 2017 - as previously stated	**218**
Increase in provision	(28)
Amounts utilised	(5)
Allowances as at 31 Mar 2018	**185**

Note 17.4 Exposure to credit risk

	31 March 2019	31 March 2018
	Trade and other receivables	Trade and other receivables
Ageing of impaired financial assets	**£000**	**£000**
0 - 30 days	1	-
30-60 Days	1	-
60-90 days	-	-
90- 180 days	11	20
Over 180 days	57	164
Total	**70**	**184**
Ageing of non-impaired financial assets past their due date		
0 - 30 days	5,542	1,855
30-60 Days	143	409
60-90 days	32	104
90- 180 days	25	18
Over 180 days	71	547
Total	**5,813**	**2,933**

Note 18 Non-current assets held for sale and assets in disposal groups

	2018/19	2017/18
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**-**	**3,100**
Assets classified as available for sale in the year	375	154
Assets sold in year	(375)	(3,254)
NBV of non-current assets for sale and assets in disposal groups	**-**	**-**

Note 19.1 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.

	2018/19	2017/18
	£000	£000
At 1 April	**26,619**	**21,402**
Net change in year	4,180	5,217
At 31 March	**30,799**	**26,619**
Broken down into:		
Cash at commercial banks and in hand	4,611	5,112
Cash with the Government Banking Service	26,188	21,507
Total cash and cash equivalents as in SoFP	**30,799**	**26,619**
Total cash and cash equivalents as in SoCF	**30,799**	**26,619**

Note 19.2 Third party assets held by the Trust

The Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2019	31 March 2018
	£000	£000
Bank balances	5	5
Total third party assets	**5**	**5**

Note 20 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	5,711	4,958
Capital payables	1,306	657
Accruals	3,796	4,092
Receipts in advance (including payments on account)	-	-
Social security costs	1,387	1,367
VAT payables	757	-
Other taxes payable	-	796
PDC dividend payable	-	1
Other payables	2,687	2,913
Total current trade and other payables	**15,644**	**14,784**
Of which payables from NHS and DHSC group bodies:		
Current	3,677	2,910
Non-current	-	-

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note . IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 21 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	154	129
Total other current liabilities	**154**	**129**

Note 22 Provisions

	Legal claims	Re-structuring	Other	Total
	£000	£000	£000	£000
At 1 April 2018	**79**	**816**	**-**	**895**
Arising during the year	29	1,201	420	**1,650**
Utilised during the year	(34)	(260)	-	**(294)**
Reversed unused	-	(703)	-	**(703)**
At 31 March 2019	**74**	**1,054**	**420**	**1,548**
Expected timing of cash flows:				
- not later than one year;	44	1,054	420	**1,518**
- later than one year and not later than five years;	30	-	-	**30**
- later than five years.	-	-	-	**-**
Total	**74**	**1,054**	**420**	**1,548**

The restructuring provision relates to the liability from service re-design. The Trust was asked to decommission a number of clinical services, which result in a number of redundancies.

A MAR Scheme (MARs) was also agreed as an enabler to deliver the DCHS workforce plan and to further secure the Trust's financial position ahead of the 19/20 financial year

Other provision relates to staff back pay.

The legal provision relates to 10 cases currently with the NHS Litigation Authority.

Note 22.1 Clinical negligence liabilities

At 31 March 2019, £472k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Derbyshire Community Health Services NHS Foundation Trust (31 March 2018: £624k).

Note 23 Contractual capital commitments

	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	-	-
Intangible assets	-	-
Total	**-**	**-**

Note 24 Financial instruments

Note 24.1 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 2019 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 it's capital investment plans from internally generated cash resources. The Trust is not, therefore, exposed to significant liquidity risks.

Note 24.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied restrospectively 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	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non-financial assets	10,178	-	-	**10,178**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents at bank and in hand	30,799	-	-	**30,799**
Total at 31 March 2019	**40,977**	**-**	**-**	**40,977**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	**£000**	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non-financial assets	8,876	-	-	-	**8,876**
Other investments / financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	26,619	-	-	-	**26,619**
Total at 31 March 2018	**35,495**	**-**	**-**	**-**	**35,495**

Note 24.3 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively 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	Held at fair value through the I&E	Total book value
	~~£000~~	~~£000~~	~~£000~~
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9			
Trade and other payables excluding non-financial liabilities	12,655	-	**12,655**
Other financial liabilities	-	-	**-**
Provisions under contract	1,128	-	**1,128**
Total at 31 March 2019	**13,783**	**-**	**13,783**

	Other financial liabilities	Held at fair value through the I&E	Total book value
	~~financial liabilities~~	~~through the I&E~~	~~Total book value~~
	£000	**£000**	**£000**
Carrying values of financial liabilities as at 31 March 2018 under IAS 39			
Trade and other payables excluding non-financial liabilities	12,621	-	**12,621**
Total at 31 March 2018	**12,621**	**-**	**12,621**

Note 24.4 Maturity of financial liabilities

	31 March 2019	31 March 2018
	£000	£000
In one year or less	13,783	12,621
Total	**13,783**	**12,621**

Note 25 Losses and special payments

	2018/19		2017/18	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	3	-	-	-
Bad debts and claims abandoned	55	6	86	5
Total losses	**58**	**6**	**86**	**5**
Special payments				
Ex-gratia payments	4	2	12	3
Total special payments	**4**	**2**	**12**	**3**
Total losses and special payments	**62**	**8**	**98**	**8**
Compensation payments received		-		-

Note 26 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018. As the implementation of IFRS 9 is inmaterial, no adjustment to reserves on 1 April 2018 is required.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £0k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £2k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classifiction of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £382k.

Note 26.1 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in Paragraph C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

Note 27 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

Katherine Bagshaw 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'.

Transactions with Board Members

Prem Singh is also appointed as Chairman of George Eliot Hospital NHS Trust. Transactions are in the normal course of business and are on an arms-length basis. There were no transactions with this NHS Body during 2018/19.

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 DCHS contract. There were no transactions with this NHS Body during 2018/19.

Prem Singh declared that he is the managing director of PMS Consulting Ltd. There are no transactions with this company

Tracy Allen declared that her husband is employed as interim Director of Primary Care with Derbyshire CCGs which commission services from DCHS. 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'.

Tracy Allen also declared that her sister-in-law is Business Development Director Race Cottam Associates. This organisation has undertaken (via tender) a number of projects for the DCHS Estates team. Transactions are in the normal course of business and are on an arms-length basis.

Amanda Rawlings Director of People and Organisational Effectiveness was also appointed as membership of the board of directors of Derbyshire Healthcare NHS Foundation Trust. Her day-to-day operational management responsibility is split equally between the Trust and Derbyshire Healthcare NHS Foundation Trust. 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'.

Transactions with Other Related Parties

The Department of Health is regarded as a related party. During the year to 31 March 2019 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.

The value of transactions with Government bodies and Other Related Parties with which the Trust has had significant dealings and which therefore require disclosure are as below:

	Receivables		Payables	
Receivables/payables over £250k	**2018/19**	**2017/18**	**2018/19**	**2017/18**
	£000	**£000**	**£000**	**£000**
Chesterfield Royal Hospital NHS Foundation Trust	128	321	297	224
University Hospitals of Derby & Burton NHS Foundation Trust	2,219	442	1,191	910
Derbyshire Healthcare NHS Foundation Trust	145	209	468	322
NHS England	3,322	3,062	223	-
NHS England - North Midlands	634	68	-	-
NHS North Derbyshire CCG	272	11	52	35
NHS Southern Derbyshire CCG	636	1,514	103	24
Community Health Partnership	48	46	52	145
NHS Property Services	1	3	1,166	951
Derbyshire County Council	1,935	1,724	414	(13)

	Income		Expenditure	
Income/expenditure over £1m	**2018/19**	**2017/18**	**2018/19**	**2017/18**
	£000	**£000**	**£000**	**£000**
NHS England	11,051	12,771	1,714	112
NHS North Derbyshire CCG	53,339	54,931	252	370
NHS Southern Derbyshire CCG	54,595	56,158	271	146
NHS Hardwick CCG	18,232	18,933	79	77
NHS Erewash CCG	17,572	19,691	177	588
Derbyshire County Council	19,286	20,827	308	637
Derby City Council	2,300	2,171	30	44
University Hospitals of Derby & Burton NHS Foundation Trust	2,316	2,625	4,597	4,896
Derbyshire Healthcare NHS Foundation Trust	2,693	1,129	1,860	2,101
Chesterfield Royal Hospital NHS Foundation Trust	744	677	1,888	1,694
Community Health Partnership	481	458	6,362	6,401
NHS Property Services	-	9	2,577	2,341
Health Education England	1,682	1,082	4	3
Department of Health	2,093	149	-	1,422
NHS Arden & GEM CSU	147	204	1,709	1,974