Derbyshire Community Health Services NHS Foundation Trust

Annual report and accounts 2019/20

Deliberately blank page

Derbyshire Community Health Services NHS Foundation Trust

Annual report and accounts 2019/20

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

Deliberately blank page

Annual report contents

Foreword

Welcome to our 2019/20 annual report and accounts. It will come as no surprise to you to hear that the final couple of months of our reporting period were dominated by the coronavirus pandemic response and mobilising our staff and services to meet this unprecedented situation.

It has been a huge team effort and we are immensely proud of, and grateful to, all our colleagues across Derbyshire Community Health Services NHS Foundation Trust who have played such a vital role in minimising the impact of the virus on our local communities and protecting the most vulnerable, while often being on the frontline themselves.

The spontaneous outpouring of public gratitude for the NHS – including the Thursday clap for carers – was truly amazing and well deserved recognition for the health service's key workers at a most challenging time. At the time of writing we are beginning to see beyond the crisis response and to restore more services for patients, which is heartening.

Up until February 2020 we were focused on our routine "business as usual" objectives of providing the best possible community health services to patients in Derby and Derbyshire, and had celebrated the organisation's rating of outstanding overall by the Care Quality Commission in September 2019.

This report, produced in line with the NHS' statutory reporting requirements, shows our progress for the whole of 2019/20, including the 10 months before the pandemic overshadowed life for all of us. We are pleased to be able to share it with you as a record of a challenging but successful year at Derbyshire Community Health Services NHS Foundation Trust.

Tracy Allen
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.

A brief history and statutory background of the organisation

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

We have operated as a standalone NHS organisation since April 2011 and we became a fully-fledged foundation trust on 1 November 2014.

During 2019/20:

- We were rated outstanding overall by the Care Quality Commission following a well-led inspection in September 2019. More details in the Directors report under the heading Ensuring services are well led
- We remained 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 statement Tracy Allen, chief executive, providing her perspective on the performance of the trust over the year

Last year I opened this statement reflecting on one of the most difficult years on record for the NHS. 2019/20 has matched it and of course ended with the global Covid-19 pandemic posing an enormous challenge for the NHS and our society as a whole.

We ended the year playing our part in the national NHS response to the pandemic, adapting quickly to the new clinical issues and challenges it posed for us locally in Derbyshire. We temporarily stopped some of our non-critical services while adapting others, in line with a nationally-determined prioritisation framework. Our brilliant and flexible colleagues volunteered to work in new and unfamiliar areas, using their skills and experience in different ways to support our most pressured services. We

significantly increased our cleaning, driving and personal protective equipment (PPE) logistical capacity, and we welcomed the support of local volunteers.

We very rapidly implemented new ways of working, making use of all available technology to deliver virtual patient consultations and treatment wherever it was safe and appropriate. We engaged with colleagues in new ways and supported them to connect with each another remotely, given the unprecedented 'Stay home, Protect the NHS, Save lives' and social distancing guidance from the Government. We bolstered our staff welfare and wellbeing offer, doing all we could to look after our front-line colleagues so they could focus on delivering expert patient care. Our corporate services were equipped to deliver their essential support functions from home. Indeed, each and every one of us at Team DCHS played a vital role, maintaining our essential services while doing all we could to keep ourselves, our families and our communities safe and well.

A colleague of mine coined the phrase 'physical distancing' as opposed to social distancing. This really struck a chord with me at a time when the number of people falling ill continued to rise and our loved ones, neighbours and work colleagues were affected. The phrase highlighted the importance of maintaining social connection for our collective emotional wellbeing during an unparalleled period in our lives.

2019/20 was a big year for us in many other ways too. Ordinarily I would have opened this update with the wonderful news that, following a summer 2019 inspection, the Care Quality Commission rated DCHS as Outstanding overall. We showed our credentials then – and we continue to do so today. You can read more about the inspection in the directors' report in this document. We also met all of our financial performance obligations and commitments while consistently performing well against targets across the board. Our 'segment one' provider status was maintained, allowing us maximum autonomy and the lowest level of oversight from regulators. The financial and contracting climate we're now operating it is very different to previous years, with nationally-agreed contracts rather than locally-agreed frameworks between commissioners and providers.

We've progressed our major capital estate projects in the towns of Belper, Bakewell and Buxton, with the aim of securing state-of-the-art healthcare facilities for future generations. We continued to have a strong focus on quality improvement, with our clinical assessment and accreditation scheme going from strength to strength with many more teams achieving and retaining their 'Quality Always gold' accreditation. More than 80% of staff received their flu vaccination this year, and through a 'jab for a jab' partnership with Unicef we also managed to sponsor more than 10,000 life-saving vaccines in the developing world. We are proud that 97.8% of our patients would recommend our services to their friends and family.

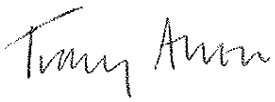
The annual staff survey results were published once again in February, with 62.4% of the trust taking the time to reflect on life at DCHS. 85.5% of those colleagues said

they would recommend our care to their friends and family (national average 78.3%), while 65.3% would recommend DCHS as a place to work (national average 59.4%). Overall we scored better than the previous year in nine of the eleven measures and remained the same in the other two. I was particularly pleased to see great improvements in areas where we has really focused our efforts, such as staff wellbeing and bullying and harassment. We are fully committed to continuing to improve the experience of everyone working for DCHS.

I'm writing this statement as we move beyond the first so-called 'peak' of the Covid-19 pandemic, and begin to look ahead to our recovery and restoration plans as part of the next phase. We are by no means 'back to normal'; the threat of Covid-19 remains very real and promises to be with us for many months and possibly years to come. Instead we are looking at a 'new normal', learning from our response and using it as an opportunity to reset some of our thinking on the delivery of care and services for local people. This important work is being done jointly with our partners as part of a coordinated Derbyshire health and social care system response. Collectively, as part of 'Joined Up Care Derbyshire', we are focused on building on the transformation and innovation colleagues have led, recognising the long term impact of Covid-19 on our communities, increasing health inequalities and the need to reshape and refocus our plans and priorities to address these challenges with the people we serve.

I am incredibly proud of what my colleagues have achieved in 2019/20 and have responded to Covid-19, but I am not at all surprised. What each and every one of them delivers every day for the people of Derby and Derbyshire is nothing short of amazing. They truly are the embodiment of the 'DCHS Way' and their energy, compassion and commitment will ensure that we are able to play a major role in restoring, recovering and re-setting the NHS locally and supporting the great communities we're part of with the challenges ahead.

Signed



Tracy Allen
Chief Executive

A statement on the purpose and activities of the organisation

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

specialist services, and health, wellbeing and inclusion. Details of the services we provided are included on our website: www.dchs.nhs.uk.

We employ around 4,200 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.

Brief description of the business model and environment

Health and social care organisations in Derbyshire have been working closely together for some time, to improve care and services for people and make them as efficient and effective as possible. We are fully aligned to this business model and environment, developing services which promote a system-level approach as part of Joined Up Care Derbyshire's sustainability and transformation partnership. You can find more details here: https://joinedupcarederbyshire.co.uk/

Objectives and strategies

In May 2019 we refreshed our organisational strategy, known as our Quadruple Aim, to:

- improve the health of the population
- enhance the experience and outcomes of the patient
- improve staff experience
- reduce the per capita cost of care for the benefit of communities.

This has followed on from work on our clinical strategy, first developed in 2016, which developed the 'Triple Aim' as 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'. Since then there have been significant changes at both national and local level, including:

- The publication of the NHS Long Term Plan in January 2019 which sets out the priorities for healthcare over the next 10 years along with the implementation of Primary Care Networks and the move towards Integrated Care Systems and regulation at a system level
- Changes to our portfolio of services
- Development of clinical supporting and enabling strategies including frailty, people, leadership and management, informatics
- The development of the Quality Conversations approaches and the creation of the Quality Improvement Faculty.
- Development of closer system working and the adoption of the 'Triple Aim' approach within the Joined Up Care Derbyshire Clinical Strategy.

Community services are at the heart of the local and national long term plans for the NHS. Here at Derbyshire Community Health Services NHS Foundation Trust we have a role to play in supporting the delivery of the majority of

priority areas identified within the NHS Long Term Plan, either directly or indirectly, working with our partners in the health and social care system locally.

It therefore seemed timely to revisit and refresh our organisation's overarching clinical strategy, reflecting on these challenges and the important roles all colleagues play in continuing to transform the care we deliver.

Good progress had been made in delivering our Triple Aim and we know these achievements, including our journey to becoming an 'Outstanding' organisation has been directly dependent upon our workforce and we wanted to recognise this contribution within our strategy. Our refreshed strategy has been developed with the input of colleagues across the organisation. Engagement sessions held across the county provided the opportunity to talk to colleagues, to hear their views and understand what really matters to them. Our refreshed strategy has been developed to reflect our commitment to all our colleagues as we focus on improving the experience of work, including 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. This is now our 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'

Financial performance

Despite the current financial difficulties facing the NHS and economy as a whole, we have ultimately performed well during 2019/20. We made a net surplus of £4,033m which was in excess of our original plan of £3.878m by £0.155m. Due to the coronavirus pandemic, we incurred additional revenue costs in relation to its operational response during March 2020. In line with the national commitment, these costs were fully reimbursed to us and therefore did not impact on our financial performance in 2019/20. The table below details the Trust's key areas of financial performance for the year:

2019/20 Performance	£'000 plan	£'000 achieved
Surplus	3,154	3,309
EBITDA (Earnings before interest, tax, depreciation and amortisation)	10,776	10,624
Cash balance at period end	30,830	35,154
Better payment practice code	95.0%	97.6%

Target is to pay 95% of all non-NHS creditors within 30 days of the receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.		

EBITDA is a way of representing how much of our operating income exceeds our operating costs. Our EBITDA for 2019/20 was £10.624m which equates to 5.6%. This measure demonstrates sound financial health and the efficient use of our resources. The next table details our financial performance and over-achievement on the control total set by NHS Improvement.

	£'000s
Surplus for the year	3,309
Less gains on transfers by absorption	-125
Less impact of donated income	-141
Add back impairments charged to I&E	990
Adjusted Surplus for the year	4,033
Control Total	3,878
Performance Against Control Total	**155**

The year-end surplus figure includes Provider Sustainability Fund (PSF) of £2,046m. This is funding that is given to Trusts who agree to their control total and deliver on financial performance. In 2019/20 the Trust had a control total of a surplus of £1,832m excluding PSF. Removing the impact of PSF funding from the Trust's reported surplus demonstrates that the Trust has over-performed against its control total by £0.15m as shown in the table below.

	£'000s
Adjusted Surplus for the year	4,033
Less PSF funding	-2,046
Adjusted Surplus for the year excluding PSF	1,987
Control Total excluding PSF	1,832

Performance Against Control Total excluding PSF	155

Capital expenditure

Our capital expenditure for 2019/20 was £6.8m against a capital plan of £8.4m. The £1.6m we did not utilise on expected capital spending related to deferment of Bakewell, Belper, Buxton and Walton site developments. The most significant schemes we undertook were the purchase of Belper Clinic and continued investment in our IM&T infrastructure.

The table summarises our capital expenditure for 2019/20.

Capital expenditure schemes 2019/20	Cost £'000
Estate - General refurbishment	924
Estate – Purchase of Belper Clinic	670
Estate – Walton Hospital development	568
Estate – Staff cost	365
Estate - Upgrade Ilkeston physiotherapy unit	293
Estate – LED lighting	250
Estate - Belper development	210
Estate – Buxton development	170
Estate – Upgrade Ripley Hospital's physiotherapy unit	163
Estate – Whitworth Hospital's car park	113
Estate – Bakewell development	78
Equipment	555
IM&T - desktop renewal and local infrastructure	2,064
IM&T -NHS Wi-Fi	352
IM&T -End user licence	58

Other schemes	130
Total capital expenditure	**6,800**

Efficiency

During 2019/20 we generated efficiency savings of £5.6m against a target of £5.6m. A total of £4.2m of the £5.6m are recurrent savings. The savings were required to deliver a 1.14% national efficiency requirement for commissioners and to cover local cost pressures. A summary of our main savings delivered during 2019/20 is shown below:

Service Area	**£m**
Corporate and estate	2.92
Health, wellbeing & inclusion	1.17
Planned care and outpatients	0.44
Integrated community based services	0.77
Other	0.28
Total	**5.58**

Key opportunities and risks

Future financial performance

As a result of the coronavirus pandemic, temporary funding arrangements have been introduced for NHS organisations, initially for a four month period up until the end of July 2020.

The Board of Directors has approved an interim financial plan in response to this which sets out to deliver a revenue surplus of £2.23m supported by a requirement to deliver efficiency savings of £5.1m.

Successful delivery of this plan will achieve the maximum Use of Resources rating of 1 against which we will be assessed as an NHS foundation trust.

Covid-19 response and digital transformation

The Covid-19 pandemic accelerated a number of changes, including digital solutions, we had already planned. As we move to reinstate as many services as possible, we continue to support new ways of working, to ensure they are

appropriate, effective and offer the safest alternative to staff and patients in line with the aspirations we had already set out for the coming year.

In response to the pandemic, command centres were quickly set up to manage staff and resources like personal protective equipment (PPE) and to support teams to work in different ways. These command centres themselves then had to work 'differently' and quickly took advantage of technology like Microsoft Teams to undertake remote meetings and support staff. Our health and wellbeing team set up support and counselling sessions by phone and online and new communication channels were created so staff could get up-to-date information easily as the situation changed. Additionally the transformation team facilitated operational teams to support each other using online and mobile apps.

Our IT and procurement teams reacted swiftly to make sure we had access to laptops, headsets and phones for staff working remotely and a team of drivers was set up to move equipment and PPE around.

Our services have started using online virtual consulting software wherever they can – led by what's needed by the patient or family. We are also redesigning referral processes and remote training for staff and for patients who undertake courses and attend education groups with us.

The transformation team used their project management skills to manage increasing ward capacity and the associated resource requirements (equipment and staffing) to provide extra capacity. Another project that was supported was to implement the Covid-19 hospital discharge guidance at pace to be responsive and support flow to maintain capacity. Ongoing work is being undertaken to identify which measures are most effective and able to be sustained after the pandemic.

Virtual visits/triage will be further explored for therapy services within integrated community services. Other changes over the last year include:

- Supporting our integrated community services to deliver a rapid response workforce
- Review of clinical documentation to ensure recording and retrieving information is simple
- Supported the out-of-hours provider (DHU Health Care) to transition onto SystmOne TPP, our core electronic patient record, improving efficiency and effectiveness of treatment in and out of hours
- Reduced the burden on general practice by undertaking wound dressings in our local clinics – we'll be adding 3D technology to this service soon
- The trial of body worn cameras in Derby community teams is underway to reduce aggressive behaviour against staff
- The creation of a single point of access to improve access for our families and other professionals in to our children's services

- The development and use of “I’m on my way” technology so that young families know when to expect us
- The implementation of an anonymous text service for children and young families to get in contact with us in June 2020
- Exploring the use of robotic process automation to speed up triage processes
- The trial of voice recognition to support clinicians in musculoskeletal services to improve the patient pathway.

Managing strategic risks

Strategic risks are determined in line with the Trust Board and managed through our Board Assurance Framework, which is presented to the Quality Committees, Audit and Assurance Committee and the Board on a quarterly basis.

By the end of 2019/20 the three main strategic risks on the Board Assurance Framework and our actions in relation to those risks were:

- **A risk of national and local workforce supply shortages resulting in staff being unable to provide high quality, safe and effective care.** Our workforce plan, outlined in the Staff Report section of this annual report, gives details of how we have been addressing this in terms of being an employer of choice and aligning our offer to staff with the changing needs of local health care provision, and maps out future priorities and how we are taking action on those during 2020/21.

- **A risk to the financial stability of the organisation due to not meeting the future Sustainable Quality Improvement Programme and the potential loss of service contracts or decommissioning of services.** We have a robust plan to achieve our financial obligations again in 2020/21, as we have in all previous years, while remaining responsive to emerging factors in the wider environment and across the health system. As a result of the coronavirus pandemic, temporary funding arrangements have been introduced for NHS organisations, initially for a four month period up until the end of July 2020. More details about this are included under the Future Financial Performance heading in this chapter.

- **A risk that leaders may be unable to deliver the behavioural and competency aspirations contained within our Leadership Development Strategy due to the organisational and system-wide pressures**. During 2019/20 we have further enhanced and embedded our leadership work to equip our workforce to lead internally and across the system. We continue, through our workforce priorities for 2020/21, to strengthen and support good, compassionate and diverse leadership at all levels – managerial and clinical – to meet the complex practical, financial and cultural demands of the NHS

Long Term Plan. More details are provided in the Staff Report section of this annual report.

Brexit

On the 31 January 2020 the UK officially left the European Union, beginning a period of transition until 31 December 2020. The NHS continues to prepare for any changes coming out of the Government's negotiations with the EU and will continue to monitor any associated risks, such as to supply chains or recruitment. We are managing these risks through our organisational business continuity plan to address any emerging uncertainties and to ensure that disruption to our patients and other stakeholders is kept to a minimum in relation to supply of goods, employment opportunities or retention of staff from overseas. We followed national guidance from the Department of Health and Social Care, preparing us for all eventualities.

Operational plan for 2020/21

On 17 March 2020, Sir Simon Stevens, NHS chief executive, and Amanda Pritchard, NHS chief operating officer, wrote to all NHS providers detailing the important and urgent actions the NHS needed to take in response to Covid-19 pandemic. These actions included measures to:

1. Free-up the maximum possible inpatient and critical care capacity
2. Prepare for, and respond to, the anticipated large numbers of Covid-19 patients in need of respiratory support
3. Support staff and maximise their availability
4. Play our part in the wider population measures newly announced by Government
5. Stress-test operational readiness
6. Remove routine burdens, as to facilitate the above.

Within this the measures included the decision to suspend the operational planning process for 2020/21.

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

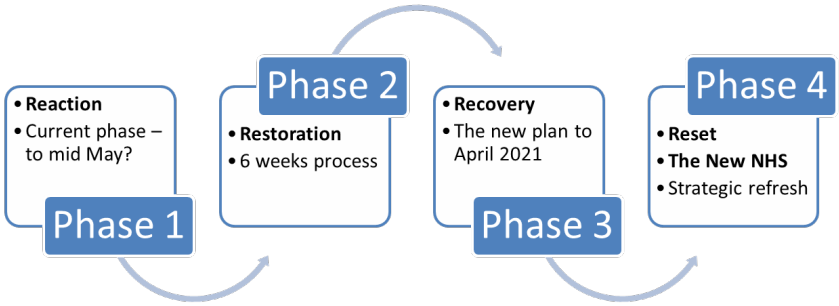
The world, and the NHS as we know it, all looks very different now and sadly coronavirus looks set to be us for some time to come. However, the ambitions identified within the NHS Long Term Plan in January 2019, and within our clinical strategy still hold true.

Throughout 2020/21 we will move from reaction, through to restoration and recovery. As part of this journey we will take this opportunity to 'lock in' the beneficial changes that we and our partners have been able to deliver, such as enhanced system

working, and flexible and remote working, including the rapid increase in delivering consultations digitally.

We will continue to adapt to this new world, supporting the people we care for and those close to them across all our services, ensuring that they continue to receive the care they need in a timely and safe way.

We will work closely with our colleagues across the organisation, listening to and supporting them. We will continue to ensure that our colleagues within Derbyshire Community Health Services NHS Foundation Trust have the equipment they need and that their wellbeing is our top priority.



Before the impact of the Covid-19 pandemic was felt, we had already identified a range of improvement programmes of work with clear outcomes that are aligned to our Quadruple Aim, including:

- **Refreshing the DCHS Way** – the way we do things around here – and making it right for the current and future environment
- **People first** – embedding a personalised leadership culture will support our leaders to have the confidence to do the right thing for our people and to challenge the culture of the organisation through behaviour, not just process
- **Clinical, professional and operational leadership** – reviewing our structures and roles to support leadership in an integrated system and a culture of shared governance and leadership
- **System working across boundaries** – ensuring we understand the system organisational groupings and that we are able to contribute effectively to the improvement of high quality healthcare delivery in Derbyshire and Derby
- **Data and information -** Advancing the use of data to drive improvement and intelligent decision-making – ensuring all data and information we receive, generate, require and report is value adding to the purpose of continuous quality improvement, relevant assurance and delivering the Quadruple Aim

- **From governance for assurance to governance for improvement and empowerment** – ensuring quality assurance and quality improvement drive us forward and manage and mitigate our risks.

As a Joined Up Care Derbyshire partner we remain committed to ensuring that we work together to improve population health outcomes for the people and communities we serve as we work to deliver our collective vision to enable people to have the best start in life, to stay well, age well and die well.

Our work in 2020/21 will be different from previous years as we respond to the very unusual, challenging and changing circumstances we are all facing. However, our ambitions and priorities remain consistent with those of our strategy: improving the health of the population, enhancing experience and outcomes, reducing the per capita cost of care and improving the experience of work for everyone working within our trust at this challenging time, as we recognise the hard work and sacrifices people are making to ensuring Derbyshire Community Health Services NHS Foundation Trust and the NHS remains 'open for business'.

Service developments

Musculoskeletal clinical assessment and treatment service

The musculoskeletal (MSK) clinical assessment and treatment service provides a specialist clinical review of referrals for MSK conditions and supports improved health outcomes. Patients were often being referred to acute hospital outpatients (secondary care) despite evidence suggesting some could be more appropriately cared for in the community. The service is delivered by highly skilled advanced physiotherapy practitioners who can assess and treat a range of conditions, and ensure there are no delays where secondary care intervention is the best option.

We've made good progress this year – comparing April to July 2019 to the comparable period the previous year:

- A reduction of 42% in the number of routine consultant outpatient appointments referred by GPs

- A reduction of 40.8% in the number of outpatient procedures carried out
- A reduction of 22.9% in the number of injections carried out in secondary care
- A reduction of 22.9% in the number of day case procedures undertaken
- A reduction of 15% in the number of elective procedures.

Derbyshire wound care service

People living longer with ever more complex long-term health problems, has resulted in an increase in the volume of chronic leg ulcers. A network of wound care hubs was established at sites across the county to meet the increasing demand while delivering high quality outcomes for patients, including improved healing time. Formerly provided in general practice, this service is now run by specialist wound care nurses using our award-winning 'Time to Heal' principles, improving both healing rates and patient experience. Wounds have a significant impact, both on the quality of life of those who have them as well as the health care system. The service operates seven days a week in clinically-appropriate settings, a number of which have been recently refurbished. Transport support is also available for patients who aren't able to make their own way to one of the hubs.

Rapid response community nursing service

We can report that our new rapid response community nursing service, initially piloted in Swadlincote and Derby, has now been rolled out across Derbyshire. As a listening organisation, we agreed to pilot the new model after the idea was initially suggested by our colleagues in community nursing. The aim was to improve caseload management and general day-to-day planning for 'core' (non-urgent) patients and build clinical capacity for those patients requiring urgent care, or a 'rapid response'. Colleagues have been through a significant training and development programme and have welcomed this new way of working.

Integration project in Derby receives national recognition

A partnership project with social care staff to support patients in Derby was recognised at the prestigious HSJ Awards in November, as finalists in the health and local government partnership award. Judges said that the project, known as the 'Derby City Road to Integration', was chosen "based on its ambition, visionary spirit and the demonstrably positive impact that this has had on patient experiences within the health and social care sector." Teams work in partnership to support patients identified as needing a range of therapy, home assessments and adaptations to maintain their independence and mobility at home or help them return home from hospital. Most of the patients cared for in this way are elderly. One Derby resident in her eighties said "the physiotherapy was wonderful. I was having the therapy three times a day and it got me going. Now I'm back home and I'm slow but I can cope, and that's the main thing."

New facilities for integrated care

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

In Belper, revised plans for a £10 million pound investment in Belper's community health services were unveiled in December 2019. Brand new state-of-the-art health facilities are to be built on the site of the current Belper Clinic, on part of the Babington Hospital site on Derby Road.

Original plans were set to build on Derwent Street in the centre of town, but this was changed to build a larger building on the site of the existing Belper Clinic. We conducted a public engagement programme of events and other communications activity to ensure local people were well informed of the news.

The revised scheme honours all the promises made to local people in the engagement process of 2018 to develop services fit for the 21st century in a sustainable way and in line with the ambitions set out in Joined Up Care Derbyshire to replace out-dated facilities at Babington Hospital. Full background information can be accessed on our website here: https://www.dchs.nhs.uk/home/our-services/service_development

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

We purchased the chosen plot, a 3.5 acre site at the former Buxton Water plant, in January 2018 and outline planning consent for the community hub has already been granted by High Peak Borough Council. The next step will be to share the outline business case with the senior teams of all 11 organisations – from across the public, charitable and health sectors – which are currently considering the proposed new development. There is no central government funding for the building costs of the project which will require all the eventually confirmed organisations to contribute towards the costs.

In Bakewell, we have purchased a plot which formed part of the Newholme Hospital site and we are working with East Midlands Ambulance Service partners to combine the site we have purchased with the current ambulance station site to develop new state-of-the-art health facilities and ambulance service accommodation. Early designs have been drafted and by the end of 2019/20 we were working with Peak District National Park planning department prior to formerly submitting a full planning application. Capital funding of £8.58m has been provisionally secured by way of

government STP wave 4 capital funding, pending the submission and approval of a full business case for the scheme. The business case will be completed and submitted once we are clear regarding the planning requirements and the final design and cost schedule.

In Langwith, the new £1.1 million Langwith Medical Centre opened on 12 August 2019. It replaced an outdated surgery building with a much larger state-of-the-art facility which can accommodate a wider range of GP practice and primary care services for patients, so securing the provision of locally based services into the future.

A summary of performance to the extent not already covered

Performance against CQUINs 2019/20

A total of 1.25% of our patient care income in 2019/20 was conditional on achieving the nationally and locally set CQUIN measures (Commissioning for Quality and Innovation), as agreed between us and Derby and Derbyshire Clinical Commissioning Group.

During 2019/20 we had four CQUINs, three set at a national level and one was agreed locally with the CCG:

- Flu vaccination of frontline staff
- Alcohol and tobacco screening and brief advice
- Three high impact actions to prevent inpatient falls
- Using personalised goals in the treatment of patients within wound clinics (local).

The total contract value relating to these for 2019/20 was £1,703,606 and an 80% financial outturn was agreed as part of the block contract for our Trust.

A number of risk assessments were undertaken in relation to the achievement of CQUINs throughout 2019/20 and it was anticipated that some of the targets would be difficult to achieve fully due to the significant clinical pathway development required; this included the challenge of developing the necessary electronic patient record functionality to enable robust data reporting. However, as a result of continued focus we were able to progress significantly against the milestones.

Due to the impact of the Covid-19 pandemic, all national and local CQUIN work was paused on 17 March 2020; this halted a number of audit activities being undertaken to collect quarter four data for some of the CQUIN indicators. Further national guidance published on 23 March 2020 advised all Trusts to base the final position for CQUINs on the data available and this has therefore been taken from the quarter three position.

The 2019/20 flu campaign 'Spread Love Not Flu' was launched which involved sponsoring UNICEF to vaccinate three children for every member of staff who had the flu immunisation. In addition improvements were put in place as to the ways in which staff provided consent, and to the process of booking vaccinations. As a result we achieved 80.7**%** of frontline staff being vaccinated against the national target of 80% which was a significant improvement over previous years.

Performance against the alcohol and tobacco CQUIN saw achievement across all three indicators throughout the year, with staff undertaking screening of inpatient for alcohol and tobacco use, and providing brief advice and onward referral where appropriate.

Performance against the prevention of falls CQUIN improved continually throughout the year, with inpatient clinical teams introducing the measuring and recording of blood pressure, taken when patients were both lying and standing, as standard practice on admission to inpatient wards. The introduction of changes to SystmOne enabled advanced care practitioners and pharmacists to record rationale against specific medications which can lead to an increased risk of falls. Our specialist falls team also supported pathway and patient record changes which help patients receive a mobility assessment and provision of a mobility aid within 24 hours of admission to the ward.

In line with the wider national focus on personalisation, colleagues in our wound care clinics were supported to discuss, and record personalised goals with patients within SystmOne, in relation to their wound care and treatment. A detailed review of the clinical care provided was undertaken and shared with clinic staff to support improved compliance with wound assessments.

Clinical accreditation

A clinical care assessment accreditation system, known as Quality Always, was first introduced in late 2014 and the process is supported by the DCHS Quality Assurance Framework, which consists of self-assessment and peer review, leadership development, insight visits, external inspection and triangulation visits. The aim is to ensure clinical care received by all our patients is of high quality regardless of where or when they are treated. It involves continuous monitoring of standards for clinical teams to attain and then retain gold standard and is well embedded across the organisation to ensure our patient care is of a consistent and high standard.

Financial statements

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. Our annual report and accounts cover the 12 month period from the 1 April 2019 to 31 March 2020. Our accounts have been prepared in accordance with

directions given by the Department of Health and NHS Improvement. They are also prepared to comply with International Financial Reporting Standards (IFRS) and are designed to present a true and fair view of our financial activities.

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

External audit

Our auditors for 2019/20 are:
PricewaterhouseCoopers LLP (PwC)
Donington Court
Pegasus Business Park
Herald Way
East Midlands
DE74 2UZ.

The total fees for external auditors for 2019/20 accounts were £55,000 (plus VAT) in respect of the completion of the statutory audit work, made up of:

PwC (appointed auditors) £55,000 (plus VAT)

Due to the coronavirus pandemic, there is no requirement for a foundation trust to prepare a quality report and include it in its annual report for 2019/20. Additionally, there is no requirement for a foundation trust to commission external assurance on its quality report for 2019/20.

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 received regular updates in respect of the work of PwC. The Group also met with PwC in August 2019 which allowed 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 its meeting on 8 May 2018.

As PwC's appointment is coming to an end, the Trust has successfully appointed new external auditors with effect from October 2020.

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 2019/20 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.

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 2019/20 with a healthy cash balance of £35.1m which equates to 71 days' worth of operating expenditure. We have continued to invest surplus cash in 2019/20 in the National Loans Fund to generate a modest return on investment.

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.

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.

Due to the Covid-19 pandemic, revised financial arrangements for NHS contracting and payment will apply for part of the year 2020/21. The arrangements for the remainder of the year are yet to be confirmed but it remains the case that the Government has issued a mandate to NHS England for the continued provision of services in England. CCGs will be provided with sufficient funding for the year and therefore the NHS providers can continue to expect funding to flow where services are expected to continue.

Therefore, after making enquiries, the directors have a reasonable expectation that the NHS foundation 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.

Signed

Tracy Allen
Chief Executive **10 June 2020**

Accountability report

Directors' report

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

Directors

The following directors were appointed to membership of the Board of Directors, and were in post during the year 1 April 2019 to 31 March 2020:

Designation	Date	Name
Chairman	1 April 2019 to 31 March 2020	Prem Singh
Vice chair	1 April 2019 to 31 March 2020	Kaye Burnett
Chief executive	1 April 2019 to 31 March 2020	Tracy Allen
Director of finance and strategy/deputy chief executive	1 April 2019 to 31 March 2020	Chris Sands
Chief information and transformation officer	1 April 2019 – 31 March 2020	Jim Austin
Director of quality/chief nurse	1 April 2019 to 31 March 2020	Michelle Bateman
Director of strategy	1 April 2019 – 31 March 2020	Tim Broadley
Associate director of corporate governance/trust secretary	2 September 2019 to 31 March 2020	Melanie Curd
Associate director of corporate governance/trust secretary	1 April 2019 to 31 August 2019	Kirsteen Farrar
Chief operating officer	1 April 2019 to 31 March 2020	William Jones
Medical director	1 April 2019 to 31 May 2019	Dr Rick Meredith
Medical director	3 June 2019 to 31 March 2020	Dr Ben Pearson
Director of people and organisational effectiveness	1 April 2019 to 28 February 2020	Amanda Rawlings
Interim director of people and organisational effectiveness	9 March to 31 March 2020	Paul Renshaw

Designation	Date	Name
Non-executive director	1 April 2019 to 31 March 2020	Kay Fawcett
Associate non-executive director	1 April 2019 to 31 March 2020	Richard Harcourt
Non-executive director	1 April 2019 to 31 March 2020	Joy Hollister
Non-executive director	1 April 2019 to 31 March 2020	Julie Houlder
Non-executive director	1 April 2019 to 31 March 2020	Ian Lichfield
Non-executive director	1 April 2019 to 31 March 2020	James Reilly

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

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

Ensuring services are well led

In 2019 the the Care Quality Commission (CQC) conducted their Well-Led inspection of the Trust and rated the Trust as Outstanding. This rating is fantastic, and well deserved, recognition of the commitment, energy and effort that everyone within DCHS puts into their role on a day to day basis. As Professor Baker, the Chief Inspector of Hospitals, said in his summary: “An Outstanding rating is the result of a tremendous amount of hard work and commitment” and I count myself very privileged to work alongside so many colleagues that I see demonstrating that effort and dedication every day.

The CQC has recognised the amazing improvement that our Integrated Sexual Health Services Team has delivered in the last couple of years, moving their rating as a service from Requires Improvement to Outstanding. They have continued to rate the whole trust as Outstanding for Caring, and have improved the trust’s overall rating for Well Led from Good to Outstanding. The full report is available on our website: www.dchs.nhs.uk.

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 2019/20.

Prompt payment practice code

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

	NHS	Non NHS
Value	96.99%	98.33%
Volume	97.36%	98.26%

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

NHS Oversight Framework

NHS England and NHS Improvement's 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 4 reflects providers receiving the most support, and 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 2020. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

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 NHS Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

Area	Metric	**2019/20**				**2018/19**			
		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	4	4	4	3	1	1	1	1
Overall score		**3**	**3**	**3**	**1**	**1**	**1**	**1**	**1**

We were successful in mitigating our agency spending towards the end of the year with a number of additional measures, including: recruitment to a responsive workforce team of 10 whole-time equivalent ward healthcare assistants; recruitment to vacant posts within the central responsive workforce team to support a range of community teams and successful recruitment to a pilot of a local responsive workforce team in the north east Derbyshire/Chesterfield community team. An incentive 'bonus payment' programme for Bank Workers to work more shifts was very successful during February, with a fill rate of 84.7%. In our learning disabilities

service we continued to secure ways to contain agency spend. We talk about staffing in more detail in the Staff Report chapter of this annual report.

Income disclosures

During the year ending 31 March 2020, our Trust generated income of £196m for the provision of services, principally to the people of Derbyshire.

Of that total, £176.8m 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 £18.9 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.

Tracy Allen

Chief Executive **10 June 2020**

Annual statement on remuneration 2019/20

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 2019/20.

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

There were no substantial changes to senior managers' remuneration during 2019/20.

Prem Singh
Chairman **10 June 2020**

Senior managers' remuneration policy
Future policy table - executive directors

Components:

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

Component	How this operates	How this supports the Trust's short and long term strategic objectives	Maximum that can be paid	Framework used to assess performance and performance measures that apply	Provisions for recovery or withholding of payments
Annual flat-rate salary, taxable benefits and pension benefits reviewed regularly with reference to the wider NHS directors pay and the pay award to other NHS staff in any given year (applies to all executive directors with no specific differences for	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.

individual directors).					

Notes on future policy table

No new components of the remuneration package have been introduced in 2019/20 nor have any changes been made to existing components.

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

The chief executive was paid £139,956 pro-rata £155,507 during 2019/20 (2018/19: £139,009 pro-rata £154,445). We are satisfied that this remuneration is reasonable having undertaken benchmarking work, both in terms of salaries of chief executive officers of small to medium-sized trusts and gender equality. The salary paid was approved by both NHS Improvement and the Treasury.

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

Non-executive directors

Component	Additional fees	Other remuneration
Annual flat-rate non pensionable fee, with a higher rate payable for the chair of the Trust. The total monetary amount of these fees was £145,000 in 2019/20 (£131,400 in 2018/19)	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.

Information not subject to audit

Details of the service contract for each executive director at 31 March 2020

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

Tim Broadley	*Director of strategy*	*6 January 2020 (retire and return)*	*n/a*	✓		
Jim Austin	*Chief information and transformation officer*	*1 May 2015*	*n/a*		✓	
Paul Renshaw	*Interim director of people and organisational effectiveness*	*9 March 2020*	*n/a*		✓	

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

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

The Remuneration and Terms of Service Committee

The Remuneration and Terms of Service Committee is chaired by Trust chairman Prem Singh, and comprises non-executive directors. The committee has delegated responsibility to determine the remuneration, allowances and other terms and conditions of the executive directors and to oversee any new executive director appointments during the year. The committee met on five occasions during the period 1 April 2019 to 31 March 2020. The membership and attendance at the committee is detailed in the table below.

Attendance at Remuneration and Terms of Service Committee		30 May 2019	25 July 2019	24 Oct 2019	19 Dec 2019	27 Feb 2020
Prem Singh	Chairman	✓	✓	✓	✓	✓
Kaye Burnett	Non-executive director	✓	✓	×	✓	✓
Kay Fawcett	Non-executive director	✓	×	✓	✓	✓
Richard Harcourt	Associate non-executive director	✓	×	✓	✓	✓
Joy Hollister	Non-executive director	×	✓	✓	×	✓
Julie Houlder	Non-executive director	✓	✓	✓	×	✓

Attendance at Remuneration and Terms of Service Committee		30 May 2019	25 July 2019	24 Oct 2019	19 Dec 2019	27 Feb 2020
Ian Lichfield	Non-executive director	×	✓	✓	✓	✓
James Reilly	Non-executive director	✓	✓	✓	✓	×

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

During 2019/20 we made two new executive appointments for our medical director and for our associate director of corporate governance due to the retirement of the 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 an interview panel and a stakeholder panel.

For both posts we conducted the long listing and short listing ourselves in January 2019 and August 2019 respectively

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 2019/20.

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:

	2019/20			2018/19		
	Number			Number		
	Total	Receiving expenses	Expenses £ '00	Total	Receiving expenses	Expenses £ '00
Directors	9	9	22	9	9	14
Non-executive directors	8	8	12	10	10	14
Governors	28	18	6	30	16	5
Total	45	35	40	49	29	33

Information subject to audit

Trust board salaries and allowances

		1 April 2019 to 31 March 2020					
		Salary and fees	*Taxable benefits **	*Annual performance related bonuses*	*Long-term performance related bonuses*	*All pension related benefits*	*Total*

		(bands of £5,000)	***(Rounded to the nearest £00)***	*(bands of £5,000)*	*(bands of £5,000)*	*(bands of £2,500)*	*(bands of £5,000)*
Name	*Title*	*£0*	*£0*	*£0*	*£0*	*£0*	*£0*
Prem Singh	Chairman	45-50	-	-	-	-	45 - 50
Tracy Allen	Chief executive	140-145	41	-	-	22.5-25	165-170
Chris Sands	Director of finance and strategy/deputy chief executive Acting chief executive 01.05.2019 – 31.08.2019	125-130	41	-	-	32.5-35	165-170
Amanda Rawlings	Director of people and organisational effectiveness	55-60	10	-	-	5-7.5	65-70
Paul Renshaw	Interim director of people and organisational effectiveness (from 09.03.2020)	5-10	-	-	-	35-37.5	45-50
Rick Meredith	Medical director (01.04.2019 to 31.05.2019)	15-20	7	-	-	-	15-20
William Jones	Chief operating officer	115-120	48	-	-	25-27.5	145-150
Michelle Bateman	Chief nurse/director of quality	105-110	45	-	-	157.5-160	270-275
Ben Pearson	Medical director (from 01.06.2019)	110-115	34	-	-	125-127.5	245-250
Jim Austin	Chief information and transformation officer	115-120	7	-	-	25-27.5	140-145
Tim Broadley	Director of strategy	95-100	14	-	-	-	95-100
Cath Benfield	Acting director of finance (01.05.2019 to 31.08.2019)	25-30	-	-	-	40-42.5	70-75
Kirsteen Farrar	Trust secretary/associate director of corporate governance (01.05.2019 to 31.08.2019)	45-50	3	-	-	-	45-50
Mel Curd	Trust secretary/associate director of corporate governance (from 01.09.2019)	40-45	-	-	-	25-27.5	70-75
Kaye Burnett	Non-executive director	10-15	-	-	-	-	10-15

Richard Harcourt	Associate non-executive director	10-15	-	-	-	-	10-15
Kay Fawcett	Non-executive director	10-15					10-15
Joy Hollister	Non-executive director	10-15	-	-	-		10-15
Julie Houlder	Non-executive director	10-15	-	-	-		10-15
Ian Lichfield	Non-executive director	10-15	-	-	-	-	10-15
James Reilly	Non-executive director	10-15	-	-	-	-	10-15

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

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 in the previous table and her total remuneration is shown in the next table. Amanda resigned on 29 February 2020.

The calculation on Jim Austin's pension-related benefits resulted in negative value. The result is expressed as zero. This is mainly due to him having membership only of the 2015 scheme. No lump sum will be shown for senior managers who only have membership in the 2015 scheme.

Tim Broadley, director of strategy retired on 6 December. He was re-appointed as director of strategy on 23 December 2019 on a part-time basis in line with the Agenda for Change rules on retire and return applications.

Kirsteen Farrar, trust secretary/associate director of corporate governance, retired on 31 August 2019.

Information subject to audit

		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
Richard Harcourt	Associate non-executive director (From 1.09.18)	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

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

Information subject to audit

Name	Title	1 April 2019 to 31 March 2020					
		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**	115-120	19	-	-	12.5-15.0	130-135

*relates to lease car allowance, shown in £100s

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	-	-	15.0-15.0	135-140

*relates to lease car allowance, shown in £100s

Pensions

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

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

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

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

Information subject to audit

The pension benefit table provides further information on the pension benefits accruing to the individual at 31 March 2020.

Name	Title	Real increase in pension at age 60	Real increase in pension lump sum at age 60	Total accrued pension at age 60 at 31 March 2020	Lump sum at age 60 related to accrued pension at 31 March 2020	Cash equivalent Transfer Cash equivalent transfer value at 31 March 2020	Real increase cash equivalent transfer value	Cash equivalent transfer value at 31 March 2020	Employer's contribution to stakeholder pension
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	(bands of £1,000)	(bands of £1,000)	(bands of £1,000)	(bands of £1,000)
Tracy Allen	Chief executive	0-2.5	0	55-60	130-135	1,041	50	1,116	20
Chris Sands	Director of finance and strategy/deputy chief executive Acting chief executive 01.05.2019 – 31.08.2019	0-2.5	0	45-50	95-100.	720	26	763	19
Michelle Bateman	Chief nurse/ director of quality	7.5-10	22.5-25	40-45	130-135	766	185	969	15
Amanda Rawlings	Director of people and organisational effectiveness	0-2.5	0	30-35.	65-70.	554	28	597	15
William Jones	Chief operating officer	0	0	50-55.	160-165	1,214	31	1,275	**17**
Rick Meredith *	Medical director (01.04.2019 to 31.05.2019)	-	-	-	-	-	-	-	-
Ben Pearson	Medical Director (01.06.19 to 31.03.2020)	5-7.5	10-12.5	50-55	125-130	881	137	1,039	16
Kirsteen Farrar	Trust secretary/associate director of corporate governance (01.04.2019 to 31.08.2019)	-	-	-	-	-	-	-	-
Mel Curd	Trust secretary/associate director of corporate governance (From 01.09.2019)	0-2.5	0-2.5	15-20	30-35	218	22	262	6

Jim Austin	Chief Information and Transformation Officer	0-2.5	0	10-15	0	129	31	163	17
Tim Broadley	Director of Strategy	-	-	-	-	-	-	-	-
Cath Benfield	Acting director of finance 08.05.2019 to 31.08.2019	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.

There is no entry for Tim Broadley, director of strategy. He retired on 6 December. He was re-appointed as Director of Strategy on 23 December 2019.

There is no entry for Kirsteen Farrar, trust secretary/associate director of corporate governance. She retired on 31 August 2019.

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

Cash equivalent transfer value

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

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

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

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

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

Real increase in CETV

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

Information subject to audit

Fair pay multiples

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

The banded remuneration of the highest paid director at the Trust during 2019/20 was £155k-160k (2018/19 £150-155k); this was 6.2 times more than the median pay of £25,171 (2018/19 6.1 times or £26,275).

The Trust is required to calculate the fair pay multiple based on all staff in post as at the end of March 2020 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 2019/20 no employee received remuneration in excess of the highest paid director.

Total remuneration includes salary, non-consolidated performance pay and benefits in kind. It does not include severance payments, employer pension contributions or the cash equivalent transfer value of pensions. During 2019/20, there are no significant changes on either side of the ratio.

Tracy Allen
Chief Executive **10 June 2020**

Staff report

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

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 over 1,300 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 1.49% of our total pay bill. Historically, we have performed well in this area and we have consistently contained spend on agency staffing below the target set. However, during 2019/20 there have been a number of specific challenges:

- Complex patient admissions in learning disability services that are supported by agency staff
- GP locum spend due to vacancies
- Medical locum cover within the learning disability service
- Agency spending on the wards, particularly in the south of the county, due to high patient acuity alongside sickness absence and vacancies.

Measures that have been put in place to reduce this include further recruitment to responsive workforce, established reviews and eRoster support meetings.

Agency spend is above the NHSI ceiling of £1.36m, spend for 2019/20 at year end was £1.936m (42.5% above the plan).

Staff turnover has risen slightly to 9.55% for 2019/20, which is lower than the local East Midlands NHS turnover which stands at 10.60% (based on most current NHS Digital data from November 2019. Analysis of the reasons why staff have left us has not highlighted any trends or causes for concern. Currently our vacancy rate is 4.93%.

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.

Information subject to audit

Our staff

Total staff as at 31 March 2020 *		
Gender	**2018/19**	**2019/20***
Female	3,818	3,725
Male	461	457
Total	**4,279**	**4,182**
Executive directors as at 31 March 2020*		
Gender	**Total**	
Female	4	3
Male	3	4
Total	**7**	**7**

Senior managers as at 31 March 2020*		
Gender	**2018/19**	**2019/20***
Female	12.70	18.6
Male	5.0	4.8
Total	**17.70**	**23.40**

* Based on staff employed at 31 March 2020 as whole-time equivalents.

Average number of employees (WTE basis)

Our average whole time equivalent (WTE) staff numbers in 2019/20 are based on an accumulation of the total WTE staff throughout the year, divided by 12 to give the average WTE.

Information subject to audit

	2019/20 permanent number	2019/20 other number	2019/20 total number	2018/19 total number

Medical and dental	34.05	4.68	38.73	39.72
Ambulance	0	0	0	0
Administration and estates	711.01	20.26	731.27	760.33
Healthcare assistants and other support staff	890.97	10.08	901.05	946.79
Nursing, midwifery and health visiting staff	1,093.50	11.55	1105.05	1,119.95
Scientific, therapeutic and technical staff	561.37	10.82	572.19	579.56
Other	0	0	0	0
Total average numbers	**3290.90**	**57.40**	**3348.30**	**3,446.35**
Of which:	6.53			5.46

Information subject to audit

Staff group	Average of fixed term temporary staff	Average of permanently employed staff*
Administration and estates staff	20.26	711.02
Ambulance staff	00.00	00.00
General payments	00.00	00.00
Health care assistants and other support staff	10.08	890.97
Healthcare science	00.00	13.21
Medical and dental staff	4.68	34.05
Nursing, midwifery and health visiting learners	3.95	12.57
Nursing, midwifery and health visiting staff	7.60	1,080.93
Scientific, therapeutic and technical staff	10.82	548.15
Total	**57.40**	**3,290.90**

Gender pay gap

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

Results and actions taken to reduce the gender pay gap further are regularly reported to our Quality People Committee. During 2019/20 this included:

- A Diversity Recruitment Group, championed by our director of people and organisational effectiveness, undertake an audit on our job descriptions and person specifications to ensure they are clear, ask for appropriate qualifications etc, to reduce bias
- Continued promotion of opportunities for flexible working, shared parental leave, career progression, promotion and leadership development opportunities
- Gap analysis of 'what works - good practice and evidenced based actions' – as recommended by the Government Equalities Office to ensure we are implementing effective initiatives within our workforce: https://gender-pay-gap.service.gov.uk/

Attendance

Our average absence rate for 2019/20 is 4.96%, which is slightly higher than the previous year (2018/19, 4.89%). 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.

It should be noted that the Covid-19 pandemic has increased absence figures from mid-March 2020 onwards, increasing in March by 1% from the previous month. The impact has been to increase the overall absence for the year 2019/20 slightly, however, we need to be aware that at the time of writing (May 2020) absence is anticipated to be significantly more over the next couple of months. Our wellbeing focus will be adapted accordingly to specific requirements.

The workforce plan

Our workforce plan is based on a strong commitment to strengthen our position within the system and particularly within the Primary Care Networks. 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 across our system: targeting the right skills, in the right place, at the right time, for the benefit of our patients.

Our workforce planning process aligns to the developing governance of the Derbyshire system as we move to a 'system by default' operational model and prepare to become an Integrated Care System (ICS) by April 2021. Our role is to provide a skilled community workforce to support the development of the 15 Primary Care Networks (PCNs) and four Integrated Care Partnerships. We recognise the important contribution that the voluntary and community sector make in the delivery of care and the promotion of social value; for this reason we will continue to work with our partners in these areas. The plan has been developed in collaboration with our health and social care partners, including engagement with private, independent and voluntary providers. We recognise their contribution to developing a sustainable workforce, developing services in partnership with them and working to explore new opportunities for them to make a difference to the wellbeing of our patients. This partnership will strengthen as services are developed to support Joined Up Care Derbyshire, including the development of Primary Care Networks (PCNs).

Our three year workforce plan establishes how we will provide the right workforce, in the right place, delivering the right care for the population of Derbyshire. It also outlines how we will deliver the objectives of the NHS Long Term Plan, and the interim People Plan, to ensure that we can achieve the ambitious improvements we want to see for our patients. The plan establishes how we will overcome the challenges we face in terms of our workforce, including staff shortages, against a backdrop of a growing demand for our services.

Our services are seeing an increase in patients with higher levels of complexity and acuity, requiring the need to ensure that our clinical colleagues are supported with the competencies and the capacity to deliver safe and effective care.

In order to achieve this transformation, we must support and equip our workforce to deliver this different model of care.

Key workforce achievements for 2019/20

- Developed new workforce roles to meet emerging care models, including nursing associate
- 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
- 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 increase our placement opportunities over the coming year

- Successful Return to Practice project working in partnership with Derbyshire system colleagues, which has resulted in returnees obtaining permanent positions with us
- Enhanced the available learning and development funds so as to implement innovative training solutions to meet the strategic needs of the organisation
- Continued to develop apprenticeship opportunities that assist in the development of new workforce models to meet the government's public sector target of 2.3%
- Enhanced the use of technology to deliver learning and development, including online training materials, bespoke e-learning, interactive distance learning, e.g. via WebEx, Skype, podcasts and access to virtual library services
- Further enhanced and embedded our leadership work to equip our workforce to lead internally and across the system
- Increased 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
- Ensured a continuous supply of a high calibre workforce which is able to work flexibly across the organisation and provide seven-day services. 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
- Worked with Health Education England 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.

Our aspirations and key workforce priorities for 2020 onwards are:

- To be the employer of choice that attracts a diverse and talented workforce
- To provide an engaging and supportive culture.

To achieve this, we will:

- Support current staff to balance their home and work commitments - more flexible rostering that supports services and individuals
- Ensure we have enough people to match the services needed, people with the right skills and experience, so that our colleagues have the time and expertise they need to care for patients safely and effectively

- Ensure our people have rewarding jobs, work in a positive culture, with opportunities to develop their skills and have support to manage the complex and sometimes stressful nature of delivering healthcare
- Strengthen and support good, compassionate and diverse leadership at all levels – managerial and clinical – to meet the complex practical, financial and cultural demands of the NHS Long Term Plan
- Further embed a health coaching approach across the organisation, to support our colleagues and patients and to expand the public health knowledge and skills to ensure we help the people we serve to stay healthier for longer
- Meet the strategic needs of the Joined Up Care Derbyshire sustainability and transformation plan priorities by ensuring that recruitment is targeted in key areas, including: learning disabilities, urgent care, expanding multidisciplinary roles and teams, improving resilience in general practice and ensuring equitable provision across a seven-day period.

To be the best employer for supporting career development we need to secure the future talent pipeline and provide stability with a varied and rewarding career. The challenge is substantial. However, there are real opportunities to make improvements. Research shows that more people want to train to join the NHS than are currently in education or training. Many of those leaving the NHS would remain if they were offered improved development opportunities and more control over their working lives. Therefore, this is an area of great potential for our organisation.

To achieve this, we will:

- Provide flexible and accessible support for continuing professional development (CPD)
- Develop and support new roles and inter-disciplinary credentialing programmes which will enable more workforce flexibility across an individual's NHS career and between individual staff groups
- Ensure our colleagues have the skills and competencies to respond to changes in how and where we deliver care, reflecting the changes in acuity and dependency of our patients
- Ensure established staffing numbers per team and service, match the patient and care demand
- Secure investment to increase the number of advanced clinical practitioners described in this plan, including senior medical resources necessary to provide adequate clinical supervision for advanced practice and non-medical prescribing
- Develop a cohesive workforce plan to ensure that as truly integrated teams develop within the primary care networks across places in Derbyshire, the benefits of advanced practice are recognised and valued for the contribution

they make to patient care, maintaining people's health and promoting self-management
- Further develop "grow our own" initiatives, such as apprenticeships and work experience schemes
- Develop our offer for career development and support for individuals developing their careers in the roles described in this paper as it is clear that remuneration is not the only factor in retaining these valuable colleagues.

To be the best provider of healthcare education and training we need to provide excellent practice placements, supervision and preceptorship and continuing development opportunities.

We want to be renowned for ensuring all our staff are educated, developed and trained to achieve the highest standards of leadership and patient care. We value the importance of education and training, to develop our own workforce, to support the delivery of high quality care on a sustainable basis, and to play a part in the wider training of the future NHS workforce.

Significant education and training also supports the creation of a learning culture so that the organisation keeps itself up-to-date with academic and research developments, informing innovation and improvements in care and delivery to benefit patients and staff. We are committed to developing a culture of lifelong learning and establishing our Trust as a learning organisation.

To achieve this, we will:

- Develop our education and training programmes to maximise the use of money available for training and become a leader in this field
- Establish a local system for education that is developed and maintained for the current and future workforce
- Offer excellent practice placements, supervision, preceptorship, apprenticeships and continuing development opportunities while constantly evaluating to make improvements
- Achieve the Skills for Health quality mark that demonstrates we meet the unique health sector quality framework for learning and training and that we meet the high standards expected by health care employers
- Work with education providers and Health Education England to understand future training requirements.

There are two underlying principles which need to be reflected in all elements of our workforce plan.

Firstly, we are committed to integration of services working with our Derbyshire partners on this agenda and are currently supporting the redesign of integrated care systems in Primary Care Networks and place settings.

Secondly, we have a significant challenge to ensure financial stability. We need to achieve recurrent sustainable quality improvement plans so there is demand that our future workforce is leaner and more efficient whilst still providing the same or improved quality and safety outcomes. Workforce productivity is a key factor to delivering this, but we also need to ensure we have adequate staffing levels in services to deliver the care we aspire to provide.

Working within the confines of those two underlying principles, we will deliver the aspirations set out in the section above by:

1. Doing things differently: we will make a significant difference to our ability to recruit and retain staff by making us an employer of choice by:

- Widening participation to support a "grow our own" workforce
- Supporting career development and developing new roles into our organisation; including a new on-the-job apprenticeship route to include a registered nurse, nursing associate, clinical associate psychologist, occupational therapist, and physiotherapist, podiatrist and speech and language therapist
- Being the best provider of education and training for our workforce by maximising the training and education resources available to us through effective economies of scale
- Increasing the number of clinical placements we provide for students by 25% in year 1, with the expectation this will increase further in the next three years. Currently we provide 142 placements. This will increase to 189 initially
- Maximising our workforce supply which will include working with Health Education England on return to practice
- Creating new roles and career development opportunities for our workforce, taking them from support roles through to advanced practice
- Expanding our offer of development opportunities to all registered practitioners who are eligible to progress to advanced practitioner and independent prescriber status
- Increasing our flexible contracts to meet the needs of a multi-generational workforce
- Improving our workforce age profile. Our workforce is ageing and the total number of our under-25 workforce is 3.7%. We will increase the number of our staff who are under 25-years-old by 5% per year in the next three years. Currently we have a total of 164 under-25s; this will increase to 172 in 2020, 181 in 2021,191 in 2022 and 201 in 2023
- Ensuring we bring people together to deliver our vision for a personal, fair and diverse workforce, where everyone counts and the values of the NHS Constitution are brought to life. We will be an inclusive workplace, ensuring equality across the organisation, working on promoting workforce equality, and working to support inclusive healthcare.

2. Developing our workforce: we will continue to increase our workforce by training and recruiting more professionals, including offering an excellent clinical placement for undergraduate nurses in the community setting and offer more routes into the NHS including apprenticeships. We will explore the possibilities of training medical students, student allied health professionals and training a wider range of registered staff in our new training hubs. We will also make our organisation a better place to work, so we retain our workforce and feel able to make better use of their skills and experience for patients. We will provide access to funding for training and education and increase access to suitable training programmes. We are supporting 41 apprenticeships in 2019 and this will increase to 105 by 2020. We will develop a continuing professional development offer for our workforce and develop a visible flexible career pathway. We believe that everyone has the ability to be a leader and we will support development in this area.

3. Delivering on the vision of the NHS Long Term Plan: we will transform our workforce by developing a different skill mix across our services, new types of roles and different ways of working to deliver the new service model for community and primary care services. While activities are already progressing well at scale and pace in some parts of our service, the introduction of new roles including nursing associates, advanced clinical practitioners and colleagues working at advance practice level will need to accelerate further. We will grow our workforce with a different skill mix and new ways of working to provide holistic care that meets the biopsychosocial needs of our population and helps support them to stay well. We will promote the concepts of trusted assessments and multidisciplinary working. We will grow our advanced clinical practitioner workforce from 17.53 whole time equivalents (WTE) in 2019 aiming to employ 50.6 WTE by 2023. We will review existing roles to ensure they remain appropriate for the future and we will work in partnership with our Primary Care Networks to develop an integrated workforce.

4. Offering career development and upskilling opportunities: for our workforce to enable us to make the best use of their talents, with core underpinning training including Quality Conversations. In turn we will support our workforce through high quality appraisal and personal development programmes. We will request more support from Health Education England to ensure we invest sufficiently in continuing professional development. We know this is an important factor in enabling us to recruit and retain our staff. It will also enable us to change our skill mix to that of the required future service model.

5. Developing our services and workforce modelling: to ensure we support more collaboration between Primary Care Networks and community services, to increase the services provided jointly and increase the focus on NHS organisations working with their local partners as ‘Integrated Care Systems’. To plan and deliver services which meet the needs of the population. A programme of workforce modelling is taking shape that will identify what the workforce should look like in a Primary Care Network and Place setting based on population health and demographic.

6. Making better use of data and digital technology: We have already enhanced our learning programmes to include a range of digital technology. We aspire to develop digital skills across all staff groups. We will make it easy for our colleagues to record their personal learning achievements and to share learning from incidents with a "person centred" environment that utilises digital media to share best practice within the permissions of information governance. We will ensure teams have the relevant business information data to manage and plan their teams effectively.

7. Being an inclusive employer: Our vision is to be an exemplar of good equalities practice. We are committed to advancing equality of opportunity and working productively with key stakeholders across the protected characteristics. We plan to attract, recruit and retain a wide range of colleagues from all sections of society to work in a positive, inclusive and nurturing environment. We also want to deliver, with dignity and respect, inclusive and accessible services that meet our patients' individual needs. The proportion of Black Minority Ethnic (BME) colleagues employed within the organisation was 4.18% in 2018/19; an increase from 3.82% in the previous year. However, the Derbyshire BME population represent 6.7% of Derbyshire's total population as per the Office of National Statistics. We will increase our BME profile to reflect that of the local population through targeted recruitment and retention programmes. Currently we have 184 people from BME backgrounds and this will need to increase to 295 if we are to represent that of the local population.

Supporting staff wellbeing

Following the launch of the Staff Wellbeing Strategy in 2018/19 the focus for 2019/20 has been on implementation across the three key areas of:

- Prevention
- Resilience
- Support.

During Covid-19 the wellbeing team has scaled up the wellbeing support for staff and developed alternative methods of delivery. Along with the existing offer a central website hub was developed as a one stop shop for wellbeing information, a 24/7 phoneline launched and clinical psychologist capacity made available. Wobble rooms were set up, creating safe spaces for staff to take a moment and refresh. Calm kits have been created to facilitate the same for our community and remote workers. A virtual support menu has also been launched with Schwartz rounds, parent peer support, carers groups, diet clubs and exercise classes all available via video conferencing.

During the year we achieved our highest ever staff flu vaccination rate, reaching 80.7%, beating the previous best of 68.5%. This also meant we sponsored over 9000 life-saving vaccinations across the third world via our 'jab for a jab' UNICEF partnership.

The launch of a Derbyshire-wide system wellbeing group has been aimed at developing the Derbyshire system staff wellbeing offer, increasing best practice and reducing inequity.

The completion of further research projects from Sheffield University Business School with DCHS staff included post-graduate projects exploring factors impacting staff engagement and the impact of staff self-compassion on absence and a PHD project looking at ageing workforce.

We launched the Women's Health Project which is a dedicated role looking at understanding the key factors affecting women's health at work and launching interventions to make DCHS a best practice employer for women.

We revised the stress policy to take a new approach based around wellness action plans to encourage a positive relationship between staff and line managers in matters relating to stress and mental health.

An improved staff wellbeing planner now offers 12 months of training bookable in advance, a wellbeing conference, new information sessions relating to finances, relationships and caring responsibilities and a broader range of wellbeing champion activities.

The launch of the Thrive mental health app, has provided mindfulness, breathing, relaxation and cognitive behaviour therapy exercises via employees' phones. This was nominated for an award for technology use in staff wellbeing at the InsideOut staff wellbeing awards.

The mediation service was relaunched with 15 new accredited mediators able to provide mediation support which has dramatically increased our capacity.

The Resolve service has supported over 10% of the workforce to access counselling, and an average time to appointment of less than two working weeks. Of the staff accessing Resolve support 85% said it helped them not to take time off sick.

These elements, along with the day to day offer of bespoke team sessions, coaching and manager support, has seen DCHS increase the NHS Staff Survey wellbeing score, which takes us further beyond the average for similar trusts than in previous years. The goal for 2020/21 is to become the best community trust for staff wellbeing.

Freedom to Speak Up

The Freedom to Speak up agenda has continued to develop during the year.
A change of Freedom to Speak Up Guardian in September 2019 was the opportunity to have defined hours dedicated to the role.

Promotional material has been updated and the Guardian has undertaken a series of site and service visits to publicise the role and support staff to have the confidence to raise concerns through the variety of routes available. This is reflected in the year on year increase of reported concerns through the Freedom to Speak up Guardian and the positive feedback from staff using the process. Themes and learning are shared with Trust Board and the Audit and Assurance Committee, as well as wider within the organisation, to ensure improvements are made.

A safe and healthy workplace

No-one should be injured or suffer ill health as a result of their work. In 2019/20 we have seen a slight increase in the overall number of injuries from incidents at work (454 from 411) but also in the number of the more serious injuries (20 from 16) reportable under RIDDOR (the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013).

We launched a new Health and Safety strategy during the year, focusing our efforts on a number of key topic areas. These include leadership development, learning from incidents, providing the best information and guidance, and everyone playing our part. We have worked in detail on violence and aggression, slips and trips, and lifting/handling injuries, which account for many of the injuries suffered by colleagues.

Our work on violence and aggression has reinforced the message that it is not acceptable, recognising that our services need different solutions. We have provided additional support for managers and colleagues to address behaviour through our Aggressive and Violent Behaviour towards Staff Policy, as well as to services where patients' behaviours that challenge are as a result of illness. We know that we have more work to do and are committed to improving our colleagues' experience further in 2020/21.

We have seen a significant reduction in injuries from household animals, from 14 injuries in 2018/19 down to 1 injury in 2019/20. This follows a campaign to raise awareness amongst teams and asking patients to keep their pets secured during clinical home visits.

We have been working hard to ensure the safety of our colleagues during the Covid-19 pandemic, and this will continue to have a significant impact on how we work in the future. Our plans for 2020/21 will focus on how we protect the safety of our colleagues whilst adapting our ways of working and ensuring that we continue to improve our approach to managing existing risks.

Essential training

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

Due to the Covid-19 emergency response, we continue to work on a four month extension on all training in line with national recommendations. However, all our essential training is accessible via e-learning and reminders are being sent regularly to all staff via the communications team encouraging completion of essential e-learning packages. A lot of focus will be directed at improving fire training and appraisal compliance and managers are being encouraged to take advantage of the newly introduced technology and trial new ways of working.

Training programmes	Compliance 31 March 2019	Compliance 31 March 2020	% DCHS target
Essential learning	96%	97.90%	*96%*
Information governance	95%	97.52%	*96%*
Fire training	94%	95.12%	*96%*
Appraisal	92%	89.88%	*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 are also continuing to undertake 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. We have taken part in an NHS Employers webinar to promote this work.

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.

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.

During the Covid-19 response, members of the engagement and organisational development team temporarily changed their roles to support the wider team, sourcing donations for the staff welfare work stream and supporting wider staff wellbeing. We also developed alternative ways to reward and recognise our colleagues during this difficult time.

A virtual version of our DCHS Thank you, Time and Tea parties was launched, where all colleagues due to attend a tea party (whether that be for their long service award, a specific TTT nomination or teams who have retained their gold Quality

Always award), were instead posted out their certificates/badges and a treat sourced from a Derbyshire based company and featured on our social media channels #DCHSvirtualTTT.

Working with the chairman, we also launched the DCHS Donations Draw – whereby Derbyshire-based companies kindly offered to provide donations towards a monthly prize draw. Colleagues were in with a chance of winning anything from a bottle of wine, an afternoon tea, attraction tickets, subscriptions, to an overnight stay in a hotel when the pandemic is over.

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.

#DCHSTTT
thank you,
time and
tea

Now into its second year, #DCHSTTT – thank you, time and tea party - reward and recognition scheme continues. Hosted by the Board, in 2019, we held nine parties to celebrate and thank staff by inviting them to take some time out and enjoy tea and cakes with colleagues and friends. Nominees are 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.

Seasonal
STARS

We held again our ‘Seasonal Stars’ festive initiative leading up to Christmas. This feel good campaign began in 2018 and is sponsored in part by Thorntons. In 2019, we recognised over 200 colleagues. Where we were able to, they were featured on our social media channels throughout December.

The Extra Mile Awards have become an established event in our calendar. In 2019, we held our sixth awards ceremony that seeks to recognise those who inspire others and deliver beyond expectations. We received a record breaking number of nominations this year, with over 400!

NHS Staff Survey 2019

The 2019 NHS Staff Survey was conducted between Monday 23 September and Friday 29 November 2019. In total, 2,586 DCHS employees completed the survey giving a response rate of 62.4%, compared with our response rate of 61% in 2018.

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 ten 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.

	2019/20		2018/19		2017/18	
	Trust	**Bench-marking group**	**Trust**	**Bench-marking group**	**Trust**	**Bench-marking group**
Equality, diversity & inclusion	9.5	9.4	9.4	9.3	9.4	9.4
Health & wellbeing	6.3	6.0	6.2	5.9	6.3	6.3
Immediate	7.2	7.2	7	7	7	7

managers						
Morale	6.5	6.3	6.3	6.2	N/A	N/A
Quality of appraisals	5.8	5.8	5.6	5.6	5.7	5.7
Quality of care	7.7	7.4	7.6	7.3	7.6	7.6
Safe environment – bullying & harassment	8.6	8.4	8.5	8.4	8.6	8.6
Safe environment – violence	9.6	9.7	9.6	9.7	9.6	9.6
Safety culture	7.2	7.0	7.1	7	7	7
Staff engagement	7.3	7.2	7.2	7.1	7.2	7.2
Team working	6.9	7.0	6.9	6.9	6.9	6.8

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 focused on the following areas 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 detailed action plans of our targets to improve staff satisfaction in each of these key areas is reported bi-monthly to our Staff Health, Wellbeing, Safety and Engagement Group and Quality People Committee.

Upon publication and analysis of the 2019 NHS Staff Survey results, it has been approved that we are to focus on the following themes for improvement during 2020:

- Health and wellbeing
- Quality of appraisals
- Safe environment – violence and aggression
- Team working.

We are addressing these four areas as follows:

Health and wellbeing

- Increase the visibility of the staff wellbeing offer: staff wellbeing services are gold standard, however awareness and subsequent access to them can be patchy across our services. We will launch pathways for musculoskeletal and mental health that will help us tackle the most common causes of sickness absence, ensure staff know what is available and when they might require it, whilst also increasing a sense of organisational support for staff.

- 'Cause of the cause' factors: we continue to implement the staff wellbeing 2020 planner which places a specific focus on the causes of staff wellbeing issues such as finances, relationships and caring responsibilities, utilising training, resources and support services to increase awareness and reduce stigma around these topics whilst linking staff with support they may require.

- Implement the women's health project: Following staff feedback we have recruited a fulltime role focusing on women's health, including menopause, fertility and maternity. This project is currently gathering data from staff before trialling interventions.

- Embed staff wellbeing within DCHS ways of working: we are looking into multiple ways of embedding staff wellbeing within regular practices and decision-making of DCHS. This could take the form of a wellbeing section within Quality Always reviews, a staff wellbeing checklist to be applied at decision-making committees or specific sections within appraisals or 1-1s focused on wellbeing.

- Implement the stress policy: The new DCHS stress policy provides clear guidance that all staff should have a wellness action plan completed with their manager and that all managers should complete the HSE stress risk assessment for their teams. This will highlight specific issues at an early stage.

- Develop a 'comfortable with conflict' culture and increase use of mediation: We have increased our pool of accredited mediators to make mediation more widely available and to provide coaching for managers about how to manage conflict as it arises. This will link with our courageous conversations training.

- Link to wider leadership development: Feedback shows that staff wellbeing is impacted by the quality of the line manager relationship. Prioritising the development of our leaders and managers, ensuring appraisals are effective and promoting a compassionate application of our people policies will all have a large impact on our staff wellbeing performance.

Quality of appraisals

- Appraisal paperwork: We are refreshing the language of our appraisal paperwork to ensure it reflects person-centred leadership at all levels.

- Business intelligence: We are able to drill down to see where compliance/training levels are lower to understand what action needs to be taken.

- Training: We are looking at offering additional new bitesize training sessions for appraisers and at alternative ways of delivery through Webinars/Skype/eLearning etc. to get the most out of appraisal.

Safe environment – violence and aggression

- Reporting: The key message is that colleagues should report all incidents (via Datix), so that managers can appropriately support/follow up, and to help us understand the full scale of the issue, and provide additional support where it's needed.

- Policy: We have recently reviewed the policy on violence and aggression against staff and we are producing further supporting guidance.

- Communication and promotion: A leaflet has been produced to support community colleagues to have conversations with patients around appropriate behaviour, as well as other ways of ensuring a safe environment for us to work in. It's important that we continue to send the message that we will challenge unacceptable behaviour towards our staff.

- Learning disability/older people's mental health focus: We are working with colleagues in these areas of care-giving to identify lessons learnt and see what further support we can provide.

Team working

- 'Organisational effectiveness offer': A team support referral form has been successful and we are now developing a more specific offer around what the organisational effectiveness team can support teams with, eg development/away days, additional wellbeing support or bespoke training sessions.

- Team support packs: The launch of an electronic team support pack filled with helpful ideas and resources to support leaders engaging with their teams.

- Leadership development: We are prioritising the development of our leaders and managers, ensuring our programmes and masterclasses are fit for purpose, appraisals are effective and promote a compassionate application of our people policies.

Pulse Check

Pulse Checks were launched in 2013. 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 changed the way we run the Pulse Check in 2019/2020. To enable more time to analyse the results and to act on them, the decision was taken to only have one full census and two samples. 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 score for quarter 1 in 2019/2020:

- Q1 April to June: 77%

This was an increase of 2% from the previous Pulse Check.

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 2019: 91%

This was an increase of 1% from the previous Pulse Check

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 2019: 72%

This was an increase of 3% from the previous Pulse Check

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 continue to seek to enhance and maintain these excellent employee relations through early involvement, engagement and intelligence sharing with our trade union partners. This has been particularly true with our Covid-19 pandemic response work.

In line with the Trade Union (Facility Time Publication Requirements) Regulations 2017 we have published details of facilities time carried out by our trade union representatives during the 2019/20 year on our website www.dchs.nhs.uk. 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
14	12.23

Percentage of time union officials spent on facility time	Number of employees
0%	3
1-50%	8
51-99%	3
100%	0

Percentage of pay bill spent on facility time	
Total cost of facility time	£71,009.49
Total cost of pay bill	£129,697,415.27

Percentage of the total pay bill spent on facility time, calculated as: Total cost of facility time divided by total pay bill x 100	0.05%

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	5%

Defence Employer Recognition Scheme – gold award

In August 2019 we attained gold standard in the Ministry of Defence's Employer Recognition Scheme. It recognises that our organisational values are aligned with the Armed Forces Covenant and that as gold holders the Ministry of Defence is satisfied we have demonstrated:

- we are an exemplar within our NHS sector, advocating support for defence people issues to partner organisations, suppliers and customers
- support for Reservists on mobilisations and that we provide at least 10 days' additional leave for training, fully paid, to Reservist employees
- forces-friendly credentials in our recruiting and staff selection
- our workforce is aware of positive policies towards defence people issues.

Counter fraud/anti-bribery activities

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

Information subject to audit

Staff costs

	2019/20			2018/19		
	Total	Permanent	Others	Total	Permanent	Others
	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	102,677	102,544	133	101,965	101,813	152
Social security costs	8,945	8,945	-	8,745	8,745	-
Apprenticeship levy	518	518	-	515	515	-
Pension cost - defined contribution plans employer's contributions to NHS pensions	13,820	13,820		13,821	13,821	-
Pension cost - other	56	56	-	17	17	-
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	6,051	6,051	-	-	-	-
Termination benefits	(449)	(449)	-	498	498	-
Other employment benefits	2,841	-	2,841	2,440	-	2,440
Temporary staff - agency/contract staff	1,937	-	1,937	875	-	875
Total gross staff costs	**136,396**	**131,485**	**4,911**	**128,876**	**125,409**	**3,467**

Total staff costs - included within:

	2019/20			2018/19		
Costs capitalised as part of assets	365	365	-	268	268	-
Employee expenses - staff	135,477	130,566	4,911	127,116	123,649	3,467
Employee expenses - executive directors	1,003	1,003	-	994	994	-

Analysed into operating expenditure

	2019/20			2018/19		
Employee expenses - staff	135,477	130,566	4,911	127,116	123,649	3,467
Employee expenses – executive directors	1,003	1,003	-	994	994	
Redundancy	(449)	(449)		498	498	
Total employee benefits excluding capitalised costs	**136,031**	**131,120**	**4,911**	**128,608**	**125,141**	**3,467**

Expenditure on consultancy

	2019/20 £'000	2018/19 £'000
Information technology – SystmOne optimisation	196	-
Community engagement and nursing	32	-
Coaching and development	24	-
Service line reporting system	23	-
International financial reporting standards and VAT financing	18	-
Service integration	-	91
Governance review	21	9

Estate valuation	2	26
Estate management	52	35
Workforce development	5	59
Recruitment	41	35
Other	18	12
Total	**432**	**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 2020, for more than per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2020	3
Of which:	
The number that have existed for less than one year at the time of reporting	-
The number that have existed for between one and two years at the time of reporting	3
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 2019 and 31 March 2020, for more than £245 per day and that last for longer than six months:

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

months in duration between 1 April 2019 and 31 March 2020	
Of which:	
Number assessed as within the scope of IR35	-
Number assessed as not within the scope of IR35	-
Number engaged directly (via PSC contracted to trust) and are on the Trust's payroll	-
Number of engagements reassessed for consistency/assurance purposes during the year	-
Number of engagements that saw a change to IR35 status following the consistency	-

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

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

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020:

	2019/20 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 responsibility'. This figure should include both off-payroll and on-payroll engagements.	17

The 17 individuals are the Board members listed in the remuneration report.

Exit packages

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

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

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

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

Information subject to audit

Exit packages

Exit packages cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
	2019/20		
£0 - £10,000	9	(2)	7
£10,001 - £25,000	(12)	4	(8)
£25,001 - £50,000	(5)	1	(4)
£50,001 - £100,000	(2)	-	(2)
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
Total number of exit packages by type	(10)	3	(7)
Total resource cost	(£516,000)	£67,000	(£449,000)

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	£145,000	£353,000	£498,000

Information subject to audit

Non-compulsory departure payments

2019/20	Agreement number	Total value of agreements
Mutually agreed resignations (MARs) contractual costs	3	67,000
2018/19		
Mutually agreed resignations (MARs) contractual costs	27	353,000

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 2019/20.

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 2019/20 the Board membership consisted of the following executive directors:

Name	Title	Date
Tracy Allen	Chief executive	1 April 2019 to 31 March 2020
Jim Austin	Chief information and transformation officer	1 April to 31 March 2020
Michelle Bateman	Chief nurse/director of quality	1 April 2019 to 31 March 2020
Tim Broadley	Director of strategy	1 April 2019 to 31 March 2020
Melanie Curd	Associate director of corporate governance	2 September 2019 to 31 March 2020
William Jones	Chief operating officer	1 April 2019 to 31 March 2020
Rick Meredith	Medical director	1 April 2019 to 31 May 2019
Ben Pearson	Medical director	3 June 2019 to 31 March 2020
Amanda Rawlings	Director of people services and organisational effectiveness	1 April 2019 28 February 2020
Paul Renshaw	Interim director of people services and organisational effectiveness	9 March 2020 to 31 March 2020
Chris Sands	Director of finance and strategy/deputy chief executive	1 April 2019 to 31 March 2020

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

In addition the non-voting members of the Board are : Jim Austin (chief information and transformation officer), Tim Broadley (director of strategy), Melanie Curd (associate director of corporate governance) and an associate non-executive director, Richard Harcourt.

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

Members and governors are actively encouraged to attend the 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, 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 2019/20 the Council of Governors met six times:

- Wednesday 8 May 2019
- Wednesday 10 July 2019
- Wednesday 11 September 2019
- Wednesday 13 November 2019
- Wednesday 8 January 2020
- Wednesday 11 March 2020.

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 2019 to 31 March 2020, 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	3/3
Paul Gibbons		1 November 2017	31 October 2019	3/3
Paul Mason		1 November 2016 (first term) 1 November 2019	31 October 2022	5/6
Janine McKnight		1 November 2019	31 October 2022	1/3
Kevin Miller		1 November 2017	31 October 2020	3/6
Terence Watson		1 November 2017	31 October 2020	6/6
Sarah Naylor		1 November 2019	31 October 2022	2/2
Janet Hitchenor	Bolsover, Chesterfield & North East Derbyshire	1 November 2016	31 October 2019	0/3
Julian Miller		1 November 2016 (first term) 1 November 2017 (second term)	31 October 2020	3/6
Claire McCann		1 November 2019	31 October 2022	3/3
Julia Ward		1 November 2017	31 October 2020	0/6
Lynn Walshaw		1 April 2018	31 October 2020	4/6
Jacqueline		1 April 2018	31 October	1/3

Healy			2019	
Ann Button	Derbyshire Dales & High Peak	1 November 2016 (first term) 1 November 2019 (second term)	31 October 2022	6/6
Andrea Cooke		1 November 2014 (first term) 1 November 2016 (second term)	31 October 2019	3/3
Stephen Dawes		1 November 2019	31 October 2022	3/3
John Dick		1 November 2017	31 October 2020	6/6
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	5/6
Ian Beck		24 May 2019 (first term) 1 November 2019 (second term)	31 October 2020	5/6
David Boddy	Rest of England	1 April 2018	31 October 2020	6/6
Elected staff governor	**Constituency**	**Term of office began**	**Term of office ends**	**Attendance (actual/possible)**
Adele Clements	Nursing	1 November 2019	30 October 2022	1/3
Hannah Edwards	A&C & managers	1 November 2017	31 October 2020	2/6
Jo Stanhope	A&C & managers	1 August 2019	31 October 2020	3/4
Mandy Grogan	Nursing	1 November 2019	31 October 2020	3/3
Wendy Hodgkinson	Healthcare Support Facilities and Estate Staff	1 November 2016 (first term) 1 November 2019 (second term)	31 October 2022	5/6
Jennifer Kirk	Healthcare	1 April 2018	31 October	0/6

	support staff		2020	
Karon Mather	Healthcare Support Facilities and Estate Staff	1 November 2019	31 October 2020	1/3
Clare Rowland	Healthcare Support Facilities and Estate Staff	1 November 2019	31 October 2020	2/3
Veronica Hunting-Young	Nursing	12 March 2015 (first term) 1 November 2016 (second term)	31 October 2019	2/3
Lynne Bakewell	Other registered professionals	1 November 2016 (first term) 1 November 2019 (second term)	31 October 2022	5/6
Sara Nash	Other registered professionals	1 November 2014 (first term) 1 November 2017 (second term)	31 October 2020	4/6
Alex Carberry	Dental and medical	1 April 2018	31 October 2020	3/6

The following governors resigned from their post during 2019/20:

Elected public governor	Constituency	Term of office began	Term of office ends	Attendance (actual/possible)
Julian Miller	Bolsover, Chesterfield & North East Derbyshire	1 November 2016 (first term) 1 November 2017 (second term)	24 October 2019	3/3
Janine McKnight	Amber Valley, Erewash & South Derbyshire	1 November 2019	30 October 2022	1/3
Julia Ward	Bolsover, Chesterfield & North East Derbyshire	1 November 2017	31 October 2020	0/6

Elected staff governor	Constituency	Term of office began	Term of office Ends	Attendance (actual/possible)
Jennifer Kirk	Facilities and estates and healthcare support staff	1 April 2018	31 July 2019	0/1
Hannah Edwards	Admin, clerical and managers	1 November 2017	31 July 2019	2/2
Nominated governor	**Constituency**	**Term of office began**	**Term of office ends**	**Attendance (actual/possible)**
Katherine Bagshaw	Derbyshire Clinical Commissioning Group	2 October 2018	15 April 2019	1/2

One nominated governor seat became vacate following resignation. The relevant organisation appointed the following replacement:

Nominated governor	Constituency	Term of office began	Term of office ends	Attendance (actual/possible)
Emma Pizzey	Derbyshire Clinical Commissioning Group	29 July 2019	28 July 2022	1/3
Paula Holt	University of Derby	10 May 2019	9 May 2022	3/5

Governor elections

In 2019 we held governor elections for nine public and eight staff governor. UK Engage were the electoral agents who managed the process. The ballot stage of the election process closed on Monday 30 September 2019 and results were declared on Tuesday 1 October 2019.

Constituency	Number of seats vacant	Number of seats filled
Amber Valley, Erewash and South Derbyshire	3	3
Bolsover, Chesterfield and North East Derbyshire	3	1
Derbyshire Dales and High Peak	2	2
City of Derby	1	1
Facilities, estates and	3	3

healthcare support staff		
Nursing	3	3
Other registered professionals	1	1
Administrative, clerical and managers	1	1
Total	17	15

There were 24 candidates who stood for election and as a result 15 vacant seats were successfully filled.

We received the same number of nominations for the number of seats within healthcare support, facilities and estates and therefore the three governors were elected uncontested.

The Bolsover, Chesterfield and North Derbyshire constituency had three vacancies and one nomination was received. Therefore one appointment was uncontested and it was agreed to hold the remaining two vacancies in this constituency until the 2020 elections.

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, 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.

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 2019/20 the committee oversaw the review of the senior independent job description and also supported the appointment of Kaye Burnett as senior independent director.

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

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

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

Governor training and development activities in 2019/20

- 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 2019 – March 2020**
Prem Singh (chairman)	5/6
Tracy Allen (chief executive)	3/6
Kaye Burnett (non-executive director)	2/6
Kirsteen Farrar (associate director of corporate governance)	1/2
Melanie Curd (associate director of corporate governance)	4/4
Kay Fawcett (non-executive director)	2/6
Richard Harcourt (associate non-executive director)	4/6
Joy Hollister (non-executive director)	2/6
Julie Houlder (non-executive director)	3/6
William Jones (chief operating officer)	5/6
Ian Lichfield (non-executive director)	3/6
Ben Pearson (medical director)	3/5

Amanda Rawlings (director of people services and organisational effectiveness)	2/5
James Reilly (non-executive director)	1/6
Chris Sands (director of finance and strategy/deputy chief executive)	6/6
Michelle Bateman (chief nurse/director of quality)	5/6

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 2019	May 2019	June 2019	July 2019	September 2019	October 2019	November 2019	December 2019	January 2020	February 2020	March 2020
Prem Singh	Chairman	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tracy Allen	Chief executive	✓	x	x	✓	✓	✓	✓	✓	✓	✓	✓
Kaye Burnett	Non-executive director	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	✓
Kirsteen Farrar	Associate director of corporate governance	✓	✓	✓	✓							
Melanie Curd	Associate director or corporate governance					✓	✓	✓	✓	✓	✓	✓
Kay Fawcett	Non-executive director	✓	✓	✓	x	✓	✓	✓	✓	✓	✓	✓
Richard Harcourt	Associate non-executive	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

		April 2019	May 2019	June 2019	July 2019	September 2019	October 2019	November 2019	December 2019	January 2020	February 2020	March 2020
	director											
Joy Hollister	Non-executive director	✓	x	✓	✓	✓	✓	✓	x	✓	✓	✓
Julie Houlder	Non-executive director	✓	✓	✓	x	✓	✓	✓	x	✓	✓	✓
William Jones	Chief operating officer	✓	✓	✓	✓	x	✓	x	✓	✓	✓	x
Ian Lichfield	Non-executive director	✓	x	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rick Meredith	Medical director	✓	✓									
Ben Pearson	Medical director			✓	✓	✓	✓	✓	x	✓	✓	✓
Amanda Rawlings	Director of people & organisational effectiveness	✓	x	✓	✓	✓	✓	✓	✓	✓	✓	✓
James Reilly	Non-executive director	x	✓	✓	✓	✓	✓	✓	✓	✓	x	x
Chris Sands	Director of finance and strategy/deputy chief executive	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	✓
Michelle Bateman	Director of quality & chief nurse	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Paul Renshaw	Interim Director of People Services and Organisational Effectiveness											✓

Audit and Assurance Committee

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

We have an internal audit function, provided by KPMG, which provides:

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

Recommendations from internal audit reports are tracked by the Audit and Assurance Committee to ensure prompt implementation.

The Audit and Assurance Committee monitors the integrity of the financial statements, and any formal announcements relating to the Trust's financial performance, reviewing significant financial reporting judgements contained in them.

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

Periodically, the Chair and Chief Executive attend the Audit and Assurance Committee to observe the meeting.

Audit and Assurance Committee members attendance		24 April 2019	20 May 2019	22 May 2019	19 July 2019	19 October 2019	24 January 2020
Ian Lichfield	Non-executive director	✓	✓	✓	✓	✓	✓
Kaye Burnett	Non-executive director	x	x	✓			
Julie Houlder	Non-executive director	✓	✓	✓	✓	✓	✓
Kay Fawcett	Non-executive director	✓	✓	x	x	✓	✓

Audit and Assurance Committee other attendees		24 April 2019	20 May 2019	22 May 2019	19 July 2019	19 October 2019	24 January 2020
Cath Benfield	Deputy director of finance	✓	✓	✓	✓	x	✓

Audit and Assurance Committee other attendees		24 April 2019	20 May 2019	22 May 2019	19 July 2019	19 October 2019	24 January 2020
Kirsteen Farrar	Associate director of corporate governance	x	x	x	x		
Melanie Curd	Associate director of corporate governance					✓	✓
Chris Sands	Director of finance and strategy/deputy chief executive	✓	✓	✓	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		20 June 2019	30 July 2019	24 October 2019	8 January 2020	12 February 2020
Prem Singh	Chair, non-executive director	✓	✓	✓	x	✓
Kaye Burnett	Vice chair (chairing)				✓	x
Bernard Thorpe	Public governor - City of Derby	✓	✓	✓	✓	x
Lynne Bakewell	Staff governor – other registered professionals			✓	✓	✓
Lynne Walshaw	Public governor – Bolsover, Chesterfield and North East Derbyshire				x	✓
Julian Miller	Public governor – Bolsover, Chesterfield and North East Derbyshire	✓	✓	✓		
Hannah Edwards	Staff governor – administrative, clerical and managers	✓	✓			

Nominations and Remuneration Committee members attendance		20 June 2019	30 July 2019	24 October 2019	8 January 2020	12 February 2020
Terence Watson	Public governor – Amber Valley, Erewash and South Derbyshire	✓	✓	✓	✓	✓
David Boddy	Public governor – Rest of England	x	✓	x	✓	✓

Nominations and Remuneration Committee other attendees		20 June 2019	30 July 2019	24 October 2019	8 January 2020	12 February 2020
Kirsteen Farrar	Associate director of corporate governance	✓	✓			
Melanie Curd	Associate director of corporate governance		✓	✓	✓	✓
Tracy Allen	Chief executive				✓	
Amanda Rawlings	Director of people services and organisational effectiveness			✓		
Nigel Smith	Non-executive director	x	✓			

Board members – executive directors

Chief executive: Tracy Allen

Tracy Allen was appointed as chief executive on 1 April 2011. She was previously managing director when the services operated as an autonomous provider within NHS Derbyshire County Primary Care Trust. She led the creation of Derbyshire Community Health Services and its establishment as an NHS community trust. She was previously executive director of strategy and service improvement at Sherwood Forest Hospitals NHS Trust, leading strategies which underpinned the organisation's successful authorisation as an NHS foundation trust. Tracy is an ex-NHS management trainee and has a wide range of operational and strategic management experience in NHS organisations.

Chief information and transformation officer - Jim Austin

Jim Austin joined the trust in April 2015, following a year-long induction through the NHS executive fast track programme, attached to Salford Royal NHS Foundation Trust. Prior to joining the NHS, Jim had accumulated 20 years of experience in the private, non-health sector and was, for seven years, the sales and customer service director at the AA. There he was responsible for over 2,500 people, the vast majority of whom were customer facing. During his time at the AA, and previously in the financial services sector and telecommunications, he led and implemented wide-spread change and transformation, to improve customer experience and meet demanding financial constraints. Prior to working in the private sector, Jim was a commissioned officer in the Royal Artillery and served both in the UK and abroad. Jim is the board champion for reservists and the LGBT+ community.

Chief nurse/director of quality: Michelle Bateman

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

Director of strategy – Tim Broadley

Tim has over 36 years NHS experience, the past 20 of which have been in community services in Derbyshire. He has a background in planning, operations, strategy and business development and has worked across all sectors of the NHS and has gained extensive Board experience. He has masters qualifications in health studies and in commercial and contract management with further post graduate qualifications in management, leadership and coaching. He is an active member of the East Midlands coaching database and has a strong interest in team and personal development. Beyond this Tim is committed to system working and to the evolution of sustainable community-based services which build on the legacy of previous initiatives and organisations and which respond to the current needs of the communities we serve.

Associate director of corporate governance: Melanie Curd

Melanie Curd has worked in the NHS for 18 years, the majority of her experience has been within community Trusts. Melanie has held a variety of posts within governance, the most recent being our deputy trust secretary until her appointment

as associate director of corporate governance /trust secretary in September 2019. Melanie has an LLM in health law and a post-graduate qualification in health services management.

Chief operating officer: William Jones

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

Medical director: Dr Ben Pearson

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

Director of people and organisational effectiveness: Amanda Rawlings

From September 2016 Amanda Rawlings held a combined 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 left our trust in February 2020 to become director of people and organisational development of University Hospitals of Derby and Burton.

Interim Director of People Services and Organisational Effectiveness: Paul Renshaw

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

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

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

Board members – non-executive directors

Chairman - Prem Singh

Prem has been Chairman of Derbyshire Community Health Services NHS Foundation Trust since Dec 2013 and runs his own consultancy business.

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

Prem has developed extensive networks and a national reputation, he is currently the senior independent trustee of the NHS Confederation Board and an invited member of the Chairs Advisory Group of 25 chairs nationally hosted by the Chair of NHS Improvement. He was previously appointed to take the lead on inclusive leadership on the National Leadership Council and named, in the inaugural HSJ listing, as a (Top 50) BME pioneer. He is a highly experienced leadership mentor and an ILM 7 qualified executive coach. Originally from Malaysia, he is very proud to have been part of the NHS's journey over the past 4 decades.

Non-executive director: Kaye Burnett

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

Non-executive director: Kay Fawcett OBE

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

Associate non-executive director: Richard Harcourt

Richard Harcourt is a former Derby-based Rolls-Royce director who joined us as an associate non-executive director in September 2018. He retired from Rolls-Royce in July 2018 after 20 years with the company, latterly as director of group operations. Richard served in executive roles at Rolls-Royce for 10 years and spent the previous decade in senior management roles at the company, including four years in Canada. He is an authority on "lean" processes and principles which support continuous improvements in systems and the development of high performance teams.

Non-executive director: Joy Hollister

Joy Hollister was the strategic director of adult care and public health at Derbyshire County Council for three years until her retirement from the council in July 2018. While at the council, she chaired the Place Board for Derbyshire's Sustainability and Transformation Partnership, the strategic body pushing forward on making health and social care services more seamless and integrated across the county. A social

worker by background, Joy held senior roles in social care, public health, adult and children's services in London, East Sussex and the East Midlands before returning to Derbyshire in 2015. She worked at executive level for 14 years including at the City of London Corporation and the London Borough of Havering. In March 2019 Joy started as the independent chair of Nottingham City Safeguarding Adults Board.

Non-executive director: Julie Houlder

Julie Houlder is a former West Midlands Centro executive who joined us on 1 October 2018. She brings a unique mix of analytical and soft skills, as a qualified accountant and also a personal development coach with her own consultancy and qualifications in psychological coaching, stress management and NLP (Neuro Linguistic) training. Julie worked at Centro for 32 years in increasingly senior financial positions, serving as head of business management and chief audit executive 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: Ian Lichfield

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

Non-executive director: James Reilly

James Reilly was chief executive of Central London Community Healthcare NHS Trust, the largest community healthcare organisation in London, from 2011 until his retirement in February 2016. He spent 27 years in local government roles, 10 of these serving as an executive director with responsibilities for social services, council housing, community safety and regeneration. He is an active associate of the Association of Directors of Adult Social Services. James currently serves as a trustee of Methodist Homes for the Aged. He is the independent chair for the Adult

Safeguarding Partnership Boards in the London Boroughs of Camden and Islington. He also chairs the Independent Safeguarding Commission of the British Jesuit Province (an order of Catholic Priests).

Evaluation

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

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

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

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

Name	Role	Appointment date	Expiry date
Prem Singh	Chairman	1 December 2013	30 November 2017 20 January 2017 given extension to **30 November 2020** (with effect from 1 December 2017) Extension given to **30 November 2021** (with effect from 1 December 2020)
Ian Lichfield	Non-executive director	1 April 2015	31 March 2018 1/3/17 second term of office agreed to **31 March 2021**
Kaye Burnett	Non-executive director	1 August 2016	31 July 2019 Extension given to **31 July 2022** on 20 June 2019
James Reilly	Non-executive	1 December 2016	30 November 2019 Extension given to **30**

	director		**November 2022** on 20 June 2019
Kay Fawcett	Non-executive director	1 October 2018	30 September 2021
Julie Houlder	Non-executive director	1 October 2018	30 September 2021
Joy Hollister	Non-executive director	1 October 2018	30 September 2021
Richard Harcourt	Associate non-executive director	1 September 2018	31 August 2019 Extension given until **31 August 2020** on 20 June 2019

Our membership

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

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

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

During 2019/20 we were not engaged in any specific recruitment targets on our membership numbers, having previously reached the target of membership numbers above 1% of the population we serve in Derbyshire.

The population we serve is just over one million across Derby City and Derbyshire (1,059,996 https://observatory.derbyshire.gov.uk/population-estimates/) and our membership remains above the 1% target, with 11,067 public members and 4,300 staff members, as at 31 March 2020.

During 2019/20 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 monitors 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 monitors the level and effectiveness of member engagement via its established sub-committee reporting structure and 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 2019/20

Our membership stands at 15,367 members, comprising 11,067 public members and 4,300 staff members* (figures accurate on 31 March 2020). See below for a breakdown of constituencies in both public and staff membership and an illustration of constituency boundaries.

Membership profile by constituency (March 2020)

Public	
Amber Valley, Erewash and South Derbyshire	2,898
Bolsover, Chesterfield and North East Derbyshire	2,469
City of Derby	2,043
Derbyshire Dales and High Peak	1,223
Rest of England	2,434
Total	**11,067**
Staff	
Medical and dental	81
Nursing	1,320

Other registered professionals	701
Administrative, clerical and managers	850
Healthcare support staff	53
Facilities and estates	1,295
Total	**4,300**

*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.

Tracy Allen
Chief Executive **10 June 2020**

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. Email: dchst.members@nhs.net

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

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

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

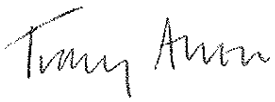
In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care's Group Accounting Manual and in particular to:

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

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

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



Tracy Allen
Chief Executive **10 June 2020**

ANNUAL GOVERNANCE STATEMENT 1st APRIL 2019 – 31st MARCH 2020

ORGANISATION NAME: 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 DCHS' approach to risk management including the processes, roles and responsibilities which underpin it.

3.2 The Trust has an effective Board, with an appropriate balance of skills and experience and with constructive challenge from the Non-Executive Directors.

There is an induction and development programme in place for Board members 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 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 and Quality 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)
- Primary Care Networks
- Local Health Providers
- Local Authorities (LAs)
- Improvement and Scrutiny Committee (ISC)
- Health and Wellbeing Boards
- Joined Up Care Derbyshire
- Care Quality Commission (CQC)
- NHS England
- 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. This related to a review of staff communications which identified a disparity between the composition of the staff list on the Electronic Staff Record (ESR) and the Subscribers list used by communications to send emails to Trust employees. The Communications team are completing a business case to procure a new mailing system which is compatible with ESR.

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 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.

4.18 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 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.

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

4.20 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

4.21 The Trust has a Raising Concerns Policy in place. The policy sets out how concerns will be investigated, with regular updates provided through to the Audit and Assurance Committee and Board. The Trust has appointed a Freedom to Speak Up Guardian who staff can contact directly with any concerns.

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

4.23 *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.*

4.24 *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.*

4.25 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.

4.26 *The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission.*

4.27 The Trust has published on its website an up to date register of interests, including gifts and hospitality, for decision making staff (as defined by the

Trust with reference to the guidance) within the past 12 months, as required by the "Managing Conflicts of Interest in the NHS" guidance

4.28 For the financial year 2019/20, PwC are the Trust's external auditors and KPMG are the internal auditors and providers of Counter Fraud services.

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

4.30 There have been 2 serious clinical incidents in year that were classed as a Never Event.

The first in June 2019 related to a patient receiving dental restoration under inhalation sedation and local anaesthetic which was completed without apparent event. Following the procedure, the dental nurse noticed that the back of the "slow hand piece" was missing. An investigation showed that a small piece of the equipment (approx. 5mm) had been swallowed. No patient harm was caused. A full root cause analysis of this incident has been completed, and lessons learnt. Duty of candour was followed.

The second was in August 2019. A patient had nail surgery undertaken under local anaesthetic on both great toes. The agreed plan on record was to remove nail sections and phenolise the nail bed of the fibular sulcus of both great toes. The patient actually had nail sections removed from both tibial and fibular sulcus areas of both big toe nails. The patient had sections of nail removed from both sides but this was not agreed the agreed surgical plan as indicated in the patient record. No patient harm was caused. A full root cause analysis of this incident has been completed, and lessons learnt. Duty of candour was followed.

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

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

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

5.3 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 no data security breaches at Level 2, which required reporting to the Information Commissioner.

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

7 Data Quality and Governance

7.1 The Trust has assigned the Chief Information Officer as the Board Director responsible for data quality and governance

7.2 The Trust receives assurance on data quality through the data quality kitemark to indicate the robustness of service and organisational data. The kitemark assesses service line data against the following six categories before an overall score is provided: audit, timeliness, sign off, relevance,

completeness and source. External assessment of data quality is via performance metrics against national quality standards.

7.3 To ensure that there are appropriate controls in place to ensure the accuracy of data, the Trust has a data quality improvement plan in place. Key indicators, such as elective waiting time data, are reviewed through management and audit resource. Progress with improving data quality is reported through the Informatics Strategy Group and then through to the Audit and Assurance Committee.

8. Review of effectiveness

8.1 *As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn upon performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, audit and assurance committee,* quality service committee, quality people committee and quality business committee *and a plan to address weaknesses and ensure continuous improvement of the system is in place.*

8.2 Executive Directors within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by major sources of assurance detailed below.

8.3 I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board of Directors, the Audit and Assurance Committee, the Quality Service Committee, the Quality People Committee and the Quality Business Committee. A plan to address weaknesses and ensure continuous improvement of the system is in place.

8.4 The processes that have been applied in maintaining and reviewing the effectiveness of the system of internal control include the roles of the following:

- The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. The Head of Internal Audit Opinion for 1st April 2019 to 31st March 2020 is as follows: **Significant assurance with minor improvement opportunities can be given on the adequacy and effectiveness of the Trust's framework of governance, risk management and control**

- The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its strategic objectives have been reviewed.
- The Care Quality Commission (CQC) inspection of our services in July 2019, which resulted in an overall rating of "Outstanding", and their rating of "Outstanding " for Well Led, provides me with assurance over our clinical and corporate governance systems and quality of care of the services provided
- An independent review of leadership and governance across the Trust by Deloitte in 2018/19, using the Well Led Framework, provides me with assurance that it is effective. In particular, Deloitte noted the following areas of good practice, which were also noted in the CQC review in July 2019:
    - Strongly embedded vision and values
    - A highly respected Executive Team
    - Positive culture
    - Focus on assurance and risk management
- 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
- 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 Audit and Assurance Committee provide me with assurance that the trust met the requirements of its License conditions

- Our Staff Survey results provides me with assurance that our staff feel supported and involved in the work of the Trust, and triangulates with the findings of the Care Quality Commission Well Led Review earlier in the year.
- The Audit and Assurance Committee provides the Board with an independent and objective view of arrangements for internal control within the Trust and to ensure the Internal Audit service complies with mandatory auditing standards, including the review of all fundamental financial systems.
- The Trust undertook an internal audit against the information governance toolkit, which provided evidence to support the Trust's view that it was compliant with the standards. The Trust continues to take action to ensure the standards of information governance are improved further in line with best practice.

- The Board of Directors has identified the strategic risks facing the organisation during the period and has monitored the controls in place and the assurances available to ensure that these risks are being appropriately managed.

9. Significant Control Issues

9.1 During the year, there have been no significant control issues from business as usual.

9.2 However, in March 2020, the Trust enacted its business continuity plan with other partners to respond to the Covid 19 Pandemic. This event has caused the Trust to change its normal operational arrangements. The pandemic has required the Trust to redirect resources to focus upon critical services to support the health and social care system response.

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

10. Conclusion

10.1 My review confirms that Derbyshire Community Health Services NHS Foundation Trust has a generally sound system of risk management and internal control that supports the achievement of its policies, aims and objectives.

10.2 The Trust will continue to use the assurance framework to assure the Board of Directors and others that the Trust's key controls to manage strategic risks are being assessed and continuously improved Where areas of concern are identified, action plans have been put in place to close the gap in control or assurance.

Signed (on behalf of the *Board of Directors)*

Chief Executive

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 ("the Trust") financial statements (the "financial statements"):

- give a true and fair view of the state of the Trust's affairs as at 31 March 2020 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 2019/20.

We have audited the financial statements, included within the Annual Report and Accounts 2019/20 (the "Annual Report"), which comprise: the Statement of Financial Position as at 31 March 2020; the Statement of Comprehensive Income for the year then ended; the table of adjusted financial performance (control total basis); the Statement of Changes in Equity for the year ended 31 March 2020; the Statement of Cash Flows 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 predominantly funded by local Clinical Commissioning Groups ("CCGs") and NHS England.

Our audit for the year ended 31 March 2020 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 the impact of the COVID-19 pandemic. Additional associated risks identified relating to expenditure classification and cut-off as a result of the pandemic, resulted in the inclusion of COVID-19 as a key audit matter.

Our audit also involved forming a conclusion on the arrangements for securing economy, efficiency and effectiveness in the use of resources (the "3 Es"), in accordance with the Code of Audit Practice.

Overview

- Overall materiality: £3.783 million (2019: £3.792 million) which represents 2 % of total revenue (operating income from patient care activities plus other operating income).
- 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 Trust was subject to a full audit scope. All work was performed by a single audit team who assessed the risk of material misstatement, taking into account the nature, likelihood and potential magnitude of any misstatement and determined the extent of testing required over each balance in the financial statements.

Our key audit matters were:

- Risk of fraud in the recognition of revenue and expenditure;
- Valuation of property, plant and equipment; and
- Impact of the COVID-19 pandemic.

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 the conclusion on the arrangements for securing economy, efficiency, and effectiveness in the use of resources, 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 focussed on this area because there is a heightened risk as: • The Trust reported exceeding its control total of a £3.878 million surplus with an outturn of a £4.034	We read the accounting policies for revenue and expenditure recognition and found them to be consistent with the requirements of the Department of Health and Social Care Group Accounting Manual 2019/20 and IFRS 15. We noted no issues in this respect. **Income from Activities** For a sample of healthcare income, we 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 that were signed by the relevant counterparty and the Trust. No issues were

million surplus (before additional Provider Sustainability Funding). Given the pressure to deliver the control total there is an incentive to increase reported income. Elements of income which may be subject to manipulation are healthcare income derived from cost and volume contracts and year-end agreements for under/over performance on block contracts.

- There is an incentive not to recognise expenditure in 2019/20 relating to the current year, to improve the financial result. Expenditure relating to judgemental estimates, including provisions and accruals could be under-estimated in order to improve reported performance.

Given these incentives, we focussed our work on the elements of income and expenditure that are most susceptible to manipulation, being:

- healthcare income derived from cost and volume contracts and year-end healthcare income settlements with commissioners;
- items of expenditure where the value is dependent upon estimates, in particular the completeness of provisions and accruals; and
- non-standard journal transactions; and unrecorded expenditure and liabilities.

identified from the work performed.

We used the Agreement of Balances report provided by NHS Improvement to auditors to identify any differences between the Trust's income, expenditure, receivables and payables balances, and those reported by other NHS organisations. We investigated all disputed amounts over £0.3 million and checked that the Trust's position agreed to underlying audited accounting records. We read correspondence with the counterparties, and then considered the impact, if any, that the remaining disputed amounts would have on the Trust's financial statements and determined that there was no material impact.

We tested a sample of remaining clinical income and other income by tracing the transaction to invoices or other correspondence and cash receipt (if not received, we agreed these to the trade receivables ledger). We used our knowledge and experience in the sector to determine whether revenue was recognised in the correct period. Items of other revenue included education and training, Provider Sustainability Funding and CCG pass through costs.

We tested a sample of income transactions recognised around year end (March and April 2020) and confirmed that income 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.

No issues were identified from the work performed.

Provisions

We obtained an understanding of the movement for each category of expenditure provision and performed testing by agreeing a sample to supporting evidence, confirming the accuracy of the provision calculations and that the Trust had a constructive obligation at 31 March 2020. We considered the completeness of provisions by testing cash payments made after the year end and assessing the completeness of lower value provisions.

No issues were identified from the work performed.

Expenditure Accruals

We targeted a sample of the highest value accruals which related to holiday pay, pharmacy costs and travel expenses and agreed these to the supporting evidence available. 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.

To assess the completeness of accruals, we considered a sample of current year accruals compared to prior year accruals to determine if any balances had been omitted.

We performed an analysis of non-pay expenditure throughout the year and post year-end in order to identify any inconsistencies in trends which could indicate an understatement in 2019/20. In addition, we tested a sample of non-pay expenditure transactions recognised post year end to ensure they had been recognised in the correct period.

No issues were identified from the work performed.

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
- 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 notes 14-16 for further information.

We focussed on this area because Property, Plant and Equipment (PPE) represents the largest asset balance 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 PPE were appropriate and correctly applied.

Following a full revaluation of PPE undertaken in 2017/18, in 2018/19 and 2019/20 the Trust has applied indices as the basis of updating the valuation of its land and buildings.

In 2019/20, the Trust has also engaged an external expert to provide a revised 2017/18 valuation for a new Buxton asset which incorporates services provided by Buxton Health Centre, acquired in 2018/19.

Our specific areas of focus were:

- the accuracy and completeness of detailed information on assets used as the input data for each valuation;
- the appropriateness of the Trust's assumptions underlying the classification of properties;
- the basis of revaluation, assumptions and underlying data; and
- the accounting transactions resulting from this valuation, and whether they were accurately recorded in the financial statements.

We assessed the assumptions and the estimates used in the valuation and considered the reasonableness of these using our valuation experts. We have also considered the professional capabilities of the Trust's external valuer who provided the indices for the Trust to apply.

We 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 inspected the repairs and maintenance expense codes to confirm that there had been no significant alterations to the existing value and use of assets, and to address the risk that capital expenditure had not been misclassified as repairs and maintenance spend.

No issues were identified from the work performed.

The indices used by the Trust are designed to be applied to either residential or commercial buildings, rather than premises used for healthcare. Where the distinction between industrial and residential properties was unclear, the Trust chose to apply an average of these indices. We requested that the Trust include additional disclosure in note 1 in the financial statements in respect of this judgement.

We identified that the indices had been applied to the depreciated replacement cost of the building assets, a simplistic method of valuation, rather than being applied to the gross replacement cost and then adjusted for the remaining useful life and asset condition to arrive at the current year depreciated replacement costs. Our valuation experts estimated an alternative percentage increase should have been applied to the Trust's valuation of its land and buildings, had the indices been applied correctly. This estimated increase would not materially impact on the valuation of land and buildings, and the Trust chose not to adjust its valuation to reflect the estimated increase that should have been applied.

We held meetings with the Trust's valuer to understand the potential impact of the COVID-19 pandemic on the Trust's valuation. Our own valuation expert was also in attendance at this meeting. Due to the uncertainty created by the COVID-19 pandemic regarding the valuation of the Trust's land and buildings, the Trust has disclosed a material uncertainty on property valuation in note 1 of its financial statements and we agree with this view. This explains that there is material valuation uncertainty in relation to the valuation of properties of included in the Statement of Financial Position as at 31

	March 2020. The Trust's valuers engaged by management have included a material valuation uncertainty clause in their report. This clause highlights that less certainty, and consequently a higher degree of caution, should be attached to the valuation as a result of the COVID-19 pandemic.
COVID-19 – Trust and 3 Es During the course of the audit, both management and the audit team considered the impact that the ongoing COVID-19 pandemic has had on the activities, suppliers and wider economy of the Trust and its financial statements. Management's assessment is that the impact on 2019/20 outturn was not significant, as operations only significantly changed in scope during the last three weeks of the financial year 2019/20. ***The Trust received financial support from NHS Improvement in relation to additional COVID-19 costs incurred during 2019/20.*** ***Due to the significance of the pandemic, the financial statements have recognised the impact as a significant narrative disclosure and a non-adjusting post balance sheet event in the financial statements.*** As a result of this, we determined that the impact of COVID-19 should be a key audit matter.	We performed the following procedures to address the impact that the COVID-19 pandemic had on the financial statements: • Performed additional sample testing of non-pay expenditure transactions posted after 31 March 2020 to address the heightened risk that transactions may have been posted to the wrong period. • Performed sample testing on items recognised as COVID-19 related costs to ensure the classification as reimbursable, was appropriate. • Evaluated and challenged management's assessment of the COVID-19 pandemic impact on valuations, going concern and value for money. • Assessed that disclosures on going concern, material valuation uncertainty and post balance sheet events made by management in the financial statements appropriately address the impact of COVID-19. • Held regular discussions with the Director of Finance & Strategy and the Deputy Director of Finance to understand the impact of the COVID-19 pandemic on the financial governance of the Trust. We concluded that management's assessment of the impact of the COVID-19 pandemic on the financial statements and the arrangements for securing economy, efficiency and effectiveness in its use of resources was reasonable as disclosed on page 110 of the Annual Report.
Financial sustainability, delivery of cost savings and agency spend - 3 Es The Trust's has recognised a risk on its Board Assurance Framework in respect of the financial stability of the organisation and its ability to deliver against future Sustainable Quality Improvement Programmes (SQIP) over the next two years. In previous years, the Trust's has performed well in delivering its cost savings plans, but the health economy faces ongoing financial challenge, and the deteriorating financial health of other NHS bodies in Derbyshire could impact the Trust's future contractual obligations, including service cuts. The Trust also recognised early in 2019/20 that it was likely to exceed its agency staff spend ceiling of £1.36m. With the added challenge of delivering the conditions to secure access to Provider Sustainability Funding from the Department of Health and Social Care, this was an area of focus for our audit in relation to our conclusion on economy, efficiency and effectiveness.	In response to the identified risk, the following specific procedures were performed: • Understood the 2019/20 financial outturn position and the Trust's performance against its 2019/20 cost savings target; • Read the Trust's 2020/21 budget and SQIP plans. • Understood the Trust's medium-term financial strategy and the sensitivities around this. • Understood the wider Derbyshire healthcare environment and the current commitments which the Trust has made to support the 'Joined Up Care' initiative. • Understood the underlying causes of increased agency staff usage and reviewed plans to reduce dependency on agency employees. • Tested the completeness of agency costs by analysing monthly trends and testing other categories of non-pay expenditure to ensure appropriate classification. Based on our risk assessment and work performed, we have summarised the following outcomes from our Value for Money assessment: • The Trust is in a relatively strong financial position given it has exceeded its control total in 2019/20 and has reported a

surplus. The Trust has also exceeded its planned cost savings target in 2019/20, although there is an over-reliance on non-recurrent schemes compared with the budgeted position.

- The latest CQC inspection of services in July 2019, resulted in an overall rating of 'Outstanding', and a rating of 'Outstanding' for Well Led.
- The NHS Improvement's Single Oversight Framework has continually rated the Trust in the highest category as '1' in all areas.
- The Trust's outturn on agency expenditure was above the ceiling cap, however, this was less than 50% above this threshold and therefore had no impact on the Trust's Use of Resource score of 1.
- From our audit work performed, we have not identified any significant impact of the COVID-19 pandemic on the Trust's financial governance relating to the 2019/20 financial year. Additional COVID-19 costs incurred by the Trust in 2019/20 were also immaterial.
- The outlook for 2020/21 has become more uncertain as a result of the COVID-19 pandemic. The Trust produced an updated financial plan which takes into account the key circumstances arising from the pandemic and forecasts a continued surplus with sufficient cash resources.
- Whilst the Derbyshire healthcare environment remains financially challenging, and funding plans for 2020/21 are unclear as 2020/21 income contracts are not yet signed, the Trust anticipates block funding arrangements will continue to be received up until October 2020. Further guidance on the impact to potential risk sharing agreements is expected in the coming months.

We determined that there were no further key audit matters to communicate in our report relating to the financial statements of the Trust or the Trust's arrangements for securing economy, efficiency, and effectiveness in its use of resources.

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 financial statements. Books and records for the Trust are retained by the finance team based at Walton Hospital. We focused our work on the key audit matters described above. We performed our audit of the financial information from Walton Hospital and remotely as a result of the COVID-19 pandemic.

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	£3.783 million (2019: £3.792 million)
How we determined it	2% of total revenue (operating income from patient care activities plus other operating income) (2019: 2% of total revenue)
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 £189,000 (2019: £190,000) as well as misstatements below that amount that, in our view, warranted reporting for qualitative reasons.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which ISAs (UK) require us to report to you, where:

- 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.

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.

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 2019/20 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 2020 is consistent with the financial statements and has been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2019/20.

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 2019/20.

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 28, the directors are responsible for the preparation of the financial statements in accordance with the Department of Health and Social Care Group Accounting Manual 2019/20, 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 on our 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 2020. Key audit matters relating to this reporting requirement are set out in the Key audit matters table above and identified as relating to the 3 Es conclusion.

We determined that there were 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 78, 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 76, 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 2019/20 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
East Midlands
16 June 2020

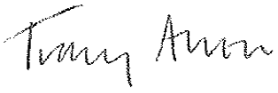
Derbyshire Community Health Services NHS Foundation Trust

Annual accounts for the year ended 31 March 2020

Foreword to the accounts

Derbyshire Community Health Services NHS Foundation Trust

These accounts, for the year ended 31 March 2020, 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 

Name **Tracy Allen**
Job title **Chief Executive**
Date **10 June 2020**

DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

Statement of Comprehensive Income

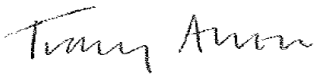
	Note	2019/20 £000	2018/19 £000
Operating income from patient care activities	3	176,837	173,444
Other operating income	4	18,961	19,770
Operating expenses	6, 8	(190,470)	(184,633)
Operating surplus from continuing operations		**5,328**	**8,581**
Finance income	11	270	190
PDC dividends payable		(2,067)	(2,075)
Net finance costs		**(1,797)**	**(1,885)**
Other gains / (losses)	12	(346)	141
Surplus for the year from continuing operations		**3,310**	**6,837**
Surplus for the year		**3,310**	**6,837**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(197)	(741)
Revaluations	16	459	(170)
Total comprehensive income for the period		**3,572**	**5,926**
Adjusted financial performance (control total basis):			
Surplus for the period		3,310	6,837
Remove net impairments not scoring to the Departmental expenditure limit		990	(706)
Remove (gains) / losses on transfers by absorption		(125)	0
Remove I&E impact of capital grants and donations		(141)	44
Adjusted financial performance surplus		**4,034**	**6,175**
Control total		3,878	4,072
Overperformance against control total		156	2,103

DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

Statement of Financial Position

	Note	31 March 2020 £000	31 March 2019 £000
Non-current assets			
Intangible assets	13	1,811	1,920
Property, plant and equipment	14	77,478	76,199
Receivables	17	191	170
Total non-current assets		**79,480**	**78,289**
Current assets			
Receivables	17	8,475	11,044
Cash and cash equivalents	19	35,154	30,799
Total current assets		**43,629**	**41,843**
Current liabilities			
Trade and other payables	20	(15,349)	(15,644)
Provisions	22	(984)	(1,518)
Other liabilities	21	(168)	(154)
Total current liabilities		**(16,501)**	**(17,316)**
Total assets less current liabilities		**106,608**	**102,816**
Non-current liabilities			
Provisions	22	(30)	(30)
Total non-current liabilities		**(30)**	**(30)**
Total assets employed		**106,578**	**102,786**
Financed by			
Public dividend capital		1,597	1,377
Revaluation reserve		28,206	28,065
Income and expenditure reserve		76,775	73,344
Total taxpayers' equity		**106,578**	**102,786**

The notes on pages 6 to 43 form part of these accounts.



Signed
Name **Tracy Allen**
Position **Chief Executive**
Date **10 June 2020**

DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

Statement of Changes in Equity for the year ended 31 March 2020

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

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' and others' 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 retained earnings on disposal of assets	-	(52)	52	**-**
Public dividend capital received	464	-	-	**464**
Taxpayers' and others' equity at 31 March 2019	**1,377**	**28,065**	**73,344**	**102,786**

DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

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 and Social Care as the public dividend capital dividend.

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

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

DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

Statement of Cash Flows

	Note	2019/20 £000	2018/19 £000
Cash flows from operating activities			
Operating surplus		5,328	8,581
Non-cash income and expense:			
Depreciation and amortisation	6.1	3,685	3,840
Net impairments	7	1,879	(706)
Income recognised in respect of capital donations	4	(263)	(76)
(Increase) / decrease in receivables and other assets		2,446	(1,005)
Increase in payables and other liabilities		307	237
Increase / (decrease) in provisions		(534)	653
Other movements in operating cash flows		1	5
Net cash flows from operating activities		**12,849**	**11,529**
Cash flows from investing activities			
Interest received		270	190
Purchase of intangible assets		(466)	(269)
Purchase of PPE and investment property		(6,839)	(6,652)
Sales of PPE and investment property		23	520
Receipt of cash donations to purchase assets		372	-
Net cash flows (used in) investing activities		**(6,640)**	**(6,211)**
Cash flows from financing activities			
Public dividend capital received		220	464
PDC dividend paid		(2,074)	(1,602)
Net cash flows used		**(1,854)**	**(1,138)**
Increase in cash and cash equivalents		**4,355**	**4,180**
Cash and cash equivalents at 1 April - brought forward		**30,799**	**26,619**
Cash and cash equivalents at 31 March	19.1	**35,154**	**30,799**

DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

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 2019/20 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts

Accounting convention

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

Note 1.2 Going concern

The Trust's Annual Report and Accounts have been prepared on a Going Concern basis. International Accounting Standard 1 requires the Board to assess , as part of the accounts preparation, the Trust's ability to continue as a going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than to dissolve the Trust without the transfer of it's services to another entity within the public sector. The Board of Directors has a reasonable expectation that the Trust will have access to sufficient cash resources to continue to support service delivery over the foreseeable future.

Due to the COVID-19 pandemic there have been significant changes to the way NHS providers are being funded in 20/21 for the period April to July 2020 which will impact on the Trust.

The Trust has a track record of successfully delivering its financial plan and ended the 2019/20 financial year with £35m in its bank account. In response to the changing financial landscape, the Board has approved an interim financial plan for 2020/21 which will deliver a surplus of £2.2m with an assumption that all reasonable costs incurred during 2020/21 in responding to the pandemic will be reimbursed. The plan will need to be reviewed once further clarity is given regarding the funding arrangements beyond the initial four month period. These changes to the finance regime in 2020/21 provide the Trust with certainty regarding its income streams for the first part of the financial year and it is expected that block funding arrangements will be in place for the remainder of 2020/21.

The Board of Directors is therefore satisfied and considers it appropriate that the accounts for the year ended 31st March 2020 should be prepared on a Going Concern basis.

Note 1.3 Interests in other entities

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

Charitable Funds

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

Following Treasury's agreement to apply IAS27 to NHS Charities from 1st April 2013, the Trust has established that as the Trust is the corporate Trustee of the linked NHS Charity, The Derbyshire Community Health Services Charitable Trust, it effectively has the power to exercise control so as to obtain economic benefits. However, the transactions are immaterial in the context of the group and 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,

The Trust has no joint arrangements during 2019/20 and 2018/19.

The Trust has no joint arrangements during 2019/20 and 2018/19.

Note 1.4 Revenue from contracts with customers

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

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

Revenue from NHS contracts

The 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.

Provider sustainability fund (PSF) and Financial recovery fund (FRF)

The PSF and FRF enable providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

Note 1.5 Other forms of income

Grants and donations

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

Apprenticeship service income

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

Note 1.5.1 Other income

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

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the 2020/21 and 2021/22

Pension costs

NHS Pension Scheme

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

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

Note 1.7 Expenditure on other goods and services

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

Note 1.8 Discontinued operations

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

DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

Note 1.9 Property, plant and equipment

Note 1.9.1 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.

In January 2019 The Royal Institute of Chartered Surveyors issued guidance clarifying that where a large asset includes a number of components with significantly different asset lives, then these components must be treated as separate assets and depreciated over their own useful lives. The Trust's asset valuation, undertaken as at 31 March 2019, took account of this clarification and has resulted in an decreased depreciation charge of £329k in 2019/20.

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.

Note 1.9.2 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.

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

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

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

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

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.

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' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

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

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

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

Impairments

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

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

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

De-recognition

Non-current assets intended for disposal are reclassified as 'held for sale' if their carrying amount will be recovered principally through a sale transaction rather than through continuing use and 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 i.e.:
- management are committed to a plan to sell the asset,
- an active programme has begun to find a buyer and complete the sale,
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale',
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value (open market value including alternative uses) less costs to sell'. Depreciation ceases to be charged. Assets are derecognised when all material sale contract conditions have been met.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

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 economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

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

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

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	52
Dwellings	-	-
Plant & machinery	5	15
Transport equipment	7	7
Information technology	5	8
Furniture & fittings	5	10

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

Note 1.10 Intangible assets

Recognition

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

Internally generated intangible assets

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

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements

Software

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

Measurement

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

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

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

Amortisation

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

Useful lives of intangible assets

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

	Min life Years	Max life Years
Software licences	5	10

Note 1.11 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 1.12 Financial assets and financial liabilities

Recognition

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

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

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques. Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost

Financial assets and financial liabilities at amortised cost

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

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.
Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).
HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.
Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

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 1.13 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as a lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.
The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

The Trust as a lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2020:

		Nominal rate
Short-term	Up to 5 years	0.51%
Medium-term	After 5 years up to 10 years	0.55%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2020:

	Inflation rate
Year 1	1.90%
Year 2	2.00%
Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.5% in real terms.

Note 1.14.1 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 23.2 but is not recognised in the Trust's accounts.

Note 1.14.2 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 1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed as note where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed as note, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:
• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.16 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated and grant 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 calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.17 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 1.18 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 1.19 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.20 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.

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 1.21 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 1.22 Transfers of functions to / from other NHS bodies / local government bodies

The Trust has not transferred any functions to / from other NBS bodies / local government bodies during 2019/20 and 2018/19.

Note 1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2019/20.

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 2019-20. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2021-22, 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 on1 April 2021, as adapted and interpreted by the FReM.
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.

IFRS 16 Leases

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2021, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate (1.27%). The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2021 for existing finance leases.

For leases commencing in 2021/22, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

HM Treasury revised the implementation date for IFRS16 in the UK public sector to 1 April 2021 on 19th March 2020. Due to the need to reassess lease calculations, together with the uncertainty on expected leasing activity in from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable. However, the trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

Note 1.25 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Accounting for property, plant and equipment

During 2019/20 the Trust applied industry recognised indices (provided by a Chartered Surveyor) to its non current asset base. Indices are applied to land and property using the DRC method of valuation. Indices on land are based on average of estimated movement on industrial (commercial) land values and residential development land index. Indices on the buildings are based on BCIS All-Property Tender Price Index.

A full physical valuation is undertaken when there has been significant expenditure in the year on a particular property to ensure that any impairments are recognised as they are brought into use.

Modern Equivalent Asset Valuation

The Trust undertook a full revaluation of its land and building portfolio as at 31 March 2018, adopting the Modern Equivalent Asset (MEA) methodology. This has resulted in the Trust recognising impairments of £11,927k in the 2017/18 accounts.

In 2019/20, the Trust commissioned the District Valuer to provide a valuation as at 31 March 2018, on a new asset combining the Community Hospitals and the Health Centre in the Buxton locality. This has resulted in the Trust recognising impairments of £973k in the 2019/20 Accounts.

Department of Health guidance specifies that the Trust's land and buildings should be valued on the basis of depreciated replacement costs, applying the Modern MEA concept. The MEA is defined as the "cost of a modern replacement asset that has the same productive capacity as the property being valued". Therefore the MEA is not a valuation of the existing land and buildings that the Trust owns, but a theoretical valuation for accounting purposes.

The Trust is satisfied that the assumptions underpinning the MEA valuation are robust and are based on the Trust's estate strategy. The assumptions allow for the same productive capacity that would enable the Trust to continue to deliver the current range of services. In determining the assumptions to be used for the valuation, the Trust has not opted to exercise the "alternative site" option

Material valuation uncertainty due to Novel Coronavirus (COVID – 19)

The outbreak of the Novel Coronavirus (COVID-19), declared by the World Health Organisation as a “Global Pandemic” on the 11th March 2020, has impacted global financial markets. In the UK, market activity is being impacted in all sectors. The valuation exercise was carried out in March 2020 with a valuation date of 31 March 2020. As at the valuation date, the valuer considered that they attached less weight to previous market evidence for comparison purposes to inform opinions of value. The current response to COVID-19 means that they are faced with an unprecedented set of circumstances on which to base a judgement. Their valuations are therefore reported on the basis of ‘material valuation uncertainty’ per VPGA 10 of the RICS Valuation – Global Standards. Consequently, less certainty and a higher degree of caution should be attached to their valuation than would normally be the case. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust. Given the unknown future impact that COVID-19 might have on the real estate market, they recommended that the Trust keep the valuation of these properties under frequent review.

Consolidation of the associated charity

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

Note 1.26 Key Sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily available from other sources. The estimations and associated assumptions are based on historical experience and any other factors that are considered to be relevant. By the very nature of these estimates, actual results will differ and the Trust continually reviews it's approach to estimation.

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. Due to the COVID pandemic, employees are able to carry forward any remaining annual leave not taken in 19/20 into the next two financial years. This has been factored into the calculation of the accrual provided for in the 19/20 accounts.

Accounting for doubtful debts

A general provision is made for doubtful debts . This is based on 100% for expected loss on non-NHS invoices older than 90 days.

DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

Note 2 Operating Segments

No segmental analysis is shown as the sole activity of Derbyshire Community Health Services NHS Foundation Trust in 2019/20 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 2020/21 dependent upon the information received by the Trust Board.

The Trust has five customers that account for more than 10% of its total revenue derived from providing specialist community services. Customers are defined for this purpose as "Clinical Commissioning Groups and NHS England" and Local Authorities.The total income that the Trust received during the period 1st April 2019 to 31st March 2020 was £177m (2018/19: £173m) for the provision of specialist community services.

DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

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

Note 3.1 Income from patient care activities (by nature)	**2019/20 £000**	**2018/19 £000**
Acute services		
Elective income	2,703	3,906
First outpatient income	1,279	1,973
Follow up outpatient income	2,199	3,385
A & E income	6,552	5,453
Other NHS clinical income	265	337
Mental health services		
Block contract income	16,208	16,769
Community services		
Community services income from CCGs and NHS England	116,241	112,656
Income from other sources (e.g. local authorities)	21,089	21,146
All services		
Agenda for Change pay award central funding*		2,005
Additional pension contribution central funding**	6,051	
Other clinical income	4,252	5,814
Total income from activities	**176,837**	**173,444**

*Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 this funding is incorporated into tariff for individual services.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2019/20 £000**	**2018/19 £000**
NHS England	14,307	6,855
Clinical commissioning groups	140,377	142,651
Department of Health and Social Care	-	2,005
Other NHS providers	94	5
Local authorities	21,152	21,146
Injury cost recovery scheme	384	230
Non NHS: other	523	552
Total income from activities	**176,837**	**173,444**
Of which:		
Related to continuing operations	176,837	173,444
Related to discontinued operations	-	-

DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

Note 4 Other operating income

	2019/20			2018/19		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	80	-	**80**	84	-	**84**
Education and training	1,367	-	**1,367**	1,671	-	**1,671**
Provider sustainability fund (PSF)	2,046		**2,046**	4,065		**4,065**
Receipt of capital grants and donations		263	**263**		76	**76**
Other income*	15,187	18	**15,205**	13,874	-	**13,874**
Total other operating income	**18,680**	**281**	**18,961**	**19,694**	**76**	**19,770**
Of which:						
Related to continuing operations			**18,961**			**19,770**
Related to discontinued operations			**-**			**-**

* Other income

	2019/20	2018/19
	£000	£000
Main items are:		
CCG pass through cost - Dressings	2,554	2,509
People Services - Joint venture income	1,506	1,480
Domestic	1,156	932
SALTS	969	879
CCG pass through cost - Community Pharmacy	856	707

DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2019/20 £000	2018/19 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	154	129
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	4,010	3,857

Note 5.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2020 £000	31 March 2019 £000
within one year	2,629	4,010
after one year, not later than five years	-	-
after five years	-	-
Total revenue allocated to remaining performance obligations	**2,629**	**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 licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2019/20 £000	2018/19 £000
Income from services designated as commissioner requested services		
Income from services not designated as commissioner requested services	176,837	173,444
Total	**176,837**	**173,444**

Note 5.4 Profits and losses on disposal of property, plant and equipment

Loss on disposal is mainly on IT equipment due to the roll out of Windows 10, making the equipment obsolete.

DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

Note 6.1 Operating expenses

	2019/20 £000	2018/19 £000
Purchase of healthcare from NHS and DHSC bodies	6,407	8,657
Purchase of healthcare from non-NHS and non-DHSC bodies	3,086	3,284
Staff and executive directors costs	136,480	128,110
Remuneration of non-executive directors	160	155
Supplies and services - clinical (excluding drugs costs)	9,836	11,432
Supplies and services - general	1,268	1,305
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	2,139	2,178
Consultancy costs	432	267
Establishment	2,185	1,803
Premises	9,209	8,726
Transport (including patient travel)	4,543	4,078
Depreciation on property, plant and equipment	3,110	3,255
Amortisation on intangible assets	575	585
Net impairments	1,879	(706)
Movement in credit loss allowance: contract receivables / contract assets	24	10
Increase/(decrease) in other provisions	(20)	-
Audit fees payable to the external auditor		
audit services- statutory audit	74	68
other auditor remuneration (external auditor only)	1	10
Internal audit costs	86	91
Clinical negligence	664	573
Legal fees	260	248
Insurance	38	39
Education and training	683	1,224
Rentals under operating leases	6,647	7,843
Redundancy *	(449)	498
Car parking & security **	(31)	43
Hospitality	6	9
Losses, ex gratia & special payments	5	2
Other	1,173	846
Total	**190,470**	**184,633**
Of which:		
Related to continuing operations	190,470	184,633
Related to discontinued operations	-	-

* Negative redundancy costs of £449k is represented by prior year provision no longer required
** Negative car parking & security cost of £31k is represented by prior year accrual in relation to keep safe security disputed cost of £39k no longer required.

Included in the analysis above are costs of £282,991 which the Trust incurred in response to the COVID 19 pandemic during 2019/20. These costs will be fully reimbursed by NHS England and Improvement in 2020/21 and the Trust received confirmation of this reimbursement in April 2020. The Trust has recognised the expenditure in its operating expenditure and recognised the income due the reimbursement in “Income from Patient Care Activities”.

DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

Note 6.2 Other auditor remuneration

	2019/20	2018/19
Other auditor remuneration paid to the external auditor:		
Other non-audit services not falling within items 2 to 7 above	1	10
Total	**1**	**10**

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2018/19: £1m).

Note 7 Impairment of assets

	2019/20	2018/19
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	97	-
Abandonment of assets in course of construction	792	-
Changes in market price	990	(706)
Total net impairments charged to operating surplus / deficit	**1,879**	**(706)**
Impairments charged to the revaluation reserve	197	741
Total net impairments	**2,076**	**35**

Following purchase of Belper Health Centre for development, the Derwent Street site development is abandoned. As the site is no longer in development and there is no clear plan to bring the asset back into use. This meant recognising an impairment of Derwent Street site development costs of £792k, excluding land cost.

During 2019/20, the Trust revalued its Buxton land and buildings. Specialised buildings were valued at depreciated replacement cost on a modern equivalent asset basis. 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 £973k in the Accounts, and £17k for other impairments.

DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

Note 8 Employee benefits

	2019/20 Total £000	2018/19 Total £000
Salaries and wages	102,677	101,965
Social security costs	8,945	8,745
Apprenticeship levy	518	515
Employer's contributions to NHS pensions	19,927	13,821
Pension cost - other	-	17
Other employment benefits	2,841	2,440
Termination benefits	(449)	498
Temporary staff (including agency)	1,937	875
Total gross staff costs	**136,396**	**128,876**
Recoveries in respect of seconded staff	-	-
Total staff costs	**136,396**	**128,876**
Of which		
Costs capitalised as part of assets	365	268
Operating expenses		
Staff and executive directors costs	136,480	128,110
Redundancy	(449)	498
Costs capitalised as part of assets	365	268
Total staff costs	136,396	128,876

The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Negative redundancy costs of £449k is represented by prior year provision no longer required.

Note 8.1 Retirements due to ill-health

During 2019/20 there were 3 early retirements from the trust agreed on the grounds of ill-health (5 in the year ended 31 March 2019). The estimated additional pension liabilities of these ill-health retirements is £100k (£461k in 2018/19).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

DERBSYHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

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 and Social Care 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 2020, is based on valuation data as at 31 March 2019, updated to 31 March 2020 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 to 20.6%, and the Scheme Regulations were amended accordingly.

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.

C) NEST pension

As of 1st April 2013 it became a statutory requirement to enrol all eligible staff into a workplace pension scheme. Where employees are not eligible to enrol in the NHS Pension scheme they are enrolled in the NEST Pension scheme as an alternative. The employee can choose to "opt-out" of the scheme after they have been auto-enrolled, this opt out last for three years after which time the Trust will be required to re-enrol the employee. The Trust is required to make employer contributions of 1% of the employee's qualifying salary to the NEST Pension scheme. For the period 1st April 2019 to 31st March 20120 the Trust has contributed £56,002 (2018/19: £16,715)

DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

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.

	2019/20 £000	2018/19 £000
Operating lease expense		
Minimum lease payments	6,647	7,843
Total	**6,647**	**7,843**

	31 March 2020 £000	31 March 2019 £000
Future minimum lease payments due:		
- not later than one year;	7,049	7,718
- later than one year and not later than five years;	24,376	23,960
- later than five years.	51,498	65,941
Total	**82,923**	**97,619**

The reduction in operating lease expense is mainly due to a substantial reduction in future annual lease payments to Community Health Partnership and NHS Property Services as a result of planned estate reconfigurations , and termination of all leases in relation to provision of dental services which the Trust will no longer provide from 1st April 2020.

DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2019/20	2018/19
	£000	£000
Interest on bank accounts	270	190
Total finance income	**270**	**190**

Note 12 Other gains / (losses)

	2019/20	2018/19
	£000	£000
Gains on disposal of assets	-	145
Losses on disposal of assets	(346)	(4)
Total gains / (losses) on disposal of assets	**(346)**	**141**
Total other gains / (losses)	**(346)**	**141**

Loss on disposal is mainly on IT equipments due to the roll out of Windows 10, making the equipments obsolete.

DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

Note 13 Intangible assets - 2019/20

	Software licences £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2019 - brought forward	**4,349**	**38**	**4,387**
Additions	-	466	**466**
Reclassifications	357	(357)	**-**
Valuation / gross cost at 31 March 2020	**4,706**	**147**	**4,853**
Amortisation at 1 April 2019 - brought forward	**2,467**	**-**	**2,467**
Provided during the year	575	-	**575**
Amortisation at 31 March 2020	**3,042**	**-**	**3,042**
Net book value at 31 March 2020	**1,664**	**147**	**1,811**
Net book value at 1 April 2019	**1,882**	**38**	**1,920**

Note 13.1 Intangible assets - 2018/19

	Software licences £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2018 - as previously stated	**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 - as previously stated	**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**

DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

Note 14.1 Property, plant and equipment - 2019/20

	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 2019 - brought forward	**12,030**	**60,283**	**2,449**	**4,426**	**17**	**6,707**	**1,296**	**87,208**
Transfers by absorption	-	-	125	-	-	-	-	**125**
Additions	-	-	6,251	-	-	-	-	**6,251**
Impairments	(1,050)	(258)	(792)	-	-	-	-	**(2,100)**
Revaluations	(27)	560	-	-	-	-	-	**533**
Reclassifications	-	1,593	(4,320)	623	-	2,104	-	**-**
Transfers to / from assets held for sale	(23)	-	-	-	-	-	-	**(23)**
Disposals / derecognition	-	-	-	(608)	-	(2,556)	(77)	**(3,241)**
Valuation/gross cost at 31 March 2020	**10,930**	**62,178**	**3,713**	**4,441**	**17**	**6,255**	**1,219**	**88,753**
Accumulated depreciation at 1 April 2019 - brought forward	**-**	**2,359**	**-**	**3,371**	**17**	**4,061**	**1,201**	**11,009**
Provided during the year	-	1,950	-	238	-	865	57	**3,110**
Impairments	-	(24)	-	-	-	-	-	**(24)**
Revaluations	-	74	-	-	-	-	-	**74**
Disposals / derecognition	-	-	-	(599)	-	(2,219)	(76)	**(2,894)**
Accumulated depreciation at 31 March 2020	**-**	**4,359**	**-**	**3,010**	**17**	**2,707**	**1,182**	**11,275**
Net book value at 31 March 2020	**10,930**	**57,819**	**3,713**	**1,431**	**-**	**3,548**	**37**	**77,478**
Net book value at 1 April 2019	**12,030**	**57,924**	**2,449**	**1,055**	**-**	**2,646**	**95**	**76,199**

Note 14.2 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 - as previously stated	**10,824**	**57,019**	**1,501**	**4,718**	**17**	**6,055**	**1,296**	**81,430**
Prior period adjustments	-	763	-	-	-	-	-	**763**
Valuation / gross cost at 1 April 2018 - restated	**10,824**	**57,782**	**1,501**	**4,718**	**17**	**6,055**	**1,296**	**82,193**
Additions	1,414	1,156	4,731	-	-	-	-	**7,301**
Impairments	-	(1,842)	-	-	-	-	-	**(1,842)**
Reversals 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**	**60,283**	**2,449**	**4,426**	**17**	**6,707**	**1,296**	**87,208**
Accumulated depreciation at 1 April 2018 - as previously stated	**-**	**211**	**-**	**3,954**	**17**	**3,382**	**1,129**	**8,693**
Prior period adjustments	-	763	-	-	-	-	-	**763**
Accumulated depreciation at 1 April 2018 - restated	**-**	**974**	**-**	**3,954**	**17**	**3,382**	**1,129**	**9,456**
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	**-**	**2,359**	**-**	**3,371**	**17**	**4,061**	**1,201**	**11,009**
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**

DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

Note 14.3 Property, plant and equipment financing - 2019/20

	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 2020								
Owned - purchased	10,930	54,492	3,713	1,303	-	3,548	37	**74,023**
Owned - donated	-	3,327	-	128	-	-	-	**3,455**
NBV total at 31 March 2020	**10,930**	**57,819**	**3,713**	**1,431**	**-**	**3,548**	**37**	**77,478**

Note 14.4 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**

DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

Note 15 Donations of property, plant and equipment

The Trust did not receive any donated assets during the financial years 2019/20 and 2018/19.

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.

	Total	Land	Buildings excluding dwellings
	£000	£000	£000
Gross	686	(27)	713
Depreciation	(43)	-	(43)
Net Revaluation	643	(27)	670

Economic Lives of Plant, Property, Equipment and Intangible Assets

	Minimum (years)	Maximum (years)
Software Licences	5	10
Licences and Trademarks	5	10
Buildings excl. Dwellings	16	52
Plant and Machinery	5	15
Transport Equipment	7	7
Information Technology	5	8
Furniture and Fittings	5	10

DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

Note 17 Receivables

	31 March 2020 £000	31 March 2019 £000
Current		
Contract receivables	7,744	10,112
Capital receivables	-	109
Allowance for impaired contract receivables / assets	(153)	(141)
Prepayments (non-PFI)	747	763
PDC dividend receivable	134	127
VAT receivable	3	37
Other receivables	-	37
Total current receivables	**8,475**	**11,044**
Non-current		
Contract receivables	251	218
Allowance for other impaired receivables	(60)	(48)
Total non-current receivables	**191**	**170**
Of which receivable from NHS and DHSC group bodies:		
Current	4,398	7,402

*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.

DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

Note 17.1 Allowances for credit losses

	2019/20		2018/19	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**189**	**-**	**-**	**185**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018			185	(185)
New allowances arising	19	-	8	-
Changes in existing allowances	6	-	2	-
Reversals of allowances	(1)	-	-	-
Utilisation of allowances (write offs)	-	-	(6)	-
Allowances as at 31 Mar 2020	**213**	**-**	**189**	**-**

Note 17.2 Exposure to credit risk

	31 March 2020	31 March 2019
	Trade and other receivables	Trade and other receivables
	£000	£000
Ageing of impaired financial assets		
0 - 30 days	4	1
30-60 Days	3	1
60-90 days		-
90- 180 days	24	11
Over 180 days	67	57
Total	**98**	**70**
Ageing of non-impaired financial assets past their due date		
0 - 30 days	3,055	5,542
30-60 Days	557	143
60-90 days	828	32
90- 180 days	78	25
Over 180 days	132	71
Total	**4,650**	**5,813**

DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

Note 18 Non-current assets held for sale and assets in disposal groups

	2019/20	2018/19
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	-	-
Assets classified as available for sale in the year	23	375
Assets sold in year	(23)	(375)
NBV of non-current assets for sale and assets in disposal groups at 31 March	-	-

DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

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.

	2019/20	2018/19
	£000	£000
At 1 April	**30,799**	**26,619**
Net change in year	4,355	4,180
At 31 March	**35,154**	**30,799**
Broken down into:		
Cash at commercial banks and in hand	4	5
Cash with the Government Banking Service	35,150	30,794
Total cash and cash equivalents as in SoFP	**35,154**	**30,799**
Total cash and cash equivalents as in SoCF	**35,154**	**30,799**

Note 19.2 Third party assets held by the trust

Derbyshire Community Health Services NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2020	31 March 2019
	£000	£000
Bank balances	5	5
Total third party assets	**5**	**5**

DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

Note 20 Trade and other payables

	31 March 2020 £000	31 March 2019 £000
Current		
Trade payables	4,508	5,711
Capital payables	718	1,306
Accruals	4,129	3,796
Social security costs	1,422	1,387
Other taxes payable	929	757
Other payables	3,643	2,687
Total current trade and other payables	**15,349**	**15,644**
Of which payables from NHS and DHSC group bodies:		
Current	2,818	3,677
Non-current	-	-

DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

Note 21 Other liabilities

	31 March 2020 £000	31 March 2019 £000
Current		
Deferred income: contract liabilities	168	154
Total other current liabilities	**168**	**154**

DERBYSHIRE COMMUNITY HEALTH SERVICES FOUNDATION TRUST

Note 22.1 Provisions for liabilities and charges analysis

	Legal claims	Re-structuring	Other	Total
	£000	£000	£000	£000
At 1 April 2019	**74**	**1,054**	**420**	**1,548**
Arising during the year	**29**	**115**	**400**	**544**
Utilised during the year	(23)	(491)	-	**(514)**
Reversed unused	**-**	**(564)**	**-**	**(564)**
At 31 March 2020	**80**	**114**	**820**	**1,014**
Expected timing of cash flows:				
- not later than one year;	50	114	**820**	**984**
- later than one year and not later than five years;	30	-	**-**	**30**
Total	**80**	**114**	**820**	**1,014**

The restructuring provision relates to costs incurred from undertaking a Mutually Agreed Resignation Scheme (MARS) to drive further efficiencies in non-clinical facing services, and a provision for redundancy costs from loss of a contract.

The other provision relates to the potential cost to the Trust of a national legal case and the potential cost in relation to tax for self-employed consultants.

The legal provision relates to the Trust liability for 8 cases currently with the NHS Litigation Authority

Note 22.2 Clinical negligence liabilities

At 31 March 2020, £2,410k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Derbyshire Community Health Services NHS Foundation Trust (31 March 2019: £472k).

Note 23 Contractual capital commitment

	31 March 2020	31 March 2019
	£000	£000
Property, plant and equipment	**-**	**-**
Intangible assets	**-**	**-**
Total	**-**	**-**

DERBSYHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

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 it's 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 20120 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.

DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

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.

Carrying values of financial assets as at 31 March 2020	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	7,779	-	-	**7,779**
Cash and cash equivalents	35,154	-	-	**35,154**
Total at 31 March 2020	**42,933**	**-**	**-**	**42,933**

Carrying values of financial assets as at 31 March 2019	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	10,178	-	-	**10,178**
Cash and cash equivalents	30,799	-	-	**30,799**
Total at 31 March 2019	**40,977**	**-**	**-**	**40,977**

Note 24.3 Carrying values 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.

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Trade and other payables excluding non financial liabilities	11,234	-	**11,234**
Provisions under contract	194	-	**194**
Total at 31 March 2020	**11,428**	**-**	**11,428**

Carrying values of financial liabilities as at 31 March 2019	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Trade and other payables excluding non financial liabilities	12,655	-	**12,655**
Provisions under contract	1,128	-	**1,128**
Total at 31 March 2019	**13,783**	**-**	**13,783**

Note 24.4 Maturity of financial liabilities

	2020	2019
	£000	£000
In one year or less	11,398	13,783
In more than one year but not more than two years	30	-
Total	**11,428**	**13,783**

DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

Note 25 Losses and special payments

	2019/20		2018/19	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	3	1	3	-
Bad debts and claims abandoned	54	3	55	6
Total losses	**57**	**4**	**58**	**6**
Special payments				
Ex-gratia payments	3	1	4	2
Total special payments	**3**	**1**	**4**	**2**
Total losses and special payments	**60**	**5**	**62**	**8**
Compensation payments received		-		-

DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

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

Dr Emma Pizzey is the CCG Partner Governor on the DCHS Board of governors. She declared that she is the GP Governing Body member of Erewash Clinical Commissioning Group. Transactions are in the normal course of business and are on an arms-length basis. Transactions with this NHS body are disclosed under 'Transactions with Other Related Parties'

Stuart Swan declared that he is a South Derbyshire District Councillor for Church Greasley Ward and County Councillor for Swadlincote South Division. He is also a Derbyshire County Council's Cabinet Support Member for Health and Communities. Transactions are in the normal course of business and are on an arms-length basis. Transactions with this local government body are disclosed under 'Transactions with Other Related Parties'.

Transactions with Board Members

Prem Singh declared that his partner is employed as Chief Executive of Rotherham, Doncaster and South Humberside NHS Foundation Trust. She has no direct commissioning responsibility for 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 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'.

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'.
William Jones chief Operating Officer declared that he is a director of Lift Co South Derbyshire. Transactions are in the normal course of business and are on an arms-length basis.

Transactions with Other Related Parties

The Department of Health and Social Care is regarded as a related party. During the year to 31 March 2020 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.

DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST

Note 27 Related parties (continued)

	Receivables		Payables	
Receivables/payables over £250k	**2019/20**	**2018/19**	**2019/20**	**2018/19**
	£000	**£000**	**£000**	**£000**
Chesterfield Royal Hospital NHS Foundation Trust	314	128	319	297
University Hospitals of Derby & Burton NHS Foundation Trust	1,538	2,219	435	1,191
Derbyshire Healthcare NHS Foundation Trust	-	145	435	468
NHS England	762	955	-	-
NHS England - North Midlands	389	634	-	-
NHS Derbyshire CCG	853	-	60	-
NHS North Derbyshire CCG	-	272	-	52
NHS Southern Derbyshire CCG	-	636	-	103
Community Health Partnership	137	48	154	52
NHS Property Services	26	1	817	1,166
NHS Arden & GEM CSU	10	13	432	223
Derbyshire County Council	2,502	1,935	63	414
Total	**6,531**	**6,986**	**2,715**	**3,966**

	Income		Expenditure	
Income/expenditure over £1m	**2019/20**	**2018/19**	**2019/20**	**2018/19**
	£000	**£000**	**£000**	**£000**
NHS England	3,525	2,360	-	-
NHS England - North Midlands	7,196	6,821		-
NHS Derbyshire CCG	142,180	-	374	-
NHS North Derbyshire CCG	-	53,339	-	252
NHS Southern Derbyshire CCG	-	54,595	-	271
NHS Hardwick CCG	-	18,232	-	79
NHS Erewash CCG	-	17,572	-	177
Derbyshire County Council	19,119	19,286	297	308
Derby City Council	2,277	2,300	29	56
University Hospitals of Derby & Burton NHS Foundation Trust	3,019	2,316	4,110	4,597
Derbyshire Healthcare NHS Foundation Trust	2,943	2,693	809	1,860
Chesterfield Royal Hospital NHS Foundation Trust	838	744	1,636	1,888
Community Health Partnership	663	481	6,390	6,362
NHS Property Services	-	-	1,616	2,577
Health Education England	1,265	1,682	-	4
Department of Health		2,093		-
NHS Arden & GEM CSU	158	147	1,729	1,709
NHS Business Services Authority		294		1,020
	183,183	184,956	16,990	21,161

Note 28 Transfers by absorption

The Trust is the recipient in the transfer of a funding of £125k at 31 March 2020 in relation HSLI Community Field Force Management, it recognises the asset received as at the date of transfer. The corresponding credit reflecting the gain is recognised within income, but outside of operating activities.

Note 29 Post Balance Sheet Events - non adjusting

The implications of the global COVID-19 pandemic began to emerge in the final weeks of March 2020, therefore there was a limited impact in the financial year 2019/20. Any costs incurred by the Trust were subsequently reimbursed to the Trust in April 2020. In response to the pandemic, significant changes to the way NHS providers are funded have been introduced for an initial period of April to July 2020. These changes provide certainty over income streams and provide cash-flow to support operational activities and to enable prompt payment to suppliers. Operational planning has been suspended in 2020/21 and it is expected that some form of block funding arrangement will remain in place for the remainder of 2020/21. At this stage it is not possible to quantify the financial implications of the pandemic in 2020/21 on the Trust , but the expectation is that any reasonable capital and revenue costs incurred will continue to be reimbursed.